United States General Accounting Office

GAO

Report to Congressional Committees

February 1998

RURAL PRIMARY CARE HOSPITALS

Experience Offers Suggestions for Medicare's Expanded Program

GAO/HEHS-98-60

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-278799

February 23, 1998

The Honorable William V. Roth, Jr.
Chairman
The Honorable Daniel P. Moynihan
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable Bill Archer
Chairman
The Honorable Charles B. Rangel
Ranking Minority Member
Committee on Ways and Means
House of Representatives

The Honorable Tom Bliley
Chairman
The Honorable John D. Dingell
Ranking Minority Member
Committee on Commerce
House of Representatives

One of the issues before the Congress is controlling Medicare costs while maintaining access to basic hospital and physician services in rural areas.[1] In the past, full-service rural hospitals provided these services for Medicare beneficiaries. However, many rural hospitals have closed or are at risk of being closed, usually because of financial difficulties. To maintain rural access to primary health care services, the Congress in 1989 authorized limited-service hospitals, known as rural primary care hospitals (RPCH), to operate in seven states—California, Colorado, Kansas, New York, North Carolina, South Dakota, and West Virginia. Beginning October 1, 1997, the Congress replaced RPCHs with critical access hospitals (CAH), which were authorized to operate nationally.[2] RPCHs existing as of October 1, 1997, are automatically eligible to participate in Medicare as CAHs. In this report, we refer to limited-service hospitals as RPCHs.

[1]Medicare classifies a rural area (or county) as a location not part of a metropolitan statistical area.

[2]Critical access hospitals are part of the Rural Hospital Flexibility Program, established by the Balanced Budget Act of 1997 (BBA) (P.L. No. 105-33, sec. 4201(a), Aug. 5, 1997). They can have a maximum of 15 inpatient beds and are designed to provide access to basic emergency care, outpatient services, and up to 4 days of limited inpatient care.

RPCHs were limited to a maximum of six beds, and Medicare paid them (as it pays CAHs) on a reasonable cost basis for services provided to its beneficiaries. For cost-reporting periods begun between October 1, 1995, and October 1, 1997, RPCHs were limited on a cost-reporting year basis to an average inpatient stay of 72 hours. Before October 1995, inpatient stays were limited to 72 hours, and this was the criterion in effect for the data available for analysis.

The Social Security Act Amendments of 1994 required us to review the RPCH program. That act asked us to assess compliance with the requirements that RPCHs have an average length of stay of 72 hours or less and that physicians certify that inpatients are expected to be discharged within 72 hours. Data were not readily available to answer those two questions (see app. I for details). The act also asked us to assess whether these two requirements affected the type of patients treated by RPCHs, so we reviewed the diagnoses of the patients they treated. In addition, your offices asked us, consistent with the legislative mandate, to compare Medicare's cost for inpatient services in RPCHs to what those costs would likely have been in hospitals paid under the prospective payment system (PPS).[3] Finally, as discussed with your offices after the enactment of the Balanced Budge Act of 1997 (BBA), we looked at how the experience under the RPCH program could be used in implementing the expanded CAH program. To address these questions, we visited three RPCHs and analyzed all 1,708 inpatient claims and more than 38,000 outpatient claims submitted by the 13 RPCHs that had submitted cost reports to Medicare as of March 1997. These claims covered admissions from September 1993 through May 1996 from RPCHs in Kansas, North Carolina, South Dakota, and West Virginia. We did not independently test the reliability of the paid claims information provided by intermediaries. With this exception, we conducted our work between December 1996 and November 1997, in accordance with generally accepted government auditing standards. Details regarding our methodology appear in appendix I.

Results in Brief

RPCHs provide additional and, likely, much more proximate access to health care for Medicare beneficiaries residing in the rural areas where the facilities operate. These facilities treat, on an inpatient basis, beneficiaries with less complex illnesses and furnish important stabilization and transfer services for those with more complex conditions. Moreover, RPCHs serve as the source of outpatient care ranging from primary to emergency

[3]Most hospitals are paid under the PPS system, which establishes in advance the amount a hospital will receive for treating patients. Payment amounts vary by the type of illness or injury the patient has.

care. The 13 RPCHs for which complete data were available had 1,708 Medicare inpatient cases since they were certified to participate in the program. The RPCHs provided the full inpatient stay for 1,545 beneficiaries who had less complex needs and stabilized and transferred an additional 163 beneficiaries to full-service hospitals. The RPCHs treated primarily patients (65 percent of the total) who had respiratory ailments such as pneumonia, circulating system problems such as congestive heart failure, and digestive system illnesses such as inflammation of the digestive canal.

In addition, during the most recent cost-reporting period, these RPCHs provided more than 28,000 outpatient visits for more than 6,700 beneficiaries. These outpatient visits ranged from those for primary care to emergency treatment for injuries.

Medicare payments for the 1,545 cases from September 1993 to May 1996 treated solely by an RPCH were slightly more than if these cases had been treated at full-service rural hospitals—$404,000, or 8.8 percent—and somewhat less than if they had been treated at urban hospitals—$207,000, or 4.5 percent. A primary reason why RPCH costs were higher than those for rural hospitals was that about 21 percent of the stays exceeded the 72-hour stay limitation in effect at the time. Without the extra inpatient days these cases involved, RPCH costs would likely have been lower than those for rural full-service hospitals. The Health Care Financing Administration (HCFA) had not established a way to enforce the 72-hour maximum length-of-stay requirement for RPCHs, and it is important that the agency do so for the replacement CAH program's 96-hour maximum.

