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The Omnibus Burden Reduction (Conditions of Participation) Final Rule for RHCs Webinar

October 15, 2019

3:00 Eastern

HBS

Healthcare Business Specialists

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Contact Information

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Become a fan and Like us on Facebook for more RHC information

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Contact Information

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www.ruralhealthclinic.com

RHC Information Exchange Group on Facebook

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

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What does Healthcare Business Specialists do?

1. We prepare Medicare and Medicaid Cost Reports for Rural Health Clinics.
2. We prepare Program evaluations of RHCs.
3. We help clinics startup as RHCs.
4. Emergency Preparedness for RHCs.

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

RHC Cost Report Brochure

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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/

RHC Information Exchange Group on Facebook


2019
2020
SAVE THE DATE!
RHC UPDATE SEMINARS
FREE
LOCATIONS & REGISTRATION
Nashville, TN 10/30/19 http://bit.ly/rhc-nashville
Somerset, KY 11/06/19 http://bit.ly/rhc-somerset
Clanton, AL 01/16/20 http://bit.ly/rhc-clanton
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502 Shadow Pkwy Ste 214, Chattanooga, Tennessee 37421 | (833) 787-2542

RHC Update Seminar - Nashville

Agenda and Topics Outline

October 30, 2019

Healthcare Business Specialists, Azalea Health, and chartspan are providing a **free** seminar for RHCs at the Tennessee Hospital Association, 5201 Virginia Way, Brentwood, TN 37027. To register go to our website at www.ruralhealthclinic.com or use this link: http://bit.ly/rhc-nashville

Time	Subject Matter
9:00 AM to 9:50AM Catch-Up Session for people new to RHCs	Welcome and Introductions. Mark Lynn will provide a Catch-Up session for people new to the Rural Health Clinic Program. We will go over the 9 Conditions of Participation for RHCs and some basic 101 information for people new to the program. If you have been an RHC for awhile you may want to just come at 10.
10:00 AM to 10:50AM Omnibus Burden Reduction and RHC Modernization Act	Mark Lynn, CPA, CRHCP will present information on the Omnibus Burden Reduction Regulations which reduces the compliance thresholds for Emergency Preparedness & Program Evaluations and the RHC Modernization Act which could increase the independent RHC cap to $115 per visit.
11:00 AM to 12:00AM What you need to know about the RHC Cost Report	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, CPA, CRHCP and Dani Gilbert, CPA, CRHCP
12:00 to 1:00 Lunch Provided by Azalea Health & chartspan	Boxed Lunches Provided on site by Azalea Health, chartspan, and Healthcare Business Specialists- At 12:30 Clark Bishop will discuss Rural Health Services provided by Azalea Health including the new Telehealth offering.
1:00 PM to 1:50 PM Emerging Trends in Reimbursement	In this session, Mark Lynn will discuss Telehealth, Mental Health, and Remote Monitoring in RHCs as well as Travis Stephens of chartspan will discuss Chronic Care Management and how RHCs can utilize chronic care management to increase revenues.
2:00 PM to 2:50 PM RHC Billing	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, and other FAQs.**
3:00 PM to 3:30 PM Tenncare Moratorium Lifted & Quarterly Reporting	Tenncare Moratorium, Block Grant Update and Tenncare Quarterly Reporting. How to complete the Quarterly Tenncare Wrap-around Settlement report. Dani Gilbert, CPA, CRHCP

Join our Facebook Group for more RHC Information: https://www.facebook.com/groups/1503414633296362/

