CAH Finance and Operations Webinars

July 13, 2023

The Post-Acute Care Lever: Hospital Swing Beds

The mission of the Oregon Office of Rural Health is to improve the quality, availability and accessibility of health care for rural Oregonians.

The Oregon Office of Rural Health's vision statement is to serve as a state leader in providing resources, developing innovative strategies and cultivating collaborative partnerships to support Oregon rural communities in achieving optimal health and well-being.

Webinar Logistics

- Audio muted and video off for all attendees.
- Select to populate the ⋯ to populate the chat feature on the bottom right of your screen. Please use either the chat function or raise your hand on the bottom of your screen to ask your question live.
- Presentation slides and recordings will be posted shortly after the session at: https://www.ohsu.edu/oregon-office-of-rural-health/resources-and-technical-assistance-cahs.

Upcoming CAH Operation and Finance Webinars

Aug. 3, 12 p.m. - 1:00 p.m.
How to Build Revenue: Front-End Competencies

Aug. 31, 12 p.m. – 1:00 p.m.
The No Surprises Act: Revenue Protections and Transactional Compliance

Sept. 14, 12 p.m. – 1:00 p.m.
Fund Your Mission: Practice Steps to Move from Volume to Value

Jonathan Pantenburg is a Principal at Wintergreen. He is an accomplished, results-driven senior executive with nearly 20 years of progressively responsible experience advising profit, nonprofit, and governmental entities. Over the past six years, Jonathan has worked with entities ranging from independent practices to multi-state health care systems on how to leverage rural opportunities to improve financial and operational performance. Prior to that, Jonathan served as chief financial officer and chief operating officer for a 21-bed nonprofit critical access hospital.

The Post-Acute Care Lever
CAH Hospital Swing Beds

July 13, 2023

Overview

- With uncertainty around several significant provisions, such as payment, insurance, and delivery-system reforms, the healthcare industry must address future market changes

- Swing-bed services provide an important care resource for rural patients and a volume growth opportunity for the hospital
  - **Best practice** peer rural hospitals target swing-bed ADC at a minimum of 4.0 per 10,000 people in service area (if possible)

- An effective Swing Bed strategy and process will have a significant impact on the number of patients in your Swing Bed program and serves as a vital care resource through:

Access	▪ Patients remain local and close to families ▪ Care is coordinated within a region
Quality	▪ Reduced readmissions and avoidable ED visits ▪ Shorter lengths of stay
Financial	▪ Compliance with the annual 96-hour length of stay ▪ Financial benefit to the hospital

Performance Improvement Model

- Value to Community
  - Strategy
  - Operations
    - Financial
      - Revenue
        - Productivity
        - Compensation
      - Expense
        - Staffing
    - Quality

Strategy: Rural practices, regardless if they are Independent or Provider-based, serve an essential and unique role in the rural healthcare safety net. Organizations that have direct control or contractual alignment with its service area's primary care provider network can shape and guide how prevention, education and patient care processes are implemented across the service area.

Productivity: In rural America, we've learned to do more with less. This principle should apply to the clinic's providers where your clinical team all practice at the top of their license and are busy and efficient.

Compensation: Compensation scale and design are key drivers of performance and satisfaction. How providers are paid can vary widely but compensation models should be tailored to your market realities.

Staffing: The clinic team (staff and providers) is an RHC's single most important asset and should be the primary focus for practice managers. Having the right mix of motivated professionals is the key to performance.

Quality: Long an elusive goal, a consensus-driven set of quality measures is starting to emerge. The monitoring and target-setting process for rural relevant primary care quality measures represents for many practices a new priority and challenge. Quality measures will also increasingly influence reimbursement via Value Based Payment programs.

