



GAO

Accountability • Integrity • Reliability

United States General Accounting Office
Washington, DC 20548

Health, Education, and
Human Services Division

B-285973

September 15, 2000

The Honorable William B. Thomas
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

Subject: Medicare Hospital Payment: PPS Includes Several Policies Intended to Help Rural Hospitals

Dear Mr. Chairman:

Since the inception of Medicare's prospective payment system (PPS) for inpatient hospital services in 1983, many special payment provisions have been enacted to adjust Medicare payments to rural hospitals. Despite these provisions, rural hospitals on average have not fared as well under PPS as have their urban counterparts. In 1998, an estimated 40 percent of rural hospitals incurred losses on their Medicare inpatient business. This has raised questions about existing policies for rural hospitals under PPS.

This letter responds to your request for information on the scope and efficacy of Medicare's existing rural hospital inpatient payment policies. Specifically, you asked us to inventory the major special payment provisions available to rural hospitals under PPS and to provide information on the inpatient financial performance of these hospitals under PPS.¹ For this work, we reviewed current and past federal regulations and Health Care Financing Administration (HCFA) program manuals and memorandums on Medicare payment rules. We also interviewed officials from HCFA and the Medicare Geographic Classification Review Board (MGCRB). We estimated the number of rural hospitals using HCFA's fiscal year 2000 PPS Impact File. We performed this work in accordance with generally accepted government auditing standards between June and August 2000.

¹We confined our analyses to payment policies for inpatient services under PPS. Hospitals may receive Medicare payments for other services, such as outpatient services, skilled nursing facility care, and home health care.

In brief, we found that Medicare has implemented a variety of inpatient payment policies that have the effect of increasing payments under PPS to certain rural hospitals. Two-thirds of rural hospitals obtain some sort of special status to modify their Medicare PPS payments. Rural hospitals with special designations generally have fared better than other rural hospitals, although as a group they have still experienced consistently poorer financial performance under Medicare's PPS than have urban hospitals. There is considerable variation in performance behind this average, and many rural hospitals operate at a loss in providing Medicare inpatient services.

BACKGROUND

Medicare's inpatient PPS provides a prospectively determined, per-case payment for all required hospital services associated with a Medicare beneficiary's hospital stay. Separate base payments, or standardized amounts, are established for large urban areas and all other areas.² In fiscal year 2000, the standardized amount for large urban areas is \$3,951.03 and the amount for other areas is \$3,888.46. The base payment is adjusted to reflect each admitted beneficiary's expected resource needs and the variation in local wage rates. Other hospital-specific payment adjustments account for the higher costs of facilities with teaching programs and compensate certain hospitals with a large share of low-income patients (termed the disproportionate share hospital, or DSH, adjustment).

Of the roughly 5,000 short-stay hospitals serving Medicare beneficiaries, more than 2,100 are in rural areas.³ Despite making up 40 percent of the industry, they account for only about 20 percent of inpatient discharges in 2000. Rural hospitals are generally small, with an average of 63 beds per facility, and operate with an average occupancy rate of only 35 percent. One-quarter of rural facilities have fewer than 30 beds, with an average daily census of six inpatients. These small rural hospitals generally depend heavily on Medicare revenues. By contrast, urban hospitals average 202 beds each, with an average occupancy rate of 50 percent.

Some hospitals in rural areas face particular circumstances that may make them vulnerable to financial difficulties. Their challenges include low patient volume, sparse infrastructure, and particular demographic characteristics among the populations they serve. Certain small rural hospitals may be the only hospital in their

²Before 1995, the Medicare inpatient hospital PPS incorporated separate standardized amounts for "large urban," "other urban," and rural areas. The Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, phased out the differential between "other urban" and rural hospital standardized payment amounts by fiscal year 1995, leaving two base payment rates.

³Medicare defines "rural" and "urban" under the Office of Management and Budget's (OMB) metropolitan-nonmetropolitan system. OMB defines metropolitan statistical areas (MSA) as cities with 50,000 or more inhabitants or urbanized areas with at least 50,000 inhabitants and a total MSA population of at least 100,000. Counties outside MSAs are regarded as rural. To account for the geographic variation in labor costs, Medicare's hospital payment rates are adjusted separately for each MSA and for each state's rural area, defined by the state's rural counties taken as a whole.

geographic area and are essential for inpatient and other health care services. Rural populations themselves tend to be different, being older, poorer, and less likely to be insured, on average, than inhabitants of urban areas.

MORE THAN HALF OF RURAL HOSPITALS ARE COVERED BY SPECIAL PAYMENT METHODS

Over the years, the Congress has established a number of PPS payment policies aimed at aiding facilities that serve beneficiaries in rural areas. As a result, 65 percent of rural hospitals benefit from some sort of special payment treatment in fiscal year 2000. In general, these policies provide relief to rural hospitals by allowing them to receive payments based at least in part on their actual costs in providing inpatient care to Medicare beneficiaries or by exempting them from some payment provisions altogether (see table 1). Generally, these special policies raise payments that these hospitals receive for providing care to the program's beneficiaries.

Table 1: Overview of Special Medicare Payment Policies for Rural Hospitals

Hospital designation	Created	Hospital type	Number of hospitals in 2000^a	Payment method^b
Sole community hospital (SCH)	1974 ^c	Urban or rural hospitals that are the sole source of care in their community.	747	Higher of the PPS payment rate or updated 1982 or 1987 hospital-specific rate. The Balanced Budget Refinement Act of 1999 (BBRA) added hospital-specific 1996 costs as a payment option.
Rural referral center (RRC)	1983	Larger, rural hospitals that serve a wide geographic area and provide broad array of services; operating characteristics and costs are similar to those of urban hospitals.	235	No special payment but qualify more easily for urban standardized payment amount and wage index and receive higher disproportionate share payment.
Essential access community hospital (EACH)	1989	Rural hospitals (or urban hospitals with similar service characteristics) that might otherwise close because of reduced volumes, low payment levels, and rising costs. EACHs were larger hospitals that provided medical backup services to smaller hospitals in a network. The Balanced Budget Act of 1997 (BBA) prohibited additional hospitals from being designated EACHs.	8	Higher of PPS payment rate or updated 1982 or 1987 hospital-specific rate.

Hospital designation	Created	Hospital type	Number of hospitals in 2000 ^a	Payment method ^b
Rural primary care hospital (RPCH)	1989	Same as EACH; RPCHs were very small, limited-service hospitals operating as part of a provider network. In 1997, the RPCH designation was subsumed by critical-access hospitals.	0	Cost-based reimbursement.
Medicare-dependent, small rural hospital (MDH)	1990	Small, rural, high-Medicare-volume hospitals explicitly defined as hospitals that do not qualify as SCHs.	360	In 1993 and earlier, the higher of PPS payment rate or updated 1982 or 1987 hospital-specific rate. In 1994 and later, the PPS payment rate plus half the difference between the PPS rate and 1982 or 1987 hospital-specific rate, if applicable.
Critical-access hospital (CAH)	1997	Very small rural hospitals (in general, no more than 15 beds) that are either isolated or an essential source of care in their areas; they must have an average length of stay of no more than 96 hours.	195	Cost-based reimbursement.

