REPORT OF THE

DEPARTMENT OF HEALTH TO STUDY THE FEASIBILITY

OF DEVELOPING A SWING-BED POLICY FOR HOSPITALS

AND NURSING HOMES TO

PROVIDE ALTERNATIVE LEVELS OF CARE OF PATIENTS

TO

THE GOVERNOR

AND

THE GENERAL ASSEMBLY OF VIRGINIA

House Document No. 19

COMMONWEALTH OF VIRGINIA
Richmond, Virginia
1980

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Report of the

Department of Health to Study the Feasibility of Developing A Swing-Bed Policy for Hospitals and Nursing Homes To Provide Alternative Levels of Care of Patients

To

The Governor and the General Assembly of Virginia

Richmond, Virginia

January 1980

To: Honorable John N. Dalton, Governor of Virginia

and

The General Assembly of Virginia

I. INTRODUCTION

During its 1979 session, the General Assembly passed House Joint Resolution No. 234 creating this study. That resolution is as follows:

HOUSE JOINT RESOLUTION NO. 234

WHEREAS, State and national scrutiny of health care costs and of the quality of health care available has initiated research into the capabilities of hospitals to provide more than one level of care for their patients; and

WHEREAS, hospitals and nursing homes are subject to increased pressure to lower their costs by increasing their occupancy rates, a practice which may result in the inappropriate utilization of beds; and

WHEREAS, there are few viable alternatives to institutional care to provide the appropriate placement and the correct levels of health care in cases where acute care is not medically necessary; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Health is requested to study the feasibility of developing a swing-bed policy for hospitals and nursing homes to provide alternative levels of care of patients, in addition to assuring hospitals and nursing homes that the designation of beds may be reinstated in cases where hospital beds have been designated for another level of care under the swing-bed policy.

The Department of Health shall seek the cooperation and assistance of health care providers, third-party payers and other pertinent interest groups in conducting this study and shall conduct its work in cooperation with the Virginia Health Care Costs Commission.

The Health Department shall report its findings and recommendations to the Governor and to the nineteen hundred eighty Session of the General Assembly.

The Study Group consisted of: Robert L. Wood, M.D., Director, Division of Emergency Medical and Health Facilities Services; Ms. Katherine Goolsby, Senior Attorney, Division of Legislative Services (Commission to Study the Containment of Health Care Costs); Mr. Robert Ham, Director, Bureau of Medical and Nursing Facilities Services; Freeman C. Hays, M.D., Director, Division of Medical Assistance (Medicaid); Mr. Stuart D. Ogren, Executive Vice President, Virginia Hospital Association; Mr. Raymond O. Perry, Director, Division of Health Planning and Resource Development; Mr. Frank R. Plichta, Provider Program Specialist, Blue Cross and Blue Shield of Virginia; Ms. Martha Pritchard, Staff Director, Virginia Health Services Cost Review Committee; Lawrence Prybil, Ph.D., Professor and Chairman, Department of Health Administration, Medical College of Virginia; and Mr. Robert Seiler, Executive Director, Virginia Health Care Association.

The Study Group acknowledges the assistance of various individuals for their input into this report. Those individuals include: Bedford H. Berrey, M.D., Edwin M. Brown, M.D., Mrs. Margaret P. Crane, Mrs. Elinor E. Garst, R.N., Mr. Thomas Harrigan, Mrs. Judi Passerini, R.N., Miss Sarah E. Sayres, R.N., Mr. Esten Shomo, Thomas W. Terbush, Ph.D., and Ms. Marilyn H. West.

This report is the Department of Health's final report.

II. DISCUSSION

The 1979 General Assembly passed House Joint Resolution #234 which directed the State Health Department to study the "Swing Bed" concept. This concept postulates that if a need exists for long-term care beds this need can be partially met by utilizing a certain number of existing unoccupied beds in hospitals. These beds would be considered to be swing beds in that they could be utilized for either acute or long-term care. The study was broadened to address the swing bed concept in nursing homes because of the impact that swing beds could have on all long-term care facilities. The "swing" in nursing homes would involve skilled and intermediate levels of care.

It should be recognized that prior to 1965 and the passage of federal Medicaid and Medicare legislation nothing remarkable was seen in the intermix of acute and long-term care patients in the hospital setting. In 1965, and again in 1976, amendments to the Social Security Act restricted the ability of hospitals to provide long-term care. Requirements were imposed that acute care facilities, i.e., hospitals, could not, or chose not to, meet.

The "Swing Bed" concept is a part of the broader medical care continuum known as "progressive patient care." This envisions that an individual should be able to move in stages [up or down] from a high level of intensive care through decreasing intensities of care until the appropriate level of care is provided or vice versa as required.

The current interest in the swing bed idea appears to have had its origin in the State of Utah early in 1972 where small rural hospitals (less than 100 beds) were experiencing occupancy rates of 30 - 60%. At the same time a need was recognized for additional long-term care beds. Initial approval to study the concept was granted by the Commissioner of Social Security, December 8, 1972. Twenty-five rural Utah hospitals, ranging in size from 10 - 93 beds, with occupancy rates below 60%, were invited to participate in a swing bed program beginning in January 1973. Admission to the program was based on the need of the patient for services. With certain waivers, Medicare covered skilled care for Title XVIII Medicare patients. Medicaid, with certain waivers, covered services under Title XIX.

