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Critical Access Hospital

RURAL HEALTH SERIES

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

This publication provides the following information about Critical Access Hospitals (CAHs):

- ❖ Background;
- ❖ CAH designation;
- ❖ CAH payments (including hospital inpatient admission certification requirements);
- ❖ Additional Medicare payments;
- ❖ Grants to States under the Medicare Rural Hospital Flexibility Program (Flex Program);
- ❖ Resources; and
- ❖ Lists of helpful websites and Regional Office Rural Health Coordinators.

When “you” is used in this publication, we are referring to Medicare Fee-For-Service health care providers.



BACKGROUND

Legislation enacted as part of the Balanced Budget Act (BBA) of 1997 authorized States to establish a State Flex Program under which certain facilities participating in Medicare can become CAHs.

The following providers may be eligible to become CAHs:

- ❖ Currently participating Medicare hospitals;
- ❖ Hospitals that ceased operation after November 29, 1989; or
- ❖ Health clinics or centers (as defined by the State) that previously operated as a hospital before being downsized to a health clinic or center.

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Unlike facilities such as Medicare Dependent Hospitals and Sole Community Hospitals, CAHs represent a separate provider type with their own Medicare Conditions of Participation (CoP) as well as a separate payment method. The CoPs for CAHs are listed in the “Code of Federal Regulations” (CFR) at 42 CFR 485.601–647.

For more information about CAHs and CAH payment rules, refer to Sections 1814(a)(8), 1814(l), 1820, 1834(g), 1834(l)(8), 1883(a)(3), and 1861(v)(1)(A) of the Social Security Act (the Act) and 42 CFR 410.152(k), 412.3, 424.15, 413.70, and 413.114(a).

CAH DESIGNATION

A hospital that already participates in Medicare and seeks CAH status must meet the following criteria to be certified and remain certified as a CAH:

- ❖ Be located in a State that established a State rural health plan for the State Flex Program (as of September 2011, only Connecticut, Delaware, Maryland, New Jersey, and Rhode Island did not have a State Flex Program);
- ❖ Be located in a rural area or be treated as rural under a special provision that allows qualified hospital providers in urban areas to be treated as rural;
- ❖ Demonstrate compliance with the CoPs at 42 CFR Part 485 subpart F at the time of application for CAH certification and all times subsequent to the initial certification;
- ❖ Furnish 24-hour emergency care services 7 days a week, using either on-site or on-call staff, with specific on-site response timeframes for on-call staff;
- ❖ Maintain no more than 25 inpatient beds that may also be used for swing bed services. It may also operate a distinct part rehabilitation and/or psychiatric unit, each with up to 10 beds;
- ❖ Have an annual average length of stay of 96 hours or less per patient for acute care (excluding swing bed services and beds that are within distinct part units [DPUs]). This requirement cannot be assessed on initial certification but applies subsequent to CAH certification. (Note that payment rules require a physician to certify that an individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH); and
- ❖ Be:
 - Located more than a 35-mile drive from any hospital or other CAH; or
 - Located more than a 15-mile drive from any hospital or other CAH in an area with mountainous terrain or only secondary roads; OR
 - Certified as a CAH prior to January 1, 2006, based on State designation as a “necessary provider” of health care services to residents in the area.

Effective October 1, 2014, under new Office of Management and Budget (OMB) delineations, some CAHs previously located in rural areas may now be located in urban areas. A 2-year transition period is provided, effective October 1, 2014, through September 30, 2016, for affected CAHs to seek rural classification under 42 CFR 412.103 to retain their CAH status after the 2-year transition period ends. This policy to provide for a 2-year transition period also applies to future changes in OMB delineations.

CAH PAYMENTS

CAHs are paid for most inpatient and outpatient services to Medicare patients at 101 percent of reasonable costs.

CAHs are not subject to the Inpatient Prospective Payment System (IPPS) or the Hospital Outpatient Prospective Payment System (OPPS).



CAH services are subject to Medicare Part A and Part B deductible and coinsurance amounts. The copayment amount for most outpatient CAH services is 20 percent of applicable Part B charges and is not limited by the Part A inpatient deductible amount.

The Centers for Medicare & Medicaid Services (CMS) encourages CAHs to engage in consumer-friendly communication with patients about their charges to help patients understand their potential financial liability for services they may obtain at the CAH.

CAH DPUs

Services furnished in rehabilitation DPUs of CAHs are paid under the Inpatient Rehabilitation Facility PPS. Services furnished in psychiatric DPUs of CAHs are paid under the Inpatient Psychiatric Facility PPS.

