Closures of Hospital-Based SNF Units: Insights from Interviews with Administrators, Discharge Planners and Referring Physicians

A study conducted by staff from the Urban Institute for the Medicare Payment Advisory Commission

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March 2007 • No. 07–1

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Research in this report was supported by the Medicare Payment Advisory Commission (MedPAC), Contract Number RFP 02-06-MedPAC. Guidance was provided by MedPAC staff Sally Kaplan (Project Officer), Craig Lisk and Kathryn Linehan. Inferences and conclusions in this report are solely those of the authors and do not necessarily reflect the views of the Urban Institute or MedPAC.

I. Introduction

Skilled Nursing Facility (SNF) units provide Medicare post-acute care services either in acute hospitals or in freestanding nursing homes. While there is also great variation within each category, hospital-based (HB) units tend to differ from freestanding (FS) SNFs in terms of average patient acuity, staffing, and costs of care. Since the implementation of the Medicare SNF prospective payment system (PPS) in 1998, more than one third of HB SNFs have closed. The total number of FS SNFs has increased slightly over the same time period.

The high closure rate of HB SNFs raised questions about the reasons, and consequences, of hospitals' decisions to close their SNF units. To gain insight on these issues, we conducted interviews with officials at fifteen acute care hospitals with Medicare SNF units in 1998, which today are either open or closed. We selected a convenience sample of hospitals in several urban and rural geographic areas for this qualitative study. We also interviewed administrators of three FS SNFs that are geographically near to some of those hospitals.

Hospitals that closed their SNF units mentioned various reasons. Financial losses associated with operating the SNF were cited as one major reason for closing the unit. The need for additional acute beds, or other uses for the space occupied by the SNF unit, was cited frequently as another important reason. Hospitals justified the alternative use of space as related to their basic goals of focusing on the provision of acute medical care. Other factors contributing to hospitals' decisions to close their SNF units included burdensome SNF regulations, reflected by the survey and certification process, and difficulties in providing skilled staffing. Such factors were noted to add costs to the operation of the units.

Hospitals that kept SNF units open noted that the units fostered savings on the acute care side by providing an easily accessible source of post-acute care (PAC). In some areas, there were few PAC alternatives particularly for medically complex patients. Other

hospitals reported that keeping the SNF open was important to maintain continuity of care or good relationships with physicians in the community or provide resources for teaching health care professionals.

The consequences of SNF closures varied among the hospitals we interviewed. In some cases, especially for metropolitan hospitals, there were so many PAC options that the process of patient discharge from hospitals were apparently unaffected by closure of HB SNF units. In other areas, however, discharge from hospitals was more problematic, due to the limited capacity of PAC providers. In such situations, acute hospital length of stay (LOS) likely increased with the SNF units' closures.

Regardless of the presence of other PAC options, hospitals told us that some categories of patients were hard to place with alternative PAC providers. Medically complex patients, such as those requiring wound vacuum assisted closures (VAC) care, ventilator, or intensive IV antibiotic care, can be hard to place because many FS SNFs are not staffed with requisite RN or respiratory specialists needed by such patients. Some hospitals noted that placement of such patients could be improved if the SNF PPS were refined to more directly address the types and intensity of services needed by these patients. Where available, long-term care hospitals (LTCHs) accepted some of these difficult cases. Extended stays in acute care inpatient units were another option.

The next section presents background on differences between HB and FS SNFs based on extant research, Medicare's SNF PPS, and the landscape of PAC providers available to Medicare beneficiaries. We then describe our methodology in selecting the sample and conducting the study. Findings are then presented in four sections addressing why hospitals opened SNFs in the pre-PPS period, hospitals that closed SNFs after PPS, hospitals that maintained their SNF units after PPS, and challenges to the placement of patients after hospitals closed their SNF units. The last section discusses implications of our findings from the interviews.

II. Background

Medicare provides coverage in SNFs for beneficiaries in need of additional rehabilitation or recuperative care after a prior hospital stay of 3 days or longer. Because SNF services under Medicare are strictly for post-acute care, the prior hospital stay, which must have occurred in the past 30 days, is a necessary event for individuals to be eligible for these services. In addition, the SNF benefit covers a maximum of 100 days of care in any given spell-of-illness. A new spell-of-illness begins only after an individual has not been in an institution for 60 consecutive days. There is no deductible for SNF care, but a daily coinsurance payment (equal to one-eighth the hospital deductible in a given year) is required after the first 20 days of a SNF stay.

