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Findings Brief
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The Financial Importance of Medicare Post-Acute and Hospice Care to Rural Hospitals

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INTRODUCTION

The provision of post-acute (PAC) and hospice care by rural hospitals allows patients to receive such care locally, avoiding unnecessary travel and staying close to family and friends. Typically, rural residents discharged from an acute care facility receive PAC either locally or in the urban center where acute care was provided. Rural residents requiring inpatient hospice care are admitted either from a facility or home setting. For this study, PAC and hospice care provided by rural hospitals are defined as the following services:

- Swing beds – Transitional care beds that allow a patient to be discharged from an acute hospital stay, but remain in the hospital for skilled after-care. Swing bed services are provided by Critical Access Hospitals (CAHs) and Prospective Payment System (PPS) hospitals that are located in rural areas and have fewer than 100 beds; however, the majority of swing bed services are provided in CAHs
- Skilled Nursing Facility (SNF) – Facilities that provide short-term skilled nursing and rehabilitation services
- Home Health (HH) – Beneficiaries can receive skilled nursing, physical therapy, occupational therapy, speech therapy, aide services, and/or medical social work in their homes
- Hospice – Patients with a terminal diagnosis can receive these services, which are meant to provide pain relief, comfort, and emotional and spiritual support
- Inpatient Rehabilitation Facility (IRF) – Facilities that provide intensive rehabilitation services to patients after an illness, injury, or surgery

The Centers for Medicare & Medicaid Services (CMS) pays rural hospitals for PAC and hospice care provided to Medicare beneficiaries using a variety of prospective payment (PPS hospitals) and cost-based reimbursement methods (CAHs). However, CMS is implementing several new payment models focused on value-based care and bundled payments that aim to improve quality and reduce costs of both acute and PAC. Accountable Care Organizations (ACOs) continue to scrutinize the quality and costs of participating providers. Finally, the Medicare Payment Advisory Commission recently recommended moving to a unified post-acute care provider PPS across skilled nursing facilities, home health agencies, inpatient rehabilitation facilities and long-term care hospitals. The commission recommends the payments under the new system be based on patient characteristics rather than site of service.[1] These changes will increasingly affect Medicare reimbursement of rural hospitals if the number of rural PAC and hospice care providers included in ACO and bundled payment contracts drops, or if more rural residents choose to receive PAC and hospice care in urban centers rather than closer to home.

KEY FINDINGS

- Almost all CAHs reported Medicare revenue for swing bed services.
- Among rural hospitals paid under PPS, about a third reported Medicare revenue for swing bed and home health services.
- The number of CAHs and PPS hospitals that reported Medicare revenue for PAC and hospice care declined between 2012 and 2015 (except for swing bed services in CAHs).
- The largest mean amount of Medicare revenue was for swing bed services in CAHs and for inpatient rehabilitation facility (IRF) services in rural PPS hospitals.
- In total, Medicare PAC and hospice revenue as a percentage of net patient revenue was much higher for CAHs than for rural PPS hospitals.

Access to and quality of PAC provided by rural hospitals has been studied previously,[2,3,4] but the importance of PAC and hospice care as a source of revenue to rural hospitals has not received as much attention. The purpose of this brief is to describe Medicare post-acute and hospice care provided by rural hospitals (or in rural areas) by characterizing 1) the variation in the number of rural hospitals that provide PAC and hospice care, 2) the average amount of Medicare revenue rural hospitals receive for these services, and 3) the financial importance of PAC and hospice care services to rural hospitals.

How Many Rural Hospitals Provided PAC and Hospice Care?

Table 1 shows that the number of rural hospitals that reported Medicare revenue for each type of post-acute and hospice care decreased between 2012 and 2015 (except for swing bed services at CAHs). Over 90 percent of CAHs provided swing bed services, and the number increased slightly over the study period. A much smaller number of CAHs provided SNF, HH, and hospice services, and very few offered IRF services. Among rural PPS hospitals, the most common types of post-acute care were HH and swing bed services. PPS hospitals were much more likely than CAHs to report no post-acute or hospice care.

Table 1: Number of Rural Hospital Medicare Cost Reports (MCRs)

	MCRs with Medicare PAC and Hospice Revenue > $0					MCRs with Medicare PAC and Hospice Revenue = $0	Total Number of MCRs
	Swing	SNF	HH	Hospice	IRF		
	Critical Access Hospitals (CAHs)						
2012	1,123	186	302	141	4	53	1,203
2013	1,124	171	291	127	3	51	1,196
2014	1,127	166	279	134	3	49	1,195
2015	1,133	167	261	131	4	52	1,205
	Prospective Payment System (PPS) Hospitals						
2012	349	236	371	172	170	266	1,013
2013	337	225	366	171	167	270	991
2014	327	213	345	165	165	279	981
2015	314	193	327	156	156	294	964

How Much Medicare Revenue Did Rural Hospitals Receive for PAC and Hospice Care?

