



Critical Access Hospital



LEGISLATION ENACTED AS PART OF THE **BALANCED BUDGET ACT (BBA) OF 1997** authorized states to establish State Medicare Rural Hospital Flexibility Programs (Flex Program), under which certain facilities participating in Medicare can become Critical Access Hospitals (CAH). The following providers may be eligible to become CAHs:

- Currently participating Medicare hospitals;
- Hospitals that ceased operation during the 10 year period from November 29, 1989 through November 29, 1999; 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.

Unlike facilities such as Medicare Dependent Hospitals or Sole Community Hospitals, CAHs represent a separate provider type with their own Medicare Conditions of Participation as well as a separate payment method.

Critical Access Hospital Designation

A hospital must meet the following criteria to be designated a CAH:

- Be located in a state that has established a State Flex Program (as of December 2008, only Connecticut, Delaware, Maryland, New Jersey, and Rhode Island did not have such a 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 for purposes of becoming a CAH;
- Furnish 24-hour emergency care services, using either on-site or on-call staff;
- Provide no more than 25 inpatient beds that can be used for either inpatient or swing bed services; however, a CAH may also operate a distinct part rehabilitation or psychiatric unit, each with up to 10 beds;
- Have an average annual length of stay of 96 hours or less (excluding beds that are within distinct part units [DPU]); and
- Be located either more than 35 miles from the nearest hospital or CAH or more than 15 miles in areas with mountainous terrain or only secondary roads OR prior to January 1, 2006 were State certified as a “necessary provider” of health care services to residents in the area.

Critical Access Hospital Payments

Medicare pays CAHs for most inpatient and outpatient services to Medicare beneficiaries on the basis of reasonable cost. Under the Medicare ambulance benefit, if a CAH or an entity that is owned and operated by the CAH is the only provider or supplier of ambulance service located within a 35 mile drive of that CAH or entity, the CAH is paid based on reasonable cost for the ambulance services. CAHs are not subject to the Inpatient Prospective Payment Systems (IPPS)

and Hospital Outpatient Prospective Payment System (OPPS).

The Medicare Part A and Part B deductible and coinsurance rules applicable to hospital services also apply to CAHs. All outpatient CAH services are subject to Part B deductible and coinsurance except as follows:



- The beneficiary pays no Part B deductible or coinsurance for the following services:
 - Current Procedural Terminology (CPT) codes 90669 and 90732—Pneumococcal vaccines;
 - Healthcare Common Procedure Coding System (HCPCS) code G0009—Related administration of the pneumococcal vaccines;
 - CPT codes 90655, 90656, 90657, 90658, and 90660—Influenza vaccines;
 - HCPCS code G0008—Related administration of the influenza vaccine;
 - CPT codes 77052, 77057, and HCPCS code G0202—Screening mammography;
 - All codes for clinical diagnostic laboratory tests;
 - CPT code 82270—Fecal occult blood test; and
 - HCPCS code G0328—Fecal occult blood test (alternative to CPT code 82270).
- The beneficiary pays no Part B deductible and is responsible for paying the coinsurance for the following colorectal cancer screening services:
 - HCPCS code G0104—Flexible sigmoidoscopy;
 - HCPCS code G0105—Colonoscopy (high risk);
 - HCPCS code G0106—Barium enema (alternative to HCPCS code G0104);

- HCPCS code G0120—Barium enema (alternative to HCPCS code G0105); and
- HCPCS code G0121—Colonoscopy (not high risk).

Reasonable Cost Payment Principles that Do NOT Apply to Critical Access Hospitals

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, payment to a CAH for inpatient CAH services is 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 OPFS.

Election of Standard Payment Method or Optional (Elective) Payment Method

Standard Payment Method—Reasonable Cost-Based Facility Services, With Billing of Carrier or A/B Medicare Administrative Contractor for Professional Services

Under Section 1834(g)(1) of the Social Security Act (the Act), CAHs are paid under the Standard Payment Method unless they elect to be paid under the Optional (Elective) Payment Method. For cost reporting periods beginning on or after January 1, 2004, outpatient CAH services payments have been increased to the lesser of:

- 80 percent of the 101 percent of reasonable costs for outpatient CAH services; or
- 101 percent of the reasonable cost of the CAH in furnishing outpatient CAH services less the applicable Part B deductible and coinsurance amounts.

