**Supporting Statement**
**Critical Access Hospital (CAH) Conditions of Participation**
**and Supporting Regulations**

A. Background

This information collection package is being submitted as a revision of the current, OMB-approved collection. This package has been updated to reflect the current number of facilities and the current Bureau of Labor (BLS) salary information.

The Critical Access Hospital (CAH) Program, Distinct Part Units (DPUs)

Section 1820 of the Act, as amended by section 4201 of the Balanced Budget Act of 1997 (Pub. L.105-33), provides for the establishment of Medicare Rural Hospital Flexibility Programs (MRHFP), under which individual States may designate certain facilities as CAHs. The MRHFP replaced the Essential Access Community Hospital (EACH)/Rural Primary Care Hospital (RPCH) program.

CAHs represent a separate provider type with their own Medicare Conditions of Participation (CoPs) as well as a separate payment method. Unlike traditional hospitals that are paid based on a prospective payment system, CAHs are currently paid 101 percent of their reasonable costs. The CoPs for CAHs are listed in the Code of Federal Regulations (CFR) at 42 CFR 485.601 et seq.

The Act at Section 1820(c)(2)(B) requires a Medicare participating hospital to meet the following criteria in order be certified as a CAH status:

- Be located in a State that has established a State rural health plan for the State Flex Program (as of September 2011, only Connecticut, Delaware, Maryland, New Jersey, and Rhode Island did not have a State Flex Program);
- Be located in a rural area or be treated as rural pursuant to Section 1886(d)(8)(E);
- Makes available 24-hour emergency care services 7 days a week;
- Provide no more than 25 inpatient beds that can be used for either inpatient or swing bed services;
- Have an average annual length of stay of 96 hours or less per patient for acute care; and
- Be located either more than a 35-mile drive from any hospital or CAH or more than a 15-mile drive in areas with mountainous terrain or only secondary roads OR certified as a CAH prior to January 1, 2006, based on State designation as a "necessary provider" of health care services to residents in the area.

Section 1820(c)(2)(E)(i) of the Act provides that a CAH may establish and operate a psychiatric or rehabilitation distinct part units (DPU). Each DPU may maintain up to 10 beds and must comply with the hospital requirements specified in 42 CFR Subparts A, B, C, and D of part 482.

For purposes of Information Collection Request (ICR) compliance, CAHs which have DPUs are treated separately from CAHs without DPUs. For CAHs without DPUs, which make up the bulk of the CAH program, their associated ICR burden is addressed in the present package CMS-10239, (0938-1043).

At the outset of the CAH program, the information collection requirements for all CAHs were addressed together under CMS-R-48 (0938-0328). As the CAH program has grown in scope of services and in number of providers, for purposes of ICR compliance, the burden associated with CAHs with DPUs was separated from the CAHs without distinct part units (DPUs). CAHs with DPUs must meet additional requirements, including the CoPs for hospitals, as specified in Subparts A, B, C, and D of Part 482. Presently, 105 CAHs have rehabilitation or psychiatric DPUs. The burden associated with CAHs that have DPUs continues to be reported under CMS-R-48, along with the burden for all 4,890 accredited and non-accredited hospitals.

At the time of this revision of the current OMB-approved collection (CMS-10239), the total number of CAHs is 1,233. This figure represents the 1,338 CAHs (an average of 1,329 existing CAHs over the past 3 years, plus 9 over a 3-year period), minus the 105 CAHs that have DPUs.

Patient-Related Activities

The burden associated with most patient-related activities (such as healthcare plans, patient records, and clinical records) is not included in this ICR because these activities would take place in the absence of the Medicare and Medicaid programs. These activities are considered usual and customary business practices and, as stated in 5 CFR 1320.3(b)(2), are exempt from the Paperwork Reduction Act (PRA) requirements.

Salary Data

Salary data is based on the U.S. Department of Labor Bureau of Labor Statistics (BLS) May 2012 National Occupational Employment and Wage Estimates found at www.bls.gov. We used the data from this website because it identifies many different healthcare industry occupations and specialties, and the data is updated monthly. Where we were able to identify positions linked to specific positions, we used that compensation information. However, in some instances, we have used a general position description or information for comparable positions, or we have generated the average wage of multiple positions. We calculated the estimated hourly rates based upon the national median salary for that particular position, including fringe benefits and overhead estimated at 31 percent of the base salary. Since CAHs are located in rural areas, where salaries tend to be lower, we have used the national "median" (rather than the higher "mean") salary reported by BLS. We welcome comments on the accuracy of our compensation estimates.

