

Final Edition
TENNESSEE
CRITICAL ACCESS HOSPITAL
PROGRAM MANUAL



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1. Critical Access Hospitals: An Overview

Several rural communities in Tennessee are struggling to maintain access to high quality health care services. Shifts in the population composition, difficulty in recruiting and maintaining physicians, and low reimbursement from payers, particularly TennCare, have placed the community hospitals in jeopardy. The loss of a hospital impacts the entire health care system of a community and may result in the loss of physicians, which reduces the availability of basic primary care services.

Recognizing the benefits of preserving their hospital to the health of rural communities, the Balanced Budget Act of 1997 established the Medicare Rural Hospital Flexibility Program (MRHFP). The MRHFP creates a new category of rural, limited service hospital, the Critical Access Hospital (CAH). The CAH allows a community to maintain access to primary care and emergency care when the maintenance of a full service acute care hospital is no longer feasible. The MRHFP is available to any state that chooses to develop a rural health care plan that provides for the creation of one or more rural networks, promotes regionalization of rural health services, and improves access to hospital and health services for rural residents.

Prior to implementing this national program, HCFA conducted demonstration projects in eight states. Based on analyses from these demonstrations, the Medicare program determined that it actually saved money by reimbursing these hospitals at cost and maintaining services in the rural communities. The savings were calculated by comparing actual costs to the program from the participating facilities with the cost that would have been incurred if the patients had traveled to the acute care facility that was closest to the participating hospital to receive care.

In Tennessee, rural hospitals have been severely impacted by the Medicaid managed care program, TennCare. Data for 1997, the most current complete data available from the Joint Annual Report of Hospitals, show that overall rural hospitals are reimbursed approximately 54% of their cost of providing care to TennCare enrollees. The data also show that 26 of the State's 69 rural hospitals lost money in 1997. These data precede the first year that Medicare began implementing the cuts required by the Balanced Budget Act which will also negatively impact these more vulnerable hospitals that are typically very high volume Medicare.

Since 1996, four rural hospitals have closed or converted to ambulatory care facilities. In 1996, Lewis Community Hospital closed leaving that county with no hospital. Also that year, Baptist Hospital of Roane County converted to an ambulatory care facility. In 1998,

Jackson County Hospital was scheduled to close, but the county obtained a limited license to keep the facility open as an emergency center and then to expand it to a full service acute care hospital. The county commissioner has decided that the hospital cannot continue as a full service acute care hospital, and they are attempting to convert to a Critical Access Hospital in order to improve reimbursement and possibly stay open in the community. Also, in 1998, Johnson County Hospital discontinued all inpatient care and only provides emergency and diagnostic services, leaving Johnson county with no inpatient services.

The major objective of the Critical Access Hospital program is to keep emergency and primary care services available in the rural communities. Tennessee rural hospitals provided almost 780,000 emergency visits in Tennessee in 1997, with the smallest hospitals providing over 156,600 of these. Continuing to have emergency services available in all rural communities is contingent on providing some financial relief to these smallest hospitals.

**EMERGENCY ROOM VISITS FOR RURAL HOSPITALS
BY BED SIZE 1995-1997**

Hospital Staffed Bed Size	1995	1996	1997
Less than 50 Beds	132,924	148,106	156,620
50-99 Beds	384,564	346,279	365,374
100 + Beds	240,451	254,527	257,469
Total	757,939	748,912	779,453

The Tennessee Medicare Rural Hospital Flexibility Program encourages 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, and provide the care that fits their realm of acute and specialty care services. The result: communities with access to an extensive, high quality, efficient, financially viable health care system.

2. Federal and State Criteria for Participation

The Balanced Budget Act of 1997 (Public Law 105-33) requires that to be eligible for designation as a Critical Access Hospital, the facility must have the following characteristics:

- Licensed and operating not-for-profit hospital;
- Currently participating in the Medicare program;
- Located in rural area (this does not include those hospitals in a MSA); and
- Located at least 35 miles from another hospital (or 15 miles if mountainous and/or secondary roads) **OR** certified by the State as being a necessary provider.

Tennessee Criteria For Determining “Necessary Provider” Status

A hospital certified as a necessary provider must meet one of the following criteria:

- The hospital is located in a county where the percentage of the population aged 65 or older exceeds the state average;
- The hospital is located in a county where the percentage of families with incomes less than 200% of the federal poverty level is higher than the state average for families with incomes less than 200% of the federal poverty level;
- The hospital is located in a county where the percentage of unemployment exceeds the state average;
- The hospital is located in a county that exceeds the state average for poverty;
- The hospital trade/service area includes a Medically Underserved Area (MUA); or
- The hospital trade/service area includes a Health Professional Shortage Area (HPSA).

