Definition of a Hospital: Primarily Engaged Requirement Call

Moderated by: Hazeline Roulac
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Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® Event. All lines will remain in a listen-only mode until the question-and-answer session.

This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. I will now turn the call over to Hazeline Roulac. Thank you. You may begin.

Announcements & Introduction

Hazeline Roulac: Thank you, Dorothy. Hello, everyone. Thank you for joining us today. I am Hazeline Roulac from the Provider Communications Group here at CMS, and I am your moderator. I would like to welcome you to this Medicare Learning Network call on the Definition of a Hospital: Primarily Engaged Requirement.

During this call, CMS subject matter experts talk about the new guidance in Appendix A of the State Operations Manual that discusses the Medicare definition of a hospital, including the requirement for hospitals to be primarily engaged in providing care to inpatients. A question-and-answer session follows the presentation.

As part of the registration process, this call – for this call, you were able to email your questions in advance. We want to thank everyone who submitted questions as they help to inform today's presentation.

Before we get started, I just want to remind you that there is a slide presentation for this call. A link to the presentation was included in your call confirmation email. If you haven't already done so, you can download the presentation from the CMS website at go.cms.gov/npc. That's go.cms.gov/npc.

And now at this time, it is my pleasure to turn the call over to our first speaker, David Wright.

Presentation

David Wright: Thanks, Hazeline. So good afternoon, everyone. My name's David Wright. I'm the director of the Survey and Certification Group here at CMS and happy that you all took this time to join us to discuss this surveyor guidance that provides more clarification on the issue of primarily engaged hospitals.

And the reason that we came to this interpretation clarification—and I'm going off slide 4 of the presentation here—to issue this new guidance is that we've had several facilities that have been denied participation and certification to Medicare Program as a hospital mainly because we lack some of the clarity that we needed to have with regard to issues like micro-hospitals, which are hospitals that have traditionally lower inpatient beds, and also facilities that may not, in fact, be a hospital. We have smaller hospitals coming into the program with disproportionately large off-campus emergency departments. We've also identified issues with especially hospitals and also some disconnect between state licensing criteria of the hospital and what we would expect under Medicare certification for a hospital. So we wanted to provide a little more clear guidance and parameters for hospitals considering coming into the Medicare Program as to what the expectations are and provide additional factors for surveyors to be able to review because historically we've had very little guidance and clarification on what we're actually looking for with regard to this definition of primarily engaged.

And so, the intent of the next hour or so is to provide you all with information about this guidance—where we're coming from and what we're looking for—especially as surveyors come out to the facility and look at existing facilities or facilities that want to come into the program. So with that, I'm happy to turn it over to Marie Vasbinder, who is our director of the Division of Acute Care Services here at CMS.

Overview of New Guidance

Marie Vasbinder: Thank you very much, David. Hello. This is Marie. I want to just go over briefly – very briefly how we look at this and this guidance and what was behind that. I know David talked about the impetus for writing the guidance. I just want to talk at a high level on what this guidance really says and what we're going to do with that. And then, Lisa will follow with the nuts and bolts, if you will, of the guidance.

So when we look at that, clarifying the guidance was particularly important around the issue of the statutory definition of a hospital as well as: What does primarily engaged mean, and how could we see that when we survey? How do we define that, and what is included in that? And we also know that, besides being primarily engaged in inpatient services, you have to qualify for a provider agreement as well and that, under Medicare–Medicaid, the entity must meet and continue to meet all the statutory provisions of 1861 and Conditions of Participation requirements that we'll talk a lot about as we go through this slide and this webinar, but it's 488.3 and 489.12.

One thing to come away from in this discussion is that the psychiatric hospitals and CAHs, the Critical Access Hospitals, are not part of this guidance. This – none of these requirements apply to them, because they are actually defined as a hospital under their own in section 1861(f) of the act.

The other thing we wanted to note – stress upon, we'll talk about how that will work and how you'll survey for it, is the hospital must have inpatients—plural—at the time of the survey in order for surveys – surveyors, I'm sorry, to directly observe the actual provision of care and services to patients and the effects of that care. We will also introduce some ideas in terms of benchmarks for an average daily census and average length of stay data that help to – are just two of the factors that help to define are they actually primarily engaged in inpatient care. There are other – again, additional other factors that Lisa will review, but those are two that are very important to determining if they are primarily engaged.

