

RURAL **HEALTH** WORKSHOP

Louisiana Licensing Updates



Speakers

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 - Medical Certification Program Manager
 - Louisiana Department of Health



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Louisiana Department of Health & Hospitals

Health Standards Section

Rural Health Clinics

May 26, 2023

Libby Gonzales, RN, BSN

Medical Certification Program Manager

RHC Surveys/Regulations

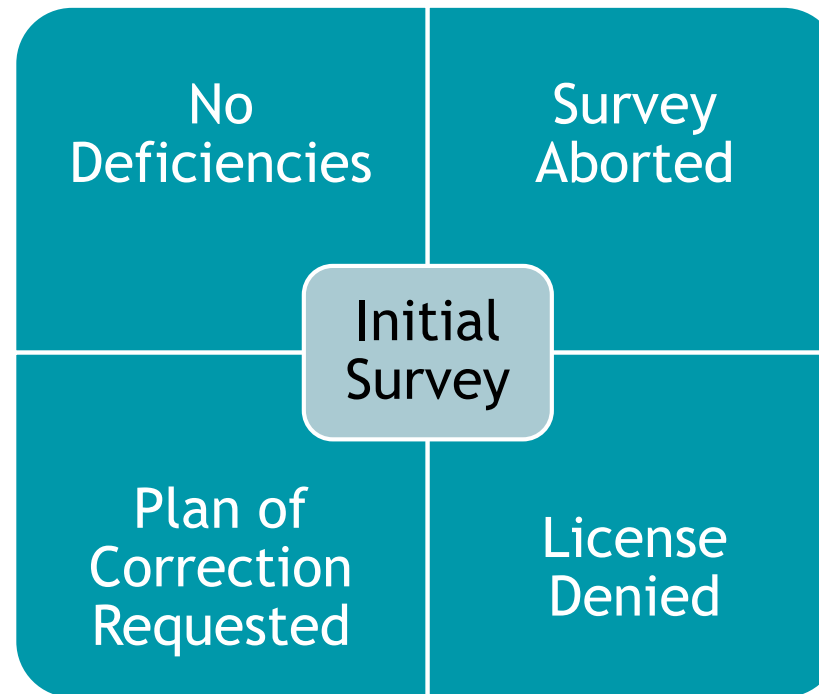
Type of Survey	Licensing Regulations	Federal Regulations
Initial Licensing Survey	RHC Licensing Standards	
Relicensing Survey	RHC Licensing Standards	
Initial Certification Survey		RHC Conditions for Coverage & AO Standards
Recertification Survey		RHC Conditions for Coverage & AO Standards (if accredited)
Complaint Survey	RHC Licensing Standards	RHC Conditions for Coverage

Initial Licensing Survey

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

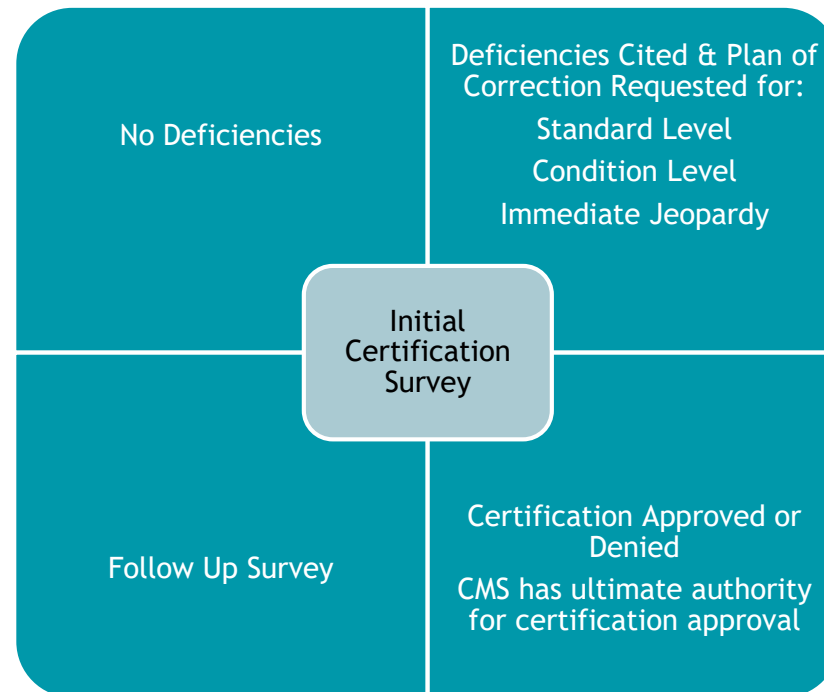


Initial Certification Survey

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.