Additional Federal CAH Criteria

In addition, all eligible hospitals must adhere/agree to the following federal criteria:

- Apply for CAH designation;
- Limit inpatient acute care beds to no more than 15. Facilities participating in the swing-bed program may maintain up to 25 beds, provided that no more than 15 beds are used for acute care at one time;
- Provide inpatient care for not more than 96 hours unless discharge or transfer is precluded by weather or another emergency condition. The PRO, on request, can also waive the 96-hour limitation on a case-by-case basis, based on special circumstances (See Section 6);

- Comply with all of the licensure and certification requirements established by the federal and state governments;
- Participate in a rural health network, defined as an organization consisting of at least one CAH and at least one full-service acute care affiliate hospital where participants have developed network-related agreements ([See Section 6](#)), for the following:
 - 1) Patient referral and transfer;
 - 2) Development and use of communications systems, where feasible, including:
 - Systems for electronic sharing of patient data, and
 - Telemetry; and
 - 3) Transportation agreements for emergency and non-emergency transfers.
- Establish a credentialing and quality assurance agreement ([See Section 6-D](#)) with at least one eligible affiliate hospital and/or agency (network hospital or peer review organization) including:
 - 1) Medical staff credentialing and privilege delineation;
 - 2) Medical staff peer review; and
 - 3) Quality improvement.
- Make available 24-hour emergency services;
- Make available 24-hour nursing services, but the hospital is not required to staff the inpatient facility unless an inpatient is present; and
- If the hospital uses extenders, develop plans/protocols/procedures for assuring adequate physician oversight.

Other Federal Criteria/Assurances

The Tennessee Department of Health (TDH), in conjunction with THA, will send documentation to the Health Care Financing Administration in the case of a hospital that did not meet the mileage requirements, but was certified by the State as a “necessary provider of health care services.” THA will document to TDH the “necessary provider” criteria met by the hospital.

3. Financial Feasibility Study Guidelines

The financial feasibility study is an evaluation of the financial feasibility of the delivery plan based upon anticipated utilization, payor mix and the reimbursement methodologies of the various third parties.

To obtain the financial feasibility study, complete and mail the attached **Financial Feasibility Study Application** (Appendix C) to:

*Bill Jolley, Assistant Vice-President
THA – An Association of Hospitals and Health Systems
500 Interstate Boulevard, South
Nashville, Tennessee 37210-4634
Ph: 615-256-8240 Fax: 615-242-4803*

The study **must** include:

- Audited financial statements and notes for the three most recently completed years;
- Adult and pediatric admissions, adult and pediatric patient days, deliveries, inpatient surgeries;
- List of currently available inpatient services offered by the hospital;
- Inventory of medical staff by name, age, and medical specialty;
- Payor mix (based on percent of billed charges and percent of admissions);
- A CAH cost and revenue projection;
- Any other supporting documents.

A positive result of the Financial Feasibility Study must be obtained before the hospital can continue the process for Critical Access Hospital designation, unless the applicant can provide adequate justification to proceed. In addition, the hospital must respond to each of the recommendations proposed by the study's consultant and outline a plan of action to address each recommendation.

Through the use of Federal grant funds, THA will underwrite the applicant's cost to perform the Financial Feasibility Study - if THA's consultant is used. The applicant hospital has the option of using a privately chosen consultant, but at the applicant's expense. It should be noted that the consultant must provide the minimum information as required.

These Federal funds will be made available to assume the full cost of the financial feasibility study, but demand may well exceed resources in the short term. Therefore, a process has been devised to create an objective and equitable hospital priority list for completion of the financial feasibility study based upon greatest need.

THA will rank all hospital applications using the following criterion:

- ❖ Distance to the next nearest hospital.
- ❖ Whether hospital meets current federal participation criteria.
- ❖ History of closure/strong possibility of closure.
- ❖ Percentage of Medicare participation.
- ❖ County's level of poverty.
- ❖ Hospital's financial condition.

Candidate hospitals may choose to enter the process at any time by having a financial feasibility study performed. This will not, in any way, deny the facility the opportunity to ultimately access grant funds for the financial feasibility study (or to apply for designation as a CAH). However, these later requests for financial support will be considered only after all other requests submitted by the original June 1999 deadline.

