Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COULD HAVE SAVED BILLIONS AT CRITICAL ACCESS HOSPITALS IF SWING-BED SERVICES WERE REIMBURSED USING THE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM RATES

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Office of Inspector General

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EXECUTIVE SUMMARY

Medicare could have saved billions over a 6-year period at Critical Access Hospitals if swing-bed services were reimbursed using the skilled nursing facility prospective payment system rate.

WHY WE DID THIS REVIEW

Congress established the Rural Flexibility Program, which created Critical Access Hospitals (CAHs) to ensure that beneficiaries in rural areas have access to a range of hospital services. CAHs have broad latitude in the types of inpatient and outpatient services they provide, including "swing-bed" services, which are the equivalent of services performed at a skilled nursing facility (SNF). Medicare reimburses CAHs at 101 percent of their reasonable costs for providing services to beneficiaries rather than at rates set by Medicare's prospective payment system (PPS) or Medicare's fee schedules.

CAHs must meet the requirements set forth in the CAH Conditions of Participation (CoP) to receive CAH certification, although before January 1, 2006, States had discretion to designate a hospital that did not meet the distance requirement as a "necessary provider" CAH. As a result, the number of hospitals classified as CAHs and the corresponding total Medicare reimbursement for swing-bed services at CAHs increased. Effective January 1, 2006, States were prohibited from creating new "necessary provider" CAHs, but existing "necessary provider" CAHs were allowed to retain their CAH status indefinitely, as long as they continued to meet all other CAH requirements. In a 2005 report to Congress, the Medicare Payment Advisory Commission stated that cost-based reimbursement has led to more rapid cost growth among CAHs than other rural hospitals. This cost growth was related specifically to post-acute skilled care services provided in swing-beds.

This growth continued, and CAH swing-bed usage increased from about 789,000 days in calendar year (CY) 2005 to about 914,000 days in CY 2010. Medicare's annual expenditures for these services almost doubled during that 6-year period; expenditures exceeded $1.1 billion in CY 2010.

Since September 2011, the Office of Management and Budget (OMB) has proposed to reduce CAH reimbursements and to eliminate the certification for CAHs located within 10 miles of another hospital. In fiscal year (FY) 2015, OMB estimated $1.7 billion in savings over 10 years if Medicare reduced CAH reimbursements from 101 percent of reasonable costs to 100 percent.

This report estimates potential savings by comparing reimbursement methodologies at CAHs and other facilities offering similar SNF-type services.

Our objectives were to determine (1) how much swing-bed usage at CAHs has increased over a 6-year period, (2) how much average swing-bed reimbursement rates at CAHs differ from rates at alternative facilities, (3) whether similar care was available at alternative facilities, and (4) whether Medicare would have saved on payments for swing-bed services at CAHs if it had paid SNF PPS rates.

BACKGROUND

For a hospital to be designated as a CAH, it must meet certain CoP. Some of these CoP requirements include: (1) being located in a rural area, (2) either being at a certain distance from other hospitals or being grandfathered as a State-designated necessary provider, (3) having 25 or fewer beds used for inpatient care or swing-bed services, and (4) having an annual average length of stay for a patient that does not exceed 96 hours.

Medicare beneficiaries in inpatient status at CAHs may transition or "swing" from receiving inpatient services to receiving SNF services without physically changing beds within the hospital. Because these services are provided in an inpatient setting, beneficiaries typically do not incur a copay while in swing-bed status. Unlike CAH swing-bed services, which are reimbursed at 101 percent of "reasonable cost," Medicare pays for SNF services provided in SNFs at predetermined daily rates (under the SNF PPS). The daily rates vary on the basis of the resource utilization group to which a beneficiary is assigned. These payment rates represent payment in full for all costs (routine, ancillary, and capital-related) associated with furnishing covered SNF services to beneficiaries. Similarly, Medicare pays SNF services provided in non-CAHs at the same SNF PPS daily rates.

Over the last couple of years, the Office of Inspector General has performed several reviews at CAHs. In one such review, we determined that nearly two-thirds of CAHs would not meet the location requirement if required to re-enroll; a vast majority would not be able to meet the distance requirement. That report concluded that Medicare and beneficiaries would have saved $449 million if Congress granted Centers for Medicare & Medicaid Services (CMS) the authority to reassess whether all CAHs should maintain their certification based on location and distance requirements and CMS implemented procedures to reassess. That report also concluded that only CAHs that serve beneficiaries who would be otherwise unable to reasonably access hospital services should remain certified.

HOW WE CONDUCTED THIS REVIEW

We reviewed swing-bed Medicare claims data at CAHs and claims data at alternative facilities providing care at the skilled nursing level that submitted claims to CMS for services provided from CYs 2005 through 2010. Alternative facilities included acute care hospitals authorized and offering swing-bed services and SNFs. We determined the swing-bed usage at CAHs for the 6-year period. We also compared the average swing-bed reimbursement at CAHs to reimbursement at alternative facilities. The daily CAH swing-bed cost to Medicare is not known because these costs are reported by hospitals in the aggregate rather than separately. To compute an average daily swing-bed cost at CAHs, we divided total yearly swing-bed costs by total swing-bed service days. We then compared the CAH average daily cost to the alternative facility average daily cost.

From a sampling frame of the 1,200 CAHs that submitted swing-bed claims, we randomly sampled 100 CAHs to determine whether beneficiaries would have access to the same SNF services provided by CAHs at alternative facilities. Specifically, we reviewed FY 2010 cost

report information submitted by sampled CAHs and alternative facilities within 35 miles of the sampled CAH facilities.

Finally, we calculated and estimated the potential savings to Medicare on payments for swing-bed services at CAHs if it had paid using SNF PPS rates by comparing the difference in per diem amounts for CAHs and alternative facilities.

WHAT WE FOUND

Swing-bed usage at CAHs has significantly increased from CYs 2005 through 2010; Medicare spending for swing-bed services at CAHs steadily increased to, on average, almost four times the cost of similar services at alternative facilities. Of the 100 CAHs we sampled, 90 had alternative facilities within a 35-mile radius with alternative skilled nursing care available. On the basis of our sample results, we estimated that swing-bed services provided at 1,080 of the 1,200 (or 90 percent) of the CAHs in our sampling frame could have been provided at alternative facilities within 35 miles of the CAHs during CY 2010. We estimated that Medicare could have saved $4.1 billion over a 6-year period if payments for swing-bed services at CAHs were made using SNF PPS rates.