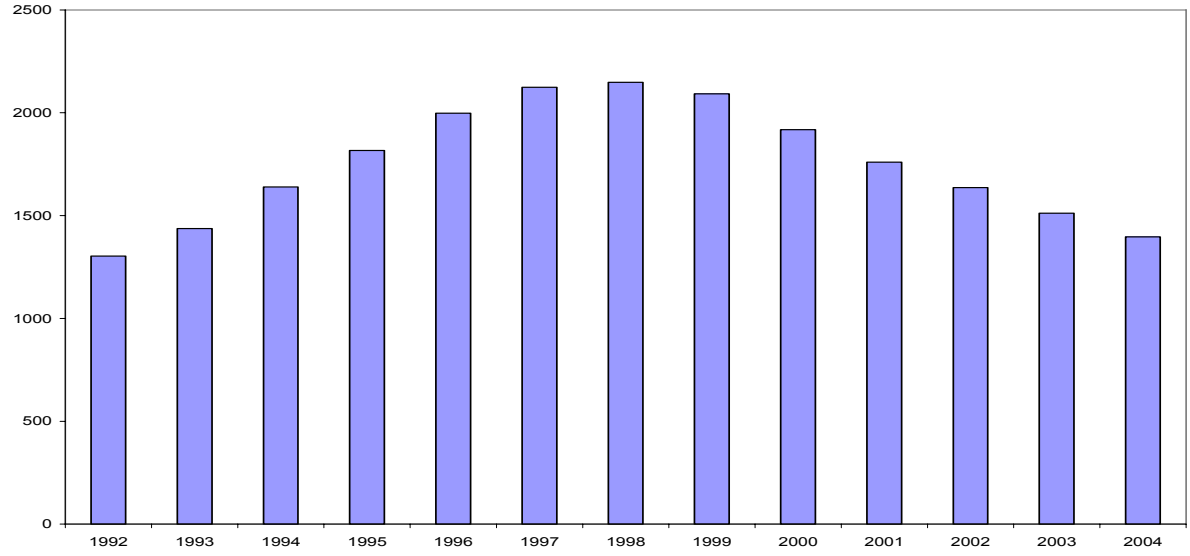
Until the late 1980s, SNF services accounted for only a small percentage of total Medicare expenditures and were viewed as cost-effective and less intensive alternatives to extended acute-care hospital stays. After implementation of Medicare's acute-care hospital PPS in 1984, however, Medicare expenditures for SNF services began to grow rapidly. For more than a decade after the acute PPS was instituted, Medicare SNF spending rose an average of 30 percent each year.[1] [2] The rapid increase in SNF expenditures catalyzed concern among policy makers that use of these services had become excessive and did not necessarily improve the health of Medicare beneficiaries. Acting on these concerns, Congress enacted provisions in the 1997 Balanced Budget Act (BBA) mandating that Medicare SNF services should be paid under a PPS. Consequently, the Medicare SNF PPS was implemented starting in 1998. Overall SNF spending grew, but at slower rate than in the preceding period. In 2003, Medicare spending on SNF care totaled $14.4 billion, or 6% of total Medicare spending.[3]

Change in the supply of Medicare SNFs also showed two distinct phases that coincide with the periods before and after implementation of the SNF PPS, but the magnitude of

[1] GAO-01-816.
[2] Changes in Medicare SNF coverage guidelines, resulting from *Fox v. Bowen (1986)*, were also a major catalyst of increased utilization and expenditures during this period.
[3] MedPAC, 2006.

these changes differed for HB and FS SNFs. Between 1992 and 1998, the number of HB SNFs increased dramatically from 1,300 to over 2,100 (Figure 1). The number of FS SNFs also increased, but at a slower rate, from 9,500 to 13,000. After a peak in 1998, the supply of HB SNFs declined to about 1,400 in 2004. Unlike HB SNFs, the total number of FS SNFs did not decline, but the rate of increase was much slower than before the PPS.

Figure 1 Trend in the supply of HB SNFs shows rapid increase before, and decline after, implementation of the SNF PPS



A. Hospital-Based and Freestanding SNFs

Medicare SNF services can be provided either by facilities that are in or on the grounds of acute care hospitals (HB) SNFs or by facilities that are primarily independent nursing homes (FS SNFs). SNFs must have a transfer agreement with a hospital to accept patients recommended for SNF care, sufficient staff to provide 24-hour nursing services, a physician who supervises patient care and is available 24 hours a day on an emergency basis, and dietary, pharmaceutical, dental, and medical social services available.

In 2003, 90% of SNFs were freestanding, and 83% of Medicare patient days were provided in FS SNFs.[4] Although the main function of most FS SNFs is the provision of long-term care services to people with chronic conditions and disabilities, HB SNFs generally focus on the provision of post-acute care. FS SNFs tend to be larger than HB SNF units, and have about 100 beds on average, compared to 20-30 beds in HB SNFs. HB SNFs have, on average, much higher proportions of Medicare post-acute care patients than FS SNFs.

