RURAL HEALTH CARE WHITE PAPER SERIES:

ILLINOIS CRITICAL ACCESS HOSPITALS:

Exploring the Financial Impacts of the Swing Bed Program

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EXECUTIVE SUMMARY

The Swing Bed Program is a Medicare program available to Critical Access Hospitals (CAHs) and rural Prospective Payment System (PPS) hospitals with fewer than 100 beds. The term "swing bed" may be simply thought of as a bed that moves from an inpatient bed to a skilled nursing bed, as needed. In rural communities, hospital-based swing beds are vital in keeping services close to home, as well as helping ensure coordinated care for rural Medicare beneficiaries. The Swing Bed Program is also an important contributor to the CAHs' overall inpatient revenues.

To better understand the significance of the Swing Bed Program in rural Illinois, the Illinois Critical Access Hospital Network (ICAHN) partnered with Northern Illinois University's Center for Governmental Studies (CGS) to survey Illinois CAHs regarding the importance of their Swing Bed Programs in terms of financial indicators, quality outcomes, and community benefits. Of the 48 CAHs in Illinois, 30 completed an online survey administered between June and August 2018[1]. Highlights of the survey results, and this report, include:

- Swing bed patient readmission rates have generally been below 5% in recent years. These readmission rates are significantly lower than the Illinois statewide average rate for skilled nursing facilities. According to the Centers for Medicare and Medicaid Services *Nursing Home Compare* data, the percentage of short-stay residents in Illinois who were re-hospitalized after a nursing home admission was 24.4% in 2016-2017.
- The average length of stay for patients in CAH swing beds is significantly lower than that of stand-alone skilled nursing facilities. Patients are discharged from swing beds in an average of approximately 10 days, while those in skilled nursing facilities stay for an average of 26 days.
- The importance of swing bed revenues varies significantly among Illinois CAHs. While swing bed revenues accounted for an average of 12.5% of all 2016 CAH inpatient revenues, many hospitals received a much higher percentage of inpatient revenues from swing beds. Swing bed revenues accounted for over 20% of total inpatient revenues at more than one-third of all CAHs (17 out of 48). In addition, nine CAHs received more than 30% of total inpatient revenues from swing beds.

[1] The online survey was supplemented with data from a variety of other sources including Flex Monitoring and Centers for Medicare and Medicaid Services *Nursing Home Compare* data.

- Considering the small margins under which CAHs operate, losing swing bed revenues would cause significant financial distress for these hospitals. According to a recent national study, a 20% decline in revenue would cause 72% of CAHs to have negative operating margins. A 30% loss in revenue would cause 80% of CAHs to operate with negative margins.
- Through several follow-up interviews conducted as a part of the survey process, CEOs and nursing staff acknowledged that without the Swing Bed Program their hospitals would be forced to cut staff, reduce services, and in some instances, close their doors. This, in turn, would negatively impact the larger community economically and from an access to local, quality health care standpoint.
- Currently, there are no standard quality and benchmarking initiatives specific for the Swing Bed Program, nor are swing beds able to be star rated; consequently, payors and potential referring health care facilities may overlook look swing beds as the best option. This may be an opportunity for CAHs to collectively evaluate their programs and begin benchmarking quality outcomes.

Overall, the Swing Bed Program yields positive outcomes at both the patient and community levels. Providing post-acute care to patients in rural communities relieves the stress of them having to be transported outside the comfort of their local community and social networks and promotes restorative and transitional care. This approach leads to better patient outcomes – a goal of every health care organization. Research and data show that with a shorter average length of stay and lower readmission rates, patients are receiving quality health care with access to specialists, physicians, and high level nursing staff in their own communities. Furthermore, using swing beds to fill vacant hospital beds can arguably help strengthen the CAH's financial stability, which has economic implications for the community and its workforce.

INTRODUCTION AND PURPOSE

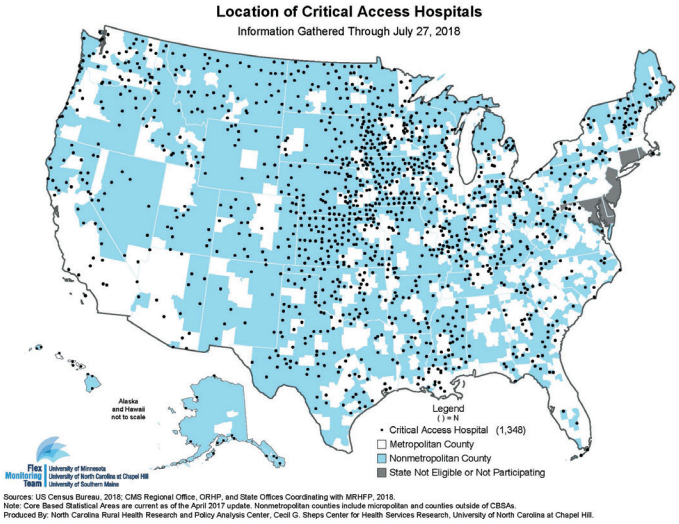
The Critical Access Hospital (CAH) Program was authorized by Congress under the Medicare Rural Hospital Flexibility (Flex) Program in 1997 to ensure access to quality health care for rural residents and to stabilize small rural hospitals. The CAH designation is designed to reduce the financial vulnerability of rural hospitals and improve access to more localized health care by keeping essential services in rural communities. The quality of care challenges facing CAHs are rooted in their unique purpose and mission. As licensed acute care hospitals, CAHs have specific operational requirements that differ from their urban and other rural counterparts in several ways, including:

- 25 or fewer beds;
- Average length of stay less than 96 hours;
- Furnish 24-hour emergency services;
- Located in a designated rural area; and
- Meet program and distance requirements

In addition, CAHs have a different reimbursement structure, receiving 101% of reasonable costs for their skilled nursing facility level services provided to Medicare patients. It should be noted that sequestration,[2] the two percent reduction in Medicare payments associated with the Budget Control Act of 2011, also impacts reimbursements to CAHs.[i] Rural residents are likely to be among those most negatively impacted by this policy. As discussed later in the demographic section, rural Americans are older, sicker, and poorer than those living in urban and suburban counties. Rural hospitals, especially CAHs that rely heavily on Medicare payments to keep their doors open and serve their rural community, will be at even greater risk of closure. In addition, CAHs provide a variety of resources for their communities including health education, wellness programs, and physical facilities, as well as often being one of the largest employers and local economic drivers so their viability is essential.[ii]

According to the Flex Monitoring Team[3], as of July 27, 2018, there were 1,348 CAHs spread across 45 states, with 51 CAHs being located in the state of Illinois (Figure 1). Kansas and Texas have the highest number of CAHs (85), followed by Iowa (82), Minnesota (78), and Nebraska (64). Five states—Connecticut, Delaware, Maryland, New Jersey, and Rhode Island - have no CAHs[iii].

FIGURE 1. LOCATION OF CRITICAL ACCESS HOSPITALS

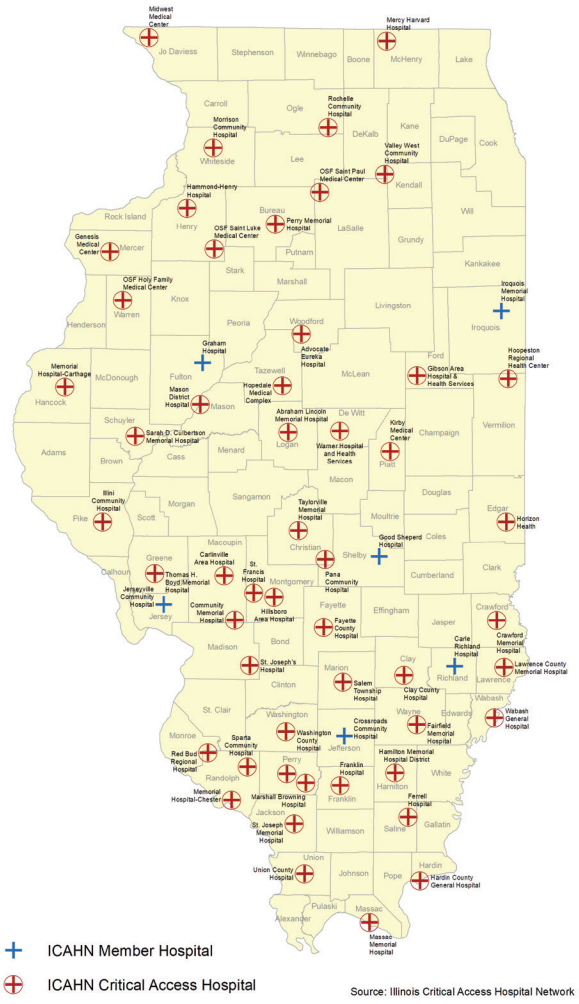


The Illinois Critical Access Hospital Network (ICAHN) has 57 members including 51 critical access hospitals and 6 additional rural service providers located across Illinois (Figure 2). Most rural hospitals, including CAHs, rely heavily on Medicare patients as their primary source of revenue. The Balanced Budget Act (BBA) passed in 1997 led to declines in Medicare reimbursements and caused financial hardship for many rural hospitals.[iv]

[2] "Sequestration" is a process of automatic, largely across-the-board spending reductions under which budgetary resources are permanently canceled to enforce certain budget policy goals. It was first authorized by the Balanced Budget and Emergency Deficit Control Act of 1985 and was applied again by Congress to affect budgetary policy through the Budget Control Act of 2011 and the American Taxpayer Relief Act (ATRA) of 2012 taking effect in April 2013. It is currently in effect until 2025 unless Congressional action is taken.