Table 2 shows that the mean Medicare dollar amount received by rural hospitals varies widely across hospital classification, type of care, and year. Among CAHs, the largest amount was for swing bed services ($1,268,795 in 2016). The mean Medicare revenue to CAHs was higher in 2016 than 2012 for swing bed and hospice services, and lower for SNF, HH, and IRF services. Among rural PPS hospitals in 2016, the largest amount was for IRF services ($467,477). The 2016 Medicare revenue to rural PPS hospitals was higher than 2012 revenue for hospice and IRF services and lower for swing bed, SNF and HH services.

Table 2: Mean Medicare Revenue for PAC and Hospice Care Provided by Rural Hospitals

	Swing	SNF	HH	Hospice	IRF
	Critical Access Hospitals (CAHs)				
2012	$1,054,250	$56,027	$103,309	$62,388	$4,731
2013	$1,113,702	$49,170	$97,985	$61,798	$6,031
2014	$1,195,224	$46,820	$94,129	$68,341	$5,286
2015	$1,276,383	$43,728	$92,201	$66,370	$7,330
2016*	$1,268,795	$45,542	$81,678	$70,357	$2,677
	Prospective Payment System (PPS) Hospitals				
2012	$58,997	$266,193	$405,853	$220,164	$451,278
2013	$60,667	$256,431	$407,364	$229,959	$456,418
2014	$62,135	$241,284	$389,899	$225,291	$468,651
2015	$62,111	$225,930	$376,271	$230,991	$494,725
2016*	$45,838	$229,517	$375,019	$248,299	$467,477

* 2016 means based on 1,607 MCRs available at time of study

How Important Were Medicare PAC and Hospice Care Revenue to Rural Hospitals?

Figures 1 and 2 show 2015 Medicare PAC and hospice care revenue as a percentage of net patient revenue for 1,205 CAHs and 964 rural PPS hospitals, respectively. Among CAHs, the mean Medicare PAC and hospice care revenue was 10 percent, and the range was zero to 63 percent. For 140 CAHs, Medicare PAC and hospice care revenue was greater than 20 percent of net patient revenue, while 54 CAHs had no Medicare PAC and hospice care revenue. Among rural PPS hospitals, the mean Medicare PAC and hospice care revenue was two percent, and the range was zero to 30 percent. Medicare PAC and hospice care revenue was greater than 20 percent of net patient revenue for only two rural PPS hospitals, and zero for 295 PPS hospitals.

Figure 1. 2015 Medicare PAC and Hospice Care Revenue as a Percentage of Net Patient Revenue

1,205 Critical Access Hospitals

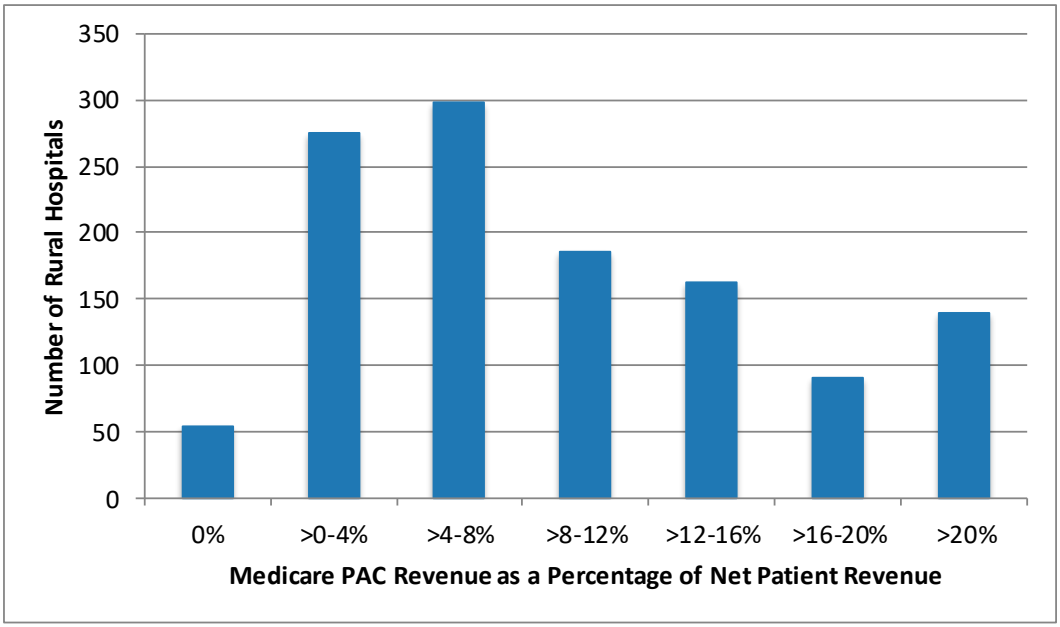
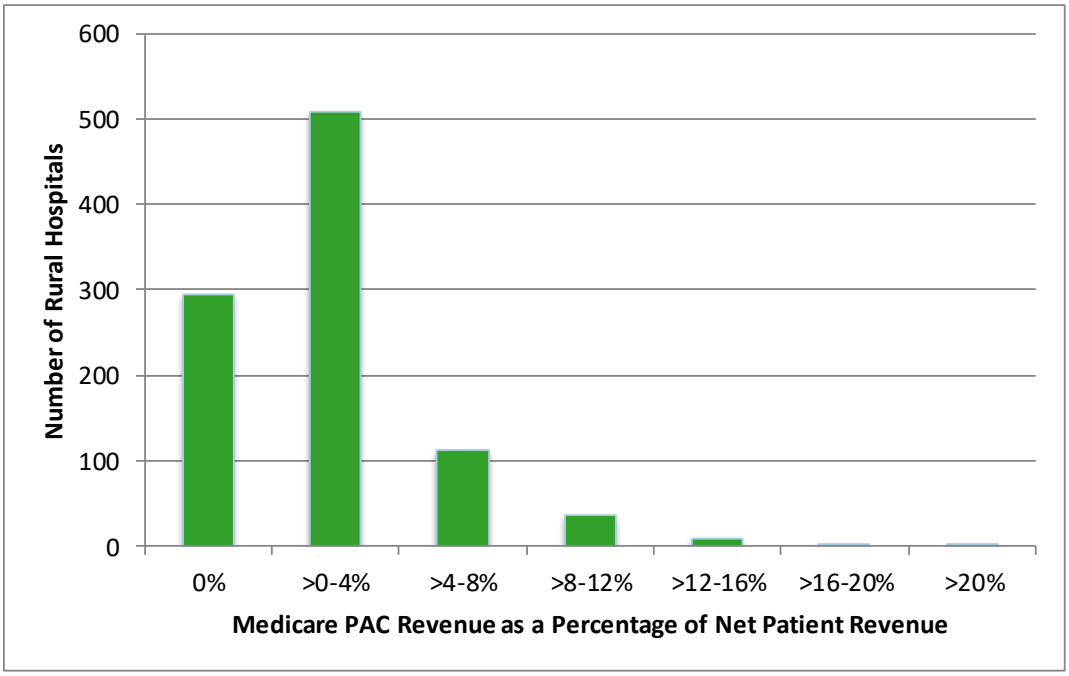


