Arizona Critical Access Hospital Designation Manual

Arizona Rural Hospital Flexibility Program (AZ Flex)

Revised: December 2011

This manual is made possible with funding from the: Health Resources and Services Administration (HRSA), Office of Rural Health Policy, to The University of Arizona, Mel and Enid Zuckerman College of Public Health, Center for Rural Health, Arizona Rural Hospital Flexibility Program (AZ Flex).
For more information:

Kevin Driesen, PhD, MPH
Director, Arizona Rural Hospital Flexibility Program
Phone: (520) 626-5837 • Fax: (520) 626-3101
kdriesen@email.arizona.edu

Mailing Address:
Center for Rural Health
P.O. Box 245210
Tucson, AZ 85724-5210

For Express Mail:
Center for Rural Health, AZ Flex
1295 N. Martin Ave., Bldg. 202A
Tucson, AZ 85719
# Table of Contents

1. **Background** .................................................................................................................................................................................. 1

2. **Arizona Rural Hospital Flexibility Program** ................................................................................................................................. 2

3. **Arizona’s Special Reimbursement for Critical Access Hospitals** .................................................................................................... 3

4. **Critical Access Hospital Designation Criteria**
   A. Federal Criteria ................................................................................................................................................................................. 4
   B. State Criteria ..................................................................................................................................................................................... 8

5. **Designation Process**
   A. Steps to Submitting the Application ................................................................................................................................. 9
   B. Technical Assistance ........................................................................................................................................................................ 10
   C. Forms ............................................................................................................................................................................................ 10

6. **Revision Effecting the Operations and Designation of CAH**
   A. Rebuilding/Relocating a CAH (2005) ................................................................................................................................. 12
   B. Medicare Modernization Act (2003) ........................................................................................................................................... 14

## Application Materials

- Appendix 1. Checklist: Arizona Critical Access Hospital Designation
- Appendix 2. AZ CAH Application Form
- Appendix 3. Sample Application Letter
- Appendix 4. Sample Rural Health Network Agreement
- Appendix 5. Sample Rural EMS Agreement and Arizona Regional EMS Councils
- Appendix 6. Sample Community Needs Assessment Template
- Appendix 7. Required Federal and State Forms

## Resources

- Appendix 8. Federal Regulations
1. Background

Since Congress established the **Medicare Rural Hospital Flexibility Program** in 1997, Arizona’s Center for Rural Health (formerly known as Rural Health Office) has assisted rural hospitals in determining the feasibility of critical access designation. Currently, fifteen hospitals are designated as Arizona Critical Access Hospitals. The designation rules were modified by the Centers for Medicare and Medicaid Services (CMS), effective January 1, 2006, to narrow the eligibility requirements to achieve critical access hospital designation. As of March 31, 2011 there were 1,327 Critical Access Hospitals located throughout the United States (http://www.raconline.org).

The Arizona Rural Hospital Flexibility Program (AZ Flex) utilizes funds provided by the Office of Rural Health Policy at the Health Resources and Services Administration (HRSA), to support operational and financial improvement, quality improvement, and community engagement. Each year the AZ Flex staff develops an updated workplan in response to needs and opportunities identified by program partners.

Our vision is a Rural Hospital Flexibility Program that is Arizona’s foremost technical assistance and information resource for critical access hospitals, hospital-based rural health clinics, and EMS agencies. Our mission is to strengthen the availability and quality of services offered by CAH hospitals and also the EMS systems in their geographic areas. Collaboration and partnership with stakeholders in the health care and EMS communities is fundamental to achieving the AZ Flex mission.
2. Arizona Rural Hospital Flexibility Program

The Office of Rural Health Policy (ORHP) requires all Flex programs to organize efforts to three program areas: Quality Improvement, Operational and Financial Improvement, and Health System Development. The AZ Flex 2011-1012 Workplan (available upon request) addresses the following goals and objectives:

**Goal I (Quality Improvement)**

*Critical Access Hospitals will develop the workforce, procedures and systems, and HIT infrastructure necessary to deliver high-quality, appropriate care to rural community residents in their communities.*

- Objective 1: Organize the AZ-CAH Quality Collaborative as a formal network comprised of fifteen Critical Access Hospitals, whose CEOs sign a Memorandum of Agreement that confirms participation and identifies member responsibilities.
- Objective 2: Provide technical assistance to fifteen AZ-CAHs in the use of Hospital Compare so that all AZ-CAHs achieve Phase I MBQIP standards (i.e. data entry for pneumonia, congestive heart failure, and readmissions).
- Objective 3: In collaboration with Arizona’s Regional Extension Center (REC), develop the (HIT) capacity of fifteen AZ-CAHs to achieve Meaningful Use standards by 2014.

**Goal II (Operational and Financial Improvement)**

*Every AZ-CAH will demonstrate improvement in operational and financial stability.*

- Objective 4: Provide educational programs and technical services to develop AZ-CAH capacity to improve financial and operational performance.
- Objective 5: Develop a grant development infrastructure that enables AZ-CAHs and EMS providers to identify and pursue local, state, federal and private foundation funding.

**Goal III (Health System Development and Community Engagement)**

*Rural communities throughout Arizona will have better access to a comprehensive and coordinated array of high quality healthcare services organized by a coherent system of prevention, primary care, specialty care, and emergency services.*

- Objective 6: Conduct a patient migration study and hospital service profile to identify patient migration trends, unmet community health needs, and health service gaps.
- Objective 7: Continue with established AZ-Flex EMS partners (Bureau of EMS, Banner Health System, Southeast AZ-EMS [SEAMS], and Arizona-EMS [AEMS]) in providing educational opportunities, increasing Level IV Trauma Center (L4TC) designations, and assessing the impact that L4TCs have within the state's Critical Access Hospital communities.
- Objective 8: Provide technical support to hospitals regarding CAH designation.
3. **Arizona’s Special Reimbursement for Critical Access Hospitals: Medicaid**

Subject to the availability of state funds, beginning May 1, 2002, supplemental payments will be made to non-I.H.S. in-state hospitals, certified by Medicare as Critical Access Hospitals (CAHs) under 42 CFR 485, Subpart F and 42CFR 440.170(g). These supplemental CAH payments shall be made in addition to the other payments described in Attachment 4.19-A (inpatient hospital) and 4.19-B (outpatient hospital). Supplemental payments shall be made based on each CAH designated hospital’s percentage of total inpatient and outpatient Title XIX reimbursement paid relative to other CAH designated hospitals for the time period from July 1 through June 30 of each year.

AHCCCS will allocate the amount available through legislative appropriation in the following manner:

a. Gather all adjudicated claims/encounters with dates of service from July 1 through June 30 of the prior year for each CAH-designated hospital.

b. Sum the AHCCCS payments for inpatient and outpatient services for the year to establish a hospital-specific hospital paid amount.

c. Total all AHCCCS payments for inpatient and outpatient services for the year to establish a total paid amount.

d. Divide the hospital paid amount by the total paid amount to establish the hospital's utilization percentage.

e. Divide the hospital's utilization percentage by the sum of all CAH hospital's utilization percentages for the month and multiply that figure by the monthly sum of the CAH hospital months divided by the annual sum of the CAH hospital months to establish the monthly relative utilization.

f. Multiply the monthly relative utilization by the annual CAH dollars to establish each hospital's monthly payment.

Funding will be distributed based on the number of CAH-designated hospitals in each month and their Medicaid utilization. Because there may be a different number of CAH-designated hospitals each month, the hospital-specific weightings and payments may fluctuate from month to month. The calculations will be computed monthly and the distribution of the CAH dollars to the CAH-designated hospitals will be made twice a year.  

---

1 For questions regarding Medicaid reimbursement, contact:
Jean Ellen Schulik, Reimbursement Administrator
Arizona Health Care Cost Containment System
Phone: (602) 417-4335 • Email: jeanelleen.schulik@azahcccs.gov
4. **Critical Access Hospital Designation Criteria**

**A. Federal Criteria**

To be eligible for designation as a Critical Access Hospital, the facility must have the following characteristics (see Appendix 8):

I. The facility is a public, not-for-profit, or for-profit hospital and is, at the time of the application, licensed as a general acute care hospital in accordance with A.R.S. §§ 36-401 and 36-422 and A.A.C. Title 9, Chapter 10, Articles 1 and 2.

II. The facility has a provider agreement to participate in the Medicare program as a hospital at the time the hospital applies for CAH designation.

III. The hospital is capable of providing emergency care necessary to meet the needs of its inpatients and outpatients;

IV. The hospital has all necessary equipment and medical items;

V. The hospital maintains no more than 25 acute care beds and also may have 10 distinct rehabilitation beds or 10 psychiatric beds (reimbursement for the distinct beds is based on a prospective payment method); and

VI. The hospital provides acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient.

VII. The facility is located in a rural area. Definitions for rural and urban areas are in Table 1.

VIII. The facility is located more than a 35 mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, more than a 15 mile drive) from a hospital or another Critical Access Hospital. Table 2 identifies the distance factors used in CAH designation.
<table>
<thead>
<tr>
<th>Territory/Population/ Housing Unit or Block Groups</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rural</strong></td>
<td>The U.S. Census Bureau defines rural as any territory, population not categorized as urban. (Source: US Census Bureau. <a href="http://www.census.gov/population/censusdata/urdef.txt">www.census.gov/population/censusdata/urdef.txt</a>)</td>
</tr>
<tr>
<td><strong>Urban</strong></td>
<td>“For Census 2000, the Census Bureau classifies as ‘urban’ all territory, population, and housing units located within an urbanized area (UA) or an urban cluster (UC). It delineates UA and UC boundaries to encompass densely settled territory, which consists of core census block groups or blocks that have a population density of at least 1,000 people per square mile and surrounding census blocks that have an overall density of at least 500 people per square mile.” (Source: United States Census Bureau. Census 2000 Urban and Rural Classification, <a href="http://www.census.gov/geo/www/ua/ua_2k.html">www.census.gov/geo/www/ua/ua_2k.html</a>.)</td>
</tr>
<tr>
<td><strong>Urbanized Area</strong></td>
<td>According to the U.S. Census Bureau, an urbanized area “consists of contiguous, densely settled census block groups (BGs) and census blocks that meet minimum population density requirements, along with adjacent densely settled census blocks that together encompass a population of at least 50,000 people.” (Source: United States Bureau of the Census. Urban Area Criteria for Census 2000, <a href="http://www.census.gov/geo/www/ua/uafedreg031502.txt">http://www.census.gov/geo/www/ua/uafedreg031502.txt</a>)</td>
</tr>
<tr>
<td><strong>Urban Cluster</strong></td>
<td>According to the U.S. Census Bureau, an urban cluster “consists of contiguous, densely settled census [block groups] and census blocks that meet minimum population density requirements, along with adjacent densely settled census blocks that together encompass a population of at least 2,500 people, but fewer than 50,000 people.” (Source: United States Bureau of the Census. Urban Area Criteria for Census 2000. <a href="http://www.census.gov/geo/www/ua/uafedreg031502.txt">http://www.census.gov/geo/www/ua/uafedreg031502.txt</a>)</td>
</tr>
</tbody>
</table>
Table 2. Explanation of Distance Factors Used in CAH Designation

<table>
<thead>
<tr>
<th>Facility</th>
<th>Location</th>
<th>Population Served</th>
<th>Distance Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tribal or IHS</td>
<td>Federal reservation</td>
<td>Indian population only</td>
<td>Hospital <strong>does not</strong> have to be located more than 35 miles from another hospital or CAH.</td>
</tr>
<tr>
<td>2 Hospitals or 2 CAHs</td>
<td>Federal reservation</td>
<td>Indian population only</td>
<td>Hospitals need to be at least 35 miles apart from another hospital or CAH.</td>
</tr>
<tr>
<td>Hospital affiliated with IHS</td>
<td>Not on federal reservation</td>
<td>Indian population only</td>
<td>Hospital <strong>does not</strong> have to be located more than 35 miles from another hospital or CAH.</td>
</tr>
<tr>
<td>Hospital not affiliated with IHS</td>
<td>Not on federal reservation</td>
<td>Other population</td>
<td>Hospital needs to be at least 35 miles apart from another hospital or CAH.</td>
</tr>
<tr>
<td>Tribally owned and managed hospital not affiliated with IHS*</td>
<td>Federal reservation</td>
<td>Indian population only</td>
<td>Hospital needs to be at least 35 miles apart from another hospital or CAH.</td>
</tr>
</tbody>
</table>

* Per CMS, Marjorie Eddinger’s Memo to the AZ Flex Director on October 18, 2005

Distance requirements for designation include the exception for mountainous terrain. There are many geographic regions that include foothills and mountains but are not considered mountainous terrain by CMS for CAH designation purposes. Foothills or worn down mountains may not have the fundamental characteristics of mountainous terrain. It is not uncommon for roads through mountainous areas to travel through valleys, over areas of high elevation, over high plateaus and other areas that do not have the characteristics of “mountainous terrain.” Being located at the foot of a mountain, or being able to view mountains from the CAH does not, in and of itself, mean the CAH is located in “mountainous terrain.”

Slope and ruggedness of terrain, together with absolute altitude determine many of the fundamental characteristics of mountainous terrain. For the purposes of this regulation, to be considered located in mountainous terrain, the CAH must comply with the criteria on Table 3.

A CAH meets the 15-mile secondary road distance requirement when the CAH is located less than 35 miles, but more than 15 miles, from a hospital or another CAH and at least one section of the shortest route to the nearest hospital or CAH consists of more than 15 miles of continuous uninterrupted secondary roads. Table 4 describes primary and secondary roads.

Travel distance is measured using the driving distance on the shortest possible route on federal, state, or local roads. The distance requirement is not limited to the State boundaries. The distance requirement applies to ANY hospital or CAH, regardless of state boundary lines.
Table 3. Explanation of Mountainous Terrain

<table>
<thead>
<tr>
<th>CAH Location</th>
<th>The CAH must be located in a mountain range. The CAH, or portions of the road to the nearest hospital or CAH, must be located at an elevation above 3000 feet and the travel route is regularly or seasonally subjected to weather-related hazardous driving conditions, such as poor visibility, slippery roads, or snow-covered roads resulting in slow driving speeds, required use of snow chains, or road closures. (Being located at a high elevation, in and of itself, does not constitute “mountainous terrain.”).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Road Characteristics</td>
<td>The roads on the travel route must be considered a mountainous terrain by the State Department of Transportation. The travel roads consist of extensive sections of roads with grades greater than 5 percent, and/or consist of continuous abrupt and frequent changes in elevation or direction. (These roads typically have frequent areas of low speed limits (15-25 mph) and warning signs denoting sharp curves, and steep grades.)</td>
</tr>
<tr>
<td>Speed Limits</td>
<td>The safe speed limit on the travel route to the nearest hospital/CAH is less than 45 mph. When calculating the mountainous terrain travel distance to the nearest hospital/CAH, subtract the total of the distances represented by those sections of the travel route that are not considered “mountainous terrain.” Sections of the travel route of at least 1 mile in length, where the safe driving speed limit is 45 mph or greater, do not count toward the 15-mile mountainous terrain distance.</td>
</tr>
<tr>
<td>Road Grade</td>
<td>Sections of the travel route at least one mile in length, where the roads on the travel route have grades less than 5 percent and/or do not have frequent, abrupt changes in direction or elevation are not considered mountainous terrain and do not count toward the 15-mile mountainous terrain distance.</td>
</tr>
</tbody>
</table>
### Table 4. Federal Definitions of Roads

<table>
<thead>
<tr>
<th>Road</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Road</strong></td>
<td>A primary road is an interstate highway, a U.S. highway, an expressway, an intrastate highway, a State-divided highway with two or more lanes each way, or any road with at least two contiguous miles with a speed limit of 45 mph or greater.</td>
</tr>
<tr>
<td><strong>Secondary Road</strong></td>
<td>A secondary road is any state or local road, paved or unpaved, that does not meet the definition of “primary road.”</td>
</tr>
</tbody>
</table>

**B. State Criteria**

Eligible hospitals must provide the following information:

1. Verification that it meets basic state requirements for CAH designation;

2. Plan to coordinate EMS admission/transport to-and-from the Critical Access Hospital;

3. Memorandum of Agreement or other documentation that the facility is part of a coordinated health service delivery system (network that includes at least one larger tertiary care facility and a local EMS provider);

4. Explanation of how CAH designation will improve availability of local health services;

5. Evidence that the hospital’s conversion is consistent with its own Mission Statement and Bylaws including assessment of:
   
   a. The probable reduction in inpatient utilization resulting from service limitations (i.e. acute beds and average length of stay);
   
   b. The effect the probable decline in inpatient utilization would have on facility revenue and cost; and
   
   c. The impact on facility profitability of converting from prospective payment for inpatient and outpatient services to cost-based reimbursement for Medicare and Medicaid.

