

Swing Beds in Rural Hospitals

WEB CAST

Monday, January 24th | 12:00 – 1:00p.m.



Snoqualmie Valley Hospital Swing Bed Program

Presented by:

Rodger McCollum, CEO

Philip Koziol, Senior Care Services Manager

Shawn Boynton, Swing Bed Coordinator


$$2005 = 11$$

2005 = 11

2006 = 1,169

2005 = 11

2006 = 1,169

2007 = 1,643

2005 = 11

2006 = 1,169

2007 = 1,643

2008 = 1,590

2005 = 11

2006 = 1,169

2007 = 1,643

2008 = 1,590

2009 = 3,631

2005 = 11


2006 = 1,169


2007 = 1,643


2008 = 1,590

2009 = 3,631

2010 = 5,071

- 
- ▶ Insure quality of care across the CAH swing bed network (role for RHQN?).

- 
- ▶ Insure quality of care across the CAH swing bed network (role for RHQN?)
 - ▶ Initiate a system that will allow for the sharing of resources; both knowledge and clinical.

- 
- ▶ Insure quality of care across the CAH swing bed network (role for RHQN?)
 - ▶ Initiate a system that will allow for the sharing of resources; both knowledge and clinical
 - ▶ Prepare to meet the demand with program development, systems improvement, and ease of use by PPS hospitals.

Critical Access Hospitals & Medicare

- ▶ Medicare law allows the establishment of a Medicare rural hospital flexibility program designated as Critical Access Hospitals (CAH). CAH's must provide:
 - 24-hour emergency care services
 - Provide no more than 25 beds for both acute inpatient care and Swing Beds for the sub-acute skilled nursing level of care.

Swing Bed Program

- ▶ The development of our Swing Bed program was accomplished with the active involvement from each discipline:
 - Nursing
 - Social Work
 - Rehabilitation – OT, PT, Speech and Language, Recreation
 - Pharmacy
 - Hospitalist

Nursing

▶ Policies & Procedures:

- ▶ Staffing for Swing Beds
- ▶ Swing Bed Patient Placement
- ▶ Admission, Transfers & Discharges
- ▶ Comprehensive Assessments
- ▶ Developing Care Plans
- ▶ Required Documentation
- ▶ Hospitalist
- ▶ Multidisciplinary Treatment Team Meetings

Social Work

▶ Policy & Procedures

- Social Work Assessments
- Medicare Information
- Tracking Medicare Days
- Multidisciplinary Treatment Team Meeting
- Discharge Planning and Referrals

Rehabilitation – OT, PT, Speech and Language, Recreation

▶ Policy & Procedures

- ▶ Staffing for Swing Beds
- ▶ Assessments
- ▶ Rehab Goals
- ▶ Multidisciplinary Treatment Team Meeting
- ▶ Monitoring Patient Progress
- ▶ Rehab at Bedside, on the Unit or in the Rehab Gym
- ▶ Self-Med Program
- ▶ Community Reintegration Program

