mln BOOKLET
KNOWLEDGE • RESOURCES • TRAINING

Information for Critical Access Hospitals

What's Changed?

We added:

- Information on reviewing rural reclassification status (page 4)
- Information on new promoting interoperability measures that start January 1, 2026 (page 5)
- Information on the Transforming Episode Accountability Model skilled nursing facility 3-day rule waiver (page 6)
- A new resource link for the latest telehealth information (page 9)
- Specific dates for implementing the new conditions of participation for emergency readiness and obstetrical services (page 14)

Substantive content changes are in dark red.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

Contents

CAH Designations 3
Hospice Care 4
CAH Payments 5
Inpatient Admissions 6
Outpatient Services: Standard Payment Method (Method I) or Optional Payment Method (Method II) 8
Additional Medicare Payments 11
Intensive Outpatient Program Services 12
Flex Program State Grants 13
Obstetrics Services CoPs & New Requirements 13
Rural Emergency Hospitals 15
Resources 15

Section 1820 of the Social Security Act established the Medicare Rural Hospital Flexibility Program (Flex), which allows individual states to designate certain facilities as critical access hospitals (CAHs). A CAH is a separate provider type with its own Medicare conditions of participation (CoPs) and separate payment methods, unlike Medicare dependent hospitals and sole community hospitals (SCHs).

A rural hospital that provides limited services can become a CAH if it meets these conditions:

- Currently a Medicare-participating hospital
- A hospital that stopped operating after November 29, 1989
- A health clinic or center that, according to the state definition, operated as a hospital before downsizing to a health clinic or center

CAH Designations

A Medicare-participating hospital can become, and remain, a certified CAH by meeting these regulatory requirements*:

- Located in a state that has a state rural health plan for the Flex program. Connecticut, Delaware, Maryland, New Jersey, and Rhode Island haven't established Flex programs.
- Located in a rural area or treated as rural under a special provision that qualifies hospital providers in urban areas.
- Provides 24-hour emergency services, 7 days a week, using on-site or on-call staff, with specific on-site, on-call staff response times.
- Doesn't exceed 25 inpatient beds for inpatient or swing bed services.
  - It may operate a distinct part rehabilitation and a psychiatric unit, each with up to 10 beds
  - If it has distinct part units (DPUs), it must follow all hospital and CAH CoPs in the DPU
- Reports an annual average acute care inpatient length of stay (LOS) of 96 hours or less, excluding swing bed services and DPU beds. We don't assess this requirement on initial certification; it only applies after CAH certification.
- **More than** a 35-mile drive on primary roads from any other CAH or hospital or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive if a state didn't designate a CAH as a necessary provider before January 1, 2006. A primary road of travel for determining the driving distance of a CAH and its proximity to other providers is a numbered federal highway, including interstates, intrastates, expressways, or any other numbered federal or state highway with 2 or more lanes each way.

*This list contains basic requirements and isn't all inclusive. See the complete list at 42 CFR Part 485 Subpart F

The CAH must inform each patient, or their representative, of their rights before starting or ending patient care. This requires CAHs to establish a process for overseeing and promptly resolving patient grievances, including whom to contact to file a grievance.

If the CAH is part of a health system with more than 1 hospital or CAH, it may have a unified and integrated Quality Assessment and Performance Improvement (QAPI) program and must make sure each separately certified CAH meets requirements.

CAH Status

Periodically, the Office of Management and Budget (OMB) publishes revised delineations of core-based statistical areas, which we use to determine a CAH's rural vs. urban status. The latest revisions are in OMB Bulletin 23-01. We adopt changes in urban and rural designations based on the OMB delineations through the Inpatient Prospective Payment System (IPPS) final rules. CAHs have a 2-year transition period, starting from the effective date of the new designation, to reclassify as rural if the new OMB delineation changes their location designation to urban. During the transition period, an affected CAH must reclassify as rural using regulations at 42 CFR 412.103 to retain its CAH status after the 2-year transition period ends.