[3] The Flex Monitoring Team is a consortium of the Rural Health Research Centers in Minnesota, North Carolina, and Maine. The Team evaluate the impact of the Medicare Rural Hospital Flexibility Grant Program (the Flex Program). The Team and tracks state-level CAH data found here http://www.flexmonitoring.org/data/critical-access-hospital-locations/.

FIGURE 2. CAH LOCATIONS IN ILLINOIS



To address financial constraints as well as changes in technology and regulations, rural hospitals sought other ways to fill the gap between decreasing reimbursements and increasing health care costs and demand for services. One strategy was for rural hospitals to provide more outpatient and post-acute care services. This was achieved, in part, through the use of the Swing Bed Program, a Medicare program available to CAHs and rural Prospective Payment System (PPS) hospitals with fewer than 100 beds. The term "swing bed" is a bed that moves from an inpatient bed to a skilled nursing bed as needed. While the Swing Bed Program is an important source of post-acute care for many patients residing in rural communities, Medicare requires rural hospitals that receive reimbursement through PPS to report data on their swing bed patients through the Minimum Data Set (MDS), but does not require CAHs to collect similar information.

To better understand the utilization and economic impact of the Swing Bed Program on Illinois CAHs and their respective communities, ICAHN Executive Director Pat Schou engaged the Center for Governmental Studies (CGS) at Northern Illinois University and the University of Illinois Chicago-College of Medicine Rockford, National Center for Rural Health Professions. The goal was to better understand the contributions these hospitals and their Swing Bed Programs make to the economy and quality of life in rural Illinois communities. An online survey of Illinois CAHs was distributed in late June 2018 assessing swing bed utilization, quality of care, and financial indicators. Thirty, or 62.5% of 48 CAHs, responded.[4] In addition to the survey data, CGS also analyzed data from other sources regarding recent trends, operating practices, and innovative services offered by CAHs throughout Illinois.

The purpose of this report is to:

1. Discuss the background of the Swing Bed Program and rural Illinois demographics;
2. Evaluate the quality of care based on CAH survey responses;
3. Explore the financial impact of the Swing Bed Program in Illinois CAHs; and
4. Share challenges and best practices regarding the Swing Bed Program in Illinois CAHs.

[4] Several Illinois CAHs are part of larger systems and were not able to retrieve data specific to their Swing Bed Programs within the survey time-frame. In the future, the response rate may be higher with a longer lead-time.

BACKGROUND ON THE SWING BED PROGRAM

> "The Swing Bed Program provides patients with an environment in which they can thrive."
>
> – TRACY BAUER, PRESIDENT AND CEO, MIDWEST MEDICAL CENTER

Swing bed legislation was enacted nationwide in 1980, following a trial period from 1976 to 1977 in which swing beds proved to be a cost effective strategy through a series of demonstrations in 82 rural hospitals across the South and Midwest regions of the United States.[v] The legislation granted rural hospitals with 100 or fewer licensed routine care beds eligibility to participate in the Swing Bed Program, meaning that a bed can be used for either an acute care patient or a post-acute care patient who has been discharged from a medically necessary three-day minimum acute stay. The main purpose of swing beds is to improve the access and quality of health care services to vulnerable patient populations such as senior citizens in rural communities while managing costs. While each rural community has its own unique attributes (e.g., demographics, resources, geographic considerations, etc.), implications of swing beds may be viewed using a broader rural perspective.[vi]

The Swing Bed Program provides CAHs and other rural facilities more flexibility in their delivery of care by allowing them to use their beds interchangeably to provide acute, skilled, or intermediate care for their Medicare patients.[vii] In other words, while the bed itself does not physically swing, the care provided by health care professionals swings from providing acute care to post-acute care. The use of swing beds in CAHs has demonstrated benefits regarding both patient and financial outcomes and these outcomes will be explored throughout this report.

Approximately 1,182 CAHS (88%) nationally[viii] and 48 CAHs (94.1%) in Illinois provide swing bed services. Research supports expanding the role of CAHs in providing health care services to include post-acute care. The utilization of CAHs for transitional and post-acute care promotes patients' restorative care by allowing them to remain in their local community and near their social and supportive networks.[ix] Furthermore, one study reported that swing beds provide more effective care for outcomes related to daily living functions whereas care provided in nursing homes is better suited for long-term care needs. Some patients prefer swing beds because of the perceived stigma and fear of nursing homes. In addition, short-term swing bed stays can allow families time to make arrangements for future care. Overall, research has not provided sufficient evidence to argue that swing beds cannot offer the services needed to address patient's post-hospitalization needs. Several of the administrators that discussed their innovative practices emphasized that the mental health of the patients, as well as the perception of their care and health status, were improved by being in the Swing Bed Program.

> "Being at the hospital in a transitional Swing Bed Program improves the mental health of the patient, their perception of their care and ultimately health status."
>
> – CAROL LAWSON, RN, CASE MANAGEMENT, UR, SWING BED COORDINATOR, MASON DISTRICT HOSPITAL

COST OF CARE AND FINANCIAL IMPLICATIONS

Swing beds contribute to CAHs' financial health by helping fill hospital beds that would otherwise be vacant.[x] In addition, hospital staff are able to provide care to the patient in a swing bed without that patient relocating to another unit or leaving the hospital for skilled care services, helping to ensure an efficient transition of care. The revenue generated by swing bed Medicare reimbursements has become a major financial resource for critical access hospitals, enabling them to continue providing critical medical services at a time when utilization and cash flow from acute care sources have decreased.[xi] Stronger CAHs provide health care services to their rural communities, which improves both patient outcomes and community health. Further, as important economic drivers in their respective communities, CAHs help diversify small rural economic bases.

> "The Swing Bed Program helps with job security for staff and fosters staff retention which in turn offers a better quality of care for patients."
>
> – JENNIFER BRACKENHOFF, DIRECTOR OF QUALITY ASSURANCE AND CASE MANAGEMENT GIBSON AREA HOSPITAL

ASSESSING QUALITY

There are differences in the quality of care provided in swing beds and skilled nursing facilities (SNFs). Research has found that up to 40% of hospital admissions from skilled nursing facilities may be avoidable and reflect the poor quality of care received at skilled nursing facilities.[xii] Medicare data from the *Nursing Home Compare* datasets indicate that SNFs may have low nurse-to-patient ratios, and the data is ambiguous about access and availability to onsite primary care providers. On the other hand, CAH swing bed patients have access to their primary care providers as well as to diagnostic and emergency services on a daily basis. Additionally, patients are often rounded on multiple times a week by a primary care provider, as opposed to SNFs, in which primary care providers are only intermittently available. This may allow for the provision of higher quality care than what would be found in a typical SNF.

In April 2018, the University of Minnesota's Rural Health Research Center investigated how CAHs measure the quality of care provided to their swing bed patients[xiii]. A total of 20 interviews were conducted with three groups including: 1) representatives of three CAH networks in Illinois, New York State, and West Virginia; 2) four consultant groups working with CAHs on swing bed quality issues; and 3) CEOs, quality improvement staff, and nurse managers who are responsible for swing bed services at 10 CAHs and two rural PPS hospitals in 10 states (Alaska, Kentucky, Minnesota, Montana, Mississippi, Nebraska, New Hampshire, South Carolina, West Virginia, and Wisconsin). CAHs in the study recognized the need to find ways to measure swing bed quality of care, particularly as a means for comparing quality of care to SNFs.

