



Medicare Critical Access Hospital Version

KEY CONCEPTS OUTLINE

Module 1: Overview of Critical Access Hospital Designation

I. Medicare Rural Hospital Flexibility Program

A. The Medicare Rural Hospital Flexibility Program was created by the Balanced Budget Act of 1997. Under this program, states can designate certain facilities as critical access hospitals (CAHs). <Social Security Act §§ 1814(l), 1820, 1834(g)>

1. Under the Program, a CAH must also meet *Medicare Conditions of Participation* and guidelines established by CMS. <42 C.F.R. 485 Subpart F>

Connecticut, Delaware, Maryland, New Jersey, and Rhode Island do not participate in the Medicare Rural Hospital Flexibility Program. Rural hospitals located in these states are not eligible to be designated as a CAH.

II. Requirements for Designation as a CAH

A. CMS publishes a helpful guide - "Rural Health Fact Sheet Series – Critical Access Hospital, March 2021" included in the materials behind the outline.

See Handout 3 for a summary of the basic requirements for designation as a CAH.

1. The facility must be:

a. Currently participating in the Medicare program; or

b. A hospital that ceased operations on or after November 29, 1999; or

- c. A health clinic or health center that previously operated as a hospital before downsizing to a health clinic or health center. <42 C.F.R. 485.610(a)>
2. The facility must be located in a rural area of the state that has established a flexibility program, or it must be located in a Metropolitan Statistical Area (MSA) that is treated as being located in a rural area based on a state law or regulation. <42 C.F.R. 485.610(b)>
3. The facility must be located more than 35 miles on primary roads from a hospital or another CAH. Mileage is based on the route primary route (federal highways (interstates, intrastate, expressways, or any other Federal highway with 2 or more lanes each way) between hospitals. <42 C.F.R. 485.610(c)>
 - a. Two exceptions to the 35-mile distance criteria
 - (i) Designation as a "necessary provider" CAH
 1. Prior to January 1, 2006, a state had the authority to waive the 35-mile relative location requirement by designating a facility as a "necessary provider" CAH.
 - a. Section 405(h)(2)(B) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 amended section 1820 of the *Social Security Act* and eliminated a state's authority to waive the 35-mile requirement.
 - b. Existing necessary provider CAHs were grandfathered under the MMA and were able to keep their designation after January 1, 2006.
 - (ii) Mountainous terrain, only secondary roads available, or location on an island
 1. Where mountain passes exist or in areas where only secondary roads are available between hospitals, the facility must be located 15 miles or more from the nearest hospital or another CAH.
 - a. Mountainous terrain and secondary road criteria are verified by state surveyors. <Medicare State Operations Manual, Chapter 2, § 2256A>

2. A CAH may qualify for the exception if it is located on an island that is entirely surrounded by water and is not accessible by any road, it is the only hospital or CAH on the island, and it is located in a rural area of the state as designated by the current Office of Management and Budget (OMB) delineations. <42 C.F.R. 485.610(b)>

b. Off-campus provider-based department or distinct part units

- (i) If a CAH or necessary provider CAH operates an off-campus provider-based location, excluding a rural health clinic, the CAH will continue to meet the location requirement only if the department is more than 35 miles from a hospital or another CAH. <42 C.F.R. 485.610(e)(2)>
 1. Prior exceptions for mountainous terrain, only secondary roads available, and location on an island apply to the off-campus provider-based department.
 - (ii) If a CAH or necessary provider CAH operates an off-campus psychiatric or rehabilitation distinct part unit (DPU), the CAH will continue to meet the location requirement only if the unit is more than 35 miles from a hospital or another CAH. <42 C.F.R. 485.610(e)(2)>
 1. The prior exceptions for mountainous terrain, only secondary roads available, and location on an island apply to a CAH's off-campus DPU (discussed in more detail later).
4. In addition to designation by the state, the facility must meet the *Medicare Conditions of Participation* for Critical Access Hospitals and be certified by CMS as a CAH. <42 C.F.R. Part 485, Subpart F; *Medicare State Operations Manual*, Appendix W – Survey Protocol, Regulations, and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs>

In a state that licenses a CAH under the same licensure rules as other hospitals, a CAH must comply with those licensure rules which may be stricter than the Medicare Conditions of Participation.