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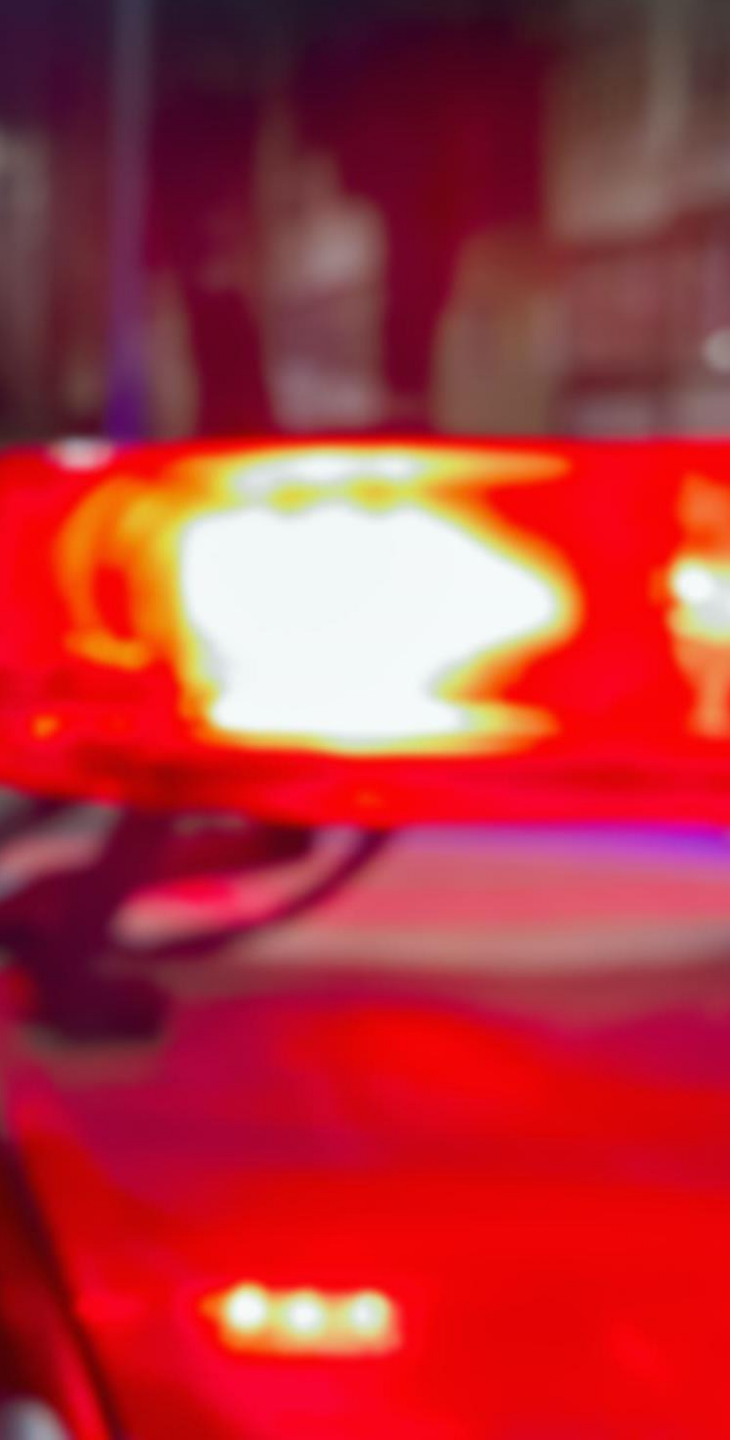

Emergency Preparedness Webinar for RHCs

- **Please register for Emergency Preparedness Update for Rural Health Clinics on Oct 17, 2019 2:30 PM EDT at:**

- **https://attendee.gotowebinar.com/register/3801785055429650188**

- **After registering, you will receive a confirmation email containing information about joining the webinar.**

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Emerging Issues in RHC Reimbursement: Telemedicine, Behavioral Health, and Remote Monitoring Webinar

October 23, 2019

11:00 AM to 12:00 PM Eastern Time

Overview

The purpose of this webinar is to provide a rapid review of the use of telemedicine in rural health clinics. Additionally, we will identify barriers to use either technological, reimbursement issues, or legalities which hinder the acceptance of telehealth in rural health clinics. The webinar will take a deeper dive into telemedicine uses in behavioral health and Remote Monitoring.

The webinar will provide RHC managers the following:

- Guidance on Medicare reimbursement for emerging technologies
- Pitfalls to implementation and reimbursement issues with RHC status
- Changes in technology costs and capabilities
- Improved patient experiences and outcomes using telehealth

The Speakers and time frames are as follows:

Mark R. Lynn CPA – RHC Consultant, Healthcare Business Specialists, Chattanooga Tennessee – Topic – A Rapid Review of use of Telemedicine in Rural Health Clinics. 10 minutes

(Not yet Confirmed) Jay Ostrowski – President, Adaptive Telehealth, West Virginia?

Topic: Telemedicine and Behavioral Health Opportunities and Risks. 20 minutes

Bonnie Britton – President, Reconnect4Health, Greenville, North Carolina.

Topic – Remote Monitoring for Rural Health Clinics. 20 minutes.

Reconnect 4 Health

ADAPTIVE TELEHEALTH

https://www.azaleahealth.com/webinars/emerging-issues-in-rhc-reimbursements/?fbclid=IwAR3cdDdQ1J1usnPqCE_28nXk7cN6t8witoRFhWUV4A39ONLsEISn9ULI9p8

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Agenda

The Omnibus Burden Reduction (Conditions of Participation) Final Rule

Appendix G Update – Emergency Kit Contents

Appendix Z Update – Infectious Diseases

Required Signage in the Lobby

Questions

Tenncare – Lifting of the Moratorium

Questions

Where to find Materials from this Webinar

RHC CERTIFICATION AND CONVERSION

CHANGES TO THE RHC PROGRAM - FALL, 2019

The Omnibus Burden Reduction (Conditions of Participation) Final Rule was finalized on September 30, 2019 and it relieves RHCs of some of the administrative burdens of the RHC status. We have webinars on October 2, 2019 and October 15, 2019 on the changes to the RHC program in the last year from a compliance standpoint.

