Health Standards Section
Rural Health Clinics
Role & Structure of Health Standards Section
June 25, 2019

Jenny Haines, RN, BSN
Medical Certification Program Manager
Beginner to Expert

This presentation is set up to address items that range form beginners to experts in navigating the licensing & certification process.

If you are one of the experts, please be patient as we address some of the beginning processes.
Objectives

 ► Define the role & structure of Health Standards

 ► Explain the workload as it relates to RHCs

 ► Explain the licensing & certification processes for RHCs.

 ► Provide an overview of the types of surveys and survey process.
The Secretary of the Department of Health and Human Services (DHHS) has designated CMS to administer the Medicare and Medicaid programs.
CMS Central Office

CMS’ Health Standards & Quality Bureau is responsible for:

- survey and certification policies & procedures
- monitoring adherence to program requirements
- responding to questions
- working with states to provide joint oversight of the Medicaid program
CMS Regional Office

- Determines eligibility for participation in Medicare
- Works with state agencies to evaluate performance
- Provides technical assistance
- Allocates funds to state agencies for certification activities
- Prepares and analyzes CMS data
- Conducts Federal surveys
CMS Regions

Region 1
- Boston

Region 2
- New York

Region 3
- Washington

Region 4
- Atlanta

Region 5
- Chicago

Region 6
- Dallas (LA, TX, NM, AR, OK)

Region 7
- Kansas City

Region 8
- Denver

Region 9
- San Francisco

Region 10
- Seattle

Central Office in Baltimore
Federal & State Relationship

Section 1864 of the Social Security Act (the Act) establishes the framework within which State Agencies (SAs), under agreements between the State and the Secretary, carry out the Medicare certification process.
Federal & State Relationship

State Agency = LDH

- Designated by the Governor as responsible for performing the functions created by Section 1864 of the Social Security Act.

- Responsibilities include:
  - certification/recertification functions
  - records maintenance
  - identifying potential participants in Medicare/Medicaid
  - complaint investigations
  - validation surveys
  - CLIA activities
  - licensing activities.
Health Standards Section (HSS)

- Agency within the Louisiana Department of Health
- Contracted by CMS to perform the survey & certification functions in the state of Louisiana
- Enforces regulatory compliance for health care facilities
- Referred to as the “State Agency” (SA)
HSS Mission/Vision

Mission
To enforce regulatory compliance for health care facilities in the State of Louisiana

Vision
The section will be recognized as a unit of dedicated health professionals who are focused on assuring all Louisiana citizens receive good health services that encourage better health and promote quality of life.
LDH & HSS

Office of The Secretary
Secretary = Dr. Rebekah Gee

Office of Management & Finance
Undersecretary = Jeff Reynolds

Office of Management & Finance
Deputy Director = Michelle Aletto

Health Standards
Director = Cecile Castello
HSS Hospital Program

Director = Cecile Castello

Program Manager 2 NLTC = Dora Kane

Licensing for Hospital RHCs

Jennifer Haines (Hospital Program Manager)
- Short Term Acute Care Hospitals
- Critical Access Hospitals
- Long Term Care Hospitals
- Rehabilitation Hospitals
- Psychiatric Hospitals
- Children’s Hospitals
- Medicaid Specialty Units
- RHC off-site Campuses
- Trauma Centers

Licensing for Free Standing RHCs

New Program Manager (Hospital Program Manager)
- Short Term Acute Care Hospitals
- Critical Access Hospitals
- Long Term Care Hospitals
- Rehabilitation Hospitals
- Psychiatric Hospitals
- Children’s Hospitals
- Medicaid Specialty Units
- RHC off-site Campuses
- Trauma Centers

RHC Program Manager
- Licensing of all independent free standing RHCs

Certification for RHCs

Program Manager RHCS & FQHC
- All certification action for RHCs

Administrative Supervisor = Carla Jerome, Katri Martin
Administrative Assistant = Destinn O’Bear, Shelly Tyree, Tammy Walton
HSS Field Offices
As they relate to hospitals

Field Office 1
New Orleans & Thibodeaux
Cherylann Westerfield
FOM

Field Office 2
Mandeville & Baton Rouge
Becky Knight
FOM

HSS State Agency Field Manager
Darren Guillory

Field Office 3
Lafayette
Rita Simon
FOM

Field Office 6
Alexandria
Jackie Green
FOM

Field Office 4/5
Monroe & Shreveport
Clarice Steele
FOM

Title 18 Supervisor
Bill Whatley

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## HSS Field Office Parishes

<table>
<thead>
<tr>
<th>Field Office 1</th>
<th>Field Office 2</th>
<th>Field Office 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ascension</td>
<td>East Baton Rouge</td>
<td>Acadia</td>
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<tr>
<td>Assumption</td>
<td>East Feliciana</td>
<td>Calcasieu</td>
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<td>Iberville</td>
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<td><strong>St. Mary</strong></td>
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<td>Terrebonne</td>
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## *HSS Field Office Parishes*

<table>
<thead>
<tr>
<th>Field Office 4</th>
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<tr>
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<td>Catahoula</td>
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<td>DeSoto</td>
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<td>Webster</td>
<td>Grant</td>
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<td>Rapides</td>
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<td>Union</td>
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<td>Sabine</td>
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<td>West Carroll</td>
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<td>Vernon</td>
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<td>Winn</td>
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### HSS Regulated Programs

<table>
<thead>
<tr>
<th>Adult Day Health Care Centers</th>
<th>Community Mental Health Centers (CMHCs)</th>
<th>Federally Qualified Health Centers (FQHCs)</th>
<th>Medicaid Specialty Units</th>
<th>Portable X-Ray</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion Facilities</td>
<td>Comprehensive Outpatient Rehabilitation Facilities (CORFs)</td>
<td>Forensic Supervised Transitional Residential &amp; Aftercare Facilities</td>
<td>Minimum Data Set (MDS) Resident Assessment Instrument (RAI)</td>
<td>PPS-Excluded Hospital Units</td>
</tr>
<tr>
<td>Adult Brain Injury</td>
<td>Crisis Receiving Centers (CRCs)</td>
<td>Home &amp; Community Based Service Providers (HCBS)</td>
<td>Non Emergency Medical Transportation (NMET)</td>
<td>Psychiatric Residential Training Facilities (PRTFs)</td>
</tr>
<tr>
<td>Adult Day Care Facilities</td>
<td>Direct Service Workers (DSWs)</td>
<td>Home Health Agencies</td>
<td>Nurse Aid Certification &amp; Training</td>
<td>Rural Health Clinics</td>
</tr>
<tr>
<td>Adult Residential Care (ARCP)</td>
<td>Elderly or Adult Abuse or Neglect</td>
<td>Hospices</td>
<td>Nursing Homes</td>
<td>Sanction Collection</td>
</tr>
<tr>
<td>Ambulatory Surgical Centers (ASCs)</td>
<td>Emergency Medical Transportation (EMT)</td>
<td>Hospitals</td>
<td>OASIS</td>
<td>Therapeutic Group Homes</td>
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<tr>
<td>Behavioral Health Service Providers (BHSPs)</td>
<td>Emergency Preparedness</td>
<td>Informal Dispute Resolution</td>
<td>Organ Procurement Organizations</td>
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<tr>
<td>Case Management</td>
<td>End Stage Dialysis Centers (ESRDs)</td>
<td>Intermediate Care Facility for the Developmental Disabled (ICF/DDs)</td>
<td>Pain Management Clinics</td>
<td></td>
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<tr>
<td>CLIA (Clinical Laboratory Improvements Amendment)</td>
<td>Facility Need Review</td>
<td>Medicaid Attendant Certified (MACs)</td>
<td>Pediatric Day Health Care Facilities</td>
<td></td>
</tr>
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</table>
Louisiana Department of Health & Hospitals

Health Standards Section
Rural Health Clinics
Budget & Workload
June 25, 2019

Jenny Haines, RN, BSN
Medical Certification Program Manager
Budget & Workload

A Real Balancing Act
Budget & Workload

The Federal Budget Call Letter identifies the priorities (tiers) of the State workload.