WHAT WE RECOMMEND

We recommend that CMS seek legislation to adjust CAH swing-bed reimbursement rates to the lower SNF PPS rates paid for similar services at alternative facilities.

CMS COMMENTS AND OUR RESPONSE

In written comments on our draft report, CMS agreed with our finding that CAHs' swing-bed utilization has increased but disagreed with our recommendation because of concerns with our findings on the availability of skilled nursing services at nearby alternative facilities and our calculation of savings. We also received and considered technical comments from the Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA), which is authorized to advise the Secretary of HHS on Medicare regulatory issues in rural communities.

After considering CMS's and HRSA's comments, we have adjusted our report language as appropriate to clarify certain points. However, because (1) the sample design achieved its intended purpose, (2) the type and intensity of services provided in a CAH swing bed or in a SNF bed at an alternative facility are the same, and (3) recent swing-bed utilization research shows that discharges from CAHs are sent equally to SNFs or kept in swing beds and that patient characteristics are comparable regardless of discharge destination, we maintain our findings and recommendation are valid.

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INTRODUCTION

WHY WE DID THIS REVIEW

Congress established the Rural Flexibility Program,[1] which created Critical Access Hospitals (CAHs) to ensure that beneficiaries in rural areas have access to a range of hospital services. CAHs have broad latitude in the types of inpatient and outpatient services they provide, including "swing-bed" services, which are the equivalent of services performed at a skilled nursing facility (SNF).[2] Medicare reimburses CAHs at 101 percent of their reasonable costs[3] for providing services to beneficiaries rather than at rates set by Medicare's prospective payment system (PPS) or Medicare's fee schedules.[4]

CAHs must meet the requirements set forth in the CAH Conditions of Participation (CoP) [5] to receive CAH certification, although before January 1, 2006, States had discretion to designate a hospital that did not meet the distance requirement[6] as a "necessary provider" CAH.[7] As a result, the number of hospitals classified as CAHs and the corresponding total Medicare reimbursement for swing-bed services at CAHs increased. Effective January 1, 2006, States were prohibited from creating new "necessary provider" CAHs, but existing "necessary provider" CAHs were allowed to retain their CAH status indefinitely, as long as they continued to meet all other CAH requirements.[8] In a 2005 report to Congress, the Medicare Payment Advisory Commission stated that cost-based reimbursement has led to more rapid cost growth among CAHs than other rural hospitals. This cost growth was related specifically to post-acute skilled care services provided in swing-beds.[9]

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[1] Balanced Budget Act (BBA) of 1997, P.L. No. 105-33 § 4201. The BBA amended several sections of the Social Security Act, including sections 1814(l), 1820, 1834(g), and 1861(mm).

[2] A "swing-bed" is a hospital bed that may be used as needed to furnish either an acute or a SNF level of care.

[3] "Reasonable costs" are the direct and indirect costs associated with providing services to Medicare beneficiaries (42 CFR § 413.9(b)(1)).

[4] Social Security Act, §§ 1814(l) and 1834(g), 42 U.S.C. §§ 1395f(l) and 1395m(g). Before January 1, 2004, Medicare reimbursed CAHs at 100 percent of reasonable costs.

[5] 42 CFR §§ 485.601–485.647.

[6] Facilities wishing to be certified as CAHs must be either (1) located more than a 35-mile drive from a hospital or another CAH or (2) located more than a 15-mile drive from a hospital or another CAH in areas of mountainous terrain or areas where only secondary roads are available (Social Security Act, § 1820(c)(2)(B)(i); 42 U.S.C. § 1395i-4(c)(2)(B)(i)).

[7] BBA, § 4201; Social Security Act, § 1820(c)(2)(B)(i)(II); 42 U.S.C. § 1395i-4(c)(2)(B)(i)(II).

[8] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173 § 405(h); Social Security Act, §§ 1820(c)(2)(B)(i)(II) and 1820(h)(3); 42 U.S.C. §§ 1395i-4(c)(2)(B)(ii)(II) and 1395i-4(h)(3).

[9] Medicare Payment Advisory Commission, *Report to the Congress: Issues in a Modernized Medicare Program*, chapter 7, "Critical Access Hospitals," June 2005.

This growth continued, and CAH swing-bed usage increased from about 789,000 days in calendar year (CY) 2005 to about 914,000 days in CY 2010. Medicare's annual expenditures for these services almost doubled during that 6-year period; expenditures exceeded $1.1 billion in CY 2010.

Since September 2011, the Office of Management and Budget (OMB) has proposed to reduce CAH reimbursements and to eliminate the certification for CAHs located within 10 miles of another hospital.[10] In fiscal year (FY) 2015, OMB estimated $1.7 billion in savings over 10 years if Medicare reduced CAH reimbursements from 101 percent of reasonable costs to 100 percent.[11]

This report estimates potential savings by comparing reimbursement methodologies at CAHs and other facilities offering similar SNF-type services.

OBJECTIVES

Our objectives were to determine (1) how much swing-bed usage at CAHs has increased over a 6-year period, (2) how much average swing-bed reimbursement rates at CAHs differ from rates at alternative facilities, (3) whether similar care was available[12] at alternative facilities, and (4) whether Medicare would have saved on payments for swing-bed services at CAHs if it had paid SNF PPS rates.

BACKGROUND

Critical Access Hospitals and Swing-Bed Services

For a hospital to be designated as a CAH, it must meet certain Medicare CoP. Some of these CoP requirements include: (1) being located in a rural area, (2) either being at a certain distance from other hospitals or being grandfathered as a State-designated necessary provider, (3) having 25 or fewer beds used for inpatient care or swing-bed services,[13] and (4) having an annual average length of stay for a patient that does not exceed 96 hours.

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[10] OMB, *Living Within Our Means and Investing in the Future: The President's Plan for Economic Growth and Deficit Reduction*, September 2011.

