Critical Access Hospitals and Their Emergency Departments
Selected Issues and Opportunities

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Recent changes in federal and state law have provided small, rural hospitals an extraordinary opportunity to survive – and thrive – in an exceedingly difficult healthcare market. Prominent among these changes is the availability of Critical Access Hospital designation. Among the advantages of the designation is the ability to more effectively and efficiently provide and pay for Emergency Department Physician services for the hospital.

The Rural Hospital Flexibility Program (Flex Program) was created by the Balanced Budget Act of 1997 and was intended to strengthen rural health care by encouraging states to take a holistic approach. A major requirement for participation in the Flex Program is the creation of a state rural health plan. Formally, the language of this act defines its intent as:

- Preserving access to primary care and emergency health care services
- Providing health care services that meet community needs
- Helping assure the financial viability of program participants through improved reimbursement and different operating requirements

The Flex Program provides grants to each state which are used to implement a Critical Access Hospital program, to encourage the development of rural health networks, to assist with quality improvement efforts, and improve rural emergency medical services. The Flex Program promotes a process for improving rural health care, using the Critical Access Hospital (CAH) program as one method of promoting strength and longevity through CAH conversion for appropriate facilities.

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. (Information about Necessary Provider status is available in Appendix A)

Designation as a Critical Access Hospital is an alternative for small, rural hospitals that creates the potential for enhanced reimbursement from Medicare, the opportunity to better match the local community's needs to the hospital’s capabilities, and the foundation of a rural health network. The CAH designation only affects Part A (hospital services) Medicare reimbursement and does not affect other government or private reimbursement (however, most hospitals that elect to be a CAH have a Medicare patient mix of greater than 60%). The bottom
line goal of the CAH designation is improved financial viability and stability for the hospital in order to assure access to quality medical care in rural areas.

Prominent among the advantages for a critical access hospital is the opportunity to increase revenues through cost-based reimbursement from Medicare and to have greater flexibility in their delivery of services. The hospital continues to provide the same services and function under the same hospital licensure standards and Medicare Conditions of Participation, including an explicit requirement for 24-hour emergency services along with core inpatient and outpatient services.

To qualify for consideration as a Critical Access Hospital, a facility must be a licensed acute care hospital, located in a rural designated county, be certified by the state as a Necessary Provider of 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 and have credentialing and quality assurance programs in place. (One facet of these criteria, the total bed composition, has changed recently. This matter is addressed below in the “Recent Changes: Medicare Prescription Drug, Improvement, and Modernization Act” section.)

Other advantages of Critical Access Hospital status include opportunity to refocus efforts to meet community needs, collaboration with the CAH network of hospitals, flexibility with staffing and hospital programs, the ability to expense capital improvements and equipment, outpatient Prospective Payment System (PPS) exemption for reimbursement, increased access to CAH grants and telehealth support.

Critical Access Hospitals, and the communities in which they are located, are also able to receive free technical assistance in the following areas:

- Integration of emergency medical services
- Quality improvement programs
- Community health planning
- Network development
- Delivery of community oriented primary care services

The change to CAH is confusing to some important stakeholders of facilities seeking that designation. The term itself, “critical access”, can suggest that the hospital is a lesser entity unworthy of consideration of the citizenry's healthcare needs. Some administrators choose to emphasize the term “cost-based reimbursement” rather than “critical access” in their dealings with the press, the public and their medical staff. Increasingly, the onus associated with the designation has become minimal, as the status becomes better known and accepted. Nevertheless, the substantial advantages are relatively easy to convey. (An example of a tool to assist administrators, Points of Considerations for Physicians, is included as Appendix C)

The Oregon Health and Science University directly addresses the effect on the principal stakeholders as a hospital considers CAH status: “From the community's perspective, the goal is to keep the hospital as a vibrant community player focusing on the health needs of the service area. From the patients' perspective, the goal is to meet their needs in the best way possible, especially in regard to emergency and acute care services. Reimbursement levels for physicians are not affected by the change to a critical access hospital under the federal rules and regulations currently in place.”
While the most obvious benefit to licensure as a CAH is the increased revenue generated by the switch to cost-based reimbursement, other advantages conferred by the designation can significantly contribute to the success of the hospital. Facilities that struggled to make ends meet should be able to utilize this additional funding to stabilize their finances. Additionally, the state Medicare Rural Hospital Flexibility Program offers grants for projects such as financial feasibility studies, consultant studies, legal reviews, and quality improvement initiatives. This support, in concert with cost-based reimbursement, will make many improvements within reach for CAH facilities that were once only concerned with keeping their doors open.