As is to be expected with limited-service hospitals, RPCHs in the four states we studied transferred a higher portion of patients to other hospitals than did full-service rural hospitals—9.5 versus 5.6 percent. Total Medicare payments for the 163 transfer cases were about $148,000 higher than if a full service rural hospital had transferred the patients to another acute care hospital because of differences in the way payments are determined in the two situations.

Background

The Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239, Dec. 19, 1989) authorized Medicare payment to RPCHs for inpatient and outpatient services. Program participation was limited to seven states and HCFA selected California, Colorado, Kansas, New York, North Carolina, South Dakota, and West Virginia. California has no certified RPCHs.

RPCHs had to be located in rural counties and were limited to six inpatient acute care beds. Initially, RPCH inpatient stays were limited to a 72-hour maximum, but section 102 of the Social Security Act Amendments of 1994 (P.L. 103-432, Oct. 31, 1994) changed the requirement to an average of 72 hours during a cost-reporting year for periods beginning on or after October 1, 1995. RPCHs employ midlevel practitioners—physician assistants and nurse practitioners—working under the supervision of a physician, who is not required to be located at the RPCH. RPCHs are not allowed to provide surgery requiring general anesthesia but may perform surgeries normally done under local anesthesia on an outpatient basis at a hospital or ambulatory surgical center. We found few surgical procedures being performed at RPCHs during 1993-96.

In September 1993, the first RPCH, located in South Dakota, was certified to participate in Medicare. As shown in table 1, there were 38 certified RPCHs as of August 1997.

Table 1: Number of Certified RPCHs, August 1997

State	Number of certified RPCHs
Colorado	3
Kansas	14
New York	4
North Carolina	3
South Dakota	8
West Virginia	6
Total	**38**

In addition to RPCHs, the Congress authorized a demonstration program for the operation of limited-service hospitals that was implemented by Montana. Under this program, Medicare was authorized to pay for basic emergency care, outpatient services, and limited inpatient care (maximum stay of 96 hours) provided at these limited-service hospitals, known as medical assistance facilities (MAF).

In our October 1995 report, we found that the MAFs were important sources of emergency and primary care for their communities.[4] MAFs primarily served patients with urgent but uncomplicated conditions and stabilized patients with more complicated needs before transferring them

[4]Montana's Medical Assistance Facilities (GAO/HEHS-96-12R, Oct. 2, 1995).

to full-service hospitals. Moreover, Medicare's costs for inpatient care at MAFs were lower than if the care had been furnished in rural hospitals.

While full-service hospitals normally are paid under Medicare's PPS, both RPCHs and MAFs are paid on a cost reimbursement basis, as are CAHs, the replacement program for them. Like MAFs, CAHs are limited to 96-hour inpatient stays but can have 15 beds rather than the 6 for RPCHs. Both types of limited-service hospitals are scheduled to make the transition into CAHs by October 1, 1998.

RPCHs Treat Patients With Less Complex Illnesses or Stabilize Them for Transfer

As envisioned when the program was authorized, most RPCH inpatients have less complex illnesses that do not require intensive or high-technology care. Patients with more extensive health needs who go to RPCHs are generally stabilized and transferred to larger acute care hospitals, another important service to the community. In addition, RPCHs often serve as the source of primary care for residents in their areas.

The average stay for the 1,708 inpatients treated by RPCHs between September 1993 and May 1996 was 2.85 days. They were assigned to 137 different DRGs—9 surgical DRGs covering 11 cases and 128 medical DRGs covering 1,697 cases.[5] Ten of the eleven surgical cases were from one RPCH located in South Dakota. A state official confirmed that this RPCH performs surgeries like those performed in ambulatory surgery centers that do not require general anesthesia. As we found when we reviewed services provided by MAFs in Montana, the three medical conditions most commonly treated by the RPCHs were pneumonia (247 cases), heart failure and shock (141 cases), and inflammation of the digestive canal (99 cases). Together these three conditions accounted for 29 percent of the 1,708 cases, which is similar to the 28 percent they represented in MAFs. Conditions classified as respiratory, circulatory, and digestive disorders accounted for 1,107 cases (65 percent) and 48 of the DRGs (35 percent) treated at RPCHs. (See app. II for a summary of inpatient DRGs treated at RPCHs.)

During the period covered by our review, 163 of the 1,708 inpatients (9.5 percent) were transferred from an RPCH to an acute-care hospital. The average RPCH stay for these patients was 1.9 days. During calendar years 1993 through 1996, about 5.6 percent of Medicare inpatients at other rural hospitals in Kansas, North Carolina, South Dakota, and West Virginia were

[5]Diagnosis-related groups (DRG) are used to classify inpatients into groups that determine the rate of payment under Medicare's hospital PPS. Patients covered by a DRG are expected to need the same level of hospital resources to treat their conditions.

transferred to another hospital. The percentage of RPCH patients transferred is 4 percentage points higher because one function of an RPCH is to stabilize patients and prepare them for transfer to a facility if the treatment they need is beyond the scope of RPCH services.