[11] OMB, *Fiscal Year 2014 Budget of the U.S. Government*, 2013, p. 196.

[12] For this review, we defined whether similar care was available at alternative facilities by determining whether sufficient bed capacity was available in the aggregate at alternative facilities to cover the number of bed days at sampled CAHs.

[13] Before January 1, 2004, CAHs were permitted to have no more than 15 acute care inpatient beds, unless they were authorized by the State to have swing beds, in which case they could have no more than 25 total beds, as long as no more than 15 beds were used as acute care inpatient beds at any given time. Effective January 1, 2004, CAHs were permitted to have up to 25 beds to be used in any combination to provide acute care inpatient and extended care services (Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173 § 405(e); Social Security Act, §§ 1820(c)(2)(B)(iii) and 1820(f)(3); 42 U.S.C. §§ 1395i-4(c)(2)(B)(iii) and 1395i-4(f)).

Swing-Bed Services Are Reimbursed Differently at Critical Access Hospitals

Medicare beneficiaries in inpatient status at CAHs may transition or "swing" from receiving inpatient services to receiving SNF services without physically changing beds within the hospital. Because these services are provided in an inpatient setting, beneficiaries typically do not incur a copay while in swing-bed status. Unlike CAH swing-bed services that are reimbursed at 101 percent of "reasonable cost," Medicare pays for SNF services provided in SNFs at predetermined daily rates (under the SNF PPS).[14] The daily rates vary on the basis of the resource utilization group to which a beneficiary is assigned. These payment rates represent payment in full for all costs (routine, ancillary, and capital-related) associated with furnishing covered skilled nursing services to beneficiaries. Similarly, Medicare pays SNF services provided in non-CAHs at the same SNF PPS daily rates.[15]

Prior Reviews Related to Critical Access Hospitals

Over the last couple of years, the Office of Inspector General has performed several reviews at CAHs. In one such review,[16] we determined that nearly two-thirds of CAHs would not meet the location requirement if required to re-enroll; a vast majority would not be able to meet the distance requirement. That report concluded that Medicare and beneficiaries would have saved $449 million if Congress granted the Centers for Medicare and Medicaid Services (CMS) the authority to reassess whether all CAHs should maintain their certification based on location and distance requirements and CMS implemented procedures to reassess. That report also concluded that only CAHs that serve beneficiaries who would be otherwise unable to reasonably access hospital services should remain certified.

HOW WE CONDUCTED THIS REVIEW

We reviewed swing-bed Medicare claims data at CAHs and claims data at alternative facilities providing skilled-nursing-level care that submitted claims to CMS for services provided from CYs 2005 through 2010. Alternative facilities included acute care hospitals authorized and offering swing-bed services and SNFs.

We calculated the swing-bed usage at CAHs for a 6-year period. We then compared the average swing-bed reimbursement at CAHs to reimbursement at alternative facilities. The daily CAH swing-bed cost to Medicare is not known because these costs are reported by hospitals in the aggregate rather than separately. To compute an average daily swing-bed cost at CAHs, we divided total yearly swing-bed costs by total swing-bed service days. We then compared the CAH average daily cost to the alternative facility average daily cost.

[14] Social Security Act, § 1888(e); 42 U.S.C. § 1395yy(e).

[15] Social Security Act, § 1888(e)(7); 42 U.S.C. § 1395yy(e)(7).

[16] *Most Critical Access Hospitals Would Not Meet the Location Requirements If Required To Re-enroll in Medicare* (OEI-05-12-00080), issued August 2013.

From a sampling frame of the 1,200 CAHs that submitted swing-bed claims, we randomly sampled 100 CAHs to determine whether beneficiaries would have access to the similar SNF services provided by CAHs at alternative facilities. Specifically, we reviewed FY 2010 cost report information submitted by sampled CAHs and alternative facilities within a 35-mile radius of the sampled CAH facilities. We defined similar SNF care to be available if sufficient bed capacity was available in the aggregate at alternative facilities to cover the number of bed days at sampled CAHs.

Finally, we calculated and estimated the potential savings to Medicare on payments for swing-bed services at CAHs if it had paid using SNF PPS rates by comparing the difference in per diem amounts for CAHs and alternative facilities.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our scope and methodology, Appendix B contains our mathematical calculation plan, Appendix C contains our sample design and methodology, Appendix D contains our sample results and estimates, Appendix E contains the results of our analysis of bed availability at sampled CAHs, Appendix F contains the mathematical calculation of potential Medicare savings for CAH swing-bed services, and Appendix G contains a list of our previously issued reports on CAHs.

