

Critical Access Hospital CoPs Part 1 of 5 2026

Introduction, General Information, Memos, Compliance with Laws, Number of Beds, Length of Stay, Observation Status, Governing Body, Agreements and Contracted Services, Telemedicine, Emergency Services & EMTALA

Speaker



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- Email questions to CMS: QSOG_CAH@cms.hhs.gov

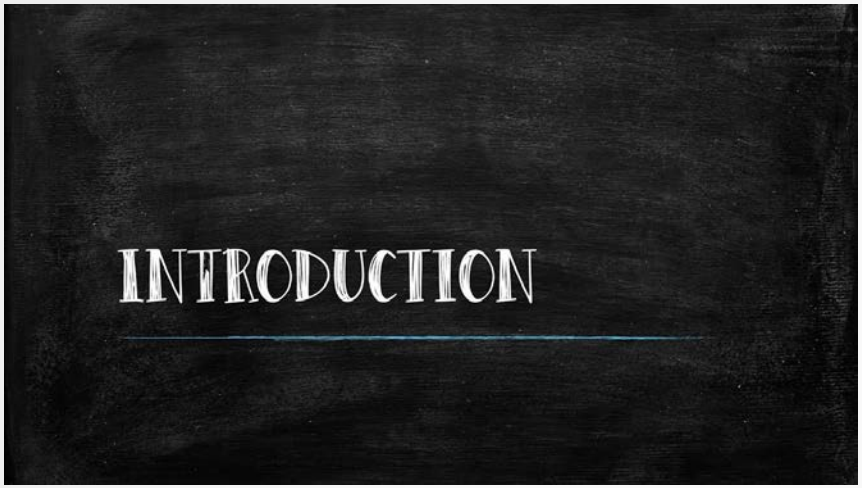
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DISCLAIMER

The information provided during this program/webinar is informational only. It is not intended to be legal advice or to establish an attorney-client relationship. Please consult with your in-house counsel or professional legal representative for advice.

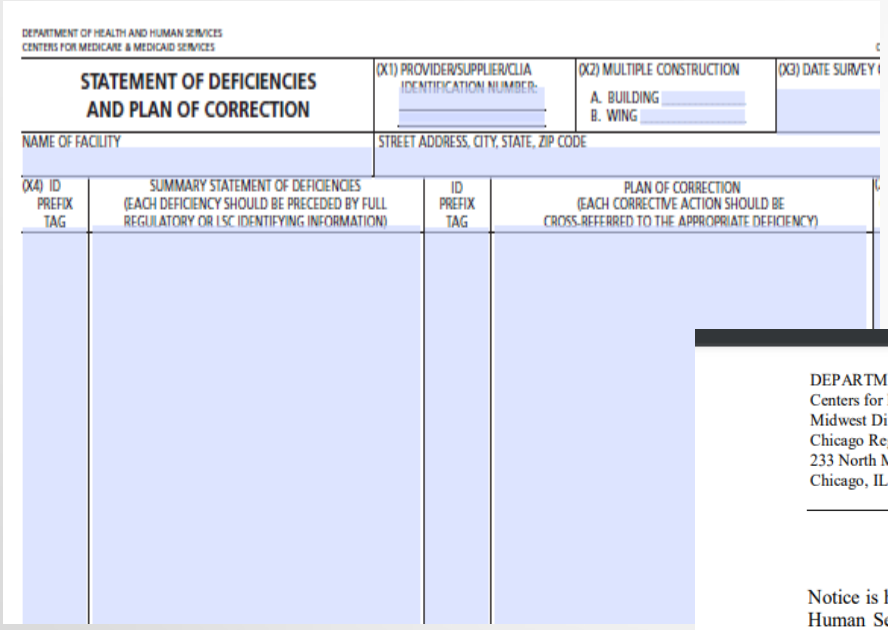
Objectives

- Describe: CMS requirement for the Board to enter into a written agreement for telemedicine services
- Describe: CMS has a list of emergency drugs and equipment every CAH must have
- Recall: all CAHs must comply with EMTALA requirements
- Recall: the average length of stay in a CAH should not exceed 96 hours on an annual basis



Introduction

Why We are Here Today



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

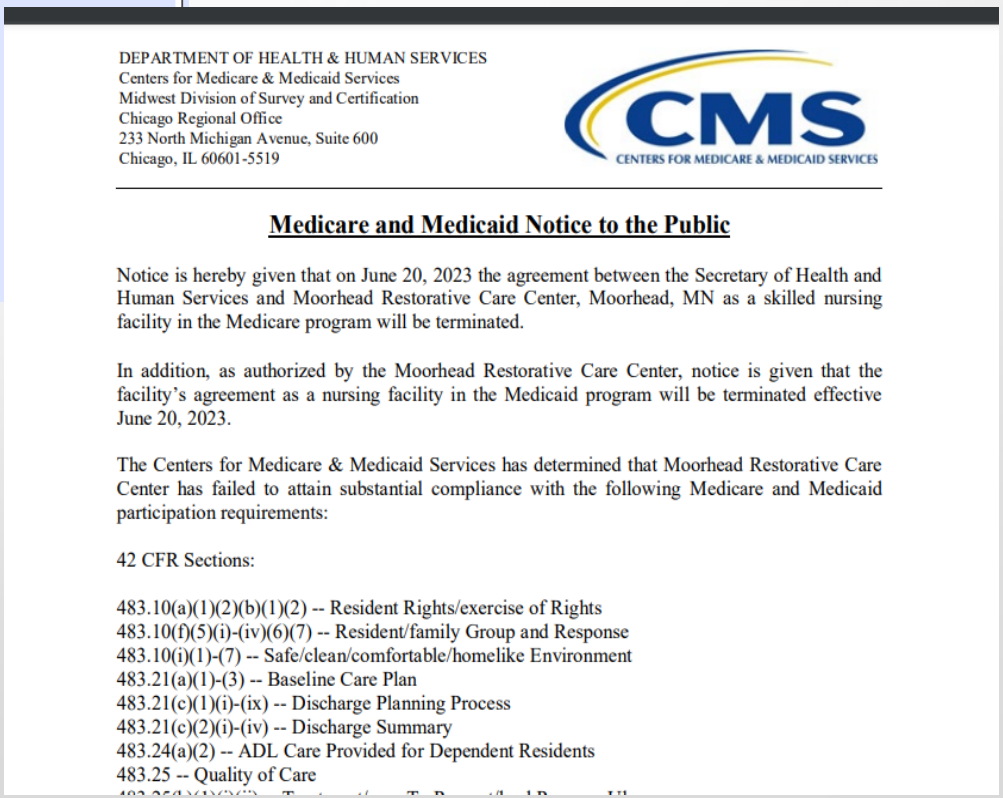
B. WING _____

(X3) DATE SURVEY

NAME OF FACILITY

STREET ADDRESS, CITY, STATE, ZIP CODE

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare and Medicaid Notice to the Public

Notice is hereby given that on June 20, 2023 the agreement between the Secretary of Health and Human Services and Moorhead Restorative Care Center, Moorhead, MN as a skilled nursing facility in the Medicare program will be terminated.

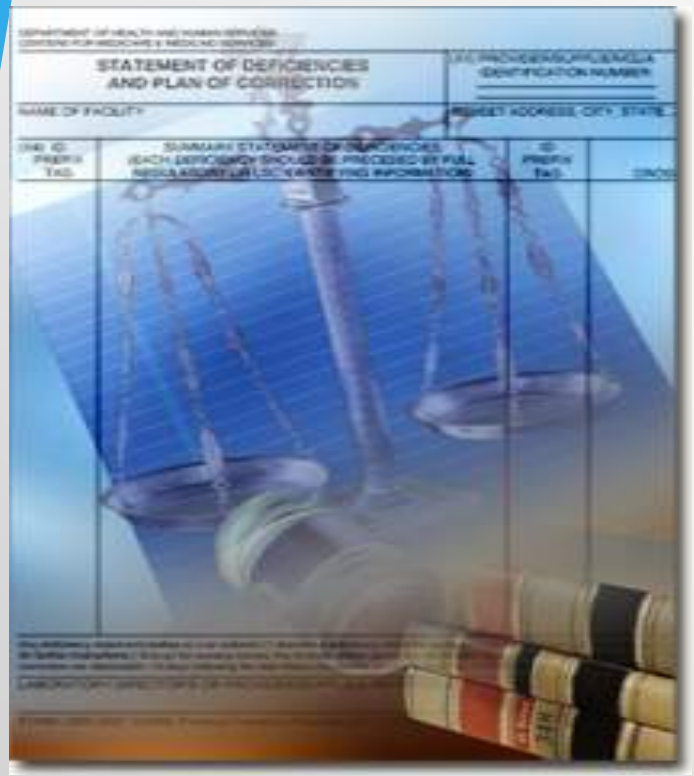
In addition, as authorized by the Moorhead Restorative Care Center, notice is given that the facility's agreement as a nursing facility in the Medicaid program will be terminated effective June 20, 2023.

The Centers for Medicare & Medicaid Services has determined that Moorhead Restorative Care Center has failed to attain substantial compliance with the following Medicare and Medicaid participation requirements:

42 CFR Sections:

483.10(a)(1)(2)(b)(1)(2) -- Resident Rights/exercise of Rights
483.10(f)(5)(i)-(iv)(6)(7) -- Resident/family Group and Response
483.10(i)(1)-(7) -- Safe/clean/comfortable/homelike Environment
483.21(a)(1)-(3) -- Baseline Care Plan
483.21(c)(1)(i)-(ix) -- Discharge Planning Process
483.21(c)(2)(i)-(iv) -- Discharge Summary
483.24(a)(2) -- ADL Care Provided for Dependent Residents
483.25 -- Quality of Care

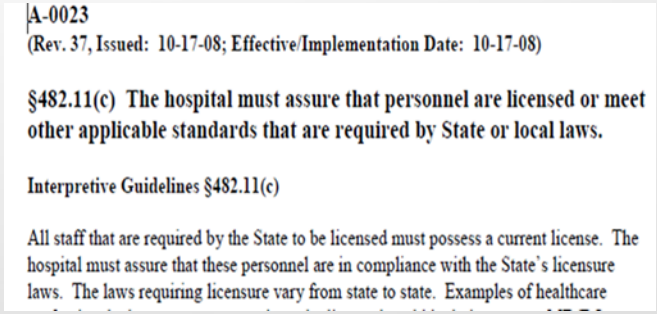
Mandatory Compliance



- Hospitals that participate in Medicare or Medicaid
  - Must meet the Conditions of Participation (CoPs)
  - For all patients in the facilities
  - "Deemed Status" – accredited by the Joint Commission (TJC), HFAP, CIHQ, or DNV Healthcare

How it Works

- Regulation published in the Federal Register
- CMS publishes the regulation in a transmittal
  - Will develop Interpretive guidelines and survey procedures
  - Updates the hospital CoP manual
- Types of surveys
  - Certification
  - Validation
  - Complaint



A-0023
(Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08)

§482.11(c) The hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws.

Interpretive Guidelines §482.11(c)

All staff that are required by the State to be licensed must possess a current license. The hospital must assure that these personnel are in compliance with the State's licensure laws. The laws requiring licensure vary from state to state. Examples of healthcare

How to Keep Up with Changes

- Consider subscribing to the Federal Register [1].
- Confirm current CoP [2].
  - Last update 2020
- If new manual – check CMS transmittal page [3].
- Check the survey and certification website monthly [4].

- [1] https://public.govdelivery.com/accounts/USGPOOFR/subscriber/new
- 2, http://www.cms.hhs.gov/manuals/downloads/som107_Appendicestoc.pdf
- 3 http://www.cms.gov/Transmittals
- 4 http://www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

CoP Manual

https://www.cms.gov/files/document/appendices-table-content.pdf.