And if I can turn your attention to slide 6, the Definition of a Hospital. As we have defined it at CMS, facilities must meet the statutory definition of a hospital to participate in Medicare as a hospital. This is section 1861(e) of the act, and the regulatory requirements around that participation are found in part 488; 488.3 talks about the conditions of participation, conditions for coverage, conditions for certification, and the long-term care requirements.

Basic rules—important to note that, to be approved for participation in or coverage under the Medicare Program, a prospective provider or supplier must meet the following. And you'll see a list of applicable statutory definitions, and there are a variety of sections. And I'm not going to read all of those, because there would be no point.

So the other piece I want you to be cognizant of is to be in compliance with these applicable conditions or certification requirements prescribed in part 405 and subparts U or X, part 410, other various parts throughout

there. You have to be, again, in compliance with those conditions, not just that you meet statutory definition. And the regulation requires compliance with applicable statutory definition, so we'll talk a little bit about those as well.

And the definition of a hospital further, though, specifically requires that a hospital be primarily engaged in providing care to inpatients. Inpatient is probably the most difficult part of this to define what is considered an inpatient, whether you are looking at it from a payer point of view, CoP standard, or whether you're a surveyor trying to find out are these truly inpatients.

But in 1861(e), the term "hospital," for the purposes of all of this section, means an institution which is primarily engaged in providing, by or under the supervision of physicians, to inpatients the following services: diagnostic services, therapeutic services for the medical diagnosis, treatment, and care of the injured, disabled, or sick; or the rehabilitation services for the rehabilitation of injured, disabled, or sick persons. So when we're looking again at inpatients, that key piece is the supervision of physicians and the care that they render.

Page 8. Surveyors must observe the provision of care and services to inpatients, again, why we want to see patients at the time of survey. And this is a different piece because, in doing the clarifying guidance, we added this, and Lisa will probably talk a little bit more about that.

But we – you need to have patients present at the time of the service – of the survey; 488.26(c)(2)—the survey process uses resident and patient outcomes as the primary means to establish the compliance process of facilities and agencies. Specifically, surveyors will directly observe the actual provision of care and services to residents and/or patients, the effects of that care, and assess whether the care provided meets the needs of the individual residents or patients.

Important point to remember—the potential or capacity to provide care to inpatients is not the same as the actual provision of care to inpatients. I really can't stress that enough, although I am trying.

Facility must have at least two inpatients for a survey to be conducted. All of those pieces are, again, extremely important so that we can observe that care and define that care.

And I'm going to turn it over to Lisa Marunycz and have her go over the nuts and bolts as we talked about.

Appendix A New Interpretive Guidance

Lisa Marunycz: Good afternoon. My name is Lisa Marunycz, and I'm with the Division of Acute Care Services, and I'm part of the hospital team here who will take you through the new guidance that came out in a published memo just recently.

So we're going to start with the licensing requirement. So as you all know or should know, one requirement to participate in Medicare, the hospital, you must have a license from the state where you want to operate your hospital.

And there has been a lot of confusion around that, and, hopefully, this new guidance will help to clear that up. And the confusion has been where a state issues a license and it just says on it "Hospital License." And some

state agencies as well as accreditation organizations have taken that to mean that if, you know, the facility presents a license at this hospital, then that automatically means they've met the definition of a hospital for Medicare purposes. And that is absolutely not true. The licensing requirement in each state is different. And so, again, while the license is a requirement to participate, it's only one, and to have that does not mean that you're meeting the statutory or the regulatory definition of a hospital. It's just that it's one part of the checkbox you need to check off as you are applying to participate in Medicare as a hospital. You need to provide a license or show that you've met the licensing standard to operate as a hospital within your state.

Slide 11. So now we're going to talk about basis and scope, and that is at 482.1. That is where you will find the new tag in appendix A of the State Operations Manual. This is not a new requirement. However, we did not have it as part of the State Operations Manual, but it has been – it has always been one of the Conditions of Participation to participate as a hospital.