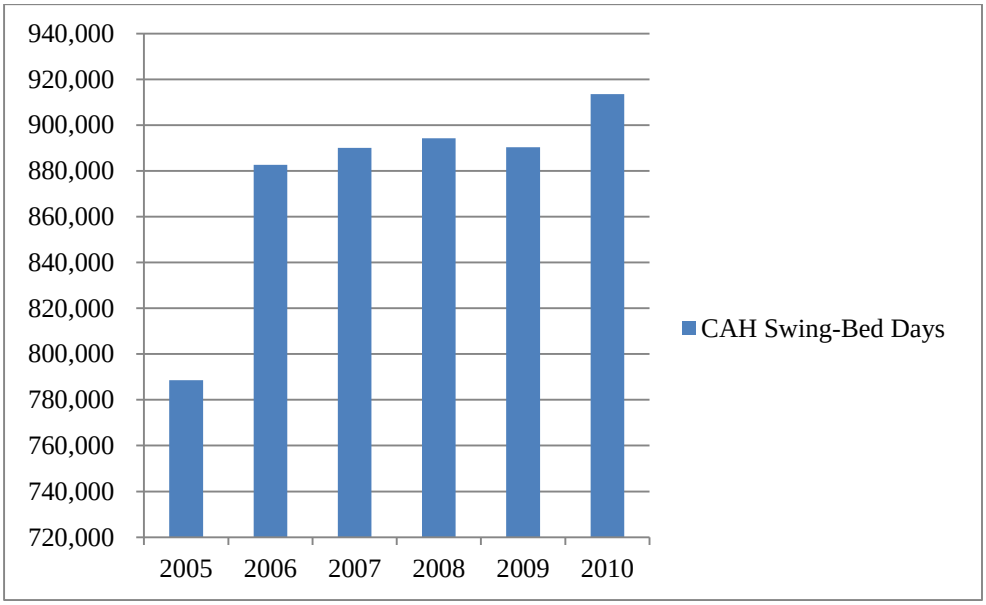
FINDINGS

Swing-bed usage at CAHs has significantly increased from CYs 2005 through 2010, and Medicare spending for swing-bed services at CAHs steadily increased to, on average, almost four times the cost of similar services at alternative facilities. Of the 100 CAHs we sampled, 90 had alternative facilities within 35 miles with alternative skilled nursing care available. On the basis of our sample results, we estimated that swing-bed services provided at 1,080 of the 1,200 (or 90 percent) of the CAHs in our sampling frame could have been provided at alternative facilities within 35 miles of the CAHs during CY 2010. We estimated that Medicare could have saved $4.1 billion over a 6-year period if payments for swing-bed services at CAHs were made using SNF PPS rates.

SWING-BED USAGE AT CRITICAL ACCESS HOSPITALS HAS INCREASED SINCE 2005

Medicare CAH swing-bed usage has increased from about 789,000 days in CY 2005 to about 914,000 days in CY 2010 (Figure 1).

Figure 1: Swing-Bed Usage at Critical Access Hospitals



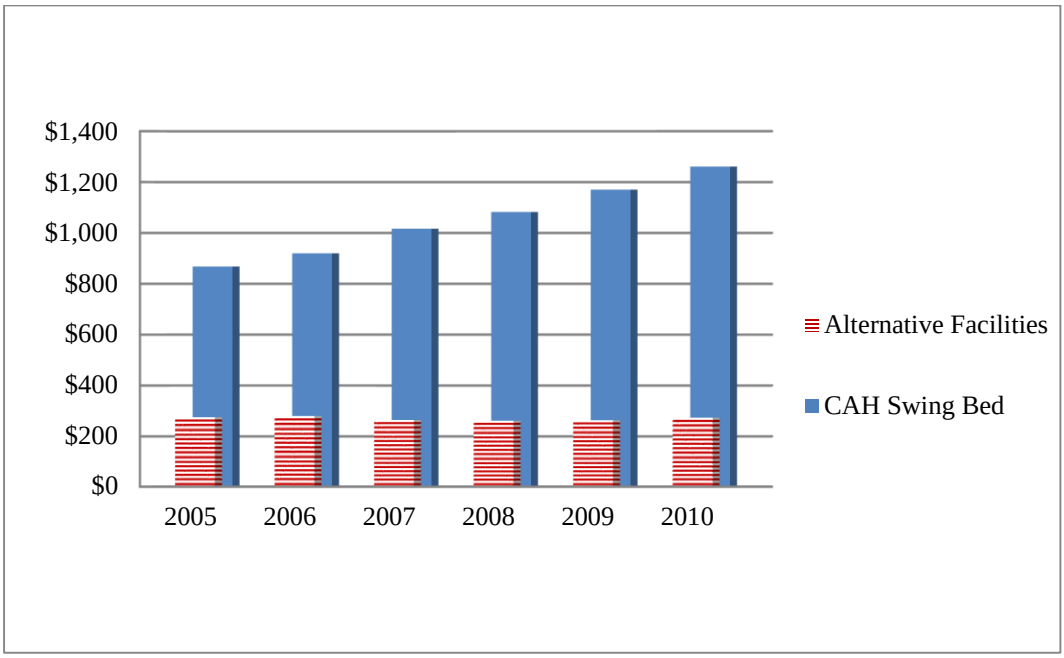
The increase in swing-bed days was due primarily to an increase in the number of CAHs throughout the Nation from CYs 2004 to 2006. This increase was likely caused by the fact that the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 granted CAHs more flexibility in their use of beds as swing-beds, thus increasing reimbursement and grandfathering of previously State-designated "necessary provider" CAHs. Additionally, federally funded research shows that some CAHs have placed an increased focus on swing-bed care.[17] The research suggests that using swing-beds has a positive financial impact on a hospital because of the benefits of cost-based reimbursement in helping support a hospital's fixed costs and offset losses from other lines of business, such as uncompensated care.

[17] North Carolina Rural Health Research & Policy Analysis Center, *Why Use Swing Beds? Conversations with Hospital Administrators and Staff*, findings brief, April 2012.

THE AVERAGE SWING-BED REIMBURSEMENT IS MUCH HIGHER AT CRITICAL ACCESS HOSPITALS THAN AT ALTERNATIVE FACILITIES

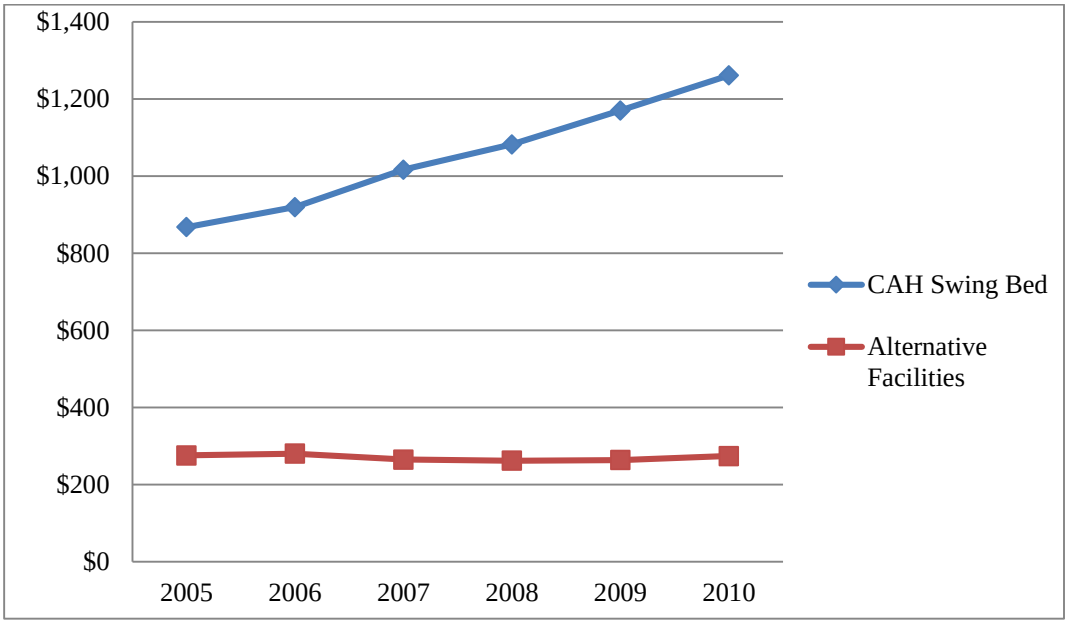
For the 6-year period reviewed, Medicare spent, on average, almost four times more for swing-bed services at CAHs than for similar services at alternative facilities (Figure 2).