**Emergency Departments**

Another significant but often unrecognized expense is classified as "standby time". In certain staffing models, Emergency Department physicians are required to be "in-house" 24 hours a day, seven days a week. Patients with a variety of injuries and illnesses arrive in emergency departments any time of day or night. There is a value to the community and the nation in maintaining these readiness capabilities. As a result of the unscheduled nature of emergency medicine, emergency physicians may spend a portion of their time in an "availability" or "readiness" status awaiting the arrival of patients. There is substantial economic cost for this "down-time" which may account for an average of two to three hours per evening. Paying physicians for this "standby time" is a significant overhead expense for the emergency physician group and well above the expense incurred providing an LPN or medical assistant in the usual physician’s office.

Existing CAH regulations do allow for the payment (as a submission in the Medicare cost report) of physician availability services in emergency room settings provided certain criteria are met. Historically, it has been very difficult for small, rural hospitals to meet these criteria because the hospital must be able to demonstrate that it has been unable to obtain emergency room physician coverage without paying for standby coverage.

**Recent Changes: Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)**

On December 21, 2000, President Clinton signed into law P.L. 106-554, The Consolidated Appropriation Act 2001, which included H.R. 5661, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). The following provisions were included in the legislation:

*BIPA addresses the payment in critical access hospitals for emergency room on-call physicians. When determining the allowable, reasonable cost of outpatient CAH services, the secretary is to 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 was effective for cost reporting periods beginning on or after October 1, 2001.*

The Act also addresses treatment of ambulance services furnished by certain critical access hospitals. Ambulance services provided by a CAH or provided by an entity that is owned or operated by a CAH are to 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.
By expanding the scope of Critical Access Hospital (CAH) services eligible for cost-based reimbursement to include swing beds, ambulance services and certain “on-call” emergency room costs, BIPA is likely to extend CAHs role as a significant safety-net provider in rural America. Moreover, in allowing for the inclusion of enhanced reimbursement for professional services in a CAH, BIPA will allow CAHs to become important hubs in the network of delivering services throughout rural America.

As the new legislation allows for cost-based reimbursement for emergency room physicians who are “on call”, hospital administrators at Critical Access Hospitals are investigating inclusion of fees paid to contract services providers of emergency physician services in their Medicare cost report. According to Rural Health Consultants, “The new law provides for cost-based reimbursement for reasonable compensation and related costs of emergency room physicians who are ‘on-call but off the premises of a CAH’ (CAHs who qualify are already reimbursed for the costs of “standby” physicians, those doctors who are on the premises of the facility). In addition, the on-call physician may not otherwise be furnishing services during the on-call time or be on-call for another facility. The legislation leaves the definition of ‘on-call’ to the Secretary, therefore requiring CMS regulations to clarify the issue.”

Those rules, outlined in (Section 204) “Payment in Critical Access Hospitals for Emergency Room On-Call Physicians” section of the Medicare Hospital Manual, Department of Health & Human Services (DHHS)” are explained as follows in an explanatory memo from CMS, “This provision would direct the Secretary to recognize the 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 actual language is also included in Appendix B)

New legislation expands cost-based reimbursement of on-call emergency room physicians to include physician assistants, nurse practitioners, and clinical nurse specialists for costs incurred for covered Medicare services furnished on or after January 1, 2005. (Section 405(b))

Recent Changes: Medicare Prescription Drug, Improvement, and Modernization Act

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

Of particular interest is the revision of bed limitation for Critical Access Hospitals. Under previous law, a CAH could operate only 25 beds and was limited to 15 acute care beds and 10 swing beds. New legislation removes this limitation and permits CAHs to operate up to 25 swing beds or acute care beds. The provision applies to CAH designations made before, on or after January 1, 2004. However, the provision will apply prospectively for any election made after regulations for this provision have been promulgated.

Under previous law, a CAH had to be located more than 35 miles from another hospital, or 15 miles in areas with mountainous terrain or areas where only secondary roads are available.
The mileage standards could be waived if the hospital had been designated by the state as a Necessary Provider of health care.