Performance Improvement Opportunities

Organizations must focus and establish plans for each of the four identified areas to improve the organizational position

Operating

- Demand-Based Staffing tools
- Departmental performance improvement
- Revenue cycle and coding
- Cost report optimization
- Practice / clinic designations
- Process improvement
- Supply chain & purchasing

Financial

- Define performance gaps
- Integrate department leaders into budgeting process
- Determine cash position and run rates
- Establish actionable metrics
- Pricing transparency and patient engagement

Value

- New market entry and increased competition
- Explore clinically integrated model
- Ambulatory network establishment
- Increase access to care
- Direct contracting
- Improve patient engagement and satisfaction

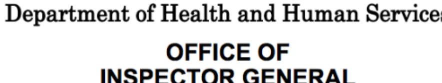
Market

- Payor contract reviews
- Value-based initiatives
- Population-based strategy
- Self-insured insurance plan offering
- Medicare Advantage negotiations
- Establish payor and provider partners
- Manage overall cost of care

Swing Bed Value

$$\text{VALUE} = \frac{\text{COST}}{\text{QUALITY}}$$

OIG Report: March 2015


Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

MEDICARE COULD HAVE SAVED BILLIONS AT CRITICAL ACCESS HOSPITALS IF SWING-BED SERVICES WERE REIMBURSED USING THE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM RATES

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Daniel R. Levinson
Inspector General

March 2015
A-05-12-00046

FINDING

"We estimated that Medicare could have saved $4.1 billion over a 6-year period if payments for swing-bed services at CAHs were made using SNF PPS rates."

$691M per Year

Quality Position

- Swing-bed programs in rural Prospective Payment System (PPS) hospitals and Skilled Nursing Facilities (SNF) must submit Minimum Data Set patient data to CMS
  - CAHs are exempt
- CAHs are not uniformly demonstrating the quality of care provided to their swing-bed patients
  - In fact, broad differences exist in the quality of services received at one CAH when compared to another
- Inability to demonstrate swing bed quality potentially limits CAHs' ability to participate in alternative payment models
- In 2019, Ira Moscovice of the University of Minnesota assessed CAH Swing-Bed Quality to compare patient outcomes for CAH swing-beds with other post-acute care facilities
  - The research was supported by the Federal Office of Rural Health Policy (FORHP), Health Resources Services Administration (HRSA), U.S. Department of Health and Human Services (HHS) under PHS Grant #5U1CRH03717

Overview

COST
—
QUALITY

Discharge disposition
- To home
- Transferred to a NH/LTC facility
- Transferred to a higher level of care

30-day follow-up status
- Readmitted to CAH
- Readmitted to other hospital
- ED visit at CAH
- ED visit at other hospital

Functional status
- Change in self-care score between swing-bed admission and discharge
- Change in mobility score between swing-bed admission and discharge

Risk-Adjusted Outcome Measures

	CAHs in sample (n=124)	Rural SNFs (n=4,250)*
30-day readmission rate	13.6%	21.1%
30-day ED visit rate	9.3%	n/a
Patients discharged to community	72%	n/a
Change in self-care score	7.1	8.3
Change in mobility score	20.0	21.3

*Source: 2018 Nursing Home Compare data for SNFs located in rural counties as designated by HRSA

