

*How to Establish
A
Rural Health Clinic
In
Louisiana*



Prepared by:

Bureau of Primary Care and Rural Health

Louisiana Department of Health

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Table of Contents

SECTION 1: INTRODUCTION.....	4
SECTION 2: OVERVIEW.....	8
A Brief History of Rural Health Clinics	8
What is a Rural Health Clinic? Does Your Clinic Qualify?	11
Overview of the Rural Health Clinic Program	12
How does a Certified RHC Differ from a Private, Rural Physician’s Office? .	15
SECTION 3: IMPLEMENTATION	20
The Decision Process.....	20
Implementation Process (summary/checklist)	21
Step 1: Site Qualifications.....	24
Step 2: Implementation Team.....	25
Step 3: Provider-based or Freestanding	27
Step 4: For-Profit or Not-For-Profit.....	28
Step 5: Ownership Structure.....	28
Step 6: Financial Projections and Budgets	28
Step 7: Licensing Application.....	32
Step 8: Site/Building Plans	33
Step 9: Local Zoning Authority.....	34
Step 10: Plan Approval – Office of State Fire Marshall.....	34
Step 11: Construction	34
Step 12: Occupational License	35
Step 13: Inspection – Office of State Fire Marshall.....	35
Step 14: Inspection – Office of Public Health.....	35
Step 15: CLIA Application	36
Step 16: Medicare Application	37
Step 17: Select Fiscal Year End	38
Step 18: Complete Louisiana Medicaid Application	39
Step 19: State Licensing Application	40

Step 20: Policies and Procedures.....	42
Step 21: Job Descriptions, Organization Charts	43
Step 22: Referral Agreements	44
Step 23: Healthy Louisiana	44
Step 24: Information System	45
Step 25: Hire Medical Director and Physician.....	46
Step 26: Hire Midlevel.....	46
Step 27: On-call Agreements.....	47
Step 28: Additional Staffing	47
Step 29: Commercial Insurance.....	47
Step 30: Liability Insurance.....	48
Step 31: Begin Operations.....	48
Step 32: Site Inspections	49
Step 33: Correct Deficiencies	53
ASSISTANCE	54
GLOSSARY	55
APPENDICES.....	57
Appendix A: Sample Policy and Procedure	58
Appendix B: Sample Organization Chart	59
Appendix C: Sample Job Description	60

SECTION ONE

INTRODUCTION:

This manual has been developed by the Louisiana Bureau of Primary Care and Rural Health. Its purpose is to provide information and guidance to organizations and providers interested in the learning about and/or converting to the rural health clinic model of delivering primary care services in the State of Louisiana.

Mission and Priorities

The Bureau of Primary Care and Rural Health (Bureau) is within the Louisiana Department of Health Office of Public Health and is dedicated to improving the health status of residents living in rural and underserved areas by working proactively to build the capacity of community health systems to provide integrated, efficient and effective health care services. The Bureau provides technical assistance to communities, federally qualified health centers, physician practices, rural health clinics, small rural hospitals, school-based health centers, and public health units.

The Bureau is committed to developing strong community partnerships and integrated primary health care services in order to reduce health disparities across Louisiana. The Bureau works to ensure a sustainable health care system that provides access to all by supporting effective clinical practices and health care organizations and recruiting and retaining primary health care providers.

Units and Services

The Bureau currently provides services through three Units and two assistance programs: The Health Systems Development Unit, Operations Support Unit, Healthcare Workforce Development Unit, Practice Management Consulting Service, and primary care technical support to the Adolescent School Health Program. Together, these units and services provide a continuum of assistances to establish, enhance, and sustain health care services for all Louisiana residents.

The **Health Systems Development (HSD) Unit:**

- Provides strategic planning, needs assessments, group facilitation, and resource development to create community support and ensure the success of health care development projects;
- Offers extensive technical assistance for rural health clinics, as well as support for developing federally qualified health centers;
- Designates health professional shortage areas and provides incentives for the recruitment and retention of physicians to practice in underserved areas;
- Manages the Conrad 30 Program, the State Loan Repayment Program for physicians and nurses, and the National Health Service Corps; and
- Administers the federal State Office of Rural Health Grant, the State Office of Primary Care Grant, Rural Hospital Flexibility Grant, and the Small Rural Hospital Improvement Grant.

The **Operations Support Unit** manages and administers state budget appropriations, line item appropriations, budgets for federal and philanthropic grants, and any other ancillary budgets administered and/or received by the Bureau.

The **Healthcare Workforce Development Unit** offers a number of services to help communities recruit and retain primary care health professionals to serve the medically underserved areas in Louisiana.

The **Practice Management Consulting Service** provides services to promote better patient health outcomes for primary care providers in rural and underserved areas by:

- Using market analyses, feasibility studies, patient flow analysis, and medical records review; and
- Providing technical assistance for Medicaid and other insurance billing, as well as training on medical coding to promote better financial performance.

Primary Care Technical Support is provided to the **Adolescent School Health Program: School-Based Health Centers.**

Funding and Support

The Bureau operates with funding from the U.S. Department of Health and Human Services' Health Resources and Services Administration's Bureau of Health

Professions, Bureau of Primary Care, Office of Rural Health Policy, as well as the State of Louisiana.

The Bureau's work depends on strong partnerships with our state and federal partner organizations. Through collaboration and information sharing, the support services for primary and rural health care development are effectively provided to communities to build sustainable health care solutions.

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or visit the Bureau Website at

<http://ldh.louisiana.gov/index.cfm/subhome/25>

RECOMMENDATIONS FROM THE BUREAU OF PRIMARY CARE AND RURAL HEALTH

In determining whether or not a rural health clinic (RHC) is the right fit for your organization, the following recommendations by the Bureau could make the decision-making process easier and the implementation process flow smoother:

- **Become familiar** with the rural health clinic model;
- **Waiting to learn the “ins and outs”** of operating a rural health clinic until after it has opened could prove detrimental to the clinic's success;
- **Valuable resources** to aid in understanding the details of opening and operating a rural health clinic include:
 - × National Association of Rural Health Clinics
<http://narhc.org/resources/rhc-rules-and-guidelines/>

- × Novitas Solutions
http://www.novitas-solutions.com/webcenter/portal/MedicareJH/page/pagebyid?contentId=00025177&_adf.ctrl-state=y35x2rx8e_55&_afLoop=1107899716889684#!
 - × HRSA [Starting a Rural Health Clinic – A How-To Manual](ftp://ftp.hrsa.gov/ruralhealth/RHCmanual1.pdf)
<ftp://ftp.hrsa.gov/ruralhealth/RHCmanual1.pdf>
 - × Centers for Medicare and Medicaid Services (CMS)
www.cms.hhs.gov/center/rural.asp
- **Read this manual, as it is specific to opening and operating a rural health clinic in the State of Louisiana.** It is especially important to read and understand all of the steps listed in the **IMPLEMENTATION Section** before beginning the process. It may be preferable or even necessary to complete the steps in a different order than listed. NOTE: Many steps can be completed simultaneously, while others must happen chronologically.
 - **Visit the Bureau's [Health Systems Development \(HSD\) Unit](#)** Website for more answers to questions regarding RHCs. The HSD team can also provide:
 - × Demographic and economic information about potential service areas;
 - × Other available primary care delivery options; and
 - × Referrals to other Bureau resources and programs that can provide additional technical assistance.

SECTION TWO

OVERVIEW:

A BRIEF HISTORY OF RURAL HEALTH CLINICS

In the mid-1960s, the physician shortage in rural areas had reached a crisis. The supply of physicians had become insufficient to meet the demands of many communities, particularly in small, isolated rural areas. To alleviate the effects of the crisis, midlevel health professionals were introduced to serve as physician extenders.

While midlevel providers, such as physician assistants and nurse practitioners, were easily accepted by many communities, their services were not eligible for reimbursement by Medicare (or by Medicaid in some states). For most midlevel providers, third-party reimbursement remained dependent upon them working under the immediate supervision of a physician. This lack of third-party reimbursement from public payers was a substantial disincentive for physician assistants and nurse practitioners to locate in rural areas.

After considerable political mobilization directed toward resolving this issue, Congress passed Public Law 95-210, the Rural Health Clinic Services Act, in December 1977. The act was intended to address the midlevel reimbursement issue and increase the availability and accessibility of primary care services for residents of rural communities.

The Act authorized Medicare and Medicaid payment to qualified RHCs for “physician services” and “physician-directed services” whether provided by a physician, physician assistant, or nurse practitioner. Reimbursement under the Rural Health Clinic Services Act became available to midlevel provider practices, even when services were delivered at a clinic in the absence of a physician, as long as the practice of the physician assistant or nurse practitioner was within the scope of state law and regulations.¹

The legislation had two main goals: to improve access to primary health care in rural, underserved communities and to promote a collaborative model of health care delivery using physicians, nurse practitioners, and physician assistants. In subsequent legislation, Congress added nurse midwives to the core set of primary

¹ “The Rural Health Clinic Services Act: Public Law 95-210”, January 1991, A report of the Office of Rural Health Policy prepared by the National Rural Health Association

care professionals and included mental health services provided by psychologists and clinical social workers as part of the rural health clinic (RHC) benefit.

