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Medicare Could Save Billions With Comparable Access for Enrollees if Critical Access Hospital Payments for Swing-Bed Services Were Similar to Those of the Fee-for-Service Prospective Payment System

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REPORT HIGHLIGHTS

December 2024 | A-05-21-00018

Medicare Could Save Billions With Comparable Access for Enrollees if Critical Access Hospital Payments for Swing-Bed Services Were Similar to Those of the Fee-for-Service Prospective Payment System

Why OIG Did This Audit

- Congress established the Rural Flexibility Program, which created Critical Access Hospitals (CAHs), to ensure that enrollees in rural areas have access to a range of hospital services.
- CAHs provide "swing-bed" services, which are similar to services performed at a skilled nursing facility (SNF).
- Medicare reimburses CAHs at 101 percent of their reasonable costs rather than at rates set by Medicare's prospective payment system (PPS) or Medicare's fee schedules.
- A prior Office of Inspector General report issued in 2015 recommended that CMS seek legislation to adjust CAH swing-bed reimbursement rates to the lower SNF PPS rates paid for similar services at alternative facilities. The recommendation remains open and unimplemented.

What OIG Found

- Swing-bed utilization for skilled nursing services at CAHs increased by 2.8 percent from CY 2015 through 2020; meanwhile, the average daily reimbursement amount increased by 16.6 percent over the same period.
- Based on our sample results, we found that 87 of 100 sampled CAHs were within a 35-mile driving distance of an alternative facility that had skilled nursing care available and estimate that 1,128 of the 1,297 CAHs in our sampling frame had an alternative facility within 35 miles that could have provided care during CY 2020.
- Based on our sample results and mathematical calculation, we estimate that Medicare could have saved up to $7.7 billion over a 6-year period if payments made at CAHs were reimbursed using SNF PPS rates.

What OIG Recommends

We recommend that CMS seek a legislative change that will allow it to reimburse CAHs at rates that align with those paid to alternative facilities when it determines that similar care is available at alternative facilities.

CMS did not concur with our recommendation.

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INTRODUCTION

WHY WE DID THIS AUDIT

The Balanced Budget Act of 1997 (BBA), which established the Rural Flexibility Program, created Critical Access Hospitals (CAHs) to ensure that enrollees in rural areas have access to a range of hospital services.[1] 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] The BBA requires Medicare to reimburse CAHs at 101 percent of their reasonable costs[3] for providing services to enrollees rather than using rates set by Medicare's prospective payment system (PPS) or Medicare's fee schedules, which are used to reimburse alternative facilities.[4] Alternative facilities include SNFs and acute care hospitals authorized to offer skilled nursing services similar to those provided in swing beds.

CAHs must meet the requirements set forth in the CAH Conditions of Participation (CoPs)[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] 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 if they continued to meet all other CAH requirements.[8]

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[1] 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] 42 CFR § 485.645 identifies requirements for a swing bed in a hospital bed in a CAH. A swing bed may be used as needed to furnish either an acute or a SNF level of care. A CAH "can 'swing' its beds between the hospital and SNF levels of care, on an as needed basis, if it has obtained a swing bed approval from the Department of Health and Human Services." (Centers for Medicare & Medicaid Services [CMS], *Medicare Benefit Policy Manual,* Chapter 8, section 10.3. Accessed on Sept. 18, 2024.)

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

[4] Social Security Act, §§ 1814(l) and 1834(g). Before Jan. 1, 2004, Medicare reimbursed CAHs at 100 percent of reasonable costs.

[5] 42 CFR § 485 subpart F.

[6] Facilities wishing to be certified as CAHs must be: (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)).

[7] BBA, § 4201; Social Security Act, § 1820(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).

In September 2011, the Office of Management and Budget (OMB) proposed to reduce CAH reimbursements and eliminate the certification for CAHs located within 10 miles of another hospital.[9] 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.[10]

In a March 2015 report, the Office of Inspector General (OIG) found that 90 of 100 sampled CAHs had alternative facilities within 35 miles with alternative skilled nursing care available and recommended that the Centers for Medicare & Medicaid Services (CMS) seek legislation to adjust CAH swing-bed reimbursement rates to the lower SNF PPS rates paid for similar services at alternative facilities.[11] The recommendation remains open and unimplemented.

CMS cannot change how CAHs are paid; rather, CMS would need legislative action from Congress. Medicare could save billions with comparable access for enrollees if CAH payments for swing-bed services were similar to those of the fee-for-service PPS.

OBJECTIVES

Our objectives were to determine whether: (1) swing-bed utilization at CAHs for skilled nursing care changed between calendar years (CYs) 2015 and 2020, (2) average reimbursement per day at CAHs for skilled nursing care in a swing bed differed from the average reimbursement per day at alternative facilities, and (3) similar care was available at alternative facilities.[12]

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[9] OMB, *Living Within Our Means and Investing in the Future: The President's Plan for Economic Growth and Deficit Reduction.* Accessed on Sept. 10, 2024.

[10] OMB, *Fiscal Year 2015 Budget of the U.S. Government,* p. 179, accessed on Sept. 18, 2024.

[11] OIG, *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), Mar. 6, 2015.

[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.

BACKGROUND

The Medicare Program

Medicare provides health insurance for people aged 65 and older, people with disabilities, and people with permanent kidney disease. Medicare Part A provides inpatient hospital insurance benefits and coverage for extended care services for patients after discharge. CMS administers the Medicare program and contracts with Medicare Administrative Contractors to, among other things, process and pay claims submitted by health care providers.