Figure 2: 2015 Medicare PAC and Hospice Care Revenue as a Percentage of Net Patient Revenue

964 PPS Rural Hospitals



CONCLUSION

This study examined the financial importance of Medicare PAC and hospice care to CAHs and rural PPS hospitals. The main findings are:

- Almost all CAHs reported Medicare revenue for swing bed services. Fewer than 25 percent of CAHs reported revenue for HH, SNF, and hospice services, and almost none reported revenue for IRF services.
- Among rural PPS hospitals, about one-third reported Medicare revenue for swing bed and HH services. About 20 percent reported revenue for SNF, and about 16 percent reported for hospice and IRF services.
- The number of CAHs and PPS hospitals that reported Medicare revenue for PAC and hospice care declined between 2012 and 2015 (except for swing bed services in CAHs).
- The largest mean amount of Medicare revenue was for swing bed services in CAHs and for IRF services in rural PPS hospitals.
- In total, Medicare PAC and hospice care revenue as a percentage of net patient revenue was much higher for CAHs than for PPS hospitals.

This findings brief examines Medicare PAC and hospice care by characterizing 1) the variation in the number of rural hospitals that provide PAC and hospice care, 2) the average amount of Medicare revenue received for these services, and 3) the financial importance of PAC and hospice care services to rural hospitals. Previous studies have explored the reasons for these variations and found that the availability of post-acute skilled care varies by rural county size.[5] Another study found that CAHs reported a wider range of health problems among their swing bed patients than PPS hospitals reported, and "medically complex" patients were more likely to be cared for in their swing beds than in their local SNFs. The study also noted that some hospitals operate a SNF in addition to swing beds, as well as mentioning some of the challenges hospitals face maintaining PAC services (e.g., staffing and availability of other care in the community).[6]

Adding to previous research, the description of PAC and hospice care provided in this brief is meant to help highlight the potential impact a change in reimbursement might have on rural hospitals and their communities. If the number of rural providers of PAC and hospice care included in ACO and bundled payment contracts drops, or if more rural residents choose (or are required) to receive PAC and hospice care in urban centers rather than closer to home, then this could have serious financial consequences for many rural hospitals. Cessation of PAC and hospice care services by rural providers could also reduce access by rural residents who would have no choice but to receive such care farther from home. For some rural hospitals, reduction in Medicare PAC and hospice care revenue could be sufficient to result in the closure of the hospital with even greater consequences for access to care. To avoid reducing access, it is important for policy makers and rural health advocates to understand and monitor the effect of changes in Medicare PAC and hospice care reimbursement on the financial performance and condition of rural hospitals.

METHOD

Data were obtained from Medicare cost reports for years 2012-2016. Hospitals were identified as rural using the definition from the Federal Office of Rural Health Policy. Any Medicare Cost Reports with fewer than 360 days in the reporting period (a total of 400 observations) were dropped due to unreliable values. After omitting the submissions with fewer than 360 days, at the time of the study, only 1,607 rural hospitals had submitted 2016 cost reports (compared to a total of 2,169 in 2015), so the number of hospitals is not reported in Table 1; however, the number of hospitals was considered sufficiently large for calculation of the 2016 means in Table 2.

REFERENCES AND NOTES

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