Based on analyses of nursing home patient assessment data and constructed case mix indices, HB SNFs have larger proportions of patients with medically complex problems than do FS SNFs.[5] FS SNFs have higher proportions of rehabilitation therapy patients, but HB SNFs have higher proportions of patients in the "extensive services" category (11.3% vs. 6.6%)[6], which includes patients who are medically complex. Differences in the case-mix of HB and FS SNFs appear associated with differences in staffing. On average, HB SNFs have higher nurse-to-patient ratios.[7] Patients in HB SNFs receive, on average, almost twice the number of nursing hours per day as do patients in FS SNFs.[8]

The average length of stay (LOS) also differs between HB and FS SNFs. HB SNFs have an average LOS of around 13 days, while FS SNFs have an average LOS that is twice that long. The shorter LOS of HB SNFs is due partly to their greater likelihood than FS SNFs of selecting patients who are likely to recover faster and be discharged home [9]

Despite the differences between HB and FS SNFs, when considering national averages, it is important to recognize the fact that overlap exists between the two types of Medicare SNFs. Some FS SNFs, for example, have high nurse-to-patient ratios and large proportions of patients with medically complex problems, while some HB SNF have very low proportions of Medicare patients and look like traditional FS facilities.

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[4] MedPAC, 2006.
[5] Pizer, White, and White, 2002. Liu and Black 2003.
[6] Liu and Black, 2003.
[7] Liu and Black, 2003.
[8] Health Care Financing Administration, 2000.
[9] Dalton, Stearns, and Thorpe, 2004.

B. Medicare Payment Policies

Prior to the implementation of the PPS in 1998, SNFs were reimbursed by Medicare on a cost-related basis, and new providers were exempt from the routine-care cost limits for four years.[10] Although cost limits applied to nursing services, SNFs were effectively fully reimbursed for all costs they incurred for rehabilitation therapy and non-therapy ancillary (NTA) services (e.g., respiratory therapy, drugs, supplies).

The Medicare SNF PPS pays an all-inclusive per diem rate, adjusted for case-mix, urban/rural status, and area wage rates. The daily rate covers all nursing, rehabilitation therapy, and NTA services. The nursing and therapy components are explicitly adjusted for variations in case-mix by the RUG-III patient classification system. Variations in NTA service costs were not researched in the development of the patient classification system, and NTA service cost variations were assumed to reflect variations in nursing service costs under the SNF PPS. Thus, payments for NTA services are conceptually bounded by the range of nursing weights, of which the highest value is approximately twice that of the lowest one. Many types of NTA service (e.g., intensive IV antibiotic therapy, ventilator care) can, in fact, involve costs that greatly exceed the expected payment inferred from the range of nursing component weights.[11]

The PPS for SNF was implemented following a period of rapid growth in Medicare SNF expenditures that raised concerns among policymakers that use of these services had become excessive and did not necessarily improve the quality of care delivered to Medicare beneficiaries. Because of policymakers' concerns about the level of hospital-based SNFs costs, the derivation of the PPS base rates explicitly did not recognize all of the higher costs of HB SNFs. The base rates for the SNF PPS were set at a weighted average of the FS SNF average cost plus 50 percent of the difference between the FS

[10] GAO-03-183

[11] The GAO found that, in 1999, two thirds of SNFs had actual NTA costs that were outside the possible range of payments.

average and a weighted average of all facilities' (FS and HB) costs. In addition, the base rate did not include the costs of SNFs that were exempt from Medicare cost limits.[12]

Only a few services are excluded, or carved out, from the case-mix adjusted per diem rates of the SNF PPS. These include physician services, dialysis, cardiac catheterization, MRI and CT scans provided in an outpatient setting, angioplasty, some chemotherapy and radioisotope services, and custom prosthetics. To be excluded, services generally have to meet three criteria; they must be high cost, infrequent, and unlikely to be overprovided.[13]

Under the PPS, Medicare SNF services are paid regardless of actual costs of service provision. While FS SNFs lowered their costs by $49 per diem between 1997 and 1999, HB SNFs' costs rose by $29 per diem during the same period.[14] In absolute terms, per diem costs of HB SNFs are approximately twice that of FS SNFs. On average, HB SNFs have higher nursing and NTA costs, while FS SNFs have higher rehabilitation therapy costs.

In light of the persistent cost differences between HB and FS SNFs, average Medicare margins have differed widely between HB and FS SNFs since 1998. For example, the 2004 margin for FS SNFs was 13.5 percent, while the margin for HB SNFs was minus 86 percent.[15] Differences due to staffing, case mix, and types of services provided likely all contribute to the observed differences in margins between the two types of Medicare SNFs. In addition, interpreting the negative Medicare margin for HB SNFs is complicated by the standard practice of allocating the hospital's overhead costs across all of the units in its facility. The effect of this practice may be that HB SNF units likely record higher overhead and total costs than they would if they only recorded costs of providing services to SNF patients. The magnitude of the effects of the different factors

[12] MedPAC, 2001.
[13] GAO-01-816.
[14] GAO-13-183.
[15] MedPAC, 2006.

are difficult to quantify because of inadequate data on case-mix and services provided, and lack of transparency in accounting practices.