6. Community support including the following items:
   
   a. Minutes from a “town meeting” or community function organized by the hospital and/or governing board to explain the concept of Critical Access Hospital designation and how CAH designation would affect hospital operations, personnel, and services;
   
   b. Completed community needs assessment (see Appendix 6).
5. Designation Process

A. Steps to Submitting the Application

Step One: Submit Notice of Intent letter to the AZ-Flex Director signed by the rural facility hospital administrator seeking to convert to CAH status. Upon receipt of a Notice of Intent, the AZ Flex Director will forward a packet of information to the hospital about the AZ Flex program along with all applicable rules, regulations, and application forms. AZ Flex staff will also forward a copy of the applicant hospital’s notice of intent to ADHS.

Step Two: Complete the required Hospital Financial Assessment. Financial feasibility studies are necessary to ensure that the rural hospital administration has correctly assessed the financial impact of conversion to a Critical Access Hospital based on the facility’s payer mix and financial standing.

Step Three: Complete and submit the application to the University of Arizona, Mel and Enid Zukerman College of Public Health, Center for Rural Health, AZ Flex Program Office. The Hospital must provide three copies of the application (see Appendices 1 and 2). AZ Flex staff will review the completed application packet to ensure accuracy. After it has been determined that the application is consistent with the designation guidelines, then the AZ Flex Director will submit a completed copy to the Arizona Department of Health Services (ADHS), Division of Licensing Services, Office of the Medical Facilities Licensing.

Step Four: Obtain final review - the CAH application needs to be reviewed and approved by ADHS. The Department will review the application and make a site visit to complete a Medicare Survey. The Department may require a Plan of Action, and if a Plan of Action is necessary, the hospital must submit the Plan to the Department before the Department submits the application to CMS for approval.

Critical Access Hospital applications received from Indian Health Services affiliated hospitals will not be submitted to ADHS for review. AZ Flex staff will send the application directly to CMS unless CMS instructs otherwise. Indian Health Services affiliated hospitals may choose to have site reviews conducted by either CMS or The Joint Commission.

Step Five: Upon acceptance by ADHS of the application and completion of a successful survey, AZ Flex will submit a copy of the application to CMS who will then make the final determination regarding designation. CMS will issue an approval letter, notifying the Medicare Fiscal Intermediary, the ADHS, Division of Licensing Services, Office of Medical Facilities Licensing, the applicant facility, and AZ Flex of its findings. A new provider number will be issued to the hospital. The hospital will be given a choice of an implementation date within an appropriate time frame based on the application date. The hospital representative should be prepared to suggest that the designation date take effect in a manner that synchronizes with cost reporting periods. It is recommended that the designation effect date avoid split billing periods.

There is no deadline to submit applications.
**B. Technical Assistance**

Hospitals interested in conversion to CAH status may contact AZ Flex staff for technical assistance in developing the hospital’s application, including a financial feasibility study, a community health needs assessment, development of a Rural Health Network with referral hospital(s) and emergency medical services, and community education support.

If an eligible hospital requires assistance with the feasibility study from the AZ Flex staff, the CEO of the hospital should submit a letter requesting the technical assistance. Upon receipt of the letter, and as funding permits\(^2\), the AZ Flex staff will provide financial support for consultant services to work directly with the applicant hospital. The eligible hospital may also contract with another agency to complete their current fiscal feasibility study. Consultants supported with AZ Flex dollars shall forward any reports completed to AZ Flex. The results of the feasibility study should be included as Attachment C.

Technical assistance is also available by contacting the Arizona Department of Health Services (ADHS), Centers for Medicare and Medicaid Services (CMS), Indian Health Service (IHS), and Arizona Health Care Cost Containment System (AHCCCS). All applicants are encouraged to use multiple sources of expertise in preparing the application for CAH designation. Table 5 contains the technical assistance provided by various offices and contact information, including websites.

**C. Forms**

Application forms that need to be included as part of the application process. Those forms include:

- Checklist: Arizona Critical Access Hospital Designation (see Appendix 1)
- Arizona Critical Access Hospital Application (see Appendix 2)

---

\(^2\) AZ Flex consultant arrangements are supported upon funding availability
<table>
<thead>
<tr>
<th>Technical Assistance</th>
<th>AZ Flex</th>
<th>Other Resources</th>
</tr>
</thead>
</table>
| **General Questions**                                    | Kevin Driesen: (520) 626-5837 kdriesen@email.arizona.edu  
Jill Bullock: (520) 626-3722 bullock1@email.arizona.edu   | National Rural Health Resource Ctr.  
http://www.ruralcenter.org/tasc  
Rural Assistance Center  
http://www.raconline.org/topics/hospitals/cah.php |
| **Financial Feasibility:** Assess impact of conversion; identify personnel/bed needs; compare effect of conversion on inpatient/outpatient; and identifying potential outlier to 96 hour average length of stay rule | Kevin Driesen: (520) 626-5837 kdriesen@email.arizona.edu | Hospitals may contact an accounting firm directly to conduct the fiscal assessment. |
| **Community Health Assessment:** Assess out-migration of services; identify community health needs; identify data sources | Howard Eng: (520) 626-5840 hjeng@email.arizona.edu  
ADHS - Bureau of Health Systems Development  
Patricia Tarango: (602) 542-1436 tarangp@azdhs.gov  
| **Community Support:** Educate hospital staff and board and facilitate community meetings | Kevin Driesen: (520) 626-5837 kdriesen@email.arizona.edu  
ADHS - Bureau of Health Systems Development  
Patricia Tarango: (602) 542-1436 tarangp@azdhs.gov  
| **Application Requirements:** Complete application; State/CMS Medicare Survey; and develop Rural Health Network | Kevin Driesen: (520) 626-5837 kdriesen@email.arizona.edu  
Office of Medical Facilities Licensing  
Connie Belden: (602) 364-3030 beldenc@azdhs.gov  
| **Emergency Medical Services**                           | Joyce Hospodar: (520) 626-2432 hospodar@email.arizona.edu | Bureau of Emergency Medical Services  
Terry Mullins: (602) 364-3150 Terry.Mullins@azdhs.gov  
| **Tribal/HIS:** All of the types of assistance stated above | Kevin Driesen: (520) 626-5837 kdriesen@email.arizona.edu  
IHS Office of Resource Access and Partnerships  
Jim Driving Hawk: (301) 443-1016  
| **Medicaid (AHCCCS) Reimbursement Pool**                 | Kevin Driesen: (520) 626-5837 kdriesen@email.arizona.edu  
AHCCCS  
Jean Ellen Schulik: (602) 417-4335 JeanEllen.Schulik@azahcccs.gov  
|
6. Revisions Effecting the Operations and Designation of CAHs

A. Rebuilding/ Relocating a CAH (2005)

On August 12, 2005, CMS released new guidelines regarding the relocation of Critical Access Hospitals. If a Critical Access Hospital was designated under the Necessary Provider rules prior to January 1, 2006 and decided to relocate the hospital to a new location, if the relocation is within the same service area, serving the same population, and providing essentially the same services with the same staff, then the hospital may maintain its status as a CAH. At least seventy five percent of the same staff and seventy five percent of the range of services must be maintained in the new location as the same provider of services. CMS proposed the use of a seventy five percent threshold guideline because it believed it indicated that the CAH relocation demonstrated it would maintain a high level of involvement, as opposed to only a majority involvement, in the current community.

CAHs that construct a new facility will be considered to have relocated. The CMS Regional Office will determine if the CAH meets the requirements for relocation on a case-by-case basis. In all cases of relocation, the CAH must meet all of the Conditions of Participation identified in 42 CFR Part 485, Subpart F, including location in a rural area as required at §485.610.

Prior to the relocation of a CAH, the Hospital must send a letter of intent to the AZ Flex Director at the Center for Rural Health, the Arizona Department of Health Services, Division of Licensing Services, Office of Medical Facilities Licensing, and the CMS Regional Office. The CAH should send the letter early in the planning stage of relocation and prior to spending or obligating significant funds and resources. The Letter of Intent should:

- Include addresses for both the present location and the proposed new location;
- Provide documentation that supports it will continue to be the same provider at the new location;
- Include travel distance from the current location to the new location;
- Provide the names, addresses, and travel distances to all hospitals that share and surround the community at the current and future locations;
- Provide a time table for the relocation;
• Any CAH with a grandfathered Necessary Provider designation that is planning to relocate and that wishes to maintain its designation as a Necessary Provider must provide documentation that it will meet the requirements in §485.610(d)(1) in every area (75 percent community served, services provided, and staff). Documentation must include references and sources for numbers and statistics used;

• Any grandfathered CAH planning to relocate that wishes to maintain its designation as a Necessary Provider must provide documentation that demonstrates it will continue to meet the same criteria originally used by the State for its designation as a Necessary Provider. In addition, the CAH must include a letter of assurance from the AZ Flex Program at the Center for Rural Health, that the AZ Flex Program has determined the CAH will continue to meet the original criteria for its designation as a Necessary Provider at its new location; and

• All documentation must identify source(s) and references used by the CAH to develop statistics, numbers, and other attestation requirements
B. Medicare Modernization Act (2003)

The following revisions were made to operation of CAHs resulting from the Medicare Modernization Act of 2003.

**Summary of Adjustments: P.L. 108-173**
*(Medicare Prescription Drug, Improvement and Modernization Act of 2003 for CAH designation)*

<table>
<thead>
<tr>
<th>Item</th>
<th>Provision</th>
<th>Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient, outpatient, swing beds skilled nursing services to Medicare beneficiaries Sec. 405(a)</td>
<td>101% of reasonable costs</td>
<td>1/1/04</td>
</tr>
<tr>
<td>Reimbursement to on-call providers includes physician assistants, nurse practitioners, and clinical nurse specialists, and on-call ER physicians Sec. 405 (b)</td>
<td>On-call costs are included when determining reasonable costs of outpatient CAH services</td>
<td>1/1/05</td>
</tr>
<tr>
<td>Interim Payment Methodology Sec. 405 (c)</td>
<td>Periodic interim payments (PIP) are allowed for inpatient services. Alternative methods for the timing of PIP payments are to be developed but have not yet been specified.</td>
<td>7/1/04</td>
</tr>
<tr>
<td>Professional services – facility fee Sec. 405 (d)</td>
<td>Physicians or practitioners providing services in a CAH are no longer required to assign billing rights to CAH before the CAH can bill Medicare for the combined payment that includes the facility fee and 115% of the fee schedule.</td>
<td>1/1/03 for CAHs that elected the 115% prior to the law; otherwise start date is 7/1/04</td>
</tr>
<tr>
<td>Bed limitations Sec. 405 (e)</td>
<td>CAHs can operate up to 25 beds, including swing beds.</td>
<td>1/1/04</td>
</tr>
<tr>
<td>Distinct part psychiatric or rehabilitation beds Sec. 405 (g)</td>
<td>A CAH can establish a distinct part unit (e.g., psychiatric or rehabilitation) that meets the requirements for such beds as established for a short-term, general hospital. Medicare payment for servicers in these units will be on a prospective payment basis. These beds will not count towards the CAH bed limit. The total number in the distinct part unit cannot exceed 10 beds.</td>
<td>10/1/04</td>
</tr>
<tr>
<td>State waiver authority – necessary provider rule Sec. 405 (h)</td>
<td>The state necessary provider rule is eliminated. CAHs must be located 35 miles apart or 15 miles in areas with mountainous terrain or where only secondary roads are available.</td>
<td>1/1/06</td>
</tr>
</tbody>
</table>
Application Material
Appendix 1

Application Checklist
# Arizona Critical Access Hospital Designation Application Checklist

The completed checklist must be returned to the Arizona Rural Hospital Flexibility Program with the application.

<table>
<thead>
<tr>
<th>Completed</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>1. Fill in all blanks on the Arizona CAH Application.</td>
</tr>
<tr>
<td>□</td>
<td>2. Completed application signed by authorized representatives (President/Board of Directors and Hospital or Chief Executive Officer).</td>
</tr>
<tr>
<td>□</td>
<td>3. Copy of Intent letter sent to notify AZ Flex Director of the Hospital’s intent to convert to CAH status.</td>
</tr>
<tr>
<td>□</td>
<td>4. <strong>Attachment A</strong>: Hospital documentation (i.e. Articles of Incorporation).</td>
</tr>
<tr>
<td>□</td>
<td>5. <strong>Attachment B</strong>: Copy of hospital license.</td>
</tr>
<tr>
<td>□</td>
<td>6. <strong>Attachment C</strong>: Copy of the unabridged financial feasibility analysis by the hospital CFO and/or consultant that determines the fiscal benefit of CAH designation.</td>
</tr>
<tr>
<td>□</td>
<td>7. <strong>Attachment D</strong>: Minutes from “town meeting” or other community function organized by the hospital and/or governing board members to explain the concept of Critical Access Hospital designation, and how CAH designation would affect hospital operations, personnel, and services.</td>
</tr>
<tr>
<td>□</td>
<td>8. <strong>Attachment E</strong>: Community needs assessment.</td>
</tr>
<tr>
<td>□</td>
<td>9. <strong>Attachment F</strong>: List of hospital governing board members, addresses, and phone numbers.</td>
</tr>
<tr>
<td>□</td>
<td>10. <strong>Attachment G</strong>: Letter from hospital governing board plus meeting minutes where facility’s intent to seek designation as a Critical Access Hospital was approved.</td>
</tr>
<tr>
<td>□</td>
<td>11. <strong>Attachment H</strong>: Letter from Regional EMS Council supporting the Hospital’s request for CAH conversion.</td>
</tr>
<tr>
<td>□</td>
<td>12. <strong>Attachment I</strong>: EMS Plan describing how emergency services will be provided at the Critical Access Hospital.</td>
</tr>
<tr>
<td>□</td>
<td>13. <strong>Attachment J</strong>: Copy of hospital policies and procedures regarding patient transfers.</td>
</tr>
</tbody>
</table>
14. **Attachment K**: Memorandum of Understanding, or other final document that identifies the Rural Health Network, including at least one other hospital and an EMS provider.

15. **Attachment L**: Hospital’s patient referral and transfer agreement with rural health network partner/s.

16. **Attachment M**: Agreement with network partner/s for the electronic sharing of patient data and medical records.

17. **Attachment N**: Agreement with network partner/s addressing emergency/non-emergency transport.

18. **Attachment O**: Agreement with network partner/s addressing credentialing and quality assurance.


   - CMS 855A
   - CMS 1537C (only required if hospitals want swing beds)
   - CMS 1561

**Office of Civil Rights:**

- Medicare Certification Civil Rights Information Request Form
- HHS 690 – Assurance of Compliance
Appendix 2

AZ CAH Application Form
AZ CAH Application Form

(Please submit three original copies to AZ Flex)

1. Hospital information

A. Contact information

Name of Hospital: ________________________________________________________________
Contact Person: ________________________________________________________________
Address: ______________________________________________________________________
City: ___________________________ State: ________________ Zip: ________________
Telephone: ______________________ Fax: __________________________________________
E-mail: __________________________

B. In what county is the hospital located? Check the appropriate box as to the county status.

   County: ___________________________ Status: □ Rural  □ Urban

C. Check the appropriate hospital ownership status and attach legal proof of category selected (include as Attachment A).

   □ Public  □ Not-for-Profit  □ For-Profit  □ Tribal

D. Is the hospital currently licensed in accordance with the Arizona Department of Health licensure standards? Please include a copy of the hospital’s license as Attachment B.

   □ Yes  □ No  □ NA

E. Please list ALL of the hospital’s current Medicare and Medicaid provider members:

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
2. **Eligibility Criteria**

A hospital requesting AZ CAH designation must meet the following criteria (check all that apply). The hospital:

- Is a public hospital, a not-for-profit hospital, or a for-profit hospital and is currently licensed by the state, or is a tribal facility;
- Has a hospital provider agreement to participate in the Medicare program;
- Is in compliance with applicable federal laws and regulations related to the health and safety of patients;
- Has staff licensed, certified or registered in accordance with applicable federal, state, and local laws and regulations;
- Is located more than a thirty-five mile drive (in the case of mountainous terrain, or, in areas with only secondary roads available, more than 15 mile drive) from another Critical Access Hospital (see CMS definition of mountainous terrain on page 7 of the Application Manual);
- Is a member of a Rural Health Network;
- Is capable of providing emergency care services to meet county needs;
- Has available all necessary equipment and medical items;
- Maintains no more than twenty-five acute care beds;
- Provides acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient; and,

3. **Financial Feasibility**

- Include as Attachment C a copy of the unabridged financial feasibility analysis completed by the Hospital’s CFO and/or consultant that determines the fiscal benefit of CAH designation.

