

Materials for Participation in the Oregon Critical Access Hospital Program

Developed By: **The Oregon Office of Rural Health**
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In Consultation With: Oregon Department of Human Services - Health Services
Oregon Association of Hospitals and Health Systems
Region X Office of Centers for Medicare & Medicaid Services
Oregon Critical Access Hospital Advisory Committee

The Oregon Office of Rural Health can also be found at: www.ohsu.edu/oregonruralhealth

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Overview

The Medicare Rural Hospital Flexibility Program

The Medicare Rural Hospital Flexibility Program, established by the Balanced Budget Act of 1997 (Public Law 105-33), is available to all 50 states. Its intent is to allow rural communities to: preserve access to primary care and emergency health care services, provide health care services which meet community needs, and help assure the financial viability of program participants through improved reimbursement and different operating requirements.

The Medicare Rural Hospital Flexibility Program creates the Critical Access Hospital (CAH) designation, and provides the funds to develop state level Critical Access Hospital programs in each state. A CAH is a limited service hospital that is eligible for enhanced Medicare reimbursement and may be an attractive alternative to the current hospital licensing standards. To qualify as a CAH, the hospital must meet/agree to the following requirements as stated in the Balanced Budget Act of 1997, those amended by the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), or the Medicare Improvement Act of 2003:

- ◆ Be a for-profit, non-profit, or public hospital that is open and operating. Hospitals that have either closed or downsized to health centers or clinics in the past 10 years (from November 29, 1999) are also eligible for CAH designation;
- ◆ Be 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 December 31, 2005, will maintain its necessary provider designation after January 1, 2006.
- ◆ Located in a rural area **or** classified by the Secretary as rural in an urban county if located in a census tract that is considered rural under the most recent update of the Goldsmith Modification; **or** located in an area designated by State law or regulation as a rural area or designated by the state as rural providers; **or** meets other criteria as specified by the Secretary;
- ◆ Limit bed size to 25 inpatient beds that can be used as acute care or swing interchangeably;
- ◆ Have an annual average length of stay of less than 96 hours;
- ◆ Make available 24 hour emergency services and nursing services but need not meet all the staffing and service requirements that apply to a full service hospital;
- ◆ Participate in a rural health network, which is defined as an organization consisting of at least one CAH and at least one full-service hospital where

participants have entered into specific agreements regarding patient referral and transfer, communication, and patient transportation; and

- ◆ Establish credentialing and quality assurance agreements with at least one hospital that is a member of the network, a PRO or equivalent or another entity identified in the rural health plan of the state.

In addition, all eligible hospitals (both federal and state) must adhere/agree to the following federal criteria:

1. Apply for designation;
2. Comply with all of the licensure and certification requirement for CAHs established by the federal and state governments;
3. Make available 24 hour nursing services, but not required to staff unless an inpatient is present;
4. The facility is also required to meet certain staffing and other requirements as specified in CFR Part 485, Subpart F – Conditions of Participation: Critical Access Hospitals (CAHs).

Potential benefits of the Medicare Rural Hospital Flexibility Program include the following provisions as stated in the Balanced Budget Act of 1997, those amended by the Balanced Budget Refinement Act of 1999, or the Medicare Improvement Act of 2003:

- ◆ Reimbursed at 101% of reasonable costs basis for inpatient, outpatient, and covered skilled nursing services provided to Medicare beneficiaries *who are not covered under a Medicare managed care plan*.
- ◆ Allowed to bill under the all-inclusive rate structure (this allows the hospital to bill for both the hospital and physician services);
- ◆ A mid-level practitioner (physician assistant or nurse practitioner) may provide inpatient care under remote supervision of a physician.
- ◆ Reimbursement of on-call emergency room providers includes (in addition to physicians) physician assistants, nurse practitioners and clinical nurse specialists for the cost assessed with covered Medicare services (beginning January 1, 2005).
- ◆ Distinct part psychiatric or rehabilitation unit beds will not count against the CAH 25 bed limits.

Goals of the Oregon Critical Access Hospital Program

The goals of the Oregon Critical Access Hospital Program are to (1) improve access to health care services, (2) promote regionalization of health care services, and (3) foster the development of rural health networks.

Improve and Maintain Access to Rural Health Care Services

The Oregon Critical Access Hospital Program promotes communities' access to care by: providing additional financial resources to small rural hospitals that are essential to rural Oregon, fostering regionalization, and encouraging continued surveillance of some of Oregon's necessary providers of health care. Financially, this program offers increased reimbursement and different licensing standards for a Critical Access Hospital. Other benefits should result from regionalization and network development.

