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Boost Your Critical Access Hospital Bottom Line with Swing Bed Designation

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Nationally, profit margins are declining for health care facilities and especially in the Critical Access Hospital (CAH). After several years of climbing margins, facilities are experiencing reduced profits; CAHs are especially vulnerable with this trend as they do not have the cash reserves or the volumes to sustain the declines without looking for new ways to gain additional reimbursement. One of the options may be to obtain **swing bed designation** from Medicare. BIPA 2000 established a new reimbursement provision for CAHs that provides a full reasonable cost payment (101%) for CAH swing bed services instead of a payment based on SNF PPS Reimbursement. Differences in payment would be a swing bed payment of $1,500-$2,000 a day versus a RUGS payment of approximately $275 a day. **The swing bed payment methodology is getting paid acute care rates for skilled level of care**.

Critical Access Hospitals wishing to provide swing bed services must apply and receive swing bed certification from CMS to become eligible. See 42CFR 485 for designation, CFR 482.66 for requirements and 42CFR 413.70 for cost based reimbursement. Once approved, the facility is required to maintain Medicare conditions of participation.

Medicare provides CAHs the option of utilizing their inpatient hospital facilities for the provision of extended care services. The total number of beds being used for the furnishing of either acute care or post-acute care inpatient services may not exceed 25 beds. This can occur without the need to physically transfer a patient between different nursing units within the hospital or even between different facilities.

Once swing bed designation is granted, the swing-bed patients in CAHs are considered to be exclusively patients of the CAH. For example, if a CAH has 10 licensed swing beds, then those 10 beds would count towards their 25 acute inpatient bed cap, but the rest of the SNF beds in that separately licensed facility would not count towards the CAH's 25-inpatient bed limit.

Swing beds need not be located in a special section of the CAH. The patient need not change locations in the facility merely because their status changes unless the facility requires it. There must be discharge orders from acute care services, appropriate progress notes, discharge summary, and subsequent admission orders to swing-bed status regardless of whether the patient stays in the same facility or transfers to another facility. If the patient does not change facilities, the same medical chart or electronic medical record (EMR) can be utilized but the swing-bed section of the chart or EMR must be distinctly separate from the

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acute care section with appropriate admission orders, progress notes, and supporting documents.

There is no requirement for a CAH to use the full MDS form for recording the patient assessment or for nursing care planning.

By utilizing swing beds, facilities with higher acute admission rates may be able to manage their acute inpatient beds more effectively; swing bed admissions can contribute to improved quality of care. For example:

- In rural areas where access to services may be limited, patients ready for acute discharge from a facility may need more care and support than can be achieved through a discharge to home with home health services.
- Psychologically and emotionally, swing bed admissions may be less traumatic and threatening for the patient. Admission to a swing bed feels more like a continued hospital stay to the patient and helps improve continued recovery and a return to independence.

In summary, there are multiple advantages to the effective use of swing beds for the CAH, the physician, the patient and the community. Swing beds can significantly improve both the facility's patient care outcomes as well as financial viability since CAH swing bed services are reimbursed on a cost-related basis.

There are significant reimbursement strategies on the Medicare & Medicaid cost reports for reporting swing beds. Ask a consultant to review your cost report and consider reopening if there are substantial reimbursement impacts for your facility.

See FCAW's upcoming articles in the Washington Healthcare News for other financial options for Critical Access Hospital's to improve their bottom line.

Donna Herbert *is the founder of Financial Consultants of Alaska & Washington (FCAW). Since 1979, she has provided advice and counsel to health care providers in both Alaska and Washington concerning all aspects of budget, finance, and preparation of third-party cost reports. FCAW has expanded their client base throughout the U.S. She can be reached at 907-790-1026 or by email at fcaw@fcawreimbursement.com.*

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