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Why Do Some Critical Access Hospitals Close Their Skilled Nursing Facility Services While Others Retain Them?

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Overview

Critical Access Hospitals (CAHs) have long played an important role in the provision of Skilled Nursing Facilities (SNF), swing bed, and other long term care (LTC) in rural communities and are more likely than other rural and urban hospitals to offer these services (Race, et al, 2011). The implementation of the Medicare SNF prospective payment system (PPS) in 1998 and subsequent exemption of CAH-based swing bed services from the SNF PPS in July, 2002 created financial incentives from CAHs to close their SNF units in favor of providing skilled level care using swing beds (AHA, 2012). During the period 2004 through 2007, 42 CAHs closed their SNF units. Despite the changing financial incentives related to the operation of SNF units by CAHs, 42% of CAHs (456) in 2010 continued to operate SNF units. Little is known about the reasons CAHs decide to close or retain their LTC services. This policy brief addresses this gap by examining the factors related to operation of skilled nursing services by CAHs, and specifically the factors related to closure of skilled nursing units by some CAHs and the continued provision of these services by others.

Background: The Role of Skilled Nursing Facilities and Swing Beds in Managing Inpatient Lengths of Stay

SNF units allow CAHs and other hospitals to manage inpatient acute care lengths of stay by providing an option to care for patients needing short-term 24 hour per day skilled nursing care and rehabilitation services for recovery from knee and hip replacements, stroke, pneumonia, strokes, or other conditions (MedPAC, 2012). The swing bed program allows rural hospitals to use empty hospital beds interchangeably as either acute care or skilled nursing facility beds based on hospital census levels and patient needs. Medicare's eligibility and coverage policies are the same for skilled nursing care provided in either a SNF or swing bed (MedPAC, 2008). For practical purposes, the differences between services provided in either type bed should be imperceptible to the patient. For CAHs, the primary differences are financial (i.e., swing beds in a CAH are reimbursed on a cost basis) and administrative (i.e., how the services are billed and the fact that swing beds in a CAH are

Key Findings

- Critical Access Hospitals (CAHs) that closed Skilled Nursing Facility (SNF) units cited a range of financial challenges related to payer mix, operating costs, cost allocation methods, and service utilization patterns.
- The availability of alternative local long term care services, including swing beds, often contributed to hospitals' decisions to close their SNF units.
- CAHs that continued to operate SNF units were driven primarily by community need, despite the financial disincentive for doing so.
- Hospitals reported substantial variation in their strategies for using swing beds for SNF, rehabilitation, and post-acute services.
- Given ongoing concerns about financial viability and low census rates among some CAHs, further research on the ability of CAHs to expand patient services and revenues through swing bed use is warranted.
- Additional research on the quality and outcomes of skilled care delivered by CAHs in SNF and swing beds is also recommended.

For more information about this study, please contact John Gale at jgale@usm.maine.edu

exempt from CMS's Minimum Data Set reporting requirements) (Trailblazers Health Enterprises, 2011; Idaho State Office of Rural Health and Primary Care, 2007).

Flex Monitoring Team SNF Study

To understand the reasons supporting CAH decisions to either close or maintain their SNF services, we identified a sample of CAHs that had closed their SNF units as well as a sample that continued to operate these services during the period 2004 through 2007 using Medicare hospital cost reports. We completed telephone interviews with key respondents from 20 CAHs operating in eleven states, including 11 hospitals that had closed their SNF units and 9 that continued to operate their services using semi-structured qualitative interview protocols.¹ The following highlights our study findings.

SNF Closure Findings

Factors Influencing SNF Closure: Study hospitals' decisions to close their SNF units focused primarily on the poor financial performance of these units due to:

- Low SNF reimbursement rates from Medicare and, in many cases, Medicaid;
- Higher operating costs due to greater staffing levels, assumption of hospital overhead, increased diagnostic, therapy, and pharmaceutical use, higher patient acuity, and longer lengths of stay;
- The negative impact on acute care reimbursement rates due to the need to allocate facility and overhead costs away from acute care services to the PPS-reimbursed SNF beds; and
- The ability to substitute cost-based swing beds for PPS-based SNF beds.

