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Critical Access Hospital

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

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What's Changed?

- CAH temporary emergency coverage without a qualifying hospital stay due to COVID-19 Public Health Emergency (PHE)
- Waiving limitation on number of swing beds (25) and Length of Stay (LOS) of 96 hours during the COVID-19 PHE

You'll find substantive content updates in dark red font.

Introduction

States may establish their own Medicare Rural Hospital Flex 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 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 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. Get the list of CAH CoP at 42 CFR Section 485.601–647.

Get information about CAHs and CAH payment rules at: SSA Sections 1814(a)(8), 1814(l), 1820, 1834(g), 1834(l)(8), 1883(a)(3), and 1861(v)(1)(A); and at 42 CFR Sections 410.152(k), 412.3, 413.70, 413.114(a), and 424.15.

CAH Designations

A Medicare participating hospital can become and remain a certified CAH by meeting these regulatory requirements (this list isn't all-inclusive but indicates some of the 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 an area treated as rural under a special provision that allows treating qualified hospital providers in urban areas as rural (42 CFR Section 412.103). A CAH has a 2-year transition period to reclassify as rural if its location changes to an urban area due to changes in the Office of Management and Budget designation.
- Provides 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.
- Doesn't exceed 25 inpatient beds also used for swing bed services. It may operate either a distinct part rehabilitation or psychiatric unit, each with up to 10 beds. CAHs with Distinct Part Units (DPUs) must follow all hospital 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 doesn't assess this requirement on initial certification and it only applies after CAH certification.
- If a CAH wasn't designated by a state as a necessary provider before December 31, 2005, it 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

- Medicare pays CAHs for most inpatient and outpatient services provided to patients at 101% of reasonable costs.
- Medicare doesn't include CAHs in hospital Inpatient Prospective Payment System (IPPS) or hospital Outpatient Prospective Payment System (OPPS).
- Medicare pays CAH services according to Part A and Part B deductible and coinsurance amounts and doesn't limit the 20% CAH Part B outpatient copayment amount by the Part A inpatient deductible amount.
- CMS encourages CAHs help patients understand charges for services and potential financial obligation.

CAH DPUs

- Medicare pays CAH DPU inpatient rehabilitation services under the Inpatient Rehabilitation Facility Prospective Payment System (PPS).
- Medicare pays CAH DPU psychiatric services under the Inpatient Psychiatric Facility PPS.

CAH Swing-Beds

- Medicare pays CAHs for swing-bed services under SSA Section 1883(a)(3) and in the regulations at 42 CFR Section 413.114(a)(2).
- During the COVID-19 Public Health Emergency (PHE), we waive the limit on the number of swing-beds.
- CAH swing-bed services aren't subject to the Skilled Nursing Facility (SNF) PPS. Instead, Medicare pays CAHs based on 101% of reasonable costs.
- CAHs may bill for 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 arrangements.

Inpatient Admissions

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

- Medicare pays inpatient stays if a physician or other qualified practitioner orders the admission and the physician certifies the individual is expected to be discharged or transferred to a hospital within 96 hours of CAH admission according to 42 CFR Section 412.3 and Section 485.638(a)(4)(iii).

- An individual may remain a CAH inpatient for more than 96 hours. However, if the physician can't certify at the time of admission that the individual is expected to be discharged or transferred to a hospital within 96 hours, the CAH won't get payment for the inpatient service. 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 in the medical record no later than 1 day before submitting the inpatient services claim. Medicare doesn't apply the 96-hour certification requirement to the following services:
  - Time as a CAH outpatient
  - Time providing 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.

- Quality Improvement Organizations, MACs, Recovery Audit Contractors, and Supplemental Medical Review Contractors (SMRCs) no longer make auditing the CAH 96-hour certification requirement a medical records review high priority. CAHs should no longer expect to get 96-hour certification medical record requests from these contractors unless we or the contractors find:
  - Gaming evidence
  - Screening and revalidation provider compliance failure
  - Other medical review issues

NOTE: Although the MACs, Recovery Audit Contractors, 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 DSCs), the State Survey Agencies (SAs), and the Accrediting Organizations (AOs) will verify CAH CoP compliance according to 42 CFR Section 485.620(b). Standard Payment Method: LOS – The CAH provides acute inpatient care for a period that doesn't exceed 96 hours per patient, on average, annually.