Improving access to primary care services in underserved rural communities and utilizing a team approach to health care delivery are still the main focuses of the RHC program. The law authorizes special Medicare and Medicaid payment mechanisms for RHCs and uses these special payment mechanisms as the principal incentive for becoming a federally-certified RHC. For Medicare, the payment mechanism is a modified cost-based method of payment. For Medicaid, states are mandated to reimburse RHCs using the Prospective Payment System (PPS). Federal law allows states to use an alternative payment method for Medicaid services, as long as the payment amounts are no less than the clinic would have received under the PPS method.

An RHC may be a public or private, for-profit or not-for-profit entity. There are two types of RHCs: provider-based and independent. Provider-based clinics are those clinics owned and operated as an "integral part" of a hospital, nursing home or home health agency. Independent RHCs are those facilities owned by an entity other than a "provider" or a clinic owned by a provider that fails to meet the "integral part" criteria.

The mission of the RHC program has remained remarkably consistent during the lifetime of this unique benefit. Improving access to primary care services in underserved rural communities and utilizing a team approach to health care delivery are still the main focuses of the RHC program. The information found in this book is geared toward those individuals and organizations that share that same mission.

There are over 4,000 federally-certified RHCs located throughout the United States, of which over 50% are provider-based clinics. According to a national RHC survey conducted by the University of Southern Maine (USM), independent clinics are most commonly owned by physicians, and provider-based clinics are most commonly owned by hospitals.

Despite the tremendous growth we have seen in the RHC program over the past two decades, and the considerable contribution RHCs are making towards alleviating or eliminating access to care problems, thousands of rural communities continue to receive the underserved designation.

Rural communities have historically had difficulty attracting and retaining health professionals. For some rural communities, the inability to access the health care delivery system may be because there are no health care providers in the area. The lack of health professionals may be due to the fact that rural communities are disproportionately dependent on Medicare and Medicaid as the principle payers for health services. In the typical RHC, Medicare and Medicaid payments account for close to 60 percent of practice revenue. Consequently, ensuring adequate Medicare and Medicaid payments is essential to the availability of health care in rural underserved areas.

There was tremendous growth in the RHC program through the early '90s. Between 1990 and 1997, nearly 3,000 clinics received initial certification as an RHC. Since 1997, the total of RHCs has risen to over 4,000 certified to participate in the program; however, many clinics approved in the early '90s have chosen to discontinue participation in the program. Consequently, we have seen a slight drop in the aggregate number of clinics.

The year 1997 is considered a threshold year for the RHC community because it was this year that Congress enacted legislation to better target growth in the RHC program. While the growth in the RHC program during the early and mid-90s was not unexpected, there were some in Congress that felt that some of the clinics certified as RHCs during this period were not really appropriate for participation in a program aimed at improving health care in underserved areas.

For example, it was discovered that the MUAs list used for participation in the RHC program had not been updated by the federal government since the early 1980's. This meant that some communities that were no longer underserved were deemed eligible for participation in the program. One of the changes Congress enacted in response to this discovery was that new **RHCs can no longer be certified in areas where the shortage area designation is more than three years old.**

As successful as the program has been for thousands of rural communities, the fact is that the RHCs program may not be appropriate for every rural underserved community. While the payment methodologies available to RHCs can be attractive, they are not magical. Indeed, depending upon the payer mix or range of services that are offered or plan to be offered, traditional fee for service, or some other form of payment could be better. It is important, therefore, that you complete a financial assessment to make sure that the methodologies are right for your particular practice.²

² "Starting a Rural Health Clinic: A How-To Manual" Winter 2004, A publication funded by HRSA's Office of Rural Health Policy with the National Association of Rural Health Clinics under Contract Number 00-0245 (P).

WHAT IS A RURAL HEALTH CLINIC? DOES YOUR CLINIC QUALIFY?

What is a certified rural health clinic?

A rural health clinic (RHC) is a primary care clinic located in a non-urbanized area that has been shown to have a shortage of health care services or health care providers and has been certified as an RHC under Medicare.

Does your site or proposed site qualify for RHC designation?

To determine if a clinic site meets the basic location requirements for RHC designation, send a letter or e-mail requesting verification of site qualifications to:

Tracie Ingram
Rural Health Officer
Louisiana Department of Health
Bureau of Primary Care and Rural Health
P. O. Box 3118
Baton Rouge, Louisiana 70821-3118
Tracie.Ingram@la.gov

PLEASE NOTE: *If at any time you propose to change the location of the RHC you are developing, or the completed RHC, you **must** notify LDH Health Standards and the Bureau of Primary Care and Rural Health to assure the new location qualifies for RHC designation. If you move a rural health clinic to a location that does not meet the shortage area and rural designation criteria, you could lose RHC certification.

OVERVIEW OF THE RURAL HEALTH CLINIC PROGRAM

The following is an overview of the major requirements clinics must meet in order to become certified as a rural health clinic (RHC). Each of the subjects addressed in this overview are discussed in further detail in HRSA's "*Starting a Rural Health Clinic: A How-To Manual*," available online at: <http://www.hrsa.gov/ruralhealth/pdf/rhcmanual1.pdf>.

Location - Rural health clinics must be located in communities that are both "rural" and "underserved." For purposes of the Rural Health Clinics Act, the following definitions apply to these terms:

- **Rural Area** - Census Bureau designation as "non-urbanized area"; and
- **Shortage Area** - A federally-designated health professional shortage area (HPSA), a federally-designated medically underserved area (MUA), or an area designated by the State's Governor as underserved.

Unlike some other programs that are not concerned about the location of the facility, but rather the types of patients seen by the facility, the RHC program ties certification to the location of the facility. A non-urbanized area is any area that does not meet the Census Bureau's definition of urbanized. The U.S. Census Bureau definition of an Urbanized Area can be found in Chapter 2 of the HRSA manual, "*Starting a Rural Health Clinic: A How-To Manual*."

Physical Plant - The rural health clinic program does not place any restrictions on the type of facility that can be designated as an RHC. An RHC may be either a permanent location that is a stand-alone building or a designated space within a larger facility. The clinic can also be a mobile facility that moves from one community to another community.

Staffing - The rural health clinic program was the first federal initiative to mandate the utilization of a team approach to health care delivery. Each federally-certified RHC must have:

- One or more physicians;
- One or more physician's assistant (PA), nurse practitioner (NP) or certified nurse midwife (CNM); and
- The required staffing (PA, NP or CNM) must be on-site and available to see patients 50 percent of the time the clinic is open for patients;
- **Provision of Services** - Each RHC must be capable of delivering outpatient primary care services, although they are not limited to primary care services;

- The RHC must also maintain written patient care policies that are developed by a physician, physician assistant, or nurse practitioner, and one health practitioner who is not a member of the clinic staff;
- Describe the services provided directly by the clinic's staff or through arrangement. Provide guidelines for medical management of health problems; and
- Provide for annual review of the clinic's policies. A sample policy and procedures manual describing this requirement has been included in Appendix D of the HRSA's RHC Manual, available online as described at the beginning of this section.

Direct Services - These are services that the clinic's staff must provide directly. Clinic staff must provide the diagnostic and therapeutic services commonly furnished in a physician's office. Each RHC must be able to provide the following six (6) laboratory tests:

- Chemical examinations of urine;
- Hemoglobin or Hematocrit;
- Blood sugar;
- Examination of stool specimens for occult blood;
- Pregnancy test; and
- Primary culturing for transmittal.

Emergency Services - Rural health clinics must be able to provide "first response" services to common life-threatening injuries and acute illnesses. In addition, the clinic must have access to those drugs commonly used in life-saving procedures.

Services Provided through Arrangement - In addition to the services that clinic staff must provide directly, the RHC may provide other services utilizing individuals other than clinic staff. Those services that a clinic may offer that can be provided by non-RHC staff are:

- Inpatient hospital care;
- Specialized physician services;
- Specialized diagnostic and laboratory services;
- Interpreter for foreign language if indicated; and

- An interpreter for the deaf, and devices to assist communication with blind patients.

Patient Health Records - Each clinic must maintain an accurate and up-to-date record-keeping system that ensures patient confidentiality. A description of the clinic's system must be included in the policy and procedures manual (see Appendix D of the HRSA's RHC Manual). Clinic staff must be involved in the development of this record-keeping system.

Records must include the following information:

- Identification data;
- Physical exam findings;
- Social data;
- Consent forms;
- Health status assessment;
- Physicians orders;
- Consultative findings;
- Diagnostic and laboratory reports;
- Medical history; and
- Signatures of the physician or other health care professionals.

