



June 2023

CRITICAL ACCESS HOSPITALS

Views on How
Medicare Payment
and Other Factors
Affect Behavioral
Health Services

GAO Highlights

Highlights of [GAO-23-105950](#), a report to congressional committees

Why GAO Did This Study

As of March 2023, there were 1,365 CAHs nationwide, according to officials from the Centers for Medicare & Medicaid Services. Medicare FFS pays CAHs based on their costs for most services, which may be greater than predetermined fixed amounts that other hospitals are paid. However, services provided in psychiatric units are not paid based on costs and are instead paid through Medicare's prospective payment system. This has led to questions about whether Medicare payment policies make it difficult for CAHs to meet Medicare beneficiaries' behavioral health needs.

House Report 116-450 includes a provision for GAO to review the behavioral health services provided by CAHs. This report describes (1) how selected CAHs provide behavioral health services and (2) selected CAHs' and stakeholders' views on how Medicare FFS payment policies and other factors affect CAHs' ability to provide these services.

GAO interviewed officials from 10 CAHs selected to reflect variation in geography and the settings in which they offer behavioral health services. GAO also interviewed stakeholders from six organizations that advocate for, or conduct research on, CAHs or rural hospitals, as well as officials from the Centers for Medicare & Medicaid Services. In addition, GAO reviewed federal laws, regulations, and agency policy documents.

View [GAO-23-105950](#). For more information, contact Michelle B. Rosenberg at (202) 512-7114 or RosenbergM@gao.gov

June 2023

CRITICAL ACCESS HOSPITALS

Views on How Medicare Payment and Other Factors Affect Behavioral Health Services

What GAO Found

Critical access hospitals (CAH) are small rural hospitals, which are often the principal or sole source of health care services in their communities. Officials from the 10 selected CAHs GAO interviewed said they provided behavioral health services in a variety of ways in different settings.

- **Emergency department.** The CAHs provided limited behavioral health services in their emergency department to stabilize patients in crises. Officials from multiple CAHs said staff coordinate with behavioral health practitioners, when necessary, to obtain recommendations for treatment.
- **Inpatient settings.** The CAHs typically transferred patients who needed inpatient psychiatric care to other facilities or admitted the patients to their psychiatric unit. Officials from CAHs with such units said they typically treated patients with anxiety, depression, or neurocognitive disorders.
- **Outpatient settings.** Officials from CAHs that operated behavioral health clinics said they were staffed by psychiatrists. Multiple CAHs also had licensed clinical social workers at their primary care or rural health clinics—clinics in rural areas that have a shortage of health professionals.

Unlike other hospitals, under Medicare fee-for-service (FFS), CAHs are paid based on the cost of providing services in most, but not all, care settings. Officials from the selected CAHs expressed mixed views on how Medicare FFS payment policies affect CAHs' ability to provide behavioral health services in various care settings that are not paid solely based on cost.

- **Psychiatric units.** Officials from multiple CAHs said they were able to operate a psychiatric unit in a financially sustainable manner, even though Medicare pays for services in these units based on fixed amounts rather than costs. However, officials from other CAHs cited the lack of cost-based Medicare payments for psychiatric units as one of several factors that influenced their decision not to open a unit.
- **Rural health clinics.** Officials from multiple CAHs said Medicare payment limits implemented in 2021 could make it difficult to open a new clinic that provides behavioral health services or add such services to existing clinics. Officials from other CAHs were unsure whether the payment limits would affect their provision of behavioral health services.
- **Telehealth.** Officials from multiple CAHs said Medicare pays less for telehealth visits than a comparable in-person visit, which they said could make it difficult to provide behavioral health services.

In contrast, officials from multiple CAHs and stakeholders said that factors outside of Medicare were substantial challenges to their ability to provide behavioral health services and patients' (including Medicare patients') access to these services. Hiring and recruitment of behavioral health professionals, such as psychiatrists and licensed clinical social workers, was cited as one of their biggest challenges due to nationwide workforce shortages. In addition, they said shortages of inpatient psychiatric beds made it difficult to find inpatient treatment for their patients. As a result, patients were sometimes stuck in an emergency department for several days waiting to be transferred to an open psychiatric bed elsewhere in their community or state, according to CAH officials.

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Abbreviations

CAH	critical access hospital
CMS	Centers for Medicare & Medicaid Services
DPU	distinct part unit
FFS	fee-for-service
RHC	rural health clinic

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June 22, 2023

The Honorable Tammy Baldwin
Chair
The Honorable Shelley Moore Capito
Ranking Member
Subcommittee on Labor, Health and Human Services, and Education,
and Related Agencies
Committee on Appropriations
United States Senate

The Honorable Robert Aderholt
Chair
The Honorable Rosa L. DeLauro
Ranking Member
Subcommittee on Labor, Health and Human Services, and Education,
and Related Agencies
Committee on Appropriations
House of Representatives

Residents in rural areas are less likely to receive treatment for behavioral health disorders—mental health and substance use disorders—even though they experience these disorders at similar rates as residents in urban areas.¹ Researchers have found that this treatment disparity is a result of several long-standing challenges that are greater in rural areas, including shortages of behavioral health professionals, long travel distances to receive services, a lack of health insurance covering behavioral health services, and stigma that can prevent residents from seeking treatment. For example, in 2015, 65 percent of counties outside of metropolitan areas lacked a psychiatrist compared with 27 percent of counties within metropolitan areas.²

¹See, for example, J. Gale et al., *Behavioral Health in Rural America: Challenges and Opportunities* (Iowa City, IA: Rural Policy Research Institute, 2019) and D. A. Morales, C. L. Barksdale, and A. C. Beckel-Mitchener, “A Call to Action to Address Rural Mental Health Disparities,” *Journal of Clinical and Translational Science*, vol. 4, no. 5 (2020): 463-467.

²C. Holly et al., “Geographic Variation in the Supply of Selected Behavioral Health Providers,” *American Journal of Preventive Medicine*, vol. 54, no. 6, supplement 3 (June 2018): S199-S207.

