SWING BEDS

What, When, Why, and How

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KARL PALMER, RN, MS

Karl Palmer, RN, MS is owner and principal at Karl Palmer Consulting, LLC. An RN for 28 years, Karl brings more than 12 years experience in supporting over 150 Swing Bed Transitional Care programs in 26 states. Prior, Karl worked in Med-Surg, ICU, outpatient clinic leadership, emergency preparedness, process improvement teaching/coaching, and quality leadership across the Mayo Clinic system. He has a Bachelors in Nursing from Winona State University in Winona, MN and a Masters in Science in Nursing and Healthcare Systems Administration from the University of Minnesota.

GOALS

This presentation will provide an introduction to the Medicare Swing Bed option to include patient coverage criteria, an overview of relevant regulatory elements and Michigan-specific statutes, tips for Swing Bed program success, and a summary of the benefits of Swing Bed recovery for patients, regional acute care hospitals, and Critical Access Hospitals.

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OBJECTIVES

At the end of this presentation, attendees will be able to

- List Medicare Swing Bed hospital participation and Medicare Beneficiary coverage criteria
- Describe key Swing-Bed related Medicare regulatory resources and key areas of compliance
- Identify approaches to maintain and grow a high-quality Swing Bed program
- Communicate the key benefits of Critical Access Hospital Swing Bed recovery for patients, regional partners, and Swing Bed hospitals

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THE BASICS

- Since Omnibus Reconciliation Act of 1980, Critical Access Hospitals (CAHs) and certain rural fee-for-service (PPS) hospitals (geography and < 100 beds) may use inpatient beds **interchangeably for acute and skilled post-acute skilled**
- **Medicare Part A** covers **up to 100 days per benefit period** if all criteria are met, **20% co-pay after day 20**
- **Medicare Advantage and other commercial payers may pay** based on contract or prior authorization
- **Medicaid typically not a good payer in most states**, some states have additional Medicaid patient expectations or rules
- Since 1997 Balanced Budget Act, **CAHs paid on cost-basis** (PPS Hospital Swing Bed paid via nursing home Patient Driven Payment Model…more on that later!)

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MICHIGAN SPECIFIC LAWS – ML SECTION 333.22210

- Hospital must go through MI LARA Certificate of Need process, approval of requested number of **up to 10 specific beds**
- Annual total days under the state program may not exceed **1,825 patient days** in a fiscal year for a single hospital.
- *"(f) Not provide extended care services in a swing bed if the hospital owns or operates a hospital long-term care unit that has **beds available** at the time a patient requires admission for extended care services."*
- Specific language regarding several patient rights **in addition to** those expected by CMS
- Submit **specific data** on Swing Bed use to LARA annually

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MCRH AND SWING BED

- **Past MCRH involvement in Swing Bed support**
  - Facilitated Swing Bed support at 6 MI CAHs via FLEX Funding for over six years (with Allevant Solutions, operations concluded 2025)
  - Facilitated four-year HRSA FORHP Outreach Grant focusing on Transitional Care (Swing Bed) and Staff/Patient Wellness with a consortium of 6 MI CAHs, 2 MI Acute Care Hospitals, and Allevant Solutions (grant complete 2025)
- **Current MCRH involvement in Swing Bed support**
  - MCRH and Karl Palmer Consulting supporting Corewell Reed City in swing bed re-implementation
  - MCRH facilitating new four-year HRSA FORHP Outreach Grant with Karl Palmer Consulting (2025-2029) to impact participating hospitals/communities
    - Swing Bed
    - Staff, Patient, and Community Wellness
    - Staff, Patient, and Community access to, and support for completion of, Advance Directives

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WHY IS RURAL SWING BED A THING?

- **Nursing Home Deserts** (2018)*
  - **7.7%** of U.S. counties
  - **10.1%** of the 1,976 nonmetro counties
  - **3.7 %** of metro counties
- **Nursing home RN turnover rates** (2018)**
  - Rural Median **94%**
  - Urban Median **105%**
  - National Mean **140%**
  - Medicare Care Compare SNFs rated 1 Star Quality **135%**, rated 5 Star Quality Rating **77%**
- **Rural Hospital RN turnover rates 20-25% +/-** (no single source)
- Provides continuity of care (for CAH inpatients) and patient choice
- Uses staff, equipment, expertise **ALREADY IN PLACE** and **SUSTAINS ACCESS**

* 2018, RUPRI Center for Rural Health Policy Analysis, University of Iowa College of Public Health
**Ashvin, Ga., Huizi, Y., Grabowski, D., (2021). *High nursing staff turnover in nursing homes offers important quality information*. Health Aff (Millwood). Mar;40(3):384–391.

