Critical Access Hospital

RURAL HEALTH FACT SHEET SERIES

This publication provides the following information about Critical Access Hospitals (CAH):

- Background;
- CAH designation;
- CAH payments;
- Reasonable cost payment principles that do not apply to CAHs;
- Election of Standard Payment Method or Optional (Elective) Payment Method;
- Medicare Rural Pass-Through funding for certain anesthesia services;
- Incentive payments;
- Grants to States under the Medicare Rural Hospital Flexibility Program; and
- Resources.

Background

Legislation enacted as part of the Balanced Budget Act (BBA) of 1997 authorized States to establish a State Medicare Rural Hospital Flexibility Program (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 or 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.
Critical Access Hospital Designation

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

- Be located in a State that has 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 status;
- Furnish 24-hour emergency care services 7 days a week, 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, 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); and
- Be located either more than a 35-mile drive from the nearest hospital or CAH or more than a 15-mile drive in areas 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.

Critical Access Hospital Payments

Medicare pays CAHs for most inpatient and outpatient services to Medicare beneficiaries at 101 percent of reasonable costs. 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, the CAH or the CAH-owned and operated entity is paid 101 percent of the reasonable costs of the CAH or entity in furnishing ambulance services. Additionally, if there is no other provider or supplier of ambulance services within a 35-mile drive of the CAH but there is a CAH-owned and operated entity furnishing ambulance services that is more than a 35-mile drive from the CAH, that CAH-owned and operated entity can be paid 101 percent of reasonable costs for its ambulance services as long as it is the closest provider or supplier of ambulance services to the CAH. CAHs are not subject to the Inpatient Prospective Payment System (IPPS) and the 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, with the exception of certain preventive services. To find additional information about Medicare preventive services, visit [http://www.cms.gov/PrevntionGenInfo](http://www.cms.gov/PrevntionGenInfo) on the Centers for Medicare & Medicaid Services (CMS) website.

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 OPPS.

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

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

Under Section 1834(g)(1) of the Social Security Act (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, 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 costs 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 (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 (Method 2)**

Under Section 1834(g)(2) of the Act, a CAH may elect the Optional 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 who furnishes 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 Payment Method, attest in writing that he or she will not bill the Medicare 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 Medicare Carrier or A/B MAC for standard payment under the Medicare PFS (i.e., either by billing directly to the Medicare Carrier or A/B MAC or by authorizing the CAH to bill on his or her behalf via a valid reassignment of benefits).

If you, the practitioner who furnishes professional services to CAH outpatients, reassign your Part B billing rights and agree to be included under a CAH’s Optional Payment Method, you must not bill the Medicare Carrier or A/B MAC for any outpatient professional services furnished at the CAH once the reassignment becomes effective. You must sign an attestation which clearly states that you will not bill the Medicare Carrier or A/B MAC for any services furnished in the CAH outpatient department once the reassignment has been given to the CAH. 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 the completed assignment form (Form CMS 855R) to the FI and Medicare Carrier or A/B 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 its FI or A/B MAC. A CAH is no longer required to make an annual election in order 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 FI or A/B MAC at least 30 days prior to the start of the next cost reporting period. The optional method election 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 Payment Method, completed a Form CMS 855R, and attested in writing that they will not bill the Medicare Carrier or A/B MAC for their outpatient professional services. To find Form CMS 855R, visit [http://www.cms.gov/CMSForms/CMSForms/list.asp](http://www.cms.gov/CMSForms/CMSForms/list.asp) on the CMS website.

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 has 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 (NPP) professional services is 115 percent of the amount that otherwise would be paid for the practitioner’s professional services under the Medicare PFS.
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 has elected the Optional 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 receive reasonable cost-based funding for certain anesthesia services as an incentive to continue to serve the Medicare population in rural areas. The "CFR" at 42 CFR 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 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 method election. For CAHs that opt to receive payment for outpatient anesthesia as a professional service, 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.

Incentive Payments

Health Professional Shortage Area Incentive Bonus Payment

Physicians (including psychiatrists) who furnish care in a CAH that is located within a geographic-based, primary 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 bonus payment for outpatient professional services furnished to a Medicare beneficiary. If you, the physician, have reassigned your billing rights and the CAH has 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.

On an annual basis CMS publishes an updated list of ZIP codes that are eligible for automatic payment of the HPSA bonus. The list is effective for services furnished on or after January 1 of each calendar year. If you furnished services in an area that is on the CMS list of ZIP codes, the HPSA bonus will be paid automatically on a quarterly basis. 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 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.

In these situations, you must utilize the AQ modifier – Physician providing a service in an unlisted Health Professional Shortage Area (HPSA) – to receive payment. You must verify that you are eligible for the bonus and that the modifier was used only if you are eligible during the current year. Only services furnished in an area that was designated as of December 31 of the prior year are eligible for the HPSA bonus during the current year.

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 ZIP codes that are 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

Under the Affordable Care Act, effective for services furnished on and after January 1, 2011, the following physician and NPP specialties are potentially eligible for a Primary Care Incentive Payment of 10 percent of allowed charges for Part B primary care services furnished to beneficiaries:

- 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 allowed charges under the Medicare PFS (excluding hospital inpatient care and emergency department visits) during the designated period are eligible. Eligibility for the incentive payment is determined annually.

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

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

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.

Resources

For more information about CAHs, refer to the following:

- The “Medicare Claims Processing Manual” (Publication 100-04) located at http://www.cms.gov/Manuals/IOM/list.asp on the CMS website;
- The “Critical Access Hospital” section of the Medicare Learning Network® publication titled “MLN Guided Pathways to Medicare Resources Provider Specific” booklet at http://www.cms.gov/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf on the CMS website; and

For more information about HPSAs, including eligible ZIP codes, visit http://www.cms.gov/hpsapsaphysicianbonuses/01_overview.asp on the CMS website. To find the compilation of Social Security laws, visit http://www.ssa.gov/OP_Home/ssact/title18/1800.htm on the U.S. Social Security Administration website. To find Medicare information for beneficiaries (e.g., Medicare basics, managing health, and resources), visit http://www.medicare.gov on the CMS website.
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) 861-4097
  - 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**
- **Christine Davidson**
  - E-mail: christine.davidson@cms.hhs.gov
  - Telephone: (312) 866-3642
  - States: Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin

**Region VI – Dallas**
- **Becky Peal-Sconce**
  - E-mail: becky.peal-sconce@cms.hhs.gov
  - Telephone: (214) 767-6444
  - States: Arkansas, Louisiana, New Mexico, Oklahoma, and Texas

**Region VII – Kansas City**
- **Claudia Odgers**
  - 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, American Samoa, Marshall Islands, Republic of Palau, and Federated States of Micronesia

**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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