In addition to providing inpatient care, RPCHs provide local primary care for many Medicare beneficiaries. The 13 RPCHs treated more than 6,700 different Medicare beneficiaries during their latest available cost-reporting period and submitted more than 28,000 outpatient claims for services for these patients (see table 2). Outpatient services included visits with physicians and physician assistants, laboratory tests, influenza shots, colonoscopies, electrocardiograms, diagnostic radiology services, and emergency care. Medicare paid about $4.9 million for these outpatient services (see app. III for a summary of Medicare outpatient costs by RPCH by cost-reporting year).

Table 2: Number of RPCH Outpatient Claims Submitted and Medicare Beneficiaries Treated

RPCH	Cost-reporting year	Number of outpatient claims submitted	Number of Medicare beneficiaries treated
Kansas			
Ashland District Hospital	1/1/95-12/31/95	2,508	257
Cedar Vale Community Hospital	2/1/95-12/31/95	3,250	670
Ellinwood District Hospital	10/1/94-9/30/95	2,738	530
Grisell Memorial Hospital	1/1/95-12/31/95	2,581	372
Lane County Hospital	1/1/95-12/31/95	2,599	341
Oswego Health Center	10/27/94-10/31/95	1,187	343
North Carolina			
Our Community Hospital	4/18/95-9/30/95	[a]	168
Yancy County Medical Center	12/15/94-9/30/95	[a]	1,090
South Dakota			
Douglas County Memorial Hospital	8/23/95-5/31/96	1,370	389
Faulk County Hospital	3/1/95-2/28/96	2,451	362
Gettysburg Medical Center	2/1/95-1/31/96	2,613	398
West Virginia			
Broaddus Hospital	1/1/95-12/31/95	5,265	1,141
Webster County Memorial Hospital	1/24/94-6/30/94	2,067	694
Total		**28,629**	**6,755**

[a]Outpatient data for North Carolina did not identify the number of claims submitted by the two North Carolina RPCHs.

Comparison of RPCH Payments With Current PPS Rates

Medicare payments for the 1,545 beneficiaries who received all their inpatient care from an RPCH totaled about $4.6 million, a little over $1,000 per day (see app. III). The average length of stay for these beneficiaries was 2.95 days. As we found when we made a similar comparison for MAF inpatient costs, these costs compared favorably with the amount Medicare would have paid if those patients had been treated at rural PPS hospitals.

Table 3 shows by RPCH and cost-reporting year the difference in payments to RPCHs comparing the payments that would have been made to rural and urban PPS hospitals. Overall costs at the 12 RPCHs covering 17 cost-reporting periods were about $404,000 more than the amount

Medicare would have paid rural PPS hospitals.[6] However, payments for treatment at the 12 RPCHs were about $207,000 less than the amount Medicare would have paid for treating the same conditions at urban hospitals. (See app. IV for individual RPCH cost comparisons to PPS payments.)

Table 3: Net Difference in Medicare Costs for 1,545 RPCH Patients Compared With Estimated PPS Payments

RPCH	Cost-reporting year	Number of inpatients treated	RPCH costs higher (lower) when compared with PPS payments to rural and urban hospitals	
			Rural hospitals[a]	Urban hospitals[b]
Kansas				
Ashland District Hospital	1/1/95-12/31/95	18	$49,546	$35,498
Cedar Vale Community Hospital	2/1/95-12/31/95	84	25,328	(39,479)
Ellinwood District Hospital	10/1/94-9/30/95	63	70,115	26,762
Grisell Memorial Hospital	1/1/94-12/31/94	51	81,996	38,410
Grisell Memorial Hospital	1/1/95-12/31/95	23	47,553	33,051
Lane County Hospital	1/1/95-12/31/95	96	(3,027)	(65,562)
Oswego Health Center	10/27/94-10/31/95	12	121,593	113,490
North Carolina				
Our Community Hospital	4/18/95-9/30/95	24	43,092	33,709
South Dakota				
Douglas County Memorial Hospital	8/23/95-5/31/96	125	36,224	(4,453)
Faulk County Hospital	9/8/93-2/28/94	65	62,030	28,277
Faulk County Hospital	3/1/94-2/28/95	85	231,860	191,341
Faulk County Hospital	3/1/95-2/28/96	81	218,230	191,752
Gettysburg Medical Center	8/25/94-1/31/95	31	(30,186)	(43,628)

(continued)

[6]We did not use in our comparison the higher PPS payments that some rural PPS hospitals are entitled to because they qualified as rural referral centers, disproportionate share hospitals, or sole community hospitals.

RPCH	Cost-reporting year	Number of inpatients treated	RPCH costs higher (lower) when compared with PPS payments to rural and urban hospitals: Rural hospitals[a]	Urban hospitals[b]
Gettysburg Medical Center	2/1/95-1/31/96	98	(53,847)	(90,324)
West Virginia				
Broaddus Hospital	1/1/94-12/31/94	364	(258,597)	(341,544)
Broaddus Hospital	1/1/95-12/31/95	284	(264,380)	(332,978)
Webster County Memorial Hospital	1/24/94-6/30/94	41	26,393	18,658
Total		**1,545**	**$403,923**	**($207,020)**

[a]For Kansas, this represents a comparison of RPCH costs with an average of the PPS payments for rural hospitals in Kansas and Oklahoma. For South Dakota, this represents a comparison of RPCH costs with an average of the PPS payments for rural hospitals in South Dakota and North Dakota. For West Virginia and North Carolina, this represents a comparison of RPCH costs with the PPS payments for rural hospitals in West Virginia and North Carolina.