The federal fiscal year runs from October 1 through September 30.
Priority Tiers

► Tiers reflect statutory mandates and program emphasis.

► States must assure that Tiers 1 and 2 will be completed as a pre-requisite to planning for subsequent Tiers.
## Tier Workload

<table>
<thead>
<tr>
<th>Tier 1</th>
<th>Complaint surveys prioritized as potential Immediate Jeopardy complaints.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full surveys following complaint investigations in which a Condition of Coverage (CoC) was found to be out of compliance.</td>
</tr>
</tbody>
</table>

### Tier 2

<table>
<thead>
<tr>
<th>Complaint Surveys prioritized as non-Immediate Jeopardy High complaints.</th>
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</thead>
<tbody>
<tr>
<td>Recertification Surveys of at least 5% of the non-deemed RHCs.</td>
</tr>
<tr>
<td>Relocations of any provider displaced during a public health emergency declared by the Governor.</td>
</tr>
</tbody>
</table>
## Tier Workload

<table>
<thead>
<tr>
<th>Tier 3</th>
<th>Tier 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaint Surveys prioritized as non-Immediate Jeopardy Medium complaints.</td>
<td>Additional Recertification Surveys of non-accredited RHCs to ensure a 6 year average.</td>
</tr>
<tr>
<td>Recertification Surveys on RHCs to ensure no more than 7 years elapses between surveys.</td>
<td>Initial Certification Surveys of all RHCs since RHCs have the option to achieve deemed Medicare status through an approved AO.</td>
</tr>
<tr>
<td></td>
<td>Relocations of deemed providers.</td>
</tr>
</tbody>
</table>
Tier Workload

CMS is targeting national annual recertification coverage priorities for the non-LTC providers including Rural Health Clinics.
Accreditation & Deemed Status

Section 1865 (a) of the Act:
Accredited hospitals are deemed to meet Medicare CoPs

IF

the accrediting organization (AO) conducts a DEEMING survey of a RHC and the RHC can provide a copy of the survey report & approval letter indicating the deemed status.
Deemed To Meet

A successful accreditation survey means the RHC is deemed to meet all Conditions for Coverage.
## Approved AOs for RHCs

<table>
<thead>
<tr>
<th>American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)</th>
<th>The Compliance Team</th>
</tr>
</thead>
</table>

**American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)**

- **Address:** 5101 Washington St., Suite 2F, P.O. Box 9500, Gurnee, IL 60031
- **Phone:** 1-888-545-5222

**The Compliance Team**

- **Address:** 905 Sheble Lane, Suite 102, P.O. Box 160, Springhouse, PA 19477
- **Phone:** 1-215-654-9110
- **Email:** khill@TheComplianceTeam.org

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**Medical Examiners Council**

- **Address:** 2731 S. Ridge Road, Suite 101, Schaumburg, IL 60173-1040
  - **Phone:** 1-800-MEC-1234
  - **Fax:** 847-259-5279
  - **Email:** mec@mec.org

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**American Society for Quality**

- **Address:** 11220 W. 126th Street, Suite 130, Lenexa, KS 66219
  - **Phone:** 913-433-8471
  - **Fax:** 913-433-8410
  - **Email:** info@asq.org

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**American College of Healthcare Executives**

- **Address:** 2460 Palisades Drive, Suite 200, Rhinelander, WI 54501
  - **Phone:** 715-361-1000
  - **Fax:** 715-361-1004
  - **Email:** info@ACHE.org

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**American Board of Internal Medicine**

- **Address:** 1400 Wilson Blvd., Suite 900, Arlington, VA 22209
  - **Phone:** 703-706-2200
  - **Fax:** 703-725-8950
  - **Email:** info@abim.org

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**American Board of Psychiatry and Neurology, Inc.**

- **Address:** 2214 Wilson Blvd., Suite 420, Arlington, VA 22201
  - **Phone:** 703-725-8940
  - **Fax:** 703-725-8950
  - **Email:** info@abpn.org

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**American Society of Clinical Oncology**

- **Address:** 11430 West Olympic Blvd., Suite 700, Los Angeles, CA 90064
  - **Phone:** 310-447-3000
  - **Fax:** 310-447-3005
  - **Email:** info@asco.org

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**American Board of Thoracic Surgery**

- **Address:** 9700 Sunset Blvd., Suite 600, Los Angeles, CA 90069
  - **Phone:** 310-859-2626
  - **Fax:** 310-859-2629
  - **Email:** info@abts.org

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**American Board of Dermatology**

- **Address:** 11430 West Olympic Blvd., Suite 700, Los Angeles, CA 90064
  - **Phone:** 310-447-3000
  - **Fax:** 310-447-3005
  - **Email:** info@abo.org
Federally Qualified Health Centers (FQHCs)

Certification and recertification surveys are not required for FQHCs. However, CMS investigates complaints that make credible allegations of substantial violations of CMS regulatory standards for FQHCs as a Tier 2 priority. States will use most of the same health and safety standards as they do for RHCs when investigating FQHC complaints.
Participation in Entirety

- A Medicare hospital must participate in its entirety. Selective participation of certain beds, units, campuses, services, etc, is not permitted.

- Even where SSA permits certain exceptions, the exceptions apply only to those distinct parts of an institution which may and do enter into a separate Medicare agreement (i.e. RHCs)

- If a hospital is going to have a RHC as an outpatient department of the hospital, the RHC must be certified.
Licensing Standards
Definitions

*Rural Health Clinic (RHC)*

- *an* outpatient primary care clinic
- seeking or possessing certification by the Health Care Financing Administration (HCFA) (now CMS) as a rural health clinic,
- which provides diagnosis and treatment to the public by a qualified mid-level practitioner and a licensed physician.
*Licensing Standards*

- 7501 – Definitions & Acronyms
- 7503 – Licensing
- 7505 – Denial, Revocation, or Non-Renewal
- 7507 – Changes/Reporting
- 7509 – Annual Licensing Renewal
- 7511 – Notice & Appeal Process
- 7513 – Complaint Process
- 7515 – Voluntary Cessation of Business
- 7517 – Personnel Qualifications/Responsibilities
- 7519 – Services
- 7521 – Agency Operations
- 7523 – Procedural Standards
- 7525 – Record Keeping
- 7529 – Quality Assurance
- 7531 – Patient’s Rights & Responsibilities
- 7533 – Advisory Committee
- 7535 – Physical Environment
Licensing

► All Rural Health Clinic’s, regardless of type, are licensed as RHC or an offsite/department of the hospital

► License must be displayed in an obvious place in the RHC at all times

► License Types:
  
  ▪ **Full License:** In substantial compliance with the rules, standards and law. These are issued for 12 months.

  ▪ **Provisional License:** Not in substantial compliance with the rules, standards and law. These can be issued for up to 6 months if there is no immediate and serious threat to the health & safety of patients.
License

- Not assignable or transferable

- Issued to a specific owner and to a specific geographic location.

- Immediately voided if Rural Health Clinic ceases to operate or if its ownership changes.

- Voided if the hospital (or off-site campus) relocates.

- The rural health clinic must notify HSS at least fifteen days prior to any operational changes.

- RHC must be open and operational prior to the licensing survey.
3 Types of Rural Health Clinic’s

1. **Independent RHC** – licensed and certified as a stand alone facility.

2. **Provider–Based RHC**- licensed and certified independently but CCN number is linked to the hospital CCN number (should meet the provider based criteria).