Pharmacy

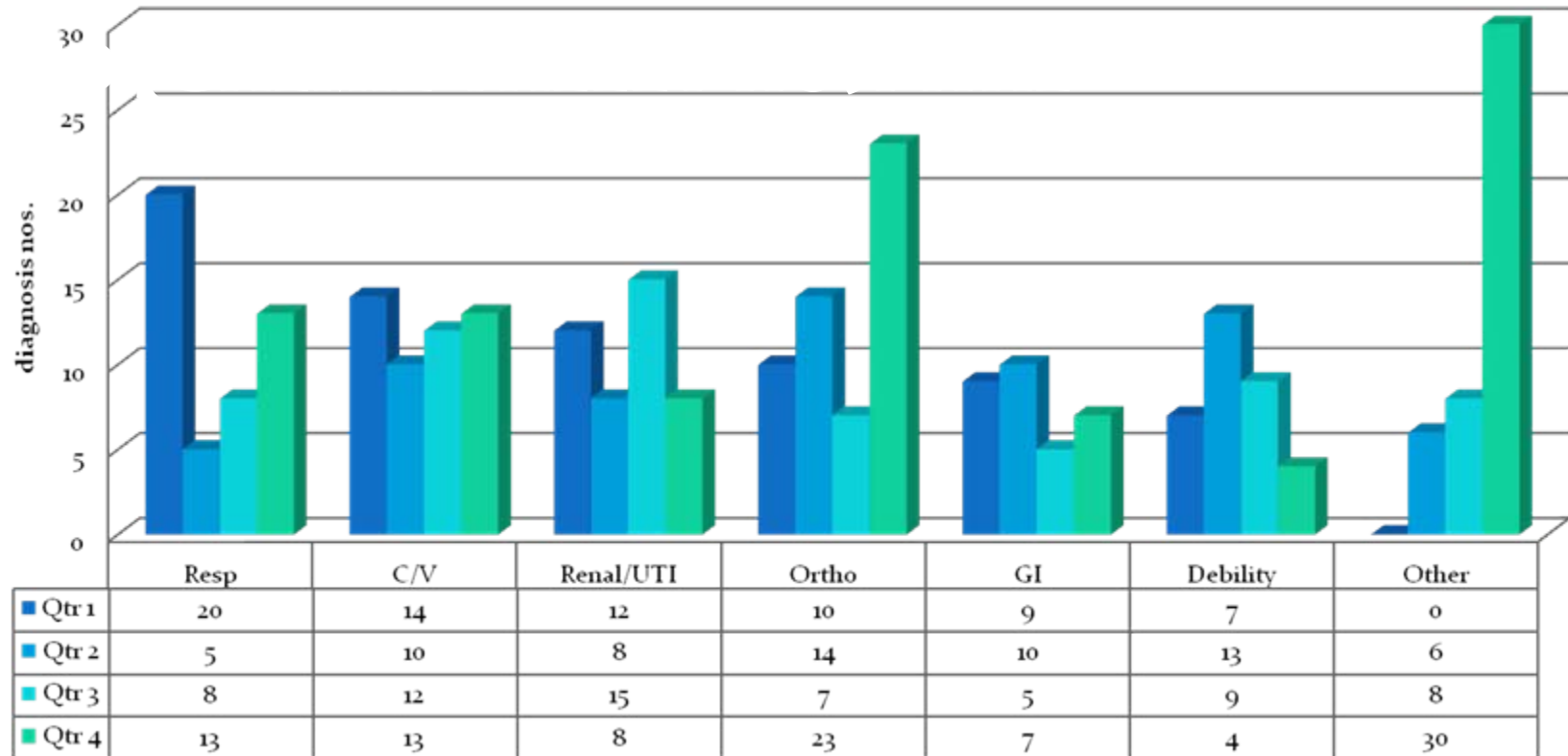
▶ Policy & Procedures

- Patient Controlled Analgesia
- Inpatient Anticoagulation Monitoring
- On-call Pharmacist
- Total Parenteral Nutrition (TPN)
- Self Medication Management