The findings from the 2018 report suggested various measures for consideration:

MEASURE	DESCRIPTION
Discharge disposition	Number of swing bed patients discharged home and to other settings; percent of swing bed patients going back to same level of assistance as prior to stay; number of discharges to home or long-term care facility
Average length of stay	Average number of days for swing bed stay, average length of stay compared to goal
Readmission	Number of swing bed discharges readmitted to the CAH for acute care within 30 days; number of readmissions back to swing bed; combined CAH acute care readmission rate for acute and swing bed discharges
Functional status	Admission and discharge scores on Barthel Index, Functional Independence Measure, or Minimum Data Set (MDS) Section GG; various physical therapy and occupational therapy tests to measure walking, gait and balance, sit to stand, and cognitive performance
Process of care/teamwork	Frequency of team rounds to patient bedside to discuss goals, updating of communication board in patient room, etc.
Patient experience of care/ Patient satisfaction	Hospital Consumer Assessment of Health care Providers and Systems (HCAHPS) survey for discharged swing bed patients and inpatients combined, consultant-developed survey for discharged swing bed patients, food satisfaction card with meals, post-discharge follow-up phone calls
Additional measures	Falls, skin integrity, infections

THREATS AND CHALLENGES TO THE CAH SWING BED PROGRAM

As identified in the research conducted by the University of Minnesota's Rural Health Research Center, several of the suggested measures reflect the challenges or threats encountered by the Swing Bed Program. First, the public, and thus potential patients, are generally not familiar with the Swing Bed Program and lack knowledge about the benefits, quality and shorter length of stay. Several of the follow-up interviews CGS conducted involved discussions about marketing and promotion to help overcome and/or mediate this challenge. Second, there is a general perception that the cost of staying in a swing bed is more than other skilled nursing facilities based on cost per day; however, the cost is not evaluated for length of stay, quality of care, and/or status upon discharge. These measures are described in a later section as part of the survey conducted by CGS. The results demonstrate that quality outcome measures, including readmission rates and average length of stay, are better for swing bed patients in Illinois CAHs compared to SNFs, thus possibly saving money. Lastly, there are no standard quality and benchmarking initiatives specific for the Swing Bed Program, nor are swing beds able to be star rated; consequently, payors may overlook look swing beds as the best option. This may be an opportunity for CAHs to collectively evaluate their programs and begin benchmarking quality outcomes.

> "Marketing and promoting the Swing Bed Program is necessary to encourage patients, and referring providers, to become more knowledgeable about the quality care options close to home."
>
> – TRACY BAUER, PRESIDENT AND CEO, MIDWEST MEDICAL CENTER

SNAPSHOT OF RURAL ILLINOIS AND CAH COMMUNITIES

Rural residents often experience barriers that limit their ability to obtain the health care they need. For rural residents to have sufficient health care access, necessary and appropriate services must be available and obtainable in a timely manner. According to Healthy People 2020, access to health care is important for:

- Overall physical, social, and mental health status
- Prevention of disease
- Detection and treatment of illnesses
- Quality of life
- Prevent death
- Life expectancy

Illinois has 102 counties with 1.5 million residents living in 62 non-metropolitan counties. As stated previously, there are 51 CAHs located in 44 counties across Illinois. To better understand the communities in which CAHs operate, the data shared next is organized by metro and non-metro counties using the U.S. Department of Agriculture's (USDA's) definition through their rural-urban continuum codes (Figure 3).[5]

FIGURE 3. RURAL-URBAN CONTINUUM CODE BREAKDOWN

CATEGORIES	# OF COUNTIES IN ILLINOIS	# OF COUNTIES WITH CAHS	
1: Counties in metro areas of 1 million population or more	17	4	Metro
2: Counties in metro areas of 250,000 to 1 million population	10	4	
3: Counties in metro areas of fewer than 250,000 population	13	5	
4: Urban population of 20,000 or more, adjacent to a metro area	9	5	Non-Metro
5: Urban population of 20,000 or more, not adjacent to a metro area	3	0	
6: Urban population of 2,500 to 19,999, adjacent to a metro area	23	14	
7: Urban population of 2,500 to 19,999, not adjacent to a metro area	17	11	
8: Completely rural or less than 2,500 urban population, adjacent to a metro area	5	0	
9: Completely rural or less than 2,500 urban population, not adjacent to a metro area	5	1	

Sources: USDA Economic Research Service Rural-Urban Continuum and 2010 and 2016 American Community Survey, Five-Year Estimates.

The demographics suggest the critical need for health care services in non-metro counties (Figure 4). Non-metro residents tend to be older, less educated, more likely to have a disability, and less likely to be in the labor force compared with metro residents. Each of these trends is associated with worse health outcomes.[xiv] In 2016, 18.6% of persons in non-metro counties were 65 years or older, compared with slightly more than 13% of metro residents. While high school completion rates are the same for metro and non-metro populations, metro residents are twice as likely to earn at least a bachelor's degree (35% vs. 17.6% in non-metro counties). Disability rates are also higher in non-metro counties (10.2%) vs. metro counties (6.8%).

[5] The 2013 Rural-Urban Continuum Codes distinguish metropolitan counties by the population size of their metro area, and nonmetropolitan counties by degree of urbanization and adjacency to a metro area. https://www.ers.usda.gov/data-products/rural-urban-continuum-codes/

Each of these demographic characteristics (higher age, disability status, and lower education levels) are associated with a decreased likelihood of labor force participation. While two-thirds (66.4%) of metro residents were in the labor force, just 58.7% of non-metro residents participated in 2016. While both saw declines between 2010 and 2016, non-metro labor force participation rates declined at a greater rate.

FIGURE 4. DEMOGRAPHIC INFORMATION, METRO VS. NON-METRO COUNTIES, ILLINOIS 2010-2016

	METRO COUNTIES			NON-METRO COUNTIES		
	2010	**2016**	**% Chg.**	**2010**	**2016**	**% Chg.**
Total Population	11,211,964	11,355,718	1.3%	1,533,395	1,495,966	-2.4%
% Population Under 18	25.1%	23.5%	-1.5%	22.4%	21.3%	-1.1%
% Population 65 and older	11.6%	13.3%	1.6%	17.0%	18.6%	1.6%
% Population 25 and older with at least a HS Diploma	86.3%	88.3%	2.0%	85.8%	88.3%	2.5%
% Population 25 and older with at least a Bachelor's Degree	32.3%	35.0%	2.7%	16.0%	17.6%	1.6%
% Population Under 65 with a Disability	NA	6.8%	NA	N/A	10.2%	NA
% Population Under 65 Without Health Insurance	NA	11.3%	NA	N/A	9.5%	NA
% Population Age 16+ in Civilian Labor Force	67.3%	66.4%	-1.0%	61.0%	58.7%	-2.3%
Median Household Income	$54,230	$58,004	7.0%	$42,639	$46,877	9.9%
% Population in Poverty	12.3%	13.6%	1.4%	12.9%	14.0%	1.1%

Sources: U.S. Bureau of the Census, 2010 and 2016 American Community Survey, Five-Year Estimates.

As the demographics illustrate, operating in a rural environment presents both challenges and opportunities. In August 2018, a rural health summit was organized by the Department of Population Science and Policy at Southern Illinois University's (SIU) School of Medicine. The summit gathered rural health stakeholders to discuss rural health issues as well as innovative programs and policies addressing these issues. Several of the key findings are relevant to the issues facing CAHs and the Swing Bed Program.[xv]

Those key findings included[6]:

It is critically important to address rural Illinois residents' struggles to maintain healthy, active, and productive lives in their communities

The fastest growing older population group is age 85 and older. In fact, this age group is projected to total 402,311 people, an increase of 109%, by 2030

The rural Illinois' economy and health care system depend on each other. Strong economies produce healthier residents; strong health care systems power economies

These findings highlight rural residents' need to have quality health care close to home throughout their lifetime, especially later in life as many older adults are aging in place. This older group may be making decisions about their health care and continuity of care where having the Swing Bed Program as an option is even more important. In addition, the economies of these communities often depend on the economic vitality of their CAHs, including employment and spending in and around the community, both of which are discussed later in the report.

