CRITICAL ACCESS HOSPITALS PAYMENT SYSTEM

*payment***basics**

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Medicare beneficiaries can receive care in approximately 1,300 small hospitals called critical access hospitals (CAHs). CAHs are limited to 25 beds and primarily operate in rural areas. Unlike traditional hospitals (which are paid under prospective payment systems), Medicare pays CAHs based on each hospital's reported costs. Each CAH receives 101 percent of its costs for outpatient, inpatient, laboratory and therapy services, as well as post-acute care in the hospital's swing beds.[1]

In addition to 25 acute beds, CAHs are allowed to have distinct-part skilled nursing facilities, 10-bed psychiatric units, 10-bed rehabilitation units, and home health agencies. However, these departments of the CAH are paid through Medicare's prospective systems and are not eligible for cost-based reimbursement.

History of the CAH program

In 1988, the Montana Hospital Research and Education Foundation designed a demonstration of a type of hospital called a medical assistance facility (MAF) that received cost-based reimbursement from Medicare. MAFs were isolated, limited-service hospitals that could admit patients for no more than a four-day length of stay. In 1989, the Congress authorized the Rural Primary Care Hospital (RPCH) program, a second demonstration program whereby small, rural hospitals would receive cost-based payments from Medicare. In 1997, the Balanced Budget Act of 1997 merged the MAF and RPCH programs into a new category of hospitals called critical access hospitals. CAHs would receive cost-based inpatient and outpatient payments from Medicare.

To qualify for the CAH program, a hospital had to be at least 15 miles by secondary road and 35 miles by primary road from the nearest hospital or be declared a "necessary provider" by the state. Because states could waive the distance requirement, the CAH program became an option for almost all small rural hospitals, as opposed to being limited to helping isolated hospitals. Approximately 65 percent of CAHs are between 15 and 35 miles from the nearest hospital. However, some are less than 5 road miles from another hospital and others (approximately 20 percent of CAHs) are more than 35 road miles from an alternative source of emergency care.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 eliminated states' ability to declare additional hospitals "necessary providers" starting in January 2006. As a result, CMS has authorized few additional CAHs since 2006 because most hospitals that meet the distance and size criteria have already converted to CAH status. Current CAHs will retain their CAH status, even if they do not meet the distance criteria.

Defining the care that Medicare buys from CAHs

Medicare pays for the same services from CAHs as from other acute care hospitals (e.g., inpatient stays, outpatient visits, laboratory tests, and post-acute skilled nursing days). However, CAHs' payments are not based on the type of service provided or the number of services provided. Payments are based on each CAH's costs and the share of those costs that are allocated to Medicare patients.

Computing Medicare payments

Medicare pays CAHs 101 percent of their allowable costs for most services. The cost of treating Medicare patients is estimated using cost accounting data from Medicare cost reports. CMS's cost accounting methodology allocates costs among patients based on a combination of factors such as

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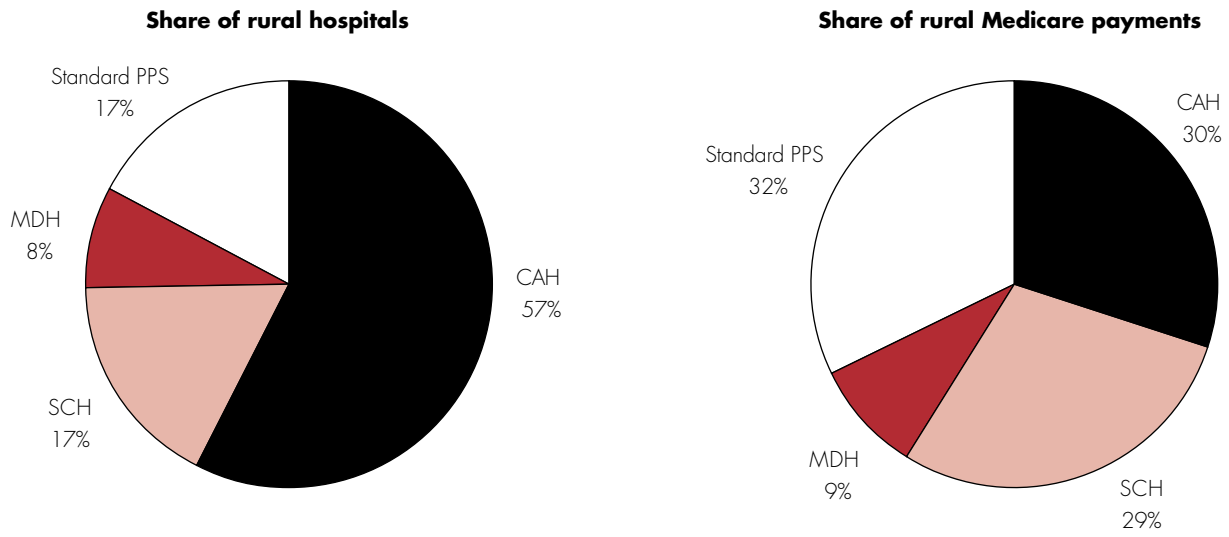
Figure 1 Share of hospitals and Medicare payments by rural hospital type



Note: CAH (critical access hospital), SCH (sole community hospital), MDH (Medicare-dependent hospital), PPS (prospective payment system). Payments are from 2008 Medicare cost reports. Standard PPS refers to hospitals paid under the traditional PPS payment rates and includes rural referral centers that are not SCHs or MDHs. Percentages may not add to 100 percent due to rounding.

the number of days a patient stays in the hospital and the dollar value of charges the patient incurs for ancillary services.

Medicare's cost-based payments to CAHs were over $7 billion in 2008, representing 5 percent of all Medicare inpatient and outpatient payments to hospitals.

Differences between CAH, SCH, and MDH Medicare payments

As Figure 1 illustrates, most rural hospitals are either CAHs (57 percent), sole community hospitals (SCHs) (17 percent), or Medicare-dependent hospitals (MDHs) (8 percent). These hospitals receive a majority of rural inpatient Medicare payments. "Cost-based payments" provided to CAHs differ from "cost-based payments" paid to SCHs and MDHs. SCHs receive the higher of either (a) standard inpatient prospective payment rates or (b) payments based on the hospital's costs in a base year updated to the current year and adjusted for changes in their case mix. MDHs are similar to SCHs, but they are eligible for a prospective payment rate based on a blend of current PPS rates (25 percent) and their historical costs (75 percent). The SCH and MDH payment methodology differs in two significant ways from CAH cost-based payments. First, SCHs and MDHs only receive cost-based payments for inpatient care; CAHs receive cost-based payments for inpatient, outpatient, lab, therapy, and post-acute services in swing beds. Second, SCHs' and MDHs' payments are based on historical costs trended forward. Therefore, if a SCH or MDH increases its expenditures per patient, its payments will not be affected. In contrast, if a CAH increases its expenditures per patient, Medicare payments increase accordingly.

To qualify for the SCH program, a hospital must be located at least 35 miles from the nearest like hospital (excluding CAHs), or meet other federal criteria for being deemed a community's sole source of care. To qualify for MDH designation, a facility must be located in a rural area, have no more than 100 beds, not be classified as an SCH, and have at least 60 percent of inpatient days or discharges attributable to Medicare patients. ■

1 Most CAH beds are "swing beds", which can be used for acute or post-acute care. In some states, these beds can also be used for long-term care of Medicaid patients.