4. 96-Hour LOS Exceptions Guidelines

A CAH may only provide inpatient care for up to 96 hours unless discharge or transfer to another facility is precluded by weather or another emergency condition. A Peer Review Organization may, on request, waive the 96-hour restriction on a case-by-case basis. In response to this, an exception process for Tennessee has been established.

The exception process applies to all Tennessee CAHs and is intended to give them the ability to extend treatment to acute care patients beyond the 96-hour length of stay because of inclement weather, emergency conditions, or on a case-by-case basis as deemed appropriate by the attending physician or practitioner. The purpose of the CAH is to provide inpatient primary care and a range of outpatient services including emergency medical services. Although these services typically will be provided under the 96-hour limitation, there may be certain unusual circumstances where it is in the best interest of the patient to extend the length of stay in the CAH. These extensions of care should be the exceptions and not the rule.

THA's review of exceptions will be retrospective, will not address the validity of clinical justifications for extension requests, and will not be conducted as a permission-granting exercise. This is the role of the Peer Review Organization. THA's retrospective review will be conducted from the Peer Review Organization's record of approval and/or denial documentation.

Length of Stay (LOS) Procedures

The following procedures will be used by Peer Review Organizations (PRO) and Tennessee CAHs to apply for and approve exceptions to the 96-hour length of stay:

- When exception to the 96-hour length of stay is needed, the physician, practitioner, or their designee must request an extension beyond the 96-hour limit. The request must be made to the participating Peer Review Organization no later than five hours prior to the expiration of the 96 hours. At the same time the request is made, the CAH will fax or overnight a copy of the patient's medical record to the PRO.
- The PRO will complete the review and send a notification of the determination to the CAH within one working day after receipt of the medical record. If the waiver is approved, the notification will include the number of days approved and the PRO will notify the payor. In the event the patient's medical condition requires care beyond the initial approved extension, the CAH must submit another request to the PRO.
- Prior to issuing a denial, the PRO will provide the attending physician and/or hospital an opportunity to discuss the case.

- The Peer Review Organization will submit a copy of the results of their review to THA.

THA will coordinate with the PRO to ensure each approved CAH facility complies with program regulations and restrictions regarding length of stay.

5. Community Needs Assessment Report Requirements

In an effort to produce an objective source of data to support the provision of health care services for the community, the hospital must become a part of the Community Diagnosis Project (CDP) conducted by the local health council through the guidance of the Community Development Staff in the CAH's Regional Health Office. A listing of all offices and the contact person for each region is attached (Appendix D).

The hospital will become a dynamic member of the project playing an active role in the council meetings. During this process the hospital should obtain support for the potential conversion to a CAH through a formal resolution or other appropriate health council action. Another vital responsibility of the hospital administrator is a review of the health-related needs identified by the local health council. A determination must be made of how the CAH designation will impact the needs identified through the CDP process and other assessments that may have been completed. The affect of this impact on the health needs and health status of the community shall be included in a *Community Needs Assessment Report* for the CAH Application.

The Community Diagnosis assesses availability and utilization of health care services for the community, including acute care, primary care and emergency medical services. Using the CDP information as a baseline, the *Community Needs Assessment Report* should include the following information:

- Geographic boundaries of the hospital service area, using zip code patient origin data, township lines and road patterns;
- Estimated population for the hospital service area;
- Population characteristics for the hospital service area, using county data;
- Volume/capacity of the hospital;
- Distance/travel time to other health care facilities in the service area;
- Any barriers preventing access to health care in neighboring service areas because of the applicant's CAH status.

In addition, any health-related issues not identified through the CDP process that may be impacted by the conversion to a CAH, such as access to particular health care services, should also be addressed.

6. Network Agreement Requirements

In general, the minimum rural health network requirement is for each CAH to have a written agreement with *at least one* affiliate hospital addressing:

1. Patient referral and transfer;
2. Communications systems including (where feasible and if applicable) the development of:
 - Telemetry systems
 - Systems for electronic sharing of patient data;
3. Provision for Emergent and Non-Emergent Transportation;
4. Credentialing, Quality Assurance and Peer Review.

NOTE: The CAH may choose to have a Peer Review Organization (also via written agreement) assist with these services in lieu of the affiliate hospital.

A Model Network Agreement is attached in Appendix I.

A. Patient Referral and Transfer

The agreement should:

- specify in detail how the hospital will determine which patients are to be transferred to the affiliate hospital, including the list of DRGs that would be appropriate to stay in CAH. If services are provided by mid-level practitioners, the agreement specifies the limits of practice imposed upon the mid-level practitioner by the supervising physician;
- identify a process for classifying patients upon admission to the CAH which takes into consideration the availability of staff, equipment and other services in the CAH;
- specify the roles and functions of personnel participating in the referral and transfer process; and
- identify the patient information to be exchanged in the transfer and referral process, the means by which it is transferred, and the frequency with which it will be communicated.

