United States General Accounting Office

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Report to Congressional Committees

September 2003

MEDICARE

Modest Eligibility Expansion for Critical Access Hospital Program Should Be Considered

GAO-03-948

September 2003

GAO
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Highlights

Highlights of GAO-03-948, a report to the Senate Committee on Finance, the House Committee on Ways and Means, and the House Committee on Energy and Commerce

MEDICARE

Modest Eligibility Expansion for Critical Access Hospital Program Should Be Considered

Why GAO Did This Study

Critical Access Hospitals (CAHs) are small rural hospitals that receive payment for their reasonable costs of providing inpatient and outpatient services to Medicare beneficiaries, rather than being paid fixed amounts under Medicare's prospective payment systems. Between fiscal years 1997 and 2002, 681 hospitals have become CAHs.

In the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000, GAO was directed to examine requirements for CAH eligibility, including the ban on inpatient psychiatric or rehabilitation distinct part units (DPUs) and limit on patient census, and to make recommendations on related program changes.

What GAO Recommends

GAO suggests that the Congress may wish to consider allowing hospitals with a DPU to convert to CAH status. GAO also suggests that the Congress may wish to consider changing the CAH limit on acute care patient census from an absolute limit of 15 patients to an annual average of 15 patients. The Department of Health and Human Services said that these modifications to CAH eligibility criteria would provide the needed flexibility for some additional facilities to consider conversion to CAH status, and emphasized the importance of maintaining financial incentives for efficiency as well as health and safety standards.

www.gao.gov/cgi-bin/getrpt?GAO-03-948.

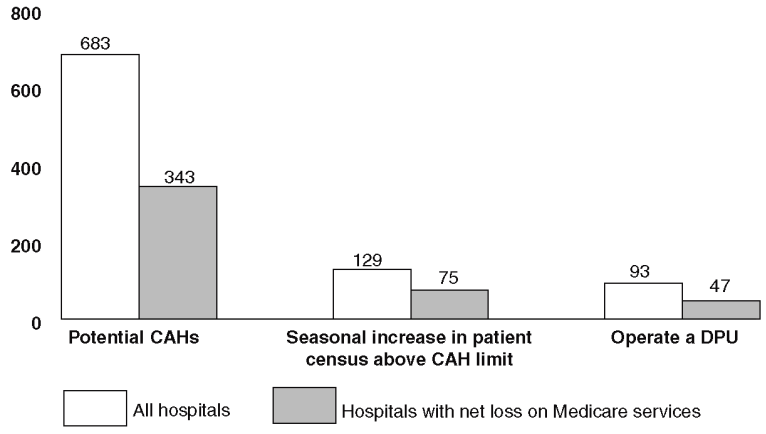
To view the full product, including the scope and methodology, click on the link above. For more information, contact A. Bruce Steinwald at (202) 512-7119.

What GAO Found

Using fiscal year 1999 hospital cost report data, GAO identified 683 rural hospitals as "potential CAHs" based on their having an annual average of no more than 15 acute care patients per day. About 14 percent (93) of these potential CAHs operated an inpatient psychiatric or rehabilitation DPU, which they would have to close to convert to CAH status. Among existing CAHs, 25 previously operated a DPU but had to close it as part of becoming a CAH. Among the potential CAHs that operated a DPU, about half had a net loss on Medicare services, indicating they might benefit from CAH conversion. Officials in some hospitals expressed a reluctance to close their DPU, even if conversion would benefit the hospital financially, as they believe the DPU maintains the availability of services in their community. Because inpatient rehabilitation and psychiatric services are disproportionately located in urban areas, even a small number of rural DPU closures may exacerbate any disparities in the availability of these services.

Using 1999 Medicare claims data, GAO found 129 potential CAHs that likely would have been able to meet the CAH census limit of no more than 15 acute care patients at any given time if not for a seasonal increase in their patient census. Seasonal increases in patient census were common among the hospitals GAO studied, generally occurring during the winter flu and pneumonia season. For most potential CAHs, their patient census was typically low enough that a small seasonal increase did not cause them to exceed CAH limits. For the 129 potential CAHs that would have had difficulty staying under the CAH limit due to seasonal variation, they could have accommodated their patient volume and had greater flexibility in the management of their patient census if the CAH census limit were changed from an absolute limit of 15 patients per day to an annual average of 15 patients.

Potential CAHs That May Otherwise Be Eligible to Conversion If Not for Seasonal Variation in Patient Stays or Because They Operate a DPU



Sources: Fiscal year 1999 Medicare hospital cost reports and 1999 Medicare inpatient claims.

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Abbreviations

BBA	Balanced Budget Act of 1997
BIPA	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
CAH	Critical Access Hospital
CMS	Centers for Medicare & Medicaid Services
DPU	distinct part unit
EACH	essential access community hospital
EMS	emergency medical services
FORHP	Federal Office of Rural Health Policy
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
MSA	metropolitan statistical area
OMB	Office of Management and Budget
PPS	prospective payment system
RHFTP	rural hospital flexibility tracking project
RPCH	rural primary care hospital
SCHIP	State Children's Health Insurance Program
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982

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United States General Accounting Office
Washington, DC 20548

September 19, 2003

Congressional Committees

Medicare beneficiary access to hospital services in rural areas has been a source of concern for policymakers for many years. To bolster the financial stability of rural hospitals, the Congress approved several special payment provisions both before and after the implementation of the Medicare acute care inpatient prospective payment system (PPS)[1] in 1983. These provisions enhanced Medicare payments to certain groups of rural hospitals, such as those that are the only source of care in their community; larger hospitals that serve as referral sites for rural physicians and community hospitals; and hospitals highly dependent on Medicare payments. Many rural hospitals have, however, continued to experience financial difficulties.

In the Balanced Budget Act of 1997 (BBA), the Congress established additional special payment provisions for Critical Access Hospitals (CAH).[2] When designated as a CAH, a hospital generally receives payment for its reasonable costs of providing inpatient and outpatient services to Medicare beneficiaries, rather than being paid the PPS fixed amount for those services. Thus, the CAH designation provides higher payments to hospitals whose reasonable costs are higher than their PPS payment. The CAH program has grown steadily to 681 CAHs at the end of fiscal year 2002.[3]

The CAH designation is targeted to small rural hospitals with a low patient census and short patient stays. Statutory provisions specifying criteria for CAHs do not specifically exclude facilities with distinct part units (DPUs) —separate sections certified to provide inpatient rehabilitation or psychiatric care. However, statutory and regulatory provisions concerning

[1]Under the PPS, hospitals are paid a fixed amount for each hospital discharge, based on national average costs, adjusted for such factors as local wage costs and type of illness treated.

[2]Pub. L. No. 105-33, § 4201(c), 111 Stat. 251, 373-374 (1997).

[3]CAH enrollment figures were provided by the Rural Hospital Flexibility Tracking Project (RHFTP), a federally funded national evaluation by a consortium of five rural health research centers and the Rural Policy Research Institute.

payment for such DPUs effectively require them to be operated by hospitals paid PPS rates. Thus, because CAHs are paid their reasonable costs, they are effectively banned from having DPUs. Some hospital officials have raised concerns that because CAHs cannot operate DPUs, it may be more difficult to ensure that rural beneficiaries have access to the kind of psychiatric and rehabilitation services these units provide, if hospitals choose to close their DPU as part of becoming a CAH. In addition, to be a CAH, a hospital must remain under CAH limits on the number of hospital beds ("bedsize") and average patient length of stay, and can have no more than 15 acute care patients on any given day. Some hospitals may have difficulty remaining under CAH limits during the entire year because they may experience fluctuations in patient demand due to seasonal tourism or illnesses, like influenza or pneumonia, that are more prevalent at certain times of the year.

In the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA),[4] the Congress directed us to study CAH eligibility requirements including with respect to limitations on average length of stay, bedsize, and DPU operations, and to make related recommendations on program changes. As agreed with the committees of jurisdiction, we have examined (1) the characteristics of a group of hospitals prior to their designation as CAHs compared to a group of small rural hospitals that have not become CAHs, but were in a position to consider doing so based on their low patient census, (2) the impact that the effective ban on CAHs operating DPUs has had on the availability of psychiatric and rehabilitation services in rural areas and on rural hospitals' decisions to seek CAH conversion, possible options for Medicare payment to DPUs and CAH eligibility requirements if CAHs were allowed to operate DPUs, and (3) the extent to which seasonal variation in patient census or length of stay prevents hospitals from being eligible for CAH status.