3. **Hospital Department or Offsite**- licensed to the hospital and certified independently as a RHC (should meet the provider based criteria).
Only 1 License

A Rural Health Clinic can only be licensed as one type. The RHC can’t have 2 or more licenses, i.e. it can’t be licensed as a free standing RHC and a Hospital Outpatient Department simultaneously.
Independently Licensed RHC that is Independently Certified as a RHC

- Has its own independent license which is not linked with any other facility type.
- Submits a Rural Health Clinic license application to become a licensed RHC (not a hospital license application)
- Submits a CMS 855A to become a certified Rural Health Clinic and check off that it is enrolling as a “Rural Health Clinic”
- Not associated with a hospital.
Independently Licensed RHC that is Certified as an Independent RHC but Provider Based to a Hospital

- Has its own independent license which is not linked with any other facility type.
- Submits a Rural Health Clinic license application to become a licensed RHC (not a hospital license application)
- Submits a CMS 855A to become a certified Rural Health Clinic, check off that it is enrolling as a “Rural Health Clinic” (not a hospital), and indicate that it will be provider based to the hospital.
- Associated with a Hospital
- Please keep in mind that this type must be able to demonstrate compliance with provider based requirements if asked by CMS
Licensed as an Outpatient Department of a Hospital, Certified as an Independent RHC but Provider Based to a Hospital

- Only hospitals with fewer than 50 beds can be considered for this option.
- This type will have a HOSPITAL license with “RHC” included in the license number. Please remember that this type must demonstrate that it is 100% owned by the hospital and can’t operate separately from the hospital. Example: If the hospital closed, the RHC will automatically close.
- Submits a Hospital license application to become a licensed offsite campus outpatient department of the hospital (not a Rural Health Clinic license application)
- Submits a CMS 855A to become a certified Rural Health Clinic, check off that it is enrolling as a “Rural Health Clinic” (not a hospital), and indicate that it will be provider based to the hospital. (Do Not submit a CMS 855A to become a practice location of the hospital)
- Please keep in mind that this type must be able to demonstrate compliance with provider based requirements if asked by CMS
More Information Relative to Hospital Off-Site Campuses as it relates to RHCs

- All premises on which hospital services (inpatient and/or outpatient) are provided and that are NOT adjoined to the main hospital buildings or grounds.

- State licensing purposes = within 50 miles of the main campus and in the state of Louisiana.

- If you participate in Medicare then the off-site campus must be within 35 miles of the main campus and in the state of Louisiana.

- Provider-based designation = within 35 miles of the main campus and in the state of Louisiana.
Off-site Campuses

- Submit a [Hospital Off-site RHC Application Packet](#)

- Fee of $300.00 per off-site campus

- Submit CMS 855A to enroll as a Rural Health Clinic (not as a practice location of the hospital)

- POPS is linked to the Federal Aspen database and Health Standards is prohibited from making changes to the Federal system without the CMS 855A.

- Contact CMS for provider-based designation
Off-site Campuses

MUSTS:

- MUST function under the same ownership structure as the main campus
- MUST function under ONE governing body
- MUST function under ONE medical staff
- MUST function under ONE tax ID number
- MUST function under ONE unified medical record system
- MUST function under ONE organization-level policies
- MUST function under ONE nursing department
- MUST function under ONE quality assurance/performance improvement department
- MUST function under ONE infection control department
Off-site Campuses

MUST NOTS

- MUST NOT have a different ownership structure than the main campus

- MUST NOT have a separate tax ID number from the main campus

- MUST NOT have independent compliance at different locations. Non-compliance at one location equals non-compliance at all locations
Off-site Campuses

- Providers must provide notice to CMS and the SA when plans are made to add practice locations.

- In the absence of notification of an expansion, CMS has the authority to deny bills for services furnished at the expanded site.
# Packets

<table>
<thead>
<tr>
<th>Licensing</th>
<th>Name/Ownership</th>
<th>Location</th>
<th>Personnel/Hours</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Licensing</td>
<td>Legal Name Change</td>
<td>Relocation</td>
<td>Key Personnel Change</td>
<td>Conversion from Hospital Offsite to Free Standing</td>
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<tr>
<td>License Renewal</td>
<td>DBA Name Change</td>
<td>Mailing Address Change</td>
<td>Operational Hours Change</td>
<td>Conversion from Free Standing to Hospital Offsite</td>
</tr>
<tr>
<td>Closure</td>
<td>Ownership Structure Change</td>
<td>Corporate Address Change</td>
<td>Other</td>
<td></td>
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</tbody>
</table>
Initial Licensing & Certification Packets

RHCs must be licensed in the state of Louisiana
(either independently or as an outpatient department of a hospital)
## Initial Licensing & Certification

### Step 1. Submit a Complete Licensing & Certification Packet

<table>
<thead>
<tr>
<th>Licensing Documents For Free Standing RHCs</th>
<th>Licensing Documents for Hospital Offsite RHCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHC License Application</td>
<td>HSS-HO-55 Offsite Addition and Changes</td>
</tr>
<tr>
<td>Payment of $600</td>
<td>HSS-HO-017e Hospital Offsite Campus RHC Addition Supplement</td>
</tr>
<tr>
<td>Site Verification</td>
<td>Payment of $300</td>
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<tr>
<td>OSFM Plan Review (DH Plan Review)</td>
<td>Site Verification</td>
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<td>Plan Review Attestation</td>
<td>OSFM Plan Review (DH Plan Review)</td>
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<td>OSFM Walk Through Inspection</td>
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<td>OPH Walk Through Inspection</td>
<td>OSFM Walk Through Inspection</td>
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<tr>
<td>Ownership Diagram</td>
<td>OPH Walk Through Inspection</td>
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<td>EP Attestation</td>
<td>Ownership Diagram</td>
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# Initial Licensing & Certification

## Step 1. Submit a Complete Licensing & Certification Packet

<table>
<thead>
<tr>
<th>Licensing Packets</th>
<th>Licensing Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mail to:</strong></td>
<td><strong>Mail to:</strong></td>
</tr>
<tr>
<td>Louisiana Department of Health Health Standards Section ATTN: RHC P.O. Box 3767 Baton Rouge, LA 70821</td>
<td>LDH Licensing Fee P.O. Box 62949 New Orleans, LA 70162-2949</td>
</tr>
</tbody>
</table>
## Initial Licensing & Certification

### Step 1. Submit a Complete Licensing & Certification Packet

<table>
<thead>
<tr>
<th>Certification Documents for Free Standing RHCs</th>
<th>Certification Documents for Hospital Offsite RHCs</th>
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<tbody>
<tr>
<td>Approved CMS 855A for the Initial Enrollment as a RHC</td>
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</tr>
<tr>
<td>CMS 29</td>
<td>CMS 29</td>
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<tr>
<td>CMS 1561A</td>
<td>CMS 1561A</td>
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<td>OCR Clearance</td>
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## Initial Licensing & Certification

### Step 1. Submit a Complete Licensing & Certification Packet

#### Enrollment

<table>
<thead>
<tr>
<th>Tips to Facilitate the Medicare Enrollment Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider using PECOS (Provider Enrollment Chain &amp; Ownership System)</td>
</tr>
<tr>
<td>Submit the correct application for your provider type</td>
</tr>
<tr>
<td>Submit a complete application</td>
</tr>
<tr>
<td>Request &amp; obtain your NPI number before enrolling or making a change in your Medicare enrollment info</td>
</tr>
<tr>
<td>Submit the Electronic Funds Transfer Authorization Agreement (CMS-588) with your enrollment (if applicable).</td>
</tr>
<tr>
<td>Submit all supporting documentation</td>
</tr>
<tr>
<td>Sign &amp; date the application (by the appropriate individuals)</td>
</tr>
<tr>
<td>Respond to requests for additional information promptly.</td>
</tr>
</tbody>
</table>

Contact Information for Medicare Administrative Contractors (MAC)

Part A Contractor:  Novitas Solutions
JH Provider Enrollment Services, P.O. Box 3095, Mechanicsburg, PA 17055-1813
http://www.novitas-solutions.com/ 855-252-8782, Option 4

Medicare Enrollment Application for Institutional Providers
This is the one for all hospital & Rural Health Clinic actions.