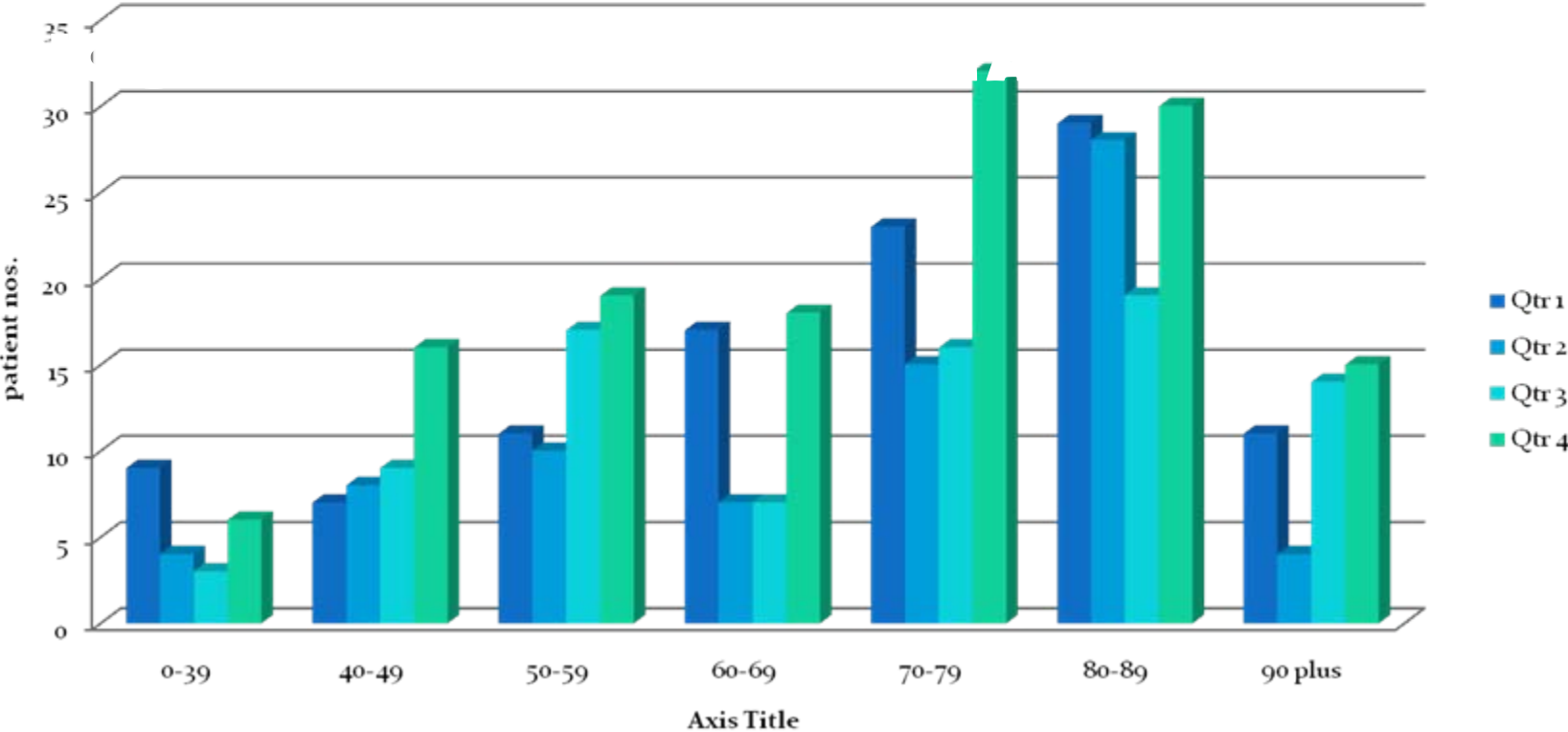
Hospitalists

- ▶ The addition of the Hospitalist provided better medical coverage for Swing Bed and Acute Care patients.
 - Increased accessibility to families

Most Frequent Admitting Diagnosis 2010



Patient Age Ranges, 2010



Program Development

- ▶ Program Development uses guidance from compliance requirements with the following skilled nursing facility participation requirements:
 - Resident Rights as specified under 42 CFR 482.66b (1) and (2)
 - Admission, Transfer and Discharge Rights
 - Patient Behavior and Facility Practice
 - Patient Activities
 - Comprehensive Care Plans
 - Social Service
 - Discharge Planning
 - Nutritional Services
 - Specialized Rehabilitation Services
 - Dental Services

The Same BUT Different

- ▶ There are rehabilitation services that are familiar in a traditional skilled nursing facility setting and services that set us apart. Combined, they include:
 - Daily Groups and Individualized Activities
 - Animal Assisted Therapy
 - Home Exercise Programs
 - Home Safety Evaluations
 - Caregiver Training

The Same BUT Different cont.

- Horticultural Therapy
- Community Reintegration with Shuttle Service
- Transportation to outpatient medical appointments and dialysis with staff escort
- Self-Medication Management Program
- Inpatient psychiatric consults
- Unlimited in-patient rehabilitation based on patient capability
- Unlimited outpatient rehabilitation based on treatment needs

Putting Principle to Practice

- ▶ Swing Bed programs benefit the patient and the community by allowing local patients to return to their community hospital for nursing and rehabilitation services.

