

Rural Hospital Reimbursement for Employee Education Programs

A Briefing Paper

Produced by

The Oregon Health Career Center



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Executive Summary

The Oregon Health Career Center is working with community colleges and hospitals to develop nursing education programs for hospital employees. Employees who go through the program agree to work for the hospitals when they graduate. The participating hospitals pay for most of the program costs and support the employees during their studies. This paper describes how certain hospitals can be reimbursed for those costs through Medicare and Medicaid.

Rural hospitals classified as Critical Access Hospitals (CAH) by the Centers for Medicare and Medicaid Services (CMS), receive 101% of allowable costs for the care of Medicare patients. Oregon's Medicaid program recognizes certain small, rural hospitals (including all Critical Access Hospitals) as "Type A" or "Type B" hospitals and reimburses them for 100% of allowable costs. Costs associated with educating hospital employees to become nurses appear to be allowable, claimable costs. Costs are claimed from Medicare via an annual cost report submitted to the Medicare fiscal intermediary. Oregon's Medicaid program bases its reimbursement on the hospital's Medicare cost report, adjusted to reflect the Medicaid mix of services. The amount of reimbursement received for nurse training is dependent on the percentage of the hospital's total services that are provided to Medicare and/or Medicaid patients.

The Issue

The Oregon Health Career Center (OHCC) provides a program that addresses the shortage of nurses available to work in hospitals. The model involves hospitals supporting the education of existing employees who agree to continue working for the sponsoring hospital after graduation. The education program is supported by the participating hospitals. Hospital support may take a variety of forms including:

- payments for the educational costs of the program
- payment of salaries and benefits to the hospital's employees while they are attending classes
- payment to reimburse employee/students for expenses associated with education such as books, uniforms and supplies
- provision of mentoring and clinical training to employee/students by nurses who are employees of the hospital
- purchase and operation of distance learning technology such as two-way video conferencing equipment

Rural hospitals in Oregon are particularly interested in increasing the pool of available nurses. However, many rural hospitals have tight operating margins and are concerned about their ability to finance project-related expenditures.



Medicare and Medicaid, the two major publicly-operated health insurance programs, have provider manuals that describe allowable education costs. This briefing paper presents the circumstances under which hospitals could claim nursing education as allowable costs and the methodology they can utilize to claim these costs in their cost reports. It also describes the process for claiming costs and estimating hospital reimbursement.

Critical Access Hospitals (CAH)

The Medicare program recognizes a special type of provider, the Critical Access Hospital, or CAH, and provides favorable reimbursement to such facilities. In Oregon, the State Office of Rural Health (www.ohsu.edu/oregonruralhealth) has the initial responsibility for determining that a hospital meets the federal criteria to be designated as a CAH. The Centers for Medicare and Medicaid, or CMS, which is the Federal entity responsible for the Medicare program, issues the final designation as a CAH. Oregon has 25 facilities that have been designated as Critical Access Hospitals; Attachment A lists those designated as of July 2006. Attachment B lists the criteria for designation and describes more thoroughly the benefits of being designated a CAH.

Generally CAHs are small, rural hospitals that are the sole providers of hospital care for their communities. The requirements for CAH designation have many elaborations and qualifications, but generally a hospital must:

- Be rural (or treated as rural by the State)
- Have 25 or fewer inpatient beds (raised from 15 beds in 2004)
- Be located 35 miles from another hospital or more than 15 miles in areas with mountainous terrain or only secondary roads
- Provide 24 hour emergency care services
- Have an average length of stay under 96 hours (excepting Skilled Nursing Facility patients)

Medicaid Type A and B Hospitals

The Medicaid program is a state-federal partnership that provides health care coverage to low-income residents (some of whom also qualify for Medicare). The State Medicaid program is operated by the Office of Medical Assistance Programs (OMAP) located in the Department of Human Services (DHS). Each state Medicaid program sets its own criteria for payment within federal parameters. Oregon's Medicaid program recognizes Type A and Type B rural hospitals (using an Oregon State definition of rural). There are 32 of these facilities, many of which are also designated as critical access hospitals. State Statute, Section 1 ORS 414.065 (Attachment C), requires that Type A/ B and rural critical access hospitals receive cost-based reimbursement for services provided to Medicaid patients under the fee-for-service component of Medicaid. Type A/B hospitals do not receive cost-based reimbursement for services provided to patients enrolled in a Medicaid managed care plan.



