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BOOKLET
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# Critical Access Hospital




CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

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## What's Changed?

- Note: No substantive content updates

A Critical Access Hospital (CAH) represents a separate provider type with its own Medicare Conditions of Participation (CoP) and separate payment methods, unlike Medicare Dependent Hospitals and Sole Community Hospitals (42 CFR 485.601–647).

States may establish their own Medicare Rural Hospital Flexibility Programs (MRHFPs). A Medicare rural, limited services, participating hospital can become a CAH if it meets these conditions:

- Currently a Medicare-participating hospital
- Hospital that stopped operating 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

Together we can advance health equity and help eliminate health disparities in rural populations. Find these resources and more from the CMS Office of Minority Health:

- Rural Health
- Data Stratified by Geography (Rural/Urban)
- Health Equity Technical Assistance Program

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; and 42 CFR 410.152(k), 42 CFR 412.3, 42 CFR 413.70, 42 CFR 413.114(a), and 42 CFR 424.15 have CAH information and payment rules.

## Critical Access Hospital Designations

A Medicare participating hospital can become, and remain, a certified CAH by meeting these regulatory requirements (this isn't an all-inclusive list but includes basic criteria):

- Located in a state that established a rural health plan for MRHFPs (currently only Connecticut, Delaware, Maryland, New Jersey, and Rhode Island haven't established MRHFP State Rural Plans)
- Located in a rural area or treated as rural under a special provision treating qualified hospital providers in urban areas as rural (42 CFR 412.103)
  - CAHs have a 2-year transition period to reclassify as rural if the Office of Management and Budget changes their location designation to urban
- Provide 24-hour emergency services, 7 days a week, using on-site or on-call staff, with specific on-site, on-call staff response times
- Doesn't exceed 25 inpatient beds used for inpatient or 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 and CAH CoPs in the DPU
- Report an annual average acute care inpatient Length of Stay (LOS) of 96 hours or less (excluding swing bed services and DPU beds)
  - We don't assess this requirement on initial certification; it only applies after CAH certification
- If a state didn't designate a CAH a necessary provider before January 1, 2006, it must be **more than** a 35-mile drive from any other CAH or hospital (or a 15-mile drive if mountainous terrain or areas with only secondary roads available)

In hospice care cases, a hospice may contract with a CAH to provide the hospice hospital benefit. We reimburse the hospice.

The CAH may dedicate beds to hospice care but they must count them toward the 25-bed maximum. However, don't include hospice patients in the 96-hour annual average LOS calculation.

You can admit hospice patients to a CAH for any care in their hospice treatment plan or respite care. The CAH negotiates reimbursement through an agreement with the hospice.

## Critical Access Hospital Payments

- We pay CAHs most inpatient and outpatient services provided to patients at 101% of reasonable costs
- We don't include CAHs in the hospital Inpatient Prospective Payment System (IPPS) or the hospital Outpatient Prospective Payment System (OPPS)
- We pay CAH services according to Part A and Part B deductible and coinsurance amounts and don't limit the 20% CAH Part B outpatient copayment amount by the Part A inpatient deductible amount
- We encourage CAHs to help patients understand service charges and potential financial obligations

### Critical Access Hospital Distinct Part Units

- We pay CAH DPU inpatient rehabilitation services under the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS)
- We pay CAH DPU psychiatric services under the Inpatient Psychiatric Facility (IPF) PPS

### Critical Access Hospital Swing Beds

- We pay CAHs swing-bed services under section 1883(a)(3) of the Social Security Act and 42 CFR 413.114(a)(2)
- During the COVID-19 Public Health Emergency (PHE), we've waived the limit on the number of swing beds
- CAH swing bed services aren't subject to Skilled Nursing Facility (SNF) PPS
  - Instead, we pay CAHs based on 101% of reasonable costs
- CAHs may bill bed and board, nursing, and other related services, use of CAH facilities, medical social services, drugs, biologicals, supplies, appliances, and equipment for inpatient hospital care and treatment
  - CAHs can bill diagnostic or therapeutic items or services they, or others, provide under arrangement

## Inpatient Admissions

We pay CAHs under Part A (inpatient) when they meet these requirements:

- Physician or other qualified practitioner orders admission and physician certifies they expect the individual discharged or transferred to a hospital within 96 hours of CAH admission (42 CFR 412.3 and 42 CFR 485.638(a)(4)(iii))
- An individual may remain a CAH inpatient for more than 96 hours
  - If physician can't certify at time of admission that they expect the individual to be discharged or transferred to a hospital within 96 hours, the CAH will not get inpatient service payment
- Physician must complete certification, sign it, and document in medical record no later than 1 day before submitting inpatient services claim
- We don't apply the 96-hour certification requirement to these services:
  - Time as CAH outpatient
  - Time providing skilled nursing swing bed services
  - Time in CAH DPU

The 96-hour certification clock begins when the physician or other qualified practitioner admits the patient via a written order in the patient's medical record.

