# CRITICAL ACCESS HOSPITALS: HISTORY, CRITERIA, & REIMBURSEMENT

This information has been carefully compiled through collaboration to be relevant to a nurse's understanding of the Critical Access Hospitals (CAHs) in Montana. It should, also, provide an appreciation and increased knowledge of the convoluted regulations.

Throughout the United States there are 1,332 certified Critical Access Hospitals (CAH)- approximately 3.5% are located in Montana. There are 46 CAHs that are licensed by the State of Montana and 2 federal CAHs (Fort Belknap Service Unit in Harlem and Crow/Northern Cheyenne Indian Hospital at the Crow Agency).

## HISTORY AND DEFINITION

"Critical Access Hospital" (CAH) is a designation given to eligible rural hospitals, or those grandfathered as a "necessary provider" rural hospital by the Centers for Medicare and Medicaid Services (CMS). Congress created the (CAH) designation through the Balanced Budget Act of 1997 in response to a string of rural hospital closures during 1980's and early 1990's.

To determine the CAH model attributes, two existing programs were considered. These models were known as the highly successful Montana's Medical Assistance Facility (MAF) project and the Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) Project. These two "stopgap" measures were set up as demonstration projects involving a handful of small, struggling hospitals to determine a successful model to keep hospitals from permanently closing. The model determine is now known as a CAH.

## BALANCED BUDGET ACT

From 1990 through 1996, 140 rural hospitals closed in the United States These hospitals were generally smaller and treated fewer patients than the national average. Small rural hospitals faced growing difficulty in meeting the full certification requirements for a hospital and were facing growing financial pressures due mainly to inadequate payments from Medicare and other government programs.

In 1997, the Balanced Budget Act enacted by the U.S. Congress included a response to many of the closed hospitals. The purpose of the rural hospital provisions contained in the Balanced Budget Act was to provide regulatory relief to rural facilities, address financial vulnerability, and to improve access to essential health care services in rural areas.

Financial support, then, became possible through cost-based reimbursement by the Centers for Medicare and Medicaid Services (CMS) to hospitals that qualified for the CAH designation and who were determined to be at risk for financial stress. This support was very timely in its delivery. For instance, year 2008 added to the widespread *decrease* in profitability of the hospital industry possibly due to the worsening recessionary economy. The significant long term event would undoubtedly resulted in many more small hospital closures.

The Balanced Budget Act, also, established a Medicare Rural Hospital Flexibility Program (Flex Program) encouraging states to strengthen their rural healthcare initiatives that would add the most value to CAHs in each specific state, support CAH health system development and improvement, and support community continued engagement in the CAH health system.

**GENERAL LICENSING/CERTIFICATION CRITERIA**

**1. Twenty-five (25) or fewer acute care inpatient beds**. The beds (some or all) can be used for either inpatient acute care or long-term (swing bed) care services. A "swing bed" provides flexibility in meeting unpredictable demands for acute care and long-term care. Swing beds are an alternative to both a skilled and intermediate long-term care facility in a rural setting where, usually, there is an older patient population. Swing beds are common in rural hospitals with a CAH status. The most common use of a swing bed is for aging patients needing rehabilitation.

Excluded from this bed count are examination, observation, emergency room or procedure beds, operating room tables, stretchers, and similar surfaces.

**2. Location must be thirty-five (35) miles or more from another hospital or fifteen (15) miles from another hospital in mountainous terrain or areas with only secondary roads.** (Hospitals designated as a "necessary provider" by their state and approved by CMS prior to January 1, 2006 are exempt from these distance requirements.)

**3. An agreement must be developed and maintained with one or more other hospitals regarding patient referral, transfer, communication, and emergency or non-emergency patient transportation.** The receiving hospital can, also, be a CAH, but it must offer services at a higher level of care, such that the sending facility isn't "dumping" patients. The agreement ensures that patients always have at least one place to go. Under the transfer agreement, the receiving facility cannot refuse to accept the sending facility's patients at any time.