**Summary**

The Rural Hospital Flexibility Program provided for the creation and implementation of the Critical Access Hospital program. Implementation of this program has been the salvation for many small and rural healthcare facilities. Facilities that faced extinction have adopted the designation and, in many cases, stabilized their financial situation and ensured the survival of the hospital’s ability to provide important services to their patients.

Benefits of the designation as a CAH include the increased revenue generated by the switch to cost-based reimbursement and grants for projects such as financial feasibility studies, consultant studies, legal reviews, and quality improvement initiatives.

Most recently, there have been other significant additions to the advantages of the CAH program. Notable among these changes is the change away from the 15 acute / 10 swing bed system that was the original criteria to a 25 total beds criterion for inclusion in the program. Hospitals that had been ineligible previously are now considering filing their application before the program “sunsets” in 2006. This change is directly responsive to concerns pertaining to the original law. Speculation exists that the program may be further modified to encompass facilities with more total beds (possibly 50) and extend the program into other underserved and vulnerable areas (probably the inner city).

There are specific CAH advantages that pertain to staffing the Emergency Department. These include the ability to bill Medicare for the payment of physician availability services in emergency room settings, for amounts associated with the compensation and related costs for on-call emergency room physicians who are not present on the premises, and cost-based reimbursement of on-call physician assistants, nurse practitioners, and clinical nurse specialists.

Critical Access Hospital designation, and the support of the state and federal government for this important program, has provided the opportunity for vulnerable hospitals in rural areas to survive, keeping in place an important part of the nation’s healthcare safety net and maintaining access to that care for citizens of their communities.
Sources Cited

Rural Assistance Center
http://www.raonline.org/info_guides/hospitals/cah.php

Iowa Department of Public Health
http://www.idph.state.ia.us/ch/health_care_access_content/CAH/default.htm

USDA, Rural Information Center

Centers for Medicare and Medicaid Services (CMS) - Critical Access Hospitals
http://www.cms.hhs.gov/providers/cah/

Oregon Health and Science University, CAH Frequently Asked Questions
http://www.ohsu.edu/oregonruralhealth/faq.html
Appendix A: State Necessary Provider

If a facility does not meet the 35-mile distance criteria it may, in substitution, apply to be recognized as a necessary provider by the Iowa Department of Public Health. The criteria for this designation are listed below. Each possible characteristic equals one point, six of 11 total, including at least two from the facility subsection, are required for approval.

Population Characteristics
- Applicant must have a three-year average poverty rate equal to or greater than the three-year state average.
- Applicant must have a two-year average unemployment rate greater than or equal to the state two-year average.
- Applicant must demonstrate an elderly population (65 years old and older) percentage greater than or equal to the state average.
- Applicant must demonstrate that 30 percent of the hospital catchment area is in a shortage area.

Geographic Characteristics
- Applicant must demonstrate a motor vehicle accident rate or farm injury rate greater than or equal to the state average.
- Facility must be located on or near a Department of Transportation categorized C or D level road.

Facility Characteristics
- Applicant must be an Essential Community Provider as defined by the Iowa Department of Public Health, Office of the Director, Administrative Directive 95-25 April 20, 1995.
- Applicant must be a participant in the Medicare program.
- Applicant must be an emergency medical services (EMS) provider or demonstrate a cooperative and collaborative relationship with the local EMS provider and/or meet one or all of the following criteria:
  - A hospital representative is on the EMS Board or an EMS representative is on the hospital board.
  - The hospital provides medical control for the EMS provider.
  - The hospital shares financial responsibility for EMS.
  - Applicant must be an obstetric and/or prenatal service provider.
  - Applicant is the only hospital in the county.

In addition to meeting six of these criteria (including two from the facility subsection), a Necessary Provider applicant must submit information pertaining to their organizational structure, services provided, financial feasibility study, community health planning activity, facility information and patient data as well as a network agreement with a secondary hospital.
Appendix B: Changes in BIPA, Section 415.22, Payment for Services Furnished by a Critical Access Hospital

Costs of Emergency Room On-call Physicians. For cost reporting periods beginning on or after October 1, 2001, the reasonable costs of outpatient CAH services may include the reasonable compensation and related costs for an emergency room physician who is on call but not present at the premises of the CAH, if the physician is not otherwise furnishing physicians’ services and is not on call at any other provider or facility. The costs are allowable only if they are incurred under a written contract which requires the physician to come to the CAH when the physician’s presence is medically required. An emergency room physician must be a doctor of medicine or osteopathy who is immediately available by telephone or radio contact, and available on site, on a 24-hour a day basis, within 30 minutes, or within 60 minutes in areas described in 42 CFR 485.618 (d)(2).
Appendix C: Points of Consideration for Physicians

