RURAL HEALTH CLINIC

RHC UPDATE SEMINAR
NASHVILLE TENNESSEE

FALL, 2018

Healthcare Business Specialists
Specializing in RHC reimbursement
502 Shadow Parkway Suite 214 Chattanooga, TN 37421
Email: marklynnrhc@gmail.com
Website: www.ruralhealthclinic.com
Telephone: (423) 243-6185
TAB 1

Agenda and Administrative

Healthcare Business Specialists
Specializing in RHC reimbursement
144 Hancock Oaks Trace NE Cleveland, Tennessee 37323
Email: dani.gilbert@outlook.com
Website: www.ruralhealthclinic.com
Telephone: (423) 650-7250
Rural Health Clinic Update Seminar
Agenda and Topics Outline
Nashville, Tennessee
November 6, 2018

<table>
<thead>
<tr>
<th>Time</th>
<th>Subject Matter</th>
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</thead>
<tbody>
<tr>
<td>8:30AM to 9:00AM</td>
<td>Introductions, Administrative Details, New to RHC Basics. What is a Rural Health Clinic. Differences between Independent and Provider-based and the certification process. This is the same information every year. If you want to come at 9:00 and hear the updates, please feel free to do so.</td>
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<td>Emergency Preparedness, Certification, and Annual evaluations updates and information on how to avoid the top two condition level deficiencies and changes in how to perform annual evaluations due to the Interpretative Guidelines.</td>
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<tr>
<td>10:15AM to 10:50AM</td>
<td>Cost Reporting Updates, Electronic Filing of Cost Reports, What is needed to file cost reports. How to accumulate your information, Prevnar 13 and 23, Influenza and Pneumococcal and Medicare Bad Debts. Timing of settlements and critical deadlines. Mark Lynn and Dani Gilbert</td>
</tr>
<tr>
<td>10:50AM to 11:20AM</td>
<td>Billing Update. Questions and Answers. What is a visit, bundled services, preventive services, incident to, procedure billing, no global billing, no groups, non-rhc services, commingling, setting up non-RHC time.</td>
</tr>
<tr>
<td>11:00AM to 11:30AM</td>
<td>Tenncare Quarterly Reporting. How to complete the Quarterly Tenn Care Wrap-around Settlement report. Dani Gilbert</td>
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<tr>
<td>12:00AM to 12:30PM</td>
<td>Tenncare Moratorium. In October, 2017 Tenncare issued a moratorium on new RHCs being paid the enhanced Tenncare rates. In September 2018 Tenncare issued new RHC cost reporting and wrap reporting.</td>
</tr>
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<td>12:30PM to 1:00PM</td>
<td>Tenncare Panel Discussion. Rebecca Jolley, Shannon Haynes, Angela Youngberg, Bill Jolley, Dani Gilbert, and Mark Lynn to discuss the Tenncare Moratorium and the November 27th hearing.</td>
</tr>
</tbody>
</table>

Dismissal – Thanks for coming!! We appreciate your loyalty.
Rural Health Clinic Update Seminar
Agenda and Topics Outline
Jackson, Tennessee
November 7, 2018

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<td>Box Lunches to be served</td>
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www.ruralhealthclinic.com
Healthcare Business Specialists

UPCOMING RHC WEBINARS

Medicare Billing for Independent and Provider-Based RHCs (Session 1)
12/4/2018 @ 2:15PM EST

Medicare Billing for Independent and Provider-Based RHCs (Session 2)
12/5/2018 @ 2:15PM EST

Medicare Billing for Independent and Provider-Based RHCs (Session 3)
12/6/2018 @ 2:15PM EST

Regulatory, Cost Reporting, and Billings Changes for RHCs
12/11/2018 @ 2:15PM EST

Emergency Preparedness for RHCs
12/12/2018 @ 2:15PM EST

Preparing for the RHC Certification Inspections or Re-Inspection
12/12/2018 @ 2:15PM EST
TAB 2

Regulatory and Updates Presentation
What does Healthcare Business Specialists do?

1. We prepare Medicare and Medicaid Cost Reports for Rural Health Clinics. In 2018, we will prepare 150 cost reports.
2. We prepare annual evaluations of RHCs. We conduct 50 of these on an annual basis.
3. We help clinics startup as RHCs. (about 30 per year)

New to RHC/ Beginner/Basics of RHCs
**Fall RHC Update Seminar Locations – 2018**

<table>
<thead>
<tr>
<th>Date</th>
<th>Location/Website</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/2/2018</td>
<td>Somerest, Kentucky</td>
<td>The Seminar isencial to Rural Health Clinic, to discuss the current Medicaid program and how it affects RHCs.</td>
</tr>
<tr>
<td>11/4/2018</td>
<td>Tuscumbia, Tennessee</td>
<td>The seminar will cover the current Medicaid program and its impact on RHCs.</td>
</tr>
<tr>
<td>11/7/2018</td>
<td>Martinsville, Virginia</td>
<td>The seminar will focus on Medicaid program changes and their effects on RHCs.</td>
</tr>
<tr>
<td>11/14/2018</td>
<td>Birmingham, AL</td>
<td>The seminar will discuss Medicaid program changes and their impact on RHCs.</td>
</tr>
</tbody>
</table>

**Disclaimers:**

1. Information is current as of 11/2/2018.
2. Medicaid is different in each state. We will not be able to answer state specific questions in many states.
3. I am not young enough to know everything, nor am I an expert in all areas of RHCs.
Goals of the RHC Update Seminar

1. To Update everyone on RHC Billing, Cost Reports, Annual Evaluations, Emergency Preparedness, and new and proposed RHC Regulations.

If you need help with your medically underserved area. http://hpsa.us/

Joe Lampard
HPSA Acumen
PO Box 274
201 E 4th Street, 3rd Floor
Jamestown, NY 14701
Telephone: 716.483.0888
Email: jos@hpsa.us

THE BASICS OF RURAL HEALTH CLINICS

RURAL HEALTH CLINICS ARE THE FABRIC OF RURAL HEALTH

Senator Wyden "We have been at it for almost two and a half hours. You all have been tense, but what I am struck by is I don't think we have mentioned, over the course of two and a half hours, what is really the backbone of rural health care. Literally, from sea-to-shining sea, and that is RURAL HEALTH CLINICS..."
RHC Status only affects reimbursement from:

Medicaid
Medicare

There are 4,453 RHCs in the USA out of 230,187 physician practices (1.7%)

Who are the RHCs in your State
CMS listing updated 5/23/2017

RHCs in the Southeast

<table>
<thead>
<tr>
<th>State</th>
<th>RHCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kentucky</td>
<td>240</td>
</tr>
<tr>
<td>Mississippi</td>
<td>186</td>
</tr>
<tr>
<td>Florida</td>
<td>135</td>
</tr>
<tr>
<td>Tennessee</td>
<td>133</td>
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<tr>
<td>Alabama</td>
<td>112</td>
</tr>
<tr>
<td>Georgia</td>
<td>91</td>
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<tr>
<td>South Carolina</td>
<td>88</td>
</tr>
<tr>
<td>North Carolina</td>
<td>76</td>
</tr>
</tbody>
</table>

Qcor has a listing of most common deficiencies and has reports by provider.

Qcor is Available from CMS

https://qcor.cms.gov/main.jsp
What is a rural health clinic?
RHC Fact Sheet

There are Nine Conditions of Participation
1.491.4 Comply with Fed, State, & Loc Laws
2.491.5 Must meet location requirements
3.491.6 Physical Plant and Environment
4.491.7 Organizational Structure
5.491.8 Staffing and Staff Responsibilities
6.491.9 Provision of Services
7.491.10 Patient Health Records
8.491.11 Program Evaluation
9.491.12 Emergency Preparedness

Resources for RHCs
CMS Rural Health Clinics Center
http://www.cms.gov/Centers/Provider-Type/Rural-Health-Clinics-Center.html

Chapter 13 – Medicare Benefits Manual. Section 230 Covers CCM services including Transitional Care Management Services

National Association of Rural Health Clinics
http://narhc.org/

Survey Resources for New RHCs
State Surveyors
CMS State Survey Agency Directory

Quad A RHC Accreditation
https://www.aaasrf.org/programs/medicare-programs/medicare-rural-health-clinics-program

The Compliance Team
http://www.thecompliancebaas.org/rural_health_clinic.aspx

New to RHC/ Beginner/Basics of RHCs
www.ruralhealthclinic.com
RHC Resources

- RHTC Webinars: Rural Health Information Hub
  - Go to: https://www.ruralhealthinfo.org/topics/rural-health-clinics/technical-assistance-calls
- National Association of Rural Health Clinics
  - General questions: rhtc@narhc.org
  - Bill Finerfrock: bf@narhc.org
  - Nathan Baugh: Baughn@capitolassociates.com
- Other Resources
  - CMS RHC Website: https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html
  - State Offices of Rural Health: https://nosorh.org/
  - CMS Regional Office Rural Health Coordinators

NARHC's Certified Rural Health Clinic Professional (CRHCP) Course

https://www.web.narhc.org/assnfce/ev.asp?id=380

Certified Rural Health Coder

https://mailchi.mp/ruralhealthcoding.com/become-a-certified-rural-or-community-health-coding-billing-specialist-670773?e=20a5f6a402

RHC Training Modules

On August 22, 2017 CMS published RHC and FQHC Basic Training Online Course (RFBTOC) which is a series of training modules for RHC inspectors or new RHCs. The course will take approximately 25 hours to complete. Rural Health Clinics (RHC) are required to comply with the Federal requirements set forth in the Medicare Conditions for Certification/Conditions for Coverage in order to receive Medicare and/or Medicaid payment. The goal of an RHC survey complaint survey is to determine whether the RHC complies with its applicable Conditions of Participation at 42 CFR, Subpart A. The link to find the RHC survey training course is as follows:


Rural Health Clinic

How are RHCs Paid

Actual Medicare Payment
RHCs may be either Independent or Provider-based.

**Reimbursement Differences between Independent and Provider-based RHCs**

- **Independent RHCs**
  - Payment capped at $83.45
  - Use Form 222
  - Owned by physicians, NPs, PAs, or even hospitals.

- **Provider-based RHCs**
  - Payment capped at $83.45 except for less than 50 beds
  - Use Form 2552, M-Series of the cost report
  - Owned by the hospital

**Payment Differences for RHCs**

1. They are paid on a cost per visit basis.
2. They file Medicare Cost Reports.
3. Medicaid Rates are based upon cost.
4. The cost per visit is not all-inclusive.
5. Some services are still paid fee for service:
   - A. Lab (minus CPT 36415)
   - B. Radiology
   - C. Hospital

**Advantages of RHCs**

- Enhanced Medicaid Reimbursement
- No payment reductions for NPs, PAs, CNMs. No MACRA reductions.
- Provider-based RHC > 50 beds are paid at cost.

**What are the Medicare RHC Payment Rates?**

<table>
<thead>
<tr>
<th>Type</th>
<th>Cap</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent RHC</td>
<td>83.45</td>
<td>$65.75</td>
</tr>
<tr>
<td>Provider-based RHC &lt; 50 beds (2015) CAH</td>
<td>None</td>
<td>Mean Cost= $164.36</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mean Payment = $129.85</td>
</tr>
</tbody>
</table>

Medicare pays 80% minus 2% sequestration.
Comparison of Total Medicare Payments

<table>
<thead>
<tr>
<th>Type</th>
<th>Charge</th>
<th>Copayment</th>
<th>Medicare</th>
<th>Total Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>$125</td>
<td>$25*</td>
<td>$64.52</td>
<td>$89.52</td>
</tr>
<tr>
<td>Provider-based (less than 50 beds)</td>
<td>$125</td>
<td>$25*</td>
<td>$140.30</td>
<td>$165.30</td>
</tr>
</tbody>
</table>

*No Par limits

Are RHC Services Part A or B

Claims are paid through Part A

The money comes from the Part B Trust Fund. Patients receive all Part B benefits.

REGULATORY UPDATES AND PROPOSED REGULATIONS

RHCS ARE BEING ATTACKED FROM ALL SIDES

RHC Modernization Act of 2018 – What does it do?

1. Raising the Cap on Rural Health Clinic Payments. Increases the upper limit (or cap) on RHC reimbursement to: $110 in 2017 - $105 in 2020 - $110 in 2021 - $115 in 2022. And by MEL each year thereafter. Provision could cost as much as $39 million over next 16 years.

2. Allowing Rural Health Clinics to be the Distanc Site for a Telehealth Visit. Allows RHCS to offer telehealth services as the distant site (where the provider is located) and bill for such telehealth services as RHC visits.

WHY IT IS POSSIBLE THAT INDEPENDENT RHCS MAY GET AN INCREASE

New to RHC/ Beginner/Basics of RHCS

www.ruralhealthclinic.com
CMS Administrator Seema Verma:

Medicare pays for things differently based on the site of care, paying more or less for the same service, but different locations. Now, sometimes it makes sense, as some facilities provide a higher level of service. But other times, it creates misaligned incentives – decisions about whether a patient receives a service in a hospital or in a doctor's office is influenced by how Medicare pays.

Because when we pay more for services provided in a hospital setting than in an office setting, we are discouraging the consolidation of providers around hospital systems. When consolidation gets to the point where there is only one large competitor in a market, prices will go up and the competitive forces that encourage higher quality and lower costs will disappear.

The same market shifts that caused Congress to begin this move to site neutral payment policy is occurring in the RHC space.

To date, RHCs have been exempt from this policy; however, we believe it is inevitable that Congress will seek to apply the site-neutral policy to all hospital-based providers, including RHCs.

We have endorsed a policy that we should move to a single, uniform CAP that would be applicable to all RHCs. This new cap MUST be significantly higher than the current cap ($83,451) and must result in a payment level that is sufficient to cover the cost of delivering care for MOST unsupervised RHCs, allowing them to remain economically viable.

THE SHIFT TO PROVIDER-BASED RHCS

PROVIDER-BASED RHC VISIT PERCENT HAS GROWN
RHC EXPENDITURES/PROVIDER-BASED/INDEPENDENT

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<td>560</td>
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<td>640</td>
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<td>720</td>
<td>740</td>
<td>760</td>
<td>780</td>
<td>800</td>
<td>820</td>
<td>840</td>
</tr>
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Selected U.S. Consumer Goods and Services, and Regions

THE MEDICARE ECONOMIC INDEX DOES NOT REFLECT THE ACTUAL COST INCREASES IN PROVIDING MEDICAL SERVICES.

Some Clinics may be better off not being a RHC
RHCs are nearer and nearer to the tipping point or the point were being a rural health clinic for Medicare purposes is no longer an advantage for most physician practices.

RHC EXPENDITURES/PROVIDER-BASED/INDEPENDENT

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MEDICARE RHC PAYMENT PER VISIT

RHC Medicare Payment Per Visit

RHC and FQHC Payment Limits Per Visit Over the Past 10 Years
The CY 2019 Medicare Physician Fee Schedule Proposed Rule with comment period was placed on display at the Federal Register on July 12, 2018. This proposed rule updates payment policies, payment rates, and other provisions for services furnished under the Medicare Physician Fee Schedule (PFS) on or after Jan. 1, 2019.

This proposed rule proposes potentially misvalued codes, adds procedures to the telehealth list and other policies affecting the calculation of payment rates. This proposed rule includes a number of new proposals, including a proposal to change documentation, coding and payment to reduce administrative burden and improve payment accuracy for office/outpatient Evaluation and Management visits, and a proposal to pay separately for two newly defined physicians' services furnished using communication technology.

CMS will accept comments on the proposed rule until September 10, 2018, and will respond to comments in a final rule. The proposed rule can be downloaded from the Federal Register at: https://www.federalregister.gov/public-inspection.

Effect of Proposed E and M Payment Changes

<table>
<thead>
<tr>
<th>CPT 99213</th>
<th>RHC</th>
<th>PFS Physician</th>
<th>PPSA</th>
<th>HPSA</th>
</tr>
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<tbody>
<tr>
<td>Charge</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>Payment (including co-pay)</td>
<td>$88</td>
<td>$93</td>
<td>$93</td>
<td>$93</td>
</tr>
<tr>
<td>Reduction for NPPA</td>
<td>$8</td>
<td>$8</td>
<td>$14</td>
<td>0</td>
</tr>
<tr>
<td>NPPA 10%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Payment</td>
<td>$88</td>
<td>$93</td>
<td>$79</td>
<td>$102</td>
</tr>
</tbody>
</table>

If an RHC charged $135 it would not net the same as FFS ($93)

2019 Proposed Changes to the CCM program for RHCs

1. Revision to Payment for Care Management Services (HCPCS code G0511) Up to around $65.

Proposed Payment for Office/Outpatient Based EM Visits

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<td>$102</td>
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Proposed Requirements

1. At least 5 minutes of communications-based technology or remote evaluation services
2. Furnished by an RHC practitioner
3. To a patient that has been seen in the RHC within the previous year
Proposed Requirements

- May be billed when the medical discussion or remote evaluation is for a condition not related to an RHC service provided within the previous 7 days, and
- Does not lead to an RHC service within the next 24 hours or at the soonest available appointment (since in those situations the services are already paid as part of the RHC AIR).

Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction

This rule would produce an additional $1.12 billion in savings every year, on top of savings already achieved as part of the Patients Over Paperwork initiative that we started last year. Between 2018 and 2021, CMS now projects the Patients Over Paperwork Initiative to eliminate more than 53 million hours of burden for providers and save our healthcare system close to $3.2 billion.


Palmetto Asks for $60 Million back due to Cahaba GBA not checking Medicare Advantage Enrollment

A proposed rule would take steps to help CMS recover improper payments made to Medicare Advantage organizations. CMS conducts Risk Adjustment Data Validation audits to confirm that diagnoses submitted by Medicare Advantage Organizations for risk adjusted payments are supported by medical record documentation. CMS recovers improper payments based on these audits. The proposed rule would strengthen CMS's ability to return dollars to the Medicare Trust Funds as a result of these audits. If finalized, the proposed changes would result in an estimated $4.5 billion in savings to the Medicare Trust Funds over a ten-year period, largely from the recovery of improper payments to Medicare Advantage plans.

What we have heard lately

NEW INTERPRETATIVE GUIDELINES RELEASED

CMS released a long update to SOM Appendix G Interpretative Guidelines for RHCs (Appendix G was updated in January, 2018) Here is the link to this 93 page PDF.


While not legally binding, it can be used by surveyors to justify non-compliance.
Changes to Survey due to the Interpretative Guidelines

The NARHC met with CMS to get certain things changed and succeeded on these:

1. Physician responsibility to review all records
2. Clinical policies must be developed by one physician, NP, or PA outside the RHC
3. Rural Health Clinics must stocks costly drugs and biologicals such as snake antivenin (there was typically thrown out (will need an antidote)
4. CMS would not agree to change the following:
5. Survey team must include a registered nurse
6. Surveyors must witness a visit
7. Medical Director must practice in the RHC (1 visit per year minimum

Changes to the annual Evaluation

Snake Venom Antidote

Snake Venom Antiserum

Questions, Thank You

marklynrhc@gmail.com
www.ruralhealthclinic.com
RHC Update – Regulatory and Legislative Issues

Legislative Update ~ Senate Finance Hearing

Senator Wyden “We have been at it for almost two and a half hours. You all have been terrific, but what I am struck by is I don’t think we have mentioned, over the course of two and a half hours, what is really the backbone of rural health care. Literally, from sea-to-shining-sea, and that is RURAL HEALTH CLINICS…”

CMS has proposed reducing the reporting requirements for RHCs.

1. Changing the annual review of patient care policies and program evaluations to an every other-year requirement.
2. Allowing facilities to review their Emergency Preparedness program every other year instead of every year.
3. Eliminating the requirement that RHCs must document their communication with emergency preparedness officials.
4. Allowing facilities to train their staff on emergency preparedness every other year.
5. Reducing the number of emergency preparedness exercises required per year to one.

RHC Modernization Act of 2018 – What does it do?

Raising the Cap on Rural Health Clinic Payments. Increases the upper limit (or cap) on RHC reimbursement to: -$100 in 2019 -$105 in 2020 -$110 in 2021 -$115 in 2022 -And by MEI each year thereafter. Provision could cost as much as 539 million over next 10 years.

Allowing Rural Health Clinics to be the Distant Site for a Telehealth Visit. Allows RHCs to offer telehealth services as the distant site (where the provider is located) and bill for such telehealth services as RHC visits.
CMS released a long update to SOM Appendix G

Interpretative Guidelines for RHCs (Appendix G was updated in January, 2018) Here is the link to this 93 page PDF.


While not legally binding, it can be used by surveyors to justify non-compliance

The NARHC met with CMS to get certain things changed and succeeded on these

1-Physician responsibility to review all records

2-Clinical policies must be developed by one physician, NP, or PA outside the RHC

3-Rural Health Clinics must stock costly drugs and biologicals such as snake antidote that are typically thrown out

CMS would not agree to change the following

4-Survey team must include a registered nurse

5-Surveyors must witness a visit

6-Medical Director must practice in the RHC
Proposed Rate Increase for CCM in 2019

Proposed payment methodology for HCPCS code G0511 would be the average of the 4 national non-facility PFS payment rates for

- CPT 99490 (20 minutes or more of CCM services)
- CPT 99487 (60 minutes or more of complex CCM services)
- CPT 99484 (20 minutes or more of BHI services)
- CPT 994X7 (30 minutes or more of CCM furnished by a physician or other qualified health care professional)

• Proposed payment rate for 994X7 is $74.26 • Average of the four is around $65

2019 Physician Fee Schedule – Communication Technology Based Services

• At least 5 minutes of communications-based technology or remote evaluation services

• Furnished by an RHC practitioner

• To a patient that has been seen in the RHC within the previous year

• May be billed when the medical discussion or remote evaluation is for a condition not related to an RHC service provided within the previous 7 days, and

• Does not lead to an RHC service within the next 24 hours or at the soonest available appointment (since in those situations the services are already paid as part of the RHC AIR)

New Virtual Communications G code for use by RHCs (and FQHCs) only

• Payment rate set at the average of the PFS national non-facility payment rates for HCPCS code GVCI1 (communication technology-based services) and HCPCS code GRAS1 (remote evaluation services)
• Payment around $14

• Many of the details will need to be worked out in final rule and accompanying guidance from CMS

Payment rate would be around $14

MACRA – Does it Apply to RHCs?