Promote Regionalization in Providing Rural Health Care Services

Small rural communities may be unable to sustain the entire array of health care providers and services necessary to meet the health care needs of the population. With a limited number of providers providing care, it may not be feasible to both meet the needs of the patients and maintain the skill that is inherent in specialty care. As a result, communities that share resources through a prearranged plan will be able to work together to maximize access to quality primary, acute, and specialty health care while increasing efficiency and effectiveness.

Regionalization occurs when various health care providers and facilities, within a geographical area, establish working relationships to provide health care services. As health care resources become more scarce and technology and specialty care increase and improve, regionalization may occur in rural areas.

The Oregon Critical Access Hospital Program promotes regionalization. This is done by encouraging small rural hospitals to redesign themselves as the experts in providing primary and emergency health care services. To do this, hospitals will reduce their excess hospital beds, maintain high quality emergency and primary care services, provide

the care that fits their expertise, and network with other hospitals and health care providers to expand their realm of acute and specialty care services. The result: communities with access to an extensive, high quality, efficient, financially viable health system.

Foster Network Development in Rural Areas

Local networks have the potential to create economies of scale and improve access to and coordination of care. They may also better address local needs and promote the use of community-based services. The stability and accountability to the community that these networks provide are additional advantages for rural communities.

For those small rural hospitals that have not already engaged in networking activity, the Critical Access Hospital Program is an opportunity to: build partnerships, share expertise, reduce duplication, create efficiencies and economies scale, and enhance quality of care. Hospitals that are already participating in networking activity will continue to build upon these opportunities and, in addition, they will have other avenues to explore: building upon current relationships, expanding relationships to include other health care providers and further reducing unnecessary duplication of services.

Accessibility to additional technology is another potential outcome of the network relationship from the Oregon Critical Access Hospital Program. The use of telemedicine has grown substantially in recent years, due in large part to advances in telecommunications technology. Growth in telemedicine has been evident in rural areas, primarily because of telemedicine's potential to increase access to health care and to relieve the sense of isolation and stresses of a small practice often experienced by rural practitioners.

Program Funding

Federal funds available from the Federal Office of Rural Health Policy to the Oregon Office of Rural Health allows ORH Critical Access Hospital program staff to:

Inventory prospective program participants.

Facilities with an average daily census of less than 20 patients and an average length of stay of approximately 96 hours or less, or eligible facilities that have been determined to be in financial crisis will be identified as potential candidates for conversion to a CAH.

Work with communities to inform them of the CAH option.

ORH staff will promote the program by preparing written information and dedicating space to the program on the office's web page. Staff will be available to present information to hospital staff and boards, and other appropriate groups. Assistance will be provided to communities wanting to organize local planning sessions.

Provide technical assistance to potential applicants.

Office of Rural Health program staff will work directly with facilities interested in establishing CAH networks. Technical assistance will be provided in conducting community needs assessments and fiscal analyses, as well as meeting all state and federal assurances. The Office of Rural Health is committed to providing assistance to communities; however, in the spirit of the legislative intent, the first priority of the CAH program is to work with open, existing hospitals. The second priority is to work with facilities that have either closed or downsized to health clinics or centers. The third priority is to help those communities who seek to build a new facility for conversion purposes.

Oregon Criteria for Participation in the Critical Access Hospital Program

In order to satisfy all requirements for designation as a CAH, a hospital must first agree to meet all Federal requirements for designation. Additionally, the facility must agree to the following state-specific criteria:

1. The hospital must be able to demonstrate that a thorough fiscal assessment (to be coordinated through the Office of Rural Health) has determined that conversion to a CAH will be fiscally appropriate; and
2. The hospital must demonstrate that public notice of the intent to convert to a CAH has occurred, and that the community's concerns, if any, have been adequately addressed.

Oregon Criteria for "Necessary Provider of Health Care Services"

Federal statute allows the state to designate hospitals as "necessary providers" if hospitals do not otherwise meet the federal criteria for CAH eligibility. In response, Oregon has adopted the following criteria for determining a "Necessary Provider of Health Care Services."

(The Medicare Improvement Act of 2003 established a sunset clause removing the Necessary Provider provision, effective January 1, 2006.)

- ◆ The hospital is located in an area that is defined as "rural" by the Office of Rural Health; and
- ◆ The hospital also meets one of the following criteria:
 1. The Office of Rural Health has determined that the facility is located in an "Area of Unmet Health Care Need" (AUHCN) through its authority granted by ORS 442.555(4) or
 2. The hospital is located in a federally designated Health Professions Shortage Area (HPSA) or Medically Underserved Area (MUA).

In addition, any hospital determined to be a "necessary provider" must demonstrate that it is substantially at risk for imminent closure due to loss of physician staff or fiscal crisis.