Medicare Enrollment Application for Clinics, Group Practices, and Certain Other Suppliers
Not for certification of hospitals & RHCs. Also, cant use CMS 855I, CMS 855R, CMS 855O & CMS 855S
### Initial Licensing & Certification

#### Step 2. License Issued

<table>
<thead>
<tr>
<th>Free Standing RHCs</th>
<th>Hospital Offsite RHCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>License Issued By Attestation</td>
<td>License Issued By Attestation</td>
</tr>
<tr>
<td>Expiration Date is the last date of month prior to anniversary month of the following year.</td>
<td>Expiration Date will be the Expiration Date of the Hospital</td>
</tr>
<tr>
<td>On-site Licensing Survey will be Completed Within 6 to 8 months</td>
<td></td>
</tr>
</tbody>
</table>
Initial Licensing & Certification

3. Certification

<table>
<thead>
<tr>
<th>Free Standing RHCs</th>
<th>Hospital Offsite RHCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Must successfully undergo an Accrediting Organization (AO) Survey</td>
<td>Must successfully undergo an Accrediting Organization (AO) Survey</td>
</tr>
<tr>
<td>The AO will issue an approval letter to CMS</td>
<td>The AO will issue an approval letter to CMS</td>
</tr>
<tr>
<td>CMS will forward the AO letter to the Health Standards</td>
<td>CMS will forward the AO letter to the Health Standards</td>
</tr>
<tr>
<td>Health Standards will update the Federal Database for CMS &amp; forward the Initial Certification Packet to CMS</td>
<td>Health Standards will update the Federal Database for CMS &amp; forward the Initial Certification Packet to CMS</td>
</tr>
<tr>
<td>CMS will place the packet in line for processing. Once processed CMS will issue a CMS number to the provider using the email address updated into the system.</td>
<td>CMS will place the packet in line for processing. Once processed CMS will issue a CMS number to the provider using the email address updated into the system.</td>
</tr>
</tbody>
</table>
Initial Certification

- Must be licensed prior to undergoing an accrediting survey

- A successful (deeming) survey by an approved AO will count as an initial certification survey and will be your quickest way to certification

- These are always UNANNOUNCED.
Provider Number

- CMS will issue the CCN (CMS certification number).

- In Louisiana that number will always start with “19”

- NPI (National Provider Identifier) numbers are different from the CCN.

- Anything being billed under any of the hospital’s NPI numbers must be licensed to the hospital.
License Renewals

- Must be renewed annually using:
  - RHC License Renewal Packet if independently licensed as a RHC
  - Hospital License Renewal Packet if licensed as an outpatient department of a hospital
  - YOU CAN’T HAVE BOTH TYPES OF LICENSES

- Renewal letters are sent out at least 75 days prior to the expiration of the license.

- According to the licensing standards you must return the renewal packet at least 15 days before your license expires.

- However, in reality if you wait that long to submit your packet, it will not make it to Health Standards with enough time to process it before your license expires.
License Renewals

The best recommendation is to submit it so that it arrives at least 30 days before your license expires. If you do submit it at the last minute, we can’t guarantee that it will be renewed by the expiration date.

Please don’t hold your license renewal packet while awaiting the fire/health inspections. If your inspection has not been completed by the OSFM/OPH, please include an email from the respective offices confirming that you are on the schedule for an inspection. Once the inspection has been completed, you are required to submit the inspection form to Health Standards.
License Renewals

► Don’t submit changes on your License Renewal Packet. If you want to make a change, submit two packets: one packet showing exactly what you are already licensed for and a second packet showing the change.

► Don’t pay for a license renewal twice. If you get a second renewal notice, check with Destinn or Tammy to see if they have the payment before sending a second one.
“However, assignment of this CCN does not constitute a CMS determination that you have satisfied all applicable requirements for provider-based status established under 42 CFR 413.65. You are under no obligation to seek a determination from CMS that you satisfy all applicable requirements to be considered provider-based. You are, however, obligated to meet these requirements and you could be subject to recovery by CMS of overpayments, should you fail to comply with any applicable provisions of 42 CFR 413.65. You may, therefore, wish to consider seeking on a voluntary basis a CMS determination of whether you satisfy the provider-based requirements, in an effort to reduce your potential exposure to recovery of overpayments. For questions regarding obtaining a CMS provider-based determination, please contact the Division of Financial Management and Fee for Services Operations at 214-767-6441.”
Ownership
Ownership Diagram

Ownership Diagrams quickly show all individuals and entities with direct or indirect ownership in the enrolled provider.
Changes in Ownership

Changes in ownership structure can be processed in one of two ways:

- Change in Information (CHOI)
- Change in Ownership (CHOW)

Regardless of which way it is processed you will need to submit a change of ownership structure packet to Health Standards.
Changes in Ownership

Licensing Standards & Federal 42 CFR 489.18

- A change in ownership (CHOW) is the sale or transfer (whether by purchase, lease, gift or otherwise) of a RHC by a person/corporation of controlling interest that results in:
  - a change of ownership or control of 30% or greater of either the voting rights or assets or
  - the acquiring person/corporation holding a 50% or greater interest in the ownership.
Changes in Ownership

Examples of CHOWS:

- Unincorporated sole proprietorship: transfer of title and property to another party

- Corporation: The merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation.
Changes in Ownership

Examples of CHOWS:

- Partnership & LLCs: In the case of a partnership, the removal, addition or substitution of a partner, unless partners expressly agree otherwise, as permitted by applicable state law.

- Leasing: The lease of all or part of a provider facility constitutes a CHOW of the leased portion.
Changes in Ownership

Notice to HSS

- No later than 15 days after the effective date of the CHOW, the prospective owner shall submit to the department a completed application for the CHOW. A license is not transferable from one entity or owner to another.

- Please note that as soon as the CHOW occurs (effective date) the current license is no longer valid. Upon submission of a CHOW packet 15 days following the CHOW, the RHC may be granted up to 90 days to obtain the CMS 855A on a case-by-case basis.

- **No other licensing actions will be processed** until the CHOW is completed because the license is no longer valid.

Notice to CMS

- A provider who is contemplating or negotiating a change of ownership must notify CMS.
Changes in Ownership

If the RHC undergoes multiple CHOWs/CHOIs in a short period of time (even if 1 minute apart), EACH transaction must be processed in its entirety before another transaction will be processed.
Changes in Ownership

Provider Agreement

CMS automatically assigns the provider agreement to the new owners.

The new owners may formally notify CMS that they plan to reject “assignment” of the provider agreement.

When the new owner does not accept assignment of the previous owner’s provider agreement, the provider agreement is voluntarily terminated. If the new owner wishes to participate in Medicare/Medicaid, it is treated as a new applicant.
Changes in Ownership

Effects of **Accepting** Assignment of the Provider Agreement

- New owners retain the Medicare and Medicaid provider agreements.
- New owners are responsible for all known and **unknown** Medicare and Medicaid liabilities of previous owners.
- No break in Medicare or Medicaid payments.
- No survey of CoPs required.
- Retains all applicable payment statuses, including rural designation.
Changes in Ownership

Effects of **Rejecting** Assignment of the Provider Agreement

- A rejection of the provider agreement is a voluntary termination of the agreement and means the provider no longer exists.

- When the Medicare provider agreement terminates so does the Medicaid provider agreement.

- If the new owner wishes to continue to participate it must reapply as an initial applicant (855, OCR, full survey after the new owners begin providing services).

