HBS

Healthcare Business Specialists

RHC Update
Sponsored by North American HMS
February 15, 2022

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Healthcare Business Specialists

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Healthcare Business Specialists

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RHC Information Exchange Group on Facebook

- *"A place to share and find information on RHCs."*

HBS

Healthcare Business Specialists

We prepare Medicare and Medicaid Cost Reports for Rural Health Clinics.

We prepare Program evaluations of RHCs.

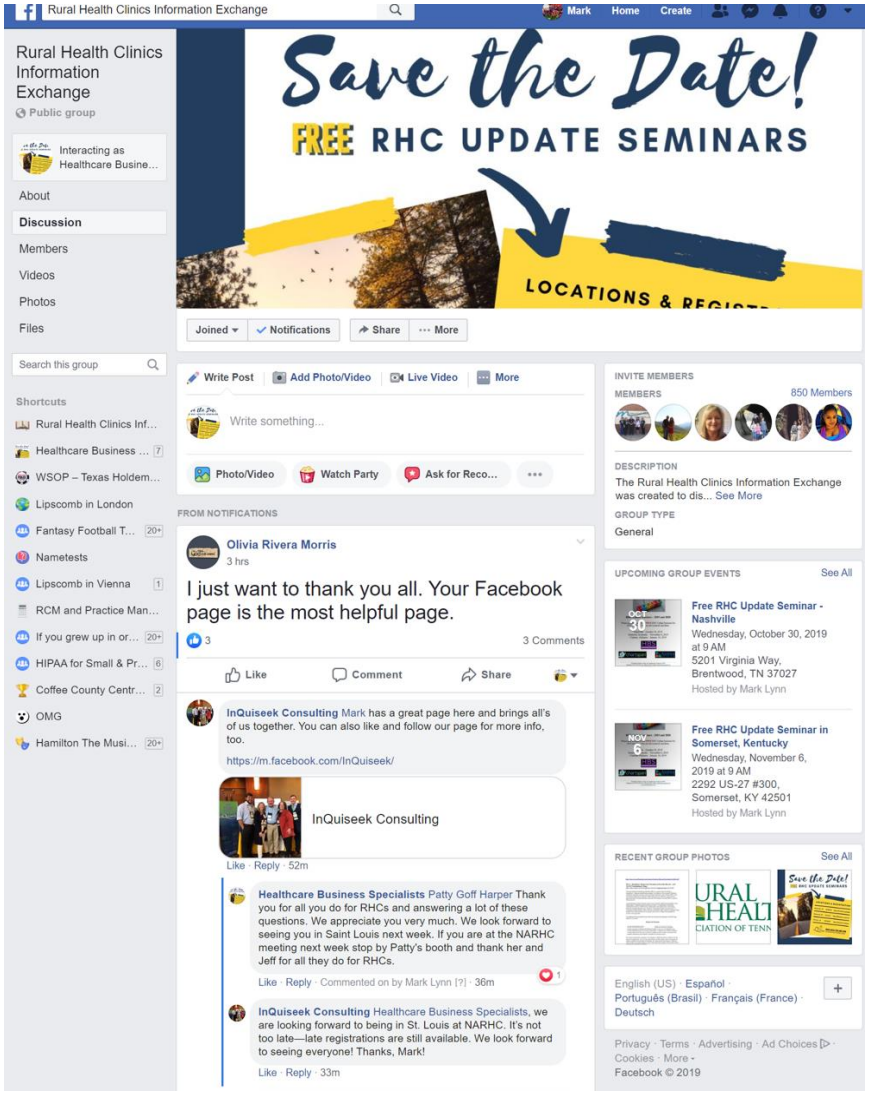
We help clinics startup as RHCs.

Emergency Preparedness for RHCs.

We prepare Tenncare Quarterly Reports

Our Cost Reporting Brochure can be found at the following link:

http://www.ruralhealthclinic.com/s/2019-Cost-Report-Preparation-Brochure-mjsy.pdf

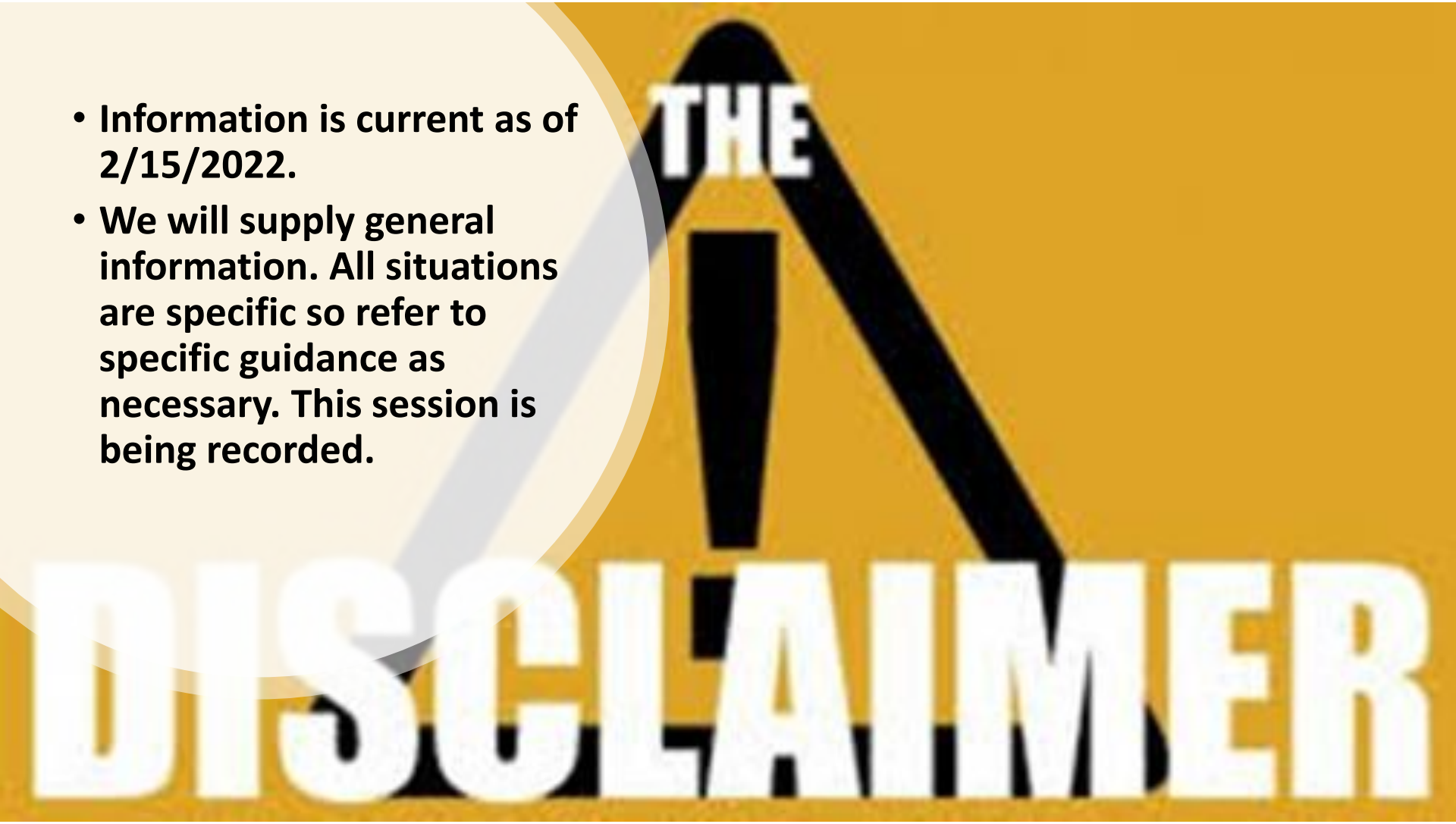


RHC Information Exchange Group on Facebook

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/

- Information is current as of 2/15/2022.
- We will supply general information. All situations are specific so refer to specific guidance as necessary. This session is being recorded.



Please type your questions in the Question box and submit them and if you raise your hand at the end of the session, we will open your line to ask a question.

Slides and Recording of this session will be posted to the Facebook Group and on the HBS Website.

The Agenda

Topics	Speaker	Organization	Time/minutes	Subject Matter
Introductions	Mark Lynn	Healthcare Business Specialists	10	Introduce Speakers and Administrative. Sponsor Message
RHC Billing	Charles James	North American HMS	15	Payment for attending physician services furnished by RHCs to hospice patients Mental Health Services furnished via telecommunications
CCM and Principal Care	Shannon O'Neal	Chart Span	10	Concurrent Billing for Chronic Care Management Services (CCM) and Transitional Care Management (TCM) Services for RHCs Change to the general care management HCPCS code G0511 to replace G2064 and G2065 with CPT code 99424 and 99426 Increased rates for CCM 7 Principal Care services in 2022.
Provider-based RHC Rates	Jonathan Pantenburg	Stroudwater Associates	10	Payment limit per visit changes for independent and provider-based RHCs
Medicare Bad Debts	Julie Quinn	Health Services Associates	5	The impact of higher Medicare caps on crossover bad debts.
Grants Management	Elizabeth Burrows, JD	Burrows Consulting, Inc.	10	Financial Management Reviews (FMR) for HRSA RHC Grant Recipients
PRF Fund Reporting	Mark Lynn	Healthcare Business Specialists	5	Period 2 PRF fund reporting for Independent RHCs/ No Surprise Act update

We offer a selection of educational seminars and webinars throughout the year to guide you through the challenges of RHC startup, billing and cost reporting. To stay up to date with what's coming up, you can follow our blog or register for our email newsletter **here.**

Rural Health Clinic Information Exchange Lunch and Learn Webinar Series

Spring, 2022

The Rural Health Clinic (RHC) Information Exchange Facebook Group is conducting a series of lunch and learn webinars in the winter/spring of 2022. These webinars are free and will focus on rural health clinic billing and updates for the RHC community.

Each webinar is set up as a stand-alone webinar, so you will have to sign up for each of them to attend. Each will be recorded for later viewing and the slide presentations and recordings may be found at www.ruralhealthclinic.com. Each webinar will have speakers and panelists to help with questions and to provide insight or perspective to the material presented. The billing sessions (except the Update session) are designed for people new to RHC billing and each session will build on the previous sessions. If you have not yet joined the Facebook Group, here is the link: (https://www.facebook.com/groups/150341463329636 2)

A word from our Sponsor

Charles James, Jr.-Charles took the position of President & CEO in 2004 after the loss of the company founder, Charles James, Sr. North American celebrates its 25th year in business in 2017. Charles began his career with James Clinic running the IT department. As part of North American, Charles has overseen & helped develop all aspects of the company. Today, North American is a proud gold-certified, Aprima EHR/PRM. In addition, he provides Revenue Cycle Management, RHC certification/cost reporting/Annual Evaluations, Provider Enrollment, and Financial Consulting to all types of healthcare entities.

About the Speakers

Shannon O'Neal · 2nd

Director of Client Experience at ChartSpan Medical Technologies

Johns Island, South Carolina, United States · Contact info

ChartSpan Medical Technologies

Penn State University

https://www.chartspan.com/

About the Speakers

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Jonathan Pantenburg

Jonathan Pantenburg joined Stroudwater in 2016, and brings to the firm a strong record of leadership in rural healthcare. A highly accomplished, results-driven senior executive, Jonathan has more than 15 years of progressively responsible experience advising profit, non-profit, and governmental entities through complex issues including cost reduction, acquisitions, contracts, financial analysis, and operations. At Stroudwater, he brings his expertise to the Rural team.

Before joining Stroudwater, Jonathan served as Chief Financial Officer and Chief Operating Officer of Kahuku Medical Center, a 21-bed non-profit critical access hospital (CAH) on the north shore of Oahu, Hawaii. Under his leadership, Kahuku Medical Center received accreditation from The Joint Commission, and saw increased post-audit total margin and operating revenue; Jonathan modified, maintained, and performed ongoing internal audits, expanded services to include primary care and computed tomography, and implemented fully integrated clinical EHR in five months and business office functions in 11 months, among other improvements.

Jonathan holds a BA in history from the University of Hawaii at Manoa and a BBA with honors in accounting from the University of Phoenix. In 2016, he earned a master's in health administration from Ohio University.

Contact Jon at 207-221-8253

About the Speakers

JULIE QUINN

VP of Compliance and Cost Reporting

Julie Quinn is Vice President of Compliance and Cost Reporting. Julie is a CPA with over 25 years experience in governmental compliance and cost reporting, 15 of which she spent in the Medicare Contractor arena. She holds an MBA with a concentration in Healthcare Administration.
She assists RHCs with cost reporting, audit resolution, rate setting, and various other cost and compliance issues.