- The hospital does not have to change its services or de-license beds. For the most part, business as usual.
- Medicare will reimburse appropriate observation stays. Under CAH, observation is paid as an outpatient service. Observation patients are not included in the daily acute care census count.
- The critical access hospital is required to maintain an annual average length of stay 96 hours or less for acute care patients. There is no requirement for an annual average length of stay for swing bed patients. The swing bed patient must meet Medicare skilled nursing requirements where the length of stay and benefits depend on how the patient meets the need for extended care services.
- Case management is critical to maintaining an average length of stay 96 hours or less. The patient’s plan of care which includes the expected date of discharge needs to be developed as soon as possible. The hospital staff must then implement and provide the care in the most efficient, safe manner. Some type of daily surveillance through utilization review or a discharge planning program is important to monitor the length of stay and each patient’s progress/status. Some hospitals have daily patient conferences. Case management is seven days a week. Nursing homes and home health services have to be ready to take patients on weekends and even holidays.
- The hospital has a responsibility to keep its number of acute care inpatients 15 or under and the number of swing bed patients at 10 or 25 patients as a total number for the hospital.
- If a physician transfers an acute care patient to another hospital, the hospital will receive the complete DRG reimbursement for the patient. The critical access hospital will be reimbursed for its costs; there is no splitting of the DRG reimbursement with the other hospital. This should be a positive for the other hospital accepting a patient from a critical access hospital.
- Critical access hospitals can be reimbursed for physician recruitment. Also, critical access hospitals can be reimbursed for physicians on call for the emergency department. There are specific guidelines the CAH must follow for that reimbursement.
- The critical access hospital program allows Mid-level providers to provide inpatient and emergency department care as long as the mid-level provider has physician supervision. The physician does not have to be on-site but can be accessible by phone or fax.
- Capital improvements which includes capital equipment can be reimbursed through the CAH program based on percentage of Medicare business.
- CAHs are exempt from APCs.
- There are specific Medicare critical access hospital standards of participation. A critical access hospital applicant must go through an Illinois Department of Public Health survey prior to approval as a CAH. The hospital is surveyed to see if it meets the CAH standards as well as state guidelines found in the Illinois Hospital Licensing Act. Surveyors review hospital operations, emergency care services, nursing care, physical plant and life safety. Surveyors will also review the physician credentialing and re-credentialing program, quality improvement program which includes medical care and medical staff bylaws and committee reports.
- A critical access hospital is required to have at least one transfer agreement with another hospital and a regional EMS agreement. This allows the CAH to have a resource hospital to accept its patients without difficulty and establish a working relationship for both medical staff.
Memorandum

To: All Credentialed Physicians at ___________ Hospital

From: Paul Hudson, Vice President

Re: Medicare Hospital Reporting Requirements Related to ED Physician On-call Time

Date: February 27, 2004

What it is: Many of our smaller hospitals face unique reporting requirements from Medicare. ACUTE CARE, INC. is working with our facilities to inform you that we need your help in collecting the baseline data. This requirement relates to allotment of ED physicians time in direct patient care versus standby time.

The use of your time is typically divided into 3 categories:
- Patient care → Patient care and charting;
- Administration → committee meetings or work done on behalf of hospital;
- Personal/Other → downtime (sleeping, reading, etc.).

How to collect the needed data: A form has been developed by the hospital that you need to complete for any shift worked. A sample is attached.

When this will begin: Immediately! Look for the form on your next shift.

Why we need your help: The accurate recording of patient care versus non-patient care time assists the hospital in filing of their Medicare cost report. The cost report is a tool that assures that the hospital can be correctly paid for all allowable costs related to the provision of Emergency Department care.

A sample is enclosed showing how a form would be completed.

Questions: Please contact __________ Hospital, or any member of the ACI Performance Improvement Department.

We appreciate your help and cooperation with this form. The new form will be located near the facility sign in sheet.
In the following pages, you will find:

Appendix D: CMS Memo Regarding the Medicare Modernization Act,
Appendix E: A Listing of Iowa Certified Critical Access Hospitals,
Appendix F: A Map of Iowa’s Medicare Rural Flexibility Program, and
Appendix G: Location of Critical Access Hospitals in the United States