Protection of Record Information Policies - In addition to maintaining the confidentiality of patient information, the clinic must have written policies and procedures that govern the use, removal and release of information. The policy and procedures manual must also document the mechanism through which a patient can provide consent for the release of his or her medical records. RHCs like all other Medicare providers must also be compliant with the HIPAA privacy standards.³

The **Louisiana** Rural Health Clinic Regulations can be found at the following link:
<http://new.dhh.louisiana.gov/assets/medicaid/hss/docs/RHC/laregvol25no10october201999.pdf>

The **Federal** Rural Health Clinic Regulations can be found at the following links:
<http://narhc.org/?s=federal+guidelines>

RHC Certification (42CFR, 491.1- 491.11) -
<http://cfr.vlex.com/vid/491-1-purpose-and-scope-19808565>

³ "Starting a Rural Health Clinic: A How-To Manual" winter 2004, A publication funded by HRSA's Office of Rural Health Policy with the National Association of Rural Health Clinics under Contract Number 00-0245 (P).

HOW DOES A CERTIFIED RURAL HEALTH CLINIC (INDEPENDENT AND PROVIDER-BASED) DIFFER FROM A PRIVATE, RURAL PHYSICIAN'S OFFICE?

CRITERIA	Private Physician's Office	Independent or Free-Standing	Provider-Based RHC
Location	Determined by marketplace and physician preference.	Restricted to HPSAs or MUAs <u>and non-urbanized</u> areas.	Same as free-standing.
Ownership	Owned and governed by physician(s)	May be owned and operated by a Physician, NP, CNM, PA, for-profit or non-profit corporation.	An RHC is operated as an integral and subordinate part of a parent entity (hospital, nursing home, or home health agency), along with other applicable service departments of parent entity.
Staffing	Licensed physician, clinic aide or nurse	Minimum requirements of a licensed physician as medical director and mid-level practitioner (NP, PA, CNM) at least 50% of the time.	Same as freestanding.
Clinic Policies and Procedures	Generally informal, often unwritten	Written policies and procedures are required. They must be developed, reviewed and approved by a Patient Care Committee (medical director and mid-level	Same as freestanding.

HOW DOES A CERTIFIED RURAL HEALTH CLINIC (INDEPENDENT AND PROVIDER-BASED) DIFFER FROM A PRIVATE, RURAL PHYSICIAN'S OFFICE?

CRITERIA	Private Physician's Office	Independent or Free-Standing	Provider-Based RHC
		provider). Quality Assurance activities by the Patient Care Committee must document policies and procedures being followed.	
Job Descriptions; Staff Credentials; Defined Scope of Practice; Protocols	Generally informal, often unwritten	Required to be documented and judged to be appropriate for clinic patient population and staffing by Patient Care Committee.	Same as freestanding.
Medical Records	Left to Physician's judgment	Structured medical record system required. Medical record must be complete enough for surveyors to determine if clinic is in compliance with Medicare regulations.	Same as freestanding.
Governing Body, Administration	Not applicable unless physician is incorporated, then must meet IRS and State requirements.	Must show documentation that administrator is designated and that an advisory board is kept informed of clinic operations.	Same as freestanding.

HOW DOES A CERTIFIED RURAL HEALTH CLINIC (INDEPENDENT AND PROVIDER-BASED) DIFFER FROM A PRIVATE, RURAL PHYSICIAN'S OFFICE?

CRITERIA	Private Physician's Office	Independent or Free-Standing	Provider-Based RHC
Financial Management and Reporting	To be determined by the physician, with input from his/her CPA, banker and the IRS.	An annual budget is required. The system must be in place to capture financial and demographic data needed for the annual Medicare Cost Report.	Same as freestanding.
Formal Annual Clinic Evaluation	None required	A written annual evaluation of all aspects of clinic operations must be on file. An annual site review must be performed by LDH or a Medicare accreditation body.	Same as freestanding.
Building and Facilities	Physician's preference, local zoning, licensing and fire code, if any	Fire and sanitation inspection is required. A preventive maintenance schedule must be maintained and an on-site inspection by Medicare for health or safety problems must be performed. Emergency evacuation procedures must be posted.	For off-site clinics: Fire inspection may be required. A preventive maintenance schedule must be maintained. On-site inspection by Medicare for health or safety problems must be performed. Emergency evacuation procedures must be posted. On-site clinics must meet

HOW DOES A CERTIFIED RURAL HEALTH CLINIC (INDEPENDENT AND PROVIDER-BASED) DIFFER FROM A PRIVATE, RURAL PHYSICIAN'S OFFICE?

CRITERIA	Private Physician's Office	Independent or Free-Standing	Provider-Based RHC
			licensing standards or parent entity: Hospital, SNF or Home Health.
Third Party Payments	It is the physician's option to accept Medicaid and Medicare. They may accept Medicare and not accept the assignment. All Medicare and Medicaid billing must be done on CMS form 1500 with CPT codes and ICD-10 diagnosis codes.	By law, an RHC is not required to accept Medicare or Medicaid. However, if they contract with either entity, acceptance of Medicare and Medicaid is mandatory. They must accept assignments on Medicare. Medicare billing must be on UB-04 forms with revenue codes 52X or 9XX and must be sent to Fiscal Intermediary. Medicaid billing must be on CMS 1500 to Molina Medicaid Solutions.	Same as freestanding, except Medicare and Medicaid claims must be billed to Fiscal intermediary of the owner-provider.
Reimbursement	Medicare and Medicaid are based on a fee-for-service system, These are "final" payments.	Medicare: Cost-based reimbursement, with capped amount that is	Medicare/Medicaid reimbursement is usually higher than freestanding, as costs typically

HOW DOES A CERTIFIED RURAL HEALTH CLINIC (INDEPENDENT AND PROVIDER-BASED) DIFFER FROM A PRIVATE, RURAL PHYSICIAN'S OFFICE?

CRITERIA	Private Physician's Office	Independent or Free-Standing	Provider-Based RHC
		<p>adjusted annually. There is an annual cost settlement based on the actual cost per encounter as determined from the clinic's cost report.</p> <p>Medicaid: Reimbursement is based on cost, with an annual adjustment, based on the Medical Economic Index (MEI).</p>	<p>increase when owned and operated by a parent entity.</p> <p>Medicare: Same as freestanding except there is no capped amount for cost-based reimbursement (provided parent entity is less than 50 beds). Cost information is included on the parent entity's annual cost report.</p> <p>Medicaid: Same as freestanding, except the cost information is included in the parent entity's cost report.</p>
Quality Assurance and Performance Improvement	None required	A formal program must be in place.	Same as freestanding.

Table based on data provided by the South Carolina Office of Rural Health

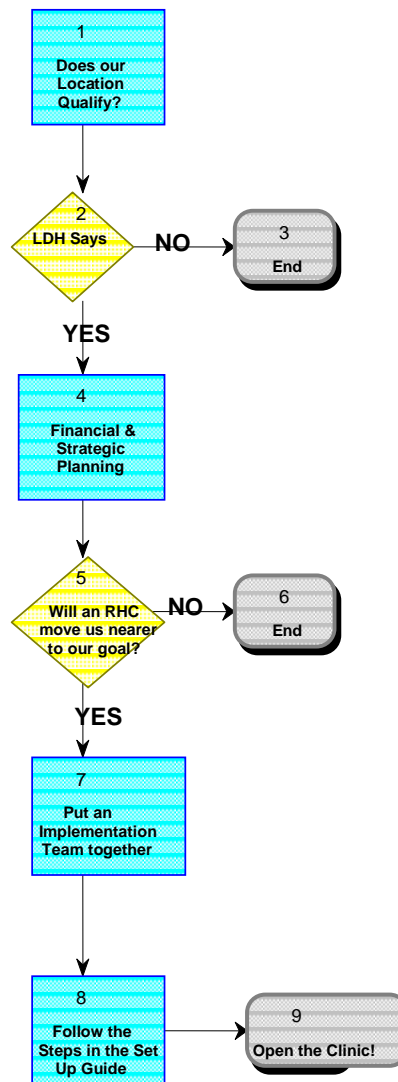
SECTION THREE

IMPLEMENTATION:

YES, I WANT TO APPLY FOR RURAL HEALTH CLINIC CERTIFICATION - THE DECISION PROCESS-

There are three (3) phases to the decision process for setting up an RHC. If the site meets the State's qualifications and the RHC status meets the financial and operational goals of the owners, implementation can begin. An overview of the process is shown:

Setting Up a Rural Health Clinic



THE IMPLEMENTATION PROCESS

Following is a listing of all the steps necessary to establish and obtain certification for an RHC. A more detailed explanation of each step is included in the next section of this manual. The steps have been placed in chronological order, as much as possible, although the sequence of the steps may vary for each clinic, depending on its circumstances.

