

“LET’S TALK CAH”

A Critical Access Hospital (CAH) is a hospital designation made possible by the Medicare Rural Hospital Flexibility Program created by the federal government in the Balanced Budget Act of 1997. The program is available to any state that chooses to establish a state rural health plan and implement the Centers for Medicare and Medicaid Services (CMS) requirements of the CAH program. The state plan then defines the rural and necessary provider eligibility requirements for hospitals within that state.

A critical access hospital is an opportunity for small, rural hospitals to increase revenues through cost based reimbursement from Medicare and to have greater flexibility in their delivery of services. The hospital will essentially provided the same services and function under the same hospital licensure standards and Medicare Conditions of Participation. The hospital must provide 24-hour emergency services along with core inpatient and outpatient services.

Most hospitals that elect to be a CAH have a Medicare patient mix of greater than 60% and find that the business has shifted from inpatient to outpatient. The cost based reimbursement program becomes an economic advantage to these hospitals.

CRITERIA TO BE A CAH

- Be a licensed acute care hospital
- Located in a rural designated county
- Be certified by the state as a Necessary Provider o health Services
- Have a maximum of 15 acute care beds or 25 total, if the hospital has a swing bed program
- Maintain an annual average inpatient stay of 96 hours
- Have a transfer agreement to accommodate inpatient transfer and referral
- Have 24-hour emergency services
- Have credentialing and quality assurance arrangements with a member of a health network or the hospital has its own free-standing program

QUESTIONS ABOUT CAH

What about observation patients?

Patients can be admitted as an observation patient and follow the same CMS guidelines for observation as before. Patients in observation are not counted in the daily acute care census.

Are newborns counted in the daily acute care census?

Newborns are not counted in the daily census; however, if a newborn is admitted as a pediatric patient, the newborn is counted.

Are pediatric patients counted in the daily acute care census?

Yes, pediatric patients are counted unless the baby or child is admitted as an observation patient.

How are hospice patients counted?

Hospice patients (Medicare certified) admitted as an inpatient are included in the daily acute care count of 15; hospice patients admitted to a swing bed are included in that count of 10. Hospice patients in a respite, SNF, or long-term bed are not included in the CAH daily census count.

Can a CAH accept a transfer patient?

Yes, a transfer patient can be accepted in both the acute care and swing bed program.

Will a CAH have an annual survey? (*State-specific to Illinois*)

The Illinois Department of Public health will do an initial follow up review of the hospital swing bed and acute care programs. IDPH will inspect for life safety conditions as well as for health and nursing conditions of participation. The initial follow up review will follow a process similar to the long-term care annual review. Critical access hospitals will then be surveyed by the Department on a random basis (unannounced).

Will JCAHO accredit critical access hospital?

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has applied for “deemed status” and expects to have approval to survey CAHs beginning summer 2002. JCAHO has developed its own standards of operation for CAHs and will include the Medicare Conditions of Participation for CAHs.

What happens if a CAH exceeds the Average length of stay (ALOS) of 96 hours?

A CAH must have some type of monitoring program in place either through a case management approach or through discharge planning activities. The hospital will need to monitor on a periodic basis and be prepared to make arrangements if the daily acute care census exceeds the 15 inpatient limit.

If the hospital would exceed the year-end ALOS of 96 hours, CMS will require a plan of correction and will then monitor the hospital until the hospital can demonstrate its ability to meet the ALOS of 96 hours.

Will staffing requirements change when a hospital receives CAH designation?

The federal requirements for CAH allows for flexibility with staffing; however, each has its own hospital staffing requirements. Illinois requirements necessitate a RN on duty based on need for inpatient and skilled care services along with appropriate support staff.

What is the role of a mid level in a CAH?

The federal requirements for CAH allow for a nurse practitioner and physician assistant to admit and provide inpatient and emergency care under the supervision of a MD. The physician does not have to be onsite but available through telecommunications. IL has several ER telemedicine demonstration sites; however, a physician, dentist, and podiatrist are still the only practitioners who can independently admit patients and provide inpatient care.

Can a hospital change its CAH designation?

Yes, hospitals would be responsible to notify CMS and the fiscal intermediary. The provider number would then need to be changed and a new billing process established. The hospital may be required to go through another survey because of the change in provider number.

Are CAHs exempted from using ambulatory procedure codes (APCs) and line item dates of services on outpatient bills?

Yes. Since CAHs are paid under the cost based reimbursement system, CMS exempted critical access hospitals from the new outpatient coding and billing system. CAH can implement the AACS within their hospital and use line item billing, if they choose to do so.

Annual CAH Evaluation

Critical access hospitals are required to complete an annual evaluation of hospital services and the CAH program.

WHAT ARE THE ADVANTAGES OF CAH?

- Cost based reimbursement/potentially increased revenues
- Opportunity to refocus efforts to meet community needs
- CAH network of hospitals
- Flexibility with staffing and hospital programs (state requirements)
- Expense capital improvements and equipment per guidelines
- Outpatient P.P.S. exemption for reimbursement
- Network development opportunities
- Increase in operating margin and greater financial stability
- Capital improvement costs included in the Medicare cost report
- CAH grants and telehealth support
- Increased hospital viability - patient satisfaction with hospital
- Opportunity to cost out ER physician stand by time

FUTURE FOR THE CAH PROGRAM

- Consideration of an average daily census of 15
- Consideration of cost based reimbursement for CAH ambulance services, home health, long-term care, and in patient psychiatric care
- Greater focus on quality improvement and network development
- Viability of the small rural hospital