Medicare State Operations Manual

Appendix

- Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.
- The appendices are in PDF format, which is the format generally used in the IOM to display files. **Click on the corresponding letter in the "Appendix Letter" column to see any available file in PDF.**
- To return to this page after opening a PDF file on your desktop. Use the browser "back" button. This is because closing the file usually will also close most browsers

Appendix Letter	Description
A	Hospitals
AA	Psychiatric Hospitals- *Deleted (See Appendix A)*
B	Home Health Agencies
C	Laboratories and Laboratory Services

Appendix Letter	Description
L	Ambulatory Surgical Services Interpretive Guidelines and Survey Procedures
M	Hospice
N	Psychiatric Residential Treatment Facilities (PRTF) Interpretive Guidance
P	Survey Protocol for Long-Term Care Facilities
PP	Interpretive Guidelines for Long-Term Care Facilities
Q	Determining Immediate Jeopardy
R	Resident Assessment Instrument for Long-Term Care Facilities
S	Mammography Suppliers - **Deleted**
T	Swing-Beds – ***Deleted (See Appendix A and Appendix W)***
U	Responsibilities of Medicare Participating Religious Nonmedical Healthcare Institutions
V	Responsibilities of Medicare Participating Hospitals In Emergency Cases
W	Critical Access Hospitals (CAHs)
X	Survey Protocol and Interpretive Guidelines for Organ Transplant Programs
Y	Organ Procurement Organization (OPO)
Z	Emergency Preparedness for All Provider and Certified Supplier Types

State Operation Manual – Critical Access

State Operations Manual

Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs

(Rev. 247; Issued: 09-18-26)

Transmittals for Appendix W

INDEX

Survey Protocol

Introduction
Regulatory and Policy Reference
Tasks in the Survey Protocol
Survey Team
Task 1 - Off-Site Survey Preparation
Task 2 - Entrance Activities
Task 3 - Information Gathering/Investigation
Task 4 - Preliminary Decision Making and Analysis of Findings
Task 5 - Exit Conference
Task 6 - Post-Survey Activities

Regulations and Interpretive Guidelines for CAHs

§485.601 Basis and Scope
§485.603 Rural Health Network

Update to Regulations

This content is from the eCFR and is authoritative but unofficial.

Displaying title 42, up to date as of 8/28/2025. Title 42 was last amended 8/26/2025.

Title 42 —Public Health
Chapter IV —Centers for Medicare & Medicaid Services, Department of Health and Human Services
Subchapter G —Standards and Certification
Part 485 —Conditions of Participation: Specialized Providers

ENHANCED CONTENT - TABLE OF CONTENTS

Subpart F Conditions of Participation: Critical Access Hospitals (CAHs) 485.601 – 485.649
§ 485.601 Basis and scope.
§ 485.603 Rural health network.
§ 485.604 Personnel qualifications.
§ 485.606 Designation and certification of CAHs.
§ 485.608 Condition of participation: Compliance with Federal, State, and local laws and regulations.
§ 485.610 Condition of participation: Status and location.
§ 485.612 Condition of participation: Compliance with hospital requirements at the time of application.
§ 485.614 Condition of participation: Patient's rights.
§ 485.616 Condition of participation: Agreements.
§ 485.618 Condition of participation: Emergency services.
§ 485.620 Condition of participation: Number of beds and length of stay.
§ 485.623 Condition of participation: Physical plant and environment.
§ 485.625 Condition of participation: Emergency preparedness.
§ 485.627 Condition of participation: Organizational structure.
§ 485.631 Condition of participation: Staffing and staff responsibilities.
§ 485.635 Condition of participation: Provision of services.
§ 485.638 Conditions of participation: Clinical records.
§ 485.639 Condition of participation: Surgical services.
§ 485.640 Condition of participation: Infection prevention and control and antibiotic stewardship programs.
§ 485.641 Condition of participation: Quality assessment and performance improvement program.
§ 485.642 Condition of participation: Discharge planning.
§ 485.643 Condition of participation: Organ, tissue, and eye procurement.
§ 485.645 Special requirements for CAH providers of long-term care services ("swing-beds")
§ 485.647 Condition of participation: psychiatric and rehabilitation distinct part units.
§ 485.649 Condition of participation: Obstetrical services.

Transmittal Page

Rev #	Issue Date	Subject	Impl Date	CR#
R220SOMA	04/19/2024	Revisions to State Operations Manual (SOM) Appendix A-Hospitals	04/19/2024	N/A
R216SOMA	07/21/2023	Revision to State Operations Manual (SOM) Appendix A- Hospitals	07/21/2023	N/A
R200SOMA	02/21/2020	Revisions to the State Operations Manual (SOM) Appendix A - Hospitals, Appendix AA – Psychiatric Hospitals, Appendix B – Home Health Agency, Appendix D - Portable X-Ray, Appendix G - Rural Health Clinics/Federally Qualified Health Centers, Appendix H- End Stage Renal Disease Facilities (ESRD), Appendix K – Comprehensive Outpatient Rehabilitation Facility, Appendix L - Ambulatory Surgical Centers, Appendix M – Hospice, Appendix U - Religious Nonmedical Healthcare Institutions, Appendix W - Critical Access Hospitals (CAHs), Appendix X - Organ Transplant Program and Appendix Z - Emergency Preparedness	02/21/2020	N/A
R183SOMA	10/12/2018	Revisions to Medicare State Operations Manual (SOM) Table of Contents, Medicare	10/12/2018	N/A

Example – Transmittal Page

CMS Manual System
Pub. 100-07 State Operations
Provider Certification

Department of Health & Human Services (DHHS) Centers for Medicare & Medicaid Services (CMS)

Transmittal 200 **Date: February 21, 2020**

SUBJECT: Revisions to the State Operations Manual (SOM) Appendix A - Hospitals, Appendix AA – Psychiatric Hospitals, Appendix B – Home Health Agency, Appendix D - Portable X-Ray, Appendix G - Rural Health Clinics/Federally Qualified Health Centers, Appendix H- End Stage Renal Disease Facilities (ESRD), Appendix K – Comprehensive Outpatient Rehabilitation Facility, Appendix L - Ambulatory Surgical Centers, Appendix M – Hospice, Appendix U - Religious Nonmedical Healthcare Institutions, Appendix W - Critical Access Hospitals (CAHs), Appendix X - Organ Transplant Program and Appendix Z - Emergency Preparedness

I. SUMMARY OF CHANGES: This Transmittal includes regulatory revisions based on recent federal regulation changes (CMS-3346-F; CMS-3334-F; CMS-3295-F; CMS-3277-CN). In addition, several updates to the appendices have been made for technical correction and clarity. The psychiatric hospital tags have moved from Appendix AA to Appendix A. Appendix AA is being deleted as surveyors will now refer to Appendix A for the psychiatric special condition tags and guidance. Specific references to the United States Pharmacopeia (USP) have been removed from Appendices A, G, and W accordingly, as CMS requires compliance with applicable Federal and State law and adherence to accepted general standards of practice or guidelines for pharmaceutical services and medication administration issued by nationally recognized professional organizations. Appendix H updates the regulatory text based on requirements set forth in the 2008 Conditions for Coverage for ESRD Facilities and also includes revisions based

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Medicare State Operations Manual Appendices
R	Appendix A/Table of Contents
R	Appendix A/A-0148
R	Appendix A/A-0168
R	Appendix A/A-0172
R	Appendix A/A-0175
R	Appendix A/A-0176
R	Appendix A/A-0178
R	Appendix A/A-0182
R	Appendix A/A-0214
R	Appendix A/A-0273
N	Appendix A/A-0320/§482.21(f) Standard: Unified and integrated QAPI program for multi-hospital systems.
N	Appendix A/A-0321/§482.21(f)(1) The unified and integrated QAPI program is established in a manner that takes into account each member hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital; and
N	Appendix A/A-0322/§482.21(f)(2) The unified and integrated QAPI program establishes and implements policies and procedures to ensure that the needs and concerns of each of its separately certified hospitals, regardless of practice or location, are given due consideration, and that the unified and integrated QAPI program has mechanisms in place to ensure that issues localized to particular hospitals are duly considered and addressed.
R	Appendix A/A-0358
R	Appendix A/A-0359
N	Appendix A/A-0360/§482.22(c)(5) - Include a requirement that --
N	Appendix A/A-0361/[The bylaws must:] §482.22(c)(5) - Include a requirement that --
N	Appendix A/A-0362/[The bylaws must:] §482.22(c)(5) - Include a requirement that --
D	Appendix A/A-0364

CMS Survey Memos

www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions

Policy & Memos to States and CMS Locations

CMS Quality Safety & Oversight memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Locations.

Showing 1 – 10 of 636 entries

Show Entries: 10 per page

Filter On:

Title	Memo #	Posting Date	Fiscal Year
REVISED: Interim CMS Rural Health Clinic (RHC) Rural Location Determinations due to Census Bureau (CB) Regulatory Changes	QSO-23-20-RHC	2023-07-27	2023
EXPIRED: Revised Guidance for Staff Vaccination Requirements	QSO-23-02-ALL (EXPIRED)	2023-07-26	2023
Ligature Risk and Assessment in Hospitals	QSO-23-19-Hospitals	2023-07-18	2023
Posting of Nursing Home Ownership/Operatorship Affiliation Data on Nursing Home Care Compare Website and data.cms.gov	QSO-23-18-NH	2023-06-29	2023

Sample Survey Memo

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality

Ref: QSO-23-19-Hospitals

DATE: July 17, 2023

TO: State Survey Agency Directors

FROM: Directors, Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG)

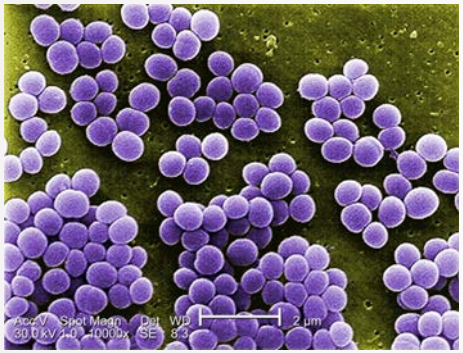
SUBJECT: Ligature Risk and Assessment in Hospitals

Memorandum Summary

- ***Patients in Medicare-certified hospitals have a right, by regulation, to receive care in a safe setting.***
- ***Hospitals can demonstrate compliance with this standard through appropriate patient assessments, adequate staffing and monitoring, and mitigation of environmental risks.***

Background:

Medicare-certified hospitals have a regulatory obligation to care for patients in a safe setting under the Medicare Hospital Conditions of Participation at §482.13(c)(2). The intention of this requirement is to specify that each patient receives care in an environment that a reasonable person similarly situated as the patient would consider to be safe. Additionally, this standard is intended to provide protection for the patient's emotional health and safety as well as his/her physical safety. Respect, dignity, and comfort would also be components of an emotionally safe



Deficiencies

Condition vs. Standard vs. ???