Hospitals are often the principal or sole source of health care services in rural communities. Most of these hospitals provide emergency and inpatient care, as well as other essential health care services, such as primary care.³ The Balanced Budget Act of 1997 created the Medicare critical access hospital (CAH) certification for small rural hospitals that meet certain criteria, such as having 25 or fewer inpatient beds.⁴ According to data from the Medicare Payment Advisory Commission, 65 percent of rural hospitals were certified as CAHs in 2020.⁵

To bolster the financial stability of CAHs, Medicare’s traditional fee-for-service (FFS) program pays CAHs for most inpatient and outpatient services based on their actual costs; such payments may be greater than those for other hospitals that are paid predetermined fixed amounts under Medicare’s prospective payment system.⁶ However, some services provided at CAHs, including behavioral health services provided through inpatient psychiatric departments called psychiatric distinct part units (DPU), are not eligible for cost-based payment and are instead paid under the same Medicare prospective payment system as other inpatient psychiatric facilities. This has led to questions about whether Medicare payment policies make it difficult for CAHs to meet the behavioral health needs of their Medicare beneficiaries.

House Report 116-450, accompanying the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2021, includes a provision for GAO to review behavioral health services at CAHs.⁷ This report describes

1. how selected CAHs provide behavioral health services in their communities, and

³H.D. Miller, *Saving Rural Hospitals and Sustaining Rural Healthcare* (Pittsburgh, PA: Center for Healthcare Quality & Payment Reform, September 2020). For additional information on access to health care services in communities served by rural hospitals, see GAO, *Rural Hospital Closures: Affected Residents Had Reduced Access to Health Care Services*, [GAO-21-93](#) (Washington, D.C.: Dec. 22, 2020).

⁴Pub. L. No. 105-33, § 4201, 111 Stat. 251, 369.

⁵Medicare Payment Advisory Commission, *Critical Access Hospitals Payment System* (Washington, D.C.: October 2022).

⁶“Other hospitals” refers to those receiving payment under the hospital inpatient prospective payment system. See 42 U.S.C. § 1395ww(d).

⁷See H.R. Rep. No. 116-450 (2020); H.R. 7614, 116th Cong. (2020) (as introduced in House).

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2. selected CAHs' and stakeholders' views on how Medicare FFS payment policies and other factors affect the ability of CAHs to provide behavioral health services to Medicare beneficiaries.

To describe how selected CAHs provide behavioral health services in their communities, we interviewed hospital officials from a non-generalizable sample of 10 CAHs. We selected CAHs to reflect geographic variation and variation in the settings in which they offer behavioral health services.⁸ Specifically, among the 10 selected CAHs at the time of our interviews:

- five had or recently had a psychiatric DPU;
- six had or recently had outpatient clinics where behavioral health services were provided;
- six offered behavioral health services through rural health clinics (RHC)—Medicare-participating health clinics located in rural areas designated as having a shortage of health professionals; and
- one did not provide behavioral health services in a psychiatric DPU, outpatient clinic, or RHC.⁹

During our interviews with CAH officials, we asked about the settings in which their hospitals provide behavioral health services as well as the type of patients and conditions treated, services provided, and behavioral health professionals employed. (See app. I for characteristics of the selected CAHs.) This sample is not generalizable to all CAHs nationwide.

Our interviews with officials from the 10 selected CAHs also helped to inform our description of selected CAHs' and stakeholders' views about how Medicare FFS payment policies and other factors affect CAHs' ability

⁸Specifically, using the Centers for Medicare & Medicaid Services' (CMS) Provider of Services data file as of the first quarter of calendar year 2022, we randomly identified five CAHs from each of the following categories: (1) had a psychiatric DPU and rural health clinic (RHC); (2) had a psychiatric DPU only; (3) had RHCs only; and (4) did not have either a psychiatric DPU or RHC. We then selected 10 of these 20 CAHs to interview, in part based on the availability of hospital officials. During our interviews with officials from the 10 CAHs, we confirmed or clarified the settings where the hospitals provide behavioral health services. In some cases, these settings were different from those listed in the Provider of Services file.

⁹These counts are not mutually exclusive because some CAHs operated or provided behavioral health services in more than one type of setting. For example, four selected CAHs operated both a psychiatric DPU and an outpatient clinic where behavioral health services were provided. Officials from one CAH said the hospital's psychiatric DPU and outpatient geriatric psychiatric clinic were closed in 2020 because the psychiatrist who oversaw both settings resigned, and they could not fill the vacancy.

to provide behavioral health services to Medicare beneficiaries.¹⁰ We asked officials from the selected CAHs about how Medicare pays their hospitals for behavioral health services by setting, and how differences in those payments affect their ability to provide such services to Medicare beneficiaries.

We also interviewed stakeholders from six organizations that advocate for or conduct research on CAHs or rural hospitals in general.¹¹ In addition, we interviewed officials from two agencies within the Department of Health and Human Services—(1) the Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program, and (2) the Health Resources and Services Administration, which is responsible for programs that help support rural hospitals, including CAHs. We also interviewed two Medicare Administrative Contractors selected from jurisdictions where our selected CAHs are located.¹² We asked the selected stakeholders, agency officials, and Medicare Administrative Contractors about how Medicare pays CAHs for behavioral health services provided in various settings, and how those payment policies affect CAHs' ability to provide such services.

During our interviews, officials from the selected CAHs and four stakeholders discussed other factors, aside from Medicare payment policy, that affect CAHs' ability to provide behavioral health services to Medicare beneficiaries in their communities. We also reviewed documentation on how Medicare pays CAHs, including federal laws, regulations, and CMS policy guidance, such as the Medicare Claims Processing Manual.

We conducted this performance audit from March 2022 to June 2023 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain

¹⁰Our review was limited to Medicare FFS payment policies for CAHs and generally did not include Medicare Advantage—a private plan alternative to traditional Medicare.

¹¹We interviewed officials from the following six organizations: American Hospital Association, CAH Coalition, Flex Monitoring Team, Medicare Payment Advisory Commission, National Rural Health Association, and a CAH that has advocated for Medicare payment reform. Officials from three CAHs that are members of the National Rural Health Association and one CAH that is a member of the CAH Coalition participated in the interviews. Officials from these four CAHs self-selected to participate in the interviews when the CAH Coalition and National Rural Health Association notified their members about our interviews with their organization.