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MAIN CMS RESOURCES – MEDICARE PART A SKILLED COVERAGE

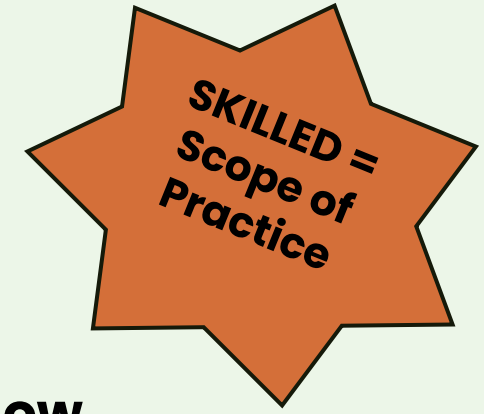
- **Medicare Benefits Policy Manual Chapter 8** (What is Covered)
  - Skilled level of care criteria, daily skilled need requirements, coverage exclusions
  - Physician certification and recertification
- **Medicare Claims Processing Manual Chapter 10** (How to Bill)
  - Billing mechanics, bundling rules, revenue codes
  - Part A payment logic and cost reporting

SKILLED CARE CRITERIA - MBPM CHAPTER 8

- **No prior auth needed for Part A** if all criteria met and benefit days available
- **Three consecutive days in acute care**
  - Medicare Advantage, other commercial payers, & CMS TEAMS model may waive 3 day stay
- At least one **"daily" skilled need**
  - Only **Nursing** needs - **7 days per week**
  - Only **Rehab Therapy** needs - at least **5 days per week**
- **"Practical Matter" Reason(s) -** Why the patient can't reasonably or effectively recover in a less costly or less restrictive setting like home care or with outpatient clinic support
  - Patient-specific & community-specific
- **Discharge** from acute and **admission** orders to Swing Bed
- **Physician Certification of Skilled Need** at admission, day 14, day 30, and every 30 days after

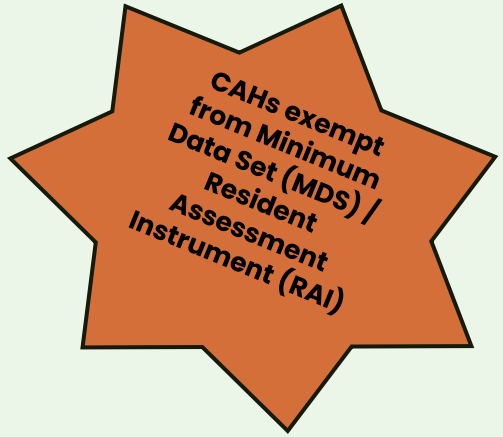
SKILLED NEEDS – MBPM CHAPTER 8

- Patient needs require **provision of or oversight** by **licensed nurse or therapist**
  - **Direct Skilled Nursing**
  - **Direct Skilled Therapy**
  - **Management and Evaluation of Complex Plan of Care**
  - **Observation and Assessment of Patient Condition**
  - **Teaching and Training**
- To **improve condition, maintain condition,** or **prevent/slow deterioration**
- Based on **patient-specific** assessment
- End of life **may or may not** qualify



SURVEY COMPLIANCE

- **Medicare State Operations Manual Appendix W** (CAH standards)
  - All relevant general CAH standards
  - Additional standards cross-walk to Appendix PP
- **Medicare State Operations Manual Appendix PP** (SNF standards)
  - Resident Rights
  - Admission, Transfer and Discharge Rights
  - Freedom From Abuse, Neglect, and Exploitation
  - Social Services
  - Comprehensive Assessment, Comprehensive Care Planning, and Discharge Planning
  - Specialized Rehab Services
  - Dental Services
  - Nutrition



Note: This content does not cover <u>all</u> survey standard language and guidance to surveyors.