6 Population data was obtained from the Illinois Department on Aging, State Plan on Aging, 2017-2019, https://www2.illinois.gov/aging/Resources/Documents/StatePlanOnAging.pdf .

REVIEW OF ICAHN SWING BED SURVEY RESULTS

As mentioned previously, Medicare currently requires rural hospitals that receive reimbursement through the PPS to report data on their swing bed patients through the MDS, but does not yet require CAHs to report similar information. To better understand the swing bed data for Illinois CAHs, in June 2018, hospital CEOs and CFOs in all 48 CAHs with Swing Bed Programs were asked to complete an online survey. An electronic questionnaire addressing financial indicators, quality measures, staffing, and best practices in the area of swing bed programming was sent to the CAHs via an email from ICAHN executive director, Pat Schou.

The survey was vetted by ICAHN staff and several hospital CFOs for consistency and data availability. In total, 30 CAHs (63.5% response rate) from throughout Illinois responded to the electronic survey[xvi] (see Appendix A for a list of responding hospitals). In addition to the survey, other sources used for data collection included Flex Monitoring, Centers for Medicare and Medicaid Services *Nursing Home Compare* data, and CAH Measurement & Performance Assessment System (CAHMPAS)[7] data, as well as follow-up phone discussions with hospital CEOs and CFOs. Sources are noted with each figure.

The survey results are presented for two groups of hospitals as well as for overall totals. Hospitals are grouped using the procedure employed by CAHMPAS based on FY 2016 Net Patient Revenue (NPR). CAHMPAS uses two groups: under $20 million NPR and over $20 million NPR. Eight smaller and 22 larger hospitals completed the survey. For additional information on survey methodology see Appendix B.

SWING BED PROGRAMS

The vast majority – over 80% – of swing bed patients are covered under Medicare (Figure 5). Most of the remaining patients are covered by Medicare Advantage. There is very little difference in the payor mix between small and large hospitals.

Figure 5. Swing Bed Payor Mix, FY 2017

	MEDICARE	MEDICARE ADVANTAGE	BCBS/OTHER COMMERCIAL	SELF-PAY/ NURSING CARE	OTHER
Under $20m	83.4%	12.1%	3.9%	0.0%	0.6%
Over $20m	80.6%	13.2%	5.3%	0.5%	0.5%
All	81.3%	12.9%	4.9%	0.4%	0.5%

Source: Center for Governmental Studies, 2018 ICAHN Swing Bed Program Critical Access Hospital Survey.

Figure 6 displays average lengths of stay for swing bed patients. Overall, swing bed patients had an average length of stay of 10 to 11 days. There is not a significant difference between lengths of stay at small and larger hospitals.

The average length of stay for patients in CAH swing beds is considerably less than the 2016 average of 26.2 days at stand-alone SNFs. While a variety of factors affect length of stay, it is likely that increased intensity of care for hospital-based patients contributes to short stays. CAH swing bed patients have more contact with primary care providers (PCP)[8] and RNs/LPNs, as well as more sophisticated medical equipment.

7 Critical Access Hospital Measurement & Performance Assessment System (CAHMPAS), compiled and maintained by the Flex Monitoring Team.
8 Primary care provider refers to a physician, advanced practice registered nurse, or physician assistant.

Figure 6. Swing Bed Average Length of Stay

	FY15	FY16	FY17
Under $20m	9.2	8.5	11.9
Over $20m	10.7	10.2	10.7
All Swing Bed	10.4	9.9	10.9
All SNF	27.2	26.2	Not yet released

Source: Center for Governmental Studies, 2018 ICAHN Swing Bed Program Critical Access Hospital Survey.

Based on comments from survey participants, hospital staffing levels are based on need. With larger hospitals often having more patients, their staffing levels tend to be higher (Figure 7). Smaller hospitals (under $20 million net patient revenue) dedicate one or two nurses to their Swing Bed Programs while half of the larger hospitals (over $20 million net patient revenue) dedicate three or more. Swing bed patients in all responding hospitals have daily access to medical providers. These medical providers conduct rounds at least twice weekly in 9 out of 10 hospitals, with no significant difference between large and small. Due to the fact that swing bed patients are housed in an acute care hospital, they have around the clock access to a primary care providers and specialized medical equipment. SNF patients typically only have the opportunity to see a primary care provider every few days and must be transported to a hospital for acute care when necessary.

Figure 7. Average Staffing Levels in Med/Surg. Unit - Swing Bed Program, FY 2017

	UNDER $20M (N=8)	OVER $20M (N=22)	ALL (N=30)
1 RN or LPN	3	3	6
2 RN/LPNs	5	8	13
3 RN/LPNs	0	6	6
More than 3 RN/LPNs	0	3	3
Other	0	2	2
Daily Access to Medical Providers	100%	100%	100%
Medical Providers Make Rounds at Least Twice Weekly	88%	91%	90%

Source: Center for Governmental Studies, 2018 ICAHN Swing Bed Program Critical Access Hospital Survey.

Nearly all hospital Swing Bed Programs offer IV therapy and rehabilitation services (Figure 8). The vast majority also offer medication management, infection management, clinical management of conditions, and special procedures such as PICC lines. Other services not on the list include respite and wound care.

Figure 8. Types of Services Offered in CAH Swing Bed Programs

	UNDER $20M (N=8)	OVER $20M (N=22)	ALL (N=30)
IV Therapy	100%	95%	97%
Rehabilitation - Recovery to Home	100%	95%	97%
Medication Management	75%	95%	90%
Post-Surgical Infection Management	75%	91%	87%
Frequent Monitoring - Clinical Management of Conditions	75%	86%	83%
Special Procedures – e.g., PICC line	63%	82%	77%
Palliative Care	50%	32%	37%
Other (includes respite, wound care, tracheostomy, etc.)	25%	9%	13%
Ventilator Care	0%	9%	7%
Long-Term Care	0%	5%	3%

Source: Center for Governmental Studies, 2018 ICAHN Swing Bed Program Critical Access Hospital Survey.

Swing bed patient readmission rates have generally been below 5% in recent years (Figure 9). Smaller hospitals have tended to have lower readmission rates, although sample sizes are too small to make meaningful comparisons between the two groups. Similarly, a comparison of rates over time is problematic due to the increasing number of hospitals reporting this data in FY 2017.

These readmission rates are significantly lower than the Illinois statewide average rate for skilled nursing facilities. According to the Centers for Medicare and Medicaid Services *Nursing Home Compare* data, the percentage of short-stay residents in Illinois who were re-hospitalized after a nursing home admission was 24.4% in 2016-2017. Short-stay re-hospitalization measures the percentage of all unplanned new admissions or readmissions to a nursing home from a hospital where the resident was re-admitted for an inpatient stay or observation within 30 days of entry or reentry. Higher rates for short-stay re-hospitalization indicate worse performance.[xvii]

Figure 9. Swing Bed Patient Readmission Rate Back to Inpatient Status[9]

	FY15	FY16	FY17
Under $20m	2.3% (4)	1.5% (4)	5.9% (6)
Over $20m	5.4% (12)	3.6% (13)	4.9% (15)
All	4.6% (16)	3.1% (17)	5.2% (21)

Source: Center for Governmental Studies, 2018 ICAHN Swing Bed Program Critical Access Hospital Survey.

Hospitals were asked to indicate the five most common primary patient diagnoses for swing bed patients. Orthopedic surgeries (especially joint replacement), heart failure, chronic obstructive pulmonary disease (COPD), and non-orthopedic surgery recovery were reported by the majority of hospitals (Figure 10). Pneumonia and weakness were the most common diagnoses specified in the 'other' category.

[9] Information was not available for all responding hospitals in all years. The number of respondents included in each average is indicated in parentheses.

Figure 10. Swing Bed Patients, Most Common Primary Diagnoses

	UNDER $20M (N=8)	OVER $20M (N=22)	ALL (N=30)
Joint Replacement	88%	82%	83%
Congestive Heart Failure (CHF)	63%	68%	67%
Other Orthopedic Surgeries	63%	59%	60%
Chronic Obstructive Pulmonary Disease (COPD)	75%	50%	57%
Post Non-Orthopedic Surgery Recovery	38%	55%	50%
Sepsis	25%	41%	37%
Other (pneumonia, weakness, cellulitis, etc.)	50%	32%	37%
Wound Care	38%	27%	30%
Uncontrolled Diabetes	0%	14%	10%
Post Myocardial Infarction (MI) Recovery	0%	9%	7%
Nursing Home Stay	13%	5%	7%
Respite	13%	5%	7%

Source: Center for Governmental Studies, 2018 ICAHN Swing Bed Program Critical Access Hospital Survey.