- Omnibus Regulatory Burden Reduction, Appendix G, Appendix Z, and Tenncare Moratorium lifted Webinar Slides on October 3, 2019
- Omnibus Regulatory Burden Reduction Regulation issued September 30, 2019 and Effective November 29, 2019
- Biennial Program Evaluation Policy Updated on October 1, 2019
- Signage Required to be placed in the Lobby for RHCs
- Emergency Preparedness Infectious Disease Policy
- Emergency Preparedness Infection Disease Transfer Form

THE PROCESS TO BECOME A RURAL HEALTH CLINIC

The process to become a rural health clinic is long and will involve pulling together certain documents for various governmental entities which will review the submissions and approve them as we go along. The usual process takes between 6 months to a year to complete all five steps listed below.

1. Preparation and submission of the 855As , State application, and deeming authority applications.
2. Preparation for State Inspection including preparing RHC and Emergency Preparedness Policy and Procedure manuals
3. **Emergency Preparedness Training and Testing.**
4. Passing the RHC survey or responding to deficiencies in the survey.
5. Obtaining provider numbers for Medicare and Medicaid as well as rate setting.

RURAL HEALTH CLINIC INFORMATION RESOURCES

We also would like to inform you of our educational resources including our Facebook Group, website, webinars, YouTube channel and seminars on RHCs. We highly recommend joining our Facebook Group as we use this to notify the 550 members about our free webinars and educational offerings by other consultants or the NARHC.

- Facebook Group (https://www.facebook.com/groups/1503414633296362/
- Our website which is http://www.ruralhealthclinic.com/
- Youtube: https://www.youtube.com/channel/UCXW4pkwNzDXYTMFrFwMy2_A
- Certification Resources: http://www.ruralhealthclinic.com/certification-materials

http://www.ruralhealthclinic.com/certification-materials

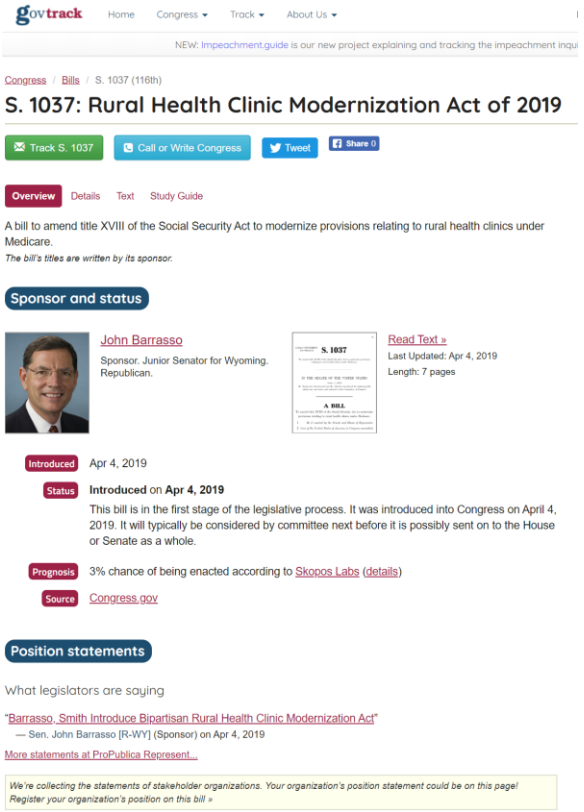
S. 1037 - Rural Health Clinics Modernization Act

S. 1037 - Rural Health Clinics Modernization Act

- **Sec. 2 Modernizing Physician, Physician Assistant, and Nurse Practitioner Utilization Requirements.**
- Modernizes RHC physician supervision requirements by aligning them to state scope of practice laws governing PA and NP practice. Now that all states have Practice Acts governing PA and NP scope of practice, federal standards are unnecessary. Allows PAs and NPs to practice to the top of their license without unnecessary federal supervision requirements that apply only because the PA or NP is practicing in an RHC.
- **Sec. 3 Removing Outdated Laboratory Requirements.**
- Removes a requirement that RHCs must "directly provide" certain lab services on site, and allows RHCs to satisfy this requirement if they have *prompt access* to the required lab services.
- **Sec. 4 Allowing Rural Health Clinics the Flexibility to Contract with Physician Assistants and Nurse Practitioners.**
- Removes a redundant requirement that RHCs employ a PA or NP (as evidenced by a W2) and allows RHCs to satisfy the PA, NP, or CNM utilization requirements through a contractual agreement if they choose to do so.
- **Sec. 5 Allow 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. Currently, RHCs are limited to being the originating site (where patient is located).
- **Sec. 6 Creating a State Option for Rural Designation**
- Gives new authority to States (with HHS certification) to define areas as rural for the purposes of establishing a RHC. Similar authority currently exists for state designation of shortage areas.
- **Sec. 7 Raising the Cap on Rural Health Clinic Payments.**
- Beginning in CY 2020, increase the upper limit (or cap) on RHC reimbursement to $105 per visit, in CY 2021 to $110 per visit and in CY 2022, to $115 per visit. Thereafter, cap is adjusted annually by MEI.