And that forms a basis for all of the survey activities that will take place to render whether or not the facility meets the definition of a hospital and, therefore, they can be surveyed for the rest of the Conditions of Participation.

And if a facility does not meet the statutory requirements of a hospital, then it is not eligible to participate in Medicare as a hospital. So the starting point is, really, does the facility meet the very basic fundamental statutory requirements at 1861(e), which is the definition of a hospital. And that is where that comes into play with 482.1, and that would be the citation if you do not meet 1861(e).

Slide 12. So as Marie had pointed out earlier, the primarily engaged requirement is part of 1861(e), and a hospital must, must, must be primarily engaged in providing by, or under the supervision of physicians, and I've emphasized "to inpatients." And like Marie says, we can't emphasize this enough.

The focus is on caring – providing the care to inpatients, not providing inpatient services, and that's a real distinction. Where a facility may say, "We have the ability to provide inpatient services," that is not the same as providing care to inpatients. You may have inpatient beds, but you have to have patients in the beds to be providing care to inpatients.

Slide 13. So who do we consider as an inpatient? Because we've said you have to have two inpatients to conduct a survey, and we'll talk about average length of stay in ADC. And that's all predicated on inpatients.

So we define, here at CMS, an individual who is formally admitted as an inpatient. So I mean, that goes without saying: Everybody has to have an admission order with the expectation that he or she will be required and are expected to span their stay at least two midnights and occupy a bed even though it may later develop that the patient can be discharged or transferred to another hospital and doesn't actually use the hospital bed overnight. We realize, you know, not everybody – they may be admitted, but, you know, their condition changes, a bed opens up somewhere else, they need to be transferred. That is expected. But there must be – the patient must be admitted as an inpatient with the expectation that they are expected to stay at least two midnights.

So that leads into how did we come up with our length of stay criteria. So therefore, the average length of stay of two midnights is one benchmark for determining whether a facility is meeting the definition of a hospital. So

that wasn't something that we just sort of, you know, came up with. It is based on what CMS considers to be an inpatient as somebody who has been admitted and is expected to stay at least two midnights.

And it's important to point out individuals in observation status are not considered inpatients. Observation patients are outpatients, so observation patients that are in beds at the time of a survey would not be considered when we look at "do you have two inpatients." If there is two observation patients, the survey would not be conducted.

And we've also received a question about swing bed status because I know it will come up. And if you have swing bed patients, they are not considered inpatients as well for hospital purposes in this regard, because they are there to receive post-hospital SNF-level care. So we would not be surveying inpatient services. Those patients are there for post-hospital SNF-level care.

Slide 14. So inpatients present at the time of a survey—very important for you. So there must be two inpatients present at the time the surveyors are there. They cannot conduct a survey if there are not two inpatients present at that time.

A second survey could be attempted or may be attempted if the facility meets certain criteria, and we're going to talk about what those criteria are: average daily census, the average length of stay, and other factors that we will get into further.

And this requirement of having two inpatients at the time of the survey, it applies to all surveys: initial, recert, validation, complaint. There still has to be inpatients there to directly observe the care being rendered to inpatients. And again, that goes back to 488 under survey, certification, regulations, and it says surveyors will directly observe the provision of care and services to patients.

Second Survey Attempt

So slide 16. So if you do not have two patients at the time the surveyors present, now you say, "Now what? What happens?" On slide 16. So what will happen next is that the surveyors, and this includes accreditation organization surveyors, as well as state and federal surveyors, will then determine if a second survey should be attempted at a later date. And this will be based on the facility's average length of stay and their average daily census from the previous 12 months. So surveyors will be asking providers to see the average length of stay and the average daily census. So you will have to have that information available.

If the facility can demonstrate an average length of stay of at least two midnights and an average daily census of at least two inpatients from the previous 12 months, the state agency or AO may attempt a second survey at a later date. They will not conduct the survey then, because, again, there are no inpatients present. They are merely asking for that information to say "Well, you know, today they don't have patients but they can show us they have a history of two and two. We will come back at a later date."