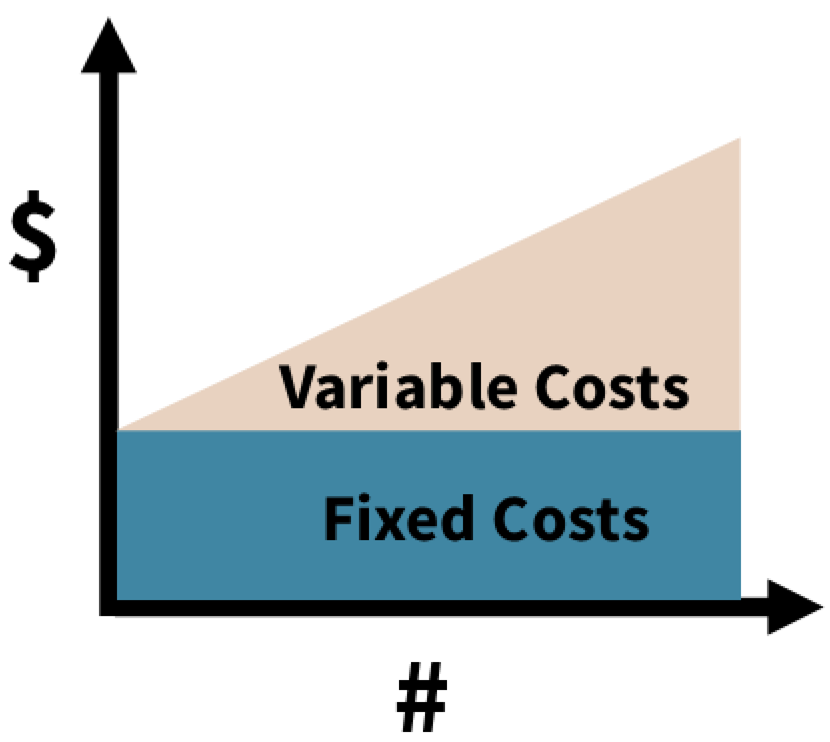
Swing Bed Utilization

- **Best practice** CAHs achieve a swing-bed ADC at a minimum of 4.0 per 10,000 people in service area

Meets ADC Target
Meets Target
Below Target

Fixed versus Variable Costs

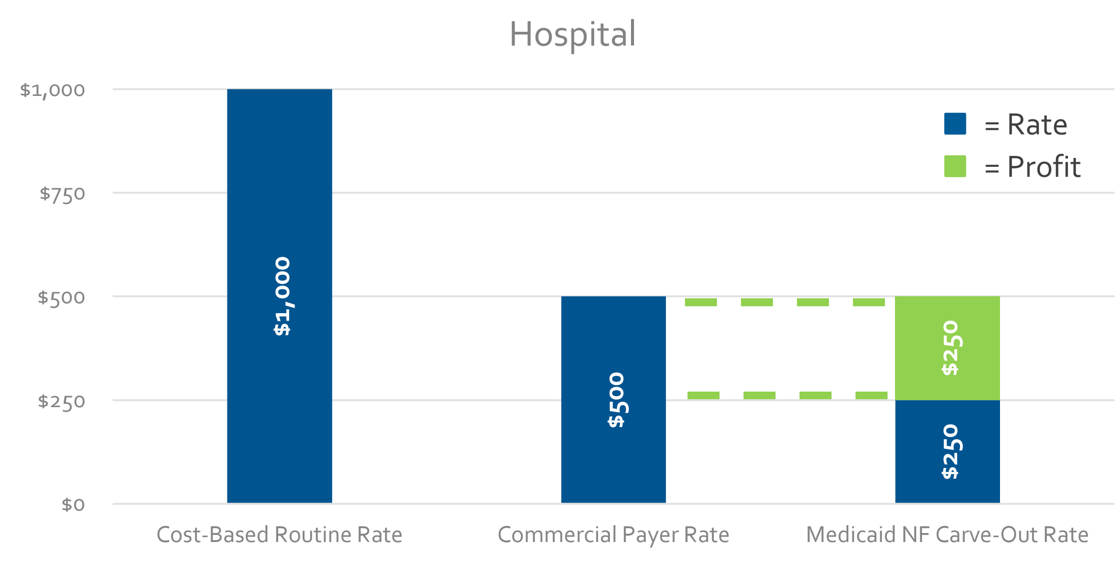
- Fixed costs are those which exist irrespective of volume
  - Unit staffing, medical direction, medical equipment, par levels of supplies
- Variable costs are those which would be incurred with each additional IP day
  - Incremental medical supplies, pharmaceuticals, food for patient meals
- In comparison to fixed costs, variable costs represent only a fraction of IP costs
  - As volume grows, fixed costs are diluted faster than variable costs grow



Non-Cost-Based Swing Bed Days

- Cost-based reimbursement will only ever allow a hospital to break even

- The opportunity: Non-Medicare or Medicare Advantage (Swing Bed NF) patient days
  - Common misconception: If contracted reimbursement rate is less than cost-based rate, negative financial impact
    - Medicaid NF carve-out rate
      - Carved out of routine costs at statewide
      - Do not negatively impact cost-based rates
  - If contracted reimbursement rates exceed statewide NF carve-out rate, **the hospital makes profit**



