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"Let's Stay Together"
Managing The Changing Relationships Between Hospitals and Skilled Nursing Facilities

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Skilled nursing facilities (SNFs) owned or operated by hospitals (hospital-owned SNFs) have a demonstrated track record of delivering positive outcomes for post-acute care patients. Such success, however, has not been without challenges. In recent years, the combination of increased scrutiny of SNFs, staffing shortages, and increased operating costs resulting from the COVID-19 pandemic has led to decreased profitability of many hospital-owned SNFs, thereby resulting in a large number of hospitals selling or closing their hospital-owned SNFs. However, due to the growing number of seniors entering hospitals seeking care, and despite current challenges, hospital-owned SNFs still play a vital role in our health care system and remain a viable care strategy for a number of hospitals. For others, the utilization of more financially feasible alternative affiliations or integration arrangements can provide benefits similar to those of hospital-owned SNFs.

Over the last decade, hospitals have reported seeing improved outcomes for patients receiving care in hospital-owned SNFs. In 2016, for example, the Journal of Health Economics reported that patients in hospital-owned SNFs are discharged into the community more rapidly than patients discharged from freestanding SNFs. More recently, in February 2023, the JAMA Network published a study that explored the outcomes and the total 30-day stay payments for Medicare beneficiaries undergoing elective hip replacement surgery in hospitals with hospital-owned SNFs. The study reported that care by hospital-owned SNFs resulted in quicker recovery times for the procedure discussed in the study, significant cost savings to Medicare overall, lower readmission rates, and shorter SNF lengths of stay. Similarly, a Health Care Management Review article published in the fall of 2020 concluded that hospital ownership of SNFs and other post-acute care providers "may be a viable strategy for success in reimbursement programs that reward[s] hospitals for managing the total costs for episodes of care."

While hospital-owned SNFs have been a recognized model of care based mostly on patient success rates, the number of hospital-owned SNFs in the United States decreased considerably after a Medicare prospective payment system for SNFs was adopted in 1998, which led to a decline in profitability for many hospital-owned SNFs. And, more recently, the combination of increased scrutiny of SNFs, staffing shortages, and increased operating costs resulting from the COVID-19 pandemic has led to increased financial difficulties for hospital-owned SNFs.

This has resulted in a significant uptick in the sale or closure of hospital-owned SNFs across the country. However, because of a recent nationwide decline in the number of SNFs, it has become imperative for hospitals to find a cost-effective way to accommodate the growing number of seniors who arrive at their doors seeking care. Accordingly, in recent months, many hospitals have begun transitioning from owning, to partnering with SNFs.

If your hospital is interested in a vertical integration relationship that does not involve the ownership of an SNF, you may wish to consider one or more of the following arrangements that could potentially reduce costs while maintaining the benefits of an affiliation with an SNF:

Management and Lease Arrangements. Delegating the management authority of an SNF to a third-party manager can lead to a potential reduction in hospital operating and overhead costs, while still allowing the hospital to maintain clinical input with respect to patients' post-acute care. In many management arrangements, as compensation for its services, the manager receives a percentage of the SNF's revenue, while the hospital operator remains financially liable for the cost of operating the SNF. Alternatively, a hospital can consider leasing its SNF unit to a third-party operator. In this arrangement, the hospital, as lessor, receives rental payments from the operator, as lessee, while the operator holds the SNF license and, therefore, is responsible for all costs and obligations of operating the SNF.

Swing Beds. Hospitals designated as critical access hospitals (CAH) and certain other rural hospital providers may be eligible to designate some of their beds as "swing beds," which allow patients to "swing" from receiving acute-care services to receiving SNF services without the patient being required to leave the hospital. This typically results in a more favorable reimbursement status for the hospital. CAH swing beds are exempted from Medicare's prospective payment system for SNFs and are reimbursed at 101 percent of Medicare costs. Thus, swing bed reimbursements can provide financially challenged rural hospitals with a new revenue stream. CMS issues "swing bed approval," thereby allowing the hospital to operate swing beds, if the facility meets the applicable requirements, such as participation in Medicare.

Bed Reservation Agreements. Bed reservation agreements allow a hospital to reimburse an SNF that keeps a certain number of beds open for the hospital's discharging of acute-care patients. When structured appropriately, these arrangements can provide improved care transitions for discharged patients. These arrangements can also be an answer to hospitals struggling with patients who are occupying acute care beds despite no longer needing acute care, but who are still in need of skilled nursing services.

Shared-Care Coordinators and Supervising Clinicians. Shared-care coordinators and supervising clinicians can improve patient care coordination and reduce unnecessary readmissions of patients transitioning from acute care to post-acute care settings. To accomplish this, the hospital and SNF share physicians, advanced practice clinicians, or other care coordinators so that the same providers see patients in both settings, which can lead to significant improvements in patient outcomes.

It is critical that each of these arrangements, if utilized, is structured and implemented correctly to avoid running afoul of applicable health care fraud and abuse laws, including the Stark Law and Anti-Kickback Statute.

Whether your hospital is interested in improving an existing hospital-owned SNF model or finding an alternative arrangement with a freestanding SNF, we recommend consulting with outside legal counsel experienced in matters unique to both hospitals and SNFs for advice on the regulatory considerations of these complex arrangements.

If you have questions about this topic, please contact any member of Baker Donelson's Hospital-SNF Initiative.