And we've had this question before, and it's a good one: How do you assess ADC and average length of stay calculated for each location where there're inpatient services, or is this the total of the entire facility? It's the total for all inpatient locations of the facility combined because they are all operating as one hospital under

one CCN. So that is all to be one big number—one big ADC, one ALOS—based on all locations that have inpatients.

Slide 17. So facilities that have not been in operation for 12 months, and that may be true for many initial applicants, the ADC may be based on the number of months the facility has been open or – but not less than 3 months. So if a facility is an initial applicant and they've only been operational for 1 month, we still require that you calculate that ADC and ALOS of – with a denominator of no less than 3 months. But if you've been in operation 6 months, you will calculate those figures based on a denominator of 6 months.

But this doesn't mean that a facility must be operational for at least 3 months before a survey can be completed. We don't want you to think that you have to be operational for 3 months—you do not. It's just that you cannot calculate those – the ADC based on a denominator of less than 3 months.

Slide 18. Now if the facility is unable to demonstrate an average length of stay and an ADC of at least 2 from the previous 12 months or however many months they've been in operation, the facility is most likely not engaged – or primarily engaged in providing care to inpatients. And the second survey may or may not be attempted, and we'll talk about why we say may or may not. At that point, the state agency and AO – and/or AO must contact the CMS regional office to say "Hey, we haven't been able to do a survey today. There were not two patients on – in the hospital at that time—two inpatients. They don't have historical data of an average length of stay or an ADC of 2."

And at that point, the state agency or AO must look then at other factors to provide this information to the regional office so that the regional office will then make a determination in conjunction with the state agency and AO whether or not a second survey should be attempted. And the reason for that is, if – okay, they already haven't been able to provide historical data of meeting an average length of stay or an ADC of 2, you know, what's the sense in attempting a second survey if we don't look at a few other things, you know, and go back and they really aren't meeting the definition of a hospital. That's a lot of – there's a lot of resources, time, and money involved in going back for a second survey that really may should not ever happen.

We also have to point out that if your facility is in that situation and a second survey – a possible second survey is being looked at and it is determined that, yes, we will do a second survey at a later date, there is no timeline or deadline that we have prescribed for that second survey to be attempted or completed. This is solely at the discretion of the state agency or the AO, again, based on their survey schedule. So again, we're not saying "Oh, you have to get back out there within 2 weeks, 2 months," whatever it is. That will be based on, you know, however the state agency or the AO schedules their surveys.

Slide 19. So what are the other factors that we require the state agency and accrediting organizations to gather so that they can share this information with the regional office? So we ask that they look at the number of provider-based off-campus emergency departments. And when you look at that, we're saying "Look, is there 1 inpatient location, but there are 10, 14 off-campus EDs?" Well, that's a very disproportionate number of an inpatient site to outpatient. Now, we're not going to use that as the full basis, but it's one – it's a starting point—it's a factor that will be considered. You know, how can a hospital with more off-campus EDs than it has in inpatient locations be primarily engaged in providing care to inpatients? And that would be one factor that would be looked at.

They would look at the number of inpatient beds in relation to the size of the facility and all the services offered. You know, if it's a very large facility with 20 OR suites and 2 inpatient beds, that doesn't make a whole lot of sense. I would think an operation that had a very large surgical operation with that many OR suites but two inpatient beds probably can't accommodate that many inpatient surgeries. So again, that would be another trigger to look further. And the volume of inpatient surgical procedures compared to the volume of outpatient surgical procedures would be also looked at.

And again, to stress, there is no absolute threshold for all of this. We're not going to look at one factor here and say it's all or nothing. We look at all of this and make a determination based on the totality of all of these factors.

Slide 20, other factors that will be considered. What are the patterns and trends in the average daily census by the day of the week, and why is that important? You know, is the facility – do they drop down to zero patients every Saturday and Sunday? You know, hospitals are to be operational 7 days a week, 24 hours a day. And if there's a pattern of, you know, you're closing the doors every Friday night at midnight and there's no inpatients every Saturday and Sunday, again, that would cause someone to probe further.