Critical Access Hospitals and Swing-Bed Services

For a hospital to be designated as a CAH, it must meet certain Medicare CoPs.[13] Some CoPs requirements are: (1) being located in a rural area, (2) being at a certain distance from other hospitals or being grandfathered in 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.

Payment for Skilled Nursing Services at Critical Access Hospitals

Medicare enrollees in inpatient status at CAHs may transition or "swing" from receiving inpatient services to receiving SNF services without physically changing beds within the hospital. Unlike skilled nursing services in a CAH swing bed, which are reimbursed at 101 percent of reasonable cost, Medicare pays for skilled nursing services provided in SNFs at predetermined daily rates under the SNF PPS.[14] The daily rates vary based on the level of care required, which is based on an enrollee's physical functioning, disease diagnoses, health conditions, and treatment received. These payment rates represent payment in full for all costs (routine, ancillary, and capital-related) associated with furnishing covered skilled nursing services to enrollees.[15]

Prior Reviews Related to Critical Access Hospitals

OIG has performed several reviews of CAHs. In one such review, OIG determined that nearly two-thirds of CAHs would not meet the location requirement if required to re-enroll, and a vast

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[13] 42 CFR § 485 subpart F.

[14] Social Security Act, § 1888(e).

[15] Social Security Act, § 1888.

majority would not meet the distance requirement.[16, 17] That report also concluded that only CAHs that serve enrollees who would otherwise be unable to reasonably access hospital services should remain certified. In addition, that report concluded that Medicare and enrollees would have saved $449 million in 2011 if Congress granted CMS the authority to reassess whether CAHs should maintain their certification based on location and distance requirements and if CMS implemented procedures to reassess whether CAHs were meeting requirements.

OIG also concluded in an audit report that 90 percent of CAH swing-bed services could have been provided at alternative facilities within 35 miles of the CAH during CY 2010.[18] OIG estimated that Medicare could have saved $4.1 billion over a 6-year period if payments for skilled nursing services in swing beds at CAHs were made using SNF PPS rates. In response to the report, CMS concurred that changes should be made to CAH designation and payment systems that balance access to care with patient efficiency; however, CMS did not concur with the recommendation based on methodological concerns. Specifically, CMS expressed concern that our determination about whether similar care was available at alternative facilities was based on a radius measurement rather than driving distances. OIG considers this recommendation open and unimplemented.

HOW WE CONDUCTED THIS AUDIT

Our audit covered Medicare claims submitted between January 1, 2015, and December 31, 2020. We reviewed Medicare claim data for CAHs that provided skilled nursing services to patients in swing beds and for alternative facilities nationwide that submitted claims to CMS for skilled nursing services. We determined the swing-bed usage at CAHs for the 6-year reimbursement period. We also compared the average daily swing-bed reimbursement at CAHs with the average daily reimbursement for similar services at alternative facilities. To compute an average daily swing-bed reimbursement at CAHs, we divided total yearly swing-bed reimbursement by total swing-bed service days. From a sampling frame of the 1,297 CAHs that submitted swing-bed claims, we selected a random sample of 100 CAHs to determine whether enrollees would have had access to the same skilled nursing services provided by CAHs at alternative facilities. Finally, to identify the potential savings for Medicare if CAHs had been paid using SNF PPS rates, we calculated the difference between the average daily reimbursement for skilled nursing services at CAHs and the average daily reimbursement at alternative facilities.

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[16] OIG, *Most Critical Access Hospitals Would Not Meet the Location Requirements if Required To Re-enroll in Medicare* (OEI-05-12-00080), Aug. 14, 2013.

[17] Appendix B contains a list of previously issued reports on CAHs.

[18] See footnote 11.

To determine whether enrollees would have access to the same skilled nursing services at alternative facilities, we reviewed CY 2020 cost report information submitted by sampled CAHs and alternative facilities within a 35-mile driving distance of the sampled facilities.[19] Using publicly available mapping software, we were able to identify total driving time and distance between CAHs and alternative facilities. Using the cost report information, we calculated whether alternative facilities had sufficient bed capacity to cover the number of bed-days at sampled CAHs. We considered sampled CAHs to have similar care available at alternative facilities if they were within a 35-mile driving distance of an alternative facility with sufficient bed capacity.

Finally, to determine the potential savings for Medicare, we calculated the difference between the average daily reimbursement for skilled nursing services at CAHs and the average daily reimbursement at alternative facilities. We multiplied this difference by the total days of skilled nursing services at CAHs where care was available at alternative facilities.[20]

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 details of our audit scope and methodology, Appendix B contains related OIG reports, Appendix C contains our mathematical calculation plan, Appendix D contains our statistical sampling methodology, Appendix E contains our sample results and estimates, and Appendix F contains a summary of our sample results.

FINDINGS

Swing-bed utilization at CAHs for skilled nursing services increased by 2.8 percent from CYs 2015 through 2020; meanwhile, the average daily reimbursement amount increased by 16.6 percent over the same period. We found that the average daily CAH reimbursement for skilled nursing services in a swing bed was over five times more than the average alternative facility reimbursement per day. In addition, we found that 87 of 100 sampled CAHs were within a 35-mile driving distance of an alternative facility that had skilled nursing services available. Based on our sample results and mathematical calculation, we estimate that Medicare could have saved up to $7.7 billion over a 6-year period if payments made at CAHs for skilled nursing services in a swing bed were reimbursed using SNF PPS rates.

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[19] Cost reports contain provider information such as facility characteristics, utilization data, cost and charges by cost center, Medicare settlement data, and financial statement data. This information is reported by the CAHs and uploaded to the Healthcare Provider Cost Reporting Information System.

