American Hospital Association

CAH Legislative History

Four key pieces of legislation have resulted in the creation and modification of the critical access hospital program:

1. H.R. 2015, Balanced Budget Act (BBA) of 1997 (P.L. 105-33)
2. H.R. 3426, Balanced Budget Refinement Act (BBRA) of 1999 (P.L. 106-113);
3. H.R. 5661, Medicare, Medicaid, SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, (P.L. 106-554), and
4. H.R. 1, Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (P.L. 108-173, Section 405).

The BBA created the program, outlining the criteria, plan development, quality assurance, and network requirements. BBRA established a length of stay of an average of 96 hours; established an optional payment methodology at 115% of the fee schedule for hospital-based physicians; and permitted participation of rural areas of metropolitan counties. BIPA established interim payments for CAHs and cost-based reimbursement for swing-bed stays and for on-call physicians. MMA expanded inpatient capacity from 15 to 25 beds; established distinct-part units for psych and rehab of up to 10 beds; increased Medicare payments to 101% of cost for inpatient, outpatient, and swing-bed services, and reauthorized the rural hospital flexibility grant program.

The Balanced Budget Act (BBA) of 1997
Section 402 of the BBA describes the critical access hospital program and the application process for CAH designation. Specifically, the BBA discusses inpatient and outpatient payments, program criteria, network development, agreements, credentialing and quality assurance, certification, grants, rural emergency medical services, the grandfathering of certain facilities that had previously been part of the Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program and the Medical Assistance Facilities (MAFs) demonstration in Montana.

Below are the original criteria set forth in the BBA that hospitals must meet in order to apply for CAH status:

- Must be rural, located within a state participating in the Medicare Rural Hospital Flexibility program
- Must be more than a 35-mile drive from any other hospital or CAH (or, in the case of mountainous terrains or in areas where only secondary roads are available, more than 15 miles from any other hospital are CAH)

- Must have 15 or fewer acute inpatient care beds (or, in the case of swing bed facilities, up to 25 inpatient beds which can be used interchangeably for acute of SNF-level care, provided no more than 15 beds are used at any one time for acute care) as reported on the cost report
- Must restrict patient length of stay to no more than 96 hours unless a longer period is required because of inclement weather or other emergency conditions, or a physician review organization (PRO) or other equivalent entity, on request, waives the 96-hour restriction
- Must offer 24-hour emergency services
- Must be owned by a public or nonprofit entity
- Of if a hospital does not meet the above conditions, it may be designated by other state criteria as a critical access hospital

The Balance Budget Refinement Act (BBRA) of 1999

The BBA contained a number of payment provisions that adversely affected hospitals. Responding to grassroots advocacy pressures, Congress and the Administration recognized that aspects of the BBA had gone too far, hurt many hospitals, and they acknowledged the need for legislative and regulatory relief. The Balanced Budget Refinement Act of 1999 (BBRA) was the first of such relief measures, and it included several changes aimed at increasing the flexibility of the critical access hospital program. The BBRA changes to the program criteria include the following:

- Replaced the per patient 96 hour length-of-stay limitation with an annual average 96-hour length-of-stay limitation
- Permitted CAHs to bill at the all-inclusive rate or continue to bill hospital and physician services separately. The all-inclusive rate would combine both cost-based hospital outpatient payments and fee schedule payments for professional services
- Granted CAH status to hospitals that have closed in the past 10 years, and to those hospitals that had downsized to a health clinic or center
- Allowed CAHs to continue providing long-term care services via the swing bed program
- Eliminated beneficiary coinsurance for clinical laboratory services furnished on an outpatient basis
- Extended CAH eligibility to for-profit hospitals

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)

On December 21, 2000, President Clinton signed into law the second relief measure, H.R. 5661, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). This measure provided further improvement to the CAH program. The Congressional Budget Office estimated that CAH provisions in the new legislation

represented a restoration to hospitals of $350 million over five years. The following provisions were included in the legislation:

Clarification of No Beneficiary Cost-Sharing for Clinical Diagnostic Laboratory Tests Furnished by Critical Access Hospitals. Effective for services furnished on or after the enactment of BBRA, Medicare beneficiaries would not be liable for any coinsurance, deductible, copayment, or other cost sharing amount with respect to clinical diagnostic laboratory services furnished as an outpatient critical access hospital service. Conforming changes that clarify that CAHs are reimbursed on a reasonable cost basis for outpatient clinical diagnostic laboratory services were also included.

Assistance with Fee Schedule Payment for Professional Services Under All-Inclusive Rate. Effective for items and services furnished on or after July 1, 2001, Medicare would pay a CAH for outpatient services based on reasonable costs or, at the election of an entity, would pay the CAH a facility fee based on reasonable costs plus an amount based on 115 percent of Medicare's fee schedule for professional services.

Exemption of Critical Access Hospital Swing Beds from SNF PPS. Swing beds in critical access hospitals (CAHs) would be exempt from the SNF prospective payment system. CAHs would be paid for covered SNF services on a reasonable cost basis.

Payment in Critical Access Hospitals for Emergency Room On-Call Physicians. When determining the allowable, reasonable cost of outpatient CAH services, the Secretary would recognize amounts for the compensation and related costs for on-call emergency room physicians who are not present on the premises, are not otherwise furnishing services, and are not on-call at any other provider or facility. The Secretary would define the reasonable payment amounts and the meaning of the term "on-call." The provision would be effective for cost reporting periods beginning on or after October 1, 2001.