Inpatient Admissions

To receive payment under Part A, the CAH must include:

- ❖ An order for inpatient admission by a physician or other qualified practitioner in accordance with the regulations at 42 CFR 412.3 and 485.638(a)(4)(iii); and

- ❖ Certification in accordance with the regulations at 42 CFR 424.15 that the patient may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH. Because this statutory certification requirement is based on an expectation that if a physician certifies in good faith that an individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH and then something unforeseen occurs causing him or her to stay longer at the CAH, Medicare will pay for the costs of care for that stay. That longer stay will not necessarily result in the loss of CAH designation as long as that longer stay does not cause the CAH to exceed its 96-hour annual average CoP requirement. However, if a physician cannot in good faith certify that an individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH, the CAH will not receive Medicare Part A payment for any portion of that individual's inpatient stay. This certification requirement must be completed, signed, and documented in the medical record no later than 1 day before the date on which the claim for payment for the inpatient CAH service is submitted. The following are not included in applying the 96-hour certification requirement:

- Time as an outpatient at the CAH; and
- Time in a CAH swing bed used to furnish skilled nursing services.

The clock for the 96-hour certification requirement only begins once the individual is admitted to the CAH as an inpatient.

Additional certification requirements must be met for cases that are 20 inpatient days or more. For more information about these requirements, refer to 42 CFR 424.13.

Ambulance Transports

The following apply to payments for ambulance transports:

- ❖ A CAH can be paid for its ambulance transports or for the ambulance transports provided by a CAH-owned and operated entity, based on 101 percent of reasonable costs, if the CAH is the only provider or supplier of ambulance transports located within a 35-mile drive of the CAH; and
- ❖ If there is no other provider or supplier of ambulance transports within a 35-mile drive of the CAH and the CAH owns and operates an entity furnishing ambulance transports that is more than a 35-mile drive from the CAH, the CAH can be paid based on 101 percent of the reasonable costs of that entity's ambulance transports as long as that entity is the closest provider or supplier of ambulance transports to the CAH.

Reasonable Cost Payment Principles That Do NOT Apply to CAHs

Payment for inpatient or outpatient CAH services is **not** subject to the following reasonable cost principles:

- ❖ Lesser of cost or charges; and
- ❖ Reasonable compensation equivalent limits.

In addition, in general, payments to a CAH for inpatient CAH services are not subject to ceilings on hospital inpatient operating costs or the 1-day or 3-day preadmission payment window provisions applicable to hospitals paid under the IPPS and OPSS. However, if a patient receives outpatient services at a CAH that is wholly owned or operated by an IPPS hospital and is admitted as an inpatient to that IPPS hospital, either on the same day or within 3 days immediately following the day of those outpatient services, the outpatient services are subject to payment window provisions.



Outpatient Services: Standard Payment Method (Method I) or Election of Optional Payment Method (Method II)

Standard Payment Method – Reasonable Cost-Based Facility Services, With Billing Medicare Administrative Contractor (MAC) for Professional Services

Under Section 1834(g)(1) of the Act, a CAH is paid under the Standard Payment Method unless it elects to be paid under the Optional Payment Method. For cost reporting periods beginning on or after January 1, 2004, under the Standard Payment Method, payments for outpatient CAH facility services are made at 101 percent of reasonable costs.

Payment for professional medical services furnished in a CAH to registered CAH outpatients is made by the MAC under the Medicare Physician Fee Schedule (PFS), as is the case when such professional services are furnished in a hospital outpatient department. For purposes of CAH payment, professional medical services are defined as services furnished by a physician or other qualified practitioner.

Optional Payment Method – Reasonable Cost-Based Facility Services Plus 115 Percent Fee Schedule Payment for Professional Services

Under Section 1834(g)(2) of the Act, a CAH may elect the Optional Payment Method, under which it bills the MAC for both facility services and professional services furnished to its outpatients by a physician or practitioner who has reassigned his or her billing rights to the CAH. However, even if a CAH makes this election, each physician or practitioner who furnishes professional services to CAH outpatients can choose to either:

- ❖ Reassign his or her billing rights to the CAH, agree to be included under the Optional Payment Method, attest in writing that he or she will not bill the MAC for professional services furnished in the CAH outpatient department, and look to the CAH for payment for the professional services; or
- ❖ File claims for his or her professional services with the MAC for standard payment under the Medicare PFS.

For each physician or practitioner who agrees to be included under the Optional Payment Method and reassigns benefits accordingly, the CAH must forward a copy of a completed Form CMS-855R/Medicare Enrollment Application for Reassignment of Medicare Benefits to the MAC and keep the original on file. This attestation will remain at the CAH.

Once a CAH elects the Optional Payment Method, it will remain in effect until the CAH submits a termination request to the MAC. CAHs are not required to make an annual election to be paid under the Optional Payment Method in a subsequent year. If a CAH elects to terminate its Optional Payment Method, the termination request must be submitted in writing to the MAC at least 30 days prior to the start of the next cost reporting period.

