

## Chapter 15

## Section 1

# Critical Access Hospitals (CAHs)

Issue Date: November 6, 2007

Authority: [32 CFR 199.14\(a\)\(3\)](#) and [\(a\)\(6\)\(ii\)](#)

Revision: C-2, May 17, 2017

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### 1.0 APPLICABILITY

This policy is mandatory for the reimbursement of services provided either by network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the Defense Health Agency (DHA) and specifically included in the network provider agreement.

### 2.0 DESCRIPTION

A CAH is a small facility that provides limited inpatient and outpatient hospital services primarily in rural areas and meets the applicable requirements established by [32 CFR 199.6\(b\)\(4\)\(xiv\)](#).

### 3.0 ISSUE

How are CAHs to be reimbursed?

### 4.0 POLICY

#### 4.1 Background

**4.1.1** Hospitals are authorized TRICARE institutional providers under 10 United States Code (USC) 1079(j)(2) and (4). Under 10 USC 1079(j)(2), the amount to be paid to hospitals, Skilled Nursing Facilities (SNFs), and other institutional providers under TRICARE, "shall be determined to the extent practicable in accordance with the same reimbursement rules as apply to payments to providers of services of the same type under [Medicare]." Under [32 CFR 199.14\(a\)\(1\)\(ii\)\(D\)\(1\)](#) through [\(9\)](#) it specifically lists those hospitals that are exempt from the Diagnosis Related Group (DRG)-based payment system. Prior to December 1, 2009, CAHs were not listed as excluded, thereby making them subject to the DRG-based payment system.

**4.1.2** Legislation enacted as part of the Balanced Budget Act (BBA) of 1997 authorized states to establish State Medicare Rural Hospital Flexibility Programs (MRHFPs), under which certain facilities participating in Medicare could become CAHs. CAHs represent a separate provider type with their own Medicare conditions of participation as well as a separate payment method. Since that time, a number of hospitals, acute care and general, as well as Sole Community Hospitals (SCHs), have taken the necessary steps to be designated as CAHs. Since the statutory authority requires TRICARE to apply the same reimbursement rules as apply to payments to providers of services of the same type under

Medicare to the extent practicable, effective December 1, 2009, TRICARE is exempting CAHs from the DRG-based payment system and adopting a reasonable cost method similar to Medicare principles for reimbursing CAHs. To be eligible as a CAH, a facility must be a currently participating Medicare hospital, a hospital that ceased operations on or after November 29, 1989, or a health clinic or health center that previously operated as a hospital before being downsized to a health clinic or health center. The facility must be located in a rural area of a State that has established a MRHFP, or must be located in a Core Based Statistical Area (CBSA) of such a State and be treated as being located in a rural area based on a law or regulation of the State, as described in 42 CFR 412.103. It also must be located more than a 35-mile drive from any other hospital or CAH unless it is designated by the State, prior to January 1, 2006, to be a "necessary provider". In mountainous terrain or in areas with only secondary roads available, the mileage criterion is 15 miles. In addition, the facility must make available 24-hour emergency care services, provide not more than 25 beds for acute (hospital-level) inpatient care or in the case of a CAH with a swing bed agreement, swing beds used for SNF-level care. The CAH maintains a Length-Of-Stay (LOS), as determined on an annual average basis, of no longer than 96 hours. The facility is also required to meet the conditions of participation for CAHs (42 CFR Part 485, Subpart F). Designation by the State is not sufficient for CAH status. To participate and be paid as a CAH, a facility must be certified as a CAH by the Centers of Medicare and Medicaid Services (CMS).

## **4.2 Scope of Benefits**

### **4.2.1 Inpatient Services**

**4.2.1.1** For admissions on or after December 1, 2009, payment for inpatient services of a CAH other than services of a distinct part unit, shall be reimbursed 101% of reasonable costs. Reference [paragraph 4.3](#) for information on the reasonable cost method.