^aSome hospitals are in more than one category. A hospital can be both a rural referral center (RRC) and a sole community hospital or both an RRC and an essential access community hospital.

^bA hospital's PPS payment rate is made up of the base per-case payment rate, adjusted for the hospital's mix of cases and relative level of its workers' wages, and other special adjustments, if applicable. A hospital-specific rate is based on each hospital's costs in a particular year, updated to the present. Cost-based reimbursement pays hospitals the Medicare-allowed, reasonable costs of care they provide to beneficiaries.

^cThe SCH designation existed before Medicare's PPS was created. SCHs were exempted from the hospital cost limits in effect in 1974 under the Social Security Amendments, Pub. L. No. 92-603, sec. 223.

Source: GAO analysis of Federal Register notices, Code of Federal Regulations, and HCFA program manuals and memorandums.

Hospitals are determined to be eligible for the special policies, based on factors such as size and distance from similar hospitals or from urban areas. (See enclosures II-V for descriptions of these rural hospital payment categories.) Special designations benefit large rural hospitals—those that have more than 275 beds—that qualify as rural referral centers (RRC). A hospital that meets other criteria can qualify to be a Medicare-dependent, small rural hospital (MDH) if it has fewer than 100 beds or a critical-access hospital (CAH) if it has no more than 15 beds.⁴ In addition to qualifying for special designations on the basis of these criteria, hospitals that do not otherwise qualify can receive these designations by means of legislative action. Many hospitals have been grandfathered into sole community hospital (SCH) and RRC designations.

⁴A CAH may have up to 25 beds if it also provides skilled nursing care and the number of beds used for acute care inpatient services does not exceed 15.

It is not clear whether the criteria used to determine eligibility actually identify all, or only, facilities that were meant to be targeted. First, Medicare's definition of rural does not distinguish among the wide variety of rural areas, which range from suburban fringe districts to remote frontier locations in the West.⁵ Under this definition, hospitals on the suburban fringe of a large urban area can be categorized as rural, even though they may face the same labor costs as urban hospitals. Conversely, hospitals in a large county in southern California can be classified as urban, even if they are located in an area conventionally considered rural. As a result, some hospitals are classified as urban when they resemble rural facilities and vice versa. Other policy-specific criteria may also be problematic. For example, the MDH criterion that hospitals must have served a large share of Medicare beneficiaries in 1987 or 1988 may be unrelated to their current dependence on Medicare. Finally, the benefits of some special designations do not increase payments for the majority of hospitals so defined. In fiscal year 2000, about 65 percent of MDHs and SCHs will not benefit from their special payment provision because their PPS rates are higher than the special payment rate. However, they retain their designation to qualify for other payment adjustments.

A provision of PPS known as "geographic reclassification," which has increased Medicare payments for as many as 20 percent of rural hospitals, overlies these special designation policies (see enc. VI). Under this provision, hospitals in lower-cost areas (predominantly rural but including some urban areas) that are close to higher-cost areas can apply annually to be paid as if they were actually located in the higher-cost area. Hospitals may apply to be reclassified for the purpose of using another area's standardized amount, wage index, or both. In general, a hospital may be reclassified for the payment rate of another area if its wages and costs per case meet thresholds defined in the law and regulation. In fiscal year 2000, nearly 500 hospitals are reclassified under PPS (see table 2).

Table 2: Number of Reclassified Hospitals, Fiscal Years 1993-2000

Location	1993	1994	1995	1996	1997	1998	1999	2000
Urban	370	218	234	195	159	109	87	83
Rural	823	451	452	407	318	314	398	416
Total	1,193	669	686	602	477	423	485	499

Source: HCFA, PPS Impact File, fiscal years 1993-2000.

The payment adjustments under geographic reclassification are made within the context of budget neutrality—that is, the Medicare program can spend no more as a result of this policy than it would have spent in its absence. Therefore, increases in payments to reclassified hospitals are offset by reductions in payments to all other hospitals. The 416 rural hospitals that were reclassified in fiscal year 2000 received a relative increase in their payments of 6.5 percent and, as a result, the 1,725 rural hospitals that were not reclassified had their payments decreased by 0.4 percent.

⁵Medicare's definition of rural areas is in section 1886(d)(2)(D) of the Social Security Act.

Geographic reclassification relies heavily on Medicare's hospital wage index, which itself is the subject of two ongoing policy disputes. First, the metropolitan statistical area (MSA)–non-MSA dichotomy may not accurately differentiate hospital labor markets. All rural areas in a state are combined for payment purposes and the statewide rural area may not fully distinguish the variability in wages across some states. Second, the hospital wage index measures average wages in an area and therefore reflects both the costliness of labor and the skill mix of workers employed. Thus, hospitals with a relatively high-cost or low-cost mix of employees will be disadvantaged or advantaged, respectively, by the wage index adjustment.

Under the various special policies, a single hospital can qualify for multiple designations and can be considered urban for one provision and rural for another. For example, a hospital may qualify as both an RRC and an SCH and may benefit from both programs. Or, because reclassification allows hospitals to be simultaneously urban and rural for its separate provisions, an SCH may reclassify from rural to urban to have the urban wage index used to determine its payments and yet may still be considered a rural provider (see table 3). However, if it is reclassified to receive the urban standardized amount, it could lose its SCH designation. By contrast, RRCs can be reclassified to an urban area for both the wage index and standardized amount and still retain their RRC status, thereby being eligible to receive higher DSH payments and making it easier to be reclassified in future years.

Table 3: Status of Special Designation Hospitals Under Geographic Reclassification

Special designation	Retains special designation when hospital is reclassified for	
	Wage index	Standardized amount
RRC	Yes	Yes
MDH	Yes	No
SCH	Yes	Varies

Source: GAO analysis of Federal Register notices and interviews with HCFA officials.

