

Illinois Department of Public Health

Critical Access Hospital Program

Certification Process Preparation

Overview of the process

The Critical Access Hospital (CAH) program is an opportunity for rural hospitals to have greater flexibility in their delivery of services and to increase revenues through cost based reimbursement. A rural hospital will essentially provide the same services and function under the same hospital licensure standards for the state. However, a CAH applicant must meet the Medicare Conditions of Participation (CoP) specifically for CAHs to be certified. The CAH applicant will be required to complete an initial survey for compliance and then be re-surveyed every year. The Illinois Department of Public Health Division of Health Care Facilities and Programs will coordinate the survey process.

State surveyors will assess CoP compliance through observation, interviews with staff and patients, policy review, facility tour, and review of open and closed patient records. The surveyors will look to see if appropriate processes and procedures are in place. If the hospital applicant is requesting swing bed certification, the hospital will be surveyed for its compliance to the CAH Medicare Conditions of Participation for swing beds by the Division of Long Term Care Field Operations staff. These conditions are similar to those for Medicare certified skilled nursing facilities.

Surveyors are required to notify the hospital prior to their initial visit and determine the hospital's readiness for each survey. The life safety survey is conducted first. The health survey is generally conducted within one to two weeks of the life safety survey. The hospital may be surveyed in response to the completion of its plan of correction. The survey division must sign off on both surveys and forward them to the HCFA Region V Office. The date of certification will be when the life safety survey plan of correction is accepted. The Hospital will be notified by HCFA when approved as a CAH.

Suggested Steps To Prepare For The Survey And CAH Certification

1. It is helpful to create a pre-survey preparation team to assess the hospital's compliance with the Hospital Licensing Act and the Medicare CoP and its readiness for the survey. The Team generally consists of: the administrator, director of nursing, financial officer or business office manager, plant operations director, a medical staff representative, and the quality assurance coordinator. Other hospital department managers and staff can be added.

The Team should first conduct an assessment as to its present level of compliance to the IDPH Hospital standards and Medicare CoP. Use the three CAH survey preparation checklists (*i.e. CAH Program – Policy and Procedure Requirements; Optional Written Policies and Procedures for CAH; and Documents to be Available for the Survey*) to assess the hospital's readiness and learn what is expected. In addition, the Team should

conduct a facility tour to evaluate life safety requirements. The facility may want to hire an architectural firm to do facilities assessment as part of the life safety review if the hospital has not been inspected by the state for several years.

The Team should meet periodically and set goals and deadlines for those specific tasks necessary to complete for the survey. The Team may need to write new policies or repair areas of the physical facility in preparation.

If the hospital plans to include the ten swing beds in the CAH application, the Team will need to evaluate the hospital for its compliance to the CAH Medicare Conditions of Participation for swing beds. The MDS assessment requirement for swing beds does not start until the hospital has been certified. However, it is recommended that hospitals implement the MDS assessment procedure two weeks prior to the initial survey. This will allow the state surveyors to evaluate the MDS procedures and assist you in meeting this particular standard. The survey team will only evaluate the hospital's compliance to those procedures in place; the team does not evaluate the hospital's compliance to those procedures. The annual survey will evaluate the implementation of the MDS assessment.

What happens with the MDS once the hospital is certified as a CAH? The MDS must be completed for each swing bed patient. The hospital is not required to transmit the MDS for billing purposes as it does for the SNF patients. The MDS needs to be initiated and completed in the assigned time frame and filed in the medical record of each swing bed patient.

2. The required CAH policies and procedures must be changed to reflect the CAH status. The approval of these changes needs to be included in the minutes of the hospital's leadership committees (board of directors, medical staff, and hospital depts.). These documents will need to be available at the time of the health survey. Other hospital and department specific policies and procedures do not have to be changed to bear the CAH designation.
3. It is important that the hospital employees are involved with the survey process. They may be asked if they understand the new CAH program and how the program will affect their job. Meetings with employees, department managers, and medical staff are highly recommended. All individuals need to be aware of the new program. Handouts posted in the different areas would be helpful for staff and others. Nursing and other professional staff may be concerned on how CAH status will affect their scope of practice, if additional training will be required, or if the care of patients will change.
4. A hospital can apply for CAH status without having a swing bed program. If a hospital does not have a swing bed program and wishes to add swing beds, the hospital must apply for certificate of need through the State Health Planning Board. Once the CON has been obtained, the hospital can then apply for swing beds through the long term care division and must be surveyed by the Department before implementing the swing bed program.