¹²CMS uses regional contractors called Medicare Administrative Contractors to enroll health care providers in the Medicare program and to process, pay, and audit claims for health care items and services submitted by enrolled Medicare providers and suppliers under Medicare's traditional FFS program.

sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Critical Access Hospitals

As of March 2023, there were 1,365 CAHs, according to CMS officials. To qualify as a CAH, a facility must be designated as a CAH by the state in which it is located, and it must meet certain criteria. In general, the facility must be located in a rural area and a certain distance from other hospitals; provide emergency services 24 hours per day, 7 days a week; have 25 or fewer inpatient beds; and have an average length of stay of 96 hours or less for acute inpatient care, among other things.¹³

CAHs are required to provide inpatient and certain outpatient services but have latitude in the specific services that they provide. Among other things, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 allowed CAHs to establish up to 10 beds in a psychiatric DPU in addition to the 25 inpatient bed maximum.¹⁴ Patient stays in the psychiatric DPU are not counted toward the average length of stay requirement of a CAH. CAHs can also operate hospital outpatient departments and RHCs.

Medicare FFS Payment Policies for CAHs

Under Medicare's traditional FFS program, Medicare payments for health care services provided by CAHs generally consist of two components—payments for facility services and payments for professional services. Payments for facility services generally are for costs related to performing a procedure or furnishing a service on an inpatient or outpatient basis, such as nursing services, drugs and biologics, and overhead costs of operating the hospital facilities. Payments for professional services are for the costs of services provided by physicians and certain non-physician practitioners, such as nurse practitioners and physician assistants. Some payments to CAHs—such as inpatient and outpatient facility services—are based on the hospitals' costs, while other payments are based on the same prospective payment systems and fee schedules that Medicare uses to pay other types of hospitals. For CAHs, Medicare generally

¹³During the COVID-19 public health emergency, CMS temporarily waived the requirements relating to CAH locations, inpatient beds, and length of stay, among others.

¹⁴Pub. L. No. 108-173, § 405(g), 117 Stat. 2066, 2268 (codified as amended at 42 U.S.C. § 1395i-4(c)(2)(E)).

deducts the portion of the payment for inpatient and outpatient services that the beneficiary is responsible for before determining the amounts it should pay for services. Medicare beneficiaries' cost-sharing responsibilities typically include a standard hospital deductible for inpatient services (\$1,566 in 2023) and 20 percent of charges for outpatient services.

The payment methodology or rate for both the facility and professional service components varies by setting. (See table 1.)

Table 1: Overview of Medicare Fee-for-Service Payments for Care Provided by Critical Access Hospitals

Service setting	Medicare payment method	
	Facility service costs	Professional service costs
Most inpatient	101 percent of allowable costs, per diem payment	100 percent of Physician Fee Schedule ^a
Most outpatient (including emergency department)	101 percent of allowable costs, per visit payment	100 or 115 percent of Physician Fee Schedule ^b
Psychiatric distinct part unit	Inpatient Psychiatric Facility Prospective Payment System rate, per diem payment ^c	100 percent of Physician Fee Schedule ^a
Rural health clinic	All-inclusive rate ^d	All-inclusive rate ^d
Telehealth	100 percent of a predetermined facility fee	100 percent of Physician Fee Schedule ^e

Source: GAO review of Centers for Medicare & Medicaid Services and other Medicare related information. | GAO-23-105950

Notes: The amounts in this table represent Medicare fee-for-service payments after deductions, such as beneficiary cost-sharing, which generally includes a deductible for an inpatient hospital stay and 20 percent of charges for outpatient services. Separately, the Budget Control Act of 2011 required across-the-board reductions in federal spending, also known as sequestration, that were extended by subsequent legislation, most recently in 2021. See Pub. L. No. 112-25, §§ 302, 401, 125 Stat. 240, 256, 259; Pub. L. No. 117-328, 136 Stat. 4459 (codified as amended at 2 U.S.C. § 901a(6)(D)). Due to sequestration, all Medicare benefit payments at the time of our review, including payments to providers, were reduced by 2 percent. This reduction is applied after taking into account beneficiary cost-sharing.

Facility service costs generally include costs related to performing a procedure or furnishing a service on an inpatient or outpatient basis, such as nursing services, drugs and biologics, and overhead costs of operating the hospital facilities. Professional service costs are costs of services provided by physicians and certain non-physician practitioners, such as nurse practitioners and physician assistants.

The Medicare Physician Fee Schedule is a listing of all the services and payment rates that Medicare uses to pay for services provided by physicians and certain non-physician practitioners, such as nurse practitioners.

^aFor inpatient professional services provided at a critical access hospital (CAH), including those provided in a psychiatric distinct part unit, physicians and certain non-physician practitioners bill Medicare directly. The CAH does not receive Medicare payments for inpatient professional services.

^bMedicare pays CAHs for outpatient professional services when physicians and non-physician practitioners elect to assign their billing rights to the CAH. In these cases, Medicare generally pays the CAH 115 percent of the Physician Fee Schedule amount, after deducting the beneficiary cost-sharing amount. If the practitioner does not assign their billing rights to the hospital and instead bills Medicare directly, the CAH does not receive Medicare payments for professional services. Instead, Medicare pays the practitioner directly at 100 percent of the Physician Fee Schedule amount.

^cUnder this system, Medicare makes predetermined, per diem payments based primarily on the patient's condition (e.g., age, diagnosis, comorbidities), length of stay, and the location of the psychiatric facility.

^dMedicare generally pays rural health clinics a per visit bundled payment, referred to as an all-inclusive rate, for qualified primary care and preventive health services provided in person or via telehealth. The calculation of the all-inclusive rate generally accounts for the costs of all the services provided to a patient during a single visit, including both facility and professional service costs.

^eIf practitioners do not assign their billing rights to the hospital and instead bill Medicare directly, the CAH does not receive the Medicare payments for professional services.