**4. Acute care patients can only be kept for an annual average length of stay of ninety-six (96) hours or less; although, case-by-case exceptions may be granted under special circumstances, such as a transfer putting a patient's well-being at risk.** Non-Medicare/Medicaid long-term care (swing bed) bed patients have no length of stay limit.

However, in Montana, patients on Medicaid must be transferred to a Skilled Nursing Facility (SNF) within a twenty-five (25) mile radius that has an open bed. If there is no SNF within 25 miles, there is no limit on a patient's swing bed length of stay. (Transfer swing-bed policy is a Medicaid policy, only.)

**5. Emergency services must be provided 24/7.** Medical staff must be on-site or on-call and available on-site within 60 minutes, although many CAHs choose to require a shorter time frame in their Medical Staff By-Laws to ensure a higher standard of care. Coverage can be provided by a Medical Doctor (M.D.), Doctor of Osteopathy (D.O.), Physician Assistant (P.A.), Nurse Practitioner (N.P.), or a Clinical Nurse Specialist with experience and training in emergency care. In frontier areas, if no physician or mid-level practitioner is available, a Registered Nurse (R.N.) can provide temporary coverage in the form of a screen examination, patient stabilization, and arrangement of transfer to another facility.

**6. There must be at least one physician on the medical staff, but he/she is not required to be onsite.** A physician is required, however, to be accessible, such as by phone. Mid-level practitioners can be an independent part of the medical staff and can provide direct services to patients, including emergency services and voting on medical staff issues.

**7. There must be a registered nurse (R.N.) on site 24/7.** Federal requirements do allow temporary hospital closure if the facility has no patients, no providers, and/or no nursing staff. Some state licensure requirements may vary.

**8. According to the services provided, the same requirements of a general acute hospital must be met by a CAH.** This doesn't mean that all CAHs must offer the same services as a larger hospital, but if they do, they will be held to the same operating standards. Some variance in state licensure laws could exist.

**9. State hospital licensure law(s) must be met if the state law(s) are stricter than the Medicare Conditions of Participation (CoP) required for a CAH.** Most often, state laws simply refer to the Medicare CoPs or replicate them.

**10. Quality assurance (QA) must occur as a part of a network or through a credentialing body.** (e.g. Joint Commission or Healthcare Facilities Accreditation Program). Generally, each state's Flex Program includes an element of QA that meets the criteria.

**11. Each CAH must undertake quality improvement through the Medicare Beneficiary Quality Improvement Project (MBQIP) by encouraging self-reported quality data used to improve facility activities as a part of the Flex Program.**

## STATE RECERTIFICATION

Recertification occurs according to the consistent accreditation interval of the accrediting organization. For instance, those with JCAHO certification are usually surveyed every 12 months and at least every 15 months. Those who choose not to be JCAHO will be surveyed under state licensure laws (which are every three years in Montana) as well as being subjected to federal oversight surveys. Decertification of the CAH occurs if something presents an immediate jeopardy to patients and/or the public and if concern(s) are not fixed quickly.

## CAPITAL IMPROVEMENT FUNDING—GRANTS AND LOANS

Two federal programs are available to CAHs to assist with capital improvements. Those programs are:

A) U.S. Department of Agriculture (USDA) Community Facilities Loan and Grant Program for construction, expansion, and facility improvement, and,

B) U.S. Department of Housing and Urban Development (HUD), Section 242: Hospital Mortgage Insurance Program (Funding/95) for new construction, refinancing debt, or purchasing of new equipment, e.g. hospital beds and office machines.

## PAYMENT FOR SERVICES

Hospitals, in general, are paid, licensed, and meet related certification requirements in either ONE OF TWO categories:

1. **Inpatient Prospective Payment System (IPPS or PPS)—Medicare system.**

A certain amount of IPPS reimbursement is influenced by hospital costs; however, most reimbursement involves defined, fixed payment mechanisms, such as Diagnosis Related Groups (DRGs). Under this program, hospitals are paid a fixed amount for each of its services, regardless of how much it costs to deliver those services. There are a variety of *payment exceptions* related to the IPPS/PPS payment system. The payment exceptions are different as to the following IPPS/PPS hospitals/center/project. The three payment exceptions are as follows:

A) Sole Community Hospital (SCH) under the IPPS/PPS system receives the greater of the reimbursement made under pure IPPS/PPS methodology or the cost-based reimbursement rate indexed for inflation. Furthermore, even though CAH's do not fall under this category of

reimbursement, a CAH can be a SCH. This designation is often used to allow access to certain programs that benefit a hospital's patient population—e.g. 340B Drug Pricing Program.