- a) Verify that site meets RHC location qualifications from the Louisiana Department of Health (LDH): Bureau of Primary Care and Rural Health. Obtain site verification letter for licensing application packet;
- b) Select your implementation team;
- c) Determine if the clinic will be provider-based or freestanding;
- d) Download a Licensing Application from LDH/Bureau of Health Services Financing: Health Standards Section
<http://dhh.louisiana.gov/index.cfm/page/1584>
- e) Determine if the clinic is to be for-profit or not-for-profit;
- f) Designate and set up the ownership structure of the clinic;
- g) Prepare financial projections and budget. RHC feasibility study available through Bureau of Primary Care and Rural Health, Practice Management Service;
- h) Prepare or obtain site/building plans for the clinic. You will need an 11x17" map to attach to the RHC licensing application packet, with denoted identification of service areas;
- i) Obtain written approval from your local zoning authority for new construction or renovation;
- j) Have the architectural plan and specifications reviewed and approved by the Office of State Fire Marshall. Obtain Health Facility Plan Review Approval Letter from Fire Marshall for licensing application packet. Obtain floor map of building RHC is located in and denote where RHC is located.
- k) Complete any construction to the facility, order and install any necessary furniture and/or equipment;
- l) Obtain an occupational license;

- m) Have the clinic facility inspected by the Office of State Fire Marshall. Obtain Walk-Through Inspection Approval with three parts (fire, architectural, and sprinkler) for each building for licensing application packet.
- n) Obtain certificate for occupancy from the Office of the State Fire Marshal;
- o) Have the clinic facility inspected by the LDH Office of Public Health;
- p) Fill our Letter of Intent on the Checklist for Initial Licensing and Certification for licensing application;
- q) Complete the Clinical Laboratory Improvement Act (CLIA) application;
- r) Novitas will be your fiscal intermediary. On the Checklist for Initial Licensing, select a fiscal year-end date;
- s) Complete Medicaid application;
- t) Complete the LDH licensing application;
- u) Complete the Medicare application (855A);
- v) Prepare written policies and procedures;
- w) Prepare job descriptions and an organizational chart;
- x) Obtain written agreements, as needed, with inpatient hospitals, specialists and diagnostic facilities, to accept patient referrals;
- y) Complete all agreements necessary to participate in Health Louisiana plans;
- z) Select a practice management information system;
- aa) Hire a medical director and physician. Complete all necessary contracts;
- bb) Hire a midlevel provider;
- cc) Complete any on-call agreements needed;
- dd) Hire additional staffing, as needed;
- ee) Apply for provider status with commercial insurance companies;
- ff) Obtain appropriate general liability and professional liability insurance;
- gg) Begin operations;

- hh) Schedule a site inspection from LDH; and
- ii) Correct any deficiencies noted during the inspection;
- jj) Choose Medicare deeming authority (AAAASF or The Compliance Team) on the Checklist for Initial Licensing and Certification;
- kk) Have Medicare survey by deeming authority;
- ll) Correct any deficiencies noted during the inspection and submit a Plan of Correction (BPCRH can help assist with this, if needed).

WHAT HAPPENS NEXT?

All paperwork is sent to CMS Dallas by the deeming authority for approval letter. Once you receive the approval letter from Medicare, follow the instructions contained in the letter for State licensing.

STEP 1: VERIFY SITE LOCATION

To determine if a clinic site meets the basic location requirements for RHC designation, send a letter or e-mail requesting verification of site qualifications to:

Tracie Ingram
Rural Health Officer
Louisiana Department of Health
Bureau of Primary Care and Rural Health
P. O. Box 3118
Baton Rouge, Louisiana 70821-2870
Tracie.Ingram@la.gov

NOTE: You will need to include this letter with your RHC application to the Louisiana Department of Health, Health Standards Section.

STEP 2: SELECT YOUR IMPLEMENTATION TEAM

The complete process of implementing an RHC, particularly a new clinic, is complex and time consuming. Having access to the right planning and expertise from the beginning of the process can save time and unnecessary steps. At different times during the process you may have need for:

- A physician;
- A practice management consultant;
- An accountant;
- An attorney;
- An architect; and/or
- A midlevel provider.

If you are an existing health care provider, you may already have a relationship with one or more of these professionals. If you must look for and select a professional, look for these attributes:

The **physician** on your team should be the primary care provider or the medical director who will be working in the RHC. If the RHC provider has not been selected yet, get advice and input from a primary care physician, preferably one who has worked in an RHC.

The **practice management consultant** may be your current clinic administrator. If you need additional expertise, you may request assistance from the Practice Management Consulting team within the LDH - Bureau of Primary Care and Rural Health, by completing the Health Systems Development application on the Bureau's Website (http://new.dhh.louisiana.gov/assets/oph/pcrh/2012_HSDapplication.pdf).

For other recommendations, you may request referrals from colleagues, conduct an Internet search, or refer to the following:

- The Medical Group Management Association: www.mgma.com;
- Louisiana Medical Group Management Association: www.lmgma.org;
- American Academy of Family Physicians: www.aafp.org; and
- Society of Louisiana Certified Public Accountants: www.lcpa.org.

The **accountant** can be found through referrals, the Yellow Pages®, or through the Society of Louisiana Certified Public Accountants, www.lcpa.org. The accountant you select should be familiar with Medicare Cost Reports, the state and federal income tax issues appropriate to your clinic's ownership structure, financial information systems and budgeting. The accountant may be needed to prepare loan applications or grant applications, budgets, and financial projections.

The **attorney** can provide support in setting up your organizational structure and tax status. The attorney can also draft and review contracts and agreements with the medical director that may be required, providers accepting referrals, and an equipment or real estate leaser. The attorney you select should have experience in health care (or access to health care legal expertise).

An **architect** or engineer may be needed to prepare site plans for review by the Fire Marshall and the Division of Engineering and Architectural Services. The architect may need to draft plans for any corrective action needed at the clinic site.

A **midlevel provider** can provide additional manpower in drafting clinical policies and procedures. The type of midlevel provider to be hired will determine the type of collaborative agreement needed by the Louisiana State Board of Nursing Practice (www.lsbnp.state.la.us) or the Louisiana State Board of Medical Examiners (www.lsbme.org).

STEP 3: IS THE CLINIC TO BE PROVIDER-BASED OR FREESTANDING?

There are two basic control configurations for an RHC:

- Freestanding; and
- Provider-based.

Three types of health care providers may own **provider-based** RHCs:

- Hospital;
- Skilled nursing facility; and
- Home health agency.

Freestanding RHCs may be any entity. The types of organizations range from:

- “A physician in a private general practice, located in a shortage area, who employs either a nurse practitioner, certified nurse-midwife, or a physician assistant;
- A nurse practitioner, certified nurse-midwife, or a physician assistant in solo practice, in a shortage area, who develops the required relationship with a physician for medical direction; to
- Organizations either for profit or not for profit, that own primary care clinics located in shortage areas.”⁴

Medicare reimbursement rules are different for freestanding and provider-based RHCs. These reimbursement differences will impact your financial projections and budgets and should be considered as you make decisions about your ownership and control structure.

Freestanding clinics and provider-based clinics receive an all-inclusive visit rate from Medicare. The clinic will receive the lesser of their cost per visit, or the maximum (“capped”) visit rate set by Medicare. There is an exception to the Medicare maximum rate for provider-based clinics owned by hospitals of less than 50 beds. The case rate for these clinics is cost without a maximum. A clinic’s initial rate set by Medicare is equal to 75% of the current capped visit rate. This rate is adjusted upon completion of a clinic’s first cost report.

Medicaid pays RHCs an all-inclusive case rate based on the RHC’s cost, increased annually by the Medical Economic Index (MEI). A clinic’s initial rate set by Medicaid is equal to the rate of the closest clinic, geographically, of like services.

⁴ Interpretive Guidelines – Rural Health Clinics, Rev 247

STEP 4: IS THE CLINIC TO BE FOR-PROFIT OR NOT-FOR-PROFIT?

Most organizations are required to pay state and federal taxes unless they apply for and are granted tax exempt status. Refer to the Internal Revenue Service publication 4220, [Applying for 501\(c\)\(3\) Tax Exempt Status](https://www.irs.gov/pub/irs-pdf/p4220.pdf), <https://www.irs.gov/pub/irs-pdf/p4220.pdf>

STEP 5: DESIGNATE THE OWNERSHIP STRUCTURE OF THE CLINIC

If the ownership entity is not yet established, determine the business structure of the entity and complete all legal and tax documents necessary to set up the entity. Draft the bylaws and other documents that outline the governance and control of the ownership entity. The attorney on your implementation team should be familiar with business structure and governance. For further information about the types of business entities available to you in Louisiana, refer to the Secretary of State's "Geaux Biz" page: <http://www.sos.la.gov/tabid/1027/Default.aspx>.

Ownership of five percent or more must be disclosed to the state and Medicare. Members of a corporate board of directors must be identified, and the board minutes must be made available to LDH. The board must meet at least once per year.