Justification for “Necessary Provider of Health Care Services” criteria

Oregon is a very rural state. The majority of its population and health care workforce is clustered around the Interstate 5 corridor, which bisects the western half of the state from the north to the south. In considering issues of access to health care, one must review not only the adequacy of health care workforce, but also the geographic, topographic and climatic challenges that may exist. Oregon’s coastal and mountainous communities often experience sudden and prolonged isolation during seasonal rain and snowstorms. At the same time, fragile rural hospitals within 20 miles of one another may be most at risk of closure because of market share, selective contracting practices and other economic pressures. Maintaining access to basic hospital services in these areas is a high priority of Oregon’s Office of Rural Health.

The Office of Rural Health also recognizes that the intent of Congress was to make this program available to those facilities and populations that are most at need. Consequently, the Oregon criteria contain additional safeguards to assure that the Congressional intent will be honored, and that no abuses of this program will occur.

Technical Assistance

Technical Assistance Available for Eligible Hospitals

Technical assistance for those interested in the Oregon Critical Access Hospital Program is available through the Office of Rural Health, Oregon Health Division, and the Oregon Association of Hospitals and Health Systems. The table below describes some of the assistance available. We encourage you to contact us with questions, requests, and/or for on-site assistance.

Type of Assistance Available	Contact Person
General Questions	ORH - Sandra Assasnik
Financial Feasibility Studies	ORH - Sandra Assasnik
Community Awareness <ul style="list-style-type: none"> • attend community meetings • explain the program 	ORH - Sandra Assasnik ORH - Scott Ekblad
Facility Education and Training <ul style="list-style-type: none"> • attend or facilitate information and/or training sessions within facilities • provide resource directory of contacts within operating CAHs 	ORH - Sandra Assasnik OAHHS - Kent Ballantyne
Meeting the Application Requirements <ul style="list-style-type: none"> • completing CAH application forms • developing agreements for referral and transfer, communications, and transportation • providing proof of community awareness 	ORH - Sandra Assasnik ORH - Scott Ekblad
Survey Preparation <ul style="list-style-type: none"> • responding to questions • acting as a liaison between the hospital and OMPRO and/or CMS 	OHD - Judy Lubeck

Sandra Assasnik: (503) 494-4450 or assasnik@ohsu.edu

Kent Ballantyne: (503) 636-2204 or kentb@oahhs.org

Scott Ekblad: (503) 494-4450 or ekblads@ohsu.edu

Judy Lubeck: (503) 731-4013 or judy.k.lubeck@state.or.us

Contact Listing

For additional information regarding the Oregon Critical Access Hospital Program, please contact:

Office of Rural Health: Sandra Assasnik
Community Grants Coordinator
Office of Rural Health
Oregon Health Sciences University
3181 SW Sam Jackson Park Rd, L-593
Portland, OR 97201-3098
Tel: (503) 494-4450
Fax: (503) 494-4798
E-mail: assasnik@oshu.edu

Scott Ekblad
CAH Program Manager
Office of Rural Health
Oregon Health Sciences University
3181 SW Sam Jackson Park Rd, L-593
Portland, OR 97201-3098
Tel: (503) 494-4450
Fax: (503) 494-4798
E-mail: ekblads@ohsu.edu

OAHHS: Kent Ballantyne
Senior Vice President
Oregon Association of Hospitals and Health Systems
4000 Kruse Way Place, Building 2, Suite 100
Lake Oswego, OR 97035
Tel: (503) 636-2204
Fax: (503) 636-8310
E-mail: kentb@oahhs.org

Survey: Judy Lubeck
Oregon Health Division
Health Care Licensure and Certification
Portland State Office Building
800 N.E. Oregon Street
Portland, OR 97232
Tel: (503) 731-4013
Fax: (503) 731-4080
E-mail: judy.k.lubeck@state.or.us

Quality Assurance: Stacy Aguas
Oregon Medical Professional Review Organization
2020 SW 4th St.
Portland, OR 97201
Tel: (503) 382-3918
Fax: (503) 279-0190
E-mail: saguas@ompro.org

Fiscal Intermediary: Denise Arnold
Medicare Northwest
Regence Blue Cross and Blue Shield of Oregon
100 SW Market Street
Portland, OR 97201
Telephone: (503) 721-7013
E-mail: ddarnol@regence.com

EMS: Sandra Assasnik
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Application Materials

Application Forms

All application forms on the following pages need to be completed as part of the application process. Those forms include:

- ◆ Oregon Critical Access Hospital Program Application
- ◆ Oregon Critical Access Hospital Program Application Completion Check List

The application instructions are found at the end of this section. The application process is outlined in the flow chart on page 28.

Please note: **there is no deadline for applications at this time**

If you have additional questions, please contact Sandra Assasnik, Community Grants Coordinator, at (503) 494-4450 or e-mail at assasnik@ohsu.edu.