RESIDENT RIGHTS – SOM APPENDIX PP

- Power of Attorney/Guardianship
- Informed in language patient/guardian can understand
- Right to refuse treatment
- Aware of and can contact attending physician
- Maintain personal possessions (within reason)
- Share a room with a hospitalized spouse (if reasonable given room arrangement)
- Immediate access to visitors (within “reasonable clinical and safety restrictions”)
- Right to send and receive mail
- Be aware of costs Medicare or Medicaid may not cover/situations of financial liability
- Privacy and confidentiality

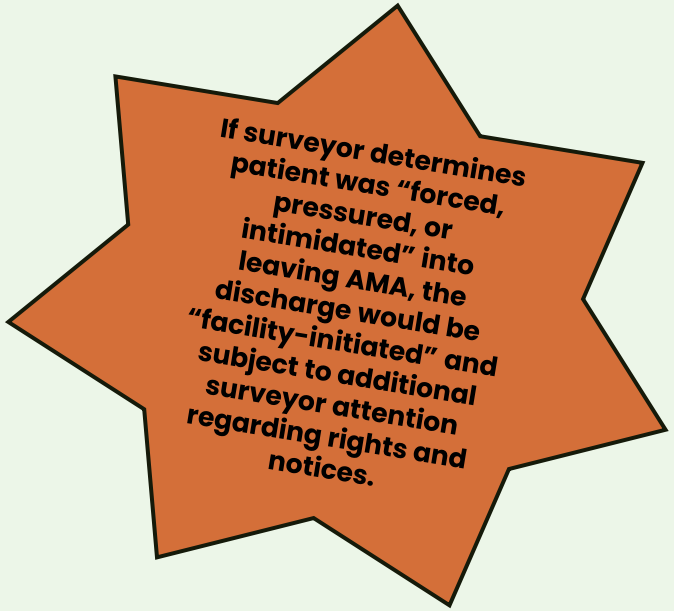
ADMISSION, TRANSFER AND D/C – SOM APPENDIX PP

All Discharges:

- Information provided to the **receiving facility/provider** must include at least
  - Contact information of the practitioner responsible for the care of the resident
  - Resident representative information including contact information
  - Advanced directive information
  - All special instructions or precautions for ongoing care as appropriate
  - Comprehensive care plan goals
  - All other necessary information, including a copy of the patient's discharge summary
  - Any other documentation, as applicable, to ensure a safe and effective transition of care

FACILITY INITIATED D/C – SOM APPENDIX PP

- **Facility-initiated transfer or discharge**: "A transfer or discharge which the resident objects to, did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences."
- **Resident-initiated discharge:** "The resident or, if appropriate, the resident's representative has provided verbal or written notice of intent to leave the facility (leaving the facility does not include the general expression to return home or the elopement of residents with cognitive impairment)."
- **Emergent Transfers:** CMS considers all "emergent" patient transfers or discharges to an acute inpatient facility to be "facility-initiated".



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FACILITY INITIATED D/C – SOM APPENDIX PP

Facility-Initiated Discharge: Patients **may not be discharged without their consent** and are **able to stay in the facility except for limited circumstances** (and **retain the right to stay** in the facility during an appeal except for limited circumstances):

- Patient's **medical needs cannot be met** at your facility
- Transfer is **necessary for patient welfare**
- Patient's **health has improved significantly** to the point **services no longer needed**
- Patient's **clinical or behavioral condition is endangering individuals** in the facility
- **Individuals' health** at the facility **would be endangered** if the patient remains in the facility
- Patient has **failed** (after reasonable and appropriate notice) **to pay** for (or have CMS pay for) the stay
- Your **hospital is planning to cease facility-wide services** (close) while the patient is still admitted

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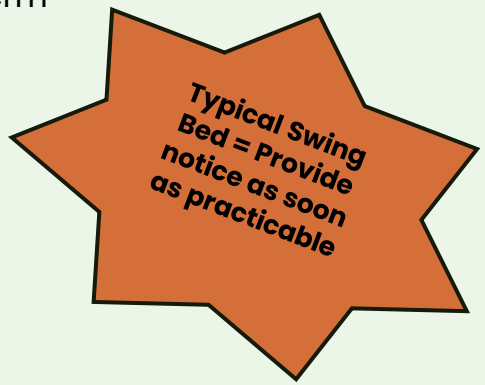
FACILITY INITIATED DISCHARGE – SOM APPENDIX PP