The salary estimates (including estimated fringe benefits and overhead at 31%) contained in this package are based on the following healthcare personnel:

"Administrator" refers to the BLS May 2012 national estimates for Management Occupation, Chief Executives (11-1011). The median wage is $168,140 per year or $80.84 per hour. For purposes of this ICR, we use the figure $105.90 per hour, representing the median wage plus fringe benefits and overhead.

"Clerical person" refers to the BLS May 2012 national estimates for Healthcare Support Workers, all healthcare workers not listed separately (31-9099). The median wage is $32,800 per year or $15.77 per hour. For purposes of this ICR, we use the figure $20.66 per hour, representing the median wage plus fringe benefits and overhead.

"Clinical Nurse Specialist" refers to the BLS May 2012 national estimates for "Registered Nurses" (29-1141), which, the BLS explains, includes Clinical Nurse Specialists. The median wage is $65,470 per year or $31.48 per hour. For purposes of this ICR, we use the figure $41.24 per hour, representing the median wage plus fringe benefits and overhead.

"Clinician" refers to the BLS May 2012 national estimates for a Registered Nurse (29-1141). The median wage is $65,470 per year or $31.48 per hour. For purposes of this ICR, we use the figure $41.24 per hour, representing the median wage plus fringe benefits and overhead.

"Coordinator" refers to the BLS May 2012 national estimates for Medical and Health Service Managers (11-9111). The median wage is $88,580 per year or $42.59 per hour. For purposes of this ICR, we use the figure $55.79 per hour, representing the median wage plus fringe benefits and overhead.

"Nurse practitioner" refers to the BLS May 2012 national estimates for Nurse Practitioners (29-1171). The median wage is $89,960 per year or $43.25 per hour. For purposes of this ICR, we use the figure $56.66 per hour, representing the median wage plus fringe benefits and overhead.

The "Physician" salary refers to the BLS May 2012 national estimates for Internists, General (29-1063). The median wage is equal to or greater than $90.00 per hour or $187,199 per year. For purposes of this ICR, we use the figure $117.90 per hour, representing the median wage plus fringe benefits and overhead.

"Physician Assistant" refers to the BLS May 2012 national estimates for Physician Assistants (29-1071). The median wage is $90,930 per year or $43.72 per hour. For purposes of this ICR, we use the figure $57.27 per hour, representing the median wage plus fringe benefits and overhead.

"Records technician" refers to the BLS May 2012 national estimates for Medical Records and Health Information Technicians (29-2071). The median wage is $34,160 per year or $16.42 per hour. For purposes of this ICR, we use the figure $21.51 per hour, representing the median wage plus fringe benefits and overhead.

## B. JUSTIFICATION

1. Need and Legal Basis

The regulations containing these information collection requirements are located at 42 CFR 485, Subpart F. These regulations implement sections 1102, 1138, 1814(a)(8), 1820(a-f), 1861(mm), 1864, and 1871 of the Act. Sections 1820 and 1861(mm) of the Act provide that CAHs participating in Medicare meet certain specified requirements. Section 1861(e) of the Act authorizes promulgation of regulations in the interest of the health and safety of individuals who are furnished services by a hospital or CAH. The Secretary may impose additional requirements if they are necessary in the interest of the health and safety of the individuals who are furnished services in the hospital or CAH.

Section 1864 of the Act provides for the use of State survey agencies to ascertain whether certain entities, including CAHs, comply with the applicable statutory definitions and implementing regulations for that provider or supplier type. Section 1865(a) of the Act permits providers and suppliers accredited by an approved Medicare accreditation program of a national accrediting body to be "deemed" to meet the applicable CoPs for that provider or supplier type. To receive approval, a national accrediting organization (AO) must demonstrate to CMS that its Medicare accreditation program requirements meet or exceed the applicable Medicare CoPs. To the extent that a program has higher standards than the Medicare CAH CoP, such "higher" requirements are not the result of the CoPs but rather of voluntary decisions by the AO.