Type A hospitals are small and remote, have fewer than 50 beds, and are more than 30 miles from the nearest hospital. Type B hospitals are small and rural, have fewer than 50 beds but are 30 miles or fewer from the nearest hospital. Some of the smaller Type A and B hospitals (those with under 25 operating beds) also qualify as Critical Access Hospitals and have elected to be recognized as such for purposes of enhanced Medicare and Medicaid reimbursement. Because CAHs are limited to 25 beds and Type A/B hospitals are limited to 50 beds, there are some hospitals which do not qualify as a CAH but are nonetheless recognized as a small hospital by the Medicaid program. Attachment A lists the 32 Type A/B and rural critical access hospitals in the state and indicates with an asterisk which are also CAH facilities.

State statute (Section 1 ORS 414.065) requires Medicaid to reimburse Type A, Type B and rural critical access hospitals at 100% of their allowable costs for their Medicaid fee-for-service patients. Allowable costs are computed using the same cost report and standards that all hospitals, including Critical Access Hospitals, use for Medicare. Therefore, the subsequent materials on Medicare reimbursement also apply to Type A/B hospitals receiving reimbursement under fee-for-service Medicaid. Type A/B hospitals being reimbursed under a contract for managed care are not entitled to cost-based reimbursement and receive the amounts negotiated in their contracts.

Medicare Reimbursement for Critical Access Hospitals

Medicare reimburses CAHs for inpatient, outpatient and skilled nursing facility (swing-bed) services provided to its beneficiaries at 101% of reasonable costs with no ceiling on operating costs. This means CAHs are not reimbursed under the usual Prospective Payment System where a hospital is paid a “case rate” based on the patient’s diagnosis regardless of the actual cost of care. This reimbursement system for Medicare inpatients is called “Diagnosis Related Groupings” or DRGs. Part B physician services provided to patients in a CAH are reimbursed by Medicare under a fee schedule using either of two methods, called Method I and Method II. For a CAH, reasonable compensation equivalent limits do not apply to the costs of physician services in the hospital setting.

The opportunity to receive cost-based reimbursement for Medicare patients means that a Critical Access Hospital may claim *“101% of the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement.”* (CMS Manual System, Publication 100-04 Medicare Claims Processing Transmittal 68, January 16, 2004)

Medicare hospital reimbursement is paid by a fiscal intermediary (FI), a private company contracted with Medicare that administers various elements of the program. In Oregon, Washington, Idaho and Utah, the fiscal intermediary is Nordion, which is headquartered in North Dakota.



The Medicare fiscal intermediary reimburses Medicare services billed by the CAH at an interim rate based on the prior year's cost report. At the end of each hospital's calendar or fiscal year, the hospital submits a cost report to the Medicare FI. This cost report "trues up" Medicare payments made on an interim basis to the Medicare program's actual share of cost. If interim payments received by the facility did not cover 101% of the actual, allowable costs during the previous year, the hospital receives an additional settlement. If the interim payments exceeded actual, allowable costs, the hospital owes that amount to the intermediary at the time the cost report is submitted.

Each annual cost report forms the basis for next year's interim payments. The fiscal intermediary may audit the cost report either through a "desk audit" or by going on-site to the hospital. The audit confirms that the hospital can document its claimed costs and that it has correctly classified and allocated these costs. Many CAH facilities receive an on-site audit in Oregon. In regions served by other fiscal intermediaries, this may not be the case. It is worth noting that there is some variability among fiscal intermediaries on issues that are not specified in detail. Therefore, when seeking a precedent, it is wise to look for a hospital that had its cost report audited by the same fiscal intermediary that covers the region in question.