**4.2.1.2** Items and services that a CAH provides to its inpatients shall be covered if they are items and services of a type that would be covered if furnished by an acute care hospital to its inpatients. A CAH may use its inpatient facilities to provide post-hospital SNF care and be paid for SNF-level services if it meets the following requirements:

- The facility has been certified as a CAH by CMS;
- The facility operates up to 25 beds for either acute (CAH) care or SNF swing bed care; and
- The facility has been granted swing-bed approval by CMS.

**4.2.1.3** Payment for post-hospital SNF care furnished by a CAH, shall be reimbursed under the reasonable cost method.

**4.2.1.4** Payment to a CAH for inpatient services shall not include any costs of physician services or other professional services to CAH inpatients. Payment for professional medical services furnished in a CAH to CAH inpatients shall be made on a fee schedule, charge, or other fee basis, as would apply if the services had been furnished in a Hospital Outpatient Department (HOPD). For purposes of CAH payment, professional medical services are defined as services provided by a physician or other practitioner, e.g., a Physician Assistant (PA) or a Nurse Practitioner (NP). These services are to be billed on the CMS 1500 Claim Form using the appropriate Healthcare Common Procedure Coding System (HCPCS) code or a UB-04 using the appropriate HCPCS code and professional revenue codes.

**4.2.1.5** A CAH may establish psychiatric and rehabilitation distinct part units effective for cost reporting periods. The CAH distinct part units must meet the following requirements:

- The facility distinct part unit has been certified as a CAH by CMS;
- The distinct part unit meets the conditions of participation requirements for hospitals;
- The distinct part unit must also meet the requirements, other than conditions of participation requirements, that would apply if the unit were established in an acute care hospital;
- Inpatient services provided in psychiatric distinct part units are subject to the CHAMPUS mental health per diem system and inpatient services provided in rehabilitation distinct part units shall be reimbursed based on billed charges or set rates.
- Beds in these distinct part units are excluded from the 25 bed count limit for CAHs;
- The bed limitations for each distinct part unit is 10.
- CAHs are not subject to the lesser of cost or charges principle.

#### **4.2.2 Outpatient Services**

**4.2.2.1** Outpatient services including ambulatory surgery, provided by a CAH shall be reimbursed 101% of reasonable costs. Reference [paragraph 4.3](#) for information on the reasonable cost method.

**4.2.2.2** Payment to a CAH for outpatient services shall not include any costs of physician services or other professional services to CAH outpatients. Payment for professional medical services furnished in a CAH to CAH outpatients shall be made on a fee schedule, charge, or other fee basis, as would apply if the services had been furnished in a HOPD. For purposes of CAH payment, professional medical services are defined as services provided by a physician or other practitioner, e.g., a PA or a NP. These services are to be billed on a CMS 1500 Claim Form using appropriate HCPCS code or a UB-04 using the appropriate HCPCS code and professional revenue code.

**4.2.2.3** Payment for clinical diagnostic laboratory tests shall be reimbursed under the reasonable cost method only if the individuals are outpatients of the CAH and are physically present in the CAH at the time the specimens are collected (bill type 85X). A CAH cannot seek reasonable cost reimbursement for tests provided to individuals in locations such as rural health clinics, the individual's home or SNF. Individuals in these locations are non-patients of a CAH and their lab test would be categorized as "referenced lab tests" for the non-patients bill type 14X), and shall be paid under the CHAMPUS Maximum Allowable Charge (CMAC).

**4.2.2.4** Multi-day supplies of take-home oral anti-cancer drugs, oral anti-emetic drugs, and immunosuppressive drugs, as well as the associated supplying fees and all inhalation drugs and the associated dispensing fees shall be paid under the allowable charge method. The associated supplying and dispensing fees must be billed on the same claim as the drug. Hospitals shall submit a separate claim for these services on a CMS 1500 Claim Form identifying the specific drugs and supplies. The drugs should be identified by both the appropriate J code and National Drug Code (NDC).