STEP 6: PREPARE FINANCIAL PROJECTIONS AND BUDGETS

Before committing to a project as lengthy and complex as establishing an RHC, you will want to be sure that you have sufficient funding to meet your operational goals and to succeed. You will want input from your full implementation team when preparing financial projections. If needed, the Bureau's Practice Management Consulting team is also available to assist your team in preparing financial projections. If you are an existing clinic looking to convert to an RHC, much of this information can be based on historical data. You will need the following information and more to make accurate estimates:

- Construction or renovation costs;
- Equipment and furnishing cost;
- Information systems cost;

- Cost of consultants/outside experts needed for the application and start-up;
- Start date for clinic operations (be conservative!);
- Number of patient visits per month. If this is a new clinic, assume that patient volume will grow over time;
- Payer mix of patients:
 - Medicare;
 - Medicaid;
 - Self-pay;
 - Insured; and
 - Charity care.
- Expected payment/collection per visit for each of the above payers;
- Staffing numbers and cost:
 - Physician;
 - Midlevel provider;
 - Clinical staff (nursing assistant, licensed practical nurse (LPN), registered nurse (RN));
 - Clerical staff (registration, billing and collections, medical records, appointments, other clerical tasks);
 - Management staff (office manager, accountant, business manager); and
 - Maintenance (housekeeping, maintenance and repair).
- Employee benefit expense:
 - Health insurance;
 - Life insurance;
 - Retirement;
 - Other benefits; and

- Uniforms.
- Electronic Health System
- Supplies expenses:
 - Medical supplies:
 - Drugs, vaccinations;
 - Syringes, alcohol wipes;
 - Blood collection supplies; and
 - Laboratory test supplies and kits.
 - Patient room supplies:
 - Gowns;
 - Gloves;
 - Table covers;
 - Tongue depressors; and
 - Other disposables.
 - Office supplies:
 - Paper and envelopes;
 - Forms;
 - Medical records, if no electronic health record;
 - Billing forms;
 - Patient education brochures;
 - Folders and fasteners (minimal if using EHR);
 - Staples, tape;
 - Pens, pencils, markers; and

- Stickers, labels.
- Maintenance:
 - Mops, brooms, buckets;
 - Disinfectants, cleaner;
 - Hand soap;
 - Hand towels, toilet paper; and
 - Wax.
- Equipment and instruments:
 - Copier and supplies; and
 - Fax and supplies.
- Dues and subscriptions:
 - Licensing fees; and
 - Professional society dues.
- Insurance:
 - General liability;
 - Professional liability; and
 - Other insurance.
- Communication expense:
 - Telephones;
 - Internet access;
 - Other computer access;
 - Cell phones;
 - Pagers; and

- Answering service.
- Marketing expense:
 - Yellow pages;
 - Signage;
 - Brochures;
 - Web site;
 - Direct mail; and
 - Other marketing.
- Facility expense:
 - Rent/Mortgage;
 - Utilities;
 - Repair; and
 - Maintenance and housekeeping.

STEP 7: OBTAIN A LICENSING APPLICATION FROM LDH

If you are sure that you want to proceed with your application for RHC certification, you must obtain original application documents available online:

Independently Licensed RHC that is Independently Certified as an RHC:
<http://dhh.louisiana.gov/index.cfm/page/1944>

Independently Licensed RHC that is Certified as an Independent RHC but Provider Based to the Hospital:
<http://dhh.louisiana.gov/index.cfm/page/1945>

RHC that is Licensed as an Outpatient Department of the Hospital, Certified as an Independent RHC but Provider Based to the Hospital:
<http://dhh.louisiana.gov/index.cfm/page/1946>

On these sites you will find the following information/forms:

- Initial supplier memorandum;
- Licensing application;
- Licensing requirements;
- Federal conditions for certification;
- CMS 29 – application form;
- CMS 1561A – health insurance benefits agreement (3 copies);
- Lab letter and application.

STEP 8: PREPARE OR OBTAIN SITE AND/OR BUILDING PLANS FOR THE CLINIC

If the clinic is a new facility, have architectural plans developed. The “physical environment” requirements are described in §7535 of the Louisiana regulations. The architectural plans and specifications of the clinic, whether currently in operation or planned, must be reviewed and approved by the LDH Division of Engineering and Architectural Services and the Office of State Fire Marshal. You will need documentation of the approval of your plans to submit with your application.

Either of the above offices may require changes to the facility in order to obtain their approval and to meet the RHC facility requirements. If changes are required, you will need to amend the architectural drawings and resubmit them until you receive approval. You will need an 8” x 11” sketch of the final approved clinic floor plan to submit with the RHC application.

STEP 9: OBTAIN WRITTEN APPROVAL FROM YOUR LOCAL ZONING AUTHORITY FOR NEW CONSTRUCTION OR RENOVATION

The federal regulations require that the physical plant be “maintained consistent with appropriate state and local building, fire, and safety codes.” Be sure to obtain any parish or city authorizations you may need for your facility. Louisiana regulations require proof of zoning approval.

STEP 10: HAVE THE ARCHITECTURAL PLAN AND SPECIFICATIONS REVIEWED AND APPROVED BY THE OFFICE OF THE STATE FIRE MARSHAL

You will need documentation of the approval of your plans to submit with your application. Send the plans for review to:

Office of State Fire Marshal
8181 Independence Boulevard
Baton Rouge, LA 70806
(800) 256-5452
www.dps.state.la.us/sfm

The Fire Marshal may require changes to the facility in order to obtain approval and to meet the RHC facility requirements. If changes are required, you will need to amend the architectural drawings and resubmit the drawings until you receive approval.

STEP 11: COMPLETE ANY CONSTRUCTION TO THE FACILITY; ORDER AND INSTALL ANY FURNITURE OR EQUIPMENT NECESSARY

You may schedule site visits when the facility is near completion. The Fire Marshal and Public Health representative will let you know how “complete” the facility must be before they will approve the facility after a site visit.

STEP 12: OBTAIN AN OCCUPATIONAL LICENSE

Medicare will want to see proof of proper licensure, including occupational license, when you apply for your Medicare provider number. If your city or parish does not require occupational licenses, or you are exempt from needing an occupational license, be prepared to prove your exemption.

STEP 13: HAVE THE CLINIC FACILITY INSPECTED BY THE OFFICE OF STATE FIRE MARSHAL

When the facility is complete, have the site inspected by a representative of the State Fire Marshal (See contact information in Step 10 above). If the Fire Marshal cites any deficiencies, these will need to be corrected before a site approval letter will be issued. If the deficiencies are minor, the Fire Marshal may accept a letter stating that the deficiencies have been corrected before issuing an approval. If the deficiencies are significant, the Fire Marshal may schedule a return site visit.

STEP 14: HAVE THE CLINIC FACILITY INSPECTED BY THE OFFICE OF PUBLIC HEALTH

Schedule a site visit by the **Sanitation Officer** of your local Parish Health Unit of the LDH Office of Public Health. You can find your local Public Health Office through the Office of Public Health Web site: <http://new.dhh.louisiana.gov/index.cfm/page/394>. You will need to include a copy of the approval letter from the Office of Public Health in your application packet.

STEP 15: COMPLETE CLIA APPLICATION

Federal regulations require that the RHC “provide basic laboratory services essential to the immediate diagnosis and treatment of the patient including:

- Chemical examinations of urine by stick or tablet method or both (including urine ketones);
- Hemoglobin or hematocrit;
- Blood glucose;
- Examination of stool specimens for occult blood;
- Pregnancy test; and
- Primary culturing for transmittal to a certified laboratory.”⁵

Federal regulation requires that all laboratory facilities must meet the requirements of the Clinical Laboratory Improvement Amendments (CLIA). In order to meet these requirements, the facility must complete CMS Form–116. You may download a packet for CLIA certification from:

<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms116.pdf>

If the tests listed above are the only tests to be done in your lab, you will be applying for a “Certificate of Waiver”. Send the completed CLIA application (CMS-116) to:

LDH/BHSF Health Standards Section
P. O. Box 3767
Baton Rouge LA 70821-3767
Phone (225) 342-0318 Fax (225) 342-5292

⁵ 42CFR §491.9 Provision of Services

STEP 16: COMPLETE THE MEDICARE APPLICATION

Request and obtain your National Provider Identifier (NPI) number before enrolling or making a change in your Medicare enrollment information.

CMS requires that providers and suppliers obtain their National Provider Identifier (NPI) prior to enrolling or updating their enrollment record with Medicare. A Medicare contractor will not process your enrollment application without the NPI and a copy of the NPI notification letter received from the National Plan and Provider Enumeration System, or from the organization requesting your NPI.

The NPI notification is required with each CMS-855 application you submit. If you do not have a NPI, please contact the NPI Enumerator at <https://nppes.cms.hhs.gov>, or call the Enumerator at 1-800-465-3203, or TTY 1-800-692-2326). NOTE: To apply for an NPI number, you will also need to have the correct ten-character taxonomy code for your provider type. A list of all taxonomy codes can be found at

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf>

All appropriate RHC forms for enrollment in Medicare can be obtained from www.cms.hhs.gov/CMSForms/CMSForms/list.asp, or from Novitas. You must send the completed enrollment application to Novitas for processing. Any questions you have about the forms should be directed to Novitas Provider Enrollment at **855-252-8782**.

To enroll in Medicare as an RHC, you will need to complete forms **CMS 855A**

<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855a.pdf>

and **CMS 588**

<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms588.pdf>

For each physician and midlevel provider working in the clinic, you will need to prepare form **CMS 855R**.

<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855r.pdf>

The form 855R “connects” the individual provider with the RHC and gives Medicare authorization to pay the RHC for services provided by the individual provider.