C. Post-Acute Care Landscape

In addition to SNFs, Medicare post-acute care can be provided by other institutional and non-institutional entities. The most relevant other institutional PAC options are inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). Medicare also finances home health care provided by home health agencies (HHAs). Selection of a particular setting for each patient depends on a number of factors, including clinical and functional status, patient and family preference and the capacity of the different providers in a given market area. The importance of these other entities, when examining the effects of HB SNF closures, is that they become, along with FS SNFs, PAC providers for patients who would otherwise have been cared for by the HB SNFs.

IRFs were designed to provide care for patients who need—and can tolerate—at least 3 hours of physical, occupational, or speech therapy each day. Orthopedic patients and other patients recovering from surgery or trauma, rather than medically complex patients, populate IRFs. Most SNF patients do not require or can tolerate this amount of rehabilitation therapy services. While more than 85 percent of SNF patients receive some level of therapy services daily, the highest rehabilitation payment category in the SNF PPS calls for 720+ minutes (approximately 12 hours) of therapy per week.

LTCHs were designed to serve patients who need long-term acute care due to multiple, complex medical problems. Since they are an acute care facility, LTCHs have the capacity to provide intensive medical and nursing care. A LTCH is often the only option, other than continued care in a general hospital, for some types of hard-to-place patients, such as people who are ventilator dependent.. In fact, many LTCHs focus on the provision of care to patients with respiratory problems Because Medicare certification requires an average LOS of 25 days or more, LTCHs are most suitable for patients who need extended stays in a hospital setting.

HHAs provide care to persons in residential settings who are home bound and require only intermittent care. Under Medicare, skilled nursing, rehabilitation therapy, social work and aide services are provided to eligible persons. The health and functional status of persons receiving HHA care, which is intermittent, is likely to be different than those requiring care from one of the institutional providers, which provide round-the-clock supervision. HHA service recipients may also have stronger informal care networks that allow them to be in residential rather than institutional settings.

There is overlap in the types of patients served by Medicare PAC providers. For example, patients with different degrees of need for rehabilitation are found in all of the PAC providers' caseloads. Patients with intensive medical problems are more likely to be found in HB SNFs or LTCHs. In the absence of suitable PAC providers, patients could remain for extended periods of time in acute care inpatient units.

Motivation

The high rate of closures among HB SNFs after 1998 appears to be linked to the implementation of the SNF PPS. Despite the likely relationship, there are important policy-relevant questions that remain unanswered. One question is why so many HB SNFs did not respond to the incentives of the Medicare SNF PPS by lowering costs per day or reducing the range of services they provide. Second, why did some hospitals maintain their SNF units while others closed theirs? Third, what was the role of financial isssues relative to other factors? Fourth, how did HB SNF closures affect placement of patients who required PAC? This study was initiated to develop insight on these issues.

III. Methods

We conducted structured interviews in person or on the telephone with knowledgeable persons working at hospitals with SNF units that were open prior to the SNF PPS in 1998. Because we selected a convenience sample of hospitals, our findings are not necessarily generalizeable. Nevertheless, they provide insights on factors behind

hospitals' decisions regarding their SNF units, and the effects of closures on placement of patients with alternative PAC providers.

We spoke with administrators of fifteen HB SNFs and three FS SNFs. At the hospital-based facilities, we also spoke with discharge planners and referring physicians whenever possible. Ten of the interviews were conducted by phone, and we visited the other eight facilities in person. We designed an Interview Protocol to cover all of our issues of interest, and most of our interviewees had a chance to prepare for the interview by reviewing the Protocol. Each informant was told of the confidential nature of this study, and assured that their facility would not be identifiable in the public version.

The facilities included in our study are from eight market areas around the country, including five in mid-to-large cities in Maryland, California, New York, Nebraska, and Florida. We originally chose our target cities with an eye toward geographic diversity, and thus balanced our choice of two East Coast cities, and one in Florida, with a city in California and one in the Midwest. We also wanted to look at two fairly large cities, in addition to a few midsized choices with nearby rural areas. We also focused on the proportion of SNF units that closed in each city. Three cities that we selected experienced the closure of more than half of their HB SNF units, while the other two had fewer closures.

Originally, we sought to focus on five market areas, but we chose additional areas to further understand the unique considerations facing rural and suburban facilities. We chose one rural area near the urban area we investigated in Nebraska because we were interested in why none of the HB facilities there had closed. We chose the other rural area in West Virginia because all of the HB SNFs there closed, and we were interested in the effect on patient placement in post-acute care.

Once we had chosen our target cities, we chose the facilities to interview. When possible, we interviewed individuals from at least one hospital that closed its SNF in each city. Since it was too difficult to speak with someone at a facility that was closed before

2004, we spoke almost exclusively with administrators from hospitals that closed their SNFs more recently. Regardless of the date of closure, many facilities refused to speak with us, further narrowing our choices of closed facilities to speak with.