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**Note:** When an outpatient service includes an oral anti-cancer drug, oral anti-emetic drug or immunosuppressive drug, so long as no more than one day's drug supply (i.e., only today's) is given to the beneficiary, and the beneficiary receives additional services, the claim shall be processed and paid under the reasonable cost method. Inhalation drugs that are an integral part of a hospital procedure (inpatient or outpatient) shall also be processed and paid under the reasonable cost method, when billed in conjunction with other services on the same day.

**4.2.2.5** Authorized Partial Hospitalization Programs (PHPs) shall be reimbursed under the reasonable cost method.

**4.2.2.6** CAHs are not subject to the lesser of cost or charges principle.

### **4.2.3 Ambulance Services**

**4.2.3.1** Ambulance services furnished by CAHs exempt from the allowable charge methodology, are paid under the reasonable cost method.

**4.2.3.2** Effective for services provided on or after October 1, 2013, ambulance services furnished by CAHs exempt from the Medicare Ambulance Fee Schedule (AFS)/TRICARE CMAC (see [Chapter 1, Section 14](#)), are paid under the reasonable cost method.

**4.2.3.3** To be exempt, the provider must "self-attest" on each claim by using the B2 condition code. This self-attestation indicates compliance with the eligibility criteria included in 42 CFR 413.70(b)(5) and requires the provider to be the only provider or supplier of ambulance services located within a 35 mile drive of the CAH. Additionally, if there is no provider or supplier of ambulance services located within a 35 mile drive of the CAH, but there is an entity owned and operated by the CAH located more than a 35 mile drive from the CAH, that CAH-owned and operated entity can only be paid 101% of reasonable costs for its ambulance services if it is the closest provider or supplier of ambulance services to the CAH. Under TRICARE, these ambulance services shall be reimbursed using the hospital's outpatient Cost-to-Charge Ratio (CCR).

**4.2.3.4** Reasonable cost will be determined without regard to any per-trip limits or fee schedule that would otherwise apply. The distance between the CAH or entity and the other provider or supplier of ambulance services will be determined as the shortest distance in miles measured over improved roads between the CAH or the entity and the site at which the vehicles of the nearest provider or supplier of ambulance services are garaged. An improved road is any road that is maintained by a local, state, or federal Government entity and is available for use by the general public. An improved road includes the paved surface up to the front entrance of the CAH and the front entrance of the garage.

**Note:** CAHs that are not exempt from the allowable charge methodology or the Medicare AFS/CMAC (as described in [Chapter 1, Section 14](#)), may not report condition code B2.

## **4.3 Reasonable Cost Methodology**

Reasonable cost is based on the actual cost of providing services and excluding any costs, that are unnecessary in the efficient delivery of services covered by the program.

**4.3.1** DHA shall calculate an overall inpatient CCR and overall outpatient CCR, obtained from data on the hospital's most recently filed Medicare cost report as of July 1 of each year.

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**4.3.2** The inpatient and outpatient CCRs are calculated using Medicare charges, e.g., Medicare costs for outpatient services are derived by multiplying an overall hospital outpatient CCR (by department or cost center) by Medicare charges in the same category.

**4.3.3** The following methods are used by DHA to calculate the CCRs for CAHs. The worksheet and column references are to the CMS Form 2552-96 (Cost Report for Electronic Filing of Hospitals).

INPATIENT CCRs	
Numerator	Medicare costs were defined as Worksheet D-1, Part II, line 49 MINUS (worksheet D, Part III, Column 8, sum of lines 25-30 PLUS Worksheet D, Part IV, line 101).
Denominator	Medicare charges were defined as Worksheet D-4, Column 2, sum of lines 25-30 and 103.
OUTPATIENT CCRs	
Numerator	Outpatient costs were taken from Worksheet D, Part V, line 104, the sum of Columns 6, 7, 8, and 9.
Denominator	Total outpatient charges were taken from the same Worksheet D, Part V, line 104, sum of Columns 2, 3, 4, and 5 for the same breakdowns.

