Chapter 15 Section 1

Critical Access Hospitals (CAHs)

Issue Date: November 6, 2007
Authority: 32 CFR 199.14(a)(3) and (a)(6)(ii)

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 TRICARE Management Activity (TMA) 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)(xvi)

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 Prior to December 1, 2009, inpatient services provided by CAHs are subject to the DRG-based payment system.

4.2.1.2 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 under the reasonable cost method, reference paragraph 4.3.

4.2.1.3 Items and services that a CAH provides to its inpatients are 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.

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

4.2.1.5 Payment to a CAH for inpatient services does 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 is 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.

4.2.1.6 A CAH may establish psychiatric and rehabilitation distinct part units effective for cost reporting periods beginning on or after October 1, 2004. 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 Prior to December 1, 2009, outpatient facility services provided by CAHs were reimbursed in accordance with the provisions in Chapter 1, Section 24. CAHs are excluded from the Outpatient Prospective Payment System (OPPS) reimbursement.

4.2.2.2 Effective December 1, 2009, outpatient services including ambulatory surgery, provided by a CAH shall be reimbursed under the reasonable cost method, reference paragraph 4.3.

4.2.2.3 Payment to a CAH for outpatient services does 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 is 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.

4.2.2.4 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 are paid under the CHAMPUS Maximum Allowable Charge (CMAC).

4.2.2.5 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).

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.

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

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

4.2.3 Ambulance Services

4.2.3.1 Effective for services provided on or after December 1, 2009, 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/ TRICARE 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 TMA 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.

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 TMA 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. The CAH Fiscal Year (FY) is effective on December 1 of each year. For FY 2012, the inpatient CCR cap is 2.46 and the outpatient CCR cap is 1.32. For FY 2013, the inpatient CCR cap is 2.48 and the outpatient CCR cap is 1.36. For FY 2014, the inpatient CCR cap is 2.75 and the outpatient CCR cap is 1.37. Thus, for FY 2014, TRICARE will pay the lesser of 2.75 multiplied by the billed charges or 101% of costs (using the hospital's CCR and billed charges) for inpatient services and the lesser of 1.37 multiplied by the billed charges or 101% of costs for outpatient services. Following is the two step comparison of costs.

Step 1: Inpatient, pay the lesser of:

FY cap x billed charges (minus non-covered charges) OR
1.01 x (hospital-specific CCR x billed charges (minus non-covered charges))

Step 2: Outpatient, pay the lesser of:

FY cap x billed charges OR
1.01 x (hospital-specific CCR x billed charges)

4.3.5 TMA shall provide a list of CAHs to the contractors with their corresponding inpatient and outpatient CCRs by November 1 each year. 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 TMA shall also provide the contractors 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 Adjustments (GTMCPAs)

4.4.1 The TMA Director, or designee, may approve a GTMCPA based on the following:

- The hospital serves a disproportionate share of Active Duty Service Members (ADSMs) and Active Duty Dependents (ADDs), i.e., 10% or more of an CAH's total admissions are for ADSMs 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, Department of Defense's (DoD's) ability to meet military contingency mission requirements will be significantly compromised.

4.4.2 Following is the GTMCPA Process for the first TRICARE CAH GTMCPA year (January 1, 2014 through December 31, 2014) and subsequent years to follow same periods.

4.4.2.1 The Director, TRICARE Regional Office (DTRO), shall conduct a thorough analysis and recommend approval to the TMA Director of an appropriate year-end adjustment to total CAH payments for a network hospital qualifying for a GTMCPA.

4.4.2.2 In analyzing and recommending the appropriate year-end percentage adjustment, the DTRO shall ensure the CAH meets the four criteria listed in paragraph 4.4.1 and the GTMCPA does not exceed a ratio of 1.15 above the hospital's costs during the previous TRICARE CAH year.

4.4.3 Following are the annual Data Requirements for GTMCPAs for the first TRICARE CAH GTMCPA year (January 1, 2014 through December 31, 2014) and subsequent years.

4.4.3.1 The hospital's request for a GTMCPA for the first CAH GTMCPA year shall include the data requirements in paragraph 4.4.4, and a full 12 months of claims payment data from the TRICARE CAH year the GTMCPA is requested.

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

- The total number of admissions during the previous TRICARE CAH year and the number of ADSM and ADD admissions for this same period.
- The hospital's rationale and the recommended percentage adjustment as supported by the above data requirement submissions.

4.4.4 Following are the annual Contractor Data Review Requirements for the first TRICARE CAH GTMCPA year (January 1 through December 31) and subsequent years, to evaluate network adequacy necessary to support military contingency mission requirements:

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

4.4.5 If upon initial evaluation, the contractor determines the hospital meets the disproportionate share criteria in paragraph 4.4.1 and is deemed essential for continued network adequacy, the request from the hospital along with the supporting documentation in paragraph 4.4.4 shall be submitted to the DTRO for review and determination.