Many hospitals with open SNFs also refused to speak with us, but we were able to choose more freely which facilities to speak with since they refused at a lower rate than closed facilities. Within each city, we sought balance in our target facilities in terms of ownership status (private, public, or nonprofit), teaching status, the presence of other PAC or psychiatric units, size of the hospital and the SNF unit, proportion of SNF patients covered by Medicare, and SNF profit margin. In all, eighteen facilities refused to speak with us, ten of them with closed SNF units and eight with open units.

IV. Findings

Hospitals with which we spoke viewed themselves as being primarily in the business of providing acute medical care. Decisions regarding opening, closing, or retaining SNF units were incidental to their views about their acute care missions. Subsequently, the specific factors that were noted to be important determinants of those decisions—shortening LOS, keeping referring physicians connected, use of space, continuity of patient care, financial consequences—were all considered in the context of the primary goal of the hospital. Each hospital tried to optimize the specific factors, but ultimately had to make trade-offs. How each of the factors influenced the decision was a function of each hospital's unique situation. When hospitals closed their SNF units, some patients with certain conditions were challenging to place with FS SNFs and other PAC providers. While straightforward rehabilitation patients seemed to be relatively easy to place, some types of clinically complex patients were difficult, because they required intensive nursing and extensive NTA services.

With the acute care mission and complex set of factors influencing decisions and their effects as a backdrop, the following sections present findings on (a) reasons for opening hospital-based SNF units, (b) hospitals that closed their units after PPS, (c) hospitals that

retained their SNF units after PPS, and (d) challenges in placing patients with alternative PAC providers after HB SNFs closed.

A. Why Hospitals Opened SNFs: Pre-PPS Period

Hospitals opened SNFs for a variety of reasons, ranging from maximizing Medicare payments to improving continuity of care. The ability to place patients more quickly and easily in post-acute care was cited by most respondents as a major reason for opening the SNF unit. Under Medicare's hospital PPS, implemented in 1984, hospitals had strong incentives to reduce inpatient length of stay (LOS). Having SNF units could facilitate discharge from acute care while also receiving Medicare SNF payments. Prior to the PPS, Medicare payments for SNFs were reimbursed on a cost-related basis. While limits were imposed on routine services (e.g., nursing, accommodations), all ancillary services were essentially reimbursed their full costs. A few hospitals we spoke with also faced excess demand for inpatient beds, so reducing average LOS enabled them to admit greater numbers of inpatients. At the same time, other hospitals with low occupancy rates opened SNF units to fill the excess capacity.

Several hospitals indicated that they opened the SNF unit to fill a community need for post-acute care services, while others noted that SNF units were opened to improve continuity of care, since physicians like the convenience of having the patient close by, where they could easily make visits and order diagnostic tests as needed. One hospital noted that opening the SNF unit helped it to create a niche in a competitive hospital market.

B. Hospitals That Closed SNF Units After PPS

Although most hospitals noted multiple contributing reasons for closing their SNF units, chief among them were financial losses and alternative use for the space occupied by the SNF unit. Additional considerations leading to the decision to close SNF units included difficulties meeting staffing needs, administrative burdens associated with the SNF

survey and certification process, and awareness that providing SNF care was not contributing directly to the hospitals' broader goal of providing acute medical care.

Financial Reasons

Many hospitals we interviewed cited financial losses because the costs of operating their SNF units exceeded Medicare payments. While some HB SNF units were not profitable before, the PPS system exacerbated financial losses. These financial losses stem from two general reasons-- the clinical needs of the patients in the HB SNFs and care patterns associated with being a unit in an acute care hospital. Many patients in these HB SNFs were medically complex and had high NTA service costs (e.g., IV antibiotic drugs, respiratory therapy). As noted above, the SNF PPS assumes that NTA costs are proportional to the case-mix weights for the nursing component. Exceptionally costly NTA services can greatly exceed expected payment for those services.

We also heard from most respondents that HB SNFs' practice patterns were strongly influenced by the parent facility being an acute care hospital, which tends to lead to higher staffing and utilization costs. Nursing coverage was extensive, in terms of hours per patient and skill level of nursing staff. All of our respondents said their HB SNFs had, for example, registered nurses (RNs) on the unit around the clock. Salary levels and benefits of HB SNF staff were also comparable to those of other units of the hospital. The hospitals expressed a tension between keeping staffing levels sufficiently high to manage medically complex patients, while wanting to lower staffing to control costs. Concerns about cost control aside, our interviewees indicated that HB SNFs are usually unable to reduce staffing levels because physicians, as well as patients and their families, expect SNF staffing to be about the same as other units in the hospital.

Because of easy access to patients in HB SNFs, referring physicians visited HB SNF patients often and tended to order lab and other diagnostic tests on a relatively frequent basis. In contrast, we were told that physicians' visits to patients discharged to FS SNFs were less frequent, if at all, because it was less convenient or physicians did not have "credentialing" arrangements with particular FS SNFs.