CAHs reported few difficulties accessing SNF and other LTC services following closure, particularly for lower complexity patients due to the availability of alternative local services. Similarly, respondents reported relatively little negative response from the community regarding their decisions to close their units. Following closure, respondents reported using swing beds as a substitute for SNF beds; for the provision of rehabilitative services following an inpatient stay; for complex patients requiring intravenous antibiotics or other therapies; and for

patients requiring shorter stay courses of care prior to being discharged to a nursing facility or their homes. Given participants' reported SNF census levels prior to closure and acute care census levels at less than full capacity, it seems surprising that respondents did not report higher swing bed utilization. This may present an opportunity to improve hospital revenues by using unused bed capacity to provide needed SNF and LTC services.

Continued SNF Operation Findings

Community need was the most common reason offered for the continued operation of a SNF unit, notwithstanding the financial disincentives for providing SNF services. Most hospitals provided services in dually certified bed and were able to provide LTC services to a range of Medicare, Medicaid, and private pay patients. Four of the nine respondents noted that their hospitals were the primary source of SNF and other LTC services in the community with the next closest SNF provider typically located 15 or more miles away.

Respondents described their SNF/intermediate level services as important components of their hospital's continuum of care which typically included SNF, intermediate, swing bed, and custodial/residential services. Most described the use of swing beds for complex post-acute care patients requiring therapy, rehabilitative services, or intravenous medications, with the SNF and intermediate beds used for less complex patients.

Challenges to the Continued Operation of SNF Services:

- Low reimbursement rates, particularly from Medicaid, were identified as a major barrier to the continued operation of SNF/LTC services by study participants. Despite this, few respondents reported that their hospital's leadership was considering closing the service.
- The difficulty of recruiting and retaining appropriately trained staff was identified as another ongoing challenge, as was the burden imposed by regulatory requirements, such as the need for additional certification surveys for the SNF/LTC services.
- The expense of maintaining and upgrading the facilities to meet patient and family expectations

¹The eleven states included: Iowa, Indiana, Illinois, Kentucky, Maine, Minnesota, Montana, North Carolina, Oregon, Washington, and Wisconsin.

were noted by two respondents as an ongoing challenge, particularly regarding the desire for private rather than shared rooms.

- Difficulties serving certain types of patients including those with mental health, dementia, and other cognitive problems were noted by a number of respondents. These included “difficult” patients who had trouble getting along with their roommates; violent or aggressive patients; and patients with more complex needs such as those on ventilators. These types of patients often require placement in facilities in larger cities that are distant from the hospital.
- Waiting lists or an inability to accept routine patients due to census levels were reported by only a few respondents, and these tended to be episodic occurrences. When occupancy problems arise, the hospitals referred patients to other local LTC services or, less commonly, to facilities in more distance communities.

Conclusions

CAHs are an important, and sometimes the only, source of SNF and other LTC services in rural communities. However, the closure of hospital-based SNF units does not seem to have had a significant negative impact on access to needed SNF and LTC services, as swing beds and alternative community service providers appear to have filled the gap.

Areas for Further Study

One of the more interesting findings in this study is the variation in the use of swing beds across the study hospitals for SNF, rehab, and post-acute services. Although this is a very limited look at the SNF activities of a small subset of CAHs in 11 states, the findings suggest that further study is warranted to more fully understand the role of swing beds in rural systems of care, and whether or not a more consistent approach to the use of swing beds represents an opportunity for CAHs to improve their service capacity and ability to generate patient care revenues. Given the ongoing concerns about financial viability and low census rates among some CAHs, an exploration of the ability of CAHs to expand patient services and revenues by meeting community needs through consistent swing bed use seems particularly timely.

It is also interesting and important that CAHs that continue to operate SNF and other LTC services

commonly report that the services are not profitable. This suggests the need for further study to better understand the reasons for this lack of profitability and to identify opportunities to enhance the financial performance of these important rural services.

One additional area that warrants further study is the quality of care provided in CAH-based SNF units and swing beds. We were unable to find any current studies describing the quality of SNF and other long term care services in CAHs. Given the important role of CAHs in providing SNF and other long term care services in rural communities, further study is needed to understand the quality of care provided and any potential differences in quality and health outcomes for care provided in SNF and swing beds.

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