Any CAH located in an urban area may apply for reclassification as rural by meeting **1** of these criteria:

1. It's in a rural census tract of a Metropolitan Statistical Area in the most recent version of the Goldsmith Modification using Rural-Urban Commuting Area codes and any additional criteria determined by the Federal Office of Rural Health Policy of the Health Resources & Services Administration (HRSA)
2. Any state law or regulation deems it to be a rural hospital or located in a rural area
3. It would meet all requirements of a rural referral center or an SCH if it was in a rural area

CAHs may mail a written application to the CMS regional office at any time with an explanation of how the hospital meets the reclassification criteria, and the application must include any supporting data and documentation. We approve or deny applications within 60 days of the date we receive the application.

Note: We encourage all CAHs with active rural reclassifications to review their original reclassification application and determine whether the reclassification status still applies.

Hospice Care

In hospice care cases, a hospice may contract with a CAH to provide general inpatient hospice care. We pay the hospice in these cases.

You may dedicate beds to hospice care, which count toward the 25-bed maximum. However, hospice patients aren't part of the 96-hour annual average LOS calculation.

You can admit hospice patients to a CAH for any care in their hospice treatment plan or respite care. The CAH negotiates payment through an agreement with the hospice.

CAH Payments

- We pay CAHs for most inpatient and outpatient services provided to patients at 101% of reasonable costs
- We don't include CAHs in the IPPS or the Hospital Outpatient Prospective Payment System (OPPS)
- We pay CAH services according to Medicare Part A and Medicare Part B deductible and coinsurance amounts, except we don't limit the 20% Part B outpatient coinsurance amount by the Part A inpatient deductible amount
- We encourage CAHs to help patients understand service charges and potential financial obligations
- On CAH claims using modifier 51 (Multiple Procedures), we pay technical components on a cost basis, and they aren't subject to multiple procedure reductions

CAHs Participation in the Medicare Promoting Interoperability Program

The American Recovery and Reinvestment Act of 2009 authorized incentive payments under Medicare as well as downward payment adjustments for the meaningful use of certified electronic health record technology (CEHRT). As of 2016, CAHs that don't successfully demonstrate meaningful use of CEHRT are subject to a reduction of their payments from 101% to 100% of reasonable costs. Hardship exceptions are available, but by law, we limit a CAH to 5 years of these exceptions. See Promoting Interoperability Programs for more information.

Starting January 1, 2026:

- The Medicare Promoting Interoperability Program defines the electronic health record reporting period as a minimum of any continuous 180-day period within that CY
- CAHs must attest "yes" to conducting security risk management along with the existing requirement for attesting "yes" to security risk analysis
- CAHs have to attest "yes" to completing an annual self-assessment using the 8 SAFER Guides published in January 2025
- We add an optional bonus measure under the Public Health and Clinical Data Exchange objective for data exchange to occur with a public health agency using the Trusted Exchange Framework and Common Agreement

CAH DPUs

- We pay for CAH DPU inpatient rehabilitation services under the Inpatient Rehabilitation Facility Prospective Payment System (PPS)
- We pay for CAH DPU psychiatric services under the Inpatient Psychiatric Facility PPS

CAH Swing Beds

- We pay for CAH swing bed services as section 1883(a)(3) of the Social Security Act and 42 CFR 413.114(a)(2) require.
- CAH swing bed services aren't subject to skilled nursing facility (SNF) PPS. Instead, we pay CAHs based on 101% of reasonable costs.
- We require a 3-day hospital stay, commonly known as the SNF 3-day rule, before admitting a patient to a swing bed. Starting January 1, 2026, we'll allow acute care hospitals participating in the Transforming Episode Accountability Model (TEAM), a mandatory model, to discharge patients without a 3-day hospital stay to a participating CAH, under swing bed arrangements, for post-acute care. See MLN Matters® article MM14098 for more information and payment criteria on the SNF 3-day rule waiver.
- CAHs may bill for:
  - Bed and board, nursing, and other related services
  - Using CAH facilities
  - Medical social services
  - Drugs
  - Biologicals
  - Supplies, appliances, and equipment for inpatient hospital care and treatment and diagnostic or therapeutic items or services they, or others, provide under arrangement

See Swing Bed Providers for more information.