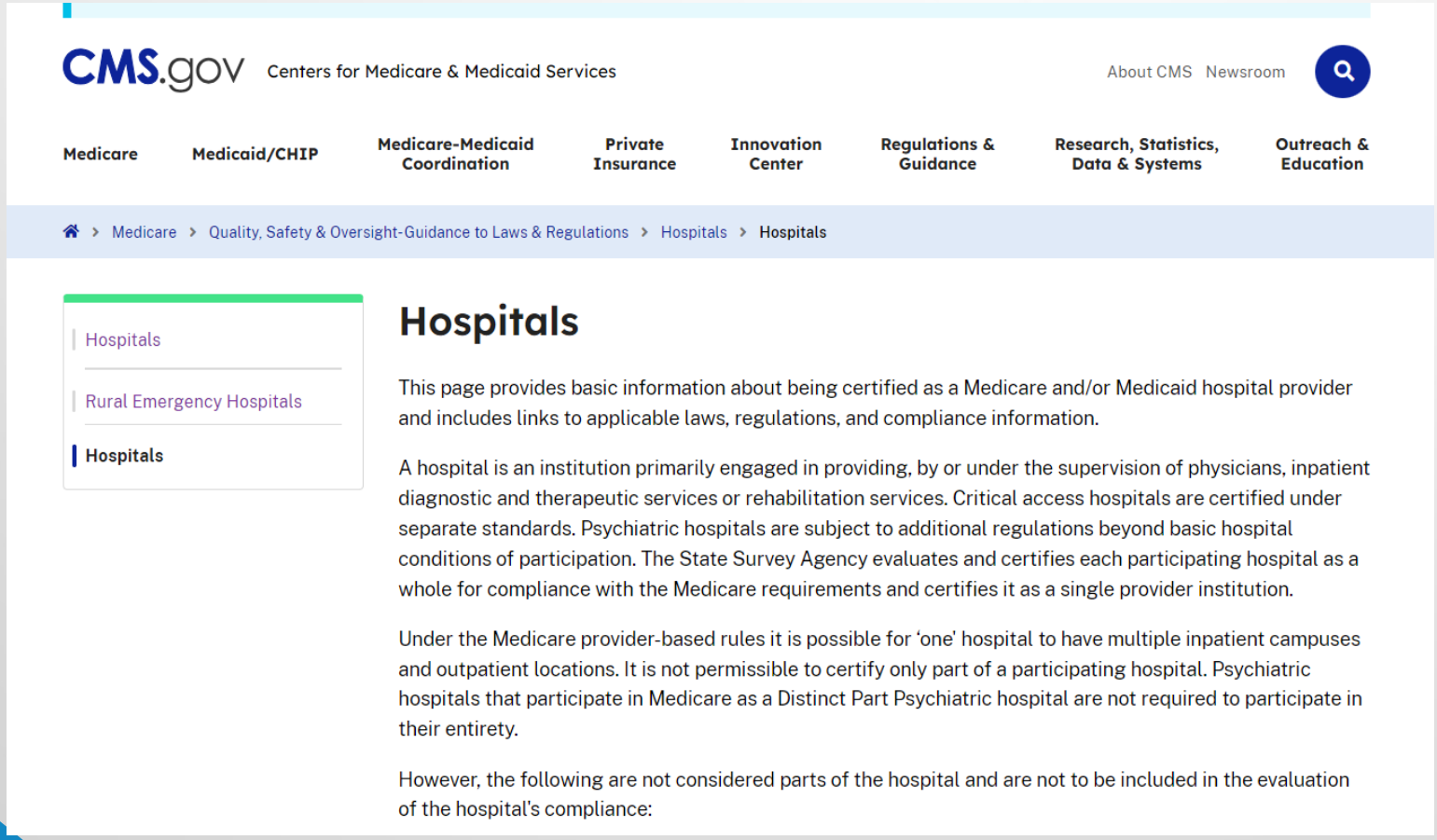
- **"Condition"** – must meet to participate
  - If deficiencies substantially limit ability to furnish care that adversely affects health and safety of patients could result in termination
  - Must do Plan of Correction and send in reports
- "Standard" – must submit acceptable plan of correction within reasonable period of time
  - Determined by CMS – usually 60 – 90 days
  - Cannot jeopardize health/safety of patients
- Other – not designated

Can Access Deficiency Data

- Includes acute care and CAH hospitals
  - List tag numbers
  - Does not include the plan of correction but can request
  - Questions to bettercare@cms.hhs.com
- Updated quarterly

Deficiency Reports

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Hospitals



Scroll to "Downloads"

The Interpretive Guidelines include three parts:

- The first part contains the survey tag number.
- The second part contains the wording of the regulation.
- The third part contains guidance to surveyors, including additional survey procedures and probes.

See the **downloads** section below for the Patient's Rights Final Rule that includes more information on the hospital death reporting requirements related to restraint and seclusion.



Problematic Standards

- Orders/entries dated and timed
- Verbal orders
- Life Safety Code issues
- H&Ps
- EMTALA
- Restraints & Seclusion
- Medications and administration
- Services per P&P
- Timing of medications
- Documentation reflecting nursing process
- Discharge planning

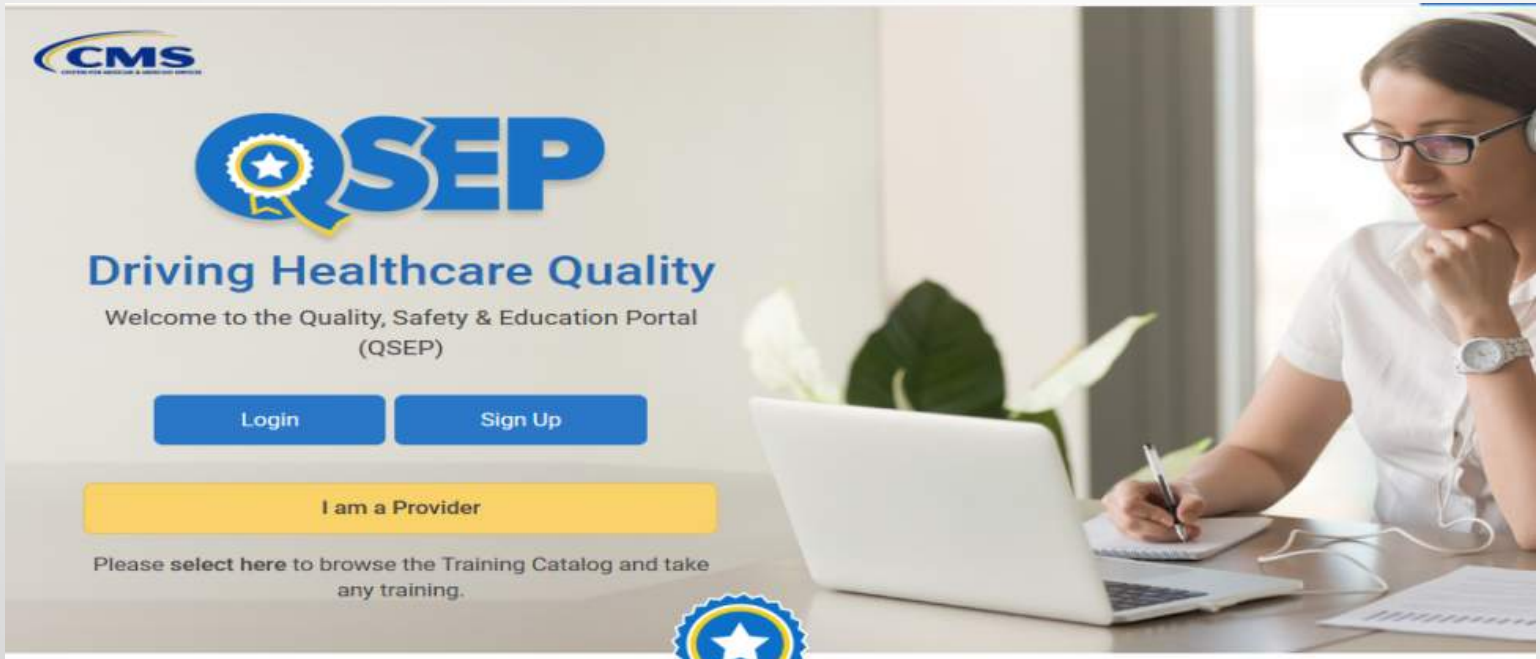
Problematic Standards – cont'd

- Equipment and supplies used in life saving procedure
- Hand Hygiene & Gloving
- Suicide precautions
- Infection prevention and control
- Informed consent
- Privacy
- Legibility
- No orders
- Safe Injection practices
- Medical records - security



CMS Surveyor Training - Website

Surveyor Training Click on Catalog



https://qsep.cms.gov/welcome.aspx

The Quality, Safety & Education Portal (QSEP) provides the full curriculum of surveyor training and guidance on health care facility regulations.

CAH Basic Training 24 hr.

https://surveyortraining.cms.hhs.gov/pubs/ClassInformation.aspx?cid=0CMSCAHBasic_CEU_ONL

CRITICAL ACCESS HOSPITAL BASIC TRAINING (CAH)

Class Information

Activity Code: 0CMSCAHBasic_CEU_ONL

Class Dates: Web-based Training

Status: Guest

Location: ISTW

Class Description: Critical Access Hospitals (CAH) are required to comply with the Federal requirements set forth in the Medicare Conditions of Participation (CoPs) in order to receive Medicare or Medicaid payment. The goal of a CAH survey is to determine if the CAH complies with CoPs at 42 CFR 485, Subpart F.

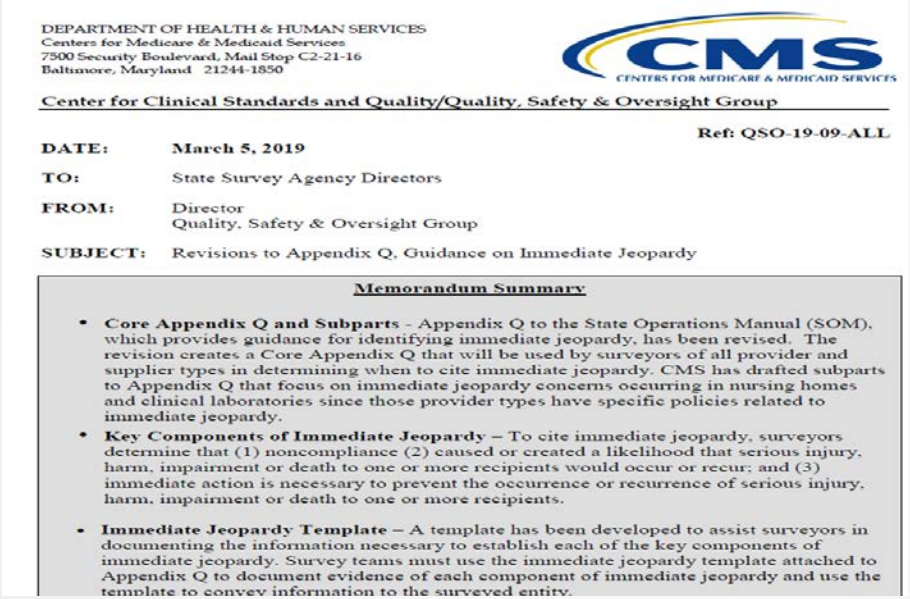
Therefore, to ensure beneficiaries receive quality care and services, the Critical Access Hospitals Basic Training Online Course is designed to increase surveyor proficiency in the CAH survey process.

The estimated course completion time for this training is 24 hours.

If you have any questions regarding course related content, please direct all correspondence to CAHSCG@cms.hhs.gov.

Prerequisites:

1. Principles of Documentation for Long Term Care *OR* Principles of Documentation for Non-Long Term Care *OR* Principles of Documentation for Non-Long Term Care
2. Electronic Code of Federal Regulations Simulation
3. S & C Policy Memo Navigation Simulation
4. SOM Navigation Simulation
5. Introduction to Surveying for Non-Long Term Care *OR* Introduction to Surveying for Long Term Care
6. Basic Writing Skills for Survey Staff
7. Foundational Investigative Skills
8. Hospital Basic Training Part 1 *OR* Hospital Basic: Part 1 (Blackboard) *OR* CMS Basic Hospital Via Attestation - Prior to LMS set up in 2002 *OR* CMS Basic Hospital Surveyor Training Course *OR* Live Webinar Basic Hospital April 2013
9. Hospital Basic Training Part 2 *OR* Hospital Basic: Part 2 (Blackboard) *OR* CMS Basic Hospital Via Attestation - Prior to LMS set up in 2002 *OR* CMS Basic Hospital Surveyor Training Course *OR* Live Webinar Basic Hospital April 2013



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-19-09-ALL

DATE: March 5, 2019

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Revisions to Appendix Q, Guidance on Immediate Jeopardy

Memorandum Summary

- **Core Appendix Q and Subparts** - Appendix Q to the State Operations Manual (SOM), which provides guidance for identifying immediate jeopardy, has been revised. The revision creates a Core Appendix Q that will be used by surveyors of all provider and supplier types in determining when to cite immediate jeopardy. CMS has drafted subparts to Appendix Q that focus on immediate jeopardy concerns occurring in nursing homes and clinical laboratories since those provider types have specific policies related to immediate jeopardy.
- **Key Components of Immediate Jeopardy** – To cite immediate jeopardy, surveyors determine that (1) noncompliance (2) caused or created a likelihood that serious injury, harm, impairment or death to one or more recipients would occur or recur; and (3) immediate action is necessary to prevent the occurrence or recurrence of serious injury, harm, impairment or death to one or more recipients.
- **Immediate Jeopardy Template** – A template has been developed to assist surveyors in documenting the information necessary to establish each of the key components of immediate jeopardy. Survey teams must use the immediate jeopardy template attached to Appendix Q to document evidence of each component of immediate jeopardy and use the template to convey information to the surveyed entity.