1. MACRA (Medicare Access and CHIP Re-authorization Act) does it affect RHCs? Mostly NO!!!! Must have more than $90,000 in paid claims to apply
2. We anticipate that most RHCs will not be affected by MACRA
3. MIPS includes a low volume exception – RHCs should qualify
4. APMs vs “Advanced APM models” for the purposes of MACRA
5. Could it affect RHCs in the future?
6. Quality is coming to the RHC program but it is unclear how
Emergency Preparedness – Requirements

Hospitals, Critical Access Hospitals, and Rural Health Clinics must comply with all applicable Federal, State and local emergency preparedness requirements. The organization must establish and maintain an emergency preparedness program that includes, but is not limited to:

1. An Emergency Plan that is reviewed and updated annually.
2. An Emergency Plan that is based on a documented, facility- and community-based risk assessment.
3. A Communication Plan that complies with Federal, State and local laws and must be reviewed and updated annually.
4. Emergency preparedness training of all new hospital personnel, volunteers and individuals providing services under arrangement; training is to be repeated annually.
5. Testing of the emergency plan at least annually.
6. Policies and procedures that address, but are not limited to:
   • Evacuation or provision of shelter for patients
   • Food, water, medical, and pharmaceutical supplies
   • Alternate sources of energy
   • Emergency lighting
   • Fire detection, extinguishing, and alarm system
   • A system of medical documentation that preserves patient information and protects confidentiality of patient information

Please click the link below to learn more about this regulatory requirement:


Emergency Preparedness

• NEW regulations as of 2017! • Implementation Date Nov. 15th 2017

§491.12 (b) Policies and Procedures

• Policies/procedures must be updated annually

Healthcare Business Specialists
Specializing in RHC reimbursement
Suite 214 502 Shadow Parkway  Chattanooga, TN 37421
Email: marklynrhc@gmail.com
Website: www.ruralhealthclinic.com
Telephone: (423) 243-6185
• Policy on evacuation w/ exit signs, staff responsibility and a means to shelter in place

System to preserve patient info §491.12 (c) Communication Plan

• Must be updated annually

• Include contact info for all staff, contractors, physicians, volunteers, gov't emergency preparedness staff, other RHCs, etc.

• Must include primary and alternate means of communication with all

• Info about the condition of RHC and patients

• Info about ability of the RHC to provide assistance

§491.12 (d) Training and Testing

• Yearly training all staff and contractors

• Yearly full-scale community-based exercise
Rural Health Clinic Introduction

1. What is a rural health clinic?
   a. Is a certification from CMS that allows physician practices to qualify for cost-based reimbursement from Medicare and Medicaid.
   b. May be either independent or provider-based.
      i. Independent is owned by physicians, non-profits, or even hospitals.
         1. Reimbursement is capped at $83.45 in 2018
         2. Uses the Form 222 Cost Report Form
         3. Bills use the UB-04 Form for billing Medicare services.
      ii. Provider-Based is owned by hospitals and meets the provider-based criteria (location, common governance, common medical direction, financially integrated, etc.)
         1. Reimbursement is not limited to $83.45 per visit if the hospital has less than 50 beds (not licensed, but beds that could be operational within a 24 hour period of time); otherwise, the Medicare rate is limited to $83.45.
         2. Uses the UB-04 for billing Medicare services.
   c. Must meet 9 conditions of participation including location in a non-urban area and in a medical shortage area.
## Citation Frequency Report

### Selection Criteria
- **Display Options:** Display all results
- **Provider and Supplier:** Rural Health Clinics
- **Type(s):** National
- **Year Type:** Fiscal Year
- **Year:** 2018
- **Quarter:** Full Year

### Tag Table

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<th>Tag Description</th>
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<th>% Surveys Cited</th>
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Totals represent the # of providers and surveys that meet the selection criteria specified above.

Active Providers = 4453
Total Number of Surveys = 797

Source: CASPER (10/22/2018)
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Source: CASPER (10/22/2018)
October 29, 2018

PRESIDENT TRUMP SIGNS LEGISLATION TO COMBAT OPIOID CRISIS

On October 24th, President Trump signed into law the “SUPPORT for Patients and Communities Act.” This legislation represents the culmination of bipartisan efforts to combat the opioid crisis gripping our country. In an otherwise partisan environment, the SUPPORT for Patients and Communities Act passed the Senate (98 to 1) and the House (396 to 14) with overwhelming bipartisan majorities.

The legislation contains a wide array of policy changes and is the combination of many smaller pieces of legislation all aimed at different aspects of the opioid epidemic. Majority Leader McConnell described the legislation on the Senate floor as “the collaborative product of contributions from 70-plus members of this body. Five different committees had a say. The result is a landmark package that will deliver critical resources to establish opioid-specific recovery centers and equip local medical practitioners. It will help law enforcement stop the flow of opioids across borders and increase safeguards against over prescription.”

Despite strong support in Congress, some critics charge the legislation does not go far enough. Senator Elizabeth Warren (D - MA), supported the final package but noted in her statement that “Congress could have gone further in providing communities with the resources they need to address the epidemic, I supported this bill because it makes some common-sense changes that will help us in our fight against the opioid crisis.”

There is one provision specifically directed towards Rural Health Clinics in the bill. Section 6083 of the legislation designates two million dollars for RHCs to cover the costs of practitioners obtaining a “DATA 2000 Waiver.” Physicians or practitioners need this waiver to administer buprenorphine as part of an opioid dependency treatment plan.

Physicians or practitioners who are interested in practicing opioid dependency treatment, must follow the waiver process and undergo the required training as described here.

The details about how RHC physicians or practitioners can apply for the grant, including the total amount of the grant payment, will be promulgated in forthcoming rulemaking by the Secretary of Health and Human Services. We expect that RHCs will be able to apply for these funds sometime in 2019.

While physicians groups such as the AMA were largely supportive of the opioid legislation, there are a few provisions that concern provider groups. For instance, section 2003 of the law requires that all schedule II, III, IV, and V controlled substances under Medicare part D be prescribed electronically by January 1, 2021. The AMA opposed this mandate on the grounds that it was duplicative with other federal and state prescribing regulations.

Nathan Baugh,
Nathan.Baugh@narhc.org
(202) 543-0348
CMS Finalizes Changes to Advance Innovation, Restore Focus on Patients

Changes to the Medicare Physician Fee Schedule and Quality Payment Program will shift clinicians’ time from completing unnecessary paperwork to providing innovative, high-quality patient care.

“The historic reforms CMS finalized today move us closer to a healthcare system that delivers better care for Americans at lower cost,” said Health and Human Services (HHS) Secretary Alex Azar. “Among other advances, improving how CMS pays for drugs and for physician visits will help deliver on two HHS priorities: bringing down the cost of prescription drugs and creating a value-based healthcare system that empowers patients and providers.”

“Today’s rule finalizes dramatic improvements for clinicians and patients and reflects extensive input from the medical community,” said CMS Administrator Seema Verma. “Addressing clinician burnout is critical to keeping doctors in the workforce to meet the growing needs of America’s seniors. Today’s rule offers immediate relief from onerous requirements that contribute to burnout in the medical profession and detract from patient care. It also delays even more significant changes to give clinicians the time they need for implementation and provides time for us to continue to work with the medical community on this effort.”

Coding requirements for physician services known as “evaluation and management” (E&M) visits have not been updated in 20 years. This final rule addresses longstanding issues and also responds to concerns raised by commenters on the proposed rule. CMS is finalizing several burden-reduction proposals immediately (effective January 1, 2019), where commenters provided overwhelming support. In response to concerns raised on the proposal, the final rule includes revisions that preserve access to care for complex patients, equalize certain payments for primary and specialty care, and allow for continued stakeholder engagement by delaying implementation of E&M coding reforms until 2021.

For the first time this rule will also provide access to “virtual” care. Medicare will pay providers for new communication technology-based services, such as brief check-ins between patients and practitioners, and pay separately for evaluation of remote pre-recorded images and/or video. CMS is also expanding the list of Medicare-covered telehealth services. This will give seniors more choice and improved access to care.

CMS is also finalizing an overhaul of electronic health record (EHR) requirements in order to focus on promoting interoperability. Today’s rule finalized changes to help make EHR tools that actually support efficient care instead of hindering care. Final policies for Year 3 of the Quality Payment Program, part of the agency’s implementation of MACRA, will advance CMS’s Meaningful Measures initiative while reducing clinician burden, ensuring a focus on outcomes, and promoting interoperability. CMS also introduced an opt-in policy so that certain clinicians who see a low volume of Medicare patients can still participate in the Merit-based Incentive Payment System (MIPS) program if they choose to do so. In addition, CMS is providing the option for clinicians who are based at a healthcare facility to use facility-based scoring to reduce the burden of having to report separately from their facility.

To view the CY 2019 Physician Fee Schedule and Quality Payment Program final rule, please visit: [https://www.federalregister.gov/public-inspection/](https://www.federalregister.gov/public-inspection/)


###
### E&M Payment Amounts

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<td>Revised Payment Amount***</td>
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*This is not a new code. The current prolonged service code, describing 60 minutes of additional time but billable after 31 minutes of additional time, is only billed approximately once per one thousand visit codes reported. It is paid at approximately $133.

Physician groups have routinely complained to CMS that billing prolonged with any regularity tends to prompt medical review and is ultimately cost-prohibitive.

**In cases where one could bill both the primary and specialized care add-on, there would be an additional $13.

***The dollar amounts included in this projection are based on 2019 payment rates; actual amounts in 2021 when the policy takes effect will differ.
New Primary Care Complexity Code:
Visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services (Add-on code, list separately in addition to level 2 through 4 office/outpatient evaluation and management visit, new or established)

New Non-procedural Specialty Care Complexity Code:
Visit complexity inherent to evaluation and management associated with non-procedural specialty care including endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, interventional pain management, cardiology, nephrology, infectious disease, psychiatry, and pulmonology. (Add-on code, list separately in addition to level 2 through 4 office/outpatient evaluation and management visit, new or established)

New Extended Visit Code:
Extended time for evaluation and management service(s) in the office or other outpatient setting, when the visit requires direct patient contact of 34-69 total face-to-face minutes overall for an existing patient or 38-89 minutes for a new patient (List separately in addition to code for level 2 through 4 office or other outpatient Evaluation and Management service)

Existing Prolonged Services Code:
Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management or psychotherapy service)
Emergency Preparedness and Annual Evaluations
Why do we have these new Emergency Preparedness Rules?

The difference between an Emergency and a Disaster is often Preparation. Katrina is cited as an example.

Compliance Deadlines for RHCs

Facilities were expected to be in compliance with the requirements as of 11/15/2017.

In the event facilities are non-compliant, the same general enforcement procedures will occur as is currently in place for any other conditions or requirements cited for non-compliance.

Source: CMS MLM Webinar

CMS will follow the normal inspection schedule for RHCs. There will not be special inspections for Emergency Preparedness.

The New Emergency Preparedness Plans Began being Enforced on 11/15/2017

Emergency Preparedness Timeline

17 Provider Types and 72,000 providers are affected by these regulations

- If you have a CCN Number you must comply.
- RHCs must comply.
- Physician offices do not.

Why is Emergency Preparedness important?

Adds a Condition of Participation

- Is a Condition Level Deficiency. (You can be terminated - Lose Medicare Certification)
- Is time consuming and costly to implement.

What are the Goals and Objectives of EP

Emergency Preparedness (EP) will be Time Consuming and Costly

10/5/2016 Emergency Preparedness Requirements MLN Connects*
Call 10/5/16

10/6/2016 10 Keys to Healthcare Emergency Planning

3/10/2014 Understanding the Proposed Rule on Emergency Preparedness

3/7/2017 CMS Emergency Preparedness: Local Community Guidelines

START HERE! Emergency Preparedness Videos

<table>
<thead>
<tr>
<th>Date</th>
<th>Title</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/5/2016</td>
<td>Emergency Preparedness Requirements MLN Connects*</td>
<td><a href="https://www.youtube.com">https://www.youtube.com</a></td>
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<tr>
<td>3/7/2017</td>
<td>CMS Emergency Preparedness: Local Community Guidelines</td>
<td><a href="https://www.youtube.com">https://www.youtube.com</a></td>
</tr>
<tr>
<td>10/6/2016</td>
<td>10 Keys to Healthcare Emergency Planning</td>
<td><a href="https://www.youtube.com">https://www.youtube.com</a></td>
</tr>
</tbody>
</table>
Updated Appendix G Interpretative Guidelines for RHCs (90 page PDF)

Updated Interpretative Guidelines for RHCs were released in January, 2018
- Nothing on Emergency Preparedness
- Must have Snake Venom?
- Must review 5% of charts or minimum 50 charts for Annual Evaluation?


AAAASF Updated Accreditation Standards Updated in 2017

AAAASF updated their Standards to include Emergency Preparedness in 2017. See Page 42 through 47 for the new standards.


The Compliance Team Issues EP Standards in July, 2017


Appendix Z Interpretative Guidelines

On June 2, 2017, CMS released Appendix Z which is the Interpretative Guidelines for Emergency Preparedness. (All 17 provider types are included)


EP Basic Surveyor Training Course

https://surveysurveytraining.cms.hhs.gov/pubs/ClassInformation.asp?id=007EMPrep_ONL
Emergency Preparedness

Emergency Preparedness Program: The Emergency Preparedness Program is a facility's comprehensive approach to meeting the health and safety needs of their patient population and provides facilities with guidance on how to respond to emergency situations that could impact the operation of the facility, such as natural or man-made disasters. It includes (1) all-hazards risk assessment and emergency planning, (2) development and implementation of policies and procedures, (3) a communication plan, and (4) training and testing. The program as a whole consists of the Emergency Plan, which is based on the four core elements.

Step One – Complete a Hazards Vulnerability Assessment

Definitions of Key Terms


Hazard Vulnerability Assessments (HVAs)

Hazard Vulnerability Assessments (HVAs) are systematic approaches to identifying hazards or risks that are most likely to have an impact on a healthcare facility and the surrounding community. The HVA describes the process by which a provider or supplier will assess and identify potential gaps in its emergency plan(s). Potential loss scenarios should be identified first during the risk assessment. Once a risk assessment has been conducted and an facility has identified the potential hazards/risks they may face, the organization can use those hazards/risks to conduct a Business Impact Analysis.

Tools from https://www.ruralhealthclinic.com/emergency-preparedness

Kaiser Risk Assessment Tools
Kaiser Risk Assessment Instructions from Tabletop Exercise (CMS All Hazards FAQ 42 pages)

Kaiser Permanente has developed a revised Hazard Vulnerability Analysis tool and instruction sheet.
Four Core Elements of Emergency Preparedness

1. Risk Assessment and Emergency Plan

Identify the Following:

- Hazards likely in geographic area (an all hazards approach)
- Care-related emergencies
- Equipment and Power failures (one emergency leads to another)
- Interruption in Communications, including cyber attacks
- Back up communication plans if primary plan fails.

- Loss of all/portion of facility
  - Test your generator for 4 hours at full 100% power annually.
  - Back up communication plans if primary plan fails.
- Loss of all/portion of supplies
- Plan is to be reviewed and updated at least annually
- Risk assessment must already be done by local agencies if the RHC responds for using it is included in the ISP Policies.

What is a Risk Mitigation Plan

- Stafford Act - Risk Mitigation

The Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act) is a United States federal law designed to bring an orderly and systematic means of federal natural disaster assistance for state and local governments in carrying out their responsibilities to aid citizens. Congress's intention was to encourage states and localities to develop comprehensive disaster preparedness plans, prepare for better intergovernmental coordination in the face of a disaster, encourage the use of insurance coverage, and provide federal assistance programs for losses due to a disaster.

Local communities and jurisdictions are required to have a Risk Mitigation plan updated every five years. Search for these plans to aid in our planning.

Morgan County - Risk Mitigation

<table>
<thead>
<tr>
<th>Hazards</th>
<th>Mitigation Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Floods</td>
<td>Evacuation plans</td>
</tr>
<tr>
<td>Earthquakes</td>
<td>Structural improvements</td>
</tr>
<tr>
<td>Tornadoes</td>
<td>Tornado shelters</td>
</tr>
<tr>
<td>Landslides</td>
<td>Landslide mitigation</td>
</tr>
<tr>
<td>Storms</td>
<td>Storm shelters</td>
</tr>
<tr>
<td>Floods</td>
<td>Flood barriers</td>
</tr>
</tbody>
</table>

All Hazards Risk Assessment

A comprehensive risk assessment is conducted to identify potential hazards, assess the likelihood of occurrence, and determine the impact on the facility and its operations.
Poll Question 3 – Community Hazards

Which natural hazards pose the largest threat to the clinic based upon your assessment?

A. Flood
B. Fire
C. Storms
D. Tornado
E. Other

Four Core Elements of Emergency Preparedness – 2. Policies & Procedures

Policies and procedures. The RHC must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.

At a minimum, the policies and procedures must address the following:

1. Safe evacuation from the RHC, which includes appropriate placement of exit signs; staff responsibilities and patient needs.
2. A means to shelter in place for patients, staff, and volunteers who remain in the facility. (Not required to maintain food, water, etc.)
The Regulations are not one size fits all.

Communication Plan - Continued

(2) Contact information for the following:
   (i) Federal, State, tribal, regional, and local emergency preparedness staff.
   (ii) Other sources of assistance.

(3) Primary and alternate means for communicating with the following:
   (i) RHC staff.
   (ii) Federal, State, tribal, regional, and local emergency management agencies.

Four Core Elements of Emergency Preparedness

4. Training & Testing

(1) Testing.
   The RHC must conduct exercises to test the emergency plan at least annually. The RHC must do the following:
   (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the RHC experiences an actual natural or man-made emergency that requires activation of the emergency plan, the RHC is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

Four Core Elements of Emergency Preparedness

4. Training & Testing (2)

(1) Training program.
   The RHC must do all of the following:
   (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
   (ii) Provide emergency preparedness training at least annually.
   (iii) Maintain documentation of the training.
   (iv) Demonstrate staff knowledge of emergency procedures.

Four Core Elements of Emergency Preparedness

4. Training & Testing (3)

(1) Conduct an additional exercise that may include, but is not limited to following:
   (A) A second full-scale exercise that is community-based or individual, facility-based.
   (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
Employee Training – Initial Testing

We have developed a 10-question test for all employees with an answer key and a place to obtain communication plan information. See Handouts.

Full-Scale & Facility-Based Exercises

Lessons Learned: If you are having a drill ensure that all authorities and participants are informed ahead of time.

TESTING THE PLAN

- Participate in a tabletop exercise (TTX) that is community-based (personally).
- If not feasible, conduct a facility-based exercise.
- Conduct a second formal exercise (can be a TTX) at least annually involving a witness, typically related to emergency scenarios, with limited feedback into the testing of the plan.
- Analyze response to exercise using an After Action Report.
- Use as your action items the fire training priorities over the next year.

Types of Drills

- Tabletop Exercise (TTX): A tabletop exercise involves key personnel discussing simulated scenarios in an informal setting. TTXs can be used to assess plans, policies, and procedures.
- Operations-based Exercises: operations-based exercises validate plans, policies, agreements and procedures, clarify roles and responsibilities, and identify resource gaps in an operational environment. Types of operations-based exercises include:
  - Drills: a coordinated, supervised activity usually employed to test a single, specific operation or function within a single entity (e.g., a fire department conducts a decontamination drill).
  - Functional Exercise (FE): A functional exercise examines and/or validates the coordination, command, and control between various multi-agency coordination centers (e.g., emergency operation center, joint field office, etc.). A functional exercise does not involve any "boots on the ground" (i.e., first responders or emergency officials responding to an incident in real time).
- Full-Scale Exercises (FSE): A full-scale exercise is a multi-agency, multi-jurisdictional, multi-discipline exercise involving functional (e.g., joint field office, emergency operation centers, etc.) and "boots on the ground" response (e.g., firefighters decontaminating mock victims).

Table-Top Exercise

<table>
<thead>
<tr>
<th>Type</th>
<th>IOMA</th>
<th>Multi-agency</th>
<th>Multi-Jurisdiction</th>
<th>Multi-discipline</th>
<th>Harmless</th>
<th>Moderate</th>
<th>Minimal</th>
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<tr>
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<td>FSE</td>
<td>Multi-agency</td>
<td>Multi-Jurisdiction</td>
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<td>Internal</td>
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<td>Minimal</td>
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<tr>
<td>Functional Exercise</td>
<td>FE</td>
<td>Multi-agency</td>
<td>Yes</td>
<td>No</td>
<td>Moderate</td>
<td>Minimal</td>
<td></td>
</tr>
<tr>
<td>Operation Based Drill</td>
<td>None</td>
<td>RHC</td>
<td>No</td>
<td>Yes</td>
<td>Mild</td>
<td>More</td>
<td></td>
</tr>
<tr>
<td>Tabletop Exercise</td>
<td>TTX</td>
<td>RHC</td>
<td>No</td>
<td>Dependant</td>
<td>Mild</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Full-Scale & Facility-Based Exercises

- Full-Scale Exercise: A full scale exercise is a multi-agency, multi-jurisdictional, multi-discipline involving functional (for example, field office, emergency operation centers, etc.) and "boots on the ground" response (for example, firefighters decontaminating mock victims).
- Facility-Based: When discussing the term "all-hazards approach" and facility-based risk assessments, we consider the term "facility-based" to mean that the emergency preparedness program is specific to the facility. Facility-based includes, but is not limited to, hazards specific to a facility based on the geographic location; Patient/Resident/Client population; facility type and potential surrounding community assets (i.e., rural area versus a large metropolitan area).
Table-Top Exercise

Table-top Exercise (TIX): A table-top exercise is a group discussion led by a facilitator, using narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. It involves key personnel discussing simulated scenarios, including computer-simulated exercises, in an informal setting. TTXs can be used to assess plans, policies, and procedures.
Local weather forecasters and the National Weather Service has received confirmation from weather chasers that there is a large tornado heading towards your community. Wind speeds have been estimated at being close to 200 MPH. It was reported that they witnessed large vehicles in its debris cloud. The weather forecasters plead for everyone in the area to take proper precautions and seek shelter. The Warning for your community has been elevated to an Emergency.

Poll Question 6. Tornado Watch

What preparations are taking place when a tornado watch (may last several hours) has been issued?
A. Listen to NOAA Weather Radio, radio or TV for updates.
B. Be alert to changing weather conditions. Look for storms.
C. Follow instructions from local EMA officials.
D. All of the Above.

Poll Question 7 – Tornado Warning

What should occur when a Tornado Warning (tornado cited- 30 minutes or so) is issued?
A. Begin shelter in place procedures.
B. Evacuate the building immediately.
C. Notify the Emergency Management Director.
D. Call 911.
E. Other.
Keep this documentation in your EP Plan

The Elephant in the Room

How do provider-based RHCs and other provider types comply

Facilities with Multiple Locations versus Integrated Health Systems

Q: If multiple sites within the same county, each with separate CCN (such as an RHC/FQHC) exist, does each location need to have its own program risk assessment?

A: Each separately certified facility (separate CCN) must have its own risk assessment.