Both inpatient and outpatient hospital reimbursement are subject to Medicare's required deductibles and co-pays. As of 2006, Medicare required the patient to pay the first \$952 for each hospital inpatient stay. Coinsurance payments are required for stays over 60 days, which are unlikely in a CAH since their average length of stay must be under 4 days (96 hours) in order to meet CAH criteria.

Hospital outpatient services include emergency room visits, diagnostic tests, and treatments such as physical therapy, chemotherapy and radiation. Hospital outpatient services are subject to Medicare Part B requirements. For Part B services in a CAH, patients pay 20% of hospital charges for outpatient services (rather than 20% of the Medicare allowed amount under OPSS - commonly called outpatient prospective payment system - in the non-CAH hospital). Thus, to determine outpatient Medicare reimbursement, the total cost of outpatient services is multiplied by 101%, then the patient's 20% co-pay of charges is deducted and Medicare pays the remaining balance. Medicare coinsurance and deductibles written off as a bad debt can be claimed on the cost report for reimbursement.

Allowable Costs for Nursing Education

Over the 40 years it has been in operation, Medicare has developed detailed regulations that govern the complex process of hospital cost reporting and payment. These regulations are found in CMS Provider Reimbursement Manual 15-1. CAH facilities are subject to the same standards regarding allowable costs as are hospitals paid under Medicare's usual DRG process. As part of researching this paper,



consultation and discussion with rural hospital reimbursement experts took place.* These advisors confirmed that many of the costs associated with the proposed educational model are allowable educational program costs and provided advice on how best to claim those costs.

The CMS Medicare Provider Reimbursement Manual, Section 400, describes the circumstances under which employee education expenses are allowable (e.g. claimable) Medicare costs. The “Principle” as stated in the Manual is that, *“The net cost of approved educational activities is an allowable cost.”* Approved educational activities *“mean formally organized or planned programs of study operated or supported by an institution, as distinguished from ‘on-the-job,’ ‘inservice or similar work-learning programs.”* To be an allowable cost, the educational activity must be licensed by state law when required, or if not required, approved by the recognized professional organization for the particular activity. Net costs are defined as *“the direct and general service cost of approved educational activities (including stipends of trainees, compensation of teachers and other costs, less reimbursement from grants tuition and donations received for educational purposes.”*

Section 404.2 of the Manual, entitled **“Costs of Approved Nursing and Paramedical Education Programs”** provides more detail as follows:

“The responsibility for operating and supporting approved educational programs which are necessary to meet the community’s needs for nursing and paramedical personnel should be borne by the community. Where the community has not yet recognized and accepted this responsibility, the Medicare program does participate appropriately in the support of such approved programs as are operated by providers in conjunction with their patient care activities. However, it is not intended that Medicare should be responsible for expenditures by a provider in subsidizing such programs that are operated by other organizations where the provider receives no, or disproportionately little, benefit for the amount it expends.

Accordingly, a provider’s reasonable costs associated with approved nursing and paramedical education programs are allowable as follows:

A. Provider-Operated Programs. --Costs incurred in these programs including costs of classroom training and costs of clinical training are allowable.

B. Non-provider-Operated Programs Supported by Providers. --The manner in which provider support whether in cash or in kind is furnished may vary depending on the circumstances. The classroom portion of these programs is often, but not always, conducted in a non-provider setting. The clinical training portion generally is conducted in a provider or other health care setting. Costs incurred for the clinical training at the provider are allowable. Costs incurred which are related to the classroom portion are allowable if the following three criteria are met:

* The author and the Oregon Health Career Center are indebted to Cheryl Storey, CPA at Moss Adams LLP in Portland, and her associate Susan Ruchin, for their invaluable assistance researching and communicating this material. The Oregon Office of Rural Health, located at OHSU, provided support for this collaborative process and is also thanked!