Inpatient Admissions

We pay CAHs under Part A when they meet these requirements:

- A physician or other qualified practitioner orders admission and certifies they expect the patient to be discharged or transferred to a hospital within 96 hours of CAH admission per 42 CFR 424.15 and 42 CFR 485.638(a)(4)(iii)
- A person may remain a CAH inpatient for more than 96 hours. However, if a physician can't certify at admission that they expect to discharge or transfer the person to a hospital within 96 hours, we won't pay the CAH.
- A physician must complete the certification, then sign and document it in a medical record no later than 1 day before submitting an inpatient services claim.
- We don't apply the 96-hour certification requirement to these services:
  - Time as a CAH outpatient
  - Time providing skilled nursing swing bed services
  - Time in a CAH DPU

The 96-hour certification clock starts when a physician or other qualified practitioner admits the patient via a written order in the patient's medical record.

- Quality Improvement Organizations (QIOs), Medicare Administrative Contractors (MACs), Recovery Audit Contractors (RACs), and Supplemental Medical Review Contractors (SMRCs) don't audit the CAH 96-hour certification requirement as a medical record high priority
- CAHs shouldn't 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 MACs, RACs, and SMRCs no longer make auditing the CAH 96-hour certification requirement a high priority, the CMS Regional Office (RO) Division of Survey and Certification (DSC), State Survey Agencies (SAs), and accrediting organizations will verify CAH CoP LOS compliance under 42 CFR 485.620(b), which states the CAH provides acute inpatient care for a period that doesn't exceed 96 hours per patient, on average, annually.

MACs determine 96-hour annual average LOS CoP compliance and calculate the CAH's LOS based on patient census data. If a CAH exceeds the LOS limit, their MAC sends a report to the CMS RO DSC and provides a copy to the SA. The CMS RO requires CAHs to develop and apply an acceptable correction plan or provide adequate information demonstrating compliance.

Inpatient hospital services with 20 inpatient days or more cases **must** meet additional certification requirements at 42 CFR 424.13.

Ambulance Transports

- We pay for CAH-provided ambulance services, and ambulance services provided by an entity the CAH owns and operates, based on 101% of reasonable costs if it's the only ambulance provider or supplier within a 35-mile drive of the CAH. The 35-mile drive requirement excludes ambulance providers or suppliers who aren't legally authorized to provide ambulance services to transport to or from the CAH.
- If no ambulance provider or supplier is within a 35-mile drive of the CAH and the CAH owns and operates an entity providing ambulance services more than a 35-mile drive from the CAH, we base the entity's ambulance payment on 101% of 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

We don't apply limits 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 OPPS.

We apply 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 Optional Payment Method (Method II)

We pay for CAH outpatient facility services at 101% of reasonable costs as section 1834(g)(1) of the Social Security Act requires.

Standard Payment Method: Reasonable Cost-Based Facility Services with MAC Professional Services Billing

We pay CAHs under the standard payment method unless they elect the optional payment method.

Under the standard payment method, the physician or practitioner bills their outpatient professional medical services under the Physician Fee Schedule (PFS). We define outpatient professional medical services payment as physician- or other qualified practitioner-provided services.

Optional Payment Method: Reasonable Cost-Based Facility Services Plus 115% Professional Services Fee Schedule Payment

CAHs may elect the optional payment method instead of the standard payment method per section 1834(g)(2) of the Social Security Act. The CAH bills for facility and professional outpatient services **only** when physicians or practitioners reassign their billing rights to the CAH. Additionally, physicians and practitioners can't bill for professional services once they reassign their billing rights to the CAH.