Medicare Sequestration

The Budget Control Act of 2011 and subsequent legislation require across-the-board reductions in federal spending, also known as sequestration. See Pub. L. No. 112-25, §§ 302, 401, 125 Stat. 240, 256, 259; Pub. L. No. 117-328, 136 Stat. 4459. Due to sequestration, all Medicare benefit payments at the time of our review were reduced by 2 percent. For example, payments to critical access hospitals for facility services are generally limited to 101 percent of allowable costs. In general, the beneficiary is responsible for a cost-sharing amount, such as 20 percent of the amount that a critical access hospital charges for outpatient services. After beneficiary cost-sharing, the amount paid by Medicare was reduced by 2 percent due to sequestration.

Source: GAO review of relevant legislation. | GAO-23-105950

Most inpatient and outpatient services. For facility services, Medicare's traditional FFS program generally pays CAHs at 101 percent of allowable costs for most inpatient and outpatient services, including those provided in the emergency department. CAHs report these costs in their annual Medicare cost report.¹⁵ Medicare uses the report to help determine a CAH's allowable costs—those costs that are necessary and proper in providing services and are related to patient care.¹⁶

Medicare FFS payments for professional services are made based on a list of services and their payment rates, referred to as the Medicare Physician Fee Schedule. Medicare pays CAHs for outpatient professional services when physicians and non-physician practitioners elect to assign their billing rights to the CAH. This is referred to as the Optional Payment Method or "method 2" billing.¹⁷ Under the Optional Payment Method for outpatient services, the CAH bills Medicare for the professional service costs. In these cases, Medicare FFS generally pays the CAH 115 percent of the Physician Fee Schedule amount after applicable deductions, such as beneficiary cost-sharing. For inpatient professional services, physicians and certain non-physician practitioners bill Medicare directly and receive 100 percent of the Physician Fee Schedule amount.¹⁸

Psychiatric distinct part unit (DPU). Medicare FFS pays CAHs for facility services provided in an inpatient psychiatric DPU based on the

¹⁵Each fiscal year, hospitals submit Medicare cost reports to CMS that contain information such as facility characteristics, utilization data, and costs to provide services for both Medicare beneficiaries and other patients.

¹⁶Some CAH expenses, such as some forms of advertising, lobbying, and bad debts, are not allowable costs and thus are not included in the cost-based payment formula.

¹⁷If medical professionals do not assign their billing rights to the hospital and instead bill Medicare directly (referred to as the Standard Method or "method 1" billing), the CAH does not receive Medicare payments for professional services. Instead, Medicare pays the medical professionals directly at 100 percent of the Physician Fee Schedule amount.

¹⁸The Optional Payment Method is not available for inpatient professional services.

Inpatient Psychiatric Facility Prospective Payment System, as opposed to the facility costs. Under this system, Medicare makes predetermined, per diem payments that are determined by adjusting a base payment rate for the patient's condition (e.g., age, diagnosis, comorbidities), length of stay, and the location of the DPU facility.¹⁹ The Inpatient Psychiatric Facility Prospective Payment System base payment rate for fiscal year 2023 was \$866 per day. Medicare pays physicians and certain non-physician practitioners for their services that are provided in a psychiatric DPU under the Physician Fee Schedule.

Rural health clinic (RHC). Medicare FFS pays RHCs—including those operated by CAHs—a per-visit bundled payment, referred to as an all-inclusive rate, for providing services, including behavioral health services.²⁰ Unlike payments in other settings, the RHC all-inclusive rate covers both professional and facility services. The all-inclusive rate for independent RHCs and provider-based RHCs operated by hospitals with 50 or more beds is either the RHC's costs or the national payment limit specified in statute, whichever is lower. Provider-based RHCs operated by hospitals with fewer than 50 beds, which include those operated by CAHs, were not historically subject to a statutory limit. Rather, these RHCs were paid based on their costs.

However, the Consolidated Appropriations Act, 2021 restructured payment limits for RHCs beginning on April 1, 2021.²¹ As a result of these changes, payments for RHCs that were in existence as of December 31, 2020 and operated by hospitals with fewer than 50 beds are capped at the greater of (1) the RHC's 2020 or 2021 all-inclusive rate increased by an inflation index related to physician practice costs and wages or (2) the

¹⁹Under the Inpatient Psychiatric Facility Prospective Payment System, Medicare's payment rates are intended to cover all routine, ancillary, and capital costs that efficient providers are expected to incur in furnishing inpatient psychiatric care. Payments to inpatient psychiatric facilities are determined by adjusting a daily base payment rate for geographic differences in labor costs and for differences in the costs of care related to specified patient and facility characteristics.

²⁰RHCs can be either independent or provider-based. Independent RHCs are stand-alone or freestanding clinics. Provider-based RHCs are an integral and subordinate part of a hospital (including a CAH), skilled nursing facility, or a home health agency.

²¹Pub. L. No. 116-260, § 130, 134 Stat. 1182, 2973 (codified as amended at 42 U.S.C. § 1395l(f)). The Consolidated Appropriations Act, 2021 also increased the national statutory payment limit. Specifically, beginning in April 2021, the payment limit increased to \$100 and increases incrementally until it reaches \$190 in 2028. In subsequent years, the payment limit is set to increase annually based on an inflation index related to physician practice costs and wages.

Selected Critical Access Hospitals Provide Behavioral Health Services in a Variety of Ways

national statutory payment limit.²² New RHCs—those that apply for or enroll in Medicare on or after January 1, 2021, including those operated by hospitals with fewer than 50 beds—are paid the lesser of (1) their costs or (2) the national statutory payment limit.

Telehealth. For outpatient professional services provided through telehealth (including behavioral health services), Medicare FFS generally pays CAHs 100 percent of the Physician Fee Schedule (after deducting any beneficiary cost-sharing amounts) when medical professionals are located in the CAH and assign their billing rights to the hospital. In certain circumstances, the CAH may also receive 100 percent of a predetermined set amount, referred to as the originating site facility fee.²³ Starting in 2022, Medicare began paying for mental health visits provided via telehealth through a RHC at the same rate as for an in-person visit.²⁴

Officials from the selected CAHs told us they provide behavioral health services in a variety of ways across different care settings, in some cases by leveraging available staff and community resources to support these services.