More than two-thirds of swing bed patients were discharged to their homes (Figure 11). About half of those returning home received home health services. Another 12% moved to an external long-term care/nursing facility.

By comparison, Centers for Medicare and Medicaid Services *Nursing Home Compare* data indicate the percentage of short-stay residents in Illinois who were successfully discharged to the community was 53.4%. Measures of short-stay successful community discharge reflect the percentage of all new admissions to a nursing home from a hospital where the resident was discharged to the community within 100 calendar days of entry, and for 30 subsequent days they neither died, were admitted to a hospital for an unplanned inpatient stay, nor were readmitted to a nursing home. Lower rates of short-stay successful community discharge indicate worse performance.[xviii]

Figure 11. Discharge Disposition of Swing Bed Patients, FY 2017

	UNDER $20M (N=8)	OVER $20M (N=22)	ALL (N=30)
Home without Special Services	41%	35%	36%
Home with Home Health Services	36%	32%	33%
Other	8%	15%	13%
External Long-Term Care/Nursing Facility	13%	12%	12%
Hospice	2%	2%	2%
Self-Pay Swing Bed Patient/Nursing Care	2%	1%	1%
Rehabilitation Facility	1%	1%	1%
Veterans Affairs Care	0%	1%	1%

Source: Center for Governmental Studies, 2018 ICAHN Swing Bed Program Critical Access Hospital Survey.

TOP CHALLENGES TO PROVIDING A SWING BED PROGRAM

To gain a deeper understanding of the practical implications of the Swing Bed Program in CAHs, survey respondents were asked to describe challenges they encountered while managing their programs. The most frequently mentioned challenges shared by survey participants included:

- Qualifying patients;
- Insurance coverage requirements and compliance;
- Marketing and community awareness;
- Competition with local nursing facilities;
- Managing referrals; and
- Lack of quality activities and programs

Many CAHs pointed to the difficulty of ensuring that the hospital only accept patients who qualify for the Swing Bed Program as that requires a thorough understanding of the patient's needs. Insurance coverage also poses a challenge for many CAHs. Obtaining approval from Medicare Advantage plans, reduced numbers of straight Medicare members resulting in lower reimbursements, and an influx of Medicaid patients to the market have all had an impact on the Swing Bed Program. Lack of awareness of the Swing Bed Program as a care option by the community and other health care facilities was identified by many CAHs as a barrier since it resulted in a lack of referrals. For example, one survey respondent explained that referrals from larger facilities do not appear on the Medicare website and another mentioned that referrals from regional tertiary hospitals are not always appropriate. These challenges reflect only some of the issues CAHs encounter with their Swing Bed Programs. For a more comprehensive and detailed list provided by the CAH survey respondents, please see Appendix C. The next section reviews the financial impact of the Swing Bed Program in Illinois.

FINANCIAL IMPACT OF SWING BED PROGRAM IN ILLINOIS

The closure of rural health care facilities or discontinuation of health care services can negatively impact access to care and the economic vitality of both the hospitals and the communities they serve. A recent increase in rural hospital closures, particularly CAHs, has been reported frequently in the news. Significant concerns for rural communities who lose their hospital is the loss of emergency services and the lack of acute and outpatient services close to home.[xix]

An April 2015 policy brief from the North Carolina Rural Health Research Program, *A Comparison of Closed Rural Hospitals and Perceived Impact*, identifies the following potential impacts on health care access due to hospital closure:[xx]

- Unstable access to health services, particularly diagnostic and lab tests, obstetrics, rehabilitation, and emergency medical care;
- Rising emergency medical services costs;
- Residents not receiving needed care or services due to lack of transportation; and
- Disproportionately greater impact on access for the elderly, racial/ethnic minorities, the poor, and people with disabilities.

Several of the CEOs and hospital representatives interviewed shared that without the Swing Bed Program the hospital would be forced to cut staff, reduce services, and in some cases, close their doors.

Because the financial health of CAHs in Illinois is important to rural health care services and the economic well-being of their host communities, the next section examines three categories of financial indicators: profitability, liquidity, and utilization.

> "The Swing Bed Program changed our hospital around financially, from closure, to thriving. The program offered our patients a quality, local option for skilled services in a Swing Bed Program and the hospital an opportunity to utilize its beds and staff to the fullest."
>
> – EVA HOPP, RB, BSN, CNE, PINCKENYVILLE HOSPITAL

FINANCIAL INDICATORS

This section examines indicators of financial health of Illinois CAHs for 2010 through 2016 (Figure 12).[10] For some measures, values are compared to national medians for small (less than $125 million net patient revenue) not-for-profit hospitals provided by Standard and Poors (S&P). S&P publishes select financial ratios for hospitals that have been rated for credit worthiness with the following grades: A, BBB+, BBB, BBB-, and Speculative.

Financial indicators are presented for two groups of CAHs based on total inpatient revenue. Smaller hospitals are those with less than $10 million in inpatient revenues in 2016 while larger hospitals have greater than $10 million in revenue. All values presented are averages weighted by total inpatient revenues. Many of the indicators declined from 2015 to 2016. However, results from the ICAHN swing bed survey suggest that conditions improved in 2017. Swing bed utilization and revenue both grew from 2016 to 2017.

TOTAL MARGIN

Total Margin is an indicator of a hospital's overall profitability, calculated by dividing net income by total revenue. On average, larger hospitals have been more profitable than small. Total margin for larger hospitals was generally in the 4% to 5% range through 2015, but fell in 2016. Small hospitals had increasing margins in the years up to 2015, but also declined in 2016.

CASH FLOW MARGIN

Another measure of profitability, *Cash Flow Margin,* is the total cash flow from patient services divided by total patient revenue. This is important because hospitals need cash flow to pay their obligations such as payroll. Larger hospitals tend to have higher cash flow margins, although the gap between large and small hospitals closed significantly in 2014 and 2015. As with total margins, cash flow margins for smaller hospitals dropped significantly in 2016 after growing in previous years.

OPERATING MARGIN

A final measure of profitability considered here, *Operating Margin*, is the ratio of net operating income to operating revenue. Larger hospitals have generally seen operating margins in the 4.0 to 5.0% range in recent years, growing to an average of nearly 8.0% in 2017. Smaller hospitals have seen more variable operating margins, falling to 0.4% in 2017 after two years of averages above 3.0%.

Nationally, the median hospital with an S&P credit grade of BBB had an operating margin of 1.9% in 2016. According to S&P, an investment grade of BBB indicates adequate capacity to meet financial commitments, but greater vulnerability than higher rated firms to adverse economic conditions. However, hospitals with an S&P grade of A or higher had a median operating margin of 5.2%. The operating margin for smaller Illinois CAHs is in line with hospitals with an S&P grade of BBB-, indicating the hospitals are potentially vulnerable and dependent on favorable business and economic conditions to meet financial commitments.

CURRENT RATIO

Current Ratio is a measure of liquidity that indicates a hospital's ability to pay obligations with available assets. It is calculated as the ratio of current assets to current liabilities. A current ratio greater than one indicates that the hospital has more current assets than current liabilities, however financially strong organizations typically have a current ratio above 2.0.

On average, large and small hospitals tend to have similar levels of current ratio. The average current Ratio has consistently been about 2.5, growing to 3.0 in 2016. The average for smaller hospitals has been slightly higher than larger hospitals in recent years.

10 The financial indicators are calculated by the Flex Monitoring Team using data from hospitals' Medicare cost reports.

DAYS CASH ON HAND

Another measure of liquidity, *Days Cash on Hand*, is a hospital's total cash divided by average daily operating expenses. It represents the number of days a hospital can pay its operating obligations without receiving any new cash inflow. Larger CAHs tend to have higher levels of cash on hand relative to their daily expenses, although smaller hospitals had higher levels in 2015 and 2016. On average, this indicator has been growing for both smaller and larger hospitals. Both groups did see a slight decline in 2016, though.

Illinois CAHs 2016 average days cash on hand of 157 was somewhat higher than the median (138) for hospitals with an S&P rating of BBB-. Hospitals with higher S&P ratings had well over 200 days cash on hand.