What are the staffing patterns looking like? They will ask to see staffing schedules. Can the staffing schedules demonstrate that nurses, pharmacists, physicians, and other support staff, are they scheduled in a way that would support 24/7 inpatient care? They're going to be looking at that. You know, if you see every, you know, Saturday and Sunday they only have a pharmacist on call and one nurse staff for the whole facility, that wouldn't be staffing to support a hospital that provides – or should be providing 24-hour, 7-day-a-week inpatient care.

How does the facility advertise itself to the community? Again, very simple, but, you know, is the facility calling itself a specialty hospital of some sort? Is it a specialty? Is it calling itself a surgical hospital? Is it an emergency hospital? Again, it doesn't – you know, you can't make a decision based on that, but it certainly gives you cause to say "Let me just look a little bit further." Are they a surgical specialty hospital, or are they really an ASC? You know, those types of things. Is this a standalone ED that says that they're an emergency hospital, but they really are just a standalone ED providing outpatient emergency-level care?

And again, at the bottom of this slide, we will – there is not one single factor that will be an absolute. It will be all taken into consideration and there will be a decision based on all of these factors.

Slide 21. Now, that all is being looked at is just one piece of the statutory definition of – and the requirements of a hospital under 1861(e). Don't forget about all the other criteria, okay?

So just because the primarily engaged requirement may be met, that does not automatically mean that the facility meets the definition of a hospital. There are other criteria that have to be met to meet that statutory requirement.

Slide 22. And what are those? So if you've never looked at 1861(e), the other requirements are the facility must maintain clinical records on all patients; it must have medical staff bylaws; and it has a requirement that every patient with respect to whom the payment may be made under this title has to be under the care of a physician; and provides 24-hour nursing service rendered or supervised by a registered nurse.

Slide 23. The statutory requirement also requires that the hospital has in effect a hospital utilization review plan. You have to have a utilization review plan that is in the CoP, but it is also in the statutory definition as well. It must have in place a discharge planning process. If it's located in a state in which state or applicable local laws provide for the licensing of hospitals, they must have that license as we talked about in the beginning. And there must be an overall plan and budget that meets the requirements of another section of the act. But if you look closer into the CoP, the CoP do contain a budgetary plan requirement, and I believe that is under governing body.

"Other" Factors Don't Support Primarily Engaged Requirement

Slide 24. So what are the other factors – or what if the other factors do not support primarily engaged requirements? So the – whether it's the AO or the state survey agency has looked at staffing patterns, they've looked at the size of the facility, the beds in relation to the size of the facility, the average length of stay, all of those things, and they basically say, you know, "We're going to recommend that they are not meeting the definition of a hospital." They discuss this with the regional office, and the regional office also agrees. What happens next?

Slide 25. What happens next is that a second survey will not be conducted, because, as I said, you know, after all of that has been exhausted and there has been discussion and the decision is made, you know, even if we went out and looked at everything else, they're not a hospital. So why waste everybody's resources that are very valuable? So a second survey would not be conducted.

For initial applicants, what would happen next, the regional office will deny enrollment and follow existing denial procedures to enroll.

For currently participating hospitals, so again, if a currently participating hospital is found to no longer meet the requirements of a definition of a hospital, the RO would move towards termination of the provider agreement for noncompliance with the new tag under 482.1 Basis and scope, but after the regional office would consider any access-to-care issues that may exist.

Twenty-six. There are many other things you need to keep in mind in relation to all of this. And this is important, and there has been some confusion about this as well. So the Medicare Administrative Contractor, when they approve the enrollment form, the Form 855A, that does not mean that the facility meets the definition of a hospital. And we have had confusion. I've had a lot of questions that said "Well the MAC had approved the enrollment form, so that must mean they're a hospital." That is not what that means. And there has to be, you know, a review of whether or not the facility meets the criteria under the statutory definition of a hospital.

Hospital accreditation by an accrediting organization does not mean that a facility meets – or is truly a hospital for Medicare purposes as well. So just because an accrediting body offers up or accredits them under their hospital program, that – from a CMS perspective, that does not mean that they are truly a hospital as well.