B) Medicare Dependent Hospital (MDH) under the IPPS/PPS system, a hospital receives an upward cost adjustment to the purely-acquired IPPS program.

C) Rural Referral Center (RRC) under the IPPS/PPS system is a specialty designation reserved for reimbursement of high-volume acute care rural hospitals that treat a large number of diagnosis-related groups (DRGs). It is *not* technically cost-based under the RRC guidelines; rather, it is based on *federal rates*.

**2. Cost-Based Reimbursement—(CAH and FCHIP).**

A CAH cost report is required from every CAH by the Centers for Medicare and Medicaid Services (CMS) for the purpose of comparing and reimbursing the CAH at the lowest rate and making adjustments for difficult populations, such as Medicaid Disproportionate Share Hospital (DSH) program which provides additional funding to hospitals who treat a disproportionate share of indigent patients. The outcome of the DSH rate can greatly affect CAH care rates.

Interim rates are established at the CAH's start of a fiscal year, and a settlement is made at the end of the fiscal year according to the CAH cost report. Currently, a CAH is reimbursed at 101% to help provide a source for hospital/facility improvements.

The National Rural Health Resource Center is associated with providing federal grants to each state that has a CAH program. A Technical Assistance and Services Center within the National Rural Health Resource Center provides information and technical assistance.

A study was performed by the National Rural Health Research Policy Analysis Center in 2010 that determined the following benefits about CAH hospitals in comparison to the other hospital classifications:

1. Experienced a higher amount of financial pressure
2. More revenue came from outpatient business
3. Fewer allowances and discounts
4. Profitability was one of the lowest of the classifications, possibly due to low volumes, private insurance, Medicaid, and self-pay
5. Lowest fixed assets, possibly resulting in ability to attract patients and retain physicians
6. Within two years post conversion to a CAH classification, the average total profit margin *increased* from -2.5% to 3.7%.

In addition, small hospitals participating in a current CMS demonstration project, Frontier Community Integration Project (FCHIP), also receive cost-based reimbursement. FCHIP is a three-year demonstration project authorized under the Affordable Care Act (ACA) and is

technically an off-shoot of the CAH program. It was designed to test new models for healthcare delivery in frontier designated areas and was originally developed and proposed in Montana. Participants in this project are limited in quantity—three in Montana, three in North Dakota, and four in Nevada. These 10 participants (Montana, North Dakota, and Nevada) are some of the smallest CAHs in the nation, and as such, continue to receive cost-based reimbursement. Montana's three FCHIP health care programs are McCone County Medical Center in Circle, Roosevelt Medical Center in Culbertson, and Dahl Memorial Healthcare Association in Ekalaka.

**ELECTRONIC HEALTH RECORDS (EHRs)**

Incentive payments (like other hospitals) are available for EHRs; however, with a limit period of four years of incentive payment.

**FINANCIAL VIABILITY**

Conversion to a CAH hospital has been found to improve financial viability in small rural hospitals. Yet, in some hospitals, being a CAH was shown to cause significant financial distress and loss.

The measurement of financial distress is measured over the long-run, not over a short-run of time. For example, extraordinary expenses could result in a negative cash flow margin for one year only, which is considered by financial measurement to be a short-run of time.

Some newly converted CAHs tend to believe their generated income will increase significantly every year, so they overextend themselves building a new hospital. The reality is that cost-based reimbursement is still a delicate mechanism that needs to be carefully managed, since CAHs can still become extended. Generally, hospitals hire a consultant to determine if they have the potential to be in a financial bind before converting to a CAH status.

**SUGGESTED READING**

RHI hub (Rural Health Information Hub)

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