These waivers were provided under authority of Section 402 of Public Law 92-603, which states in part:

> "(a)(1) The Secretary of Health, Education and Welfare is authorized, either directly or through grants to public or nonprofit private agencies, institutions and organization to develop and engage in experiments and demonstration projects for the following purposes:
>
> "(A) to determine whether, and if so which, changes in methods of payment or reimbursement . . . would have the effect of increasing the efficiency and economy of health services under such programs through the creation of additional incentives . . . without adversely affecting the quality of such services.
>
> "(B) to determine whether payments for services other than those for which payment may be made under such programs . . . would . . . result in more economical provision and more effective utilization of services . . ;
>
> "(C) to determine whether the rates of payment or reimbursement for health care services . . . would have the effect of reducing the costs of such programs without adversely affecting the quality of such services;
>
> "(D) to determine whether payments under such programs based on a single combined rate of reimbursement or charge . . . would result in more equitable and economical patient care arrangements without adversely affecting the quality of such care... ."

Under the provision of Section 402, the 25 Utah Hospitals in UCIP were allowed to:

1. Use empty, costly, acute care beds for long-term care patients.
2. Charge a lower rate which would be commensurate with the level of services provided.
3. Use staff and resources as needed without being hampered by distinct part accounting requirements.
4. Receive certification and provider agreements for Title XIX and Title XVIII Programs.
5. Extend the use of hospital beds to all categories of patients including private pay, Veterans Administration and other, regardless of age.

6. Allow hospitals in the project to participate in a developmental role by applying broad guidelines which could be tried, tested and formulated around the individual hospital community.

7. Receive payment for care through existing programs without introducing another payment mechanism.

8. Increase utilization and revenues from lab, x-ray and other departments.

The Utah Hospital Association, the Utah Medical Association and Blue Cross and Blue Shield of Utah were involved in program development. From its beginning in 1973 until 1978, 80,000 days of long-term care had been provided. Approximately 86% of this care has been provided at the skilled nursing facility (SNF) level and 14% at the intermediate care (ICF) facility level.

The formula for reimbursement was based on incremental costs. This was based on the idea that the acute care hospital exists to provide acute care to acute care patients. If long-term care is to be provided, reimbursement should cover the "add-on" or incremental costs generated by providing this additional care. An evaluation of the Utah cost-improvement program has been accomplished in the Center for Health Research, University of Colorado Medical Center, Denver, Colorado, and published in July 1978.

The first four major conclusions in their evaluation were as follows:

1. Increase in long-term care utilization and changes in the patterns of such utilization during the experimental period in Utah suggest the existence of an unmet need for institutional long-term care in rural Utah.

2. The use of acute care hospital beds to provide institutional long-term care to skilled nursing patients is less costly than the primary institutional alternatiave, the skilled nursing facility. This conclusion is based on the incremental cost of providing long-term care.

3. In many respects, the capacity to provide long-term care in rural hospitals is adequate relative to rural patients. Nonetheless, it appears that it may be appropriate to require that hospitals provide certain rehabilitative and social services if a swing bed program is implemented nationally.

4. With widespread implementation of this program, it is likely that total health care costs would increase slightly as a result of increased long-term care utilization. Yet, existing facilities would be more effectively utilized and the unit cost of patient care lowered.

Subsequent to the initiation of the Utah cost-improvement program, a program has been instituted in South Dakota and western Iowa where 22 hospitals are involved. The program is administered by Blue Cross and Blue Shield. A Texas program involves 38 hospitals and is administered by the Texas Hospital Association. Other areas in which the swing bed concept exists are Ohio, where licensing of hospital bed for specific purpose is not required. Arizona is a non-Medicaid participating state and so is not constrained by Title XIX regulations. Their rate negotiation process provides the basis for level of

care provided in which every bed might be utilized.

As a result of these programs and studies, legislation (HR 4000) has been introduced in the U. S. Congress to provide for implementation of a national swing bed program. (See: Appendix B.)

From available information it seems quite likely that a bill will be passed during the current session of Congress. If this occurs, the information developed for this study could provide a basis for a Virginia swing bed program.

Data upon which to base the Study Group's conclusions and recommendations were assembled in three processes. First, a literature search was made using computer capability to access the National Library of Medicine, Excerpta Medica, National Technical Information Service, S ial Scisearch and the Federal Register.

Secondly, a cooperative arrangement with the Medical College of Virginia, Department of Hospital Administrators, resulted in the update of a previous study by that department and the information provided by hospital administrators.

Thirdly, a survey of nursing home administrators was conducted by the Division of Emergency Medical and Health Facilities of the State Health Department and resulted in the information as relates to nursing homes. As a result of inputs, suggestions and review comments from the organizations represented by the Advisory Committee, the final product was achieved.