Determine Needs for Compliance - Multiple Certification

Note: Medicare certified providers are covered by CMS regulations. The CCN is the facility's unique identifier that is assigned by CMS to each provider. Providers that operate multiple sites must register each site with CMS and obtain a separate CCN for each site. The CCN is a unique identifier that is assigned by CMS to each provider. Providers that operate multiple sites must register each site with CMS and obtain a separate CCN for each site.

www.ruralhealthclinic.com
Emergency Preparedness

What is ASPR Tracie

The U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR) sponsors the ASPR Technical Resources, Assistance Center, and Information Exchange (TRACIE).

https://asprtracie.hhs.gov/cmsrule

Note: Think Regional Extension Center for Emergency Preparedness.
The Emergency Preparedness Action Plan

1. Read the Regulations, Resources, Templates & watch NIMV Videos.
2. Document any and all activities that are spent on EP (phone calls)
3. Select an Emergency Preparedness Champion to lead the process and an Executive Team of 3 or more to implement EP.
4. Reach out to the local, CERT, county, state EP officials or coalitions and piggyback off their efforts. Be involved with any drills or tabletops.
5. Conduct the all hazards risk assessment or use the one obtained in 4. if appropriate.
6. Prepare your Emergency Plan to address the most common hazards.
7. Prepare your Emergency Policy and Procedures implementing EP.
8. Prepare your Communication Plan including how to contact people.

The Emergency Preparedness Action Plan (2)

10. Train volunteers (spouses or immediate family in smaller RHCs) on HIPAA, OSHA, and the Emergency Plan.
11. Participate in a community-wide drill or a facility-drill if one is not available. Write up any lessons learned from the drill.
12. Participate in another community-wide drill or facility-drill or conduct a tabletop exercise instead. (Recommended)
13. Review, Update and authorize changes to the EP, EPP, and CP yearly.

A Vinyl Guide to Emergency Procedures is a good idea

Get Started. This will take Time!!!
CMS requirements for November 2017

1. The clinic must have an emergency preparedness program that addresses an emergency on-site, off-site (natural disaster) and disruption of service. This program must comply with all applicable Federal, State and local emergency preparedness requirements.

2. The clinic must develop and maintain an emergency preparedness plan that is reviewed and updated annually.
   a. The emergency preparedness plan must contain the following elements:
      i. A documented, clinic-based and community-based risk assessment that utilizes an all hazards approach.
      ii. Strategies for addressing emergency events identified by the risk assessment.
      iii. Addresses patient population, including, but not limited to, the type of services the clinic has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.
      iv. A process for cooperation and collaboration with local, tribal, regional, State and Federal emergency preparedness official's efforts to maintain an integrated response during a disaster or emergency, including documentation of the clinic's efforts to contact such officials and when, applicable, of its participation in collaborative and cooperative planning efforts.

3. The clinic must develop and implement emergency preparedness policies and procedures that are based on its emergency preparedness plan, risk assessment, and communication plan.
   a. The policies and procedures are reviewed and updated, at a minimum annually.
   b. The policies and procedures include the following elements:
      i. Safe evacuation from the clinic, which includes appropriate placement of exit signs, staff responsibilities and needs of patients.
      ii. A means to shelter in place for patients, staff, and volunteers who remain in the clinic.
      iii. A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of patient health records.
      iv. The use of volunteers in an emergency or other staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.
      v. How refrigerated/frozen medications such as vaccines, etc. are handled in a power outage.
4. The clinic develops and maintains an emergency communication plan that complies with Federal, State and Local laws.
   a. The clinic’s emergency preparedness communication plan is reviewed and updated, at a minimum, annually.
   b. The clinic’s communication plan includes the following elements:
      i. Names and contact information for the following:
         1. Staff
         2. Entities providing services under arrangement.
         3. Patient’s physicians.
         4. Other RHCs
         5. Volunteers
      ii. Contact information for the following:
         1. Federal, State, tribal, regional, and local emergency preparedness staff.
         2. Other sources of assistance
      iii. Primary and alternate means for communicating with the following: (§491.12(c)(3)
         1. RHC
         2. Federal, State, tribal, regional, and local emergency management agencies.
      iv. A means of providing information about the general condition and location of patients under the facility’s care as permitted under
      v. A means of providing information about the clinic’s needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee.
      vi. An organized process for handling an on-site emergency which addresses the following:
         1. How employees will be notified of emergency
         2. Staff responsible for calling the Fire department
         3. Location of where employees should meet outside the building
      vii. An organized process for handling an off-site emergency) e.g., snowstorm, flood, hurricane, etc.)
         1. How employees will be notified of emergency
         2. Staff responsible for notification and triaging of patient services
         3. Contingency plan that includes alternative provider in the event the clinic cannot service its own patients.

5. The clinic develops and maintains an emergency preparedness training and testing program that is based on the emergency preparedness plan, risk assessment, policies and procedures and the communication plan.
   a. The training and testing program is reviewed and updated, at a minimum, annually.
   i. The training program includes all of the following:
1. Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

2. Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with expected roles.

3. Provide emergency preparedness training, at a minimum, annually.

4. Emergency preparedness training of staff, individuals providing services under arrangement and volunteers is documented. This documentation demonstrates knowledge of emergency procedures.

ii. The Testing Program requires the clinic to conducts exercises that test the emergency preparedness plan, at a minimum annually. The clinic must do the following:

1. Participate in a full-scale exercise that is community-based or when a community-based exercise is not assessable, an individual, facility based. If the clinic experiences an actual natural, or man-made emergency that requires activation of the emergency plan, the clinic is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

2. Conduct an additional exercise that may include, but is not limited to the following:
   a. A second full-scale exercise that is community-based or individual, facility based.
   b. A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
   c. Analyze the clinic's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the clinic's emergency plan, as needed.

6. If a clinic that is part of a healthcare system consisting of multiple separately certified healthcare facilities elects to have a unified and integrated emergency preparedness program, the clinic may choose to participate in the healthcare system's coordinated emergency preparedness program.

   a. If the clinic elects to participate in the healthcare system's emergency preparedness plan, the unified and integrated emergency preparedness program must do all of the following: (§491.12(e))
i. Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program. (§491.12(e)(1))

ii. Be developed and maintained in a manner that takes into account each separately certified facility’s unique circumstances, patient populations, and services offered. (§491.12(e)(2))

iii. Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance with the program.

iv. Include a unified and integrated emergency plan that meets the requirements of 42 CFR 491.12(a)(2), (3), and (4). The unified and integrated emergency plan must also include the all of the following elements

1. A documented community-based risk assessment, utilizing an all-hazards approach.

2. A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.

3. Include integrated policies and procedures that meet the requirements at 42 CFR 491.12(b), a coordinated communication plan, and training and testing programs that meet the requirements at 42 CFR 491.12(c) and 42 CFR 491.12(d).
Regional HPCs
TAB 4

Medicare Cost Reporting
Helpful Tips on Preparing Your Next Cost Report
Fall, 2018

Contact Information
Dani Gilbert, CPA
RHC Consultant
Healthcare Business Specialists
Suite 214, 502 Shadow Parkway
Chattanooga, Tennessee 37421
Phone: (423) 650-7250
dani.gilbert@outlook.com
www.ruralhealthclinic.com

RHC Information Exchange Group on Facebook
Join this group to post or ask questions regarding RHCs. Anyone is welcome to post about meetings, seminars, or things of interest to RHCs
https://www.facebook.com/groups/1503414633296362/

Cost Report Update
So after all that hard work it’s time to start preparing for next Christmas... cost reports

www.ruralhealthclinic.com
Electronic Filing of Cost Reports

“What in the Sam Hill is that?”

Electronic Filing of RHC Cost Reports

Currently 50,000 cost reports claiming $200 billion of Medicare funds are filed annually to 12 different MACs

Effective July 2, 2018 Cost Reports may be filed by the following methods:

1. Via mail or express delivery services
2. Via MCREF portal in the EDM system

Electronic filing is not Required

Electronic Filing Details

MCREF - a new application allows you to electronically transmit (e-File) your Medicare Cost Report

- Available as of 5/1/2018
- Usage is optional. Mail and hand-delivery remain filing options.
- Accessible by your EDM (Enterprise Identity Management System) PS&R Security Official (SO) and Backup Security Official (BSO)
- Your MAC will have access to e-filed cost report materials

MCREF (M-Cref) Detailed Overview

System Login: https://mcref.cms.gov

- Access is controlled by EDM
- Restricted to EDM PS&R SO / BSO
- Existing PS&R SOS / BSOS already have access
- Any organization without access to PS&R must register a PS&R SO with EDM.

EIDM: Change Password FAQ

Q: How do I change my SP0T/EIDM password, and how often do I need to change it?

As the user of the EIDM portal, every 60 days you must change your password. You may change your password as well as your personal information associated with your Enterprise Identity Management (EIDM) account through the My Profile menu on the EIDM website.

Change Password

1. Navigate to CMS EIDM portal: https://ruralhealthclinic.com

Important: Keep a written record of the login and Passwords in the RHC Policy and Procedure Manual at all times since the EDM Security Official may change. You will need to access the system to print the PS and you will need to change the password every 60 days.
Healthcare RHC Cost Reporting

Electronic Signature

- 2018 IPPS final rule issued in August 2017, authorized providers to file with an electronic signature effective for FYEs on or under 12/31/2017.
- Note: IPPS final rule does not change the authorized signatures (CFR §413.24(a)(4)(i)(C)).
- CMS will release new MCR transmission which support e-signature.
- If you use MCR v5 for the paper version which do not yet support e-signature you must:
  - Upload a scanned copy of the certification page via the "Signed Certification Page" link.
  - Mail hard copy of the signed page with a signature signed in ink for your MAC which must be received by the MAC within 10 days of MCR submission.

CMS will release new MCR transmission which support e-signature effective 2018 IPPS final rule issued in August 2017.

Note: Tentative the cost report.

Solution:

1. Obtain or maintain access to the EIDM system.
2. Assign your cost report preparer as the authorized cost report filer.
3. Do not expect changes in the cost report filing process until RHCs obtain approval for Electronic Signature.

RHCs are NOT eligible for Electronic Signature - RHCs require a Wet Signature

RHCs have to be registered in EIDM and obtain their own P & R. Cahaba was excellent at allowing cost report preparers to request P & R for clients. That is not the case with Palmetto.

Rate setting for new RHCs is extremely slow so far and communication on how to get rates set has been extremely poor.

Palmetto has lost more than their share of cost reports this cost report season and cut off payments when the cost report was timely filed.

Cost Report Updates

Palmetto GBA awarded the JJ Contract from Cahaba in 2017

For interim rate review, provider based determinations and other reimbursement documentation -

JIRC@palmettogba.com

For cost report filing documentation or questions -

JJCOSTREPORT@palmettogba.com

For PS&R requests -

JJPSR@palmettogba.com

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For PS&R requests -

JJPSR@palmettogba.com

Current Cost Report filing issues

Tentative settlement not including preventive visits and creating paybacks. Solution: Always have the cost report preparer review and tentative settlement or adjustment.

Interim payments received reported at $354,000 when they were $35,400 from one MAC. Always review proposed adjustments for errors.

Chronic Care Management Costs are non-allowable. Many RHCs do not realize this and the cost must be excluded from the cost report.

Is Prevnar 13 allowable on the Cost Report?

The CDC released new standards in September, 2014 recommending two doses of Prevnar 13. Can we include this cost on the cost report?

Yes, we asked Cahaba in a webinar in October and she indicated that this expense was allowable. CMS has indicated that two doses are allowable as well. The cost of Prevnar 13 is around $180 per dose and $80 for Prevnar 23.
RHC Cost Report can be divided in 3 sections

<table>
<thead>
<tr>
<th>CR Description- WKS A</th>
<th>CR Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Staff Costs</td>
<td>1-25</td>
</tr>
<tr>
<td>Facility Overhead</td>
<td>26-50</td>
</tr>
<tr>
<td>Non-RHC and Non-Reimb</td>
<td>51-60</td>
</tr>
</tbody>
</table>

Separate General Ledger accounts for Non-allowable Expenses

Certain services may need separate accounting or general ledger accounts.

- A. Laboratory supplies/reagents/licenses
- B. Radiology supplies/film/licenses
- C. EKGs tracing supplies or Part B technical component costs
- D. Any service billed to Part B and there is a supply cost.

Non-RHC Hours - What you have heard?
1. Your going to jail.
2. Its complicated
3. Cost Report Nightmare
4. AIR will go down.

Non-RHC Hours - Reality
1. No one is going to jail
2. Not that hard
3. Cost Report is designed for it.
4. AIR will not go down if done correctly

Keys to making it work
1. Treat everyone the same
2. Keep up with Non-RHC visits
3. Place a sign on the door indicating times

What services can be done during Non-RHC Hours

- 99214 Trigger Point Injections
- 99215 Procedures
- 36415 Allergy Shots
- AWE Nurse Only Visits
- IPPE TCM
RHC Cost Report Mistakes

WHAT COULD POSSIBLY
GO WRONG?

The Provider FTE calculation is important
For Productivity Calculations

<table>
<thead>
<tr>
<th>Provider</th>
<th>Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>4,200</td>
</tr>
<tr>
<td>Physician Assistant</td>
<td>2,100</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>2,100</td>
</tr>
</tbody>
</table>

Other Cost Report Mistakes

Recording Collection or Billing Fees such as Athena as a reduction in net revenue instead of an expense. One clinic almost missed $50,000 of expense in the TennCare Base year.

Not keeping up with provider hours for FTE calculations on Worksheet B and productivity standards.

How to increase Cost Report Payments?

Increase Your CHARGES
MEDICARE ECONOMIC INDEX

An index often used in the calculation of the increases in the prevailing charge levels that help to determine allowed charges for physician services. In 1992 and later, this index is considered in connection with the update factor for the physician fee schedule.

Adjusted Cost Per Visit

<table>
<thead>
<tr>
<th>RHC Characteristic (n)</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Cap</td>
<td>$80.44</td>
<td>$81.32</td>
<td>$82.30</td>
<td>$83.45</td>
</tr>
<tr>
<td>Medicare Economic Index</td>
<td>0.80%</td>
<td>1.10%</td>
<td>1.20%</td>
<td>1.40%</td>
</tr>
</tbody>
</table>

Table 1: Mean Adjusted Cost per Visit for RHCs
Not Paying Salaries to Owners in LLCs and Subchapter S Corps

In Tennessee LLCs and Subchapter S Corps pay a 6.5% franchise tax on profits. This can be avoided by paying salaries for any excess cash flow to the owners.

Plus, Compensation is much easier to prove to Medicare if a W-2 is available to support payments. Some MACs do not understand K-1 income or consider it a return of equity.

Allowability of Physician Owners Table Released by Medicare in July, 2017

Medicare Provider Reimbursement Manual Part I, Chapter 9, Compensation of Owners

Table 907.1

<table>
<thead>
<tr>
<th>Month</th>
<th>Allowable</th>
<th>Non-Allowable</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2017</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>July 2017</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Allowability Table

RHC Cost Reporting

What is a Credit Balance (838) Report?

Providers use the quarterly CMS-838 report to disclose Medicare credit balances. Medicare credit balance is an amount determined to be refundable to Medicare. The CMS-838 is specifically used to monitor identification and recovery of 'credit balances' owed to Medicare. A credit balance is an improper or excess payment made to a provider as the result of patient billing or claims processing errors.

When is the credit balance report due?

A completed CMS-838 must be submitted within 30 calendar days after the close of each calendar quarter.

RHC Cost Reporting

Represents an Invoice to Medicare for services rendered
What is a Medicare Cost Report?
Form 222 - Medicare Cost Report is required by all RHC's to be completed on an annual basis.
If covers a 12-month period of time with some exceptions: You may have up to a 13-month cost report or you may have a short period if you sale the RHC or change ownership including partners.

What comprises the Medicare Settlement?
1. The difference in the interim and final cost per visit.
2. Influenza and pneumococcal injections
3. Medicare Bad debt, and

Why is a Cost Report important?
1. Medicare will not pay you if you do not file a cost report and will ask for any Medicare money paid during the year to be refunded.
2. RHC Medicare and TennCare rates are based upon the cost report.
3. RHCs receive a cost report settlement for flu, pneumonia, bad debts, preventive co-pays/deductibles and rate settlements.
4. You are responsible for preparing the Cost Report accurately and in compliance with Medicare and Medicaid rules.

Mandated Cost Reporting Timeframes

<table>
<thead>
<tr>
<th>Description</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost Report prepared by the clinic and due to Medicare</td>
<td>5 months year-end</td>
</tr>
<tr>
<td>Number of days the MAC has to accept the cost report</td>
<td>30 days</td>
</tr>
<tr>
<td>Number of days the MAC has to pay a tentative settlement</td>
<td>60 days</td>
</tr>
<tr>
<td>Time to final settle cost report</td>
<td>1 year from acceptance</td>
</tr>
</tbody>
</table>


Deadlines for 12/31/2018 Fiscal Year Ends

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To claim Medicare Bad Debt, the bad debt must be written off by the fiscal year-end (usually 12/31)</td>
<td>12/31/2018</td>
</tr>
<tr>
<td>2. Liquidate accrued bonuses or payments to owners</td>
<td>75 days after year-end, March 15, 2019</td>
</tr>
<tr>
<td>3. Liquidate accrued for non-owners</td>
<td>One year after year-end, December 31, 2019</td>
</tr>
<tr>
<td>4. Prevac 13 and 23 - Purchase by 12/31 to cut down your wait for reimbursement</td>
<td>12/31/2018</td>
</tr>
<tr>
<td>5. Sign up with EMIA/SACS for the F S and R</td>
<td>12/31/2018</td>
</tr>
</tbody>
</table>
Steps for Filing the Medicare Cost Report

Step 1. Sign agreements and send retainer
Step 2. Receive Cost Report Checklist from HBS
Step 3. Obtain information from Checklist (P & R)
Step 4. Mail, Fax, Email information to HBS
Step 5. HBS prepares the Report and mails to you.
Step 6. Sign the cost reports and mail to Care/Caid

What to file with Medicare Cost Report

1. Medicare Cost Report – Form 222 (ECR File on USB)
2. Cost Report 339 Questionnaire
3. Medicare Workpapers
4. Trial Balance of expenses that ties to WKS A.
5. Workpapers to support reclassifications or adjustment.
6. How total visits were computed.
7. How Provider FTEs are computed
8. Flu and Pnu logs and invoices
9. P S and R including preventive services
10. Medicare Bad Debt listing in Excel

Authorized Person from the RHC will sign the Cost Reports.

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL, AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR OTHERWISE ILLEGAL, CRIMINAL, CIVIL, AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

What Information will I need to prepare the cost report?

Click the links below to download the reports you need to accumulate your information. These links are on our website at www.ruralhealthclinic.com

- RHC Cost Report Checklist for 2016 Medicare Cost Reports
- P & R - How to obtain the P & R for the Cost Report
- RHC Medicare Cost Report Visit Count Summary in Word Format
We need to know how much you spent!!!

We need your Total Costs
We need at least one of these
1. Financial Statements
2. Trial balance
3. Tax return

How much did you Spend?

1 WE NEED AT LEAST ONE OF THE FOLLOWING ITEMS TO DETERMINE THE TOTAL EXPENSES PAID BY CLINIC DURING THE YEAR. THE REPORTS SHOULD BE FOR THE ENTIRE ACCOUNTING PERIOD WHICH IS TYPICALLY 12 MONTHS.

   a. Accounting trial balance of expenses for the cost report period.
   b. Financial statements from the accountants or QuickBooks expense statements for the cost report period.
   c. Federal Tax returns for the corporation, partnership, or 1040.

For Cost Reporting you must think backwards

Visits

Expenses

Total Visit Counts

2 WE NEED AT LEAST ONE OF THE FOLLOWING (A OR B) TO DETERMINE THE TOTAL PATIENT VISITS OR ENCOUNTERS AND NEED ONE OF THE FOLLOWING.

   a. CPT Frequency report by Provider from your computer system.
   b. Written or manual visit count with physician, physician assistant, and nurse practitioner visits provided.

Remember to provide TOTAL visits from all payer types

1. Medicare
2. Medicaid
3. Insurance
4. Self-pay
5. Charity Care

If you have a face to face encounter with a Provider and a patient, Count it as a visit.

Why are Visits so Important?

Visits are important because
They are the denominator in The cost per visit calculation.
The lower the number the Better.

Do not count 99211 visits, Injections, lab procedures, etc.
Do you have to produce visit reports by payer for the cost report?

1. You do not have to produce reports by payer to prepare the cost report.
2. Medicare provides a P S and R report which summarizes visits and the information needed to complete the cost report.
3. Some state cost reports may require special reports which will require Medicaid visits and payments.

---

Influenza and Pneumococcal is settled on the cost report. And it takes up to Three Years to get your Money!!

1. Do not bill on the UB-04.
2. Include on the cost report.
3. Cahaba says that CMS tells them to limit tentative settlements to 997 for Pneumo and $35 for Influenza.
4. You should get your full cost on final settlement.
5. Make sure to include your invoices to justify your costs.

---

Influenza and Pneumococcal Shot Logs

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>HIC Number</th>
<th>Date of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Smith</td>
<td>4119926540A</td>
<td>12/31/2013</td>
</tr>
<tr>
<td>Steve Jones</td>
<td>2341239030A</td>
<td>12/31/2013</td>
</tr>
<tr>
<td>Ashley Taylor</td>
<td>902149340A</td>
<td>12/31/2013</td>
</tr>
</tbody>
</table>

Medicare Influenza and Medicare Pneumococcal shots should be maintained on separate logs. Pneumo pays around $125 per shot and influenza is $35 or so.

---

W-2s may be required

3. W-2s with the employee's position listed on the W-2 or what the employee did during their employment. Please write the number of hours the employee worked during the year on the W-2 as well and if the employee split time in laboratory or X-Ray.

---

Influenza and Pneumococcal

4. We need all of the following information to claim influenza and pneumococcal reimbursement on the cost report.

a. Medicare logs with patient name & HIC number and date of service for pneumococcal and influenza patients.

b. A count, listing, or log on non-Medicare patients in order for us to determine total flu shots provided.

c. Invoices supporting influenza and pneumococcal purchases during the year. This will help us to determine the cost of the supply cost.

---

EIDM Access - P S and R

Start here first. This takes the longest and is the most confusing. NO MORE CAHABA!!! THIS COULD BE A PROBLEM.
Obtaining the P S and R

Important – Ask for Preventive Charge Report
Report Type: 710 and 715 (Summary) not Detailed

Ask for the P S and R report that has preventive charges on it.

It is a separate report from the P S and R.

It is important to enter these charges as this is where you get your co-pays paid.

Medicare Bad Debt Listing – Write off

Medicare Bad Debts must be written off by the end of the fiscal year to be claimed on the cost report.

Collection efforts must cease.

What can be Medicare Bad Debt?

1. Medicare coinsurance 20% of charges.
3. Billed to the Part A MAC.
4. Nothing else is allowed.
5. Must try to collect for 120 days from first bill.
6. Must treat everyone the same.
7. Do not have to turn over to collection agency.
8. Must be written off in the fiscal year of the cost report.
9. Collection efforts must cease.

IACS to EIDM Transition

Effective February 9, 2015 the existing system for controlling access to the PS&R applications hosted by CMS- IACS (Individuals Authorized for Access to CMS Computer Systems) – will be replaced by EIDM (Enterprise Identity Management).