**4.3.4** To reimburse the vast majority of CAHs for all their costs in an administratively feasible manner, TRICARE will identify CCRs that are outliers using the method used by Medicare to identify outliers in its Outpatient Prospective Payment System (OPPS) reimbursement methods. Specifically, Medicare classifies CCR outliers as values that fall outside of three standard deviations from the geometric mean. Applying this method to the CAH data, those limits will be considered the threshold limits on the CCR for reimbursement purposes. If a hospital's CCR exceeds the outlier threshold, the CCR is replaced with the statewide median CCR. The 101% of reasonable cost is determined by taking the applicable CCR (hospital specific or statewide median listed in the CAH CCR file sent to the contractors by DHA) multiplied by billed charges, which are then multiplied by 101%. The CAH Fiscal Year (FY) is effective on December 1 of each year.

**4.3.5** DHA will provide a list of CAHs to the contractor with their corresponding inpatient and outpatient CCRs by November 1 each year. Based on the requirement in [paragraph 4.3.4](#), CCRs with outliers have been replaced with the statewide median CCRs. The CCRs shall be updated on an annual basis using the second quarter CMS Hospital Cost Report Information System (HCRIS) data. The updated CCRs shall be effective as of December 1 of each respective year, with the first update occurring December 1, 2009.

**4.3.6** DHA will also provide the contractor the State median inpatient and outpatient CAH CCRs to use when a hospital specific CCR is not available.

## **4.4 General Temporary Military Contingency Payment Adjustment (GTMCPA) Payments**

**4.4.1** The Director, DHA or designee, may approve a GTMCPA **payment** based on **all of** the following:

- The hospital serves a disproportionate share of Service members and Active Duty Dependents (ADDs), i.e., 10% or more of an CAH's total admissions are for Service members and ADDs;

- The hospital is a TRICARE network hospital;
- The hospital's actual costs for inpatient services exceed TRICARE payments or other extraordinary economic circumstance exists; and
- Without the GTMCPA **payment**, Department of Defense's (DoD's) ability to meet military contingency mission requirements will be significantly compromised.

**4.4.2** Following is the GTMCPA **payment** process for the first TRICARE CAHs.

**4.4.2.1** The hospital may submit a request for a discretionary GTMCPA payment to their contractor. The request must be made to the contractor within 12 months of the end of the CAH year (December 1 through November 30) for which the hospital is requesting a GTMCPA payment. For example, a hospital must submit a request for a GTMCPA payment for the CAH year ending November 30, 2016, by November 30, 2017. Late submissions or requests for extensions will not be considered. Hospitals will be given a grace period of six months from January 1, 2017, ending June 30, 2017, to submit GTMCPA payment requests for CAH years ending on or before November 30, 2015.

**4.4.2.2** The hospital shall submit the following information to the contractor for review and consideration:

- The total number of **inpatient** admissions during the previous TRICARE CAH year and the number of Service member and ADD admissions for this same period. **Hospitals shall not include admissions by non-ADSM or non-ADFM beneficiaries (i.e., retiree or retiree dependents), TRICARE for Life (TFL) beneficiaries, overseas beneficiaries, or beneficiaries with Other Health Insurance (OHI). Only inpatient admissions should be reported. Uniformed Services Family Health Plan (USFHP) Service member and ADD inpatient admissions visits may be included in the hospital's submission if the visits were paid utilizing the CAH Reimbursement System, but shall be separately identified by the hospital.**
- A full 12 months of claims payment data for the previous TRICARE CAH year.

**4.4.2.3** The contractor shall perform a thorough evaluation of the hospital's request in paragraph 4.4.2.2. The evaluation shall consist of the following:

**4.4.2.3.1** The contractor shall evaluate the hospital's package for completeness. The contractor shall verify the hospital has provided all components in [paragraph 4.4.2.2](#).