4. **Community Involvement**

- Include as Attachment D a copy of the minutes from a “town meeting” or other community function organized by the Hospital to explain Critical Access Hospital designation, and how designation would affect hospital operations, personnel, and services.

5. **Community Needs Assessment**

The community needs assessment provides an objective source of data that addresses primary, acute, preventive, and emergency health care needs in the community. It is not necessary for the Hospital to undertake a new community needs assessment if a recent assessment exists (within three years of the date of the application). At a minimum, the community health needs assessment should include:

- Description of the Hospital’s geographic and demographic service area;
• Description of the current delivery system (number and types of providers and services);
• Assessment of the health care services’ needs within the service area;
• Assessment of unmet need and patient out-migration patterns; and,
• Description of existing rural health networks including services available at the Hospital and those available by referral to hospitals within the network.

☐ Include the community needs assessment as Attachment E (see Appendix 6).

6. Organizational Structure

☐ Provide a list of all governing board members, addresses, phone numbers, and years of service and include as Attachment F.

☐ Provide information for the governing body and the designated representative who will assume full legal responsibility for determining, implementing, and monitoring policies governing the operations of the Critical Access Hospital:

Name of Governing Body: ____________________________________________

Designated Representative: ___________________________________________

Address: ____________________________________________________________

City: ____________________ State: ________________ Zip: _________________

Telephone: __________________ Fax: _________________________________

E-mail: ____________________________________________________________

☐ Include as Attachment G a copy of the formal Letter of Intent from the governing board and/or its representative, and a copy of the minutes from the meeting in which the Hospital’s intent to seek designation as a Critical Access Hospital was approved.

☐ Identify the person who will be principally responsible for day-to-day operations of the Critical Access Hospital.

Name: ______________________________ Title: ___________________________

Address: ____________________________________________________________

City: ____________________ State: ________________ Zip: _________________

Telephone: __________________ Fax: _________________________________

E-mail: ____________________________________________________________
Identify the physician who will be responsible for **medical direction** at the Critical Access Hospital.

Physician’s Name: ___________________________ License No.: __________________

Address: ________________________________________________________________

City: _______________ State: _______________ Zip: ___________________________

Telephone: ___________________________ Fax: _____________________________

E-mail: ________________________________________________________________

If applicable, identify all current owners, or those with a controlling interest in the hospital or any subcontractor in which the facility directly or indirectly has a five percent or more ownership interest (if more than one, attach an additional sheet of paper).

Name of Individual Corporation: ____________________________________________

Designated Representative: _________________________________________________

Address: __________________________________________________________________

City: _______________ State: _______________ Zip: ___________________________

Telephone: ___________________________ Fax: _____________________________

E-mail: ________________________________________________________________

**7. Emergency and Trauma Services**

Each Critical Access Hospital is required to actively participate in its Regional Emergency Medical Services (EMS) Council. Please fill in the name, title, address, telephone number, fax number, and e-mail address of the hospital’s **designated representative for attendance** at the Regional EMS Council meetings.

Designated EMS Council Representative: ________________________________

Address: __________________________________________________________________

City: _______________ State: _______________ Zip: ___________________________

Telephone: ___________________________ Fax: _____________________________

E-mail: ________________________________________________________________

Include as **Attachment H** a copy of the letter from the Regional EMS Council stating that the hospital meets the Council’s participation requirements.

Do you agree to make available 24-hour-a-day emergency care?  □ Yes  □ No
Include as Attachment I a copy of the Hospital’s EMS Plan that describes how emergency medical services will be provided at the Critical Access Hospital. Include hours of staffing and the call plan for emergency services when the Critical Access Hospital is closed (see Appendices 4 and 5).

8. Current Number of Beds by Service and Length of Stay

Provide the number of beds by service that are currently offered at the Hospital and services that will be available if the Hospital is designated as a Critical Access Hospital.

<table>
<thead>
<tr>
<th>Service</th>
<th>Current Number of Beds (Date _________)</th>
<th>Number of Beds to be Available as a CAH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Beds</td>
<td>Acute Care Beds*: _____</td>
<td>#: _____</td>
</tr>
<tr>
<td>Staffed Beds</td>
<td>Licensed Beds: _____</td>
<td>#: _____</td>
</tr>
<tr>
<td>Swing Beds</td>
<td>Beds: _____</td>
<td>#: _____</td>
</tr>
<tr>
<td>Distinct Part Psychiatric</td>
<td>Beds: _____</td>
<td>#: _____</td>
</tr>
<tr>
<td>Distinct Part Rehab</td>
<td>Beds: _____</td>
<td>#: _____</td>
</tr>
<tr>
<td>Skilled Nursing Facility On-Campus</td>
<td>Beds: _____</td>
<td>#: _____</td>
</tr>
<tr>
<td>Skilled Nursing Facility Off-campus</td>
<td>Beds: _____</td>
<td>#: _____</td>
</tr>
</tbody>
</table>

Include as Attachment J a copy of the policies and procedures addressing patient transfers. Inpatient discharges and transfers must occur within an annual average of 96 hours.

9. Rural Health Networks

Include as Attachment K a Memorandum of Understanding, or a copy of any other formal document, that identifies the members of your Rural Health Network (i.e., at least one larger, tertiary care hospital and an EMS provider). If there are multiple agreements, label each with the letter “K” followed by a sequential number, for example: Attachment K1, Attachment K2, and so on (see Appendix 4).

The following protocols must also be described as part of the Rural Health Network agreement:

- Patient Referral and Transfer
- Communications System
- Emergency and Non-Emergency Transportation
- Credentialing and Quality Assurance
Include separate narratives for each of the following components:

- **Patient Referral and Transfer Agreement** – Include as Attachment L a copy of the hospital’s patient referral and transfer agreement with Rural Health Network partner/s (multiple agreements should each be labeled separately with the letter “L” followed by a sequential number).

- **Communication System Agreement** – Where feasible, include as Attachment M a copy of the agreement the Hospital has with other area secondary and tertiary care hospitals in the network for the electronic sharing of patient data, telemetry, and medical records (multiple agreements should each be labeled separately with the letter “M” followed by a sequential number).

- **Emergency and Non-Emergency Transportation Agreement** – Include as Attachment N a copy of the agreement the hospital has with another area hospital to provide or arrange for emergency and non-emergency transportation (multiple agreements should each be labeled separately with the letter “N” followed by a sequential number).

- **Credentialing and Quality Assurance** – Include as Attachment O agreements the hospital has with other organizations for credentialing and quality assurance and include (multiple agreements should each be labeled separately with the letter “O” followed by a sequential number).


### 10. Federal and State Forms

Please complete the Federal and State Forms on-line at [http://www.cms.hhs.gov/CMSForms](http://www.cms.hhs.gov/CMSForms) and include a copy of each completed form as Attachment P (see Appendix 7):

- CMS 855A
- CMS 1537C (only required if hospitals want swing beds)
- CMS 1561
- **Office of Civil Rights Forms**:
  - Medicare Certification Civil Rights Information Request Form
  - HHS 690 – Assurance of Compliance

For completed application, please certify that the information provided is correct and sign by an authorized representative(s):

On behalf of the Board of Directors of ____________________________
I hereby certify that the above information is true and correct.

__________________________________________  _________________________
President, Board of Directors                Date

__________________________________________  _________________________
Hospital Administrator                      Date
Appendix 3

Sample Application Letter
Dear Director:

The Board of Directors of ____________________________ (hospital’s name) requests your assistance in processing the enclosed application for designation as a Critical Access Hospital. This initiative was approved by the Board of Directors at its ___________ (date) meeting. A copy of the minutes of this meeting is attached.

The Board of Directors and Hospital leadership has reviewed the completed application and support its submission. We have reviewed, understand and agree to the federal and state rules and regulations pertaining to the Critical Access Hospital program.

Sincerely,

Chairman, Board of Directors

Secretary, Board of Directors
Appendix 4

Sample Rural Health Network Agreement
Sample Rural Health Network Agreement
A Critical Access Hospital, an EMS Provider, and a Base Hospital

This agreement, made and entered on this ________ day of ________, ________, is by and between _________________________________________________________ which is seeking certification by the Centers for Medicare and Medicaid Services as Arizona Critical Access Hospital, hereinafter referred to as (name of hospital) ____________________________________________, administrator of the Regional Emergency Medical System operating in the Critical Access Hospital’s region, hereinafter referred to as the EMS, and ____________________________________________, which is a hospital currently accredited by a nationally recognized commission on hospital accreditation and licensed by the state according to A.R.S. §§ 36-401 and 36-422 and A.A.C. Title 9, Chapter 10, Articles 1 and 2, hereinafter referred to as the Supporting/Base Hospital.

The parties agree to the following terms and conditions:

WHEREAS, the Critical Access Hospital, the EMS and the Supporting/Base Hospital agree to establish a Rural Health Network, hereinafter called a Network, in compliance with Section 1820 of the Social Security Act relating to the Medicare Rural Hospital Flexibility Program; and,

WHEREAS, the Critical Access hospital, the EMS and the Supporting/Base Hospital wish to integrate related health care provider and service activities into a Network; and,

WHEREAS, the Critical Access Hospital, the EMS and the Supporting/Base Hospital wish to maintain and promote the availability of a range of high quality and cost-effective health care services within the Critical Access Hospital and the Network; and,

WHEREAS, the Critical Access Hospital, the EMS and the Supporting/Base Hospital wish to assure the coordination of health care and service activity at a level most appropriate to a patient’s need; and,

WHEREAS, the Critical Access Hospital, the EMS Provider and the Supporting/Base Hospital wish to facilitate the continuity of health care service delivery among all levels of care needed by patients in the Network; and,

NOW, THEREFORE, in consideration of the mutual covenants and principles contained herein, the Critical Access Hospital, the EMS Provider and the Supporting/Base Hospital agree as follows:
I. Advisory Council

The Network shall establish an advisory council comprised of representatives of both member facilities, which shall include the principal administrators and finance officers of both hospital facilities, the Regional manager of the EMS, physicians, mid-level providers, nurses, UR/QA coordinators and community representatives. The Advisory Council shall implement and monitor the covenants and protocols encompassed by this Agreement, identify and resolve issues and problems related to the delivery of services within the Network to foster the development and expansion of high quality, cost effective and appropriate services needed by the residents of the Network’s combined service area.

II. Operations Plan

The Network shall develop an operations plan. The plan shall include, but not be limited to: the policies and procedures by which the services of related health care providers will be integrated to assure coordination among levels of care and promote optimal and cost-effective utilization of those services. These providers shall include, at a minimum, physicians, mid-level providers, home health providers, nursing homes, mental health providers and public health departments.

III. Emergency Medical Service Plan

The Network shall establish an Emergency Medical Service Plan that ensures the provision of care to patients with both urgent and emergent medical problems. The Plan shall be written, adopted and executed by the Critical Access Hospital, the EMS and the Supporting/Base Hospital. The Plan shall specify:

a. Services provided by the EMS, the Critical Access Hospital, and EMS;
b. Hours of available service of each of the Network members;
c. Qualifications and availability of appropriate medical personnel at each site, including the initial evaluation;
d. Limited range of definitive treatments, necessary resuscitation and stabilization;
e. Procedures for obtaining emergency services if EMS is unavailable or the Critical Access Hospital is understaffed;
f. Necessary transport between the Critical Access Hospital and/or the Supporting/Base Hospital;
g. Assurances that appropriate ambulance services are available, and include protocols for its role in the transfer of patients from the field to the Critical Access Hospital and from the Emergency Department at the Critical Access Hospital to the Supporting/Base Hospital; and
h. Written protocols for the referral of emergency patients between the Critical Access Hospital and Supporting/Base Hospital, including protocols for the referral of patients for which the Supporting/Base Hospital is unable to provide appropriate, definitive treatment, to another facility that has the capacity to care for the patients in an appropriate manner.
IV. Patient Transfer and Referral

The Network shall establish transfer and referral agreements and protocols that facilitate and coordinate the provision of inpatient and outpatient services by the Critical Access Hospital, the EMS and the Supporting/Base Hospital. The agreement shall specify protocols that include, but are not limited to the following:

a. Defining the level of care needed by the patient, and where the services should best be provided; this process shall include a system for the classification of the patient point-of-contact, if by emergency personnel, at admission and discharge, if by facility, that reflects the availability of staff, equipment and services in the field and at the Critical Access Hospital available physician specialties; and the limits of practice imposed on the mid-level providers by the supervising physician at the Critical Access Hospital;

b. Determining the role and functions of those personnel who would be involved in the patient referral and transfer process; and

c. Identifying the patient information to be exchanged in the transfer and referral process; the form/means by which it shall be transferred; and the frequency with which the information will be communicated.

V. Quality Assurance and Risk Management

The Network shall establish quality assurance and risk management plans or systems that involve ongoing monitoring and reporting activities related to the provision of care within the Network. The system shall be designed to enable the EMS and the Critical Access Hospital to carry out their responsibilities for quality assurance and risk management through the involvement of and support of the Supporting/Base Hospital.

VI. Credentialing Process

The Network shall establish an integrated medical staff credentialing process that supports the Critical Access Hospital governing body in carrying out its responsibilities in granting privileges to physicians, mid-level providers and allied health professionals practicing at the Critical Access Hospital. This process may involve an analysis by the medical staff administrator at the Supporting/Base Hospital of a Critical Access Hospital staff application in order to verify credentials and determine privileges which could be afforded at the Critical Access Hospital, with consulting assistance from a physician in the appropriate clinical department. This process would include a provision for Critical Access Hospital medical staff to provide recommendations on membership and privilege recommendations to the Critical Access Hospital’s governing board. Critical Access Hospital physicians desiring privileges at the Supporting/Base Hospital must apply for them in accordance with the medical staff credentialing policies and procedures in place at that facility.

VII. Communication

The Network shall develop and use communications systems including, where feasible:

a. Telemetry systems; and
b. Systems for electronic sharing in patient data

VIII. Modifications

Nothing in this AGREEMENT shall preclude the modification of any covenants contained herein, or the formulation of supplemental covenants, provided that such modifications further the overall goals of the Network, or reflect and incorporate alterations in the applicable federal or state laws or regulations, and that any such modifications in the agreement are mutually approved and adopted by each of the Network members.

IX. Responsibility

Nothing in this AGREEMENT shall be construed to limit the responsibility of either the Critical Access Hospital or the Supporting/Base Hospital for assuring that all services are provided according to acceptable standards of practice, regardless of whether the services are provided by employees, medical staff members or independent contractors.

X. Liability for Employee Actions

Neither party to this AGREEMENT shall be held jointly and severally liable for the actions of its employees on behalf of the other party.

XI. Changes in Partners

Notice of any modification to this AGREEMENT involving changes in partners shall be given to the Centers for Medicare and Medicaid Services and The Center for Rural Health, AZ Flex Program within 90 days.

XII. AGREEMENT Effective Time Frame

This AGREEMENT shall remain in effect indefinitely, unless one of the parties to this AGREEMENT provides to the other party no less than 90 days written notice of its intent to terminate the AGREEMENT.

In witness whereof, the parties hereto have caused this AGREEMENT to be executed on the day and year first written above.

Critical Access Hospital Representative/Title

EMS Regional Council Representative/Title

Supporting/Base Hospital Representative/Title
Appendix 5

Sample Rural EMS Agreement and Arizona Regional EMS Councils
Rural EMS Agreement

Network agreement by and between ____________________________________ (Hospital) and ____________________________________ (EMS Provider).

WHEREAS, (hospital) is a private, non-profit organization serving (service area); and

WHEREAS, (EMS provider) is a duly licensed provider of Emergency Medical Services (EMS) to the residents of (service area); and

WHEREAS, the (EMS provider) has sufficient personnel, vehicles and equipment to provide 24-hour emergency and non-emergency services to the area, including pre-hospital services and inter-facility transfers, both now and when (hospital) converts to Critical Access Hospital status.

BE IT THEREFORE RESOLVED:

That (hospital) recognizes the (EMS provider) as one of its principal providers of emergency and non-emergency transportation; and

That the (EMS provider) both now and in the future will look to (hospital) for its medical control; and

Both parties assert that they now have and will continue to maintain sufficient resources to operate effectively when (hospital) becomes a Critical Access Hospital; and

Both parties pledge their full cooperation to help one another maintain appropriate levels of access to and coordination of high quality pre-hospital, hospital emergency department, and inter-hospital emergency capacities in the (service area) region; and

Both parties stipulate that (hospital) and the (EMS provider) will collaborate with one another to assure a smooth transition to a Critical Access Hospital environment.