A Medicare Bad Debt must meet the following Criteria:

1. The debt must be related to a covered service and derived from the Deductible and Coinsurance amounts.
   A. No Fee for Service. IE. Hospital, Technical Components.
   B. No Medicare Advantage plans.
2. The provider must be able to establish that reasonable collection efforts were made.
   A. At least 120 days of first bill.
   B. First Bill as least within 45 to 60 days of service.
   C. Four documented collection efforts made.
3. The debt was actually uncollectible when claimed as worthless.
4. Sound business judgment indicated there was little likelihood of recovery in the future.

Source: 42 CFR 413.89(e)

Capturing the information for Bad Debt

1. Use an Excel Spreadsheet
2. Keep Regular and Crossover Bad Debt in separate spreadsheets
3. Provide Medicare with the spreadsheet.
4. Start early. Start NOW.
5. Provide it to the Preparer ASAP.

How much does Medicare pay for Bad debts?

88 percent - 2013
76 percent - 2014
65 percent - 2015 and forward

Write off as much as you can as soon as you can. This is likely going away in the future.

What information does Medicare need to pay Bad Debt?

- Patient Name
- HIC Number
- Date of Service
- Indigency or Medicaid? Y or N
- Medicaid Number
- Date of First Bill sent to Patient
- Write off Date
- Remittance Advise Date
- Deductible
- Co-Insurance
- Total

Crossover or Duel Eligible Bad Debt

*If Medicaid does not pay the complete coinsurance or deductible; a RHC can include this difference as an allowable bad debt on the cost report and Medicare will reimburse you for this bad debt. Keep up with in a separate file.*
Bad Debt – Excel Spreadsheets

<table>
<thead>
<tr>
<th>Description</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Bad Debt Log in Excel</td>
<td><a href="http://www.dropbox.com/s/0ev163n5i019%20Sample%20Bad%20Debt%20Log%20in%20Excel?dl=0">http://www.dropbox.com/s/0ev163n5i019%20Sample%20Bad%20Debt%20Log%20in%20Excel?dl=0</a></td>
</tr>
<tr>
<td>Medicare/Medicaid Crossover Bad Debt Log in Excel</td>
<td><a href="http://www.dropbox.com/s/0ev163n5i019%20Sample%20Bad%20Debt%20Log%20in%20Excel?dl=0">http://www.dropbox.com/s/0ev163n5i019%20Sample%20Bad%20Debt%20Log%20in%20Excel?dl=0</a></td>
</tr>
</tbody>
</table>

Related Party Transactions, 1099s, Non-RHC Hours, and Depreciation Schedule

7 List any related party transactions (RPT) which include any rental payments by the corporation to the physician/owner or the owner's relatives. Copy 1099s for our file if you think you may have a RPT.

8 On Tab 1 – Worksheet S, Part 1, Please indicate the hours of operation of the clinic and if you have any non-rural health clinic hours.

9 Please include a depreciation schedule, so we can convert depreciation to straight-line depreciation.

Related Party Transactions

- Provide the actual cost of the transaction. For example, related party rent would produce mortgage interest, repairs, insurance, property taxes and depreciation. We need a Schedule E from the tax return (personal).
- Identify employees who are related (family members) to the owners and the compensation paid to these related family members.
- Provide Provider FTE Calculation.
- Provide Lab Time Log and Payroll classification if you do not have a dedicated employee to lab.

Questions, Comments, Thank You
TAB 5

RHC Billing
RuralHealthClinic.com
Experienced Knowledge

RHC Update Seminar
RHC Billing
Fall, 2018

HBS
Healthcare Business Specialists

Contact Information
Mark Lynn, CPA (Inactive)
RHC Consultant
Healthcare Business Specialists
Suite 214, 502 Shadow Parkway
Chattanooga, Tennessee 37421
Phone: (423) 263-6185
marklynnrhc@gmail.com
www.ruralhealthclinic.com

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To view any of past Webinars go to our Youtube channel:
https://www.youtube.com/channel/UICW4plwTrtXAVTMFrswMy2

RHC Billing Update and Basics

www.ruralhealthclinic.com
What is a rural health clinic?

RHC Fact Sheet


Experienced Knowledge

The RHC Program has been around since 1977. the visit definition has not changed (much) since then. Also, most of the incentives do not apply. Its like we are driving around in the 1977 Car of Year, a Chevy Caprice.

Four Categories of Services

RHC Services: Face to Face Encounters
Non-RHC Services: Medicare Non-covered services

Face to Face Encounters - Visits

RHC Services - Face to Face Encounters - Visits

The History of the RHC Visit

<table>
<thead>
<tr>
<th>Date Began</th>
<th>Definition</th>
<th>Date Changed</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/1/1978</td>
<td>Face to Face, Med necessary, Physician, NP, PA</td>
<td>12/31/2015</td>
</tr>
<tr>
<td>1/1/2016</td>
<td>Added Chronic Care Management - No face to face</td>
<td>3/31/2016</td>
</tr>
<tr>
<td>4/1/2016</td>
<td>Must Be on QVL to Bill. Procedures held until 10/1/2016</td>
<td>9/30/2016</td>
</tr>
<tr>
<td>10/1/2016</td>
<td>No more QVL. Now add CG modifier</td>
<td>Present</td>
</tr>
</tbody>
</table>
What is a Rural Health Clinic Visit?

- Is a face to face encounter with a physician, nurse practitioner, PA, NP, or CNM, CP, or CSW.
- There is a medically necessary service provided (should reach the level of a 99212).
- Is provided by the appropriately trained provider within their scope of practice.

Where can an RHC Visit Occur?

- In the certified rural health clinic (0521)
- In the patient's home
  - Home (0522)
  - SNF (Part A) (0524)
  - ICF/NF (Not Part A) (0525)
  - Assisted Living Facility (0522)
- Scene of an accident (0528)
- Telehealth (0780)
- Behavioral Health (0900)

Note: Do not use POS 72 on any Medicare Claim

The Definition of a Visit per Chapter 13 of the RHC Manual

A Rural Health Clinic (RHC) visit is defined as a medically-necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between the patient and a physician, NP, PA, CNM, CP, or CSW during which time one or more RHC services are rendered. A Transitional Care Management (TCM) service can also be an RHC visit. Services furnished must be within the practitioner's state scope of practice.

Where can you have an RHC Visit?

1. In the RHC
2. The patient's residence
3. An assisted living facility
4. A Medicare-covered Part A SNF (see Pub. 100-04, Medicare Claims Processing Manual, chapter 6, section 20.1.1) or the scene of an accident.

RHC visits may not take place in either of the following:

- An inpatient or outpatient department of a hospital, including a CAH, or
- A facility which has specific requirements that preclude RHC visits (e.g., a Medicare comprehensive outpatient rehabilitation facility, a hospice facility, etc.).

RHC Revenue Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0521</td>
<td>Clinic visit by member to RHC</td>
</tr>
<tr>
<td>0522</td>
<td>Home visit by RHC practitioner</td>
</tr>
<tr>
<td>0524</td>
<td>Visit by RHC practitioner to a member in a covered Part A stay at the Skilled Nursing Facility (SNF)</td>
</tr>
<tr>
<td>0525</td>
<td>Visit by RHC practitioner to a member in a SNF (not in a covered Part A stay) or Nursing Facility (NF) or Intermediate Care Facility for Mental Retardation (ICF-MR) or other residential facility</td>
</tr>
<tr>
<td>0780</td>
<td>Telemedicine origination</td>
</tr>
<tr>
<td>0900</td>
<td>Behavioral Health</td>
</tr>
</tbody>
</table>
Preventive Services – Key Points

1. If a sick visit and a preventive visit are provided on the same day, only the sick visit will be paid at the AIR. (Exception IPPE)
2. Most Preventive services do not have a co-pay or deductible due from the patient.
3. If a preventive service is provided as a standalone visit, the RHC will receive the full AIR. (No reduction for co-pay)
4. If the preventive service is provided with a sick visit, Medicare will reimburse the clinic for the lost co-pays on the cost report.
5. Validate that the patient has not exceeded the frequency limitations before providing the service. (ABN?)

IPPE – Only Preventive Service eligible for both the preventive and sick visit paid on the same day

<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS Code</th>
<th>Short Description</th>
<th>Eligible for Same Day Billing</th>
<th>Covered Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Work</td>
<td>98960</td>
<td>Social Work Services</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Medical Services</td>
<td>98961</td>
<td>Medical Services</td>
<td>Yes</td>
<td>100%</td>
</tr>
</tbody>
</table>

Medicare Stand Alone Encounters

<table>
<thead>
<tr>
<th>Medicare Preventive Service</th>
<th>HCPCS Code/Short Description</th>
<th>AAR%</th>
<th>Day</th>
<th>Co-pay/Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Wellness Visit – Initial</td>
<td>G0025</td>
<td>Yes</td>
<td>No</td>
<td>Worked</td>
</tr>
<tr>
<td>Annual Wellness Visit – Select</td>
<td>G0029</td>
<td>Yes</td>
<td>No</td>
<td>Worked</td>
</tr>
<tr>
<td>Preventive Health Services on the QVL</td>
<td>G0027</td>
<td>Yes</td>
<td>No</td>
<td>Worked</td>
</tr>
<tr>
<td>G0028</td>
<td>No</td>
<td>No</td>
<td>Not Reim</td>
<td></td>
</tr>
</tbody>
</table>
RHCs Must Report a Qualifying Visit of the UB-04 effective April 1, 2016

RHC qualifying medical visits are typically Evaluation and Management (E/M) type of services or screenings for certain preventive services. RHC qualifying mental health visits are typically psychiatric diagnostic evaluation, psychotherapy, or psychoanalysis.

The charges for all services that create a deductible or co-payment are bundled into the charge for this Qualifying visit. (exclude the charges for the majority of the preventive services)

MLN 9269 – What You Need to Know

Effective April 1, 2016, All RHCs are required to report the appropriate HCPCS code for each service line along with the revenue code, and other required billing codes.

Payment for RHC services will continue to be made under the All-Inclusive Rate (AIR) system when all of the program requirements are met.

Medlearn Matters – MM9269 Released and Revised

What the Memorandum covers

1. HCPCS Coding
2. Procedures
3. Modifier 59
4. Qualified Visit Listing

Visits - The RHC Qualifying Visit List (QVL)

The RHC Qualifying Visit List for a list of HCPCS codes that are defined as qualifying visits, which corresponds with the following guidance on service level information. CMS will no longer update this list. It is more of a guideline as to what is payable as a visit.

Medicare Stand Alone Encounters

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Visit Description</th>
<th>AR7</th>
<th>Services</th>
<th>Encounters</th>
</tr>
</thead>
<tbody>
<tr>
<td>99403</td>
<td>Screening for Sexually Transmitted Infections</td>
<td>Yes</td>
<td>No</td>
<td>Included</td>
</tr>
<tr>
<td>99406</td>
<td>Tobacco Cessation Counseling</td>
<td>Yes</td>
<td>No</td>
<td>Included</td>
</tr>
<tr>
<td>99407</td>
<td>Tobacco Cessation Counseling</td>
<td>Yes</td>
<td>No</td>
<td>Included</td>
</tr>
<tr>
<td>99410</td>
<td>Smoking Cessation Counseling</td>
<td>Yes</td>
<td>No</td>
<td>Included</td>
</tr>
<tr>
<td>99419</td>
<td>Smoking Cessation Counseling</td>
<td>Yes</td>
<td>No</td>
<td>Included</td>
</tr>
<tr>
<td>99446</td>
<td>Smoking Cessation Counseling</td>
<td>Yes</td>
<td>No</td>
<td>Included</td>
</tr>
</tbody>
</table>

It's All about that Visit (QVL)


Fall, 2018
Home visits, Transition Care, and Advanced Care Planning are included on the QVL.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99314</td>
<td>Home visit - new patient</td>
</tr>
<tr>
<td>99343</td>
<td>Home visit - new patient</td>
</tr>
<tr>
<td>99344</td>
<td>Home visit - new patient</td>
</tr>
<tr>
<td>99345</td>
<td>Home visit - new patient</td>
</tr>
<tr>
<td>99348</td>
<td>Home visit - established patient</td>
</tr>
<tr>
<td>99349</td>
<td>Home visit - established patient</td>
</tr>
<tr>
<td>99345</td>
<td>Home visit - established patient</td>
</tr>
<tr>
<td>99355</td>
<td>Home visit - established patient</td>
</tr>
<tr>
<td>99377</td>
<td>Advance care plan, 30 min</td>
</tr>
</tbody>
</table>

99211 Visits (Nurse Only) are not Medicare RHC Visits

- Brief Established visits (99211's) do not meet the RHC guidelines. No history or judgment involved with this level of service. Do not bill Medicare a visit for these services.

Paid RHC Encounters are very limited

The definition of a rural health clinic encounter does not include:

1. Nurses
2. Physical Therapists
3. Dietitians
4. Nutritionists

Define Incident to Services

Chapter 13 - 110 - Services and Supplies Furnished “Incident to” Physician’s Services (Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-01-15). “Incident to” refers to services and supplies that are an integral, though incidental, part of the physician's professional service and are:

- Commonly rendered without charge or included in the RHC bill;
- Commonly furnished in an outpatient clinic setting;
- Furnished under the physician’s direct supervision; and
- Furnished by a member of the RHC staff.

Incident to Services and supplies include:

- Drugs and biologicals that are not usually self-administered, and Medicare covered preventive injectable drugs
- Venipuncture;
- Bandages, gauze, oxygen, and other supplies; or
- Assistance by auxiliary personnel such as a nurse, medical assistant, or anyone acting under the supervision of the physician.

Mark's Note: Funny thing – the example CMS gives of this are not really incident to – (Influenza and Pnu)
Incident to services and supplies can be furnished by auxiliary personnel. All services and supplies provided incident to a physician’s visit must result from the patient’s encounter with the physician and be furnished in a medically appropriate timeframe.

More than one incident to service or supply can be provided as a result of a single physician visit.

Incident to services and supplies must be provided by someone who has an employment agreement or a direct contract with the RHC to provide services.

Many services do not qualify as a visit under RHC
- Dressing changes
- Allergy shots/inject.
- Nutritional counseling
- Diabetic counseling
- Paperwork

The 30 Day Rule – Incident to
- Incident to services can be combined with claims with visits within 30 days. List only the date of the visit and bundle all charges into Revenue Code 0521.

This is the tricky one
Multiple Services with a billable visit

<table>
<thead>
<tr>
<th>Description</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>The patient has a 99213 E &amp; M-visit</td>
<td>$100</td>
</tr>
<tr>
<td>Blood is drawn</td>
<td>$20</td>
</tr>
<tr>
<td>Venipuncture (36415)</td>
<td></td>
</tr>
<tr>
<td>A shot of Rocephin is administered</td>
<td>$50</td>
</tr>
<tr>
<td>Total Charges</td>
<td>$170</td>
</tr>
</tbody>
</table>

Note: Total charges for all services provided during the encounter, minus any charges for the approved preventive services.
### Multiple services provided with a Billable Visit

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>HCPCS Description</th>
<th>Visit Date</th>
<th>Days</th>
<th>Charges</th>
<th>Billable</th>
<th>Applied Knowledge</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>99219CG</td>
<td>Established Visit</td>
<td>04/01/2016</td>
<td>1</td>
<td>$300.00</td>
<td>Included in AIR</td>
<td>No</td>
<td>$300.00</td>
</tr>
<tr>
<td>8969C</td>
<td>VENIPUNCTURE</td>
<td>04/01/2016</td>
<td>1</td>
<td>$20.00</td>
<td>Included in AIR</td>
<td>No</td>
<td>$20.00</td>
</tr>
</tbody>
</table>

*Note: Total charge $320.00, included in AIR.*

---

### Bundling Under April 1, 2016 HCPCS Coding Guidelines

The visit is coded as a 99214. Patient receives ancillary services which could occur on the same day of the visit or within 30 days of the visit. (incident to).

- **Established Visit – [1]**
  - Charges computed on this line: $160.210
- **Injection Code: 40**
- **Venipuncture: 10**
- **Transminole acet.: 10**

### Bundling using .01 for the Ancillary Services

The clinic may elect to only show .01 as the charge for the ancillary services if it chooses. Depending on the billing and software that you use. Either way is approved by CMS.

<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS Code</th>
<th>Days</th>
<th>Charges</th>
<th>Billable</th>
<th>Applied Knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injection</td>
<td>40</td>
<td>0.01</td>
<td>$160.210</td>
<td>Included in AIR</td>
<td>No</td>
</tr>
<tr>
<td>Venipuncture</td>
<td>10</td>
<td>0.01</td>
<td>$160.210</td>
<td>Included in AIR</td>
<td>No</td>
</tr>
<tr>
<td>Transminole acet.</td>
<td>10</td>
<td>0.01</td>
<td>$160.210</td>
<td>Included in AIR</td>
<td>No</td>
</tr>
</tbody>
</table>

### Preventive Visit Only

- Preventive Service
- When a preventive service is the only qualifying intervention for the encounter, the permitment and applicable code-assurance codes are deductible, and the deductible will be based upon the adjusted charges for this encounter. Frequency edits will apply.

**Example:**

<table>
<thead>
<tr>
<th>Service Code</th>
<th>HCPCS Code</th>
<th>Days</th>
<th>Charges</th>
<th>Billable</th>
<th>Applied Knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td>E &amp; M Service</td>
<td>99214</td>
<td>1</td>
<td>$160.210</td>
<td>Included in AIR</td>
<td>No</td>
</tr>
</tbody>
</table>

*Note: The RHC will receive the full AIR minus sequestration.*

---

### An E & M Code & a Preventive Visit

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>HCPCS Description</th>
<th>Visit Date</th>
<th>Days</th>
<th>Charges</th>
<th>Billable</th>
<th>Applied Knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td>99219CG</td>
<td>Established Visit</td>
<td>04/01/2016</td>
<td>1</td>
<td>$300.00</td>
<td>Included in AIR</td>
<td>No</td>
</tr>
<tr>
<td>G0101</td>
<td>Preventive Visit</td>
<td>04/01/2016</td>
<td>1</td>
<td>$25.00</td>
<td>Included in AIR</td>
<td>No</td>
</tr>
</tbody>
</table>

### Non-RHC Hours – What you have heard?

1. You're going to jail.
2. It's complicated
3. Cost Report Nightmare
4. AIR will go down.

---

### Description | Amount
---|---
An independent RHC at the cost cap would receive from Medicare | $54.32
A co-pay on the E & M visit could be collected on | $20
A co-pay for the G0101 should be paid on the Cost Report of | $25

---

**RuralHealthClinic.com**

**RHC Billing Update and Basics**

**www.ruralhealthclinic.com**

**Fall, 2018**
Non-RHC Hours - Reality

1. No one is going to jail
2. Not that hard
3. Cost Report is designed for it.
4. AIR will not go down if done correctly.

What services can be done during Non-RHC Hours

- 99214: Trigger Point Injections
- 99215: Procedures
- 36415: Allergy Shots
- AWE: Nurse Only Visits
- IPPE: TCM

Payment Comparison of Typical CCM Services

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>FFS</th>
<th>Ind RHC</th>
<th>Prov RHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>99495</td>
<td>TCM - 14 Days</td>
<td>155.27</td>
<td>66.75*</td>
<td>128.85*</td>
</tr>
<tr>
<td>99496</td>
<td>TCM - 7 days</td>
<td>221.27</td>
<td>66.75*</td>
<td>128.85*</td>
</tr>
<tr>
<td>G0402</td>
<td>IPPE (No Co-pay/Ded)</td>
<td>159.73</td>
<td>83.45</td>
<td>164.35</td>
</tr>
<tr>
<td>G0438</td>
<td>AWE - Initial (No Co-pay/Ded)</td>
<td>164.46</td>
<td>83.45</td>
<td>164.35</td>
</tr>
<tr>
<td>G0439</td>
<td>AWE - Subsequent (No Co-pay/Ded)</td>
<td>111.36</td>
<td>83.45</td>
<td>164.35</td>
</tr>
</tbody>
</table>

* Plus 20% of charges

Procedures - Chapter 13 Updates

RHC Billing Update and Basics

Keys to making it work

1. Treat everyone the same
2. Keep up with Non-RHC visits
3. Place a sign on the door indicating times

Procedures - Continued

Surgical procedures furnished at locations other than RHCs or FQHCs may be subject to Medicare global billing requirements. If a RHC or FQHC furnishes services to a patient who has had surgery elsewhere and is still in the global billing period, the RHC or FQHC must determine if these services have been included in the surgical global billing. If the service furnished by the RHC or FQHC was included in the global payment for the surgery, the RHC or FQHC may not also bill for the same service.
Hospital Services are not covered under the RHC Benefit

Hospital services for independent and provider-based RHCs are billed on the UB-04 form and paid fee for service.

Can we bill a Hospital Admission and an Office Visit on the same day?

We asked CMS this question and their response was to bill it to the MIC and let them decide if it is payable or not. Most are paid; however, some do get rejected if the patient becomes observation instead of a hospital admission.

Medicare Advantage Plans

When a beneficiary enrolls in a Medicare Advantage (MA) plan, they are no longer classified as a Medicare patient for cost reporting purposes. These individuals are effectively treated as privately insured individuals.

MA plans must show that they have an "adequate" provider network in each market they serve. In an underserved area, it may be difficult for the MA plan to meet the market adequacy requirement if an existing RHC is not part of the network.

If an RHC is a contracted provider within a MA network, the RHC is obligated to follow whatever is established in the contract. Payment could be cost-based, fee-for-service, or even capitation.

Flu and pneumonia vaccines administered to MA patients are not captured on the RHC cost report. Reimbursement should come through the MA plan.

Three Day Payment Window

The statute requires that hospitals' bundle the technical component of all outpatient diagnostic services and related nondiagnostic services (e.g., therapeutic) with the claim for an inpatient stay when services are furnished to a Medicare beneficiary in the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1-day) preceding an inpatient admission in compliance with section 1886 of the Act. RHC's services are not subject to the Medicare 3-day payment window requirements.

Note: If the admitting hospital is a CAH, the payment window policy does not apply.

Place of Service (POS)

The UB-04 does not have Place of Service (POS) codes, but when billing Medicare on the UB-04 use Place of Service 72.
What are the six laboratory tests required for Rural Health Clinic certification?

1. Chemical examinations of urine by stick or tablet method or both
2. Hemoglobin or hematocrit
3. Blood sugar
4. Examination of stool specimens for occult blood
5. Pregnancy tests
6. Primary culturing for transmittal to a certified laboratory (No CPT code available)

Reference: CMS Publication 100-04, Chapter 9, Section 130

Laboratory services are not covered under the RHC benefit

All Laboratory services are not included under the RHC benefit including the six required laboratory tests.

