Trends over Time in the Provision of Skilled Nursing Care in Critical Access Hospitals

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EXECUTIVE SUMMARY

This study examines trends in the delivery of skilled nursing facility (SNF) services in both hospital-based units and swing beds during a period of dramatic change in Medicare payments for post-acute care, focusing on critical access hospitals (CAHs). In Prospective Payment System (PPS) hospitals swing bed skilled nursing care is now reimbursed under SNF-PPS, but CAHs continue to receive cost-based reimbursement. CAHs do not receive cost-based reimbursement for SNF services delivered in a dedicated hospital-based SNF unit; these are paid under the SNF-PPS rules for PPS and CAH facilities alike. However, the financial incentives for operating a SNF unit are very different for CAHs than they are for PPS hospitals because of the potential impact on overhead allocations.

We examined whether CAHs differed from other hospitals with respect to long-term care participation between 1997 and 2004. We found:

- The number of hospital-based facilities declined, but the largest absolute and proportional reductions were found in urban rather than rural areas. When comparing rural hospitals that had converted to CAH status by June 2004 to those that remained under PPS, CAHs were *less* likely to have divested themselves of hospital-based SNF units.
- An increasing number of rural hospitals used swing beds. Most of the increase came from CAHs: Swing bed participation in this group rose from 83% in 1996 to 95% by 2003, while it remained around 40% for all other eligible facilities.[1]
- From 1997 through 2003 the trend in intensity of use of swing beds in CAHs, as measured by average daily swing bed census, was similar to that in other hospitals.
- Total Medicare SNF days grew by about 2.5% per year over this period, despite the decline in the number of hospital-based facilities. While the total number of swing bed days also increased, swing bed care declined as a share of all hospital-related SNF days. Increases in total Medicare days appear to have been absorbed by the freestanding facilities.

[1] Eligible hospitals are those licensed for 100 or fewer routine care beds and are located in nonmetropolitan counties or in non-urbanized areas within an MSA.

BACKGROUND

Skilled nursing facility (SNF) services can be delivered in freestanding nursing homes, in separately certified hospital-based units, or in hospital swing beds, which are routine care beds in certain qualifying rural hospitals that can be used for either acute or long-term care. Most SNF admissions are covered by Medicare. A number of regulatory changes occurred between 1998 and 2002 that resulted in CAHs receiving full cost-based reimbursement for swing bed SNF care, while all other SNF care (including that provided by CAHs in a separate skilled nursing unit) is now reimbursed under SNF-PPS (Table 1)[2].

Table 1: Medicare payment changes for acute and long-term care

Type of Facility	Level of Care	1996	1997	1998	1999	2000	2001	2002	2003	2004
PPS Hospitals	Acute care	IP-PPS			IP-PPS w/ expanded transfer policies					
	Swing beds	cost-based ancillary; per-diem routine							full SNF-PPS	
	SNF units	cost-based			SNF-PPS phase-in				full SNF-PPS	
CAHs	Acute care	IP-PPS			cost-based					
	Swing beds	cost-based ancillary; per-diem routine						full cost-based		
	SNF units	cost-based			SNF-PPS phase-in				full SNF-PPS	
Freestanding SNFs	SNF units	cost-based			SNF-PPS phase-in				full SNF-PPS	

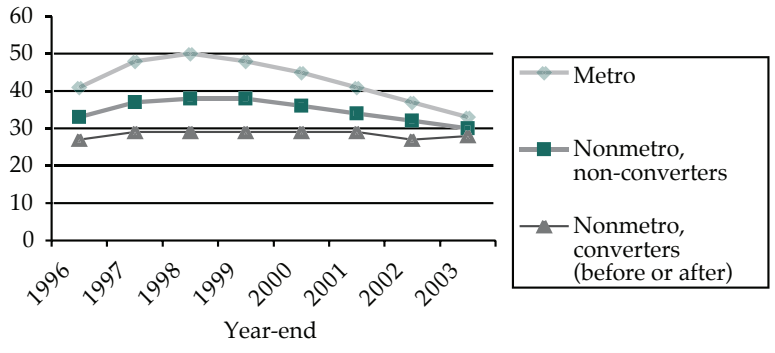
These payment changes have the potential to alter the strategic and financial incentives for hospitals to participate in long-term care, and financial incentives for operating a SNF unit are very different for CAHs than they are for PPS hospitals. This Findings Brief reports on how CAHs differ from other hospitals with respect to long-term care participation, and whether they have responded differently than other rural hospitals to the introduction of SNF-PPS.

RESULTS

Hospital-based SNF units

The number of hospital-based facilities declined over the period studied (Figure 1). The largest proportional reductions were in urban areas, where there was a 43% decline from the last full year before the implementation of SNF-PPS. When comparing two groups of rural hospitals, i.e., those that converted to CAH status some time prior to June 2004 and those that have remained under PPS, CAHs were *less* likely than other nonmetropolitan hospitals to divest themselves of hospital-based SNF units, despite the cost accounting advantages to

Figure 1: Percent of hospitals that operate Medicare-certified SNF units, 1996-2003



Data aggregated by calendar year-end.
Source: CMS HCRIS files released June 2004.