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SOUTHEAST REGIONAL OFFICE
RINGGOLD, GEORGIA 30736

About the Speakers

Elizabeth Burrows

Owner

Elizabeth earned her undergraduate degree in Political Science and Communications from DePauw University and received her Doctorate of Jurisprudence from Indiana University School of Law. She is a graduate of the National Leadership Academy for the Public's Health and is a National Leadership Academy fellow for the Public's Health.

She has also assisted numerous FQHC LALs in multiple capacities, including applying for operational assistance, billing assistance, and CEO selection. Prior to starting her consulting business, she served as the founding Chief Executive Officer for seven years for Valley Professionals Community Health Center, and FQHC in rural Indiana. During her time there, she brought in over $10,000,000 in grant funding and started three financially viable and clinically strong clinics and one mobile school-based health center. This health center had excellent reviews of grant applications, stellar federal site visits, and was a certified Level 3 Patient Centered Medical Home.

She is a licensed attorney in the State of Indiana. Prior to starting her own consulting business, she was the Director of the State Office of Rural Health in Indiana, where she tripled the amount of grant money received by the Indiana Office of Rural Health. Elizabeth went on to serve as the Interim CEO of and FQHC Look-Alike in central Indiana that completed 30,000 patient visits per year.

Elizabeth lives with her husband Steve and daughters Eleanor and Amelia in rural Indiana. They enjoy spending time at her family's farm, traveling, hiking at state parks, and competing in 4H sheep shows.

Elizabeth Morgan Burrows, JD
Principal
Burrows Consulting, Inc.
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elizabethburrowsconsulting@gmail.com

New Medicare Fact Sheet

What's Changed?

- We pay Rural Health Clinics (RHCs) a bundled payment, or All-Inclusive Rate (AIR) per visit, for qualified primary care and preventive health services provided by an RHC practitioner (page 6)
- Added hospices as a location where RHC visits can take place (page 7)
- Beginning January 1, 2022, RHCs can bill Transitional Care Management (TCM) and general care management services furnished for the same patient during the same service period, if the RHC meets the requirements for billing each code (page 8)
- Beginning April 1, 2021, RHCs will receive a prescribed national statutory payment limit per visit increase over an 8-year period for each year from 2021 through 2028 (page 8)
- Added COVID-19 monoclonal antibody products as services Medicare covers (page 8)
- Beginning January 1, 2022, RHCs can report and get payment for mental health visits furnished via real-time telecommunication technology (page 9)
- Beginning January 1, 2022, RHCs are eligible to get payment for hospice attending physician services when provided by a RHC physician, nurse practitioner, or physician assistant who's employed or working under contract for an RHC, but isn't employed by a hospice program (page 10)

Source: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/RuralHlthClinfctsht.pdf

Mental Health Services Billing in 2022

In addition, beginning January 1, 2022, RHC mental health visits will include visits furnished using interactive, real-time telecommunications technology. This change will allow RHCs to report and receive payment for mental health visits furnished via real-time telecommunication technology in the same way they currently do when visits take place in-person, including audio-only visits when the beneficiary is not capable of, or does not consent to, the use of video technology. Therefore, we are finalizing that there must be an **in-person mental health service furnished within 6 months prior to the furnishing of the telecommunications service and that in general, there must be an in-person mental health service (without the use of telecommunications technology) must be provided at least every 12 months** while the beneficiary is receiving services furnished via telecommunications technology for diagnosis, evaluation, or treatment of mental health disorders. However, exceptions to the in-person visit requirement may be made based on beneficiary circumstances (with the reason documented in the patient's medical record) and more frequent visits are also allowed under our policy, as driven by clinical needs on a case-by-case basis.

In order to bill for mental health visits furnished via telecommunications for dates of service on or after **January 1, 2022, RHCs should bill Revenue code 0900, along with the appropriate HCPCS code for the mental health visit along with modifier CG. Use modifier 95 for services furnished via audio and video telecommunications and use modifier FQ for services that were furnished audio-only.**

Description	In-Person Requirement	Revenue Code	Modifier	Payment
Visual & Audio	Within 6 months before and at least once every 12 months	0900	95	All-Inclusive Rate
Audio only	Within 6 months before and at least once every 12 months	0900	FQ	All-Inclusive Rate

New CMS Billing Guidance
RHC Mental Health Telemedicine

https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center?fbclid=IwAR1zj5-2gr6YfzDd8r5YtRuinmZiur7zPomysgrMaHWzei2A6x2z507Wqag

In order to bill for mental health visits furnished via telecommunications for dates of service on or after January 1, 2022, RHCs should bill Revenue code 0900, along with the appropriate HCPCS code for the mental health visit along with modifier CG. Use modifier 95 for services furnished via audio and video telecommunications and use modifier FQ for services that were furnished audio-only.

Source: Patty and Jeff Harper, InQuiseek Consulting, LLC

https://www.inquiseek.com/

RHC Distant Site **Mental Health** Telehealth Example
Audio/Visual Two-Way Synchronous
Reimburses at AIR

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0900	Telehealth	90791 CG 95	01/31/2022	1	100.00
0001	Total Charge				100.00

90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvcs
90832	Psytx pt&/family 30 minutes
90834	Psytx pt&/family 45 minutes
90837	Psytx pt&/family 60 minutes
90839	Psytx crisis initial 60 min
90845	Psychoanalysis

Revenue Code = 0900

CPT = one from the mental health section of the QVL

Modifiers = -CG plus -95 for audio/visual

Source: Patty and Jeff Harper, InQuiseek Consulting, LLC
https://www.inquiseek.com/

RHC Distant Site **Mental Health** Telehealth Example
Audio ONLY
Reimburses at AIR

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0900	Telehealth	90791 CG FQ	01/31/2022	1	100.00
0001	Total Charge				100.00

90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvcs
90832	Psytx pt&/family 30 minutes
90834	Psytx pt&/family 45 minutes
90837	Psytx pt&/family 60 minutes
90839	Psytx crisis initial 60 min
90845	Psychoanalysis

Revenue Code = 0900

CPT = one from the mental health section of the QVL

Modifier = -CG plus -FQ for audio only

Source: Patty and Jeff Harper, InQuiseek Consulting, LLC

https://www.inquiseek.com/

Negative Reimbursement

Rural Health Clinics (RHC)

For Rural Health Clinics (RHCs), negative reimbursement is encountered when the cost of the visit is greater than the provider encounter rate and the billed amount is applied to the patient's Medicare deductible.

Example	2022	
Total billed amount	$233	$115.00
Provider all-inclusive reimbursement rate	$113	$75.00
Amount applied to deductible	$233	$115.00
Beneficiary's responsibility	$233	$115.00
Medicare reimbursement	-$120	-$40.00

When posting it is important to balance to the patient responsibility per the EOB.
The variance is Medicare contractual and is an adjustment (not collectable from the patient.

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PROVIDING VALUE-BASED-CARE PROGRAMS FOR MORE THAN 100 OF THE TOP HEALTH SYSTEMS AND PRACTICES IN THE U.S

2022 CMS Updates for RHCs

Effective January 1, 2022

- **TCM & CCM can be billed concurrently**
- **General Management Code G0511**
- **New Reimbursement Rate for G0511**

Get Paid for Your Time

CMS is now allowing full reimbursement for CCM and TCM billing within in the same 30 day service period!

G0511 + 99495/99496

General Care Management for RHCs is…

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G0511

1

CCM

20’ of non-face-to-face care coordination for a patient with two or more chronic conditions

2

PCM

30’ of care coordination for a patient with a single chronic condition

3

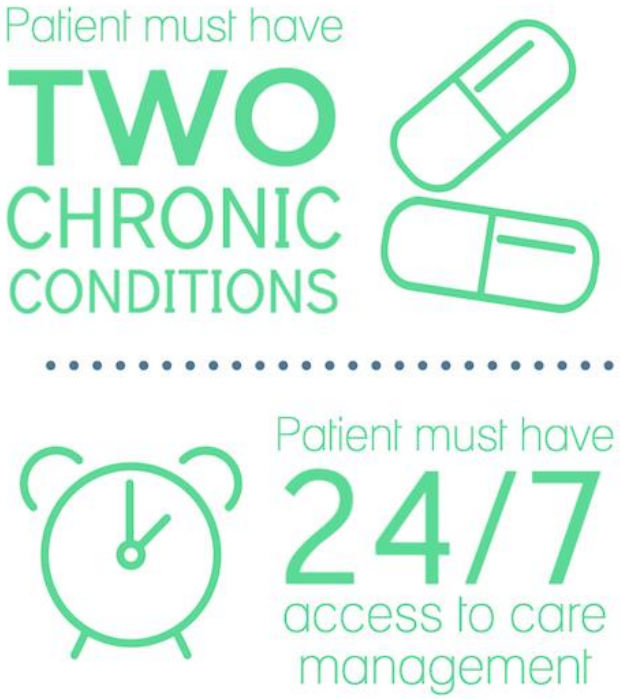
BHI

20’ of clinical staff time spent monitoring and reporting on eligible patients

Replacing 99424, 99426, G2064, G2065, and 99484. Does not require face-to-face visit. Service can be provided under general supervision.

CHRONIC CARE MANAGEMENT for RHCs

PREVENTATIVE CARE PROGRAM FOR MEDICARE PATIENTS



NEW 2022 CCM RATES

REIMBURSEMENT INCREASES TRANSLATE TO LARGER PROFITS FOR PRACTICES

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*RHCs – G0511

$81.26 pppm (2022 national avg. reimbursement)

$65.19 pppm (2021 national avg. reimbursement)

$16.07 pppm (YoY Increase)

TRADITIONAL PRACTICES – 99490

$64.02 pppm (2022 national avg. reimbursement)

$41.17 pppm (2021 national avg. reimbursement)

$22.85 pppm (YoY Increase)

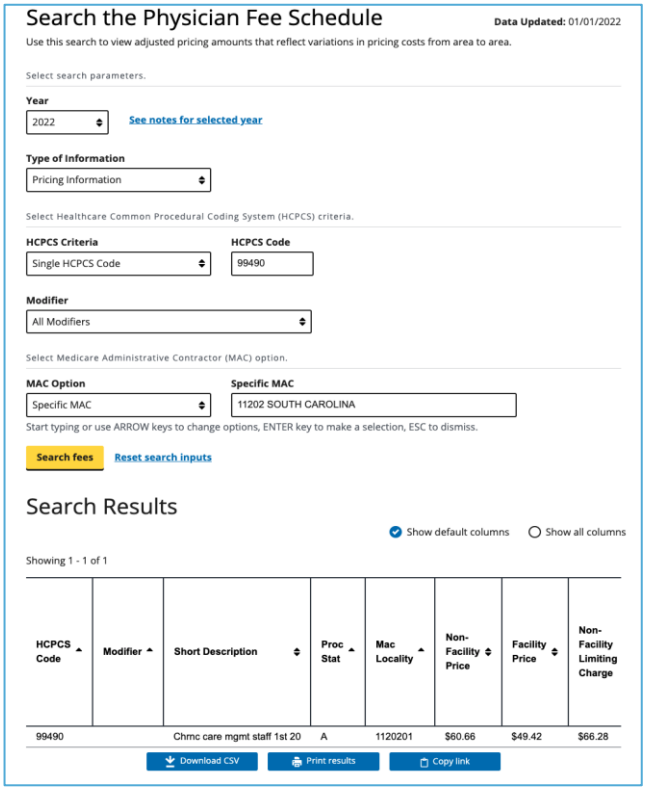
*Avg. of the national non facility payment rates for 99484, 99487, 99490, 99491, 99424 and 99426.