If a CAH elects this option, each physician or practitioner providing professional outpatient CAH services can choose to:

- Reassign their billing rights to the CAH and agree to the optional payment method
- File MAC claims for their professional CAH outpatient services under the PFS

For physicians or practitioners who elect the optional payment method, a CAH must submit the reassignment application online via PECOS or the paper Form CMS-855I. The CAH should maintain a copy of the form for its own record. If a Method II CAH receives reassigned benefits, it doesn't need to submit a separate online or paper Form CMS-855B. Physicians and practitioners can reassign benefits directly to the CAH's Part A enrollment. We'll deny a CAH's claims for professional services if a reassignment isn't in PECOS.

We don't make CAHs submit an annual payment election under the optional payment method, so when CAHs elect the optional payment method, it stays in effect until the CAH submits a termination request. If the CAH elects to end its optional payment method, it must submit a written request to its MAC at least 30 days before the start of the next cost reporting period. For more information, find your MAC's website.

We base the CAH outpatient optional payment method services payment on the sum of these, after applicable deductions:

- **Facility services:** 101% of CAH reasonable costs
- **Physician professional services:** 115% of our PFS allowable amount
- **Non-physician practitioner professional services:** 115% of PFS amount we normally pay practitioner's professional services

Telehealth Services Payment

We pay for telehealth services at 80% of PFS when the distant site physician or other practitioner location is in a CAH electing the optional payment method and the physician or other practitioner reassigns their billing rights to the CAH. Submit such claims with the GT modifier. CAHs bill their regular Part A MAC for professional services provided at the distant site via telehealth, with revenue codes 096X, 097X, or 098X. All requirements for billing distant-site telehealth services apply.

Visit the CMS Telehealth webpage for the latest information. It's intended to help physicians, practices, and health systems navigate changes to Medicare telehealth policy.

For telehealth services, CAH-based renal dialysis centers (including satellites) must use revenue code 078X when billing for the originating site facility fee. Use HCPCS code Q3014, telehealth originating site facility fee, on a separate revenue line from any other services provided to the patient.

Teaching Anesthesiologist Services Payment

When a teaching anesthesiologist is in a CAH that elected the optional payment method and the anesthesiologist reassigns their billing rights, we pay 115% of PFS if the anesthesiologist participates in 1 of these cases:

- Training a resident in a single anesthesia case
- Two concurrent resident anesthesia cases
- Single resident anesthesia case concurrent to another case paid under the medically directed rate

You can qualify for payment by meeting these requirements:

- A teaching anesthesiologist or a different anesthesiologist in the same anesthesia group is present during all critical or key portions of the anesthesia service or procedure
- A teaching anesthesiologist or an anesthesiologist the CAH has an arrangement with and is 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
- Immediate availability of another teaching anesthesiologist as necessary

Report the NPI of the teaching anesthesiologist who started the case on the claim during critical or key procedure times and when different teaching anesthesiologists are 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

CAHs can choose to incur residency training costs directly or function as a Medicare graduate medical education non-provider setting for payment purposes.

- If a CAH incurs residency training costs directly, we pay them 101% of reasonable costs for training the full-time equivalent (FTE) residents
- If a CAH functions as a non-provider site, a hospital can include the FTE residents' training at the CAH in its FTE resident count if it meets the non-provider site requirements at 42 CFR 412.105(f)(1)(ii)(E) and 42 CFR 413.78(g)

Medicare Certified Registered Nurse Anesthetist Services Rural Pass-Through Funding

- As incentive to continue serving the rural population, CAHs can get reasonable cost-based funding for certain Certified Registered Nurse Anesthetist (CRNA) services
- Rural hospitals and CAHs must meet specific requirements to get Medicare rural pass-through funding per 42 CFR 412.113(c)
- CAHs qualifying for CRNA pass-through funding can get reasonable cost-based inpatient and outpatient CRNA professional services payments whether they use the standard payment method or optional payment method
- If a CAH opts to include a CRNA in its optional payment method election, we pay for the CRNA's services based on 115% of the PFS, and the CAH gives up inpatient and outpatient CRNA pass-through delivered services payments