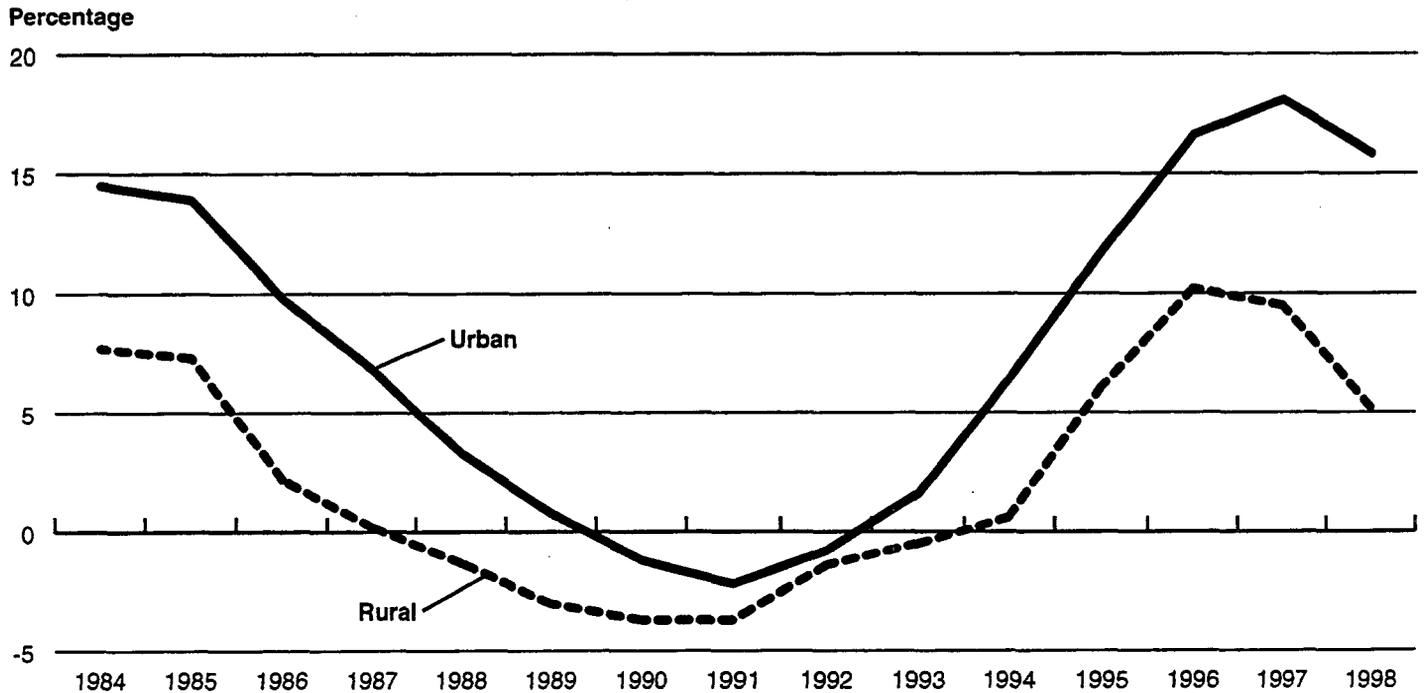
POSITIVE MEDICARE MARGINS FOR RURAL HOSPITALS ARE STILL LOWER THAN FOR URBAN HOSPITALS

Measured by Medicare inpatient margins—the relationship between a hospital's Medicare PPS payments and its reported Medicare-allowable costs—rural hospitals have demonstrated poorer financial performance under PPS than urban hospitals have (see fig. 1).⁶ In 1984, urban hospitals' PPS margins were 7 percentage points higher, on average, than were those for rural hospitals. After narrowing through 1992, the gap between rural and urban margins grew, and by 1998 it was 10 percentage points, reflecting slower cost growth among urban hospitals. In fiscal year

⁶The inpatient PPS margin is calculated as the difference between PPS payments and Medicare-allowed inpatient costs as a percentage of payments.

1998, the average rural margin was a little more than 5 percent, compared with an almost 16 percent margin for their urban counterparts (see table 4).

Figure 1: Medicare Inpatient PPS Margins, 1984-98



Note: The inpatient PPS margin is the difference between PPS payments and reported Medicare-allowed inpatient costs as a percentage of payments. Margins reflect Medicare operating and capital payments and costs and relevant adjustments and do not include separate direct graduate medical education payments made to teaching hospitals. The data for 1998 are preliminary and are based on data from 56 percent of all hospitals covered by PPS. The 1998 data have been weighted by teaching status to improve predictive accuracy.

Source: Medicare Payment Advisory Commission, Report to the Congress: Selected Medicare Issues (Washington D.C.: MedPAC, June 2000).

Table 4: Hospital Medicare Inpatient Margin by Hospital Group, 1995-98

Hospital group	1995	1996	1997	1998
All hospitals	11.1%	15.8%	17.0%	14.4%
Urban	11.8	16.6	18.1	15.8
Rural	6.1	10.2	9.5	5.2
RRC	5.8	10.2	10.3	6.1
SCH	8.6	12.2	10.3	5.7
MDH	6.7	9.2	10.3	3.2
Other rural				
Fewer than 50 beds	4.5	9.7	7.9	9.3
50 beds or more	4.6	8.7	7.8	2.6

Note: The inpatient PPS margin is the difference between PPS payments and reported Medicare-allowed inpatient costs as a percentage of payments. Margins reflect Medicare operating and capital payments and costs and relevant adjustments and do not include separate direct graduate medical education payments made to teaching hospitals. The data for 1998 are preliminary and are based on data from 56 percent of all hospitals covered by PPS. The 1998 data have been weighted by teaching status to improve predictive accuracy.

Source: Medicare Payment Advisory Commission, Report to the Congress: Selected Medicare Issues (Washington, D.C.: MedPAC, June 2000).

Financial performance under PPS varied considerably across rural hospital groups, with rural facilities in special categories generally outperforming facilities that have no special designation. However, these averages mask considerable variation within each rural hospital group (see table 5). About a third of RRCs, SCHs, and MDHs had negative Medicare inpatient margins in 1998. The 10 percent MDHs with the lowest margins exhibited poorer financial performance under PPS than the lowest 10 percent of rural hospitals overall and only slightly better performance than the bottom 10 percent of small rural hospitals with no special designation.

Table 5: Distribution of Hospital Medicare Inpatient Margins by Hospital Group, 1998

Hospital group	Percentile					Percent with negative margin
	10 th	25 th	50 th	75 th	90 th	
All hospitals	-14.4%	-2.1%	8.8%	19.3%	28.7%	28.9%
Urban	-7.4	1.8	11.8	21.3	30.7	20.6
Rural	-21.6	-7.0	4.3	16.3	25.7	39.4
RRC	-8.4	-3.8	4.3	11.6	23.2	31.7
SCH	-19.7	-6.1	6.1	18.7	28.2	36.6
MDH	-26.0	-6.7	6.6	19.3	26.7	35.2
Other rural						
Fewer than 50 beds	-29.4	-14.5	1.8	14.7	25.5	46.3
50 beds or more	-17.6	-7.2	1.9	14.2	21.7	43.2

Note: The inpatient PPS margin is the difference between PPS payments and reported Medicare-allowed inpatient costs as a percentage of payments. Margins reflect Medicare operating and capital payments and costs and relevant adjustments and do not include separate direct graduate medical education payments made to teaching hospitals. The data for 1998 are preliminary and are based on data from 56 percent of all hospitals covered by PPS. The 1998 data have been weighted by teaching status to improve predictive accuracy.

