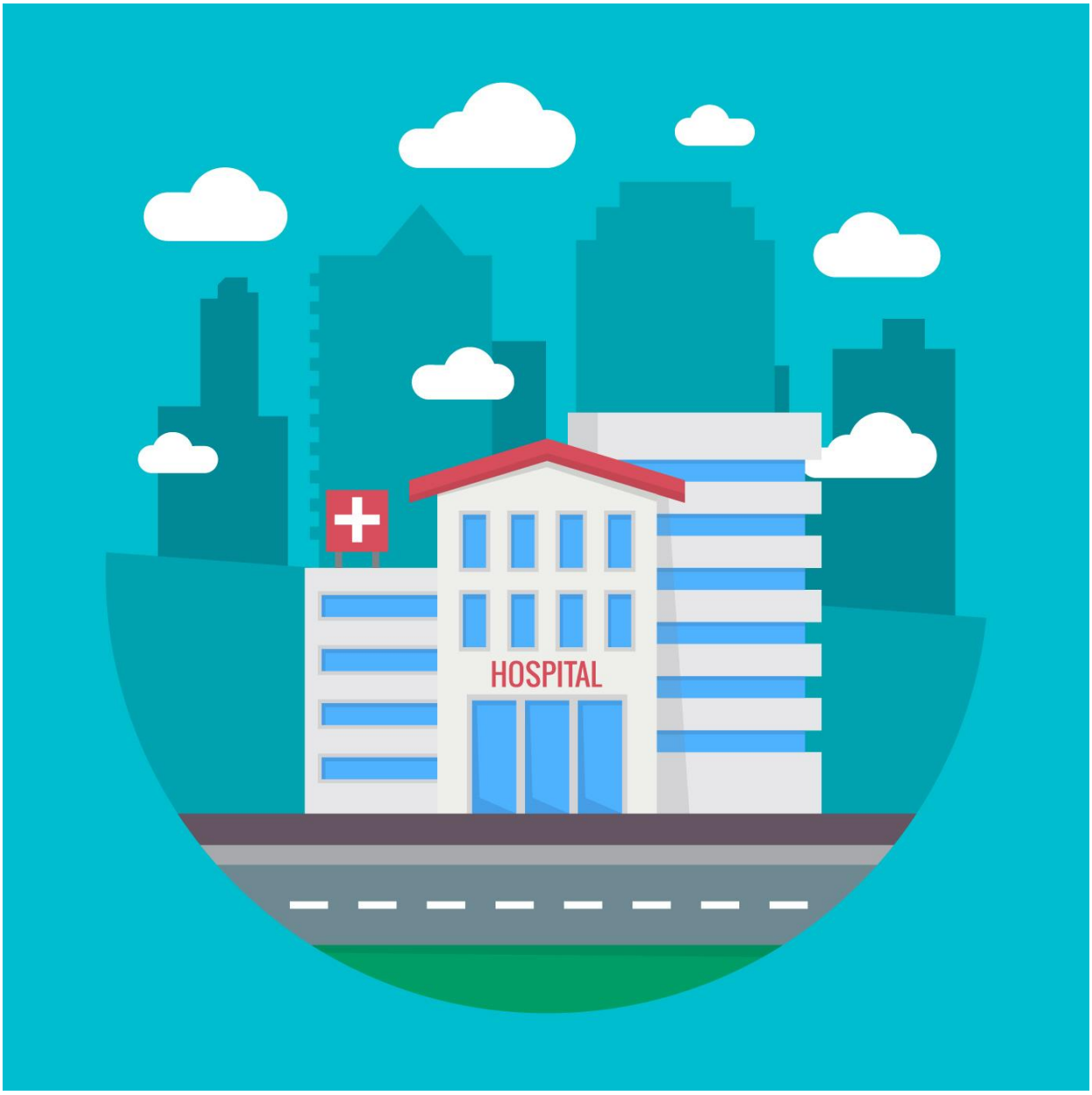
HOSPITAL

CRITICAL ACCESS HOSPITALS: HISTORY, CRITERIA, & REIMBURSEMENT
(Includes a Montana perspective)

GOALS

1. To increase the appreciation, knowledge, and history regarding Critical Access Hospitals.
2. To better understand the role of Medicare and Medicaid.
3. To identify the number and location of CAHs in the State of Montana.
4. To understand the purpose of the Balanced Budget Act.
5. To reiterate the General/Licensing/Certification Criteria of a CAH.
6. To state the criteria for a CAH.
7. To understand the CAH cost system.
8. To reiterate the licensing and funding restrictions of a CAH.

KEYWORDS FOR APPLICATION

1. Critical Access Hospitals (CAH)
2. Centers for Medicaid and Medicaid Services (CMS)
3. Balanced Budget Act
4. Rural Hospital Montana Flexibility Program (Flex Program)
5. Acute Care Inpatient Beds
6. Long Term Swing Bed Services
7. State Certification and Recertification Requirements
8. Grants and Loans (for Capital Improvements)
9. Inpatient Prospective Payment System (IPPS or PPS) Medicare System
10. General Licensing and Certification Criteria
11. Sole Community Hospital (SCH)
12. Medicare Dependent Hospital (MDH)
13. Rural Referral Center (RRC)
14. Frontier Community Health Integration Project (FCHIP)
15. Electronic Health Records (EHR)
16. Medicaid Reimbursement
17. Capital Funding
18. Financial Viability

This information has been carefully compiled to be relevant to a nurse's understanding of Montana's CAHs. It should also provide an appreciation and increased knowledge of the complex regulations.