- Quality Improvement Organizations (QIOs), Medicare Administrative Contractors (MACs), Recovery Audit Contractors (RACs), and Supplemental Medical Review Contractors (SMRCs) aren't auditing the CAH 96-hour certification requirement as a medical record high priority
- CAHs should not expect to get 96-hour certification medical record requests from these contractors unless we or contractors find:
  - Gaming evidence
  - Screening and revalidation provider compliance failure
  - Other medical review issues

**Note:** Although the MACs, RACs, and SMRCs no longer make auditing the CAH 96-hour certification requirement a high priority, the CMS Regional Office Division of Survey and Certification (RO DSC), the State Survey Agencies (SAs), and the Accrediting Organizations (AOs) will verify CAH CoP LOS compliance according to 42 CFR 485.620(b), which states that the CAH provides acute inpatient care for a period that doesn't exceed 96 hours per patient, on average, annually.

MACs determine 96-hour annual average LOS CoP compliance. They calculate the CAH's LOS based on patient census data. If a CAH exceeds the LOS limit, their MAC sends a report to the CMS RO DSC and a copy to the SA. The CMS RO requires CAHs develop and implement an acceptable Plan of Correction or provide adequate information demonstrating compliance.

**Note:** During the COVID-19 PHE, we waived the 96-hour LOS requirement.

Inpatient hospital services with 20 inpatient days or more cases **must** meet additional certification requirements (42 CFR 424.13).

## Ambulance Transports

- We pay CAH-provided ambulance services and ambulance services provided by an entity the CAH owns and operates based on 101% of reasonable costs if it's the only ambulance provider or supplier within a 35-mile drive of the CAH
  - The 35-mile drive requirement excludes ambulance providers or suppliers not legally authorized to provide ambulance services to transport to or from the CAH
- If there's no ambulance provider or supplier within a 35-mile drive of the CAH, and the CAH owns and operates an entity providing ambulance services more than a 35-mile drive from the CAH, we base the entity's ambulance payment on 101% of reasonable costs if that entity is the closest ambulance provider or supplier to the CAH

## Critical Access Hospital Reasonable Cost Payment Principles That Don't Apply

CAH inpatient or outpatient services payments **aren't** subject to these reasonable cost principles:

- Lesser of cost or charges
- Reasonable compensation equivalent limits

We don't apply limits 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.

We apply payment window provisions to outpatient services if a patient receives 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 Optional Payment Method (Method II)

## Standard Payment Method: Reasonable Cost-Based Facility Services with Medicare Administrative Contractor Professional Services Billing

We pay CAHs under the Standard Payment Method unless they elect the Optional Payment Method (section 1834(g)(1) of the Social Security Act). We pay CAH outpatient facility services at 101% of reasonable costs.

Under the Standard Payment Method, the physician or practitioner bills their outpatient professional services under the Medicare Physician Fee Schedule (PFS). We define professional medical services payment as physician- or other qualified practitioner-provided services.

## Optional Payment Method: Reasonable Cost-Based Facility Services Plus 115% Professional Services Fee Schedule Payment

CAHs may elect the Optional Payment Method (section 1834(g)(2) of the Social Security Act). The CAH bills their MAC facility and professional outpatient services when physician(s) or practitioner(s) reassign their billing rights to them. We pay CAH outpatient facility services at 101% of reasonable costs. If a CAH elects this option, each physician or practitioner providing professional outpatient CAH services can choose to:

- Reassign their billing rights to the CAH and agree to the Optional Payment Method
  - Must attest in writing they won't bill their MAC for professional CAH outpatient services
- File MAC claims for their professional services under the Medicare PFS

For physicians or practitioners who elect the Optional Payment Method, a CAH must forward a completed Medicare Enrollment Application: Reassignment of Medicare Benefits (CMS-855R) to their MAC and reassign their benefits. The CAH keeps the original form on file.