While the frequent contact between patients and physicians in HB SNFs was considered attractive, our respondents also suggested the possibility of some degree of over-utilization, which led to financial losses. They said that referring physicians were generally not aware of Medicare's methodology for paying SNF care, and ordered services for patients as if they were in standard medical/surgical units.

Among the hospitals that emphasized the issue of financial losses, some seemed to consider the financial health of the SNF unit in isolation, without factoring in how the SNF functions to reduce acute LOS and draw additional reimbursement. While concerned about the financial impact of closing their SNF units, other hospitals were employing "hospitalists," or applying other strategies to help control inpatient LOS in the absence of the SNF unit.

Alternative Use of Space

The second major reason mentioned for closing the SNF unit was the need to use the space for acute care beds. While the financial losses on the SNF operation affected the consideration of alternative uses for the space, some hospitals already had pre-conceived plans for the space. Some hospitals noted increasing occupancy and excess demand for standard medical/surgical unit beds, which could not otherwise be met because of the constrained size of their physical plant. Other hospitals had specialty acute care units they planned to install in the SNF space. Cardiac catheter labs, orthopedic "joint camps," and imaging departments are examples of such alternative uses mentioned by our interviewees. One hospital was also making room available for the opening of a LTCH, while two were deliberating opening IRFs in the SNF space. Yet another hospital was renting the former SNF space for the purpose of clinical research.

Additional Considerations

Staffing Problems

Several hospital noted that nursing shortages forced them to use temporary agency nurses to fully staff their SNFs. Because costs of agency nurses are higher than those of

employed nurses, this need added to financial problems. In addition, hospital nurses had a preference for medical/surgical units, rather than SNF units, because they actually cared for fewer patients in the former. Given identical salary and benefits for nurses across all of a hospital's units, these hospitals experienced difficulty in retaining nursing staff for the SNF units. One hospital closed its SNF unit simply because it could not staff it, and found that it was more convenient to discharge its acute care patients to alternative PAC providers.

Burdensome Survey and Certification Process

Another consideration leading to closing the SNF unit was the burden of the survey and certification process, as noted by several hospitals. While functioning like a hospital unit, the HB SNFs have to be responsive to a process focused on nursing homes. This paradox presented multiple problems. For example, because hospital-wide departments such as housekeeping and food service also serve the SNF unit, employees in these units had to be screened by the SNF even though they were not directly under the SNFs' management. In addition, the nursing home standards expect SNF patients to be active and move about the facility, but our respondents indicated that many patients in their HB SNFs were too sick to leave their rooms.

Contributing to Hospitals' Broader Goals

Another reason cited by hospitals for closing SNF units was their sense that operating SNF units was not contributing to, and possibly detracting from, the hospital's major mission of providing acute medical care. Several hospitals we interviewed were tertiary care centers, which had clear preferences for focusing on "new and innovative directions" like opening specialty (e.g., cardiac, trauma, cancer) units.

C. Hospitals That Maintained SNF Units After PPS

Our interviews with hospitals in different states, and urban and rural settings, indicated that goals and operations of HB SNFs are not uniform. Information from the respondents suggests three broad models of HB SNFs with respect to the patients they serve. The first

model focuses on selecting patients who need short-term rehabilitation care and are likely to be discharged home. In the absence of alternative PAC options, these HB SNFs also provide care to medically complex patients. The second model focuses on selecting medically complex patients to shorten their hospital LOS. These HB SNFs have more nursing staff than other SNFs, and patients are visited by physicians frequently. Patients requiring uncomplicated rehabilitation are discharged by the hospital to FS SNFs. The third model focuses on providing care to a small number of Medicare patients and a large number of long-term care residents. This model, similar to FS SNFs, was found in New York.

Most hospitals continuing to maintain SNF units indicated that the units were operating under financial losses, but some, particularly ones focusing on rehabilitation patients, were approximately "breaking even." When asked why they continue to operate the SNF, three sets of reasons were mentioned. First, some hospitals are keenly aware of the need to manage the acute care DRG payment. Second, some facilities stated that PAC alternatives were unable or unwilling to accept certain types of medically complex patients. Third, some hospitals reported that maintaining the SNF met broader goals of the hospital, including fostering continuity of care to the satisfaction of both patients and physicians, and providing resources for teaching health care professionals.

Managing the DRG

Under Medicare's inpatient PPS, hospitals have strong incentives to discharge patients from acute care as soon as possible. Keeping the acute LOS short was noted to be a major reason for keeping the SNF unit open by many hospitals with open SNF units. Moreover, transferring the patient to the hospital's SNF "restarts the flow of Medicare reimbursement for that patient."