BE IT FURTHER RESOLVED:

That this Agreement shall remain in effect and shall be automatically renewed on an annual basis, unless either party gives to the other 60 days advance notice of intent to cancel.

(Hospital)  (EMS Provider)
By:  By:  Date:  Date:
Arizona Regional EMS Councils (Grouped by Regional Counties)

Gila, Maricopa and Pinal
Peggy Baker, Executive Director
Arizona Emergency Medical System (AEMS)
P.O. Box 28442 • Scottsdale, AZ 85255
Phone: (623) 847-4100 • Fax: (480) 452-0469
www.aems.org

Apache, Coconino, Navajo and Yavapai
Paul Coe, Chair
Northern Arizona Emergency Medical Services (NAEMS)
P.O. Box 2127 • Flagstaff, AZ 86003
Phone: (928) 284-2689 • Fax: (928) 284-2640
www.naems.org

La Paz, Mohave, and Yuma
Rod Reed, Executive Director
Western Arizona Council of EMS (WACEMS)
3463 W. 13th Place • Yuma, AZ 85364
Phone: (928) 246-4208 • Fax: (888) 803-1540
www.wacems.org

Cochise, Graham, Greenlee, Pima and Santa Cruz
Taylor Payson, Executive Director
Southeast Arizona EMS Council (SAEMS)
PMB321/6890 East Sunrise • Tucson, AZ 85750
Phone: (520) 529-1450 • Fax: (520) 529-2369
www.saems.net
Appendix 6

Sample Community Needs Assessment Template
Community Needs Assessment Template

Part I: Community Health Profile

Please attach a copy of Arizona Department of Health Services, Office of Health Systems Development, Arizona Community Health Profile for the Hospital service region. (http://www.azdhs.gov/hsd/chpprofiles.htm)

Part II: Hospital Utilization Profile

A. Specify Time Period (most recent calendar or fiscal year): ________________

B. Service Utilization by Type Provided at Hospital (Number/Percent)

<table>
<thead>
<tr>
<th>Hospital Service</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

C. Patient Mix (Number/Percent)

<table>
<thead>
<tr>
<th></th>
<th>Medicare (#/%)</th>
<th>AHCCCS (#/%)</th>
<th>Other (specify) (#/%)</th>
<th>Total (#/%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

D. Number and Percent of Patients Using Facility by Zip Code

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>Inpatient (#/%)</th>
<th>Outpatient (#/%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

E. Type, Number, and Name of Hospital Receiving Patient Referrals

<table>
<thead>
<tr>
<th>Type of Referral</th>
<th>Number</th>
<th>Hospital Receiving Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>From ER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>From Inpatient Unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>From Other (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
F. Please include the following information for each of the hospital’s satellite clinics.

<table>
<thead>
<tr>
<th>Name</th>
<th>Location</th>
<th>License Type</th>
<th>Medicare Billing Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Not Applicable: ___________

Part III: Other Information

G. Name/location of Ambulance Service(s) supporting hospital:
___________________________________________________________________

H. Does the hospital employ any of the ambulance service personnel while they are “off duty?”

□ Yes  □ No

• If yes, please specify number and type of positions(s):
____________________________________________________________

I. Please identify the type/topic of training needed for the following:

<table>
<thead>
<tr>
<th>Category</th>
<th>Type/Topic of Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Nurses</td>
<td></td>
</tr>
<tr>
<td>ER Nurses</td>
<td></td>
</tr>
<tr>
<td>Physicians</td>
<td></td>
</tr>
<tr>
<td>Other Medical Personnel (specify)</td>
<td></td>
</tr>
<tr>
<td>Billing/Coding Staff</td>
<td></td>
</tr>
<tr>
<td>Quality/Performance Improvement Staff</td>
<td></td>
</tr>
<tr>
<td>Compliance Staff</td>
<td></td>
</tr>
<tr>
<td>Health Information Technology Staff</td>
<td></td>
</tr>
<tr>
<td>Hospital Board Members</td>
<td></td>
</tr>
<tr>
<td>Administration/Management Staff</td>
<td></td>
</tr>
</tbody>
</table>

(Please use additional pages to expand the Community Needs Assessment)
Appendix 7

Required Federal and State Forms

J. CMS 855A
K. CMS 1537C
L. CMS 1561
M. Medicare Certification Civil Rights Information Request Form and Office of Civil Rights Nondiscriminatory Policies and Notices
N. HHS 690 - Assurance of Compliance
CMS 855A
CMS 855A
Medicare Enrollment Application: Institutional Providers

CMS Form 855A, Medicare Enrollment Application: Institutional Providers is available online at:  http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp.

The original completed form should be mailed directly to the fiscal intermediary of preference. A copy of the form should be included as Attachment P with a notification of the date the form was mailed to the fiscal intermediary.

Please go to: http://www.cms.hhs.gov/contacts/incardir.asp for a directory of fiscal intermediaries. The provider’s fiscal intermediary of preference does not automatically guarantee that it will be assigned to that fiscal intermediary. The fiscal intermediary will answer any questions you have concerning completion of the CMS 855A. Providers, who are currently enrolled in the Medicare program and are requesting to change their fiscal intermediary, must submit their request to the Medicare Regional Office prior to submission of the CMS 855A . Arizona’s Medicare Regional Office is:

Centers for Medicare and Medicaid Services – Region IX
Michelle Griffin
75 Hawthorne Street, Suite 408
San Francisco, CA 94105
(415) 744-3501
(866) 539-5596

The Medicare Fiscal Intermediaries for Arizona’s non-tribal hospitals are Noridian Administrative Services, LLC and Mutual of Omaha. Their contact information is:

Mutual of Omaha
P.O. Box 1602
Omaha, NE 68101
(402) 342-7600
http://www.mutualmedicare.com

Noridian Administrative Services, LLC
901 40th Street S. Suite 1
Fargo, ND 58103
(701) 277-6500
http://www.noridianmedicare.com

Trailblazer Health Enterprises, LLC is the Fiscal Intermediary for Medicare Part A for Indian Health Service (IHS) hospitals and skilled nursing facilities. Their contact information is:

Trailblazer Health Enterprises, LLC
8330 LBJ Freeway
Dallas, TX 75243
(469) 372-1816
http://www.trailblazerhealth.com


## MEDICARE/MEDICAID HOSPITAL SWING-BED SURVEY REPORT

<table>
<thead>
<tr>
<th>PROVIDER NUMBER</th>
<th>FACILITY NAME AND ADDRESS <em>(City, State, Zip Code)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| VENDOR NUMBER   |                                                  |
|-----------------|                                                  |

| SURVEY DATE      |                                                  |
|-----------------|                                                  |

### TYPE OF SURVEY

- [ ] Initial Approval
- [ ] Reverification
- [ ] Complaint

### NUMBER OF BEDS *(Check One)*

- [ ] 49 or fewer beds
- [ ] 50–59 beds

### SURVEY TEAM COMPOSITION

Indicate the Number of Surveyors According to Discipline:

<table>
<thead>
<tr>
<th>A.</th>
<th>Administrator</th>
<th>H.</th>
<th>Life Safety Code Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.</td>
<td>Nurse</td>
<td>I.</td>
<td>Laborator</td>
</tr>
<tr>
<td>C.</td>
<td>Dietitian</td>
<td>J.</td>
<td>Sanitarian</td>
</tr>
<tr>
<td>D.</td>
<td>Pharmacist</td>
<td>K.</td>
<td>Therapist</td>
</tr>
<tr>
<td>E.</td>
<td>Records Administrator</td>
<td>L.</td>
<td>Physician</td>
</tr>
<tr>
<td>F.</td>
<td>Social Worker</td>
<td>M.</td>
<td>Psychologist</td>
</tr>
<tr>
<td>G.</td>
<td>Qualified Mental Retardation Professional</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- [ ] Other

Note: More than one discipline may be marked for surveyors qualified in multiple disciplines.

Indicate the Total Number of Surveyors Onsite: ____________________________
<table>
<thead>
<tr>
<th>Data Tag No.</th>
<th>CoP/STND No.</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Tag No.</td>
<td>CoP/STND No.</td>
<td>COMMENTS</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------</td>
<td>----------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Evaluate each of the discrete requirements identified in the Hospital Swing-Bed Interpretive Guidelines (Appendix to the SOM). For each identified deficiency:

A. In the first column, identify the data tag number.

B. In the second column, write the regulatory citation. If it is a Condition of Participation, enter “CoP” below the regulatory citation.

C. In column three, describe the findings and evidence under “Comments.”

D. Draw horizontal lines to separate identified tag numbers.

E. If more space is needed, photocopy FIRST page (front and back).

F. Each surveyor must sign the certifying statement on the last page.

G. If there are more surveyors to sign the last page, than are lines available on which to sign, photocopy the last page and add the additional signatures.
For Certification Survey: I certify that I have reviewed each Hospital Swing-Bed Condition of Participation and related Standard(s) and unless indicated on this form, the facility was found to be in compliance with the Standard and/or the Condition of Participation.

Signature: ________________________________ Title: ________________________________ Date: ____________

Signature: ________________________________ Title: ________________________________ Date: ____________

Signature: ________________________________ Title: ________________________________ Date: ____________

Signature: ________________________________ Title: ________________________________ Date: ____________

Signature: ________________________________ Title: ________________________________ Date: ____________

Signature: ________________________________ Title: ________________________________ Date: ____________

Signature: ________________________________ Title: ________________________________ Date: ____________

Signature: ________________________________ Title: ________________________________ Date: ____________

Signature: ________________________________ Title: ________________________________ Date: ____________

Signature: ________________________________ Title: ________________________________ Date: ____________

For Resurvey: For the purpose of a resurvey, I certify that I have reviewed each Condition of Participation and related Standard(s) found not to be in compliance with the survey on ____________ and unless indicated on this form, the facility was found to be in compliance with the Standard and/or Condition of Participation.

Signature: ________________________________ Title: ________________________________ Date: ____________

Signature: ________________________________ Title: ________________________________ Date: ____________

Signature: ________________________________ Title: ________________________________ Date: ____________

Signature: ________________________________ Title: ________________________________ Date: ____________

Signature: ________________________________ Title: ________________________________ Date: ____________

Signature: ________________________________ Title: ________________________________ Date: ____________

Signature: ________________________________ Title: ________________________________ Date: ____________

Signature: ________________________________ Title: ________________________________ Date: ____________

Signature: ________________________________ Title: ________________________________ Date: ____________

Signature: ________________________________ Title: ________________________________ Date: ____________
HEALTH INSURANCE BENEFIT AGREEMENT

(Agreement with Provider Pursuant to Section 1866 of the Social Security Act, as Amended and Title 42 Code of Federal Regulations (CFR) Chapter IV, Part 489)

AGREEMENT

between

THE SECRETARY OF HEALTH AND HUMAN SERVICES

and

__________________________________________________

doing business as (D/B/A) ____________________________

In order to receive payment under title XVIII of the Social Security Act,

D/B/A ___________________________________________________________________ as the provider of services, agrees to conform to the provisions of section 1866 of the Social Security Act and applicable provisions in 42 CFR.

This agreement, upon submission by the provider of services of acceptable assurance of compliance with title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Secretary of Health and Human Services, shall be binding on the provider of services and the Secretary.

In the event of a transfer of ownership, this agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited.

ATTENTION: Read the following provision of Federal law carefully before signing.

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than 5 years or both (18 U.S.C. section 1001).

Name __________________________ Title __________________________

Date __________________________

ACCEPTED FOR THE PROVIDER OF SERVICES BY:

NAME (signature)

TITLE __________________________ DATE __________________________

ACCEPTED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES BY:

NAME (signature)

TITLE __________________________ DATE __________________________

ACCEPTED FOR THE SUCCESSOR PROVIDER OF SERVICES BY:

NAME (signature)

TITLE __________________________ DATE __________________________

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 0938-0832. The time required to complete this information collection is estimated to average 5 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.
Medicare Certification Civil Rights Information Request Form
and
Office of Civil Rights Nondiscriminatory Policies and Notices
Instructions: Healthcare providers applying for participation in the Medicare Part A program must receive a civil rights clearance from OCR. Complete all fields and return this form, with the required policies and procedures, to your State Health Department, along with your other Medicare application materials.

I. Healthcare Provider Information

CMS Medicare Provider Number:

Name of Facility:

Address:  
Street Number and Name  
City or Town  
State or Province  
Zip Code

Administrator’s Name:  
Contact Person:

Telephone: ( ) -  
TDD: ( ) -  
FAX: ( ) -

E-mail:

Type of Facility:  
Number of employees:

Corporate Affiliation:  
Reason for Application:  
Circle One  
Initial Medicare or Change of Certification  
Ownership

II. Documents Required for Submission

Additional guidance is available at: (http://www.hhs.gov/ocr/civilrights/clearance/index.html)

1. **Assurance of Compliance Form**, HHS 690 completed, signed and dated.

2. **Nondiscrimination Policy** that provides for admission and services without regard to race, color, national origin, disability, or age, as required by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975 (see sample policy).

   Learn more about regulatory requirements

3. Description of methods used to disseminate your nondiscrimination policies/notifications:
   a) Describe where you post your Nondiscrimination Policy; and
   b) Include brochures, websites, pamphlets, postings, or ads with general information about your services.

4. Facility admissions policy that describes eligibility requirements for your services.

5. A description/explanation of any policies or practices restricting or limiting your facility’s admissions or services on the basis of age. In certain narrowly defined circumstances, age restrictions are permitted.

   Learn more about regulatory requirements

6. For healthcare providers with 15 or more employees: copy of your procedures used for handling disability discrimination grievances along with the name/title and telephone number of the Section 504 coordinator (see sample policy). Learn more about regulatory requirements

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 0990-0243. The time required to complete this information collection is estimated to average 8 hours 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: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 336-E, Washington D.C. 20201, Attention: PRA Reports Clearance Officer.
**DEPARTMENT OF HEALTH & HUMAN SERVICES**  
Office for Civil Rights (OCR)  
Civil Rights Information Request  
For Medicare Certification

### 7. Procedures to effectively communicate with persons who are limited English proficient (LEP), including:
- a) Process for how you identify individuals who need language assistance;
- b) Procedures to provide services (interpreters, written translations, bilingual staff, etc.). Include the name(s) and telephone number(s) of your interpreter(s) and/or interpreter service(s);
- c) Methods to inform LEP persons that language assistance services are available at no cost to the person being served;
- d) Appropriate restrictions on the use of family and friends as LEP interpreters; and
- e) A list of all written materials in other languages, if applicable. Examples may include consent and complaint forms, intake forms, written notices of eligibility criteria, nondiscrimination notices, etc. (see sample policy). Learn more about regulatory requirements.

### 8. Procedures used to communicate effectively with individuals who are deaf, hard of hearing, blind, have low vision, or who have other impaired sensory, manual or speaking skills, including:
- a) Process to identify individuals who need sign language interpreters or other assistive services;
- b) Procedures to provide interpreters and other auxiliary aids and services. Include the name(s) and telephone number(s) of your interpreter(s) and/or interpreter service(s);
- c) Procedures used to communicate with deaf or hard of hearing persons over the telephone, including the telephone number of your TTY/TDD or State Relay System;
- d) A list of available auxiliary aids and services;
- e) Methods to inform persons that interpreter or other assistive services are available at no cost to the person being served; and
- f) Appropriate restrictions on the use of family and friends as sign language interpreters (see sample policy). Learn more about regulatory requirements.

### 9. Notice of Program Accessibility and methods used to disseminate information to patients/clients about the existence and location of services and facilities that are accessible to persons with disabilities (see sample policy). Learn more about regulatory requirements.

#### III. Certification
I certify that the information provided to the Office for Civil Rights is true, complete, and correct to the best of my knowledge.

<table>
<thead>
<tr>
<th>Name and Title of Authorized Official</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Office for Civil Rights

Civil Rights Information Request
For
Medicare Certification

Technical Assistance

Nondiscrimination Policies and Notices 1
Communication with Persons Who Are Limited English Proficient 2
Auxiliary Aids and Services for Persons with Disabilities 4
Requirements for Facilities with 15 or More Employees 6
Age Discrimination Act Requirements 7
Policy Examples 9

Go to (http://www.hhs.gov/ocr/civilrights/resources/providers/medicare_providers/index.html) for more information, including links to the full regulations.
Nondiscrimination Policies and Notices

The regulations implementing Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975 require health and human service providers that receive Federal financial assistance from the Department of Health and Human Services to provide notice to patients/residents, employees, and others of the availability of programs and services to all persons without regard to race, color, national origin, disability, or age.