If one of the clinic physicians or midlevel providers is not yet enrolled as a Medicare provider in Louisiana, that individual will have to complete forms **CMS 855I**, **CMS 460** and **CMS 588** in order to be individually enrolled as a Medicare provider. These completed forms must then be submitted to Novitas, the Medicare Part B carrier for Louisiana:

<https://www.novitas-solutions.com/>

If the clinic will have more than one individual provider, you may also want to enroll with the Medicare Part B Carrier as a clinic/group. This will allow the clinic to bill Medicare as a group for all non-RHC services (as opposed to each individual provider billing Medicare separately). To enroll as a Medicare clinic/group, you will need to complete forms **CMS 855B**, **CMS 460** and **CMS 588** and submit them to the Medicare Part B carrier for Louisiana (see above).

NOTE: Medicare must have separate NPI numbers for each provider type (individual, clinic/group, RHC). You **MUST** obtain these numbers prior to submission of any Medicare enrollment application (see NPI enrollment information at beginning of this section).

STEP 17: SELECT FISCAL YEAR END

Novitas is the company with whom Medicare has contracted to process claims and make Medicare Part A payments to RHCs. If your clinic will be provider-based, you will select the fiscal intermediary already being used by the controlling provider. It will also be necessary to select the fiscal year end of your ownership in Section 2 of CMS-855A. The fiscal year end you select will be the same as that of your controlling entity. If in doubt, use the calendar year.

The Medicare contractor is Novitas Solutions, Inc. CMS 855-A should be submitted to:

Novitas Solutions
JH Provider Services
PO Box 3095
Mechanicsburg, PA 17065-1813

For more information about Novitas Medicare go to:

http://www.novitas-solutions.com/webcenter/portal/MedicareJH?_afLoop=1172424890119195#!%40%40%3F_afLoop%3D1172424890119195%26_adf.ctrl-state%3D7uhnpjmc_355

(You will need to accept the end user agreement.)

STEP 18: COMPLETE LOUISIANA MEDICAID APPLICATION

Once you have received a letter from CMS indicating your Medicare approval as an RHC and an effective date, and you are not already a Medicaid provider, you may submit your completed Medicaid RHC enrollment packet.

http://www.lamedicaid.com/provweb1/provider_enrollment/Enrollment_Individuals.pdf

At this time, you may also enroll your entity. This is the link for the basic enrollment packet for entities:

http://www.lamedicaid.com/provweb1/provider_enrollment/Enrollment_Entities.pdf

Provider type packets:

Provider Based:

http://www.lamedicaid.com/provweb1/provider_enrollment/PT79_RHC_Prov.pdf

Independent:

http://www.lamedicaid.com/provweb1/provider_enrollment/PT87_RHC_Ind.pdf

For questions concerning the application process, contact Molina Provider Relations at (225) 216-6000. These forms can also be downloaded from

http://www.lamedicaid.com/provweb1/provider_enrollment/newenrollments.htm

Choose the Basic Enrollment Packet, plus the appropriate Provider Type Enrollment Packet for your RHC. Be sure to complete a linkage form for each individual provider in the RHC (provided in the Provider Type Enrollment Packet).

These applications must be completed and submitted to:

Molina Provider Enrollment
P.O. Box 80159
Baton Rouge, LA 70898-0159

As with Medicare, if any clinic provider is not currently enrolled as a Medicaid provider in Louisiana, a Basic Enrollment Packet plus the appropriate Provider Type Enrollment Packet, must be completed for each individual provider and submitted (be sure to link them to the RHC, using the linkage forms provided).

NOTE: It is important that you read ALL instructions before completing the above applications, and follow them exactly. If you do not, your application could be returned to you, causing further delay in obtaining Medicaid provider status.

STEP 19: COMPLETE THE LDH LICENSING APPLICATION

You should now have all of the documents in hand to complete the initial application as an RHC supplier. Mail the completed application packet to:

LDH/BHSF Health Standards Section
P.O. Box 3767
Baton Rouge, LA 70821-3767

Phone (225) 342-0158
Fax (225) 342-0157

The completed packet must contain the following:

- Completed *Health Standards Section Checklist for Initial Licensing & Certification for Rural Health Clinics* with all attachments;
- Completed CMS 29 – *Request to Establish Eligibility to Participate in the Health Insurance for the Aged and Disabled Program to Provide Rural Health Clinic Services*
<http://dhh.louisiana.gov/assets/medicaid/hss/docs/RHC/cms29.pdf>
- Completed CMS 1561A – *Health Insurance Benefits Agreement* (three signed originals);
<http://dhh.louisiana.gov/assets/medicaid/hss/docs/RHC/cms1561a.pdf>
- Copy of the confirmation from the Medicare Administrative Coordinator (Novitas) showing that they received the CMS 855A for initial enrollment as a Rural Health Clinic, along with a copy of the CMS 855A that was sent to Novitas.
- If received at the time of licensing application submission, approved CMS 855A and Summary Letter from the MAC recommending initial enrollment as a Rural Health Clinic.
- If RHC will be provider based to a hospital, a copy of the Office of Civil Rights Forms & Policies.

You must be very sure that the application is complete before submission. LDH states:

“The application process will be terminated for applicants who have not completed the submission of all the required forms and supplemental information within 90 days of the initial application date. Applicants who are still interested in applying must begin the initial process with the submission of a new application fee.”

The application packet should be submitted to the Health Standards Office approximately six (6) weeks prior to your anticipated opening date.

The **application fee of \$600** in the form of a company check, cashier’s check, or money order, payable to LDH, along with the Payment Transmittal Form, must be sent under separate cover to:

LDH Licensing Fee
PO Box 62949
New Orleans, LA 70162-2949

Link to Payment Transmittal Form:

http://dhh.louisiana.gov/assets/medicaid/hss/docs/ALL_Prgms/hss-01_Payment_Form_Final.doc

A Payment Transmittal Form MUST accompany your check or money-order to ensure the payment is credited to the correct facility and the appropriate licensing application.

STEP 20: PREPARE WRITTEN POLICIES AND PROCEDURES

- Clinical policies and procedures;
- Medical records policies and procedures;
- Business policies and procedures;
- Personnel policies and procedures;
- Emergency procedures;
- Preventive maintenance procedures; and
- Quality assessment and performance improvement procedures.

There are three options for developing your policy and procedure manual:

1. Develop your own manual based on RHC Rules and Regulations;
2. Modify existing P&P manual. Make sure it is absolutely relevant to your clinic;
3. Use a template – There are companies that provide these for a fee.

A sample policy and procedure is included in the Appendix A of this manual.

STEP 21: PREPARE JOB DESCRIPTIONS AND ORGANIZATIONAL CHARTS

An organizational chart represents the control and supervisory relationships among staff in the RHC.

A sample organizational chart is included in Appendix B of this manual.

A written job description must be prepared for each type of position. The job description should include:

- General summary of duties;
- Supervision received;
- Supervision exercised;
- Essential functions of the position;
- Education required;
- Experience required;
- Other requirements, such as certification or license;
- Knowledge required;
- Skills required;
- Abilities required;
- Physical and mental demands of the position; and
- Environmental and working conditions.

A sample job description is included in the Appendix C of this manual.

STEP 22: OBTAIN WRITTEN AGREEMENTS, AS NEEDED, WITH INPATIENT HOSPITALS, SPECIALISTS, AND DIAGNOSTIC FACILITIES TO ACCEPT PATIENT REFERRALS

The regulations require that the RHC show that patients have access to inpatient care, diagnostic facilities and specialty care. The clinic may document these relationships through letters of agreement or formal contracts, or by showing actual instances of these providers accepting referrals from the existing clinic.

STEP 23: COMPLETE ALL AGREEMENTS NECESSARY TO PARTICIPATE IN HEALTHY LOUISIANA

If you are seeing Medicaid patients at a primary care fee-for-service clinic, you are most likely already contracted with the Healthy Louisiana Plans. You will need to update each contract after you receive your new RHC Medicaid number and rate.

If you do not currently serve Healthy Louisiana Plan members, go to the following link for the Healthy Louisiana plan contacts: <http://new.dhh.louisiana.gov/index.cfm/page/1065>. These contacts (As of 9/21/2016) are for Medicaid providers interested in contracting with a Healthy Louisiana Plan:

Prepaid Plans

Aetna

Sherrell Austin, Director of Network Development
AustinS@aetna.com
(504) 667-4682

Amerigroup Louisiana Inc.

Scott Thevenot, Network Development Manager
scott.thevenot@amerigroup.com
(225) 819-4893 or (877) 440-4065

Amerihealth Caritas of Louisiana

Sherry Wilkerson, Director of Network Management
Network@amerihealthcaritasla.com
(877) 588-2248

Louisiana Healthcare Connections

George Bucher, VP Network Development and Contracting
gbucher@louisianahealthconnect.com
(225) 201-8467

Shared Savings Plans

United Healthcare Community Plan
Network Management Resource Team
(866) 574-6088

It is important to remember that as soon as you receive your new Medicaid RHC number and payment rate, you will need to inform the Healthy Louisiana Plans of your RHC status and your rate. The contracts will need to be readdressed with each plan.