Swing Bed Economics

WINTERGREEN

- Deliver additional inpatient (IP) rehabilitation services to the community
- Provide increased reimbursement while assisting in length-of-stay management
- Help to dilute fixed and step-fixed costs in the nursing unit
- Financial benefit occurs by increasing the proportion of IP costs that are reimbursed on a cost basis
  - Reduces overall unit costs by diluting fixed costs related to IP services

Base Case

	ADC	Total Days	Cost-Based Mix	Cost-Based Days	Non-Cost-Based Days	Payment Per Day	Non-Cost-Based Payment
Acute (includes ICU)	5.9	2,154	83%	1,787	366	$ 1,750	$ 640,666
Observation	2.7	986	27%	266	719	1,250	899,269
Swing Bed - SNF	3.2	1,168	96%	1,121	47	1,250	58,400
Swing Bed - NF	0.1	37	0%	-	37	250	9,125
Total Days	11.9	4,344		3,175	1,169		$ 1,607,460
Total Acute, SB SNF, Obs		4,307	73%				
Inpatient Fixed Costs		$6,765,480					
Inpatient Variable Costs		1,096,825 [1]					
Swing Bed - NF Carve Out		(6,908)					
Total Inpatient Costs		$7,862,305					
Inpatient Costs Per Day				$ 1,825.47			
Cost-Based Payment				$5,795,451			$ 5,795,451
Total Payment							$ 7,402,911
Inpatient Costs Per Day							7,862,305
Net Margin							**$ (459,393)**

Swing Bed ADC Increase of 2.0

	ADC	Total Days	Cost-Based Mix	Cost-Based Days	Non-Cost-Based Days	Payment Per Day	Non-Cost-Based Payment
Acute (includes ICU)	5.9	2,154	83%	1,787	366	$ 1,750	$ 640,666
Observation	2.7	986	27%	266	719	1,250	899,269
Swing Bed - SNF	5.2	1,898	96%	1,822	76	1,250	94,900
Swing Bed - NF	0.1	37	0%	-	37	250	9,125
Total Days	13.9	5,074		3,876	1,198		$ 1,643,960
Total Acute, SB SNF, Obs		5,037	73%				
Inpatient Fixed Costs		$6,765,480					
Inpatient Variable Costs		1,242,825 [1]					
Swing Bed - NF Carve Out		(6,908)					
Total Inpatient Costs		$8,001,396					
Inpatient Costs Per Day				$ 1,588.52			
Cost-Based Payment				$6,156,437			$ 6,156,437
Total Payment							$ 7,800,397
Inpatient Costs Per Day							8,001,396
Net Margin							**$ (201,000)**
						Difference:	**$ 258,394**

1- Assumes $275/day marginal Acute/Obs costs and $200/day marginal swing bed SNF and NF costs

Scope of Care

- Organizations must evaluate the services provided and continue efforts to expand service delivery to increase reliance on the hospital for post-acute care services
- **Best practice** rural hospitals define the Scope of Care (those patients able to receive care at your facility) across applicable departments (Med/Surg, ED, Rehab, etc.) as a collaborative, multi-disciplinary group inclusive of the following categories:
  - Medical Staff, Nursing, Pharmacy, Medical Equipment, Rehabilitation, and Business Office

Example: Wound Care Program

	Yes The hospital **HAS** the resources to effectively provide service	**No** The hospital **DOES NOT HAVE** the resources to effectively provide service
Yes The hospital **PROVIDES** the identified service	**MATCH** The hospital **HAS** the necessary resources and provides service	**CONFLICT** The hospital **DOES NOT** have the necessary resources but still provides the service
No The hospital **DOES NOT PROVIDE** the identified service	**OPPORTUNITY** The hospital **HAS** the necessary resources but **DOES NOT** provide service	**NOT IN SCOPE** The hospital **DOES NOT** have the necessary resources and **DOES NOT** provide service

