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.

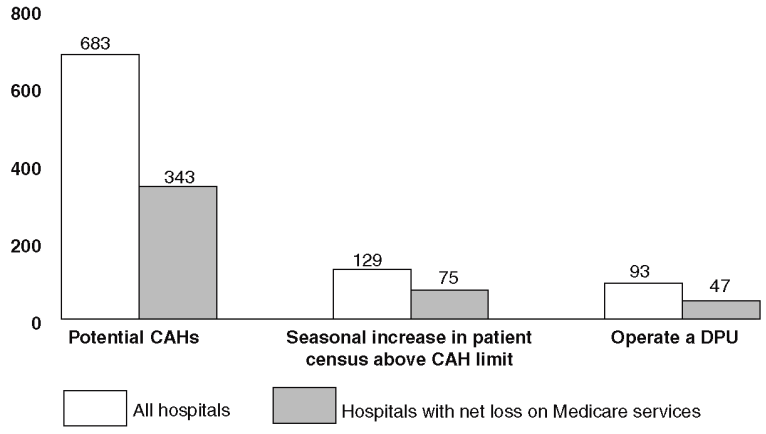
To view the full product, including the scope and methodology, click on the link above. For more information, contact A. Bruce Steinwald at (202) 512-7119.

## 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.