The Optional Payment Method election applies to all CAH professional services furnished in the CAH outpatient department by physicians and practitioners who:

- ❖ Agree to be included under the Optional Payment Method by reassigning their billing rights to the CAH;
- ❖ Complete Form CMS-855R; and
- ❖ Attest in writing that they will not bill the MAC for their outpatient professional services.

You can find Form CMS-855R at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855r.pdf> on the CMS website. To find MAC contact information, visit <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map> on the CMS website.

As of January 1, 2004, payment for outpatient CAH services under the Optional Payment Method is based on the sum of:

- ❖ For facility services – 101 percent of reasonable costs, after applicable deductions, regardless of whether the physician or practitioner reassigned his or her billing rights to the CAH;
- ❖ For physician professional services – 115 percent of the allowable amount, after applicable deductions, under the Medicare PFS; and
- ❖ For non-physician practitioner professional services – 115 percent of the amount that otherwise would be paid for the practitioner’s professional services, after applicable deductions, under the Medicare PFS.

Payment for Telehealth Services

The payment amount is 80 percent of the Medicare PFS for telehealth services when the distant site physician or other practitioner is located in a CAH that elected the Optional Payment Method and the physician or practitioner reassigned his or her benefits to the CAH.

Payment for Teaching Anesthesiologist Services

For a teaching anesthesiologist who has reassigned billing rights to the CAH, payment for outpatient CAH services under the Optional Payment Method is based on 115 percent of the Medicare PFS if he or she is involved in:

- ❖ The training of a resident in a single anesthesia case;
- ❖ Two concurrent anesthesia cases involving residents; or
- ❖ A single anesthesia case involving a resident that is concurrent to another case paid under the medically directed rate.

The following requirements must be met to qualify for payment:

- ❖ The teaching anesthesiologist or different anesthesiologist(s) in the same anesthesia group must be present during all critical or key portions of the anesthesia service or procedure; and
- ❖ The teaching anesthesiologist or another anesthesiologist with whom he or she has entered into an arrangement must be immediately available to provide anesthesia services during the entire procedure.

The patient's medical record must document:

- ❖ The teaching anesthesiologist's presence during all critical or key portions of the anesthesia procedure; and
- ❖ The immediate availability of another teaching anesthesiologist as necessary.

When different teaching anesthesiologists are present with the resident during the critical or key portions of the procedure, report the National Provider Identifier of the teaching anesthesiologist who started the case on the claim.

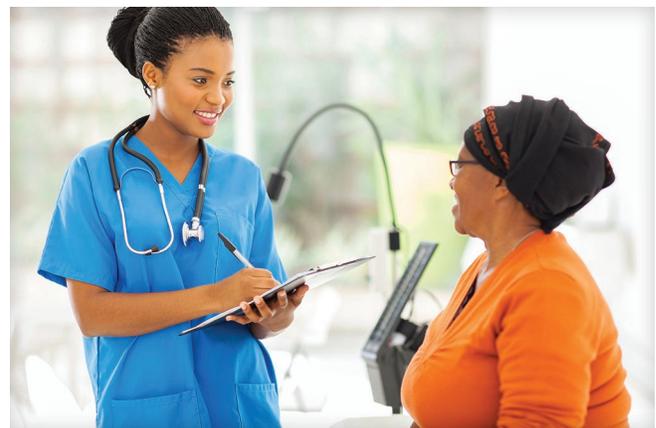
Submit teaching anesthesiologist claims using the following modifiers:

- ❖ AA – Anesthesia services performed personally by anesthesiologist; and
- ❖ GC – This service has been performed in part by a resident under the direction of a teaching physician.

ADDITIONAL MEDICARE PAYMENTS

Residents in Approved Medical Residency Training Programs Who Train at a CAH

For cost reporting periods beginning on or after October 1, 2013, Medicare payments are made to CAHs for training full-time equivalent (FTE) residents in approved residency training programs at the CAH. That is, a hospital can no longer claim residency training time at a CAH for purposes of the hospital's direct graduate medical education and/or indirect medical education FTE resident count. If a CAH incurs the cost of training FTE residents for the time the residents rotate to the CAH, the CAH may receive payment based on 101 percent of reasonable costs for the costs it incurs in training those residents.



Medicare Rural Pass-Through Funding for Certified Registered Nurse Anesthetist (CRNA) Services

CAHs may receive reasonable cost-based funding for certain CRNA services as an incentive to continue to serve the Medicare population in rural areas. The regulations at 42 CFR 412.113(c) list the specific requirements hospitals and CAHs must fulfill to receive rural pass-through funding from Medicare for certain CRNA services furnished by CRNAs whom they employ or contract with to furnish such services to CAH patients.