Results of Initial Certification Survey



Re-Certification Survey

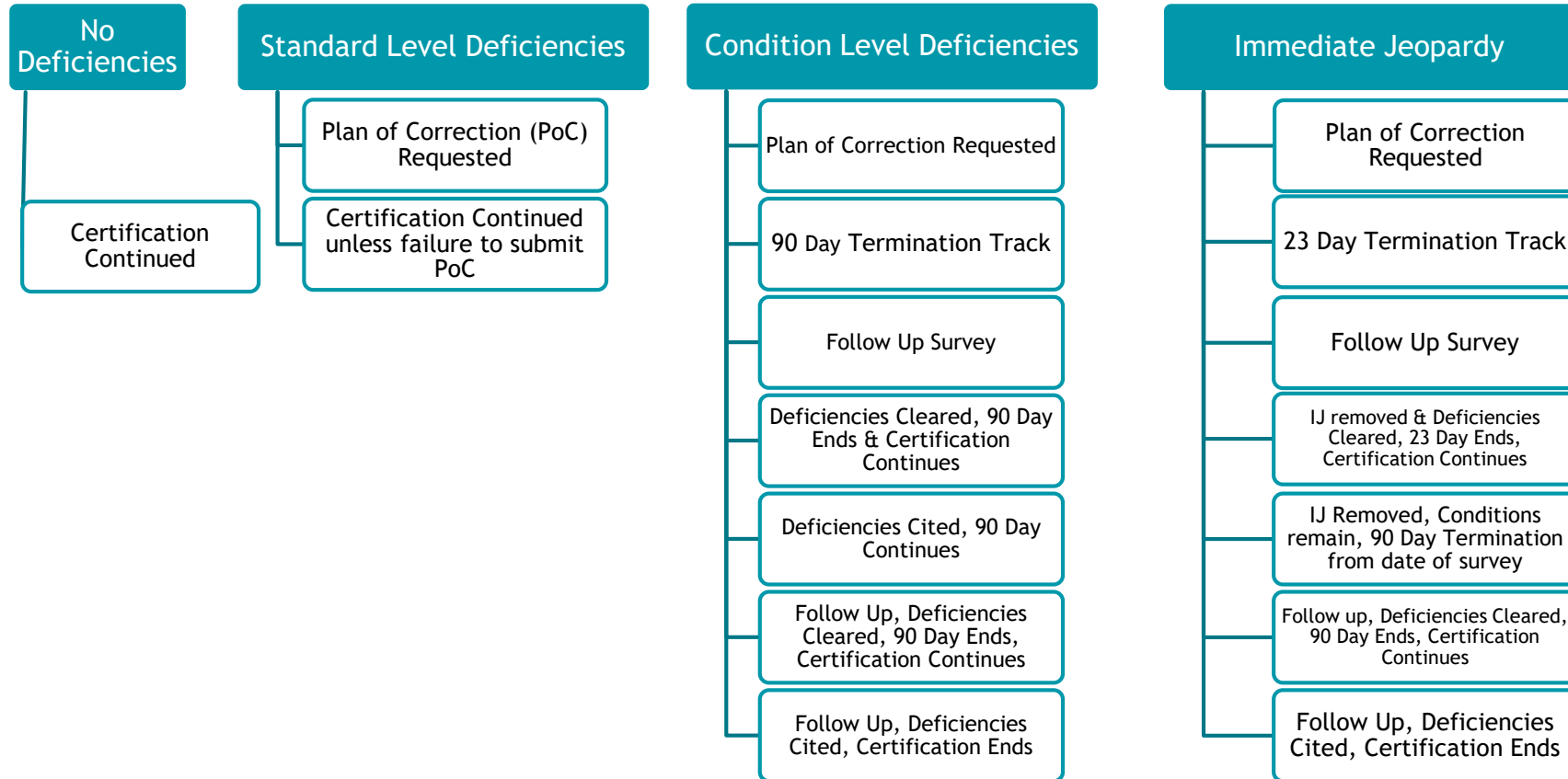
Accredited RHCs

- ▶ 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.

