

Critical Access Hospitals (CAHs) Continued Efforts over the Past Years

Critical Access Hospitals (CAHs) are required to be in compliance with the Federal requirements set forth in the Medicare Conditions of Participation (CoP) in order to receive Medicare/Medicaid payment. The goal of a CAH survey is to determine if the CAH is in compliance with the CoP set forth at 42 CFR Part 485 Subpart F.

- The most current CAH interpretive guidance, the State Operations Manual (SOM) Appendix W, can be found at – https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_w_cah.pdf

Certification of CAH compliance with the CoP is accomplished through observations, interviews, and document/record reviews. The survey process focuses on a CAH's performance of organizational and patient-focused functions and processes. The CAH survey is the means used to assess compliance with Federal health, safety, and quality standards that will assure that the beneficiary receives safe, quality care and services.

- See *SOM Chapter 2 - The Certification Process* for additional information - <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf>

In order to initially become certified as a CAH, a conversion survey is required. Prospective CAHs must first be certified and enrolled as a hospital, and only thereafter, may seek conversion to CAH status.

- Requests from a non-deemed hospital to be certified as a CAH are, therefore, not treated as initial surveys but as conversions, and may be surveyed as a Tier 2, 3, or 4, priority at State option.
- Accrediting Organizations (AOs) with a CMS-approved CAH program are able to conduct a CAH conversion survey.

For CAH recertification, annually, the RO must request from each State Agency (SA) a list of all CAHs expected to undergo a recertification survey over the next 12 months. This list should include and identify both deemed and non-deemed CAHs. For CAHs that are deemed, the SA reviews the deemed status tab in the Automated Survey Processing Environment (ASPEN) for accreditation dates of CAHs. Prior to the date of an SA or AO CAH recertification survey, the RO must determine whether the CAH meets the status and location requirements.

- Information regarding the *CAH Recertification Checklist: Rural and Distance or Necessary Provider Verification* within the S&C Memo: 16-08-CAH (REVISED 09.02.16) can be found at - <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-16-08.pdf>

For CAHs adding a provider-based location, a CAH submits a provider-enrollment application (Form CMS-855) to its affiliated MAC noting that it is adding a provider-based location. The CAH should also submit documentation noting how it continues to comply with the CAH distance requirements at 42 CFR 485.610(e)(2) to ensure that the CAH will retain its status as a CAH.

The MAC reviews the CAH's Form CMS-855 for the addition of a provider-based location and, once completed, forwards the form and any submitted documentation to their CMS RO Division of Survey and Certification (DSC) for review of compliance with 42 CFR 485.610(e)(2). If the CAH does not submit documentation noting how it continues to comply with the CAH distance requirements in the provider-enrollment application (Form CMS-855), the CMS RO DSC requests that information from the CAH during their distance review.

The CMS RO DSC reviews the Form CMS-855 and any corresponding documentation from the CAH, as well as any information received from the SA, for evidence that the CAH's off-campus provider-based location is more than a 35 mile drive (or 15 miles in the case of mountainous terrain or an area with only secondary roads) from another hospital or CAH.

If the CMS RO DSC verifies that the CAH will continue to meet the CAH distance requirements with the added provider-based location, the CMS RO DSC issues a tie-in notice and notifies the MAC, the CMS RO Division of Financial Management and Fee for Service Operations (DFMFFSO), and the SA of the tie-in.

However, if the CMS RO DSC review verifies that the CAH's provider-based location does not meet the CAH distance requirements at §485.610(e)(2), the CMS RO DSC notifies the CMS Central Office (CO), the MAC, the CMS RO DFMFFSO, and the SA. Once notified of the CMS RO DSC review:

- The MAC does not take further action on the submitted CAH Form CMS-855 to add the provider-based location (under Chapter 15 of the Medicare Program Integrity Manual) until the MAC is notified of the CAH's decision as outlined below.
- The CMS RO DSC informs the CAH that its provider-based location causes the CAH to no longer meet the 42 CFR 485.610(e)(2) distance requirement and offers the CAH the following options (A, B, or C):
 - A. **Termination of participation:** By adding the provider-based location, the CAH would be placed on a 90 day involuntary termination track (as outlined in Section 3012 of the SOM) or the CAH can voluntarily terminate its participation from the program all together.
 - B. **Continued CAH certification:** The CAH may retain its CAH status by terminating the off-campus provider-based location arrangement that led to the non-compliance with the 42 CFR 485.610(e)(2) distance requirements within the 90 day termination period or by physically moving the provider-based location so that the distance requirements are met.

- C. **Conversion:** The CAH may continue to participate in Medicare by converting to a hospital. If the CAH chooses to convert to a hospital, the CAH would need to submit to the MAC another Form CMS-855 to terminate their CAH enrollment along with a separate Form CMS-855 to enroll as a hospital. The effective date of the CAH's hospital certification would coincide with the effective date of termination of CAH status. See Section 2005 of the SOM for the Medicare enrollment process.

Once the CMS RO DSC notifies the MAC of its review that the CAH is in compliance with 42 CFR 485.610(e)(2) distance requirements or, if not in compliance, of the CAH's choice of option A, B, or C (as described above), the MAC then proceeds with sending the Form CMS-855 and its recommendation for approval on the provider-based location to its affiliated CMS DFMFFSO for a determination under 42 CFR 413.65.

- The CMS RO DFMFFSO reviews the Form CMS-855 and confers with CMS CO and RO DSC on specific issues as needed.
- The CMS RO DFMFFSO sends the CAH/Hospital (Form CMS-855 applicant) a notice letter with the determination on its request for provider-based location designation, with copies sent to the MAC, CMS RO DSC, and the SA.
- The CMS RO DSC notifies the AOs (for those accredited CAHs deemed as meeting Medicare and Medicaid certification requirements).

Please see updates to Publication 100-07 - SOM Chapter 2 at –
<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/QSO-19-16-CAH.html?DLPage=1&DLEntries=10&DLFilter=cah&DLSort=3&DLSortDir=descending>

The CMS Center for Program Integrity (CPI), Provider Enrollment Division Publication 100-08 Program Integrity Manual, Chapter 15.10.2(E) instructs the MACs and aligns with the SOM Chapter 2 guidance. See <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c15.pdf>