Facility-Initiated Discharge Minimum Documentation:

- **Reason** for the transfer or discharge
- If the transfer/discharge is **because patient needs cannot be met** in your facility, documentation must explain
  - **What** you're unable to provide
  - **How** you attempted to meet the needs
  - **Services that will be available** at the receiving facility that will meet the needs
- If the transfer/discharge is because patient needs cannot be met in your facility or the patient has improved to no longer need services, the **patient's attending physician must contribute to the discharge documentation**
- If the transfer/discharge is because the **patient is a threat to the health or safety of others**, **a physician** must contribute to the discharge documentation, but it **does not need to be the patient's attending physician**

NOTICE OF DISCHARGE – SOM APPENDIX PP

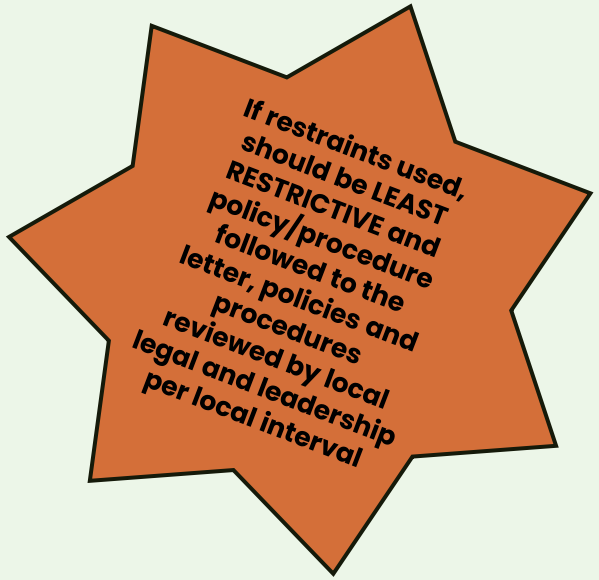
- Patients/Families/Guardians must receive **notice of transfer/discharge** with **CMS-specified content** prior to transfer/discharge and be **oriented to the process**
  - **Reason, effective date, and location** to which patient is going
  - **Statement of appeal rights**, including contact information, how to obtain appeal form, and right to assistance in completing appeal
  - Name, address, email, and phone of **State Office of Long-Term Care Ombudsman**
  - If **intellectual or developmental disabilities**, contact info for agency responsible for protection and advocacy per federal law
  - **Facility-initiated transfer/discharge**, **copy must be sent** to Office of the State Long-Term Care Ombudsman
- Provide **30 days prior** to discharge **UNLESS**
  - Transfer/discharge due to **concerns over health and safety**
  - Patient health has improved to allow for more **immediate transfer/discharge** than 30 days in the future
  - **Immediate medical need** necessitates transfer
  - Patient has **not been in facility for 30 days**



*CMS State Operations Manual Appendix PP

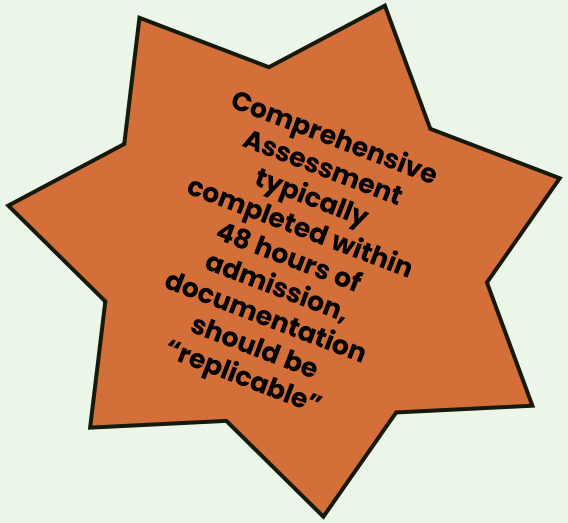
ABUSE, NEGLECT, AND EXPLOITATION – SOM APPENDIX PP

- Patients have the **right to be free of abuse, corporal punishment, involuntary seclusion, physical or chemical restraint not medically necessary**
- Facilities must ensure they **do not employ/engage individuals found guilty of abuse, neglect, exploitation, mistreatment or theft** and have **policies in place** to protect patients
- **Report** to State registries any **court actions** that indicate a staff member is **unfit** related to abuse, neglect, exploitation, mistreatment or theft **within 10 days of knowledge of the court action**
- **Allegations (and injuries of unknown source)** must be reported to **facility admin (and State agencies as applicable)**, and **investigated**
  - **Reported immediately (< 2 hours) if allegation of abuse or result of serious injury**
  - **Reported < 24 hours if events do not include abuse or result in serious injury**
- Patients must be protected during investigation