1. *The provider's support does not constitute a redistribution of non-provider costs to the provider.*

The support must be in addition to the costs already being incurred by the non-provider operated program. If the nonprovider reduces its costs due to receiving provider support, such reduction constitutes a redistribution of cost from an education institution to a patient care institution and as such is not an allowable provider cost (regulation §405.421(c)).

2. *The provider is receiving a benefit for the support it furnishes.*

3. *The provider's support is less than the cost the provider would be expected to incur with a program of its own.*

C. Examples of Provider Support.

1. *A provider begins support of a new, or an expansion of an existing, nonprovider program for the purpose of assuring an adequate supply of trained staff not otherwise available in the area. Criterion 1 is met because the support is for costs not previously borne by the nonprovider. Criterion 2 is met because the provider is receiving a benefit, i.e., assurance of availability of trained staff, for the support it furnishes. For criterion 2 to continue to be met, the provider must be able to document on an ongoing basis that it continues to receive a supply of trained staff. Criterion 3 is met if the provider can document that it incurs less cost under this arrangement than with a program of its own.*

2. *A provider agrees to support a nonprovider program already supported by other providers in order to assure itself an adequate supply of trained staff not otherwise available in the area. There is no increase in the total amount of support being made by all of the participating providers except for increases reasonably related to inflation. Criterion 1 is met because the provider is not bearing costs previously borne by the nonprovider but rather costs that were borne by the other providers. Criterion 2 is met so long as the provider can document that it continues to receive the benefit of a supply of trained staff for the support it furnishes. Criterion 3 is met if the provider can document that it incurs less cost under this arrangement than with a program of its own.*

D. Clinical Training Conducted In a Provider Setting Where Classroom Training Costs Are Not Allowable. --Costs of clinical training are allowable provided the training is conducted in conjunction with an approved program and relates to the care of provider patients."

It appears that the program operated by the Oregon Health Career Center and its partners qualifies as a "non-provider-operated program supported by providers" (B of section 404.2, above). The Manual states that both cash and in-kind contributions are appropriate and that cost for the clinical training component delivered in the provider setting is also an allowable cost. There are three conditions for classroom activity costs to be allowable: the community-based educational partner must be incurring new costs (not shifting its existing costs to the health care provider); the provider must benefit; and the provider's cost must be less than if the provider operated the program directly.



Section 416.3 of the CMS Reimbursement Manual continues to deal with education and is also applicable to the type of program under consideration, as follows:

Costs of part-time education for bona fide employees (excluding part-time employees) at properly accredited academic or technical institutions devoted to undergraduate and/or graduate work are allowable costs provided that:

- *Allowable costs are limited to expenses incurred for training materials, text books, and tuition charges by the educational institutions; and*
- *The employee agrees in writing to complete the course of training and to continue in the provider's employ for a reasonable period (usually not less than 6 months) following completion of the course of study.*

When authorizing part-time educational courses for employees, the provider must consider whether:

- *There is a demonstrable need within the provider's organization for the skills, knowledge, and/or attitudes that are expected to result from the employee's participation in the course of training;*
- *The course of study undertaken by the employee is the most economical and feasible method of acquiring such skills, knowledge, or attitudes; and*
- *A direct relationship exists between the recommended training and job responsibilities.*

In addition to the guidance in the Provider Reimbursement Manual, Nordian, the Fiscal Intermediary for Medicare Hospital payments in Oregon, was consulted regarding allowable costs for education. While they did not provide official, written guidance, Nordian staff indicated they “were comfortable” with the “common sense” approach being developed.

Claiming Allowable Costs on the Cost Report

Each hospital is responsible for properly accounting for its costs and for filing and defending its cost reports. Even expert advice cannot anticipate every situation and does not relieve a hospital of its responsibility to know and properly apply accounting principles.

The allowable costs should be claimed on the Medicare and Medicaid cost reports as follows:

- Payments to OHCC, or to a community college, to provide nursing education programs that meet the requirements in Section 404.2 should be classified as “education.” This is a component of administrative overhead and as such is distributed across the hospital’s cost centers including inpatient and outpatient centers.