Clinical Need and Community Supply of PAC Providers

Access to suitable PAC services in the community was noted by some hospitals as another important reason to keep the SNF unit open. This situation was a particular problem for high cost NTA patients and others who were at high risk of developing

complications and required continuous monitoring by skilled nursing staff. Some hospitals determined that FS SNFs in their market areas were not sufficiently staffed to care for some of these complex patients. Other hospitals were directly informed by FS SNFs that they would only admit rehabilitation patients. Although LTCHs could manage some of these patient types, LTCHs are not available in many market areas. Thus, in many locations, HB SNFs are retained to serve the most nursing intensive and clinically challenging patients, because of necessity, and therapy patients are discharged to FS SNFs.

Broader Goals

Some hospitals that maintained their units placed very high value on the contribution of the SNF to their broader role as a community hospital. These hospitals cited the important value to them of providing opportunities for physicians to easily follow-up their patients after they were transferred to PAC. In fact, the SNF stay is often explicitly built into the plan of care, even before a (orthopedic) procedure is performed during the acute care stay. They also noted the value of increasing the satisfaction of patients and their families, because of the frequent physician visits in their HB SNFs. Moreover, we were told that some of these hospitals' patients feared FS SNFs as destinations where people are discharged to die. In addition, some teaching hospitals saw maintaining the SNF as a useful resource for training geriatricians and nurses.

D. Effects of HB SNF Closings on Patient Placement

In general, our interviewees indicated that hospitals' closing their SNF units did not create a systematic problem with placing PAC patients. They tended to concur that uncomplicated rehabilitation patients, because of their financial attractiveness under the SNF PPS, are relatively easy to place in almost all market areas. Some medically complex patients, however, are challenging to place even in areas with many PAC providers present. The following types of cases were mentioned repeatedly in our interviews:

High cost IV antibiotics, and other drugs. Semi-permanent or mainline IV patients require extensive skilled nursing care to manage. The SNF PPS reimbursement does not explicitly cover the cost of expensive antibiotic and other types of drugs (e.g., epogen). While some *chemotherapy drugs* are carved out of the SNF PPS payment, others are not and are prohibitively expensive.

Wound VAC care. Equipment rental costs are high, in part because the equipment is available only from a single vendor. Beyond the equipment rental, nursing costs are also high.

HIV patients. Both drug and nursing costs are high for these patients.

Ventilator dependent patients. Patients who are not candidates for weaning are particularly difficult to place in PAC, because of high staffing costs for respiratory therapists and nurses.

Patients with tracheostomies. Particularly if the wound requires suctioning, nursing costs would be high to keep airways open.

Bariatric patients. Most facilities cannot afford to maintain the necessary equipment (e.g., oversized beds, wheelchairs, and lifts) and additional staff to care for these patients.

Psychiatric and behavioral problems. Patients with collateral, or primary, mental health problems induce elevated staffing costs.

Alternative PAC Providers Used

Information from our interviews suggests that the vast majority of alternative PAC providers used by hospitals are FS SNFs. While most FS SNFs do not, or cannot, employ the resources needed to manage some of the most medically complex patients, some FS SNFs had developed programs to specialize in treating such patients. For example, a few FS SNFs have developed the capacity to provide ventilator care. These FS SNFs are able to do so by benefiting from the economies of scale associated with serving many (e.g., 20) such cases on a daily basis. It is notable that one state in our sample provides state-funded supplemental payments for Medicaid ventilator patients in nursing homes. Other FS SNFs had developed a specialty in providing wound VAC care. Based on our selective sample, such specialty FS SNFs are not numerous.

We were also informed that larger FS SNFs are better able to absorb the losses from unprofitable patients. The size advantage gave such providers latitude, for example, to accept high cost medically complex patients in exchange for the hospital transferring multiple profitable (e.g., uncomplicated rehabilitation) patients.

LTCHs were mentioned several times as providers for many of the medically complex patients. On the other hand, use of LTCH as a PAC alternative was limited by their being few in number and concentrated in particular geographic areas. IRFs were also mentioned, but frequently as a facility type that provides complementary, rather than substitutable, care with HB SNFs.

Geographic Variation

In PAC supply rich areas, the problems of patient placement seemed minimal. Such areas contain numerous FS SNFs, as well as IRFs and LTCHs. One hospital noted that, given the wealth of alternative PAC providers in its market area, there was no need to take financial losses to keeps it own SNF open.

Hospitals in other market areas said that there are few providers with the capacity to care for medically complex patients. While this situation prevents some hospitals from closing their SNFs, other hospitals elected to close the SNF units anyway. Hospitals have resorted to sending some medically complex patients long distances to receive appropriate PAC, including across state lines. In other cases, patients continued to reside in medical units of the hospitals In addressing a shortage of PAC capacity in their market areas, some hospitals were considering opening other types of PAC units, such as IRFs, or encouraging the establishment of LTCHs. A few of the hospitals we talked to were also re-considering the SNF option. One hospital, for example, is in the initial stages of leasing SNF beds from a local nursing home, in order to set up a unit to care for bariatric patients, ventilator patients, and other hard-to-place patients who do not need to stay in acute care.