Source: Medicare Payment Advisory Commission, Report to the Congress: Selected Medicare Issues (Washington, D.C.: MedPAC, June 2000).

AGENCY COMMENTS

In commenting on a draft of this correspondence, HCFA said that, as we pointed out, a variety of Medicare PPS policies have the effect of increasing payments to certain rural hospitals. HCFA noted the challenges rural hospitals face in serving the medical needs of their beneficiaries and outlined the various initiatives under way to ensure that the unique needs of these providers are addressed.

HCFA also provided technical comments, which we have incorporated where appropriate. HCFA's comments appear in enclosure VII.

We are sending copies of this letter to the Honorable Ms. Min-DeParle, Administrator of HCFA, and others who are interested. We will also make copies available to others on request.

B-285973

Please call me at (202) 512-7114 or Carol Carter, Assistant Director, at (312) 220-7711 if you or your staff have any questions. Staff who made major contributions to this letter include Jean Chung, Christine DeMars, and James E. Mathews.

Sincerely yours,

A handwritten signature in cursive script that reads "Laura A. Dummit". The signature is written in black ink and is positioned above the printed name and title.

Laura A. Dummit
Associate Director, Health Financing
and Public Health Issues

Enclosures - 7

SCOPE AND METHODOLOGY

To document the historical development of Medicare's rural hospital payment policies, we reviewed relevant legislation and regulations, published notices of changes in policies, and program manuals and memorandums from the Health Care Financing Administration (HCFA). We also reviewed research conducted by the Office of Rural Health Policy within the Department of Health and Human Services (HHS), the Medicare Payment Advisory Commission (MedPAC), and rural research and advocacy organizations. We interviewed officials at HCFA and the Medicare Geographic Reclassification Review Board (MGCRB) to clarify points in the documentary evidence.

We used HCFA's prospective payment system (PPS) Impact File for fiscal year 2000 to estimate counts of each provider type and to develop other statistical information. We contacted HCFA staff to clarify any questions we had about these data.

MEDICARE PAYMENT FOR SOLE COMMUNITY HOSPITALS

The sole community hospital (SCH) designation is intended to ensure beneficiaries' access to hospitals that are essential providers of health care within a geographic area. It was first used in 1974 to exempt hospitals from the limits Medicare placed on payments for routine inpatient operating costs (Medicare-allowed costs exclusive of those associated with capital-interest depreciation and rent). Concern for beneficiary access and hospital services underlies the designation's continuation under PPS.

SCHs are generally small rural hospitals that are isolated by location, weather or travel conditions, or the absence of other hospitals. In fiscal year 2000, 747 hospitals have an SCH designation, and 57 of these hospitals are also rural referral centers (RRC). Medicare inpatient operating payments to SCHs for fiscal year 2000 are estimated at \$3.2 billion, or 34 percent of payments to rural hospitals.

QUALIFYING CRITERIA

Because hospitals can qualify as SCHs under various criteria, SCHs are not a homogeneous group. Rural and urban hospitals can qualify as SCHs if they are geographically isolated by more than 35 miles from other similar hospitals. Alternatively, rural hospitals qualify even if they are less than 35 miles from other like hospitals by meeting specific criteria related to treating the majority of patients in the area, weather and travel conditions, or prior SCH designation.

Before the implementation of PPS, HCFA's regional offices had discretion in designating hospitals SCHs. The absence of a clear standard led to substantial variation across regions. When the Congress established PPS in 1983, Medicare developed criteria to certify new SCHs, limiting SCH status only to rural hospitals while retaining all 259 rural and urban SCHs designated before PPS.⁷ The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) relaxed the eligibility requirements, allowing urban hospitals again to qualify for SCH designation.

PAYMENT

From the beginning of PPS until April 1, 1990, an SCH was paid a blended rate based on the applicable PPS payment rate and its historical costs. It could apply for an additional payment if it had had a significant increase in operating costs because of the addition of new inpatient facilities or services or a decrease in inpatient discharges because of circumstances beyond its control. Unlike other hospitals, SCHs were reimbursed for 100 percent of their Medicare-related capital costs.

⁷Because of this grandfather clause, some hospitals designated SCHs do not meet any of the current qualifying criteria.

Beginning in April 1990, SCHs have received payments that are the higher of (1) the PPS payment rate or (2) a rate based on their updated fiscal year 1982 or 1987 costs. The Balanced Budget Refinement Act of 1999 (BBRA) provided that for cost reporting periods beginning on or after October 1, 2000, an SCH can also choose to receive a transitional rate based on its fiscal year 1996 costs if it was paid on the basis of its historical costs during fiscal year 1999. An SCH may receive additional payments if, because of circumstances beyond its control, its total number of inpatient discharges decreases by more than 5 percent from one year to the next.⁸ SCHs, unlike other hospitals, are paid for their Medicare-related capital costs in their entirety. Further, SCHs, like RRCs, are eligible for higher disproportionate share (DSH) payments than other rural hospitals.

RECLASSIFICATION

SCHs receive special treatment under Medicare's geographic reclassification policies (see enc. VI). Like RRCs, SCHs are not required to meet the proximity criteria that apply to other hospitals for reclassification, meaning that they may be farther than 35 miles away from the metropolitan statistical area (MSA) or rural area to which they are seeking reclassification. Furthermore, some SCHs can retain their SCH status upon reclassification and are thus able to continue to benefit from their special payment rules.⁹

⁸Medicare's claims administration contractors for hospitals, called intermediaries, determine this lump-sum payment, which cannot exceed the difference between the SCH's Medicare inpatient costs and its Medicare inpatient revenue.

⁹All SCHs more than 35 miles from another hospital retain their status upon being reclassified. Those located less than 35 miles from another hospital lose their SCH status.

To qualify as an SCH, a hospital must

- *Be geographically isolated by more than 35 miles from other similar hospitals.*

Or

- *Be located in a rural area, be between 25 and 35 miles from other like hospitals, and meet one of the following criteria regarding market share, availability of specialty services, and accessibility:*
 - At least 75 percent of the residents or Medicare beneficiaries in the service area who are admitted as inpatients are admitted to the hospital rather than other like hospitals located within a 35-mile radius of the hospital or the hospital's service area (whichever area is larger).*
 - The hospital has fewer than 50 beds and does not meet the 75 percent market share criterion because patients sought specialty care outside the service area that the hospital was unable to provide.*
 - Because of local topography or severe weather conditions, the other like hospitals are inaccessible.*

Or

- *Be located in a rural area between 15 and 25 miles from other similar hospitals but the other hospitals are inaccessible because of local topography or periods of prolonged severe weather conditions.*

Or

- *Be located in a rural area and be at least 45 minutes' travel time from the nearest hospital because of distance, posted speed limits, and predictable weather conditions.*

Or

- *Have been an SCH before PPS was implemented and the circumstances under which the hospital received SCH status have not changed.*