To address these objectives, we analyzed Medicare hospital cost reports[5] from fiscal year 1999, the most recently available audited cost report data, and Medicare inpatient claims data for 1999. We defined 683 rural hospitals that had not converted to CAH status as of January 1, 2003, as

[4]Pub. L. No. 106-554, App. F, § 206, 114 Stat. 2763A-463, 2763A-483 (2000).

[5]The Medicare cost report is the financial document that hospitals are required to submit annually to the Centers for Medicare & Medicaid Services (CMS). The reports include information about Medicare inpatient and outpatient costs and payments, as well as information about payments from other revenue sources.

"potential CAHs," based on their having an annual average patient census of no more than 15 acute care patients.[6] We estimated how many of the 683 potential CAHs might be prevented from converting to CAH status because they operate a DPU or experience seasonal variation in their patient census or average length of stay. We also examined the characteristics of 620 hospitals that were not yet CAHs in fiscal year 1999 but have since converted to CAH status ("existing CAHs") and compared their preconversion characteristics to those of potential CAHs in fiscal year 1999. We evaluated how many potential CAHs and existing CAHs experienced financial losses under the Medicare PPS and likely could benefit from cost-based reimbursement. Since DPUs are paid under different payment methodologies from acute care hospitals, we evaluated how many of the DPUs operated by potential CAHs experienced financial gains or losses under the payment methodology that applied to them in fiscal year 1999 as well as the possible impact if cost-based reimbursement were extended to DPUs operated by CAHs. We also evaluated how many of the potential CAHs with DPUs could have met CAH bedsize and length of stay criteria in fiscal year 1999 if their DPU beds and lengths of stay were counted towards the limits. We interviewed officials with the Centers for Medicare & Medicaid Services (CMS) and the Federal Office of Rural Health Policy (FORHP), which administers a grant program supporting CAHs. We interviewed administrators of 24 CAHs and potential CAHs across 10 states, and made site visits to 7 of these hospitals in 3 states. We also interviewed state staff administering FORHP grants, and conducted an e-mail survey of state CAH coordinators.[7] We did our work in accordance with generally accepted government auditing standards from April 2001 through August 2003. A detailed discussion of our scope and methodology is in appendix I.

[6]Most of the 683 potential CAHs (79 percent) exceeded the CAH bedsize limit. We did not exclude these hospitals from our definition of potential CAHs because hospitals have the option of reducing their bedsize in order to become eligible for CAH conversion. Our inclusion of hospitals with an average census up to 15 is likely a high estimate of the number of potential CAHs because hospitals with an annual average of 15 acute care patients per day may need more than 15 acute care beds to accommodate variation in their patient census that periodically causes them to exceed 15.

[7]New Jersey, Rhode Island, Delaware, and Washington D.C. do not participate in the CAH program. All but 5 state CAH coordinators participated in the e-mail survey or were interviewed.

Results in Brief

Existing CAHs averaged six fewer beds and about three fewer patients per day prior to their conversion than did potential CAHs. Existing CAHs had to make smaller operational changes to qualify for CAH status, such as reducing bedsize or length of stay, than potential CAHs would have had to make if they had chosen to convert. While both groups had a median loss on Medicare inpatient and outpatient services, existing CAHs tended to experience bigger losses prior to their conversion (8.9 percent) than did potential CAHs (0.8 percent). Existing CAHs also had a median loss on all sources of revenue of 0.3 percent before conversion, while potential CAHs had a median gain of 1.8 percent.

The effective ban on CAHs operating DPUs may have contributed to the disparity between urban and rural areas in the availability of inpatient psychiatric and rehabilitation services in fiscal year 1999. While one-quarter of Medicare beneficiaries reside in rural areas, only 8 percent of rehabilitation hospital and DPU beds and 17 percent of psychiatric hospital and DPU beds were in rural areas in fiscal year 1999. The subsequent closure of 25 DPUs by hospitals converting to CAH status may have exacerbated this difference in availability. Of the 93 potential CAHs that operated a DPU, about half lost money on Medicare inpatient and outpatient services, giving them a financial incentive to convert. If, however, the other financial benefits associated with the DPU exceeded their losses under the PPS, these potential CAHs would have a countervailing incentive to stay under the PPS rather than close their DPU and convert. Some rural hospital administrators told us that, even when it was financially advantageous to seek CAH status, they were reluctant to close their DPU because it is needed to maintain access to psychiatric or rehabilitation services in the community they serve. While allowing hospitals to convert to CAH status and retain their DPU would alleviate this concern, extending cost-based reimbursement to DPUs operated by CAHs diminishes the incentives for efficiency that are inherent in PPS payments. If DPU patient stays and beds were counted against current CAH limits without any adjustment, nearly all potential CAHs with DPUs would have exceeded the limits in fiscal year 1999.

Among hospitals we studied, seasonal fluctuations in patient volume or length of stay were common, particularly during the winter. Such increases can be an obstacle for some hospitals considering CAH conversion if it causes them to exceed the CAH patient census limit of no more than 15 patients at any time or length of stay limit of an annual average of 4 days. We found 129 potential CAHs that likely would have been able to meet the CAH patient census limit in fiscal year 1999 if not for the seasonal increase in their patient census. While these 129 hospitals, as

a group, averaged 13.2 patients per day over the entire year, their daily census increased to an estimated average of 16.9 during their high season. If the CAH patient census limit were changed from an absolute limit of 15 acute care patients per day to an annual average of 15, these potential CAHs would have been able to remain under such a limit because they all had an annual average below 15. It would not be necessary to increase the number of acute care beds CAHs are allowed to maintain in order to implement this relaxation of the patient census limit, since more than three-quarters of existing CAHs and potential CAHs have swing beds[8] which they could use to accommodate additional acute care patients beyond 15. About 40 percent of these 129 potential CAHs, however, had positive Medicare margins, meaning they would have had little financial incentive to switch from the PPS to the cost-based payment CAHs receive. In contrast to the CAH patient census limit, the patient length-of-stay limit gives CAHs the flexibility to keep some acute care patients beyond the limit because it is an average.

We suggest that the Congress may wish to consider allowing hospitals with DPUs to convert to CAH status while making allowances for DPU beds, patients, and lengths-of-stay when determining CAH eligibility, and that CAH-affiliated DPUs be paid under the same formulas as other inpatient psychiatric or rehabilitation providers. We also suggest that the Congress may wish to consider changing the CAH limit on acute care patient census from an absolute limit of 15 acute care patients to an annual average of 15 in order to give CAHs greater flexibility in the management of their patient census.

In commenting on a draft of this report, the Department of Health and Human Services said that these modifications to CAH eligibility criteria would provide the needed flexibility for some additional facilities to consider conversion to CAH status. The department also emphasized several considerations, including maintaining financial incentives for efficiency as well as health and safety standards for DPUs, if they are allowed to be operated by a CAH.

[8]A hospital with swing beds can "swing" its beds between hospital and skilled nursing levels of care, on an as needed basis.

Background

CAHs are an outgrowth of the seven-state Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program established in 1989. The BBA replaced the EACH/RPCH program with the state-administered Rural Hospital Flexibility Program (the "Flex" Program), which includes the CAH designation. The reimbursement component of the Flex Program is the responsibility of CMS. The Flex Program also includes a grant program that supports hospital participation in the program as well as state emergency medical services systems (EMS), and is the responsibility of the FORHP within the Health Resources and Services Administration (HRSA).