5. The CAH must provide acute inpatient care. <42 C.F.R. 485.635(b)(1)(ii)>

- a. The acute care length of stay is limited to an annual average of 96 hours per patient. <42 C.F.R. 485.620(b)>
 - (i) The length of stay is calculated by the CAH's MAC based on patient census data.
 - b. If the CAH exceeds the annual average length of stay limitation, the facility will be required to develop and implement a corrective action plan that must be approved by the CMS Regional Office. <Medicare Claims Processing Manual, Chapter 3, § 30.1>
 - (i) If the plan is not accepted, the CAH may have its Medicare provider agreement terminated.
6. A CAH cannot operate more than 25 inpatient beds for either acute care or for skilled nursing level of care. <42 C.F.R. 485.620(a)>
- a. A CAH may use its beds interchangeably for either acute care or post-acute care.

A "swing bed" is a change in patient status and level of care. The patient "swings" from receiving acute care services to receiving skilled nursing (SNF) services (discussed in a later module).

- b. Certain beds do not count toward the 25-bed limit.
 - (i) Beds used for outpatient services such as observation services, sleep studies, and emergency services will not count toward the inpatient bed limit, but only if they are never used for inpatient services. <See Medicare State Operations Manual, Appendix W, § 485.620(a)>
 - (ii) Bed types that do not count toward the 25- bed limit include, but are not limited to:
 - 1. Beds used solely for patients receiving observation services;
 - a. CMS has instructed surveyors to determine that CAHs are using observation beds appropriately and not as a means to circumvent the acute care bed and length of stay limitations. <See Medicare State Operations Manual, Appendix W § 485.620(a)>
 - i. There should be a reasonable relationship between the size of the CAH's inpatient and observation operations.

For example, a 10-bed observation unit in a 25-bed CAH might be disproportionately large and may be an indication that the observation unit is functioning as an inpatient overflow unit.

- ii. An observation unit that routinely operates at a high occupancy rate could also be an indicator that the area is being used as an inpatient overflow unit.
 - iii. If a CAH maintains beds that are dedicated to observation services, it must be able to provide evidence to demonstrate that its observation beds are not being used for inpatient services, such as the clinical criteria for admission to that unit and how patients in the unit meet those criteria.
 - iv. Observation beds are not included in the calculation for a CAH's average annual acute care inpatient length of stay.
2. Examination, procedure, or operating room tables;
 3. Beds in a surgical recovery room used exclusively for surgical patients during recovery from anesthesia;
 4. Stretchers;
 5. Beds in an OB delivery room used exclusively for OB patients in labor or recovery after delivery of a newborn infant;
 6. Newborn bassinets and isolettes;
 - a. If the baby is being held for treatment in the CAH, the bassinet or isolette will count toward the 25-bed limit.
 7. Stretchers in emergency departments;
 8. Inpatient beds in Medicare-certified rehabilitation or psychiatric distinct part units (discussed later in this module);
 9. A CAH may dedicate beds to a hospice under arrangement. <See *Medicare State Operations Manual*, Appendix W, § 485.620(a)>

The beds will count towards the 25-bed limit. The 96-hour annual average length of stay does not apply to hospice patients.

7. A CAH must provide 24-hour emergency services in accordance with accepted standards of practice for emergency departments. <42 C.F.R. § 485.618(a), (b)>
 - a. A practitioner (i.e., doctor of medicine (MD) or osteopathy (DO), physician assistant, nurse practitioner, or clinical nurse specialist) with training and experience in emergency care may be on-site or on-call. <42 C.F.R. § 485.618(d)>
 - (i) The on-call practitioner must be immediately available by telephone or radio 24-hours a day and on-site within 30 minutes.
 1. In designated frontier areas, the on-call practitioner must be on-site within 60 minutes and meet certain other requirements. <42 C.F.R. § 485.618(d)>
 - (ii) CMS requires that any hospital, including a CAH, that does not have an MD or DO on-site 24-hours per day, seven days per week, must provide a written notice to its patients to assist them in making informed decisions about their care. <42 C.F.R. § 489.20(w)>

The individual notice must indicate how the hospital will meet the medical needs of any patient who develops an emergency medical condition when a physician may not be present when services are being provided.

1. Before admitting a patient or providing certain outpatient services, the hospital must receive a signed acknowledgment from the patient stating that the patient understands that a physician may not be present during all hours of operation when services are furnished to the patient.
 - a. For inpatients, a written notice must be provided at the beginning of the planned or unplanned hospital stay.