**OREGON
APPLICATION FOR DESIGNATION
AS A CRITICAL ACCESS HOSPITAL (CAH)**

The following is a list of Oregon rural hospitals located 35 miles from another hospital (15 miles in mountainous terrain or areas with only secondary roads). A primary road is defined as “an interstate or limited access state divided highway” and a secondary road is defined as “all other roads in Oregon.” All the hospitals on this list are also in possession of a provider’s agreement to participate in the Medicare program. Hospitals **not** in this list **may** be eligible to seek Critical Access Hospital designation if they meet State of Oregon criteria for status as a Necessary Provider of Health Services.* This list in no way indicates an expectation that any hospital will seek Critical Access Hospital designation.

** In order to be deemed a Necessary Provider of Health Care Services the applicant must meet state criteria for Necessary Provider Health Services. These requirements are listed on page 8.*

1. Check here if applicant facility is on this list and proceed to question 2.

<u>Hospital Name</u>	<u>Location</u>	<u>County</u>
Ashland Community Hospital	Ashland	
Blue Mountain	John Day	Grant
Columbia Memorial	Astoria	Clatsop
Coquille Valley	Coquille	Coos
Cottage Grove Community Hosp.	Cottage Grove	Lane
Curry General	Gold Beach	Curry
Good Shepherd Hospital	Hermiston	Umatilla
Grand Ronde	La Grande	Union
Harney County	Burns	Harney
Holy Rosary	Ontario	Malheur
Lake District	Lakeview	Lake
Lebanon Community	Lebanon	Linn
Lower Umpqua	Reedsport	Douglas
Mercy Medical Center	Roseburg	Douglas
Mid-Columbia Medical Center	The Dalles	Wasco
Mountain View	Madras	Jefferson
Peace Harbor	Florence	Lane
Pioneer Memorial	Heppner	Morrow
Pioneer Memorial	Prineville	Crook
Providence Hood River Hospital	Hood River	Hood River
Providence Seaside	Seaside	Clatsop
Samaritan North Lincoln	Lincoln City	Lincoln
Samaritan Pacific Communities	Newport	Lincoln
Santiam Memorial Hospital	Stayton	Marion
Silverton	Silverton	Marion
Southern Coos	Bandon	Coos

St. Anthony	Ontario	Malheur
St. Charles	Redmond	Deschutes
St. Elizabeth	Baker City	Baker
Three Rivers Community Hosp.	Grants Pass	Josephine
Tillamook County General	Tillamook	Tillamook
West Valley Community	Dallas	Polk
Wallowa Memorial	Enterprise	Wallowa
Willamette Valley Medical Cntr.	McMinnville	Yamhill

2. Applicant identifying information

Hospital Name: _____

Legal Name of Organization owning/operating facility: _____

Mailing Address: _____

City: _____ Zip: _____

County: _____

Telephone Number: _____ Fax: _____

3. Name and title of hospital administrator

Name: _____

Title: _____

E-mail: _____ Phone: _____

4. Financial feasibility contact for your hospital

Name: _____

E-mail: _____ Phone: _____

5. Premises located at (if different than mailing address)

6. Medicare Provider Number: _____

7. **What level (if any) Trauma Center Designation does this facility currently have?** _____

8. **Does this facility intend to maintain current level of Trauma Center Designation?** Yes No If no, explain: _____

9. **Number of Acute Care Beds Designated?** _____

10. **Swing-beds Designated?** Yes.....Number: _____ No

11. **Are you a member of a Rural Health Network?** Yes No

Do you have signed written agreement for (check applicable boxes)?

- Emergency and non-emergency patient referral and transfer;
- Patient transportation;
- Development and use of communications systems;
- Credentialing and quality assurance with at least one hospital that is a member of the Rural Health Network, or with a Professional Review Organization.

Referral Hospital Name: _____

Referral Hospital Address: _____

City: _____ Zip: _____

12. **CAH statutory requirements. A hospital electing CAH status must meet the following statutory requirements. Please check all that apply.**

- Has determined that conversion to a CAH will be fiscally appropriate as indicated by a financial feasibility analysis.
- Has notified the public of the intent to convert to a CAH and the community substantially agrees with the plan.
- Agrees to provide up to 25 inpatient beds that can be used interchangeably for acute or swing level care.
- Agrees to maintain staffing levels of at least one physician assistant or nurse practitioner as long as there is physician oversight.

- Agrees to limit the annual average length of inpatient stays to no more than 96 hours.
- Agrees to remain open at all times when there is at least one acute care patient in the facility.
- Agrees to make available 24-hour emergency care services, seven days a week, regardless of inpatient census.
- Has established procedure under which a practitioner (MD, DO, NP or PA) is on call and immediately available by telephone or radio contact, and available on site within 30 minutes, on a 24-hours a day basis.