Payment for professional medical services furnished in a CAH to registered CAH outpatients is made by the Medicare Carrier or A/B Medicare Administrative Contractor (MAC) under the Medicare Physician Fee Schedule (MPFS), 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 (Elective) Payment Method—Reasonable Cost-Based Facility Services Plus 115 Percent Fee Schedule Payment for Professional Services (Method 2)

Under Section 1834(g)(2) of the Act, a CAH may elect the Optional (Elective) Payment Method, under which it bills the Medicare Fiscal Intermediary (FI) or A/B MAC for both facility services and professional services to its outpatients. However, even if a CAH makes this election, each practitioner furnishing professional services to CAH outpatients can choose whether to:

- Reassign his or her billing rights to the CAH, agree to be included under the Optional (Elective) Payment Method, attest in writing that he or she will not bill the Carrier or A/B 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 Carrier or A/B MAC for standard payment under the MPFS (i.e., either by billing directly to the Carrier or A/B MAC or by authorizing the

CAH to bill on his or her behalf via a valid reassignment of benefits).

If a physician or other practitioner reassigns his or her Part B billing rights and agrees to be included under a CAH's Optional (Elective) Payment Method, he or she must not bill the Carrier or A/B MAC for any outpatient professional services furnished at the CAH once the reassignment becomes effective. For each physician or practitioner who agrees to be included under the Optional (Elective) Payment method and reassigns benefits accordingly, the CAH must forward a copy of the completed assignment form (Form CMS 855R) to the FI and Carrier or A/B MAC and keep the original on file. Each practitioner must sign an attestation which clearly states that he or she will not bill the Carrier or A/B MAC for any services furnished in the CAH outpatient department once the reassignment has been given to the CAH. This attestation will remain at the CAH. The Optional (Elective) Payment Method remains in effect for the entire cost reporting period and applies to all CAH professional services furnished in the CAH outpatient department by physicians and practitioners who have agreed to be included under the Optional (Elective) Payment Method, completed a Form CMS 855R, and attested in writing that they will not bill the Carrier or A/B MAC for their outpatient professional services. An Optional (Elective) Payment Method election and each practitioner's agreement to be included under the election must be renewed yearly based on the cost reporting year. Form CMS 855R can be found at <http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp> on the CMS website.

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

- For facility services, the lesser of 80 percent of 101 percent of the reasonable cost of the CAH in furnishing CAH services OR 101 percent of the outpatient CAH services less applicable Part B deductible and coinsurance amounts; and
- For physician professional services, 115 percent of the allowable amount, after applicable deductions, under the MPFS. Payment for non-physician practitioner professional services is 115 percent of the amount that otherwise would be paid for the practitioner's professional services under the MPFS.

To elect the Optional (Elective) Payment Method or to change a previous election, a CAH should notify the FI or A/B MAC at least 30 days before the start of the affected cost reporting period.

Effective January 1, 2007, the payment amount is 80 percent of the MPFS for telehealth services when the distant site physician or other practitioner is located in a CAH that has elected the Optional (Elective) Payment Method and the physician or practitioner has reassigned his or her benefits to the CAH.

Medicare Rural Pass-Through Funding for Certain Anesthesia Services

CAHs may participate in the Medicare Rural Pass-Through Program to secure reasonable cost-based funding for certain anesthesia services as an incentive to continue to serve the Medicare population in rural areas. The **Code of Federal Regulations (CFR)** under 42 CFR Section 412.113(c) lists the specific requirements hospitals or CAHs must fulfill to receive rural pass-through funding from Medicare for anesthesia services furnished by certified registered nurse anesthetists (CRNA) that they employ or contract with to furnish such services to CAH patients. CAHs that qualify for a CRNA pass-through exemption receive reasonable cost for CRNA professional services, regardless of whether they choose the

Standard Payment Method or the Optional (Elective) Payment Method for outpatient services, unless they opt to receive payment for outpatient anesthesia as a professional service. In that case, the anesthesia is paid on the anesthesia fee schedule and the CAH gives up the CRNA pass-through exemption for both outpatient and inpatient services.