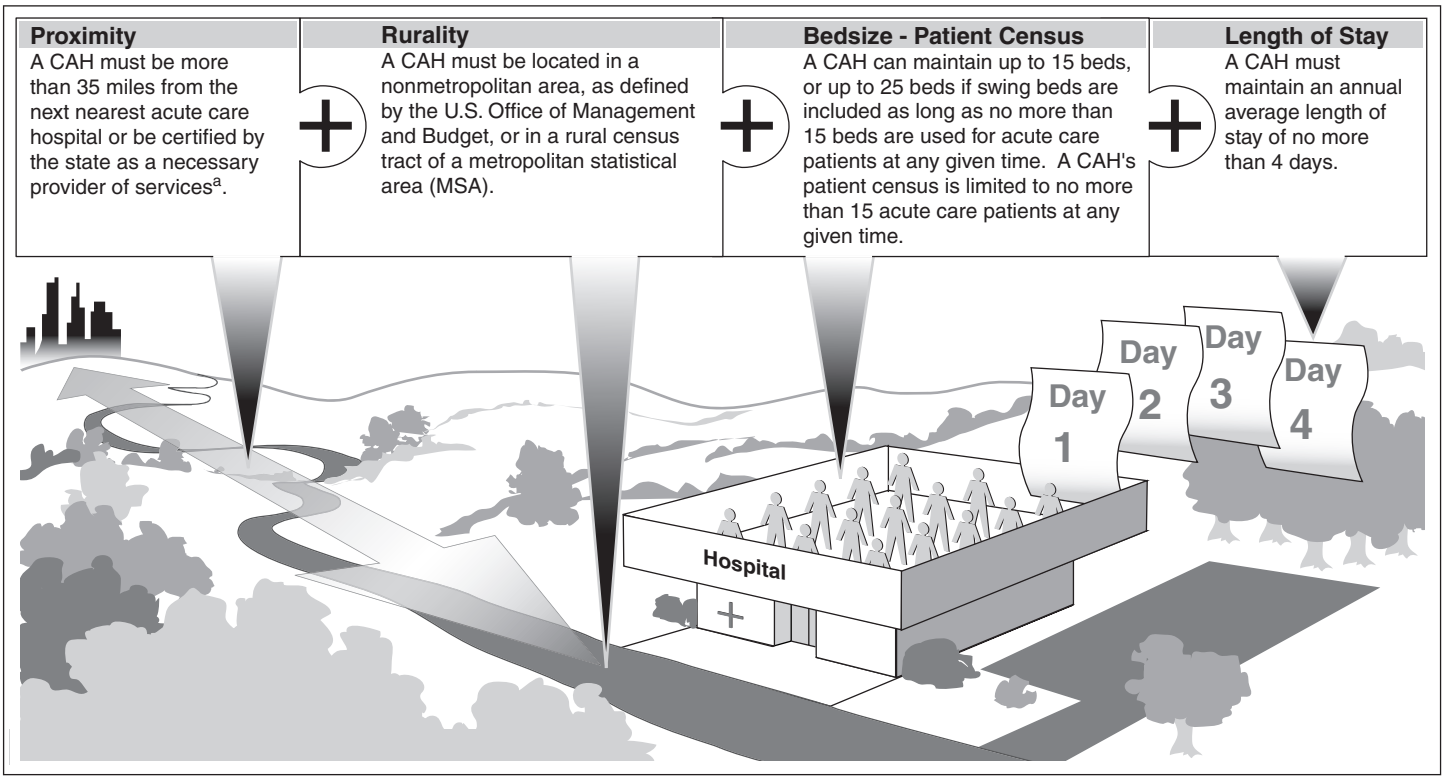
The CAH program allows eligible rural hospitals to receive Medicare payments based on their reasonable costs rather than under a PPS. Under the Medicare inpatient PPS, hospitals are generally paid a fixed amount per patient discharge, providing an incentive for hospitals to control their costs to stay under this fixed amount because they can retain the difference between the PPS payment and their costs. Under cost-based reimbursement, hospitals are reimbursed for their reasonable costs, which does not provide the same incentive to control costs, but benefits hospitals whose Medicare costs exceed their PPS payments.

In addition to receiving cost-based payment for inpatient services to Medicare beneficiaries, CAHs receive cost-based payment from Medicare for skilled nursing care provided in their swing beds and for outpatient care.[9] To become a CAH, a hospital must meet certain criteria with respect to its location, size, patient census, and patient length of stay (see figure 1). CAHs are also subject to different health and safety regulations, known as "conditions of participation," from other acute care hospitals.[10]

[9]Among 42 states responding to a RHFTP survey, 17 states provide enhanced Medicaid payments to CAHs, and 13 states provide enhanced reimbursement for outpatient services.

[10]42 C.F.R. §§ 485.601 *et seq.* (2002).

Figure 1: Major Eligibility Criteria for Critical Access Hospitals



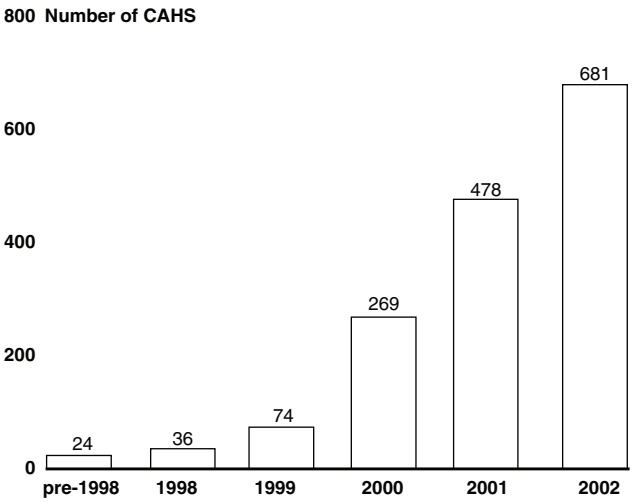
Source: GAO.

Note: The Office of Management and Budget (OMB) defines a metropolitan statistical area as a core area of at least 50,000 people together with adjacent areas having a high degree of economic and social integration with that core. Nonmetropolitan areas include all counties outside of a metropolitan area.

[a]The statutory provision outlining the certification exception does not specify the criteria for a hospital to be a necessary provider of services.

Growth in the number of CAHs has been steady (see figure 2). There is a large concentration of CAHs in the central states, although 45 states had at least one CAH as of September, 2002 (see figure 3).[11]

Figure 2: Number of Critical Access Hospitals through Fiscal Year 2002



Source: Rural Hospital Flexibility Tracking Project.

[11]Connecticut, Delaware, Maryland, New Jersey, and Rhode Island did not have CAHs as of September 2002.

Figure 3: Location of the 681 Critical Access Hospitals, September 2002

Source: Rural Hospital Flexibility Tracking Project.

Note: Some Critical Access Hospitals may not be visible because they are obscured by state boundary lines.

Since the inception of the CAH program, two factors have been important in increasing the number of hospitals qualifying for the designation. First, the length-of stay criterion was changed. Until 1999, patient stays at CAHs were limited to 4 days, after which patients would have to be transferred to another health care facility or discharged. In 1999, the Congress relaxed the criterion to require that CAHs keep their annual average length of stay to no more than 4 days.[12] Second, states have widely utilized their authority to designate hospitals as "necessary providers," thereby exempting such hospitals from the otherwise applicable CAH criterion that they be more than 35 miles from the nearest hospital. According to the Rural Hospital Flexibility Tracking Project (RHFTP), a little more than half of all CAHs had qualified for the CAH program through state designation rather than by meeting the mileage and location requirements, as of September 2002.[13]

Hospitals considering CAH conversion weigh numerous factors in their decision, including the impact on hospital finances and community reaction. Financial impact studies are commonly used to estimate how a hospital's reimbursement for services would change under CAH status. The financial impact may change as Medicare reimbursements to hospitals changes. For example, Medicare payment for hospital outpatient services shifted in 2000 from cost-based payment to a new PPS for outpatient services. Because CAHs are exempt from this PPS and continue to receive cost-based payment for outpatient services, potential CAHs may factor into their decision the impact of being paid reasonable costs, rather than a fixed PPS payment, for outpatient services. They may also consider the possible reaction from the community and from other health care providers to CAH conversion. Some communities have been reluctant to support a hospital's conversion because they perceive it as the last step before closure. In other cases, hospital officials reported that their physicians expressed concern that if a hospital became a CAH, they would occasionally be unable to admit patients to it because this would bring the CAH over the patient limit.

[12]Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. No. 106-113, App. F, § 403(a), 113 Stat. 1501A-321, 1501A-370-372.

[13]List of CAH conversions by state downloaded from www.rupri.org/rhfp-track on September 27, 2002.