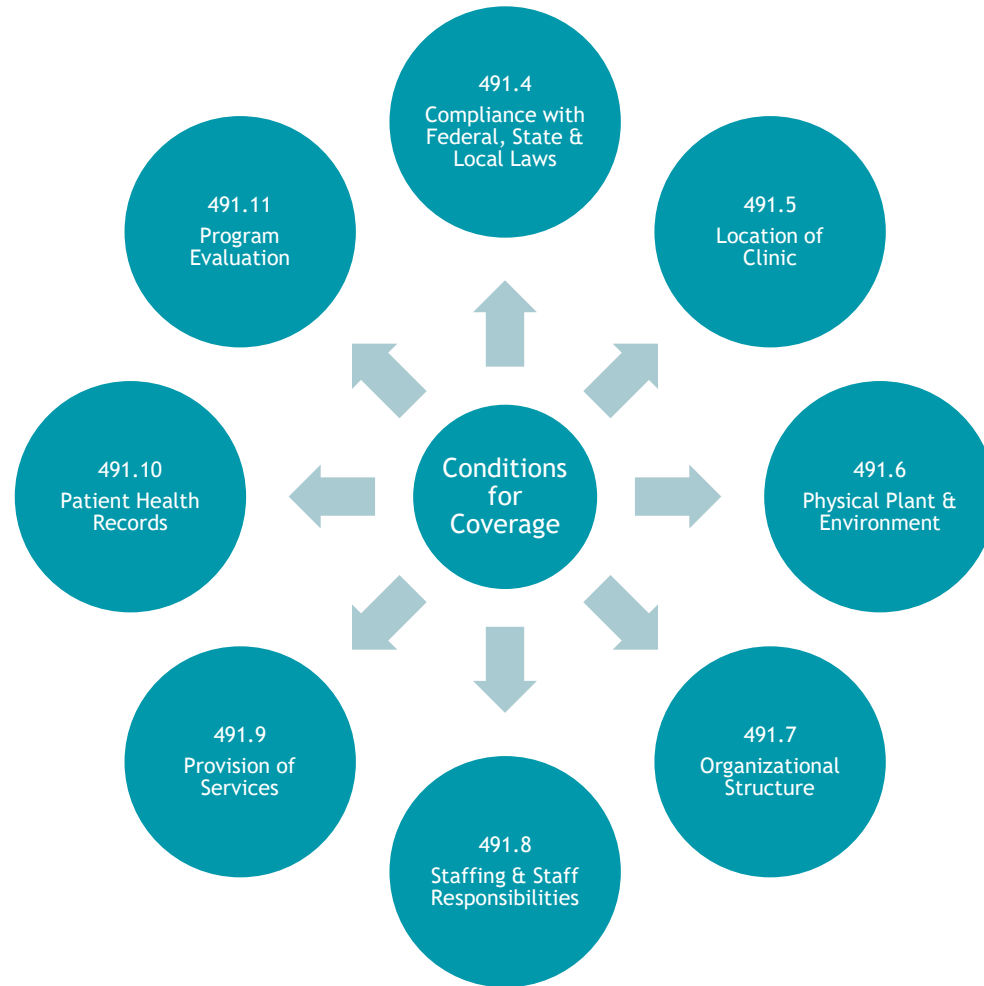
Non-Accredited RHCs

- ▶ Once a year CMS issues a priority schedule to Health Standards outlining the types of federal surveys to be conducted.
- ▶ RHC 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.

Re-Certification Survey



Conditions of Coverage



Most frequently cited tags



Complaint Survey

- ▶ Rebecca Havard, 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.

You have a Deficiency-What is next?

► Standard Level Deficiency

- The surveyor will email the statement of deficiencies to the administrator
- The RHC will submit a plan of correction within 10 calendar days from the date of receipt

► Condition Level Deficiency

- The RHC is placed on a 90 day termination track
- State Office will email the statement of deficiencies to the administrator along with a 90 day termination letter.
- VERY TIME SENSITIVE



What to do now?

- ▶ First-Get started fixing the problem as soon as it is 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
 - Nicole Coarsey's group with the State Office of Rural Health can be a very valuable resource

Standard Deficiencies Only

- ▶ Statement of deficiencies sent to the provider.
- ▶ Provider has:
 - **10 calendar** 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.