MEDICARE PAYMENT FOR RURAL REFERRAL CENTERS

In the original 1983 PPS legislation, the Secretary of HHS was authorized to make adjustments to PPS payments to take into account the special needs of RRCs. RRCs are relatively large rural hospitals that provide a broad array of services and treat patients from a wide geographic area. These hospitals serve as referral sites for rural physicians and community hospitals that may lack the resources or expertise to handle more complicated cases. There are 235 RRCs with Medicare inpatient operating payments estimated to be \$3.6 billion (39 percent of Medicare payments to rural hospitals) for fiscal year 2000.¹⁰

QUALIFYING CRITERIA

Under the original legislation, RRCs had to be either large hospitals or primary providers of care in their area. Later, criteria were added to qualify hospitals whose operating costs and characteristics resembled their urban counterparts. Over time, the Congress has liberalized these criteria so that more hospitals can qualify for RRC designation.¹¹ Additionally, as a result of provisions contained in the Balanced Budget Act of 1997 (BBA), HCFA has reinstated as an RRC any rural hospital that ever had, but lost, its RRC status.¹²

Beyond the basic requirement of being located in a rural area, there are three ways a hospital may qualify as an RRC. First, the hospital may qualify by having at least 275 beds. Second, a rural hospital that does not meet the bed-size criterion can demonstrate that it is a primary provider of care in the area. Third, a hospital may meet criteria that, in general, show that its mix of cases and volume of discharges are similar to the urban hospitals in its census region and either that it is a primary source of care or that it offers a full range of services.

RRC PAYMENT

Originally, RRC payments were based on the other urban rather than the rural standardized payment amount. In fiscal year 1995, RRCs lost some of the benefit of their status when the other urban and rural standardized amounts were consolidated. However, RRCs still receive special treatment under the DSH payment adjustment. An RRC that qualifies for DSH payment receives higher DSH payments than other rural hospitals.

¹⁰Fifty-seven of these hospitals are also SCHs, and 3 are also essential access community hospitals.

¹¹The criteria that were relaxed were those related to a hospital's minimum bed size and minimum volume of discharges

¹²As a result of a BBRA provision, former RRCs in urban areas will be reinstated as such on October 1, 2000.

RECLASSIFICATION

Relaxed geographic reclassification criteria make reclassification easier for RRCs than for other hospitals (see enc. VI).¹³ Before BBA, any hospital that was reclassified to an urban area for purposes of the standardized amount lost its RRC status. However, because provisions in BBA and BBRA will result in reinstating all RRCs that had lost their status, all reclassified RRCs will be redesignated as such and continue to benefit from this designation in subsequent years.

To be an RRC, a hospital must be rural and

- *Have at least 275 beds.*

Or

- *Have at least half of its Medicare patients referred from other hospitals or from physicians not on the hospital's staff and have at least 60 percent of its Medicare patients and 60 percent of its Medicare services delivered to patients residing more than 25 miles from the hospital.*

Or

- *Meet the following criteria:*

—Have a case-mix index that is equal to either the median case-mix index for urban hospitals in its census region or all urban hospitals nationally and

—Have at least 5,000 discharges a year or, if fewer, the median number of discharges in urban hospitals in its census region and

—One of the following must be true:

—At least 40 percent of its inpatients are referred from other hospitals or physicians not on the hospital's staff or

—At least 60 percent of its discharges are beneficiaries who reside more than 25 miles from the hospital or

—More than half of its medical staff are specialists.

Or

- *Qualify under a grandfathering provision.*

¹³RRCs are not subject to the proximity requirement, meaning that they may be more than 35 miles from the MSA or rural area to which they are seeking reclassification. Additionally, to be reclassified for the wage index, an RRC need be only more similar to the hospitals in the area to which it is seeking reclassification. It is not compared with hospitals in its actual geographic location.

MEDICARE PAYMENT FOR ESSENTIAL ACCESS COMMUNITY HOSPITALS,
RURAL PRIMARY CARE HOSPITALS, AND
CRITICAL-ACCESS HOSPITALS

EACHS AND RPCHS

The program for essential access community hospitals (EACH) and rural primary care hospitals (RPCH) was created by OBRA 89 to target hospitals that could not meet the RRC minimum volume requirements or that had fixed costs that were not adequately covered by SCH payment provisions.¹⁴ The purpose of the program was to allow rural hospitals (or urban hospitals with similar service area characteristics) that might otherwise close because of reduced volumes, low payments, or rising costs to operate on a reduced scale.

By statute, the EACH-RPCH program was limited to seven states that received grants to develop rural health networks consisting of EACHs and RPCHs.¹⁵ EACHs were larger facilities that provided medical backup services to designated RPCHs in the network. RPCHs were limited-service rural hospitals that provided emergency outpatient and inpatient hospital care.

THE MEDICARE RURAL HOSPITAL
FLEXIBILITY PROGRAM AND
CRITICAL ACCESS HOSPITALS

BBA built on the experience of the EACH-RPCH program and replaced it with the Medicare Rural Hospital Flexibility Program (MRHFP). MRHFP differs from EACH-RPCH in that it is a national program. Through MRHFP, states establish rural health networks that consist of at least one critical-access hospital (CAH) and at least one full-service hospital. The goals of MRHFP are to maintain the health care infrastructure in small rural communities by preserving access to existing primary care services and to enable hospitals to provide limited acute care (especially emergency care) services to rural Medicare beneficiaries.

QUALIFYING CRITERIA

BBA eliminated the EACH category but allowed existing EACHs to retain this designation. In fiscal year 2000, eight hospitals continue to be paid under Medicare's EACH designation.¹⁶ To be designated an EACH, a hospital must have had medical backup service and transfer agreements with RPCHs in its network. Furthermore, in

¹⁴Although the program was created in 1989, HCFA did not publish the final rules until May 1993.

¹⁵These states were California, Colorado, Kansas, New York, North Carolina, South Dakota, and West Virginia.

¹⁶Three of these hospitals are also RRCs.

general, it must have had at least 75 beds and must have been located more than 35 miles from another EACH, RRC, or hospital with more than 75 beds. To be designated an RPCH, a hospital could not have had more than six inpatient beds and had to have maintained an average inpatient length of stay of 72 hours or less.

BBA also repealed the RPCH classification and allowed RPCHs to be considered CAHs if they met the CAH eligibility criteria. To be designated a CAH, a hospital must be geographically isolated or certified as a necessary provider of health care services and must be located in a state that has an MRHFP. In general, CAHs can have no more than 15 beds and the annual average patient stay cannot exceed 96 hours.¹⁷ There are currently 195 CAHs—51 were formerly part of the EACH-RPCH program, and 144 are newly designated facilities. Medicare payments to CAHs totaled \$772 million in fiscal year 1997.¹⁸

PAYMENT

EACHs are considered SCHs for payment purposes and are paid the higher of their PPS payment rate or a rate based on the hospital's updated fiscal year 1982 or 1987 costs. Like RPCHs before them, CAHs are paid their actual Medicare-allowable reasonable costs of providing inpatient services.