Venipuncture – Lab Draw (36415)

Effective 1/1/2014, Venipuncture is covered by Part A and is included in the billing to Part A on the UB-04 Form. You can continue to charge for the service. It will increase the co-pay from the patient. MLM 8504.
Laboratory Services

- Venipuncture is included in A/R and is not separately billable
- Laboratory services are not an RHC benefit and not included in A/R
  - Provider-based RHCs bill under parent provider to an UB-04 or 837P equivalent
  - Independent RHCs submit claim on CMS-1500 Claim Form or 837P equivalent

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>BILL TYPE</th>
<th>CLAIM FORM</th>
<th>PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory Use the Hospital</td>
<td>851</td>
<td>UB-04</td>
<td>Cost</td>
</tr>
<tr>
<td>Outpatient Provider Number</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Independent RHC - Laboratory Services

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>BILL TYPE</th>
<th>CLAIM FORM</th>
<th>PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory Except 36415</td>
<td>NA</td>
<td>1500</td>
<td>Fee for Service</td>
</tr>
</tbody>
</table>

RHC Laboratory services are paid as follows in a CAH

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>BILL TYPE</th>
<th>CLAIM FORM</th>
<th>PAYMENT</th>
</tr>
</thead>
</table>
| Provider-based RHCs - Diagnostic Tests - Technical Component Only - CAH

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>BILL TYPE</th>
<th>CLAIM FORM</th>
<th>PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiology, EKG</td>
<td>NA</td>
<td>1500</td>
<td>Fee for service</td>
</tr>
</tbody>
</table>

Diagnostic Tests are not covered under the RHC Benefit

Technical components were excluded under Public Law 95-10 establishing RHCs.

RHC Provider-based - Diagnostic Tests - Technical Component Only - CAH

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>BILL TYPE</th>
<th>CLAIM FORM</th>
<th>PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiology, EKG</td>
<td>0851</td>
<td>UB-04</td>
<td>Cost</td>
</tr>
</tbody>
</table>
Professional components are covered under the RHC benefit and are included on the UB-04 and billed to the RHC MAC. (they must be billed with a face to face encounter)

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>BILL TYPE</th>
<th>CLAIM FORM</th>
<th>PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiology, EKG</td>
<td>0711</td>
<td>UB-04</td>
<td>Cost</td>
</tr>
</tbody>
</table>

Commomingling refers to the sharing of RHC space, staff (employed or contracted), supplies, equipment, and/or other resources with an onsite Medicare Part B or Medicaid fee-for-service practice operated by the same RHC physician(s) and/or non-physician(s) practitioners. Commomingling is prohibited in order to prevent:
• Duplicate Medicare or Medicaid reimbursement (including situations where the RHC is unable to distinguish its actual costs from those that are reimbursed on a fee-for-service basis), or
• Selectively choosing a higher or lower reimbursement rate for the services.

RHC practitioners may not furnish or separately bill for RHC covered professional services as a Part B provider in the RHC, or in an area outside of the certified RHC space such as a treatment room adjacent to the RHC, during RHC hours of operation. If an RHC practitioner furnishes an RHC service at the RHC during RHC hours, the service must be billed as an RHC service. The service cannot be carved out of the cost report and billed to Part B.
Costs must be properly allocated

If an RHC is located in the same building with another entity such as an unaffiliated medical practice, x-ray and lab facility, dental clinic, emergency room, etc., the RHC space must be clearly defined. If the RHC leases space to another entity, all costs associated with the leased space must be carved out of the cost report.

Sharing Services - Commingling

RHCs that share resources (e.g., waiting room, telephones, receptionist, etc.) with another entity must maintain accurate records to assure that all costs claimed for Medicare reimbursement are only for the RHC staff, space, or other resources. Any shared staff, space, or other resources must be allocated appropriately between RHC and non-RHC usage to avoid duplicate reimbursement.

CG Modifier FAQ Summary

<table>
<thead>
<tr>
<th>FAQ#</th>
<th>Question</th>
<th>CG Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>Use when bundling charges, the primary reason for the face-to-face encounter</td>
<td>Yes</td>
</tr>
<tr>
<td>Q2</td>
<td>Use for dates of service on or after April 1, 2016</td>
<td>Yes</td>
</tr>
<tr>
<td>Q3</td>
<td>Use to report the line subject to coinsurance and deductible</td>
<td>Not Necessarily</td>
</tr>
<tr>
<td>Q4</td>
<td>Use when only one service is provided</td>
<td>Yes</td>
</tr>
<tr>
<td>Q5</td>
<td>Use when preventive service only</td>
<td>Yes</td>
</tr>
<tr>
<td>Q6</td>
<td>Use when a medical service and preventive service is furnished on the same day</td>
<td>No in</td>
</tr>
</tbody>
</table>
**FAQ #** | **Question** | **CG Modifier**
---|---|---
Q22 | Will secondary payers accept the CG modifier? | Hopefully
Q23 | Should RHCs use more than one UB-04? | No
Q24 | Does Medicare use total charges to compute co-pays? | No.
Q25 | Does this affect Part B – technical comps. | No.
Q26 | Does the affect flu and pneumonia? | No

---

**FAQ #** | **Question** | **CG Modifier**
---|---|---
Q27 | Does CG affect lab billing? | No.
Q28 | How will the EB appear to the patient? | Some may look like the claim was inflated.
Q29 | How to get additional information? | www.ruralhealthclinic.com

---

**Flu and Pnu shots are paid very well in the RHC setting. Use a log on the cost report. Do NOT Bill!!!**

Average payment was $135 for pneumococcal (Cost is $63)

Average payment was $35 for Influenza in 2013. (Cost is $11)

Place Patient Name, HIC Number, and Date of injection on a Log.

---

**Questions, Comments, Thank You**

HBS

www.ruralhealthclinic.com

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TAB 6

TennCare Quarterly Reports
Becoming a Tennessee Rural Health Clinic

- New RHCs must obtain a new TennCare billing number specifically for RHC transactions.

Provider Registration
Bureau of TennCare - Provider Services
310 Great Circle Rd., 2-West
Nashville, TN 37243
(800) 852-2683
www.tn.gov/tenncare

TennCare Provider Enrollment
- Website to enroll in TennCare online:
  - http://admin.tennicare.tn.gov/Account/Login.aspx
- Website that includes forms you may need:
  - http://www.tn.gov/tenncare/pro-forms.shtml
- Website with step-by-step instructions for enrollment:

Why is the TennCare Settlement Report Important?
- Once you become a Rural Health Clinic, MCOs will not change the rate that they pay you for visits. The way you receive your enhanced TennCare RHC rate is to prepare this quarterly report.

<table>
<thead>
<tr>
<th>Paid Visits</th>
<th>MCO Payment per Visit</th>
<th>Total Payments from MCO</th>
<th>TennCare RHC Rate per Visit</th>
<th>TennCare Settlement Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,000</td>
<td>$75</td>
<td>$35,000</td>
<td>$150</td>
<td>$25,000</td>
</tr>
</tbody>
</table>

Report ONLY Paid Claims for the Quarter
- Visits and claims paid in January - March will be reported on the Q1 TennCare Settlement Report.
- On the Q2 report, visits from 1st and 2nd quarter that were paid during the first quarter will be reported. The 1st and 2nd quarter net totals will be on separate columns of the report.
Counting Payments

- When counting payments, you must include all payments for core services, as well as ancillary services — even if there is no "visit" associated with the service (i.e., labs, vaccinations, x-rays, etc).

- All payments must be included, including patient co-pays and payments from third party insurance payers.

Counting Visits

- TennCare visits are face-to-face encounters with a Physician, Physician Assistant, Nurse Practitioner, Certified Nurse Midwife, Clinical Psychologist, Clinical Social Worker, or Licensed Professional Counselor — some common examples include:
  - Office Visits
  - Hospital Visits
  - Physicals
  - Prenatal and Postnatal Visits

- PLEASE NOTE: What constitutes a visit for TennCare does not always constitute a RHC Medicare visit and cannot be billed as such (i.e., hospital visits, physicals, etc).

Report ONLY Paid Claims for the Quarter

Counting Payments

- This amount received should include all monies received for services including lab services provided to TennCare enrollees, excluding crossover claims. This includes monies received from commercial insurers for TennCare enrollees and all patient liability amounts. Also include capitation or other lump-sum payments from MCOs for which there is such an arrangement:

- Julie Rogers, CPA, CISA
  Legislative Audit Manager
  Tennessee Comptroller of the Treasury

TennCare Moratorium
Counting Payments

Visit and Payment Summary

<table>
<thead>
<tr>
<th>Type of Visit</th>
<th>Visit</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits</td>
<td>Count</td>
<td>Count</td>
</tr>
<tr>
<td>Hospital Visits</td>
<td>Count</td>
<td>Count</td>
</tr>
<tr>
<td>Mental Health Visit</td>
<td>Count</td>
<td>Count</td>
</tr>
<tr>
<td>Physicals</td>
<td>Count</td>
<td>Count</td>
</tr>
<tr>
<td>Labs, X-rays, etc</td>
<td>Do NOT Count</td>
<td>Count</td>
</tr>
</tbody>
</table>

NOTE: Medicare Crossover is when Medicare is primary and TennCare is secondary. This type of payer mix is completely excluded from the TennCare Settlement Report (NO Visit and NO Payment).

Completing the Report

- Every TennCare remittance should be sorted by MCO and then reviewed for visits and payments by quarter.
- On the Excel spreadsheet (accumulation log), you can summarize the EOB information in the following columns: RA/Check #, RA Date, # of visits by quarter, and payment amounts by quarter – see Dani’s spreadsheet.

TennCare Settlement Report Changes

- In June 2017, TennCare announced changes in the way CoverKids patients would be processed.

Questions??

Dani Gilbert, CPA
Healthcare Business Specialists
(423) 630-7230
dani@billycooper.com
www.ruralhealthclinic.com
FQHC/RHC Cumulative Report of TennCare Visits and Payments

<table>
<thead>
<tr>
<th>Name of Provider:</th>
<th>Sample Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Number:</td>
<td>XX-XXXX</td>
</tr>
<tr>
<td>Period:</td>
<td>QX-201X</td>
</tr>
</tbody>
</table>

### Core Services

<table>
<thead>
<tr>
<th>Submitted Q3-2017</th>
<th>Q4-2017</th>
<th>Q1-2018</th>
<th>Q2-2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cumulative Totals</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7</td>
<td>2</td>
<td></td>
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</tbody>
</table>

### Core Services

<table>
<thead>
<tr>
<th>Submitted Q3-2017</th>
<th>Q4-2017</th>
<th>Q1-2018</th>
<th>Q2-2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Cumulative Totals</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>206</td>
<td>$96</td>
<td>$302</td>
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</table>

### Summary of TennCare Quarterly Report

<table>
<thead>
<tr>
<th>9 Total Visits</th>
<th>$121.47 TennCare Rate</th>
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</thead>
<tbody>
<tr>
<td>$1,183.23 Total Amount Owed from TennCare</td>
<td></td>
</tr>
<tr>
<td>$ (301.54) Payments Received on RA</td>
<td></td>
</tr>
<tr>
<td>$ 881.69 Settlement Amount</td>
<td></td>
</tr>
</tbody>
</table>

(1) Include only covered visits paid by MCOs. Denied claims must be excluded.

(2) Include fee for service payments for all services provided to TennCare enrollees, with the exception of cross-over claims. This includes monies received from commercial insurers for TennCare enrollees and all patient liability amounts. Also include capitation or other special lump-sum payments from MCOs for which there is such an arrangement.
Summary for TennCare Quarterly Report from All MCOs

MCO: AMERIGROUP
Submission Date:

<table>
<thead>
<tr>
<th>Check Number</th>
<th>Remittance Date</th>
<th>Q3-2017 Visits</th>
<th>Q3-2017 Payments</th>
<th>Q4-2017 Visits</th>
<th>Q4-2017 Payments</th>
<th>Q1-2018 Visits</th>
<th>Q1-2018 Payments</th>
<th>Q2-2018 Visits</th>
<th>Q2-2018 Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>201804091996542</td>
<td>4/9/2018</td>
<td>-</td>
<td>-</td>
<td>$</td>
<td>-</td>
<td>7</td>
<td>$205.68</td>
<td>2</td>
<td>$95.86</td>
</tr>
</tbody>
</table>

Totals: - $ - - $ - 7 $205.68 2 $95.86
TAB 7

TennCare Moratorium
TennCare Proposed RHC Regulations

November 6, 2018

Contact Information

Mark Lynn, CPA (Inactive)
RHC Consultant
Healthcare Business Specialists
Chattanooga, Tennessee
Phone: (423) 243-6185
Email: marklynnrhc@gmail.com
Website: www.ruralhealthclinic.com

RHC Information Exchange Group on Facebook

“A place to share and find information on RHCs.”

A Little History

*A big pile of Horse Manure
*Tennessee’s Heart Failure

RHC Moratorium

In October 2017 TennCare applied for and received a moratorium from the federal government on the registration of new RHCs with the TennCare program. The initial moratorium period is for 6 months, with applications for extensions permitted by law. In April 2018, the federal government approved a moratorium extension that runs through October 2018. The purpose of the moratorium was to allow for the creation of rules by the Division of TennCare, in consultation with the Comptroller’s office, to address issues concerning the RHC payment methodology. The new TennCare rules will allow for greater clarity concerning 1) what constitutes permissible, reasonable cost elements that are includable in the cost report which is basic element of Medicaid RHC payments and 2) what counts as a countable visit for purposes of Medicaid payment.

Source: http://www.tn.gov/tenncare/moratorium-on-rural-health-centers.html
What the Moratorium really meant?

You can become an RHC under Medicare rules, you just can not get paid your Tenncare Quarterly Settlements. (The reason you became an RHC in the first place)

<table>
<thead>
<tr>
<th>TennCare Proposed RHC Rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountant's Full-time Employment Act (FEAA)</td>
</tr>
<tr>
<td>(If any RHCs survive)</td>
</tr>
<tr>
<td>I LOVE ACCOUNTING</td>
</tr>
</tbody>
</table>

Twelve Rural Tennessee Hospitals have closed in the last two years


Proposed RHC Regulations

- Tennessee Proposed Tenncare RHC Regulations
A Hearing will be held November 27th

<table>
<thead>
<tr>
<th>Address 1</th>
<th>Division of TennCare</th>
</tr>
</thead>
<tbody>
<tr>
<td>City</td>
<td>Nashville, TN</td>
</tr>
<tr>
<td>Zip</td>
<td>37243</td>
</tr>
<tr>
<td>Hearing Date</td>
<td>November 27, 2018</td>
</tr>
<tr>
<td>Hearing Time</td>
<td>9:00 a.m. CST/CDT</td>
</tr>
</tbody>
</table>

https://ixas-drbub- 

This is the first step in a long process
Tenn care must approve
The State must approve
CMS must approve
We could take another year or two

Rate Setting for RHCs

Base Year Cost Reports are your School Picture
You want to look your best

The State will look under every rock and review Base Year Cost reports in much more detail than any other

Rate Setting for New RHCs

Tenn care Moratorium

www.ruralhealthclinic.com
Summary of how RHC rates will be set

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Method to set RHC rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brand New</td>
<td>Average rate of similar entities</td>
</tr>
<tr>
<td>12 Months</td>
<td>New Interim PPS Rate</td>
</tr>
<tr>
<td>24 Months</td>
<td>Permanent PPS Rate</td>
</tr>
</tbody>
</table>

Current State wide average for RHCs is $131

Interim Rates will not be settled when PPS rates are changed

TennCare will rebase every cost report
And no less than one time every five years!

(a) The Controller will perform a rebase of all RHCs, FQHCs, or FQHCAs no more than once per fiscal year and no less than one time every five (5) fiscal years without prior notice and using the previous two (2) fiscal years of Medicare Cost Report data.

1. RHCs will not be certain of the rates paid by TennCare.
2. Which years will they use to rebase.
3. Will the state “randomly” select a year with a low rate.

RHC Cost Report Limitations

Administrative Costs Limited to 30%

1. Administrative Costs. Expenses incurred in operating the clinic as a whole that are related to the administration and management of the clinic and are not directly associated with furnishing patient care. Administrative costs include but are not limited to: office salaries, office supplies, legal, accounting, or billing services, consulting services, insurance, telephone, fringe benefits, and payroll taxes.

Hospital Overhead from Hospital Cost Report?

RHC Cost Report can be divided in 3 sections

<table>
<thead>
<tr>
<th>CR Description- WKS A</th>
<th>CR Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Staff Costs</td>
<td>1-25</td>
</tr>
<tr>
<td>Facility Overhead</td>
<td>26-37</td>
</tr>
<tr>
<td>Administrative Costs</td>
<td>38-50</td>
</tr>
<tr>
<td>Non-RHC and Non- Reimbursable</td>
<td>51-50</td>
</tr>
</tbody>
</table>

RHC Cost Report – Facility Costs

<table>
<thead>
<tr>
<th>FACILITY OVERHEAD – FACILITY COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>2600 RENT</td>
</tr>
<tr>
<td>2700 INSURANCE</td>
</tr>
<tr>
<td>2800 INTEREST ON MORTGAGE OR LOANS</td>
</tr>
<tr>
<td>2900 UTILITIES</td>
</tr>
<tr>
<td>3000 DEPRECIATION – BUILDINGS AND FIXTURES</td>
</tr>
<tr>
<td>3100 DEPRECIATION – EQUIPMENT</td>
</tr>
<tr>
<td>3200 HOUSEKEEPING AND MAINTENANCE</td>
</tr>
<tr>
<td>3300 PROPERTY TAX</td>
</tr>
<tr>
<td>3400 OTHER FAC O/V FAC COSTS (SPECIFY)</td>
</tr>
<tr>
<td>3500 OTHER FAC O/V FAC COSTS (SPECIFY)</td>
</tr>
<tr>
<td>3600 MINOR MOBILE AND EQUIPMENT PURCHASE</td>
</tr>
<tr>
<td>SUBTOTAL – FACILITY COSTS</td>
</tr>
</tbody>
</table>
RHC Cost Report Administrative Costs

<table>
<thead>
<tr>
<th>FACILITY OVERHEAD</th>
<th>ADMINISTRATIVE COSTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1800 OFFICE SALARIES</td>
<td></td>
</tr>
<tr>
<td>9000 DEPRECIATION-OFFICE EQUIPMENT</td>
<td></td>
</tr>
<tr>
<td>6000 OFFICE SUPPLIES</td>
<td></td>
</tr>
<tr>
<td>4200 LEGAL</td>
<td></td>
</tr>
<tr>
<td>4300 INSURANCE (OTHER)</td>
<td></td>
</tr>
<tr>
<td>4400 TELEPHONE</td>
<td></td>
</tr>
<tr>
<td>4500 FRINGE BENEFITS AND PAYROLL TAXES</td>
<td></td>
</tr>
<tr>
<td>4600 PRACTICE MANAGEMENT FEES</td>
<td></td>
</tr>
<tr>
<td>4700 MISCELLANEOUS BUSINESS EXPENSES</td>
<td></td>
</tr>
<tr>
<td>4800 NON-ALLOWABLE EXPENSES</td>
<td></td>
</tr>
<tr>
<td>SUBTOTAL ADMINISTRATIVE COST</td>
<td></td>
</tr>
<tr>
<td>TOTAL OVERHEAD</td>
<td></td>
</tr>
</tbody>
</table>

Reasonable Cost Limitations

The following factors will be considered in determining reasonable costs:

(a) Fees paid by an RHC, FOHIC, or FOHCRA pursuant to any contract to pay contingency fees for consulting, accounting, bookkeeping or similar services, or any contract to pay the vendor a percentage of the fund generated from TennCare will be presumed unreasonable and will not be reimbursable.

(b) Imputed salaries will be presumed unreasonable. All salary amounts must be reported on an IRS Form W-2 or an IRS Form 1099 to be considered for reasonableness.

(c) Salaries or contracted costs shall be accompanied by an FTP calculation

No Contingency Fees or “Value of Services”

Why was the RHC Enacted?

“The Rural Health Clinic Services Act of 1977 (Public Law 95-210) was enacted to address an inadequate supply of physicians serving Medicare patients in rural areas and to increase the use of non-physician practitioners, such as nurse practitioners (NPs) and physician assistants (PAs) in rural areas.”

Tennessee will require the following

1. A Medicare Form-222 or Form 224 (nothing in the regs about 2552- M Series
2. Tennessee will develop a supplemental Medicaid Cost Report which must be submitted.

### Supplemental Information Requirements

(2) Along with a Medicare Cost Report and supplemental Medicaid Cost Report, an RHC, FQHC, or FQHCLA shall submit the Congratulatory per year of operation, a written statement of the RHC's, FQHC's, or FQHCLA's maximum hours per day, days per week, and weeks per year of operation, total balance, detailed general ledger, depreciation schedules, schedule listing all expenses, all management and consulting contracts, all billing NPI numbers, a listing of all related parties with whom the provider does business, total visit log, schedule of owner's compensation, a schedule of all employee salaries by title, documentation for reclassification and adjustments. If an RHC, FQHC, or FQHCLA does not submit this written statement, TennCare shall continue to pay the

### TennCare Cost Report Supplemental Worksheet Checklist

(If you submit information below for the submission of the TennCare cost report)

<table>
<thead>
<tr>
<th>ITEM NUMBER</th>
<th>DESCRIPTION OF WHAT IS NEEDED</th>
<th>TO BE INCLUDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Written statement of the RHC's maximum hours per day, days per week, and weeks per year of operation</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Total Balance</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Detailed General Ledger</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Depreciation Schedule</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Schedule Expenses</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>All Management and Consulting Contracts</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>All Billing NPI Numbers</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>A Listing of All Related Parties with which the Provider Does Business</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>RHC Visit List</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Schedule of Direct Compensation</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Schedule of All Expenses Subject to the</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Depreciation for Reclassification and Adjustments Provided to RHC</td>
<td></td>
</tr>
</tbody>
</table>

### Its All about that Visit (QVL)


### TennCare will create a Qualified Visit List (QVL)

(1) RHCs, FQHCS, or FQHCLAs shall only be reimbursed for allowable paid TennCare visits. This applies to both PPS and APM methodologies.

(2) TennCare shall adopt or amend a list of CPT codes that will be published on the TennCare website. The list of CPT codes will be presented allowable visits for both the PPS and APM methodologies and may be periodically updated with additions, deletions, or modifications. TennCare will post any amendments to the list on its website at least thirty (30) days prior to making any changes. When amendments to the CPT code list become effective, any changes in payments to providers will also become effective on the same date.
Tenncare will create a Template for the Quarterly Reports

For EPS or APM programs, the RHC, FQHC, or FOHCA must submit visits to the Comptroller using the template that will be posted at the Tenncare website, in order for the visits to be reimbursed. All data elements on the template must be complete and in the requested format for a claim to be considered as a visit. Tenncare may change the template after providing at least thirty days prior notice.

Tenncare Reimburseable Visit Determination Summary

EXCLUDED REIMBURSABLE VISITS

1 An encounter for the purpose of medication therapy management shall not be considered a reimbursable visit.

2 An encounter or session aimed to provide non-medical invents needed to be considered a reimbursable visit.

3 An encounter or session aimed to augment the_fnancial modeling visit shall not be considered a reimbursable visit.

4 An encounter or session aimed in any other types of payment (i.e., assessment halted by any provider for a patient covered by TennCare, transported or per encounter per payment visit rates or encounter payments based on established payment criteria, shall not be considered a reimbursable visit.

5 Medical necessity claims are ineligible for being included as visits.

Who is going to fight for Access to Care?