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 for 90 day Terminations

- ▶ **Fifteenth Working Day-** State Agency sends the statement of deficiencies and a letter to the supplier indicating there is a determination of noncompliance and placing facility on 90 termination track. Supplier has 10 calendar days to complete plan of correction.
- ▶ **Thirty-Fifth Calendar Day-** If supplier submits acceptable plan of correction, the State Agency conducts a revisit survey to determine compliance. **Only 2 revisits permitted**
- ▶ **Fifty-Fifth Calendar Day-** If compliance has not been achieved, the State Agency certifies noncompliance. Supporting documentation sent to Regional Office.
- ▶ **Sixty-Fifth Calendar Day-** Regional Office determines whether survey findings continue to support a determination of noncompliance
- ▶ **Seventieth Calendar Day-** Regional Office sends an official termination notice to the supplier.
- ▶ **Ninetieth Calendar Day-** termination takes effect if compliance is not achieved
- ▶ *****Please ensure the CEO/Administrator's e-mail is accurate*****

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.

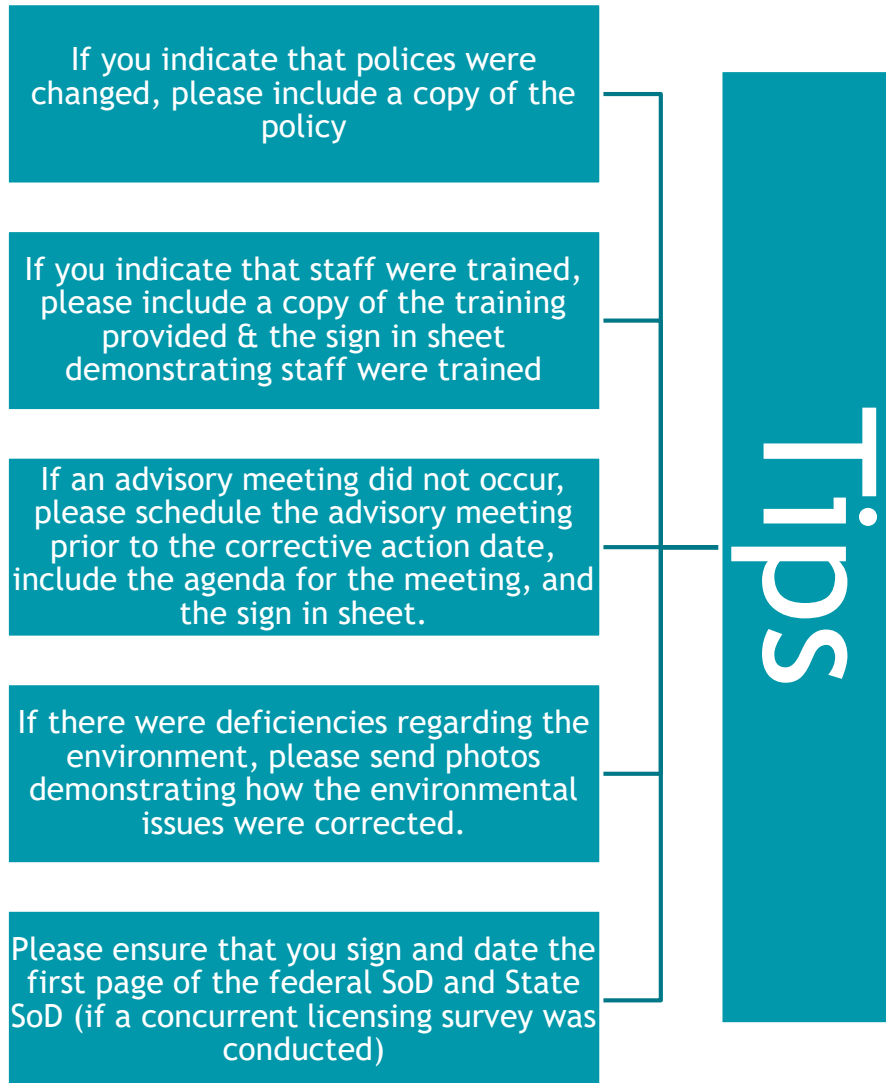
90 day termination letter

Plan of Correction

THE REQUIRED COMPONENTS FOR A PLAN OF CORRECTION MUST CONTAIN THE FOLLOWING 5 COMPONENTS:

1. Address how corrective actions were accomplished for those residents/clients/patients found to have been affected by the deficient practice; (refer to the survey identifier list; if applicable)
2. Describe how other residents/clients/patients that have the potential to be affected by the deficient practice will be identified; and what will be done for them.
3. The measures that will be put in place or the system changes that will be made to ensure that the deficient practice will not recur.
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. Indicate how the corrective measures will be monitored. What quality assurance program will be put into place? Monitoring must include who (what discipline), how (chart audits, direct observations, specific procedures), how often (daily, weekly, twice a month), and what will be done if problems are discovered.
5. Include dates when corrective action will be completed.

Plans of Correction



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

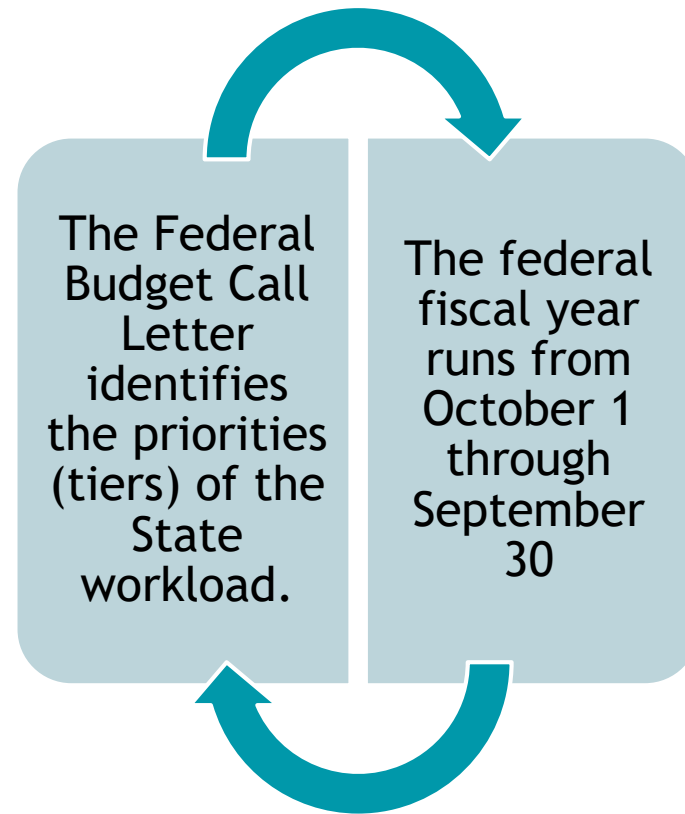
Both a hard copy and e-mail are not needed!

