Critical Access Hospital

RURAL HEALTH FACT SHEET 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 (CAH):

- Background;
- CAH designation;
- CAH payments;
- 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.

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.

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.
CAH DESIGNATION

A Medicare participating hospital must meet the following criteria to be designated 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 for purposes of becoming a CAH;
- Demonstrate compliance with the CoPs found at 42 CFR Part 485 subpart F at the time of application for CAH 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; however, it 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 per patient for acute care (excluding swing bed services and beds that are within distinct part units).

Note: Payment rules require a physician to certify that an individual may be reasonably expected to be discharged or transferred within 96 hours after admission to the CAH; and

- Be located more than a 35-mile drive from any hospital or other CAH; or
- Be 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.

To be considered in an area with mountainous terrain, the CAH must:

- Be located in a mountain range, identified as such on any official maps or other documents prepared for, and issued to, the public; and
- Have one of the following characteristics:
  - Extensive sections of roads with steep grades, continuous abrupt and frequent changes in elevation or direction, or any combination of horizontal and vertical alignment that causes heavy vehicles to operate at crawl speeds for significant distances or at frequent intervals; or
  - Considered mountainous terrain by the State Transportation or Highway agency based on requirements for significantly more complicated than usual construction techniques to achieve compatibility between the road alignment and surrounding rugged terrain (for example, roadbeds with frequent benching, side hill excavations, and embankment fills).


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 an outpatient CAH service is not limited by the Part A inpatient deductible amount.
Inpatient Admissions
To receive payment under Part A, a reasonable and necessary hospital inpatient admission must include a physician certification that includes:

- An order in which the physician reasonably expects the patient to require a stay that crosses 2 midnights and involves medically necessary inpatient services;
- The reason for inpatient services;
- Estimated time the patient will require in the hospital;
- Plans for post-hospital care, if appropriate; and
- Certification that the patient may be reasonably expected to be discharged or transferred within 96 hours after admission to the CAH.

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, 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 OPPS. 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.

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

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 to the MAC and keep the original on file. This attestation will remain at the CAH.

Once the Optional Payment Method is elected, it will remain in effect until the CAH submits a termination request to the MAC. A CAH is no longer 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;
- Complete Form CMS-855R; and
- Attest in writing that they will not bill the MAC for their outpatient professional services.


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; and
- For physician professional services – 115 percent of the allowable amount, after applicable deductions, under the Medicare PFS. Payment for non-physician practitioner professional services is 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**

Effective January 1, 2007, 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**

Effective January 1, 2010, 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 Certain Anesthesia Services**

CAHs may receive reasonable cost-based funding for certain anesthesia 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 anesthesia services furnished by certified registered nurse anesthetists (CRNA) whom they employ or contract with to furnish such services to CAH patients.

CAHs that qualify for CRNA pass-through payments receive reasonable cost-based payments for CRNA professional services regardless of whether they choose the Standard Payment Method or the Optional Payment Method for outpatient services, unless they opt to include CRNA outpatient professional services under their Optional Payment Method election.

For CAHs that opt to receive payment for outpatient anesthesia as a professional service, the anesthesia service is paid on the anesthesia fee schedule and the CAH gives up the CRNA pass-through exemption for both outpatient and inpatient services.

**Incentive Payments**

**Health Professional Shortage Area (HPSA) Incentive Bonus Payment**

Physicians (including psychiatrists) who furnish care in a CAH located within a geographic-based, primary care HPSA and psychiatrists who furnish care in a CAH 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 reassigned your billing rights and the CAH 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.
The HPSA physician bonus payment is made automatically to physicians who furnish services to Medicare patients in a ZIP code on the list of ZIP codes eligible for automatic HPSA bonus payment. This list is updated annually and is effective for services furnished on and after January 1 of each calendar year.

Physicians who furnish services to Medicare patients in a geographic HPSA that is not on the list of ZIP codes eligible for automatic payment must use the AQ modifier, “Physician providing a service in an unlisted Health Professional Shortage Area (HPSA),” on the claim to receive the bonus payment. Services submitted with the AQ modifier are subject to validation by Medicare. Physicians must ensure that the modifier is used only for services provided to a Medicare patient in an area designated as a geographic primary care HPSA (or a mental health geographic HPSA for psychiatrists) as of December 31 of the prior year.

An area may be eligible for the HPSA bonus payment but the ZIP code may not be on the list because:

1. It does not fall entirely within a designated full county HPSA bonus area;
2. It is not considered to fall within the county based on a determination of dominance made by the United States (U.S.) Postal Service;
3. It is partially within a non-full county HPSA; or
4. Services are provided in a ZIP code area that was not included in the automated file of HPSA areas based on the date of the data used to create the file.