By signing the below, I attest that this application is truthful and complete.

Board Chair (type or print)

Board Chair (signature)

Administrator (type or print)

Administrator (signature)

Chief of Medical Staff (type or print)

Chief of Medical Staff (signature)

Date Submitted

For Official Use Only

Date Received: _____

ORH: _____

OHD: _____

**OREGON
APPLICATION FOR DESIGNATION
AS A CRITICAL ACCESS HOSPITAL (CAH)**

COMPLETION CHECK LIST

Done	Have you...
<input type="checkbox"/>	Attached copies of all networking agreements <ul style="list-style-type: none"> <input type="checkbox"/> Emergency and non-emergency patient referral and transfer <input type="checkbox"/> Patient transportation <input type="checkbox"/> Communication between network members including systems for electronic sharing of patient data <input type="checkbox"/> Credentialing and quality assurance
<input type="checkbox"/>	Attached needs assessment documentation <ul style="list-style-type: none"> <input type="checkbox"/> Description of how community needs were assessed <input type="checkbox"/> Minutes from the board meeting discussing 17 issues <input type="checkbox"/> Copy of public notice with publication date
<input type="checkbox"/>	Attached a description of how emergency services will be provided at the CAH
<input type="checkbox"/>	Attached completed CMS forms 1514 (Hospital Request for Certification in the Medicare/Medicaid Program)
<input type="checkbox"/>	Filled in all blanks on Application form
<input type="checkbox"/>	Signed the application (all of the following must sign) <ul style="list-style-type: none"> <input type="checkbox"/> Board Chairman <input type="checkbox"/> Hospital Administrator <input type="checkbox"/> Chief of Medical Staff

OREGON CRITICAL ACCESS HOSPITAL PROGRAM

APPLICATION INSTRUCTIONS

***Numbers correspond to numbered questions on application**

1. Check the box if the applying hospital is on the list provided.
2. Fill in the name, address, telephone number (including area code), and fax number of the hospital seeking designation as a critical access hospital.
3. List the name and title of the hospital administrator. All questions about the application will be directed to this person.
4. List the name of the person at your facility who will communicate with the consultants conducting the financial feasibility study for your hospital. All questions about the financial feasibility study will be directed to this person.
5. Fill in the location of the applying hospital (if different than mailing address).
6. List the hospital's Medicare Provider Number.
7. List the hospital's Trauma Service Designation, if applicable.
8. Check either box "yes" or "no" indicating whether the hospital will maintain the current level of Trauma Service. If no, provide an explanation.
9. List the number of acute care Critical Access Hospital beds designated. The maximum number of acute care beds allowed is 15.
10. Check either box "yes" or "no" indicating whether Critical Access Hospital swing-beds are designated. [Note: Although swing beds may be used interchangeably for acute and SNF-level care, the program rules restrict the number of facility beds that may be used for acute care at any one time to 25.]
11. Check either "yes" or "no" box, indicating whether the hospital is a member of a rural health network. Continue to check boxes for all written agreements that apply to the hospital. Provide information for the referral hospital.

Attach copies of all networking agreements to the application. Each agreement should be labeled. If there is only one agreement, it should be labeled "**Attachment A.**" If there are multiple agreements, label each with the letter "A" followed by a sequential number; for example, "Attachment A1", "Attachment A2", and so on.

12. Check all boxes that apply to the hospital.

Community Needs Assessment for hospitals with current annual average length of inpatient stay (ALOS) of *more than* 96 hours

- A. The purpose of the community needs assessment is to gather objective data to support the development of a local health services delivery plan that addresses the acute, primary, preventive, and emergency health care needs of the community in a coordinated and cost effective way through a CAH-based rural health network. At a minimum, a community needs assessment should include:
- ◆ A description of the service area of the CAH in terms of geography, socioeconomics and demographics.
 - ◆ A description of the current delivery system in terms of the numbers and types of providers and services.
 - ◆ An assessment of the need for health care services in the service area.
 - ◆ A description of the rural health network including those services available at the CAH and those available by referral to hospitals within the rural health network.
- B. It is not necessary that a hospital applying for CAH designation undertake a new community needs assessment process. Planning and marketing studies completed within three years of the date of the CAH application may be submitted to satisfy the community needs assessment criteria. Community needs assessment documentation should be labeled “**Attachment B**”.
- C. Upon completion of the above assessment, the hospital must then *also* fulfill the requirements below:

Community Needs Assessment for hospitals with current annual ALOS of *96 hours or less*

- A. A public notice must be placed in the “public notices” section of the local newspaper, announcing the hospital’s intent to convert to CAH status and inviting questions and comments from the public. Hospitals with an annual ALOS of *more than* 96 hours must hold a public meeting to respond to any questions or concerns of the public. Those hospitals with an annual ALOS of *96 hours or less* may simply provide the name and telephone number of a representative of the hospital who can respond to public inquiry.
- B. The board must discuss and assess the following as positive or negative impacts on the organization as it relates to CAH conversion *and record it in their minutes*:
- 1) **Survival-** Is the CAH conversion being considered because the health center will fail without it? Could the health care facility survive as it currently exists? What happens if you do nothing?