5. Because CAH is Medicare program, a hospital must assure its compliance with the CoP. It is strongly advisable for a hospital to have a compliance program, and an individual within the organization responsible for the program. Hospitals are encouraged to have an on-going review of its billing and coding processes and a review of its charge master (charges for procedures, tests, supplies, services, etc.) to assure the hospital bills only what is authorized by Medicare and Medicaid. The individual responsible for compliance should be part of the survey preparation team. Don't forget to make sure suppliers and other associated providers are aware of your compliance program and have agreed to follow the program guidelines.
6. Effective 11/29/99, a CAH is responsible to maintain an average inpatient length of stay less than or equal to 96 hours. A waiver is no longer required for a patient to stay longer than the 96 hours. Also, a CAH can not exceed 15 acute care patients and 10 swing bed patients at one time. The CAH must stay within the assigned patient limit even though the hospital has a larger bed capacity. Observation patients are not included in the bed count or length of stay.

There are no federal or state guidelines at this time that define how the monitoring is to be done or how a CAH will report its annual average length of stay and adherence to the bed size limit. However, it is recommended that a CAH implement a case management or monitoring program in place. HCFA will probably use the ALOS identified by the hospital's cost report.

A case management program will monitor when patients are admitted and expected to be discharged. Daily logs should be kept and an individual(s) assigned the responsibility for the case management or monitoring of each patient. Hospitals will have to assure patients are discharged within an appropriate time frame and transfer arrangements made for patients requiring additional hospital care to maintain that 96-hour average. A CAH may want to explore critical pathways or case maps and involves your medical provider staff with the development of this program.

Patients may be admitted by physician assistants or nurse practitioners, who have hospital privileges, but a physician on staff must be notified and accept care for the patient. A physician must sign and authenticate the inpatient record of the patient is under the care of a physician assistant or nurse practitioner.

7. Transfer and referral agreements are required for CAH hospitals. Hospital leadership will need to make arrangements with one or more source hospitals to accept transfers and referrals, if not already in place. A CAH hospital must comply with EMTLA standards when transferring a patient to another acute care facility whether it is through the emergency department or inpatient-nursing unit. Documentation that the transferring hospital has met the EMTLA standards must accompany the transfer and a copy included in the hospital's medical record. It is strongly advised to include the Medical staff in the development of the transfer and referral arrangements.

The transfer and referral arrangement should address the following information but not limited to:

- a) CAH procedure for credentialing of medical and allied health professionals
- b) CAH quality assurance program
- c) What and how the patient data will be shared
- d) Referral and/or transfer protocols (CAH to resource hospital)
- e) Plan for communicating information on the patient transferred by the resource hospital after the patient is transferred, admitted, and discharged. (What information will the attending physician receive and hospital staff.)
- f) Plan for sharing of communication systems between the two hospitals

It is an important mandatory requirement that the CAH applicant demonstrate participation in a community assessment process. Hospital leadership can conduct its own community assessment or work in cooperation with another community or outside organization such as IRHA, extension services, and local health departments. There are several types of assessment program (i.e.: IPLAN/IL Mapping) available to use to conduct such an assessment.

Input from community member is valuable for hospital leadership to better understand the perception of the hospital within the community. The hospital leadership should be asking the community what services they need and are willing to pay for. CAH applicants should take this as an opportunity to explore new services and/or re-design those presently offered.

8. An ad hoc medical record review committee should be appointed to audit both open and closed medical records to assure compliance to the hospitals documentation procedures for both hospital staff and medical staff. An audit review form should be used to systematic examine the charts. Areas to particularly monitor are physician orders for care and treatment; coordination of care; discharge planning; medication administration and response; test results; and consents. Note accuracy, timeliness, and completion of information. Joint Commission has an excellent chart audit guide which may be helpful. There are specific documentation requirements, but surveyors will particularly monitor hospital compliance to its own standard policies and procedures.
9. Contact should be made with the CAH applicant's fiscal intermediary as to the billing format to be used and a procedure to implement a cost based reimbursement system for the hospital. The certification date assigned for your hospital will be the date the hospital is surveyed and found to be in compliance or when the hospital's plan of correction has been accepted by the Division of Health Care Facilities and Programs. Your certification date and new inpatient and swing bed Medicare numbers will be in your notification letter from HCFA. You will need to set up new accounts with the CAH Medicare numbers. You may have two cost reports for that year – one prior to CAH approval and one for after CAH approval. This, once again, will depend on your fiscal intermediary.

CAH inpatient charges will be based on a calculated per diem rate based on the hospital's inpatient costs from the previous years. Outpatient charges will be paid based on hospital's actual cost, which may or may not be the same as the outpatient charge. Your

fiscal intermediary or hospital auditors should be able to assist you in the calculation of your expected rate.

2/01 Center for Rural Health