[20] The comparison of average daily reimbursement computed for CAHs to rates at alternative facilities did not consider any potential additional costs for transporting enrollees to an alternative facility. For this reason, our estimated potential savings may be overstated by the amount of the transportation costs.

ANNUAL SWING-BED UTILIZATON

Swing-bed utilization at CAHs for skilled nursing services increased by 2.8 percent from 1,032,123 days to 1,061,074 days from CY 2015 through CY 2020. During the same period, the total number of claims submitted by CAHs decreased from 102,253 to 92,970. An increase in the number of swing-bed usage days and a decrease in the number of claims billed indicates that the increase in swing-bed utilization can be attributed to longer stays for enrollees.

The average daily reimbursement for skilled nursing services in a swing bed increased 16.6 percent, from $1,582.58 in CY 2015 to $1,845.69 in CY 2020. Table 1 shows the increase in the number of swing-bed days used in addition to the decrease in the number of claims billed. Table 1 also shows the increase in average payment per claim and average daily reimbursement.

Table 1: Total Swing-Bed Utilization Days and Average Daily Reimbursement Amount by Year for Swing Beds at Critical Access Hospitals

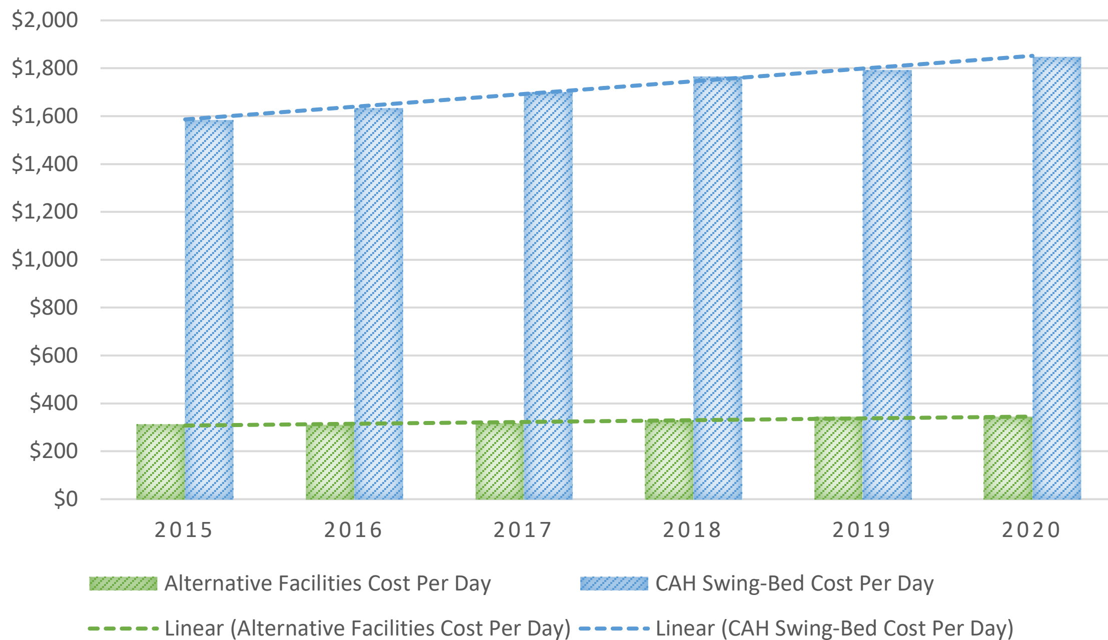
Year	Swing-Bed Usage Days	Number of Claims	Average Days per Claim	Average Payment per Claim	Average Daily Reimbursement
2015	1,032,123	102,253	10	$15,974.25	$1,582.58
2016	1,042,640	100,290	10	16,969.91	1,632.31
2017	1,052,432	101,023	10	17,694.42	1,698.49
2018	1,073,645	99,666	11	19,005.26	1,764.25
2019	1,095,614	100,064	11	19,616.79	1,791.63
2020	1,061,074	92,970	11	21,064.99	1,845.69

AVERAGE DAILY REIMBURSEMENT FOR CARE PROVIDED IN A SWING BED VERSUS CARE AT ALTERNATIVE FACILITIES

For each of the 6 years in our audit period, the average daily reimbursement for skilled nursing services in a swing bed was over five times more than that of an alternative facility. In the most recent year, 2020, the average daily reimbursement for skilled nursing services in a swing bed was $1,845.69. Daily reimbursement for similar care at alternative facilities for the same year was $343.67.

Figure 1 (next page) shows a comparison of the average cost per day for skilled nursing services provided in a swing bed and similar services provided at an alternative facility from 2015 through 2020. The average daily reimbursement for skilled nursing services in a swing bed for the entire period was $1,720.54. Daily reimbursement for similar care at alternative facilities was $325.34 for the same period.