In any instances where accreditation standards are less stringent than the Medicare CoPs, CMS works with the accreditation organization to assure:

- Appropriate changes are made to their standards; or
- The accrediting organization notifies the accredited CAHs that they must meet Federal requirements that may be more stringent than the accrediting organizations' standards.

Accreditation by an AO is voluntary on the part of a CAH and is not required for Medicare certification. There are currently 444 CAHs (out of a total of 1,329 certified CAHs) that have demonstrated compliance on the basis of their accreditation under a CMS-approved Medicare accreditation program.

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 restrained the growth of the CAH program by terminating, as of January 1, 2006, a State's authority to designate a CAH as a necessary provider and thereby waive the CAH minimum distance requirement relative to other CAHs or hospitals. As a result, CMS has certified very few new CAHs since 2006 because most hospitals that meet the location and distance criteria and which are interested in CAH status

have already converted to CAH status. As such, we anticipate that no more than 3 new CAHs per year will become certified under Medicare, based on an average of 6 new CAHs becoming certified per year and an average of 3 CAHs closing per year over the past 3 years. Therefore, the total number of CAHs would be 1,338 (an average of 1,329 existing CAHs over the past 3 years, plus 9 over a 3-year period). As explained above, this information collection request addresses those CAHs which do not have DPUs. Therefore, this information collection request uses the figure 1,233 (1,388 CAHs minus the 105 CAHs that have DPUs.)

Statutory requirements and our responsibility to assure an adequate level of patient health and safety in participating CAHs require the inclusion of these requirements in the CoPs for CAHs. We note that the ICRs contained within the regulations are comparable to those of the various AOs and are necessary safeguards against potential overpayments, excessive utilization, and poor health care that may occur in the absence of such requirements. Therefore, we believe many of the requirements applied to CAHs will impose no burden since a prudent institution would self-impose them in the ordinary course of business. Nonetheless, we have made an attempt to estimate the associated burden for a CAH to engage in these standard industry practices.

2. Information Users

The CAH CoPs and accompanying ICRs specified in the regulations are used by surveyors as a basis for determining whether a CAH meets the requirements to participate in the Medicare program. CMS and the healthcare industry believe that the availability to the facility of the type of records and general content of records, which this regulation specifies, is standard medical practice and is necessary in order to ensure the well-being and safety of patients and professional treatment accountability.

3. Use of Information Technology

CAHs may use various information technologies to store and manage patient medical records as long as they are consistent with the existing confidentiality in record-keeping regulations at 42 CFR 485.638. This regulation does not specify how the facility should prepare or maintain these records. Facilities are free to take advantage of any technological advances that they find appropriate to meet their needs.

4. Duplication of Efforts

These requirements are specified in a way that does not require a CAH to duplicate its efforts. If a facility already maintains these general records, regardless of format, they are in compliance with this requirement. The general nature of these requirements makes variations in the substance and format of these records, from one facility to another, acceptable.

5. Small Businesses

These requirements do affect small businesses. However, the general nature of the requirements allows facilities the flexibility to meet the requirements in ways that are consistent with their existing operations.

6. Less Frequent Collection

CMS does not collect this information, or require its collection on a routine basis. Nor does the rule prescribe the manner, timing, or frequency of the records or information required to be available. CAH records are reviewed at the time of a survey for initial or continued participation in the Medicare program. Less frequent information collection would impede efforts to establish compliance with the Medicare CoPs.

7. Special Circumstances

There are no special circumstances.

8. Federal Register Notice/Outside Consultation

The 60-day Federal Register notice published on June 28, 2010.

9. Payment/Gift To Respondents

We do not plan to provide any payment or gifts to respondents for the collection of this information.

10. Confidentiality

Normal medical confidentiality practices are observed. Information will be kept private to the extent provided by law.

11. Sensitive Questions

There are no questions of a sensitive nature associated with this information collection.

12. Burden Estimates (Hours & Wages)

485.610 – Standard: Relocation of CAHs with a necessary provider designation

Burden associated with this requirement is exempt from the PRA.