Hospital status is only conveyed by the CMS regional office, and the state agencies and the AOs make a recommendation to convey that status to the regional office.

And something else to keep in mind, facilities that routinely have less than two inpatients on any given day, you know, they run the risk of prolonging their survey and certification process. And, of course, the longer you wait, the longer it takes to get an effective date with your provider agreement, and that means the longer you have to wait for reimbursement.

Slide 27, more things to keep in mind. Previous approval to participate as a hospital in the Medicare Program does not guarantee future participation in Medicare as a hospital. That is not a one-time deal. The definition of a hospital and that requirement remains, and it is under the CoP. So like anything else, we're going to look at it. When we come back out, as we said on all surveys, if you don't need it, you're out of compliance with that CoP.

Very small rural hospitals that may have some issues, you know, keeping that level of census or length of stay and they may want to consider conversion to a Critical Access Hospital, but, of course, only if that's appropriate and they can meet all of the other requirements, such as distance and location located in a rural area. But it's just something they may want to consider.

Surgical specialty hospitals that have consistent ADCs and lengths of stay of less than two may want to look at or consider reclassifying as an ASC, again, if it is appropriate. But those are just things to keep in mind.

And even the smallest of the smallest hospitals that may have two inpatient beds, you still have to be compliant with all of the Conditions of Participation. So, you know, you might be a small two little bed hospital, and maybe you do have two patients there every day and they are staying for two nights or more. You still – again, we can't stress enough, they still are responsible for being in compliance with all of the CoP.

Slide 28. So that is only the beginning. Once it is determined that a facility meets the statutory requirement and, under 482.1, meets the definition of a hospital, now the surveyors can begin to evaluate all of the hospital Conditions of Participation.

So once you meet that basic first fundamental requirement of "do we meet the basic requirements of a hospital," yes. If you do, now they can begin to survey all of the rest of the CoP.

So with that said, we're on slide 29. I'm going to turn the call over to Hazeline for a question-and-answer session.

Question & Answer Session

Hazeline Roulac: Thank you, Lisa. There's a lot of good guidance, so we're ready – we are now ready to start taking your questions. As a reminder, this event is being recorded and transcribed. All right, Dorothy, we're ready for our first caller.

Operator: To ask a question, press star followed by the number 1 on your touch-tone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset before asking your question to assure clarity. Once your line is open, state your name and organization. Please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard

in the conference. If you have more than one question, press star 1 to get back into the queue, and we will address additional questions as time permits. Please hold while we compile the Q&A roster.

Please hold while we compile the Q&A roster.

Your first question comes from the line of Ann Chronister.

Ann Chronister: Hi. So if the – if some of the limits apply to all campuses under a single CCN number and one campus has no patients but other campuses have lots of patients, how – does that mean that the campuses that do not meet the ALOS – the ADC and the ALOS requirements can still be surveyed, and do they all have to be surveyed on the same day? How is that supposed to work?

Lisa Marunycz: Well, as I had said, the average length of stay in the ADC and ALOS would be based on the totality of all of your inpatient locations, so we would look at it that way. And if they did then move forward with the survey, it would be like any other survey. They would be surveying all of the different locations.

Hazeline Roulac: Thanks, Ann. Next question.

Operator: Your next question comes from the line of Jayen Patel.

Jayen Patel: Hi. My question is concerning an existing hospital in Tulsa, Oklahoma. I'm from Oklahoma Pain and Wellness Center. I have a location that cannot meet ADC for greater than 12 months, and it did not meet that criterion of more than two inpatient stays. Are we able to still benefit from the first reevaluation if management has now changed and we will meet that criterion for ADC? Will that be a factor in the reaccreditation?

Hazeline Roulac: Thanks for your question. One moment, please.

Hazeline Roulac: Can you clarify your question, please?

Jayen Patel: Yes. We have a hospital that has approximately four inpatient beds and two ED beds. It is a physician-owned hospital. And we are looking to reaccredit within the next year but cannot meet the ADC requirement in the previous 12 months. But under new management and new ownership, we will meet it. So when we get recredentialed in the next 8 months, we will have met that, but not to the extent of the whole 12 months preceding the reevaluation or the inspection.