Figure 1: Critical Access Hospital Swing-Bed Versus Alternative Facilities Cost Per Day



ENROLLEES HAD ACCESS TO SIMILAR CARE AT MOST ALTERNATIVE FACILITIES WITHIN 35 MILES OF CRITICAL ACCESS HOSPITALS

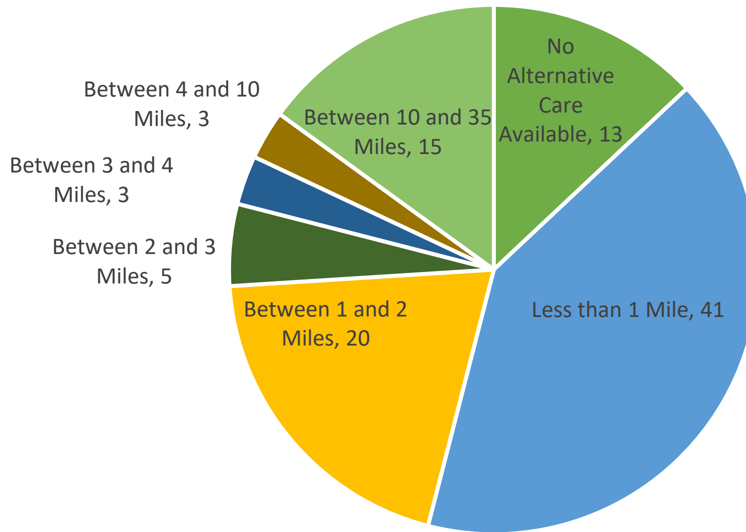
For 87 of the 100 reviewed CAHs, similar care and bed capacity was available within a 35-mile driving distance of the CAH. For example, one sampled CAH used 5,068 swing-bed days during CY 2020. Using hospital and SNF cost-report utilization data, we determined that alternative facilities within a 35-mile driving distance of this CAH had 431,704 available bed-days during the same period.

For 13 CAHs, alternative care was not available within a 35-mile driving distance, or the alternative facility did not have the capacity to provide similar care. For example, one sampled CAH used 6,278 swing-bed days during 2020; however, we identified only 4,376 available bed-days at alternative care facilities during the same period. Therefore, we determined that for this CAH similar care and bed capacity was not available within the 35-mile driving distance.

Total Mileage From the Sampled Critical Access Hospitals and Alternative Facilities

For the 100 sampled CAHs, 87 facilities had alternative care within 35 miles. Furthermore, 69 facilities had care available at an alternative facility within a 4-mile driving distance of the CAH, and 41 had care available at an alternative facility within a 1-mile driving distance. Figure 2 (next page) shows the total mileage of the closest alternative care facility to the CAHs.

Figure 2: Total Mileage From Closest Alternative Facilities to Critical Access Hospitals

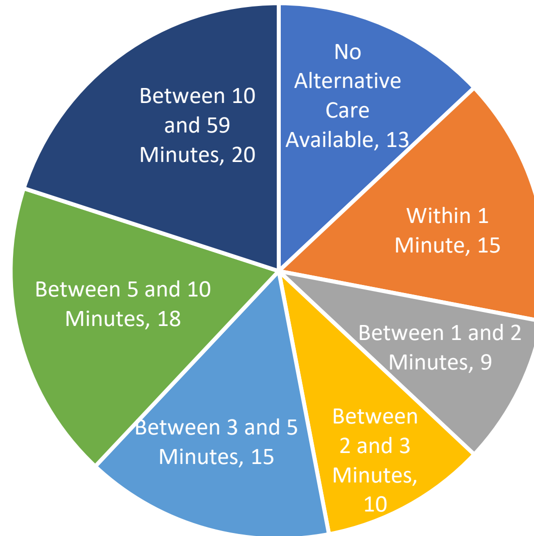


Total Driving Time Between Critical Access Hospitals and Alternative Facilities

Using publicly available mapping software, we were able to identify total driving time between CAHs and alternative facilities. We found that for 67 of the 100 sampled CAHs, the driving time between the CAH and an alternative facility was less than 10 minutes.[21] For the 87 CAHs that had care at alternative facilities available, the average driving time to the closest alternative facility was just more than 9 minutes. Twenty of the sampled CAHs had a drive time longer than 10 minutes, with the longest travel time being 59 minutes. Figure 3 (next page) shows the driving time between CAHs and closest alternative facilities.

[21] Driving time was calculated using the addresses of the CAHs and the alternative facilities.

Figure 3: Driving Time Between Closest Alternative Facilities and Critical Access Hospitals



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

Medicare paid five times more for skilled nursing services in a swing bed at CAHs than it paid at alternative facilities for similar care. Based on our sample results, we estimate that 87 percent of all CAHs were within a 35-mile driving distance of an alternative facility that had care available. Based on our sample results and mathematical calculation, we estimate that Medicare could have saved $7.7 billion during the audit period if skilled nursing services in a swing bed had been reimbursed at SNF PPS rates rather than at 101 percent of costs.[22] Figure 4 (next page) shows the estimated savings by year over our 6-year audit period.

Congress set reimbursement for services provided by CAHs, including skilled nursing services, at 101 percent of their reasonable costs. Therefore, to change the payment policy for swing-bed services at CAHs, CMS would have to request a legislative change from Congress.