Applicable Regulatory Citations:

Title VI of the Civil Rights Act of 1964: 45 CFR Part 80
§80.6(d) Information to beneficiaries and participants. Each recipient shall make available to participants, beneficiaries, and other interested persons such information regarding the provisions of this regulation and its applicability to the program for which the recipient receives Federal financial assistance, and make such information available to them in such manner, as the responsible Department official finds necessary to apprise such persons of the protections against discrimination assured them by the Act and this regulation.

Section 504 of the Rehabilitation Act of 1973: 45 CFR Part 84
§ 84.8 Notice. (a) A recipient that employs fifteen or more persons shall take appropriate initial and continuing steps to notify participants, beneficiaries, applicants, and employees, including those with impaired vision or hearing, and unions or professional organizations holding collective bargaining or professional agreements with the recipient that it does not discriminate on the basis of handicap in violation of section 504 and this part. The notification shall state, where appropriate, that the recipient does not discriminate in admission or access to, or treatment or employment in, its programs and activities. The notification shall also include an identification of the responsible employee designated pursuant to §84.7(a). A recipient shall make the initial notification required by this paragraph within 90 days of the effective date of this part. Methods of initial and continuing notification may include the posting of notices, publication in newspapers and magazines, placement of notices in recipients' publication, and distribution of memoranda or other written communications.

(b) If a recipient publishes or uses recruitment materials or publications containing general information that it makes available to participants, beneficiaries, applicants, or employees, it shall include in those materials or publications a statement of the policy described in paragraph (a) of this section. A recipient may meet the requirement of this paragraph either by including appropriate inserts in existing materials and publications or by revising and reprinting the materials and publications.

Age Discrimination Act: 45 CFR Part 91
§ 91.32 Notice to subrecipients and beneficiaries. (b) Each recipient shall make necessary information about the Act and these regulations available to its program beneficiaries in order to inform them about the protections against discrimination provided by the Act and these regulations.

See Policy Example Section for examples of Nondiscrimination Policies.
Communication with Persons Who Are Limited English Proficient

In certain circumstances, the failure to ensure that Limited English Proficient (LEP) persons can effectively participate in, or benefit from, federally-assisted programs and activities may violate the prohibition under Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d, and the Title VI regulations against national origin discrimination. Specifically, the failure of a recipient of Federal financial assistance from HHS to take reasonable steps to provide LEP persons with a meaningful opportunity to participate in HHS-funded programs may constitute a violation of Title VI and HHS's implementing regulations. It is therefore important for recipients of Federal financial assistance, including Part A Medicare providers, to understand and be familiar with the requirements.

Applicable Regulatory Citations:

Title VI of the Civil Rights Act of 1964: 45 CFR Part 80

§80.3 Discrimination prohibited.

(a) General. No person in the United States shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program to which this part applies.

(b) Specific discriminatory actions prohibited. (1) A recipient under any program to which this part applies may not, directly or through contractual or other arrangements, on ground of race, color, or national origin:

(i) Deny an individual any service, financial aid, or other benefit under the program;
(ii) Provide any service, financial aid, or other benefit to an individual which is different, or is provided in a different manner, from that provided to others under the program;
(iii) Subject an individual to segregation or separate treatment in any matter related to his receipt of any service, financial aid, or other benefit under the program;
(iv) Restrict an individual in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service, financial aid, or other benefit under the program;
(v) Treat an individual differently from others in determining whether he satisfies any admission, enrollment, quota, eligibility, membership or other requirement or condition which individuals must meet in order to be provided any service, financial aid, or other benefit provided under the program;
(vi) Deny an individual an opportunity to participate in the program through the provision of services or otherwise afford him an opportunity to do so which is different from that afforded others under the program (including the opportunity to participate in the program as an employee but only to the extent set forth in paragraph (c) of this section).
(vii) Deny a person the opportunity to participate as a member of a planning or advisory body which is an integral part of the program. 

(2) A recipient, in determining the types of services, financial aid, or other benefits, or facilities which will be provided under any such program, or the class of individuals to whom, or the situations in which, such services, financial aid, other benefits, or facilities will be provided under any such program, or the class of individuals to be afforded an opportunity to participate in any such program, may not, directly or through contractual or other arrangements, utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respect individuals of a particular race, color, or national origin.

Resources

For further guidance on the obligation to take reasonable steps to provide meaningful access to LEP persons, see HHS' "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons," available at
This guidance is also available at http://www.lep.gov/, along with other helpful information pertaining to language services for LEP persons.

Technical Assistance for Medicare and Medicare+Choice organizations from the Centers for Medicare and Medicaid for Designing, Conducting, and Implementing the 2003 National Quality Assessment and Performance Improvement (QAPI) Program Project on Clinical Health Care Disparities or Culturally and Linguistically Appropriate Services - http://www.cms.hhs.gov/healthplans/quality/project03.asp

Examples of Vital Written Materials

Vital written materials could include, for example:

- Consent and complaint forms.
- Intake forms with the potential for important consequences.
- Written notices of eligibility criteria, rights, denial, loss, or decreases in benefits or services, actions affecting parental custody or child support, and other hearings.
- Notices advising LEP persons of free language assistance.
- Written tests that do not assess English language competency, but test competency for a particular license, job, or skill for which knowing English is not required.
- Applications to participate in a recipient’s program or activity or to receive recipient benefits or services.

Nonvital written materials could include:

- Hospital menus.
- Third party documents, forms, or pamphlets distributed by a recipient as a public service.
- For a non-governmental recipient, government documents and forms.
- Large documents such as enrollment handbooks (although vital information contained in large documents may need to be translated).
- General information about the program intended for informational purposes only.
Auxiliary Aids and Services for Persons with Disabilities

Applicable Regulatory Citations:
Section 504 of the Rehabilitation Act of 1973: 45 CFR Part 84

§84.3 Definitions

(h) Federal financial assistance – means any grant, loan … or any other arrangement by which [DHHS] makes available … funds; services …

(j) Handicapped person – means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

(k) Qualified handicapped person means - (4) With respect to other services, a handicapped person who meets the essential eligibility requirements for the receipt of such services.

§84.4 Discrimination prohibited

(1) General. No qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from Federal financial assistance.

Discriminatory actions prohibited –

(1) A recipient, in providing any aid, benefits, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of handicap:

(i) Deny a qualified handicapped person the opportunity to participate in or benefit from the aid, benefit, or service;

(ii) Afford a qualified handicapped person an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded other;

(iii) Provide a qualified handicapped person with an aid, benefit, or service that is not as effective as that provided to others;

(iv) Provide different or separate aid, benefits, or services to handicapped persons or to any class of handicapped persons unless such action is necessary to provide qualified handicapped persons with aid, benefits, or services that are as effective as those provided to others;

(v) Aid or perpetuate discrimination against a qualified handicapped person by providing significant assistance to an agency, organization, or person that discriminates on the basis of handicap in providing any aid, benefit, or service to beneficiaries of the recipients program;

(vi) Deny a qualified handicapped person the opportunity to participate as a member of planning or advisory boards; or

(vii) Otherwise limit a qualified handicapped person in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving an aid, benefit, or service.

Subpart F – Health, Welfare and Social Services

§84.51 Application of this subpart

Subpart F applies to health, welfare, or other social service programs and activities that receive or benefit from Federal financial assistance …

§84.52 Health, welfare, and other social services.
(a) General. In providing health, welfare, or other social services or benefits, a recipient may not, on the basis of handicap:

1. Deny a qualified handicapped person these benefits or services;
2. Afford a qualified handicapped person an opportunity to receive benefits or services that is not equal to that offered non-handicapped persons;
3. Provide a qualified handicapped person with benefits or services that are not as effective (as defined in § 84.4(b)) as the benefits or services provided to others;
4. Provide benefits or services in a manner that limits or has the effect of limiting the participation of qualified handicapped persons; or
5. Provide different or separate benefits or services to handicapped persons except where necessary to provide qualified handicapped persons with benefits and services that are as effective as those provided to others.

(b) Notice. A recipient that provides notice concerning benefits or services or written material concerning waivers of rights or consent to treatment shall take such steps as are necessary to ensure that qualified handicapped persons, including those with impaired sensory or speaking skills, are not denied effective notice because of their handicap.

(c) Auxiliary aids. (1) A recipient with fifteen or more employees “shall provide appropriate auxiliary aids to persons with impaired sensory, manual, or speaking skills, where necessary to afford such person an equal opportunity to benefit from the service in question.” (2) Pursuant to the Department’s discretion, recipients with fewer than fifteen employees may be required “to provide auxiliary aids where the provision of aids would not significantly impair the ability of the recipient to provide its benefits or services.” (3) “Auxiliary aids may include brailed and taped material, interpreters, and other aids for persons with impaired hearing or vision.”

504 Notice

The regulation implementing Section 504 requires that an agency/facility "that provides notice concerning benefits or services or written material concerning waivers of rights or consent to treatment shall take such steps as are necessary to ensure that qualified disabled persons, including those with impaired sensory or speaking skills, are not denied effective notice because of their disability." (45 CFR §84.52(b))

Note that it is necessary to note each area of the consent, such as:

1. Medical Consent
2. Authorization to Disclose Medical Information
3. Personal Valuables
4. Financial Agreement
5. Assignment of Insurance Benefits
6. Medicare Patient Certification and Payment Request

Resources:

U.S. Department of Justice at [www.ada.gov](http://www.ada.gov)

ADA Business Brief: Communicating with People Who are Deaf or Hard of Hearing in Hospital Settings at [http://www.ada.gov/business.htm](http://www.ada.gov/business.htm)

A new on-line library of ADA documents is now available on the Internet. Developed by Meeting the Challenge, Inc., of Colorado Springs with funding from the National Institute on Disability and
Rehabilitation Research, this website makes available more than 3,400 documents related to the ADA, including those issued by Federal agencies with responsibilities under the law. It also offers extensive document collections on other disability rights laws and issues. By clicking on one of the general categories in the left column, for example, you will go to a catalogue of documents that are specific to the topic. [http://www.dbtac.vcu.edu/adaportal/]
Requirements for Facilities with 15 or More Employees

Applicable Regulatory Citations:

Section 504 of the Rehabilitation Act of 1973:

45 CFR Part 84§84.7 Designation of responsible employee and adoption of grievance procedures.

(a) Designation of responsible employee. A recipient that employs fifteen or more persons shall designate at least one person to coordinate its efforts to comply with this part.

(b) Adoption of grievance procedures. A recipient that employs fifteen or more persons shall adopt grievance procedures that incorporate appropriate due process standards and that provide for the prompt and equitable resolution of complaints alleging any action prohibited by this part. Such procedures need not be established with respect to complaints from applicants for employment or from applicants for admission to postsecondary educational institutions.
Age Discrimination Act Requirements

The Office for Civil Rights (OCR) of the Department of Health and Human Services (HHS) has the responsibility for the Age Discrimination Act as it applies to Federally funded health and human services programs. The general regulation implementing the Age Discrimination Act requires that age discrimination complaints be referred to a mediation agency to attempt a voluntary settlement within sixty (60) days. If mediation is not successful, the complaint is returned to the responsible Federal agency, in this case the Office for Civil Rights, for action. OCR next attempts to resolve the complaint through informal procedures. If these fail, a formal investigation is conducted. When a violation is found and OCR cannot negotiate voluntary compliance, enforcement action may be taken against the recipient institution or agency that violated the law.

The Age Discrimination Act permits certain exceptions to the prohibition against discrimination based on age. These exceptions recognize that some age distinctions in programs may be necessary to the normal operation of a program or activity or to the achievement of any statutory objective expressly stated in a Federal, State, or local statute adopted by an elected legislative body.

Applicable Regulatory Citations:

45 CFR Part 91: Nondiscrimination on the Basis of Age in Programs or Activities Receiving Federal Financial Assistance From HHS

§ 91.3 To what programs do these regulations apply?

(a) The Act and these regulations apply to each HHS recipient and to each program or activity operated by the recipient which receives or benefits from Federal financial assistance provided by HHS.
(b) The Act and these regulations do not apply to:
(1) An age distinction contained in that part of a Federal, State, or local statute or ordinance adopted by an elected, general purpose legislative body which:
   (i) Provides any benefits or assistance to persons based on age; or
   (ii) Establishes criteria for participation in age-related terms; or
   (iii) Describes intended beneficiaries or target groups in age-related terms.

Subpart B-Standards for Determining Age Discrimination

§ 91.11 Rule against age discrimination.

The rules stated in this section are limited by the exceptions contained in §§91.13 and 91.14 of these regulations.

(a) General rule: No person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance.
(b) Specific rules: A recipient may not, in any program or activity receiving Federal financial assistance, directly or through contractual licensing, or other arrangements, use age distinctions or take any other actions which have the effect, on the basis of age, of:
(1) Excluding individuals from, denying them the benefits of, or subjecting them to discrimination under, a program or activity receiving Federal financial assistance.
(2) Denying or limiting individuals in their opportunity to participate in any program or activity receiving Federal financial assistance.
(c) The specific forms of age discrimination listed in paragraph (b) of this section do not necessarily constitute a complete list.

§ 91.13 Exceptions to the rules against age discrimination: Normal operation or statutory objective of any program or activity.

A recipient is permitted to take an action, otherwise prohibited by § 91.11, if the action reasonably takes into account age as a factor necessary to the normal operation or the achievement of any statutory objective of a program or activity. An action reasonably takes into account age as a factor necessary to the normal operation or the achievement of any statutory objective of a program or activity, if:

(a) Age is used as a measure or approximation of one or more other characteristics; and
(b) The other characteristic(s) must be measured or approximated in order for the normal operation of the program or activity to continue, or to achieve any statutory objective of the program or activity; and
(c) The other characteristic(s) can be reasonably measured or approximated by the use of age; and
(d) The other characteristic(s) are impractical to measure directly on an individual basis.

§ 91.14 Exceptions to the rules against age discrimination: Reasonable factors other than age.

A recipient is permitted to take an action otherwise prohibited by § 91.11 which is based on a factor other than age, even though that action may have a disproportionate effect on persons of different ages. An action may be based on a factor other than age only if the factor bears a direct and substantial relationship to the normal operation of the program or activity or to the achievement of a statutory objective.

§ 91.15 Burden of proof.

The burden of proving that an age distinction or other action falls within the exceptions outlined in §§ 91.13 and 91.14 is on the recipient of Federal financial assistance.
Sample Policies

The next few pages contain samples of policies that you could use as guidance in developing civil rights policies and procedures for your facility. You may modify them to best reflect your procedures and methods.
Examples of Nondiscrimination Policies

**Example One** (for posting in the facility and inserting in advertising or admissions packages):

**Nondiscrimination Policy**

As a recipient of Federal financial assistance, (insert name of provider) does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by (insert name of provider) directly or through a contractor or any other entity with which (insert name of provider) arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.

In case of questions, please contact:

Provider Name:
Contact Person/Section 504 Coordinator:
Telephone number:
TDD or State Relay number:

**Example Two** (for use in brochures, pamphlets, publications, etc.):

(Insert name of provider) does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy, contact: (insert name of Section 504 Coordinator, phone number, TDD/State Relay).
POLICY AND PROCEDURES FOR COMMUNICATION WITH PERSONS WITH LIMITED ENGLISH PROFICIENCY

POLICY:

(Insert name of your facility) will take reasonable steps to ensure that persons with Limited English Proficiency (LEP) have meaningful access and an equal opportunity to participate in our services, activities, programs and other benefits. The policy of (Insert name of your facility) is to ensure meaningful communication with LEP patients/clients and their authorized representatives involving their medical conditions and treatment. The policy also provides for communication of information contained in vital documents, including but not limited to, waivers of rights, consent to treatment forms, financial and insurance benefit forms, etc. (include those documents applicable to your facility). All interpreters, translators and other aids needed to comply with this policy shall be provided without cost to the person being served, and patients/clients and their families will be informed of the availability of such assistance free of charge.

Language assistance will be provided through use of competent bilingual staff, staff interpreters, contracts or formal arrangements with local organizations providing interpretation or translation services, or technology and telephonic interpretation services. All staff will be provided notice of this policy and procedure, and staff that may have direct contact with LEP individuals will be trained in effective communication techniques, including the effective use of an interpreter.

(Insert name of your facility) will conduct a regular review of the language access needs of our patient population, as well as update and monitor the implementation of this policy and these procedures, as necessary.

PROCEDURES:

1. IDENTIFYING LEP PERSONS AND THEIR LANGUAGE

(Insert name of your facility) will promptly identify the language and communication needs of the LEP person. If necessary, staff will use a language identification card (or “I speak cards,” available online at www.lep.gov) or posters to determine the language. In addition, when records are kept of past interactions with patients (clients/residents) or family members, the language used to communicate with the LEP person will be included as part of the record.

