Rural Health Clinic (RHC) Provider-based status requests

What is provider-based status?

The Centers for Medicare/Medicaid Services (CMS) Regional Office designates an entity as provider-based. This is significant as it impacts different payment mechanisms. It is the intent of existing statutory and regulatory criteria for Medicare to operate as a prudent purchaser of services that enhance the care of beneficiaries. Medicare must comply with Congressional intent as reflected in Section 1861(v)(1)(A) of the Social Security Act to pay only for those costs that are necessary for the efficient delivery of needed health services. Therefore, CMS requires a strict demonstration that an entity meets the criteria for designation as provider-based. It is CMS's policy that the following applicable requirements must be met before an entity can be designated as part of a provider for payment services.

How do I request provider-based status for my RHC?

Clinics seeking provider-based status must complete and submit a written request. Request materials may be found below, or through the Bureau of Facility Standards, at (208) 334-6626.

What is included in the provider-based request packet?

The request packet includes what must be submitted to make the determination of provider-based. Please submit a *narrative report* which explains how your facility meets the following criteria:

1) Close Proximity. The entity is physically located in close proximity of the provider where it is based, and both facilities serve the same patient population (e.g. from the same service, or catchment area).

Please note, to be provider-based to a hospital, the hospital will need to be less than 50 beds and located in a rural area. Please contact the State Office of Rural Health and

Primary Care by phone, fax, or email as follows for rural designation inquiries:

(208) 334-0669
(208) 332-7262 fax

ruralhealth@dhw.idaho.gov

2) Integral and Subordinate Part. The entity is an integral and subordinate part of the provider where it is based, and as such is operated with other departments of that provider under common licensure.

3) Accreditation. The entity is included under the accreditation of the provider where it is based, and the accrediting body recognizes the entity as part of the provider.

4) Ownership and Control. The entity is operated under common ownership and control (i.e., common governance) by the provider where it is based, as evidenced by the following:

- The entity is subject to common bylaws and operating decisions of the governing body of the provider where it is based;

- The provider has final responsibility for administrative decisions, final approval for personnel actions, and final approval for medical staff appointments in the provider-based entity; and

- The entity functions as a department of the provider where it is based, with significant common resource usage of buildings, equipment, and service personnel on a daily basis.

5) Administration and Supervision. The entity director is under the direct day-to-day supervision of the provider where it is located, as evidenced by the following:

- The entity director, or individual responsible for day-to-day operations at the entity, maintains a daily reporting relationship and is accountable to the Chief Executive Officer of the provider and reports through that individual

to the governing body of the provider where the entity is based; and

- Administrative functions of the entity, e.g., records, billing, laundry, housekeeping and purchasing, are integrated with those of the provider where the entity is based.

6) Clinical Services. Clinical services of the entity and the provider where it is located are integrated as evidenced by the following:

- Professional staff of the provider-based entity have clinical privileges in the provider where it is based;

- The medical director of the entity maintains a day-to-day reporting relationship to the Chief Medical Officer or other similar official of the provider where it is based;

- Medical records for patients treated in the provider-based entity are integrated into the unified records system of the provider where the entity is based;

- Patients are treated at the provider-based entity are considered patients of the provider and have full access to all provider services; and

- Patient services provided in the entity are integrated into corresponding inpatient and/or outpatient services by the provider where it is based.

7) Public Awareness. The entity is held out to the public as part of the provider where it is based (e.g., patients know they are entering the provider and will be billed accordingly).

8) Financial Integration. The entity and the provider where it is based are financially integrated as evidenced by the following:

- The entity and the provider where it is based have an agreement for the sharing of income and expenses; and

- The entity reports its costs in the cost report of the provider where it is based using the same accounting system for the same cost reporting period as the provider

where it is based.

How do I complete the provider-based request?

Please submit a narrative report to the Bureau of Facility Standards. Please ensure all questions are answered fully, and all hand-printed applications are clearly printed and easily readable.

Where do I send my completed provider-based request materials?

The application materials can be submitted by mail or hand delivered.

PLEASE KEEP A COPY FOR YOUR RECORDS.

- If you are mailing the application packet, mail to:

  Department of Health and Welfare
  Bureau of Facility Standards
  P.O. BOX 83720
  BOISE, ID 83720-0009

- If you are hand delivering the application packet, deliver to:

  Department of Health and Welfare
  Bureau of Facility Standards
  3232 Elder Street
  Boise ID 83705

What happens after I submit my provider-based request materials?

Bureau of Facility Standards staff will review the submitted materials. If the request is incomplete, or if there are questions, Bureau staff will contact the provider. Once all request materials have been received and reviewed, the information will be forwarded to the CMS Region X Office, for final decision-making.

How long will the provider-based request process take?

The length of the process varies dependent upon multiple factors such as whether the request is complete, if additional information is needed, current work load, and availability of resources necessary to review the request, etc. Therefore, it is not possible for the Bureau of Facility Standards to establish specific timeframes.

How do I get paid for providing services?

Optional provider-based self attestation forms are available from and submitted to the FIs. The FI will review the attestation and make a recommendation. The FI forwards all information the CMS Region X Division of Financial Management for final review and approval of the self attestation. For additional information regarding provider-based self attestations, please contact your FI.

Additional information

For additional information please access the website and reference information below or contact the Bureau of Facility Standards at (208) 334-6626 or email questions to fsb@dhw.idaho.gov.

Bureau of Facility Standards Informational Letters

RHC's

Health and Welfare

State Office of Rural Health and Primary Care

Centers for Medicare & Medicaid Services

Rural Health Clinics Center