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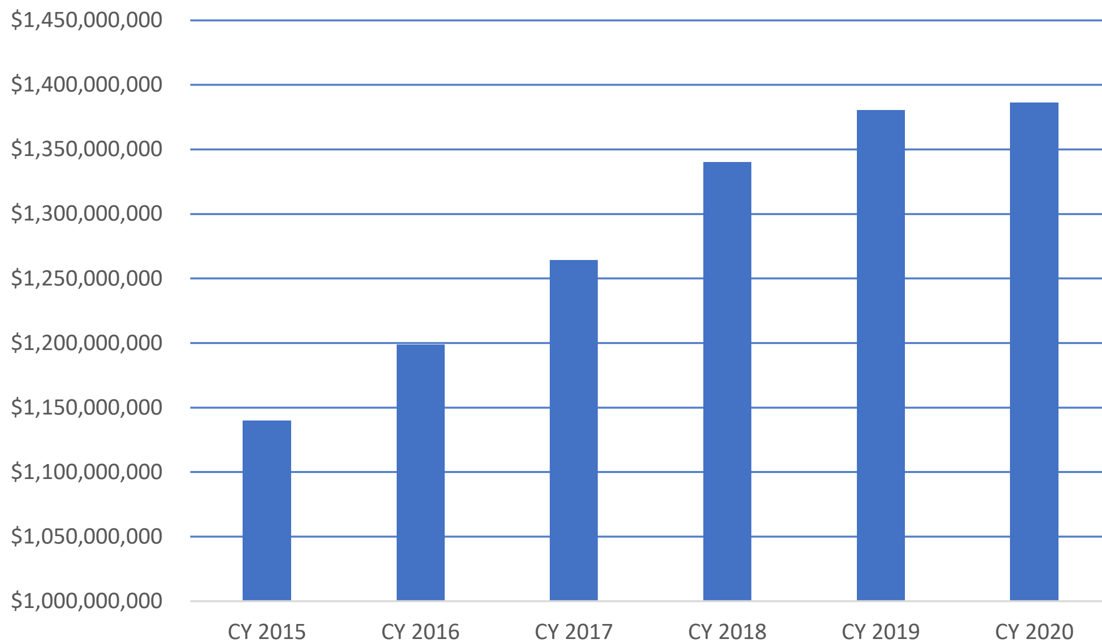
[22] When comparing average daily reimbursement computed for CAHs to rates at alternative facilities, we did not consider any potential additional costs for transporting enrollees to an alternative facility. For this reason, our estimated potential savings may be overstated by the amount of the transportation costs.

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



CONCLUSION

Similar to our 2015 audit report,[23] the findings of this audit continue to support that Medicare could save billions of dollars with comparable access for enrollees if CAH payments for swing-bed services were similar to those of the lower SNF fee-for-service PPS. We will close the previous unimplemented recommendation from the report issued in March 2015 and recommend that CMS seek a legislative change to address the findings in this report.

RECOMMENDATION

We recommend that CMS seek a legislative change that will allow it to reimburse CAHs at rates that align with those paid to alternative facilities when it determines that similar care is available at alternative facilities.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS did not concur with our recommendation, stating that any legislative recommendations would be included in the President's Budget Request. In addition, CMS has concerns with the methodology OIG used to determine the availability of skilled nursing services at nearby alternative facilities and the calculation of cost savings. CMS also noted that any reduction in payments to CAHs would likely jeopardize the viability of rural hospitals and access to care in underserved areas.

[23] See footnote 11.

After considering CMS's comments, we continue to recommend that CMS seek a legislative change that will allow it to reimburse CAHs at rates that align with those paid to alternative facilities when it determines that similar care is available at alternative facilities. CMS has the authority to develop legislative proposals for the Medicare program, and evidence from the sampled CAHs showed that the number of beds available on a yearly basis at alternative facilities far exceeded the swing-bed days used at CAHs. The change we recommend CMS consider needs only to address CAHs that would have similar care available at alternate facilities. In addition, we disagree with some of CMS's comments on our methodology and the viability of rural hospitals and provide our responses in the sections below.

CMS and the Department of Health and Human Services' Health Resources and Services Administration, which is authorized to advise the Secretary of Health and Human Services on Medicare regulatory issues in rural communities, also provided technical comments on our draft report, which we addressed as appropriate. CMS's comments, excluding the technical comments, are included as Appendix G.

SAMPLED HOSPITALS

CMS stated that the report's random sample of 100 CAHs may not adequately represent the total population of 1,297 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.

We used a simple random sample design to randomly select our sample items, meaning that each CAH regardless of whether it is an NP CAH had an equal chance of being selected. Therefore, our sample is considered representative of the sampling frame. 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 1,297 CAHs that provide swing-bed services. Our sample design achieved its intended purpose.

LEVEL OF BENEFICIARY CARE

CMS stated that our analysis does not consider the case mix for patients at CAHs versus alternative facilities and therefore does not consider differences in the type and intensity of services provided to the two groups of patients. 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."

According to the Social Security Act, the type and intensity of services provided to a patient in a CAH swing bed or in a SNF bed at an alternative facility are the same.[24] Federally funded research published in October 2022 about factors predicting the complexity of patients using CAH swing beds versus SNFs found that patients in CAH swing beds were not more likely to be more medically complex than the patients receiving care at alternative facilities. Specifically, the research found that "individuals discharged to swing beds were significantly younger . . . and had a significantly lower average number of comorbidities." In addition, "Among individuals discharged from rural CAHs, those discharged to swing beds were also significantly more likely to be primarily insured by Medicare, were significantly less likely to be primarily insured by private insurance and had a significantly shorter average length of stay than individuals discharged to SNFs."[25]

Regarding the availability of beds and variation in patient numbers on a daily, weekly, or monthly basis, our analysis did not consider these short intervals because of limitations in the cost report data. However, our evidence from the sampled CAHs showed that the number of beds available on a yearly basis at alternative facilities far exceeded the swing-bed days used at CAHs (see Appendix E).

ACCESSIBILITY AND COST OF ALTERNATIVE FACILITIES

CMS stated that, even though 87 of 100 sampled cases have an alternative facility furnishing SNF services within 35 miles of a CAH, the review did not indicate whether the alternative facilities were easily accessible by the CAH population. In addition, CMS stated that OIG's cost estimations did not include the transportation costs of moving a patient to an alternative facility as opposed to using a CAH swing bed, which would decrease the savings associated with using an alternative facility.