Recent Memos of Interest to CAHs

Discharge Planning

Ligature Risks

Reporting Respiratory Infections

Discharge Planning*

- June 2023 memo – QSO-23-16
- Reiterated requirement that hospitals have an effective discharge planning process
- Process focuses on patient's goals and treatment preferences
- Include patient and caregivers/support person(s) as active partners in the planning

- [1]https://www.cms.gov/files/document/qso-23-16-hospitals.pdf

6 Areas of Concern

- Areas of concern on missing or inaccurate information:
  - 1. Medications
  - 2. DMEs
  - 3. Skin conditions (tears)
  - 4. Communications with PACs/caregivers on needs at home
  - 5. Patients with serious mental illness, SUDs, complex behavior needs
  - 6. Preferences and goals for care

Memo: Ligature Risk & Assessment*

- Released July 17, 2023
- Discussed 3 main element to ensure patient safety related to ligature risks and to show compliance:
  - Patient assessment
  - Staffing and monitoring
  - Environmental risks

Overall

- Not expected hospitals have same ligature risk configuration throughout facility
- Rather – focus on specific needs and risk of individual patients
  - Based on clinical or psychiatric assessment
- Corrective actions implement in response to deficiencies/adverse events
  - Should focus on appropriately addressing findings/failures
  - Rather than universal remedies

Respiratory Infection Data*

- CMS renewed and revised hospital and CAH CoPs reporting data related to respiratory infections
- Rationale – help ensure hospitals have appropriate insight related to evolving infection control needs
- Beginning November 1, 2024, must report weekly electronically information re:
  - COVID-19
  - Influenza
  - RSV

Reporting Respiratory Illnesses

- Memo:
  - https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/policy-memos-states/updates-condition-participation-cop-requirements-hospitals-and-critical-access-hospitals-cahs-report
- Fact sheet:
  - https://www.cms.gov/newsroom/fact-sheets/fy-2025-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospital-prospective-0



Conditions of Participation

Introduction

Conditions – Generally

- Appendix W, Starts at tag **C-0800**
- Not all the new regulations are in the current manual – QAPI, patient rights and obstetrical services
  - Interpretive guidelines and survey procedures are pending in some areas
  - 2025 regulations not in the manual
- Manual includes swing bed regulation
  - Interpretive guidelines and Survey Procedures in Appendix PP – LTC manual – F standards

CAH with Distinct Part Units

- CAHs can have up to a ten-bed behavioral health unit or rehab unit (Tag C0500)
  - If so – governed under appendix A
- Beds are not included in the 25- bed count (C0501)
  - 96-hour rule does not apply
- Must have written criteria for both that apply to all patients including Medicare (C0504)
- Must have admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available (C0505)

Psyche Unit Requirements

- Policies that necessary clinical information is sent when a hospital patient is transferred to the unit (506)
- Meet all state laws (C0507)
- Have Utilization Review standards for the type of care offered in the psych unit (C0508)
- Beds must be separate and not commingled (C0509)
- Beds must be serviced by same fiscal intermediary as the hospital (C0511)
- Use accounting system that allocates costs (C0512)

Distinct Part Units

- Psych unit must maintain adequate statistical data to support the basis of allocation (C0513)
- Must report its cost in the hospital's cost report covering the same fiscal period and using the same method of apportionment as the hospital (C0514)
- Must be fully equipped unit and staffed regardless of whether there are any psych or rehab patients on the first day of the cost reporting period (C0515)
- If you have these two units – read this section
  - There are more tag numbers

Appendices to Keep Handy

- Appendix W Hospital CoPs ("C" tag number)
  - If have "distinct" rehab or behavioral health unit will need Appendix A
- Q – Immediate Jeopardy
  - Wording recently updated
- V – EMTALA
- PP – Long Term Care – if have swing beds
- I – Life Safety Code
- Z – Emergency Preparedness

Survey – General Information

- Survey person/team can make copies of things
  - Have surveyor make you a copy also
  - Ask surveyor not to make copy of peer review material
    - Abstract out what is needed
  - Also – cannot demand any material voluntarily submitted as "patient safety work product" (PSWP) if in a PSO
  - Memo: https://www.cms.gov/files/documents/qso-23-24-hospitals.pdf

Survey Protocol

- Off-survey preparation
- Entrance activities
- Information gathering/investigation
- Preliminary decision making and analysis of finding
- Exit conference
- Post survey activities

Survey Procedure

- Interpretive guidelines provide instructions to the surveyors
- Will have **survey procedure** instructions
- Will ask patients if the hospital told them about their rights



Swing Beds

Initial Information

Question

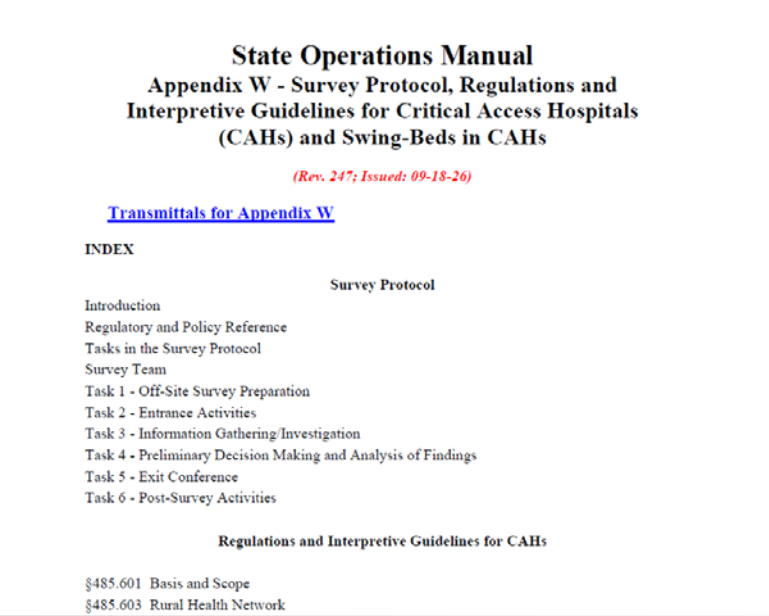
- Kremmling CAH has an average daily census of 2 – 4 patients. The Swing Bed unit has an average census of 10 with patients from the community only. Governing body wants to increase Swing Bed services to outlying metropolitan areas and other states. Is that permitted?
  - Yes
  - No – only within their community
  - Not sure/Do not know

Swing Bed Module

- Will survey under CAH swing-bed requirements
  - Regulation in Appendix W
  - Interpretive guidelines and survey procedures in Appendix PP
- Reimbursed at Skilled Nursing care
  - As opposed to Acute Care
- Term is for reimbursement
  - Not geographical

Swing Bed – Generally

- In acute care status one day – Swing bed status the next day
- 3-day qualifying inpatient stay required
  - 3 days can be in another facility
  - Can be split between CAH and another qualified facility
  - Not observation
  - Give Notice letter to outpatient observation patients (MOON Form)



State Operations Manual
Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs

(Rev. 247; Issued: 09-18-26)

Transmittals for Appendix W

INDEX

Survey Protocol

Introduction
Regulatory and Policy Reference
Tasks in the Survey Protocol
Survey Team
Task 1 - Off-Site Survey Preparation
Task 2 - Entrance Activities
Task 3 - Information Gathering/Investigation
Task 4 - Preliminary Decision Making and Analysis of Findings
Task 5 - Exit Conference
Task 6 - Post-Survey Activities

Regulations and Interpretive Guidelines for CAHs

§485.601 Basis and Scope
§485.603 Rural Health Network

Appendix W

Rural Health Network

Compliance with Laws

Required Disclosures

Designation & Certification

Status & Location

Governing Body and Agreements,

Contracted Services & Telemedicine

Basic Information

- Start with tag 800 – "C" = CAH CoPs
- Tag C0800 Basis and Scope
  - Conditions to meet to be a CAH
- Personnel Qualifications - qualifications of a CNS, NP, PA (C0804)
  - State defines the scope of practice – not CMS
  - CMS will enforce the state law and scope of practice

Rural Health Network C0802

- At least one hospital the state designated as a CAH and one that provides acute care
  - Entered into an agreement for patient referral and transfer
  - Use of communication systems such as telemetry and sharing of patient data
  - Transport among members
- Each CAH has an agreement for C&P and QAPI with one of the following:
  - One hospital that is a member of the network when applicable
  - One QIO or equivalent entity or
  - One other appropriate and qualified entity identified in the State rural health care plan

Designation & Certification C0808

- Must be in a State with an established State Medicare Rural Hospital Flexibility Program
- Located in a rural area/treated as rural
- No more than 35-miles from nearest hospital
- No more than 25 inpatient beds – swing or inpatient
- States have a Medicare rural hospital flex program
  - Can designate a CAH meeting the CoPs
- Criteria for certification
  - Hospital has been surveyed by the state agency
  - Complies with the CAH CoPs

Compliance with Laws C0810

- **Condition:** Hospital and staff must comply with all Federal, State, and local laws
  - Hospital and staff are in compliance with laws and regulations
- Failure to meet a law only cited when Federal, State or local authority with jurisdiction
  - Has decided on noncompliance
  - AND taken final action
- Surveyor will refer or report suspected violation to the appropriate authority such as
  - OSHA – TB, blood borne pathogen
  - OCR - discrimination
  - EPA – hazardous material or waste issues

IM and Detailed Notice Forms

- Hospital to provide a Medicare patient with an Important Message from Medicare within 48 hours of admission
  - Must deliver copy of signed form to the patient
  - If more than two days and within 48 hours of discharge
  - Patients must be given a more detailed notice and request the QIO to review their case

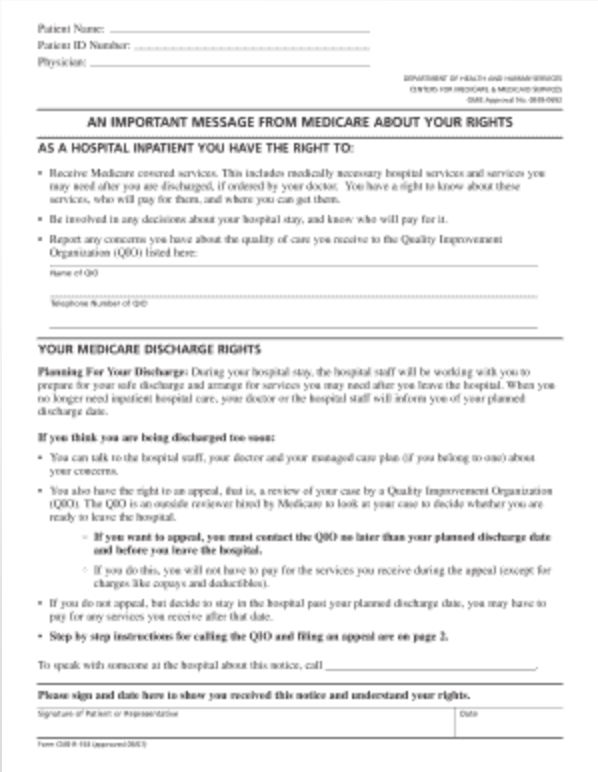
- Website for beneficiary notices www.cms.hhs.gov/bni

IM Notice & Detailed Notice

- CMS updated the important message (IM) from Medicare form and the instructions
  - Must be given to all Medicare patients – know discharge appeal rights
- Updated the Detailed Notice of Discharge (DND) Form and instructions and MOON form
  - To those who choose to appeal discharge decision
  - Revised April 2020 and new form number*
  - Questions can be addressed to https://appeals.lmi.org
  - *See appendix

"IM" Notice

- Must give ***Medicare*** patients "Important Message from Medicare" Notice
  - Within two days of admission
  - In advance of discharge if more than two days
  - Notice to certain observation patients



Patient Name: _____

Patient ID Number: _____

Physician: _____

AN IMPORTANT MESSAGE FROM MEDICARE ABOUT YOUR RIGHTS

AS A HOSPITAL INPATIENT YOU HAVE THE RIGHT TO:

- Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- Be involved in any decisions about your hospital stay, and know who will pay for it.
- Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here:

Name of QIO

Telephone Number of QIO

YOUR MEDICARE DISCHARGE RIGHTS

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

- You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.
- You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
  - **If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.**
  - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
- **Step by step instructions for calling the QIO and filing an appeal are on page 2.**

To speak with someone at the hospital about this notice, call _____.