- An initial certification survey must be conducted by the Accrediting Organization

- Loss of any special statuses (i.e. rural designation, provider-based status, etc.)
Changes in Ownership

Effects of **Rejecting** Assignment of the Provider Agreement

- Effective date is not the same as the date of the CHOW. New effective date is after the RHC meets all Federal requirements which can mean an unknown interval of time with no Medicare/Medicaid payment.
Submit

- Independent RHC: Submit a RHC license application packet and corresponding documents for the change in the DBA name only.
- Hospital Outpatient Department: Submit the Hospital Name Change Packet
Entity Name Change

Submit

► Independent RHC: Submit the RHC License Application & corresponding documents when the RHC is changing the entity name.

► Hospital Outpatient Department: Submit the Hospital Name Change Packet

Please note that if the entity name change is determined to be a CHOW you will need to submit a CHOW documents.
RHC Relocations

- Since each license is issued to a specific geographic address, a new license will need to be issued if a RHC or hospital off-site campus relocates. The original license will need to be returned to HSS.

- If you relocate the license is no longer valid meaning you don’t have a licensed RHC.

- A relocation, in most cases, will require an inspection by a Health Standards surveyor.

- Submit
  - Independent RHC: Submit the RHC license application along with corresponding documents when the RHC is relocating.
  - Hospital Outpatient Department: Submit the Hospital Offsite Addition and Changes Packet.
Relocations

- Continuation of the provider under the same provider agreement is possible if the RHC continues serving the same community. This is decided by CMS.

- Voluntary termination under 489.52 occurs if the relocation is “so far” from the original location as to result in a cessation of business to the original community.

- The specific circumstances of the community served will impact the determination of whether the RHC is serving the same community.
Service Action

If the RHC is adding/deleting a service (i.e. outpatient radiology, lab, primary care service, etc.) or changing anything about the way a service is being provided or where the service is being provided or the size of the space where the service is being provided, the RHC will need to submit:

- **Independent RHC**: Submit the RHC license application along with corresponding documents
- **Hospital Outpatient Department**: Submit the Hospital Service Action Packet
RHC Closure

Closure

- Independent RHC: Submit a RHC license application and corresponding documents for the closure.
- Hospital Outpatient Department: Submit the Hospital Voluntary Closure (Main or Offsite Campus) Packet.

The hospital is to notify HSS in writing within 14 days of the closure of an off-site campus with the effective date of closure. The original license of the off-site campus is to be returned to HSS.

Cessation of business:

- deemed to be effective with the date on which the RHC stopped providing services to the community.

- **Entire Hospital closure:**
  - The hospital must notify HSS in writing 30 days prior to the effective date of closure, must submit a written plan for the disposition of the medical records, publish notice in the newspaper and return the original license to HSS.
  - Please keep in mind that should the hospital close then all associated RHCs will no longer be licensed or certified.
  - Should the hospital lose its provider number then any associated RHCs will be impacted because there will be no certified hospital to be provider based to.
Plan Reviews

- Deletion of the Division of Engineering and Architectural Services

- Effective July 2011 the Department of Public Safety (DPS), Office of the State Fire Marshal conducts plan reviews of certain healthcare facilities licensed by the Louisiana Department of Health (LDH).

- Please keep in mind that the Office of State Fire performs two types of plan reviews:
  - 1) The LDH Plan Review referred to as the “DH Review” (the Office of State Fire Marshal can NOT exempt you from this review)
  - 2) The Life Safety/Occupancy Plan Review referred to as the “AR Review” (the Office of State Fire Marshal may exempt you from this review)

- If the healthcare entity is not licensed by LDH - Health Standards Section (HSS) then no Health Standards plan review is required by DPS.
*Plan Review*

- New buildings to be used as a RHC

- Additions to existing buildings to be used as a RHC

- Conversions of existing buildings or portions thereof for use as a RHC

- Please keep in mind that CMS states that only one building can be certified as the RHC. The RHC CAN’T have multiple buildings.
Approval of Plans

- Notice of satisfactory review from the Office of State Fire Marshal constitutes compliance with this requirement if construction begins within 180 days of the date of such notice.

- This approval shall in no way permit, and/or authorize any omission or deviation from the requirements of any restrictions, laws, ordinances, codes or rules of any responsible agency.
New RHC License Application
*Packets – What Happens To My Packet*

- Post Office Box 3767, Baton Rouge, LA 70801
- Someone from LDH retrieves the mail at the USPS
- Mail goes to the Mail Room at Bienville Building where it is sorted.
- Delivered to Health Standards receptionist in the Bienville Building and dated
- Placed in the appropriate program desk mail box
- Picked up by the administrative assistant, logged into the data system and placed in the queue for processing.
- At any one time there are MANY packets in line for processing so submit EARLY in your planning process.
- If you email the packet it will be placed in the queue by Tammy Walton
Packets – What Happens To My Packet

**License Renewal Packets** are handled by the Administrative Assistant.

- Please contact Destinn.Obear@la.gov for any questions regarding your license renewal of RHCs that are outpatient departments of hospitals.
- Please contact Tammy.Walton@la.gov for any questions regarding your license renewal of independently licensed RHCs.

**All Surveys, Plans of Correction, Regulatory Questions & Waivers for RHCs** are handled by the Program Manager for Surveys. Please contact Jennifer.Haines@la.gov or Debby.Franklin@la.gov for any questions regarding your survey, plan of correction, regulatory questions or waivers.
Packets – What Happens To My Packet

All Complaints, Self Reports and Key Personnel Changes are placed in the line for the Complaint Manager. Please contact Janice.Louis@la.gov for questions regarding complaints, self-reports and key personnel changes.

All other packets are placed in the line for processing by the RHC program manager.
Packets – What Happens To My Packet

- Once the packet makes it to the Program Manager’s desk, it is reviewed for accuracy and completeness.
- If complete it is processed.
- If incomplete an instructional letter will be sent to the provider.
- Unfortunately greater than 70% of packets are incomplete.
What you can do to assist the process

- Submit only completed packets
- Place the checklist on the front of the packets
- Submit your packet very early in your planning processes.
- Remember to submit your plan reviews early in the process
- Remember to submit your 855As early in the process since the state system is now linked to the federal system.
- When calling to check the status of your packet, please explain to Destinn or Tammy what you are calling for and she will check the status of your packet.
Team Work
## RHC Surveys/Regulations

<table>
<thead>
<tr>
<th>Type of Survey</th>
<th>Licensing Regulations</th>
<th>Federal Regulations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Licensing Survey</td>
<td>RHC Licensing Standards</td>
<td></td>
</tr>
<tr>
<td>Relicensing Survey</td>
<td>RHC Licensing Standards</td>
<td></td>
</tr>
<tr>
<td>Initial Certification Survey</td>
<td></td>
<td>RHC Conditions for Coverage &amp; AO Standards</td>
</tr>
<tr>
<td>Recertification Survey</td>
<td></td>
<td>RHC Conditions for Coverage &amp; AO Standards (if accredited)</td>
</tr>
<tr>
<td>Complaint Survey</td>
<td>RHC Licensing Standards</td>
<td>RHC Conditions for Coverage</td>
</tr>
</tbody>
</table>
Initial Licensing Survey

- This is an announced survey coordinated between the provider & Field Office
- RHCs must be operational and have seen at least 5 patients prior to the survey
- All State Licensing Standards must be met

Results of Initial Licensing Survey

- No Deficiencies
- Survey Aborted
- Plan of Correction Requested
- License Denied
Annual Licensing Survey

Although re-licensing surveys should be performed annually, the frequency of re-licensing surveys are determined by the annual budget.
To qualify for Medicare certification, providers must comply with minimum health & safety standards.

These standards are termed “Conditions for Coverage” (CfCs) as it relates to Rural Health Clinics.