Emergency departments. Officials from the 10 selected CAHs told us they provide limited behavioral health services in their emergency departments in order to stabilize patients with behavioral health crises. For example, officials from nearly all of these CAHs explained that services provided in the emergency department generally include an assessment of the patient's needs, initiation of medication, and coordination of patient transfers or referrals to other settings. According to officials from the 10 CAHs, they typically transfer emergency department patients who need inpatient psychiatric care to other facilities or admit them to the CAH's psychiatric DPU, if available.

Officials from multiple CAHs described the type of patients and conditions that they treat in their emergency department. Officials from four selected

²²See 42 U.S.C. § 1395l(f)(3). The 50-bed limit generally must be maintained after December 31, 2020 for the exception to apply, but does not take into account any increase in beds during the COVID-19 public health emergency.

²³An originating site is the location, such as a CAH or RHC, where a Medicare patient receives services via telehealth. During the COVID-19 public health emergency, CMS allowed the originating site to include other locations, including a patient's home, and permitted the facility to receive the originating site fee in certain circumstances, such as when the patient is a registered outpatient and hospital staff support the service. In 2023, the Medicare originating site facility fee was \$28.64.

²⁴For medical telehealth services provided at an RHC, all RHCs receive an all-inclusive rate per telehealth visit, which was \$98 per visit in 2023, according to CMS officials.

CAHs said their patients are typically adults who are below Medicare age or younger patients. However, officials from two other CAHs said they see a mix of patients with behavioral health crises, ranging from children at risk of suicide to elderly patients with schizophrenia.

Officials from multiple CAHs also noted that the emergency department staff at their hospitals coordinate with psychiatrists or other behavioral health practitioners when treating patients with behavioral health emergencies. Specifically, officials from four selected CAHs told us their emergency department staff work with behavioral health practitioners, when necessary, either in person or via telehealth. Services that these practitioners provide could include patient evaluations, recommendations for medications to initiate in the emergency department, and recommendations to admit, transfer, or discharge the patient. For example, officials from one CAH told us that a psychiatrist from another hospital within its larger health system can be available via telehealth. Officials from another CAH told us they work with a designated crisis responder who provides patient evaluations.

Emergency department staff in multiple selected CAHs in our review had access to resources that help with the transfer of patients who need inpatient treatment. Specifically, officials from five selected CAHs told us their emergency department staff work with an organization in their state or community that coordinates the transfer of behavioral health patients, including finding available inpatient psychiatric beds for emergency department patients who need such care. However, officials from one CAH in a state where this service is not available told us that their hospital staff must take on the responsibility of finding available beds and coordinating transfers with other hospitals.

For other emergency department patients who do not need immediate inpatient care, officials from multiple selected CAHs said their emergency department staff refer patients to, and coordinate treatment at, an outpatient setting, such as an outpatient behavioral health clinic. For example, officials from six CAHs said outpatient treatment coordination could include making referrals to outpatient treatment providers, scheduling appointments, and following up with patients.

Inpatient settings, such as psychiatric DPUs. For patients who need inpatient psychiatric services, officials from the 10 CAHs said hospital staff either transfer the patient to a different facility with an available inpatient psychiatric bed, or they admit the patient to their psychiatric DPU, if available and appropriate for the patient's needs. Officials from multiple CAHs said their inpatient units that do not specialize in behavioral health, such as a medical-surgical unit, are usually not

appropriate for patients with a primary diagnosis of a behavioral health condition. According to officials from three CAHs, this is because the CAHs do not have the appropriate behavioral health workforce, medications, or other resources available in those units to properly treat these patients. However, officials from three other CAHs told us they have had to admit patients to a medical-surgical unit or an intensive care unit on occasion while waiting for an inpatient psychiatric bed to become available at another facility so they could transfer the patient.

Officials from the four selected CAHs that had a psychiatric DPU at the time of our interviews told us their units provide acute inpatient behavioral health treatment, with two of the hospitals having units specifically for geriatric patients.²⁵ According to these officials, each DPU has one or two psychiatrists and other staff, such as nurse practitioners, physician assistants, and licensed clinical social workers. Officials from two selected CAHs who commented on the length of stay of psychiatric DPU patients said patient stays are an average of 7 to 14 days.

Officials from multiple CAHs noted that their psychiatric DPU is not an appropriate treatment setting for certain patients. Among the four CAHs with psychiatric DPUs, officials said the patients served in those units primarily had mental health conditions—most commonly depression, anxiety, and neurocognitive disorders, such as Alzheimer’s or Parkinson’s disease—as opposed to substance use disorders. In addition, officials from a selected CAH with a psychiatric DPU that focuses specifically on geriatric patients said their unit is not equipped to provide ongoing, long-term treatment for patients with severe neurocognitive disorders, such as late-stage dementia. Officials from another CAH commented that they do not typically admit patients to their psychiatric DPU who have high-acuity behavioral health conditions, such as patients with behavioral health conditions who are violent or aggressive.

Outpatient clinics. Officials from three CAHs said their hospital operates outpatient behavioral health clinics.²⁶ According to these officials, services provided at these clinics can include psychiatric evaluations, medication management, and individual and group therapy. The clinics are staffed by one to two psychiatrists who may also work in the CAH’s psychiatric DPU.

²⁵Officials from an additional CAH told us the hospital recently operated a psychiatric DPU but had to close the unit when the unit’s only psychiatrist resigned, and the CAH could not fill the position. As of March 2023, about 4 percent of CAHs nationwide (51 CAHs) had a psychiatric DPU, according to CMS officials.

²⁶Officials from an additional CAH told us they recently operated an outpatient behavioral health clinic but had to close the clinic when the psychiatrist who ran the clinic resigned, and the CAH could not fill the position.

In addition, the clinics are staffed with other professionals with specialized behavioral health training, including nurse practitioners, physician assistants, and licensed clinical social workers. For example, officials from one CAH said they have a psychiatrist and licensed professional counselors who treat a maximum caseload of 10 patients at a time in their outpatient geriatric psychiatric clinic. According to the officials, these patients typically receive a combination of individual and group therapy, with gradually declining frequency until their treatment is complete. Officials from another CAH said their clinics employ a physician who specializes in addiction medicine and can provide medications along with in-person counseling to help those addicted to opiates, alcohol, and other substances.