Distinct Part Units

Clinical research has indicated better outcomes for patients who are appropriately treated in inpatient psychiatric or rehabilitation facilities, such as DPUs, rather than in general acute or post acute care settings. For example, one study concluded that elderly depressed patients who were treated in specialty psychiatric DPUs may have received better treatment for their depression than similar patients who were treated in general medical wards.[14] Another study found better outcomes among stroke patients treated in rehabilitation facilities, such as DPUs, than those treated in nursing homes.[15]

As separate sections of hospitals, psychiatric and rehabilitation DPUs are subject to specific Medicare regulations regarding the types of patients they admit and the qualifications of their staff.[16] Psychiatric DPUs may admit only patients whose condition requires inpatient hospital care and are described by a psychiatric principal diagnosis.[17] Rehabilitation DPUs may treat only patients likely to benefit significantly from intensive therapy services, such as physical therapy, occupational therapy, or speech therapy. Both types of DPUs must provide a specified range of services and employ clinical staff with specialized training.

[14]G. Norquist et al. "Quality of Care for Depressed Elderly Patients Hospitalized in the Specialty Psychiatric Units or General Medical Wards," *Archives of General Psychiatry*, vol. 52, no. 8 (1995).

[15]R. L. Kane et al. "'Functional Outcomes of Posthospital Care for Stroke and Hip Fracture Patients under Medicare," *Journal of the American Geriatric Society*, vol. 46, no. 12 (1998).

[16]For a hospital to establish a psychiatric DPU, Medicare regulations require that a hospital must furnish, through the use of qualified personnel, psychological services, social work, psychiatric nursing, occupational therapy and recreational therapy. Inpatient psychiatric services must be under the supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program, and who is board certified in psychiatry. The DPU must have a director of nursing who is a registered nurse with a master's degree in psychiatric or mental health nursing or who is qualified by education and experience, and a director of social services. There also must be an adequate number of registered nurses to provide 24-hour-a-day coverage as well as licensed practical nurses and mental health workers. 42 C.F.R. § 412.27 (2002). For a hospital to establish a rehabilitation DPU, Medicare regulations require that a hospital must provide rehabilitation nursing, physical and occupational therapy, speech therapy, plus as needed, social services or psychological services and orthotics and prosthetics. The unit must have a director of rehabilitation who is experienced in rehabilitation and is a doctor of medicine or a doctor of osteopathy. 42 C.F.R. § 412.29 (2002).

[17]42 C.F.R. § 412.27(a) (2002). Psychiatric principal diagnoses are listed in the Third Edition of the American Psychiatric Association Diagnostic and Statistical Manual and in chapter 5 of the International Classification of Diseases, 9th Edition Clinical Modification (ICD-9-CM).

The Congress has required that CMS develop PPSs for both inpatient rehabilitation and inpatient psychiatric providers, including DPUs, to replace the payment methodology established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Under TEFRA, providers that had been exempted from the inpatient PPS, including inpatient rehabilitation and psychiatric hospitals and DPUs, receive the lesser of either their average cost per discharge or a provider-specific target amount.[18] In 2002, a PPS was implemented for inpatient rehabilitation. Because a PPS for inpatient psychiatric providers has yet to be implemented, psychiatric DPUs continue to be paid under TEFRA.

The financial incentives associated with TEFRA payments differ from those associated with cost-based payment. Under TEFRA, Medicare payments are capped by a provider's target amount, giving hospitals an incentive to restrain costs. By contrast, hospitals such as CAHs, which are paid their reasonable costs, have less incentive to restrain costs because their payments can increase as their costs increase.

Existing CAHs Had Fewer Beds and Patients and Lower Medicare Margins Than Potential CAHs

Most existing CAHs prior to their conversion had more beds in fiscal year 1999 than CAHs are allowed. Most were likely able to reduce their bedsize to 15 (or 25 with swing beds) to become CAHs without adjusting their patient volume because their average patient census of 4.8 was generally well below the CAH limit of 15 (see table 1). Likewise, potential CAHs, on average, exceeded CAH bedsize limits in fiscal year 1999 and had a patient census well below 15. To meet the CAH limit, existing CAHs, on average, had to reduce their bedsize by less than potential CAHs would have had to if they had sought CAH status. Most existing CAHs prior to their conversion and potential CAHs were below the CAH length-of-stay limit.

[18]TEFRA (Pub. L. No. 97-248, § 101(a)(1), 96 Stat. 324, 331-333) established this payment methodology for classes of hospitals deemed exempt from the PPS. The target amount is the PPS-exempt provider's Medicare-allowable costs per patient stay in a designated base year, inflated to the current year by an annual update factor.

Table 1: Selected Characteristics of Existing CAHs Prior to Their Conversion and Potential CAHs, Fiscal Year 1999

	Total	Average daily census	Average length of stay (days)	Average bedsize	Percentage with swing beds	Percentage exceeding bedsize limit	Percentage exceeding length-of-stay limit
Existing CAHs[a] (pre-conversion)	620	4.8	3.5	30	85	61	14
Potential CAHs	683	8.1	3.8	36	78	79	21

Source: Fiscal year 1999 Medicare hospital cost reports.

[a]Statistics on existing CAHs include CAH conversions reported through January 1, 2003, but do not include CAHs that had already converted to CAH status in fiscal year 1999 or for which cost report data were not available for fiscal year 1999.

In fiscal year 1999, existing CAHs prior to their conversion generally experienced greater losses on their inpatient and outpatient Medicare services than did potential CAHs (see table 2), and therefore had greater financial incentive to seek conversion. A small majority, 55 percent, of existing CAHs experienced losses on inpatient Medicare services, while more than 60 percent of potential CAHs experienced gains. Nearly all hospitals in both groups experienced losses on their Medicare outpatient services. Across all revenue sources, existing CAHs prior to their conversion experienced a 0.3 percent median loss, while potential CAHs experienced a 1.8 percent median gain.

Table 2: Financial Performance of Existing CAHs Prior to Their Conversion and Potential CAHs, Fiscal Year 1999

	Median margin[a] (percent)		Hospitals with negative margins		Hospitals with positive margins	
	Existing CAHs (preconversion) (n= 542)	Potential CAHs (n= 683)	Number (percent) of existing CAHs (preconversion)	Number (percent) of potential CAHs	Number (percent) of existing CAHs (preconversion)	Number (percent) of potential CAHs
Medicare inpatient	-2.4	6.0	296 (55)	254 (37)	236 (44)	419 (62)
Medicare outpatient	-21.0	-19.6	523 (96)	649 (96)	11 (2)	14 (2)
Medicare inpatient and outpatient	-8.9	-0.8	398 (74)	343 (51)	136 (25)	322 (48)
Total facility (all payers)	**-0.3**	**1.8**	**277 (51)**	**260 (38)**	**255 (47)**	**406 (60)**

Source: Fiscal year 1999 Medicare hospital cost reports.

Notes: For each of the four calculations of hospital margins, a small number of hospitals were excluded because of incomplete data or because their margins were extreme outliers. Three to 17 potential CAHs were excluded among the four calculations, and 2 to 10 existing CAHs were excluded. In addition, 78 existing CAHs do not have pre-conversion PPS margins statistics for fiscal year 1999 because they did not meet criteria used for the margins calculation. Results do not reflect the effects of the outpatient PPS, which was implemented in 2000.

[a]A margin is the difference between a hospital's revenue and costs, divided by its revenues.

Ban on CAHs Operating DPUs May Have Contributed to Diminished Availability of Services in Rural Areas

The effective ban on CAHs operating DPUs may have contributed to the disparity between urban and rural areas in the availability of inpatient psychiatric and rehabilitation services in fiscal year 1999. Twenty-five existing CAHs had to close their DPU as part of becoming CAHs. Of the 93 potential CAHs that operated a DPU (one-seventh of all potential CAHs), about half lost money on their Medicare inpatient and outpatient services, giving them a financial incentive to convert. If, however, the other financial benefits associated with the DPU exceeded their combined losses on inpatient and outpatient services, these potential CAHs would have had a countervailing incentive to stay under the PPS, rather than close their DPU and convert. Some rural hospital administrators told us that, even when it was financially advantageous to seek CAH status, they were reluctant to close their DPU because it was needed to maintain access to psychiatric or rehabilitation services in the community they serve. While allowing hospitals to convert to CAH status and retain their DPU would alleviate this concern, extending cost-based reimbursement to DPUs operated by CAHs diminishes the incentives for efficiency that are inherent in PPS payments. If DPU patient stays and beds were counted against current CAH limits without any adjustment, nearly all potential

CAHs with DPUs would have exceeded either the bedsize or length of stay limit in fiscal year 1999.