They are embodied in Title XVIII of the Social Security Act.
Conditions of Coverage

491.4 Compliance with Federal, State & Local Laws
491.5 Location of Clinic
491.6 Physical Plant & Environment
491.7 Organizational Structure
491.8 Staffing & Staff Responsibilities
491.9 Provision of Services
491.10 Patient Health Records
491.11 Program Evaluation
Initial Certification Survey

Resources for Initial Certification Surveys are highly constrained due to the current budget for Survey & Certification.

CMS longstanding policy makes complaint investigations, re-certifications, and other core work for existing Medicare providers a higher priority compared with certification of new Medicare providers.

Providers have the option of attaining accreditation that conveys deemed Medicare status conducted by a CMS-approved accreditation organization (in lieu of Medicare surveys by CMS or States). Providers are advised that such deemed accreditation is likely to be the fastest route to certification.

This Certification process can only take place after the provider has been issued a license by the State.
Re-Certification Survey

Accredited RHCs

- Accreditation is granted for 3 years
- The Accrediting Organization will conduct an unannounced reaccreditation survey prior to the expiration of the current accreditation survey.
- All AO standards are reviewed.

Non-Accredited RHCs

- Once a year CMS issues a priority schedule to Health Standards outlining the types of federal surveys to be conducted.
- RHCs are selected for unannounced recertification surveys based on the priority document
- All Conditions for Coverage & Life Safety Codes are reviewed
- Re-licensing & recertification surveys are usually conducted concurrently except for Hospital Offsite RHCs which may be on a different schedule.
Conditions of Coverage

Please note that if a deemed RHC is found to be not in compliance with one or more CfCs:
• CMS removes the “deemed status' and the RHC is notified by letter.
Timeline

Day 15
• State Agency sends the SoD & letter to provider indicating there is a determination of non-compliance & placing the facility on a 90 day termination track. Provider has 10 calendar days to complete plan of correction & return it to the State Agency.

Day 25
• Provider must have an acceptable Plan of Correction back to the State Agency

Day 35
• Provider MUST be ready for a the first follow up revisit by this date
• Only 2 revisits are permitted

Day 55
• If provider is not in compliance, the State Agency certifies non-compliance and sends the information to CMS

Day 65
• CMS determines whether survey findings continue to support a determination of non-compliance

Day 70
• CMS sends an official termination notice to the provider

Day 90
• Termination takes effect if compliance is not achieved.
April 3, 2014

Administrator
ABC Hospital
123 Dark Street
Happy Town, LA XXXXX

Medicare Provider # XXXXX

E-MAIL – READ RECEIPT REQUESTED

Dear Administrator:

On the basis of the deficiencies found to exist in your facility on 01/15/2014, it no longer appears that ABC Hospital qualifies as a provider of services in the Medicare program. To participate in Medicare, a provider must meet the statutory requirements established under Title XVIII of the Social Security Act and must also meet health and safety requirements prescribed by the Secretary of the U. S. Department of Health and Human Services. The results of the 01/15/2014 survey confirmed that ABC Hospital is out of compliance with the following Medicare Conditions of Participation:

42 CFR 482.13 Patient Rights

The CMS form 2567 Statement of Deficiencies is enclosed for your response and is to be returned to this office signed and dated by the administrator or other authorized official as indicated. The plan of correction must be entered on the original statement of deficiency report and must be specific, realistic and state how the deficient practice will be prevented from recurring. Refer to the enclosed “Required Components for a Plan of Correction” for guidance in developing your Plan of Correction. The Plan of Correction must be completed and returned to this agency within 10 days after receipt of this letter or action to terminate your agreement will proceed as scheduled. Proposed Plan of Correction completion dates for the Conditions of Participation and related deficiencies cannot exceed April 19, 2014 (35th day). Compliance with all Conditions of Participation must be achieved at the time of this revisit if further action is to be avoided.

If the deficiencies have not been satisfactorily corrected at the time of this revisit, a certification of non-compliance will be forwarded to the Centers for Medicare and Medicaid Services (CMS) with the recommendation that your Medicare provider agreement be terminated effective April 15, 2014. In that event, you can expect to receive a letter from CMS advising you of the exact date of termination and your appeal rights. During that period, CMS will give public notice of the date of termination and the reasons for termination. Once terminated, you can anticipate being out of the Medicare program for at least 60 days.
What to do now?

- First-Get started fixing the problem as soon as the brought to your attention. DO NOT WAIT to receive the statement of deficiencies.

- Reach out for help-especially if you have condition level deficiencies.
  - State Office is not allowed to consult....but that does not apply to all agencies
    - Traci Ingram’s group can be a very valuable resource
Complaint Survey

- Janice Louis, RN handles complaint intakes

  [State and/or Federal Regulations]

- Surveyors will review the corresponding licensing regulations and federal Conditions of Participation/Coverage relative to the complaint.
Statement of deficiencies sent to the provider.

Provider has:

- **10 business** days from the date of receipt to complete plan of correction and send to RHC C&S desk.
- Must send all documentation created or changed to address the cited deficiencies (i.e., updated or changed policies and procedures, audit sheets created, staff in-service sign in sheets).
- Plan needs to be signed dated and titled by CEO or authorized signature.
Plans of Correction

How were corrective Actions accomplished for those patients affected by the deficient practice.

Describe how others that have the potential to be affected by the deficient practice will be identified, and what will be done for them.

Document measures put into place to ensure the deficient practice will not recur.

How will the facility monitor its performance to make sure solutions are sustained (Who, How, How Often)?

Include the date the corrective action will be completed. Please keep in mind that immediate interventions should be started...don’t wait until the last possible date to make corrections.
Plans of Correction

If you indicate that policies were changed, please include a copy of the policy.

If you indicate that staff were trained, please include a copy of the training provided & the sign in sheet demonstrating staff were trained.

If an advisory meeting did not occur, please schedule the advisory meeting prior to the corrective action date, include the agenda for the meeting, and the sign in sheet.

If there were deficiencies regarding the environment, please send photos demonstrating how the environmental issues were corrected.

Please ensure that you sign and date the first page of the federal SoD and State SoD (if a concurrent licensing survey was conducted).
Most frequently cited tags

- 23 & 24 Maintenance
- 72 Protection of Records
- 250 Maintenance
- 320 Physical Environment
- 175 Procedural Standards-Infection Control
- 290 Advisory Committee
- 255 Quality Assurance
- 58 Patient Care Policies
- 77 Annual Total Program Evaluation
- 57 Patient Care Policies
Please remember:

Keep CEO/Administrator information with us
CURRENT – This database is also used by CMS

PoC’s are sent via e-mail to HSSNLTCSurveyPackets@la.gov

or

Mailed to Health Standards Section, P.O. Box 3767, Baton Rouge, LA 70821

Both a hard copy and e-mail are not needed!
Health Standards Section

The Survey Process

June 25, 2019

Jenny Haines, RN, BSN
Medical Certification Program Manager
SIX SURVEY TASKS

- Offsite Preparation
- Entrance Conference
- Information Gathering
- Decision Making/Analysis of Findings
- Exit Conference
- Post Survey Activities
## Task 1: Off-Site Site Preparation

<table>
<thead>
<tr>
<th>Determine the Team Composition</th>
<th>Team Building</th>
<th>Survey Direction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size of the Facility</td>
<td>Assign Team Leader</td>
<td>Identify concerns to be investigated</td>
</tr>
<tr>
<td>Complexity of Services</td>
<td>Coordinate time/place for team to meet</td>
<td>Identify persons to be interviewed</td>
</tr>
<tr>
<td>Type of Survey</td>
<td>Team Assignments</td>
<td>Gather form needed for the type of survey</td>
</tr>
<tr>
<td>Historical Pattern of Deficiencies</td>
<td>Facilitate Time Management</td>
<td></td>
</tr>
<tr>
<td>Media Sources</td>
<td>Encourage on-going communication</td>
<td></td>
</tr>
<tr>
<td>Complaints</td>
<td>Set projected exit date/time</td>
<td></td>
</tr>
</tbody>
</table>
### Task 2: Entrance Conference