- b. For outpatients, a written notice must be provided at the beginning of any planned or unplanned visit for observation, surgery, or any other procedure requiring anesthesia.
 - c. For emergency department patients, an individual notice is not required, but a notice must be posted in a conspicuous place so that it can be seen by all individuals entering the dedicated emergency department.
 - i. Before admitting a patient or providing an outpatient service where notice is required after an emergency visit, the individual notice provisions would apply to that patient.
8. At a minimum, the CAH must provide diagnostic and therapeutic services and supplies that are typically found in a low-intensity hospital outpatient or emergency department. <42 C.F.R. § 485.635(b)(1)(i)>
- a. The extent of the CAH's outpatient services is expected to be sufficient to meet the needs of its patients and the CAH's outpatient services must be integrated with its inpatient services.
 - b. Laboratory services that must be provided on-site at the CAH's main campus that would be considered the minimum necessary for diagnosis and treatment of a patient include:
 - (i) Chemical examination of urine by stick or tablet method;
 - (ii) Hemoglobin or hematocrit;
 - (iii) Blood glucose;
 - (iv) Examination of stool specimens for occult blood
 - (v) Pregnancy tests; and
 - (vi) Primary culturing for transmittal to a certified laboratory. <42 C.F.R. § 485.635(b)(2)>
9. A CAH's professional healthcare staff must include one or more MDs or DOs and may include one or more nurse practitioners (NP), physician assistants (PA), or clinical nurse specialists (CNS). <42 C.F.R. § 485.631(a)>
- a. An MD, DO, NP, PA, or CNS must be available to furnish patient care services at all times the CAH operates. <42 C.F.R. § 485.631(a)(4)>

- b. The physician must be present for sufficient periods of time to provide medical direction, consultation and supervision for the services provided in the CAH. <79 Fed. Reg. 27107; 42 C.F.R. § 485.631(b)(2)>
- (i) All inpatient records for patients whose treatment is primarily managed by a non-physician practitioner must be reviewed by a physician who must sign the records after the review has been completed. <42 C.F.R. § 485.631(b)(1)(iv)>
 - (ii) For outpatient records and when required under state law, the physician must periodically review and sign a sample of records for care that was provided by non-physician practitioners. <79 Fed. Reg. 27153; 42 C.F.R. § 485.631(b)(1)(v)>
- c. Physicians and one or more midlevel practitioners are required to assist in the development and periodic review of the medical staff policies. <42 C.F.R. § 485.635(a)(2)>

Inpatient and outpatient services provided by a CAH are based on the medical staff and the needs of the community and are not limited by CAH designation or licensure. The 25-bed limit and 96-hour annual average per patient length of stay may help determine the types of the services offered.

- d. Physicians within a multi-facility system can have a unified and integrated medical staff. <42 C.F.R. § 485.631(e)>
- (i) Medical staff of each separately certified CAH will need to vote on this process.
 - (ii) Medical staff can established unified bylaws, rules, and requirements that describe the self-governance, credentialing, appointment, privileging, and oversight as will as policies and procedures for the CAH
 - (iii) Medical staff must consider each specific CAH's unique circumstances and differences.

10.A CAH must have an effective Quality assessment and performance improvement (QAPI) program within a CAH or as a unified and integrated program for a multi-facility system. <42 C.F.R. § 485.641>

- a. Must be appropriate for the complexity of the CAH's organization and services provided.
 - b. Be ongoing and comprehensive.
 - c. Involve all departments of the CAH.
 - d. Address outcome indicators related to improved health outcomes and the prevention and reduction of medical errors, adverse events, CAH-acquired conditions, and transitions of care, including readmissions.
 - e. Focus on measures related to improving health outcomes.
 - f. Use measures to track and analyze performance.
 - g. Set priorities for performance improvement, considering either high-volume, high-risk services, or problem-prone areas.
11. A CAH must promote and protect each patient's rights. CAHs must inform patients of their rights before providing care or discontinuing care whenever possible. <42 C.F.R. § 485.614>
- a. A CAH must establish prompt resolution to patient grievances and inform patients who to notify/contact to file a grievance.
 - (i) Procedure for submitting grievances should be provided to patients in writing or verbally.
 - (ii) Grievance process must specify time frames for review, resolution, and response.
 - (iii) Hospital must provide the patient with a written notice to its decision and the person to contact for any questions.
 - b. A CAH must provide the patient with the right to exercise their rights regarding care.
 - (i) Patient has the right to participate in the development and implementation of their plan of care.
 - (ii) Patient or representative can make informed decisions about their care.
 - (iii) Right to formulate advance directives.

