Learn about these Critical Access Hospital (CAH) topics:

- Background
- CAH designations
- CAH payments
- Additional Medicare payments
- Medicare Rural Hospital Flex Program (MRHFP) State Grants
- Resources
- Helpful Websites and Regional Office Rural Health Coordinators
BACKGROUND

The 1997 Balanced Budget Act (BBA) allowed states to establish MRHFPs. A Medicare rural, limited-services, participating hospital could become a CAH if it met the following conditions:

- Currently a Medicare-participating hospital
- Hospital that stopped operation after November 29, 1989
- Health clinic or center (according to the state definition) that operated as a hospital before downsizing to a health clinic or center

The CAH program now represents a separate provider type having their own Medicare Conditions of Participation (CoPs) and separate payment methods, unlike Medicare-Dependent Hospitals and Sole Community Hospitals. The Code of Federal Regulations (CFR) at 42 CFR 485.601–647 list the CAH CoPs.

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

CAH DESIGNATIONS

A Medicare participating hospital can become certified and remain certified as a CAH by meeting the following regulatory requirements (this list is not all-inclusive but indicates some of the basic criteria):

- Located in a state that established a rural health plan for MRHFPs (as of February 2018, only Connecticut, Delaware, Maryland, New Jersey, and Rhode Island have not established MRHFP State Rural Plans).
- Located in a rural area or an area treated as rural under a special provision that allows treating qualified hospital providers in urban areas as rural (refer to 42 CFR 412.103 regulations). A CAH has a 2-year transition period to reclassify as rural if its location changes to an urban area due to changes in Office of Management and Budget (OMB) designation.
- Furnishes 24-hour emergency services, 7 days a week, using either on-site or on-call staff, with specific on-site, on-call staff response times.
- Does not exceed 25 inpatient beds also used for swing bed services. It may operate a distinct part rehabilitation and/or psychiatric unit, each with up to 10 beds. CAHs with distinct part units (DPUs) must follow all hospital CoP and CAH CoP.
- Report an annual average acute care inpatient length of stay (LOS) of 96 hours or less (excluding swing bed services and DPU beds). Medicare does not assess this requirement on initial certification and only applies after CAH certification.
- A CAH that has not been designated by a state as a necessary provider prior to December 31, 2005, must be located more than a 35-mile drive (or in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from any other CAH or hospital.
CAH PAYMENTS

CAHs are paid for most inpatient and outpatient services to patients at 101 percent of reasonable costs. Medicare does not include CAHs in the hospital Inpatient Prospective Payment System (IPPS) or the hospital Outpatient Prospective Payment System (OPPS).

Medicare pays CAH services according to Part A and Part B deductible and coinsurance amounts and does not limit most of the 20 percent CAH Part B outpatient services copayment charges by the Part A inpatient deductible amount.

The Centers for Medicare & Medicaid Services (CMS) encourages CAHs to help patients understand their services’ charges and potential financial obligation.

CAH DPUs

- Medicare pays CAH DPU inpatient rehabilitation services under the Inpatient Rehabilitation Facility PPS.
- Medicare pays CAH DPU psychiatric services under the Inpatient Psychiatric Facility PPS.

CAH SWING-BEDS

- Medicare pays CAH swing-bed patient bills under (Section 1862(a)(14) of the Act) and in the regulations at 42 CFR § 411.15(m).
- CAH swing-bed services are not subject to the Skilled Nursing Facility (SNF) prospective payment system. Instead, Medicare pays CAHs based on 101 percent of reasonable swing-bed services. Like CAH inpatient services, CAH swing-bed services are subject to the hospital bundling requirements and must be included on CAH swing-bed bills.
- MACs allow CAHs to bill for bed and board, nursing and other related services, use of hospital facilities, medical social services, drugs, biologicals, supplies, appliances, and equipment for inpatient hospital care and treatment. CAHs can bill for diagnostic or therapeutic items or services provided by the hospital or by others under arrangements with the hospital and costs must be included on the CAHs’ swing-bed bill.

Inpatient Admissions

Medicare pays CAHs under Part A when they meet these requirements:

- Medicare pays for an inpatient stay if a physician or other qualified practitioner orders the admission and certifies an individual is discharged or transferred to a hospital within 96 hours of CAH admission according to 42 CFR 412.3 and 485.638(a)(4)(iii).
- Medicare pays for an inpatient care stay if a physician certifies an individual is discharged or transferred to a hospital within 96 hours of CAH admission, according to 42 CFR 424.15. A patient may remain in a CAH for a longer period of time. The CAH designation stays in effect if the CAH stays within the 96-hour annual average LOS CoP requirement.
The physician must complete the certification, sign it, and document the medical record no later than 1 day before submitting the inpatient services claim. Medicare does not apply the 96-hour certification requirement to the following services:

- Time as a CAH outpatient
- Time furnishing skilled nursing swing bed services
- Time in a CAH DPU

The 96-hour certification clock begins when the physician or other qualified practitioner admits the patient.