Officials from three additional CAHs that did not operate outpatient behavioral health clinics mentioned other ways they provide access to outpatient services for their patients. For example, officials from one CAH told us that licensed clinical social workers provide behavioral health services through its primary care clinics. They said the primary care clinics also offer medication-assisted treatment for opioid use disorder.²⁷ In addition, officials from another CAH that did not operate its own outpatient behavioral health clinic told us that they refer patients to a network of federally qualified health centers with which they partner.

Rural health clinics (RHC). Officials from six selected CAHs told us about various ways their hospitals provide behavioral health services through RHCs.²⁸ For example:

- Officials from five of these CAHs said the RHCs have or will soon have behavioral health professionals, such as a psychiatrist or licensed clinical social worker, available to provide specialized

²⁷Medication-assisted treatment is a combination of behavioral health therapy and the use of certain medications (methadone, buprenorphine, and naltrexone) for the treatment of patients who misuse or are addicted to opioids.

²⁸Officials from five of these CAHs described more than one way that behavioral health services are provided at RHCs. For example, officials from one CAH told us that there is a licensed clinical social worker at the hospital's RHCs who provides behavioral health services in person and via telehealth, and the RHCs provide medication-assisted treatment for substance use disorders.

behavioral health services like counseling.²⁹ At one CAH, these professionals included a licensed clinical social worker who provides cognitive behavioral therapy and therapy that focuses on short-term problem solving and coping skills.

- Officials from three of these CAHs told us their RHCs provide medication-assisted treatment for opioid use disorder.
- Officials from three of these CAHs said primary care practitioners (e.g., primary care physicians and nurse practitioners) at the RHCs provide some behavioral health services, such as depression screenings, prescriptions for antidepressants, and referrals to behavioral health providers in the community.

Officials from multiple CAHs with RHCs also told us about ways the RHCs leverage available behavioral health professionals to provide services and enhance access for their patients. For example, officials from two CAHs told us a behavioral health professional, such as a psychiatrist or licensed clinical social worker, is shared across the hospital's RHCs in order to provide behavioral health services at each location. Furthermore, officials from two CAHs told us they contract with an organization, such as a university, that offers telehealth visits with a psychiatrist to patients who come to their RHC locations.

Views Varied on How Medicare FFS Payment Policies Affect Behavioral Health Services; Other Factors Seen as Substantial Challenges

Officials from selected CAHs and stakeholders expressed mixed views on how Medicare FFS payment policies affect CAHs' ability to provide behavioral health services to Medicare beneficiaries. In contrast, officials from nearly all selected CAHs and multiple stakeholders said behavioral health workforce and inpatient psychiatric bed shortages have substantial effects on CAHs' ability to provide behavioral health services.

²⁹Officials from one of these CAHs said they expected to start offering telehealth visits with two psychiatrists for patients at the hospital's RHCs but had not yet implemented this service at the time of our interview. According to a study based on CMS data, 1,390 RHCs were sponsored by a CAH in 2016, of which 9 percent (126 RHCs) employed a clinical psychologist or licensed clinical social worker. See J. Gale et al., *Provision of Mental Health Services by Critical Access Hospital-Based Rural Health Clinics*, Flex Monitoring Team Briefing Paper No. 45 (Portland, ME: June 2022).

Selected Critical Access Hospital and Stakeholder Views Varied on How Medicare FFS Payments Affect Behavioral Health Services

Role of Medicare Payments to Selected Critical Access Hospitals (CAH)

In general, the significance of Medicare revenue varied among the five CAHs that provided such information. According to officials from these CAHs, Medicare revenue ranged from 40 to 65 percent of total revenue based on information the officials had available at the time of our interviews. Three selected CAHs provided information on the proportion of hospital revenue from behavioral health services provided to Medicare beneficiaries, which ranged from 0.5 to 9 percent of total revenue.

Source: GAO interviews with selected CAHs. | GAO-23-105950

Officials from selected CAHs and stakeholders expressed varied views on how Medicare FFS payment policies affect CAHs' provision of behavioral health services to Medicare beneficiaries. As described above, the 10 selected CAHs were able to provide some behavioral health services to Medicare beneficiaries under Medicare payment policies. At the same time, officials from multiple CAHs and stakeholders identified challenges to providing or expanding behavioral health services through psychiatric DPUs and RHCs. In addition, officials from multiple CAHs said they faced challenges in using telehealth that they attributed to Medicare FFS payment policies.

Views on Medicare payments to psychiatric DPUs. Officials from the five selected CAHs that had or recently had a psychiatric DPU at the time of our interviews told us that Medicare payments allow them to operate their DPUs in a financially sustainable manner. As described earlier, payments for DPUs are based on fixed amounts under the Medicare Inpatient Psychiatric Facility Prospective Payment System, rather than on the CAH's costs. The officials said their financial stability under this payment system is contingent upon maintaining a minimum average daily patient volume or sufficient annual patient demand for their services. For example, officials from one CAH with a geriatric psychiatric DPU said as long as they have an average of seven patients per day in their DPU, Medicare payments enable them to cover the direct and indirect costs of the unit. Officials said that this level of demand—about seven patients per day and the DPU's resulting financial stability—has been consistent for at least the past 6.5 years.

In contrast, officials from the five CAHs that did not have a psychiatric DPU at the time of our interviews identified Medicare payments as one of several factors that influenced their decision not to open a DPU. They said these factors included insufficient patient demand, a lack of psychiatrists and other staff needed to operate a psychiatric DPU, and payments under Medicare's Inpatient Psychiatric Facility Prospective Payment System that they expected to be less than their costs.

In addition, one stakeholder from a CAH that has advocated for Medicare payment reform told us that Medicare payment policies for overhead expenses discouraged it from opening a psychiatric DPU. According to hospital officials, if the CAH opened a psychiatric DPU, it would have needed to reallocate some of its existing overhead expenses to the DPU, which would have been paid through Medicare's prospective payment

system rather than through cost-based payments.³⁰ As a result, this CAH determined it was not financially viable to open the DPU. Further, multiple stakeholders told us that Medicare payment rates for psychiatric DPUs can make it challenging for CAHs to operate such units in a financially viable manner.