Rehabilitation Gym



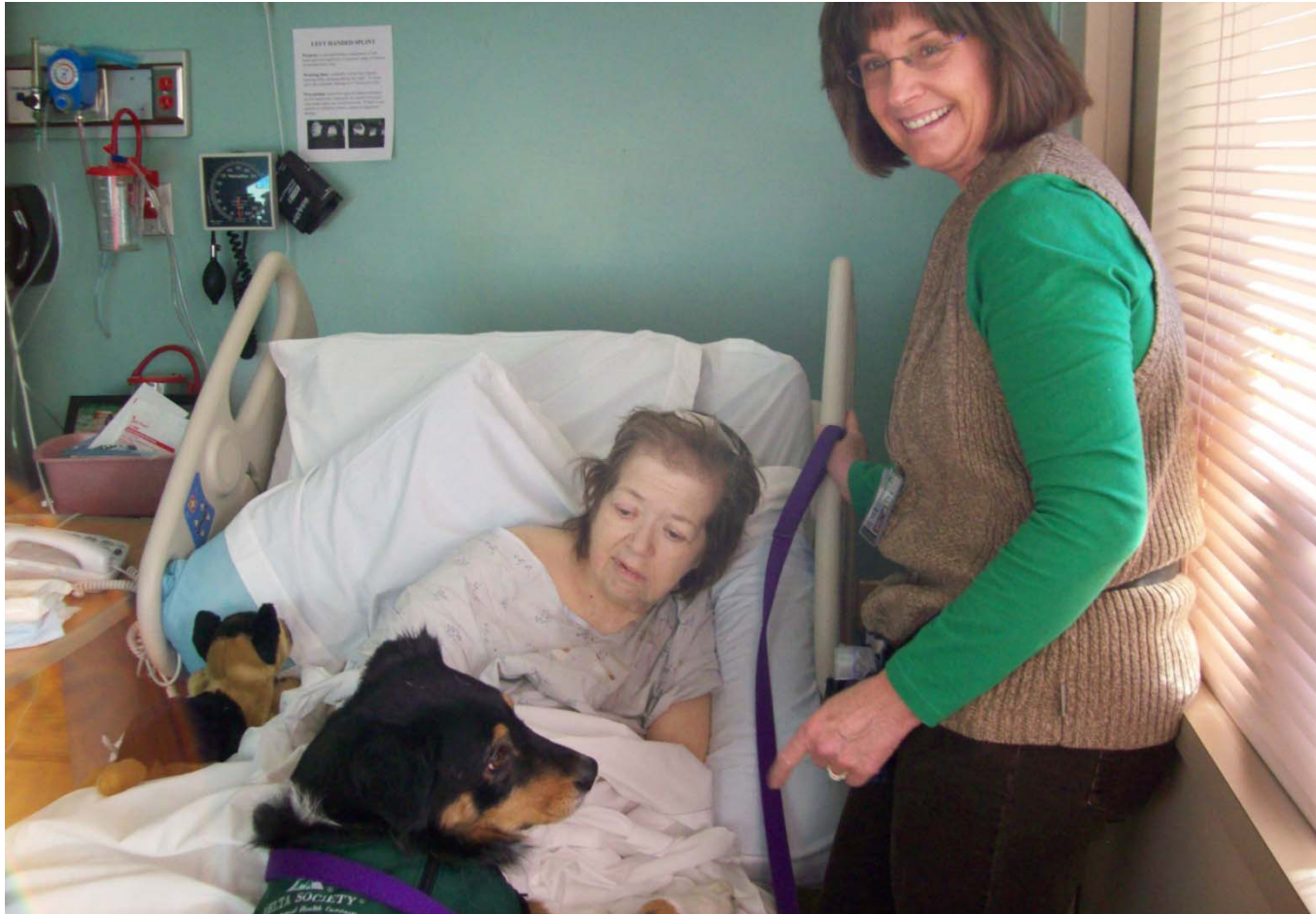
Creative use of Space



Pet Therapy



Pet Therapy



Horticulture



Recreational Therapy (Wii)



Horticulture



Community Reintegration (Snoqualmie Falls)



Snoqualmie Valley Hospital



Contact information:

Shawn Boynton:

shawnb@snoqualmiehospital.org

Philip Koziol:

philipk@snoqualmiehospital.org

(425) 831-2300

CAH Swing Bed Reimbursement

Presented to
Washington State Hospital Association
January 2011

Independent Healthcare Consultants, LLP

Mark Hollan, Phil Schmid

P.O. Box 7417

Bismarck, ND 58507-7417

701-223-8473

mhollan@ihconsultants.com, pschmid@ihconsultants.com

www.ihconsultants.com

Medicare Coverage of Inpatient Hospital Services

- ▶ Medicare covers two levels of inpatient care in hospitals with a Swing Bed program
 - Acute
 - Skilled (for a limited period – 100 days)
- ▶ Medicare does not cover a non-skilled level of care
 - Including skilled care past the 100 days
 - Certain ancillary services are covered

Medicare Payment of Inpatient Swing Bed Services

- ▶ In a rural PPS hospital with < 100 beds; Swing Bed services are paid through the SNF PPS via the RUGs IV groups
 - Modified MDS process
- ▶ In a CAH, Swing Bed services are paid at cost
 - No MDS requirement
- ▶ Cost reimbursement is typically much higher than PPS reimbursement

CAH Swing Bed Reimbursement

- ▶ Skilled Swing Bed patients are treated and paid in the same manner as acute patients
 - Routine services (Room & Board) at 101% of the routine cost per day
 - » Swing bed days are included in the computation of the hospital's routine cost per day
 - Ancillary services at 101% of cost

