



MEMORANDUM

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Final Guidance: CMS Critical Access Hospital Eligibility

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Executive Summary

CMS's August 21, 2026 memorandum, QSO-26-15-CAH, materially changes how CMS verifies whether existing Critical Access Hospitals continue to satisfy the rural-location and distance requirements at 42 CFR 485.610. It supersedes the 2016 S&C-16-08-CAH policy. The most important shift is from a recertification-driven review model to a trigger-based model with a formal decennial review cycle beginning in CY 2033.

Under the old policy, CMS Regional Offices were expected to review rural and distance eligibility before each recertification or reaccreditation survey. Under the new policy, routine surveys may proceed without prior CMS confirmation of location eligibility, while CMS Location staff conduct eligibility reviews when a specified trigger occurs and, beginning in 2033, every ten years.

For CAHs, the new framework reduces the frequency with which rural/distance status is tied to the survey cycle, but it does not eliminate eligibility risk. A new nearby acute care hospital, a newly discovered proximity issue, a change in rural classification, a proposed provider-based location, or the decennial review can prompt a fresh determination. The 2026 guidance also gives a CAH generally two years to respond to an adverse eligibility determination and expressly adds conversion to Rural Emergency Hospital (REH) status as an alternative, where eligible.

Most Important Policy Differences

Issue	2016 Policy	2026 Policy	CAH Impact
Review frequency and trigger	2016: Eligibility review was tied to each recertification/reaccreditation cycle; Regional Office clearance was required before the survey.	2026: Reviews are triggered by a proximal acute care hospital, a new CAH certification/conversion, or a decennial review beginning in CY 2033. CMS may still review eligibility at any time.	Major operational change. Most CAHs will no longer face a rural/distance review every survey cycle, but a new nearby hospital can trigger an immediate review.
Survey process	State Survey Agencies and accrediting organizations could not conduct the recertification survey until CMS had confirmed rural and distance compliance.	Surveys may proceed on the normal schedule without prior CMS confirmation of rural/distance eligibility.	Decouples quality/safety surveys from location eligibility review, reducing administrative delay and avoiding wasted survey resources.
Nearby hospital risk	Distance analysis occurred as part of recertification; nearby acute care hospitals and CAHs counted, while psychiatric, LTCH and rehabilitation hospitals did not.	CMS expressly identifies a new or newly discovered proximal acute care hospital as an independent review trigger; the same exclusions for psychiatric, LTCH and rehabilitation hospitals remain.	CAHs that are not Necessary Providers must monitor development and Medicare certification of nearby acute care hospitals continuously, not just near recertification.
Decennial review	No fixed national cycle separate from recertification.	All existing CAHs will be reviewed for rural status and distance eligibility beginning in CY 2033 and every ten years thereafter.	Creates a predictable national revalidation event. CAHs should maintain eligibility documentation well before 2033.
Adverse determination / transition	The 2016 memo said CMS would allow time to reclassify or convert; the attached checklist generally contemplated about one year for conversion in some cases, with longer periods in certain rural-status	CMS now states that a CAH will generally have two years to reclassify as rural, convert to an acute care hospital or REH, or face termination.	Provides a clearer and generally more favorable transition period; REH conversion is now an explicit pathway.

	situations.		
Provider-based locations	The 2016 memo did not establish a separate advance-review process for proposed CAH provider-based locations.	CMS recommends that a CAH seek an advance determination before adding a provider-based location because the location may affect statutory distance eligibility.	Expansion plans now carry explicit CAH-status risk. Hospitals should obtain CMS review before committing capital or finalizing a PBL.
Necessary Provider status	Pre-2006 state Necessary Provider designation exempted a CAH from the distance test; CAHs could submit supplementary evidence within 60 days if CMS could not verify the designation.	The same core rule is retained: pre-2006 Necessary Provider CAHs remain exempt from distance requirements, and the CAH has 60 days to provide qualifying evidence if CMS cannot verify status.	This is largely continuity, not a substantive policy change. Documentation remains critical because the burden rests on the CAH.

Implications for Critical Access Hospitals

- **Lower routine review burden** — The most favorable change is that CAH location eligibility is no longer re-cleared before every recertification survey. That should reduce recurring administrative work and remove a potential bottleneck in the survey process.
- **Greater exposure to market changes between surveys** — CMS can now act when a new acute care hospital is certified nearby or when updated data identify a proximity issue that was previously missed. For non-Necessary-Provider CAHs, a hospital development project within the 35-mile or applicable 15-mile threshold can threaten CAH status even if the CAH recently completed a successful survey.
- **2033 becomes a material planning date** — Every existing CAH will face a rural/distance review beginning in 2033. Health systems should inventory each CAH's current mileage, road characteristics, rural reclassification status, and Necessary Provider documentation well in advance, particularly where suburban growth or new hospital construction has changed the market.
- **Rural classification remains independently important** — A CAH must still be located in a rural area or be treated as rural. CMS will use the current County-to-CBSA crosswalk adopted with the IPPS final rule to identify changes. A facility may satisfy the distance test yet still face a status problem if its rural classification changes.
- **Necessary Provider CAHs remain best protected on distance** — CAHs validly designated by a state as Necessary Providers before January 1, 2006 remain exempt from the distance requirement. Systems should preserve contemporaneous state designation records because CMS places the burden on the CAH to establish the exemption if CMS cannot verify it.
- **Expansion strategy now requires eligibility review** — Before adding a provider-based location, a CAH should obtain the advance CMS determination recommended in QSO-26-15-CAH. A PBL located too near another CAH or acute care hospital could jeopardize the parent CAH's status, making the issue relevant to capital planning, acquisitions and service-area expansion.
- **More time and more conversion options after an adverse finding** — The general two-year response period is clearer than the old guidance and gives systems time to pursue rural reclassification or plan conversion. The addition of REH status may be particularly important for low-volume CAHs that cannot preserve CAH eligibility but still need a viable Medicare rural-hospital model.

Recommended Near-Term Actions

CAHs should not wait for 2033. Each non-Necessary-Provider CAH should confirm current driving distances to nearby CAHs and acute care hospitals, identify planned or newly certified hospitals in the service area, and verify its current rural classification. Necessary Provider CAHs should assemble and retain the pre-2006 state documentation supporting that designation. Any CAH considering a new provider-based location should seek CMS review before finalizing the project. These steps will allow systems to identify eligibility threats early enough to pursue rural reclassification, modify expansion plans, or evaluate acute-care-hospital or REH conversion options.

Sources

CMS, QSO-26-15-CAH (Aug. 21, 2026): <https://www.cms.gov/files/document/qso-26-15-cah-original-release-2026-08-21.pdf>
 CMS, S&C-16-08-CAH (rev. Sept. 2, 2016; expired Aug. 21, 2026): <https://www.cms.gov/files/document/sc-16-08-cah-expired-2026-08-21.pdf>