Figure 2: Comparison of Average Swing-Bed Reimbursement per Day



Specifically, swing-bed reimbursement at CAHs ranged from $868 per day in CY 2005 to $1,261 per day in CY 2010. In contrast, the daily average reimbursements for similar services at alternative facilities ranged from $275 to $273 over the same time period. Swing-bed reimbursement at CAHs also continued to steadily increase while reimbursement for similar services at alternative facilities stayed steady (Figure 3).

Figure 3: Average Swing-Bed Reimbursement per Day Over Time



BENEFICIARIES HAD ACCESS TO THE SIMILAR SKILLED NURSING FACILITY SERVICES AT ALTERNATIVE FACILITIES WITHIN 35 MILES OF CRITICAL ACCESS HOSPITALS

We reviewed cost report information for the sampled CAHs and for alternative facilities within a 35-mile radius of the sampled CAHs. We determined that there was available capacity[18] at alternative facilities to service the needs of beneficiaries at 90 of the 100 sampled CAHs (see Appendix E).

For example, one sampled CAH used 3,222 swing-bed days during CY 2010. Using hospital and SNF cost-report utilization data, we determined that within a 35-mile radius of this CAH, 61 alternative facilities offering similar services existed with an available capacity of 432,299 SNF or swing-bed days during CY 2010. Therefore, Medicare beneficiaries had access to the similar SNF services at alternative facilities for this sampled CAH.

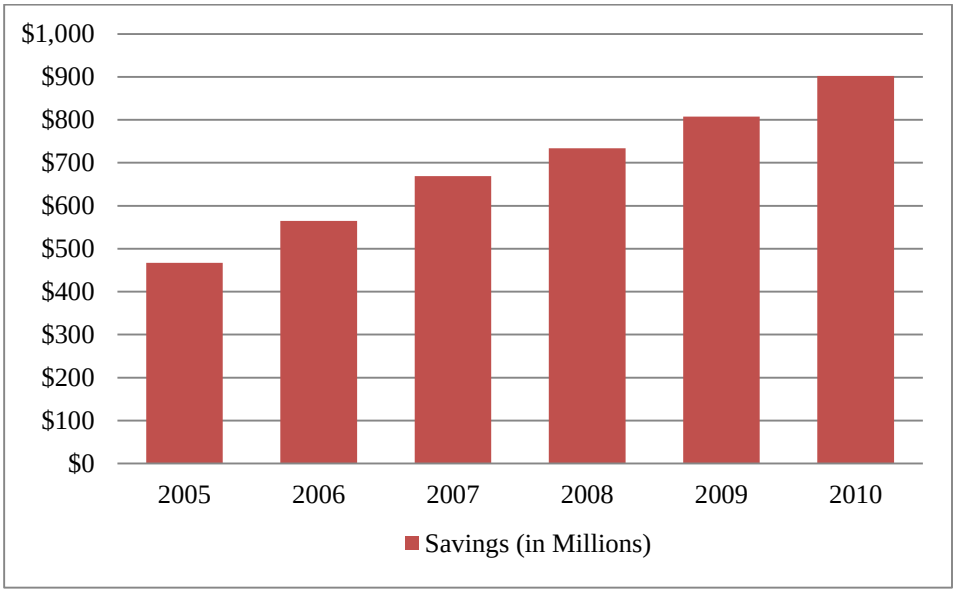
On the basis of our sample results, we estimated that for 1,080 of the 1,200 CAHs that offered swing-bed services during CY 2010, beneficiaries had access to the similar SNF services within a 35-mile radius at alternative facilities. Having the bed availability for beneficiaries at alternative facilities could provide Medicare with a less costly alternative for providing health care to beneficiaries. This less costly alternative would also be a low-risk alternative because it would not limit beneficiary access to care.

[18] Using cost report information, we derived available capacity at alternative facilities by subtracting total used beds from total beds for the year. Given cost report data limitations and potential variation in patient numbers on a daily, weekly, or monthly basis, availability at these intervals could not be determined.

MEDICARE COULD SAVE BILLIONS IN THE REIMBURSEMENT OF SWING-BED SERVICES

Medicare pays almost four times more for swing-bed services provided at CAHs than it pays to alternative facilities for the skilled nursing needs of Medicare beneficiaries. Also, about 90 percent of CAHs are located within a 35-mile radius of at least one alternative facility that offers similar SNF services. We estimated that Medicare could have saved a total of $4.1 billion over the 6-year period covered by our audit if payments for swing-bed services were reimbursed using the SNF PPS rates rather than 101 percent of costs (Figure 4).

Figure 4: Estimated Amounts That Medicare Could Have Saved Over 6 Years



RECOMMENDATION

We recommend that CMS seek legislation to adjust CAH swing-bed reimbursement rates to the lower SNF PPS rates paid for similar services at alternative facilities.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS agreed with our finding that CAHs' swing-bed utilization has increased but disagreed with our recommendation because of concerns with our findings on the availability of skilled nursing services at nearby alternative facilities and our calculation of savings. CMS's comments are included in their entirety as Appendix H. We also received and considered technical comments from the Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA), which is authorized to advise the Secretary of HHS on Medicare regulatory issues in rural communities.