2022 CMS LOOKUP TOOL

EASY TOOL TO USE TO SEE YOUR SPECIFIC REIMBURSEMENT

2022 CMS LOOKUP TOOL LINK

https://www.cms.gov/medicare/physician-fee-schedule/search



RHC Reimbursement Methodology Application

February 15, 2022

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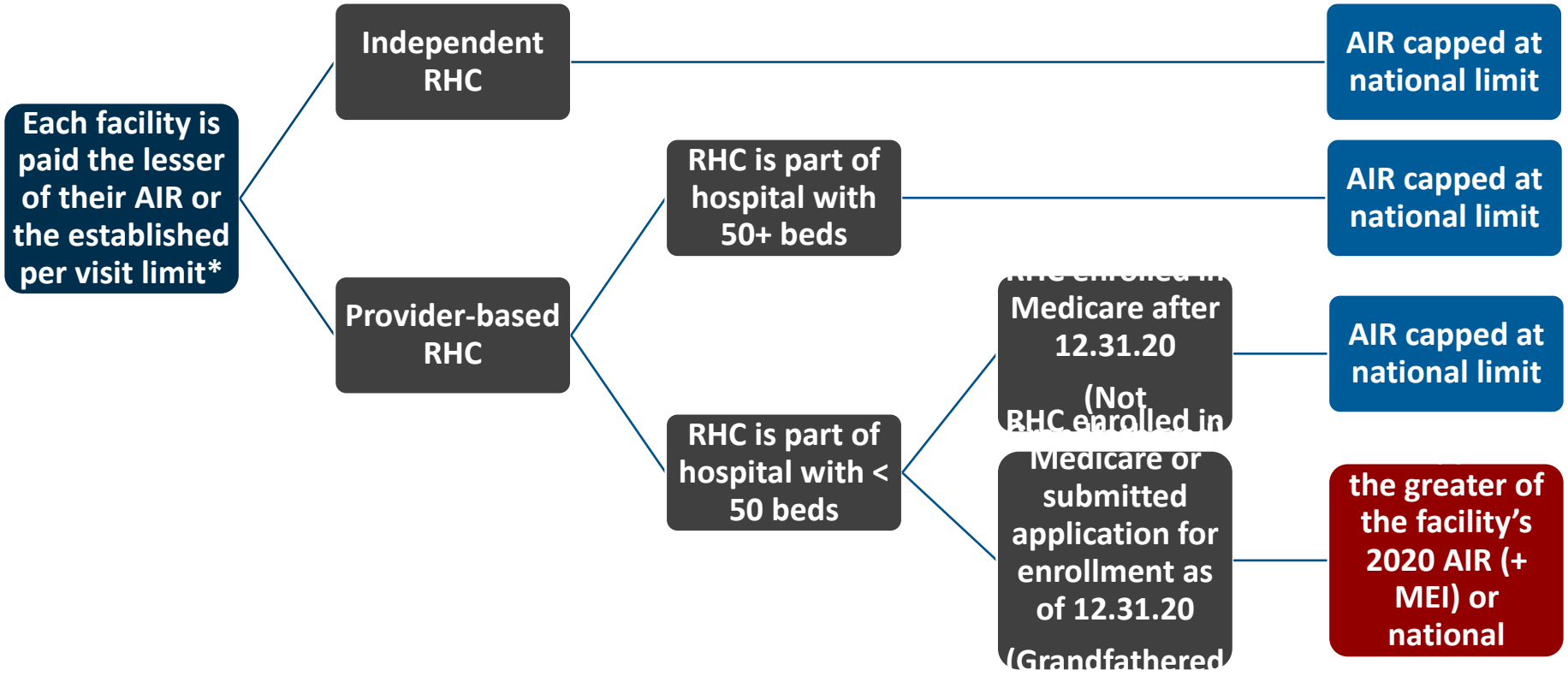
RHC Reimbursement Methodology

- On December 27, 2020, the President signed into law, the "*Consolidated Appropriations Act, 2021 (CAA)"* which changed the reimbursement methodology for Rural Health Clinics (RHC) starting on April 1, 2021
  - Starting on April 1, 2021, all new RHCs established after December 31, 2019 (2020 after signing of H.R. 1868), regardless of whether they are independent, owned and operated by a hospital with fewer than 50 beds, or owned and operated by a hospital with greater than 50 beds, shall be reimbursed based on reasonable cost with an upper payment limit (UPL) set at the following rates:
    a) In 2021, after March 31, at $100 per visit;
    b) In 2022, at $113 per visit;
    c) In 2023, at $126 per visit;
    d) In 2024, at $139 per visit;
    e) In 2025, at $152 per visit;
    f) In 2026, at $165 per visit;
    g) In 2027, at $178 per visit;
    h) In 2028, at $190 per visit;
    i) In subsequent years, the rate will increase based on the Medicare Economic Index (MEI) for primary care services
  - RHCs owned and operated by a hospital with fewer than 50 beds and established on or before December 31, 2019 (2020 after signing of H.R. 1868), will use their 2020 rate to establish a clinic-specific grandfathered UPL that will then be increased each year based on the MEI
- Since the final legislation varied greatly from the RHC Modernization Act and due to the impact on provider-based RHCs (PB-RHC), efforts are underway to change certain provisions
  - On April 14, 2021, the President signed H.R. 1868 into law which fixed some of the grandfathering issues caused through the change of the RHC reimbursement methodology in the Consolidated Appropriations Act, 2021

RHC Rate Establishment



Independent or Provider-Based (Not Grandfathered)

- General
  - RHC with 10,000 annual visits of which 3,500 are Medicare (Includes provider-based w/ 50+ beds and Not Grandfathered provider-based w/ <50 beds)
  - Annual Cost Increase: 3%
  - Medicare Economic Index (MEI): 1.5%

- Trended Upper Payment Limit Comparison
  - The following table trends forward the adjusted cost-based rates (applying the annualized cost increase) from 2021 through 2028 and compares to the new RHC upper payment limits (UPL) to determine the Medicare rate received by the RHCs from 2021 through 2028
    - The green-shaded cells would be the RHC per visit rate used for 2021 through 2028

Rate	2020	2021	2022	2023	2024	2025	2026	2027	2028
Prior Capped RHC Rate	$ 86.31	$ 87.52	$ 88.83	$ 90.17	$ 91.52	$ 92.89	$ 94.28	$ 95.70	$ 97.13
Adj. Cost-Based Rate	125.00	128.75	132.61	136.59	140.69	144.91	149.26	153.73	158.35
UPL		100.00	113.00	126.00	139.00	152.00	165.00	178.00	190.00
Variance		$ 12.48	$ 24.17	$ 35.83	$ 47.48	$ 52.02	$ 54.97	$ 58.04	$ 61.21

- Trended RHC Reimbursement Impact
  - The following table compares the net revenue received from Medicare under the prior reimbursement methodology with net revenue received from Medicare under the new RHC reimbursement methodology for 2021 through 2028

Impact	2020	2021	2022	2023	2024	2025	2026	2027	2028
Variance		$ 12.48	$ 24.17	$ 35.83	$ 47.48	$ 52.02	$ 54.97	$ 58.04	$ 61.21
Medicare Visits		3,500	3,500	3,500	3,500	3,500	3,500	3,500	3,500
Net Impact		$ 43,680	$ 84,595	$ 125,405	$ 166,180	$ 182,070	$ 192,395	$ 203,140	$ 214,235

Provider-Based w/<50 Beds (Grandfathered)

- General
  - RHC with 10,000 annual visits of which 3,500 are Medicare
  - Annual Cost Increase: 3%
  - Medicare Economic Index (MEI): 1.5%

- Trended Upper Payment Limit Comparison
  - The following table trends forward the adjusted cost-based rates (applying the annualized cost increase) from 2021 through 2028 and compares to the new RHC upper payment limits (UPL) to determine the Medicare rate received by the RHCs from 2021 through 2028
    - The green-shaded cells would be the RHC per visit rate used for 2021 through 2028

Rate	2020	2021	2022	2023	2024	2025	2026	2027	2028
Adj. Cost-Based Rate	$ 175.00	$ 180.25	$ 185.66	$ 191.23	$ 196.96	$ 202.87	$ 208.96	$ 215.23	$ 221.68
UPL		177.63	180.29	182.99	185.74	188.52	191.35	194.22	197.14
Variance		(2.63)	(5.37)	(8.23)	(11.23)	(14.35)	(17.61)	(21.01)	(24.55)

- Trended RHC Reimbursement Impact
  - The following table compares the net revenue received from Medicare under the prior reimbursement methodology with net revenue received from Medicare under the new RHC reimbursement methodology for 2021 through 2028

Impact	2020	2021	2022	2023	2024	2025	2026	2027	2028
Variance		$ (2.63)	$ (5.37)	$ (8.23)	$ (11.23)	$ (14.35)	$ (17.61)	$ (21.01)	$ (24.55)
Medicare Visits		3,500	3,500	3,500	3,500	3,500	3,500	3,500	3,500
Net Impact		$ (9,205)	$ (18,795)	$ (28,805)	$ (39,305)	$ (50,225)	$ (61,635)	$ (73,535)	$ (85,925)

Provider-Based w/<50 Beds (Grandfathered)

- **General**
  - RHC with 10,000 annual visits of which 3,500 are Medicare
  - Annual Cost Increase: Variable from 1% - 3%
  - Medicare Economic Index (MEI): 1.5%

- **Trended Upper Payment Limit Comparison**
  - The following table trends forward the adjusted cost-based rates (applying the annualized cost increase) from 2021 through 2028 and compares to the new RHC upper payment limits (UPL) to determine the Medicare rate received by the RHCs from 2021 through 2028
    - The green-shaded cells would be the RHC per visit rate used for 2021 through 2028

Rate	2020	2021	2022	2023	2024	2025	2026	2027	2028
Cost Increase		1.75%	1.00%	1.75%	3.00%	1.00%	1.00%	1.00%	1.75%
Adj. Cost-Based Rate	$ 175.00	$ 178.06	$ 179.84	$ 182.99	$ 188.48	$ 190.36	$ 192.27	$ 194.19	$ 197.59
UPL		177.63	180.29	182.99	185.74	188.52	191.35	194.22	197.14
Variance		$ (0.44)	$ 0.45	$ 0.00	$ (2.74)	$ (1.84)	$ (0.92)	$ 0.03	$ (0.45)

- **Trended RHC Reimbursement Impact**
  - The following table compares the net revenue received from Medicare under the prior reimbursement methodology with net revenue received from Medicare under the new RHC reimbursement methodology for 2021 through 2028

Impact	2020	2021	2022	2023	2024	2025	2026	2027	2028
Variance		$ (0.44)	$ -	$ -	$ (2.74)	$ (1.84)	$ (0.92)	$ -	$ (0.45)
Medicare Visits		3,500	3,500	3,500	3,500	3,500	3,500	3,500	3,500
Net Impact		$ (1,540)	$ -	$ -	$ (9,590)	$ (6,440)	$ (3,220)	$ -	$ (1,575)

STROUDWATER

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RHC Grant Management

Elizabeth Morgan Burrows, JD

Principal and Owner, Burrows Consulting

February 15, 2022

RHC Grants **Management**

- Payment Management System – Are you drawing down your funds?
  - Make sure the money is flowing to you.
- Have you tracked how you spent your funds?
- Are you submitting your FFR Reports?

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RHC Grants Management

- Are you effectively promoting your RHC?
  - Billboards
  - Health Education
  - Promotional Materials

What is a Financial Management Review?

- Virtual Review
- Review of Policies and Procedures
- Respond to Emails and HRSA Correspondence
- This is an active process. Respond to HRSA's requests and revisions as appropriate.

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Policies Needed

- Cash Management
- Accounting System
- Disbursements/Procurement
- Timekeeping
- Allowability of Costs

Lunch and Learn – Preparing for a Financial Management Review

- **February 24, 2022**
- **1:00 p.m.**
- **https://attendee.gotowebinar.com/regi.../8546400949630470923**

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CARES Act Healthcare Provider Relief Funds (PRF)

Surprisingly Simple

January 2022

Provider Relief Fund
Resource Guide (Reporting Period 2)

The Provider Relief Fund (PRF) Reporting Portal (**https://prfreporting.hrsa.gov**) opened on January 1, 2022 and will close on March 31, 2022 for Reporting Period 2. More reporting information can be found on the Reporting and Auditing Webpage.

Reporting Period 2

Deadline to Use Funds	Payment Received Period (Payments Exceeding $10,000 in Aggregate Received)	Reporting Time Period
December 31, 2021	From July 1, 2020 to December 31, 2020	January 1 to March 31, 2022

Deadline to Use Funds is the last date in which the recipient may use payments for eligible expenses, including services rendered, and lostrevenues attributable to coronavirus.

Payment Received Period describes a specific time period when the recipient received one or more payments. The payment is considered received on the deposit date for automated clearing house (ACH) payments or the check cashed date.

Reporting Time Period describes when recipients must go into the Reporting Portal and report on the use of funds. Recipients who fail to report within the respective Reporting Time Period will be considered out of compliance with the PRF *Terms and Conditions*. More details can be found on the *Reporting Non-Compliance Fact Sheet*

Helpful Links
Notice of Reporting Requirements (June 11, 2021)
Data Entry Worksheet
Reporting Resources Webpage
Nursing Home Infection Control Webpage
What's New In Reporting Period 2 Fact Sheet

Reporting Guides
Lost Revenues Guide- Reporting Period 2
Parent Subsidiary Reporting
Independent Audit Requirement
Patient Metrics
Ownership Changes

Portal User Guides	Frequently Asked Questions	Stakeholder Resources	Returning Funds
Registration Process	Reporting and Auditing-Specific FAQs	Stakeholder Webpage	Returning Funds Fact Sheet
Submitting Reporting Information	Portal-specific FAQs	Stakeholder Toolkit	Return Unused Funds Portal

Provider Support Line: (866) 569-3522 for TTY dial 711
8 a.m. to 10 p.m. CT, Monday through Friday

https://www.hrsa.gov/sites/default/files/hrsa/provider-relief/reporting-resource-guide-rp2.pdf

January 1, 2022

HRSA Provider Relief

Provider Relief Fund
Reporting Period 2 (RP2)

Providers who received one or more PRF payments exceeding $10,000, in the aggregate, during the second Payment Received Period (July 1, 2020 to December 31, 2020) must report on how these funds were used by March 31, 2022 in the PRF Reporting Portal. Payments received during this period must have been expended by December 31, 2021.