The following definitions are applicable to this study:

SWING BED: "A bed which can be utilized on an as-needed basis for the provision of acute, skilled or intermediate care in a licensed hospital or as a skilled or intermediate bed in a nursing home certified for skilled care with the expectation of appropriate financial reimbursement for the level of care provided.

ACUTE CARE: "Medical care provided to patients requiring immediate and continuous attention of short duration in institutions with organized medical staff; with permanent facilities that include inpatient beds; and with medical services, including physician services and continuous nursing services, to provide diagnosis and treatment for patients who have a variety of medical conditions which may require various types of care, such as medical, surgical, and maternity."

LONG-TERM CARE: Encompasses definitions of both skilled and intermediate care. Provided in facility where at least 50% of the patients remain 30 consecutive days or longer.

SKILLED CARE: "Provide health care services on a daily basis pursuant to a physician orders which (1) require the skills of technical or professional personnel, e.g., registered nurse, licensed practical nurse, physical therapist, occupational therapist, speech pathologist, audiologist and (2) are provided either directly by or under the

direct supervision of licensed nursing personnel and under the general direction of a physician in order to assure the safety of the patient and achieve the medically desired result." (August 1975, p. 1488, para. 4115). Medicare and Medicaid Guide.

INTERMEDIATE CARE: "Provide health care and services (on a regular basis) to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide (i.e., acute care or skilled nursing care) but who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities." (April 1977, pp. 8381-2, para. 21610). Medicare and Medicaid Guide.

DISTINCT PART: "A distinct part facility is one in which all the beds used to provide long-term care are located in the same area and operate in a manner independent of the acute care portion of the hospital. "

III. ASSUMPTIONS AND CONCLUSIONS

1. ASSUMPTION: That community hospital administrators whose hospitals currently operate a long-term facility should provide input into the study of the "swing bed" concept.

   DATA:[1]

   1. Results of responses from 15 of 17 hospital administrators who presently operate a licensed nursing home or a long-term care unit within the general hospital indicate that:

      1) 100% felt that Virginia State government should give serious consideration to establishing a swing bed policy for hospitals and nursing homes.

      2) 87% believe that both rural and urban hospitals should be eligible to participate in swing bed programs.

      3) 53% felt that both historical hospital occupancy and documented nursing home bed need should be part of the basic criteria for program participation.

      4) 67% of administrators believed that hospitals should be allowed to provide both skilled and intermediate levels of nursing care.

      5) 73% felt that latitude should be given so designated beds could be used for either acute or long-term care without further authorization.

      6) 40% indicate firm plans to attempt to expand their existing nursing home or long-term care unit.

   CONCLUSION: Hospital administrators who currently operate a long-term care facility felt that a mechanism should be available to allow for swing beds in hospitals.

2. ASSUMPTION: That community hospital administrators whose facilities have never owned or operated long-term care facilities should provide input into the study of the "swing bed" concept.

   DATA:[1]

   1. Results of a questionnaire to 65 hospital administrators with responses from 58 indicate that:

      1) 85% believe that Virginia State government should consider establishing a swing bed program in the Commonwealth.

      2) 91% believe that urban as well as rural hospitals should be eligible for participation if a swing bed program is established.

[1]"The Provision of Long-Term Care Services by Community Hospitals in Virginia: To Be Published in January 1980.

3) 47% feel that both low hospital occupancy and documented nursing home bed need should be used as criteria for participation, while 40% felt that documentation of need alone was sufficient for participation.

4) 66% feel that hospitals should be allowed to provide both skilled and intermediate levels of nursing care, while 22% felt that skilled care only was appropriate.

5) 78% felt that they should be allowed to have swing beds without additional authorization from the Health Systems Agency or state government.

6) 40% indicated that they would give serious consideration to participating in a swing bed program if one were established. 40% indicated that they have no present or future plans for such involvement.

CONCLUSION: Virginia hospital administrators whose hospitals have never owned or operated a long-term care facility feel that both rural and urban hospitals should, based on need and occupancy, be allowed within limits to swing beds from acute to long-term care.

3. ASSUMPTION: Nursing home administrators should have the opportunity to provide input into the study of the swing bed concept.

DATA:[2] Results of a questionnaire to 158 Virginia nursing home administrators with responses from 154, indicate that:

1. Sixty-eight (68%) percent indicate that there should be a mechanism to enable nursing homes to swing beds. Five (5%) percent expressed no opinion.

2. Forty (40%) percent of nursing home administrators indicated that their institution would desire to swing beds between intermediate and skilled levels of nursing care. Ten (10%) percent expressed no opinion.

3. Thirty-nine (39%) percent felt that hospitals should be allowed to swing beds between any level of care. Forty-seven (47%) percent expressed no opinion.

4. Thirty-eight (38%) percent felt that hospitals should be allowed to swing beds from acute to skilled care only. Thirty-one (31%) percent expressed no opinion.

5. Fifty-six (56%) percent felt that hospitals should not be allowed to swing beds from acute to skilled to intermediate nursing care. Twenty-four (24%) percent expressed no opinion.

[2]A survey developed and tabulated by the State Health Department, Division of Emergency Medical & Health Facilities Services, 1979. (Appendix A)

CONCLUSION: Commonwealth of Virginia nursing home administrators feel that the option to swing beds should be available to nursing homes. They also felt that Virginia hospitals should not be allowed to swing from acute to skilled to intermediate care.