- (iv) Right to have family physician notified of their admittance to the hospital.
 - (v) Right to personal privacy.
 - (vi) Receive care in a safe setting.
 - (vii) Be free from all forms of abuse and harassment.
- c. All patients have the right to be free from restraint and seclusion. A CAH is required to provide training and education to all staff regarding restraints and seclusion. <42 C.F.R. § 485.614(e)>
- (i) A restraint is:
 - 1. A physical, manual method, or mechanical device that reduces the patient from moving freely.
 - 2. A drug or medication to manage the patient's behavior or restrict freedom.
 - 3. Does not include orthopedic devices, surgical dressings, bandages, or protective helmets.
 - (ii) Seclusion is the involuntary confinement of a patient alone in a room or area in which they cannot leave.
 - (iii) Hospitals must report deaths associated with the use of restraints and seclusion to CMS by telephone, fax, or electronically.
 - 1. Report no later than the close of business on the next business day following the knowledge of the patient's death:
 - a. Death that occurs while a patient is in restraint or seclusion.
 - b. Occurs within 24 hours after the patient has been removed from restraint and seclusion.
 - c. A death 1 week after restraint and seclusion if it is reasonable to assume it is related.

(iv) Reporting of deaths due to restraints which are solely composed of soft and non-ridged materials must be reported in an internal log or other system.

1. Documented in the medical record and to CMS within 24 hours.
2. Entry into internal system made no later than 7 days after the date of death.
3. Must contain:
 - a. Name
 - b. Date of Birth
 - c. Date of Death
 - d. Name of attending physician or other practitioner
 - e. Diagnosis

d. A CAH must have policies regarding visitation rights of patients. <42 C.F.R. § 485.614(h)>

- (i) Inform patient of his or her visitation rights, including clinical restriction or limitation
- (ii) Not restrict, limit, or deny visitations privileges based on race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

12.A CAH must have an effective discharge planning process that is consistent with the patient's goals for care and individual treatment preferences, ensure an effective transition of the patient from the CAH to post-discharge care, and reduce the factors leading to preventable CAH and hospital readmissions. <42 C.F.R. § 485.642>

- a. Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-CAH care will be made before discharge to avoid unnecessary delays in discharge.

- b. A discharge planning evaluation must include an evaluation of a patient's likely need for post-acute care services with providers and suppliers, other facilities and community agencies, and other outpatient service practitioners responsible for the patient's follow-up or ancillary care.
 - c. The CAH's discharge planning process must require regular re-evaluation of the patient's condition to identify changes that require modification of the discharge plan. The discharge plan must be updated to reflect these changes and it must be discussed with the patient or the patient's representative.
 - d. Any discharge planning evaluation or discharge plan must be developed by, or under the supervision of, a registered nurse, social worker, or other appropriately qualified personnel.
 - e. The CAH must assess its discharge planning process on a regular basis.
 - (i) The assessment must include ongoing, periodic review of a representative sample of discharge plans, including those patients who were readmitted within 30 days of a previous admission, to ensure that the plans were responsive to the patient's post-discharge needs.
13. A CAH must have an active Infection prevention and control and antibiotic stewardship program. The program must provide surveillance, prevention, and control of Hospital Acquired Infections (HAIs) and other infectious disease and for the optimization of antibiotic usage. <42 C.F.R. § 485.640>
- a. The infection prevention program must demonstrate best practices to improve antibiotic use to reduce the transmission of HAIs and antibiotic-resistant organisms.
 - (i) Staff must be qualified and appointed by the governing body.
 - (ii) The programs must have policies and procedures, including methods for preventing transmission of infections within the CAH.
 - (iii) Must provide surveillance, prevention, and control of HAIs by providing a clean and sanitary environment.
 - (iv) Program must reflect the services provided by the CAH.