We found that a majority of CAHs had alternative facilities within a 4-mile driving distance. In addition, we found that for a majority of the CAHs, the drive time between the CAH and an alternative facility was less than 10 minutes.

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. However, transportation costs are small when compared to the average daily reimbursement rate for CAHs swing-bed services. For simplification and because of this uncertainty, we excluded these costs from our analysis.

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[24] Social Security Act, §§ 1883(a)(1) and (d); 42 CFR § 409.20(a).

[25] The Cecil G. Sheps Center for Health Services Research, "Discharge to Swing Bed or Skilled Nursing Facility: Who Goes Where?" Accessed on Dec. 18, 2024.

LEGISLATIVE CHANGE

CMS stated that any legislative recommendations would need to be included in the President's Budget Request. CMS also noted that any reduction in payments to CAHs would likely jeopardize the viability of rural hospitals and access to care in underserved areas.

We recognize that this change would need to be included in the President's Budget Request. CMS has the authority to develop legislative proposals for the Medicare program. CMS could study this issue and develop a legislative proposal that could be considered for future President's Budget Requests. We continue to recommend that CMS seek a legislative change that will allow it to reimburse CAHs at rates that align with those paid to alternative facilities when it determines that similar care is available at alternative facilities. The change we recommend CMS consider needs only to address CAHs that would have similar care available at alternate facilities, and it is likely that more vulnerable CAHs would not be impacted because those more rural CAHs often do not have alternative care available.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

This audit covered the total Medicare payments for SNF services at CAHs, non-critical access hospitals, and traditional SNFs for CYs 2015 through 2020. We reviewed Medicare claim data for CAHs that provided skilled nursing services to patients in swing beds and for alternative facilities nationwide that submitted claims to CMS for skilled nursing services. We determined the swing-bed usage at CAHs for the 6-year reimbursement period. We also compared the average daily swing-bed reimbursement at CAHs with the average daily reimbursement for similar services at alternative facilities. To compute an average daily swing-bed reimbursement at CAHs, we divided total yearly swing-bed reimbursement by total swing-bed service days. From a sampling frame of the 1,297 CAHs that submitted swing-bed claims, we selected a random sample of 100 CAHs to determine whether enrollees would have had access to the same skilled nursing services provided by CAHs at alternative facilities. Finally, to identify the potential savings for Medicare if CAHs had been paid using SNF PPS rates, we calculated the difference between the average daily reimbursement for skilled nursing services at CAHs and the average daily reimbursement at alternative facilities.

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 March 2021 to September 2024.

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 2015 through 2020 for CAH skilled nursing services in a swing bed and alternative facility skilled nursing claims;

- calculated and compared the average daily reimbursements to CAHs for swing-bed services and alternative facilities for similar skilled nursing services (Appendix C);

- selected a simple random sample of 100 of the 1,297 CAHs with swing-bed services nationwide and determined whether skilled nursing service care was available at an alternative facility within 35 miles during CY 2020 (Appendix D);[26]

- identified the number of CAHs in the sample that were within a 35-mile driving distance of alternative facilities with capacity to provide similar care (Appendices E and F);

- using publicly available mapping software, identified total driving time between CAHs in the sample and alternative facilities;

- estimated the savings to Medicare for skilled nursing services in a swing bed if services at CAHs were reimbursed at SNF PPS rates (Appendix E);[27] and

- discussed the results of our review with CMS officials.

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.

[26] In determining availability of care at an alternative facility, we identified facilities within a 35-mile driving distance from the sampled CAH. For simplicity, we did not consider the other distance requirements, such as the 15-mile limit in mountainous terrain.

[27] The comparison of average daily reimbursement computed for CAHs to rates at alternative facilities did not consider any potential additional costs for transporting enrollees to an alternative facility. For this reason, our estimated potential savings may be overstated by the amount of the transportation costs.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
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	3/6/2015
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	8/14/2013

APPENDIX C: MATHEMATICAL CALCULATION PLAN

DESCRIPTION OF MATHEMATICAL CALCULATION

For CYs 2015 through 2020, 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 daily reimbursement to CAHs with swing-bed services by:

- identifying total Medicare CAH swing-bed service payments during CYs 2015 through 2020,
- identifying the total number of CAH swing-bed service days during CYs 2015 through 2020, and
- dividing the total payments by the total days.

Step 2 – We calculated the average daily reimbursement to alternative facilities by:

- identifying total Medicare payments for skilled nursing services to all other skilled nursing providers (OSNPs) during CYs 2015 through 2020,
- identifying the total number of skilled nursing service days to all OSNPs during CYs 2015 through 2020, and
- dividing the total payments by the total days.

Step 3 – We estimated potential Medicare savings for CAH swing-bed services by:

- calculating the difference between the average daily reimbursement for swing-bed services at CAHs (Step 1) and the average daily reimbursement for skilled nursing services at all OSNPs (Step 2) for each year,
- multiplying the difference in the average daily reimbursement amounts by the total CAH swing-bed days for each respective year, and

- adding the estimated differences in Medicare payments for each year to get a total estimated saving for CYs 2015 through 2020.

Step 4 – We calculated total estimated Medicare savings, factoring in the percentage of CAHs that had alternative skilled nursing care available within 35 miles, by multiplying the estimated yearly savings calculated in Step 3 by the estimated percentage of CAHs that had alternative skilled nursing care available within 35 miles.