Cost Report Days

- ▶ CAHs with Swing Bed programs
 - Acute (W/S S-3, Part I, Line 1)
 - » Acute patients
 - SB SNF (W/S S-3, Part I, Line 3)
 - » Medicare and MA skilled Swing Bed patients only
 - SB NF (W/S S-3, Part I, Line 4)
 - » Medicare non skilled and skilled–no Part A Swing Bed patients
 - » Other payer skilled and non skilled SB

Swing Bed Benefits

- ▶ Allows for more efficient use of inpatient beds and inpatient capacity
- ▶ Allows for more efficient use of ancillary capacity
- ▶ May provide additional flexibility in scheduling of staff

Swing Bed Benefits

- ▶ Increases Medicare's share in the coverage of routine (Adults & Peds) costs
- ▶ Increases Medicare's share in administrative and overhead costs
- ▶ Increases Medicare's share in the coverage of ancillary costs
- ▶ Review example

Swing Bed Reimbursement Example – Routine Services

| | CAH with no Swing Beds | | CAH with Swing Beds | | | | |
|---|------------------------|-----|---------------------|-----------|-----|-----------|-----|
| Routine Cost: | | | 2,000,000 | | | 2,400,000 | 20% |
| Direct | 1,000,000 | 50% | | 1,300,000 | 54% | | |
| Overhead | 1,000,000 | 50% | | 1,100,000 | 46% | | |
| Patient Days: | | | 2,000 | | | 3,000 | 50% |
| Acute Medicare | 1,200 | 60% | | 1,200 | 40% | | |
| Acute Other | 800 | 40% | | 800 | 27% | | |
| Skilled Swing Bed | 0 | 0% | | 1,000 | 33% | | |
| Routine Cost per day | | | 1,000 | | | 800 | |
| Medicare cost - Acute | | | 1,200,000 | | | 960,000 | |
| Medicare cost - Swing Bed | | | 0 | | | 800,000 | |
| Total Medicare cost | | | 1,200,000 | | | 1,760,000 | |
| Medicare cost based payment at 101% of cost | | | 1,212,000 | | | 1,777,600 | |
| Routine cost not covered by Medicare | | | 788,000 | | | 622,400 | |

Swing Bed Reimbursement Example – Ancillary Services

| | CAH with no Swing Beds | | CAH with Swing Beds | | | |
|---|------------------------|-----|---------------------|---------|---------|-----|
| Therapy Cost: | | | 200,000 | | 230,000 | 15% |
| Direct | 130,000 | 65% | | 150,000 | 65% | |
| Overhead | 70,000 | 35% | | 80,000 | 35% | |
| Therapy Charges: | | | 280,000 | | 330,000 | 18% |
| Medicare Outpatient | 64,000 | 23% | | 64,000 | 19% | |
| Other Outpatient | 90,000 | 32% | | 90,000 | 27% | |
| Medicare Acute | 76,000 | 27% | | 76,000 | 23% | |
| Other Acute | 50,000 | 18% | | 50,000 | 15% | |
| Medicare Swing Bed | 0 | 0% | | 50,000 | 15% | |
| Cost to Charge Ratio | | | 0.7143 | | 0.6970 | |
| Medicare Outpatient Cost | | | 45,714 | | 44,606 | |
| Medicare Acute Cost | | | 54,286 | | 52,970 | |
| Medicare Swing Bed Cost | | | 0 | | 34,848 | |
| Total Medicare Cost | | | 100,000 | | 132,424 | |
| Medicare cost based payment at 101% of cost | | | 101,000 | | 133,748 | |
| Therapy cost not covered by Medicare | | | 99,000 | | 96,252 | |

Post Acute Care Transfer (Discharge) Policy

- ▶ Medicare may reduce the payment for certain DRGs to PPS hospitals that “early” discharge patients to a post acute setting including:
 - Skilled Nursing Facility (DS 03)
 - Home with home health plan of care (DS 06)
 - Psych, Rehab & LTC hospitals and units (DS 63, 65 & 62)

Post Acute Care Transfer (Discharge) Policy

- ▶ Swing Beds are not considered Skilled Nursing Facilities under this policy
 - PPS hospitals discharging to a Swing Bed program must use discharge status 61 (Swing Bed program) and not 66 (Critical Access Hospital)
- ▶ When discharging a patient to a Swing Bed unit, DRG reimbursement will not be reduced.