Treatment of Ambulance Services Furnished by Certain Critical Access Hospitals. Ambulance services provided by a CAH or provided by an entity that is owned **and** operated by a CAH would be paid on a reasonable cost basis if the CAH or entity is the only provider or supplier of ambulance services that is located within a 35-mile drive of the CAH. The provision would be effective for services furnished on or after enactment.

GAO Study on Certain Eligibility Requirements for Critical Access Hospitals. By December 2001, GAO would be required to conduct a study on the eligibility requirements for CAHs with respect to limitations on average length of stay and number of beds, including an analysis of the feasibility of having a distinct part unit as part of a CAH and the effect of seasonal variations in CAH eligibility requirements. The GAO also would be required to analyze the effect of seasonal variation in patient admissions on critical access hospitals.

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Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)
On December 8, 2003, President George W. Bush signed into law P.L. 108-173, landmark legislation that provides prescription drug benefits for approximately 40 million seniors and disabled Americans beginning in 2006 and approximately $25 billion in relief to hospitals over 10 years. Section 405 contains important provisions for CAHs that enhance reimbursement, expand bed-size flexibility, and provide continued funding of the Medicare Rural Hospital Flexibility (FLEX) Program grants.

Increase in Payment Amounts
Under previous law, payment to Critical Access Hospitals (CAHs) for inpatient CAH, outpatient CAH, and covered skilled nursing facility services furnished in a CAH will be paid at 100% of reasonable costs. Beginning on or after January 1, 2004, this provision increases the CAH payment amount to 101% of reasonable costs.

Coverage of Costs for Certain Emergency Room On-Call Providers
Previous law states that BIPA requires the Secretary to include the costs of compensation (and related costs) of on-call emergency room physicians who are not present on the premises of a CAH, are not otherwise furnishing services, and are not on-call at any other provider or facility when determining the allowable, reasonable cost of outpatient CAH services. For services furnished on or after January 1, 2005, this provision expands on-call payments to physician-assistants, nurse practitioners, and clinical nurse specialists.

Authorization of Periodic Interim Payment (PIP)
Previous law states that eligible hospitals, skilled nursing facilities, and hospices, which meet certain requirements, receive Medicare periodic interim payments (PIP) every 2 weeks, and that a CAH is not eligible for PIP payments. For payments that were made on or after July 1, 2004, this provision authorizes periodic interim payments for inpatient CAH services and requires the Secretary to develop alternative timing methods for PIP.

Condition for Application of Special Professional Service Payment Adjustment
Under previous law, CAHs can elect to be paid for their outpatient CAH services at a rate equal to the sum of its facility fee paid on a reasonable cost basis and at 115% of the fee schedule for professional services otherwise included within outpatient critical access hospital services- the "Method 2" billing option. This provision prohibits CMS from requiring that all physicians providing services in a CAH assign their billing rights to the CAH as a condition for electing the "Method 2" billing option. For CAHs that made an election before November 1, 2003, the provision is effective for cost reporting periods beginning on or after July 1, 2001. For CAHs that made an election after November 1, 2003, the provision is effective for cost reporting periods beginning on or after July 1, 2004.

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Revision of Bed Limitation for Hospitals

Previous law states that a CAH is a limited service facility that must provide 24-hour emergency services and operate a limited number of inpatient beds in which hospital stays can average no more than 96 hours. A CAH is limited to 15 acute-care beds, but can have an additional 10 swing beds that are set up for skilled nursing facility level of care. While all 25 beds in a CAH can be used as swing beds, only 15 of 25 swing beds can be used for acute care at any given time. This provision will allow CAHs to operate up to 25 beds as either acute care or swing beds and is effective January 1, 2004, though any implementing regulations shall only apply prospectively.

Provisions Relating to FLEX Grants

Under prior law, the Secretary is able to make grants for specified purposes to States or eligible small rural hospitals that apply for such awards. Funding for the Rural Hospital Flexibility Grant Program was $25 million in each of fiscal years 1998 through 2002. Authorization to award grants expired in FY 2002, but this provision reauthorizes existing FLEX grant funding for all States of $35,000,000 in each of fiscal years 2005 through 2008, effective October 1, 2004.

Authority to Establish Psychiatric and Rehabilitation Distinct Part Units

Under previous law, beds in distinct-part skilled nursing facility units do not count toward the CAH bed limit. Beds in distinct-part psychiatric or rehabilitation units operated by an entity seeking to become a CAH do count toward the bed limit. This provision, though, allows CAHs to establish psychiatric and rehabilitation distinct part units and is effective for cost reporting periods beginning on or after October 1, 2004. However, such distinct part units must meet the requirements (including conditions of participation) that would apply if they were established in an acute care hospital. Beds in these distinct part units are excluded from the bed count. Services provided in these distinct part units will be under the applicable payment system for those units.

Waiver Authority

In order to be designated a critical access hospital, prior law stated that a facility must meet one of the following criteria: (1) be located in a county or equivalent unit of a local government in a rural area, (2) be located more than a 35-mile drive from a hospital or another facility, or (3) be certified by the State as being a necessary provider of health care services to residents in the area. Effective December 8, 2003, this provision limits the State to continue to certify facilities as necessary providers in order for them to be designated as critical access hospitals until January 1, 2006.