American Hospital Association™
Advancing Health in America

Fact Sheet: 96-Hour Certification Requirement

The Issue

In order for a Critical Access Hospital (CAH) to receive payment under Medicare Part A, Medicare currently requires physicians to certify that patients will be reasonably discharged or transferred to another hospital within 96 hours. While the Centers for Medicare & Medicaid Services (CMS) had not historically enforced the requirement, in 2013, the agency implied that it would begin to do so more strictly. However, in 2017, CMS stated that 96-hour certification requirement reviews would be considered "low priority." Nevertheless, this antiquated provision remains a statutory requirement and threatens the ability of CAHs to best serve their patients. **A legislative change is needed to permanently remove this unnecessary burden on providers, prevent unwarranted penalties, and allow flexibility for CAHs to provide the types of services their communities need and seek close to home.**

The Balanced Budget Act of 1997 initially required that the inpatient length of stay be no more than 96 hours as both a condition of participation and a condition of payment for CAHs. Yet, two years later, the Balanced Budget Refinement Act (BBRA) of 1999 changed the conditions of participation to require acute inpatient care for "a period that does not exceed, as determined on an annual, average basis, 96 hours per patient."[1] This change has allowed CAHs to provide care to those patients requiring longer lengths of stay, as long as the average stay per patient is 96 hour or less annually. However, the corresponding condition of payment was never updated to reflect the BBRA condition of participation language.

AHA Position

AHA urges Congress to pass the Critical Access Hospital Relief Act of 2019 (S. 586/H.R. 1041) to permanently remove the 96-hour condition of payment for CAHs. Removing this requirement would allow CAHs to serve patients needing critical medical services that may have lengths of stay greater than 96 hours. These hospitals would still be required to satisfy the condition of participation requiring CAHs not to exceed a 96-hour annual average length of stay and meet other certification requirements that apply to all hospitals.

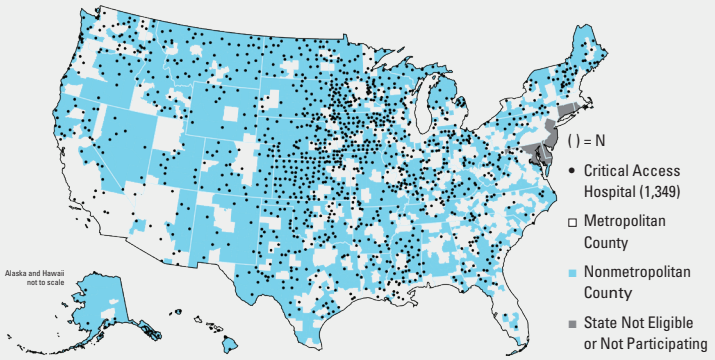
Why?

CAHs play a vital role in their communities, providing health care services close to home and preventing patients in rural areas from having to travel long distances to access the care they need – including those services that may require longer lengths of stay. These providers are dedicated to high-quality care: nearly all CAHs (about 96%) participate in HRSA's Medicare Beneficiary Quality Improvement Project[2] and the vast majority (about 90%)[3] voluntarily submit data to CMS' Hospital Compare for inpatient quality measures.

CAHs serve populations with substantial medical

Location of Critical Access Hospitals[4]

Information gathered through January 31,2019



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needs. As described in *AHA's Rural Report*, having a challenging patient mix is a persistent reality for rural hospitals. Rural populations are notably older, have higher rates of chronic disease and have higher prevalence of multiple chronic conditions.[5,6] These conditions and comorbidities, including cardiovascular disease, chronic obstructive pulmonary disorder and diabetes, may all contribute to longer inpatient stays.

Twenty years ago, Congress recognized the need for more flexibility for CAHs by changing the conditions of participation in the BBRA to allow these hospitals to provide acute care that requires more than 96 hours. It is long overdue for the conditions of payment to be consistent with that provision.

Resources

1. CMS. (April 2000). Transmittal No. A-00-17. Retrieved from: *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/A001760.pdf*.

2. HRSA. (July 2017). Quality Improvement for Critical Access hospitals. Retrieved from: *https://www.hrsa.gov/sites/default/files/hrsa/ruralhealth/Infographics/MBQIPinfograph508.pdf*.

3. Flex Monitoring Team. (April 2019). Hospital Compare Quality Measure Results for CAHs, 2017. Retrieved from: *https://www.flexmonitoring.org/wp-content/uploads/2019/04/DSR-28-National-Hospital-Compare-2017-data.pdf*.

4. US Census Bureau, 2018; CMS Regional Office, ORHP, and State Offices Coordinating with MRHFP, 2018.

   Note: Core Based Statistical Areas are current as of the April 2018 update. Nonmetropolitan counties include micropolitan and counties outside of CBSAs.

5. National Center for Health Statistics. (August 2018). Number of respondent-reported chronic conditions from 10 selected conditions among adults. Retrieved from: *https://www.cdc.gov/nchs/hus/contents2017.htm#Table_039*.

6. CDC. (September 2016). Chronic Disease Disparities by County Economic Status and Metropolitan Classification. Retrieved from: *https://www.cdc.gov/pcd/issues/2016/16_0088.html*.