A CAH that has a necessary provider designation and relocates its facility can continue its designation only if the relocated facility in its new location serves at least 75 percent of the same service area; provides at least 75 percent of the same services and is staffed by 75 percent of the staff at its original location.

Prior to any relocation of a necessary provider CAH, the CAH may voluntarily send a letter of intent to the State Agency and to the CMS Regional Office (RO) if it seeks a preliminary determination from CMS as to whether its proposed new location would meet CMS requirements. The letter should state that the CAH plans to relocate and must attest that it will continue to be essentially the same provider serving the same community but at a new location. The RO provides notice of preliminary approval of the relocation if the proposed relocation complies with the regulatory standards at 42 CFR 485.610(b) and (d). A final determination can only be made after the relocation is completed. The CAH's Administrator, or other appropriate person, would draft the attestation letter with the relocation proposal, stating that the facility meets the conditions to relocate and continue its necessary provider designation. We estimate that fewer than 5 facilities a year will relocate and that it would take one hour to draft the letter and 30 minutes for clerical personnel to put it into a final form.

As stated in 5 CFR 1320.3(c)(4), this information collection requirement is exempt from the PRA as it will impose burden on fewer than 10 entities on an annual basis.

485.616 Standard: Agreements with network hospitals

Burden associated with this requirement is exempt from the PRA.

Each CAH must have an agreement with respect to credentialing and quality assurance with at least one hospital that is a member of the network; one QIO or equivalent entity; or one other appropriate and qualified entity identified in the State rural health care plan. The agreement should include patient referral and transfer. The initial development of the agreement will take approximately two hours. We estimate that no more than six CAHs a year become certified under Medicare. As stated in 5 CFR 1320.3(c)(4), this information collection requirement is exempt from the PRA as it will impose burden on fewer than 10 entities on an annual basis.

485.618(c) – Standard: Blood and blood products

The chart below reflects the burden associated with this requirement.

The CAH must update policy agreements with blood collection establishments to ensure prompt notification about potentially infected blood and blood products. We estimate that CAH will utilize one Coordinator and one Clerical person for one hour each to update the policy agreements each year.

| Personnel, Wages, and Hours | Annual Burden Hours (for 1,233 CAHs) | Annual Cost Burden (for 1,233 CAHs) |
|---|---|---|
| 1 Coordinator @ $55.79/hr x 1hr/yr | 1,233 hours | $68,789.07 / year |
| 1 Clerical person @ $15.77/hr x 1hr/yr | 1,233 hours | $19,444.41/ year |
| **TOTAL** | **2,466 hours** | **$88,233.48 / year** |

485.618(d)(1)(ii)(C) - Emergency Services

No burden is attributed to this task.

The State must maintain documentation showing that the response time of up to 60 minutes at a particular CAH it designates is justified because other available alternatives would increase the time needed to stabilize a patient in an emergency. This information is included in each State's rural healthcare plan and is maintained by the State.

485.618(e) – Standard: Coordination with emergency response systems

Burden associated with this requirement is exempt from the PRA.

The CAH must, in coordination with emergency response systems in the area, establish procedures under which a doctor of medicine (MD) or osteopathy (DO) is immediately available by telephone or radio contact on a 24-hour a day basis to receive emergency call, provide information on treatment of emergency patients and refer patients to the CAH or other appropriate locations for treatment.

The burden associated with this requirement is the time and effort necessary to establish procedures to respond to emergencies on a 24-hour basis. While this requirement is subject to PRA, we believe that the burden associated with this requirement is exempt from the PRA as defined in both 5 CFR 1320.3(b)(2) and (b)(3). As stated in 5 CFR 1320.3(b)(2), the burden imposed by this requirement is exempt from the PRA as it is considered to be usual and customary business practice. In addition, the burden imposed by this requirement would exist even in the absence of the Federal requirement. As stated in 5 CFR 1320.3(b)(3), the burden is exempt from the PRA since the information is also collected on the State or local level.

485.623(d)(4) – Standard: Life Safety from fire

The chart below reflects the burden associated with this requirement.