4.4.6 The DTRO shall request TMA Medical Benefits & Reimbursement Office (MB&RO) run a query of claims history to determine if the network hospital qualifies for a GTMCPA, i.e., the hospital's payment-to-cost ratio is less than 1.15 for care provided to ADSMs and ADDs during the previous TRICARE CAH year (January 1 through December 31).

4.4.7 The DTRO shall review the supporting documentation and the report from TMA MB&RO to determine if the network hospital qualifies for a GTMCPA. The recommendation for approval of a GTMCPA shall be submitted to the MB&RO to be forwarded to the Director, TMA, or designee for review and approval. Disapprovals by the DTRO will not be forwarded to MB&RO for TMA Director review and approval.

4.4.8 If a hospital meets the disproportionate share criteria in paragraph 4.4.1 and is deemed essential for network adequacy to support military contingency mission requirements, the approved hospital's GTMCPA will be set so the hospital's payment-to-cost ratio for TRICARE inpatient services does not exceed a ratio of 1.15. A hospital cannot be approved for a GTMCPA if it results in a hospital earning more than 15% above its costs for TRICARE beneficiaries.

4.4.9 Total TRICARE CAH payments for the qualifying hospital will be increased by the Director TMA, or designee, by way of an additional payment after the end of the TRICARE CAH GTMCPA year (January 1 through December 31). Subsequent adjustments will be issued to the qualifying hospitals for the prior TRICARE CAH GTMCPA year to ensure claims that were incurred but not

reported the previous year are adjusted. The adjustment payment is separate from the application GTMCPA approved for the current TRICARE CAH GTMCPA year.

4.4.10 Upon approval of the GTMCPA request by the TMA Director, MB&RO shall notify the DTRO of the approval. The DTRO shall notify the Contracting Officer (CO) who shall send a letter to the contractor notifying them of the approval.

4.4.11 The contractors shall process the adjustment payments per the instructions in Section G of their contracts under Invoice and Payment Non-Underwritten - Non-TEDs, Demonstrations. No payments will be sent out without approval from TMA-Aurora, CRM, Budget.

4.4.12 TMA-Aurora shall send an approval to the contractors to issue GTMCPA payments out of the non-financially underwritten bank account based on fund availability.

4.4.13 GTMCPAs shall be reviewed and approved on an annual basis; i.e., they will have to be evaluated on a yearly basis by the DTRO in order to determine if the hospital continues to serve a disproportionate share of ADSMs and ADDs and whether there are any other special circumstances significantly affecting military contingency capabilities.

4.4.14 The Director, TMA or designee is the final approval authority. A decision by the Director, TMA, or designee to adopt, modify, or extend GTMCPAs is not subject to the appeal and hearing procedures in 32 CFR 199.10.

4.5 CAH Listing

4.5.1 Prior to July 1, 2014, TMA will maintain the CAH listing on the TMA's web site at http://www.tricare.mil/hospitalclassification/, and will update the list on a quarterly basis and notify the contractors by e-mail when the list is updated.

4.5.2 For payment purposes for those facilities that were listed on both the CAH and Sole Community Hospital (SCH) lists prior to June 1, 2006, the contractors shall use the implementation date of June 1, 2006, as the effective date for reimbursing CAHs under the DRG-based payment system. The June 1, 2006, effective date is for admissions on or after June 1, 2006. For admissions prior to June 1, 2006, if a facility was listed on both the CAH and SCH lists, the SCH list took precedence over the CAH list. The contractors shall not initiate recoupment action for any claims paid billed charges where the CAH was also on the SCH list, prior to the June 1, 2006, effective date. For admissions on or after December 1, 2009, CAHs are reimbursed under the reasonable cost method.

4.5.3 The effective date on the CAH list is the date supplied by the Centers for Medicare and Medicaid Services (CMS) upon which the facility began receiving reimbursement from Medicare as a CAH, however, if a facility was listed on both the CAH and SCH lists prior to June 1, 2006, the effective date for TRICARE DRG reimbursement is June 1, 2006. For admissions on or after December 1, 2009, CAHs are reimbursed under the reasonable cost method.

4.5.4 After June 1, 2006, and prior to January 1, 2014, 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.

4.5.5 Prior to July 1, 2014, if the contractor receives documentation from a CAH indicating their status is different than what is on the CAH listing on TMA's web site, the contractor shall send the information to TMA, MB&RO to update the listings on the web.

4.5.6 Effective July 1, 2014, TMA will no longer update and maintain the CAH listing on TMA'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.

4.5.7 Effective July 1, 2014, the contractors 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 Prior to December 1, 2009, the contractor's shall update their institutional provider files to include CAH's and their Indirect Medical Education (IDME) factors, if applicable, as the CMS Inpatient Provider Specific File used to update the annual DRG Provider File does not contain CAH information.

4.7 Billing and Coding Requirements

4.7.1 The contractors shall use type of institution 91 for services provided prior to January 1, 2014. For services provided on or after January 1, 2014, the contractors shall use type of institution 93 for CAHs.

4.7.2 CAHs shall utilize bill type 11X for inpatient services.

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

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

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

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

4.8 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.

- END -