COMPREHENSIVE ASSESSMENT – SOM APPENDIX PP

- **No MDS/RAI in CAH Swing Bed, not held to SNF intervals***
- **Comprehensive Admission Assessment** content same as MDS/RAI process, assess within scope
  - Identification, demographic info
  - Customary routine, activity pursuits (interests)
  - Cognitive patterns, communication, vision
  - Mood and behavior, psychological well-being
  - Physical functioning and structural problems
  - Continence
  - Disease dx.
  - Dental and nutritional status
  - Skin conditions
  - Medications
  - Special treatments and procedures
  - Discharge planning needs
  - Patient/family participation in assessment process



- Must involve **info from patient/family and staff from all shifts**

*Medicare Benefits Policy Manual Chapter 8

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COMPREHENSIVE CARE PLAN – SOM APPENDIX PP

- **Person-centered care plan** to meet patient's **medical, nursing, and mental/psychosocial needs** as identified in the **comprehensive assessment**
  - **Measurable objectives and timeframes**
  - **Preference and potential for future discharge**
- Must include involvement of <u>at least</u>
  - **Attending physician**
  - **RN** with responsibility for the patient
  - **Nurse Aide** with responsibility for the patient (if you staff NAs)
  - Member of **food and nutrition** services
  - **Patient/guardian/family**
  - Any **other disciplines necessary**
- If patient long term care resident with PASSR interventions, must include if able

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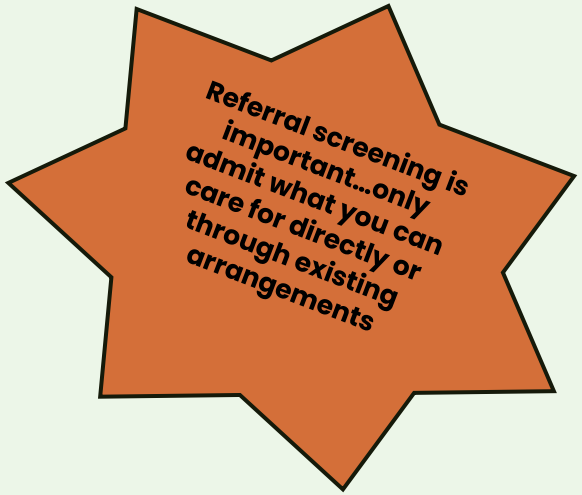
DISCHARGE – SOM APPENDIX PP

- Discharge summary **available to patient, patient representatives, and next provider(s) of care**
  - Plan for **where** patient will discharge, **how** they will get there, **what support** they will have
  - **Plans for follow-up care**
  - Recapitulation (**summary**) of patient stay to include <u>at least</u>
    - **Diagnosis**
    - **Course** of illness/treatment or therapy
    - **Pertinent lab, radiology, and consultation results**
  - **Reconciliation** of pre- and post-discharge **medications**

SPECIALIZED REHAB SERVICES – SOM APPENDIX PP

- **Patients must receive necessary rehabilitation care** to include physical therapy, occupational therapy, speech therapy, respiratory therapy and specialized mental illness/intellectual disability services either
  - **Directly from the Swing Bed facility**, or
  - **Via agreements** with outside resources that provide specialized rehab services



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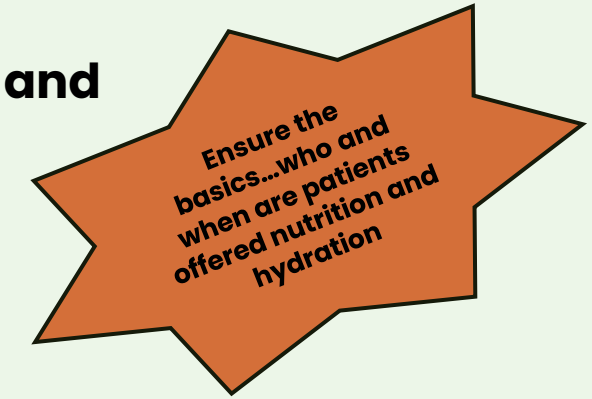
DENTAL CARE AND NUTRITION – SOM APPENDIX PP