Please sign and date here to show you received this notice and understand your rights.

Signature of Patient or Representative | Date

Medicare Advantage Notice

- MA organizations are required to provide enrollees with a notice of non-coverage
  - Known as the Notice of Discharge and Medicare Appeal Rights (NODMAR)
- Only when
  - Beneficiary disagrees with the discharge decision - OR -
  - When the organization or hospital, if the MA organization has delegated to it the authority to make the discharge decision
  - Is NOT discharging the enrollee
  - BUT no longer intends to cover the inpatient stay

Compliance with Laws C0812

- Standard: Hospital complies with applicable Federal laws and regulations related to health and safety of patients

- Guidelines discuss advance directives and notice of rights plus other changes
- With August 2025 changes – moved to new section on Patient Rights

Required Disclosures: Ownership

- Must disclose if physician owns the hospital
  - Includes ownership by immediate family member and must be in writing
  - If physician owners do not refer to the hospital – must sign attestation to this effect
- Physicians must also disclose to patients who they refer
  - This must be as a condition for getting MS privileges
- Disclose on website for advertising for the hospital
  - If owned/invested in by physicians

Disclosures: No MD/DO On-Site

- Disclose in writing if a physician is not on-site 24/7
  - Must be provided to all inpatients, outpatients surgery/procedures and Observation
  - Sign acknowledgement if patient admitted
  - Need not to give individual notices to patients in the emergency department (ED)
  - Post notice in the ED in a conspicuous place
  - Must cover how the hospital will meet the needs of the patient in an emergency
  - If separate location and no physician must give notice

Compliance with Laws C-0814

- **Condition:** CAH and staff are in compliance with applicable Federal, State and local laws and regulations (New)
- Standard: All patient care services are furnished per applicable State and local laws/regulations (New)
- Standard: Patient care services must be provided in accordance with laws
- Guidelines address delegation
  - Ensure delegation as allowed by law
  - Ensure practicing according to scope of practice, such as NP, CNS, or PA

Licensure C-0816 & 0818

- Standard: Hospital must be licensed per laws and regulations (0816)
- Standard: Staff are licensed, certified or registered per applicable laws (0818)
- Ensure staff meet all state laws for
  - Certification
  - Qualifications
  - Training and education requirements
- Surveyor will check and make sure licensure information is up to date
  - Will look at policies on certification and licensure

Status and Location

- **Condition:** Location and status (C0822)
- Must meet location requirements at the time of the initial survey
  - Compliance is reconfirmed at the time of every subsequent full survey
- Standard: discusses other options for status as CAH (C0824)
  - Recently closed facility
  - Health clinic or center

Rural Area C-0826

- Standard: Location in a Rural Area or Treatment as Rural
- CAH meets requirements:
  - CAH located outside any area that is a metropolitan statistical area
  - Not classified as urban hospital and not in a group of hospital redesignated to an adjacent urban area
  - Is withing a Metropolitan Statistical Area by the OMB but treated as rural area
  - Several more options…….

Location & Re-Location

- Standard: Location relative to other facilities or necessary provider (C-0830)
- 35-miles from another hospital
  - Discusses exception if deemed necessary provider
- Standard: Relocation with Necessary Provider Designation (C0832)
  - Serves and provides at least 75% same service area as before relocation
  - Is staff by 75% of same staff as at original location
  - If NOT meet these requirements → cessation of business

Off-Campus & Co-Locations C0834

- Standard: Off-campus and Co-Location Requirements
- Can still meet location requirements only if:
  - Is a necessary provider and co-located (shares a campus with another hospital or CAH)
  - If co-location arrangement in effect before 1/1/2008
  - Type and scope of services offered with CAH do not change
  - Change of ownership of any facility with the co-location agreement in effect before 1/1/2008 is not a new co-location arrangement

Off-Campus & Co-Locations C0836

- Standard: Off-campus and Co-Location Requirements
- Can still meet location requirements if:
  - CAH or is a necessary provider and operates an off-campus provider-based location,
  - Excluding RHC
  - But includes department or remote location if off-campus provider is more than 35-mile drive
- Distance does not apply to:
  - ASC – Comprehensive OP rehab – HHA – SNFs – Hospices – Diagnostic testing facilities – ESRD – Ambulances – Departments of providers that perform necessary functions but no separate payment (laundry, medical records)



Number of Beds & Length of Stay

Tag Nos. C0900 – 0904

Number of Beds C0902

- **Condition:** Number of beds and length of stay (C0900)
- Standard: CAH maintains no more than **25** inpatient beds
  - "Beds" counted – not patients
  - May be either inpatient or Swing beds
- **CAVEAT – under 2254D – no more than 15 beds are used for acute care** (not in Appendix W)
- Distinct 10 bed rehab or behavioral health unit not included
  - Surveyed under Appendix A (Acute hospitals)

Observation Services

- Beds not included in maximum number allowed
- Is a well-defined set of specific, clinically appropriate services
  - Usually – prolonged recovery from outpatient surgery or needs longer period of treatment/monitoring in ED
- Inappropriate use could subject beneficiary to increased coinsurance liability
  - 20% of CAH customary charges then if properly admitted as inpatient
- No pre-scheduled observations services

Observation Not Appropriate

- Substitute for inpatient admission
- Continuous monitoring
- Medically stable patients needing diagnostic testing or outpatient procedure (blood chemo, dialysis)
- Awaiting nursing home placement
- Convenience to the patient or family
- Routine prep or recovery prior to/after diagnostic/ surgical services
- Routine "stop" between the ED and inpatient admission

What Needed

- Order prior to initiation – not backdated
  - Saying "admit for observation" is NOT violation of CoPs
- Documentation – show observation bed not an inpatient bed
  - Specific criteria for observation services
  - Must be different than inpatient criteria
- Observation begins and ends with the order of the physician
- No standing orders for observation

Two Midnight Rule

- Not in the Appendix – is part of the billing manual
- If patient expected to stay at least two midnights presumption is
  - Appropriate to admit
  - Cannot be gaming the system



Length of Stay and Observation

- Medicare generally will not pay if last more than **48** hours
  - Unless more strict state limit of 24 hours
- Rewrite policy on observation beds
- Observation beds not counted in calculating the yearly-average LOS (96 hours)

Observation Not Inpatient

- Must show evidence – documentation – that observation beds are not used for inpatient services
- CMS expects reasonable relationship between size of inpatient and observation operations
- EX: Red Flag – disproportionately large 10-bed observation unit
  - Surveyor may determine observation is an inpatient overflow unit

Hospice Beds

- Hospice – can be dedicated beds
  - Are counted in maximum bed count
  - Except 96-hour average LOS rule does **not** apply
- Medicare does not reimburse the CAH for hospice patients
  - Only the Hospice

Other Beds Not Included in Count

- Exam/procedure tables
- Stretchers
- OR tables
- Recovery beds – in PACU or other locations
- OD delivery bed – for labor or recovery
- Newborn bassinets and isolettes for well-baby boarders
  - However – if baby held for treatment – then **does** count
- Inpatient in distinct rehab or psyche units

Length of Stay C0904

- Standard: Length of stay does not exceed, on an annual average basis, 96 hours per patient (4 days)
  - State Fiscal Intermediary (FI) determines compliance
- Calculated based on patient census data
- If exceed – FI sends a report to the CMS-RO as well as a copy of the report to the SA
- Requires a plan of correction



Organizational Structure

Governing Body

Agreements and Contracted Services

Governing Body C0960 & 0962

- **Condition:** Organizational Structure
- Standard: CAH has a governing body or individual that assumes legal responsibility for determining, implementing and monitoring policies
  - Governing CAH's total operation
  - Ensure policies are administered
  - To provide quality healthcare in safe setting
  - Determines categories of eligible practitioners with is written criteria for appointments
  - Must be written criteria for staff appointment

Appointment to Medical Staff

- Board responsible to appoint practitioners to medical staff
  - On advice of medical staff
  - Ensures and approves medical staff has bylaws
  - Ensures medical staff accountable to governing body for quality of care



Criteria for Selection to Staff

- Character
- Competence
- Training
- Experience
- Judgment



- Surveyors – will look for/inquire
  - Written documentation of categories/staff
  - Verification appointment

Survey Procedures - Examples

- Will verify CAH has an organized governing body or written documentation identifying responsible person
- Review documentation and verify has determined and stated categories of practitioners eligible for appointment
- Verify facility's operating policies have been updated to hospital's responsibilities
- Will review meeting minutes – involvement in day-to-day operations
- Will verify governing body periodically appraised medical staff evaluation of patient care services

Disclosure C0964 & 0966

- Standard: Person principally responsible for operation of CAH and medical direction
- Need policy or procedure - report changes of operating officials to state agency
  - i.e., – a new CEO or medical director
- Surveyor
  - Look for policy on reporting changes
  - Ensure hospital implements policy

Conditions: Agreements – Networks

- Standard: Agreements with network hospitals (0862)
- If a member of a rural health network – there is an agreement with at least one hospital that is a member of the network
  - One must be an acute hospital
- Patient referral and transfer (0864)
- Development and use of communications systems,(if any, (0866) for sharing:
  - Patient data
  - Telemetry
  - Medical record

Network Agreements - continued

- Provision of emergency and non-emergency transportation between facility and the hospital (C0868)
- Standard: Agreements for credentialing and quality assurance (C0870)
- Each CAH a member of a rural health networks shall have an agreement with respect to credentialing quality assurance with at least
  - One hospital that is a member of the network
  - One QIO or equivalent entity
  - One other appropriate and quality entity identified in the State rural health care plan

Survey Procedure

- Verify have organized governing body/person
- Review documentation and verify – stated categories of eligible candidates
- Have policies been updated to reflect responsibilities
- Will ask for evidence showing board/person involved in day-to-day operations
- Will review records of staff appointees – board's involvement in appointments

Survey Procedure – continued

- Confirm board use established policies with appointments
  - Scope of expertise, Federal and State law
- Verify written criteria for appointment
- Verify minimum criteria used for appointment
- Verify medical staff operates under bylaws

Telemedicine Agreements C&P C0872

- Standard: Agreements for credentialing and privileging of telemedicine physicians and practitioners
- Board duties:
  - Ensure there is a written agreement with distant-site hospital (DSH) or entity (DSTE)
  - Determine categories of practitioners eligible for appointment to the MS
  - Appoint practitioners with recommendation of the MS
  - Approves the MS bylaws and other rules and regulations
  - Ensures medical staff accountable for quality of care provided

Telemedicine Agreements – cont'd

- Board duties – continued
  - Ensure criteria for selection to staff based on:
    - Individual character
    - Competence
    - Training
    - Experience
    - Judgment
  - Privileges cannot be based solely on:
    - Certification
    - Fellowship
    - Membership in a speciality body or society

Telemedicine Agreements – cont'd

- Board duties – continued
  - May choose to rely on credentialing and privileging decisions of distant-site hospital regarding the providers
  - Must ensure through written agreement with distant-site hospital that:
    - Is Medicare participating
    - Distant-site physician/practitioner is privileged a the distant-site hospital with privileges provided
    - Distant-site physician/practitioner hos is licensed in CAH's state
- Requirements same if use an entity vs. hospital except "Medicare participating"

Survey Procedures

- Will want to see copy of written agreement with distant-site hospital/entity
- Will ask for documentation re: privileges granted
- Will review documentation for criteria used in granting privileges
- Will ask for list of physician/practitioners including privileges and licensure information
- Will ask for evidence of require review of services from telemedicine providers
  - Including any adverse events and complaints

Telemedicine Contracts C0872 & 0874

- Must have in writing if choose to rely on the credentialing and privileging of DSH or DSTE
- The contract must say
  - Distant site MS C&P process and standards meet the requirements in the CMS CoPs
  - The physician privileged at the other hospital
  - Physician must be licensed in state patient is located
  - Must communicate any adverse events to the other entity

Health Care Services C-1034

- Standard: Services provided through agreements ro arrangements
- CAH has agreements with one or more providers or suppliers participating under Medicare to furnish services to patients
  - Example: obtaining outside lab tests
- However – distant-site telemedicine entity (DSTE) is not required to be a Medicare provider