- Payments to a hospital employee for reimbursement of tuition at an accredited community college or university can be treated as a “fringe benefit.” Section 2144.1-3 of the Manual defines fringe benefits as *“amounts paid to, or on behalf of, an employee in addition to direct salary or wages, and from which the employee, his/her dependent or beneficiary derives a personal benefit before or after the employee’s retirement or death.”* *“Fringe benefits inure primarily to the benefit of the employee. However there may also be some intrinsic benefit to the provider such as increasing employee work efficiency and productivity, reducing personnel turnover, or increasing employee morale.”* Among the examples of fringe benefits listed in the Provider Reimbursement Manual (PRM) are *“Provider-paid education course benefiting the employee’s interest.”*
- Reimbursement to students for tuition, books, uniforms or other costs are classified as fringe benefits.
- Payments to employees of their regular salaries while attending classes or participating in clinical training are classified as “wages.”
- Salaries and benefits for nurse employees or other hospital employees who serve as adjunct faculty and help to educate students by providing clinical supervision or mentoring are coded as regular wages and benefits.
- Expenses for distance learning equipment should be classified and claimed based on the hospital’s existing capital acquisition procedure which determines whether the item is depreciated or expensed.
- Payment of scholarships for non-employees to attend school do not appear to be an allowable educational cost per Section 2105.7 of the Manual as follows: *“Costs incurred by providers for gifts or donations to charitable, civic, educational, medical or political entities are not allowable.”*
- Payment of a signing bonus to a new nurse employee is an allowable cost and that can be claimed as part of the employee’s compensation.

Education Costs for the Non-CAH Facility

Hospitals that are not classified as Critical Access Hospitals can still document expenditures for education costs on their Medicare cost reports. However these hospitals are not reimbursed by Medicare based on costs. Instead they receive a prospectively determined amount based on the diagnosis of the patient, or in the case of outpatient services, a payment based on the type(s) of service provided. Therefore, documenting an increase in allowable costs, for nursing education (or any other purpose) will not result in higher Medicare reimbursement in a non-CAH hospital.



There is one clear exception: a hospital, or group of hospitals, that operates a nursing school for employees, and has done so since 1989, may “pass through” a portion of the costs of the school to the Medicare program. The costs of the school for these hospitals are claimed on the cost report under “Approved Educational Activities” and are reimbursed in addition to the amounts paid for patient care.

Hospitals that are not designated CAH facilities may still be classified as Type A/B hospitals for the purposes of Medicaid reimbursement. Type A/B hospitals participating in the Medicaid fee-for-service program are eligible for 100% reimbursement of allowable costs for Medicaid services. They claim these costs on the OMAP 42 Cost Report form, using the same data provided in their Medicare cost reports. See the section above on Medicaid Type A and B Hospitals for more information.

Estimating Cost Reimbursement

A hospital can estimate the amount it will be reimbursed based on the proportion of its services (its utilization percentage) that are covered by Medicare and/or Medicaid. For inpatient costs, Medicare and Medicaid reimburse routine inpatient services on a per diem (daily rate) and for both inpatient and outpatient ancillary services on a ratio of costs to charges. A simplistic approach to estimating reimbursement is to take the hospital's percentage of Medicare and Medicaid utilization and multiply by the amount of incurred allowable costs.

CAH and Type A/B hospitals also serve patients with private insurance. Some or all of the hospital's costs for educational activities attributable to privately insured patients would be covered under the payment rate received from these insurances.