CAHs that qualify for CRNA pass-through payments can receive reasonable cost-based payments for inpatient and outpatient CRNA professional services regardless of whether they are paid using the Standard Payment Method or the Optional Payment Method for outpatient services. However, if a CAH opts to include a CRNA in its Optional Payment Method election, the services furnished by that CRNA are paid based on the Medicare PFS and the CAH gives up inpatient and outpatient CRNA pass-through payments for services furnished by that CRNA.

Incentive Payments

Health Professional Shortage Area (HPSA) Physician Bonus Program

Physicians (including psychiatrists) who furnish care in a CAH that is located within a geographic-based, primary care HPSA and psychiatrists who furnish care in a CAH that is located in a geographic-based mental health HPSA are eligible for a 10 percent HPSA bonus payment for outpatient professional services furnished to a Medicare patient. If you have reassigned your billing rights and the CAH has elected the Optional Payment Method, the CAH will receive 115 percent of the otherwise applicable Medicare PFS amount multiplied by 110 percent, based on all claims processed during the quarter. For

more information about the HPSA Physician Bonus Program, visit <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses> and refer to “[Health Professional Shortage Area Physician Bonus Program](#)” on the CMS website.

GRANTS TO STATES UNDER THE MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM (FLEX PROGRAM)

The Flex Program, which was authorized by Section 4201 of the BBA (Public Law 105-33), consists of two separate but complementary components:

- ❖ A Medicare reimbursement program that provides reasonable cost-based reimbursement for Medicare-certified CAHs, which is administered by CMS; and
- ❖ A State grant program that supports the development of community-based rural organized systems of care in participating States, which is administered by Health Resources and Services Administration through the Federal Office of Rural Health Policy.

To receive funds under the grant program, States must apply for the funds and engage in rural health planning through the development and maintenance of a State Rural Health Plan that:

- ❖ Designates and supports the conversions to CAHs;
- ❖ Promotes emergency medical services (EMS) integration initiatives by linking local EMS with CAHs and their network partners;
- ❖ Develops rural health networks to assist and support CAHs;
- ❖ Develops and supports quality improvement initiatives; and
- ❖ Evaluates State programs within the framework of national program goals.

RESOURCES

The chart below provides CAH resource information.

CAH Resources

For More Information About...	Resource
CAHs	“Medicare Claims Processing Manual” (Publication 100-04) on the CMS website
CAH and Swing Bed Billing	“Medicare Billing Information for Rural Providers and Suppliers” on the CMS website
Survey and Certification Critical Access Hospital Requirements	Appendix W of the “State Operations Manual” (Publication 100-07) on the CMS website https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html on the CMS website
Hospital Reclassifications	“Hospital Reclassifications” on the CMS website
OMB Metropolitan Statistical Areas	https://www.whitehouse.gov/omb/inforeg_statpolicy on the OMB website
Swing Bed Requirements for CAHs	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SwingBed.html on the CMS website “Swing Bed Services” on the CMS website
Compilation of Social Security Laws	https://www.ssa.gov/OP_Home/ssact/title18/1800.htm on the United States (U.S.) Social Security Administration website
CFRs	http://www.ecfr.gov/cgi-bin/ECFR?page=browse on the U.S. Government Publishing Office website
All Available Medicare Learning Network® Products	“MLN Catalog” on the CMS website
Provider-Specific Medicare Information	“MLN Guided Pathways: Provider Specific Medicare Resources” on the CMS website
Medicare Information for Patients	https://www.medicare.gov on the CMS website

HELPFUL WEBSITES

American Hospital Association Rural Health Care

<http://www.aha.org/advocacy-issues/rural>

Critical Access Hospitals Center

<https://www.cms.gov/Center/Provider-Type/Critical-Access-Hospitals-Center.html>

Disproportionate Share Hospitals

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html>

Federally Qualified Health Centers Center

<https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html>

Health Resources and Services Administration

<http://www.hrsa.gov>

Hospital Center

<https://www.cms.gov/Center/Provider-Type/Hospital-Center.html>

Medicare Learning Network®

<http://go.cms.gov/MLNGenInfo>

National Association of Community Health Centers

<http://www.nachc.org>

National Association of Rural Health Clinics

<http://narhc.org>

National Rural Health Association

<http://www.ruralhealthweb.org>

Rural Health Clinics Center

<https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html>

Rural Health Information Hub

<https://www.ruralhealthinfo.org>

Swing Bed Providers

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SwingBed.html>

Telehealth

<https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth>

U.S. Census Bureau

<http://www.census.gov>

REGIONAL OFFICE RURAL HEALTH COORDINATORS

To find contact information for CMS Regional Office Rural Health Coordinators who provide technical, policy, and operational assistance on rural health issues, refer to <https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/Downloads/CMSRuralHealthCoordinators.pdf> on the CMS website.



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