Figure 12. Illinois Critical Access Hospital Financial Indicators

		2010	2011	2012	2013	2014	2015	2016
Total Margin	Under $10m	1.0	0.8	0.8	2.3	3.5	4.8	1.1
	Over $10m	4.2	4.9	4.7	5.0	4.4	4.7	2.0
	All	2.3	2.4	2.3	3.4	3.9	4.8	1.4
Cash Flow Margin	Under $10m	6.0	7.0	6.4	8.0	9.7	11.1	7.6
	Over $10m	10.9	10.7	10.2	10.2	9.8	11.7	11.3
	All	8.0	8.4	7.8	8.9	9.7	11.3	9.1
Operating Margin	Under $10m	0.6	0.1	0.6	0.8	3.1	3.9	0.4
	Over $10m	4.4	4.8	4.4	4.3	3.4	5.5	7.8
	All	2.1	2.0	2.1	2.2	3.2	4.5	3.3
Current Ratio	Under $10m	2.4	2.4	2.4	2.4	2.6	2.7	3.1
	Over $10m	2.9	2.4	2.5	2.3	2.3	2.5	3.0
	All	2.6	2.4	2.4	2.4	2.5	2.6	3.0
Days Cash on Hand	Under $10m	93	112	113	118	137	177	166
	Over $10m	215	125	134	136	152	166	143
	All	139	117	121	125	143	173	157

Source: Critical Access Hospital Measurement and Performance Assessment System.

UTILIZATION INDICATORS

ACUTE BED AVERAGE DAILY CENSUS

Average Daily Census (ADC) is a measure of hospital utilization. Hospitals have been filling fewer acute beds in recent years (Figure 13). In 2010 and 2011, larger CAHs averaged about 7.0 acute bed patients per day and smaller hospitals just under 5.0 acute patients per day. By 2016, these averages had fallen to 5.4 per day for larger CAHs and 2.8 per day at smaller hospitals.

SWING BED AVERAGE DAILY CENSUS

While acute bed ADC has been falling, swing bed utilization has been steady to rising. In most years there is little difference between small and large hospitals on this measure.

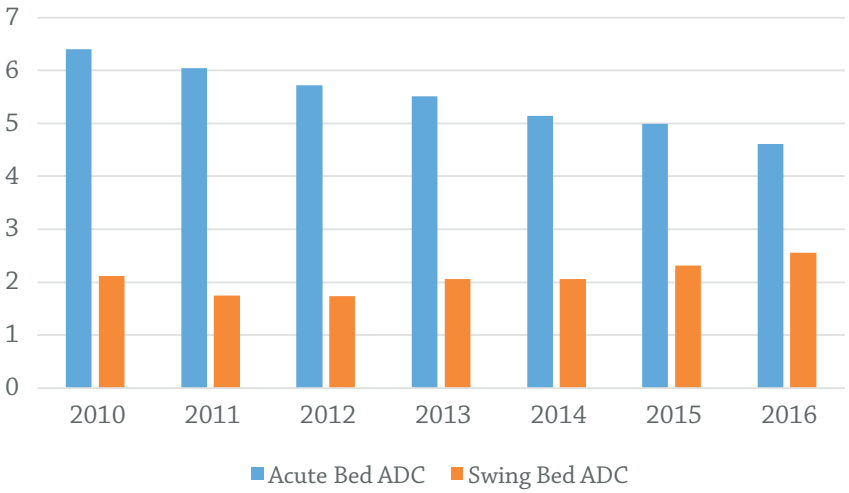
Figure 13. Illinois Critical Access Hospital Utilization Indicators

		2010	2011	2012	2013	2014	2015	2016
Acute Bed ADC	Under $10m	4.9	4.6	4.1	3.8	3.3	3.2	2.8
	Over $10m	7.3	6.9	6.7	6.4	6.0	5.8	5.4
	All	6.4	6.0	5.7	5.5	5.1	5.0	4.6
Swing Bed ADC	Under $10m	1.9	1.8	1.7	2.0	2.1	2.1	2.0
	Over $10m	2.3	1.7	1.7	2.1	2.0	2.4	2.8
	All	2.1	1.7	1.7	2.1	2.1	2.3	2.6

Source: Critical Access Hospital Measurement and Performance Assessment System.

Swing beds have become an increasingly significant part of CAH bed utilization (Figure 14). In 2010, swing beds accounted for about 25.0% of bed utilization. By 2016, this had grown to 36.0%.

Figure 14. Illinois Critical Access Hospital Swing and Acute Bed Utilization



Source: Critical Access Hospital Measurement and Performance Assessment System.

FINANCIAL IMPORTANCE OF SWING BEDS

As was shown above, Illinois CAHs operate under very small operating margins, with many below 1% in some years. This makes them vulnerable to even small losses in revenue. Swing bed revenues represent a significant portion of total inpatient revenues for many hospitals, making the program essential to the survival of many CAHs.

AVERAGE INPATIENT REVENUES

Total inpatient revenues for larger hospitals have been increasing steadily in recent years (Figure 15). Average inpatient revenues were nearly 25% higher in 2016 compared to 2010. Smaller CAHs, however, had essentially flat revenues from 2011 through 2016.

AVERAGE SWING BED REVENUES

Total swing bed revenues for larger hospitals have been increasing steadily in recent years. Average swing bed revenues for smaller CAHs grew by about 20% between 2010 and 2014 and remained relatively steady through 2016.

Figure 15. Illinois Critical Access Hospital Revenue Measures

		2010	2011	2012	2013	2014	2015	2016
Average Inpatient Revenues	Under $10m	$5,154,952	$5,803,940	$5,680,157	$5,848,961	$5,837,120	$5,442,125	$5,764,153
	Over $10m	$15,755,350	$15,411,967	$15,869,508	$16,189,034	$17,237,322	$18,964,117	$19,397,888
	All	$8,547,079	$9,607,117	$9,713,442	$10,214,770	$10,349,700	$10,794,581	$11,160,840
Average Swing Bed Revenues	Under $10m	$1,067,700	$1,043,224	$1,126,642	$1,199,596	$1,240,404	$1,194,110	$1,279,620
	Over $10m	$1,161,764	$1,066,247	$1,124,930	$1,175,497	$1,415,486	$1,693,620	$1,562,999
	All	$1,097,801	$1,052,337	$1,125,964	$1,189,421	$1,309,708	$1,391,833	$1,391,791
Swing Bed Percentage	Under $10m	20.7%	18.0%	19.8%	20.5%	21.3%	21.9%	22.2%
	Over $10m	7.4%	6.9%	7.1%	7.3%	8.2%	8.9%	8.1%
	All	12.8%	11.0%	11.6%	11.6%	12.7%	12.9%	12.5%

Source: Critical Access Hospital Measurement and Performance Assessment System.

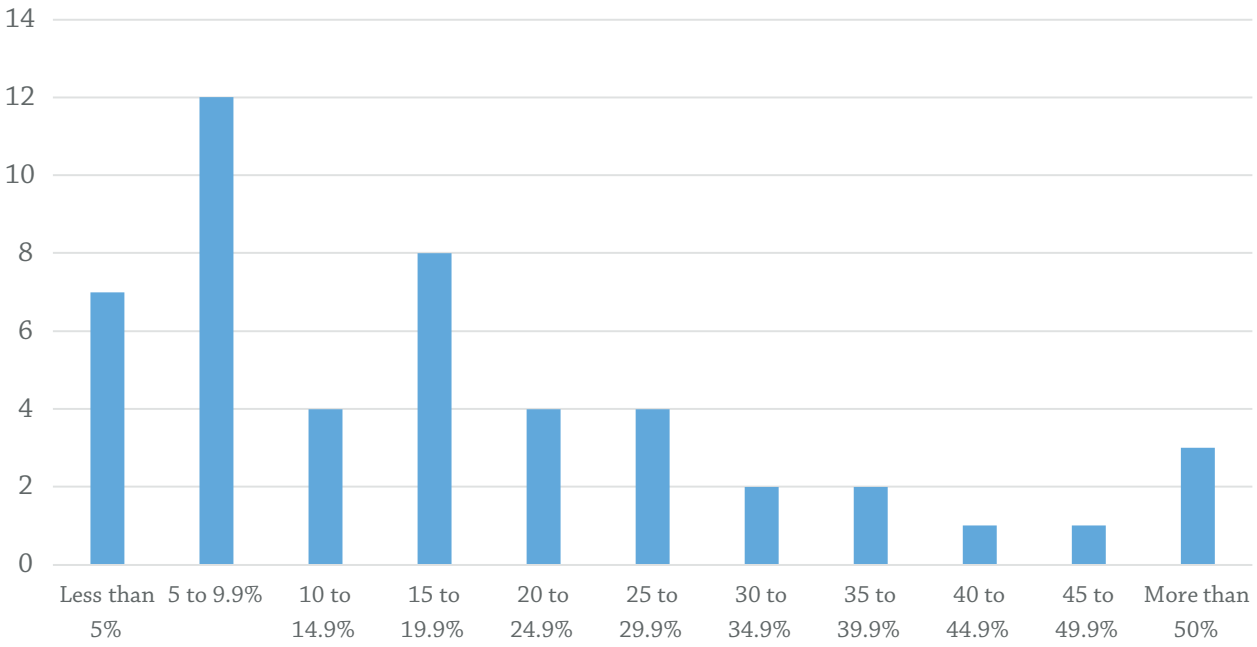
SWING BED AS A PERCENTAGE OF INPATIENT REVENUES

Swing bed revenues are a significant source of CAH inpatient revenue, especially for smaller hospitals. Swing bed revenues generally account for about 8% of total inpatient revenues at larger hospitals. For smaller CAHs, swing bed revenues have made up over 20% of total inpatient revenues in recent years. This percentage increased every year between 2011 and 2016.