Post Acute Care Transfer (Discharge) Policy

▶ Normal Formula:

➤ Full DRG / GMLOS = Per Diem

➤ 1st day paid at 2 X per diem

➤ 2nd and consecutive days paid at per diem up to the full DRG payment

▶ A payment reduction occurs if the patient is discharged sooner than the GMLOS minus 1 day

➤ Review example

Post Acute Care Transfer (Discharge) Policy - Example

| DRG Post Acute Transfer Example | | |
|------------------------------------|--|---|
| DRG: | 467 - Revision of Hip or Knee Replacement W CC | |
| DRG weight: | 3.2321 | |
| DRG GMLOS: | 4.3 days | |
| Seattle Base Rate: | \$6,452.58 | does not include IME, GME or DSH add-ons |
| Full DRG Payment: | \$20,855 | |
| Per diem amount: | \$4,850 | |
| Medicare Payment: | | |
| 1st day | \$9,700 | 2 times the per diem |
| 2 days | \$14,550 | \$9,700 plus \$4,850 |
| 3 days | \$19,400 | \$14,550 plus \$4,850 |
| 4 days | \$20,855 | \$19,400 plus \$1,455 - payment cannot exceed the full DRG amount |
| DRG payment if discharged on day 4 | \$19,400 | \$20,855 if discharge to a Swing Bed unit |
| DRG payment if discharged on day 3 | \$14,550 | \$20,855 if discharge to a Swing Bed unit |

Post Acute Care Transfer (Discharge) Policy

- ▶ For Fiscal Year 2011 there are 273 Post Acute policy DRGs
 - 27 have a special formula
- ▶ Many of these DRGs are prime candidates for skilled care in a Swing Bed program
 - Hips and knees
 - Back procedures
 - Cardiac procedures

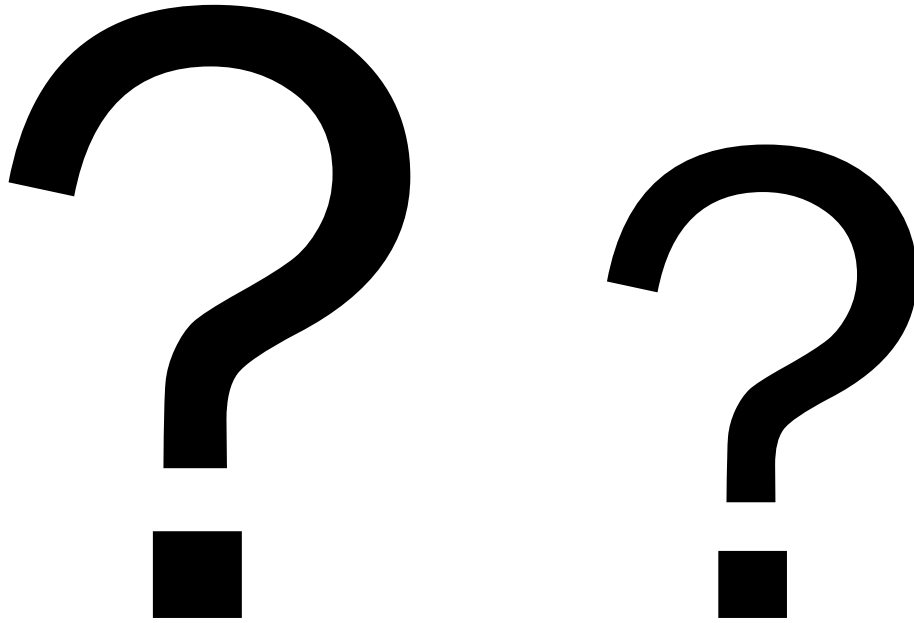
Non-Skilled Swing Bed Patients

- ▶ Routine costs are carved out of the cost report
 - Based on the state wide average Medicaid per diem nursing home payment
 - » Currently at approximately \$170.00 per day
 - Medicare shares in any cost that is in excess of the amount carved out of the cost report
 - Days are not included in the computation of Medicare's share of routine costs

Non-Skilled Swing Bed Patients

- ▶ Generally, as long as the reimbursement received by the hospital for the routine services exceeds the carve out amount; the hospital would not be harmed by increasing the number of non-skilled Swing Bed days
 - The room rate should be set higher than the per diem carve out rate
 - Each hospital should do an internal analysis

QUESTIONS



Contact Information

Independent Healthcare Consultants, LLP

Mark Hollan, Phil Schmid

P.O. Box 7417

Bismarck, ND 58507-7417

701-223-8473

mhollan@ihconsultants.com,

pschmid@ihconsultants.com

www.ihconsultants.com