4. ASSUMPTION: Any hospital that desires to provide "swing bed" care must obtain a Certificate of Need.

DATA: Virginia Medical Care Facilities Certificate of Public Need Law requires that any medical care facility initiating a new service must first obtain a Certificate of Public Need.[3]

CONCLUSION: Assuming the existence of a swing bed program for hospitals, existing facilities desiring to designate swing beds, could be eligible to have such designation made upon obtaining a Certificate of Public Need through the administrative review process if the capital costs of providing services in the swing beds would not exceed $150,000.

The study committee felt that a combination of demonstrated bed need and occupancy should be used in the decision-making process for granting of Certificate of Need.

5. ASSUMPTION: Indiscriminate use of existing hospital facilities for both acute and long-term care would thwart the ability of planning agencies to project resource needs in the future and therefore some restrictions on the numbers of beds which could be designated beds must be effected.

DATA: It is important that health planners be able to accurately identify the use of medical care facilities by the type of service provided in such facilities, in order to be able to project future medical facility resource needs. Allowing entire facilities to be used for both acute and long-term care could very well confuse the real identity of the facility. In other words, if all beds in a facility could swing between acute and long-term care, it would be theoretically possible for a hospital to turn into a nursing home while still being classified as a hospital. For purposes of planning and projecting future medical facility resource needs such situations could not be tolerated.

CONCLUSION: Hospitals desiring to designate swing beds for long-term care should only be allowed to designate a certain number of such beds in order to insure adequate base line information for the planning effort. The number of long-term care beds designated should probably not exceed 10%-20% of the total bed numbers. Within such designated beds multiple services could be provided based upon patient needs at any time. In acute care facilities where over time numbers of patients needing long-term care exceed the numbers of beds designated as swing beds, permanent long-term care units should be planned.

[3]Title 32.1, Chapter 4, Article 1, Code of Virginia, 1950, as amended.

6. ASSUMPTION: There are unoccupied medical/surgical hospital beds within the Commonwealth of Virginia that are in excess of those required for prudent management of delivery of medical care.

DATA:[4]

1. In 1978 there were in non-federal hospitals - 14,670 medical/surgical beds available for occupancy.

2. In 1978 there were 2,287 medical/surgical beds available for occupancy in hospitals of 100 beds or less.

3. The occupancy rate for all hospital medical/surgical beds in 1978 was 72.0%.

4. The occupancy rate for medical/surgical beds in hospitals of 100 beds or less was 63.7%.

CONCLUSION:

1. Assuming a desired occupancy rate of 90% for medical/surgical beds there is, in non-federal hospitals in Virginia, based on existing occupancy rates, a potential of 2,640 swing beds.

2. Assuming a desired occupancy rate of 90% for medical/surgical beds there is, in non-federal hospitals in Virginia of 100 beds or less, based on existing occupancy rates, a potential of 601 swing beds.

7. ASSUMPTION: In order to be reimbursed for the provision of skilled long-term care currently certified facilities must meet certain patient care requirements which include:

DATA:[5]

1. There must be a physician designated as medical director and the medical director reviews all incidents and accidents that occur on the premises and is responsible for employee health and patient care policies. 405.1122
405.1122(a)
405.1122(b)

2. The attending physician must see a patient at least once every 30 days for the first 90 days following admission and thereafter, may in some instances, alternate scheduled visits that never exceed 60 days. 405.1123(b)

3. The long-term care facility must have an administrator who is:

   a) a nursing home administrator with a current state license; or

   b) a hospital administrator, if the facility is a hospital qualified as a long-term care facility.
442.303(a)

[4]Summarized by the Virginia State Health Department, Division of Emergency Medical & Health Facilities Services, 1979.

[5]"Long Term Care Manual", U. S. Department of Health, Education and Welfare, Office of Nursing Home Affairs, Washington, D. C. (LTC-2 July 1975), except number three which is from Federal Register, September 29, 1978.

4. A registered nurse is assigned to a skilled nursing unit seven (7) days a week, at least during the day tour of duty. 405.1124

5. Specialized rehabilitative services are required, either directly or on a contractual basis. 405.1126

6. Utilization review of the services provided in the facility using the elements of medical care evaluation studies and review of extended duration cases must be accomplished. 405.1137

7. If a skilled nursing facility (SNF) offers social services and the designated person is not a qualified social worker, the facility has a written agreement with a qualified social worker or recognized social agency for consultation and assistance on a regularly scheduled basis. 405.1130

These are representative requirements that must be met by hospitals and intermediate care facilities to allow the swing bed concept to become functional.

8. ASSUMPTION: There is sufficient nursing time available in Joint Commission on Accreditation of Hospitals low occupancy, accredited hospitals to provide an adequate level of nursing care for the long-term care patient because there are certain minimal requirements (staffing, etc.) which must be met to retain accreditation regardless of occupancy rate.