**4.4.2.3.2** The contractor shall perform a validation that the hospital meets the disproportionate share criteria. The contractor shall independently calculate the number of ADD/Service member inpatient admissions, utilizing the contractor's data systems, and divide it by the total CAH inpatient admissions reported by the hospital in [paragraph 4.4.2.2](#). The contractor shall compare this result to the hospital's submission in [paragraph 4.4.2.2](#) to ensure the hospital met the disproportionate share criteria in [paragraph 4.4.1](#). The contractor shall work with the hospital to resolve discrepancies in the reported data prior to submission of the request to DHA if the hospital's data show that they qualify, but the contractor's data show that they do not.

**4.4.2.3.3** The contractor shall perform an evaluation to determine if the hospital is essential for continued network adequacy and is necessary to support military contingency mission requirements. The contractor shall report the following data elements for the prior CAH year, as well as provide a brief narrative with supporting rationale, describing why the hospital is essential for continued network adequacy and why a GTMCPA payment is necessary to maintain this continued network adequacy.

- Number of acute care hospitals and beds in the network locality;
- Efforts that have been made to create an adequate network;
- Availability and types of services of military acute care services in the locations or nearby; and
- Other cost effective alternatives and other relevant factors.

**4.4.2.3.4** If the contractor's independent analysis shows that: (1) the hospital met the disproportionate share criteria; and (2) the hospital is essential for continued network adequacy, the contractor shall submit all documentation in paragraphs 4.4.2.2 and 4.4.2.3.3 to the Director, TRICARE Regional Office (DTRO). If the hospital fails to meet the disproportionate share criteria or is not essential for continued network adequacy, the contractor shall notify the DTRO of their findings, but will not submit the full request for a GTMCPA payment to the DTRO unless requested by the DTRO.

**4.4.3** The DTRO shall perform a thorough review and analysis of the hospital's submission and the contractor's review, utilizing any DHA data the DTRO deems necessary, to determine if the hospital meets the four criteria listed in paragraph 4.4.1 and qualifies for a GTMCPA payment. If the hospital qualifies, the GTMCPA payment will be set, utilizing DHA data, so the hospital's Payment-to-Cost Ratio (PCR) for TRICARE inpatient hospital services does not exceed a ratio of 1.15. A hospital shall not be approved for a GTMCPA if the payment would result in the hospital's PCR exceeding 1.15. The DTRO shall forward their recommendation for approval of the GTMCPA payment and the recommended percentage adjustment to the Director, DHA. Disapprovals by the DTRO will not be forwarded to the Director, DHA, for review and approval. The PCR shall be calculated as follows:

**4.4.3.1** Step 1. Determine actual TRICARE CAH payments, excluding OHI and USFHP claims. The CAH GTMCPA payment is specific to the CAH reimbursement system and there is no authority to include non-CAH paid amounts in the PCR calculation. Claims for beneficiaries with OHI, claims for beneficiaries with USFHP, claims for ineligible beneficiaries, duplicate claims, and denied claims shall not be included in the calculation.

**4.4.3.2** Step 2. Determine the hospital's costs, by identifying the billed charges for all non-OHI, non-USFHP CAH inpatient claims. There is no authority to include non-CAH amounts in the PCR calculation. Claims for beneficiaries with OHI, claims for beneficiaries with USFHP, claims for ineligible beneficiaries, duplicate claims, and denied claims shall not be included in the calculation.

**4.4.3.3** Step 3. Divide Step 1 by Step 2.

**4.4.3.4** Step 4. If the amount in Step 3 is lower than 1.15 the hospital may receive a payment so that total TRICARE payments are equal to or less than 115% of their costs. The percentage used is at the discretion of the Director, DHA.



**4.4.4** CAH payments for the qualifying hospital will be increased by the Director, DHA, or designee, **at his/her discretion** by way of an additional **GTMCPA** payment after the end of the TRICARE CAH year (**December 1** through **November 30**). Subsequent adjustments **to the GTMCPA payment** will be issued to the qualifying hospital for the prior CAH year, **when requested by the hospital**, to ensure claims that were **paid-to-completion (PTC)** the previous year are adjusted. These adjustments separate from the **applicable GTMCPA payment** approved for the current CAH year.