Health Professional Shortage Area Incentive Payments

Physicians (including psychiatrists) who furnish care in a CAH that is located within a geographic-based, primary medical care Health Professional Shortage Area (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 incentive payment for outpatient professional services furnished to a Medicare beneficiary. If the physician has reassigned his or her billing rights and the CAH has elected the Optional (Elective) Payment Method, the CAH will receive 115 percent of the otherwise applicable MPFS amount multiplied by 110 percent, based on all claims processed during the quarter. If the service is furnished in an area that is on the Centers for Medicare & Medicaid Services (CMS) list of Zip codes that are eligible for the HPSA incentive payment, payments are automatically paid on a quarterly basis. An area may be eligible for the HPSA incentive payment but the Zip code may not be on the list because:

- 1) It does not fall within a designated full county HPSA;
- 2) It is not considered to fall within the county based on a determination of dominance made by the U.S. Postal Service;
- 3) It is partially in a sub-county HPSA; or
- 4) Services with dates of service on or after January 1, 2009 are provided in a Zip code area that was designated as of December 31 of the prior year but are not on the Zip code file.

In these situations, the CAH must utilize an AQ modifier to receive payment.

Physician Scarcity Area Bonus Payments

For dates of service through June 30, 2008, primary care physicians who furnish outpatient professional services to a Medicare beneficiary in an area that has been identified as a primary care Physician Scarcity Area (PSA) and specialty physicians who furnish outpatient professional services to a Medicare beneficiary in an area that has been identified as a specialty care PSA are eligible for a PSA bonus payment of five percent. If the physician has reassigned his or her billing rights and the CAH has elected the Optional (Elective) Payment Method, the CAH will receive 115 percent of the otherwise applicable MPFS amount multiplied by 105 percent, based on all claims processed during the quarter. If the service is furnished in an area that is on the CMS list of Zip codes that are eligible for the PSA bonus payment, payments are automatically paid on a quarterly basis. If the Zip code is not on the list but the area is in a county identified as a PSA, the AR modifier must be used. If the CAH is located in an area that is both an eligible HPSA and an eligible PSA and the Optional (Elective) Payment Method is elected, payment to the CAH for a physician's outpatient professional service will be 115 percent of the otherwise applicable MPFS amount multiplied by 115 percent.

Additional Medicare Prescription Drug, Improvement, and Modernization Act of 2003 Provisions that Impact Critical Access Hospitals

For services furnished on or after January 1, 2005, Section 405 (b) extends reasonable cost reimbursement for CAH costs of compensating physician assistants, nurse practitioners, and clinical nurse specialists who are on call to furnish emergency services.

Section 405(c) states that periodic interim payments will be paid every two weeks for CAH inpatient services furnished on or after July 1, 2004 for CAHs that apply and qualify for the periodic interim payment method.

Section 405(d) mandates that for cost reporting periods beginning on and after July 1, 2004, each physician or other practitioner furnishing professional services in the CAH is not required to reassign his or her Part B benefits to the CAH in order for the CAH to elect the Optional (Elective) Payment Method. For CAHs that elected the Optional (Elective) Payment Method before November 1, 2003 for a cost reporting period that began on or after July 1, 2001, the effective date of the rule is retroactive to July 1, 2001. For CAHs that elected the Optional (Elective) Payment Method on or after November 1, 2003, the effective date of the rule is July 1, 2004.

Under Section 405(e), beginning on January 1, 2004, CAHs may operate up to 25 beds for acute (hospital-level) inpatient care, subject to the 96-hour average length of stay for acute care patients. For CAHs with swing bed agreements, any of its beds may be used to furnish either inpatient acute care or Skilled Nursing Facility level swing bed services. Prior to January 1, 2004, CAHs could not operate more than 15 acute care beds or if they had a swing bed agreement, 25 beds.

Section 405(g) states that for cost reporting periods beginning on or after October 1, 2004, CAHs may establish psychiatric units and/or rehabilitation units that are CAH DPUs. The total number of beds in each CAH DPU may not exceed 10. These beds will not count against the CAH inpatient bed limit of 25. Psychiatric and rehabilitation DPUs must meet the applicable requirements for such beds in short-term general acute care hospitals, and Medicare payments will equal payments that would be made to general short-term acute care hospitals for these services (i.e., payments that are made under the Inpatient Psychiatric Facility Prospective Payment System or the Inpatient Rehabilitation Facility Prospective Payment System). Therefore, payment for services in DPUs of CAHs is not made on a reasonable cost basis.

Section 405(h) mandates that effective January 1, 2006, the provision permitting a state to waive the distance requirements for CAH status via State "necessary provider" designation has sunset (ended). Providers that gained CAH status via "necessary provider" designations prior to January 1, 2006 may generally continue as CAHs on and after January 1, 2006.

Grants to States Under the Medicare Rural Hospital Flexibility 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 the 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.