DATA:[6] In a study of six (6) Utah cost-improvement hospitals (swing bed), ten (10) Utah skilled nursing facilities, country-wide U. S. skilled nursing facilities and country-wide U. S. nursing homes, the minutes of care provided to the long-term care patient was for all nurses (R.N., LPN, and Aides) as follows:

Facility	Minutes per Long-term Care Patient/Day
1. 6 UCIP Hospitals (Direct & Indirect patient Care)	207.4 - 180.7
2. 10 Utah SNFs	149.4
3. U. S. SNFs	177.8
4. U.S. Nursing Homes (Intermediate Care)	150.4

[6]"Nursing Observation Study for 6 UCIP hospitals: Medicare certification forms for 10 Utah SNFs; 1973-74 NCHS Nursing Home Survey for 4,200 U. S. Medicare/Medicaid SNFs and 15,700 other nursing homes." A Swing Bed Experiment to Provide Long-Term Care in Rural Hospitals in Utah," Volume II. p. 131.

CONCLUSION: Based on the data from the Utah program there is sufficient available nursing time to provide long-term care in a low occupancy acute care hospital which has JCAH accreditation.

9. ASSUMPTION: Psycho-social needs of long-term care patients in acute care settings must be addressed in the implementation of a swing bed program.

DATA:

1. Transfer trauma can be reduced by instituting a swing bed program.[7]

2. Nursing personnel in an acute care institution can provide for social needs of long-term care patients in a limited but satisfactory manner.[8]

3. There are fixed expectations of patients and family members as to the care that will be received in an acute care institution.

4. The requirements for the social needs of patients differ between acute care, skilled long-term care, and intermediate care.

CONCLUSION: It is possible with adequately oriented nursing staff and adjustments in the normal hospital procedures (visiting privileges, activities, programs, etc.) to provide for the social needs as well as expectations for differing levels of care in a hospital. The provision of varying levels of care within the same institution will assist in coping with transfer trauma.

10. ASSUMPTION: The number of skilled and intermediate long-term care beds in Virginia certified by Medicare and Medicaid indicate a marked decline in the number of available skilled care beds.

DATA: Medicare and Medicaid Certified Institutional Beds

Year	Skilled Beds	Intermediate Beds	*N/P Beds	Total
1975	1934	10,966	1066	13,885
1976	1311	10,831	1242	13,384
1977	1361	12,030	1306	14,707
1978	1327	13,047	1445	15,819

CONCLUSION:

1. The number of certified skilled care beds has plateaued.

2. The number of certified intermediate care beds has increased at a high rate. During the period of growth, a large number of new nursing homes were opened which requested ONLY intermediate certification.

*N/P = Non-participating

[7]Christopher T. Corey, p. 35, Psychology Today, Oct. 1979
[8]F. & G., p. 134, A Swing Bed Experiment, etc., Vol. II

3. Additional long-term care beds at the skilled care level will probably satisfy some of the current demands for additional beds.

11. ASSUMPTION: There is in Virginia, a need projected to 1984, for additional long-term care beds in certain planning districts.

DATA:[10]

HSA & Planning District	Projected Bed Need 1984	Licensed & CON Approved as of 7/16/78	Additional Need
HSA I			
PD 6	1,054	1,032	22
7	717	614	103
10	632	475	157
16	441	336	105
HSA III			
PD 1	456	338	118
2	434	399	35
3	648	456	192
12	1,163	1,041	122
HSA IV			
PD 13	468	434	34
14	498	275	223
HSA V			
PD 17	326	120	206
18	381	340	41
22	355	312	43

CONCLUSION: Fourteen of twenty-two planning districts show a need for additional long-term care beds over those already licensed or approved in the certificate of need process.

12. ASSUMPTION: Reasonable payment systems can be developed for purchase of care provided in swing beds.

DATA: For a short period of time in 1973 and 1974, the Medicaid Program purchased "skilled nursing" care, on a case by case basis, for patients whom hospitals could not discharge due to shortages of skilled beds in community nursing homes. The Federal response to this effort was: "A State may not claim Federal Financial Participation in payments for SNF services rendered by an acute hospital even though payment is made at the SNF rate." The reasoning behind this ruling was that the hospital was not certified to provide skilled nursing care and Federal law requires hospitals to be paid their full reasonable costs for care whereas Virginia's Medicaid program

[10]Preliminary State Medical Facilities Plan, Virginia Department of Health

was only paying skilled nursing home rates. HR 4000, now before Congress, would permit both Medicare and Medicaid to purchase skilled nursing care in hospitals with designated swing beds with payment at average skilled care rates.

With regard to the purchase of intermediate nursing care in skilled nursing facilities, current Federal laws and regulations allow such to occur. In 1972, Virginia's Medicaid program did establish a method to purchase ICF care in skilled facilities under the following Federal direction:

"The Medical Services Administration has determined that in this situation, a State may, on a case by case basis, continue to make payment to the facility at the SNF rate, so long as the State makes continued effort to effect a proper placement in an ICF. It would not be mandatory for the State to make payment at the SNF rate. The State may make payment at a negotiated rate that is less than the SNF rate. Federal Financial Participation would be available in either case."