Budget & Workload



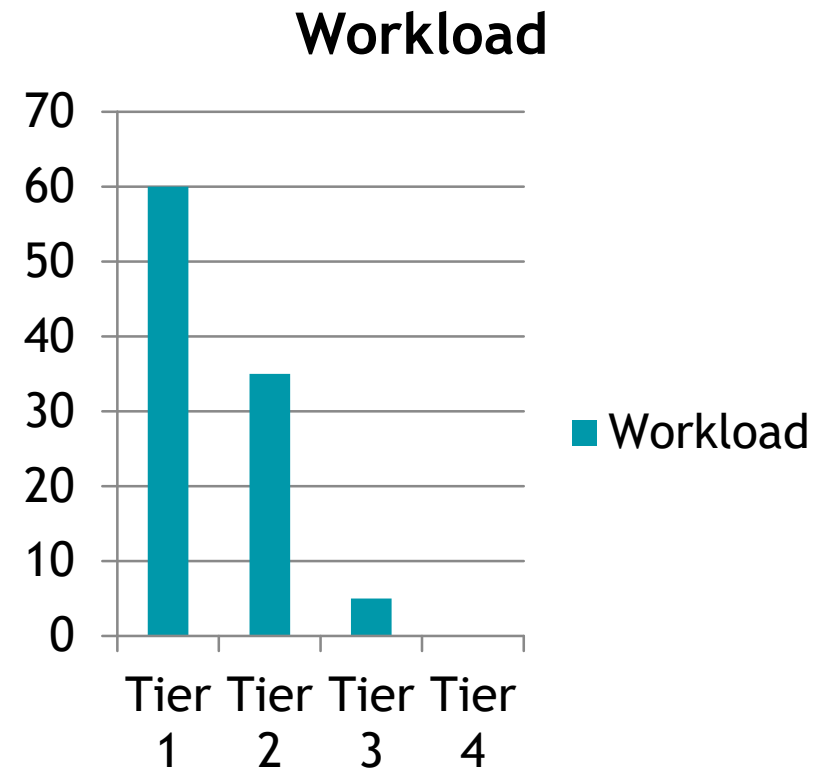
A Real Balancing Act

Budget & Workload



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

Tier 1

Complaint surveys prioritized as potential Immediate Jeopardy complaints.

Full surveys following complaint investigations in which a Condition of Coverage (CoC) was found to be out of compliance.

Tier 2

Complaint Surveys prioritized as non-Immediate Jeopardy High complaints.

Recertification Surveys of at least 5% of the non-deemed RHCs.

Relocations of any provider displaced during a public health emergency declared by the Governor.

Tier Workload

Tier 3

Complaint Surveys prioritized as non-Immediate Jeopardy Medium complaints.

Recertification Surveys on RHCs to ensure no more than 7 years elapses between surveys.

Tier 4

Additional Recertification Surveys of non-accredited RHCs to ensure a 6 year average.

Initial Certification Surveys of all RHCs since RHCs have the option to achieve deemed Medicare status through an approved AO.

Relocations of deemed providers.

Why is an AO doing my initial certification survey?

- ▶ Because of the CMS Tier Level Workload

Approved AOs for RHCs

American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) http://www.aaaasf.org/	The Compliance Team http://www.thecomplianceteam.org/
5101 Washington St., Suite 2F P.O. Box 9500 Gurnee, IL 60031 1-888-545-5222	905 Sheble Lane, Suite 102 P.O. Box 160 Springhouse, PA 19477 Kate Hill: 1-215-654-9110 khill@TheComplianceTeam.org
	

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
- ▶ 2 License Types:
 - Full License: In substantial compliance with the rules, standards and law. These are issued for 12 months and renewed annually.
 - 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.

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

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

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.

CHOWs and CHOIs

- ▶ Health Standards has changed the way we handle these actions
- ▶ The RHC program desk no longer handles the initial portion of CHOWs and CHOIs.
- ▶ Those applications should be sent to: HSSOwnerships@la.gov.
- ▶ Please copy the RHC program desk on those submissions
- ▶ Check our website under “Change of Ownership Information”
 - There is a Change of Ownership application accessible on the website. The RH-01 is no longer used
- ▶ Once all documents (including the 855A) are received and reviewed by LDH Legal Department, 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

Louisiana.gov > LDH > Health Standards Section

PROGRAMS

PROVIDER
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DATA REQUEST
PROCEDURE

PUBLIC RECORDS
REQUEST
PROCEDURE

RULEMAKING

Directory

← Select Another Division



Change of Ownership Information

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

For Health Standards to make a CHOW/CHOI determination, all providers must submit the following documents:

1. Letter of Intent (including d/b/a (doing business as) 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. CHOW/CHOI License Application
5. [Change of Ownership Application](#)
6. 855A/B approval letter for the following Medicare Certified providers: Home Health, hospice, hospitals, RHCs, ASCs, ESRDs, portable x-ray, community mental health, CORF, Nursing Facilities, and OPT.

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

If this action is a CHOW, the following are also needed:

1. Does your facility have a CLIA Certificate? If yes, you may also be required to complete a [CHOW for CLIA](#).
2. Licensing Fee: [Click here for the link for the Health Standards Fee Schedule](#)

Note: The fee for a CHOW is usually the same as a license renewal unless the facility is making additional changes. For providers completing an acquisition/merger, please contact the program desk for assistance.