The CAH must meet the applicable provisions of the 2000 edition of the Life Safety Code (LSC) of the National Fire Protection Association. If CMS finds that the State has a fire and safety code imposed by the State law that adequately protects patients, CMS may allow the State survey agency to apply the State's fire and safety code instead of the LSC if waiving the provisions of the LSC does not adversely affect the health and safety of patients. This regulation requires a CAH to maintain written evidence of regular inspections and approval by State fire control agencies. We estimate that the burden associated with maintaining written evidence of State inspections and approval would be an average of 30 minutes for clerical personnel to file the documentation.

| Personnel, Wages, and Hours | Annual Burden Hours (for 1,233 CAHs) | Annual Cost Burden (for 1,233 CAHs) |
|---|---|---|
| 1 Clerical person @ $15.77/hr. x 0.5 hr | 617 hours | $ 9,730 / year |
| **TOTAL** | **617 hours** | **$9,730 / year** |

-

Section 485.631-Staffing and staff responsibilities

The chart below reflects the burden associated with this requirement.

The burden associated with this requirement is the time it takes to review the CAH's written policies and make appropriate changes or updates. In conjunction with a non-physician practitioner, the MD or DO develops, executes, and periodically reviews the CAH's written policies governing the services it furnishes. Such non–physician practitioner would either be a physician assistant, nurse practitioner, or clinical nurse specialist. For purposes of this ICR, we estimate the wages of the non-physician practitioner by taking an average of the median wages for the above-mentioned practitioners. We also estimate that a CAH will utilize the services of one clerical person for half an hour to process any changes or updates.

| Personnel, Wages, and Hours | Annual Burden Hours (for 1,233 CAHs) | Annual Cost Burden (for 1,233 CAHs) |
|---|---|---|
| 1 Physician @ $117.90/hr x 1 hr/yr | 1,233 hours | $ 145,370.70 / year |
| 1 Non-physician practitioner @ *average wage** of $51.72/hr x 1 hr/yr<br><br>** Physician Assistant @ $57.27/hr, Nurse Practitioner @ $56.66/hr, or Clinical Nurse Specialist @ $41.24/hr* | 1,233 hours | $63,770.76 / year |
| 1 Clerical person @ $15.77/hr x 0.5 hr | 617 hours | $9,730 / year |
| **TOTAL** | **3,083 hours** | **$218,871.46 / year** |

485.631(b)(2)- Responsibilities of the Doctor of Medicine or Osteopathy

No burden is attributed to this task.

A doctor of medicine or osteopathy must be present for sufficient periods of time to provide medical direction, medical care services, consultation, and supervision for the services provided in the CAH. We believe that this can be documented in patient records and in the monthly meeting notes of the board. No burden is being assessed for this requirement, as keeping patient records is standard and keeping minutes of meetings (board and staff level) are common and practical activities for the industry.

Section 485.635(a) – Patient care policies; 485.638 – Clinical Records

No burden is attributed to this task.

The CAHs health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law. The policies include a description of the services the CAH furnishes directly and those furnished through agreement or arrangement; policies and procedures for emergency medical services and guidelines for medical management of health problems that include the conditions requiring medical consultation and/or patient referral and the maintenance of health care records.

Healthcare industry organizations establish standards that healthcare professionals use to measure their performance and the health care provided in CAHs. The information requirements contained within these regulations are comparable to such industry standards and are necessary safeguards against potential overpayments and poor health care procedures, which may occur when standards are insufficient.

We are not including burden associated with certain patient related activities such as healthcare plans, patient records, clinical records, etc., because prudent institutions already incur this burden in the course of doing everyday business. As stated in 5 CFR 1320.3(b)(2), the burden associated with usual and customary business practices is exempt from the PRA. Further, State laws require providers to maintain patient records. (For example, the annotated Code of Maryland (¶ 10.11.03.13) requires a provider to be responsible for maintaining patient records for services that it provides.) State law requires record information that should include: documentation of personal interviews; diagnosis and treatment recommendations; records of professional visits and consultations; consultant notes which shall be appropriately initialed or signed.

Section 485.635(c)(3) – Standard: Services provided through agreements or arrangements

The chart below reflects the burden associated with this requirement.