To find additional information about CAHs, see the **Medicare Claims Processing Manual** (Pub. 100-4) at <http://www.cms.hhs.gov/Manuals> on the CMS website. To find additional information about HPSAs and PSAs, including eligible Zip codes, visit http://www.cms.hhs.gov/hpsapsaphysicianbonuses/01_overview.asp on the CMS website. To access the CFR, visit <http://www.gpoaccess.gov/cfr/index.html> on the Web.

HELPFUL WEBSITES

American Hospital Association Section for Small or Rural Hospitals

http://www.aha.org/aha/key_issues/rural/index.html

Critical Access Hospital Center

<http://www.cms.hhs.gov/center/cah.asp>

Federally Qualified Health Centers Center

<http://www.cms.hhs.gov/center/fqhc.asp>

Health Resources and Services Administration

<http://www.hrsa.gov>

Hospital Center

<http://www.cms.hhs.gov/center/hospital.asp>

HPSA/PSA (Physician Bonuses)

http://www.cms.hhs.gov/hpsapsaphysicianbonuses/01_overview.asp

Medicare Learning Network

<http://www.cms.hhs.gov/MLNGenInfo>

National Association of Community Health Centers

<http://www.nachc.org>

National Association of Rural Health Clinics

<http://www.narhc.org>

National Rural Health Association

<http://www.nrharural.org>

Rural Health Center

<http://www.cms.hhs.gov/center/rural.asp>

Rural Assistance Center

<http://www.raconline.org>

Telehealth

<http://www.cms.hhs.gov/Telehealth>

U.S. Census Bureau

<http://www.Census.gov>

REGIONAL OFFICE RURAL HEALTH COORDINATORS

Below is a list of contact information for CMS Regional Office Rural Health Coordinators who provide technical, policy, and operational assistance on rural health issues.

REGION I – BOSTON

Rick Hoover

E-mail: richard.hoover@cms.hhs.gov

Telephone: (617) 565-1258

States: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

REGION VI – DALLAS

Becky Peal-Sconce

E-mail: becky.pealsconce@cms.hhs.gov

Telephone: (214) 767-6444

States: Arkansas, Louisiana, New Mexico, Oklahoma, and Texas

REGION II – NEW YORK

Miechal Lefkowitz

E-mail: miechal.lefkowitz@cms.hhs.gov

Telephone: (212) 616-2517

States: New Jersey, New York, Puerto Rico, and Virgin Islands

REGION VII – KANSAS CITY

Robert Epps

E-mail: robert.epps@cms.hhs.gov

Telephone: (816) 426-6538

States: Iowa, Kansas, Missouri, and Nebraska

REGION III – PHILADELPHIA

Patrick Hamilton

E-mail: patrick.hamilton@cms.hhs.gov

Telephone: (215) 861-4097

States: Delaware, Maryland, Pennsylvania, Virginia, West Virginia, and Washington DC

REGION VIII – DENVER

Lyla Nichols

E-mail: lyla.nichols@cms.hhs.gov

Telephone: (303) 844-6218

States: Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming

REGION IV – ATLANTA

Lana Dennis

E-mail: lane.dennis@cms.hhs.gov

Telephone: (404) 562-7379

States: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee

REGION IX – SAN FRANCISCO

Neal Logue

E-mail: neal.logue@cms.hhs.gov

Telephone: (415) 744-3551

States: Arizona, California, Hawaii, Nevada, Guam, Commonwealth of the Northern Mariana Islands, and American Samoa

REGION V – CHICAGO

Christine Davidson

E-mail: christine.davidson@cms.hhs.gov

Telephone: (312) 886-3642

States: Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin

REGION X – SEATTLE

Alma Hardy

E-mail: alma.hardy@cms.hhs.gov

Telephone: (206) 615-2387

States: Alaska, Idaho, Oregon, and Washington

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The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at <http://www.cms.hhs.gov/MLNGenInfo/> on the CMS website.

Medicare Contracting Reform (MCR) Update

In Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Congress mandated that the Secretary of the Department of Health and Human Services replace the current contracting authority under Title XVIII of the Social Security Act with the new Medicare Administrative Contractor (MAC) authority. This mandate is referred to as Medicare Contracting Reform. Medicare Contracting Reform is intended to improve Medicare's administrative services to beneficiaries and health care providers. All Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by the new A/B MACs by 2011. Providers may access the most current MCR information to determine the impact of these changes and to view the list of current MACs for each jurisdiction at <http://www.cms.hhs.gov/MedicareContractingReform> on the CMS website.

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