Health Professional Shortage Area Physician Bonus Program

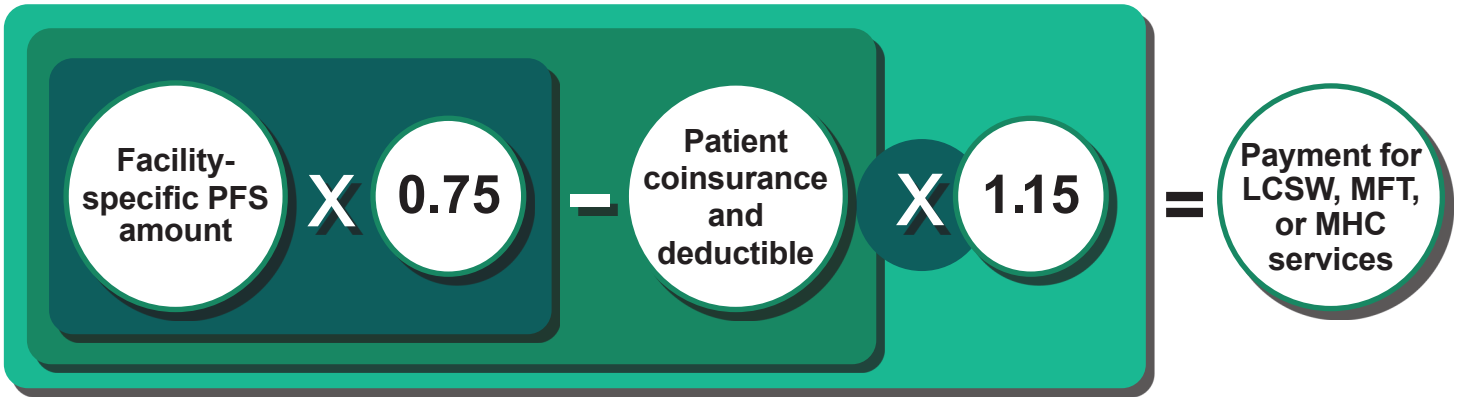
- We pay physicians, including psychiatrists, a 10% outpatient professional services Health Professional Shortage Area (HPSA) bonus if they provide CAH care in a primary care or mental health HPSA within a designated geographic area
- If you reassign your billing rights and the CAH elected the optional payment method, the CAH gets 115% of the applicable PFS amount multiplied by 110% based on all the quarter's processed claims

For more information, see Physician Bonuses.

Method II CAH Payment to Licensed Clinical Social Workers, Marriage and Family Therapists & Mental Health Counselors

- We pay claims for licensed clinical social workers (LCSWs), marriage and family therapists (MFTs), and mental health counselors (MHCs) performing services billed on type of bill (TOB) 85X with revenue codes 96X, 97X, or 98X if those providers have reassigned their billing rights to a Method II CAH
  - LCSW services require an AJ modifier
  - MFTs and MHCs must enroll as an MFT or MHC specialty
- We pay for these outpatient professional services at 115% of that which we would otherwise pay if we didn't include the services in the outpatient CAH services
- Payment for LCSW, MFT, or MHC services will be 80% of the lesser of the actual charges for the services or 75% of the amount determined for payment of a psychologist

We calculate the payment using this formula:



Medical Nutrition Therapy Services

CAHs must submit claims for medical nutrition therapy services to their MAC who will base payment on the non-facility amount for those HCPCS codes in the PFS.

Intensive Outpatient Program Services

An intensive outpatient program (IOP) provides treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation but less intense than a partial hospitalization program.

Note: For more information on CAH billing requirements for partial hospitalization services, see the Medicare Claims Processing Manual, Chapter 4, section 260.

We don't consider programs providing primarily social, recreational, or diversionary activities to be IOPs.