On or after October 1, 2017, Quality Improvement Organizations, Medicare Administrative Contractors (MACs), Recovery Audit Contractors (RACs), and Supplemental Medical Review Contractors (SMRCs) no longer make auditing the CAH 96-hour certification requirement a high priority for medical record reviews. CAHs should no longer expect to receive 96-hour certification medical record requests from these contractors unless CMS or the contractors find:

- Gaming evidence
- Screening and revalidation provider compliance failure
- Other Medical review issues

**NOTE:** Despite the MACs, RACs, and SMRCs no longer making auditing the CAH 96-hour certification requirement a high priority, the CMS Regional Office Divisions of Survey and Certification (RO DSCs), the State Survey Agencies (SAs), and the Accrediting Organizations (AOs) will verify CAH Condition of Participation (CoP) compliance according to the requirement 42 CFR 485.620(b). Standard: Length of Stay – The CAH provides acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient.

The Fiscal Intermediary (FI) will determine compliance with this CoP. The FI will calculate the CAH’s length of stay based on patient census data. If a CAH exceeds the length of stay limit, the FI will send a report to the CMS RO DSC as well as a copy of the report to the SA. The CAH will be required to develop and implement a plan of correction (POC) acceptable to the CMS RO or provide adequate information to demonstrate compliance.

Twenty or more inpatient-day cases must meet additional certification requirements. Go to 42 CFR 424.13 for more information.

**Ambulance Transports**

- Medicare pays CAH-furnished (or an entity owned and operated by a CAH) ambulance transport services based on 101 percent of reasonable costs if the CAH is the only ambulance transport provider or supplier (or entity) providing services within a 35-mile drive.
- If there is no other ambulance transport services provider or supplier within a 35-mile drive of a CAH, and the CAH owns and operates an entity furnishing ambulance services more than a 35-mile drive from it, the CAH can charge based on 101 percent of the reasonable costs of that entity’s ambulance transports, if that entity is the closest ambulance transport services provider or supplier to the CAH.
These CAH Reasonable Cost Payment Principles Do NOT Apply

CAH inpatient or outpatient services payments not subject to these reasonable cost principles:

- Lesser of cost or charges
- Reasonable compensation equivalent limits

Medicare does not apply caps to CAH inpatient payments on hospital inpatient operating costs or the 1-day or 3-day pre-admission payment window provisions that apply to hospitals paid under the IPPS and OPPS. Medicare applies payment window provisions to outpatient services if a patient gets CAH outpatient services at a wholly owned or operated IPPS hospital and that hospital admits the patient either on the same day or within 3 days immediately following the day the patient got those outpatient services.

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

Standard Payment Method – Reasonable Cost-Based Facility Services, With MAC Professional Services Billing

Medicare pays a CAH under the Standard Payment Method unless it elects payment under the Optional Payment Method (Section 1834(g)(1) of the Act). Beginning January 1, 2004, Medicare pays CAH outpatient facility services at 101 percent of reasonable costs.

MACs pay registered outpatient CAHs for CAH-furnished professional medical services under the Medicare Physician Fee Schedule (PFS). This payment happens when these professional services come from a hospital outpatient department. For payment, CMS defines professional medical services as physician- or other qualified practitioner-furnished services.

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

A CAH may elect the Optional Payment Method (Section 1834(g)(2) of the Act). The CAH bills facility and professional outpatient services to the MAC when its physicians or practitioners reassign billing rights to them. If a CAH elects this option, each physician or practitioner providing professional outpatient CAH services can choose to either:

- Reassign their billing rights to the CAH and agree to the Optional Payment Method. They must attest in writing not to bill the MAC for professional CAH outpatient department services and get their professional payment from the CAH.
- File MAC claims for their professional services for standard payment under the Medicare PFS.

For those physicians or practitioners who agree to the Optional Payment Method, a CAH must forward a copy of a completed Medicare Enrollment Application for Reassignment of Medicare Benefits (Form CMS-855R) to the MAC and reassign their benefits. The CAH keeps the original form on file.
During critical or key procedure times and when different teaching anesthesiologists are present with the resident, report the National Provider Identifier (NPI) of the teaching anesthesiologist who started the case on the claim.

When a CAH elects the Optional Payment Method, it stays in effect until the CAH submits a termination request. CMS does not make CAHs submit an annual election to get paid under the Optional Payment Method. If the CAH elects to end its Optional Payment Method, it must submit its request to the MAC in writing at least 30 days before the start of the next cost reporting period. If you have more questions, contact your MAC.

