CRITICAL ACCESS HOSPITALS PAYMENT SYSTEM

paymentbasics

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Medicare beneficiaries can receive care in nearly 1,400 small hospitals called critical access hospitals (CAHs). CAHs are limited to 25 beds and operate primarily in rural areas. Unlike traditional hospitals (which are paid under prospective payment systems), Medicare pays CAHs based on each hospital's reported costs. CAHs commonly furnish care in "swing beds," which are beds in which acute or post-acute care can be provided. In some states, these beds can also be used for the long-term care of Medicaid or private-pay residents of the hospital.

In addition to 25 acute/swing 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.

The Congress created the CAH designation in the Balanced Budget Act of 1997. To qualify as a CAH, a hospital had to be at least 35 miles by primary road or 15 miles by secondary 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 isolated hospitals. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) eliminated states' ability to declare additional hospitals "necessary providers" starting in January 2006. However, existing CAHs retained their CAH status even if they did not meet the distance criteria. CMS has authorized relatively few additional CAHs since 2006 because most hospitals that meet the distance and size criteria have already converted to CAH status.[1]

Defining the care that Medicare buys

Medicare pays for the same services in CAHs as in 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 or number of services provided. Instead, payments are based on each CAH's costs and the share of those costs that are allocated to Medicare patients.

Computing Medicare payments

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.[2] 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 the number of days a patient stays in the hospital and the dollar value of charges the patient incurs for ancillary services. Beneficiaries pay the standard hospital deductible for inpatient services ($1,676 in 2025) and cost sharing equal to 20 percent of charges (not costs) for outpatient services.

Medicare's cost-based payments to CAHs (including beneficiary cost sharing) were $12 billion in 2023. About 61 percent of that total was for outpatient services, 21 percent was for inpatient services, and 18 percent was for swing-bed services. The average Medicare payment per CAH for acute inpatient, post-acute swing-bed, and outpatient services was $9 million in 2023.[3]

Beginning in 2023, CAHs can convert to outpatient-only hospitals

To preserve emergency access in rural communities that have insufficient inpatient volume to support a traditional

hospital, the Congress enacted a program that allows small hospitals to convert to a "rural emergency hospital" (REH). REHs do not provide inpatient care but provide round-the-clock emergency department care and can furnish other services, such as outpatient services and ambulance services. Medicare pays these new providers a monthly fixed rate ($285,626 in 2025), enhanced outpatient rates, and standard rates for other types of care. The program started on January 1, 2023. While any rural hospital with 50 or fewer beds can convert to REH status, only those with financial difficulties or very low inpatient volume are expected to do so. ■

1 For example, among CAHs currently operating, fewer than 200 converted to a CAH since 2006; in contrast, more than 200 became CAHs in 2005 alone.

2 CAHs may not receive the full 101 percent of their costs under current law due to payment reductions imposed by a budget sequester on Medicare payments and limits on the share of hospital bad-debt payments reimbursable by Medicare.

3 Data are for CAHs that, as of our analysis, had a complete cost report with a midpoint in the specified fiscal year. Data are limited to revenue from inpatient, outpatient, and swing-bed skilled nursing services. These data exclude other services furnished by CAHs and paid under other payment systems, such as rural health clinic services.