Cash Flow

If a CAH's fiscal year ends in December, the Medicare cost report will be filed by May of the following year. In Oregon, Nordian settles Medicare cost reports on an interim basis within 120 days of filing. This means that a hospital will receive preliminary payment for a new expense that exceeded its interim rate, within 120 days after filing or nine months after the close of the fiscal year in which the cost was incurred. At the time the cost report is preliminarily settled, new allowable costs will be included in the new interim rate calculated by the intermediary and an interim rate adjustment is issued for the hospital's current operating year. The preliminary settlement of a cost report is followed up with a final settlement review by the Medicare fiscal intermediary. This final review may be done on-site or via “desk review” with adjustment reports issued to the hospital. At this time, the hospital reviews the adjustment reports, disputes any adjustments with the intermediary, and a “finalized” cost report is issued. Once a new program has been fully allowed as an operating cost in the “finalized” cost report, the hospital should be receiving Medicare's share of reimbursable costs.



Payment by OMAP of Medicaid costs for Type A/B hospitals is slower. Typically OMAP waits until the Medicare cost report is settled and then six months later pays its share of costs.

Hospitals typically have reserves and/or letters of credit which assure continued cash flow while they await payment of their accounts receivable. These delays should not be a serious issue, but they are relevant to projecting cost recovery for a new expense.

Summary

Small, rural hospitals that are designated as Critical Access Hospitals receive cost-based reimbursement from Medicare. Hospitals designated by the State as Type A/B hospitals, which include Critical Access Hospitals, receive cost-based reimbursement from the Medicaid fee-for-service program. Most hospital expenditures for educating existing employees to become nurses are allowable costs and may be claimed via the annual cost reports for payment by these two government insurance programs.



Attachments:

- A. List of Critical Access Hospitals and Type A, B Hospitals in Oregon
- B. CAH criteria and benefits [Office of Rural Health]
- C. Oregon Statute Section 1 ORS 414.065

Attachment A: Listing and Classification of Oregon’s Rural Hospitals

From the Oregon Office of Rural Health:

Rural is based on distance and is defined as "all geographic areas 10 or more miles from the centroid of a population center of 30,000 or more". See a complete definition on the [What is Rural?](#) page. "Rural Hospital" means a hospital characterized by one of the following:

Type A Rural Hospitals - small and remote, have less than 50 beds, and more than 30 miles from the nearest hospital.

Type B Rural Hospitals - small and rural, have less than 50 beds, and 30 miles or less from the nearest hospital

Type C Rural Hospitals - considered rural and have 50 or more beds

An asterisk * indicates **Type CAH** Rural Hospitals - [Critical Access Hospitals](#)

- The [Oregon Rural Healthcare Quality Network](#). This network of interested rural hospitals, state agencies, and other constituents was formed with the goal of improving the quality and safety of rural health care in Oregon.

[Rural Referral Hospital](#) - Federally designated as a rural referral center

For a map of Oregon Rural Hospitals, go to <http://www.ohsu.edu/oregonruralhealth/rural-hospita-map.pdf>.

Type	Hospital Name	Administrator	Address	City	Zip	Phone
A	*Blue Mountain Hospital	Robert Houser	170 Ford Road	John Day	97845-2009	(541) 575-1311
A	*Curry General Hospital	Ginny Hochberg	94220 E Fourth Street	Gold Beach	9744-7772	(541) 247-6621
A	*Good Shepherd Medical Center	Dennis Burke	610 NW 11th	Hermiston	97838-6601	(541) 567-6483
A	*Grande Ronde Hospital	James A. Mattes	PO Box 3290	La Grande	97850-7290	(541) 963-8421
A	*Harney District Hospital	Jim Bishop	557 W Washington	Burns	97720-1497	(541) 573-7281
A	Holy Rosary Medical Center	Mark Dalley	351 SW 9th	Ontario	97914-2693	(541) 881-7000
A	*Lake District Hospital	Gordon Ensley	700 South J Street	Lakeview	97630-1623	(541) 947-2114