There are (as of 2018) 1,332 certified Critical Access Hospitals (CAH)---approximately 3.5% are located in Montana throughout the United States. There are 46 CAHs that are licensed by the

State of Montana and two 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 rural hospitals 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 the 1980s and early 1990s.

To determine the CAH model attributes, two programs were considered. These models were known as the highly successful Montana's Medical Assistance Facility (MAF) project and the Essential Access and Primary Care Rural Hospital Project. These two "stopgap" measures were set up as a demonstration project involving a handful of the smallest hospitals in Montana to determine a successful model to keep hospitals from permanently closing. The model determined 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 meeting the full certification requirements for a hospital. They 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 responded to many of the closed hospitals. The purpose of the Balanced Budget Act was to provide regulatory relief to rural facilities, address the financial vulnerability, and to improve access to essential health care services in rural areas.

Financial support, then, became possible through cost-based Centers for Medicare and Medicaid Services (CMS) hospitals that qualified for the CAH designation and who were presumably at risk for financial stress. Rural hospital designations were to reduce varying amounts of hospital financial vulnerability and improve access to essential healthcare services in rural areas. The year 2008 added to the *hospital industry's decrease in profitabilit*y, possibly due to the worsening economy.

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.

PURPOSE

The CAH designation is designed to reduce rural hospitals' financial vulnerability and improve healthcare access by keeping essential services in rural communities.

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 before January 1, 2006, are exempt from these distance requirements.)

3. **An agreement must be developed and maintained with another hospital regarding patient referral, transfer, communication, and emergency or non-emergency patient transportation.**

4. **Acute care patients can only be kept for an annual average length of stay of ninety-six (96) hours or less. However, 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, 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 length of stay. (Transfer swing-bed policy is a Medicaid policy, only.)

5. **Emergency services must be provided 24/7.** Medical staff must be onsite or on-call and available onsite within 30 to 60 minutes. 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 the 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 provide direct services to patients, including emergency services and voting on medical staff issues.

7. There must be a registered nurse (R.N.) onsite 24/7. Federal requirements 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, a general acute hospital's same requirements must be met by a CAH. 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 (CoPs) required for a CAH.

10. Quality assurance (Q.A.) 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 Q.A. 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 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 and non-JCAHO facilities may also be surveyed under state licensure laws and subjected to federal oversight surveys. Decertification of the CAH occurs if something presents immediate jeopardy to patients or the public, and if concern(s) are not fixed quickly.

MEDICAID REIMBURSEMENT

Each state decides if they will provide special reimbursement to CAHs for Medicaid services.

CAPITAL IMPROVEMENT FUNDING—GRANTS AND LOANS

Three federal programs are available to CAHs to assist with capital improvements. Those programs are the U.S. Department of Agriculture (USDA) Community Facilities Loan and Grant Program for construction, expansion, and facility improvement, 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, and U.S. Department of Agriculture (USDA) Community Facilities Loan and Grant Program for construction, expansion, and facility improvement.

PAYMENT FOR SERVICES

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

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

A certain amount of IPPS reimbursement is influenced by hospital costs. However, 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 four payment exceptions are as follows:

A. Sole Community Hospital (SCH)
B. Medicare Dependent Hospital (MDH)
C. Rural Referral Center (RRC),
D. Frontier Community Health Integration Project (FCHIP).

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. A hospital can be both a CAH and an SCH. It is *not* technically cost-based under SCH guidelines; rather, it is based on *federal rates.* This designation is often used to allow access to certain programs that benefit a hospital's population—e.g., 340B Drug Pricing Program.

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

A 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 (DRG). It is *not* technically cost-based under the RRC guidelines; rather, it is based on *federal rates*.

A Frontier Community Integration Project (FCHIP) under the IPPS/PPS system is a three-year demonstration project authorized under the Affordable Health Care Act (AHCA). It is technically an off-shoot of the CAH program. It was designed to test new healthcare delivery models in frontier designated areas and was originally developed and proposed in Montana. Participants in this project are limited in quantity—3 in Montana, three in North Dakota, and four in Nevada. These 10 participants (Montana, North Dakota, Nevada) are some of the smallest CAHs in the nation and 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.

Access Hospital---One of the two totally cost-based reimbursed hospitals—(CAH and FCHIP).

A CAH cost report from every CAH is required by the Centers for Medicare and Medicaid Services (CMS). It compares and reimburses the CAH at the lowest rate and makes adjustments for difficult populations, such as Disproportionate Share Hospitals (DSH) (the nation's largest inpatient mental health hospital system.) The outcome of the DSH rate can 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 with 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 inability 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%.
7. Quality improvement through the Medicare Beneficiary Quality Improvement Project (MBQIP) by encouraging self-reported quality data used to improve facility activities. (Part of the Flex Program.)

ELECTRONIC HEALTH RECORDS (EHRs)

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

MEDICAID REIMBURSEMENT

Each state decides if they will provide special reimbursement to CAHs for Medicaid services.

CAPITAL FUNDING--GRANTS AND LOANS

1. USDA Community Facilities Loan and Grant Program: This supports construction, expansion, and facility improvement.
2. HUD Section 242 Hospital Mortgage Insurance Program (Funding/95): This supports new construction, refinancing debt, or purchasing of new equipment--e.g., hospital beds and office machines.

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.

SUGGESTED READING

RHI hub (Rural Health Information Hub)

AUTHOR: Carolyn R. Taylor, Ed.D. M.N. R.N.