RURAL HEALTH CLINIC (RHC)
INITIAL APPLICATION
FOR MEDICARE AND MEDICAID PARTICIPATION

Dear Applicant:

This letter sets forth the requirements and procedures that a facility must meet in order to participate in the Medicare Program as a Rural Health Clinic ("RHC").

Please note Indiana State Department of Health **cannot** conduct your initial survey for Medicare and that you will have to go through an accrediting organization for Medicare. The recognized accrediting organizations (AO) for Rural Health Clinics is American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) and The Compliance Team (TCT). s

This letter explains the requirements and procedures through which you may be approved to participate in the Medicare program as a provider of services ("Provider"). The Centers for Medicare and Medicaid Services (CMS) is not budgeting initial rural health clinic certification surveys at this time due to limited resources. The change in policy is applicable immediately for all rural health clinics that rely on CMS survey and certification work. The provider has an option to select a CMS-approved accreditation organization (AO) to conduct the initial certification survey. The provider must obtain accreditation with "deemed status" from the accreditation organization to be eligible for consideration as a provider of Medicare services with CMS. The Indiana State Department of Health ("Department") will continue to collect and process the paperwork for the initial applications for CMS. The provider may obtain information on Rural Health Clinics from the Medicare web page found at www.cms.hhs.gov/medicare.asp.

The Social Security Act (the Act) provides for a system of quality assurance in the Medicare program based on objective, onsite, outcome-based surveys by Federal and State surveyors. The survey and certification (S&C) system provides beneficiaries with assurance that basic standards of quality are being met by health care providers, if not met, that remedies are promptly implemented.

CMS accomplishes these vital quality assurance functions under the specific direction for the ACT and in concert with States, CMS-approved accreditation organizations (AOs), and various contracts with qualified organizations. All CMS or State certification surveys for Medicare must be performed by Medicare-qualified surveyors consistently applying federal regulations, protocols, and guidance. Most types of providers or suppliers seeking to participate in

Medicare must first demonstrate compliance with quality of care and safety requirements through an on-site survey.

Initial surveys of new providers or suppliers have become more challenging for four reasons: Resource Limitations; Many New Providers; More Responsibilities; and Anti-Fraud Initiatives. Longstanding CMS policy makes complaint investigations, recertification, and core infrastructure work for existing Medicare providers a higher priority compared with certification of new Medicare providers.

The Department will no longer be conducting initial Medicare certification surveys. The rural health clinic has the option of becoming Medicare-certified on the basis of accreditation by a CMS-approved accreditation organization instead of a survey by CMS or the Department. Such accreditation is "deemed" to be equivalent to a recommendation by the Department for CMS certification. In such cases, the applicants have an alternate route to Medicare certification via CMS acceptance of the AO's accreditation.

If the facility is found in compliance, the effective date of admission to the program will be no earlier than the date of exit for the survey or date of an acceptable Plan of Correction is received is Standard Level finding(s) are found. Those applicants that are denied approval to participate in the Medicare program will be notified of such denial, along with the reason(s) for denial and information about the right to appeal the decision.

To be approved as a supplier of rural health clinic services, a clinic must be located in an area designated by the Bureau of Census as non-urbanized and by the Secretary of Health and Human Services as a shortage area, where a shortage of personal health services or a shortage of primary medical care manpower exists. **The Centers for Medicare and Medicaid Services (CMS) determines whether a RHC area is considered non-urbanized and therefore potentially eligible to apply for RHC status.** Under the law, the clinic must also employ either a physician's assistant or a nurse practitioner; must make arrangements with a physician for medical direction, guidance and supervision; and must make arrangements with a Medicare certified hospital for referral and admission of patients by the clinic. Departmental regulations specify the minimal health and safety standards rural health clinics must meet to qualify for reimbursement under this law.

It must be determined if the RHC meets the criteria for RHC status before the Division of Acute Care, Indiana State Department of Health will approve the application. Submit a letter of approval from the Partner Relations, Indiana State Department of Health. The letter must

identify if the RHC has been approved for a HPSA, MUA, or MUP designation. Contact **Lacy Foy** at the address listed below for confirmation of the RHC designation eligibility for RHC certification.

Primary Care Office Manager
Indiana State Department of Health
2 North Meridian Street, Section 2J
Indianapolis, IN 46204
EMAIL: lfoy@isdh.in.gov

In those instances where a central organization provides rural health services at more than one clinic site, each site is considered a clinic and the location of the clinic site determines its location eligibility (i.e. rural, shortage area) rather than the location of the central organization. A separate ***Verification of Clinic Date-Rural Health Clinic Program (Form CMS-29)*** is required for each clinic site.

Please complete and return all copies of the enclosed forms as promptly as possible, keeping in mind that your institution cannot claim provider reimbursement for services furnished prior to approval. Should you have questions regarding the forms, or if you need more ***Request to Establish Eligibility*** forms for multiple clinic locations, please contact the Department at 317-233-7302.

If your facility is provider-based to a hospital, or a critical access hospital, you must receive Civil Rights Clearance for Initial Certifications and change of ownerships. You must complete and return the enclosed Office of Civil Rights application package along with all request policies and documentation. Any questions concerning the Civil Rights Application should be directed to the Office of Civil Rights.

Subject to availability, we are also enclosing the Medicare Conditions for Coverage. The Conditions are only a part of the Medicare regulations contained in Title 42, Chapter IV of the Code of Federal Regulations that Rural Health Clinics must meet. You can purchase 42 CFR Chapter IV from the Superintendent of Documents, US Government Printing Office, Washington, DC 20402. However, the information you need is supplied in Medicare materials provided to you without charge, and explanations are furnished either by this office or by your Medicare carrier.