Wound Care

Active Pursuit

- With a limited number of Swing Bed patients, Hospitals need to actively pursue patients to increase swing bed volumes

- **Best practice** Hospitals must establish relationships with larger hospitals and actively pursue Swing Bed patients whenever beds are available
  - One of the primary concerns of a PPS hospital looking for Swing Bed placement is to free up the bed for a future Acute admission
  - The goal is to establish a relationship with the other hospital so that you are the first hospital call when they have a patient needing Swing Bed services

- **Best practice** When transferring patients for Acute services elsewhere, work to ensure the return to your facility if the patient needs Swing Bed services

Admission Process

- Hospitals that operate a swing bed program should implement a defined process to pursue Swing Bed patients and increase overall IP volumes
  - The following is a best-practice admissions process for Swing Bed volume growth:

Admission Process

- **Pending Discharge Review**
  - Determine the number of available beds at the hospital
  - Reach out to all possible PPS hospitals daily to see which patients require placement
    - This can be done electronically through an EHR or by contacting a Case Manager
  - Evaluate all patients needing placement and determine which patients could receive care at the CAH
    - This should be done by a nurse or other individual who understands the care abilities of the CAH

- **Pharmacy Review**
  - The Pharmacy Review includes the following steps:
    - Determine the drugs necessary for each patient who could receive care at the CAH
    - Determine the cost of the drugs necessary
    - Determine if the Pharmacy has the drugs necessary to provide care
      - If the pharmacy does not have the drugs, how long until they could receive the drugs

Admission Process

- **Business Office Review**
  - The Business Office Review includes the following steps:
    - Determine the insurance type of each patient needing placement
    - Insurance verification for each patient can include the following:
      - Receiving prior authorizations when necessary
      - Confirming the patient has enough eligible Medicare days
    - Confirmation, if possible, with insurance company that patient had a qualifying admission justifying Swing Bed service need

- **Medical Equipment Review**
  - The Medical Equipment Review includes the following steps:
    - Evaluate medical equipment needs for the patient
    - Determine if hospital has the available equipment during the estimated length of stay
      - If hospital does not have equipment, can hospital source equipment for use
    - Determine if hospital has the staff available and trained for use of medical equipment

Admission Process

- **Rehabilitation Review**
  - The Rehabilitation Review includes the following:
    - Evaluation of the rehabilitation services needed by the patient
    - Determining if the rehabilitation service meets the skill requirement for Swing Bed services
    - Determining if the hospital has the available staff to provide the skilled services

- **Provider Review**
  - Give Provider discharge information for each patient hospital plans to pursue
    - The provider should be the last person approached and possible patients should only include those patients that passed all prior steps
  - Work with provider to determine which patients they are willing to accept into the Swing Bed program
    - This should be done by a nurse or other individual who understands the hospital scope of care
  - Provider should determine medical necessity for Swing Bed Services

Admission Process

- **Patient Pursuit**
  - After you complete all the prior steps and determine a patient meets medical necessity, contact appropriate hospitals and pursue those patients
    - Hospitals must highlight the quality of care and build relationships to regularly receive patients
    - The earlier you reach out to other hospitals, the more likely you are to receive patients
  - Regardless of whether you receive a patient, continue to build relationships with Case Managers and Discharge Planners who play a critical role in post acute care placement

CAH Swing Bed Certification

- CAHs must evaluate all opportunities to put their organization at a competitive advantage when compared to other post-acute care facilities
  - The Swing Bed Certification Program allows organizations to establish themselves as a top performing provider

Transparency Standards

- Medical Oversight
- Patient/Family Rights
- Staffing Utilization

Care and Services Standards

- Patient/Family Expectations Met
- Patient/Family Engagement and Education
- Cleanliness/Environment
- Team Approach and Coordination
- Medication Management
- Infection Prevention
- Quality of Life
- Transitional Management
- Rehabilitative Services