A	*Pioneer Memorial Hospital	Victor Vander Does	PO Box 9	Heppner	97836-0009	(541) 676-9133
A	*St. Anthony Hospital	Jeffrey Drop	1601 SE Court Avenue	Pendleton	97801-3217	(541) 276-5121
A	*St. Elizabeth Hospital	George Winn	3325 Pocahontas Road	Baker City	97814-1464	(541) 523-6461
A	*Tillamook County General Hospital	Wendell Hesseltine	1000 Third	Tillamook	97141-3498	(503) 842-4444
A	*Wallowa Memorial Hospital	Larry Davy	401 NE 1st Street	Enterprise	97828	(541) 426-3111
B	Ashland Community Hospital	Mark Marchetti	280 Maple St	Ashland	97520	(541) 482-2441
B	St. Charles - Redmond	James Diegel	1253 N Canal Blvd	Redmond	97756-1395	(541) 548-8131
B	*Columbia Memorial Hospital	Terry Finklein	2111 Exchange Street	Astoria	97103-3329	(503) 325-4321
B	*Coquille Valley Hospital	Dennis Zielinski	940 E 5th Street	Coquille	97423-1699	(541) 396-3101
B	*Cottage Grove Community Hospital	Tim Herrmann	1515 Villiage Dr.	Cottage Grove	97424	(541) 942-0511
B	*Lower Umpqua Hospital	Sandy Reese	600 Ranch Road	Reedsport	97467-1795	(541) 271-2171
B	Mid-Columbia Medical Center	Duane Francis	1700 E 19th Street	The Dalles	97058-3398	(541) 296-1111
B	*Mountain View Hospital	James "Jay" Henry	470 NE A Street	Madras	97741-1899	(541) 475-3882
B	*Peace Harbor Hospital	James Barnhart	400 Ninth Street	Florence	97439	(541) 997-8412
B	*Pioneer Memorial Hospital	Don Wee	1201 NE Elm	Prineville	97754-1299	(541) 447-6254
B	*Providence Hood River Hospital	James Arp	PO Box 149	Hood River	97031-0055	(541) 386-3911
B	Providence Newberg Hospital	Larry Bowe	501 Villa Road	Newberg	97132-1887	(503) 537-1555
B	*Providence Seaside Hospital	Bill Sexton	725 S Wahanna Road	Seaside	97138-7735	(503) 717-7000
B	*Samaritan Lebanon Community Hospital	Becky Pape	PO Box 739	Lebanon	97355-0739	(541) 258-2101



B	*Samaritan North Lincoln Hospital	Jack Flaig	PO Box 767	Lincoln City	97367-0767	(541) 994-3661
B	*Samaritan Pacific Communities Hospital	David Bigelow	PO Box 945	Newport	97365-0072	(541) 265-2244
B	Santiam Memorial Hospital	Terry L. Fletchall	1401 N 10th Avenue	Stayton	97383-1399	(503) 769-2175
B	Silverton Hospital	William E. Winter	342 Fairview	Silverton	97381-1993	(503) 873-1500
B	*Southern Coos Hospital	Jim Wathen	900 11th Street SE	Bandon	97411-9114	(541) 347-2426
B	*West Valley Hospital	Eric Buckland	PO Box 378	Dallas	97338-0378	(503) 623-8301
C	Mercy Medical Center	Victor Fresolone	2700 Stewart Parkway	Roseburg	97470-1281	(541) 673-0611
C	Three Rivers Community Hospital	Paul Janke	715 NW Dimmick	Grants Pass	97526-1596	(541) 476-6831
C	Willamette Valley Medical Center	Rosemari Davis	2700 Three Mile Lane	McMinnville	97128-6255	(503) 472-6131

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Attachment B: Critical Access Hospital Criteria and Benefits



OFFICE OF RURAL HEALTH: Critical Access Hospital Summary

The Medicare Rural Hospital Flexibility (Flex) Program, established by the Balanced Budget Act of 1997 (Public Law 105-33), is available to all 50 states. Its intent is to allow rural communities to preserve access to primary care and emergency health care services, provide health care services that meet community needs, and help assure the financial viability of small, rural hospitals.

The Flex Program enables certain rural hospitals to be classified as Critical Access Hospitals. A critical access hospital (CAH) is able to improve its financial stability through enhanced Medicare reimbursement and reduced operating costs. In Oregon the process of designation is coordinated by the Office of Rural Health, and is called the Critical Access Hospital Program. To qualify as a CAH, the hospital must meet/agree to the following requirements.