2. OBTAINING A QUALIFIED INTERPRETER

(Identify responsible staff person(s), and phone number(s)) is/are responsible for:

(For a, b, c below, choose only what is applicable to your facility)
(a) Maintaining an accurate and current list showing the name, language, phone number and hours of availability of bilingual staff *(provide the list)*;

(b) Contacting the appropriate bilingual staff member to interpret, in the event that an interpreter is needed, if an employee who speaks the needed language is available and is qualified to interpret;

(c) Obtaining an outside interpreter if a bilingual staff or staff interpreter is not available or does not speak the needed language. *(Identify the agency(s) name(s) with whom you have contracted or made arrangements)* have/has agreed to provide qualified interpreter services. The agency’s (or agencies’) telephone number(s) is/are *(insert number(s))* and the hours of availability are *(insert hours)*.

Some LEP persons may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the LEP person will not be used as interpreters unless specifically requested by that individual and after the LEP person has understood that an offer of an interpreter at no charge to the person has been made by the facility. Such an offer and the response will be documented in the person’s file. If the LEP person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided to the LEP person.

Children and other clients/patients/residents will not be used to interpret, in order to ensure confidentiality of information and accurate communication.

3. PROVIDING WRITTEN TRANSLATIONS

(a) When translation of vital documents is needed, each unit in *(insert name of your facility)* will submit documents for translation into frequently-encountered languages to *(identify responsible staff person)*. Original documents being submitted for translation will be in final, approved form with updated and accurate legal and medical information.

(b) Facilities will provide translation of other written materials, if needed, as well as written notice of the availability of translation, free of charge, for LEP individuals.

(c) *(Insert name of your facility)* will set benchmarks for translation of vital documents into additional languages over time.

4. PROVIDING NOTICE TO LEP PERSONS

*(Insert name of your facility)* will inform LEP persons of the availability of language assistance, free of charge, by providing written notice in languages LEP persons will understand. At a minimum, notices and signs will be posted and provided in intake areas and other points of entry, including but not limited to the emergency room, outpatient areas, etc. *include those areas applicable to*
your facility). Notification will also be provided through one or more of the following: outreach documents, telephone voice mail menus, local newspapers, radio and television stations, and/or community-based organizations (include those areas applicable to your facility).

5. MONITORING LANGUAGE NEEDS AND IMPLEMENTATION

On an ongoing basis, (insert name of your facility) will assess changes in demographics, types of services or other needs that may require reevaluation of this policy and its procedures. In addition, (insert name of your facility) will regularly assess the efficacy of these procedures, including but not limited to mechanisms for securing interpreter services, equipment used for the delivery of language assistance, complaints filed by LEP persons, feedback from patients and community organizations, etc. (include those areas applicable to your facility).
**Bilingual Individuals**  
*(center location here)*  
*(As of (month and year submitting information))*

**Staff Members:**
We currently have:
- [ ] no staff members available who are qualified to speak and/or interpret a language other than English.
- [ ] the following staff member(s) who are qualified to speak and/or interpret a language other than English:

<table>
<thead>
<tr>
<th>Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Title:</td>
<td></td>
</tr>
<tr>
<td>Phone Number:</td>
<td></td>
</tr>
<tr>
<td>Language(s) spoken:</td>
<td></td>
</tr>
<tr>
<td>Hours of Availability:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Title:</td>
<td></td>
</tr>
<tr>
<td>Phone Number:</td>
<td></td>
</tr>
<tr>
<td>Language(s) spoken:</td>
<td></td>
</tr>
<tr>
<td>Hours of Availability:</td>
<td></td>
</tr>
</tbody>
</table>

**Contractors:**
The Director of Clinical Services, *(First Name, Last Name – phone number)*, is responsible for maintaining a list of local bilingual interpreters/translations.

The Director of Clinical Services has chosen the following interpreter/translator to ensure that qualified persons with Limited English Proficiency (LEP) can adequately communicate with Hospice staff members.

<table>
<thead>
<tr>
<th>Company/Organization:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Person:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>City/State/Zip:</td>
<td></td>
</tr>
<tr>
<td>Voicemail:</td>
<td></td>
</tr>
<tr>
<td>Fax:</td>
<td></td>
</tr>
<tr>
<td>Email:</td>
<td></td>
</tr>
</tbody>
</table>
Example of a Policy and Procedure for Providing Auxiliary Aids for Persons with Disabilities

AUXILIARY AIDS AND SERVICES FOR PERSONS WITH DISABILITIES

POLICY:

*(Insert name of your facility)* will take appropriate steps to ensure that persons with disabilities, including persons who are deaf, hard of hearing, or blind, or who have other sensory or manual impairments, have an equal opportunity to participate in our services, activities, programs and other benefits. The procedures outlined below are intended to ensure effective communication with patients/clients involving their medical conditions, treatment, services and benefits. The procedures also apply to, among other types of communication, communication of information contained in important documents, including waivers of rights, consent to treatment forms, financial and insurance benefits forms, etc. *(include those documents applicable to your facility).* All necessary auxiliary aids and services shall be provided without cost to the person being served.

All staff will be provided written notice of this policy and procedure, and staff that may have direct contact with individuals with disabilities will be trained in effective communication techniques, including the effective use of interpreters.

PROCEDURES:

1. Identification and assessment of need:

*(Name of facility)* provides notice of the availability of and procedure for requesting auxiliary aids and services through notices in our *(brochures, handbooks, letters, print/radio /television advertisements, etc.)* and through notices posted *(in waiting rooms, lobbies, etc.)*. When an individual self-identifies as a person with a disability that affects the ability to communicate or to access or manipulate written materials or requests an auxiliary aid or service, staff will consult with the individual to determine what aids or services are necessary to provide effective communication in particular situations.

2. Provision of Auxiliary Aids and Services:

*(Insert name of your facility)* shall provide the following services or aids to achieve effective communication with persons with disabilities:

A. For Persons Who Are Deaf or Hard of Hearing
(i) For persons who are deaf/hard of hearing and who use sign language as their primary means of communication, the *(identify responsible staff person or position with a telephone number)* is responsible for providing effective interpretation or arranging for a qualified interpreter when needed.

In the event that an interpreter is needed, the *(identify responsible staff person)* is responsible for:

*(For a, b, c below, choose only what is applicable to your facility)*

(a) Maintaining a list of qualified interpreters on staff showing their names, phone numbers, qualifications and hours of availability *(provide the list)*;

(b) Contacting the appropriate interpreter on staff to interpret, if one is available and qualified to interpret; or

(c) Obtaining an outside interpreter if a qualified interpreter on staff is not available. *(Identify the agency(s) name with whom you have contracted or made arrangements)* has agreed to provide interpreter services. The agency's/agencies' telephone number(s) is/are *(insert number(s) and the hours of availability)].* [Note: If video interpreter services are provided via computer, the procedures for accessing the service must be included.]

(ii) Communicating by Telephone with Persons Who Are Deaf or Hard of Hearing

[Listed below are three methods for communicating over the telephone with persons who are deaf/hard of hearing. Select the method(s) to incorporate in your policy that best applies/apply to your facility.]

*(Insert name of facility)* utilizes a Telecommunication Device for the Deaf (TDD) for external communication. The telephone number for the TDD is *(insert number)*. The TDD and instructions on how to operate it are located *(insert location)* in the facility; OR

*(Insert name of provider)* has made arrangements to share a TDD. When it is determined by staff that a TDD is needed, we contact *(identify the entity e.g., library, school or university, provide address and telephone numbers);* OR
(Insert name of facility) utilizes relay services for external telephone with TTY users. We accept and make calls through a relay service. The state relay service number is (insert telephone for your State Relay).

(iii) For the following auxiliary aids and services, staff will contact (responsible staff person or position and telephone number), who is responsible to provide the aids and services in a timely manner: Note-takers; computer-aided transcription services; telephone handset amplifiers; written copies of oral announcements; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning; telecommunications devices for deaf persons (TDDs); videotext displays; or other effective methods that help make aurally delivered materials available to individuals who are deaf or hard of hearing.

(iv) Some persons who are deaf or hard of hearing may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the person will not be used as interpreters unless specifically requested by that individual and after an offer of an interpreter at no charge to the person has been made by the facility. Such an offer and the response will be documented in the person’s file. If the person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided.

NOTE: Children and other residents will not be used to interpret, in order to ensure confidentiality of information and accurate communication.

B. For Persons Who are Blind or Who Have Low Vision

(i) Staff will communicate information contained in written materials concerning treatment, benefits, services, waivers of rights, and consent to treatment forms by reading out loud and explaining these forms to persons who are blind or who have low vision [in addition to reading, this section should tell what other aids are available, where they are located, and how they are used].

The following types of large print, taped, Brailled, and electronically formatted materials are available: (description of the materials available). These materials may be obtained by calling (name or position and telephone number).
(ii) For the following auxiliary aids and services, staff will contact
(responsible staff person or position and telephone number), who is
responsible to provide the aids and services in a timely manner:
Qualified readers; reformatting into large print; taping or recording of print
materials not available in alternate format; or other effective methods that
help make visually delivered materials available to individuals who are
blind or who have low vision. In addition, staff are available to assist
persons who are blind or who have low vision in filling out forms and in
otherwise providing information in a written format.

C. For Persons With Speech Impairments

To ensure effective communication with persons with speech impairments,
staff will contact (responsible staff person or position and telephone
number), who is responsible to provide the aids and services in a timely
manner:
Writing materials; typewriters; TDDs; computers; flashcards; alphabet
boards; communication boards; (include those aids applicable to your
facility) and other communication aids.

D. For Persons With Manual Impairments

Staff will assist those who have difficulty in manipulating print materials by
holding the materials and turning pages as needed, or by providing one or
more of the following:
note-takers; computer-aided transcription services; speaker phones; or
other effective methods that help to ensure effective communication by
individuals with manual impairments. For these and other auxiliary aids
and services, staff will contact (responsible staff person or position
and telephone number) who is responsible to provide the aids and
services in a timely manner.
Staff Members:
We currently have:
- [ ] no staff members available who are qualified to interpret American Sign Language.
- [ ] the following staff member(s) who are qualified to interpret American Sign Language:

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Phone Number</th>
<th>Hours of Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Phone Number</th>
<th>Hours of Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Contractors:

The Director of Clinical Services, *(First Name, Last Name – phone number)*, is responsible for obtaining an outside interpreter when required.

The Director of Clinical Services has chosen the following interpreter referral agency to ensure that qualified persons with disabilities, including those with impaired hearing, can adequately communicate with Hospice staff members:

<table>
<thead>
<tr>
<th>Company/Organization</th>
<th>Contact Person</th>
<th>Address</th>
<th>Address</th>
<th>City/State/Zip</th>
<th>Voicemail</th>
<th>TTY</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Example of a Notice of Program Accessibility for Describing that your Program is Accessible to Persons with Disabilities

Section 504 Notice of Program Accessibility

The regulation implementing Section 504 requires that an agency/facility "...adopt and implement procedures to ensure that interested persons, including persons with impaired vision or hearing, can obtain information as to the existence and location of services, activities, and facilities that are accessible to and usable by disabled persons." (45 C.F.R. §84.22(f))

(Insert name of facility) and all of its programs and activities are accessible to and useable by disabled persons, including persons who are deaf, hard of hearing, or blind, or who have other sensory impairments. Access features include:

- Convenient off-street parking designated specifically for disabled persons.
- Curb cuts and ramps between parking areas and buildings.
- Level access into first floor level with elevator access to all other floors.
- Fully accessible offices, meeting rooms, bathrooms, public waiting areas, cafeteria, patient treatment areas, including examining rooms and patient wards.
- A full range of assistive and communication aids provided to persons who are deaf, hard of hearing, or blind, or with other sensory impairments. There is no additional charge for such aids. Some of these aids include:
  - Qualified sign language interpreters for persons who are deaf or hard of hearing.
  - A twenty-four hour (24) telecommunication device (TTY/TDD) which can connect the caller to all extensions within the facility and/or portable (TTY/TDD) units, for use by persons who are deaf, hard of hearing, or speech impaired.
  - Readers and taped material for the blind and large print materials for the visually impaired.
  - Flash Cards, Alphabet boards and other communication boards.
  - Assistive devices for persons with impaired manual skills.

If you require any of the aids listed above, please let the receptionist or your nurse know.
Example of a Section 504 Grievance Procedure that Incorporates Due Process Standards

Section 504 GRIEVANCE PROCEDURE

It is the policy of (insert name of facility/agency) not to discriminate on the basis of disability. (Insert name of facility/agency) has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) or the U.S. Department of Health and Human Services regulations implementing the Act. Section 504 states, in part, that "no qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from Federal financial assistance." The Law and Regulations may be examined in the office of (insert name, title, tel. no. of Section 504 Coordinator), who has been designated to coordinate the efforts of (insert name of facility/agency) to comply with Section 504.

Any person who believes she or he has been subjected to discrimination on the basis of disability may file a grievance under this procedure. It is against the law for (insert name of facility/agency) to retaliate against anyone who files a grievance or cooperates in the investigation of a grievance.

Procedure:

Grievances must be submitted to the Section 504 Coordinator within (insert timeframe) of the date the person filing the grievance becomes aware of the alleged discriminatory action. A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought. The Section 504 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 504 Coordinator will maintain the files and records of (insert name of facility/agency) relating to such grievances. The Section 504 Coordinator will issue a written decision on the grievance no later than 30 days after its filing. The person filing the grievance may appeal the decision of the Section 504 Coordinator by writing to the (Administrator/Chief Executive Officer/Board of Directors/etc.) within 15 days of receiving the Section 504 Coordinator’s decision. The (Administrator/Chief Executive Officer/Board of Directors/etc.) shall issue a written decision in response to the appeal no later than 30 days after its filing. The availability and use of this grievance procedure does not prevent a person from filing a complaint of discrimination on the basis of disability with the U. S. Department of Health and Human Services, Office for Civil Rights.

(Insert name of facility/agency) will make appropriate arrangements to ensure that disabled persons are provided other accommodations if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing interpreters for the deaf, providing taped
cassettes of material for the blind, or assuring a barrier-free location for the proceedings. The Section 504 Coordinator will be responsible for such arrangements.
HHS 690 - Assurance of Compliance
ASSURANCE OF COMPLIANCE


The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial relief.

The person whose signature appears below is authorized to sign this assurance and commit the Applicant to the above provisions.


Please mail form to:
U.S. Department of Health and Human Services
Office for Civil Rights
200 Independence Ave., S.W.
Washington, DC 20201

Date

Signature of Authorized Official

Name and Title of Authorized Official (please print or type)

Name of Healthcare Facility Receiving/Requesting Funding

Street Address

City, State, Zip Code

Form HHS-690
1/09
Appendix 8

Code of Federal Regulations
Subpart F
CONDITIONS OF PARTICIPATION: CRITICAL ACCESS HOSPITALS (CAHS)
(http://law.justia.com/cfr/title42/42-3.0.1.5.24.4.html)

§485.601 Basis and scope.
§485.602 Definitions.
§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.
§485.616 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.
§485.627 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.
§485.641 Condition of participation: Periodic evaluation and quality assurance review.
§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.
§ 485.601 Basis and scope.

(a) Statutory basis. This subpart is based on section 1820 of the Act which sets forth the conditions for designating certain hospitals as CAHs.

(b) Scope. This subpart sets forth the conditions that a hospital must meet to be designated as a CAH.


§ 485.602 Definitions.

As used in this subpart, unless the context indicates otherwise:

Direct services means services provided by employed staff of the CAH, not services provided through arrangements or agreements.


§ 485.603 Rural health network.

A rural health network is an organization that meets the following specifications:

(a) It includes—

(1) At least one hospital that the State has designated or plans to designate as a CAH; and

(2) At least one hospital that furnishes acute care services.

(b) The members of the organization have entered into agreements regarding—

(1) Patient referral and transfer;

(2) The development and use of communications systems, including, where feasible, telemetry systems and systems for electronic sharing of patient data; and

(3) The provision of emergency and nonemergency transportation among members.

(c) Each CAH has an agreement with respect to credentialing and quality assurance with at least—

(1) One hospital that is a member of the network when applicable;

(2) One QIO or equivalent entity; or
(3) One other appropriate and qualified entity identified in the State rural health care plan.


§ 485.604 Personnel qualifications.

Staff that furnish services in a CAH must meet the applicable requirements of this section.

(a) Clinical nurse specialist. A clinical nurse specialist must be a person who performs the services of a clinical nurse specialist as authorized by the State, in accordance with State law or the State regulatory mechanism provided by State law.

(b) Nurse practitioner. A nurse practitioner must be a registered professional nurse who is currently licensed to practice in the State, who meets the State's requirements governing the qualification of nurse practitioners, and who meets one of the following conditions:

(1) Is currently certified as a primary care nurse practitioner by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioners and Associates.