[b]For Kansas, this represents a comparison of RPCH costs with an average of the PPS payments for urban hospitals in Kansas City and Wichita, Kansas. For North Carolina, this represents a comparison of RPCH costs with an average of the PPS payments for urban hospitals in Greenville, Raleigh, Rocky Mount, and Charlotte, North Carolina. For South Dakota, this represents a comparison of RPCH costs with an average of the PPS payments for urban hospitals in Bismarck, North Dakota, and Sioux Falls, South Dakota. For West Virginia, this represents a comparison of RPCH costs with an average of the PPS payments for urban hospitals in Charleston, West Virginia.

Although RPCH costs are slightly higher (8.8 percent) than PPS payments to rural hospitals, RPCH costs would have been lower if claims included in our review had complied with the 72-hour maximum length-of-stay requirement in effect when these admissions occurred.[7] About 21 percent of the 1,545 stays exceeded the 72-hour limit and had 630 inpatient days incurred after the third day. These days cost the Medicare program an estimated $612,000.[8] Because of the way cost reimbursement works, not all the cost of these days would be saved by eliminating them. The fixed costs allocated to the days would be reallocated to the remaining days of care and paid by Medicare. However, variable costs should be reduced if hospitals complied with the 72-hour limit and should result in lower

[7]Nine of the RPCHs included in our review were paid under their old hospital provider number for a total of 433 inpatient days covering 136 cases, or 8 percent of the stays we examined. Retroactive certification of an RPCH that submitted claims under their old hospital number until they became aware of certification as an RPCH contributed to stays that exceeded the 72-hour time limit.

[8]Some stays exceeding 72 hours might have been justified because of weather-related delays in transferring the patient.

overall Medicare costs. We believe the effect of this would result in RPCH inpatient costs being less than similar inpatient costs in rural PPS hospitals.

Under a 96-hour limit, which CAHs have under BBA, the costs associated with longer stays would still have been significant. About 8 percent of 1,545 inpatient stays included in our analysis would have exceeded the 96-hour limit. These stays had a total of 304 covered inpatient days after the fourth day. Payments for those days totaled an estimated $295,000.

Turning to the cost to Medicare for patients who are transferred from RPCHs, regardless of what kind of hospital makes the transfer, all transfers result in higher cost to Medicare because two facilities receive payment for the same patient. Under PPS, the transferring hospital receives a per diem payment determined by dividing the PPS payment by the geometric mean length of stay associated with the patient's DRG. The hospital from which the patient is finally discharged receives the full PPS payment for the patient's DRG. When patients are transferred from RPCHs, the RPCH receives cost-based reimbursement for the patient, and the hospital from which the patient is finally discharged receives the full PPS payment. Medicare RPCH payments for the 163 beneficiaries who were initially treated at an RPCH and transferred to a full-service PPS hospital totaled about $322,000 (see app. III). These RPCH stays averaged 1.9 days. We estimate that these costs were about $148,000 (about $910 per case) greater than the amount Medicare would have paid an acute-care hospital in per diem payments if the patient had first gone to an acute-care PPS hospital for the same length of time. Appendix V lists the hospitals where patients were transferred.

Potential Problems With Expanded Program

As of August 1997, 51 limited-service hospitals (38 RPCHs and 13 MAFs) were authorized to treat Medicare patients. Effective October 1, 1997, these limited-service hospitals were to start making a transition into a new nationwide program—the Medicare Rural Hospital Flexibility Program—and to be renamed CAHs. As the number of CAHs increase, it will become more important for HCFA to monitor the inpatient stay and physician certification requirements established by the Congress.

Inpatient Stay Limitation Requires Monitoring

HCFA had no established way of ensuring that RPCHs complied with the 72-hour length of stay limitation when it was in effect or to assess whether cases outside the limit met one of the allowable exceptions. As a result, HCFA did not know whether RPCHs complied with this requirement. As our

work illustrates, when lengths of stay exceeded the limit, Medicare costs tended to be higher than if patients had gone to a rural PPS hospital.

BBA's successor program, CAHs, provides that the Medicare peer review organization (PRO) covering a CAH's area can waive the 96-hour limit case by case after a request to review a case. The statute does not define the conditions that would warrant waiving the limit. We believe that the PRO review could serve as the mechanism for ensuring compliance with the length-of-stay limit. If intermediaries were instructed to limit payment on CAH cases to no more than 4 days, unless the claim were accompanied by a PRO waiver, CAHs would have an incentive to ensure that they stay within the limit unless circumstances warranted an exception. HCFA would need to define what these circumstances are for both CAHs and PROs.

Physician Certification

Medicare regulations state that the program pays for inpatient RPCH services only if a physician certifies that the individual may reasonably be expected to be discharged or transferred to a hospital within 72 hours (96 hours, effective October 1, 1997). The physician's certification is maintained in the patient's medical record. However, HCFA had not yet initiated a method to ensure compliance with this requirement.

HCFA officials told us that the agency planned to have state facility survey personnel review compliance with the physician certification requirement when RPCHs were recertified for continued participation in the Medicare program. The officials said HCFA also plans to use this process for CAHs. The physician certification requirement is one way to help ensure that only the appropriate kinds of patients are admitted to CAHs and that the 96-hour limit is likely to be adhered to. HCFA needs to formally establish a mechanism for checking compliance with the physician certification provision.