Physicians C-1036

- Arrangement or agreement include those with 1 or more doctors
- If not in writing – must be able to show patients referred are being accepted and treated
  - Example: given appointments and seen
- Need P&P for referring patients it discharges who need additional care

Lab & Diagnostic Services C1038

- Lab or diagnostic services that are not available at the CAH
  - Want to have an agreement with 1 or more other providers
  - Want to be sure referred patients are accepted and treated
- Need to ensure basic lab services are available for immediate diagnosis and treatment
  - Staff can provide services or can contract for services

Lab and Radiology – cont'd

- Need to have agreement with a lab that can provide additional or specialized lab tests
  - Must have P&P
- If lab provides additional diagnosis
  - Must comply with CLIA
  - Lab will be surveyed separately
- Have evidence the outside lab has a CLIA certificate or waiver
- Same for radiology services – if done outside make sure CAH gets copy of report

Food Services C1040

- CAH can provide food and other services
  - Must meet inpatient's nutritional needs
- Can contract out this service
  - Ensure they are aware of the CMS requirements
  - Assess through QAPI process – ensure compliance with the contract
- Must still ensure patient nutritional needs are met
- Dietary services must be provided as per the P&P

List of Contracted Services C1042

- Must keep list of all services provided under contract or agreement
  - One location if possible
  - Update whenever services added/removed
- For each service list must include:
  - Service offered
  - Individual/entity providing the service
  - Whether on or off-site
  - Any limit on the volume or frequency of the services
  - When services are available
  - Ensure the contractor meets the requirements in the contract and the performance indicators

Person Responsible C1044

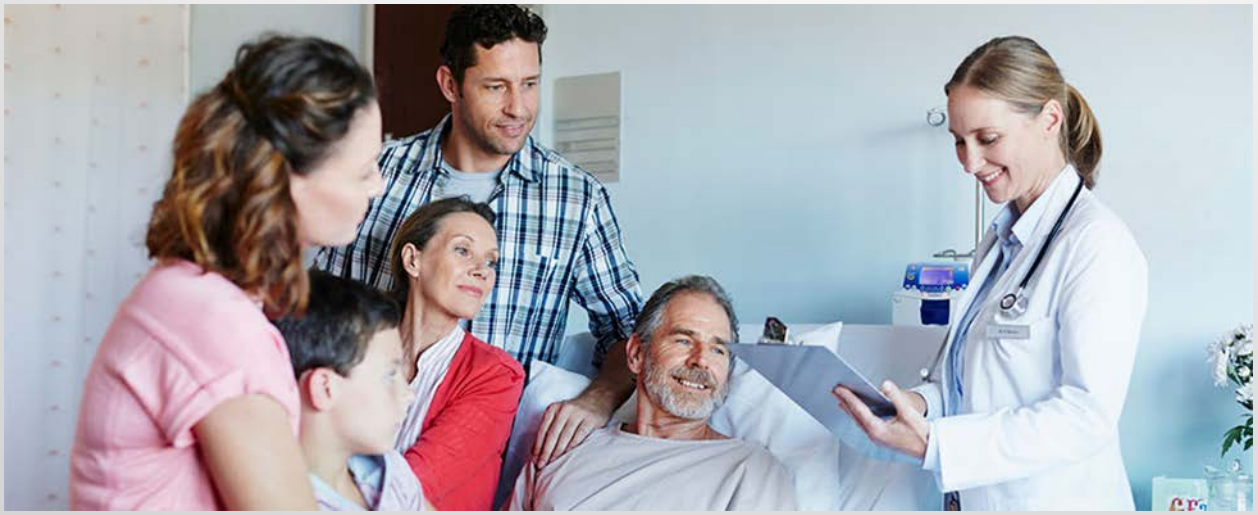
- Person principally responsible for operation of responsible for services provided
  - Must take action to assure contractor complies with CoPs
- Includes not only care provided directly to patient but also services related to patient care
  - Housekeeping > Laundry
  - Instrument cleaning and sterilization
  - Pharmacy > Lab
  - Interpreters > Security
  - Dialysis > Food service, etc.



Discharge Planning

Overall C1400

- **Condition:** Must have an effective discharge planning process
  - Focuses on the patient's goals and treatment preferences
  - Must include patients and their representatives as active partners in the discharge planning process



Process C1404

- Standard: Process must identify at an early stage of hospitalization
  - Patients likely to suffer adverse health consequences upon discharge
  - In the absence of adequate discharge planning
- Must provide a discharge planning ***evaluation***
  - For those patients so identified
  - If the patient/representative requests
  - If physician requests

Evaluation C1406 & 1408

- Evaluation must be timely
  - Ensure appropriate arrangements for post care completed
  - Avoid unnecessary delay in discharge
- Must include an evaluation if they will need post hospital services
  - Such as home health, hospice, swing bed admission, assisted living, LTC, LTCH, etc.
- Need to determine if the services the patient needs are available in the area that the patient lives

Evaluation & Plan
C1410, 1412, 1417, 1420

- Need to document results of evaluation in the medical record and discuss with the patient/representative (C1410)
- Must arrange for development and initial implementation of ***plan*** upon request of physician (C1412)
- Must be done by a qualified person
  - RN, social worker, other qualified person (C1417)
- Must have regular re-evaluations of the patient's condition (C1420)

Review of Process C1422

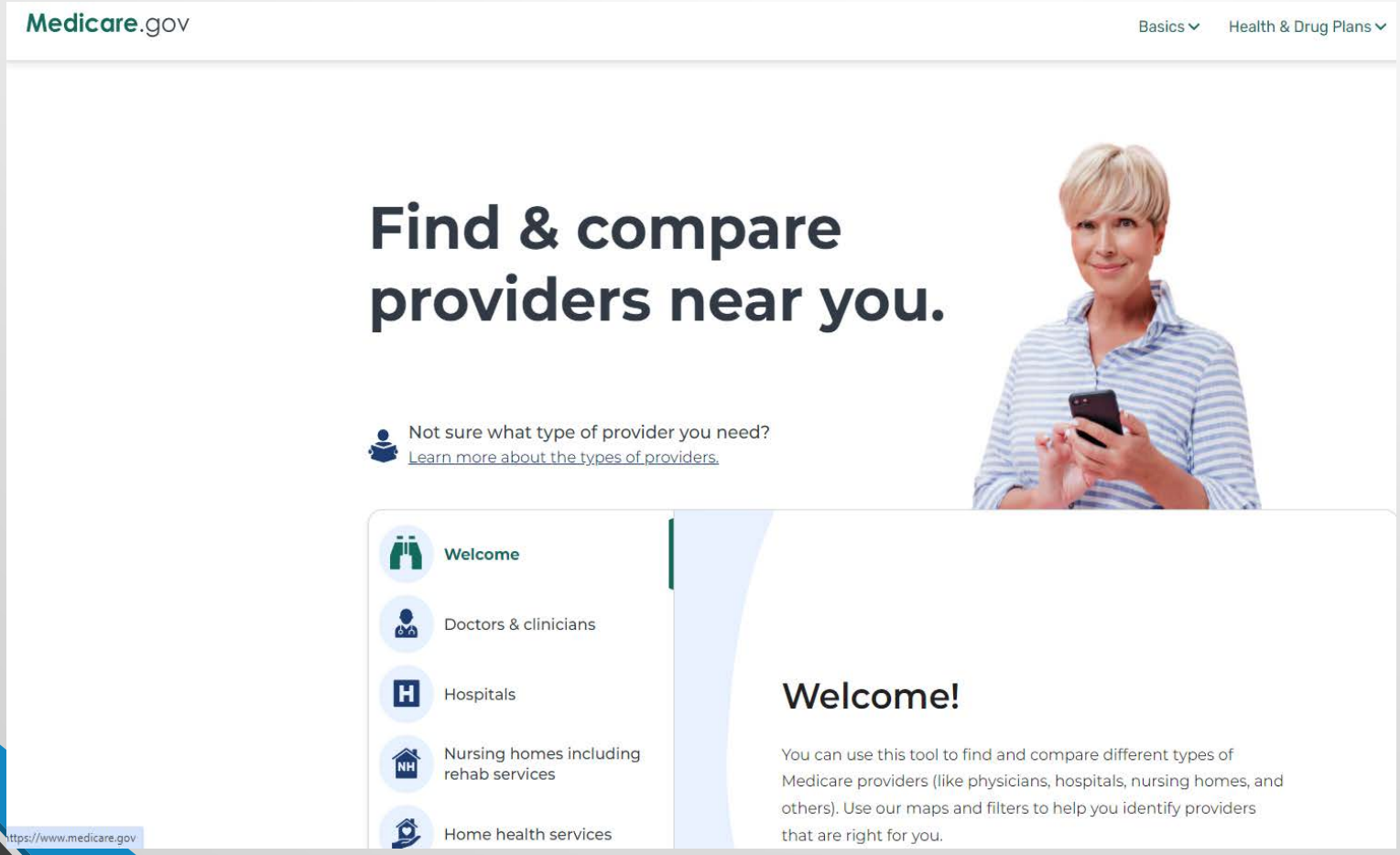
- Must review the discharge planning process on a regular basis
- This includes a sampling of patients readmitted within 30 days
  - Many hospitals review the chart of every patient who is readmitted within 30 days
  - Done to determine if there is anything the hospital could have done to prevent the readmission

Selection of PAC Provider C1425

- Must assist patients, family/representative to select post-acute provider
- Use and share data on quality and resource use measures
  - HHA – SNF – IRF – LTCH data
- Must ensure data is relevant and applicable
  - Patient's goals and treatment preferences

Care Compare Resource

- https://www.medicare.gov/care-compare/



Discharge & Patient Information C1430

- Standard: Must transfer patients if unable to provide the needed services
- If you transfer or refer the patient – must send necessary medical information
  - Must include current course of illness and treatment, post discharge goals of care, and treatment preferences
- Discharge planning evaluation must be in the patient's medical record to be used in doing a discharge plan

Additional Points

- Requirements do not prevent CAHs from using telehealth to meet the DP requirements
- Not required to include in their DP a list of the 4 PACs (LTC, HHA, LTCH, IRF)
  - **Are required** to assist patients to select a PAC provider
- Must still share data on quality measures and resource use (cost, efficiency, readmission rates)
- Guidelines are pending
- Overall – follow Appendix A very closely

June 2023 Memo – QSO-23-16*

Reiterated requirement that hospitals have an effective discharge planning process

- Process focuses on patient's goals and treatment preferences
- Include patient and caregivers/support person(s) as active partners in the planning

- [1]https://www.cms.gov/files/document/qso-23-16-hospitals.pdf

June 2023 Memo – continued

- Must discharge and transfer/refer where applicable
- Along with all necessary medical information
  - Pertaining to patient's current course of illness and treatment
  - Post-discharge goals of care and treatment preferences
  - To appropriate PAC service providers and suppliers, agencies, other outpatient providers responsible for follow-up or ancillary care

Memo – Missing Information

- Memo notes importance of providing PAC and caregivers with appropriate patient information
  - Decrease readmissions and adverse events
  - When the missing information occurs – PACs not properly prepared to care for patient at home
  - Not equipped or trained to care for certain conditions
- SAs/AOs reminded to be alert to common issues
  - Ensure discharges occur in compliant and safe manner
- Hospitals have discretion to develop own P&P to meet requirements

6 Areas of Concern

- Areas of concern on missing or inaccurate information:
  - 1. Medications
  - 2. DMEs
  - 3. Skin conditions (tears)
  - 4. Communications with PACs/caregivers on needs at home
  - 5. Patients with serious mental illness, SUDs, complex behavior needs
  - 6. Preferences and goals for care

Possible New Rule

- Part of the 2025 Medicare Hospital Outpatient Prospective Payment system
- Will be under Discharge Planning – not in the September 2025 regulations
- Does not modify EMTALA though discusses transfers between facilities/units
- Not a requirement for CAHs as this time
  - May require at a later date

Essential Elements

- Must have written policies and procedures for transfers
  - Includes intra-hospital transfers of inpatients
  - ED to inpatient
  - Transfers between units of same and different hospitals
- To appropriate level of care needed

One More Suggestion

- CMS had 3 worksheets for surveys – part of pilot programs
  - Discharge planning
  - Infection control
  - QAPI (performance improvement)
- No longer utilized
- Are available – excellent self-assessment tools

Worksheet Links

- Infection Control:
- https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationgeninfo/downloads/survey-and-cert-letter-15-12-attachment-1.pdf.
- Discharge Planning:
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-12-Attachment-3.pdf.
- QAPI:
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-12-Attachment-2.pdf.