- b. The antibiotic stewardship program must demonstrate:
 - (i) Qualified and appointed by the governing body.
 - (ii) Responsible for antibiotic use and resistance
 - (iii) Documents evidenced-based use of antibiotics in all departments.
 - (iv) Adhere to national standards and best practice.
 - (v) Report to the Quality Assessment and Performance Improvement (QAPI) Program.
- c. COVID-19 reporting must be completed during the Public Health Emergency <42 C.F.R. § 485.640(d)> electronically.
 - (i) Confirmed COVID-19 infections among patients.
 - (ii) Total deaths among patients.
 - (iii) Personal protective equipment and testing supplies.
 - (iv) Ventilator use, capacity, and supplies.
 - (v) Total bed and intensive care unit bed census and capacity.
 - (vi) Staffing shortages.
 - (vii) COVID-19 vaccine information data of patients and staff.
 - (viii) Relevant therapeutic inventories or usage, or both.
- d. Report acute respiratory illness, including influenza virus electronically through April 30, 2024
 - (i) Confirmed influenza infections among patients.
 - (ii) Total deaths among patients.
 - (iii) Confirmed co-morbid influenza and COVID-19 infections among patients.

IV. Distinct Part Unit

A. A CAH may establish a separate psychiatric and rehabilitation distinct part unit (DPU). < *Social Security Act* § 1820(c)(2)(E); 42 *C.F.R.* § 485.647 >

1. The DPU must meet specific requirements including:

a. Be certified as a CAH by CMS and meet the Medicare *Conditions of Participation*;

b. Meet the requirements that would apply to the DPU if it was established in an acute care hospital; and,

c. Limit the number of beds in each DPU to 10.

(i) DPU beds are excluded from the 25-bed limitation and the 96-hour annual average per patient length of stay limitation.

2. Services provided in the DPU are paid under the payment methodology that would apply if the unit was in an acute care hospital paid under a prospective payment system (PPS). <42 *C.F.R.* § 485.647 >

a. An inpatient rehabilitation facility in a CAH is paid under the Inpatient Rehabilitation Facility PPS (IRF PPS).

b. An inpatient psychiatric unit in a CAH is paid under the Inpatient Psychiatric Facility PPS (IPF PPS).

The following link provides current data on CAHs, including a map, specific information on individual facilities, and those with certified DPUs:

<http://www.flexmonitoring.org>



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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.

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Check for Updates

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 OPSS. 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.

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- 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.

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with emergency training or experience has been on call and available on site at the CAH within 30 or 60 minutes, as appropriate?

C-0898

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§485.618(e) Standard: Coordination With Emergency Response Systems

The CAH must, in coordination with emergency response systems in the area, establish procedures under which a doctor of medicine or osteopathy is immediately available by telephone or radio contact on a 24-hours a day basis to receive emergency calls, provide information on treatment of emergency patients, and refer patients to the CAH or other appropriate locations for treatment.

Interpretive Guidelines §485.618(e)

The CAH, not the local ambulance service, is responsible for ensuring that an effective procedure is in place to meet this requirement.

Survey Procedures §485.618(e)

- Verify that the CAH has policies and procedures in place to ensure an MD/DO is available by telephone or radio, on a 24-hour a day basis to receive emergency calls and provide medical direction in emergency situations?
- What evidence demonstrates that the procedures are followed and evaluated for effectiveness?
- Interview staff to see how an MD/DO is contacted when emergency instructions are needed.

C-0900

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§485.620 Condition of Participation: Number of Beds and Length of Stay

C-0902

(Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)

§485.620(a) Standard: Number of Beds

Except as permitted for CAHs having distinct part units under §485.647, the CAH maintains no more than 25 inpatient beds. Inpatient beds may be used for either inpatient or swing-bed services.

Interpretive Guidelines §485.620(a)

Section 1820(c)(2)(B)(iii) of the Social Security Act limits a CAH to a maximum of 25 inpatient beds that can be used for inpatient acute care or swing bed services. The statute also requires CAHs to provide inpatient acute care limited, on an annual average basis, to 96 hours per patient (see interpretive guidelines for §485.620(b)).

Section 1820(c)(2)(E) of the Act also permits a CAH to operate a 10-bed psychiatric distinct part unit (DPU) and a 10-bed rehabilitation DPU, without counting these beds toward the 25-bed inpatient limit.

The limit applies to the number of inpatient beds; not to the number of inpatients on any given day. CAHs that were larger hospitals prior to converting to CAH status may not maintain more than 25 inpatient beds, plus a maximum of 10 psychiatric DPU inpatient beds, and 10 rehabilitation DPU inpatient beds. Any bed used for inpatient services at any time must be counted when assessing compliance with the 25 inpatient bed limit.