New PRF Reporting Portal users must first register in the PRF Reporting Portal (if not yet completed). If a Reporting Entity has previously reported, they may log into the Portal with their existing username, TIN, and password.

What's New in RP2

Reporting Portal Updates

- If applicable, the Portal will auto-populate previously entered data in certain fields. Providers can edit and update any auto-populated fields. If changes are made to prepopulated data, once saved, the Portal cannot revert data back in case of error, and information must be manually re-entered.
- Users can change the contact information associated with their Portal account between reporting periods.
- The Period of Availability for RP2 payments overlaps with payments received in RP1. Therefore, providers will need to show how payments were applied to expenses and lost revenues from Q1 2020 through Q4 of 2021. The expenses and lost revenues for Q3 2021 and Q4 2021 must not be duplicative of those included in the RP1 report for Q1 2020 through Q2 2021.
- Guides for Registration and Report Submissions.

Lost Revenues

- Returning Reporting Entities may change the methodology for calculating lost revenues, but must then use the new methodology to calculate lost revenues for the entire RP2 Period of Availability.
- Returning Reporting Entities may change the previously reported financial information as part of the lost revenues calculation *if there was a change to their patient care revenue since the RP1 report was filed.* If changes are made to previously submitted data providers are required to write a justification for the change.
- For providers who reported in RP1, the Portal will calculate remaining unused lost revenues that can be reimbursed by PRF payments received during future payment periods.
- For more details refer to the Lost Revenues Guide – Reporting Period 2

Nursing Home Infection Control (NHIC) Distribution

- The NHIC Distribution includes Quality Incentive Payment (QIP) Program payments which cannot be used to reimburse lost revenues. NHIC payments may only be used for infection control expenses.
- NHIC payments are a component of a Targeted Distribution and thus the original recipient of the NHIC payment is always the Reporting Entity.
- The Portal includes a separate expense worksheet for NHIC payments. These payments have a more limited use of funds, and must be reported separately from all General/Targeted Distribution payments. Expenses not reimbursed by NHIC payments should not be reported on the NHIC expense worksheet.
- The total reportable NHIC payment amount includes the total dollar value of the NHIC payments received during the corresponding Payment Received Period plus the interest earned on those payments.

Provider Support Line
(866) 569-3522 for TTY dial 711
8 a.m. to 10 p.m. CT
Monday through Friday

Reporting and Auditing Webpage

PRF Reporting Portal

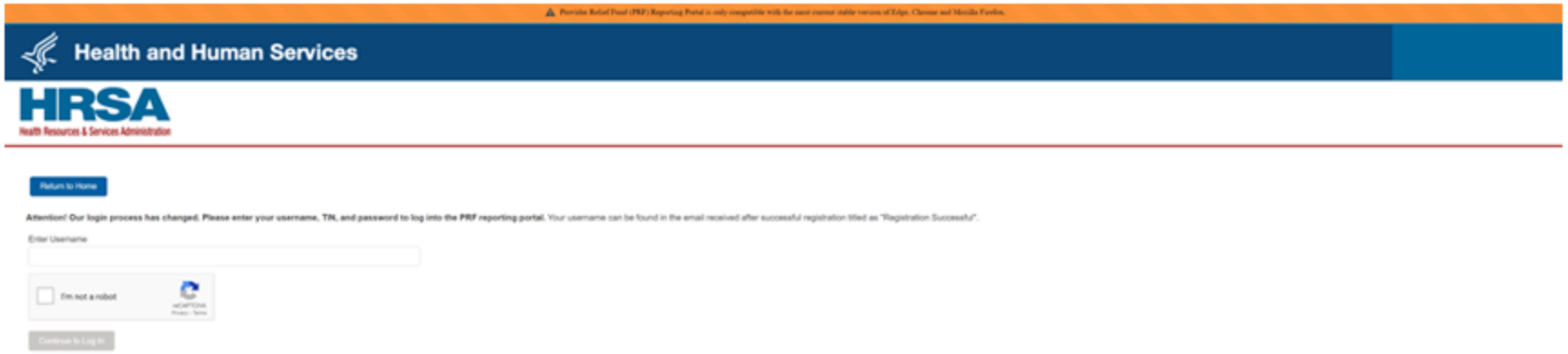
Nursing Home Infection Control Webpage

Reporting Resources

https://www.hrsa.gov/sites/default/files/hrsa/provider-relief/whats-new-in-rp2-fact-sheet.pdf

Step 1: PRF Fund Reporting Period 2

Go to PRFreporting.hrsa.gov/s/ and Log in using the Log in, password, and Tax ID number. It will look like this:



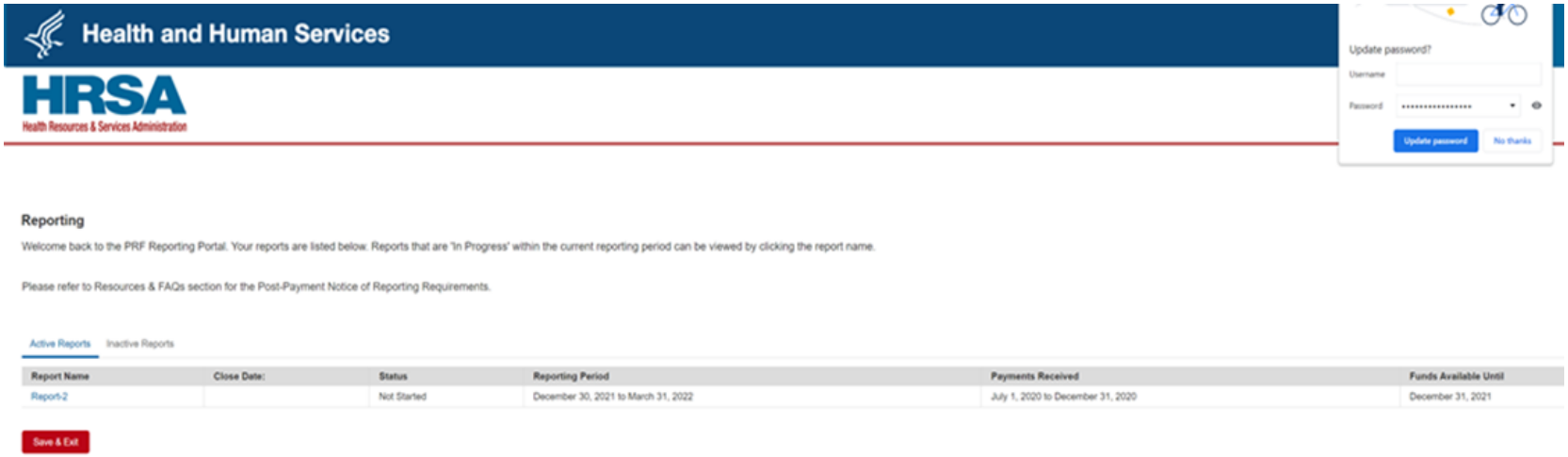
https://prfreporting.hrsa.gov/s/

Step 2: PRF Fund Reporting Period 2

The system will require you to change the password to a 15-character password.

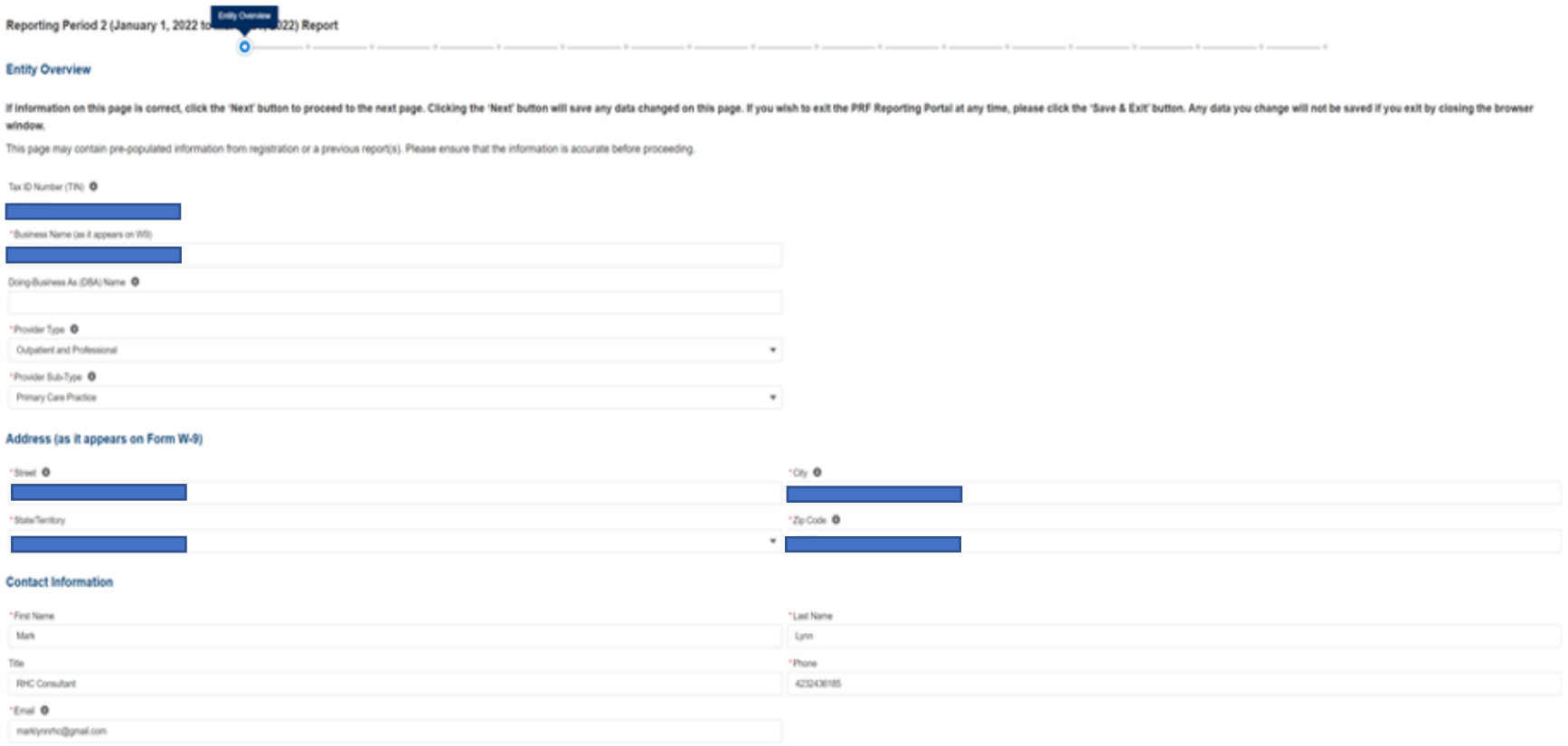
The portal will kick you out and make you go back and reenter the portal with the log-in, tax id number and the new password.

When you log in the portal again the portal will look like below. Click on Period 2 and push Save and Next.