The CAH must maintain a list of all services furnished under arrangements or agreements. The list describes the nature and scope of the services provided. The person principally responsible for the operation of the CAH is also responsible for services furnished in the CAH whether or not they are furnished under arrangements or agreements. The burden associated with this requirement is the time it takes for the administrator to ensure that the list is updated and a clerical person to maintain the list. We estimate that it will take an administrator and a clerical staff each an hour annually to update the list.

| Personnel, Wages, and Hours | Annual Burden Hours (for 1,233 CAHs) | Annual Cost Burden (for 1,233 CAHs) |
|---|---|---|
| 1 Administrator @ $105.90/hr x 1 hr | 1,233 hours | $130,574.70 / year |
| 1 Clerical @ $15.77/hr x 1 hr | 1,233 hours | $ 19,444.41 / year |
| **TOTAL** | **2,466 hours** | **$ 150,019.11 / year** |

Section 485.635(f) Condition of participation: Provision of services

The chart below reflects the burden associated with this requirement.

Section 485.635(f) requires a CAH to have written policies and procedures regarding the visitation rights of patients, including any clinically necessary or reasonable restriction or limitation that the CAH may need to place on such rights and the reasons for the clinical restriction or limitation. Specifically, the written policies and procedures must contain the information listed in §485.635(f) (1) through (f)(4). Such policies and procedures are vital to patient well-being and treatment. In their absence, physicians, nurses, and other staff caring for the patient often miss an opportunity to gain valuable patient information from individuals who may know the patient best with respect to the patient's medical history, conditions, medications, and allergies, particularly if the patient has difficulties recalling or articulating, or is totally unable to recall or articulate this vital personal information.

As stated under §485.635, the information requirements contained within these regulations are comparable to such industry standards related to the healthcare of inpatients. CAHs and other inpatient facilities have guidelines and protocol on patient visitation. We estimate that ~~T~~the ICR burden associated with this requirement is minimal as most CAHs have established policies and procedures regarding visitation rights of patients. The ICR burden associated with this requirement reflects the time and effort necessary ~~for a CAH to develop written policies and procedures with respect to visitation rights of patients and to distribute that information to the patients. The~~ the CAH

administrator or other appropriate person ~~would draft the policies and procedures and ensure~~to ensure that the information was distributed to the patients in his or her facility. The Administrator could accomplish this task in 15 minutes.

| Personnel, Wages, and Hours | Annual Burden Hours (for 1,233 CAHs) | Annual Cost Burden (for 1,233 CAHs) |
|---|---|---|
| 1 Administrator @ 105.90/hr x 0.25 hrs/yr | 308 hours | $32,617.20 / year |
| **TOTAL** | **308 hours** | **$32,617.20 / year** |

Section 485.641 – Standard Periodic evaluation and quality assurance review

The chart below reflects the burden associated with this requirement.

CAHs that participate in the Medicare or Medicaid programs shall evaluate its total program annually and the evaluation includes a review of the utilization of the CAH services. The purpose of the evaluation is to determine whether the utilization of services was appropriate, if the established policies were followed and if any changes are needed. The CAH must have an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. We have not prescribed the structures and methods for implementing this requirement and have focused the condition toward the expected results of the program. We believe that the writing of internal policies governing the CAH's approach to the development, implementation, maintenance, and evaluation of the quality assurance program will impose minimal burden. We estimate that it will take 3 hours annually for the existing CAHs to update their policies and document the outcome of all remedial action.

| Personnel, Wages, and Hours | Annual Burden Hours (for 1,233 CAHs) | Annual Cost Burden (for 1,233 CAHs) |
|---|---|---|
| Updating policies:<br>1 Coordinator @ $55.79/hr. x 3 hrs/yr | 3,699 hours | $ 206,367.21/ year |
| **TOTAL** | **3,699 hours** | **$206,367.21 / year** |

Section 485.643(a) and (b) - CoP: Organ, tissue, and eye procurement

~~The chart below reflects the burden associated with this requirement.~~

CAHs are required to have and implement written protocols that:
(1) Incorporate an agreement with an Organ Procurement Organization (OPO) under which it must notify the OPO in a timely manner of all deaths or imminent deaths;
(2) Incorporate an agreement with at least one tissue bank and at least one eye bank to ensure that all usable tissues and eyes are obtained from potential donors.