The case by case approach was difficult to administer, particularly in determining costs for the separate cost centers (ICF and skilled) of those facilities participating. This effort was subsequently abandoned as intermediate care beds increased in numbers.

CONCLUSION: Either a Federal waiver of certain existing certification and reimbursement regulations, or a Congressional law change such as H.R. 4000 is necessary for Medicaid to purchase skilled nursing care in acute care hospitals under a swing bed policy. The Medicaid program is not prohibited from purchasing intermediate care in a facility certified to provide skilled nursing care. This would require the development of appropriate reimbursement policies and mechanisms.

IV. RECOMMENDATIONS

1. THAT THE COMMONWEALTH OF VIRGINIA ATTEMPT TO IMPLEMENT NOT LATER THAN JANUARY 1, 1982, EITHER BY REQUEST FOR FEDERAL WAIVERS, OR ON THE BASIS OF FEDERAL LEGISLATION, A SWING BED POLICY APPLICABLE TO BOTH ACUTE CARE INSTITUTIONS (HOSPITALS) AND LONG-TERM CARE INSTITUTIONS (NURSING HOMES).

2. THAT THE SWING BED POLICY APPLY TO HOSPITALS ONLY IN ALLOWING A SWING FROM ACUTE TO SKILLED CARE.

3. THAT THE SWING BED POLICY APPLY TO NURSING HOMES ONLY IN ALLOWING A SWING FROM SKILLED TO INTERMEDIATE CARE.

4. THAT THE INITIAL PARTICIPANTS IN THE PROGRAM BE ON A LIMITED VOLUNTARY BASIS.

5. THAT BASED ON PRESENT AVAILABLE INFORMATION, THE TASK FORCE DOES NOT AT THIS TIME RECOMMEND LEGISLATIVE ACTION BY THE VIRGINIA GENERAL ASSEMBLY.

Respectfully submitted,

James B. Kenley, M.D.
State Health Commissioner

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APPENDIX A

COMMONWEALTH of VIRGINIA

Department of Health
Richmond, Va. 23219

JAMES B. KENLEY, M.D.
COMMISSIONER

August 20, 1979

TO: Nursing Home Administrators

FROM: Robert L. Wood, M.D., Director, Division of Emergency Medical & Health Facilities Services

SUBJECT: HOUSE JOINT RESOLUTION 234

The following six (6) questions are to provide you with an opportunity for input to the legislative request made to the Health Department to study the "swing bed" concept, House Joint Resolution 234.

The following is being used as a working definition for swing bed:

> "a bed which can be utilized on an as-needed basis for the provision of acute, skilled or intermediate care in a licensed hospital or as a skilled or intermediate bed in a nursing home certified for skilled care with the expectation of appropriate financial reimbursement for the level of care provided."

Please provide your answer by simply checking the appropriate box. If you feel so inclined, please feel free to make additional written comments:

1. Is your facility presently certified to provide:
   - Skilled Care — Yes 48 — No 74
   - Intermediate Care — Yes 137 — No 9

2. Do you feel that a mechanism should be established to enable nursing homes to "swing" beds? — Yes 106 — No 40

3. Do you feel your institution would desire to "swing" beds from skilled to intermediate care or from intermediate to skilled care if this were possible? — Yes 68 — No 68

4. In your opinion, is there a need for more
   - Skilled Beds — Yes 80 — No 40
   - Intermediate Beds — Yes 94 — No 36

   in your geographic area.

5. Is the "distinct part" concept separating skilled and intermediate care patients a deterrent to the "swing bed" concept?

Yes 99 No 29

6. Should hospitals be permitted to "swing" beds from:

Acute to skilled care only	Yes 60	No 44
Acute to skilled to intermediate	Yes 30	No 84
Not to "swing" beds under any circumstances	Yes 19	No 62

COMMENTS:

Please complete and return the questionnaire within three (3) days. Preaddressed envelope is enclosed.

RLW/jm

Enclosure

96TH CONGRESS
1ST SESSION

H. R. 4000

To amend the Social Security Act with respect to health programs authorized under it, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 8, 1979

Mr. RANGEL (for himself, Mr. CORMAN, Mr. VANIK, and Mr. FORD of Tennessee) introduced the following bill; which was referred jointly to the Committees on Ways and Means and Interstate and Foreign Commerce

A BILL

To amend the Social Security Act with respect to health programs authorized under it, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

EXPANDED MEMBERSHIP OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SECTION 1. Section 1152(b)(1)(A) of the Social Security Act is amended—

(1) by inserting "and, if the organization so elects, of other health care practitioners engaged in the practice of their professions in such area who hold inde-

pendent hospital admitting privileges," after the comma in clause (ii); and

(2) by inserting "(except as otherwise provided under section 1155(c))" after "does not" in clause (vi).

REGISTERED NURSE AND DENTIST MEMBERSHIP ON STATEWIDE COUNCIL ADVISORY GROUP

SEC. 2. Section 1162(e)(1) of the Social Security Act is amended by inserting "(including at least one registered professional nurse and at least one doctor of dental surgery or of dental medicine)" after "representatives".