Rural Health Clinics
FQHCs
Rural Health Association of Tennessee
Tennessee Hospital Association
Hospital Alliance of Tennessee
NARHC
National Rural Health Association
Tennessee Primary Care Association
RHC Consultants

What Next? How do we fight this?

The Hospitals are gone
The RHCs will be gone
The People will be next.

Tenncare Moratorium

Nothing really different here
Lake Tahoe NARHC Notes

1. The voice of RHCs should be RHCs (not consultants).
2. Access to care will make the biggest impact.
3. Can we quantify our improvement in access to care?
4. Our written responses should not contradict each other.

Questions about the Hearing

1. Who will represent RHCs?
2. What provisions should be challenged or changed?
3. How can we work with FQHCs to challenge these regulations?

Unanswered Questions

1. What about retroactive settlements to RHCs caught in the Moratorium.
2. When will the Moratorium end?
3. Is this legal? BIPA 2000

Questions, Comments, Thank You

HBS

www.ruralhealthclinic.com
TennCare RHC Regulations

Everyone agrees that rules do need to be promulgated to provide structure and guidance to the RHC/FQHCs. Currently, there is no effective way to communicate to the 155 FQHCs and 128 RHCs in Tennessee. Because there is a systematic lack of program oversight, there is a wide variation of understanding of program requirements and what is allowable and is not. Also, what should be counted as visits and payments on the quarterly TennCare reports has never been clearly communicated to the entire RHC community. While we can agree upon the need for RHC regulations, we can not agree that to stop paying new RHCs was a reasonable thing to do and continue to choke out rural health care.

It is clear that the RHC/FQHC program lacked administrative oversight and a complete underfunding of professional personnel to administer what meager regulations existed before the proposed regulations were proposed. If the proposed regulations are implemented and actually performed in accordance with the regulations, we can expect the following:

1. Less and less money for rural physicians, nurse practitioners, and physician assistants that in more and more rural communities are the last standing bastions of healthcare as more and more rural Tennessee communities lack hospitals.
2. More and More money for TennCare and State government to hire an army of urban accountants and consultants to limit payments to rural Tennessee providers.

How do we fight these proposed rules:

1. Lobby
2. Position paper
3. November 27th Hearing

What about the following:

1. Many clinics filed no utilization or low utilization cost reports (pediatrics).
2. Provider-based RHCs. How will the cost reports be reviewed and the impact of hospital overhead allocated to the RHC.
3. Rebasing every rural health clinic and rebasing every 5 years thereafter.
Unintended consequences

While many of the newer RHCs established TennCare rates in recent years with costs per visits reflective of the current costs of providing healthcare, many Tennessee RHCs have very low TennCare rates due to the unrealistic annual increases in the Medical Economic Index. A large number of RHCs may be provided a large increase in reimbursement due to the proposed regulations.

Administration costs limited to 30%.

<table>
<thead>
<tr>
<th>CCN</th>
<th>FYE</th>
<th>Total</th>
<th>Admin Costs</th>
<th>Admin Percent</th>
<th>Admin at 50% Admin</th>
<th>Total Visits</th>
<th>CPT Rate</th>
<th>Allowable Expense in Rate</th>
<th>Reduction Projected</th>
<th>Current Tenn Rate Variance</th>
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</thead>
<tbody>
<tr>
<td>44-3925</td>
<td>9/30/2017</td>
<td>805,243</td>
<td>244,793</td>
<td>30.40%</td>
<td>211,573</td>
<td>8,942</td>
<td>86.56</td>
<td>802,023</td>
<td>0.36</td>
<td>86.56</td>
</tr>
<tr>
<td>44-3951</td>
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<td>1,520,337</td>
<td>658,247</td>
<td>43.01%</td>
<td>459,101</td>
<td>10,514</td>
<td>132.06</td>
<td>1,331,151</td>
<td>18.35</td>
<td>132.06</td>
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<tr>
<td>44-3947</td>
<td>12/31/2017</td>
<td>2,013,346</td>
<td>909,404</td>
<td>19.58%</td>
<td>609,404</td>
<td>8,942</td>
<td>77.58</td>
<td>2,031,346</td>
<td>12.83</td>
<td>77.58</td>
</tr>
<tr>
<td>44-8909</td>
<td>12/31/2017</td>
<td>1,214,158</td>
<td>658,407</td>
<td>54.01%</td>
<td>459,101</td>
<td>10,514</td>
<td>132.06</td>
<td>1,331,151</td>
<td>18.35</td>
<td>132.06</td>
</tr>
<tr>
<td>44-8923</td>
<td>12/31/2017</td>
<td>764,552</td>
<td>397,637</td>
<td>51.88%</td>
<td>274,291</td>
<td>9,267</td>
<td>90.41</td>
<td>865,889</td>
<td>6.79</td>
<td>108.45</td>
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<tr>
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<td>1,530,337</td>
<td>73.88%</td>
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<td>120.69</td>
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<td>1,914,302</td>
<td>399,301</td>
<td>43.01%</td>
<td>274,291</td>
<td>9,267</td>
<td>90.41</td>
<td>865,889</td>
<td>6.79</td>
<td>108.45</td>
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<tr>
<td>44-8957</td>
<td>12/31/2017</td>
<td>2,547,055</td>
<td>674,502</td>
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<td>274,291</td>
<td>9,267</td>
<td>90.41</td>
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<tr>
<td>44-8958</td>
<td>12/31/2017</td>
<td>764,137</td>
<td>(86,615)</td>
<td>51.88%</td>
<td>459,101</td>
<td>10,514</td>
<td>132.06</td>
<td>2,031,346</td>
<td>12.83</td>
<td>77.58</td>
</tr>
<tr>
<td>44-8959</td>
<td>12/31/2017</td>
<td>909,404</td>
<td>8,942</td>
<td>98.89</td>
<td>8,942</td>
<td>98.89</td>
<td>8,942</td>
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<td>98.89</td>
<td>8,942</td>
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<tr>
<td>44-8964</td>
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<td>190,760</td>
<td>26.48%</td>
<td>190,760</td>
<td>190,760</td>
<td>190,760</td>
<td>190,760</td>
<td>190,760</td>
<td>190,760</td>
</tr>
</tbody>
</table>

TennCare Settlements that go back to the Certification date for new RHC

From Zane Seals, TennCare

“As of now, the plan is to keep the moratorium in effect until the rule is in place. I can’t say for sure when that will be, because there are a lot of mandatory waiting periods and points where approval from other state agencies (like the AG) is needed. Those parts of the process are prescribed by law and are not controlled by TennCare. At this point, my best estimate is late winter/early spring. At that point, we will allow the RHCs to come into the program and have a rate calculated in accordance with the provisions in the final rule, and the plan is to retro settlements back to when they obtained RHC status.

Zane Seals | Deputy Chief Financial Officer
310 Great Circle Rd, Nashville, TN 37243
(615) 507-6345
zane.seals@tn.gov
www.tn.gov/tenncare"
Tennicare Cost Report Supplemental Workpaper Checklist
(Please submit the information below for submission of the Tennicare cost report.)

<table>
<thead>
<tr>
<th>ITEM NUMBER</th>
<th>DESCRIPTION OF WHAT IS NEEDED</th>
<th>√ IF INCLUDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Written statement of the RHC’s maximum hours per day, days per week, and weeks per year of operation.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Trial Balance</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Detailed General Ledger</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Depreciation Schedule</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Schedule Listing Allocations</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>All Management and Consulting Contracts</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>All Billing NPI Numbers</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>A Listing of All Related Parties with which the Provider Does Business</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Total Visit Log</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Schedule of Owner’s Compensation</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Schedule of All Employee Salaries by Title</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Documentation for Reclassification and Adjustments (Provided by HBS)</td>
<td></td>
</tr>
</tbody>
</table>

Healthcare Business Specialists
Specializing in RHC reimbursement
144 Hancock Oaks Trace Cleveland, TN 37323
Email: dani.gilbert@outlook.com
Website: www.ruralhealthclinic.com
Telephone: (423) 650-7250
RuralHealthClinic.com  
Experienced Knowledge

Healthcare Business Specialists  
TennCare Reimbursable Visit Determination Summary

<table>
<thead>
<tr>
<th></th>
<th>EXCLUDED REIMBURSABLE VISITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>An encounter for the purpose of medication therapy management shall not be considered a reimbursable visit.</td>
</tr>
<tr>
<td>2</td>
<td>An encounter or service related to patient center medical home payments shall not be considered a reimbursable visit.</td>
</tr>
<tr>
<td>3</td>
<td>An encounter or service related to Tennessee Health Link payments shall not be considered a reimbursable visit.</td>
</tr>
<tr>
<td>4</td>
<td>An encounter or service related to any other types of payment reform initiatives that may be implemented by TennCare, structured as per member per month case rates or outcome payments based on established performance criteria, shall not be considered a reimbursable visit.</td>
</tr>
<tr>
<td>5</td>
<td>Medicare Crossover claims are ineligible for being counted as visits.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>ACCEPTED REIMBURSABLE VISITS (2X/DAY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>If an encounter includes both a medical visit and a mental health visit, the RHC shall report it as two separate visits.</td>
</tr>
<tr>
<td>2</td>
<td>If an encounter includes both a well-child visit and sick visit (for a minor child) at the same time, each visit may be billed separately for a maximum of two allowable paid TennCare visits.</td>
</tr>
</tbody>
</table>

Healthcare Business Specialists  
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144 Hancock Oaks Trace  Cleveland, TN 37323  
Email: dani.gilbert@outlook.com  
Website: www.ruralhealthclinic.com  
Telephone: (423) 650-7250
<table>
<thead>
<tr>
<th>CCN</th>
<th>FYE</th>
<th>Total Cost</th>
<th>Admin Costs</th>
<th>Admin Percent</th>
<th>Admin at 30%</th>
<th>Disallow</th>
<th>Total Visits</th>
<th>CR Rate</th>
<th>Allowable Expense</th>
<th>Reduction in Rate</th>
<th>Projected Rate</th>
<th>Current Tenn Rate</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>44-3925</td>
<td>9/30/2017</td>
<td>805,243</td>
<td>244,793</td>
<td>30.40%</td>
<td>241,573</td>
<td>3,220</td>
<td>8,942</td>
<td>86.92</td>
<td>802,023</td>
<td>(0.36)</td>
<td>113.81</td>
<td>113.81</td>
<td>86.56</td>
</tr>
<tr>
<td>44-3951</td>
<td>12/31/2017</td>
<td>1,530,337</td>
<td>658,247</td>
<td>43.01%</td>
<td>459,101</td>
<td>199,146</td>
<td>10,914</td>
<td>132.06</td>
<td>1,331,191</td>
<td>(18.25)</td>
<td>113.81</td>
<td>113.81</td>
<td>108.45</td>
</tr>
<tr>
<td>44-3967</td>
<td>12/31/2017</td>
<td>2,031,346</td>
<td>397,637</td>
<td>19.58%</td>
<td>609,404</td>
<td>(211,767)</td>
<td>8,942</td>
<td>120.69</td>
<td>2,031,346</td>
<td>No Impac</td>
<td>No Impac</td>
<td>120.69</td>
<td>120.69</td>
</tr>
<tr>
<td>44-8909</td>
<td>12/31/2017</td>
<td>707,459</td>
<td>253,808</td>
<td>35.88%</td>
<td>212,238</td>
<td>41,570</td>
<td>6,120</td>
<td>115.24</td>
<td>665,889</td>
<td>(6.79)</td>
<td>108.45</td>
<td>108.45</td>
<td>77.58</td>
</tr>
<tr>
<td>44-8923</td>
<td>12/31/2017</td>
<td>676,552</td>
<td>296,167</td>
<td>43.78%</td>
<td>202,966</td>
<td>93,201</td>
<td>7,267</td>
<td>90.41</td>
<td>583,351</td>
<td>(12.83)</td>
<td>77.58</td>
<td>77.58</td>
<td>77.58</td>
</tr>
<tr>
<td>44-8938</td>
<td>9/30/2017</td>
<td>2,967,085</td>
<td>647,719</td>
<td>21.83%</td>
<td>890,126</td>
<td>(242,407)</td>
<td>21,897</td>
<td>132.5</td>
<td>3,209,492</td>
<td>No Impac</td>
<td>132.50</td>
<td>132.50</td>
<td>132.50</td>
</tr>
<tr>
<td>44-8944</td>
<td>12/31/2017</td>
<td>914,302</td>
<td>399,301</td>
<td>43.67%</td>
<td>274,291</td>
<td>125,010</td>
<td>6,300</td>
<td>122</td>
<td>789,292</td>
<td>(19.84)</td>
<td>102.16</td>
<td>102.16</td>
<td>102.16</td>
</tr>
<tr>
<td>44-8957</td>
<td>12/31/2017</td>
<td>2,547,055</td>
<td>674,502</td>
<td>26.48%</td>
<td>764,117</td>
<td>(89,615)</td>
<td>8,942</td>
<td>94.67</td>
<td>2,636,670</td>
<td>No Impac</td>
<td>No Impac</td>
<td>94.67</td>
<td>94.67</td>
</tr>
<tr>
<td>44-8912</td>
<td>12/31/2017</td>
<td>950,070</td>
<td>223,232</td>
<td>23.50%</td>
<td>285,021</td>
<td>(61,789)</td>
<td>8,400</td>
<td>112.64</td>
<td>1,011,859</td>
<td>No Impac</td>
<td>No Impac</td>
<td>112.64</td>
<td>112.64</td>
</tr>
<tr>
<td>44-8913</td>
<td>12/31/2017</td>
<td>1,397,292</td>
<td>563,947</td>
<td>40.36%</td>
<td>419,188</td>
<td>144,759</td>
<td>15,150</td>
<td>90.39</td>
<td>1,252,533</td>
<td>(9.56)</td>
<td>80.83</td>
<td>80.83</td>
<td>80.83</td>
</tr>
<tr>
<td>44-8931</td>
<td>12/31/2017</td>
<td>2,376,194</td>
<td>903,618</td>
<td>38.03%</td>
<td>712,858</td>
<td>190,760</td>
<td>17,940</td>
<td>125.01</td>
<td>2,185,434</td>
<td>(10.63)</td>
<td>114.38</td>
<td>114.38</td>
<td>114.38</td>
</tr>
<tr>
<td>44-8964</td>
<td>6/30/2017</td>
<td>387,009</td>
<td>126,116</td>
<td>32.59%</td>
<td>116,103</td>
<td>10,013</td>
<td>17,940</td>
<td>98.89</td>
<td>376,996</td>
<td>(0.56)</td>
<td>98.33</td>
<td>98.33</td>
<td>98.33</td>
</tr>
<tr>
<td>44-8929</td>
<td>12/31/2017</td>
<td>1,078,301</td>
<td>480,581</td>
<td>44.57%</td>
<td>323,490</td>
<td>157,091</td>
<td>7,949</td>
<td>132.41</td>
<td>921,210</td>
<td>(19.76)</td>
<td>112.65</td>
<td>112.65</td>
<td>112.65</td>
</tr>
</tbody>
</table>
Notice of Rulemaking Hearing

Hearings will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, T.C.A. § 4-5-204. For questions and copies of the notice, contact the person listed below.

<table>
<thead>
<tr>
<th>Agency/Board/Commission:</th>
<th>Tennessee Department of Finance and Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division:</td>
<td>Division of TennCare</td>
</tr>
<tr>
<td>Contact Person:</td>
<td>George Woods</td>
</tr>
<tr>
<td>Address:</td>
<td>Division of TennCare 310 Great Circle Road</td>
</tr>
<tr>
<td></td>
<td>Nashville, TN 37243</td>
</tr>
<tr>
<td>Phone:</td>
<td>(615) 507-6446</td>
</tr>
<tr>
<td>Email:</td>
<td><a href="mailto:george.woods@tn.gov">george.woods@tn.gov</a></td>
</tr>
</tbody>
</table>

Any Individuals with disabilities who wish to participate in these proceedings (to review these filings) and may require aid to facilitate such participation should contact the following at least 10 days prior to the hearing:

<table>
<thead>
<tr>
<th>ADA Contact:</th>
<th>Talley A. Olson, Director TennCare, Office of Civil Rights Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Division of TennCare 310 Great Circle Road</td>
</tr>
<tr>
<td></td>
<td>Nashville, TN 37243</td>
</tr>
<tr>
<td>Phone:</td>
<td>(855) 857-1673 TTY dial 711 and ask for 855-857-1673</td>
</tr>
<tr>
<td>Email:</td>
<td><a href="mailto:hcfa.fairtreatment@tn.gov">hcfa.fairtreatment@tn.gov</a></td>
</tr>
</tbody>
</table>

Hearing Location(s) (for additional locations, copy and paste table)

| Address 1: | Division of TennCare 310 Great Circle Road, Conference Room 1 East A |
City: Nashville, TN  
Zip: 37243  
Hearing Date: November 27, 2018  
Hearing Time: 9:00 a.m. CST/CDT EST/EDT

Additional Hearing Information:

Revision Type (check all that apply):
- Amendment
- New
- Repeal

Rule(s) (ALL chapters and rules contained in filing must be listed. If needed, copy and paste additional tables to accommodate more than one chapter. Please enter only ONE Rule Number/Rule Title per row.)

<table>
<thead>
<tr>
<th>Chapter Number</th>
<th>Rule Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>1200-13-10</td>
<td>Reimbursement for Rural Health Clinics, Federally Qualified Health Centers, and Federally Qualified Health Center Look-Alikes</td>
</tr>
<tr>
<td>1200-13-10-.01</td>
<td>Definitions</td>
</tr>
<tr>
<td>1200-13-10-.02</td>
<td>Determination of Reimbursable Costs for RHCs, FQHCs, or FQHCLAs Provided by TennCare</td>
</tr>
<tr>
<td>1200-13-10-.03</td>
<td>Medicaid Cost Reporting</td>
</tr>
<tr>
<td>1200-13-10-.04</td>
<td>Standard Reimbursement for a New RHC, FQHC, or FQHCLA</td>
</tr>
<tr>
<td>1200-13-10-.05</td>
<td>Determination of a Reimbursable Visit</td>
</tr>
<tr>
<td>1200-13-10-.06</td>
<td>Determination of Reasonable Costs</td>
</tr>
<tr>
<td>1200-13-10-.07</td>
<td>Change in Scope and Final PPS Rate Adjustment</td>
</tr>
<tr>
<td>1200-13-10-.08</td>
<td>Standard Reimbursement for an Existing RHC, FQHC, or FQHCLA</td>
</tr>
<tr>
<td>1200-13-10-.09</td>
<td>Alternative Payment Methodology for an RHC, FQHC, or FQHCLA</td>
</tr>
<tr>
<td>1200-13-10-.10</td>
<td>Auditing of Cost Reports</td>
</tr>
</tbody>
</table>

Rules of the Tennessee Department of Finance and Administration, Division of TennCare, are amended by replacing repealed Chapter 1200-13-10 with a new Chapter 1200-13-10 Reimbursement for Rural Health Clinics, Federally Qualified Health Centers, and Federally Qualified Health Center Look-Alikes which shall read as follows:

Rules of Tennessee Department of finance and Administration
Division of TennCare
Chapter 1200-13-10

Reimbursement for Rural Health Clinics, Federally Qualified Health Centers, and Federally Qualified Health Center Look-Alikes

Table of Contents

1200-13-10-01 Definitions
1200-13-10-02 Determination of Reimbursable Costs for RHCs, FQHCs, or FQHCLAs Provided by TennCare
1200-13-10-03 Medicaid Cost Reporting
1200-13-10-04 Standard Reimbursement for a New RHC, FQHC, or FQHCLA
1200-13-10-05 Determination of a Reimbursable Visit
1200-13-10-06 Determination of Reasonable Costs
1200-13-10-07 Change in Scope and Final PPS Rate Adjustment
1200-13-10-08 Standard Reimbursement for an Existing RHC, FQHC, or FQHCLA
1200-13-10-09 Alternative Payment Methodology for an RHC, FQHC, or FQHCLA
1200-13-10-10 Auditing of Cost Reports
1200-13-10-11 PPS Rates Outside of Core Reimbursement
1200-13-10-01 Definitions. The following definitions apply to Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC), and Federally Qualified Health Center Look-Alike (FQHCLA) provider reimbursement.

(1) Administrative Costs. Expenses incurred in operating the clinic as a whole that are related to the administration and management of the clinic and are not directly associated with furnishing patient care. Administrative costs include but are not limited to: office salaries; office supplies; legal, accounting, or billing services; consulting services; insurance; telephone; fringe benefits; and, payroll taxes.

(2) Allowable Costs. Costs that are reasonable in amount and proper and necessary for the efficient delivery of RHC and FQHC services and that are incurred by an RHC, FQHC or FQHCLA that is authorized to bill based on reasonable costs.
(3) Base Year. The first full fiscal year following the effective date of an RHC's, FQHC's, or FQHCLA's enrollment in Tennessee's Medicaid PPS or APM until the rate is rebased. After a rate is rebased, the rebased rate becomes the new base rate.

(4) Core Reimbursement Rate. The payment for medically necessary primary health services and qualified preventive health services furnished by an RHC, FQHC, or FQHCLA under Tennessee's Medicaid PPS or APM. The additional services of dental, optometry, or pharmacy are reimbursed outside of the core rate. A separate rate is calculated for each additional service.

(5) Covered Service. A medically necessary item or service for which the enrollee is eligible to have payment made on his behalf under this chapter.

(6) Employee. Any individual who, under the common law rules that apply in determining the employer-employee relationship as defined by § 3121(d)(2) of the Internal Revenue Code of 1986 (26 U.S.C. § 3121(d)(2)), is considered to be employed by, or an employee of, an entity. Application of these common law rules is discussed in 20 C.F.R. § 404.1007 and 26 C.F.R. § 31.3121(d)-1(c).

(7) Federally Qualified Health Center (FQHC). An entity that has entered into an agreement with CMS to meet Medicare program requirements under 42 C.F.R. § 405.2434, and:
   (a) Is registered with the State of Tennessee, TennCare, as an FQHC; and
   (b) Is receiving a grant under Section 330 of the Public Health Service (PHS) Act (42 U.S.C. § 254b), or is receiving funding from such a grant under a contract with the recipient of such a grant and meets the requirements to receive a grant under Section 330 of the PHS Act; and
   (c) Is determined by the Health Resources and Services Administration (HRSA) to meet the requirements for receiving such a grant; and
   (d) Was treated by CMS, for purposes of Medicare Part B, as a comprehensive federally funded health center as of January 1, 1990; or
   (e) Is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an Urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act.

(8) Federally Qualified Health Center Look-Alike (FQHCLA). A community-based health care provider that meets the requirements of the HRSA Health Center Program, but does not receive HRSA Health Center Program funding.

(9) Medicare Cost Report. Form CMS-222 and Form CMS-224, the instructions for which are provided at CMS Publication 15-2, Sections 2908-2908.2, and CMS Publication 15-2, Sections 4404.1-4404.3.

(10) Owner. A person, persons, or entities with an enforceable claim or title to the asset or property, and is recognized as such by law.