After considering CMS's and HRSA's comments, we have adjusted our report language as appropriate to clarify certain points. However, because (1) the sample design achieved its intended purpose, (2) the type and intensity of services provided in a CAH swing bed or in a SNF bed at an alternative facility are the same, and (3) recent swing-bed utilization research shows that discharges from CAHs are sent equally to SNFs or kept in swing beds and that patient characteristics are comparable regardless of discharge destination, we maintain our findings and recommendation are valid.

SAMPLED HOSPITALS

CMS stated that our sample of 100 CAHs may not have adequately represented the total population of 1,200 CAHs that provide swing-bed services, resulting in an overestimation of the number of CAHs for which alternative facilities are within 35 miles. Additionally, CMS stated that we did not make a distinction in our sample between Necessary Provider (NP) CAHs, which do not have to meet distance requirements, and CAHs not designated as NP CAHs, which must meet distance requirements.

Because each CAH had an equal chance of being selected, our sampling approach did not bias the estimates we made to the total 1,200 CAHs that provide swing-bed services. Our objective did not require us to make a distinction between NP CAHs and other CAHs. Rather, it was designed to determine whether similar SNF services were available within a 35-mile radius of the sampled CAHs and to make inferences about the total 1,200 CAHs that provide swing-bed services. Our sample design achieved its intended purpose.

LEVEL OF BENEFICIARY CARE

CMS stated that our report assumed "the same case mix for patients at CAHs and alternative facilities, therefore not considering differences in the type and intensity of services provided to the two groups of patients." Specifically, CMS stated that our report did not take into account the differences in patient populations. CMS indicated that patients who receive care in swing-beds "are likely more 'medically complex' than patients receiving care at alternative facilities." CMS stated that it is "unclear whether the level of care provided to CAH swing bed patients and to patients of alternative facilities is equivalent and whether beds at alternative facilities were available on a daily, weekly, or monthly basis."

The type and intensity of services provided to a patient in a CAH's swing-bed or in a SNF bed at an alternative facility are the same.[19] Recent federally funded research on swing-bed utilization shows that post-acute patients discharged from CAHs are sent equally to SNFs or kept in swing-beds; patient characteristics are comparable regardless of hospital type or post-acute care discharge destination.[20]

[19] Social Security Act, §§ 1883(a)(1) and (d); 42 U.S.C. §§ 1395tt; 42 CFR § 409.20(a).

[20] North Carolina Rural Health Research & Policy Analysis Center, *Discharge to Swing Bed or Skilled Nursing Facility: Who Goes Where?* findings brief, February 2014.

Our analysis was not designed to, and did not, make the distinction between swing-beds and SNF beds. Regarding the availability of beds and variation in patient numbers on a daily, weekly, or monthly basis, our analysis did not take into account these short intervals because of limitations in the cost report data. However, our evidence shows that for almost all sampled CAHs, the number of beds available on a yearly basis at alternative facilities far exceeded the swing-bed days used at CAHs. (See Appendix E.) For 89 of the 90 sampled CAHs that had sufficient alternative care, alternative facilities had more than twice as many beds as the CAHs and more than 60 times the number of days available.

ACCESSIBILITY AND COST OF ALTERNATIVE FACILITIES

CMS stated that, because our report used a radius measurement to determine distances from alternative facilities, our report does not reflect the distances beneficiaries may need to travel, and, thus, the true accessibility of the facilities. Additionally, CMS stated that our cost estimates excluded transportation costs of moving a patient to an alternative facility, which would decrease the savings from using an alternative facility.

We recognize that using a radius measurement generally does not reflect the actual distances beneficiaries may need to travel. For the 100 sampled CAHs, we identified a total of 1,770 alternative facilities within a 35-mile radius. It was impractical to measure exact actual distances from sampled CAHs to all of these alternative facilities and build this analysis into our methodology. However, the excess capacity we noted indicates that there were ample alternative facilities within reasonable driving distances at practically all sampled CAHs.

We also recognize that our cost estimates excluded transportation costs to move patients to an alternative facility, as we explained in Appendix A. These transportation costs can vary greatly, they are difficult to quantify, and the extent of their impact is unknown. For simplification purposes and because of this uncertainty, we excluded these costs from our analysis.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed Medicare payments for SNF services at CAHs, Non-Critical Access Hospitals, and traditional SNFs for CYs 2005 through 2010 and computed the average daily per diem rate for each category.

We did not review the overall internal control structure of any organization. Our objective did not require a review of internal controls.

We conducted our audit work from January through September 2013.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted data from CMS's National Claims History (NCH) file for CYs 2005 through 2010 for CAH swing-bed and alternative facility skilled nursing claims;
- calculated and compared average payments to CAHs for swing-bed services, as well as average payments to alternative facilities for similar skilled nursing services (Appendix B);
- selected a random sample of CAHs nationwide and determined whether alternative SNF service care was available within 35 miles[21] during CY 2010 (Appendix C);
- estimated the number of CAHs with swing-beds that had alternative skilled nursing care available (Appendixes D and E);
- estimated the savings to Medicare for swing-bed service payments (Appendix F);[22] and
- discussed the results of our review with CMS.

[21] In determining availability of alternative care, we used a 35-mile radius measurement from the sampled CAH. While consistent with the general 35-mile rural flexibility distance requirement, using a radius measurement may yield a result somewhat different from that computed using a driving-distance measurement. For simplicity purposes, we did not take into account the other distance requirements, such as the 15-mile limit in mountainous terrain.

[22] The comparison of average daily per diem rates computed for CAHs to rates at alternative facilities did not take into account any potential additional costs for transporting beneficiaries to an alternative facility. For this reason, our estimated potential savings may be overstated by the amount of the transportation costs.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: MATHEMATICAL CALCULATION PLAN

DESCRIPTION OF MATHEMATICAL CALCULATION

For CYs 2005 through 2010, we estimated the difference between Medicare payments to CAHs for swing-bed services (reimbursed at 101 percent of costs) and Medicare payments to alternative facilities for similar services reimbursed using the PPS rates.