NONPHYSICIAN MEMBERSHIP ON NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL

SEC. 3. (a) Section 1163(a)(1) of the Social Security Act is amended by inserting "one doctor of dental surgery or of dental medicine, one registered professional nurse, and one other health practitioner (other than a physician as defined in section 1861(r)(1))," after "physicians,".

(b) Section 1163(a)(2) of such Act is amended by striking out "four members" and inserting "five members" in lieu thereof.

(c) Section 1163(a)(3) of such Act is amended by inserting "physician" after "the".

(d) Section 1163(b) of such Act is amended by striking out "Members" and inserting in lieu thereof "Physician members".

(e) Section 1173 of such Act is amended by striking out "(except sections 1155(c) and 1163)" and inserting in lieu thereof "(except section 1155(c))".

ADVISORY COMMITTEE TO THE NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL

SEC. 4. Section 1163 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(f)(1) The Council shall be advised and assisted in carrying out its functions by an advisory committee (of not less than seven nor more than fifteen members) which shall be made up of representatives of health care practitioners (other than physicians) for whose services payment may be made (in whole or in part) under any program established by or pursuant to this Act.

"(2) The Secretary shall by regulations provide the manner in which members of such advisory committee shall be selected and the terms of service.

"(3) The expenses reasonably and necessarily incurred, as determined by the Secretary, by such committee in carrying out its functions shall be considered to be expenses necessarily incurred by the National Professional Standards Review Council.".

HOSPITAL PROVIDERS OF LONG-TERM CARE SERVICES ("SWING-BEDS")

SEC. 5. (a)(1) Title XVIII of the Social Security Act is amended by adding the following new section at the end thereof:

"HOSPITAL PROVIDERS OF EXTENDED CARE SERVICES

"SEC. 1882. (a)(1) Any hospital (other than a hospital which has in effect a waiver of the requirement imposed by section 1861(e)(5)) which has an agreement under section 1866 may (subject to subsection (b)) enter into an agreement with the Secretary under which its inpatient hospital facilities may be used for the furnishing of services of the type which, if furnished by a skilled nursing facility, would constitute post-hospital extended care services.

"(2)(A) Notwithstanding any other provision of this title, payment to any hospital for services furnished under an agreement entered into under this section shall be based upon the reasonable cost of the services as determined under subparagraph (B).

"(B)(i) The reasonable cost of the services consists of the reasonable cost of routine services (determined under clause (ii)) and the reasonable cost of ancillary services (determined under clause (iii)).

"(ii) The reasonable cost of routine services furnished during any calendar year by a hospital under an agreement

under this section is equal to the product of (I) the number of patient days during the year for which the services were furnished, and (II) the average reasonable cost per patient-day, such average reasonable cost per patient-day being the average rate per patient-day paid for routine services during the previous calendar year under title XIX to skilled nursing facilities located in the State in which the hospital is located and which have agreements entered into under section 1902(a)(28).

"(iii) The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

"(b) The Secretary may not enter into an agreement under this section with any hospital unless—

"(1) for a period (of not less than twelve months) specified by the Secretary which period immediately precedes the date the agreement is entered into, the hospital has had an average daily occupancy rate of less than 60 percent, and

"(2) the hospital has been granted a certificate of need for the provision of long-term care services from the State health planning and development agency (designated under section 1521 of the Public Health Service Act) for the State in which the hospital is located.

"(c) An agreement with a hospital under this section shall, except as otherwise provided under regulations of the Secretary, be of the same duration and subject to termination on the same conditions as are agreements with skilled nursing facilities under section 1866 (unless the hospital fails to satisfy the requirements specified in subsection (b)) and shall, where not inconsistent with any provision of this section, impose the same duties, responsibilities, conditions, and limitations, as those imposed under such agreements entered into under section 1866; except that no such agreement with any hospital shall be in effect for any period during which the hospital does not have in effect an agreement under section 1866, or where there is in effect for the hospital a waiver of the requirement imposed by section 1861(e)(5). A hospital whose agreement under this section has been terminated shall not be eligible to undertake a new agreement until a two-year period has elapsed from the termination date.

"(d) Any agreement with a hospital under this section shall provide that payment for services will be made only for services for which payment would be made as post-hospital extended care services if those services had been furnished by a skilled nursing facility under an agreement entered into under section 1866; and any individual who is furnished services, for which payment may be made under an agreement under this section, shall, for purposes of this title (other than

this section), be deemed to have received post-hospital extended care services in like manner and to the same extent as if the services furnished to him had been post-hospital extended care services furnished by a skilled nursing facility under an agreement under section 1866.

"(e) During a period for which a hospital has in effect an agreement under this section, in order to allocate routine costs between hospital and long-term care services for purposes of determining payment for inpatient hospital services, the total reimbursement received for routine services from all classes of long-term care patients (including title XVIII, title XIX, and private pay patients) shall be subtracted from the hospital's total routine costs before calculations are made to determine title XVIII reimbursement for routine hospital services.