(11) Rebate. A new calculation of existing data to calculate a new base rate.

(12) Related Parties. Any person, persons, or entities that are related to the owner either by familial relationship or by a business association other than the RHC, FQHC, or FQHCLA itself.

(13) Rural Health Clinic (RHC). A facility that has:
   (a) Been determined by the Secretary of Health and Human Services to meet the requirements of § 1861(aa)(2) of the Social Security Act (42 U.S.C. § 1395x(aa)(2)) and 42 C.F.R. Part 491, concerning RHC services and conditions for approval; and
(b) Filed an agreement with CMS that meets the requirements in 42 C.F.R. §
405.2402 to provide RHC services under Medicare; and
(c) Has registered with the State of Tennessee, TennCare, as an RHC.

(14) TennCare. The state governmental agency administratively located within the Tennessee Department of Finance and Administration; includes references to the Division of TennCare, the Bureau of TennCare and to all employees and subdivisions of the agency.

(15) Visit. A medically-necessary face-to-face medical or mental health encounter or a qualified preventive health encounter between the patient and a physician, nurse practitioner (NP), physician's assistant (PA), certified nurse-midwife (CNM), clinical psychologist (CP), Clinical social worker (CSW), licensed professional counselor (LPC), or PharmD during which time one or more qualified RHC, FQHC, or FQHCLA covered services are furnished. In certain limited situations, an RHC, FQHC, or FQHCLA visit may also include a visit by a registered professional nurse or a licensed practical nurse to a homebound patient.

(16) Acronyms. Following is a list of acronyms used in this chapter:
(a) APM: Alternative Payment Method
(b) APM PPS: Alternative Payment Method, Prospective Payment System
(c) CMS: Centers for Medicare and Medicaid Services
(d) CPT: Current Procedural Terminology
(e) FQHC: Federally Qualified Health Center
(f) FQHCLA: Federally Qualified Health Center Look-Alike
(g) FTE: Full Time Equivalent
(h) HRSA: Health Resources and Services Administration
(i) MEI: Medicare Economic Index
(j) PHS: Public Health Service
(k) PPS: Prospective Payment System
(l) RHC: Rural Health Clinic

1200-13-10-.02 Determination of reimbursable costs for RHCs, FQHCs, or FQHCLAs provided by TennCare.

(1) TennCare, in consultation with the Comptroller of the Treasury, shall establish the rules for the determination of the reimbursable per visit cost for services provided to Medicaid recipients who receive services at an RHC, FQHC, or FQHCLA.

(2) Only an institution registered with TennCare as an RHC, FQHC, or FQHCLA may participate in and be reimbursed as a provider under this chapter. TennCare shall notify the Comptroller of the Treasury when a provider enters the program and when its participation terminates.

(3) The specific items and services covered under the RHC, FQHC, or FQHCLA program shall be those defined and approved by TennCare. See rule .05. Other Medicaid services that are not RHC, FQHC, or FQHCLA services may be provided and billed outside of the PPS or APM payment structure, providing TennCare covers those services.

(4) When calculating an RHC's, FQHC's, or FQHCLA's PPS settlement, the Comptroller and TennCare will multiply the number of allowable visits, as determined in rule .05, times the established PPS or APM rate for that facility to calculate the total that should be received for services rendered. From that total, the Comptroller and TennCare will
subtract any claims-based reimbursement received for those services to calculate the settlement amount.

1200-13-10-.03 Medicaid Cost Reporting.

(1) New and existing RHCs, FQHCs, or FQHCLAs shall, under the Medicare Cost Report Instructions, annually submit a Medicare Cost Report, located on the TennCare website, to the Comptroller each year by the due date imposed by Medicare. This cost report shall be for the RHC’s, FQHC’s, or FQHCLA’s most recent fiscal year that ends at least six months before July 1. If there is not a complete fiscal year of data available for the cost report because of an ownership change or the facility being new, the facility may submit a cost report with a minimum of six (6) months of data. The Comptroller will set a temporary rate based on the average rate of similar entities in the same Grand Division, or in the entire state if there are not enough similar entities in the same Grand Division, that will remain the rate for that RHC, FQHC, or FQHCLA until the RHC, FQHC, or FQHCLA has submitted and the Comptroller has accepted at least twelve (12) months of data.

(2) New and existing RHCs, FQHCs, or FQHCLAs shall annually submit a supplemental Medicaid Cost Report, which will be located on the TennCare website, to the Comptroller each year by the same due date for the Medicare cost report. This cost report shall be for the RHC’s, FQHC’s, or FQHCLA’s most recent fiscal year that ends at least six months before July 1. If there is not a complete fiscal year of data available for the cost report because of an ownership change or the facility being new, the facility may submit a cost report with a minimum of six (6) months of data. The Comptroller will set a temporary rate based on the average rate of similar entities in the same Grand Division, or in the entire state if there are not enough similar entities in the same Grand Division, that will remain the rate for that RHC, FQHC, or FQHCLA until the RHC, FQHC, or FQHCLA has submitted and the Comptroller has accepted at least twelve (12) months of data.

(3) New RHCs, FQHCs, or FQHCLAs may submit budgeted cost reports after requesting permission from the Comptroller. The Comptroller will set an interim rate based on the average rate of similar entities in the same Grand Division, or in the entire state if there are not enough similar entities in the same Grand Division. When the new RHC, FQHC, or FQHCLA has submitted and the Comptroller has accepted twelve (12) months of data with all supporting schedules and documentation, the Comptroller will set a new interim PPS rate using the facility’s data under this chapter. When the new RHC, FQHC, or FQHCLA has submitted and the Comptroller has accepted twenty-four (24) months of data with all supporting schedules and documentation, the Comptroller will set a permanent PPS rate using the facility’s data under this chapter.

(4) RHCs, FQHCs, or FQHCLAs that have just undergone an ownership change will continue to receive the same rate as before the ownership change. The new owner may formally request the setting of a new rate from TennCare. TennCare will consult with the Comptroller and evaluate the request and determine whether or not to issue a new rate.

1200-13-10-.04 Standard reimbursement for a new RHC, FQHC, or FQHCLA.
Upon receipt of a Medicare Cost Report and supplemental Medicaid Cost Report submitted by an RHC, FQHC, or FQHCLA to the Comptroller as required by rule .03, the Comptroller shall:

(a) Review the Medicare Cost Report and supplemental Medicaid Cost Report; and
(b) Notify the RHC, FQHC, or FQHCLA if additional documentation is necessary.
(c) 1. If additional documentation is necessary to establish a final PPS rate or APM PPS rate, the RHC, FQHC, or FQHCLA shall:
   (i) Provide the additional documentation to the Comptroller within thirty (30) days of the notification of need for additional documentation; or
   (ii) Request an extension beyond thirty (30) days to provide the additional documentation.
2. The Comptroller has full discretion on whether or not to grant the extension.
3. The Comptroller shall grant no more than one (1) extension.
4. An extension shall not exceed thirty (30) days.
(d) 1. If the Comptroller requests additional documentation from the RHC, FQHC, or FQHCLA but does not receive additional documentation or an extension request within thirty (30) days, TennCare shall reimburse the RHC, FQHC, or FQHCLA as it reimburses primary care centers that are not an RHC, FQHC, or FQHCLA until:
   (i) The additional documentation has been received by the Comptroller; and
   (ii) The Comptroller has established a final PPS rate.
2. If an RHC, FQHC, or FQHCLA does not submit both a Medicare Cost Report and supplemental Medicaid Cost Report to the Comptroller, TennCare shall reimburse the RHC, FQHC, or FQHCLA as it reimburses primary care centers that are not an RHC, FQHC, or FQHCLA until the RHC, FQHC, or FQHCLA submits both a Medicare Cost Report and supplemental Medicaid Cost Report to the Comptroller.
(e) The Comptroller may review an RHC's, FQHC's, or FQHCLA's paid claims listing for the period of time corresponding to the submitted cost report.
(f) If an RHC, FQHC, or FQHCLA has submitted all necessary information to the Comptroller, within 120 days of reviewing the RHC's, FQHC's, or FQHCLA's paid claims listing, the Comptroller shall:
   1. Establish a final PPS rate for the RHC, FQHC, or FQHCLA; and
   2. Notify the RHC, FQHC, or FQHCLA in writing of the RHC's, FQHC's, or FQHCLA's Final PPS rate.
(2) Along with a Medicare Cost Report and supplemental Medicaid Cost Report, an RHC, FQHC, or FQHCLA shall submit to the Comptroller per year of operation, a written statement of the RHC's, FQHC's, or FQHCLA's maximum hours per day, days per week, and weeks per year of operation, trial balance, detailed general ledger, depreciation schedule, schedule listing allocations, all management and consulting contracts, all billing NPI numbers, a listing of all related parties with which the provider does business, total visit log, schedule of owner's compensation, a schedule of all employee salaries by title, documentation for reclassification, and adjustments. If an RHC, FQHC, or FQHCLA does not submit this written statement, TennCare shall continue to pay the
RHC, FQHC, or FQHCLA as it pays primary care centers that are not an RHC, FQHC, or FQHCLA.

1200-13-10-.05 Determination of a reimbursable visit.

(1) RHCs, FQHCs, or FQHCLAs shall only be reimbursed for allowable paid TennCare visits. This applies to both the PPS and APM methodologies.

(2) TennCare shall adopt or amend a list of CPT codes that will be published on the TennCare website. The list of CPT codes will be presumed allowable visits for both the PPS and APM methodologies and may be periodically updated with additions, deletions, or modifications. TennCare will post any amendments to the list on its website at least thirty (30) days prior to making any changes. When amendments to the CPT code list become effective, any changes in payments to providers will also become effective on the same date.

(3) If an encounter between an RHC, FQHC, or FQHCLA provider and a TennCare enrollee involves a CPT code that is not on the TennCare CPT codes list, the RHC, FQHC, or FQHCLA may request reimbursement for the CPT code, which TennCare will consider in light of the reasonableness standards described in rule .06. Whether or not the code is counted as a visit will be at the sole discretion of TennCare upon consultation with the Comptroller.

(4) An encounter for the purpose of medication therapy management, whether provided by a pharmacist or other provider, shall not be considered a reimbursable visit, as payment for this service is made outside of the PPS or APM methodology.

(5) An encounter or service related to patient centered medical home payments, including the activity payments, practice transformation payments, and outcome payments, shall not be considered a reimbursable visit, as payment for this service is made outside of the PPS or APM methodology.

(6) An encounter or service related to Tennessee Health Link payments, including activity payments and outcome payments, shall not be considered a reimbursable visit, as payment for this service is made outside of the PPS or APM methodology.

(7) An encounter or service related to any other types of payment reform initiatives that may be implemented by TennCare, structured as per member per month case rates or outcome payments based on established performance criteria, shall not be considered a reimbursable visit, as payment for this service is made outside of the PPS or APM methodology.

(8) If an encounter includes both a medical visit and a mental health visit, the RHC, FQHC, or FQHCLA shall report it as two separate visits. This applies to both the PPS and APM methodologies.

(9) An RHC, FQHC, or FQHCLA shall not report multiple CPT codes that comprised one visit as multiple visits in a submission to the Comptroller, except when a minor child receives both a well-child visit and a sick visit at the same time, each visit may be billed separately for a maximum of two allowable paid TennCare visits. This applies to both the PPS and APM methodologies.

(10) Medicare Crossover claims are ineligible for being counted as visits in either the PPS or APM methodologies.
(11) Each billed item for patient care must include an invoice date and at least one CPT code for the visit to be considered an allowable visit in either the PPS or APM methodologies.

(12) For PPS or APM purposes, the RHC, FQHC, or FQHCLA must submit visits to the Comptroller using the template that will be posted at the TennCare website, in order for the visits to be reimbursed. All data elements on the template must be complete and in the requested format for a claim to be considered as a visit. TennCare may change the template after providing at least thirty days prior notice.

1200-13-10-.06 Determination of reasonable costs.

(1) Only reasonable costs will be reimbursed under this chapter. It is within the Comptroller's discretion to determine what is a reasonable cost and if it may be reimbursed.

(2) The following factors will be considered in determining reasonable costs:
   (a) Fees paid by an RHC, FQHC, or FQHCLA pursuant to any contract to pay contingency fees for consulting, accounting, bookkeeping or similar services, or any contract to pay the vendor a percentage of the fees recovered from TennCare, will be presumed unreasonable and will not be reimbursed.
   (b) Imputed salaries will be presumed unreasonable. All salary amounts must be reported on an IRS Form W-2 or an IRS Form 1099 to be considered for reasonableness.
   (c) Salaried or contracted costs shall be accompanied by an FTE calculation.
   (d) Owner's compensation and compensation to any related parties claiming salary or wages from the RHC, FQHC, or FQHCLA will be indexed to the Tennessee Occupational Employment and Wage Rates or other sources as determined by the Comptroller and will be paid only in circumstances as described in this rule.
   (e) For any employee or owner whose job functions include responsibilities other than direct patient care, the RHC, FQHC, or FQHCLA will be required to report the total number of hours the employee or owner spent performing functions that were not direct patient care.
   (f) Administrative costs will be capped at thirty percent (30%) of the total costs, with imputed costs excluded.

(3) For reimbursement purposes, a reasonable allowance or compensation for services of an owner shall be subject to the following:
   (a) The services provided by the owner must be a necessary function, meaning that had the owner not rendered the services, the institution would have been required to employ another person to perform them. The services must be related to patient care and pertinent to the operation and sound management of the institution. TennCare shall be responsible for determining which services are related to patient care and pertinent to the operation and sound management of the institution, upon consultation with the Comptroller.
   (b) Total compensation to owners must be listed on the Medicare Cost Report. Where these amounts include items other than salaries, a schedule must be attached that identifies the amounts and the method of assigning values to these benefits.
(c) The Comptroller's Office will review these amounts and compare them with allowable compensation ranges and make necessary adjustments. The Comptroller will consider the duties, responsibilities, and managerial authority of the person as well as the services performed for other institutions and his engagements in other occupations. Only one full-time position, or its equivalent, will be allowed for each person. The duties performed, time spent, and compensation received by the person must be substantiated by appropriate records.

(4) The Comptroller may review any item in the cost report for reasonableness and to determine whether or not it should be an allowable cost.

(5) This rule applies to both the standard PPS and APM methodologies.


1200-13-10-.07 Change in Scope and Final PPS Rate Adjustment.

(1) (a) If an RHC, FQHC, or FQHCLA changes its scope of services after the base year rate is established, the Comptroller shall adjust its final PPS rate if the change in scope qualifies for an adjustment under this rule, upon review and approval of the change in scope.

(b) An adjustment to a final PPS rate resulting from a change in scope that occurred after an RHC's, FQHC's, or FQHCLA's base year rate is established shall be effective from the beginning of the quarter that the change in scope request was submitted.

(2) A change in scope of service shall be restricted to:

(a) A change in type: adding or deleting a Medicaid-covered ambulatory service; or

(b) A change in intensity: a change in the type or quality of services offered in an average visit such that the average patient receives a different array of services than the service mix patients received when the PPS rate was last set. Examples include changes caused by new statutory or regulatory requirements or the introduction or expansion of specialty care; or

(c) A change in duration: a change in the average length of time it takes RHC, FQHC, or FQHCLA providers to complete an average patient visit due to changing circumstances such as the introduction of health care delivery system transformation program or patient-centered care, or a change in patient demographics including, but not limited to, populations with HIV or AIDS or other chronic diseases, homeless, elderly, migrant, or other special populations; or

(d) A Change in amount: an increase or decrease in the quantity of services that an average patient receives in an average Medicaid-covered visit such as improvements to technology or facilities that result in increased services to the RHC's, FQHC's, or FQHCLA's patients; or

(e) A statutory or regulatory change that materially impacts the costs or visits of an RHC, FQHC, or FQHCLA.

(3) The following items individually shall not constitute a change in scope:

(a) A general increase or decrease in the costs of existing services;

(b) A reduction or an expansion of hours per day, days per week, or weeks per year;

(c) A wage increase;

(d) A renovation or other capital expenditure;
(e) A change in ownership; or
(f) An addition or deletion of a service provided by a non-licensed professional or specialist.

(4) (a) The addition of a covered service shall be restricted to the addition of a licensed professional staff member who can perform a Medicaid covered service that is not currently being performed within the RHC, FQHC, or FQHCLA by a licensed professional employed or contracted by the facility.
(b) The deletion of a covered service shall be restricted to the deletion of a licensed professional staff member who performed a Medicaid covered service that was being performed within the RHC, FQHC, or FQHCLA by the licensed professional staff member.

(5) The Comptroller shall consider a change in scope request due to a statutory or regulatory change that materially impacts the costs of visits at an RHC, FQHC, or FQHCLA if:
(a) A government entity imposes a mandatory minimum wage increase and the increase was:
1. Not included in the calculation of the final PPS rate; or
2. Not subsequently included in the MEI applied yearly; or
(b) A new licensure requirement or modification of an existing requirement by the state results in a change that affects all facilities within the class. A provider shall document that an increase or decrease in the cost of a visit occurred as a result of a licensure requirement or policy modification.

(6) A requested change in scope shall:
(a) Increase or decrease the existing final PPS rate by at least five percent (5%);
(b) Remain in effect at least twelve (12) months; and
(c) Be submitted to the Comptroller as a written detailed description including documentation of the service change.

1. For the addition of a service: the description must include the service the RHC or FQHC is adding, the location(s) offering the service, the date the RHC or FQHC began providing the service, and a brief description of how the new service will benefit the patient population.

2. For a change in intensity, duration, or amount: the description must include the service change, the location(s) where the change has occurred, a description of how the average visit has changed from when the RHC's or FQHC's rate was set, along with relevant supporting documentation, and how the change has benefitted the patient population.

(7) (a) An RHC, FQHC, or FQHCLA that requests a change in scope shall submit the following documents to the department within twelve (12) months of the requested effective date of a change in scope:
1. A narrative describing the change in scope;
2. A Medicare Cost Report for the affected fiscal year; and
3. Relevant documentation including a trial balance, depreciation schedule, detailed general ledger, schedule listing allocations, total visit log, schedule of owner's compensation, a schedule of all employee's salaries by title, a list of related parties, documentation for reclassification, and adjustments.
(b) If the Comptroller requests information from the provider and does not receive the required documentation within 90 days, the change in scope shall be denied.

(c) 1. The Comptroller shall:
   (i) Review the documentation listed in this rule; and
   (ii) Notify the RHC, FQHC, or FQHCLA in writing of the:
      (I) Approval or denial of the request for change in scope within ninety (90) business days from the date the Comptroller received the request; or
      (II) Need for additional documentation from the RHC, FQHC, or FQHCLA to establish an interim PPS rate associated with the change in scope.

2. If the Comptroller requests additional documentation to calculate the interim PPS rate for a change in scope, the RHC, FQHC, or FQHCLA shall:
   (i) Provide the additional documentation to the Comptroller within thirty (30) days of the request for additional documentation; or
   (ii) Request an extension beyond thirty (30) days to provide the additional documentation.

3. (i) The Comptroller shall grant no more than one (1) extension.
   (ii) An extension shall not exceed thirty (30) days.
   (iii) The Comptroller shall have complete discretion regarding whether to grant or deny an extension.

4. If the Comptroller approves the request for a change in scope and receives all of the necessary documentation from an RHC, FQHC, or FQHCLA within the timelines established in this rule, the Comptroller shall establish an interim PPS rate for the RHC, FQHC, or FQHCLA based on the average rate of similar entities in the same Grand Division, or in the entire state if there are not enough similar entities in the same Grand Division.

8) If an RHC, FQHC, or FQHCLA requests a change in scope and it is granted, all of the rates, including the Core Reimbursement Rate and other rates outside the Core Reimbursement Rate, will be rebased.

1200-13-10-.08 Standard reimbursement for an existing RHC, FQHC, or FQHCLA.

(1) For a visit by a recipient who is a TennCare enrollee, TennCare shall reimburse:
   (a) An RHC, FQHC, or FQHCLA: a quarterly settlement based on the final PPS rate as required by 42 U.S.C. 1396a(bb); or
   (b) A satellite facility of an RHC, FQHC or FQHCLA: a quarterly settlement based on the final PPS rate.

(2) The Comptroller shall calculate a final PPS rate for a new RHC, FQHC, or FQHCLA under rule .04.

(3) The Comptroller shall adjust a final PPS rate:
   (a) By the percentage increase in the MEI applicable to RHC services on July 1 of each year; or
   (b) By the market basket measure for FQHC and FQHCLA services; and
   (c) As permitted by rule .07:
1. Upon request and documentation by an RHC, FQHC, or FQHCLA that there has been a change in scope of services; or
2. Upon review and determination by the Comptroller that there has been a change in scope of services; or
3. If necessary as a result of a desk review or audit.

(4) A final PPS rate established under this rule shall not be subject to an end of the year cost settlement.

(5) Upon implementation of this chapter, the Comptroller will review all PPS rates using the cost reports used to set those rates if available, or if not, using the best available cost report data, in order to determine if the included costs are allowable costs according to the requirements in this chapter. If it is determined that some of the costs are not allowable costs according to this chapter, the RHC, FQHC, or FQHCLA will be offered the opportunity to change to the APM methodology and either:

(a) Change to the APM methodology and a rebase will ensue under rule .09; or

(b) The PPS rate will be frozen and not allowed to experience any annual inflationary adjustments until the point that the Comptroller determines that the appropriate original rate, plus annual inflationary adjustments for each year, would surpass the current rate.


1200-13-10-.09 Alternative Payment Methodology for an RHC, FQHC, or FQHCLA.

(1) TennCare may offer to an RHC, FQHC, or FQHCLA, for which a final PPS rate exists, an alternative payment methodology. The RHC, FQHC, or FQHCLA, at the RHC, FQHC, or FQHCLA's election, may receive the alternative payment methodology rate if it notifies TennCare in writing that it elects to receive the alternate reimbursement.

(2) Establishment of base years and periodic rebasing.

(a) If the RHC, FQHC, or FQHCLA elects to use the alternative payment methodology, it will undergo establishment of a new base year. The Comptroller shall collect and review Medicare Cost Report data from the previous two (2) fiscal years, or if the provider has been in existence for fewer than two (2) years, then for as many months as are available, and use this data to compute a new PPS rate, which will be called the APM PPS rate. A minimum of twelve (12) months data must be available in order to set an APM PPS rate, and the rate must be rebased as soon as there are twenty-four (24) months of available cost report data.

(b) Following that rebase year, if an RHC, FQHC, or FQHCLA, the APM PPS Rate shall be adjusted by the market basket measure applicable to FQHC and FQHCLA services on July 1 of each year.

(c) The factors included in rule .06 will be calculated into the APM PPS rate.

(d) The Comptroller will perform a rebase of all RHCs, FQHCs, or FQHCLAs no more than one (1) time per fiscal year and no less than one time every five (5) fiscal years, without prior notice and using the previous two (2) fiscal years of Medicare Cost Report data.
(e) The Comptroller may not offer, and an RHC, FQHC, or FQHCLA may not collect, the APM PPS Rate unless the APM PPS Rate is equal to or higher than the Standard PPS Rate, as calculated according to this chapter. When an APM is first implemented, or when it is rebased, TennCare will ensure that the APM is equal to or greater than the Standard PPS as calculated according to the provisions in this chapter.