RECLASSIFICATION

A rural EACH that is reclassified to an urban area for purposes of the standardized amount loses its status as a rural EACH and, consequently, loses its special payment provision (see enc. VI). There is no special payment benefit for urban EACHs. Geographic reclassification does not apply to RPCHs and CAHs, since they are not paid on the basis of the PPS.

To qualify as a CAH, a hospital must

- *Be geographically isolated or certified as a necessary provider of health care services,*
- *Be located in a state that has an MRHFP,*
- *Have no more than 15 beds or no more than 25 beds if it also provides skilled nursing facility-level care, and*
- *Have an annual average patient length of stay of no more than 96 hours.*

¹⁷Hospitals with beds that are used interchangeably for acute care and skilled nursing facility-level care can have up to 25 beds, provided that no more than 15 beds are used at any one time for acute care.

¹⁸This amount excludes expenditure data for 10 CAHs for which data were not available.

PAYMENT POLICY FOR MEDICARE-DEPENDENT HOSPITALS

Since 1990, Medicare has given special payment protection to small rural hospitals that were a major source of care for Medicare beneficiaries. The purpose of providing special payment to these Medicare-dependent, small rural hospitals (MDH) was to maintain beneficiaries' access to hospital services.

The original MDH legislation limited this special hospital designation from April 1990 through March 1993. However, legislation has extended the program three times.¹⁹ There are 360 MDHs with Medicare inpatient operating payments estimated to be \$703 million for fiscal year 2000 (8 percent of total Medicare payments to rural hospitals) for fiscal year 2000.

QUALIFYING CRITERIA

To qualify as an MDH, a hospital must have fewer than 100 beds, must be rural, and must have served a high proportion of Medicare patients during fiscal year 1987 or 1988. Additionally, SCHs cannot be MDHs. Hospitals do not have to apply for this payment adjustment; if they qualify, they are automatically designated.

PAYMENT

Until 1993, MDHs were paid the higher of their PPS payment rate or an amount based on their updated fiscal year 1982 or 1987 average cost per case. In 1994, the payment methodology became less advantageous to MDHs. They are now paid the PPS payment rate plus half of the difference, if any, between their updated 1982 or 1987 costs and the PPS payment rate.

MDHs are also entitled to an additional payment adjustment if, because of circumstances beyond their control, their total number of inpatient discharges decreases by more than 5 percent from one year to the next. Medicare's claims administration contractors for hospitals, called intermediaries, determine this lump-sum payment, which cannot exceed the difference between the MDH's Medicare inpatient costs and its total Medicare inpatient revenue.

RECLASSIFICATION

MDHs that are reclassified to an urban area for purposes of their standardized amount lose their MDH status (see enc. VI). A HCFA official told us, however, that few MDHs seek reclassification because the financial benefits of being an MDH outweigh those of reclassification.

¹⁹First, the Omnibus Budget Reconciliation Act of 1993 extended the designation through September 1994; after a 3-year break, BBA reinstated the MDH designation from October 1997 through September 2001; and, most recently, BBRA continued the MDH designation through fiscal year 2006.

To qualify as an MDH, a hospital must

- *Be rural,*
- *Have fewer than 100 beds,*
- *Have had at least 60 percent of its inpatient days attributable to Medicare beneficiaries in fiscal year 1987 or 1988, and*
- *Not be an SCH.*

GEOGRAPHIC RECLASSIFICATION POLICIES UNDER MEDICARE'S
PROSPECTIVE PAYMENT SYSTEM

Since the beginning of PPS, a hospital's payment has been determined by its geographic location. Not only are there separate standardized amounts for large urban areas and other areas but the base payment amount is also adjusted for variations in labor costs across different locations. However, sometimes a hospital's costs of providing services are more similar to those of hospitals in other areas than its own, particularly where a rural county borders an urban area. To address these situations, OBRA 89 established a way for hospitals that are significantly disadvantaged by their actual geographic location to be reclassified for payment to an area that more closely represents the market in which they compete. In most cases, hospitals are reclassified from a rural area to an urban area or from one urban area to a larger one.

Hospitals apply annually to be reclassified for the purpose of the standardized amount, the wage index, or both. MGCRB, established by OBRA 89, evaluates hospitals' applications for reclassification to different geographic areas, using objective criteria HCFA developed. These criteria have been relatively stable over time. Individual hospitals may apply for reclassification, or all the hospitals in a county may apply as a group to be reclassified for both the standardized amount and the wage index. Some hospitals have been reclassified through legislative provisions.

RECLASSIFICATION CRITERIA

For an individual hospital to be reclassified for a different wage index or standardized amount, it must demonstrate a close proximity to the area to which it seeks reassignment. This means that it is no more than 15 miles from this area if it is an urban hospital or that it is no more than 35 miles if it is a rural hospital. Alternatively, at least 50 percent of the hospital's employees must reside in the area to which it seeks to reclassify.

Generally, after meeting the proximity criterion, a hospital may be reclassified if it can demonstrate that its costs are comparable with those of the hospitals in that area. For purposes of the wage index, (1) the hospital must seek reassignment to an area with a higher wage index, and (2) the hospital's average hourly wage must be significantly more than the average hourly wage in its actual geographic area and be reasonably similar to the area's average hourly wage to which it is reclassified. To qualify for another area's standardized amount, a hospital must demonstrate that its cost per discharge is greater than its current payment rate.

Under group reclassification, individual hospitals are able to bypass some of the specific criteria under individual requests. For example, the proximity requirement does not apply. Therefore, a rural hospital more than 35 miles from the target area can qualify if its county is adjacent to the urban area to which it seeks reclassification. Further, cost and wage data are aggregated among the hospitals in the group so that not every hospital

has to meet the hourly wage criteria (in the case of the wage index) or have high costs (in the case of the standardized amount).

THE EFFECT OF RECLASSIFICATION ON DSH PAYMENTS

Following consolidation of the rural and the other urban standardized amount, HCFA did not allow hospitals to be reclassified to areas with the same standardized amount. Some rural hospitals had sought these reclassifications because, despite getting the same standardized amount, it was easier to meet the criteria applied to urban hospitals to receive DSH payments. BBA changed this policy to allow rural hospitals to be reclassified to another area with the same standardized amount to qualify for higher DSH payments.²⁰

THE EFFECT OF RECLASSIFICATION ON SPECIAL RURAL HOSPITAL DESIGNATIONS

While all hospitals can apply for reclassification, some special types of hospitals receive preferential consideration before MGCRB. RRCs and SCHs are able to benefit from a "special access rule" that does not require a hospital to be within the reclassification proximity perimeter. RRCs are further protected in that they do not lose their RRC designation upon reclassification and they are exempt from criteria comparing them to the hospitals in their actual geographic location. Similarly, some relatively isolated rural and all urban SCHs that apply for reclassification for their standardized amount are able to retain their special status upon reclassification and will continue to receive payment as an SCH.²¹ However, other rural SCHs relatively close to other hospitals and all MDHs that reclassify for the standardized amount lose their designations that entitle them to these special payment provisions.