Conclusions

RPCHs were an important access point for inpatient and outpatient services for Medicare beneficiaries in rural areas. Medicare payments to RPCHs for inpatient stays were, however, somewhat higher than payments would have been to rural PPS hospitals to treat the same patients. A primary reason for this was that about 21 percent of the inpatient cases had lengths of stay that exceeded the 72-hour maximum in effect at the time, and 8 percent would have exceeded the 96-hour limit for CAHs. HCFA has not established a way to enforce the length-of-stay limit, and we believe one is needed to give CAHs an incentive to adhere to the limit. HCFA also needs to

define for CAHs and PROs, which are authorized to grant waivers to the 96-hour limit, the conditions and circumstances under which it would be appropriate to waive the requirement.

HCFA also has not established a way of checking compliance with the requirement that a physician certify that patients admitted to RPCHs, now CAHs, are expected to be discharged within the maximum allowed length-of-stay limit. Such a mechanism should reinforce the importance of the certification and its intent to ensure that only the appropriate kinds of patients are admitted.

Recommendations

The Secretary of Health and Human Services (HHS) should direct the Administrator of HCFA to establish a mechanism for ensuring that CAHs do not receive payment for inpatient cases that exceed the 96-hour length-of-stay maximum unless the responsible PRO waives that limit and defines the conditions and circumstances under which it would be appropriate for PROs to waive the 96-hour limit. HCFA should also establish a method to ascertain compliance with the requirement that physicians certify that patients are expected to be discharged within 96 hours of admission.

Agency Comments

We provided HCFA an opportunity to comment on a draft of this report, but the agency was unable to provide us written comments in the time required. We did, however, discuss a draft with agency officials involved with the RPCH program and incorporated their comments as appropriate.

This report was prepared under the direction of Thomas Dowdal, Senior Assistant Director. Please contact him or me at (202) 512-7114 if you have any questions. Others who made major contributions to his report include Robert Sayers, Jerry Baugher, Robert DeRoy, and Joan Vogel.

Copies of this report are also being sent to appropriate House and Senate committees, the Director of the Office of Management and Budget, the Secretary of HHS, the Inspector General of HHS, and the Administrator of the Health Care Financing Administration.

William J. Scanlon
Director, Health Financing
and Systems Issues

Contents

Letter		1
Appendix I Objectives, Scope, and Methodology		16
	Estimating RPCH Inpatient Costs	17
	Estimating PPS Rates	19
	Inpatients Who Transferred From RPCHs to PPS Hospitals	19
	RPCH Outpatient Data	19
	RPCH Compliance With Length-of-Stay Limitation and Physician Certification	20
Appendix II Inpatient RPCH Cases Reviewed by DRG Category		21
Appendix III Total Medicare Inpatient and Outpatient Costs by RPCH Cost-Reporting Years		22
Appendix IV Difference Between Individual RPCH Costs and PPS Payments		23
Appendix V Hospitals Receiving Transferred RPCH Patients		25

Tables

Table 1: Number of Certified RPCHs, August 1997 4
Table 2: Number of RPCH Outpatient Claims Submitted and Medicare Beneficiaries Treated 7
Table 3: Net Difference in Medicare Costs for 1,545 RPCH Patients Compared With Estimated PPS Payments 8
Table I.1: Cost Reports and Inpatient Claims Data Available for 13 RPCHs 18
Table IV.1: Comparison of RPCH Payments With PPS Payments for Kansas, Cost-Reporting Years 1994-96 23
Table IV.2: Comparison of RPCH Payments With PPS Payments for North Carolina, Cost-Reporting Year 1995 23
Table IV.3: Comparison of RPCH Payments With PPS Payments for South Dakota, Cost-Reporting Years 1993-96 23
Table IV.4: Comparison of RPCH Payments With PPS Payments for West Virginia, Cost-Reporting Years 1994-96 24

Abbreviations

BBA	Balanced Budget Act of 1997
CAH	critical access hospital
DRG	diagnosis-related group
HCFA	Health Care Financing Administration
HCRIS	Health Care Provider Cost Report Information System
MAF	medical assistance facility
MEDPAR	Medicare Provider Analysis and Review
PPS	prospective payment system
PRO	peer review organization
RPCH	rural primary care hospital

Objectives, Scope, and Methodology

Our objectives were to develop information on the cases treated and inpatient and outpatient services performed at RPCHs, the relative cost of providing inpatient health care services to Medicare beneficiaries at RPCHs and acute-care hospitals, and compliance with the physician certification and 72-hour inpatient stay requirement.

We visited three RPCHs—two in North Carolina and one in South Dakota—and also contacted a fourth RPCH in South Dakota. From these RPCHs, we obtained information on the types of patients they treated, how they complied with the inpatient stay limitation and the physician certification requirements, and why stays at their RPCHs exceeded the 72-hour inpatient limitation. We also met with state rural health officials and state facility surveying personnel in North Carolina and South Dakota to obtain information on the RPCH program.

We obtained automated cost and claim data for 15 RPCHs in Kansas, North Carolina, South Dakota, and West Virginia.[9] Cost data were extracted from HCFA's Health Care Provider Cost Report Information System (HCRIS), which includes selected data from hospital cost reports. Paid claims were provided by the four intermediaries—Kansas Blue Cross (Kansas), North Carolina Blue Cross (North Carolina), IASD Health Services Corporation (South Dakota), and Blue Cross of Virginia (West Virginia)—serving the RPCHs. We obtained inpatient and outpatient claims for each RPCH from the date certified through May 1996. Twelve of the 13 RPCHs submitted inpatient claims. All 13 RPCHs submitted outpatient claims.