- 2) **Community Needs-** Will the CAH conversion meet the needs of the community?
- 3) **Mission-** Will the CAH conversion enhance the mission of the health care facility? Will the mission need to change as a result of the change in sponsorship? Who will decide what the mission will be?
- 4) **Goals-** Will the CAH conversion foster goals within the current strategic plan? Change them?
- 5) **Market share-** Will the CAH conversion protect or improve market share? Will it prevent migration of rural residents to other outside services?
- 6) **Financial losses-** Will the CAH conversion lessen financial losses?
- 7) **New technologies-** Will the CAH conversion develop new services or make new technologies available (i.e., EMS, telecommunications)? Do the new services match the local scope of service/needs?
- 8) **Revenue sources-** Will the CAH conversion expand or diversify revenue sources? Will new services provide a profit? Will it change access to tax dollars or grant dollars?
- 9) **Further action-** Will the CAH conversion foster a closer relationship within the rural health network for possible further action? Is this option moving closer to the goals in the long-range plan?
- 10) **Reputation-** Will the CAH conversion enhance the reputation of the organization? What is the reputation of the network partner(s)?
- 11) **Skills and ideas-** Will the CAH conversion bring new management skills, techniques, services or ideas to the current organization?
- 12) **Political acceptability-** Will the public accept the option? Will the community resist it?
- 13) **Stability-** Will the CAH conversion so dramatically change the health center that it could falter?
- 14) **Existing personnel-** How will the CAH conversion affect existing personnel? Will they stay? What will be the process for releasing them? How will current employees be handled?
- 15) **Costs-** Does the CAH conversion involve an expenditure or debt? Is it a debt you are willing to accept? What investment is required in terms of money, time or resources?
- 16) **Style-** Will the CAH conversion substantially change the style, culture or values of the health care facility?
- 17) **Quality of care-** Will the CAH conversion affect the quality of care the health care facility has determined is necessary? How does your medical staff and other community providers think it will affect their clinical practice?

Describe how emergency services will be provided at the CAH.

CAH regulations require that a CAH “make available 24-hour emergency care.” This does not mean that the CAH must remain open 24-hours per day when it does not have inpatients. When the CAH does close, however, it must have in place an “effective system” to ensure that “a practitioner with training and experience in emergency case [is] on call and immediately available by telephone or radio contact, and available on site within 30 minutes on a 24-hour a day basis.” Describe planned hours of staffing and the call plan for emergency services when the CAH is closed. The emergency services description should be labeled “**Attachment C**”.

CMS Form 1514 (Hospital Request for Certification in the Medicare/Medicaid Program) must be completed and submitted with the application. This form is a request for the Oregon Health Division to survey the hospital for its initial CAH certification. Form 1514 is available through the Health Care Licensure and Certification Department at the Oregon Health Division. Contact Judy Lubeck at HCLC for these forms (see Technical Assistance, page 10). Please label CMS Form 1514 “**Attachment D**.”

The chair of the governing board, the hospital administrator, and the chief of the medical staff must sign all applications. The date the application is submitted to the Office of Rural Health should be listed on the application.

Completed application packages should be submitted to:

Sandra Assasnik, Community Grants Coordinator
Oregon Health Sciences University
Office of Rural Health, L-593
3181 SW Sam Jackson Park Rd
Portland, OR 97201-3098

Oregon Critical Access Hospital Designation Process

Abbreviated Overview

Conversion to a Critical Access Hospital is a process consisting of six key steps.

1. The hospital administrator submits a letter of interest in the CAH program to the Oregon Office of Rural Health (ORH).
2. A financial feasibility assessment is performed for the hospital.
3. Hospital personnel complete a written application for conversion to CAH designation.
4. ORH determines eligibility of the applying hospital as a Critical Access Hospital.
5. The hospital administrator requests that the Oregon Health Division (OHD) survey the hospital for compliance with Medicare's Conditions of Participation. OHD makes a recommendation to CMS regarding certification as a CAH.
6. The Centers for Medicare & Medicaid Services acts on the recommendation from the OHD, certifies the hospital a CAH and notifies the Medicare fiscal intermediary.