MATHEMATICAL CALCULATION METHODOLOGY

From CMS's NCH file, we identified swing-bed reimbursement to CAHs and reimbursement to alternative facilities for similar services. To estimate the potential cost savings for swing-bed reimbursement, we performed the following steps for each year of our audit period:

Step 1—We calculated the average payment to CAHs with swing-bed services by:

- identifying total Medicare CAH swing-bed service payments,
- identifying the total number of CAH swing-bed service days, and
- dividing the total payments by the total days.

Step 2—We calculated the average payment to alternative facilities by:

- identifying total Medicare alternative facility skilled nursing service payments,
- identifying the total number of alternative facility skilled nursing service days, and
- dividing the total payments by the total days.

Step 3—We estimated potential Medicare savings for CAH swing-bed services by (Appendix F):

- calculating the difference in the average payment amount for CAH swing-bed services (step 1) and the average payment amount for skilled nursing services at alternative facilities (step 2),
- multiplying the difference in the average payment amounts by the total CAH swing-bed days for each year covered by our audit, and
- adding the estimated differences in Medicare payments for each year to obtain a total estimated savings for CYs 2005 through 2010.

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of the 1,200 CAHs that provided swing-bed services to Medicare beneficiaries from January 1 through December 31, 2010.

SAMPLING FRAME

The sampling frame was an Excel file extracted from CMS's NCH file containing 1,200 CAHs that provided swing-bed services from January 1 through December 31, 2010.

SAMPLE UNIT

The sample unit was one CAH that provided swing-bed services.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a random sample of 100 CAHs.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General, Office of Audit Services (OIG/OAS), statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sampling frame. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the number of CAHs with swing-bed services that had alternative care available within 35 miles of the CAHs during CY 2010.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Results

Frame Size	Sample Size	Alternative Facility Bed Availability
1,200	100	90

Table 2: Estimated Number of Critical Access Hospitals With Swing-Beds That Had Alternative Skilled Nursing Care During Calendar Year 2010 (*Limits Calculated for a 90-Percent Confidence Interval)*

Point estimate	1,080
Lower limit	1,007
Upper limit	1,131

APPENDIX E: SUMMARY OF SAMPLE RESULTS—ALTERNATIVE SKILLED NURSING CARE AVAILABLE DURING CALENDAR YEAR 2010

Sample Number	Number of CAH Swing-Bed Days Used	Number of Bed Days Available at Alternative Facilities[23]	Sufficient Alternative Beds Available?[24]
1	596	268	NO
2	2,278	0	NO
3	2,889	117,240	YES
4	1,405	144,526	YES
5	3,437	111,559	YES
6	439	6,994	YES
7	7,204	29,615	YES
8	860	0	NO
9	867	13,140	YES
10	4,063	65,356	YES
11	1,626	112,712	YES
12	4,634	67,491	YES
13	2,354	256,501	YES
14	2,698	130,752	YES
15	2,836	184,258	YES
16	3,345	174,374	YES
17	4,199	208,705	YES
18	1,511	383,476	YES
19	3,222	432,299	YES
20	1,548	153,367	YES
21	1,834	143,663	YES
22	1,902	387,649	YES
23	1,243	129,098	YES
24	2,745	78,861	YES
25	3,217	102,626	YES
26	2,913	244,687	YES
27	1,940	127,322	YES
28	4,344	108,298	YES
29	3,844	111,629	YES
30	2,816	125,554	YES
31	1,235	122,519	YES
32	3,418	124,293	YES
33	2,188	23,534	YES

[23] Using cost report information, we derived available capacity at alternative facilities by subtracting total used beds from total beds for the year.

[24] We compared the number of swing-bed days used at sampled CAHs to the total number of beds available at alternative facilities within 35 miles of the sampled CAHs. A higher number of beds at alternative facilities than at sampled CAHs indicated sufficient bed capacity—denoted with a "YES." In contrast, a higher number of swing-bed days at CAHs than at alternative facilities indicated not enough bed capacity—denoted with a "NO."

Sample Number	Number of CAH Swing-Bed Days Used	Number of Bed Days Available at Alternative Facilities	Sufficient Alternative Beds Available?
34	751	9,266	YES
35	6,092	91,317	YES
36	3,357	53,336	YES
37	2,468	59,497	YES
38	3,656	62,936	YES
39	3,233	2,899	NO
40	1,389	30,245	YES
41	2,273	44,338	YES
42	4,772	243,532	YES
43	4,426	51,477	YES
44	6,445	50,011	YES
45	4,071	179,033	YES
46	1,977	0	NO
47	545	128,315	YES
48	1,597	70,383	YES
49	1,603	87,020	YES
50	2,203	90,309	YES
51	2,366	84,512	YES
52	954	87,524	YES
53	5,571	91,251	YES
54	4,946	68,138	YES
55	3,571	177,125	YES
56	3,346	262,102	YES
57	3,213	62,355	YES
58	2,664	0	NO
59	3,656	12,577	YES
60	1,283	30,908	YES
61	1,077	44,503	YES
62	2,851	78,239	YES
63	3,143	182,010	YES
64	2,160	22,570	YES
65	3,215	11,235	YES
66	4,894	46,342	YES
67	1,490	4,715	YES
68	4,410	112,690	YES
69	1,667	85,003	YES
70	1,435	100,837	YES
71	1,111	63,297	YES
72	1,618	47,710	YES
73	693	14,993	YES
74	1,247	120,093	YES
75	1,360	91,495	YES
76	2,373	0	NO

Sample Number	Number of CAH Swing-Bed Days Used	Number of Bed Days Available at Alternative Facilities	Sufficient Alternative Beds Available?
77	2,210	0	NO
78	3,455	86,005	YES
79	700	56,568	YES
80	772	0	NO
81	3,584	39,673	YES
82	1,317	56,373	YES
83	4,575	11,237	YES
84	1,554	27,501	YES
85	458	0	NO
86	962	136,876	YES
87	3,243	91,283	YES
88	1,726	248,685	YES
89	1,244	286,682	YES
90	2,374	10,531	YES
91	4,411	41,485	YES
92	4,724	74,253	YES
93	4,870	80,303	YES
94	3,289	92,937	YES
95	3,773	100,894	YES
96	4,954	64,685	YES
97	1,384	85,124	YES
98	1,865	196,270	YES
99	2,301	3,646	YES
100	2,688	9,634	YES