For ZIP codes that are not on the automated payment list, visit the following web pages for assistance in determining whether an area is in a geographic-based primary care or mental health HPSA:

- The Health Resources and Services Administration (HRSA) Data Warehouse located at [http://datawarehouse.hrsa.gov](http://datawarehouse.hrsa.gov) on the HRSA website;
- The American FactFinder located at [http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml](http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml) on the U.S. Census Bureau website; and

**Health Professional Shortage Area (HPSA) Surgical Incentive Payment Program (HSIP)**

Under the Affordable Care Act, effective for services furnished on and after January 1, 2011, general surgeons who furnish a 10- or 90-day global surgical procedure in a ZIP code located in a HPSA are eligible for a 10 percent HPSA bonus payment and a 10 percent HPSA Surgical Incentive Payment.

**Primary Care Incentive Payment (PCIP)**

Under the Affordable Care Act, effective for services furnished on and after January 1, 2011, the following physician and non-physician specialties are potentially eligible for a Primary Care Incentive Payment (PCIP) of 10 percent of paid charges for Part B primary care services furnished to Medicare patients:

- Family, internal, geriatric, and pediatric medicine physicians;
- Clinical nurse specialists;
- Nurse practitioners; and
- Physician assistants.

Only those practitioners enrolled in Medicare with one of the specialties listed above and whose primary care services accounted for at least 60 percent of his or her paid charges under the Medicare PFS (excluding hospital inpatient care and emergency department visits) during the designated period are eligible for the PCIP. Eligibility for the PCIP is determined on an annual basis.

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The PCIP is paid on a quarterly basis and is in addition to other applicable physician incentive payments.

The chart below lists the primary care services that are eligible for the PCIP.

### Primary Care Services Eligible for PCIP

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<tr>
<td>New and Established Patient Office or Other Outpatient Visits</td>
<td>CPT codes 99201 – 99215</td>
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<tr>
<td>Nursing Facility Care Visits and Domiciliary, Rest Home, Custodial Care, or Home Care Plan Oversight Services</td>
<td>CPT codes 99304 – 99340</td>
</tr>
<tr>
<td>Patient Home Visits</td>
<td>CPT codes 99341 – 99350</td>
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**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 HRSA 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

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<tr>
<th>For More Information About...</th>
<th>Resource</th>
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<tr>
<td>Health Professional Shortage Areas</td>
<td><a href="http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses">http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses</a> on the CMS website</td>
</tr>
<tr>
<td>Medicare Information for Patients</td>
<td><a href="http://www.medicare.gov">http://www.medicare.gov</a> on the CMS website</td>
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Helpful Websites

American Hospital Association Rural Health Care  
http://www.aha.org/advocacy-issues/rural

Critical Access Hospitals Center  
http://www.cms.gov/Center/Provider-Type/Critical-Access-Hospitals-Center.html

Disproportionate Share Hospital  
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html

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

Health Resources and Services Administration  
http://www.hrsa.gov

Hospital Center  
http://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

Physician Bonuses  
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPPSAPhysicianBonuses

Rural Assistance Center  
http://www.raconline.org

Rural Health Clinics Center  
http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

Swing Bed Providers  
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SwingBed.html

Telehealth  
http://www.cms.gov/Medicare/Medicare-General-Information/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: rick.hoover@cms.hhs.gov  
Telephone: (617) 565-1258  
States: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

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 III – Philadelphia  
Patrick Hamilton  
E-mail: patrick.hamilton@cms.hhs.gov  
Telephone: (215) 661-4097  
States: Delaware, Maryland, Pennsylvania, Virginia, West Virginia, and the District of Columbia

Region IV – Atlanta  
Lana Dennis  
E-mail: lana.dennis@cms.hhs.gov  
Telephone: (404) 562-7379  
States: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee

Region V – Chicago  
Nicole Jacobson  
E-mail: nicole.jacobson@cms.hhs.gov  
Telephone: (312) 353-5737  
States: Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin

Region VI – Dallas  
Kaleigh Emerson  
E-mail: kaleigh.emerson@cms.hhs.gov  
Telephone: (214) 767-6444  
States: Arkansas, Louisiana, New Mexico, Oklahoma, and Texas

Region VII – Kansas City  
Claudia Ogders  
E-mail: claudia.odgers@cms.hhs.gov  
Telephone: (816) 426-6524  
States: Iowa, Kansas, Missouri, and Nebraska

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 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 X – Seattle  
Teresa Cumpton  
E-mail: teresa.cumpton@cms.hhs.gov  
Telephone: (206) 615-2391  
States: Alaska, Idaho, Oregon, and Washington

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