CAH Eligibility Requirements Led to DPU Closures in Rural Communities

The closure of 25 DPUs by hospitals that needed to relinquish their DPU as part of becoming a CAH may have contributed to the lower availability of inpatient psychiatric and rehabilitation services in rural areas. Inpatient psychiatric and rehabilitation providers are concentrated in urban areas, and DPUs are least common among smaller rural hospitals. Only 8 percent of rehabilitation beds and 17 percent of psychiatric beds were located in rural areas in fiscal year 1999, while about 25 percent of Medicare beneficiaries live in rural areas. In fiscal year 1999, 14 percent (93) of potential CAHs operated a DPU.[19] By comparison, 37 percent of larger rural hospitals operated a DPU, and 53 percent of urban hospitals operated a DPU.

DPUs may be less common in rural areas due to the challenge of finding the resources needed to open a DPU. Hospital representatives and officials from rural health organizations said the difficulty in finding the specialized staff required to operate a DPU likely prevents many small rural hospitals from opening a DPU.

Many Potential CAHs Had No Financial Incentive to Close DPU

In fiscal year 1999, nearly half the potential CAHs with a DPU experienced net gains on their combined inpatient and outpatient payments for Medicare services (see table 3). These potential CAHs had a financial incentive to continue under the PPS because this allowed them to continue receiving Medicare payments that were higher than their costs, rather than being paid only their reasonable costs as a CAH. The 47 potential CAHs with DPUs that experienced losses on their combined inpatient and outpatient Medicare payments would more likely have a financial incentive to seek CAH status.

[19]Eighty-one of the 93 operated only a psychiatric DPU, 7 operated only a rehabilitation DPU, and 5 operated both types of DPUs.

Table 3: Financial Performance of Potential CAHs with DPUs, Fiscal Year 1999

	Median margin[a] in percentages (n = 93)	Number (percent) of potential CAHs with negative margins	Number (percent) of potential CAHs with positive margins
Medicare inpatient	3.9	35 (38)	56 (62)
Medicare outpatient	-17.5	88 (97)	0 (0)
Medicare inpatient and outpatient	-1.1	47 (53)	41 (47)
Total facility (all payers)	**0.6**	**42 (46)**	**46 (51)**

Source: Fiscal year 1999 Medicare hospital cost reports.

Notes: For each of the four calculations of hospital margins, three or fewer hospitals were excluded because of incomplete data or because their margins were extreme outliers. Results do not reflect the effects of the outpatient PPS, which was implemented in 2000.

[a]A margin is the difference between a hospital's revenue and costs, divided by its revenues.

Potential CAHs with DPUs can compare the financial benefits of CAH conversion to the benefits of keeping their DPUs. Some that suffered losses on their inpatient and outpatient Medicare payments may lack a financial incentive to become a CAH because DPU revenues help offset those losses. If the projected increase in revenue under cost-based payment that a hospital would receive as a CAH is lower than the loss of revenue from having to close its DPU, the hospital may chose not to convert to CAH status. Just over half of the DPUs operated by potential CAHs had net gains on their Medicare payments (see table 4). A DPU may also provide a financial benefit to the hospital because it enables the hospital to spread its fixed costs over more services. Several administrators of potential CAHs with a DPU whom we interviewed stated that their DPU had contributed positively to the hospital's financial situation, providing a revenue source they would be reluctant to relinquish to gain CAH status.

Table 4: Medicare Margins for DPUs of Potential CAHs, Fiscal Year 1999

DPUs of potential CAHs	Number	Median Medicare margin[a] (percent)	Number (percent) of DPUs with negative margins	Number (percent) of DPUs with positive margins
Psychiatric	86	0.9	28 (33)	47 (55)
Rehabilitation	12	0.0	5 (42)	5 (42)
All	98	0.9	33 (34)	52 (53)

Source: Fiscal year 1999 Medicare hospital cost reports.

Notes: Because 5 of the potential CAHs had both a psychiatric and rehabilitation DPU, there are a total of 98 DPUs among the 93 potential CAHs. Margin information is not included for 11 psychiatric DPUs and 2 rehabilitation DPUs due to incomplete data or the exclusion of units whose margins were at extreme outliers. Results do not reflect the effects of the inpatient rehabilitation PPS, which was implemented in January 2002.

[a]A margin is the difference between a hospital's revenue and costs, divided by its revenues.

Hospitals with DPUs Expressed Reluctance to Seek CAH Conversion If Access to Care Could Be Jeopardized

While hospitals report that the projected financial impact is generally a key factor in the decision about whether to become a CAH,[20] some potential CAHs with DPUs also consider how local access to services would be affected if the DPU were closed. Some rural hospital administrators told us that, even when it was financially advantageous to seek CAH status, they were reluctant to close their DPU because they believed it was needed to maintain access to psychiatric or rehabilitation services in their community. Several hospital administrators and state health officials emphasized the need for patients to be near their family during treatment and the difficulty that some families would have if they had to travel outside their community to visit family members receiving treatment. Other administrators said that if their DPU closed, alternative sources for these services could be as much as 165 miles away. We were also told of difficulties in several states with referring psychiatric patients to hospitals because of a lack of available beds or because referral hospitals prefer not to take patients with significant behavioral issues or believe that psychiatric services should be provided in smaller community-based facilities.

[20]Rural Policy Research Institute, *Rural Hospital Flexibility Program Tracking Project Year Two Report (*Columbia, Mo. 1999).

Paying DPUs Associated with CAHs Reasonable Costs Would Reduce Incentives to Operate Efficiently

If potential CAHs were allowed to convert to CAH status while retaining their DPU, the payment methodology applied to the DPUs could remain unchanged or could be shifted to cost-based payment along with the acute care hospital services. Hospitals that have been able to keep their DPU costs below their Medicare payments under the current methodologies (rehabilitation PPS for rehabilitation DPUs or TEFRA payment for psychiatric DPUs) would likely prefer no change because they can continue to keep their net gains; hospitals that have DPU costs exceeding their current Medicare payments would likely prefer cost-based payment.

If CAHs were allowed to have DPUs and the DPUs were shifted to cost-based payment, diminished incentives for efficiency could result in higher costs per case. Under cost-based reimbursement, a hospital can receive higher payments if its costs increase. Under the rehabilitation PPS or TEFRA methodologies currently applied to DPUs, their payments cannot exceed a predetermined amount, creating pressure on them to operate efficiently.

Most Potential CAHs with DPUs Exceeded CAH Bedsize and Length-of-Stay Limits When DPUs' Patients Were Counted

If CAHs were allowed to operate DPUs and the DPU beds and patients' length of stay were counted against the CAH limits, only one of the 93 potential CAHs with DPUs would have met both limits in fiscal year 1999. Among these 93 potential CAHs, the median bedsize of psychiatric DPUs was 11 and the median bedsize of rehabilitation DPUs was 13. If their DPU beds, acute care beds and swing beds were added together, 88 would have exceeded the CAH bedsize limit. Similarly, psychiatric inpatient stays at these potential CAHs averaged 11.8 days, and rehabilitation DPU inpatient stays averaged 13.7 days, both significantly longer than the CAH limit of an annual average of 4 days. About eighty percent of the potential CAHs with DPUs exceeded the CAH length-of-stay limit when the DPU length of stay and acute care length of stay were counted together.

Seasonal Variation in Patient Census Is Common and May Impede CAH Eligibility for Hospitals Near the CAH Limit

Hospitals we studied commonly experienced at least a small seasonal increase in their patient census, most often during winter. Such increases can be an obstacle for some hospitals considering CAH conversion if it causes them to exceed the CAH patient census limit of no more than 15 patients at any time, or length of stay limit of an average of 4 days. We found 129 potential CAHs that likely would have been able to meet the patient census limit of 15 in 1999 if not for the seasonal increase in their patient census. About 40 percent of these 129 potential CAHs, however, had positive Medicare margins, meaning they would have little financial incentive to switch from the PPS to CAH cost-based payment. In contrast to the CAH patient census limit, the patient length of stay limit is an annual average, and gives CAHs the flexibility to occasionally keep some acute care patients longer than 4 days as long as the average remains below 4.