Patients you admit to an IOP must be all of these:

- Under the care of a physician who certifies the need for IOP services
- Need a minimum of 9 hours of services per week, as shown by their plan of care
- Need a comprehensive, structured, and multimodal treatment requiring medical supervision and coordination provided under an individualized plan of care because of a mental disorder, such as substance use disorder, which severely interferes with multiple areas of daily life, including social, vocational, and educational functioning
- Be able to participate cognitively and emotionally in the active treatment process and tolerate the intensity of an IOP program

We'll pay CAHS for IOP services billed on TOB 85x at 101% of reasonable cost. You must include condition code 92 on the claim to identify IOP services. See Change Request 13222 for complete details.

Flex Program State Grants

Flex programs have 2 separate, complementary parts:

- We provide reasonable cost-based, Medicare-certified CAH payments
- Through the Federal Office of Rural Health Policy, the HRSA runs a state grant program supporting community-based rural organized systems of care development 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 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

See Rural Hospital Programs for more information.

Obstetrics Services CoPs & New Requirements

We developed new and revised obstetrics (OB) service CoPs to ensure all pregnant, birthing, and postpartum women receive consistent, high-quality maternal health care regardless of their geographic location. The CoPs include new baseline standards for the organization, staffing, and delivery of OB care and staff training on evidence-based maternal health practices.

To reduce burden and avoid unintended consequences for CAHs to meet these new requirements, we're implementing these provisions over 2 years.

- Effective July 1, 2025, CAHs must comply with these emergency services readiness requirements:
  - CAHs must have adequate provisions and protocols to meet emergency patient needs in accordance with the complexity and scope of services offered
  - Protocols must be consistent with nationally recognized, evidence-based guidelines for caring for patients with emergency conditions, including, but not limited to, patients with obstetrical emergencies, complications, and immediate post-delivery care
  - Applicable CAH staff must complete annual training on these protocols and provisions, with documentation of completion required
- Effective January 1, 2026, CAHs offering OB services must comply with these organization and staffing and delivery of service requirements:
  - CAHs must have appropriate organization and supervision of OB services as well as integration of OB services with other CAH departments.
  - OB services must be consistent with CAH needs and resources.
  - OB care policies must be designed to ensure consistent high standards of medical practice, patient care, and safety.
  - CAHs must have equipment readily available for treating OB cases to meet the needs of patients, including a call-in system, cardiac monitor, and fetal doppler or monitor.
  - CAHs must have adequate provisions and protocols for obstetrical emergencies, complications, immediate post-delivery care, and other patient health and safety events. Provisions include equipment, supplies, and medication used in treating emergency cases and must be readily available in the CAH.
- Effective January 1, 2027, CAHs must comply with staff training and Quality Assessment and Performance (QAPI) program requirements. CAHs must:
  - Develop policies and procedures to ensure relevant staff are trained on topics aimed at improving the delivery of maternal care, with documentation of completion required
  - Require OB services leadership to participate in OB QAPI activities
  - Incorporate publicly available maternal mortality review committee (MMRC) data and recommendations into the QAPI program, as available
  - Use its QAPI program to assess and improve health outcomes and disparities among OB patients on an ongoing basis

Rural Emergency Hospitals

The rural emergency hospital (REH) provider type started on January 1, 2023, to address rural hospital closures. REHs allow for emergency services, observation care, and additional medical and health outpatient services, if the REH elects to provide them, that don't exceed an annual per-patient average stay of 24 hours.

REHs convert from either a CAH or a rural hospital (with no more than 50 beds) and don't provide acute care inpatient services except for SNF services in a DPU. The facility may submit a CMS-855A change of information application rather than an initial enrollment application to convert from a CAH to an REH.

Resources

- Medicare Claims Processing Manual, Chapters 3 and 4
- Quality, Safety & Oversight - General Information
- Medicare Part B Overpaid and Beneficiaries Incurred Cost-Share Overcharges of Over $1 Million for the Same Professional Services
- State Operations Manual, Appendix W