Beginning January 1, 2004, Medicare bases the CAH Outpatient Optional Payment Method services payment on the sum of the following:

- **For facility services:** 101 percent of CAH reasonable costs, after applicable deductions, even if the physician or practitioner reassign their billing rights
- **For physician professional services:** 115 percent of the Medicare PFS allowable amount, after applicable deductions
- **For non-physician practitioner professional services:** 115 percent of the Medicare PFS amount. Medicare normally pays for the practitioner’s professional services, after applicable deductions

**Payment for Telehealth Services**

When the distant site physician or other practitioner is located in an Optional Payment Method CAH and reassigns their billing, Medicare pays 80 percent of the PFS for telehealth services.

**Payment for Teaching Anesthesiologist Services**

When a teaching anesthesiologist is located in an Optional Payment Method CAH and reassigns their outpatient services billing, Medicare pays 115 percent of the PFS if the anesthesiologist is involved in one of these cases:

- Training a resident in a single anesthesia case
- Two concurrent resident anesthesia cases
- A single resident anesthesia case concurrent to another case paid under the medically directed rate

**Qualify for payment by meeting these requirements:**

- The teaching anesthesiologist (or different anesthesiologist(s) in the same anesthesia group) is present during all critical or key portions of the anesthesia service or procedure
- The teaching anesthesiologist, or an anesthesiologist they entered into an arrangement with, must be immediately available to provide anesthesia services during the entire service or procedure

**The patient’s medical record must document:**

- The teaching anesthesiologist’s presence during all critical or key portions of the anesthesia service or procedure
- The immediate availability of another teaching anesthesiologist as necessary
Submit teaching anesthesiologist claims using these modifiers:

- AA – Anesthesia services personally performed by an anesthesiologist
- GC – Under a teaching physician, the resident performed part of the service

**ADDITIONAL MEDICARE PAYMENTS**

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

For cost reporting periods beginning October 1, 2013, Medicare pays CAHs for training full-time equivalent (FTE) residents in approved CAH residency training programs.

- A hospital cannot claim CAH residency training time to the hospital’s direct graduate medical education and/or indirect medical education FTE resident count.
- Medicare pays the CAH 101 percent of reasonable incurred costs when training FTE residents during the time they rotate residents to the CAH.

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

As incentive to continue serving the Medicare rural population, CAHs can get reasonable cost-based funding for certain CRNA services.

The regulations at [42 CFR 412.113(c)](https://www.gpo.gov/fdsys/grappicom/gpoaccess/75fr51551.pdf) list the specific requirements hospitals and CAHs must meet to get Medicare rural pass-through funding.

CAHs qualifying for CRNA pass-through payments can get reasonable cost-based inpatient and outpatient payments for CRNA professional services whether they use the Standard Payment Method or the Optional Payment Method.

However, if a CAH opts to include a CRNA in its Optional Payment Method election, Medicare pays the services furnished by that CRNA based on the PFS, and the CAH gives up inpatient and outpatient CRNA pass-through payments for furnished services.

**Health Professional Shortage Area (HPSA) Physician Bonus Program**

Medicare pays physicians (including psychiatrists) a 10 percent outpatient professional services HPSA bonus if they furnish Medicare-patient CAH care in a primary care HPSA or mental health HPSA, within a designated geographic area.

If you reassign your billing rights and the CAH elected the Optional Payment Method, the CAH gets 115 percent of the 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, refer to the HPSA Physician Bonus Program webpage and the Health Professional Shortage Area Physician Bonus Program fact sheet.

**MRHFP STATE GRANTS**

The BBA, Section 4201, authorizes MRHFPs, and consists of two separate, complementary parts:

1. CMS runs a Medicare reimbursement program that provides reasonable cost-based reimbursement for Medicare-certified CAHs.
2. Health Resources & Services Administration (HRSA), through the Federal Office of Rural Health Policy (FORHP), runs a state grant program that supports development of community-based rural organized systems of care in participating states.

To receive funds under the grant program, states must apply for them and engage in rural health planning by developing and maintaining a State Rural Health Plan that:

- Describes and supports the CAH conversions
- Promotes emergency medical services (EMS) integration by linking CAHs to local EMS and their network partners
- Develops CAH rural health networks
- Develops and supports quality improvement initiatives
- Evaluates state programs within the national program goals framework

For more information about the MRHFPs, visit the Rural Hospital Programs website.

**RESOURCES**

**Table 1. CAH Resources**

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<td>(see CoP § 485.645 Special Requirements for CAH Providers of Long-Term Care Services [&quot;Swing-Beds&quot;])</td>
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HELPFUL WEBSITES

American Hospital Association Rural Health Care
https://www.aha.org/advocacy/small-or-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
https://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
https://narhc.org

National Rural Health Association
https://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

Telehealth Resource Centers
https://www.telehealthresourcecenter.org

U.S. Census Bureau
https://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 CMS.gov/Outreach-and-Education/Outreach/OpenDoorForums/Downloads/CMSRuralHealthCoordinators.pdf.

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