We believe that prudent healthcare institutions would have written protocols for handling a death that occurs in its institution. Therefore, we have estimated that the burden associated with this requirement reflects the time necessary to notify the OPO of a death or an imminent death.

The FY 2012 Medicare Provider and Analysis Review (MEDPAR) hospital records indicate that 10,696 deaths occurred in all CAHs that year. Based on this data, if the average call to an OPO to report a death takes 5 minutes (0.0833 hours) and the total number of calls made for all CAHs equals 10,696, the annual burden for a single CAH would be approximately 0.66 hours (8 calls/CAH x 0.0833 hours). We therefore estimate 814 hours for the 1,233 CAHs without DPUs.

| Personnel, Wages, and Hours (for 1,233 CAHs) | Annual Burden Hours (for 1,233 CAHs) | Annual Cost Burden (for 1,233 CAHs) |
|---|---|---|
| 1 Clinician @ $41.24/hr. x 0.0833 hours/call x 8 calls/yr/CAH | 814 hours | $33,569.36 / year |
| **TOTAL** | **814 hours** | **$33,569.36 / year** |

485.645(d) SNF Services

The chart below reflects the burden associated with this requirement.

CAHs that provide long term care (swing bed) services (SNF level care) must comply with section 483.12 (a) – Standard: Transfer and discharge rights.

The facility must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare. Before a facility can transfer or discharge a resident the facility must notify the resident of the actions to be taken in writing and in a language and manner they understand. The burden associated with this requirement is the time and effort necessary to disclose the notice requirement referenced above to each patient. The FY 2012 MedPAR reported that 1,332 CAHs had a total of 397,198 discharges. We estimate that on average, a third of the discharges were from swing beds. Therefore, using the MedPAR data, we estimate a total of 132,399 annual discharges from all CAHs.

We estimate that it will take a clerical staff at each CAH 5 minutes to notify each patient receiving SNF level care of the transfer or discharge. On average, we have estimated that a CAH that provides "swing-bed care" will transfer or discharge 107 residents annually (1,233 CAHs x 107 residents x .0833 minutes) with annual burden hours of 10,990.

| Personnel, Wages, and Hours | Annual Burden Hours (for 1,233 CAHs) | Annual Cost Burden (for 1,233 CAHs) |
|---|---|---|
| 1 Clerical person @ $15.77/hr. x .0833 | 10,990 hours | $173,312.30 / year |

| | | |
|---|---|---|
| hours x 107 notices | | |
| **TOTAL** | **10,990 hours** | **$173,312.30 / year** |

13. Capital Costs

There are no capital costs.

14. Cost To Federal Government

Although the Federal Government does not collect this information, there are minimal costs associated with these requirements that are accrued at the Federal level and especially at the regional office (RO) levels. For example, RO staff is responsible for acting on the information collections requirements discussed in this package as it relates to CAH compliance. Once state survey agencies have completed their surveys and if an initial determination to terminate a CAH for noncompliance is to be made, such decisions are made by the RO.

15. Adjustments/ Program Changes

This package has been updated to reflect the current number of facilities, the current BLS salary information.

| **CFR SECTION** | **Annual Burden Hours** for 1,233 CAHs | **Annual Cost Burden** for 1,233 CAHs |
|---|---|---|
| | | |
| 485.618(c) | 2,466 hours | $88,233.48/ year |
| 485.623(d)(4) | 617 hours | $9,730 / year |
| 485.631 | 3,083 hours | $218,871.46 / year |
| 485.635(c)(3) | 2,466 hours | $150,019.11 / year |
| 485.635(f) | 308 hours | $32,617.20 / year |
| 485.641 | 3,699 hours | $206,367.21 / year |
| 485.643(a) and (b) | 814 hours | $33,569.36 / year |
| 485.645(d) | 10,990 hours | $168,439.37 / year |
| **TOTAL** | **24,443 hours** | **$907,847.19 / year** |

16. Publication/Tabulation Dates

We do not plan to publish any of the information collected.

17. Expiration Date

This collection does not lend itself to the displaying of an expiration date.