**4.4.5** Upon approval of the **GTMCPA payment** request by the Director, DHA, the **DTRO** will notify the Contracting Officer (CO) who shall send a letter to the contractor notifying them of the **GTMCPA payment** approval.

**4.4.6** The contractors shall process the **GTMCPA** payments per the instructions in Section G of their contracts under Invoice and Payment Non-Underwritten - Non-TEDs, Demonstrations. No **GTMCPA** payments shall be sent out without approval from DHA-Aurora (**DHA-A**), **Contract Resource Management (CRM)**, Budget.

**4.4.7** DHA will send an approval to the contractors to issue **GTMCPA** payments out of the non-financially underwritten bank account based on fund availability.

**4.4.8** **GTMCPA payments** shall be reviewed and approved on an annual basis; i.e., they will have to be evaluated on a yearly basis by the Director, TROs in order to determine if the hospital continues to serve a disproportionate share of Service members and ADDs and whether there are any other special circumstances significantly affecting military contingency capabilities.

**4.4.9** The Director, DHA or designee is the final approval authority **for GTMCPA payments**. A decision by the Director, DHA, or designee to **approve, reject, adopt, modify, or extend GTMCPA payments** is not subject to the appeal and hearing procedures in **32 CFR 199.10**.

**4.4.10** DHA, upon request, will provide the detailed claims data used to calculate the hospital's PCR and maximum **GTMCPA** payment, if any, to the requesting hospital through the contractor.

**4.4.11** **GTMCPAs** may be extended to CAH facilities that have changed their status during the CAH **GTMCPA** year. If an CAH network facility changes their status during the CAH year, and the facility was and remained a network facility that is essential for military readiness, contingency operations, and network adequacy and the facility served a disproportionate share of Service members and ADDs during the period of the year it was subject to CAH reimbursement, then a prorated CAH **GTMCPA** may be authorized. Any CAH adjustment will only apply to CAH payments.

## **4.5 CAH Listing**

**4.5.1** CAHs are reimbursed under the reasonable cost method.

**4.5.2** The effective date on the CAH list is the date supplied by the CMS upon which the facility began receiving reimbursement from Medicare as a CAH. If a CAH is added or dropped off of the list from the previous update, the quarterly revision date of the current listing shall be listed as the facility's effective or termination date, respectively.

**4.5.3** DHA will no longer update and maintain the CAH listing on DHA's web site. It is the contractor's responsibility to determine whether a hospital has been designated as an CAH under CMS



and to reimburse them in accordance with the provisions of this policy. The contractors shall maintain accurate network status of their regional CAHs.

**4.5.4** The contractor shall take the steps necessary to ensure they are identifying and reimbursing CAHs appropriately. This may include referencing CMS' list of CAH's on the Flex Monitoring web site at <http://www.flexmonitoring.org>, contacting hospitals in their region to verify hospital status, or some other action to meet this requirement. On the Flex Monitoring web site, the CAH list is located under the Data tab and includes effective dates. CAHs are identified by the number 13 in the third and fourth digits of a six-digit Medicare provider number.

#### **4.6 Billing and Coding Requirements**

**4.6.1** The contractors shall use type of institution 93 for CAHs.

**4.6.2** CAHs shall utilize bill type 11X for inpatient services.

**4.6.3** CAHs shall utilize bill type 85X for all outpatient services including services approved as Ambulatory Surgery Center (ASC) services.

**4.6.4** CAHs shall utilize bill type 12X for ancillary/ambulance services.

**4.6.5** CAHs shall utilize bill type 14X for non-patient diagnostic services.

**4.6.6** CAHs shall use bill type 18X for swing bed services.

#### **4.7 Beneficiary Liability**

Applicable TRICARE deductible and cost-sharing provisions apply to CAH inpatient and outpatient services.

#### **5.0 EFFECTIVE DATE**

Implementation of the CAH reasonable cost methodology is effective for admissions and outpatient services occurring on or after December 1, 2009.

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