The significance of swing bed revenues varies substantially among Illinois CAHs. While swing bed revenues accounted for an average of 12.5% of all inpatient revenues in 2016, many hospitals received a much higher percentage of inpatient revenues from swing beds (Figure 16). Swing bed revenues accounted for over 20% of total inpatient revenues at more than one-third of all CAHs (17 out of 48 with Swing Bed Programs). Nine CAHs received more than 30% of total inpatient revenues from swing beds.

Considering the small margins under which CAHs operate, losing swing bed revenues would cause significant financial distress for these hospitals. According to a national study[xxi], a 20% decline in revenue would cause 72% of CAHs to have negative operating margins. A 30% loss in revenue would cause 80% of CAHs to operate with negative margins.

Figure 16. CAHs by Swing Bed Revenues, Percentage of Total Patient Revenues, 2016



Source: Critical Access Hospital Measurement and Performance Assessment System.

The financial and utilization data demonstrate that swing bed revenues are critical to the financial health of most CAHs in Illinois. They represent a significant and growing portion of overall hospital revenues. This is especially true for smaller hospitals, which tend to operate with tighter margins.

Losing swing bed revenues would likely mean that a significant number of CAHs would be forced to close. This would represent a substantial negative impact in the rural communities served by these hospitals. Economic and health disparities between rural and urban areas would grow significantly.

EFFECTIVE PRACTICES IN ILLINOIS SWING BED PROGRAMS

In October 2018, an email was sent to all surveyed hospitals requesting they share their effective practices regarding their Swing Bed Programs. Six of the 18 CAHs agreed to follow-up interviews. Their responses are shared throughout the report where appropriate and below in these three contexts:

- Patient-centered Care
- Quality of Care
- Care Coordination/Multi-Disciplinary Team Approach

PATIENT-CENTERED CARE

Many of the CAHs that participated in follow-up interviews revealed that maintaining a successful and viable Swing Bed Program requires a patient-centered care approach. One CEO explained that it is important to take the patient's perspective into consideration when deciding whether to recover in the hospital versus a skilled nursing facility. Often the Swing Bed Program provides the patient with an environment in which they can thrive. If the patient can stay in a swing bed without transferring through different patient settings they often have a shorter length of stay. This, in turn, enhances quality of care, produces better patient outcomes, and can save money for the

patient and insurance providers. In addition, several CAHs stated they have an 'activity' nurse or other designated staff to offer activities such as bingo, church outings, garden visits, etc., to enhance the patient's quality of life during their stay. These CAHs are finding patients prefer the Swing Bed Program over a nursing home because of the patient focus, the transitional nature of the program often leading to a shorter length of stay, and continuity of care.

QUALITY OF CARE

The follow-up interviews re-enforced that many Swing Bed Programs provide a high level of care. The quality of care provided in Swing Bed Programs may be attributed to several important aspects. First, interviewees emphasized care continuity in the Swing Bed Program. For instance, patients in recovery can keep their same primary care provider, thereby enhancing continuity of care and overall recovery.

In addition, the majority of the CAHs interviewed described having high nurse-to-patient ratios which also enhances the quality of care provided. Some of the CAHs observed that high nurse-to-patient ratios have improved patient satisfaction. Additionally, health care staff conduct daily rounds on patients to ensure their needs are being addressed and meet with the entire care staff every morning to discuss the holistic needs of the patients.

To further ensure quality care is available at all times and compete with other acute care facilities, one CAH mentioned that they have a 24/7 admission policy to meet patient needs (e.g., patients discharged over the weekend will be admitted for recovery). For other CAHs, quality of care does not stop at discharge. Follow-up phone calls and in-home visits were reported by many of the CAHs. Post discharge follow-ups have resulted in improved medication compliance and reduced discrepancies which help lower readmission rates.

CARE COORDINATION/MULTIDISCIPLINARY TEAM APPROACH

The use of a multi-disciplinary team of health care professionals to aid in a patient's recovery is a common practice among the CAHs interviewed. Several of the CAHs explained that their multidisciplinary team may include physical therapists, occupational therapists, hospitalists, and physician assistants. This approach supports transitional care by providing more aggressive rehabilitation to get the patient home sooner. For example, one CEO stated that "after about an hour of surgery, therapists are in the room to get the [patient] on the road to recovery." For patients, having access to a team not only enhances their satisfaction with treatment, it also can help ease the stress of recovery and instill confidence in a positive health outcome. Providing high quality, multi-disciplinary care that results in quicker recoveries and lower costs is creating real value on many levels.

> **"Most patients are from our community, we know them and their needs. We provide excellent, personalized care."**
>
> – Brooke Mitchell, Manager of Hospital Services, Genesis Medical Center – Aledo

CONCLUSION

Swing beds are one option for post-acute skilled care in rural communities and are likely, in many rural communities, to be the only option. In March 2015, the Department of Health and Human Services, Office of Inspector General (OIG) published a report recommending that the CMS reduce swing bed reimbursement rates for CAHs from plus 1% of allowable costs to the daily rate paid under the SNF prospective payment system. CMS responded by noting that the OIG "overestimates savings by failing to incorporate important factors such as the level of care needed by swing bed patients, transportation fees to alternative facilities, and the use of point-to-point mileage distances instead of road miles" (pg. 21-22).

Through the research and survey work conducted by CGS, it was concluded that Illinois CAHs, and their communities, would be negatively affected by changes to, or elimination of, their Swing Bed Programs. A financial analysis determined that for most of the 48 CAHs with Swing Bed Programs, swing bed usage provides a significant inpatient revenue stream by utilizing otherwise empty beds. A few noteworthy statistics from the CGS survey and research:

- The importance of swing bed revenues varies significantly among Illinois CAHs. While swing bed revenues accounted for an average of 12.5% of all 2016 CAH inpatient revenues, many hospitals received a much higher percentage of inpatient revenues from swing beds. Swing bed revenues accounted for over 20% of total inpatient revenues at more than one-third of all CAHs (17 out of 48). In addition, nine CAHs received more than 30% of total inpatient revenues from swing beds.

- Considering the small margins under which CAHs operate, losing swing bed revenues would cause significant financial distress for these hospitals. A recent national study concludes that a 20% decline in revenue would cause 72% of CAHs to have negative operating margins. A 30% loss in revenue would cause 80% of CAHs to operate with negative margins.

In addition to the financial implications of changing reimbursement rates and/or eliminating swing beds for CAHs, is the reduction in quality care options for rural patients. Research conducted for this study concluded the following:

- Illinois CAH swing bed patient readmission rates have generally been below 5% in recent years - significantly lower than the Illinois statewide average rate for skilled nursing facilities. According to the Centers for Medicare and Medicaid Services *Nursing Home Compare* data, the percentage of short-stay residents in Illinois who were re-hospitalized after a nursing home admission was 24.4% in 2016-2017.

- The average length of stay for patients in CAH swing beds is significantly lower than that of stand-alone skilled nursing facilities. Patients are discharged from swing beds in an average of about 10 days, while those in skilled nursing facilities stay for an average of 26 days.

- Data specific to swing beds could also be improved by creating a standardized quality reporting program, using recommendations from the University of Minnesota's Rural Health Research Center cited earlier in this report, as well as others, to further substantiate the quality care and services being provided by CAHs through the Swing Bed Program.