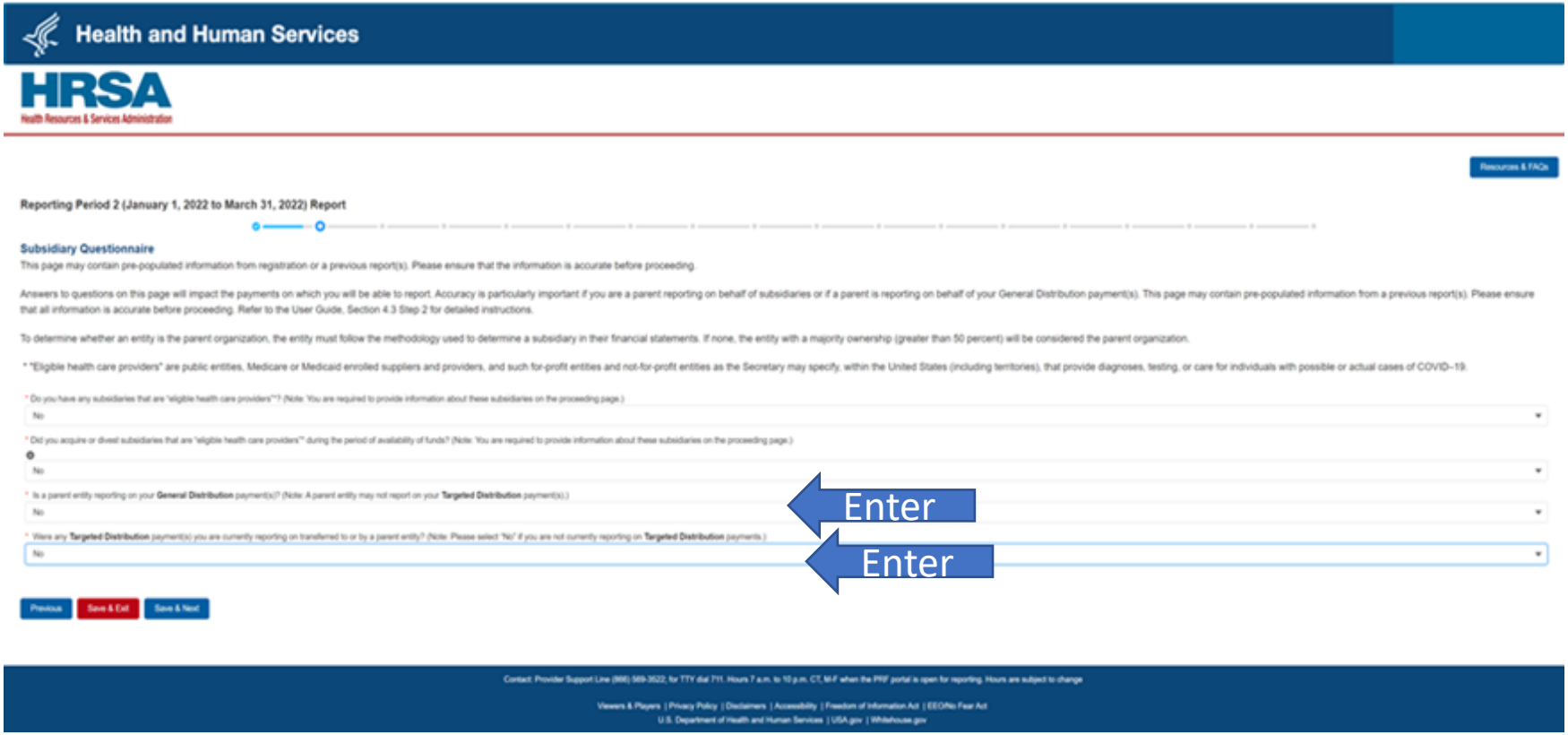
Step 3: PRF Fund Reporting Period 2

7. The next page of the portal will look like below. It is for information only, and you will hit save and next to move to the next page.



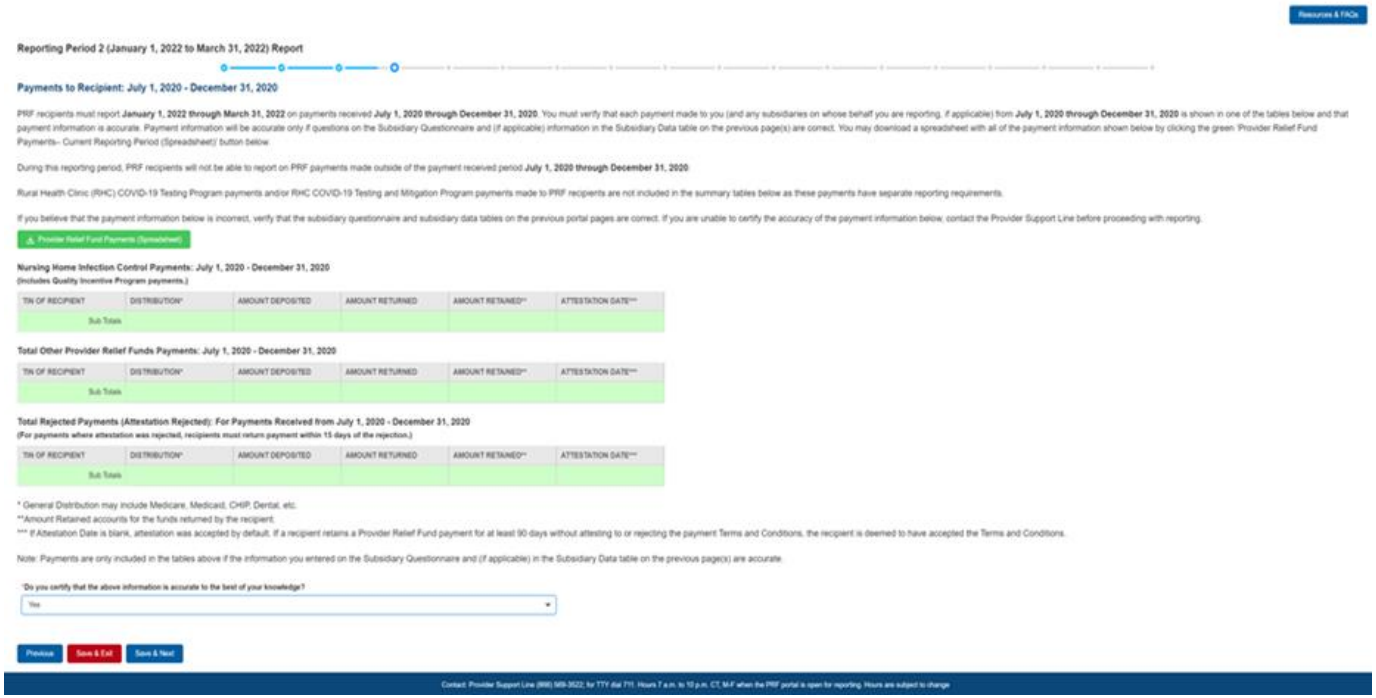
Step 4: PRF Fund Reporting Period 2

The next page will look like below. Most independent RHCs will answer No to the last two questions to go forward from this page. If you have a parent entity or transferred a targeted distribution you may need to answer yes to these questions.



Step 5: PRF Fund Reporting Period 2

- The next page of the portal will look like below. The majority of Independent RHCs will have 0 payments or less than $10,000 during this period. If that is the case, you can go forward.



Resources & FAQs

Reporting Period 2 (January 1, 2022 to March 31, 2022) Report

Payments to Recipient: July 1, 2020 - December 31, 2020

PRF recipients must report **January 1, 2022 through March 31, 2022** on payments received **July 1, 2020 through December 31, 2020**. You must verify that each payment made to you (and any subsidiaries on whose behalf you are reporting, if applicable) from **July 1, 2020 through December 31, 2020** is shown in one of the tables below and that payment information is accurate. Payment information will be accurate only if questions on the Subsidiary Questionnaire and (if applicable) information in the Subsidiary Data table on the previous page(s) are correct. You may download a spreadsheet with all of the payment information shown below by clicking the green 'Provider Relief Fund Payments– Current Reporting Period (Spreadsheet)' button below.

During this reporting period, PRF recipients will not be able to report on PRF payments made outside of the payment received period **July 1, 2020 through December 31, 2020**.

Rural Health Clinic (RHC) COVID-19 Testing Program payments and/or RHC COVID-19 Testing and Mitigation Program payments made to PRF recipients are not included in the summary tables below as these payments have separate reporting requirements.

If you believe that the payment information below is incorrect, verify that the subsidiary questionnaire and subsidiary data tables on the previous portal pages are correct. If you are unable to certify the accuracy of the payment information below, contact the Provider Support Line before proceeding with reporting.

Provider Relief Fund Payments (Spreadsheet)

Nursing Home Infection Control Payments: July 1, 2020 - December 31, 2020
(Includes Quality Incentive Program payments.)

TIN OF RECIPIENT	DISTRIBUTION*	AMOUNT DEPOSITED	AMOUNT RETURNED	AMOUNT RETAINED**	ATTESTATION DATE***
Sub Totals					

Total Other Provider Relief Funds Payments: July 1, 2020 - December 31, 2020

TIN OF RECIPIENT	DISTRIBUTION*	AMOUNT DEPOSITED	AMOUNT RETURNED	AMOUNT RETAINED**	ATTESTATION DATE***
Sub Totals					

Total Rejected Payments (Attestation Rejected): For Payments Received from July 1, 2020 - December 31, 2020
(For payments where attestation was rejected, recipients must return payment within 15 days of the rejection.)

TIN OF RECIPIENT	DISTRIBUTION*	AMOUNT DEPOSITED	AMOUNT RETURNED	AMOUNT RETAINED**	ATTESTATION DATE***
Sub Totals					

* General Distribution may include Medicare, Medicaid, CHIP, Dental, etc.
**Amount Retained accounts for the funds returned by the recipient.
*** If Attestation Date is blank, attestation was accepted by default. If a recipient retains a Provider Relief Fund payment for at least 90 days without attesting to or rejecting the payment Terms and Conditions, the recipient is deemed to have accepted the Terms and Conditions.

Note: Payments are only included in the tables above if the information you entered on the Subsidiary Questionnaire and (if applicable) in the Subsidiary Data table on the previous page(s) are accurate.

*Do you certify that the above information is accurate to the best of your knowledge?

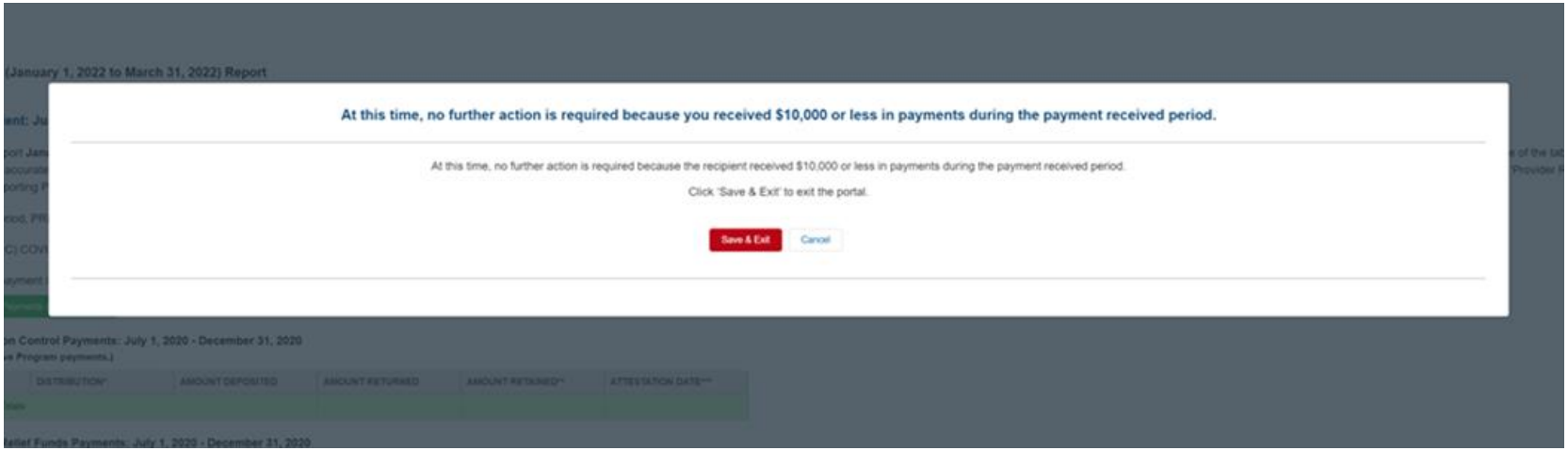
Yes

Previous | Save & Exit | Save & Next

Contact Provider Support Line (866) 569-3522; for TTY dial 711. Hours 7 a.m. to 10 p.m. CT, M-F when the PRF portal is open for reporting. Hours are subject to change

Step 6: PRF Fund Reporting Period 2

The next page of the portal will look like this, which indicates you have done everything you need to do since you received less than $10,000. Make a snapshot of this page and hit submit.



What if you did have $10,000 or more of PRF Fund payments in 2022

Reporting Period 2 (January 1, 2022 to March 31, 2022) Report

Payments to Recipient: July 1, 2020 - December 31, 2020

PRF recipients must report **January 1, 2022 through March 31, 2022** on payments received **July 1, 2020 through December 31, 2020**. You must verify that each payment made to you (and any subsidiaries on whose behalf you are reporting, if applicable) from **July 1, 2020 through December 31, 2020** is shown in one of the tables below and tha payment information is accurate. Payment information will be accurate only if questions on the Subsidiary Questionnaire and (if applicable) information in the Subsidiary Data table on the previous page(s) are correct. You may download a spreadsheet with all of the payment information shown below by clicking the green 'Provider Relief Fund Payments– Current Reporting Period (Spreadsheet)' button below.

During this reporting period, PRF recipients will not be able to report on PRF payments made outside of the payment received period **July 1, 2020 through December 31, 2020**.

