

INITIAL CERTIFICATION FOR MEDICARE PARTICIPATION

Dear Applicant:

Please note Indiana State Department of Health **cannot** conduct your survey for Medicare and that you will have to go through an accrediting organization for Medicare. Please refer to the link on the webpage for a listing of accrediting organizations. **For the purposes of the application, if you plan to apply for Medicare in addition to state licensure, you MUST check the box for Medicare at the top of the application, return all applicable forms and submit a statement in writing to this office with your application.** The note should read as follows, e.g.: *“ABC Healthcare facility plans to apply for Medicare through an accrediting organization, but would like the State to conduct my survey for state license only or for state license and Medicaid”.* (Check the appropriate box for Medicaid, too, if applicable). The State can conduct the Medicaid survey along with the state license survey, or you have the option to have the accrediting organization conduct the Medicaid survey along with the Medicare survey. Your note should be specific in regard to who you would like to have conduct the Medicaid survey, if you plan to apply for Medicaid as well.

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 home health agency certification surveys at this time due to limited resources (refer to CMS letter S&C-08-03). The change in policy is applicable immediately for all home health agencies 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 Home Health Agencies 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 home health agency 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 if 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.

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.

Title VI of the Civil Rights Act of 1964 prohibits discrimination on grounds of race, color or national origin in any program receiving federal financial assistance. Although your entity may have already given assurance in connection with other federal programs, the Department nevertheless requires that the enclosed copies of the ***Assurance of Compliance forms (HHA-690)*** and a ***Civil Rights Packet*** be filed with your application. **Any questions concerning the Civil Rights Application should be directed to the Office of Civil Rights.**

To qualify for payment, your facility must be in compliance with the requirements for participation, 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.

A link 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.

