National Rural Health Association

January 21, 2025

Christi A. Grimm
Inspector General
Department of Health and Human Services
330 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Inspector General Grimm,

The National Rural Health Association (NRHA) is writing to express its concern over the recent 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, and accompanying recommendation from the Department of Health and Human Services' (HHS) Office of the Inspector General (OIG) on swing bed utilization at critical access hospitals (CAH).

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

The Medicare swing bed program offers vital flexibility for rural hospitals with fewer than 100 beds, allowing them to utilize their inpatient beds for either acute care or Skilled Nursing Facility (SNF)-level swing bed care.[1] While swing bed services in rural Prospective Payment System (PPS) hospitals are reimbursed under the SNF PPS, CAHs receive cost-based reimbursement for such services. The 2022 cost report data shows that 94% of CAHs had swing bed days compared to 21% of PPS hospitals with under 50 beds.[2]

Given the importance of retaining post-acute care in rural communities, **NRHA is extremely troubled by OIG's recommendation** for CMS to seek a legislative change to have CAHs be reimbursed for swing bed services at the SNF PPS rate. **NRHA disagrees with this recommendation and concurs with the Centers for Medicare & Medicaid's (CMS) response to the report, highlighting concerns with the methodology used to determine availablity of SNF services and cost savings to the Medicare program.** OIG's attempt at achieving alignment with alternative facilities does not account for the unique characteristics of rural hospitals and post-acute services in rural communities.

Medicare Swing Bed Program's Foundational Purpose

In response to a wave of rural hospital closures during the 1980s and 1990s, Congress created the CAH designation in order to reduce the financial vulnerability of rural hospitals and improve access to healthcare by keeping essential services in rural communities. As the OIG report notes, CAHs are afforded enhanced payment for services set at 101% of their reasonable costs.[3] This payment scheme

[1] https://20780560.fs1.hubspotusercontent-na1.net/hubfs/20780560/Critical-Access-Hospital-Swing-Bed-Programs-Outperform-Skilled-Nursing-Facilities-on-Quality-Performance.pdf
[2] https://www.cms.gov/data-research/statistics-trends-and-reports/cost-reports/cost-reports-fiscal-year
[3] NRHA notes that this payment is effectively 99% of reasonable costs due to the current 2% Medicare sequester in place through 2032.

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has allowed CAHs to remain open and viable amidst a more recent trend of rural hospital closures relative to their rural PPS counterparts.[4]

One of the services reimbursed at 101% of reasonable costs is swing bed care, the focus of the OIG report. Swing beds were created to address rural bed shortages by allowing facilities to flexibly use beds for acute and post-acute care. The program was designed to meet unpredictable demands while sustaining rural hospitals financially. Swing beds are also crucial in rural communities because they allow patients the option to receive post-acute care in their local hospital, rather than travel outside their community.

Generation of Medicare Cost-Savings

NRHA believes that OIG grossly overestimates the potential Medicare savings that could be generated by applying a lower reimbursement rate to CAH swing bed services by removing swing beds from cost-based reimbursement. The report calculates the savings by sampling 100 CAHs and finding the difference between the average CAH payment per swing bed day and the average SNF payment per bed day, multiplied by the total number of CAH swing bed days. **OIG's simple calculation does not account for how cost-based reimbursement works in CAHs.**[5]

Medicare pays for fixed costs at CAHs based on the proportion of total inpatient days (including acute, swing, and observation) that are attributable to Medicare patients. Revenue from swing bed services stabilizes CAH finances by spreading these fixed costs across these types of services. By removing swing bed days from the reimbursement formula, a CAH's fixed costs would be allocated between acute inpatient and observation days only and Medicare would pay the resulting higher per diem costs of inpatient and observation stays for Medicare patients. The additional costs paid by Medicare would be an offset to OIG's estimated savings. Further, this change would substantially increase the cost per day for acute care services at CAHs.

Currently, nearly half of rural hospitals operate with negative margins, with more than 400 facilities vulnerable to closure.[6] Without cost-based reimbursement for swing bed services, many CAHs would be in jeopardy of closing as swing bed revenue is critical for offsetting losses and supporting fixed costs.

In addition, OIG's report fails to consider patients' average lengths of stay per claim between different settings. While SNFs may have a lower reimbursement per swing-bed usage day, the report does not address the number of days reimbursed per patient. It may be the case that although CAHs get reimbursed at a higher rate per day, swing bed patients utilize fewer days than in alternative facilities. This would reduce the difference in overall spending per patient between these facility types.