Most Hospitals Experience Higher Patient Census during Winter

Among hospitals we studied, seasonal fluctuations in patient volume were common. In 1999, over 80 percent of potential CAHs had an increase in their patient census averaging at least one additional patient per day during a 3-month period. To assess whether this finding is consistent with small and medium-size hospitals in general, we analyzed Medicare patient claims for 2,139 hospitals with an average census of no more than 50 patients and found that about 90 percent had an increase in their patient census averaging at least one additional patient per day during a 3-month period of 1999.

For nearly three-quarters of potential CAHs, the patient volume increase in 1999 occurred during the winter. This pattern was consistent with reports from hospital officials that their patient census often increased during the winter due to a higher incidence of flu and pneumonia. The seasonal increase in patient census was greater for larger potential CAHs. For example, potential CAHs with 41 to 60 beds averaged 2.8 patients more per day during their peak 3-month period, while potential CAHs with no more than 15 beds averaged 1.3 patients more per day during this period (see table 5).

Table 5: Seasonal Increase in Average Acute Care Patient Census among Potential CAHs, by Bedsize, 1999

		Patient census		Potential CAHs with a high season average census exceeding thresholds	
Bedsize	Number of potential CAHs	Estimated 3-month high season average	Annual average	Exceeded 15 acute care patients	Exceeded 20 acute care patients
1-15	45	3.5	2.2	0	0
16-25	124	7.2	5.5	3	0
26-40	284	10.5	8.3	40	2
41-60	195	13.2	10.4	72	3
>60	35	13.3	10.6	14	0
Total	**683**	**10.4**	**8.1**	**129**	**5**

Source: GAO analysis of Medicare inpatient claims.

Note: Because this analysis was based on hospitalizations of Medicare patients, rather than all patients, we used the hospital's annual ratio of all patients to Medicare patients to estimate each hospital's total patient census by season. (See app. I for a description of our methodology.)

Because CAH Patient Census Limit Is Absolute, Potential CAHs Near the Limit May Have Difficulty Staying under It

There were 129 potential CAHs that had at least a slight seasonal increase in 1999 that pushed them over the CAH limit of 15 acute care patients per day for some portion of the year. These 129 potential CAHs had an average daily patient census of about 13.2, with none having an annual average above 15. But these potential CAHs had an estimated average acute care patient census of 16.9 during their peak season (see table 6), nearly two patients per day higher than the CAH limit.

Table 6: Potential CAHs with Estimated Seasonal Increases in Patient Census That Pushed Them over CAH Limit, 1999

Potential CAHs with a seasonal increase in patient census	129
Estimated average increase in patients per day during seasonal increase	3.7
Total annual average daily census	13.2
Estimated total average daily census during seasonal increase	16.9

Source: GAO analysis of Medicare inpatient claims.

Note: Because this analysis was based on hospitalizations of Medicare patients, rather than all patients, we used the hospital's annual ratio of all patients to Medicare patients to approximate each hospital's total patient census by season.

Significant Number of Potential CAHs with Seasonal Increase in Patient Census Have No Financial Incentive to Become a CAH

About 40 percent of the 129 potential CAHs with seasonal increases that pushed them over the CAH patient census limit had net gains on combined inpatient and outpatient payments for Medicare services (see table 7). These potential CAHs would have a financial incentive to remain under the PPS, where they can keep the difference between payments and their costs, rather than convert to CAH status, where they would be paid only their reasonable costs.

Table 7: Financial Performance of Potential CAHs with a Seasonal Increase in Patient Census That Pushed Them over CAH Limit, Fiscal Year 1999

	Median margins[a] in percent (n=129)	Number (percent) of hospitals with negative margins	Number (percent) of hospitals with positive margins
Medicare inpatient	2.4	57 (44)	72 (56)
Medicare outpatient	-19.3	122 (95)	5 (4)
Medicare inpatient and outpatient	-2.7	75 (59)	52 (41)
Total facility (all payers)	**2.5**	**47 (36)**	**82 (64)**

Source: Fiscal year 1999 Medicare hospital cost reports.

Note: For each of the four calculations of hospital margins, two or fewer hospitals were excluded due to incomplete data or because their margins were extreme outliers. Results do not reflect the effects of the outpatient PPS, which was implemented in 2000.

[a]A margin is the difference between a hospital's revenue and costs, divided by its revenues.

Remaining under Length-of-Stay Limit Is Manageable Because It Is an Average

Seasonal fluctuations in patient length of stay were also common among hospitals we studied. Among the 2,139 hospitals with a patient census of no more than 50, about three-fourths had a seasonal increase in their Medicare length of stay of at least one-third of a day. Sixty-five potential CAHs had an average Medicare patient length of stay below 4 days (3.8 days) for 9 months of fiscal year 1999, but their average length of stay during the other 3 months was high enough (4.8 days) to push their Medicare annual average over the 4-day CAH limit, to 4.2 (see table 8). Among the 620 existing CAHs, 60 had an annual average length of stay greater than 4.2 days before they converted. These existing CAHs have been subject to the 4-day limit since they became CAHs, suggesting that potential CAHs with an annual average of 4.2 days would be able to remain under the limit if they converted.

Table 8: Potential CAHs with Seasonal Increase in Medicare Patients' Length of Stay That Pushed Them over the 4-day CAH Limit, 1999

Potential CAHs with increase pushing them over the limit	65
Average Medicare length of stay during 9-month period (days)	3.8
Average Medicare length of stay during 3-month seasonal increase (days)	4.8
Annual average Medicare patient length of stay (days)	4.2

Source: GAO analysis of Medicare inpatient claims.

The relaxation of the CAH length-of-stay limit in 1999 from an absolute limit of 4 days to an annual average of 4 days has made it easier to meet because hospitals are able to keep some patients for a longer period, as long as the hospital's annual average remains below the limit. Examples of how a hospital can manage its length of stay during the course of a year include discharging longer-stay patients to skilled nursing care in the hospital's swing beds or transferring them to referral facilities. Administrative staff of one rural hospital considering CAH conversion reported that its average length of stay dropped over 3 years from 5.3 to 3.7 days. The decline, in their opinion, was due to factors such as utilization review, emphasis on community-based services, increased use of post-acute care, and education of staff.

Conclusions

The ineligibility of hospitals with DPUs or with seasonal increases in patient stays that push them over a CAH limit impedes CAH conversion for some hospitals that might otherwise be able to become CAHs. The ineligibility of hospitals with DPUs may result in the loss of some rural DPU services if potential CAHs close their DPU as part of becoming a

CAH. Hospitals seeking CAH status may occasionally need to transfer patients to stay under the CAH limit of 15 acute care patients if they otherwise periodically exceed 15 due to seasonal increases.

Since inpatient rehabilitation and psychiatric services are less prevalent in rural areas, enabling rural DPUs to continue operating can help preserve the availability of services. In fiscal year 1999, 25 hospitals ceased operation of their DPU as part of becoming a CAH, and beneficiaries in the affected communities have lost a local provider of these services. Any of the 93 potential CAHs with a DPU may also relinquish it to convert to CAH status if hospital officials conclude that shifting to CAHs' cost-based payment is the best way to maximize revenue and preserve the other services they offer. Among these 93 potential CAHs, 47 had net losses on Medicare services in fiscal year 1999, indicating they might benefit from CAH conversion.

Because it is generally difficult for rural hospitals to staff and maintain a DPU, it is unlikely that allowing CAHs to operate DPUs would result in many existing CAHs opening new DPUs, as long as the DPUs continue to be paid under PPS and TEFRA. If DPUs operated by CAHs were paid their reasonable costs, however, DPUs would have less financial incentive to operate efficiently. The experience of rural DPUs under the new rehabilitation PPS or the forthcoming psychiatric PPS may provide information about whether Medicare payments under these PPSs will be appropriate for rural DPUs.

If CAHs were allowed to operate DPUs, they would generally not be able to stay under the limits on bedsize, length of stay, and patient census if the DPU beds and patient stays were counted against current limits. Relaxing the limits for CAHs with DPUs or not counting the DPU beds or patient stays for purposes of determining whether the CAH meets the limits would enable some or all potential CAHs with DPUs to convert to CAH status.