Lisa Marunycz: So, I mean, we can't make a decision right now, not, you know, looking at your facility and surveying it. But if – that decision would be made at the time that they were there to conduct a survey when you're seeking your new accreditation.

David Wright: Yes. This is David Wright. So if you didn't meet – again, part of the – as Lisa pointed out before, you know, these criteria in and of themselves aren't what makes the determination. But there could be followup with the regional office, and if, at the time of the survey, you don't meet the level of two with regard to your average daily census, then that could go to the regional office which will then look at, again, the totality of your hospital's operations.

Operator: As a reminder, if you would like to ask a question, please press star then the number 1 on your telephone keypad.

Your next question comes from the line of Ron Marshall.

Ron Marshall: Thank you. I have a question regarding frontier or rural hospitals who are in very small communities through no fault of their own—shrinking community—can't meet the two inpatients. But they're also too close by a half a mile to qualify for a Critical Access Hospital. How will you handle that when the small PPS hospitals are doing everything they can—they're primarily engaged, but just don't have the census to support this new requirement?

David Wright: So, again, this is David. You know, that's, again, part of what the evaluation would take place. Were you to not have the average daily census, then that would be part of the review that would take place at the regional office to determine how to proceed.

Operator: Again, if you would like to ask a question, please press star then the number 1 on your telephone keypad.

Your next question comes from the line of John Buck.

John Buck: A quick question, a followup to Mr. Patel's question. And I think our situation is a little bit different. If you go back and look at it from a 12-month perspective, we also, in a couple of our facilities, may not comply. But since September when the memo came out, we are now in compliance. Does the 12-month lookback still apply even before the memo was released?

David Wright: Yes. So this is David Wright. So at the time of the survey, you know, whenever your next survey's going to be and, again, we'll – again, I know I keep pointing this out, but it's not in and of itself a defining criterion. So if – it is just a trigger to go back to the regional office for further discussion about your status.

Operator: Your next question comes from the line of Valla Stewart.

Valla Stewart: Yes. My question relates to remote sites. So if you have an existing hospital and you are opening up a remote site that will bill under the main provider, does that remote site – is that remote site still subject to an initial survey?

Lisa Marunycz: Yes. I mean, it's part of a hospital, so that site would be included in the initial survey. But, again, what we're saying is and I think what you're getting at is the, you know, ADC is, again, calculated based on all inpatient sites, so remote location is to have inpatients. So again – but, yes, on an initial, all sites would be looked at on survey. But again, calculating your ADC and length of stay is calculated on all locations of the hospital where the inpatients are to be located.

Operator: Again, if you would like to ask a question, please press star then the number 1 on your telephone keypad.

You have a follow-up question from the line of Ann Chronister.

Ann Chronister: Hi. I wasn't clear in asking my question, so I wasn't clear on the answer, but it does relate to the last question. So you're saying that ADC and ALOS are calculated so that if there is a remote site or a site that is under the hospital license and under the same CCN, but isn't going to meet those numeric requirements, again, can you do a survey if one site has the – you know, the inpatients? Do those inpatients in the main site fulfill the inpatient requirement for the remote site?

Lisa Marunycz: Okay. So that's more clear. So if, in general, the entire hospital, say, the main location had two inpatients but the remote location didn't at the time of survey, it's all – we all – we consider all one hospital. So the hospital itself had two inpatients, so we would survey all locations and continue with the survey.

Operator: And there are no further questions at this time.

Additional Information

Hazeline Roulac: Okay. Well, thank you, everyone, for participating. If you do have additional questions, you can email your questions to the address that is on slide 30. For information on evaluating today's call, see slide 31. We hope you will take a few moments to evaluate your experience with today's call.

If you missed any information presented today or would like to review again, an audio recording and written transcript of today's call will be posted to the CMS website in approximately 2 weeks.

Again, my name is Hazeline Roulac. I want to thank our presenters. Also, thank you for joining today's Medicare Learning Network call on Definition of a Hospital: Primarily Engaged Requirement. Have a great day, everyone.

Operator: Thank you for participating in today's conference call. You may now disconnect.