Rural Health Clinic (RHC) COVID-19 Testi

Provider Relief Fund Payments (Spreadsheet)

Total Nursing Home Infection Control Payments: July 1, 2020 - December 31, 2020
(Includes Quality Incentive Program payments.)

TIN OF RECIPIENT	DISTRIBUTION*	AMOUNT DEPOSITED	AMOUNT RETURNED	AMOUNT RETAINED**	ATTESTATION DATE***
Sub Totals					

Total Other Provider Relief Funds Payments: July 1, 2020 - December 31, 2020

TIN OF RECIPIENT	DISTRIBUTION*	AMOUNT DEPOSITED	AMOUNT RETURNED	AMOUNT RETAINED**	ATTESTATION DATE***
621010704	Targeted Distribution	$206,506.46	$0.00	$206,506.46	Jul 18, 2020
Sub Totals		**$206,506.46**	**$0.00**	**$206,506.46**	

Total Rejected Payments (Attestation Rejected): For Payments Received from July 1, 2020 - December 31, 2020
(For payments where attestation was rejected, recipients must return payment within 15 days of the rejection.)

TIN OF RECIPIENT	DISTRIBUTION*	AMOUNT DEPOSITED	AMOUNT RETURNED	AMOUNT RETAINED**	ATTESTATION DATE***
Sub Totals					

* General Distribution may include Medicare, Medicaid, CHIP, Dental, etc.
**Amount Retained accounts for the funds returned by the recipient.
*** If Attestation Date is blank, attestation was accepted by default. If a recipient retains a Provider Relief Fund payment for at least 90 days without attesting to or rejecting the payment Terms and Conditions, the recipient is deemed to have accepted the Terms and Conditions.

Note: Payments are only included in the tables above if the information you entered on the Subsidiary Questionnaire and (if applicable) in the Subsidiary Data table on the previous page(s) are accurate.

*Do you certify that the above information is accurate to the best of your knowledge?

Yes

Previous | Save & Exit | Save & Next

OMB Number: 0906-0068
Expiration Date: 01/31/2023

Report Other Assistance Provided

Reporting Period 2 (January 1, 2022 to March 31, 2022) Report

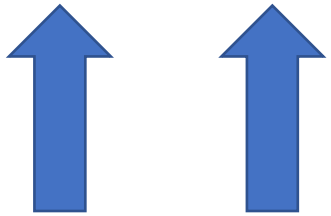
Other Assistance Received

This page may contain pre-populated information from registration or a previous report(s). Please ensure that the information is accurate before proceeding.

On this worksheet, you must enter other assistance received by quarter during the period of availability. All fields marked with an asterisk are required. If zero, you must enter a '0'. The number entered may be a value up to 14 digits, including 2 decimal places. If you are reporting on behalf of subsidiaries, the assistance received by these subsidiaries should be included in the report. The 'Tab' key may be used to navigate between cells during data entry.

Other Assistance	Q1 (2020)	Q2 (2020)	Q3 (2020)	Q4 (2020)	Q1 (2021)	Q2 (2021)	Q3 (2021)	Q4 (2021)	Total
RHC COVID-19 Testing Funds Received									$298,922.84
Treasury, Small Business Administration (SBA) (e.g., CARES Act/Paycheck Protection Program (PPP))	$0.00	$144,292.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$144,292.00
FEMA Programs (Testing, Public Assistance, Supplies, etc.)	$0.00	$22,882.32	$206,506.46	$0.00	$0.00	$0.00	$0.00	$0.00	$229,388.78
HHS Cares Act Testing (COVID-19)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Local, State, and Tribal Government Assistance	$0.00	$10,000.00	$149,900.00	$0.00	$0.00	$0.00	$0.00	$0.00	$159,900.00
Business Insurance	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Assistance	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total	**$0.00**	**$177,174.32**	**$356,406.46**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$832,503.62**

Previous | Save & Exit | Save & Next



Report Expenses by Quarter

Health and Human Services

HRSA
Health Resources & Services Administration

Resources & FAQs

Reporting Period 2 (January 1, 2022 to March 31, 2022) Report

Other Provider Relief Fund Expenses for Payments Received During Payment Period: July 1, 2020 – December 31, 2020

On this worksheet, you are required to report on your use of all Other Provider Relief Fund payments received **July 1, 2020 – December 31, 2020** for allowable expenses. You must report on the use of these payments by indicating the quarterly expenses reimbursed with these payments. If you did not use these payments to reimburse allowable expenses, you may enter zero. As a reminder, Provider Relief Fund payments must be used for expenses unreimbursed by other sources and that other sources are not obligated to reimburse.

Please see the **PRF Reporting User Guide** for detailed instructions. Further definitions are located in the Post-Payment Notice of Reporting Requirements.

All fields marked with an asterisk are required. The number entered may be a value with up to 14 digits, including 2 decimal places. If expenses are zero, you must enter a '0'. The 'Tab' key may be used to navigate between cells during data entry.

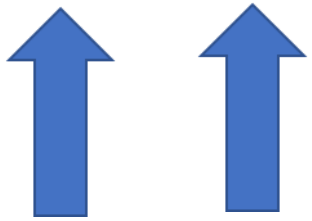
Expenses are reported by calendar year quarter (Q).

Q1: January 1 – March 31
Q2: April 1 – June 30
Q3: July 1 – September 30
Q4: October 1 – December 31

Total Reportable Other PRF Payments = $206,506.46

Other PRF Expenses	Q1 (2020)	Q2 (2020)	Q3 (2020)	Q4 (2020)	Q1 (2021)	Q2 (2021)	Q3 (2021)	Q4 (2021)	Total
General and Administrative (G&A) Expenses	* $0.00	* $0.00	* $0.00	* $0.00	* $0.00	* $0.00	* $0.00	* $0.00	$0.00
Healthcare Related Expenses	* $0.00	* $0.00	* $0.00	* $0.00	* $0.00	* $0.00	* $0.00	* $0.00	$0.00
Total Other PRF Expenses	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Previous | Save & Exit | Save & Next



Report Collections by Payor Type

HRSA
Health Resources & Services Administration

Resources & FAQs

Reporting Period 2 (January 1, 2022 to March 31, 2022) Report

Calculation of Lost Revenues Attributable to Coronavirus

Please fill out the table below with the quarterly revenue information for each calendar year. In the Total Revenue/Net Charges from Patient Care section, please report the Patient Revenue, split by Payer Type.

All fields marked with an asterisk are required. The number entered may be a value with up to 14 digits, including 2 decimal places. If there is no revenue to report for a quarter, the reporting entity must enter '0'. The 'Tab' key may be used to navigate between cells during data entry.

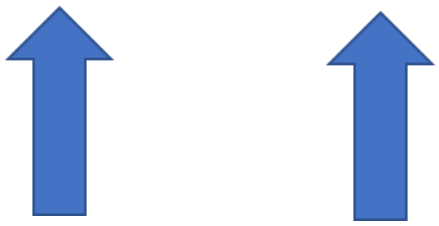
* Do you want to change values from Reporting Period 1?

No

2019 Actuals | 2020 Actuals | 2021 Actuals

Total Revenue/Net Charges from Patient Care (2021 Actuals)

	Q1 (2021)	Q2 (2021)	Q3 (2021)	Q4 (2021)	Total (2021)
Medicare A+B	$.00	$.00	$.00	$.00	$
Medicare C	$.00	$.00	$.00	$.00	$
Medicaid/Children's Health Insurance Program (CHIP)	$.00	$.00	$.00	$.00	$
Commercial Insurance	$.00	$.00	$.00	$.00	$
Self-Pay (No Insurance)	$.00	$.00	$.00	$.00	$
Other	$.00	$.00	$.00	$.00	$
Total Revenue/Net Charges from Patient Care	$	$	$	$	$



Patient Metrics for Period 2

Personnel, Patient, and Facility Metrics

Entity Overview

This page may contain pre-populated information from registration or a previous report(s). Please ensure that the information is accurate before proceeding.

HHS is collecting this information in an effort to quantify the impact of COVID-19 on the reporting entity's personnel, patients, and facilities.

Fill out the tables below with the quarterly Personnel, Patient, and Facility Metrics for calendar year 2019-2021. See the **PRF Reporting Portal User Guide** (Section 4.15) for detailed instructions.

All fields marked with an asterisk are required. The number entered must be a whole number up to 8 digits. If a metric is zero, the reporting entity must enter a '0'. The 'Tab' key may be used to navigate between cells during data entry.

Expenses are reported by calendar year quarter (Q).

Q1: January 1 – March 31
Q2: April 1 – June 30
Q3: July 1 – September 30
Q4: October 1 – December 31

* Do you want to change values from Reporting Period 1?

No

Personnel Metrics

Full Time | Part Time | Contractor | Furloughed | Separated | Hired

Full Time	Q1 (2019)	Q2 (2019)	Q3 (2019)	Q4 (2019)	Q1 (2020)	Q2 (2020)	Q3 (2020)	Q4 (2020)	Q1 (2021)	Q2 (2021)	Q3 (2021)	Q4 (2021)	Total
Clinical	11	9	9	10	9	9	8	7	7	7	*	*	86
Non-clinical	5	5	5	5	5	5	5	4	4	4	*	*	47
Total Number of Full Time Personnel	16	14	14	15	14	14	13	11	11	11			133

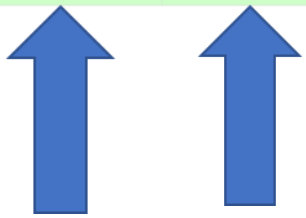
Patient Metrics

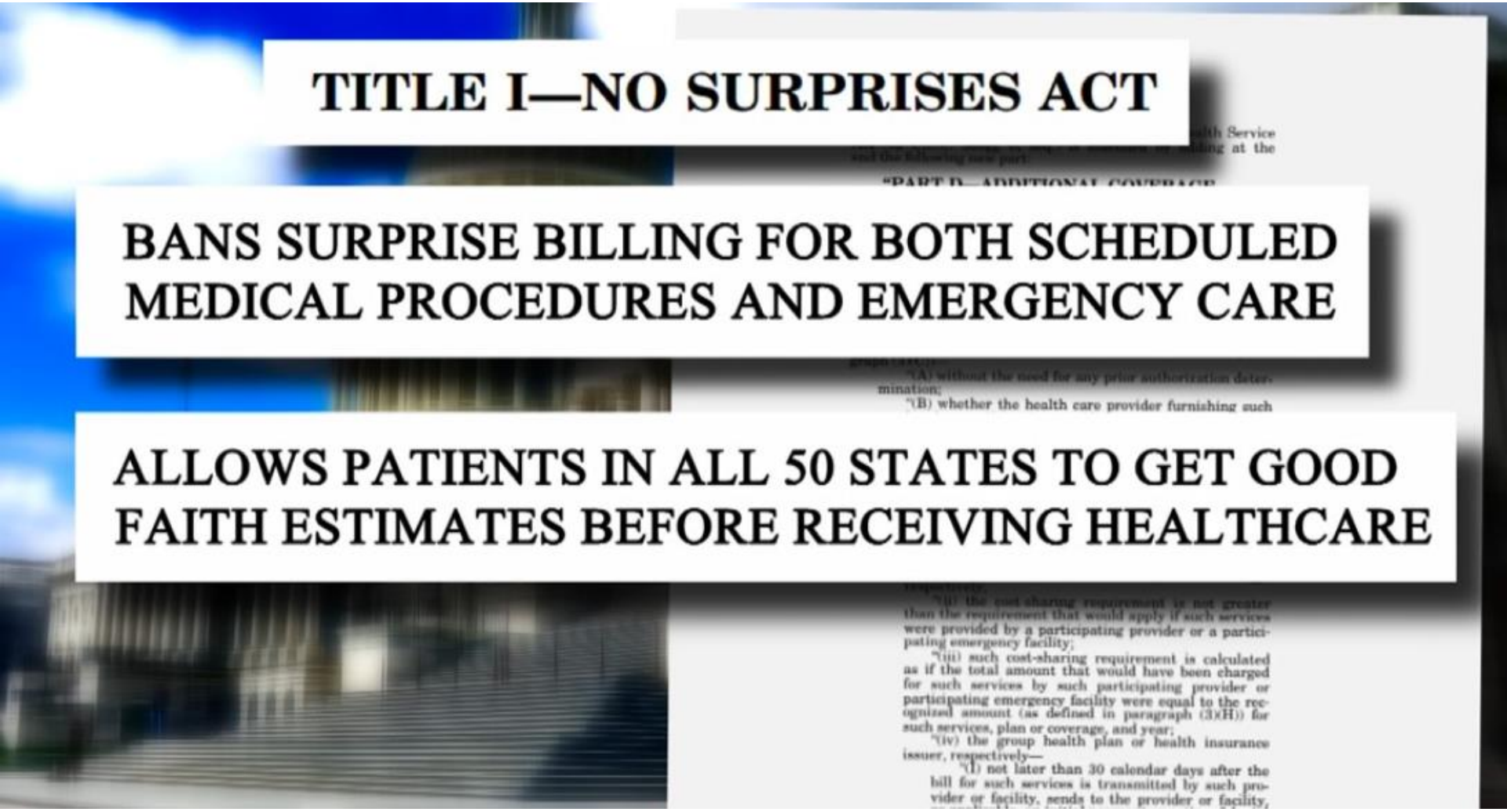
Patient Visits	Q1 (2019)	Q2 (2019)	Q3 (2019)	Q4 (2019)	Q1 (2020)	Q2 (2020)	Q3 (2020)	Q4 (2020)	Q1 (2021)	Q2 (2021)	Q3 (2021)	Q4 (2021)	Total
Inpatient Admissions	0	0	0	0	0	0	0	0	0	0	*	*	0
Outpatient Visits (In-person and Virtual)	3668	2997	3112	3324	3544	2414	2763	2988	2616	2989	*	*	30,415
Emergency Department Visits	0	0	0	0	0	0	0	0	0	0	*	*	0
Number of Facility Stays (for Long- and Short-term Residential Facilities)	0	0	0	0	0	0	0	0	0	0	*	*	0
Number of Total Patient Visits	3,668	2,997	3,112	3,324	3,544	2,414	2,763	2,988	2,616	2,989			30,415

Facility Metrics

* Does the reporting entity or its subsidiaries operate or support staffed beds?