When CAHs elect the Optional Payment Method, it stays in effect until the CAH submits a termination request. We don't make CAHs submit an annual payment election under the Optional Payment Method. If the CAH elects to end its Optional Payment Method, it must submit its request to their MAC in writing at least 30 days before the start of the next cost reporting period. For more information, find your MAC's website.

We base the CAH outpatient Optional Payment Method services payment on the sum of these:

- **Facility services:** 101% of CAH reasonable costs, after applicable deductions
- **Physician professional services:** 115% of our PFS allowable amount, after applicable deductions
- **Non-physician practitioner professional services:** 115% of PFS amount we normally pay practitioner's professional services, after applicable deductions

## Telehealth Services Payment

- We pay telehealth services at 80% of PFS when the location of the distant site physician or other practitioner is in a CAH electing the Optional Payment Method and the physician or other practitioner reassigns their billing rights to the CAH

## Teaching Anesthesiologist Services Payment

When a teaching anesthesiologist's location is a CAH that elected the Optional Payment Method and the anesthesiologist reassigns their billing rights, we pay 115% of PFS if the anesthesiologist is involved in 1 of these cases:

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

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

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

**Patient's medical record must document:**

- Teaching anesthesiologist's presence during all critical or key portions of the anesthesia service or procedure
- Immediate availability of another teaching anesthesiologist as necessary

Report the National Provider Identifier (NPI) of the teaching anesthesiologist who started the case on the claim during critical or key procedure times and when different teaching anesthesiologists are with the resident.

**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 Critical Access Hospital

CAHs can choose to incur residency training costs directly or function as a Medicare Graduate Medical Education (GME) nonprovider setting for payment purposes.

- If a CAH incurs residency training costs directly, we pay them 101% of reasonable costs of training the Full-Time Equivalent (FTE) residents
- If a CAH functions as a nonprovider site, a hospital can include the FTE residents training at the CAH in its FTE resident count if it meets the nonprovider site requirements (42 CFR 412.105(f)(1)(ii)(E) and 42 CFR 413.78(g))

## Medicare Certified Registered Nurse Anesthetist Services Rural Pass-Through Funding

- As incentive to continue serving the rural population, CAHs can get reasonable cost-based funding for certain Certified Registered Nurse Anesthetist (CRNA) services
- 42 CFR 412.113(c) lists the specific requirements rural hospitals and CAHs must meet to get Medicare rural pass-through funding
- CAHs qualifying for CRNA pass-through funding can get reasonable cost-based inpatient and outpatient CRNA professional services payments whether they use the Standard Payment Method or Optional Payment Method
- However, if a CAH opts to include a CRNA in its Optional Payment Method election, we pay the CRNA's services based on 115% of the PFS, and the CAH gives up inpatient and outpatient CRNA pass-through delivered services payments

## Health Professional Shortage Area Physician Bonus Program

- We pay physicians (including psychiatrists) a 10% outpatient professional services Health Professional Shortage Area (HPSA) bonus if they provide CAH care in a primary care 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% of applicable Medicare PFS amount multiplied by 110% based on all the quarter's processed claims
- The Physician Bonuses and Health Professional Shortage Area Physician Bonus Program have more information

# Medicare Rural Hospital Flexibility Program State Grants

MRHFPs consists of 2 separate, complementary parts:

- We provide reasonable cost-based Medicare-certified CAH reimbursements
- Health Resources & Services Administration (HRSA), through the Federal Office of Rural Health Policy (FORHP), runs a state grant program supporting community-based rural organized systems of care development in participating states

To get 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 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

Rural Hospital Programs has more information.

## Resources

- Medicare Claims Processing Manual, Chapter 3 & Chapter 4
- Payment for Posthospital SNF Care Furnished by a Swing-Bed Hospital
- Quality Safety & Oversight General Information
- Rural Providers & Suppliers Billing
- State Operations Manual, Appendix W
- Swing Bed Providers
- Swing Bed Services

### Other Helpful Websites

- American Hospital Association Rural Health Services
- Critical Access Hospitals Center
- National Association of Rural Health Clinics
- National Rural Health Association
- Rural Health Clinics Center
- Rural Health Information Hub

### Regional Office Rural Health Coordinators

Get contact information for CMS Regional Office Rural Health Coordinators who offer technical, policy, and operational help on rural health issues.