EFFECT ON PAYMENT

HCFA estimated that in fiscal year 2000, 416 rural and 83 urban hospitals would be reclassified and would receive higher payments as a result of adjustments to the wage index, the standardized amount, or both. As a whole, rural hospitals tend to benefit more than urban hospitals from geographic reclassification. Because these higher payments must be "budget neutral," payments to all other, nonreclassified hospitals are lowered to fund this increased spending.

²⁰This provision expired 30 months after BBA was implemented; there are no plans to extend it.

²¹SCHs 35 miles or further away from another hospital retain their SCH status.

For an individual hospital to be reclassified for its standardized amount, it must meet the

- **Proximity criteria**
 - An urban hospital can be no more than 15 miles, and a rural hospital no more than 35 miles, from the area to which it seeks to be reclassified or
 - At least 50 percent of its employees reside in the target area

And

- **Standardized amount criteria**
 - Its case-mix adjusted cost per discharge must be equal to or greater than the current PPS payment rate plus 75 percent of the difference between the reclassified payment rate and its original payment rate.

For an individual hospital to be reclassified for its wage index, it must meet the

- **Proximity criteria**
 - An urban hospital can be no more than 15 miles, and a rural hospital no more than 35 miles, from the area to which it seeks reclassification or
 - At least 50 percent of its employees reside in the target area

And

- **Wage index criteria**
 - An urban hospital's average hourly wage must be at least 108 percent of the average hourly wage of its home area and at least 84 percent of the area to which it seeks reclassification.
 - A rural hospital's average hourly wage must be at least 106 percent of the average hourly wage of its home area and at least 82 percent of the area to which it seeks reclassification.

For a group to be reclassified for its standardized amount and wage index, it must meet the

- **Adjacency criteria**
 - The county must be adjacent to the target MSA and
 - An urban county must be located in the same consolidated MSA (CMSA) as the target MSA

And

- **Standardized amount criteria**
 - In the aggregate, the group's case-mix adjusted cost per discharge must be equal to or greater than the current PPS payment rate plus 75 percent of the difference between the reclassified payment rate and its payment rate if it was not reclassified

And

- **Wage index criteria**
 - The average hourly wage, in the aggregate, must be at least 85 percent of target area.

COMMENTS FROM HCFA

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

AUG 29 2000

Office of the Administrator
Washington, D.C. 20201

TO: Laura A. Dummit
Associate Director
General Accounting Office (GAO)

FROM: Nancy-Ann Min DeParle *Nancy-Ann DeParle*
Administrator

SUBJECT: GAO Draft Report: "Medicare Hospital Payment: PPS Includes Several Policies Intended to Help Rural Hospitals" (GAO/HEHS-00-174R)

Thank you for the opportunity to review and comment on this draft report concerning special payment provisions that affect rural hospitals and their financial performance under the hospital Inpatient Prospective Payment System (PPS).

We agree with your finding that there are a variety of Medicare PPS policies that have the affect of increasing payments to certain rural hospitals. Assuring and enhancing access to quality care for rural beneficiaries, while acting as a responsible steward of the Medicare Trust Fund, is a priority for the Health Care Financing Administration (HCFA). About one in four Medicare beneficiaries lives in rural America, and we understand that rural providers face unique challenges in serving the medical needs of their beneficiaries. That is why we have taken a number of steps to help rural providers, including rural hospitals. These facilities tend to be smaller, have difficulty attracting and keeping health care professionals, and are more revenue dependent on Medicare patients than their non-rural counterparts. Yet many rural hospitals have higher average costs than their urban counterparts.

Although there have been several recent legislative changes to help support rural hospitals, the Administration continues to take administrative steps to ensure that the unique needs of these providers are addressed. In addition to administrative actions, the President, as part of the Mid-Session Budget proposal, has proposed a reserve for specific provisions to help rural hospitals, which total \$500 million over five years and \$1 billion over 10 years.

As part of our commitment to ensuring rural beneficiaries' continued access to quality care, we launched an aggressive monitoring effort on the effect of recent legislative on rural health care providers. For example, we have created a Rural Health Initiative within our agency to increase, and better coordinate, attention to rural issues. As part of this effort, we are continuing to closely monitor how laws and regulations governing our programs affect rural beneficiaries and providers. Also, we have enhanced our relationship with our colleagues at the Small Business Administration to ensure we consider the special needs of small health care providers in all of our programs, policies, and guidance.

We will continue to closely monitor how laws and regulations governing our programs affect rural beneficiaries and providers. We look forward to working with GAO on this and other issues.

Attachment

**Response of the Health Care Financing Administration to
GAO Draft Report: "Medicare Hospital Payment: PPS Includes
Several Policies Intended to Help Rural Hospitals"**

The Health Care Financing Administration has long recognized the special needs of rural providers. In fact, recent bi-partisan legislation has had the affect of increasing payments to rural hospitals.

**Summary of Recent Legislation and the Impact on Rural Hospitals --
Balanced Budget Act**

The bipartisan Balanced Budget Act of 1997 (BBA) created the Critical Access Hospital (CAH) program. Under this program, facilities are reimbursed based on what they spend for each patient, rather than on the average expected cost for specific diagnoses that most hospitals are paid. To qualify, the facility must have no more than 15 acute beds, offer 24 hour emergency care, and are generally located more than 35 miles from any other hospital.

The BBA also built upon other special provisions for rural providers. It:

- Reinstated the Medicare Dependent, Small Rural Hospital (MDH) designation, which had expired in 1994. These facilities have fewer than 100 beds, do not serve as a Sole Community Hospital (SCH), and Medicare patients accounted for at least 60 percent of inpatient days or discharges during 1987. They can be paid higher rates based on their own previous costs or the Federal prospective payment rate.
- Permanently grandfathered rural referral centers. These facilities have 275 or more beds, serve beneficiaries living more than 25 miles away or referred by other hospitals, or have specialists as more than half of staff physicians. They receive higher payment to assist in caring for low-income patients and can more easily qualify for higher payments based on nearby urban wage rates.
- Allowed more rural hospitals to obtain special disproportionate share hospital (DSH) payments that are available to hospitals serving large numbers of low-income patients.
- Authorized payment for telemedicine, in which medical consultations are conducted via an interactive telecommunication system, for beneficiaries residing in rural areas that have a shortage of health care professionals.

The BBA also included payment reforms for several types of providers that directly impact rural hospitals. For example, it modified inpatient hospital payment rules. It also mandated development and implementation of prospective payment systems for skilled nursing facilities, home health agencies, outpatient hospital care, and rehabilitation hospitals to encourage facilities to provide care that is both efficient and appropriate.

