CMS Manual System

Pub. 100-07 State Operations Provider Certification

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

Transmittal 247 **Date: September 18, 2026**

SUBJECT: Revisions to the State Operations Manual (SOM) Appendix W – Critical Access Hospitals (CHAs)

I. SUMMARY OF CHANGES: This Transmittal includes revisions based on recent federal regulation changes via (CMS–1809–FC) and is a follow-up to memo QSO 26-07 released on March 27, 2026. Revisions are being made to the interpretive guidance for hospital and Critical Access Hospital (CAH) requirements for emergency services protocols and provisions, with particular emphasis on emergency responses to obstetrical emergencies, to align with the obstetrical services Conditions of Participation (CoPs) implementation as of July 1, 2025, and assists surveyors in evaluating compliance with regulatory requirements for emergency patient care.

NEW/REVISED MATERIAL - EFFECTIVE DATE: September 18, 2026
IMPLEMENTATION DATE: September 18, 2026

The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

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

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N	Appendix W/C-0896/§485.618(e) Standard: Emergency services readiness. Effective July 1, 2025, in accordance with the complexity and scope of services offered, there must be adequate provisions (as required under paragraphs (b) and (c) of this section) and protocols to meet the emergency needs of patients. (1) Protocols. Protocols must be consistent with nationally recognized and evidence-based guidelines for the care of patients with emergency conditions, including but not limited to patients with obstetrical emergencies, complications, and immediate post-delivery care.

III. FUNDING: No additional funding will be provided by CMS.
IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

State Operations Manual

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

Table of Contents

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

C-0896

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

§485.618(e) Standard: Emergency services readiness. Effective July 1, 2025, in accordance with the complexity and scope of services offered, there must be adequate provisions (as required under paragraphs (b) and (c) of this section) and protocols to meet the emergency needs of patients.

> ***(1) Protocols. Protocols must be consistent with nationally recognized and evidence-based guidelines for the care of patients with emergency conditions, including but not limited to patients with obstetrical emergencies, complications, and immediate post-delivery care.***

Interpretive Guidance §485.618(e)(1)

The CAH must develop protocols to respond quickly and efficiently to emergencies for its patient population. The protocols must be based on nationally recognized and evidence-based practice for managing medical, surgical, and obstetrical emergencies, including but not limited to complications during labor, delivery, and the immediate post-delivery period. There are various professional organizations used to develop nationally recognized guidelines for the management of medical and surgical emergencies, such as American College of Emergency Physicians (ACEP), Advanced Trauma Life Support (ATLS), and American Heart Association (AHA) that can be considered. Examples of medical and/or surgical emergencies may include, but are not limited to:

- *Cardiac arrest*
- *Stroke*
- *Trauma (including pediatric trauma)*
- *Sepsis*
- *Respiratory distress*

Additionally, there are other professional organizations specializing in obstetrics and fetal medicine, such as the American College of Obstetricians and Gynecologists (ACOG) or Society of Fetal Medicine (SFM), and the American Academy of Pediatrics (AAP), for neonatal emergencies that may be used as nationally recognized guidelines for the management of obstetrical emergencies. Examples of such emergencies may include, but are not limited to:

- *Obstetric complications (e.g., hemorrhage, preeclampsia, uterine rupture)*
- *Neonatal resuscitation and other newborn care emergencies*
- *Obstetric emergencies during labor and delivery, such as shoulder dystocia, cord prolapse, emergency cesarean delivery, etc.*
- *Postpartum care and complications*
- *Any other medical emergencies that could arise in the obstetrics unit*

CAHs should have all protocols developed and approved by the medical staff and governing body, as with any other policies and protocols adopted by the CAH per § 485.627(a) and § 485.635(a). The protocols should be reviewed and updated according to CAH policy and

national standards of practice to reflect the most current and relevant practices in emergency care for all patients, taking into account the scope and complexity of the services provided. All policies and protocols should be readily available to all staff responding to medical and surgical emergencies, including obstetrical emergencies.