<table>
<thead>
<tr>
<th>Upon Arrival</th>
<th>Conference</th>
<th>Process</th>
<th>Examples of Information that may be requested</th>
</tr>
</thead>
</table>
| Ask to speak to the Administrator or to whomever is in charge at the moment the team enters if the Administrator is not available. | Explain purpose & scope of survey & set a projected exit date/time | Secure a private area for surveyors to work and discuss survey findings | List  
  - Current list of patients with name, diagnosis, admission date, age, attending MD & significant data  
  - Staff members  
  - Employees  
  - MDs/allied health workers  
  - Contracted services |
| The survey will not be delayed because the Administrator or other staff are not on site or available. | Briefly explain the survey process | Ensure that surveyors are able to obtain photocopies of materials, records, and other info needed | Governing Body Bylaws  
  Governing Body Rules  
  Medical Staff Bylaws  
  Medical Staff Rules  
  Meeting Minutes  
  Advisory Minutes |
| Introduce self, team, and state purpose of the visit. | Clarify that all areas under the license/provider number may be surveyed, including any contracted patient care activities. | Explain that all interviews will conducted privately with patients, staff and visitors, unless requested otherwise by the interviewee. | Policies & Procedures  
  Infection Control Plan  
  Quality Assurance Plan  
  Emergency Plan & Drills |
# Task 3: Information Gathering

The objective is to determine compliance with Medicare Conditions for Coverage and/or the licensing standards through observations, interviews, and document review.

<table>
<thead>
<tr>
<th>Observations</th>
<th>Interviews</th>
<th>Examples of Record/Document Review (But not limited to)</th>
<th>Policies &amp; Procedures QAPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provision of patient care</td>
<td>• The State Agency and surveyors have discretion in allowing facility personnel to accompany the surveyors during the survey/interviews based on the circumstances at the time of the survey.</td>
<td>• Patient Medical Records (open &amp; closed)</td>
<td>• Reviewed annually &amp; updated</td>
</tr>
<tr>
<td>• Interactions between staff &amp; patients</td>
<td>• Interview with patients &amp; families about their care &amp; knowledge of their illness.</td>
<td>• Actual &amp; Potential Patient Outcomes</td>
<td>Reflect the intent of State &amp; Federal regulations</td>
</tr>
<tr>
<td>• Medication storage/handling</td>
<td>• Interviews with staff regarding knowledge of patients &amp; care needs</td>
<td>• Consent Forms (dated, signed)</td>
<td>Reflect the facility practice</td>
</tr>
<tr>
<td>• Medical Record storage/handling</td>
<td>• Interviews with staff regarding policies &amp; procedures, and areas of concern found during the survey</td>
<td>• Assessments completed</td>
<td>Address all areas of practice provided by the provider</td>
</tr>
<tr>
<td>• Environment (safe/clean/uncluttered)</td>
<td>• Interviews with physicians/mid level practitioners regarding patient care services</td>
<td>• Plans of Care initiated &amp; updated</td>
<td>Does QAPI show evidence there are measurable improvements in indicators for which health outcomes will be improved.</td>
</tr>
<tr>
<td>• Biohazardous materials</td>
<td>• Interview with key personnel regarding their knowledge of policies &amp; procedures</td>
<td>• MD orders followed &amp; documented appropriately</td>
<td>Does the plan include a system to measure, analyze, and monitor the effectiveness, safety of services, quality of care and track performance?</td>
</tr>
<tr>
<td>• Pest Control</td>
<td>• If key personnel are unavailable who is the person designated to act in that person’s absence.</td>
<td>• Progress notes to include care plan problems addressed with documentation of treatments provided.</td>
<td>Are preventative actions put in place &amp; improvements sustained?</td>
</tr>
<tr>
<td>• Equipment use/inspections</td>
<td></td>
<td>• Comprehensive discharge planning</td>
<td>Is there documentation of QAPI projects conducted annually, reason for choosing the projects, and the measurable progress achieved on the projects.</td>
</tr>
<tr>
<td>• Integration of all services to ensure facility is functioning as one integrated whole</td>
<td></td>
<td>• Employee Files</td>
<td>Is there evidence all services/areas &amp; contracted services are involved in QAPI.</td>
</tr>
<tr>
<td>• Cleaning solutions (labeled &amp; used appropriately)</td>
<td></td>
<td>• Medical/Nursing Staff Files</td>
<td>Does the Governing Body have oversight &amp; specify in writing the frequency &amp; detail of data collection.</td>
</tr>
<tr>
<td>• Universal precautions</td>
<td></td>
<td>• Governing Body Bylaws, Meeting Minutes</td>
<td></td>
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<tr>
<td>• Hand Washing</td>
<td></td>
<td>• Medical Staff Bylaws, Meeting Minutes</td>
<td></td>
</tr>
<tr>
<td>• Handling/processing linen</td>
<td></td>
<td>• Quality Plans &amp; Data</td>
<td></td>
</tr>
<tr>
<td>• Handling/processing instruments</td>
<td></td>
<td>• Infection Control &amp; Data</td>
<td></td>
</tr>
<tr>
<td>• Facility Wide Quality Assurance</td>
<td></td>
<td>• Advisory Meeting Minutes</td>
<td></td>
</tr>
<tr>
<td>• Facility Wide Infection Control</td>
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<td>• Sign in Sheets</td>
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<td></td>
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<td>• Maintenance records</td>
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<td>• Equipment Inventory</td>
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<td>• Emergency Drills</td>
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<td>• Fire/Health inspections</td>
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<td>• Contracts</td>
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<td>• Grievances</td>
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</tbody>
</table>
The objective is to review & analyze findings and determine whether or not the RHC meets the regulatory requirements.

Observations

• The team meets in private to discuss all areas of concern to determine whether the facility has met the regulatory requirements.

• Surveyors will review his/her notes and share findings with the team.

• Decisions about deficiencies are to be team decisions, with each member having input.

• If deficiencies are identified the team will determine the severity of the deficiency.

• A team consensus, with consultation with State Office, will determine whether a Condition for Coverage will be considered met or not met.
Task 5: Exit Conference

This is a courtesy meeting to provide preliminary findings.

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Composition</th>
<th>Forms</th>
<th>Plans of Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>The exit conference is a courtesy meeting that can be ended at any time should the exit conference become adversarial.</td>
<td>The RHC can decide who will attend the exit conference.</td>
<td>The exit conference form will be provided to the Administrator to sign, date and return to the Team Leader.</td>
<td>You will be informed of the process for submitting a Plan of Correction</td>
</tr>
<tr>
<td>The exit conference is to inform the facility staff of the team’s preliminary findings. These could change after State Agency &amp;/or CMS review</td>
<td>Because of the ongoing dialogue between surveyors and facility staff during the survey, there should be few instances in which the facility is unaware of surveyor concerns or has not had an opportunity to present additional information prior to the exit conference</td>
<td>Please ensure that the administrator provides a current and accurate email address as this will be the address used by the State Agency and CMS in future communications.</td>
<td>POC is to be submitted to <a href="mailto:Jennifer.Haines@la.gov">Jennifer.Haines@la.gov</a> and <a href="mailto:Debby.Franklin@la.gov">Debby.Franklin@la.gov</a> either by email or mail to Health Standards Section, P.O. Box 3767, Baton Rouge, LA 70821 within 10 calendar days if the CfC is out or 10 working days is no CfC is out.</td>
</tr>
<tr>
<td>Tag numbers will not be referenced in the exit conference as these numbers could change.</td>
<td>The official results are when the RHC receives</td>
<td>It is also a good idea to give at least one other RHC staff person’s name and email as a contact.</td>
<td></td>
</tr>
<tr>
<td>The official results are when the RHC receives</td>
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</tbody>
</table>