Emergency Services

Question

Delphi Hospital is a CAH in which the emergency room nurses and providers are to respond to emergencies on the units. During one such emergency, only 1 RN from the ED could respond due to patient needs in the ED. The patient on the floor did not survive. The RCA showed lack of a provider did impact the event.

Will Delphi be cited for inadequate emergency response?

- Yes
- No
- Possibly

Emergency Services C0880

- **Condition:** Must provide emergency care necessary to meet the needs of its inpatients and outpatients
  - Cannot be a provider-based off-site location
- Must comply with acceptable standards of practice
  - National professional organizations



Requirements

- Qualified medical director
  - Criteria established by Medical staff
- MS P&P re: care provided in the ED
- Policies current and revised based on QAPI activities
- Services must be integrated into hospital-wide QAPI
- MS established qualifications for privileges to provide ED care
- ED must be adequately staffed with trained personnel
- Have adequate equipment

Emergency Services – continued

- Determine categories and numbers of staff needed
  - MD/DO, RN, ward clerks, PA, NP, EMTs,
- Must conduct ongoing assessment of emergency needs
  - Anticipate P&P
  - Staffing
  - Training
  - Other resources to address demands

Emergency Services – continued

- Emergency care for inpatients and outpatients includes provision of respiratory services as needed by ED patients
  - Intubation, breathing treatments, ABGs, etc.
  - Other tests such as CT scans, venous Doppler's, ultrasound et. al.
- Scope of diagnostic and/or therapeutic respiratory services
  - Should be defined in writing
  - Approved by medical staff

14 ED Written Policies

- Developed and approved by MS
  - Include mid-level practitioners who work in the ED
- 1. Each type of service provided
- 2. Qualifications and experience of personnel performing respiratory services and supervision if needed
- 3. Equipment assembly and operation
- 4. Safety practices including infection control

Written Policies – continued

- 5. Handling, storage and dispensing therapeutic gasses
- 6. Cardiopulmonary resuscitation
- 7. Response to adverse reactions to treatments or interventions
- 8. Pulmonary function testing
- 9. Therapeutic percussion and vibration

Written Policies – continued

- 10. Bronchopulmonary drainage
- 11. Mechanical ventilator and oxygenation support
- 12. Aerosol, humidification, and therapeutic gas administration
- 13. Administration of medications and
- 14. Procedures for obtaining and analyzing ABGs

- Consider triage protocols

Survey Procedures

- Will verify
  - Services organized under direction of qualified MS member
  - P&P established, evaluated and updated on an ongoing basis
  - Sufficient qualified medical and nurse personnel
- Will review
  - P&P for services
  - Sample of medical records



Survey Procedures – cont'd

- Will interview ED staff for knowledge within level participation:
  - Parenteral administrations
  - Prevention of contamination and cross infections
  - Provisions of emergency respiratory services
  - Care and management of injuries to extremities and central nervous system
- Will review staff schedules – appropriate to volume and type treatments provided
- If ABGs/other labs performed – current CLIA certificate

Services Available 24/7 C0882

- Standard: Must make available 24-hour emergency services
- If no inpatients – may close with no staff present
- HOWEVER – must provide effective system to meeting availability of 24-hr emergency services
- Must ensure practitioner with training/experience in emergency care
  - On call
  - Immediately available by phone/radio
  - On site within 30 minutes 24/7

Equipment, Supplies & Drugs C0884

- Standard: Equipment, supplies and medications
  - Used in treating emergency case
  - Kept and readily available
- Must maintain types, quality and numbers
  - Plus – blood and blood products (discussed later)
- Anything required by state and local law
- In accordance with accepted standards of practice
- Surveyor will interview staff: how ensure above items are always available

Emergency Drugs Co886

- Antidotes and emetics
- Serums and toxoids
- Antiarrythmics
- Cardiac glycosides
- Antihypertensive
- Analgesics
- Local anesthetics
- Antibiotics
- Anticonvulsants
- Diuretics
- Electrolytes & replacement solutions

Emergency Equipment Co888

- Airways
- Endotracheal tubes
- Ambu bag/valve/mask
- Oxygen
- Tourniquets
- Immobilization devices
- Nasogastric tubes
- Splints
- IV therapy supplies
- Suction machine
- Defibrillator
- Cardiac monitor
- Chest tubes
- Indwelling urinary catheters

Education and Survey Procedure

- Ensure staff know where equipment located
- Are equipment/supplies readily available?
- How supplies are replaced and who is responsible?
- When supplies last used?
- Surveyors
  - Will examine sterilized equipment for expiration dates
  - Will check for equipment maintenance schedule (defibrillator)
  - Will check force of suction equipment

Blood and Blood Products 0890

- Standard: Facility provides, for procurement, safekeeping, and transfusion of blood
  - Includes availability of blood products needed for emergencies on a 24-hours a day basis
- No requirement to store ***blood*** on site
- Can provide directly or through arrangement



Blood/Blood Products – cont'd

- If do tests on blood
  - Must have CLIA certificate
  - Surveyed under CLIA
- If collecting blood – must register with FDA
- If only storing blood for transfusion and refers all tests to outside lab – not performing test as defined by CLIA
- Need written agreement regarding the provision of blood between CAH and testing lab

Blood/Blood Products – cont'd

- Must store appropriately to prevent deterioration
- If type and cross match blood must have necessary equipment
- Option: always keep 4 units O-Negative on hand
- If not crossed matched:
  - Can release if signed by doctor
  - In an emergency

Blood Storage C0892

- Must be under the control and supervision of a pathologist or other qualified doctor
- If blood banking under arrangement
  - Arrangement must be approved by MS and administration
- Surveyor will look for an agreement



Standard: Personnel C0894

- Must have practitioner – MD/DO/PA/NP/CNS
  - Trained in emergency care
  - On call and immediately available within 30 minutes
- 60 minutes if in frontier area
  - Less than 6 residents per sq. mile
  - Area meets criteria for remote by the state and CMS
  - State determines longer time than 30 minutes needed is only way to provide care

RN May Meet Requirement

- RN with training/experience in emergency care can do MSE only if
  - On site and immediately available
  - Nature of patient's request for care within scope of practice, consistent with all laws
  - For temporary period
    - CAH has less than 10 beds
    - In frontier area
    - Governor sends letter to CMS (next slide)

Governor's Letter to CMS

- Governor must consult with State Medical and Nursing Boards
  - Issues related to access and quality of emergency services
  - Describe circumstances and duration of temporary request
  - Include RNS on the list of personnel
- CAH must submit letter to surveyor
  - Plus demonstrate shortage and unable to provide care

Caveat – State Law

- If State law more stringent and requires
  - More staffing or
  - Expanded operational hours
- Must comply
- EX: State law requires ED be open and staffed with MD/DO 24/7

Survey Procedures

- Will review call schedules
- Will interview staff – do they know who is on call
- Will review documentation that provider on site within time frame



Emergency Services Readiness New

- Standard: CAHs with emergency services:
- Must be adequate provision and protocols to meet emergency needs
- Must have protocols consistent with nationally recognized and evidence-based guidelines for care of patients with emergency conditions
    - Including OB emergencies, compilations and immediate post-delivery care
- See August 2025 MLN: https://www.cms.gov/files/document/mln006400-information-critical-access-hospitals.pdf

Emergency Services Readiness – cont'd

- Staff training – applicable staff trained on protocols and provisions
  - Governing body identify who must complete
  - CAH must document in personnel records
  - CAH must be able to demonstrate staff knowledge on training
  - Must use findings from QAPI to inform staff training needs, revisions or updates on ongoing basis

Coordination with EMS C0898

- Standard: Must establish a procedure
  - MD/DO available by phone or radio
  - On 24-hour basis to receive calls
  - Provide information on treatment of patients
  - Refer patients to CAH or other appropriate location
- Surveyor will
  - Verify P&P present to ensure MD/DO available
  - Ask for evidence procedures followed and evaluated
  - Talk to staff – How MD/DO contacted when needed

Emergency Procedures[1] C1032

- Hospital provides medical services as a first response to common life-threatening injuries and acute illness
  - Must be on site
  - Provided by employed staff or contractors
  - Person must be able to recognize patient's need for emergency care
    - At all times
  - Must provide appropriate initial interventions, treatment and stabilization

(1. Part of Provision of Services chapter)

EMTALA C2401 - 2403

- Still part of Appendix W – regulation only
  - Appendix V has complete information – guidelines and survey procedures
- CAH must report to CMS if they have reason to believe they have received a patient transferred in an unstable medical condition from another hospital (C2401)
- Must post signs as required by EMTALA (C2402)
  - Specifying rights of individual re: examination and treatment
- Maintain records 5 years from date of transfer (C2403)

Physician Lists C2404

- Maintain list of physician on call to provide further evaluation/treatment to stabilize patient and to meet patient's needs
- Must have written policies and procedures:
  - When specialty/on-call physician cannot respond (beyond control)
  - If elects on-call physician to do elective surgery at time on-call

Central Log C2405

- Maintain a central log all persons who come to the ED
  - If refused treatment – consider AMA form
  - If was refused treatment – document the "why"
  - If transferred
  - If admitted and treated
  - Stabilized and transferred
  - If discharged

MSE C2406

- Provide appropriate medical screening examination (MSE) to determine if emergency medical condition exists
  - Within capability to determine if a medical emergency
  - Examination done by qualified person
  - If EMC exists – provide stabilizing treatment or appropriate transfer
- If person present and nature of request makes it clear there is no emergency – need only screen to confirm "no emergency"

Admit or Transfer C2407

- If EMC – must stabilize within capabilities or transfer person
- Applies to all persons – not just Medicare
- If admits the patient – EMTALA obligation ends
  - CAVAET – case law in one district says obligation continues
- Also ends if patient refuses to consent to treatment

No Delay or Transfer C2408 - 2409

- May not delay appropriate MSE or treatment (C2408)
  - To inquire about method of payment/insurance status
  - Obtain prior authorization to direct patient to do so
  - CAN follow reasonable registration processes
- May not transfer unless (C2409)
  - Transfer appropriate under the circumstances
  - Individual requests in writing
  - Done appropriately

Whistleblower & Specialized Capabilities C2410 - 2411

- May not penalize/take action against provider who refused to authorize transfer or employee who reports violation (C2410)
- Facilities with specialized capabilities/facilities may not refuse to accept appropriate transfer (C2411)

Final Question

MJ presents to the emergency department with shortness of breath, dizziness, nausea and vomiting. He has a history of severe anxiety treated with diazepam. Admitting labs/EKG are inconclusive for AMI. He is admitted to observation and further lab work.

One hour after admit to observation, MJ experiences a return of symptoms with now positive EKG changes and elevated troponin. He is returned to the ER. Does EMTALA apply?

- Yes – MJ was in observation so EMTALA would still apply
- No – EMTALA ends with observation admission

Thank You



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Appendix

Resources

and

Internet Links

https://www.cms.gov/files/document/qso-23-16-hospitals.pdf

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-23-16-Hospitals

DATE: June 6, 2023

TO: State Survey Agency Directors

FROM: Director, Quality, Safety & Oversight Group (QSOG)

SUBJECT: Requirements for Hospital Discharges to Post-Acute Care Providers

Memorandum Summary

CMS is committed to ensuring that the health and safety of patients are protected when discharges from hospitals and transfers to post-acute care providers occur. Therefore, we are providing the following information:

- Reminding state agencies (SAs), accrediting organizations (AOs), and hospitals of the regulatory requirements for discharges and transfers to post-acute care providers.
- Highlighting the risks to patients' health and safety that can occur due to an unsafe discharge.
- Recommendations that hospitals can leverage to improve their discharge policies and procedures to improve and protect patients' health and safety.