APPENDIX F: MATHEMATICAL CALCULATION OF POTENTIAL MEDICARE SAVINGS FOR CRITICAL ACCESS HOSPITAL SWING-BED SERVICES

CY	CAH Claims Total Days	CAH Claims per Diem	Alternative Facilities Claims per Diem	Difference in per Diem	Total Potential Medicare Savings for CAH Swing-Bed Services
	A	B	C	D = (B - C)	E = (A x D)
2005	788,609	$867.95	$275.41	$592.54	$467,282,377
2006	882,690	919.75	280.19	639.56	564,533,216
2007	890,085	1,016.76	264.77	751.99	669,335,019
2008	894,286	1,082.40	261.71	820.69	733,931,577
2009	890,379	1,170.43	263.66	906.77	807,368,966
2010	913,523	1,261.12	273.75	987.37	901,985,204
Totals	**5,259,572**				**$4,144,436,359**

APPENDIX G: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Medicare Beneficiaries Paid Nearly Half of the Costs for Outpatient Services at Critical Access Hospitals	OEI-05-12-00085	10/7/2014
Services Provided by Critical Access Hospitals in 2011	OEI-05-12-00081	12/20/2013
Most Critical Access Hospitals Would Not Meet the Location Requirements If Required To Re-enroll in Medicare	OEI-05-12-00080	08/14/2013
Review of Select Medicare Conditions of Participation and Costs Claimed at Richards Hospital From October 1, 2004, Through September 30, 2007	A-05-08-00083	05/09/2011
Review of Select Medicare Conditions of Participation and Costs Claimed at Hillsboro Area Hospital From April 1, 2004, Through June 30, 2006	A-05-07-00082	04/08/2010
Review of Select Medicare Conditions of Participation and Costs Claimed at St. Vincent Frankfort Hospital From July 1, 2003, Through June 30, 2006	A-05-08-00008	12/16/2009
Review of Select Medicare Conditions of Participation and Costs Claimed at Aspirus Keweenaw Hospital From August 1, 2004, Through September 30, 2006	A-05-07-00083	09/23/2009

APPENDIX H: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

Date: NOV 13 2014

To: Daniel R, Levinson
Inspector General
Office of the Inspector General

From: Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services

Subject: Medicare Could Have Saved Billions at Critical Access Hospitals if Swing-Bed Services were Reimbursed Using the Skilled Nursing Facility Prospective Payment System Rates (A-05-12-00046)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of the Inspector General's (OIG) draft report. CMS is committed to improving the quality of health care for all Medicare beneficiaries and ensuring that rural Americans have access to high quality and affordable care in their communities, while promoting payment efficiency and protecting taxpayer dollars.

CMS concurs with the OIG's findings that Critical Access Hospitals' (CAHs) swing bed utilization has increased during the OIG's study period. However, CMS has several concerns related to the report that should be addressed.

While CMS concurs that changes should be made to CAH designation and payment systems that balance access to care with payment efficiency, CMS cannot concur with the OIG's recommendation based on methodological concerns. The OIG's findings overestimate savings by failing to incorporate important factors such as the level of care needed by swing bed patients, transportation fees to alternative facilities, and the use of point-to-point mileage distances instead of road miles.

CMS has concerns with the methodology used in the OIG report to determine the findings on availability of skilled nursing services at nearby alternative facilities and the calculation of cost savings. CMS believes the report's sample of 100 CAHs may not adequately represent the total population of 1,200 CAHs that provide swing bed services, resulting in an overestimation of the number of CAHs for which alternative facilities are within 35 miles. In addition, the OIG does not make the distinction in its sample between Necessary Provider (NP) CAHs, which do not have to meet the distance requirements, and CAHs not designated as NP CAHs, which do have to meet the distance requirements. The sample set does not indicate the proportion that fall into each category and whether they were proportionally represented in the sample.

The OIG draft report also assumes the same case mix for patients at CAHs and alternative facilities, therefore not considering differences in the type and intensity of services provided to the two groups of patients. The draft report does not account for differences in patient populations; patients receiving care in swing beds are likely more "medically complex" than patients receiving care at alternative facilities.[1] It is also unclear whether the level of care provided to CAH swing bed patients and to patients of alternative facilities is equivalent and whether beds at alternative facilities are available on a daily, weekly, or monthly basis.

The OIG's finding that 90 out of the 100 sample cases have an alternative facility furnishing SNF services within 35 miles of a CAH does not indicate whether the alternative facilities are easily accessible by the CAH population. In contrast to the distance requirement for CAHs based on driving distances, the OIG report used a radius measurement to determine distances from alternative facilities. CMS believes that a radius measurement does not reflect the distances beneficiaries may need to travel, and thus, the true accessibility of the facilities. In addition, the report does not take into account the burden on patients of being treated farther from home and family, and being transferred in an ambulance to a new facility. The OIG's cost estimations exclude transportation costs of moving a patient to an alternative facility as opposed to using a CAH swing bed, which would decrease the savings from using an alternative facility.

OIG Recommendation

The OIG recommends that CMS seek legislation to adjust CAH swing-bed reimbursement rates to the lower SNF PPS rates paid for similar services at alternate facilities.

CMS Response

CMS does not concur with the OIG findings based on the methodological issues discussed above. However, CMS concurs that changes should be made to CAH designation and payment systems that balance beneficiary access to care while promoting payment efficiency. The President's FY2015 Budget proposes a reduction in CAH payments from 101 to 100 percent of reasonable costs. It also proposes to prevent CAHs that are within 10 miles of another hospital or CAH from maintaining certification as a CAH and receiving payments based on a cost-based reimbursement structure. These facilities instead would have the option of either no longer participating in Medicare or converting to a Medicare-participating hospital and be paid under the applicable prospective payment system, which includes the SNF PPS for swing bed services. The President's budget proposal preserves beneficiary access to care while promoting payment efficiency. The basic cost-based reimbursement structure for CAHs would be preserved for facilities that are the sole source of these types of services for their communities.

[1] http://www.shepscenter.unc.edu/rural/pubs/finding_brief/FB105.pdf