(2) Has successfully completed a 1 academic year program that—

(i) Prepares registered nurses to perform an expanded role in the delivery of primary care;

(ii) Includes at least 4 months (in the aggregate) of classroom instruction and a component of supervised clinical practice; and

(iii) Awards a degree, diploma, or certificate to persons who successfully complete the program.

(3) Has successfully completed a formal educational program (for preparing registered nurses to perform an expanded role in the delivery of primary care) that does not meet the requirements of paragraph (a)(2) of this section, and has been performing an expanded role in the delivery of primary care for a total of 12 months during the 18-month period immediately preceding June 25, 1993.

(c) Physician assistant. A physician assistant must be a person who meets the applicable State requirements governing the qualifications for assistants to primary care physicians, and who meets at least one of the following conditions:

(1) Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians.

(2) Has satisfactorily completed a program for preparing physician assistants that—

(i) Was at least one academic year in length;

(ii) Consisted of supervised clinical practice and at least 4 months (in the aggregate) of classroom instruction directed toward preparing students to deliver health care; and

(iii) Was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation.
(3) Has satisfactorily completed a formal educational program (for preparing physician assistants) that does not meet the requirements of paragraph (c)(2) of this section and has been assisting primary care physicians for a total of 12 months during the 18-month period immediately preceding June 25, 1993.


§ 485.606 Designation and certification of CAHs.

(a) Criteria for State designation. (1) A State that has established a Medicare rural hospital flexibility program described in section 1820(c) of the Act may designate one or more facilities as CAHs if each facility meets the CAH conditions of participation in this subpart F.

(2) The State must not deny any hospital that is otherwise eligible for designation as a CAH under this paragraph (a) solely because the hospital has entered into an agreement under which the hospital may provide posthospital SNF care as described in §482.66 of this chapter.

(b) Criteria for CMS certification. CMS certifies a facility as a CAH if—

(1) The facility is designated as a CAH by the State in which it is located and has been surveyed by the State survey agency or by CMS and found to meet all conditions of participation in this Part and all other applicable requirements for participation in Part 489 of this chapter.

(2) The facility is a medical assistance facility operating in Montana or a rural primary care hospital designated by CMS before August 5, 1997, and is otherwise eligible to be designated as a CAH by the State under the rules in this subpart.


§ 485.608 Condition of participation: Compliance with Federal, State, and local laws and regulations.

The CAH and its staff are in compliance with applicable Federal, State and local laws and regulations.

(a) Standard: Compliance with Federal laws and regulations. The CAH is in compliance with applicable Federal laws and regulations related to the health and safety of patients.

(b) Standard: Compliance with State and local laws and regulations. All patient care services are furnished in accordance with applicable State and local laws and regulations.

(c) Standard: Licensure of CAH. The CAH is licensed in accordance with applicable Federal, State and local laws and regulations.

(d) Standard: Licensure, certification or registration of personnel. Staff of the CAH are licensed, certified, or registered in accordance with applicable Federal, State, and local laws and regulations.

§ 485.610  Condition of participation: Status and location.
Link to an amendment published at 71 FR 48143, Aug. 18, 2006. (http://law.justia.com/cfr/title42/20060818-1.49.html)

(a) Standard: Status. The facility is—

(1) A currently participating hospital that meets all conditions of participation set forth in this subpart;

(2) A recently closed facility, provided that the facility—

(i) Was a hospital that ceased operations on or after the date that is 10 years before November 29, 1999; and

(ii) Meets the criteria for designation under this subpart as of the effective date of its designation; or

(3) A health clinic or a health center (as defined by the State) that—

(i) Is licensed by the State as a health clinic or a health center;

(ii) Was a hospital that was downsized to a health clinic or a health center; and

(iii) As of the effective date of its designation, meets the criteria for designation set forth in this subpart.

(b) Standard: Location in a rural area or treatment as rural. The CAH meets the requirements of either paragraph (b)(1) or (b)(2) or (b)(3) of this section.

(1) The CAH meets the following requirements:

(i) The CAH is located outside any area that is a Metropolitan Statistical Area, as defined by the Office of Management and Budget, or that has been recognized as urban under §412.64(b), excluding paragraph (b)(3) of this chapter;

(ii) The CAH has not been classified as an urban hospital for purposes of the standardized payment amount by CMS or the Medicare Geographic Classification Review Board under §412.230(e) of this chapter, and is not among a group of hospitals that have been redesignated to an adjacent urban area under §412.232 of this chapter.

(2) The CAH is located within a Metropolitan Statistical Area, as defined by the Office of Management and Budget, but is being treated as being located in a rural area in accordance with §412.103 of this chapter.

(3) Effective only for October 1, 2004 through September 30, 2006, the CAH does not meet the location requirements in either paragraph (b)(1) or (b)(2) of this section and is located in a county that, in FY 2004, was not part of a Metropolitan Statistical Area as defined by the Office of Management and Budget, but as of FY 2005 was included as part of such an MSA as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.

(c) Standard: Location relative to other facilities or necessary provider certification. The CAH is located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital or another CAH, or before January 1, 2006, the CAH is certified by the State as being a necessary provider of health care services to residents in the area. A CAH
that is designated as a necessary provider as of October 1, 2006, will maintain its necessary provider designation after January 1, 2006.

(d) Standard: Relocation of CAHs with a necessary provider designation. A CAH that has a necessary provider designation from the State that was in effect prior to January 1, 2006, and relocates its facility after January 1, 2006, can continue to meet the location requirement of paragraph (c) of this section based on the necessary provider designation only if the relocated facility meets the requirements as specified in paragraph (d)(1) of this section.

(1) If a necessary provider CAH relocates its facility and begins providing services in a new location, the CAH can continue to meet the location requirement of paragraph (c) of this section based on the necessary provider designation only if the CAH in its new location—

(i) Serves at least 75 percent of the same service area that it served prior to its relocation;

(ii) Provides at least 75 percent of the same services that it provided prior to the relocation; and

(iii) Is staffed by 75 percent of the same staff (including medical staff, contracted staff, and employees) that were on staff at the original location.

(2) If a CAH that has been designated as a necessary provider by the State begins providing services at another location after January 1, 2006, and does not meet the requirements in paragraph (d)(1) of this section, the action will be considered a cessation of business as described in §489.52(b)(3).


§ 485.612 Condition of participation: Compliance with hospital requirements at the time of application.

Except for recently closed facilities as described in §485.610(a)(2), or health clinics or health centers as described in §485.610(a)(3), the facility is a hospital that has a provider agreement to participate in the Medicare program as a hospital at the time the hospital applies for designation as a CAH.

[66 FR 32196, June 13, 2001]

§ 485.616 Condition of participation: Agreements.

(a) Standard: Agreements with network hospitals. In the case of a CAH that is a member of a rural health network as defined in §485.603 of this chapter, the CAH has in effect an agreement with at least one hospital that is a member of the network for—

(1) Patient referral and transfer;

(2) The development and use of communications systems of the network, including the network's system for the electronic sharing of patient data, and telemetry and medical records, if the network has in operation such a system; and

(3) The provision of emergency and nonemergency transportation between the facility and the hospital.
(b) Standard: Agreements for credentialing and quality assurance. Each CAH that is a member of a rural health network shall have an agreement with respect to credentialing and quality assurance with at least—

(1) One hospital that is a member of the network;

(2) One QIO or equivalent entity; or

(3) One other appropriate and qualified entity identified in the State rural health care plan.


§ 485.618 Condition of participation: Emergency services.

The CAH provides emergency care necessary to meet the needs of its inpatients and outpatients.

(a) Standard: Availability. Emergency services are available on a 24-hours a day basis.

(b) Standard: Equipment, supplies, and medication. Equipment, supplies, and medication used in treating emergency cases are kept at the CAH and are readily available for treating emergency cases. The items available must include the following:

(1) Drugs and biologicals commonly used in life-saving procedures, including analgesics, local anesthetics, antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids, antiarrrhythmics, cardiac glycosides, antihypertensives, diuretics, and electrolytes and replacement solutions.

(2) Equipment and supplies commonly used in life-saving procedures, including airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters.

(c) Standard: Blood and blood products. The facility provides, either directly or under arrangements, the following:

(1) Services for the procurement, safekeeping, and transfusion of blood, including the availability of blood products needed for emergencies on a 24-hours a day basis.

(2) Blood storage facilities that meet the requirements of 42 CFR part 493, subpart K, and are under the control and supervision of a pathologist or other qualified doctor of medicine or osteopathy. If blood banking services are provided under an arrangement, the arrangement is approved by the facility's medical staff and by the persons directly responsible for the operation of the facility.

(d) Standard: Personnel. (1) Except as specified in paragraph (d)(2) of this section, there must be a doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist, with training or experience in emergency care on call and immediately available by telephone or radio contact, and available onsite within the following timeframes:

(i) Within 30 minutes, on a 24-hour a day basis, if the CAH is located in an area other than an area described in paragraph (d)(1)(ii) of this section; or

(ii) Within 60 minutes, on a 24-hour a day basis, if all of the following requirements are met:
(A) The CAH is located in an area designated as a frontier area (that is, an area with fewer than six residents per square mile based on the latest population data published by the Bureau of the Census) or in an area that meets the criteria for a remote location adopted by the State in its rural health care plan, and approved by CMS, under section 1820(b) of the Act.

(B) The State has determined, under criteria in its rural health care plan, that allowing an emergency response time longer than 30 minutes is the only feasible method of providing emergency care to residents of the area served by the CAH.

(C) The State maintains documentation showing that the response time of up to 60 minutes at a particular CAH it designates is justified because other available alternatives would increase the time needed to stabilize a patient in an emergency.

(2) A registered nurse satisfies the personnel requirement specified in paragraph (d)(1) of this section for a temporary period if—

(i) The CAH has no greater than 10 beds;

(ii) The CAH is located in an area designated as a frontier area or remote location as described in paragraph (d)(1)(ii)(A) of this section;

(iii) The State in which the CAH is located submits a letter to CMS signed by the Governor, following consultation on the issue of using RNs on a temporary basis as part of their State rural healthcare plan with the State Boards of Medicine and Nursing, and in accordance with State law, requesting that a registered nurse with training and experience in emergency care be included in the list of personnel specified in paragraph (d)(1) of this section. The letter from the Governor must attest that he or she has consulted with State Boards of Medicine and Nursing about issues related to access to and the quality of emergency services in the States. The letter from the Governor must also describe the circumstances and duration of the temporary request to include the registered nurses on the list of personnel specified in paragraph (d)(1) of this section;

(iv) Once a Governor submits a letter, as specified in paragraph (d)(2)(iii) of this section, a CAH must submit documentation to the State survey agency demonstrating that it has been unable, due to the shortage of such personnel in the area, to provide adequate coverage as specified in this paragraph (d).

(3) The request, as specified in paragraph (d)(2)(iii) of this section, and the withdrawal of the request, may be submitted to us at any time, and are effective upon submission.

(e) **Standard: Coordination with emergency response systems.** The CAH must, in coordination with emergency response systems in the area, establish procedures under which a doctor of medicine or osteopathy is immediately available by telephone or radio contact on a 24-hours a day basis to receive emergency calls, provide information on treatment of emergency patients, and refer patients to the CAH or other appropriate locations for treatment.

§ 485.620 Condition of participation: Number of beds and length of stay.

(a) Standard: Number of beds. Except as permitted for CAHs having distinct part units under §485.647, the CAH maintains no more than 25 inpatient beds after January 1, 2004, that can be used for either inpatient or swing-bed services.

(b) Standard: Length of stay. The CAH provides acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient.


§ 485.623 Condition of participation: Physical plant and environment.

(a) Standard: Construction. The CAH is constructed, arranged, and maintained to ensure access to and safety of patients, and provides adequate space for the provision of direct services.

(b) Standard: Maintenance. The CAH has housekeeping and preventive maintenance programs to ensure that—

1. All essential mechanical, electrical, and patient-care equipment is maintained in safe operating condition;

2. There is proper routine storage and prompt disposal of trash;

3. Drugs and biologicals are appropriately stored;

4. The premises are clean and orderly; and

5. There is proper ventilation, lighting, and temperature control in all pharmaceutical, patient care, and food preparation areas.

(c) Standard: Emergency procedures. The CAH assures the safety of patients in non-medical emergencies by—

1. Training staff in handling emergencies, including prompt reporting of fires, extinguishing of fires, protection and, where necessary, evacuation of patients, personnel, and guests, and cooperation with fire fighting and disaster authorities;

2. Providing for emergency power and lighting in the emergency room and for battery lamps and flashlights in other areas;

3. Providing for an emergency fuel and water supply; and

4. Taking other appropriate measures that are consistent with the particular conditions of the area in which the CAH is located.

(d) Standard: Life safety from fire. (1) Except as otherwise provided in this section—

(i) The CAH must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the
NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the Life Safety Code does not apply to a CAH.

(2) If CMS finds that the State has a fire and safety code imposed by State law that adequately protects patients, CMS may allow the State survey agency to apply the State's fire and safety code instead of the LSC.

(3) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the CAH, but only if the waiver does not adversely affect the health and safety of patients.

(4) The CAH maintains written evidence of regular inspection and approval by State or local fire control agencies.

(5) Beginning March 13, 2006, a critical access hospital must be in compliance with Chapter 9.2.9, Emergency Lighting.

(6) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to critical access hospitals.

(7) Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, a critical access hospital may install alcohol-based hand rub dispensers in its facility if—

(i) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities;

(ii) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls;

(iii) The dispensers are installed in a manner that adequately protects against access by vulnerable populations; and

(iv) The dispensers are installed in accordance with chapter 18.3.2.7 or chapter 19.3.2.7 of the 2000 edition of the Life Safety Code, as amended by NFPA Temporary Interim Amendment 00–1(101), issued by the Standards Council of the National Fire Protection Association on April 15, 2004. The Director of the Office of the Federal Register has approved NFPA Temporary Interim Amendment 00–1(101) for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the amendment is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the Office of the Federal Register, 800 North Capitol Street NW., Suite 700, Washington, DC. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any additional changes are made to this amendment, CMS will publish notice in the Federal Register to announce the change.
§ 485.627 Condition of participation: Organizational structure.

(a) **Standard: Governing body or responsible individual.** The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing and monitoring policies governing the CAH's total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment.

(b) **Standard: Disclosure.** The CAH discloses the names and addresses of—

1. Its owners, or those with a controlling interest in the CAH or in any subcontractor in which the CAH directly or indirectly has a 5 percent or more ownership interest, in accordance with subpart C of part 420 of this chapter;

2. The person principally responsible for the operation of the CAH; and

3. The person responsible for medical direction.

§ 485.631 Condition of participation: Staffing and staff responsibilities.

(a) **Standard: Staffing**—

1. The CAH has a professional health care staff that includes one or more doctors of medicine or osteopathy, and may include one or more physician assistants, nurse practitioners, or clinical nurse specialists.

2. Any ancillary personnel are supervised by the professional staff.

3. The staff is sufficient to provide the services essential to the operation of the CAH.

4. A doctor of medicine or osteopathy, nurse practitioner, clinical nurse specialist, or physician assistant is available to furnish patient care services at all times the CAH operates.

5. A registered nurse, clinical nurse specialist, or licensed practical nurse is on duty whenever the CAH has one or more inpatients.

(b) **Standard: Responsibilities of the doctor of medicine or osteopathy.**

1. The doctor of medicine or osteopathy—

   (i) Provides medical direction for the CAH's health care activities and consultation for, and medical supervision of, the health care staff;

   (ii) In conjunction with the physician assistant and/or nurse practitioner member(s), participates in developing, executing, and periodically reviewing the CAH's written policies governing the services it furnishes.

   (iii) In conjunction with the physician assistant and/or nurse practitioner members, periodically reviews the CAH's patient records, provides medical orders, and provides medical care services to the patients of the CAH; and
(iv) Periodically reviews and signs the records of all inpatients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants.

(v) Periodically, but not less than every 2 weeks, reviews and signs a sample of outpatient records of patients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants according to the policies of the CAH and according to current standards of practice where State law requires record reviews or co-signatures, or both, by a collaborating physician.

(vi) Is not required to review and sign outpatient records of patients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants where State law does not require record reviews or co-signatures, or both, by a collaborating physician.

(2) A doctor of medicine or osteopathy is present for sufficient periods of time, at least once in every 2 week period (except in extraordinary circumstances) to provide the medical direction, medical care services, consultation, and supervision described in this paragraph, and is available through direct radio or telephone communication for consultation, assistance with medical emergencies, or patient referral. The extraordinary circumstances are documented in the records of the CAH. A site visit is not required if no patients have been treated since the latest site visit.