- Be a for-profit, non-profit, or public hospital that is open and operating. Hospitals that have either closed or downsized to health centers or clinics in the past 10 years (from November 29, 1999) are also eligible for CAH designation;
- Be located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital or another CAH, or before January 1, 2006, the CAH is certified by the State as being a necessary provider of health care services to residents in the area. A CAH that is designated as a necessary provider as of December 31, 2005, will maintain its necessary provider designation after January 1, 2006;
- Be located in a rural area or classified by the Secretary as rural in an urban county if located in a census tract that is considered rural under the most recent update of the Goldsmith Modification; or located in an area designated by State law or regulation as a rural area or designated by the state as rural providers; or meets other criteria as specified by the Secretary;
- Limit bed size to 25 except in any combination of acute inpatient and swing beds;
- Have an annual average length of stay of less than 96 hours;
- Make available 24 hour emergency services and nursing services but need not meet all the staffing and service requirements that apply to other hospitals;
- Participate in a rural health network, which is defined as an organization consisting of at least one CAH and at least one non-CAH hospital where participants have entered into specific agreements regarding patient referral and transfer, communication, and
- Establish credentialing and quality assurance agreements with at least one network partner hospital, a Quality Improvement Organization or equivalent, or another entity identified in the rural health plan of the state.

Potential benefits of being a Critical Access Hospital include the following:

- Reimbursed at 101% of reasonable costs for inpatient, outpatient and laboratory services.
- Extends cost-based reimbursement to additional on-call emergency care providers.
- Ability to bill under the all-inclusive rate structure (this allows the hospital to bill for both the hospital and patient services).



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- Reasonable cost-based reimbursement for ambulance services provided to Medicare beneficiaries if the ambulance service is owned and operated by the CAH and is the only service within 35-miles of the CAH.
- Opportunity to receive period interim payments, as is currently the case for eligible hospitals, skilled nursing facilities, and hospices.
- A mid-level practitioner (physician assistant or nurse practitioner) may provide inpatient care under remote supervision of a physician.
- Permission to establish psychiatric and rehabilitation distinct part units.
- Opportunity to collaborate, access programs and funding through the Office of Rural Health Flex Program.

Hospitals that are potentially eligible for designation as CAHs, and the communities in which they are located, are able to receive free technical assistance in the following areas:

- integration of emergency medical services
- quality improvement programs
- community health planning
- network development

For more information about the Flex Program, please contact Kassie Clarke, Community Grants Coordinator, 503-494-4450, email clarkek@ohsu.edu.

Last updated on 03/30/2006 13:47:10 by ruralweb@ohsu.edu



Attachment C: Oregon Statute on Type A and B Hospitals

Section 1 ORS 414.065

(5) Notwithstanding the provisions of this section, the department shall cause Type A hospitals, [and] Type B hospitals **and rural critical access hospitals**, as [defined] **described** in ORS 442.470, identified by the Office of Rural Health as rural hospitals to be reimbursed for the cost of covered services as follows:

(a) For services provided to persons entitled to receive medical assistance, based on the Medicare determination of reasonable cost as derived from the Hospital and Hospital Health Care Complex Cost Report, referred to as the Medicare Report.

(b) In accordance with the terms of the agreement for services provided to persons whose medical assistance benefits are administered by the contracting health care provider under an agreement between the hospital and a health care provider contracting with the Department of Human Services under ORS 414.725 (1) for reimbursement other than that specified by ORS 414.727 (1). Hospitals reimbursed under the terms of this paragraph are entitled to no additional reimbursement for services provided.

(c) Hospitals that have been reimbursed by health care providers contracting with the Department of Human Services under ORS 414.725 (1) in accordance with ORS 414.727 (1), are entitled to full reimbursement from the department for the cost of covered services provided to persons whose medical assistance benefits are administered by the contracting health care provider according to paragraph (a) of this subsection.