Procedure

Applying for designation as a Critical Access Hospital includes the following steps (the steps below correspond to the flow chart at the end of this section):

1. The hospital learns about the Critical Access Hospital Program and decides to consider CAH designation. A letter of interest in the CAH program is mailed to the Oregon Office of Rural Health.
2. The ORH will complete a formal financial assessment through the use of external consultants in order to determine the cost-effectiveness of CAH conversion.
3. Hospitals interested in designation as a CAH will forward an application to the Office of Rural Health, where staff will determine the applicant's ability to meet all federal and state criteria for designation as a CAH. Deficient applicants will receive technical assistance to meet necessary criteria. The application packet will include:
 - (1) A Critical Access Hospital Designation Application form and instructions for filing the designation application;
 - (2) Any information on file in the ORH that may be of use to the hospital such as documentation for "Necessary Provider" criteria.

4. The hospital needs to complete other requirements toward becoming a CAH including:

- (1) Medical Staff education
- (2) Governing Board education
- (3) Community information and education about conversion to a CAH.

If the hospital encounters resistance to CAH conversion it may postpone transition to a CAH. If support for conversion is present move to step 5.

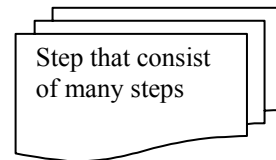
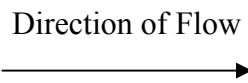
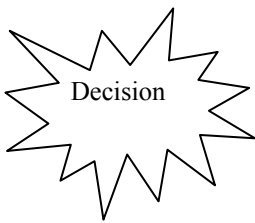
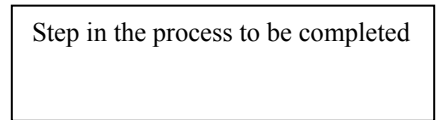
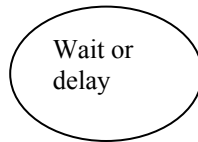
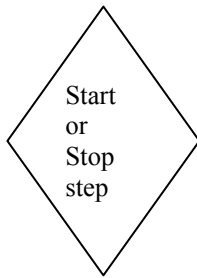
5. Within 30 days of receipt of application, the ORH will forward complete applications to the Oregon Health Division, Health Care Licensure and Certification (HCLC). ORH notifies CMS and the applicant that the application has been forwarded to HCLC.
6. Upon written request from the hospital administrator, OHD-HCLC schedules and conducts on-site survey to determine if the facility meets conditions of participation in the Medicare program as a CAH. Within 60 days, recommendation for acceptance or denial of the application will be made and the hospital notified by ODH.
7. If the hospital meets all conditions of participation, HCLC recommends certification of the application to CMS.
8. If the hospital is found to have minor deficiencies, HCLC sends the hospital a statement of deficiencies. The hospital responds with a plan of correction and if approved, HCLC recommends certification of the application to CMS. ORH staff will assist applicants in correcting deficiencies when possible.
9. If the hospital does not meet condition(s) of participation, HCLC recommends denial of the application to CMS and CMS communicates with the hospital in writing. Once condition(s) are met, a hospital must reapply with HCLC to be surveyed once again.

Note: Designation of a CAH by the ORH is required before a hospital can request certification for participation in the Medicare program as a CAH. Designation does not automatically confer certification. Also, a hospital can be certified no earlier than the date of which their certification survey was completed if all conditions are met or the date of which an approved plan of correction was submitted to HCLC.