The MAC determines compliance with the 96-hour annual average LOS CoP. The MAC calculates the CAH's LOS based on patient census data. If a CAH exceeds the LOS limit, the MAC sends a report to the CMS RO DSC and a copy of the report to the SA. The CMS RO requires the CAH to develop and implement a Plan of Correction (POC) acceptable to them or provide adequate information to demonstrate compliance.

NOTE: For the remainder of the COVID-19 PHE, we waived the 96 hour LOS requirement.

Twenty or more inpatient-day cases **must** meet additional certification requirements. Get more information at 42 CFR Section 424.13.

Ambulance Transports

- Medicare pays ambulance services provided by a CAH or an entity owned and operated by a CAH based on 101% of reasonable costs if the CAH or the entity is the only ambulance provider or supplier within a 35-mile drive of the CAH. The 35-mile drive requirement excludes ambulance providers or suppliers that aren't legally authorized to provide ambulance services to transport individuals to or from the CAH.
- If there's no ambulance provider or supplier within a 35-mile drive of a CAH, and the CAH owns and operates an entity providing ambulance services more than a 35-mile drive from the CAH, payment for the entity's ambulance services is based on 101% of the reasonable costs, if that entity is the closest ambulance provider or supplier to the CAH.

CAH 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

Medicare doesn't 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 (SSA Section 1834(g)(1)). Medicare pays CAH outpatient facility services at 101% of reasonable costs.

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

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

A CAH may elect the Optional Payment Method (SSA Section 1834(g)(2)). The CAH bills the MAC for both facility and professional outpatient services when a physician(s) or practitioner(s) reassigns billing rights to the CAH. Medicare pays 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 either:

- Reassign their billing rights to the CAH and agree to the Optional Payment Method. They must attest in writing they won't bill the MAC for professional CAH outpatient services.
- File MAC claims for their professional services 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: Reassignment of Medicare Benefits (Form CMS-855R) to the MAC and reassign their benefits. The CAH keeps the original form on file.

When a CAH elects the Optional Payment Method, it stays in effect until the CAH submits a termination request. We don't make CAHs submit an annual election for payment 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.

Medicare bases the CAH Outpatient Standard Payment Method and Optional Payment Method services payment on the sum of these:

- **For facility services:** 101% of CAH reasonable costs, after applicable deductions
- **For physician professional services:** 115% of the Medicare PFS allowable amount, after applicable deductions
- **For non-physician practitioner professional services:** 115% of the Medicare PFS amount Medicare normally pays for the practitioner's professional services, after applicable deductions

Payment for Telehealth Services

- Medicare pays telehealth services at 80% of the 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.

Payment for Teaching Anesthesiologist Services

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

- Training a resident in a single anesthesia case
- 2 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

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 present 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 CAH

A CAH can choose either to incur residency training costs directly or to function as a nonprovider setting for Medicare graduate medical education payment purposes.

- If a CAH incurs residency training costs directly, Medicare pays the CAH 101% of the 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 at 42 CFR Section 412.105(f)(1)(ii)(E) and 42 CFR Section 413.78(g).

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 Section 412.113(c) 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 provided by that CRNA based on the PFS, and the CAH gives up inpatient and outpatient CRNA pass-through payments for delivered services.

Health Professional Shortage Area (HPSA) Physician Bonus Program

- Medicare pays physicians (including psychiatrists) a 10% outpatient professional services HPSA bonus if they provide 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% of the applicable Medicare PFS amount multiplied by 110% based on all claims processed during the quarter.
- Find more information about the HPSA Physician Bonus Program on the HPSA Physician Bonus Program webpage and the Health Professional Shortage Area Physician Bonus Program fact sheet.

MRHFP State Grants

MRHFPs consists of 2 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 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 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

Find more information about the MRHFPs on the Rural Hospital Programs webpage.

Resources

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

Rural Providers Helpful Websites

- American Hospital Association Rural Health Services
- CMS Rural Health
- 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.