Background:

When a patient is discharged from a hospital, it is important to provide their post-acute provider

Memo: Ligature Risk Assessment

https://www.cms.gov/files/document/qso-23-19-hospitals.pdf

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality

Ref: QSO-23-19-Hospitals

DATE: July 17, 2023

TO: State Survey Agency Directors

FROM: Directors, Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG)

SUBJECT: Ligature Risk and Assessment in Hospitals

Memorandum Summary

- ***Patients in Medicare-certified hospitals have a right, by regulation, to receive care in a safe setting.***
- ***Hospitals can demonstrate compliance with this standard through appropriate patient assessments, adequate staffing and monitoring, and mitigation of environmental risks.***

Background:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-25-05-Hospitals/CAHs

DATE: **October 22, 2024**

TO: CMS Locations, State Agencies, Hospitals/CAHs, and other stakeholders

FROM: Directors, Quality, Safety & Oversight Group (QSOG), and Survey & Operations Group (SOG)

SUBJECT: Updates to the Condition of Participation (CoP) Requirements for Hospitals and Critical Access Hospitals (CAHs) To Report Acute Respiratory Illnesses

Memorandum Summary

- CMS is committed to taking critical steps to ensure America's healthcare facilities have appropriate insight related to evolving infection prevention and control needs.
- CMS has released new regulatory requirements for all hospitals and critical access hospitals (CAHs) at 42 C.F.R. §§482.42(e) and 485.640(d), respectively, to report information in accordance with a frequency and standardized format, as specified by the Secretary.
- Failure to report the specified data related to COVID-19, influenza, and respiratory syncytial virus (RSV), including confirmed infections of respiratory illnesses among hospitalized patients, hospital bed census and capacity (both overall and by hospital setting and population group [adult or pediatric]), and limited patient demographic information, including age, may lead to the termination of a hospital's participation from the Medicare and Medicaid programs.

Memo: June 2023 – 96-Hour Length of Stay

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality

Ref: QSO-23-17-CAH

DATE: June 9, 2023

TO: State Survey Agency Directors

FROM: Directors, Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG)

SUBJECT: One-Time Change to Critical Access Hospital (CAH) Annual Average 96-hour Patient Length of Stay Calculations to Account for the COVID-19 Public Health Emergency (PHE)

Memorandum Summary

- Medicare-certified CAHs are required to meet the annual 96-hour average patient length of stay standard for acute inpatient care under the CAH Conditions of Participation (CoPs) at 42 CFR §485.620(b).
- During the COVID-19 Public Health Emergency (PHE), CMS waived the requirement that CAHs limit the annual average patient length of stay to 96 hours. This waiver was in effect from March 1, 2020, through the end of the PHE on May 11, 2023.
- The purpose of this memo is to provide guidance to the SAs of a one-time change to the CAH 96-hour patient length of stay calculation to account for the time period of the PHE.

CAH General Resources

mln BOOKLET

KNOWLEDGE • RESOURCES • TRAINING

Information for Critical Access Hospitals



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What's Changed?

We added:

https://www.cms.gov/files/document/mln006400-information-critical-access-hospitals.pdf

AHA Website

Small or Rural Hospitals

Add to your Interests

Current & Emerging Payment Models / Rural issues

www.aha.org/advocacy/small-or-rural

Some 57 million rural Americans depend on their hospital as an important source of care as well as a critical component of their area's economic and social fabric.



AHA ensures the unique needs of our members are a national priority. Location, size, workforce, payment and access to capital challenge small or rural hospitals and the communities they serve. Collaborating with state and regional hospital associations and with advice from its member council, the Section tracks the issues, develops policies and identifies solutions to our most pressing problems. We do this through:

- Representation and advocacy in Washington, DC
- Communication and education
- Executive leadership and technical assistance
- Innovation in payment and delivery

2020 Rural Advocacy Agenda

Join the AHA Advocacy Alliance for Rural Hospitals

American Hospital Association™
Advancing Health in America
Rural Health Services

33RD ANNUAL AHA RURAL HEALTH CARE LEADERSHIP CONFERENCE
FEBRUARY 2–5, 2020
ARIZONA GRAND RESORT & SPA
PHOENIX, AZ
AHA Events

See AHA Today Coverage of the Conference

AHA's Rural Report
A Podcast Series

Rural Health Resources

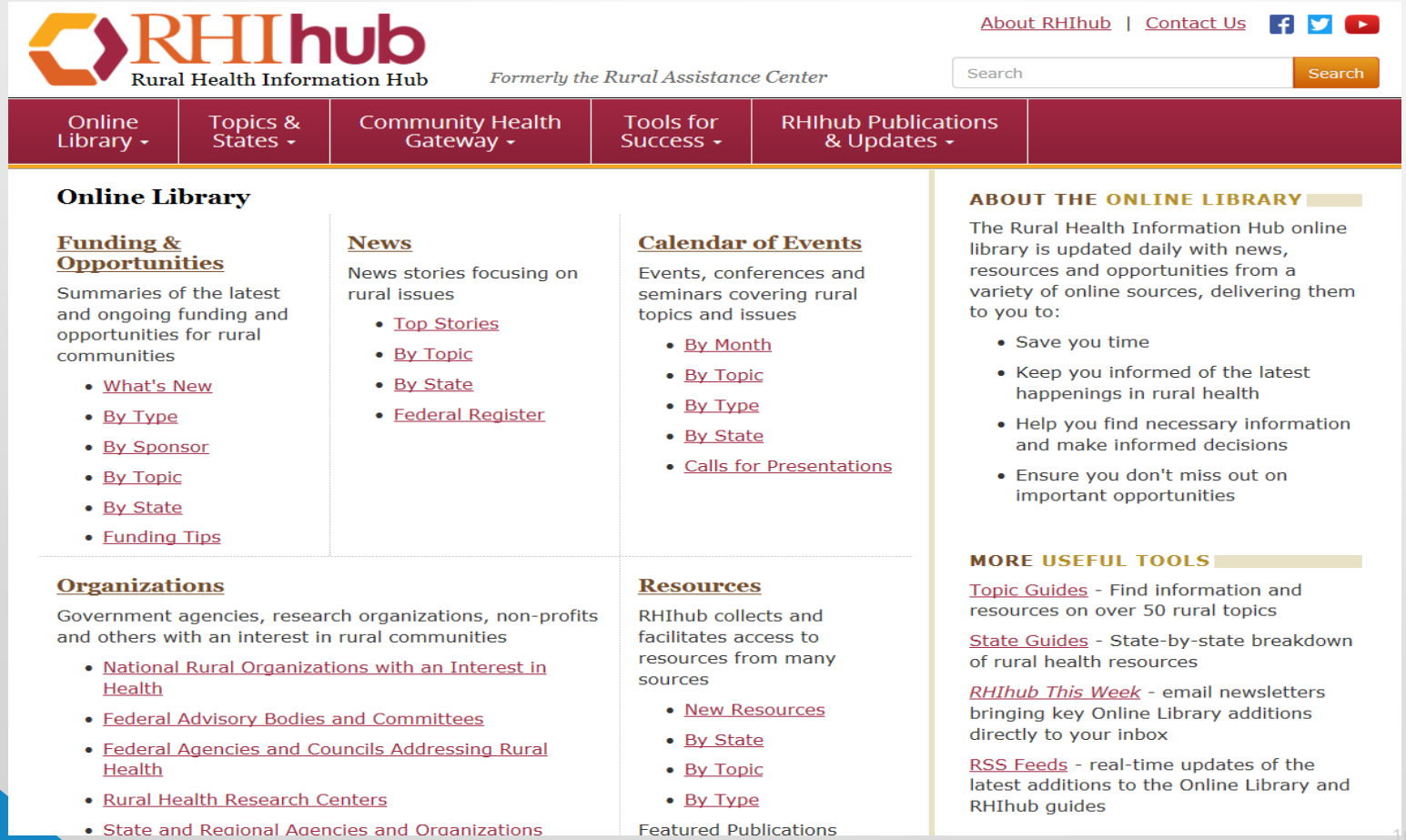
Rural Health Information Hub

www.ruralhealthinfo.org



Free On-line Library

www.ruralhealthinfo.org/library



CMS Updated Website



NATIONAL RURAL HEALTH RESOURCE CENTER

www.ruralcenter.org/tasc/flexprofile

Facebook

SERVICES PROGRAMS EVENTS RESOURCE LIBRARY ABOUT

Home › Programs › TASC › State Flex Profiles

State Flex Profile Navigation

Jump to: - Select State -

State Flex Profiles

State Flex Profiles showcase the beneficial activities occurring at the state-level to support the critical access hospitals (CAHs) and their communities around the country. No two states have the same exact approaches and the profiles are updated annually as an opportunity for states to share their excellent work and to learn from one another. The profiles include information on the work occurring in the five Flex Program areas as well as successes, best practices and innovations. Use the State Flex Profiles to identify approaches to similar rural health issues, identify best practice opportunities and access contact information for individuals at the state-level who are supporting Flex Program activities.

Use the drop-down menu in the gray box at the top of this page to see a specific state's profile. If you are looking for examples of a particular activity, for example, revenue cycle management, use the keyword search provided below.

Search State Flex Profiles

Flex Program
- Flex Program Fundamentals
- Federal Flex Updates
- Flex Program Grant and Cooperative Agreement
- Guidance
- Core Competencies
  - Self-Assessment
  - Managing the Flex Program
  - Building and Sustaining Partnerships
  - Improving Processes and Efficiencies
  - Understanding Policies and Regulations
  - Promoting Quality Reporting and Improvem
  - Supporting Hospital Financial Performance
  - Addressing Community Health Needs
  - Understanding Systems of Care
  - Preparing for Future Models of Health Care
- Critical Access Hospital Recognition
- Flex Program Forum
- 2019 Flex Program Reverse Site Visit (RSV)

MBQIP
- Key Resource List
- Overview
- Data Reporting and Use

CAH Checklist

https://ruralhealth.und.edu/projects/cah-quality-network/cop



CMS Worksheets

Hospital Worksheets

- CMS had 3 worksheets for surveys – part of pilot programs
  - Discharge planning
  - Infection control
  - QAPI (performance improvement)
- No longer utilized
- Are available – excellent self-assessment tools

Worksheet Links

- Infection Control:
- https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationgeninfo/downloads/survey-and-cert-letter-15-12-attachment-1.pdf.
- Discharge Planning:
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-12-Attachment-3.pdf.
- QAPI:
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-12-Attachment-2.pdf.

IM Notice Revised April 1, 2020

Important Message from Medicare

Patient name: **Patient number:**

Your Rights as a Hospital Inpatient:

- You can receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- You can be involved in any decisions about your hospital stay.
- You can report any concerns you have about the quality of care you receive to your QIO at: {insert QIO name and toll-free number of QIO} The QIO is the independent reviewer authorized by Medicare to review the decision to discharge you.
- You can work with the hospital to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.
- You can speak with your doctor or other hospital staff if you have concerns about being discharged.

Your Right to Appeal Your Hospital Discharge:

- You have the right to an immediate, independent medical review (appeal) of the decision to discharge you from the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the reviewer will each receive a copy of a detailed explanation about why your covered hospital stay should not continue. You will receive this detailed notice only after you request an appeal.
- If the QIO finds that you are not ready to be discharged from the hospital, Medicare will continue to cover your hospital services.
- If the QIO agrees services should no longer be covered after the discharge date, neither Medicare nor your Medicare health plan will pay for your hospital stay after noon of the day after the QIO notifies you of its decision. If you stop services no later than that time, you will avoid financial liability.
- If you do not appeal, you may have to pay for any services you receive after your discharge date.

See page 2 of this notice for more information.

Detailed Notice Revised April 1, 2020

Detailed Notice of Discharge

Date:

Patient name: **Patient number:**

This notice gives a detailed explanation of why your hospital or Medicare health plan has determined Medicare coverage for your hospital stay should end. This notice is not the decision on your appeal. The decision on your appeal will come from your Quality Improvement Organization (QIO).

We have reviewed your case and decided that Medicare coverage of your hospital stay should end.

- The facts used to make this decision:

- Detailed explanation of why your hospital stay is no longer covered, and the specific Medicare coverage rules and policy used to make this decision:

- Plan policy, provision, or rationale used in making the decision (health plans only):

If you would like a copy of the policy or coverage guidelines used to make this decision, or a copy of the documents sent to the QIO, please call us at:

{insert hospital/Medicare health plan name and toll-free telephone number}

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938- 0692. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.