### Task 6: Post Survey Activities

#### Completion of the Survey

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The survey team will complete the required paperwork and update information in the state &amp; federal database.</td>
<td>• If standard level deficiencies are cited with no Conditions for Coverage out of compliance, the survey team will email the CMS 2567/state form (statement of deficiencies) to the provider along with instructions for submitting the Plan of Correction.</td>
</tr>
<tr>
<td>• In conjunction with the State Agency &amp; at times with CMS, the survey team will finalize the survey findings.</td>
<td>• If a Condition for Coverage was found to be out of compliance, the CMS 2567/State Form will be emailed from the State Agency along with the termination notice, IDR/POC instructions.</td>
</tr>
</tbody>
</table>
Primary Reasons

- Feels that Facility Does Not Care
- Dissatisfaction with Grievance Process
- Valid, unresolved concerns that arise during treatment
- Misconceptions about goals of care
- Misconceptions about patient’s condition
- Displaced anger related to poor outcome
- Sense of Powerlessness
Offsites

Licensing “nontraditional” offsites (e.g. physicians’ offices, RHCs, clinics, etc.):

- All relevant hospital regulations now apply (State & Federal)
- Complaints will be processed by LDH
- Open to onsite surveys (i.e. complaint investigations)
- Subject to hospital policies and procedures
- Hospital administration and designees responsible for processing grievances
- Clinic/office staff members must be educated on all relevant standards
Health Standards Section
Emergency Preparedness
June 25, 2019

Jenny Haines, RN, BSN
Medical Certification Program Manager
Emergency Preparedness

Emergency Preparedness

Louisiana knows about emergencies......we must be prepared for all types of emergencies
CMS rule-emergency preparedness for Medicare and Medicaid providers

- Became effective November 16, 2017.
- Can be accessed via eCFR at https://www.ecfr.gov/cgi-bin/text-idx?SID=6762e9979ce577516fec35efa0cf02eb&mc=true&tpl=/ecfrbrowse/Title42/42tab_02.tpl
- Effects 17 provider types.
- Is a Condition of Participation
- Requires providers
  - to perform an “all hazards” risk assessment
  - Test their emergency plans by participating in a full scale operations based community wide drill if available, facility wide drill, or table top exercises at least twice per year. Classroom training for staff does not meet the testing requirement.
  - Analyze facility performance during the drill, update the emergency plan based on the analysis, and to document changes to the plan
  - Have a communication plan that includes the facility’s local emergency operations center (EOC)
  - Train employees upon hire and annually thereafter
Monitoring for Provider Compliance

- Health standards As the monitoring entity for CMS has adopted an attestation process providers are required to complete annually.

- The attestation process has been incorporated into the annual license renewal process for all affected licensed providers.

- Attestation is also required as part of other processes such as changes in ownership and changes of address.

- License renewals will not be processed without a completed approved license application addendum form for the facility.
Helpful information for completing the attestation form:

- The form is electronic and should be filled out electronically.
- The facility name must match what is on file with state office.
- Medicare # field refers to the facility federal certification # -this number begins with “19”
- Risk Assessment and Emergency Planning: Review of the facility emergency plan is an annual requirement – n/a is not an acceptable answer here.
- Training and Testing: Providers must submit 2 test dates or 1 test date along with a date the facility emergency plan was activated. Test dates submitted must be within the last calendar year.
- Activation of the facility plan, if applicable – Refers to a date the facility plan was activated in a real emergency, not when a plan or policy was updated or put in place.
Questions about Attestation Process

Contacts

- Libby Gonzales: Libby.Gonzales@la.gov
- Oklynn Broussard: Oklynn.Broussard@la.gov
Table top drills

▶ LDH Bureau of Primary Care is hosting Quarterly Virtual table top drills for providers.

▶ The next scheduled virtual table top drill in the quarterly series is July 2, 2018.

▶ For registration information, Please contact Nicole Coarsey, Louisiana department of health, Louisiana Bureau of Primary Care @ 225-342-4415 or Nicole.coursey@la.gov.
New Expedited Licensing Process

► Memo dated December 20, 2018
► Final rule published in the Louisiana Register December 20, 2018.
► Fee for RHC expedited survey is $6000 + licensing fee
► Expedited survey shall be conducted within 10 working days
  ▪ The licensing packet must be complete to start the 10 working days timeline.
  ▪ The expedited fee and licensing fee must be received by State Office and clear with the bank.

► Is this right for you?
Mobile Units

Currently, we do not license these. We license the RHC to one geographical address, and do not currently have the licensing capability for mobile units.
CHOWs and CHOIs

► Health Standards has changed the way we handle these
► The RHC program desk no longer handles the initial portion of CHOWs and CHOIs.
► Those applications should be sent to: HSSOwnerships@la.gov.
► Check our website under “Change of Ownership Information”
  ▪ There is a new form on the website-no longer using the RH-01 for this action.
► Once all documents (including the 855A) are received and reviewed by the CHOW/CHOI program manager, they will forward the paperwork to the RHC program desk.
► At this point, the license will be issued and any other actions that occurred as part of the CHOW/CHOI will be processed (DBA name changes, etc.).
HEALTH STANDARDS

Directory

Change of Ownership Information

Providers must complete this document when they have a change in the ownership structure. This document would be used for both a change of ownership (COO) as defined by state and/or federal regulations, or a change of ownership information (COI) that does not meet the state and/or federal regulations (CDM) definition.

For Health Stands to make a COO/COI determination, all providers must submit the following documents:
1. Letter of intent (including COO's listing business and entity name of the previous and the new owner, the effective date of change of ownership, address, and phone number)
2. A diagram showing the ownership structure “before” and “after” the change
3. Copy of the executed legal transaction documents (Bill of Sale, lease, etc.)
4. Certificate of Ownership Application
5. Change of Ownership Application
6. REACH approval letter for the following Medicare certified providers: Home Health Agencies, Hospitals, PCAs, NHCs, DMEs, portable x-ray, community mental health, CORF, Nursing Facilities, and PFPs.

Note: If this action is a CHM, the documents above are the only documents you need to submit. There is no fee for a CHM.

If this action is a COO, the following are also needed:
1. Does your facility have a CMA Certificate? Yes, you may also be required to complete a COOIR for CMA.
2. Unincorporated: Click here for the link for the Health Standards Fee Schedule.

Note: The fee for a COOIR is usually the same as a COO even unless the facility is making additional changes. Providers completing an acquisition/merger, please contact the Program Desk for assistance.

Please select the appropriate provider type below and use the corresponding section indicate for additional documents that are required.

<table>
<thead>
<tr>
<th>Multi-Bi Systems</th>
<th>Home Health</th>
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<tbody>
<tr>
<td>AHC</td>
<td>Medical</td>
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<tr>
<td>ARCP</td>
<td>177 D9</td>
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<tr>
<td>ASC</td>
<td>Boarding Home</td>
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<tr>
<td>Behavioral Health Services</td>
<td>Daycare/Rehab</td>
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<tr>
<td>CMHC</td>
<td>Pain Management</td>
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<tr>
<td>CRC Level III</td>
<td>PMHC</td>
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<tr>
<td>CRFP</td>
<td>Portable 3 Ray</td>
</tr>
<tr>
<td>ERTH</td>
<td>PRP</td>
</tr>
<tr>
<td>ERTH</td>
<td>RHC</td>
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<tr>
<td>FTSRA</td>
<td>Support Coordination</td>
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<tr>
<td>HEBI</td>
<td>TUL</td>
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<tr>
<td>Hospital</td>
<td></td>
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</tbody>
</table>
License Renewals

► Big Changes!!!!
► License Renewals will all be done via email now
  ▪ Will be sent to administrator’s email
  ▪ Imperative that the administrator’s email is up to date
► Can be returned to the same email address the renewal came from

► License renewals will come from:

HSS-RHC-Licensing@la.gov
Health Standards Section
Licensing & Certification Processes
The End