"(f) With respect to a hospital furnishing (under an agreement in effect under this section) of services of the type which, if furnished by a skilled nursing facility, would constitute post-hospital extended care services—

"(1) the hospital shall be required to meet all the requirements of this Act that a skilled nursing facility would be required to meet with respect to the furnishing of such services, and

"(2) the provisions of such services shall be treated and subject to the same requirements of this Act as

post-hospital extended care services furnished by a skilled nursing facility under this title,

except such requirements of section 1861(j) and such other requirements as the Secretary determines to be inappropriate in the case of these services being furnished by a hospital under this section.".

(2) Within three years after the date of the enactment of this Act, the Secretary shall submit to the Congress a report evaluating the program established by the amendment made by paragraph (1) of this subsection and shall include in such report an analysis of—

(A) the extent and effect of the agreements under the program on availability and effective and economical provision of long-term care services, and

(B) whether the program should be continued.

(b) Title XIX of the Social Security Act is amended by adding after section 1912 the following new section:

"HOSPITAL PROVIDERS OF SKILLED NURSING AND INTERMEDIATE CARE SERVICES

"SEC. 1913. (a) Notwithstanding any other provision of this title, payment may be made, in accordance with this section, under a State plan approved under this title for skilled nursing facility services and intermediate care facility services furnished by a hospital which has in effect an agreement under section 1882.

"(b)(1) Payment to any such hospital, for any skilled nursing or intermediate care facility services furnished, shall be at a rate equal to the average rate per patient-day paid for routine services during the previous calendar year under this title to skilled nursing and intermediate care facilities located in the State in which the hospital is located. The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

"(2) With respect to any period for which a hospital has an agreement under section 1882, in order to allocate routine costs between hospital and long-term care services, the total reimbursement for routine services received from all classes of long-term care patients (including title XVIII, title XIX, and private pay patients) shall be subtracted from the hospital total routine costs before calculations are made to determine title XIX reimbursement for routine hospital services.".

(c) The amendments made by this section become effective on the date on which final regulations, promulgated by the Secretary to implement the amendments, are first issued; and those regulations shall be issued not later than the first day of the sixth calendar month following the month in which this Act is enacted.

COORDINATED AUDITS UNDER THE SOCIAL SECURITY ACT

SEC. 6. (a) Title XI of the Social Security Act is amended by inserting after section 1126 the following new section:

"COORDINATED AUDITS

"SEC. 1127. If an entity provides services reimbursable on a cost-related basis under title V or XIX, as well as services reimbursable on such a basis under title XVIII, the Secretary shall require, as a condition for payment to any State under title V or XIX with respect to administrative costs incurred in the performance of audits of the books, accounts, and records of that entity, that these audits be coordinated through common audit procedures with audits performed with respect to the entity for purposes of title XVIII. The Secretary shall specify by regulation such methods as he finds feasible and equitable for the apportionment of the cost of coordinated audits between the program, established under title V or XIX and the program established under title XVIII. Where the Secretary finds that a State has declined to participate in such a common audit with respect to title V or XIX, he shall reduce the payments otherwise due such State under such title by an amount which he estimates to be the amount that would have been apportioned to the State under the title (for the expenses of the State incurred in the common audit) if it had participated in the common audit.".

(b)(1) Section 1902(a) of the Social Security Act is amended—

(A) by striking out "and" at the end of paragraph (39);

(B) by striking out the period at the end of paragraph (40) and inserting in lieu thereof "; and"; and

(C) by inserting after paragraph (40) the following new paragraph:

"(41) provide (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits, for such entities also providing services under part A of title XVIII, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such part, and (C) for payment of the proportion of costs of each such common audit of such an entity equal to the proportion of total program benefit payments to the entity (by all third-party payers participating in the common audit for the period being audited) which are payments under this title.".

(2) The amendments made by paragraph (1) shall apply to medical assistance provided, under a State plan approved

under title XIX of the Social Security Act, on and after the first day of the first calendar quarter beginning more than 30 days after the date of enactment of this Act.

(c)(1) Section 505(a) of the Social Security Act is amended—

(A) by striking out "and" at the end of paragraph (14);

(B) by striking out the period at the end of paragraph (15) and inserting in lieu thereof "; and"; and

(C) by inserting after paragraph (15) the following new paragraph:

"(16) provides (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that under part A of title XVIII, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such part, and (C) for payment of the proportion of costs of each such common audit of such an entity equal to the proportion of total program benefit payments to the entity (by all third-party payers participating in the common audit for the period being audited) which are payments under this title.".

(2) The amendments made by paragraph (1) shall apply to services provided, under a State plan approved under title V of the Social Security Act, on and after the first day of the first calendar quarter beginning more than 30 days after the date of enactment of this Act.

(d) The Secretary shall report to the Congress, not later than March 31, 1980, on actions the Secretary has taken (1) to coordinate the conduct of institutional audits and inspections which are required under the programs funded under title V, XVIII, or XIX of the Social Security Act, and (2) to coordinate such audits and inspections with those conducted by other cost payers, and he shall include in such report recommendations for such legislation as he deems appropriate to assure the maximum feasible coordination of such institutional audits and inspections.

EFFECTIVE DATE FOR PSRO AMENDMENTS

SEC. 7. The amendments made by sections 1, 2, 3, and 4 shall be effective 180 days after the date of enactment of this Act.

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