Swing Bed Quality Outcomes and Patient-Centered Care Model

As noted in the CMS response, 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

[4] *See* https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/. Between 2010 and 2025, 51 CAHs closed while 97 PPS hospitals or PPS hospitals with a special rural designation closed.
[5] *See* https://www.shepscenter.unc.edu/wp-content/uploads/2015/03/CritiqueOfOIGreportMarch2015.pdf.
[6] https://www.chartis.com/sites/default/files/documents/chartis_rural_study_pressure_pushes_rural_safety_net_crisis_into_uncharted_territory_feb_15_2024_fnl.pdf

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services provided.[7] CAHs reported a wider range of health problems among swing bed patients than reported by rural SNFs and medically complex patients may be more likely to receive care in a swing bed than a local SNF.[8] Swing beds also outperform rural SNFs on many relevant measures, more discharges to community, and less frequent unplanned returns to acute care.[9] Care in swing beds is also associated with shorter lengths of stay compared to stays in SNFs, with some studies citing a three-fold length of stay in a SNF when compared to a CAH. [10,11]

Rural Access to Skilled Nursing Services

Rural patients rely on local access to swing bed services. OIG notes that many sampled CAHs had nearby alternate post-acute care access; however, **OIG fails to consider that swing beds may be available and the best choice from a patient care and quality perspective.** The OIG report assumed availablity based on licensed beds at alternative providers based on Medicare cost reports, rather than staffed beds. Further, OIG's finding that 87% of CAHs have alternative facilities within 35 miles does not account for the unique situation of many rural patients who face transportation, financial, or logistical barriers that make access to these facilities impractical, even within this distance. The report should consider patient-centered factors beyond proximity.

Rural America is experiencing a crisis in closure of SNF facilities. Between 2008 and 2018, nearly 500 rural nursing homes shuttered resulting in 10.1% of rural counties becoming nursing home deserts.[12] This trend has continued throughout and after the COVID-19 pandemic, with largely rural states like Montana and Texas losing the majority of their rural nursing homes to closures.[13] Across all hospitals, inpatient lengths of stay for patients being discharged to post-acute care providers increased 24% between 2019 and 2022, due in part to lack of availability of post-acute care options.[14] For beneficiaries, delayed discharge is associated with increased risk of mortality, hospital-acquired infections, behavioral health concerns, and reductions in patients' mobility and activities of daily living.[15] The OIG report assumption that facilities within 35 miles can absorb swing bed patients fails to consider transportation barriers, capacity, or care quality of nearby SNF facilities.

NRHA appreciates the role that all post-acute care settings play in the rural health care delivery system and believes that ensuring all patients' post-acute care needs are met is paramount. **As such, NRHA wholly disagrees with OIG's methodology and recommendation for CAH swing bed reimbursement. NRHA urges OIG to consider the full context of Medicare CAH payment to understand the importance of swing bed services to CAH stability.**

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7 https://oig.hhs.gov/reports/all/2025/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/

8 https://www.shepscenter.unc.edu/wp-content/uploads/2014/04/FB105.pdf

9 https://20780560.fs1.hubspotusercontent-na1.net/hubfs/20780560/Critical-Access-Hospital-Swing-Bed-Programs-Outperform-Skilled-Nursing-Facilities-on-Quality-Performance.pdf

10 https://20780560.fs1.hubspotusercontent-na1.net/hubfs/20780560/Critical-Access-Hospital-Swing-Bed-Programs-Outperform-Skilled-Nursing-Facilities-on-Quality-Performance.pdf

11 https://www.shepscenter.unc.edu/wp-content/uploads/2014/04/FB105.pdf

12 https://rupri.publichealth.uiowa.edu/publications/policybriefs/2021/Rural%20NH%20Closure.pdf

13 https://kffhealthnews.org/news/article/wave-of-rural-nursing-home-closures-grows-amid-staffingcrunch/

14 https://www.aha.org/system/files/media/file/2022/12/Issue-Brief-Patients-andProviders-Faced-with-Increasing-Delays-in-Timely-Discharges.pdf

15 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5750749/

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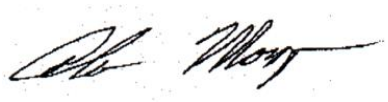
Thank you again for your consideration of NRHA's concerns. If you would like more information or to discuss further, please contact NRHA's Government Affairs and Policy Director, Alexa McKinley Abel at amckinley@ruralhealth.us.

Sincerely,



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