The link to the main provider page is:

<http://new.dhh.louisiana.gov/index.cfm/page/1065>

STEP 24: SELECT A PRACTICE MANAGEMENT INFORMATION SYSTEM

Good information systems can make a significant contribution to the success of any medical practice. It is possible for all of the RHC's scheduling, billing, accounting and medical records functions to be manual and paper-based, but it is definitely NOT recommended.

When selecting a practice management system for the RHC, look for systems that have or support the following features:

- Appointment scheduling;
- Billing:
 - UB-04 Institutional billing; and
 - HCFA-1500, Professional billing;
- HIPAA compliant transactions sets created by the system;
- Collections and follow-up support with Internet access;
- Patient statements and collections letters, with electronic send capability;
- Monthly reports;
- Ad Hoc reports and queries; and

- Supports sliding-scale fee schedules (may be needed).

Information systems capability may be in-house, a shared service, or provided by an outside contractor.

STEP 25: HIRE A MEDICAL DIRECTOR AND PHYSICIAN

State regulations require that the clinic have a licensed physician on staff, as well as a medical director. The medical director and physician provider may be the same individual, and usually are in a small clinic. The physician provides direct patient care, as well as on-site supervision of the midlevel practitioners, as required by Medicare, Medicaid and other payers. All RHC clinical records and care provided by a midlevel practitioner must be reviewed by a physician on a periodic basis, or as required.

The medical director must be credentialed to provide primary care. The medical director is responsible for providing the medical direction for the clinic's activities, and for providing supervision and consultation to the midlevel practitioner. The medical director, together with the midlevel provider, participates in the development and review of policies, procedures, and clinical services. The medical director reviews patient records periodically and provides direct care services to RHC patients. The physician and medical director may provide their services as an employee or through a contract.

STEP 26: HIRE A MIDDLELEVEL PROVIDER

A midlevel provider must be onsite and available to provide primary care services to RHC patients at least 50% of the time the clinic operates. The midlevel provider must be appropriately licensed and credentialed as an advanced practice registered nurse (APRN), family nurse practitioner or certified nurse midwife, or a physician's assistant. The midlevel provider or physician can be exempt from this requirement if the facility has a written, current agreement with an advanced life support provider who can provide care within ten minutes. Advanced practice registered nurses must be covered by a properly approved collaborative practice agreement, as required by their state license.

STEP 27: COMPLETE ANY ON-CALL AGREEMENTS NEEDED

In the event of a medical emergency, RHC patients must be able to contact a provider 24 hours per day, seven (7) days per week. This emergency access may be provided by RHC medical staff or through another on-call physician or midlevel provider. On-call coverage should be documented in a contract or letter of agreement outlining the procedures to be followed and the responsibilities of each party.

STEP 28: HIRE ADDITIONAL STAFFING AS NEEDED

The RHC must be adequately staffed to provide support to its medical professionals. Additional staff may include pharmacists, administrators, managers, accountants, clerical and medical records personnel. The level of staffing and the skill mix needed will depend on the services provided by the clinic, the number of patient encounters, and the number of providers.

STEP 29: APPLY FOR PROVIDER STATUS WITH COMMERCIAL INSURANCE COMPANIES

Private health insurance plans require that physicians and other health care providers be credentialed by the plan and placed in the plan's provider data base. Frequently, providers must sign contracts that outline payment rates and payment terms between the insurance plan and the provider. Louisiana has attempted to standardize the credentialing process and application forms required by health insurance plans doing business in the State. These standardized forms can be found at the following Louisiana Department of Insurance Website:

<https://www.multipan.com/pdf/providers/howtowork/credentialingforms/LA%20Cred%20Form.pdf>

(Louisiana Standardized Physician Credentialing Application)

Many health plans require providers to complete proprietary forms. The data required by each health plan is similar and will include:

- General information about the provider, including licensure, Medicare and Medicaid provider numbers, home address, date of birth, citizenship;
- Physical address, contact phone numbers, hours of operation for each practice location;
- Information about provider's training, board certification, subspecialty;
- Affiliations with hospitals, PHOs, IPAs;
- Education, records of continuing education;
- Work history and curriculum vitae;
- Professional licenses;
- References;
- Professional liability insurance information and recent history of claims;
- History of disciplinary action, legal history, financial relationships; and
- Tax identification information.

STEP 30: OBTAIN APPROPRIATE GENERAL LIABILITY AND PROFESSIONAL LIABILITY INSURANCE

Louisiana regulations require proof of at least \$500,000 of general liability insurance and \$500,000 of professional liability insurance. A local insurance broker or agent should be able to work with you to find appropriate insurance coverage.

STEP 31: BEGIN OPERATIONS

The clinic must be operational prior to the site inspection or survey, and have seen at least five (5) patients at the time of the survey. Primary care services must be provided at least 36 hours per week. Appropriately qualified professional staff must be on duty during all hours of operations. Professional staff attendance must be documented.

STEP 32: SCHEDULE A SITE INSPECTION FROM LDH

A representative of the Louisiana Department of Health, Health Standards Section will visit your clinic site to determine if the RHC meets all of the requirements.

The surveyor will use a standardized form to document the results of the survey..

Before the surveyor arrives, be sure that you have the following information, forms, files, and procedures available for review:

- 1) Personnel records for each staff member whether employed or on contract, including:
 - Resume or application;
 - I-9 form;
 - Hepatitis B vaccine or declination form;
 - TB test results;
 - Current licensure;
 - Continuing education;
 - Privileges of provider; and
 - Collaborative agreement.
- 2) Medical Records content:
 - Demographic information;
 - Emergency contact information;
 - Physical exam findings; and
 - Social data.
- 3) Consent forms;
- 4) Health status assessment;
- 5) Plan of care:

- Physician's orders;
 - Consultative findings;
 - Diagnostic and laboratory reports;
 - Medical history; and
 - Signatures of the physician or other health care professionals.
- 6) Policies and procedures manual;
 - 7) Medical emergency procedure;
 - 8) Local community disaster plan, showing RHC role;
 - 9) Non-medical emergency procedure;
 - 10) Preventive maintenance procedure;
 - 11) Disaster and fire drill procedure;
 - 12) Medical record content policy;
 - 13) Security procedures for patient data, paper and computerized;
 - 14) Drug storage and handling procedure;
 - 15) Handling biohazards procedure;
 - 16) Quality assurance process;
 - 17) Autoclave sterilization procedures, if you use one;
 - 18) Annual review of all contracts and agreements;
 - 19) Personnel grievance forms and procedures;
 - 20) Patient grievance forms and procedures:
 - Sign-in timesheet for professional employees (showing hours worked and on-site);
 - Patient Rights document; and
 - Advisory Committee roster and appointments.

- 21) Advisory Committee calendar and minutes should be included and should indicate at least one meeting per year, with minutes for each meeting. Also include:
- Calendar, membership, and minutes of committees;
 - Quality Assurance and Performance Improvement (QAPI) program review;
 - Mission and hours of operation;
 - Review of services;
 - Evaluation of staffing level;
 - Patient Care Committee; and
 - Quality Council – at least five members at all times.
- 22) List of nearest local support organizations and resources such as: public health units, Office of Family Support, school clinics, hospice agency, home health agencies, rehabilitation facilities, American Cancer Society, substance abuse and mental health facilities;
- 23) Written disaster plan. Post appropriate portions of the disaster plan;
- 24) Physical facility requirements:
- Emergency kit;
 - Defibrillator, or letter stating that ALS services are available within ten (10) minutes;
 - Exit signs are posted;
 - Exit corridors are 44 inches wide;
 - Doors are at least 34 inches wide;
 - Faucets must provide hot water;
 - Notice posted on one refrigerator that houses drugs and biologicals: “Not for Employee Use”;
 - Every lock in the facility must be operable;
 - All electrical devices must be in working order;

- Hallway battery backup lights in place and in working order;
- Ground fault receptacles in working order;
- Emergency supplies required by Civil Defense must be in the facility;
- Patient chart area or EHR can be closed and locked;
- Bathrooms must have adequate soap, towels, hot and cold water;
- Bathrooms must be vented to the outside;
- Handicap parking spaces must be marked and of sufficient number;
- No items can be stored under sinks;
- Hours of operation are posted;
- Fire evacuation plan must be posted in every room; and
- Patient education information must be available in the waiting room.

25) Documentation of:

- Fire drills; and
- Disaster drills.

26) Training sessions:

- Topics covered;
- Name and qualifications of instructor;
- Name and job titles of attendees;
- Organizational chart; and
- Job descriptions.

27) Clinical Laboratories Improvement Act (CLIA) certificate or waiver;

28) Quality Improvement Plan;

29) Periodic review of medical records;

30) Review of midlevel provider records by physician or Medical director; and

31) Contracts in place for the following:

- Medical director;
- Biohazard waste;
- Radiology services;
- Referral laboratory services;
- On-call coverage.