B. Communication Systems

The agreement should:

- identify which patient data is appropriate to share and how and when the data are to be shared (e.g. hard copy physically transferred, fax, telemetry); and

- specify a plan for routine communication between the CAH and the affiliate hospital on administrative and clinical matters unrelated to specific patients.

C. Emergent and Non-Emergent Transportation
(This issue is described in greater detail in Section 7)

The agreement should:

- identify the providers of the emergency medical services serving the CAH and affiliate hospital and specify the role that each will play; and
- identify a plan regarding staff, equipment, schedule and evaluation for providing non-emergency transportation.

D. Credentialing, Quality Assurance and Peer Review

The agreement should:

- identify a process through which the affiliate hospital (and/or Peer Review Organization) supports and is involved with the CAH physician credentialing process. *Note: the governing board of the CAH remains responsible for approving medical staff membership and privileges to members of the CAH medical staff.*
- identify a process through which the affiliate hospital (and/or peer review organization) supports and is involved with the CAH quality assurance and improvement plan. The agreement should be structured to demonstrate how the relationship ensures patient and public health and safety through a program of routine monitoring, problem identification and remedial action.
- identify the outpatient and inpatient roles of the CAH and the affiliate hospital in providing obstetric care and establish protocols for emergency obstetrical care.
- identify the outpatient and inpatient surgical procedures that will be performed in the CAH and establish protocols for emergency surgical cases.
- explain the relationship (clinical and administrative communication, referral, problem resolution) between the CAH and the affiliate hospital.
- specify the services to be provided by the affiliate hospital, and the terms and costs of the provision of those services (telediagnosis, reference laboratory, clinical consultation or staffing, shared FTEs, etc.).

7. Emergency Services Plan Requirements

Federal regulations require a CAH to provide 24-hour emergency care service. In order to achieve this, the CAH must have in place an “effective system” to ensure that a practitioner with training and experience in emergency care is on call and available by telephone or radio and on site within 30 minutes on a 24-hour-per-day basis (See Appendix B).

Further, the Federal regulations do not require the hospital to remain open 24 hours a day when it does not have inpatients. However, the state of Tennessee has tightened this to require that:

“When there are no inpatients, the facility may be unstaffed with licensed professionals but must maintain a receptionist or staff person for emergency situations.”

Services provided by mid-level practitioners must be provided within the limits imposed upon the mid-level practitioner as directed by their practice act which requires the supervision of a physician.

EMS Plan

As part of the CAH designation process, the applicant hospital will develop a plan to address referral and transfer of emergent and non-emergent patients to and from the affiliate hospital. The plan is to address - at a minimum - the following points and must be signed by the CAH, the affiliate hospital, and the local EMS service provider(s). A copy of the EMS plan must also provided as part of the application.

A. Referral

- The CAH must have a process that to determine which patients are to be admitted to the CAH and which patients are to be transferred to the affiliate hospital.
- The CAH must have a process that identifies the patient information to be exchanged in the transfer and referral and the means by which it is transferred.
- There must be an understanding of the specific roles and functions of personnel participating in the referral and transfer process.

B. Transportation

The local EMS provider(s) must have an understanding of the CAH and affiliate hospital agreement and the role that each will play. Therefore, the Emergency Medical Services Plan is to be signed by the emergency medical service provider(s).

8. Critical Access Hospital Designation Process

STEP	ACTION	MANUAL REFERENCE	TIMEFRAME
1	Hospital to complete financial feasibility study application.	Appendices E	To Completion
2	THA to determine if facility meets CAH eligibility criteria.	Section 2	
3	Completion of financial feasibility study.	Section 3	3-5 months
4	Hospital to complete community needs assessment, network agreement, PRO MOU; and emergency medical services agreement.	Community: Section 5 Network: Section 6 PRO: Section 4 Emergency: Section 7	
5	Hospital to complete and submit CAH application form to THA. Application review by CAH Advisory Committee. If Advisory Committee finds application deficient, hospital has opportunity to remedy and resubmit application.	Appendix A Appendix H	Quarterly 45 days after notification
6	CAH Advisory Committee to submit application to Commissioner, Department of Health for approval or denial.		10 days following approval
7	State to conduct CAH rules and regulations & Medicare survey.	Appendix A	5 days
8	Department of Health to notify HCFA of approval.		