Views on Medicare payments for behavioral health services at RHCs. Officials from multiple selected CAHs and stakeholders said the new Medicare per visit payment limits on new RHCs operated by hospitals with fewer than 50 beds could make it difficult for a CAH to add a new RHC that may provide behavioral health services. They explained that this is because the per visit all-inclusive rate for a new RHC is substantially less than what a CAH receives for an RHC established before 2021. For example, officials from one CAH said that, at the time of our interview, the hospital received approximately \$340 to \$465 per visit at their existing RHCs. However, according to the officials, if they opened a new RHC, the all-inclusive rate for that clinic would be capped at the national statutory limit (e.g., \$126 in 2023). These officials said that due to the new per visit limits they might not open a new RHC, or if they do, they may restrict the types of services they provide, such as by excluding behavioral health services.

Similarly, officials from three selected CAHs said that the new payment limits for existing RHCs operated by hospitals with fewer than 50 beds may make it difficult to add new behavioral health services at their existing RHCs. Specifically, officials from these CAHs said the per visit all-inclusive rate for treating Medicare patients at existing RHCs is based on their reported 2020 costs, but these rates would not be adjusted to account for additional costs of providing new services. They said that adding behavioral health services would increase their costs, and their Medicare all-inclusive payment rate may not cover all these additional costs. Officials from two of these CAHs said that while the new payment limits may affect them, it was too early to tell whether the payment limits would have an effect on their provision of behavioral health services through RHCs.

Views on Medicare payments for telehealth visits. Officials from multiple CAHs said that since the pandemic, the use of telehealth has enhanced their patients' access to behavioral health services. However, officials from five of the selected CAHs said the amount Medicare pays

³⁰Overhead includes indirect and capital costs of operating the hospital facility, such as general administration, maintenance, legal, and other costs that are common to a hospital's operation and allocated to each unit.

them for a telehealth visit is less than that for a comparable in-person visit, which they said could make it difficult to provide behavioral health services. For example, officials from two selected CAHs said the amount Medicare pays them for the professional services provided in a telehealth visit at an outpatient clinic is less than that for a comparable in-person visit.³¹ Officials from three CAHs also said Medicare payments for telehealth at a RHC were less than their all-inclusive rate for in-person visits. However, starting in 2022, Medicare began paying for RHC mental health visits provided via telehealth at the same rate as in-person visits.

Selected Critical Access Hospitals and Stakeholders Viewed Workforce and Bed Shortages as Substantial Challenges to Providing Behavioral Health Care

In contrast to the varying views on whether Medicare FFS payment policies affected CAHs' provision of behavioral health services, officials from nearly all selected CAHs and multiple stakeholders identified factors outside of Medicare as substantial challenges that make it difficult for CAHs to provide, and patients to access, such services. Officials from multiple selected CAHs said these nationwide challenges—specifically shortages in the behavioral health workforce and inpatient psychiatric beds—affect their ability to provide behavioral health services, refer patients to behavioral health providers in their communities, and effectively operate their emergency departments. Therefore, these challenges can adversely affect access to care for all patients, including Medicare patients.

Officials from eight selected CAHs and three stakeholder organizations said one of the biggest challenges is trying to hire and recruit behavioral health professionals, such as psychiatrists and licensed clinical social workers, due to shortages in the behavioral health workforce. They said these shortages make it difficult to offer inpatient or outpatient behavioral health services, as well as for patients to find similar services from other providers in their communities.

For example, officials from one CAH said they had to close their psychiatric DPU and outpatient behavioral health clinic after their psychiatrist left, and they could not find a replacement. Officials from two other CAHs said they wanted to expand outpatient programs such as those for substance abuse treatment, intensive outpatient group therapy, and routine psychiatry, but were unable to find additional behavioral health professionals. In addition, officials from three selected CAHs said that, due to shortages of behavioral health professionals in their

³¹CMS officials told us that under long-standing policy Medicare pays 100 percent rather than 115 percent of the Physician Fee Schedule amount, after deducting applicable beneficiary cost-sharing, for professional outpatient services furnished via telehealth when billing rights are assigned to the CAH.

community, their patients often have to wait several weeks to months for appointments with an outpatient provider. According to the officials, the longer patients have to wait for an appointment, the less likely they will show up for an appointment or consistently follow their treatment, which can result in patients returning to the emergency department with a behavioral health crisis.

These workforce challenges are not limited to CAHs and are applicable to behavioral health care in general. For example, in a 2022 report, we highlighted several key barriers that pose challenges to recruiting and retaining behavioral health providers.³² These barriers included a shortage of licensed supervisors and funded internship positions in rural areas as well as low reimbursement and compensation for behavioral health providers. In another 2022 report, we reported that workforce shortages contributed to constraints on overall capacity of the mental health care system.³³ In that report, we noted that most state health agencies and providers we interviewed cited an inability to keep up with the demand for mental health services, in some cases, because providers were unable to fill open positions.

In addition to workforce challenges, officials from nine selected CAHs said shortages of inpatient psychiatric beds in their states create access problems for their patients, and officials from multiple CAHs said these shortages can cause operational problems for their hospitals. Specifically, officials from these CAHs said they have difficulty finding inpatient treatment facilities with available psychiatric beds for their emergency department patients. As a result, they said patients with behavioral health conditions, including those at risk of suicide, can be stuck in the emergency department for several days after being stabilized waiting for a psychiatric bed to open somewhere in their community or state. For example:

- Officials from three selected CAHs said patients were stuck in their emergency department anywhere from 3 to 8 days waiting for an inpatient psychiatric bed to open in another facility or their own psychiatric DPU.
- Officials from one CAH said there were 42 patients in their state waiting for placement in an inpatient psychiatric facility at the time of

³²See GAO, *Behavioral Health: Available Workforce Information and Federal Actions to Help Recruit and Retain Providers*, [GAO-23-105250](#) (Washington, D.C.: Oct. 27, 2022).

³³See GAO, *Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts*, [GAO-22-104597](#) (Washington, D.C.: Mar. 29, 2022).

our interview, most of whom were stuck in an emergency department somewhere in the state.