Safety and Security

- Fall Prevention
- Surrounding and belongings secure

Questions

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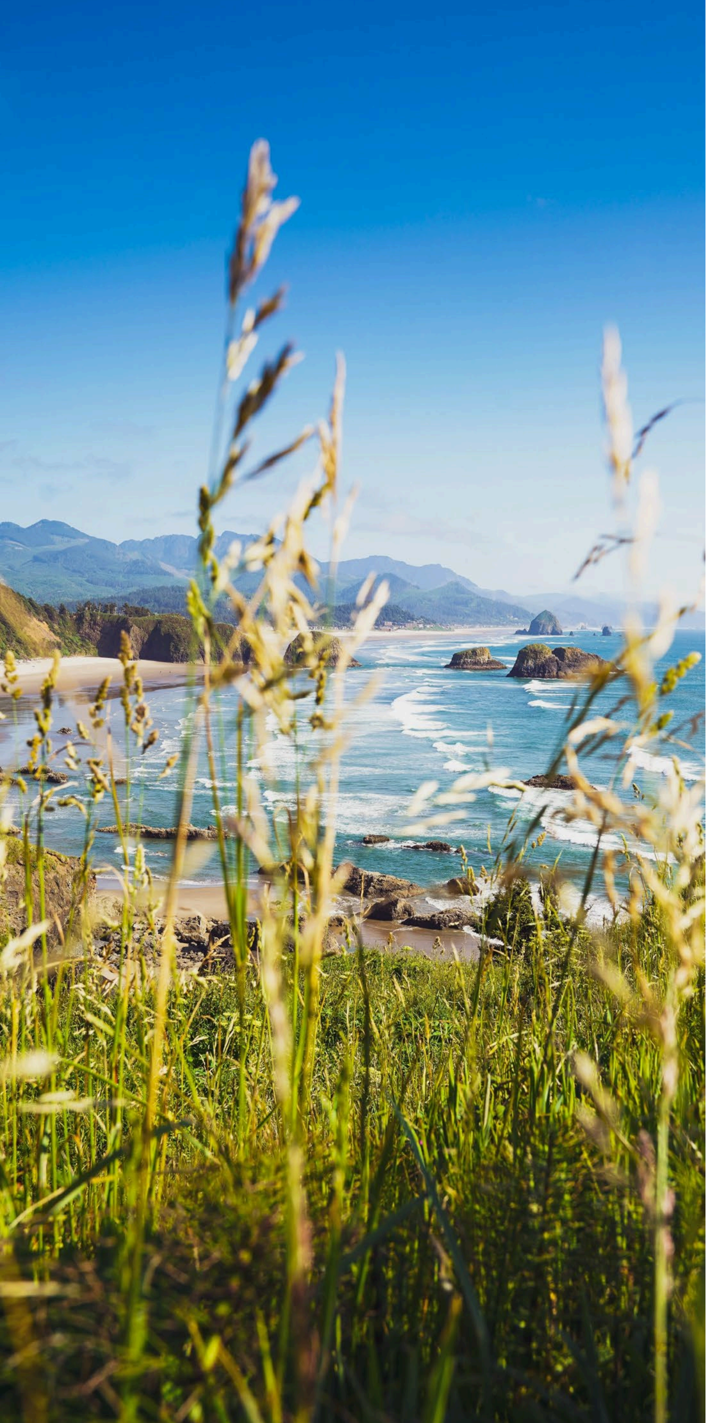

ORH Announcements

Aug. 3, 12 p.m. - 1:00 p.m. | How to Build Revenue: Front-End Competencies (*register here*)
Efficient and accurate verification of insurance eligibility and benefits streamlines the revenue cycle process and typically generates ancillary revenue, insurance incentives and improved value-based and quality scores. This presentation will focus on insurance benefits, preventative services and referred-ordered ancillary services. Reviews will include the importance of insurance verification and operational communication to optimize revenue from patient populations.

Aug. 24, 12 p.m. – 1:30 p.m. | Community Conversations: Supporting Oregon's Critical Access Hospitals and Rural Health Clinics (*register here*)
Learn about the programs and assistance the Oregon Office of Rural Health support Oregon's Rural Health Clinics and Critical Access Hospitals.

Thank you!

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