From the inpatient claims, we extracted data on the diagnoses and length of stay associated with Medicare patients admitted to RPCHs. In addition, we extracted the same data from HCFA's Medicare Provider Analysis and Review (MEDPAR) file for Medicare patients admitted to RPCHs but whose claim was paid under the RPCH's old hospital provider number. We also used MEDPAR to obtain data on Medicare patients transferred from an RPCH to an acute care hospital. For patients transferred to full-service hospitals, we obtained the name of the hospital they were transferred to and the diagnoses and length of stay.

Using the cost report data, we estimated the costs for each RPCH Medicare inpatient stay. We then compared those costs with the amount Medicare would have paid an acute-care hospital under PPS for the same DRG at

[9]We excluded 2 of 15 RPCHs, one in North Carolina, the other in South Dakota, from our analyses. The North Carolina RPCH reported no costs and submitted no claims. The South Dakota RPCH reported inpatient costs and submitted four claims, but we were unable to assure ourselves of the accuracy of its cost data.

hospitals in the rural areas of the applicable states and the urban hospitals nearest to the RPCHs. We also computed the amount Medicare paid a PPS hospital and an RPCH when it transferred patients to an acute-care hospital.

From the outpatient claims, we extracted data on the types of services provided to Medicare beneficiaries. For each RPCH cost year, we calculated the number of outpatient claims submitted and the number of Medicare beneficiaries treated by the RPCH.

Estimating RPCH Inpatient Costs

Because the 13 RPCHs in our analysis were certified at different times between September 8, 1993, and August 23, 1995, and had varying cost-reporting years, the cost report information we obtained covers different time periods for each facility, as identified in table I.1.

Table I.1: Cost Reports and Inpatient Claims Data Available for 13 RPCHs

RPCH	Location	Date certified	Cost reports available in HCRIS	Number of inpatient claims from	
				Paid claims tape	MEDPAR
Kansas					
Ashland District Hospital	Ashland	12/22/94	1	23	0
Cedar Vale Community Hospital	Cedar Vale	1/26/95	1	97	3
Ellinwood District Hospital	Ellinwood	10/1/94	1	69	1
Grisell Memorial Hospital	Ransom	12/1/93	2	43	42
Lane County Hospital	Dighton	12/8/94	1	108	1
Oswego Health Center	Oswego	10/27/94	1	12	0
North Carolina					
Our Community Hospital	Scotland Neck	4/18/95	1	13	14
Yancy County Medical Center	Burnsville	12/15/94	1	0	0
South Dakota					
Douglas County Memorial Hospital	Armour	8/23/95	1	135	3
Faulk County Hospital	Faulkton	9/8/93	3	190	60
Gettysburg Medical Center	Gettysburg	8/25/94	2	130	11
West Virginia					
Broaddus Hospital	Phillipi	1/1/94	2	703	1
Webster County Memorial Hospital	Webster Springs	1/24/94	1	49	0
Total			**18**	**1,572**	**136**

We calculated the average inpatient operating costs per patient day for each RPCH's cost-reporting period, excluding capital costs, by dividing operating costs (which includes routine and ancillary costs) by the number of Medicare days.[10] We estimated the cost of treating each RPCH patient by multiplying the facility's average daily Medicare cost by the number of days each patient was an inpatient.

[10]We excluded capital costs because they are a separate add-on to the DRG-based PPS payments.

Estimating PPS Rates

We calculated the PPS rates for the 1,708 RPCH inpatients in our analysis for hospitals in rural Kansas, North Carolina, South Dakota, and West Virginia and appropriate urban areas. We identified each patient's DRG from the paid claim file and estimated the amount Medicare would have paid for each of these RPCH discharges in a rural and urban PPS hospital, using PPS payment rates in effect when the patient was discharged. Our estimate of PPS payments does not include payments for capital costs or any additional amounts that hospitals with teaching programs or a disproportionate share of low-income patients receive from Medicare.

Inpatients Who Transferred From RPCHs to PPS Hospitals

A total of 163 inpatients were treated at an RPCH and then transferred to a PPS hospital. We estimated Medicare's cost of treating those patients at the RPCH in the same way we did for all patients—that is, by multiplying the RPCH's daily Medicare cost by the number of days the patient was at the RPCH before being transferred.

When an RPCH transfers a patient to a PPS hospital, the receiving hospital is paid the full DRG rate and the RPCH is paid its costs. PPS hospitals are reimbursed for the care provided to a patient who transfers to another hospital according to a per diem rate. This rate is obtained by dividing the PPS payment by the geometric mean length of stay expected for the patient's DRG (this number is published annually with the DRG relative weights).

We calculated the per diem PPS rate for each of the 163 transfer cases and multiplied that amount by the number of days each patient stayed at the RPCH before being transferred. The result of this calculation was the estimated payment that PPS hospitals would have received had the patient been treated at a PPS hospital for the same number of days that the patient was at the RPCH prior to being transferred.

For each patient transferred, we compared the RPCH cost to what a rural PPS hospital would have been paid if it had transferred the patient. The result showed whether the treatment at the RPCH was more or less costly than treatment would have been for a transfer case at a rural PPS hospital.