- Patients must have **access to necessary dental care** and facility must
  - Have **a plan for emergency dental care**
  - **Assist patient** with making dental appointments, sorting transportation options
- Swing Bed providers **may bill for certain aspects** of dental care
  - Have a **policy explaining when your facility is or is not responsible for lost or damage dentures**
  - Have a **policy that ensures prompt (within 3 days) referral of patients with lost or damaged dentures** for dental care
  - If **delay** in referral or dental care, **ensure patient nutrition and hydration**
- Must ensure patients maintain, to extent possible, **acceptable nutrition and hydration**
  - Patient-specific needs, assessment-identified
  - Identify risks
  - Determine when dietician involvement necessary (e.g. parameters)



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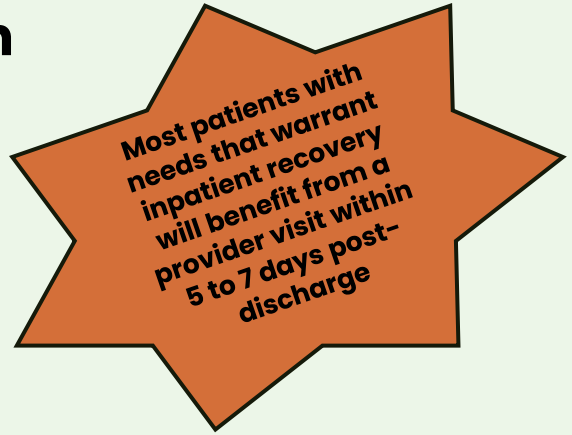
HOW TO PROVIDE GREAT SWING BED CARE

- Teamwork, culture of safety, & optimize social context of care
- Not just a checklist of documentation for compliance
- Make Swing Bed a “service line” with identified champions and owners
- Internal team meets regularly
- Involve the patient and family as much as possible
- Be good at identifying, documenting, and updating patient-specific goals and progress
- Be proactive regarding patient risks and known/expected needs
- Recognize and celebrate success with your staff so they feel the impact of the work

KEY PROCESSES – 30,000 FOOT

- **CAH acute care D/C planning** (Who would benefit from Swing Bed from within?)
- **External referral screening** (Can we provide care safe for patient and safe for us? Is reimbursement source adequate? What is the downstream plan?)
- **Admission** (hit the ground running, proactive and risk focused)
- **Care planning and D/C planning** (meetings/rounds/huddles, goal focused)
- **Early social services support** and **ongoing pre-D/C preparation**
- **Post-D/C follow up** and **readmission avoidance** (soft landings)



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GROWING YOUR PROGRAM

- **Provide great care!** Results and reputation matter!
- **Know your program**
  - Local population/service area and payer mix
  - Swing Bed volumes/census (historically and over time)
  - Average Length of Stay
  - D/C Disposition (goal = high % home/assisted, low % acute readmit or unexpected death)
  - Types of patients cared for
  - Denials and Non-Admissions (How many, why, from where)
- **Know regional needs and patterns**
  - Referrals vs admissions from regional hospitals
  - If in an integrated system, what is overall impact of poor patient flow?
  - Parter needs (e.g. Wound, Bariatric)
  - Changes in partner staff

GROWING YOUR PROGRAM

- Educate your **staff** and the **community**
- Educate your **regional partners**
- Build and maintain **relationships**
- **Inquire** about needs on ongoing basis
- **Collaborate** on resources and expertise