(f) The offer of the APM PPS is valid for only the year in which the payment is offered. Entities that do not choose the APM PPS in the year it is offered will be required to wait until APM PPS is offered again. This will be a minimum of five (5) years.

(3) If a facility elects to use the APM, it must use the APM for all rates, including the Core Reimbursement Rate and those rates outside of the Core Reimbursement rate.


1200-13-10-.10 Auditing of cost reports.

(1) The cost reports filed under this chapter and all pertinent provider records shall be subject to audit by the Comptroller of the Treasury or his agents.

(2) The cost reports filed under this chapter must provide adequate cost and statistical data. This data must be:
   (a) Based on and traceable to the provider's financial and statistical records; and
   (b) Adequate, accurate and in sufficient detail to support payment made for services rendered to enrollees; and
   (c) Available for and capable of verification by the Comptroller of the Treasury or his agents.

(3) The provider shall permit the Comptroller or his agents to examine any records and documents necessary to ascertain information pertinent to the determination of the proper amount of program payments due.

(4) Data reflected on the cost report which cannot be substantiated may be disallowed with reimbursement being required of the provider.

(5) At any point, the Comptroller may audit an RHC, FQHC, or FQHCLA to determine if unreasonable or unallowable costs are built into the rates, and adjustments shall be made so that the rates are based only on allowable costs, as defined in this chapter.


1200-13-10-.11 PPS Rates outside of core reimbursement.

RHCs, FQHCs, or FQHCLAs are permitted to establish secondary PPS rates for services outside of the core, including but not limited to, dental and pharmacy. In order to do this, a request must be submitted to the Comptroller to set these rates. All provisions in this rule apply to secondary PPS rates in the same way that they apply to core PPS rates.


I certify that the information included in this filing is an accurate and complete representation of the intent and scope of rulemaking proposed by the agency.

Date: 9/25/18
Signature: /s/ Wendy Long, M.D., M.P.H.
Name of Officer: Wendy Long, M.D., M.P.H.
Title of Officer: Director, Division of TennCare Tennessee Department of Finance and Administration
2.b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (RHC).

Payment for covered services provided by RHCs shall be in accordance with the methods of payment below:

- X The payment methodology for RHCs will conform to section 702 of the Benefit Improvement and Protection Act (BIPA) 2000 legislation.

- X The payment methodology for RHCs will conform to the BIPA 2000 requirements Prospective Payment System.

- X The payment methodology for RHCs will conform to the BIPA 2000 requirements for an alternative payment methodology. The payment amount determined under this methodology:

  1) is agreed to by the State and the center or clinic; and
  2) results in payment to the center or clinic of an amount which is at least equal to the PPS payment rate.

The State is using the cost reports filed with Medicare for FY 1999 and FY 2000. For the period January 1, 2001 to September 30, 2001, RHCs will be paid their average 1999 and 2000 costs, adjusted for any change in scope of services. The RHCs have a variety of fiscal year ends. The clinics already have Medicare cost reports so, as a practical matter, the State will use those reports. With respect to the fiscal year ends, for the 1999 year, the State will use the clinic year end that has the most months in calendar year 1999 and the 2000 year end with the most months in calendar year 2000. For a clinic with a March 31 fiscal year end, the State will use their FYE March 31, 2000 cost report for 1999 (because most of the months fall in 1999), and the State will use their FYE March 31, 2001 cost report for 2000. These are the two years used to compute the average cost for the first part of BIPA and also for computing the prospective rate for the second part.

The State is using the average cost per visit for 1999 and 2000 to compute the prospective payment system (PPS) rate. Total costs are divided by total visits for each year and then averaged to determine the rate. The PPS rate, effective October 1, 2001 will be indexed for a nine-month period to July 1, 2002 which will place the rates on the state’s fiscal year. From that point on, the Medicare Economic Index (MEI) will be applied annually so that the PPS remains on the state’s fiscal year.

TN No.: 06-003
 superseded
 TN No.: 2001-01
 Approval Date: 9/20/06
 Effective Date: 1/1/06
The cost reports submitted by the clinics are being desk reviewed, and the cost centers (and visits) excluded by Medicare, but covered by Medicaid, are being restored along with the applicable overhead costs. Also, cost centers not covered by Medicaid are excluded.

The RHCs have to undergo a formal Medicare application and approval process for a change in their scope of services. The State intends to use this process for this purpose.

The State has worksheets in place which will compute the changes in scope of services. Clinics first inform the State that they have a change and provide the actual costs, visits, and (if applicable) square footage allocated to the new services. The change in cost will then be factored into an adjusted PPS rate.

The State is requiring the clinics to submit cost reports on a continuing basis even though costs will not factor into the PPS in subsequent years. Having the cost reports will aid the State auditing effort and will alert the State to any reductions in scope of services that may not have been reported. The clinics need only incur a small postage charge to meet this requirement, the State is only asking for a copy of their as filed Medicare report.

For clinics that began operations during the 1999 and 2000 period, the State is using the past year cost report filed with Medicare. The State believes that even though one period is a short year, it will not impact the average cost per visit.

For new clinics that qualify after 2000, the State will use the average PPS rate for neighboring clinics with similar caseloads. If there are no such similar clinics, the State will use the average PPS rate for all clinics on an interim basis until the clinic can provide some projected costs upon which the State can base the clinic’s projected PPS rate. After the clinic submits its cost report, the State will compare projected costs and visits with the actual data, and the State will adjust the PPS rate as necessary.

Within 60 days after the end of each quarter, the RHCs will report to the State actual TennCare visits and the corresponding managed care organization (MCO) payments received. The State will then make quarterly payments to the clinics for the actual difference between the amount of MCO reimbursements received and the BIPA required PPS amount. In the event that a clinic does not provide the necessary visits and MCO payments timely, the State will make an estimated quarterly payment and reconcile the difference once the actual data for the quarter are received.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: TENNESSEE
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Alternative payment methodology:

The RHCs have a variety of fiscal year ends. The State is using the two most recent Medicare cost reports on file as of September 30, 2005, to determine an average cost per visit to determine the prospective payment system (PPS) rate. As examples, for a center with a March 31 fiscal year end, the State will use its FYE March 31, 2005 and FYE March 31, 2004 cost reports; for a center with a September 30 fiscal year end, the State will use its FYE September 30, 2004, and September 30, 2003 cost reports.

Total costs are divided by total visits for each of the two cost report periods and then averaged to determine the PPS rate, adjusted for any change in scope of services, to be paid to the RHCs for the period January 1, through September 30, 2006. The facility-specific PPS rates will be indexed, using the Medicare Economic Index (MEI) for a nine-month period effective for dates of service on and after October 1, 2006. The rates will again be indexed for a nine-month period to be effective for dates of service on and after July 1, 2007. Thereafter, the (MEI) will be applied annually so that the PPS coincides with the State’s fiscal year end of June 30.

The cost reports submitted by the clinics are being desk reviewed, and the cost centers (and visits) excluded by Medicare, but covered by Medicaid, are being restored along with the applicable overhead costs. Also, cost centers not covered by Medicaid are excluded.

The RHCs have to undergo a formal Medicare application and approval process for a change in their scope of services. The State intends to use this process for this purpose.

The State has worksheets in place which will compute the changes in scope of services. Clinics would first inform the State that they have had a change in their scope of services and then would provide the actual costs, visits, and square footage statistics, as applicable, allocated to the new services. The change in costs will be factored into an adjusted PPS rate.

The State is requiring the clinics to submit copies of the as-filed Medicare cost reports annually, though costs will not factor into the PPS in subsequent years. The cost reports will aid the auditing effort by alerting the State to any reductions in scope of services that may not have been reported. The clinics need only incur a nominal fee to meet this requirement.

TN No.: 06-003
Supersedes
TN No.: 2001-01

Approval Date: 9/20/06
Effective Date: 1/1/06
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: TENNESSEE
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

For existing clinics that qualify after March 31, 2005, the State is using the most recent cost report filed with Medicare to determine its average cost per visit and PPS rate. The State believes that although only one period is used, it will not materially impact the average cost per visit.

For new clinics that qualify after March 31, 2005 (thus having no cost report history), the State will use the average PPS rate for neighboring clinics with similar caseloads. If no such clinics exist, the State will use the average PPS rate for all clinics statewide on an interim basis until the clinic can provide pro forma data, which the State will use to establish an interim PPS rate. After the first full year actual cost report is received, the State will compare the pro forma data to the actual cost report data and adjust the PPS rate as necessary.

Within 60 days after the end of each quarter, the RHCs will report to the State the actual TennCare visits and the corresponding managed care organization (MCO) payments received. The State will then make quarterly payments to the clinics for the actual difference between the amount of MCO reimbursements received and the BIPA-required PPS amount.

Regardless of methodology, payment must be at least equal to the BIPA PPS rate. The State will compare the alternative rate against the PPS rate on a yearly basis. If the PPS rate is more, then the State will reimburse the facility the difference. If the PPS is less, then no recoupment will be made.

TN No.: 06-003
Supersedes TN No.: 2001-01
Approval Date: 9/20/06
Effective Date: 1/1/06
TennCare Audit Request

The office of the Comptroller of the Treasury, Division of State Audit has scheduled its examination of Cookeville Medical Clinic to begin on November 12, 2018. We will work 8-6 Monday through Thursday, there will be 4 auditors in attendance. The entrance conference will be held at 9:00 am. We will be reviewing the Medicare Cost Report FYE: 12/31/14 and 12/31/15 and TennCare Visits and payments for the period 1/1/14-6/30/18. An official engagement letter will be mailed; however, below are a list of some of the items we will be requesting. Once we are in the field we may request more items. Please continue to send the invoices/receipts, you may include the cancelled checks, lead schedules, credit card statements and bank statements as well before we arrive for the fieldwork.

1. Cash disbursements and cash receipts journal.
2. Original invoices, cancelled checks, and bank statements supporting costs reported on the Rural Health Clinic cost report for FYE 12/31/14 and 12/31/15 for the expenses that have previously been selected. For the American Express breakdowns we will need the Statement for each month in the test period and the canceled check/bank statement that supports the payments.
3. Billing records, claims reports, and remittance advices.
4. Depreciation schedule and supporting documents.
5. Payroll records. – We will need the QWR’s FYE: 12/31/14 and 12/31/15.
6. Contracts with physicians, physician assistants, nurse practitioners, pharmacies, hospitals, managed care organizations, consulting services, and billing services.
7. Copy of lease agreement.
8. Minutes of board meetings.
9. Working papers supporting allocations and calculations used in the preparations of the cost reports.
10. Annual Statement for FYE 12/31/14 and 12/31/15

11. Audited financial statements.

12. Support for your quarterly reports, visits and payments.

13. Related party information – lists of any related party that is employed or contracted with the facility.


If you have any questions or concerns, please respond to this email or you may call the number listed below.

Thank you

Tammy Fruscione, CGFM
Legislative Auditor
Division of State Audit
Tennessee Comptroller of the Treasury
Cordell Hull Building
425 Fifth Avenue North
Nashville, TN 37243

Office: 615-747-5221
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§ 413.100 Special treatment of certain accrued costs.

(a) Principle. As described in § 413.24(b)(2), under the accrual basis of accounting, revenue is reported in the period in which it is earned and expenses are reported in the period in which they are incurred. In the case of accrued costs described in this section, for Medicare payment purposes the costs are allowable in the year in which the costs are accrued and claimed for Medicare payment only under the conditions set forth in paragraph (c) of this section.

(b) Definitions -

(1) All-inclusive paid days off benefit. An all-inclusive paid days off benefit replaces other vacation and sick pay plans. It is a formal plan under which, based on actual hours worked, all employees accrue vested leave or payment in lieu of vested leave for any combination of types of leave, such as illness, medical appointments, holidays, and vacations.

(2) Self-insurance. Self-insurance is a means by which a provider independently or as part of a group undertakes the risk of protecting itself against anticipated liabilities by providing funds in an amount equal to anticipated liabilities, rather than by purchasing insurance coverage.

(c) Recognition of accrued costs -

(1) General. Although Medicare recognizes, in the year of accrual, the accrual of costs for which a provider has not actually expended funds during the current cost reporting period, for purposes of payment Medicare does not recognize the accrual of costs unless the related liabilities are liquidated timely.

(2) Requirements for liquidation of liabilities. For accrued costs to be recognized for Medicare payment in the year of the accrual, the requirements set forth below must be met with respect to the liquidation of related liabilities. If liquidation does not meet these requirements, the cost is disallowed, generally in the year of accrual, except as specified in paragraph (c)(2)(ii) of this section.

(i) A short-term liability.

(A) Except as provided in paragraph (c)(2)(i)(B) of this section, a short-term liability, including the current portion of a long-term liability (for example, mortgage interest payments due to be paid in the current year), must be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred.
(B) If, within the 1-year time limit, the provider furnishes to the contractor sufficient written justification (based upon documented evidence) for nonpayment of the liability, the contractor may grant an extension for good cause. The extension may not exceed 3 years beyond the end of the cost reporting year in which the liability was incurred.

(ii) Vacation pay and all-inclusive paid days off.

(A) If the provider's vacation policy, or its policy for all-inclusive paid days off, is consistent for all employees, liquidation of the liability must be made within the period provided for by that policy.

(B) If the provider's vacation policy, or its policy for all-inclusive paid days off, is not consistent for all employees, liquidation of the liability must be made within 2 years after the close of the cost reporting period in which the liability is accrued.

(C) If payment is not made within the required time period or if benefits are forfeited by the employee, an adjustment to disallow the accrued cost is made in the current period (that is, the latest year in which payment should have been made or the year in which the benefits are forfeited) rather than in the period in which the cost was accrued and claimed for Medicare payment. However, an contractor may choose to require the adjustment in the period in which the cost was accrued and claimed for Medicare payment if the cost report for that period is open or can be reopened as provided in § 405.1885 of this chapter, and if the contractor believes the adjustment is more appropriate in that period.

(iii) Sick pay.

(A) If sick leave is vested and funded in a deferred compensation plan, liabilities related to the contributions to the fund must be liquidated, generally within 1 year after the end of the cost reporting period in which the liability is incurred. If, within the 1-year time limit, the provider furnishes to the contractor sufficient written justification (based upon documented evidence) for nonpayment of the liability, the contractor may grant an extension for good cause. The extension may not exceed 3 years beyond the end of the cost reporting year in which the liability was incurred. Contributions to the deferred compensation plan must be reduced to reflect estimated forfeitures. Actual forfeitures above or below estimated forfeitures must be used to adjust annual contributions to the fund.

(B) If the sick leave plan grants employees the nonforfeitable right to demand cash payment for unused sick leave at the end of each year, sick pay is includable in allowable costs, without funding, in the cost reporting period in which it is earned.

(C) Sick pay paid on any basis other than that specified in paragraphs (c)(2)(iii) (A) or (B) of this section can be claimed for Medicare payment only on a cash basis for the year in which the benefits are paid.

(iv) Compensation of owners. Accrued liability related to compensation of owners other than sole proprietors and partners must be liquidated within 75 days after the close of the cost reporting period in which the liability occurs.
(v) **Nonpaid workers.** Obligations incurred under a legally-enforceable agreement to remunerate an organization of nonpaid workers must be discharged no later than the end of the provider's cost reporting period following the period in which the services were furnished.

(vi) **FICA and other payroll taxes - (A) General rule.** The provider's share of FICA and other payroll taxes that the provider becomes obligated to remit to governmental agencies is included in allowable costs only during the cost reporting period in which payment (upon which the payroll taxes are based) is actually made to the employee. For example, payroll taxes applicable to vacation benefits are not to be accrued in the period in which the vacation benefits themselves are accrued but rather are allowable only in the period in which the employee takes the vacation.

**(B) Exception.** If payment would be made to an employee during a cost reporting period but for the fact the regularly scheduled payment date is after the end of the period, costs of accrued payroll taxes related to the portion of payroll accrued through the end of the period, but paid to the employee after the beginning of the new period, are allowable costs in the year of accrual, subject to the liquidation requirements specified in paragraph (c)(2)(i) of this section.

(vii) **Deferred compensation.**

**(A)** Reasonable provider payments made under unfunded deferred compensation plans are included in allowable costs only during the cost reporting period in which actual payment is made to the participating employee.

**(B)** Accrued liability related to contributions to a funded deferred compensation plan must be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred. An extension, not to exceed 3 years beyond the end of the cost reporting year in which the liability was incurred, may be granted by the contractor for good cause if the provider, within the 1-year time limit, furnishes to the contractor sufficient written justification for non-payment of the liability.

**(C)** Postretirement benefit plans (including those addressed in Statement of Financial Accounting Standards No. 106 (December 1990)) are deferred compensation arrangements and thus are subject to the provisions of this section regarding deferred compensation and to applicable program instructions for determining Medicare payment for deferred compensation.

**(D)** Exception: Qualified defined benefit pension plans, which are funded deferred compensation arrangements, shall be reported on a cash accounting basis as follows:

**(1)** The allowable pension cost shall be equal to the amount of actual pension contributions funded during the hospital's current Medicare cost reporting period, plus any contributions funded in a prior period and carried forward, subject to the limit under paragraph (c)(2)(vii)(D)(2) of this section.

**(2)** Except as provided in paragraph (c)(2)(vii)(D)(3) of this section, the allowable pension cost shall not exceed 150 percent of the average contribution(s) funded during the three consecutive Medicare cost reporting periods that produce the
highest average contribution(s), out of the five most recent Medicare cost reporting periods (ending with the current cost reporting period). Contributions in excess of the limit may be carried forward to future period(s). In the case of a newly adopted pension plan, the 5-year look-back period and/or the 3-year averaging period will be limited to the number of cost reporting periods the provider sponsored a qualified defined benefit pension plan.

(3) A waiver of the limit imposed under paragraph (c)(2)(vii)(D)(2) of this section may be granted for a specific Medicare cost reporting period for all or a portion of the contributions in excess of the limit imposed under paragraph (c)(2)(vii)(D)(2) of this section if it is determined that such excess costs are reasonable and necessary for that period.

(viii) Self-insurance. Accrued liability related to contributions to a self-insurance program that are systematically made to a funding agency and that cover malpractice and comprehensive general liability, unemployment compensation, workers' compensation insurance losses, or employee health benefits, must be liquidated within 75 days after the close of the cost reporting period.

[ 60 FR 33136, June 27, 1995, as amended at 64 FR 51909, Sept. 27, 1999; 77 FR 53682, Aug. 31, 2012]
TennCare RHC Moratorium - A Big Pile of Horse Manure

Chattanooga, Tennessee, June 22, 2018 - In October 2017 Tennessee sought and received a moratorium from the Centers for Medicare and Medicaid Services (CMS) to no longer pay new Rural Health Clinics (RHCs) the additional costs of complying with Public Law 95-210 and providing an additional access point for healthcare to the most rural and poorest residents. This in addition to Tennessee’s failure to expand TennCare even though billions of federal dollars were available to provide this care has led to catastrophic results in Tennessee.

Eight rural Tennessee hospitals have closed since 2010. Only Texas with ten has more than Tennessee. Since hospitals have an obligation under EMTALA to treat all patients that present these eight communities have lost one of their last health access points for TennCare patients. Now by depriving new RHCs necessary funding to open, expand, and treat TennCare patients, TennCare is choking out another access point for our poor, rural, and underserved.

Tenncare indicated the reason for the moratorium on payment of the RHC Quarterly Settlements is what appears to be a multi-million-dollar fraud in the RHC program. One important revelation from TennCare is the potential fraud did not involve RHC cost reports, nor did it involve the completion of TennCare Quarterly Settlement Reports and TennCare. As of this date TennCare has not formally charged any rural health clinic with fraud. It is as if federal regulators upon discovery of potential fraud by Bernie Madoff instead of investigating the fraud issued regulations that people could no longer invest money until they figured out the nature of the crime.

As Forrest Gump once said, “I’m am not a smart man, but I know what love is”; however, it does not take a smart man to see through the flaws in TennCare’s logic as it relates to the moratorium.

1. If the fraud is being committed by RHCs already in the RHC program how does stopping new RHCs from getting paid their quarterly RHC settlements stop the fraud TennCare has potentially identified?
2. Since the fraud by TennCare’s own admission has nothing to do with RHC Cost Reports or TennCare Quarterly settlements how does stopping new RHCs from getting paid their quarterly TennCare settlements stop the alleged fraud TennCare alleges to have identified?
Even Forrest Gump could see something else is going on. The story fed to RHCs does not add up. The moratorium is a Trojan Horse. For what purpose this Trojan Horse serves is unknown except the effect is equivalent to a modern defenestration of RHCs who are being thrown out the window without representation or notification. Three lucky victims of defenestrations in Prague were saved when they landed in a pile of horse manure. It is doubtful that any of the RHCs affected by the moratorium will survive being thrown out of this window, but one thing is certain. We did find a big pile of horse manure.

End

Healthcare Business Specialists, LLC is a healthcare consulting firm that specializes in rural health clinics and works to expand access to healthcare in rural and underserved areas throughout the United States.

If you would like more information about this topic, please call or email Mark Lynn at 423.243.6185 or marklynnrhc@gmail.com.
Tennessee’s Heart Failure

In life there are things you expect and others you do not. Having a family history of heart related issues, I was not surprised when I recently experienced heart failure. Conversely, having lived in Tennessee my entire life I would never believe this great state suffered from heart failure as well. Shockingly, that is exactly what has happened.

In October 2017 Tennessee sought and received a moratorium from the Centers for Medicare and Medicaid Services (CMS) to no longer pay new Rural Health Clinics (RHCs) the additional costs of complying with Public Law 95-210 and providing an additional access point for healthcare to the most rural and poorest residents. This in addition to Tennessee’s failure to expand TennCare even though billions of federal dollars were available to provide this care has lead to catastrophic results in Tennessee.

Eight rural Tennessee hospitals have closed since 2010. Only Texas with ten has more than our state and comparing Tennessee to Texas is not exactly an apple to oranges comparison. Since hospitals have an obligation under EMTALA to treat all patients that present these eight communities have lost one of their last health access points for rural, TennCare patients. Now by depriving new RHCs necessary funding to open, expand, and treat TennCare patients, a heartless Tennessee is choking out another access point for our poor, rural, and underserved.

Next week I will spend three days in one of Chattanooga’s state of the art hospitals receiving some of the world’s best healthcare possible for my heart failure and I am not too proud to ask for your prayers for a swift recovery. In addition, I ask for your prayers for the poor, underserved of Tennessee. Pray that the once great state of Tennessee, the Volunteer State, will recover from heart failure as well and do the right thing for the residents of rural Tennessee and not continue this heartless and senseless moratorium.

For more information, please contact Mark Lynn, CPA (Healthcare Business Specialists) at 423.243.6185 or email me at marklynnrhc@gmail.com.