In addition to developing protocols for emergency response to medical and surgical emergencies, including obstetrical emergencies, complications, and immediate post-delivery care, the CAH must ensure that adequate provisions, such as medical supplies, equipment, medications, and blood products are available to meet the needs of the patient experiencing an emergency condition as described in 42 CFR § 485.618(b) and 42 CFR § 485.618(c). This includes, but is not limited to, medical, surgical, or obstetrical emergencies, and is utilized in a manner consistent with the CAH's protocol based on nationally recognized standards of practice and evidence-based guidelines, The emergency response protocols should also identify the roles and responsibilities of staff during emergencies and specify the required actions to ensure appropriate and timely responses to deliver safe quality patient care.

Survey Procedures §485.618(e)(1)

To assess compliance with this regulation, surveyors should focus on the following key elements:

1) *Identify if the protocol contains the required elements in the regulation.*
2) *Identify if the protocols are implemented and used as intended to meet the emergency needs of patients, as required.*
3) *Identify if the facility had adequate provisions to meet the emergency needs of patients, as required.*

If any of these three elements are not met, that would constitute noncompliance.

- *To assess compliance with key element number 1: Review the protocols to verify the CAH has written emergency protocols for: medical emergencies (e.g., stroke, cardiac arrest), surgical emergencies (e.g., trauma, hemorrhage), obstetrical emergencies and complications (e.g., eclampsia, shoulder dystocia), and immediate post-delivery care (e.g., neonatal resuscitation).*

- *Review the protocols to ensure they identify the condition or emergency type addressed and reflect the most current version of the nationally recognized standard or evidence-based guideline used (e.g., ACOG, ACEP, AHA).*

- *Verify that protocols are reviewed and updated according to CAH policy to reflect the current evidence-based guideline or standard of practice and have been formally approved by the governing body and medical staff.*

- *Interview a sample of clinical staff (e.g., ED nurses, providers, OB staff) to assess their awareness of the emergency protocols and their ability to access protocols during emergencies (paper, electronic, binder, etc.).*

To assess compliance with key elements numbers 2 and 3:

- *If available, review a sample of five (5) patient records involving emergency care to ensure CAH staff utilized the appropriate protocols during the emergency and if not, interview staff to identify why the protocol was not utilized.*
    - *Review the medical record of these patients to determine:*
        - *Was the facility's emergency protocol followed (key element #2)?*
        - *Did the facility have adequate provisions to meet the emergency needs of patients (key element #3). For example, were there delays in the provision of services that led to a decline in condition or adverse events?*
    - *Interview clinical staff to determine how the protocol was implemented in the emergency and does the medical record reflect that the protocol was followed?*

******Surveyors should avoid evaluating clinical judgment; focus on documentation and protocol alignment.***

- *Observe emergency care areas (e.g., ED, OB/triage, trauma room, nursery) for:*
    - *Availability of required emergency equipment and medications in accordance with CAH protocols.*
    - *Emergency kits (e.g., OB hemorrhage carts, imminent birth carts, neonatal resuscitation stations) should be clearly labeled, stocked, and accessible.*
    - *Medications are not expired.*
    - *Equipment is inspected and maintained per policy.*

- *Ask clinical staff to demonstrate or explain:*
    - *Use of specific emergency equipment (e.g., suction, defibrillator, neonatal warmer).*
    - *Step-by-step response to an emergency condition using the applicable protocol (e.g., postpartum hemorrhage).*
    - *The process for escalation and transfer, if the emergency exceeds CAH capabilities.*

- *If necessary equipment, supplies, or related items are unavailable, non-functional, or staff cannot demonstrate or explain their use in an emergency, the CAH cannot meet the patient's emergency needs. Adequate provision requires equipment, supplies, medication, and personnel to address patient needs during emergencies. The absence of any of these components constitutes noncompliance.*