In sum, many of the particular patient types that our interviewees noted were hard to place are those requiring intensive nursing and extensive NTA services. In general, other post-acute care providers are likely to restrict acceptance of referrals from hospitals either when they are unable with existing staffing to meet care needs or when the costs of care substantially exceed Medicare payment. As a last resort, hospitals have to be prepared to care for the patients in their acute care units.

V. Discussion

The decision by hospitals to close or maintain their SNF units, after implementation of the SNF PPS, was complicated and involved several considerations. Regardless of their decisions about their SNF units, the hospitals mentioned the same inter-related factors, which include financial considerations, alternative use of physical space, capacity of alternative PAC providers in the market area, and broader goals of the hospital. Based on our interviews, it seems that the "weight" of the each factor in decisions about SNF units varied substantially across hospitals.

Finances. It is likely that moving from a cost-related Medicare payment system to the SNF PPS exacerbated financial strains at HB SNF units, leading to closure of one third of those units within a few years after PPS implementation. Interestingly, two thirds of HB SNF units remained open. Thus, while the financial effects of the SNF PPS appear to be an important factor in hospitals' decisions about operating a SNF unit, it is complicated by other related considerations.

Our interviews suggest two areas where the SNF PPS likely increased financial pressure on HB SNFs. First, many of the clinically complex patients, who were also difficult to place with other PAC providers, require costly NTA services. Whereas such services used to be reimbursed by Medicare on a cost-related basis, now they are paid prices constrained by the case-mix weights of the nursing component. Second, the nursing costs of the HB SNFs were not fully recognized in the construction of the nursing base

rate under the PPS, because policy makers had been concerned about the high costs of HB SNFs. While policy makers might expect hospitals to respond to the incentives of the SNF PPS by lowering nursing costs, our interviews suggest that it may be difficult for hospitals to so, given expectations of physicians referring patients to the hospital, patients and their families, and broader goals of the hospitals themselves.

Space. Many of the hospitals in our sample indicated that alternative use for the space occupied by the SNF unit was an important reason for closing the unit. Some had specific plans for new acute care activities. Others indicated a need in their community for additional medical and surgical units. In these cases, the closing of the SNF unit after the PPS was implemented seems coincident with pre-conceived plans of the hospitals. In other cases, the SNF PPS might have caused hospitals to consider alternative uses for the SNF units' space that could generate higher revenues or lower costs for the overall hospitals' budgets. Other hospitals seemed to close their SNF units with no other plans for the use of the space.

Supply and capacity of alternative PACs. The range and patterns of PAC markets varied widely among the hospitals in our sample. At one end were markets which contained many FS SNFs, including some which were specializing in the provision of care for medically complex and costly patients. These markets were also likely to contain LTCHs and IRFs. In such areas, the extensive capacity of alternative PAC providers fostered a degree of internal competition that allowed some hospitals to easily discharge patients after closing their SNF units. At the other end of the spectrum, some hospitals' market areas contained only FS SNFs that were specializing in the provision of long-term care. In these cases, hospitals were able only to discharge patients with uncomplicated rehabilitation needs. Clinically complex cases could sometimes be referred to a geographically distant provider. While some of these hospitals kept their SNF units open, others closed the units and continued to care for these patients in their medical units.

Goals. Regardless of whether hospitals closed or maintained their SNF units after the PPS, most hospitals maintain that their primary goal is to provide acute medical care. The SNF units helped to increase overall hospital revenues prior to the SNF PPS, but they also fostered continuity of care after the acute care stay, which, also fostered better relations with referring doctors and patients' families. Financial pressures resulting from the PPS meant that hospitals had to carefully consider the relative importance of different goals. Whatever choices were made, however, do reflect their primary acute care mission. For example, preserving DRG savings by hospitals that maintained SNFs, and using the SNF space for a cardiac catheter labs by hospitals that closed SNFs, are both illustrations of hospitals' primary goal of advancing their acute care programs. Some of the teaching hospitals indicated that it was important to maintain SNFs units, even with financial losses, to provide a training resource for geriatricians and other professionals.

In conclusion, this study was designed to develop increased insight on hospitals' decisions to close or retain their Medicare SNF units after implementation of the SNF PPS. Based on the interviews, the decisions are complicated and involve numerous factors. While potential financial losses are an important factor, its weight on hospitals' decisions about SNF units varies with each hospital's unique situation. Finally, because of the nature of this study, we cannot draw strong inferences about the implications of HB SNF closings on beneficiary access to PAC. Findings from our interviews suggest that hospitals that closed SNFs have generally worked out ways to place discharged patients with alternative PAC providers. Nevertheless, some policy consideration might be given to facilitate placement of particular subgroups of PAC patients.

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