No




TITLE I—NO SURPRISES ACT
BANS SURPRISE BILLING FOR BOTH SCHEDULED MEDICAL PROCEDURES AND EMERGENCY CARE
ALLOWS PATIENTS IN ALL 50 STATES TO GET GOOD FAITH ESTIMATES BEFORE RECEIVING HEALTHCARE

Good Faith Estimates RHC Summary

Question	Answer
When are GFEs required?	Effective 1/1/2022
What about Coordinated Care Estimates?	Effective 1/1/2023
How close does the reasonable estimate have to be?	Within $400
Who gets a GFE?	Anyone scheduling an appointment 3 or more days in advance and is uninsured or does not want to use their insurance to pay.
Do we have to post this in the lobby and on our website?	Yes, see downloads.
Does it have to be in writing?	Yes, electronic or written.
What do we ask patients that are making appointments 3 days or more in advance?	“Do you wish to submit a claim to your insurance company?” or similar
How is this even possible?	Work with your Electronic Health Records provider. This is going to be impossible otherwise. Think about how you do Medicare Secondary Payer.
Who is going to get slammed by this?	Your receptionists' jobs just got exponentially harder having to ask and respond to this and create a GFE when appropriate.

Disclaimer: This table simplifies the answers. Finding solutions will be complex and nuanced.

Start here with the NARHC

- **How Does the No Surprises Act Impact RHCs?** - Details on the Good Faith Estimate
Tuesday, December 14, 2021

- Webinar Recording
- Q&A Follow-Up
- Webinar Transcript (PDF)
- Slide Presentation (PDF)
- CMS Regulations
- Good Faith Estimate Disclaimer and Template

Q & A Follow-up Document from the NARHC Webinar

How does the No Surprises Act Impact RHCs?
Good Faith Estimate Information and Webinar Q&A Follow-Up

Good Faith Estimate Summary

- Starting January 1, 2022, RHCs (and most other health care providers/facilities) will be required to provide uninsured and self-pay patients with a Good Faith Estimate (GFE) of their expected out-of-pocket costs for services, if the individual schedules the service at least 3 business days in advance, or otherwise requests information about charges. This requirement is a component of the No Surprises Act passed in December 2020 and was released by CMS as an Interim Final Rule (IFR).
    - RHCs are not subject to other provisions of the No Surprises Act, including the disclosure requirements regarding patient protections against balance billing.
- The intent of the GFE provision is to allow uninsured or self-pay patients to have access to information about health care pricing before receiving care. This information will allow uninsured (or self-pay) individuals to evaluate options for receiving health care, make cost-conscious health care purchasing decisions, and reduce surprises in relation to their health care costs for items and services.
- The GFE must include charge information for the primary service that the RHC expects to provide to the patient, and for any items/services for which there is a separate charge that are "reasonably expected" to be provided "in conjunction with the primary service."
- The Good Faith Estimate should be created based on the information know at the time of scheduling or other request of a GFE. Therefore, the individual scheduling the patient must thoroughly document the need for the visit as described by the patient and/or the services requested.
- Theoretically, the GFE must also include information for services that the patient will receive from non-RHC providers for the same "period of care". The definition of a "period of care" is open to interpretation; however, CMS will not enforce the requirement to include cost data from other, outside providers until 2023.
- While the requirements will go into effect on January 1, 2022, CMS may choose to update the regulation based on comments from the provider community.
- A flow chart outlining an RHCs responsibilities can be found at the end of this document.

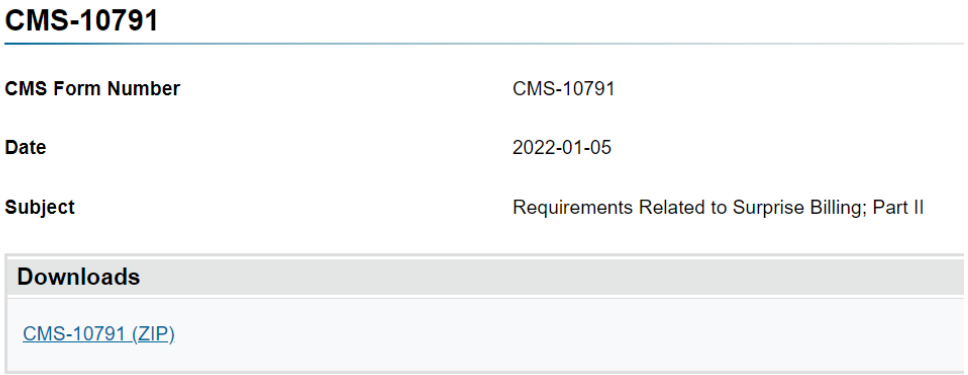
Q: When and to whom are facilities/providers required to provide a Good Faith Estimate?
A: **Every time** an individual requests charge information or is in the process of scheduling an appointment, the facility/provider must inquire whether the patient has insurance and if so, whether they plan to have a claim filed with their insurance for their visit. If the patient is uninsured or elects to be self-pay, they **must be provided** a Good Faith Estimate of charges following the timeframe below.

If an uninsured or self-pay patient:		Is a GFE required, and when?
Schedules an appointment:	10 or more business days in advance of appointment	Yes, within 3 business days of scheduling
	Between 3 to 9 business days in advance of appointment	Yes, within 1 business day of scheduling
	Less than 3 business days in advance of appointment or for walk-in patients	Not required at the time of scheduling, but patients may still request a GFE which must be provided within 3 business days.
Requests a GFE, or otherwise asks about the cost of a service, but does not schedule appointment		Yes, within 3 business days of the request
Schedule the same service on a recurring basis (e.g., multiple physical therapy appointments, lab infusions, etc.)		A single GFE can be issued for recurring services, **up to a maximum of 12 months**.

Q: Does a notice of the availability of a Good Faith Estimate need to be displayed in my facility?

A: Information regarding the availability of a “Good Faith Estimate” must be prominently displayed on the convening provider’s and convening facility’s website and in the office and on-site where scheduling or questions about the cost of health care occur. This may include other offices within your RHC where cost conversations may occur. The model notice, the second file available in this folder download, is not required to be used; however, it meets the requirements of compliance and some form of notice is required. There is no explicit requirement for this notice to be posted in all languages, but it must be made available in accessible formats and languages spoken by individuals considering or scheduling items or services. Download is here:

https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791



CMS-10791

CMS Form Number	CMS-10791
Date	2022-01-05
Subject	Requirements Related to Surprise Billing; Part II

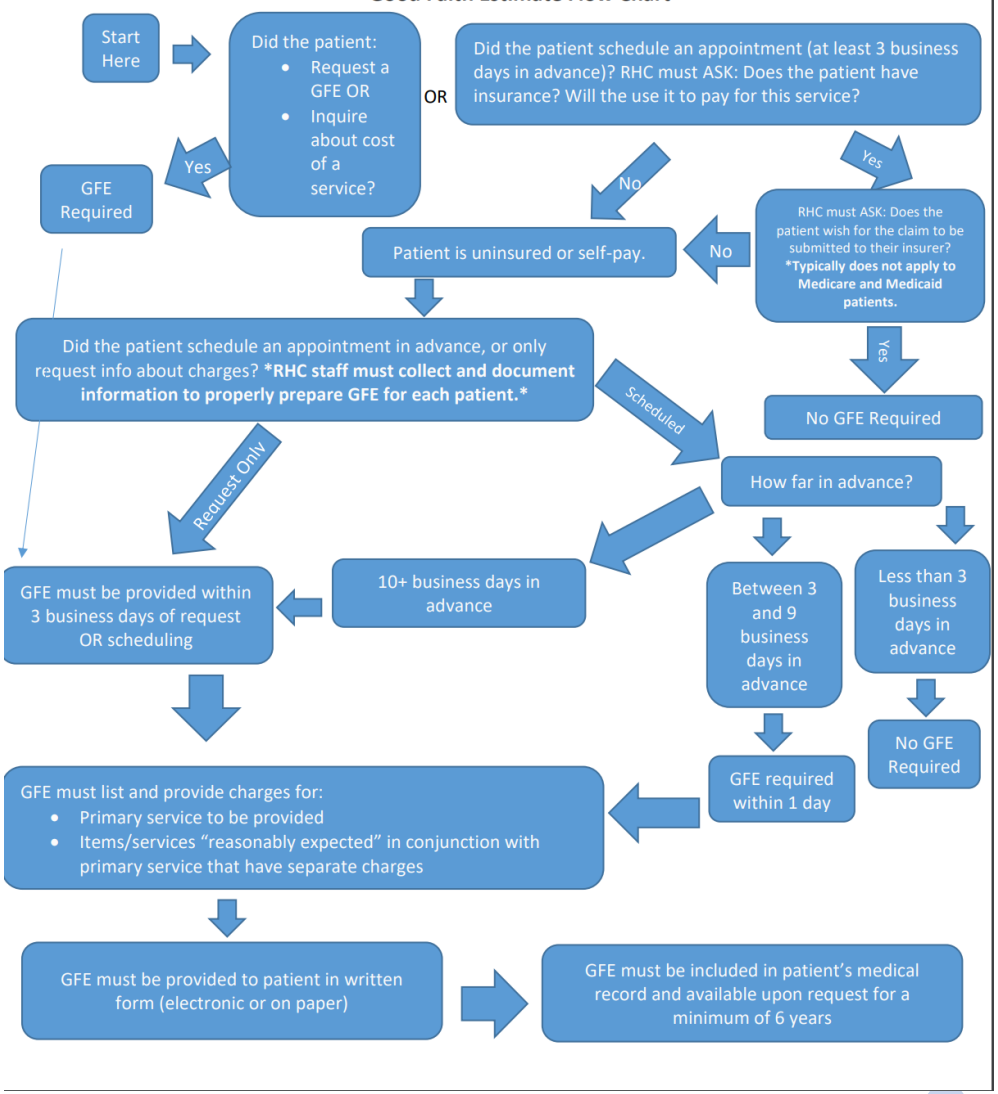
Downloads

CMS-10791 (ZIP)

Here are the files in the download. Most are 10 to 25 pages long.

Name	Type	Compressed size	Passw
CMS-10791- PPDR-SDRE Determination Notice	Adobe Acrobat Document	208 KB	No
CMS-10791 - Supporting Statement	Adobe Acrobat Document	600 KB	No
CMS-10791 - SDRE Declining Eligibility or Need More Information Notice	Adobe Acrobat Document	237 KB	No
CMS-10791 - PPDR-SDRE Selection Notice	Adobe Acrobat Document	252 KB	No
CMS-10791- PPDR-Payment Settlement Form Notice	Adobe Acrobat Document	236 KB	No
CMS-10791 - Appendix-SDR Entity Certification Data Elements	Adobe Acrobat Document	175 KB	No
CMS-10791 - Appendix-HHS Vendor Management (VM) Data Elements	Adobe Acrobat Document	179 KB	No
CMS-10791 - Appendix 13 Request for Extension Notice	Adobe Acrobat Document	228 KB	No
CMS-10791 - Right to Receive a Good Faith Estimate of Expected Charges Notice	Adobe Acrobat Document	227 KB	No
CMS-10791 - PPDR Dispute Initiation Form Notice	Adobe Acrobat Document	232 KB	No
CMS-10791 - Good Faith Estimate Template Notice	Adobe Acrobat Document	370 KB	No
CMS-10791 - Appendix-SDRE Confirmation of Receipt of Settlement Notice	Adobe Acrobat Document	298 KB	No
CMS-10791 - Appendix-HHS Good Faith Estimate Data Elements	Adobe Acrobat Document	164 KB	No
CMS-1791 - Appendix-HHS PPDR Data Elements for Patients and Providers_v2	Adobe Acrobat Document	104 KB	No

Good Faith Estimate Flow Chart



Identity Management (IDM) System

CMS created the IDM System to provide providers with a means to request and obtain a single User ID, which they can use to access one or more CMS applications.