Relaxing the CAH census limit to an annual average of 15 acute care patients rather than an absolute limit of 15 would accommodate the 129 potential CAHs that exceeded the current limit due to a seasonal increase as they all had an annual average census below 15. Such a change would provide CAHs greater flexibility in their management of patient census, just as the relaxation of the length of stay limit in 1999 to an annual average of 4 days provided CAHs greater flexibility in their management of patients' length of stay. CAHs would then not be required to transfer patients whenever they would otherwise exceed the limit, as long as they manage their census so that their annual average is below the limit. It

would not be necessary to increase the number of acute care beds CAHs are allowed to maintain in order to implement this relaxation of the patient census limit. More than three-quarters of existing CAHs and potential CAHs have swing beds which they could use to accommodate additional acute care patients beyond 15, since the limit is 25 beds for CAHs with acute and swing beds. Among the 129 potential CAHs, about 60 percent had net losses on Medicare services in fiscal year 1999, indicating they might benefit from CAH conversion, while the 40 percent with net gains would less likely have the financial incentive to convert.

Many potential CAHs that decide to seek CAH status would need to adjust their bedsize or length of stay to become CAHs, just as about 60 percent of existing CAHs needed to reduce their bedsize and 14 percent needed to reduce their length of stay in fiscal year 1999. CAH status and the cost-based reimbursement that goes with it have proven to be attractive enough that hospitals have been willing to make the necessary adjustments.

Matters for Congressional Consideration

We suggest that the Congress may wish to consider allowing hospitals with DPUs to convert to CAH status while making allowances for DPU beds, patients, and lengths-of-stay when determining CAH eligibility, and that CAH-affiliated DPUs be paid under the same formulas as other inpatient psychiatric or rehabilitation providers. We also suggest that the Congress may wish to consider changing the CAH limit on acute care patient census from an absolute limit of 15 acute care patients to an annual average of 15 to give CAHs greater flexibility in the management of their patient census.

Agency Comments and Our Evaluation

In commenting on a draft of this report, the Department of Health and Human Services said that these modifications to CAH eligibility criteria would provide the needed flexibility for some additional facilities to consider conversion to CAH status. It stated that the key is to provide the proper incentives for facilities to convert when they meet the statutory requirements and when it is the right thing to do for a particular community.

HHS suggested that we further emphasize several issues regarding CAH eligibility and payment. (See app. II for the full text of HHS's written comments.) HHS pointed out that it is important to consider that the financial incentives for efficiency under TEFRA payments to psychiatric DPUs or rehabilitation PPS payments to rehabilitation DPUs would not be preserved if CAHs were able to claim cost-based reimbursement for their

DPUs, and therefore HHS said such DPUs should continue to be paid separately from the CAH. The department also emphasized that CAHs are required to meet more limited health and safety standards compared to other acute care hospitals and raised concerns that any DPUs operated by CAHs would likewise be subject to more limited health and safety standards unless the Congress acted to maintain standards currently in place for DPUs. Furthermore, HHS suggested that we analyze the extent to which inpatient rehabilitation and psychiatric services are available to rural residents beyond their local hospitals in order to determine whether such services are more or less accessible to rural residents than other specialty services. The department expressed concern that non-CAH hospitals that are within close proximity to CAHs may perceive unfair treatment if such CAHs are allowed to operate DPUs. Finally, in commenting on the relaxation of the CAH acute care patient census limit to an annual average of 15, HHS proposed that we consider suggesting corresponding changes to the CAH bedsize limit.

As we noted in the draft report, incentives for efficiency that exist under the current payment systems for inpatient psychiatric and rehabilitation services would not be preserved under cost-based reimbursement. We revised the matters for congressional consideration to specifically suggest that CAH-affiliated DPUs be paid under the same formulas as other inpatient psychiatric or rehabilitation providers. We also agree with HHS that there are differences in conditions of participation between hospitals and CAHs and that appropriate health and safety standards should be maintained for CAH-affiliated DPUs, and we modified the report accordingly. However, determining what health and safety standards should be applied to the DPUs of CAHs was beyond the scope of this report. While we noted differences in the availability of inpatient rehabilitation and psychiatric services between rural and urban areas in the draft report, measuring in detail the level of access rural residents have to various specialty services was beyond the scope of this report. We believe that the close proximity of non-CAH hospitals to CAHs with DPUs would only present a fairness issue if such CAH-affiliated DPUs are paid cost-based reimbursement or if they are subject to less stringent regulations. If such DPUs operate under the same payment methodologies and regulations as other DPUs, this would not be an issue. A detailed examination of the levels of competition between CAH and non-CAH hospitals was beyond the scope of this report. We clarified in the report that we are not suggesting any changes to the CAH limits of 15 acute care beds or 25 total beds when swing beds are included, since most CAHs have swing beds that could be used when the acute care patient census

exceeds 15. HHS also provided technical comments, which we have incorporated as appropriate.

We are sending copies of this report to the Secretary of Health and Human Services and interested congressional committees. We will also make copies available to others upon request. In addition this report is available at no charge on the GAO Web site at http://www.gao.gov.

If you have any questions about this report, please call me at (202) 512-7119. Other major contributors are listed in appendix III.

A. Bruce Steinwald
Director, Health Care – Economic
and Payment Issues

List of Committees

The Honorable Charles E. Grassley, Jr.
Chairman
The Honorable Max Baucus
Ranking Minority Member
Committee on Finance
United States Senate

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

The Honorable W.J. "Billy" Tauzin
Chairman
The Honorable John D. Dingell
Ranking Minority Member
Committee on Energy and Commerce
House of Representatives

Appendix I: Scope and Methodology

To identify potential Critical Access Hospitals (CAHs), we selected rural, non-CAH hospitals with an annual average patient census of 15 or fewer acute care patients, based on patient census figures reported in fiscal year 1999 Medicare cost reports.[1] Any hospital that had converted to CAH status as of January 1, 2003 was excluded from the list of potential CAHs. We defined potential CAHs based on their annual average census, rather than by bedsize, because average census better represents the bed capacity a hospital would need to support its current demand for services. If potential CAHs have more beds than necessary to meet their patient demand, they can decertify beds in order to meet CAH eligibility criteria. Our inclusion of hospitals with an average census up to 15 is likely a high estimate of the number of potential CAHs. Hospitals with an annual average of 15 acute care patients per day may need more than 15 acute care beds to accommodate variations in their patient census that periodically cause them to exceed 15.

From the resulting list of 683 potential CAHs, we identified hospitals operating rehabilitation or psychiatric distinct part units (DPUs), as well as those with seasonal variation in patient census or length of stay that caused them to exceed CAH limits. For our analysis of seasonal variation in patient census, we used the volume of Medicare patients as a proxy for total patient volume because national data on day-to-day variation inpatient admissions were only available for Medicare patients. We calculated from hospital cost reports the Medicare share of each hospital's total acute care patient volume, and for each hospital multiplied the CAH limit of 15 acute care patients by its Medicare share in order to define a comparable limit based on Medicare patient stays. For example, if a hospital's Medicare share of patients was 67 percent in fiscal year 1999, then a Medicare census of about 10 acute care patients was considered to be equivalent to a total census of 15 acute care patients. Using Medicare inpatient claims data for 1999, we defined seasonal variation in daily census as having a period of 3 consecutive months with an average census greater than the estimated limit, with the remaining nine months' census averaging below the estimated limit. We identified 129 potential CAHs as having a seasonal increase that caused them to exceed the limit for a 3-month period, while staying under for the remaining 9 months. To estimate total patient census for these hospitals for each season, we multiplied their

[1]Medicare cost report data for fiscal year 1999 were used because they were the most current complete data available. There is typically a several year delay between the start of a fiscal year and the point at which a complete set of audited hospital cost report data are available for that year.

Medicare census by their ratio of total patients to Medicare patients. We defined seasonal variation in length of stay as having a period of 3 consecutive months with an average Medicare length of stay greater than 4 days with an average for the remaining 9 months of less than 4 days. In addition, we identified only those hospitals for which their seasonal increase in length of stay caused them to exceed the CAH limit of an average of 4 days.

Because we used Medicare utilization to estimate hospitals' total patient utilization for each season, the hospitals we identified as having seasonal variation that causes them to exceed CAH limits may not be precisely the same set of hospitals that would have been identified if claims data for all patients had been available. Rather, our analysis provides an estimate of the proportion of potential CAHs so affected. By broadly defining seasonal variation, we captured all the hospitals that have census or length of stay fluctuations around the CAH limits, regardless of the magnitude of the fluctuation.