Multiple stakeholders also indicated that shortages of inpatient psychiatric beds create challenges for CAHs in providing behavioral health services to patients. For example, one stakeholder said the lack of inpatient psychiatric beds could result in delays in treatment and poor quality care.

When patients are stuck in the emergency department, the hospital is basically boarding the patients, according to officials from three selected CAHs. These officials explained that in these cases their hospitals are unable to provide the patients the care they need because they do not have the appropriate staff or medications to treat them. In addition to delaying treatment, they said this creates risks to the patients because the emergency department may not be a safe place for patients in a mental health crisis. Further, these officials indicated that the lack of available inpatient beds creates burdens on patients and their families because it can force them to travel long distances to find care.

In addition, the boarding of patients with behavioral health conditions in the emergency department can result in the CAHs having to divert resources away from caring for other patients who need services, according to officials from multiple selected CAHs. For example, officials from three CAHs said at times they have to “go on diversion”—turn away other patients from their emergency department and send them to another hospital—when they board patients with behavioral health crisis. This can result in care delays for the other patients and lost revenue for the CAHs, according to the officials. Additionally, in cases where emergency department patients are at risk of harming themselves or others, officials from seven selected CAHs said they must provide full-time surveillance to ensure patient safety. They said these “sitters” are required to stay with patients until emergency department staff can transfer or admit the patient to a more appropriate setting.

The lack of inpatient psychiatric beds in the United States is a widespread, longstanding issue and does not uniquely affect CAHs or Medicare patients. One stakeholder said that an ongoing study at the time of our interview indicated a consistent decline in the number of psychiatric beds in rural areas over the past 15 years. We also reported in 2022 that a shortage of available inpatients psychiatric beds has limited consumers’ access to treatment. Further, we reported that inpatient psychiatric bed shortages occurred in at least 35 states. Some of the stakeholders we spoke with for that prior report attributed these shortages to increased

demand for services, budget cuts, or staffing issues, and, in some cases, the COVID-19 pandemic.³⁴

Agency Comments

We provided a draft of this report to the Department of Health and Human Services for comment. The department provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Secretary for Health and Human Services, and other interested parties. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff members have any questions about this report, please contact me at (202) 512-7114 or RosenbergM@gao.gov. Contact points for our Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix II.



Michelle B. Rosenberg
Director, Health Care

³⁴See [GAO-22-104597](#). For this report, we interviewed federal officials and representatives from 29 stakeholder organizations representing consumers, health plans, providers, insurance regulators, and mental health and Medicaid agencies.

Appendix I: Characteristics of Selected Critical Access Hospitals (CAH)

We selected 10 CAHs to reflect geographic variation and variation in the settings in which they offer behavioral health services. See table 2 for a description of the selected CAHs' geographic location and settings where the CAHs provide behavioral health services.

Table 2: Selected Critical Access Hospitals (CAH), by Geographic Location and Setting Where Behavioral Health Services Are Provided

CAH	State	Census region	Setting where behavioral health services are provided				
			Emergency department	Psychiatric distinct part unit	Outpatient clinic	Rural health clinic	Outpatient telehealth visits
Hospital A	PA	North	Yes	Yes ^a	Yes	Yes	Yes
Hospital B	KS	Midwest	Yes	Yes ^a	Yes	Yes ^b	Yes ^b
Hospital C	LA	South	Yes	Yes	Yes	No	Yes
Hospital D	VT	North	Yes	Yes	No	No	Yes
Hospital E	AR	South	Yes	Recently closed ^c	Recently closed ^c	No	No
Hospital F	ID	West	Yes	No	Yes ^d	Yes ^e	Yes
Hospital G	ME	North	Yes	No	Yes	Yes	Yes
Hospital H	WA	West	Yes	No	No	Yes	Yes
Hospital I	MO	Midwest	Yes	No	No	Yes ^f	No
Hospital J	OK	South	Yes	No	No	No	No
Number of selected CAHs			10	5	6	6	7

Source: GAO analysis of information obtained through interviews with selected CAHs. | GAO-23-105950

^aOfficials from these two CAHs said their hospitals operate psychiatric distinct part units that are specifically for geriatric patients.

^bAt the time of the GAO interview, officials from this CAH said they were planning to work with a company to provide telehealth visits with a psychiatrist 1 day per week through the CAH's rural health clinic (RHC).

^cOfficials from this CAH said the hospital's psychiatric distinct part unit and outpatient geriatric psychiatric clinic were closed in 2020 because the psychiatrist who oversaw both settings resigned, and they could not fill the vacancy.

^dOfficials from this CAH said at two of the CAH's outpatient clinics, a physician who specialized in addiction medicine can provide medications along with counseling to help patients addicted to opioids, alcohol, and other substances.

^eOfficials from this CAH said none of the CAH's RHCs employ behavioral health professionals. However, the CAH contracts with a local university to provide behavioral health services via telehealth with two psychiatrists once per week through the RHCs.

^fOfficials from this CAH said primary care physicians at the hospital's RHCs provide behavioral health services, such as providing some informal counseling, conducting depression screenings, and prescribing anti-depressants.

This non-generalizable sample of selected CAHs does not reflect the proportion of all CAHs nationwide. For example, as of March 2023, about

Appendix I: Characteristics of Selected Critical Access Hospitals (CAH)

4 percent of CAHs (51 CAHs) had a psychiatric distinct part unit, according to officials from the Centers for Medicare & Medicaid Services. According to a study based on their data, 1,390 rural health centers were sponsored by a CAH in 2016, of which 9 percent (126 rural health centers) employed a clinical psychologist or licensed clinical social worker.¹

¹J. Gale et al., *Provision of Mental Health Services by Critical Access Hospital-Based Rural Health Clinics*, Flex Monitoring Team Briefing Paper No. 45 (Portland, ME: June 2022).

Appendix II: GAO Contact and Staff Acknowledgments

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Staff Acknowledgments

In addition to the contact named above, Will Simerl (Assistant Director), Katie Mack (Analyst-in-Charge), David Lichtenfeld, Vincent Patierno-Beavers, and Jennifer Rudisill made key contributions to this report. Ying Hu, Daniel Lee, and Eric Peterson also made important contributions.

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