APPENDIX D: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of 1,297 CAHs nationwide that received Medicare reimbursements for swing-bed service dates during January 1, 2015, through December 31, 2020.

SAMPLE UNIT

The sample unit was a CAH that offered swing-bed services.

SAMPLE DESIGN AND SAMPLE SIZE

We used a simple random sample and selected a sample of 100 CAHs that offered swing-bed services.

SOURCE OF RANDOM NUMBERS

We used the OIG, Office of Audit Services (OIG-OAS) statistical software to generate the random numbers.

METHOD OF SELECTING SAMPLE ITEMS

We sorted the CAHs using the National Provider Identifier Standard from smallest to largest. We then consecutively numbered the items in the sampling frame. After generating the random numbers in accordance with our sample design, we selected the corresponding frame items for review.[28]

ESTIMATION METHODOLOGY

We used the OIG-OAS statistical software to estimate the number and percentage of CAHs in the sampling frame with swing beds within a 35-mile driving distance of an alternative facility that had the capacity to provide similar care.[29] We calculated a point estimate and a two-sided 90-percent confidence interval.

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[28] The National Provider Identifier Standard is a unique identification number provided to all covered health care providers.

[29] In determining availability of care at an alternative facility, we identified facilities within a 35-mile driving distance from the sampled CAH. For simplicity, we did not consider the other distance requirements, such as the 15-mile limit in mountainous terrain.

APPENDIX E: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results

Frame Size	Sample Size	Number of CAHs in the Sample With Alternative Facilities Available
1,297	100	87

Table 3: Estimated Number of Critical Access Hospitals in the Sampling Frame With Alternative Care Available During Calendar Year 2020
(Limits Calculated for a 90-Percent Confidence Interval)

Point Estimate	1,128
Lower Limit	1,043
Upper Limit	1,192

Table 4: Mathematical Calculation of Potential Medicare Saving for Critical Access Hospital Swing-Bed Services

CY	Total Payments at CAHs	CAH Claims Total Days	CAH Claim Amounts Per Day	Alternative Facilities Claim Amounts Per Day	Difference in Claim Amounts Per Day	Percentage of CAHs With Alternative Facilities Available[30]	Total Potential Medicare Savings for CAH Swing-Bed Services
		A	B	C	D = (B – C)	E	F = (A x D) x E
2015	1,633,414,665	1,032,123	$1,582.58	$313.24	$1,269.34	87%	$1,139,800,057.67
2016	1,701,912,516	1,042,640	1,632.31	310.72	1,321.59	87%	1,198,810,059.91
2017	1,787,543,657	1,052,432	1,698.49	317.40	1,381.09	87%	1,264,547,880.47
2018	1,894,177,836	1,073,645	1,764.25	329.35	1,434.90	87%	1,340,298,693.14
2019	1,962,934,951	1,095,614	1,791.63	343.41	1,448.22	87%	1,380,420,393.16
2020	1,958,412,440	1,061,074	1,845.69	343.67	1,502.02	87%	1,386,566,301.45
Totals		**6,357,528**					**$7,710,443,385.79**

[30] This is the percentage we calculated based on our review of 100 sampled CAHs, which found 87 that had alternative care available (Table 2).

APPENDIX F: SUMMARY OF SAMPLE RESULTS–SKILLED NURSING CARE AVAILABLE AT ALTERNATIVE FACILITIES DURING CALENDAR YEAR 2020

Sample Number	Care Available at an Alternative Facility	Number of CAH Swing-Bed Days Used	Number of Bed Days Available at Alternative Facilities[31]	Sufficient Alternative Beds Available?[32]
1	Yes	4,257	11,506	Yes
2	Yes	3,363	88,146	Yes
3	Yes	984	77,241	Yes
4	No	--	--	--
5	Yes	1,473	1,701	Yes
6	Yes	1,229	2,044	Yes
7	Yes	1,380	91,434	Yes
8	No	--	--	--
9	No	--	--	--
10	Yes	1,479	47,025	Yes
11	Yes	2,432	9,003	Yes
12	Yes	1,222	79,951	Yes
13	Yes	3,492	24,964	Yes
14	Yes	3,948	21,264	Yes
15	Yes	3,321	74,542	Yes
16	Yes	586	35,110	Yes
17	Yes	813	48,644	Yes
18	Yes	4,287	168,695	Yes
19	No	--	--	--
20	Yes	1,499	3,884	Yes
21	Yes	1,596	63,214	Yes
22	No	--	--	--
23	Yes	3,743	105,111	Yes
24	Yes	2,422	114,582	Yes
25	Yes	2,592	72,279	Yes
26	Yes	2,691	22,398	Yes
27	Yes	2,014	29,318	Yes

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

[32] 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	Care Available at an Alternative Facility	Number of CAH Swing-Bed Days Used	Number of Bed Days Available at Alternative Facilities[31]	Sufficient Alternative Beds Available?[32]
28	Yes	1,451	69,633	Yes
29	Yes	1,015	1,957	Yes
30	Yes	4,002	145,667	Yes
31	Yes	1,131	36,911	Yes
32	Yes	1,825	102,993	Yes
33	Yes	4,361	29,818	Yes
34	No	--	--	--
35	Yes	583	86,337	Yes
36	Yes	329	38,649	Yes
37	Yes	1,701	177,043	Yes
38	Yes	2,722	183,047	Yes
39	Yes	843	1,170	Yes
40	Yes	4,434	34,352	Yes
41	Yes	1,815	10,982	Yes
42	Yes	5,117	216,717	Yes
43	Yes	7,349	40,398	Yes
44	Yes	3,192	122,476	Yes
45	No	--	--	--
46	Yes	714	190,498	Yes
47	Yes	1,907	135,724	Yes
48	No	--	--	--
49	Yes	2,313	334,179	Yes
50	Yes	3,829	63,169	Yes
51	Yes	1,714	92,405	Yes
52	Yes	2,432	347,902	Yes
53	Yes	945	162,615	Yes
54	Yes	2,574	12,810	Yes
55	Yes	1,916	316,871	Yes
56	Yes	560	16,069	Yes
57	Yes	1,952	107,334	Yes
58	Yes	1,618	153,435	Yes
59	Yes	1,661	240,184	Yes
60	Yes	5,270	35,360	Yes
61	No	--	--	--
62	Yes	233	31,068	Yes
63	Yes	2,668	100,591	Yes
64	Yes	2,018	11,589	Yes