Through follow-up interviews conducted as a part of this research, CEOs and senior nursing staff acknowledged that without the Swing Bed Program their hospitals would be forced to cut staff, reduce services, and in some instances, close their doors. This, in turn, would negatively impact the larger community economically and from an access to local, quality health care standpoint. It is important to focus on the entire value proposition when evaluating the Swing Bed Program and health care in general, not just on cutting costs. The value proposition also takes into account quality, patient safety, service quality, and cost over time. It will be important for policy makers in the near future to evaluate the entire value proposition and consider the true cost of reducing payments and eliminating critically important health care programs, such as the Swing Bed Program, in rural Illinois and the United States.

ACKNOWLEDGMENTS

This study could not have been completed without assistance from many ICAHN members contributing valuable feedback and insight. Several CEOs provided additional guidance to help ensure the survey questions requested meaningful information. Those CEOs included: Kara Jo Carson, Pinckneyville Community Hospital, Larry Spour, Lawrence County Memorial Hospital, and Marie A. Wamsley, Midwest Medical Center. In addition, several hospitals provided follow-up information via phone interviews. These hospitals included: Genesis Medical Center – Aledo, Gibson Hospital, Mason District Hospital, Midwest Medical Center, and Pinckneyville Community Hospital.

The CGS study team would like to give a special thanks to Pat Schou, the Executive Director of ICAHN, as she provided guidance throughout the project with insights into drafting the survey and understanding the responses. Another special thanks to Hana Hinkle, Associate Director at the National Center for Rural Health Professions, UIC Health Sciences Campus-Rockford, and her research assistants William Tian and Nicole Blumenstein for their review of background material for this project.

As always, the findings and conclusions presented in this report are those of the authors/project team alone and do not necessarily reflect the views, opinions, or policies of the officers and/or trustees of Northern Illinois University. For more information, please contact Melissa Henriksen, mhenriksen@niu.edu or 815-753-0323.

APPENDICES

Appendix A: ICAHN Swing Bed Program Survey, List of Responding Hospitals

Appendix B: ICAHN Swing Bed Survey Response Analysis

Appendix C: Survey Participants, Challenges with Swing Bed Program

APPENDIX A: ICAHN SWING BED PROGRAM SURVEY, LIST OF RESPONDING HOSPITALS

Abraham Lincoln Memorial Hospital
Advocate Eureka Hospital
Carlinville Area Hospital Association
Clay County Hospital
Crawford Memorial Hospital
Ferrell Hospital
Genesis Medical Center
Gibson Area Hospital & Health Services
Hammond-Henry Hospital
Hardin County General Hospital
Hillsboro Area Hospital
Hopedale Medical Complex
Kirby Medical Center
Lawrence County Memorial Hospital
Mason District Hospital
Midwest Medical Center
OSF Health care Saint Luke Medical Center
Pana Community Hospital
Paris Community Hospital
Pinckneyville Community Hospital
Randolph Hospital District dba Memorial Hospital
Red Bud Regional Hospital
Salem Township Hospital
Sparta Community Hospital
St. Joseph Memorial Hospital
Taylorville Memorial Hospital
Thomas H. Boyd Memorial Hospital
Union County Hospital
Wabash General Hospital
Warner Hospital & Health Services

APPENDIX B: ICAHN SWING BED SURVEY RESPONSE ANALYSIS

There are 51 Critical Access Hospitals (CAHs) in Illinois, 48 of which have a Swing Bed Program. The survey produced 30 usable, unduplicated responses. This was a response rate of 63% for swing bed hospitals.

Hospitals that completed the survey tended to have slightly higher patient revenues. This was especially true for inpatient revenue that averaged 50% higher revenues for completing vs. non-completing hospitals.

Figure B1. Revenue Metrics: Survey Completers vs. Non-completers.

COMPLETED SURVEY	COUNT	AVERAGE INPATIENT REVENUE	AVERAGE OUTPATIENT REVENUE	AVERAGE TOTAL PATIENT REVENUE
Yes	30	$12,856,155	$53,491,424	$66,347,579
No	18	$8,335,315	$55,375,089	$63,710,404

Differences in inpatient revenue between survey completers and non-completers are driven by acute bed utilization. Acute bed average daily census (ADC) at hospitals that completed the survey was about one-third higher than non-completing hospitals. Swing bed ADC was nearly identical between survey completers and non-completers.

Figure B2. Utilization Metrics: Survey Completers vs. Non-completers.

COMPLETED SURVEY	COUNT	SWING BED ADC	ACUTE BED ADC
Yes	30	2.2	4.1
No	18	2.2	2.7

There were not significant differences between responders and non-responders for other metrics. Diverse measures such as payor mix, plant age, and staffing levels all had similar average levels between the two groups. Thus, the authors are confident that the data in the responses received may reasonably be used to indicate conditions for all CAHs in Illinois.

APPENDIX C: TOP CHALLENGES TO PROVIDING A SWING BED PROGRAM, SURVEY RESPONSES

CHALLENGE 1	CHALLENGE 2	CHALLENGE 3
How to handle patients whose PCP is not on staff	Ensuring hospital only accepts patients within capabilities	Getting approval from Medicare Advantage Plans
Getting patient to qualify for swing bed	Getting patients to do more than just the minimum	Getting the word out to the community
Competition from local nursing homes	Dedicated staff / staff float to other units	Community education about services
Patients with medically complex issues arriving acutely ill	Regulatory interpretations	Data collection in the EHR
Keeping the LOS expectations under 15 days	Accepting patients from other facilities and truly having an idea of patient needs	Lack of programs & activities for patients similar to LTC facilities
Market saturation of Swing Bed Programs	Influx of Medicaid patients to the market	Insurance
Placement post stay	Staffing	Insurance coverage - Fewer straight Medicare members lowers reimbursement
Community Awareness	Communication with outside facilities	Ensuring compliance with required elements of care (activities, dental, social, pastoral, etc.).
Ensuring appropriate and pertinent documentation is entered in supporting swing bed status and necessity	If receiving a swing bed referral from another facility ensuring the patient is "appropriate" for rehab status at the time of discharge from acute care. This includes educating our staff re: care and documentation requirements.	Lack of referrals/misunderstanding of CAH option
Certified for Medicare only/barriers of insurance coverage	Cost of Care impact on ACO/Higher cost than SNF	Consistent quality activities and programs
Specialized equipment to meet patient needs	Entertainment program/in-house activities for patients	3-day acute stay rule for the traditional Medicare patient which differs from Medicare Advantage which does not have the requirement
Competition from 2 local SNFs	Appropriate referrals from regional tertiary hospitals	Reminding staff of the "difference" between inpatient and swing bed for rehab care

CHALLENGE 1	CHALLENGE 2	CHALLENGE 3
Community awareness of the service. Knowing the program is available and what circumstances it would be appropriate	No CMS star rating as a CAH with the bundled system not listed as a care option	Patient compliance with discharge plan resulting in readmission
Determining the appropriateness for admitting patients	Keeping up with regulatory changes	Developed strong partnership with PT and nursing for team approach to patient care
Therapy staff challenging acceptance/admission of qualified patients	Therapy wanting to discharge patient when physicians feel patient needs additional therapy, still weak and unable to perform some tasks on their own	Medicare Advantage plans-difficulty working with them
Accepting higher acuity patients with multiple comorbidities	Began hospitalist program which decreased acceptance of swing bed admissions	Patient activity greater than expected based on review of information
Referrals from larger facilities-don't show up on Medicare website	Medicaid not accepted	3-day acute stay rule, which is increased because of the difference in traditional Medicare and Medicare Advantage rules where Medicare Advantage does not require the 3-day acute stay.
Discharge from skilled to LTC	Lack of local physician	
Community awareness of the program. The availability and what it is, etc.	No CMS star rating as a CAH, so in a bundled system hospital is not an option listed for care.	Documenting nursing rehab goals and care
Finding patients that fit criteria for admission	Bed availability	Growing Costs
Retrieving outside referrals	Shifting caregiver through process from acute to rehab	Local nursing homes wanting the business also
Consistent census	Limitation on being able to accept Swing Bed patients during high census	
Physical therapy	Patients without established physicians	
Marketing/regaining business from previously bundled payment program hospitals	Staff recruitment	
Physician Coverage	Insurance company requirements	
Managing referrals		
Referrals		

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