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BENEFITS FOR PATIENTS

- **Shorter length of post-acute stay**
  - CAH SB average LOS **10-14 days** [1,2,3] vs National Medicare Part A SNF LOS **26 days** (2023 stays)[4]
  - Rural SNF LOS **36.4 days** vs. rural SB LOS **10.2 days** (2013 data)[5]
- **Closer to home**
  - Rural Medicare beneficiaries discharged from **rural hospital** with post-d/c needs **recovered in rural community over 80% of the time**[5]
  - Rural Medicare beneficiaries discharged from **urban hospital** with post-discharge needs **recovered in rural community** only about **half of the time** (2018 study, 2013 data)[5]
- **Hospital resources on-site;** providers, lab, radiology, equipment, education, experience
- **High percent D/C to community, low likelihood of D/C back to acute care**
  - 30-day risk-adjusted hospital readmission rate: **CAHs 13.6% vs. Rural SNF 21.1%**[1]
  - Home or Assisted Living : **CAHs 72-75% vs. SNF 50%** [1,3]
  - Discharge to Acute Care : **CAHs 5-8% vs. SNF 11.4%** [1,3]
- **Two to three times more RN hours per patient per day than most SNFs**[6]
  - CAH Swing Bed = **4-6 hours** RN time per patient per day
  - Medicare Care Compare SNF National Average = **41 minutes**[6]
  - Medicare Care Compare SNF Michigan Average = **46 minutes**[6]

[1] University of MN Policy Brief Quality Measures for CAHs, 2019
[2] Illinois Critical Access Hospital Network, 2019, Illinois Critical Access Hospitals: Exploring the Financial Impacts of the Swing Bed Program
[3] Allevant Solutions press release, 2025
[4] 2025 MedPAC Report to Congress
[5] Rural and Urban Provider Market Share of Inpatient Post-Acute Care Services Provided to Rural Medicare Beneficiaries (April 2018). Schulte A, Kirk D, Randolph R; Pink G.
[6] https://www.medicare.gov/care-compare/

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BENEFITS FOR REGIONAL PPS ACUTE CARE HOSPITALS

- Reduce **under and un-reimbursed patient days** by discharging **earlier** than other options
- Keep **full DRG** in many cases due to **CAH exemption from transfer DRG rules**
- Allows patients to seek care **closer to home**
- Allows the tertiary hospitals to discharge a patient whose stay is no longer being reimbursed and **accept a new patient with a new DRG** (open beds for new patients)

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BENEFITS FOR CAHS

- Support the financial viability of rural hospitals, allowing these hospitals to remain open, and by bringing in additional revenue-generating services that also serve outpatient populations, such as physical and occupational therapy

OPERATIONAL AND COMMUNITY VALUE - CAHS

- **Reduces unnecessary transfers and rural "bypass of services"**
  - Keeps patients local by admitting more patients via ED
    - Team is more clinically confident, and swing bed is a known downstream option
  - Hospital resources often prevent need for acute readmission (CAH or regional)
  - Improves care continuity by getting patients back to the rural community to recover after regional acute stay, increase family involvement and high satisfaction
- **Community benefit**
  - Strengthens financial viability of rural hospitals
  - Allows hospitals to remain open
  - Expands revenue-generating services that also support outpatient care (PT/OT, imaging, lab)

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OPERATIONAL AND COMMUNITY VALUE - CAHS

- **Increases bed day revenue**
- **Improves inpatient cost structure**
  - Reduces acute average length of stay (compliance with 96 hr rule)
  - Aligns costs with true patient acuity
  - Prevents “bloated” acute cost centers
  - Spreads costs across more Medicare patients, reducing cost per day

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FINANCIAL IMPACT OF SWING BEDS

- **Acute inpatient services are poorly reimbursed**
  - Acute inpatient care in CAHs often reimburses at or near cost, with limited margin
  - Swing bed care shifts patient days into a more favorable, cost-based reimbursement environment
- **As swing beds grow**
  - Total costs stay relatively stable
  - Total patient days increase
- **Meaning**
  - Cost per day goes down
  - Occupancy goes up
  - Payment improves
  - Compliance improves
- **Core principle**
  - Spread fixed costs across more Medicare patients, reducing cost per patient

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WHY SWING BEDS IMPROVE THE CAH COST REPORT

- **Lower cost per day**
  - Increases total patient days while costs remain relatively stable
  - Improves CMS benchmarking and state comparisons
  - Strengthens future policy positioning
- **Stabilizes fixed and step-fixed costs**
  - Keeps beds occupied
  - Spreads nursing, dietary, housekeeping, and admin costs
  - Reduces volatility in the cost report
- **Protects compliance metrics**
  - Improves occupancy rates
  - Supports cost-based reimbursement logic

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QUESTIONS

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