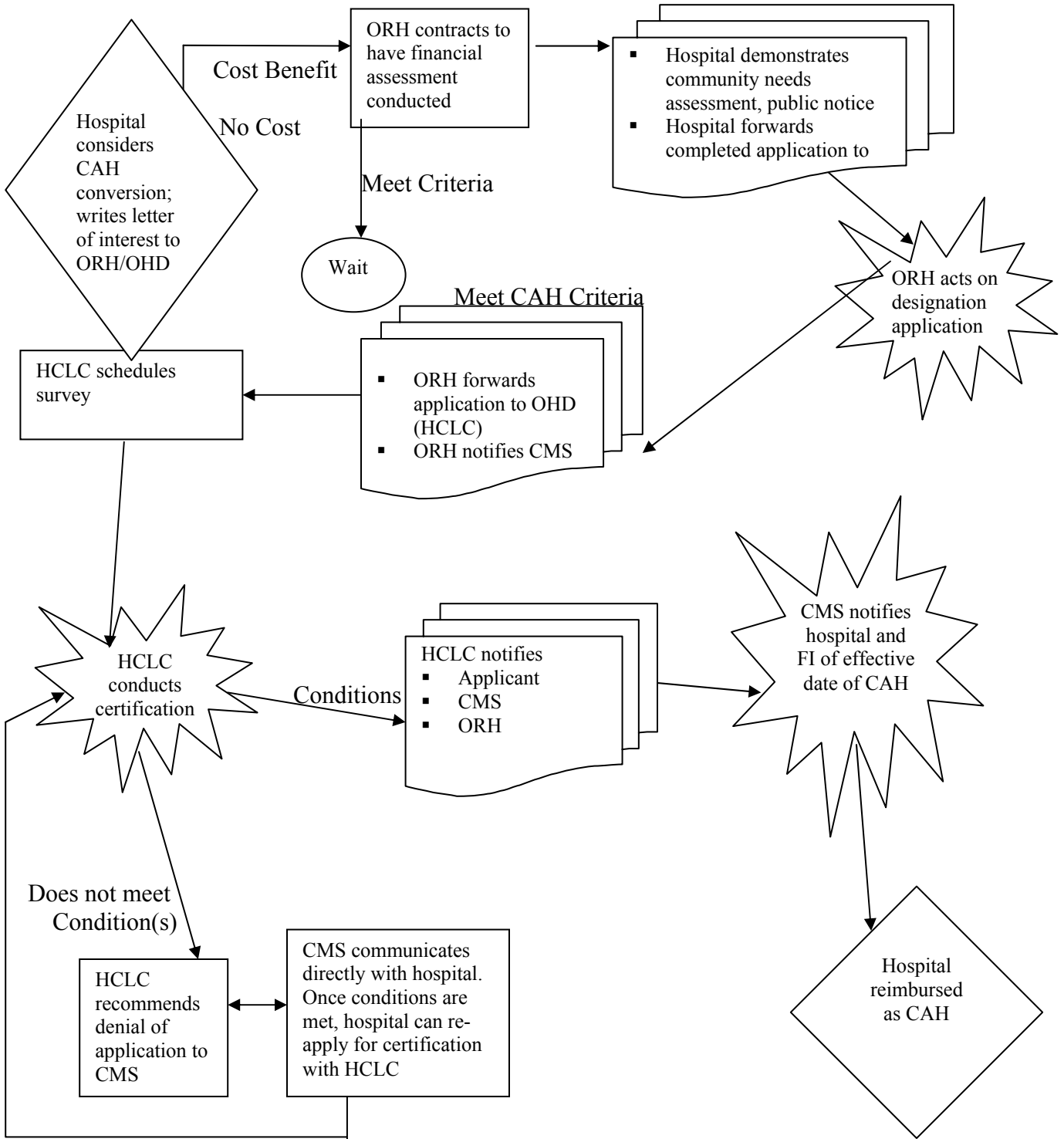
OHD notifies hospital, ORH, and Region X CMS of certification status of hospital.

10. Region X Centers for Medicare & Medicaid Services notifies hospital and Fiscal Intermediary of CAH status and effective date. CAH cost based reimbursement starts with the date of effectiveness as a CAH.

Flow Chart Symbols



Oregon Critical Access Hospital Designation Process for Hospitals Meeting Federal and State Criteria.



Appendix

Definitions

The following is a list of acronyms used throughout this document:

ALOS	Average Length of (inpatient) Stay
BBA 97	Balanced Budget Act of 1997
BBRA	Balanced Budget Refinement Act
CAH	Critical Access Hospital
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
DO	Doctor of Osteopathy
DHS - HS	Oregon Department of Human Services - Health Services
HCF	Health Care Facility
HCLC	Health Care Licensure and Certification
HPSA	Health Professional Shortage Area
LPN	Licensed Practical Nurse
MD	Doctor of Medicine
MIA	Medicare Prescription Drug Improvement and Modernization Act of 2003
MRHFP	Medicare Rural Hospital Flexibility Program
MUA	Medically Underserved Area
NP	Nurse Practitioner
OAHHS	Oregon Association of Hospitals and Health Systems
OHD	Oregon Health Division
OMPRO	Oregon Medical Professional Review Organization
ORH	Office of Rural Health
PA	Physician Assistant
PRO	Professional Review Organization
RN	Registered Nurse

List of sources for CAH information

For further clarification on issues related to Critical Access Hospitals, please see the sources below:

American Hospital Association, *Executive Briefing and Case Examples*, April 1998.

Federal Office of Rural Health Policy, *Guidance for the State Hospital Flexibility Grant Program*, March 25, 1999.

Federal Register/Vol. 62, No. 168, Friday, August 29, 1997—Rules and Regulations.

Federal Register/Vol. 63, No. 91, Tuesday, May 12, 1998—Rules and Regulations.

Centers for Medicare & Medicaid Services, HHS, *Conditions of Participation: Critical Access Hospitals (CAHs)*.

Information can also be found at the following web sites:

- www.AHA.org
- www.cms.hhs.gov/
- www.nrharural.org
- www.ohsu.edu/oregonruralhealth/cahpg.html
- www.rupri.org