If you are opening a new facility to be certified for participation in the Medicare and/or Medicaid programs, **please be advised that the provision for services to Medicare (Title XVIII) and/or Medicaid (Title XIX) recipients cannot be made prior to the official date of certification.** A facility must be in substantial compliance with federal requirements to enter the Medicare or Medicaid programs.

The Centers for Medicare and Medicaid Services (CMS) determine if ALL requirements are met. The ***Health insurance Benefits Agreement*** will be countersigned with one copy returned to the agency along with the notification that your agency has been approved. If operation of the entire institution is later transferred to another owner, ownership group, or to a lessee, the agreement will usually be automatically assigned to the successor. But you are required to notify the Centers for Medicare and Medicaid Services (CMS) at the time you are planning such a transfer.

To qualify for payment, your facility must be incompliance with the requirements for participation as determined by the AO, the requirements for reimbursement (including financial solvency), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975, the latter three of which determination is made by the Office of Civil Rights in Chicago.

If you are buying an existing certified entity, the previous owner's provider agreement(s) will be automatically assigned to you provided that your application is approved. Please note that in assuming the previous owner's provider agreements; you will also be assuming responsibility and liability for implementing and/or abiding by the terms of the previous owner's plan for correcting any deficiencies.

An attachment has been provided to a CMS informational letter and CMS approved accrediting organization contact list for your convenience. Review the letter from CMS for your options for initial certification.

Please note that the processing of your application for participation in the Medicare and/or Medicaid program(s) cannot commence until this Division has received all of the required completed forms and documentation.

In addition, please note that your application for participation in the Medicare program cannot be processed and/or initial certification survey conducted until the Fiscal

Intermediary/Carrier has approved the *Medicare Provider/Supplier Enrollment Application (Form CMS-855A)*.

In order to expedite your application make sure the application is accurate and complete. If the application is not completed accurately and/or documentation is missing it hinders and delays the processing of the application. The application must be completed in its entirety to be accepted. Review all regulations before submitting your application to the Indiana State Department of Health.

List of Enclosed Forms to be Completed and Returned with Application

- ✓ Supplementary Information to Federal Application Rural Health Clinic (RHC) (State Form 51054)
- ✓ Request to Establish Eligibility to Participate in the Health Insurance for the Aged and Disabled Program to Provide Rural Health Clinic Services (Form CMS-29). *Instructions for completion are contained on the first page of the form.*
    - ✓ One (1) copy of the Health Insurance Benefits Agreement (Form CMS-1561A).
    - ✓ **NOTE:** On the second line of the Health Insurance Benefits Agreement (Form HCFA-1561A) after the term, Social Security Act, enter the entrepreneurial name of the enterprise, followed by the trade name (if different from the entrepreneurial name). Ordinarily, this is the same as the business name used on all official IRS correspondence concerning payroll withholding taxes, such as W-3 or 941 forms. For example, the ABC Corporation, owner of the Wildwood Health Center, would enter on the agreement: "ABC Corporation d/b/a Wildwood Health Center". A partnership of several persons might complete the agreement to read: 'Robert Johnson, Louis Miller, and Paul Allen, partners, Easy Care Health Services". A sole proprietorship would complete the agreement to read: "John Smith d/b/a Wembly Walk-in Center".

      The person signing the Health Insurance Agreement must be someone who has the authorization of the owners of the enterprise to enter into this agreement.

      If the Health Insurance Benefits Agreement is signed by someone other than an officer, director or partner of the enterprise, then one of the officers, directors or partners of the enterprise as listed on the Medicare General Enrollment Health Care Provider/Supplier Application (Form HCFA-855) or Disclosure of Ownership and Control Interest Statement (Form HCFA-1513) must give that individual written permission to sign. Please submit a copy of this letter of authorization.
- ✓ Staffing and Staff Responsibilities Form – complete, sign, and return with application

- ✓ Provider Based Questionnaire. This form must be completed to determine if entity meets criteria as provider based of another Medicare certified provider for the purpose of Medicare certification and reimbursement.
- ✓ If the rural health clinic is provider-based to a hospital or critical access hospital, please review the attached Office of Civil Rights letter.

Documentation/information to be submitted with Application

- ✓ A copy of the "Articles of Incorporation" or "Certificate of Assumed Business Name" signed by the Indiana Secretary of State for doing business in Indiana
- ✓ A copy of a SS-4 form or comparable document from the Internal Revenue Services (IRS) that reflects the corporation name and EIN number
- ✓ Copies of current valid Indiana licenses on staff – refer to Supplementary Information to Federal Application Rural Health Clinic (RHC) (State Form 51054)

Any questions concerning your initial certification survey should be directed to your accreditation association.

Please ensure that all forms required for initial Certification processing are signed.

Also, note your request for participation in the Medicare program cannot be forwarded and/or processed to CMS-RO until your Fiscal Intermediary/Carrier has approved and the Department has received the Medicare Provider/Supplier Enrollment Application (Form CMS-855A), the survey results from the accreditation organization (AO) and the completed forms (CMS-29, CMS-1561A, Provider Based Questionnaire, and the OCR Attestation of Compliance, if applicable).

Submit the completed application to the address below:

Indiana State Department of Health
Acute Care
2 North Meridian Street, Section 4A

Enclosed for reference is the ISDH website for rules/regulations and/or other documentation listed below that can be accessed and downloaded from the internet:

www.in.gov/isdh/20118.htm

- ✓ Federal Regulations – 42 CFR Part 491
- ✓ Accreditation Organization listing

If you have questions, please contact the Program Coordinator at 317-233-7302.