 Beds used for outpatient services, such as observation services, sleep studies, emergency services, etc. do not count towards the CAH's 25-bed limit only if they are never used for inpatient services.

Beds Used for Observation Services

 Beds used solely for patients receiving observation services are not included in the 25-bed maximum, nor in the calculation of the average annual acute care patient length of stay. This makes it essential for surveyors to determine that CAHs with observation beds are using them appropriately, and not as a means to circumvent the CAH size and length-of-stay limits.

Inappropriate use of observation services also subjects Medicare beneficiaries to an increased beneficiary coinsurance liability that could have been avoided, had the beneficiary been properly admitted as an inpatient. This is the case because, as CAHs are not paid under the hospital Outpatient Prospective Payment System (OPPS), the beneficiary in an observation status will be liable for a coinsurance charge equal to 20 percent of the CAH's customary charges for the services. Further, as CAHs are also not subject to the preadmission payment window, a Medicare beneficiary would be liable for the coinsurance charges for the observation status services even when subsequently admitted. Depending on the terms of their health insurance coverage, other CAH patients may also face similar increased and avoidable costs when inappropriately placed in an observation status.

Observation care is a well-defined set of specific, clinically appropriate services that include ongoing short-term treatment, assessment, and reassessment, that are provided before a decision can be made regarding whether a patient will require further treatment as an inpatient, or may be safely discharged. Observation status is commonly assigned to patients with unexpectedly prolonged recovery after outpatient surgery, and to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a clinical decision is made concerning their next placement. The CAH should ensure that once there is sufficient information to render this clinical decision, the patient should be expeditiously admitted, appropriately

transferred, or discharged.

A patient may be in an observation status even though the CAH furnishes the patient overnight accommodation, food, and nursing care.

 Observation services are **NOT** appropriate:

- As a substitute for an inpatient admission;
- For continuous monitoring;
- For medically stable patients who need diagnostic testing or outpatient procedures (e.g., blood transfusion, chemotherapy, dialysis) that are routinely provided in an outpatient setting;
- For patients awaiting nursing home placement;
- To be used as a convenience to the patient, his or her family, the CAH, or the CAH's staff;
- For routine prep or recovery prior to or following diagnostic or surgical services; or
- As a routine “stop” between the emergency department and an inpatient admission.

Observation services **BEGIN** and **END** with an order by a physician or other qualified licensed practitioner of the CAH.

- The order for observation services must be written prior to initiation of the service, as documented by a dated and timed order in the patient's medical record. The order may not be backdated. Orders should be clear for the level of care intended, such as “admit to inpatient” or “place in observation.” (**NOTE:** It is not uncommon for hospitals and practitioners to refer to “admitting” a patient for observation. Technically, only inpatients are “admitted,” while patients receiving observation services are in an outpatient status. However, usage of the term “admit” in an order placing a patient in observation status does not violate any CAH CoP and is not cited.)
- Observation services end when the physician or other qualified licensed practitioner orders an inpatient admission, a transfer to another health care facility, or discharge. The inpatient stay begins on the date and time of the new order.
- Standing orders for observation services are not acceptable, since it is not necessary to employ observation services for every patient in a given category, e.g., every emergency department patient, in order to reach a clinical decision about the appropriate next step in the patient's care.

Medicare generally will not pay for observation services lasting more than 48 hours.

However, some States may have more stringent limits in their licensure or other regulatory requirements on the length of observation services, e.g., 24 hours. In such cases the State's more stringent limit on the length of an observation stay applies to Medicare beneficiaries as well, but is not enforced through the Federal survey process, unless the State has taken a final enforcement action.

The CAHs must provide appropriate documentation upon surveyor request to show that an observation bed is not an inpatient bed. The CAH must be able to document that it has specific clinical criteria for placing a patient in and discharging from, the observation service, and that these criteria are clearly distinguishable from those used for inpatient admission and discharge. CMS expects a CAH to employ the same type of clinical criteria for observation versus inpatient status for all patients, regardless of their payer status. For example, if a CAH were routinely placing only Medicare beneficiaries in its dedicated observation unit, then this could suggest that non-clinical criteria were being used in the decision to admit versus place in observation status. This would not only call the observation bed status into question, but could also violate the CAH's provider agreement requirement that prohibits differential treatment of Medicare beneficiaries. (See 42 CFR 489.53(a)(2)).