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

Adult Brain Injury	Home Health
ADHC	Hospice
ARCP	ICF DD
ASC	Nursing Homes
Behavioral Health Service	Outpatient Rehab
CMHC	Pain Management
CRC Level III	PDHC
CORF	Portable X-Ray
EMTS	PRTF
ESRD	RHC
FSTRA	Support Coordination
HCBS	TCH
Hospital	

License Renewals

- ▶ License Renewals are all done via email now
 - Will be sent to administrator's email
 - Imperative that the administrator's email is up to date
 - Key personnel change form

[RHC Key Personnel Changes | La Dept. of Health](#)

- ▶ Renewal packets can be returned to the same email address it came from
- ▶ License renewals will come from:

HSS-RHC-Licensing@la.gov

Licensing Actions

- ▶ All licensing action packets are accepted via email
- ▶ Submission via email is encouraged
- ▶ They may be submitted directly to the RHC program desk or to HSS-RHC-Licensing@la.gov
- ▶ Once received, the action will be logged and placed into the que for review
- ▶ At this time providers should receive an email notifying them of their log number
- ▶ Please include the log number in the subject line of all email communication for the action going forward.
- ▶ If you have emailed your packet to us, please do NOT mail us hard copy to us

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.
 - To be considered complete, the expedited fee and licensing fee must be received by State Office and have cleared the bank.

Is this right for you?

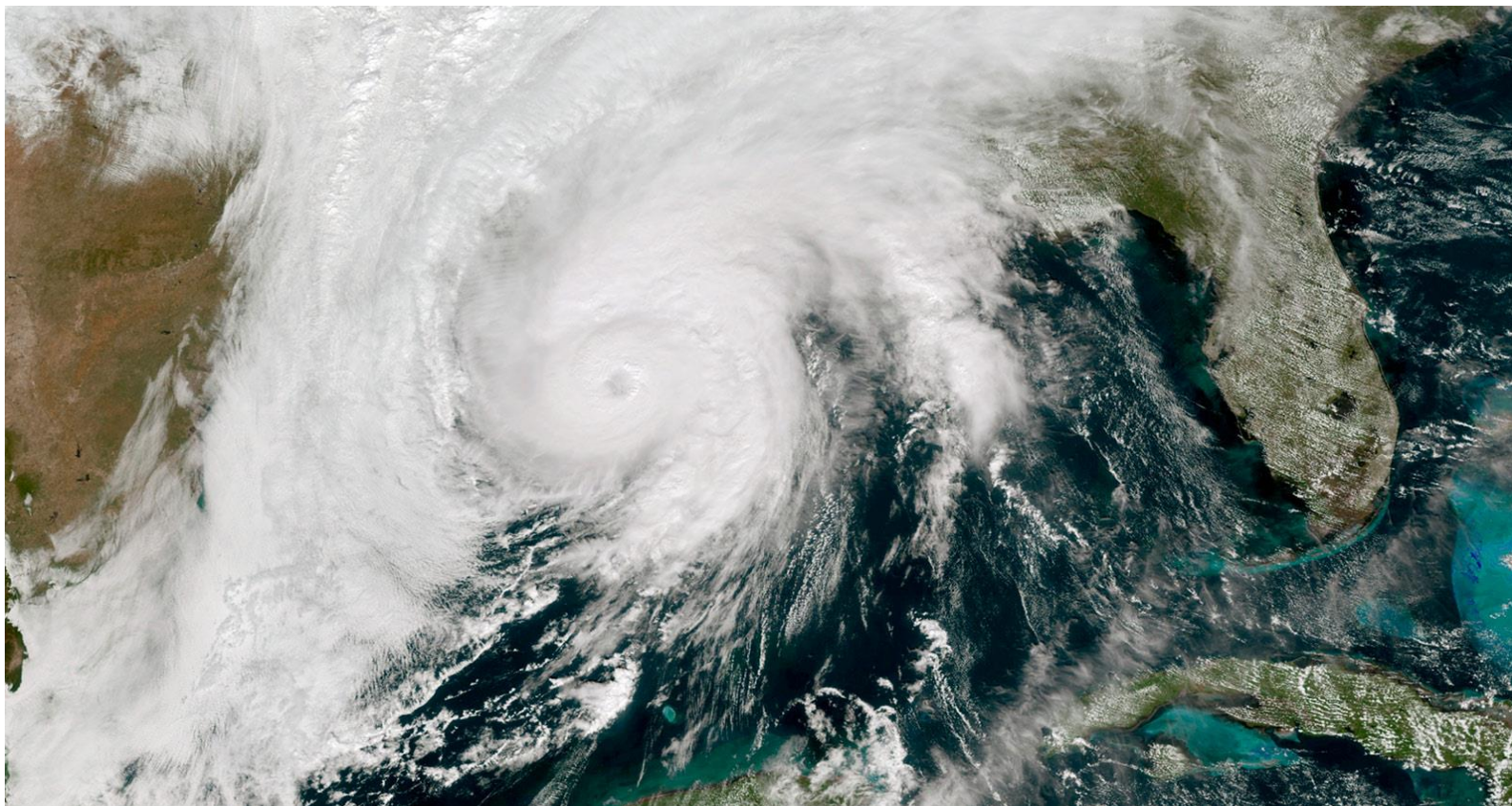
Info that Must Match Across all documents:

- Licensing Application-physical address and ownership
- Site Verification-physical address
- Plan Review Reports-physical address
- OSFM Inspection (associated with your AR Plan Review)-physical address
- OPH inspection-physical address
- 855A Application-physical address and ownership

Can a RHC have an offsite location?

- ▶ No-this is a federal regulation.
- ▶ If ever reversed, we have the ability to license a RHC with multiple offsite locations.

Not again...



Post Disaster Status Update

As soon as it is possible, Providers should:

- ▶ Notify the RHC program desk via email of the RHC's status
 - If you had no effects from the storm, let us know that your are open and conducting business as usual
 - If your facility sustained damages, tell us about them, for example: flooding and/or structural damage
 - Did your facility lose power? If so, do you have a generator?
 - Did your facility lose water?
 - Is your area under a boil advisory?

Post Disaster Re-Entry



- ▶ Who needs to submit the Re-entry request form:
 - If you were closed longer than planned for the storm
 - If you lost power for longer than 48 hours
 - If you had damages to the facility including flooding, structural damage, roof leaks, etc.
- ▶ Who needs to get the form?
 - OPH
 - RHC program desk

Additional Requirements for RHCs not found in LAC 75:

- **Criminal Background Checks for all non-licensed personnel**
 - CBGs must be conducted by a Louisiana State Police approved vendor prior to hire
- **Direct Service Worker (DSW) Registry Checks for all non-licensed personnel with direct patient contact**
 - DSW/Adverse Action checks must be completed prior to hire and every 6 months
- **Workplace Violence**
 - Act 461 (2022 Regular Session) enacted reforms to address workplace violence in healthcare settings
 - Requires specific workplace signage to be posted in the RHC
 - Requires development of a workplace violence prevention plan
 - Requires education and policies requiring all healthcare workers who provide direct care to patients to receive, at least annually, education and training in an interactive format with an opportunity for interactive questions and answers

Rural Emergency Hospitals

Beginning January 1st 2023, Medicare will pay for Medicare enrolled Rural Emergency Hospitals (REHs) to deliver emergency hospital, observation, and other services to Medicare patients on an outpatient basis.

- Must enroll in Medicare
- Have a transfer agreement in effect with a Level I or Level II trauma center.
- Must meet staff and training and certification requirements including:
 - a. A staffed emergency department 24 hours a day, 7 days a week, with staffing requirements like those for CAHs.
 - b. A physician, nurse practitioner, clinical nurse specialist or physician assistant available to provide rural emergency hospital services in the facility 24 hours per day.

- Meet Conditions of participation applicable to CAHs regarding emergency services and hospital emergency departments.
- Do not exceed an annual per patient average of 24 hours of services.
- Do not provide any acute inpatient care hospital services (other than post-hospital extended care services provided in a distinct part unit licensed as a skilled nursing facility).
- Was a CAH or small rural hospital with no more than 50 beds on December 27,2020.

HSS Home Page:

<https://ldh.la.gov/subhome/32>

Health Standards Section Licensing & Certification Processes



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Join the Provider Education Network!

- Well-Ahead Louisiana's Provider Education Network provides tools, training and technical assistance that can help you provide the best possible care to our communities
 - Biweekly Newsletters & Real-Time Email Alerts
 - Education and Training Opportunities
 - Community Linkage Coordination
 - Workforce Recruitment and Retention Support
- Join today at www.wellaheadla.com/join-provider-education-network



We want to hear from you!

<https://www.surveymonkey.com/r/RCNMXFH>



RURAL HEALTH WORKSHOP

Thank you for joining us!