The IDM System provides the means for users to be approved to access many other CMS systems and applications. IDM governs access to CMS systems by managing the creation of user IDs and passwords, setting up multi-factor authentication (MFA), and the assignment of roles within CMS applications.

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Identity Management (IDM) System
Learning Objectives

- How to Create a New User Account
- IDM Self Service Dashboard (Overview)
- How to Request a Role for a New Application
- How to Add Attributes to an Existing Role
- How to View and Cancel Role Requests

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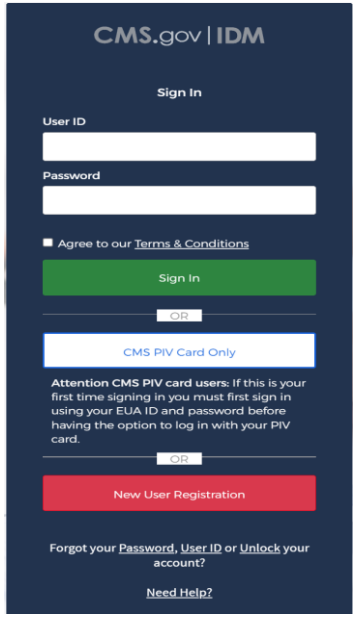
Identity Management (IDM) System

How to Create a New User Account

1. Navigate to https://home.idm.cms.gov/.
2. Click the ***New User Registration*** button.



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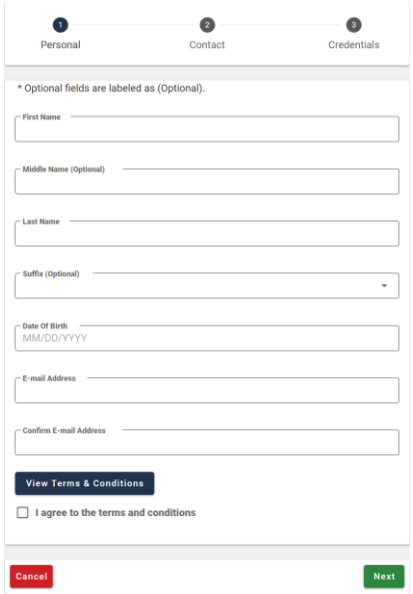
Identity Management (IDM) System

How to Create a New User Account

3. Enter the requested information (i.e., **Name**, **Date of Birth**, **E-mail Address**, etc.)
   - Make sure the you enter an exact match in the ‘E-mail Address’ and ‘Confirm E-mail Address’ fields.

4. Click the ***Terms & Conditions*** button. Read the IDM terms and conditions then click the ***Close Terms & Conditions*** button.

5. Click the checkbox to acknowledge agreement with the terms and conditions, then click the ***Next*** button.



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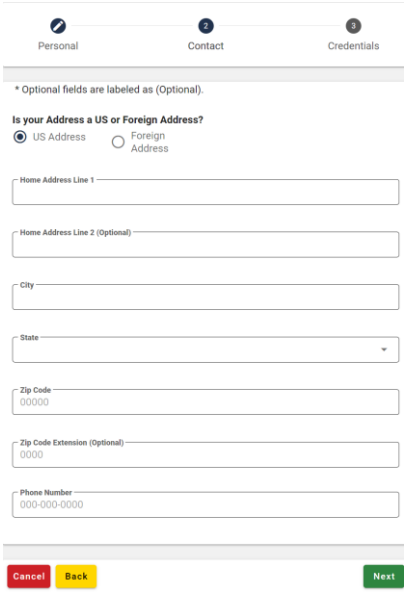
Identity Management (IDM) System

How to Create a New User Account

6. Enter the **Home Address**, **City**, **State**, **Zip Code** and **Phone Number**.

7. Click the ***Next*** button.



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Identity Management (IDM) System

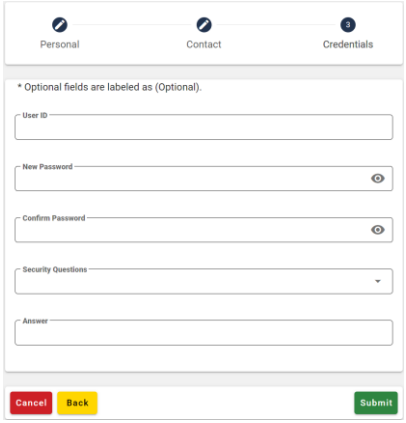
How to Create a New User Account

8. Enter the desired **User ID**, **Password** and **Confirm Password.**
   - The Password and Confirm Password must match.

9. Select a **Security Question** from the list.
   - Type the security question answer into the Answer dialog box.

10. Click the ***Submit*** button to submit the account registration request. The system will display a message that indicates the account was successfully created.

11. Click the ***Return*** button.



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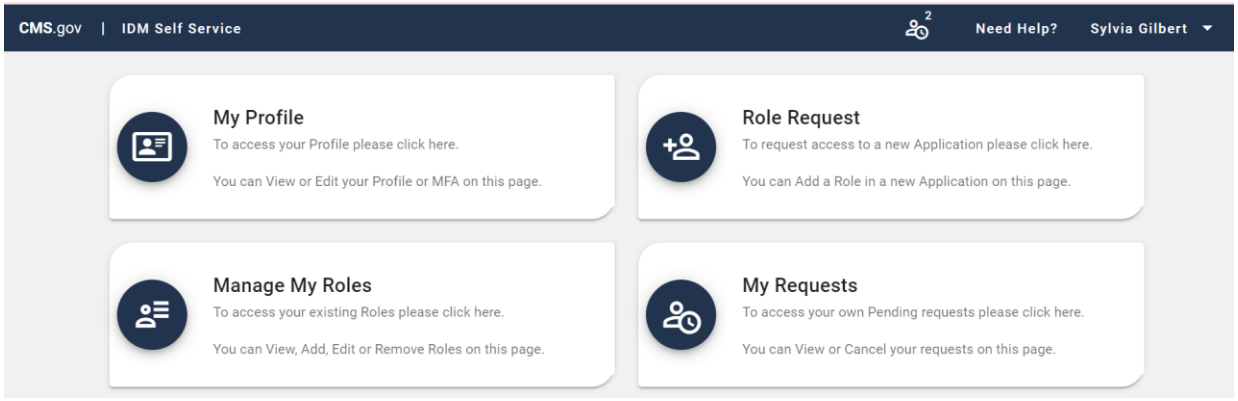
Identity Management (IDM) System

IDM Self Service Dashboard (Overview)

The IDM Self Service Dashboard provides access to functions that allow users to manage their user profile, request new applications, and manage roles for applications to which they have been granted access.



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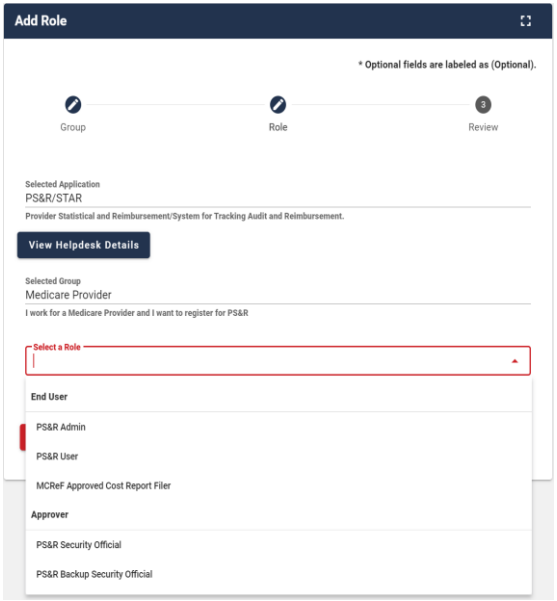
Identity Management (IDM) System

How to Request a Role for a New Application

1. Click the ***Role Request*** button.

2. Select an application (PS&R/STAR). The Select a Role menu appears after an application is selected.
   - You will want to select either 'PS&R Security Official' or 'PS&R User', depending on if someone from your clinic is already set up with access.

3. Select a role. The Remote Identity Proofing (RIDP) terms and conditions appear after role is selected.



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Identity Management (IDM) System
How to Request a Role for a New Application

4. Review the RIDP terms and conditions, check the “I agree to the terms and conditions” selection box, then clinic the ***Next*** button.

5. Complete the Identity Verification form and click the ***Next*** button.

6. Answer the proofing questions and click the ***Verify*** button.

7. Select the required attributes from the Attribute menu.

8. Review the role request information and click the ***Review Request*** button. The Reason for Request dialog box appears.

9. Enter a justification and click the ***Submit Role Request*** button. The Role Request window displays a Request ID and a message which states that the request was successfully submitted to an approver for action.

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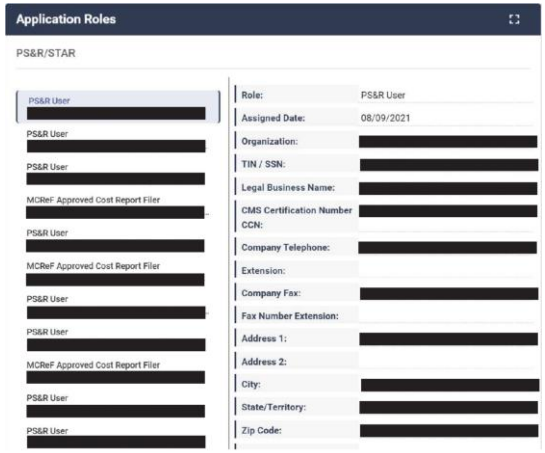
Identity Management (IDM) System
How to Add Attributes to an Existing Role

1. Click the ***Manage My Roles*** button.

2. Click the ***View Details*** button.



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Identity Management (IDM) System
How to Add Attributes to an Existing Role

3. Click the ***Modify Role*** button. The Edit Role Details window appears. This window contains fields that are similar to those used during the initial role request, but it only permits the user to modify role attributes.

4. Add one or more role attributes.

5. Enter a justification statement and click the ***Submit Changes*** button.

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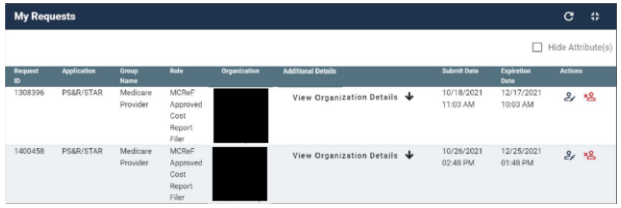
Identity Management (IDM) System

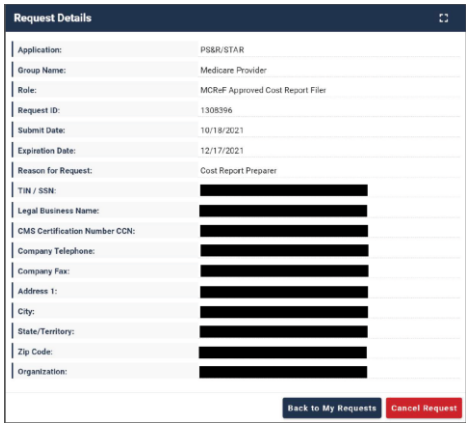
How to View and Cancel Role Requests

1. Click the ***My Requests*** button.



2. Click the ***View Details*** button.

3. Click the ***Cancel Request*** button for the role request that will be cancelled.



4. Click the ***Cancel Role Request*** button.

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Provider Statistical & Reimbursement (PS&R) System

Providers that file cost reports are required to register for the PS&R system through Individuals Authorized Access to the Centers for Medicare & Medicaid Services (CMS) Computer Services (IDM) to obtain the PS&R reports. The PS&R Redesign will be utilized for all cost reports with fiscal years ending January 31, 2009 and later. These cost reports will be both filed and settled using PS&R Redesign.

An approved PS&R User can order reports.

NOTE: For those clinics who plan on pulling their own PS&R reports, you will want to make sure that the Service Period is broken down into the following:

- **Period 1: 1/1/2021 – 3/31/2021 (RHC Capped Rate: $87.52)**
- **Period 2: 4/1/2021 – 12/31/2021 (RHC Capped Rate: $100.00)**

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