Sample Number	Care Available at an Alternative Facility	Number of CAH Swing-Bed Days Used	Number of Bed Days Available at Alternative Facilities[31]	Sufficient Alternative Beds Available?[32]
65	Yes	2,803	163,867	Yes
66	Yes	1,205	26,822	Yes
67	Yes	3,652	117,826	Yes
68	Yes	3,189	33,540	Yes
69	Yes	2,856	71,230	Yes
70	Yes	3,821	94,622	Yes
71	Yes	3,361	211,114	Yes
72	Yes	2,179	35,708	Yes
73	Yes	1,499	178,639	Yes
74	Yes	1,582	189,746	Yes
75	Yes	4,620	127,438	Yes
76	Yes	5,068	431,704	Yes
77	Yes	1,566	9,604	Yes
78	Yes	2,339	74,656	Yes
79	No	--	--	--
80	Yes	3,328	36,986	Yes
81	Yes	1,698	39,973	Yes
82	Yes	4,348	271,122	Yes
83	Yes	6,278	4,376	No
84	Yes	972	48,054	Yes
85	Yes	1,132	211,479	Yes
86	Yes	589	30,867	Yes
87	Yes	3,720	7,976	Yes
88	Yes	2,941	53,657	Yes
89	No	--	--	--
90	Yes	2,808	31,682	Yes
91	No	--	--	--
92	Yes	2,764	47,280	Yes
93	Yes	1,641	22,744	Yes
94	Yes	2,818	63,218	Yes
95	Yes	932	8,568	Yes
96	Yes	706	100,442	Yes
97	Yes	1,931	139,322	Yes
98	Yes	2,620	6,921	Yes
99	Yes	352	304,158	Yes
100	Yes	623	122,381	Yes

APPENDIX G: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: October 30, 2024

TO: Juliet T. Hodgkins
Principal Deputy Inspector General

FROM: Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: *Medicare Could Save Billions with Comparable Access for Enrollees if Critical Access Hospital Payments for Swing-Bed Services Were Similar to Those of the Fee-for-Service Prospective Payment System*, A-05-21-00018

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 supporting access to quality care for all Medicare beneficiaries and ensuring that those living in rural areas have access to high quality and affordable care in their communities, while promoting payment efficiency and protecting taxpayer dollars. CMS is working to advance health equity so that each person has a fair and just opportunity to attain their highest level of health regardless of their geography.

The Critical Access Hospital (CAH) designation was created in the Balanced Budget Act of 1997. The statute establishes cost-based reimbursement for certain services by CAHs, including swing bed services. It is crucial to consider how changes to this payment policy could affect access to care and hospital viability in designated rural areas. While OIG studied only swing-bed services, CAHs provide other vital care in their communities, including offering 24-hour emergency services, ambulance services, and many other critical services. [1]

CMS has concerns with the methodology OIG used to determine the availability of skilled nursing services at nearby alternative facilities and the calculation of cost savings. CMS believes the report's random sample of 100 CAHs may not adequately represent the total population of 1,297 CAHs cited by the OIG 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 continue to meet the distance requirements, and CAHs not designated as NP CAHs, which must continue to meet the applicable distance requirements. The sample set does not indicate the proportion of CAHs that fall into each category and whether they were proportionally represented in the sample. Furthermore, OIG's findings overestimate savings by

[1] https://www.hrsa.gov/sites/default/files/hrsa/opa/critical-access-hospital-factsheet.pdf

failing to incorporate important factors such as the level of care needed by swing bed patients and transportation fees to alternative facilities.

The OIG analysis does not consider the case mix for patients at CAHs versus alternative facilities, and therefore does not consider differences in the type and intensity of services provided to the two groups of patients. For example, patients receiving care in swing beds are likely more medically complex than patients receiving care at alternative facilities.[2] It is also unclear whether the level of care provided to CAH swing bed patients and to patients at alternative facilities is equivalent and whether beds at alternative facilities are available on a daily, weekly, or monthly basis.

The OIG's finding that 87 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 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. Furthermore, the OIG's cost estimations do not include the transportation costs of moving a patient to an alternative facility as opposed to using a CAH swing bed, which would decrease the savings associated with using an alternative facility.

OIG Recommendation

The OIG recommends that CMS seek a legislative change that will allow it to reimburse CAHs at rates that align with those paid to alternative facilities when it determines that similar care is available at alternative facilities.

CMS Response

CMS does not concur with OIG's recommendation as any legislative recommendations would be included in the President's Budget request. In addition to the methodological issues discussed above, it is also important to note the reduction in payments to CAHs would likely jeopardize the viability of rural hospitals and access to care in other underserved areas.

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[2] https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2017/07/Post-Actute-Care.pdf