RPCH Outpatient Data

The cost report information obtained for the 13 RPCHs covers the cost-reporting periods identified in table I.1. All 13 RPCHs reported Medicare outpatient costs and submitted outpatient claims. We obtained

the Medicare outpatient operating costs from HCRIS data for each RPCH, for each cost-reporting period.

From the paid claims file we determined, for each RPCH cost-reporting period, the number of outpatient claims submitted and the number of different Medicare beneficiaries treated. We also identified the types of outpatient services being provided to Medicare beneficiaries.

RPCH Compliance With Length-of-Stay Limitation and Physician Certification

We did not evaluate the RPCHs' compliance with the annual average 72-hour length-of-stay requirement that became effective for cost-reporting periods starting October 1, 1995. The RPCH cost reports available for our review covered RPCH cost-reporting periods beginning prior to October 1, 1995, when a maximum inpatient hospital stay requirement of 72 hours existed. Moreover, HCFA officials told us that they had not reviewed RPCHs' compliance with either of the two (maximum or average) 72-hour requirements.

We did not verify RPCHs' compliance with the requirement that physicians certify that a Medicare patient can reasonably be expected to be discharged within 72 hours (changed by BBA to 96 hours) because this certification is entered on patient records maintained by RPCHs and it was not practical for us to review these records. Although HCFA has not reviewed RPCHs' compliance with this requirement, HCFA officials told us the agency plans to require state facility survey personnel to determine physician compliance when they visit RPCHs as part of Medicare's recertification process for continued participation in the program.

Inpatient RPCH Cases Reviewed by DRG Category

	Cases		DRGs covered	
DRG category	**Number**	**Percent**	**Number**	**Percent**
Respiratory system	474	27.7%	17	12.4%
Circulatory sytem	454	26.6	20	14.6
Digestive system	179	10.5	11	8.0
Nervous system	98	5.7	10	7.3
Diabetes and other metabolic	90	5.3	5	3.7
Kidney and urinary tract	82	4.8	8	5.8
Subtotal	1,377	80.6	71	51.8
Other DRG categories	331	19.4	66	48.2
Total	**1,708**	**100.0%**	**137**	**100.0%**

Total Medicare Inpatient and Outpatient Costs by RPCH Cost-Reporting Years

RPCH	Cost-reporting year	Total RPCH Medicare inpatient cost for patients who		Total Medicare outpatient cost
		Remained	Transferred	
Kansas				
Ashland District Hospital	1/1/95-12/31/95	$102,649	$23,526	$285,604
Cedar Vale Community Hospital	2/1/95-12/31/95	277,774	36,960	229,208
Ellinwood District Hospital	10/1/94-9/30/95	231,815	17,320	240,652
Grisell Memorial Hospital	1/1/94-12/31/94	201,939	3,934	322,442
	1/1/95-12/31/95	105,070	26,266	291,204
Lane County Hospital	1/1/95-12/31/95	236,487	21,020	289,382
Oswego Health Center	10/27/94-10/31/95	151,811	0	234,427
North Carolina				
Our Community Hospital	4/18/95-9/30/95	121,200	7,947	95,887
Yancy County Medical Center	12/15/94-9/30/95	[a]	[a]	629,351
South Dakota				
Douglas County Memorial Hospital	8/23/95-5/31/96	357,868	14,435	222,818
Faulk County Hospital	9/8/93-2/28/94	228,467	16,388	20,423
	3/1/94-2/28/95	432,370	7,586	356,324
	3/1/95-2/28/96	422,205	40,133	286,092
Gettysburg Medical Center	8/25/94-1/31/95	60,382	2,543	76,877
	2/1/95-1/31/96	225,207	14,528	214,672
West Virginia				
Broaddus Hospital	1/1/94-12/31/94	750,492	24,624	501,113
	1/1/95-12/31/95	542,723	47,759	516,587
Webster County Memorial Hospital	1/24/94-6/30/94	117,915	17,196	68,971
Total		**$4,566,374**	**$322,165**	**$4,882,034**

[a]This facility had no Medicare inpatient admissions.

Difference Between Individual RPCH Costs and PPS Payments

The data in the tables in this appendix are for urban and rural areas for 1,545 nontransferred inpatients who received all their care at RPCHs.

Table IV.1: Comparison of RPCH Payments With PPS Payments for Kansas, Cost-Reporting Years 1994-96

		RPCH costs higher (lower) compared with PPS payments for hospitals In surrounding areas			
RPCH	Cost-reporting year	Kansas City, Kansas	Wichita, Kansas	Rural Kansas	Rural Oklahoma
Ashland District Hospital	1995-96	$36,133	$34,863	$47,852	$51,239
Cedar Vale Community Hospital	1995-96	(37,351)	(41,607)	17,819	32,836
Ellinwood District Hospital	1995-96	28,954	24,570	64,799	75,431
Grisell Memorial Hospital	1995-96	33,418	32,683	45,912	49,194
	1994-95	38,818	38,002	77,693	86,299
Lane County Hospital	1995-96	(63,154)	(67,969)	(10,553)	4,499
Oswego Health Center	1995-96	113,901	113,079	120,600	122,586
Total		**$150,719**	**$133,621**	**$364,122**	**$422,084**

Table IV.2: Comparison of RPCH Payments With PPS Payments for North Carolina, Cost-Reporting Year 1995

	RPCH costs higher (lower) compared with PPS payments for hospitals in surrounding areas				
RPCH	Greenville	Raleigh	Rocky Mount	Charlotte	Rural
Our Community Hospital	$35,693	$31,227	$37,954	$29,963	$43,092