If a CAH maintains beds that are dedicated to observation services, the CAH must be able to provide evidence, such as the clinical criteria for admission to that unit and how patients in the unit meet those criteria, to demonstrate that its observation beds are not being used for inpatient services. CMS expects there to be a reasonable relationship between the size of the CAH's inpatient and observation operations. For example, a 10-bed observation unit in a 25-bed CAH might be disproportionately large, and the surveyor must determine whether the observation unit is actually functioning as an inpatient overflow unit. A CAH observation unit that routinely operates at a high occupancy rate could also be an indicator of the need to probe further.

Other Types of Beds

Other bed types that do not count toward the 25 inpatient bed limit include, but are not limited to:

- Examination or procedure tables;
- Stretchers;
- Operating room tables;
- Beds in a surgical recovery room used exclusively for surgical patients during recovery from anesthesia;
- Beds in an obstetric delivery room used exclusively for OB patients in labor or recovery after delivery of newborn infants;
- Newborn bassinets and isolettes used for well-baby boarders (**NOTE:** If the baby is being held for treatment at the CAH, his or her bassinet or isolette

does count towards the CAHs 25-bed limit);

- Stretchers in emergency departments; and
- Inpatient beds in Medicare-certified distinct part rehabilitation or psychiatric units.

Beds Used for Hospice Services

A CAH can dedicate beds to a hospice under arrangement, but the beds must count as part of the maximum bed count. The computation contributing to the 96 hour annual average length of stay does not apply to hospice patients. The hospice patient can be admitted to the CAH for any care involved in their hospice treatment plan or for respite care.

Medicare does not reimburse the CAH for the hospice CAH benefit. Medicare reimburses the hospice. The CAH must negotiate payment for services from the hospice through an agreement.

Survey Procedures §485.620(a)

- Count the number of inpatient beds the CAH maintains, excluding any DPU beds.
- Ask the CAH how frequently it uses observation services, and for its policies and procedures governing use of observation services.
- Verify that patients are never pre-registered for observation services; there should be no scheduled observation stays.
- Check to see if the CAH has specific clinical criteria for placement in and discharge from observation status, and that these clinical criteria are clearly distinguishable from those used for inpatient admission and discharge.
- If there is a separate unit of observation beds, ask the CAH for evidence of how its criteria for placement in the observation unit differ from admission criteria for an inpatient bed. Count the number of beds in the observation unit and compare them to the number of inpatient beds. The higher the proportion of observation beds, the greater is the CAH's burden to prove these are not being used as inpatient beds. Ask for the occupancy rates for the observation unit; the higher the occupancy rate, particularly if there are more than a couple of beds, the greater is the CAH's burden to prove these are not being used as inpatient beds.
- Review the medical records for patients who are in observation status at the time of survey. Verify that the medical record includes an order to place the patient in observation status, including the clinical reason for observation, e.g., as "Place patient in observation to rule out possible myocardial infarction (MI)."

- Select a sample of closed medical records for patients who were in an observation status. Verify that the medical record includes an order to place the patient in observation status, as well as a later order to admit, discharge, or transfer the patient.
- Verify through medical record review that observation services are not ordered as a standing order following outpatient surgery or prior to admission from the emergency department.

C-0904

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§485.620(b) Standard: Length of Stay

The CAH provides acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient.

Interpretive Guidelines §485.620(b)

The Fiscal Intermediary (FI) will determine compliance with this CoP. The FI will calculate the CAH'S length of stay based on patient census data. If a CAH exceeds the length of stay limit, the FI will send a report to the CMS-RO as well as a copy of the report to the SA. The CAH will be required to develop and implement a plan of correction (POC) acceptable to the CMS Regional Office or provide adequate information to demonstrate compliance.

C-0910

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§485.623 Condition of Participation: Physical Plant and Environment

Interpretive Guidelines §485.623

This CoP applies to all locations of the CAH, all campuses, all satellites, all provider-based activities, and all inpatient and outpatient locations.

The CAH'S departments or services responsible for the CAH'S building and equipment maintenance (both facility equipment and patient care equipment) must be incorporated into the CAH'S QA program and be in compliance with the QA requirements.

C-0912

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§485.623(a) Standard: Construction

The CAH is constructed, arranged, and maintained to ensure access to and safety of patients, and provides adequate space for the provision of services.