**Summary of Recent Legislation and the Impact on Rural Hospitals --
Balanced Budget Refinement Act**

Working together, Congress and the Administration last year enacted the Balanced Budget Refinement Act of 1999 (BBRA), which further enhanced these special payments for rural

Page 2 -- Response to Ms. Dummit

providers. Some of the important changes related to CAHs. The law included several provisions to assist CAHs, such as:

- Applying the 96-hour length of stay limit on an average annual basis;
- Permitting for-profit hospitals to qualify for CAH designation;
- Allowing hospitals that closed or downsized since 1989 to be CAHs;
- Permitting CAHs to streamline their billing processes by combining physician and hospital charges; and,
- Eliminating beneficiary coinsurance for clinical laboratory tests furnished by a CAH.

The BBRA also:

- Extended the MDH program for 5 years.
- Holds harmless small rural hospitals (with 100 beds or less) for 4 years during the transition to the new prospective payment system for hospital outpatient care, and provides separate, budget-neutral payments for high-cost patients and certain drugs, devices, and biologicals for all hospitals, which will especially help hospitals that would otherwise have had to spread these costs across a small case load.
- Raised the cap on medical residents by 30 percent in rural areas.
- Included incentives to encourage urban physician education programs to establish separate training programs in rural areas.

Finally, the BBRA also strengthened the SCH provisions. The law included a one-year payment increase by providing an update of the full market basket. To qualify for this program, these facilities serve as the sole source of inpatient care in a community, either because they are geographically isolated, or because severe weather conditions or local topography prevents travel to another hospital. Under the more general program, they can be paid higher rates based on their own previous costs or the Federal prospective payment rate.

The Administration is Continuing to Support Rural Hospitals

The Administration knows that more must be done to support rural providers. That is why we continue to take steps to address the unique needs of rural hospitals through administrative actions and proposed legislative activity.

HCFA Continues to Take Administrative Steps to Ensure Appropriate Payment to Rural Hospitals

We have taken a number of administrative steps to further assist rural providers. For example, we have made it easier for rural hospitals, whose payments are now based on lower, rural area average wages, to be reclassified and receive payments based on higher average wages in nearby urban areas. This allows them to apply for all the special rural designations described above and the higher payments these designations confer.

We are helping rural hospitals adjust to the new outpatient prospective payment system by using the same wage index for determining a facility's outpatient rates that is used to calculate inpatient

Page 3 -- Response to Ms. Dummit

rates. We are postponing the expansion of the BBA "transfer policy" for 2 years which limits hospital payments when patients with certain diagnoses are discharged early to a postacute care setting, and considering whether further postponement is warranted. We also are working with colleagues at the General Accounting Office and Medicare Payment Advisory Commission to review the impact and appropriateness of the wage index that is used to factor local health care wages into Medicare payment rates and generally results in lower payments to rural hospitals than to their urban counterparts.

HCFA is Listening to Concerns Expressed by Rural Providers

To better understand and actively address the special circumstances of rural providers and beneficiaries, we launched a new Rural Health Initiative. We are meeting with rural providers, visiting rural facilities, reviewing the impact of our regulations on rural health care providers, and conducting more research on rural health care issues. We are participating in regularly scheduled meetings with the Health Resources and Services Administration's Office of Rural Health Policy to make sure that we stay abreast of emerging rural issues. And we are working directly with the National Rural Health Association to evaluate rural access to care and the impact of recent policy changes.

Our goal is to engage in more dialogue with rural providers and ensure that we are considering all possible ways of making sure rural beneficiaries get the care they need. We are looking at best practices and areas where research and demonstration projects are warranted. We want to hear from those who are providing services to rural beneficiaries about what steps we can take to ensure they get the care they need.

We have put together a team for this rural initiative that includes senior staff in our Central and Regional Offices and dedicated personnel around the country. Each of our ten regional offices has a staff person dedicated to rural issues. Providers can call this person directly to raise and discuss issues, ideas, and concerns. We are confident that this initiative will ensure that Medicare policies are attuned to the needs of rural health providers and beneficiaries.

HCFA is Working to Appropriately Expand Use of Telemedicine

We are proceeding with projects to evaluate Medicare coverage for telemedicine. We recently completed a comprehensive, \$230,000 technology assessment of telemedicine, in conjunction with the Agency for Healthcare Research and Quality, under contract with the Oregon Health Sciences University. This study involved an assessment of the clinical and scientific literature dealing with the cost-effectiveness of telemedicine, specifically looking into the areas of "store and forward" technologies, patient self-testing and monitoring, and potential telemedicine applications for non-surgical medical services. We are also testing expanded coverage for telemedicine. On February 28, 2000, we awarded a \$28 million cooperative agreement to Columbia University for the Informatics, Telemedicine, and Education Demonstration Project, as required by the BBA. This randomized, controlled study will explore how teleconsultations between physicians in New York City and rural, upstate New York affect diabetic patient care

Page 4 -- Response to Ms. Dummit

and program costs. The results of these studies will help inform future decisions on the expansion of telemedicine beyond the current payment regulations.

New Budget Proposals Would Strengthen Beneficiary Access to Care in Rural Areas

The President's Mid-Session Budget proposal includes a reserve for specific provisions to help rural hospitals, which total \$500 million over 5 years and \$1 billion over 10 years. This money would be used for policies to improve the sustainability of rural hospitals, similar to those in the bipartisan "Health Care Access and Rural Equality Act of 2000 (H-CARE)." H-CARE, for example, would accomplish several objectives supported by the Administration, such as:

- Provide payment increases that are fully adjusted for inflation to all rural hospitals with 100 beds or less;
- Make the MDH program permanent and make it easier for hospitals to qualify by letting them use any of the three most recent audited cost reporting periods rather than their 1987 cost reporting period as mandated under current law;
- Pay CAHs for clinical diagnostic services based on reasonable costs and without the beneficiary copayment;
- Extend payment flexibility for SCHs; and
- Provide grants for upgrading data systems.

We also would consider improving equity for rural hospitals in the Medicare DSH formula, which provides additional funding for facilities that serve large numbers of low-income patients.

In addition, the Mid-Session Budget proposal would provide assistance for all hospitals totaling \$10 billion over 10 years, as well as \$2 billion over 10 years for skilled nursing facilities and \$3 billion over 10 years for home health agencies. All of these provisions will result in increased payments to rural hospitals and other rural providers. Including the reserve for rural hospital policies, the proposal includes a reserve fund of \$21 billion over 10 years for developing future policies.

(201078)

Viewing GAO Reports on the Internet

For information on how to access GAO reports on the INTERNET, send 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

Reporting Fraud, Waste, and Abuse in Federal Programs

To contact GAO FraudNET use:

Web site: **http://www.gao.gov/fraudnet/fraudnet.htm**

E-Mail: **fraudnet@gao.gov**

Telephone: **1-800-424-5454 (automated answering system)**

**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
