CRITICAL ACCESS HOSPITALS PAYMENT SYSTEM

*payment***basics**

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The policies discussed in this document were current as of September 30, 2024. This document does not reflect proposed legislation or regulatory actions.

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Medicare beneficiaries can receive care in about 1,350 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. Most CAH beds are "swing beds," in which beneficiaries can receive acute or post-acute care. In some states, these beds can also be used as 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 category in the Balanced Budget Act of 1997. To qualify for the CAH program, 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 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 few additional CAHs since 2006 because most hospitals that meet the distance and size criteria have already converted to CAH status.

Defining the care that Medicare buys from CAHs

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 of service provided or the 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

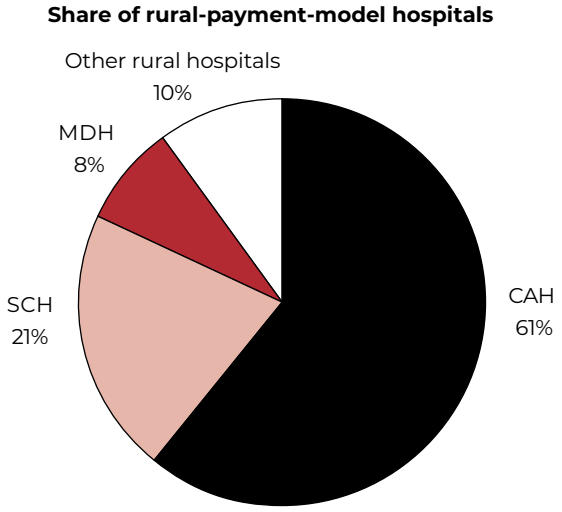
Each CAH receives 101 percent of its costs for outpatient, inpatient, laboratory and therapy services, as well as post-acute care in the hospital's swing beds.[1] The cost of treating Medicare patients is estimated using cost-accounting data from Medicare cost reports. CMS's cost-accounting methodology 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 ($1,634 in 2024) 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 2022, representing 6 percent of all Medicare inpatient and outpatient payments to hospitals. The average Medicare payment per CAH for acute inpatient, post-acute swing-bed, and outpatient services was $9 million in 2022.

Differences between CAH, SCH, and MDH Medicare payments

As Figure 1 illustrates, most rural hospitals are either CAHs (61 percent), sole community hospitals (SCHs) (21 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. An SCH receives the higher

Figure 1 Share of hospitals and Medicare payments by type of rural payment model, 2022



Note: MDH (Medicare-dependent hospital), CAH (critical access hospital), SCH (sole community hospital), PPS (prospective payment system). All MDH, CAH, and SCH hospitals are included in Figure 1, even if the hospital became eligible for its payment status through a special rural classification (such as the state declaring a certain area as rural). "Other rural hospitals" refers to hospitals that are located outside of metropolitan statistical areas and are not paid based on either current or historical costs. Some of these hospitals still receive special payments such as a low-volume adjustment or special benefits as a rural referral center.

of either (1) standard inpatient prospective payment rates or (2) payments based on the hospital's costs in a base year updated to the current year and adjusted for changes in its case mix. An MDH receives a prospective payment rate based on a blend of current PPS rates (25 percent) and the hospital's historical costs (75 percent). The SCH and MDH payment methodologies differ in two significant ways from CAH cost-based payments. First, SCHs and MDHs receive cost-based payments only 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 an SCH or MDH increases its expenditures per patient (except for an allowance for case-mix change), 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.

CAHs can convert to outpatient-only hospitals starting in 2023

To preserve emergency access in rural communities that have insufficient inpatient volume to support a traditional hospital, the Congress recently enacted a program that will allow small hospitals to convert to a "rural emergency hospital" (REH). These REHs will not provide inpatient care but will provide round-the-clock emergency department care and will be able to furnish other services, such as outpatient services and ambulance services. Medicare will pay these new providers a monthly fixed rate ($276,234 in 2024), 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 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.