FACT SHEET
CRITICAL ACCESS HOSPITAL PROGRAM

The Critical Access Hospital (CAH) Program, created by Congress in the Balanced Budget Act of 1997, is designed to support limited-service hospitals located in rural areas. CAH enhancements have been included in §403 of the Balanced Budget Refinement Act of 1999, §201 – 206 of the Benefits Improvement and Protection Act of 2000, and the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 as discussed below.

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

- Located in a rural area.

- Provide 24-hour emergency care services.

- Average length of stay of 96 hours or less.

- More than 35 miles from a hospital or another CAH or more than 15 miles in areas with mountainous terrain or only secondary roads **OR** certified by the State as being a "necessary provider" of healthcare services to residents in the area. MMA, *§405(h)* – Effective January 1, 2006, the provision permitting a State to waive the distance requirements for CAH status via State "necessary provider" designation will sunset. Providers with CAH status as "necessary providers" via State designation prior to January 1, 2006 will be grandfathered as CAHs on and after January 1, 2006.

- MMA, *§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 swing bed services. Prior to January 1, 2004, CAHs could not operate more than 15 acute care beds or more than 25 beds if it included up to 10 swing beds.

Medicare pays CAHs for inpatient and outpatient services on the basis of their current Medicare-allowable costs or "cost-based reimbursement" and are paid cost for ambulance services if they are the only ambulance supplier within 35 miles. CAHs are exempt from the inpatient and outpatient prospective payment systems.

CAHs may elect payment under either the Standard Payment Method or the Optional (Elective) Payment Method. If the Optional (Elective) Payment Method is chosen, the election remains in effect for the entire cost reporting period and applies to all CAH services furnished in the CAH outpatient department during that period. To make a new election or change a previous election, CAHs should notify their Fiscal Intermediary at least 30 days in advance of the affected cost reporting period.

1. Standard Payment Method – Cost-Based Facility Services, With Billing of Carrier for Professional Services

MMA, *§405(a)* – CAHs will be paid under this 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 CAH services, which is up from 100 percent of reasonable costs for CAH services **OR**

- 101 percent of the reasonable cost of the CAH in furnishing CAH services less the applicable Part B deductible and coinsurance amounts

2. Optional (Elective) Payment Method – Cost-Based Facility Services Plus 115 Percent Fee Schedule Payment For Professional Services

MMA, *§405(a)* – As of January 1, 2004, payment for outpatient CAH services is based on the sum of:

- 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 services less applicable Part B deductible and coinsurance amounts **AND**

- 115 percent of the allowable amount, after applicable deductions, under the Medicare Physician Fee Schedule for physician professional services. Payment for non-physician practitioner professional services is 115 percent of 85 percent of the allowable amount under the Medicare Physician Fee Schedule.

Additional MMA Enhancements

- *§405(a)* – For cost reporting periods beginning on or after January 1, 2004, reimbursement for services furnished will be based on 101 percent of the CAH's reasonable costs, up from 100 percent of reasonable costs.

- *§405(b)* – For services furnished on or after January 1, 2005, cost-based reimbursement is extended to physician assistants, nurse practitioners, and certified nurse specialists who are on-call emergency room providers.

- *§405(c)* – Periodic interim payments will be paid every two weeks for CAH inpatient services furnished on or after July 1, 2004.

- *§405(d)* – For cost reporting periods beginning on and after July 1, 2004, each physician or other practitioner providing professional services in the hospital are not required to reassign their Part B benefits to the CAH in order for the CAH to select the Optional (Elective) Payment Method. 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 this rule is retroactive to July 1, 2001. For CAHs that elected the Optional (Elective) Payment Method on or after November 1, 2003, the rule will be effective on July 1, 2004.

- *§405(f)* – The Medicare Rural Hospital Flexibility Program has been reauthorized to make grants to all states in the amount of $35 million in each of fiscal years 2005 through 2008.

- *§405(g)* – For cost reporting periods beginning on or after October 1, 2004, CAHs may establish psychiatric units and rehabilitation units that are distinct parts (DP) of the hospital. The total number of beds in each CAH DP may not exceed ten. These beds will not count against the CAH inpatient bed limit. The psychiatric and rehabilitation DPs must meet the applicable requirements for such beds in short-term general hospitals, and Medicare payments will equal payments made to short-term general hospitals for these services.

Helpful Rural Health Resources

Administration on Aging
http://www.aoa.gov

Agency for Healthcare Research and Quality
http://www.ahrq.gov

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

Indian Health Service
http://www.ihs.gov

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/

United States Department of Agriculture
http://www.usda.gov

May 2004