STEP 33: CORRECT ANY DEFICIENCIES NOTED DURING THE INSPECTION

The surveyor will send a written report, noting any deficiencies found. A corrective action plan must then be prepared for the surveyor, outlining the corrective steps to be taken and the timetable for corrective action. The surveyor should review his/her findings with you at the end of the survey, before leaving the site. At that time, the corrective action plan should be discussed. If the deficiencies are not severe and are easily correctible, the surveyor may issue a provisional approval, pending corrective action. If deficiencies are significant, the surveyor may withhold approval until corrective action is complete. The surveyor may also require a second site visit to observe the changes and corrections. Bureau of Primary Care and Rural Health can assist in reviewing your Plan of Correction, in desired.

FOR ASSISTANCE, CALL US. WE CAN HELP.

The Bureau offers support to help you through the analysis and application process. please feel free to contact our team members with your questions:

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For other services offered by the Bureau, as well as a list of useful Website links, visit the Bureau's Website at

<http://new.dhh.louisiana.gov/index.cfm/subhome/25/n/294>

GLOSSARY

Advisory Committee – RHC appointed committee, responsible for annual review of the clinic’s plan and operations. The Committee must consist of at least two medical professionals and one local consumer who are not employees of the RHC;

Bureau of Primary and Rural Health Care – Office within the Louisiana Department of Health, responsible for building and sustaining health care capacity in underserved and rural areas of the State;

Certified Nurse Midwife (CNM) - an advanced practice registered nurse trained in obstetrics and delivery;

CLIA - Clinical Laboratories Improvement Act, requires a waiver or certificate to ensure quality of laboratory testing;

CMS - Centers for Medicare and Medicaid Services (formerly HCFA) - federal regulatory agency for Medicaid, Medicare and Child Health Insurance programs;

HSS - Health Standards Section in the Bureau of Health Services Financing of LDH;

HPSA - Health Professional Shortage Area - a geographic area with fewer than necessary primary health care providers per person;

LDH - Louisiana Department of Health;

Midlevel Practitioner - a certified nurse midwife, a certified nurse practitioner, or physician assistant;

Nurse Practitioner (NP) - an advanced practice RN licensed to provide direct patient care;

OMB - Office of Management and Budget of the Executive Office of the President of the United States;

OPH - Office of Public Health of the Department of Health;

OSFM - Louisiana Office of State Fire Marshal;

Primary Care - services normally provided in a physician’s office to diagnose, treat or prevent illness or injury;

Physician Assistant (PA) - a licensed provider allowed to provide patient care under a physician's supervision;

Qualified Professionals - one of the following professionals qualified to provide services in an RHC:

- **Advanced Practice Registered Nurse** – APRN (NP or CNM);
- **Licensed Clinical Psychologist** – LP;
- **Licensed Physician's Assistant** – PA;
- **Licensed Clinical Social Worker** – LCSW; and
- **Physician** – Doctor of Medicine.

Rural Areas - US Census Bureau designation of "non-urbanized" area;

Rural Health Clinic (RHC) - an outpatient primary care clinic seeking or possessing certification by CMS as a rural health clinic, which provides diagnosis and treatment to the public by a qualified midlevel practitioner and a physician;

Shortage Area - a federally designated health professional shortage area (HPSA), a federally designated medically underserved area (MUA), medically underserved population (MUP), or an area designated by the state's Governor as underserved;

Waiver or Variance - written permission granted by the HSS or the LDH Secretary (or her designee) to a facility to operate out of compliance with a specific portion of the standards when it is determined that the health and safety of the patients will not be jeopardized.

APPENDICES

APPENDIX A

Sample Policy and Procedures

POLICY AND PROCEDURES FOR NATURAL DISASTER EMERGENCY PLAN

1) Objective:

To familiarize employees with a plan of action in the event of a natural disaster (i.e. hurricane, tornado, flood, gas leak, etc.). To be able to function in a manner that ensures the safety of patients and personnel.

2) Procedures to follow if a natural disaster occurs during office hours:

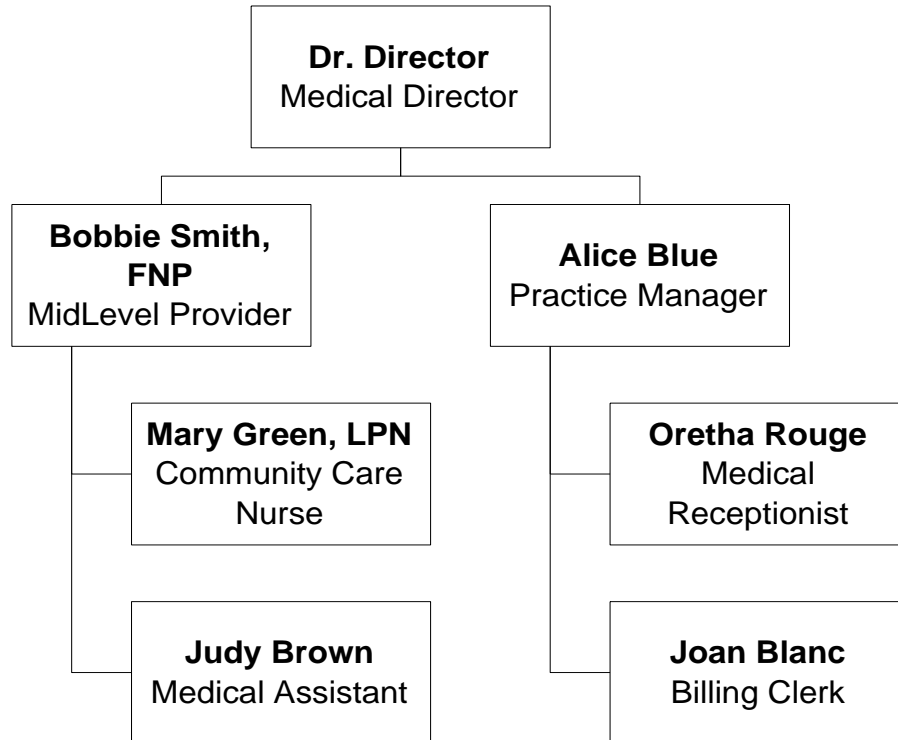
- a) Call 911 for assistance and instructions;
- b) Move patients to a safe area in the office, if possible. Rooms without windows are the best choice;
- c) If the office is unsafe, escort patients out the exit doors using the shortest and safest route;
- d) Check the office to make sure all people have been safely evacuated or await the arrival of the emergency disaster team, if conditions warrant; and
- e) Forward phones to the answering service until the situation is cleared.

3) Procedures to follow if an evacuation is necessary:

- a) Stay tuned to a local radio station for the latest information;
- b) Advise patients in the office of the impending evacuation and the closing of the office;
- c) Contact patients with appointments to advise them that the office will be closing due to the situation. Refer any emergencies to the appropriate hospital Emergency Department;
- d) Forward phones to the answering service until the situation is cleared;
- e) Secure office and computer equipment. Cover and unplug computers and medical equipment. Remove pertinent business records if time permits; and
- f) Remove charts on bottom shelves if a flood threatens the building.

APPENDIX B

Sample Organizational Chart



APPENDIX C

Sample Job Description

Billing Clerk

GENERAL SUMMARY OF DUTIES: Responsible for gathering charge information, codes, data entry, completes billing process and distributing billing information.

SUPERVISION RECEIVED: Reports to Accounting Manager.

SUPERVISION EXERCISED: None.

ESSENTIAL FUNCTIONS:

1. Researches all information needed to complete billing processes including getting charge information from physicians;
2. Codes information about procedures performed and diagnosis on charge;
3. Keys charge information into on-line entry program and produces billing;
4. Processes and distributes copies of billings according to clinic policies;
5. Prepares bank deposits, records deposits, photocopies checks for entry into billing system;
6. Works with other staff to follow-up on accounts until zero balance or turned over for collection;
7. Assists with coding and error resolution;
8. Assists with answering the telephone and provides information as requested;
9. Maintains required billing records, reports, files;
10. Participates in educational activities; and
11. Maintains strictest confidentiality.

The job holder must also demonstrate current competencies applicable to the position:

EDUCATION: High school diploma or GED.

EXPERIENCE: Minimum of one year of billing experience in a health care organization.

REQUIREMENTS: None.

KNOWLEDGE:

1. Knowledge of billing practices and clinic policies and procedures; and
2. Knowledge of coding and clinic operating policies.

SKILLS:

1. Skilled with computer programs, spreadsheets and applications; and
2. Skilled in using a calculator.

ABILITIES:

1. Ability to understand and interpret policies and regulations;
2. Ability to prepare documents in response to complaints and inquiries;
3. Ability to examine documents for accuracy and completeness; and
4. Ability to communicate effectively and work well with others.

PHYSICAL/MENTAL DEMANDS: Requires sitting and standing associated with a normal office environment. Also requires manual dexterity using calculator and computer keyboard.

ENVIRONMENTAL/WORKING CONDITIONS: Normal office environment.

This description is intended to provide only basic guidelines for meeting job requirements. Responsibilities, knowledge, skills, abilities and working conditions may change as needs evolve.

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