[2] For a more thorough description of the regulatory changes that occurred during this period, refer to *Trends in Skilled Nursing and Swing Bed Use in Rural Areas, 1996-2003*, http://www.shepscenter.unc.edu/research_programs/rural_program/

eliminating non-cost reimbursed patient care areas. From the beginning of the downward trend in hospital-based SNF care (1998), 12% of those located in CAH converting hospitals were closed by the end of 2004, compared to 26% of those in non-converting rural hospitals.

Swing bed providers

The proportion of eligible hospitals that used swing beds increased from 50% in 1996 to 68% by 2003. In 2003, 19% of this group reported operating *both* swing beds and SNF units. The greatest number of new participants were very small hospitals that had converted or were converting to CAH status. By 2003, 95% of CAH converters used swing beds, rising from 83% in 1996, while the proportion of all other eligible facilities remained around 40%.

Trends in swing bed use

Even though more hospitals participated, individual hospitals' swing bed occupancy did not change much from 1997 through 2003, as can be seen from the median and 75th percentiles for the swing bed average daily census (Table 2). Large changes in swing bed use among CAHs appear to have been anomalous behavior; large reductions were actually more common than increases in the first year following conversion.

Table 2: Median values for swing bed average daily census (ADC), over time and by type of hospital

		Swing bed hospitals by CAH status		
		Always PPS	CAH, pre-conversion	CAH post-conversion
1997	Number of hospitals	864	574	31
	Swing ADC: 50th/75th percentile	1.8/3.7	1.8/3.8	2.0/3.2
1998	Number of hospitals	867	565	34
	Swing ADC: 50th/75th percentile	1.7/3.6	1.7/3.2	1.8/4.1
1999	Number of hospitals	857	582	49
	Swing ADC: 50th/75th percentile	1.7/3.5	1.6/3.4	1.9/3.6
2000	Number of hospitals	867	509	177
	Swing ADC: 50th/75th percentile	1.7/3.6	1.7/3.0	1.7/3.1
2001	Number of hospitals	875	353	367
	Swing ADC: 50th/75th percentile	1.7/3.7	1.7/3.1	1.9/3.5
2002	Number of hospitals	838	152	554
	Swing ADC: 50th/75th percentile	1.7/3.5	1.7/3.2	1.9/3.5
2003[(1)]	Number of hospitals	691	36	579
	Swing ADC: 50th/75th percentile	1.7/3.5	1.9/3.7	1.9/3.2

[(1)] Estimated 80% of reports filed for this year.
Notes: Number of hospitals indicates number of swing bed hospitals with cost reports in final analysis, organized by calendar year-end.
Source: CMS HCRIS and SNF cost report files distributed June 2004.

Trends in Medicare SNF days of care by setting

Total Medicare SNF days grew by about 2.5% per year. Although hospitals have always accounted for a larger share of Medicare SNF days in rural areas than in urban areas, the hospital-based share of Medicare SNF days declined everywhere. The number of hospital-based facilities did not decline as sharply in rural areas, but their average Medicare census did decline, and it was freestanding nursing homes that absorbed the modest increases in total Medicare SNF days over time.

The total number of swing bed days increased gradually each year (by about 6% in total, from the 1998 to the 2003 cost reports), and CAH converting hospitals accounted for most of the increase. However, swing bed care actually declined as a share of Medicare SNF days and as a share of all hospital-related SNF days. Even in the rural counties that rely heavily on swing beds for their total SNF care capacity, additional swing bed hospitals did not compensate for any declines in hospital-based capacity. Although more than 40% of hospitals in these counties have converted to CAH status, and virtually all of these have approval to use swing beds, there is little evidence (at least for the period through 2003) that the higher swing bed payments available to CAHs translated to a competitive disadvantage for the community-based facilities.

DISCUSSION & CONCLUSIONS

CAHs have little or no reimbursement incentive to substitute skilled swing bed care for acute care, since Medicare pays under the same cost-based rules for both. They do have a strong cost accounting incentive to minimize the provision of services that do not come under cost-based reimbursement, because such services draw fixed overhead away from the cost-based acute care areas and therefore reduce Medicare payments for hospital services. Other federal agencies have expressed concern that CAHs will withdraw from hospital-based SNF care for this reason.[3] There is also concern that CAHs will develop an unfair competitive advantage over local certified facilities because cost-based swing bed payments — which reflect the average cost per day for all patients on a CAH routine care unit rather than the costs specific to a long-term care patient — are much higher than the SNF PPS payments received by freestanding facilities. However, this study finds that despite theoretical incentives to close SNF units and substitute swing bed use post conversion, there is little evidence that this is happening in the majority of CAHs.

DATA

Data for this study come from the On-line Survey and Certification Analytic Reports (September 2004) and from Medicare cost reports for hospitals and skilled nursing facilities (June 2004). Rurality is identified from the OMB's Core Based Statistical Area (CBSA) designations as of December 2003, with urban defined as "Metropolitan" and rural as either "Micropolitan" or "non-CBSA." For the time period studied, data are available for 5,267 unique hospitals.

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[3]Medicare Payment Advisory Commission. Report to Congress, June 2005. Ch 7.