We calculated Medicare margins and total facility margins using fiscal year 1999 Medicare hospital cost report data, using methods developed jointly by the Centers for Medicare & Medicare Services (CMS) Office of the Actuary and the Medicare Payment Advisory Commission. The reported median margins are hospital-weighted, meaning that each hospital counts equally in the calculation of the median, regardless of differences in hospital size or total revenues.

We interviewed officials at CMS, at the Federal Office of Rural Health Policy, and state staff administering Flex Program grants in 11 states (table 9). To get a comprehensive perspective of how current and potential CAHs are affected by CAH eligibility criteria, we also conducted an e-mail survey of all state CAH coordinators, and received e-mail responses or directly interviewed 42 out of 47. In addition, we interviewed researchers with the Rural Hospital Flexibility Tracking Project, an evaluation of the Flex Program funded by the FORHP. We interviewed administrators of 24 CAHs and potential CAHs across 10 states, and made site visits to 7 of these hospitals in 3 states. These 10 states were selected based on having significant CAH enrollment or potential enrollment, and representing different regions of the country.

Table 9: Summary of Site Visits and Interviews

State	Interviewed state staff administering Flex Program grants	Hospital site visit	Interviewed hospital administrators	Number of administrators of existing and potential CAHs interviewed
Alabama			X	1
Indiana	X	X	X	2
Iowa	X		X	2
Kansas	X		X	2
Mississippi	X	X	X	5
Montana	X		X	1
Nebraska	X			
North Carolina	X	X	X	2
South Dakota	X			
Texas	X		X	2
Vermont	X		X	1
Washington	X		X	6
Total	**11**	**3**	**10**	**24**

Source: GAO.

Appendix II: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

AUG 27 2003

Mr. A. Bruce Steinwald
Director, Health Care – Economic
and Payment Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Steinwald:

Enclosed are the Department's comments on your draft report entitled, "Medicare: Modest Eligibility Expansion for Critical Access Hospital Program Should Be Considered." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department also provided several technical comments directly to your staff.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,

George Grob for

Dara Corrigan
Acting Principal Deputy Inspector General

Enclosure

The Office of Inspector General (OIG) is transmitting the Department's response to this draft report in our capacity as the Department's designated focal point and coordinator for General Accounting Office reports. OIG has not conducted an independent assessment of these comments and therefore expresses no opinion on them.

Comments of the Department of Health and Human Services on the General Accounting Office's Draft Report, "Medicare: Modest Eligibility Expansion for Critical Access Hospital Program Should Be Considered" (GAO-03-948)

The Department of Health and Human Services (Department) appreciates the opportunity to review the General Accounting Office's (GAO) draft report entitled, Medicare: Modest Eligibility Expansion for Critical Access Hospital Program Should Be Considered. GAO suggests that Congress may wish to consider allowing hospitals with distinct part units (DPUs) to convert to critical access hospital (CAH) status. GAO also suggests that Congress may wish to consider changing the CAH limit on acute care patient census from an absolute limit of 15 patients to an annual average of 15 patients.

The Department commends GAO for conducting a thorough review of an issue that has raised concerns since the creation of the CAH designation in 1997. The report shows that GAO investigators understand the unique role played by CAHs in serving as key access points in isolated rural communities and the need to balance access to essential services with program integrity concerns for the Medicare program. The Department believes the DPUs should continue to be paid separately from the CAH, and therefore remain either under the rehabilitation prospective payment system (PPS) or the soon-to-be-implemented psychiatric hospital PPS.

The Department also agrees that the minor modifications recommended by GAO will provide needed flexibility for some additional facilities to consider conversion to CAH status. The key is to provide the proper incentives for facilities to convert when they meet the statutory requirements and when it is the right thing to do for a particular community.

General Comments

The Department has continued to monitor the appropriateness of current Medicare policy toward rural providers, including critical access hospitals (CAHs). Where appropriate, and when permitted by current law, the Department has implemented administrative changes to reduce provider burden and increase provider payments. For example, last year, we issued an instruction waiving a previous requirement that CAHs complete the Minimum Data Set (MDS) patient assessment for swing bed patients. We realized that the collected MDS data was not being used by the Department, and therefore acted to eliminate a costly administrative burden on rural providers. We appreciate your consideration of program improvements that would require a change in statute.

Throughout the report, CAHs are described as facilities that differ from other hospitals only in their payment method, bed size, and length of stay. The report does not mention that CAHs are a separate provider type from hospitals under the Medicare law, and have their own health and safety standards, known as conditions of participation (COPs). The CAHs, in keeping with their original status as small, limited service providers, are required to meet only the much more limited COPs. One possible statutory change not

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described in the report would be to link any change allowing CAHs to open specialty facilities with the adoption of more stringent rules to protect the health and safety of patients in such specialized facilities. This issue is described in more detail in the section on patient health and safety.

We are providing the following observations on the issues the report raises:

Impact of Cost Reimbursement for Specialty Units

The report recommends that Congress consider allowing CAHs to operate psychiatric and rehabilitation DPUs and seems to assume that these units would continue to be paid based on the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) payment policies and the inpatient rehabilitation facility (IRF) PPS. As the report notes, the TEFRA limits on payment to psychiatric units and the IRF PPS both include incentives for efficient operation. These incentives would not be preserved if CAHs were able to claim cost reimbursement for specialty units. This factor should be considered in deciding whether to allow cost reimbursement for specialty units of CAHs.

Current law permits CAHs which provide only acute services to inpatients to maintain no more than 15 acute beds, while CAHs with swing-bed agreements may have up to 25 beds, as long as no more than 15 are used at any one time for acute inpatient care. The GAO recommends changing the CAH acute care census limit from an absolute 15 patients to an annual average of 15 patients. The GAO may want to consider whether to recommend an appropriate adjustment to the bed count to accommodate an average of 15 patients.

Health and Safety of Patients

Throughout the report, CAHs are described as facilities that differ from other hospitals only in their payment method, bed size, and length of stay. The report does not mention that CAHs are a separate provider type from hospitals under the Medicare law, and have their own health and safety standards, known as conditions of participation (COPs).

Medicare hospitals, including those operating PPS-excluded units, are subject to COPs including patient rights and discharge planning, that can be especially important to psychiatric and rehabilitation patients. The CAHs, in keeping with their original status as small, limited service providers, are subject to the much more limited COPs. The PPS-excluded hospital units also have to meet specific exclusion requirements including requirements for psychiatric medical direction, medical direction of rehabilitation services, and provision of specialized psychiatric or rehabilitation nursing. These special staffing requirements do not apply to CAHs.

It has been documented that it is difficult for rural hospitals to find and maintain specialized staff to operate a DPU. We believe this difficulty would extend to DPUs in CAHs and would eventually affect patient safety. We suggest that the GAO consider

whether additional health and safety COPs be added to the existing CAH regulations to provide the same level of protection that exists for patients served in DPUs of hospitals.

If Congress wishes to allow CAHs to open specialty units, it may also want to consider removing the hospital/CAH distinction in connection with COPs, so that hospital COPs would apply to CAHs. Congress may also want to consider requiring that CAH specialty units meet the same exclusion criteria now applicable to PPS hospitals.

Availability of Specialty Care in Rural Areas

The report expresses concern that current CAH requirements may lead to closure of some PPS-excluded psychiatric or rehabilitation units, but does not indicate the extent to which such care might be available from other sources, including PPS-excluded hospitals and units in nearby communities. The GAO may want to consider investigating the volume of services provided by the DPUs and the distance to, or capacity of, the next closest facility providing these services. Residents of rural areas may also travel voluntarily to larger but more distant facilities to obtain psychiatric or rehabilitation services. Analysis of such factors would help determine whether psychiatric and rehabilitation care is more or less accessible to rural residents than other types of specialty care.

Competition with Full-Service Hospitals

Because of the extent to which States have given "necessary provider" status to CAHs, many CAHs are far closer to other hospitals than envisioned by the mileage limit in the CAH statute. Allowing CAHs to develop specialty units may result in rural hospitals that have not converted to CAH status claiming that CMS is creating an uneven playing field.

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Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

A. Bruce Steinwald, (202) 512-7119

Acknowledgments

Jean Chung, Chris DeMars, Michael Rose, Margaret Smith, and Kara Sokol made key contributions to this report.

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