Table IV.3: Comparison of RPCH Payments With PPS Payments for South Dakota, Cost-Reporting Years 1993-96

		RPCH costs higher (lower) compared with PPS payments for hospitals in surroounding areas			
RPCH	Cost-reporting year	Sioux Falls, South Dakota	Bismarck, North Dakota	Rural South Dakota	Rural North Dakota
Douglas County Hospital	1995-96	($10,826)	$1,920	$40,325	$32,123
Faulk County Hospital	1995-96	189,493	194,011	221,317	215,143
	1994-95	191,477	191,204	234,620	229,100
	1993-94	23,608	22,946	64,262	59,797
Gettysburg Medical Center	1995-96	(92,743)	(87,905)	(49,443)	(58,250)
	1994-95	(43,748)	(43,507)	(28,665)	(31,707)
Total		**$257,261**	**$278,669**	**$482,416**	**$446,206**

Table IV.4: Comparison of RPCH Payments With PPS Payments for West Virginia, Cost-Reporting Years 1994-96

RPCH	Cost-reporting year	RPCH costs higher (lower) compared with PPS payments for hospitals in surrounding areas	
		Charleston	Rural
Broaddus Hospital	1995-96	($332,978)	($264,380)
	1994-95	(341,544)	(258,597)
Webster County Memorial Hospital	1994	18,658	26,393
Total		**($655,864)**	**($496,584)**

Hospitals Receiving Transferred RPCH Patients

Hospital and location	Number of RPCH patients
Transferred from RPCHs in Kansas	
Asbury-Salina Regional Medical Center, Salina, Kans.	1
Central Kansas Medical Center, Great Bend, Kans.	1
Duke University Medical Center, Durham, N.C.	1
Halstead Hospital, Halstead, Kans.	3
Hays Medical Center, Hays, Kans.	10
Phillips Episcopal Memorial Medical Center, Bartlesville, Okla.	6[a]
St. Catherine Hospital, Garden City, Kans.	11[b]
St. Francis Regional Medical Center, Wichita, Kans.	6
St. Joseph Medical Center, Wichita, Kans.	1
St. Luke's Hospital, Kansas City, Mo.	1
Wesley Medical Center, Wichita, Kans.	5
Western Plains Hospital, Dodge City, Kans.	1
William Newton Memorial Hospital, Winfield, Kans.	5
Subtotal	**52**
Transferred from RPCHs in North Carolina	
Pill County Memorial Hospital, Greenville, N.C.	2
Roanoke Chowan Hospital, Ahoskie, N.C.	1
Subtotal	**3**
Transferred from RPCHs in South Dakota	
McKennan Hospital, Sioux Falls, S.D.	9
Queen of Peace Hospital, Mitchell, S.D.	3
St. Luke Midland Regional Medical Center, Aberdeen, S.D.	13
St. Mary's Hospital, Pierre, S.D.	5[c]
St. Mary's Hospital, Rochester, Minn.	1
Sioux Valley Hospital, Sioux Falls, S.D.	12
University of Minnesota Hospital and Clinic, Minneapolis, Minn.	1
Subtotal	**44**
Transferred from RPCHs in West Virginia	
Aultman Hospital, Canton, Ohio	1
Davis Memorial Hospital, Elkins, W.V.	35
Fairmount General Hospital, Fairmount, W.V.	3
Grafton City Hospital, Grafton, W.V.	6[d]
Monongalia General Hospital, Morgantown, W.V.	6
Summersville Memorial Hospital, Summersville, W.V.	1
United Hospital Center, Clarksburg, W.V.	10

(continued)

Hospital and location	Number of RPCH patients
West Virginia University Hospital, Morgantown, W.V.	2
Subtotal	**64**
Total	**163**

[a]One of these patients was subsequently transferred to St. John's Medical Center, Tulsa, Okla.

[b]One of these patients was subsequently transferred to St. Francis Regional Medical Center, Wichita, Kans.

[c]One of these patients was subsequently transferred to St. Luke Midland Regional Medical Center, Aberdeen, S.D.

[d]One of these patients was subsequently transferred to West Virginia University Hospital, Morgantown, W.V.

Ordering Information

The first copy of each GAO report and testimony is free. Additional copies are $2 each. Orders should be sent to the following address, accompanied by a check or money order made out to the Superintendent of Documents, when necessary. VISA and MasterCard credit cards are accepted, also. Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

Orders by mail:

U.S. General Accounting Office
P.O. Box 37050
Washington, DC 20013

or visit:

Room 1100
700 4th St. NW (corner of 4th and G Sts. NW)
U.S. General Accounting Office
Washington, DC

Orders may also be placed by calling (202) 512-6000 or by using fax number (202) 512-6061, or TDD (202) 512-2537.

Each day, GAO issues a list of newly available reports and testimony. To receive facsimile copies of the daily list or any list from the past 30 days, please call (202) 512-6000 using a touchtone phone. A recorded menu will provide information on how to obtain these lists.

For information on how to access GAO reports on the INTERNET, send an e-mail message with "info" in the body to:

info@www.gao.gov

or visit GAO's World Wide Web Home Page at:

http://www.gao.gov

United States
General Accounting Office
Washington, D.C. 20548-0001

Bulk Rate
Postage & Fees Paid
GAO
Permit No. G100

Official Business
Penalty for Private Use $300

Address Correction Requested