(c) Standard: Physician assistant, nurse practitioner, and clinical nurse specialist responsibilities. (1) The physician assistant, the nurse practitioner, or clinical nurse specialist members of the CAH's staff—

(i) Participate in the development, execution and periodic review of the written policies governing the services the CAH furnishes; and

(ii) Participate with a doctor of medicine or osteopathy in a periodic review of the patients' health records.

(2) The physician assistant, nurse practitioner, or clinical nurse specialist performs the following functions to the extent they are not being performed by a doctor of medicine or osteopathy:

(i) Provides services in accordance with the CAH's policies.

(ii) Arranges for, or refers patients to, needed services that cannot be furnished at the CAH, and assures that adequate patient health records are maintained and transferred as required when patients are referred.

(3) Whenever a patient is admitted to the CAH by a nurse practitioner, physician assistant, or clinical nurse specialist, a doctor of medicine or osteopathy on the staff of the CAH is notified of the admission.


§ 485.635 Condition of participation: Provision of services.

(a) Standard: Patient care policies. (1) The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.

(2) The policies are developed with the advice of a group of professional personnel that includes one or more doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists, if they are on staff under the provisions of §485.631(a)(1); at least one member is not a member of the CAH staff.
(3) The policies include the following: (i) A description of the services the CAH furnishes directly and those furnished through agreement or arrangement.

(ii) Policies and procedures for emergency medical services.

(iii) Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or patient referral, the maintenance of health care records, and procedures for the periodic review and evaluation of the services furnished by the CAH.

(iv) Rules for the storage, handling, dispensation, and administration of drugs and biologicals. These rules must provide that there is a drug storage area that is administered in accordance with accepted professional principles, that current and accurate records are kept of the receipt and disposition of all scheduled drugs, and that outdated, mislabeled, or otherwise unusable drugs are not available for patient use.

(v) Procedures for reporting adverse drug reactions and errors in the administration of drugs.

(vi) A system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel.

(vii) If the CAH furnishes inpatient services, procedures that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practices and the orders of the practitioner responsible for the care of the patients, and that the requirement of §483.25(i) is met with respect to inpatients receiving posthospital SNF care.

(4) These policies are reviewed at least annually by the group of professional personnel required under paragraph (a)(2) of this section, and reviewed as necessary by the CAH.

(b) Standard: Direct services—(1) General. The CAH staff furnishes, as direct services, those diagnostic and therapeutic services and supplies that are commonly furnished in a physician's office or at another entry point into the health care delivery system, such as a low intensity hospital outpatient department or emergency department. These direct services include medical history, physical examination, specimen collection, assessment of health status, and treatment for a variety of medical conditions.

(2) Laboratory services. The CAH provides, as direct services, basic laboratory services essential to the immediate diagnosis and treatment of the patient that meet the standards imposed under section 353 of the Public Health Service Act (42 U.S.C. 236a). (See the laboratory requirements specified in part 493 of this chapter.) The services provided include:

(i) Chemical examination of urine by stick or tablet method or both (including urine ketones);

(ii) Hemoglobin or hematocrit;

(iii) Blood glucose;

(iv) Examination of stool specimens for occult blood;

(v) Pregnancy tests; and

(vi) Primary culturing for transmittal to a certified laboratory.
(3) Radiology services. Radiology services furnished at the CAH are provided as direct services by staff qualified under State law, and do not expose CAH patients or staff to radiation hazards.

(4) Emergency procedures. In accordance with the requirements of §485.618, the CAH provides as direct services medical emergency procedures as a first response to common life-threatening injuries and acute illness.

(c) Standard: Services provided through agreements or arrangements. (1) The CAH has agreements or arrangements (as appropriate) with one or more providers or suppliers participating under Medicare to furnish other services to its patients, including—

(i) Inpatient hospital care;

(ii) Services of doctors of medicine or osteopathy; and

(iii) Additional or specialized diagnostic and clinical laboratory services that are not available at the CAH.

(iv) Food and other services to meet inpatients' nutritional needs to the extent these services are not provided directly by the CAH.

(2) If the agreements or arrangements are not in writing, the CAH is able to present evidence that patients referred by the CAH are being accepted and treated.

(3) The CAH maintains a list of all services furnished under arrangements or agreements. The list describes the nature and scope of the services provided.

(4) The person principally responsible for the operation of the CAH under §485.627(b)(2) of this chapter is also responsible for the following:

(i) Services furnished in the CAH whether or not they are furnished under arrangements or agreements.

(ii) Ensuring that a contractor of services (including one for shared services and joint ventures) furnishes services that enable the CAH to comply with all applicable conditions of participation and standards for the contracted services.

(d) Standard: Nursing services. Nursing services must meet the needs of patients.

(1) A registered nurse must provide (or assign to other personnel) the nursing care of each patient, including patients at a SNF level of care in a swing-bed CAH. The care must be provided in accordance with the patient's needs and the specialized qualifications and competence of the staff available.

(2) A registered nurse or, where permitted by State law, a physician assistant, must supervise and evaluate the nursing care for each patient, including patients at a SNF level of care in a swing-bed CAH.

(3) All drugs, biologicals, and intravenous medications must be administered by or under the supervision of a registered nurse, a doctor of medicine or osteopathy, or, where permitted by State law, a physician assistant, in accordance with written and signed orders, accepted standards of practice, and Federal and State laws.

(4) A nursing care plan must be developed and kept current for each inpatient.
§ 485.638 Conditions of participation: Clinical records.

(a) Standard: Records system—(1) The CAH maintains a clinical records system in accordance with written policies and procedures.

(2) The records are legible, complete, accurately documented, readily accessible, and systematically organized.

(3) A designated member of the professional staff is responsible for maintaining the records and for ensuring that they are completely and accurately documented, readily accessible, and systematically organized.

(4) For each patient receiving health care services, the CAH maintains a record that includes, as applicable—

(i) Identification and social data, evidence of properly executed informed consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient;

(ii) Reports of physical examinations, diagnostic and laboratory test results, including clinical laboratory services, and consultative findings;

(iii) All orders of doctors of medicine or osteopathy or other practitioners, reports of treatments and medications, nursing notes and documentation of complications, and other pertinent information necessary to monitor the patient's progress, such as temperature graphics, progress notes describing the patient's response to treatment; and

(iv) Dated signatures of the doctor of medicine or osteopathy or other health care professional.

(b) Standard: Protection of record information—(1) The CAH maintains the confidentiality of record information and provides safeguards against loss, destruction, or unauthorized use.

(2) Written policies and procedures govern the use and removal of records from the CAH and the conditions for the release of information.

(3) The patient's written consent is required for release of information not required by law.

(c) Standard: Retention of records. The records are retained for at least 6 years from date of last entry, and longer if required by State statute, or if the records may be needed in any pending proceeding.

§ 485.639 Condition of participation: Surgical services.

Surgical procedures must be performed in a safe manner by qualified practitioners who have been granted clinical privileges by the governing body of the CAH in accordance with the designation requirements under paragraph (a) of this section.
(a) *Designation of qualified practitioners.* The CAH designates the practitioners who are allowed to perform surgery for CAH patients, in accordance with its approved policies and procedures, and with State scope of practice laws. Surgery is performed only by—

1. A doctor of medicine or osteopathy, including an osteopathic practitioner recognized under section 1101(a)(7) of the Act;
2. A doctor of dental surgery or dental medicine; or
3. A doctor of podiatric medicine.

(b) *Anesthetic risk and evaluation.* (1) A qualified practitioner, as specified in paragraph (a) of this section, must examine the patient immediately before surgery to evaluate the risk of the procedure to be performed.

2. A qualified practitioner, as specified in paragraph (c) of this section, must examine each patient before surgery to evaluate the risk of anesthesia.

3. Before discharge from the CAH, each patient must be evaluated for proper anesthesia recovery by a qualified practitioner, as specified in paragraph (c) of this section.

(c) *Administration of anesthesia.* The CAH designates the person who is allowed to administer anesthesia to CAH patients in accordance with its approved policies and procedures and with State scope-of-practice laws.

1. Anesthesia must be administered by only—
   (i) A qualified anesthesiologist;
   (ii) A doctor of medicine or osteopathy other than an anesthesiologist; including an osteopathic practitioner recognized under section 1101(a)(7) of the Act;
   (iii) A doctor of dental surgery or dental medicine;
   (iv) A doctor of podiatric medicine;
   (v) A certified registered nurse anesthetist (CRNA), as defined in §410.69(b) of this chapter;
   (vi) An anesthesiologist's assistant, as defined in §410.69(b) of this chapter; or
   (vii) A supervised trainee in an approved educational program, as described in §§413.85 or 413.86 of this chapter.

2. In those cases in which a CRNA administers the anesthesia, the anesthetist must be under the supervision of the operating practitioner except as provided in paragraph (e) of this section. An anesthesiologist's assistant who administers anesthesia must be under the supervision of an anesthesiologist.

(d) *Discharge.* All patients are discharged in the company of a responsible adult, except those exempted by the practitioner who performed the surgical procedure.
(c) **Standard: State exemption.** (1) A CAH may be exempted from the requirement for physician supervision of CRNAs as described in paragraph (c)(2) of this section, if the State in which the CAH is located submits a letter to CMS signed by the Governor, following consultation with the State's Boards of Medicine and Nursing, requesting exemption from physician supervision for CRNAs. The letter from the Governor must attest that he or she has consulted with the State Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the State and has concluded that it is in the best interests of the State's citizens to opt-out of the current physician supervision requirement, and that the opt-out is consistent with State law.

(2) The request for exemption and recognition of State laws and the withdrawal of the request may be submitted at any time, and are effective upon submission.


§ 485.641 Condition of participation: Periodic evaluation and quality assurance review.

(a) **Standard: Periodic evaluation**—(1) The CAH carries out or arranges for a periodic evaluation of its total program. The evaluation is done at least once a year and includes review of—

(i) The utilization of CAH services, including at least the number of patients served and the volume of services;

(ii) A representative sample of both active and closed clinical records; and

(iii) The CAH's health care policies.

(2) The purpose of the evaluation is to determine whether the utilization of services was appropriate, the established policies were followed, and any changes are needed.

(b) **Standard: Quality assurance.** The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that—

(1) All patient care services and other services affecting patient health and safety, are evaluated;

(2) Nosocomial infections and medication therapy are evaluated;

(3) The quality and appropriateness of the diagnosis and treatment furnished by nurse practitioners, clinical nurse specialists, and physician assistants at the CAH are evaluated by a member of the CAH staff who is a doctor of medicine or osteopathy or by another doctor of medicine or osteopathy under contract with the CAH;

(4) The quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the CAH are evaluated by—

(i) One hospital that is a member of the network, when applicable;

(ii) One QIO or equivalent entity; or

(iii) One other appropriate and qualified entity identified in the State rural health care plan; and
(5)(i) The CAH staff considers the findings of the evaluations, including any findings or recommendations of the QIO, and takes corrective action if necessary.

(ii) The CAH also takes appropriate remedial action to address deficiencies found through the quality assurance program.

(iii) The CAH documents the outcome of all remedial action.


§ 485.643 Condition of participation: Organ, tissue, and eye procurement.

The CAH must have and implement written protocols that:

(a) Incorporate an agreement with an OPO designated under part 486 of this chapter, under which it must notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the CAH. The OPO determines medical suitability for organ donation and, in the absence of alternative arrangements by the CAH, the OPO determines medical suitability for tissue and eye donation, using the definition of potential tissue and eye donor and the notification protocol developed in consultation with the tissue and eye banks identified by the CAH for this purpose;

(b) Incorporate an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage and distribution of tissues and eyes, as may be appropriate to assure that all usable tissues and eyes are obtained from potential donors, insofar as such an agreement does not interfere with organ procurement;

(c) Ensure, in collaboration with the designated OPO, that the family of each potential donor is informed of its option to either donate or not donate organs, tissues, or eyes. The individual designated by the CAH to initiate the request to the family must be a designated requestor. A designated requestor is an individual who has completed a course offered or approved by the OPO and designed in conjunction with the tissue and eye bank community in the methodology for approaching potential donor families and requesting organ or tissue donation;

(d) Encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of the families of potential donors;

(e) Ensure that the CAH works cooperatively with the designated OPO, tissue bank and eye bank in educating staff on donation issues, reviewing death records to improve identification of potential donors, and maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes take place.

(f) For purposes of these standards, the term “organ” means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs).


§ 485.645 Special requirements for CAH providers of long-term care services (“swing-beds”)

A CAH must meet the following requirements in order to be granted an approval from CMS to provided post-hospital SNF care, as specified in §409.30 of this chapter, and to be paid for SNF-level services, in accordance with paragraph (c) of this section.
(a) **Eligibility.** A CAH must meet the following eligibility requirements:

1. The facility has been certified as a CAH by CMS under §485.606(b) of this subpart; and
2. The facility provides not more than 25 inpatient beds. Any bed of a unit of the facility that is licensed as a distinct-part SNF at the time the facility applies to the State for designation as a CAH is not counted under paragraph (a) of this section.

(b) **Facilities participating as rural primary care hospitals (RPCHs) on September 30, 1997.** These facilities must meet the following requirements:

1. Notwithstanding paragraph (a) of this section, a CAH that participated in Medicare as a RPCH on September 30, 1997, and on that date had in effect an approval from CMS to use its inpatient facilities to provide post-hospital SNF care may continue in that status under the same terms, conditions and limitations that were applicable at the time those approvals were granted.
2. A CAH that was granted swing-bed approval under paragraph (b)(1) of this section may request that its application to be a CAH and swing-bed provider be reevaluated under paragraph (a) of this section. If this request is approved, the approval is effective not earlier than October 1, 1997. As of the date of approval, the CAH no longer has any status under paragraph (b)(1) of this section and may not request reinstatement under paragraph (b)(1) of this section.

(c) **Payment.** Payment for inpatient RPCH services to a CAH that has qualified as a CAH under the provisions in paragraph (a) of this section is made in accordance with §413.70 of this chapter. Payment for post-hospital SNF-level of care services is made in accordance with the payment provisions in §413.114 of this chapter.

(d) **SNF services.** The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:

1. Residents rights (§483.10(b)(3) through (b)(6), (d) (e), (h), (i), (j)(1)(vii) and (viii), (l), and (m) of this chapter).
2. Admission, transfer, and discharge rights (§483.12(a) of this chapter).
3. Resident behavior and facility practices (§483.13 of this chapter).
4. Patient activities (§483.15(f) of this chapter), except that the services may be directed either by a qualified professional meeting the requirements of §485.15(f)(2), or by an individual on the facility staff who is designated as the activities director and who serves in consultation with a therapeutic recreation specialist, occupational therapist, or other professional with experience or education in recreational therapy.
5. Social services (§483.15(g) of this chapter).
6. Comprehensive assessment, comprehensive care plan, and discharge planning (§483.20(b), (k), and (l) of this chapter, except that the CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under §483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in §413.343(b) of this chapter).
7. Specialized rehabilitative services (§483.45 of this chapter).
§ 485.647 Condition of participation: psychiatric and rehabilitation distinct part units.

(a) Conditions. (1) If a CAH provides inpatient psychiatric services in a distinct part unit, the services furnished by the distinct part unit must comply with the hospital requirements specified in Subparts A, B, C, and D of Part 482 of this subchapter, the common requirements of §412.25(a)(2) through (f) of Part 412 of this chapter for hospital units excluded from the prospective payment systems, and the additional requirements of §412.27 of Part 412 of this chapter for excluded psychiatric units.

(2) If a CAH provides inpatient rehabilitation services in a distinct part unit, the services furnished by the distinct part unit must comply with the hospital requirements specified in Subparts A, B, C, and D of Part 482 of this subchapter, the common requirements of §412.25(a)(2) through (f) of Part 412 of this chapter for hospital units excluded from the prospective payments systems, and the additional requirements of §§412.29 and §412.30 of Part 412 of this chapter related specifically to rehabilitation units.

(b) Eligibility requirements. (1) To be eligible to receive Medicare payments for psychiatric or rehabilitation services as a distinct part unit, the facility provides no more than 10 beds in the distinct part unit.

(2) The beds in the distinct part are excluded from the 25 inpatient-bed count limit specified in §485.620(a).

(3) The average annual 96-hour length of stay requirement specified under §485.620(b) does not apply to the 10 beds in the distinct part units specified in paragraph (b)(1) of this section, and admissions and days of inpatient care in the distinct part units are not taken into account in determining the CAH's compliance with the limits on the number of beds and length of stay in §485.620.

[69 FR 49272, Aug. 11, 2004]