What are the chances?

The odds of the bill itself passing are very low, but if added to another bill such as Surprise Medical Bills or Pharmaceutical costs the percentage goes up to 50% to 60%.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NEW: Impeachment.guide is our new project explaining and tracking the impeachment inqui

Congress / Bills / S. 1037 (116th)

S. 1037: Rural Health Clinic Modernization Act of 2019

Track S. 1037 | Call or Write Congress | Tweet | Share 0

Overview Details Text Study Guide

A bill to amend title XVIII of the Social Security Act to modernize provisions relating to rural health clinics under Medicare.

The bill's titles are written by its sponsor.

Sponsor and status

John Barrasso

Sponsor. Junior Senator for Wyoming. Republican.

Read Text »

Last Updated: Apr 4, 2019

Length: 7 pages

Introduced Apr 4, 2019

Status **Introduced** on **Apr 4, 2019**

This bill is in the first stage of the legislative process. It was introduced into Congress on April 4, 2019. It will typically be considered by committee next before it is possibly sent on to the House or Senate as a whole.

Prognosis 3% chance of being enacted according to Skopos Labs (details)

Source Congress.gov

Position statements

What legislators are saying

"Barrasso, Smith Introduce Bipartisan Rural Health Clinic Modernization Act"

— Sen. John Barrasso [R-WY] (Sponsor) on Apr 4, 2019

More statements at ProPublica Represent...

We're collecting the statements of stakeholder organizations. Your organization's position statement could be on this page! Register your organization's position on this bill »

https://www.govtrack.us/congress/bills/116/hr2788

Email Nathan Baugh at baughn@capitolassociates.com

S. 1037 - Rural Health Clinics Modernization Act

What can you do?

Call or Write your Congressman

Who represents you in Washington?
To find out who your representatives/senators are and their contact information visit:
https://www.govtrack.us/congress/members
Below are some resources to help you advocate to your Congressional delegation.

Click Here - RHC Modernization Act Policy Narrative
Click Here - The RHC Modernization Act Section-by-Section
Click Here - Full Text of RHC Modernization Act
Click Here - Sample Letter Asking Senators For Their Support
Click Here - Sample Letter Asking For Support from the House of Representatives
Click Here - Sen. Barrasso Press Release
Click Here - Sen. Smith Press Release
Click Here - National Rural Health Association Endorsement
Click Here - Missouri Association of Rural Health Clinics Endorsement
Click Here - Indiana Rural Health Association Endorsement
Click Here - Smith/Sewell/McMorris Rodgers/Loebsack press release (5/16/2019)

https://www.web.narhc.org/narhc/RHC_Modernization_Act_Advocacy.asp

S. 1037 - Rural Health Clinics Modernization Act

We should know something in early December or possibly January 2020 at the latest.

Changes to the RHC Program

The Omnibus Burden Reduction Final Rule

Finalizes the following:

- **"Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction," published September 20, 2018 (83 FR 47686);**

https://www.federalregister.gov/documents/2019/09/30/2019-20736/medicare-and-medicaid-programs-regulatory-provisions-to-promote-program-efficiency-transparency-and

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When are these rules effective?

Effective date: **These regulations are effective on November 29, 2019.**

The Regulation on Program Evaluation

- **D. RURAL HEALTH CLINIC (RHC) AND FEDERALLY QUALIFIED HEALTH CENTER (FQHC) REVIEW OF PATIENT CARE POLICIES**

- **We are revising the requirement at § 491.9(b)(4) that RHC and FQHC patient care policies be reviewed at least annually by a group of professional personnel, to review every other year in order to reduce the frequency of policy reviews.**

- **E. RHC AND FQHC PROGRAM EVALUATION**
- We are revising the requirement at § 491.11(a) by changing the frequency of the required RHC or FQHC evaluation from annually to every other year.

Comments on the Program Evaluation Rule

Comment: Overall, the majority of comments submitted regarding this topic expressed support for both of the proposed changes to require biennial provision of services policy reviews and clinic or center total program evaluation. Some of the commenters were completely supportive of the proposed biennial change, while some of the commenters stated they were unsure whether it will provide meaningful burden reduction. Other commenters were appreciative of the CMS goal to reduce burden on the RHC or FQHC and stated that the flexibility and opportunity to allow the clinic or center to decide how to most appropriately use their staff time and resources is critical to maintaining the highest standard of care for their patients. One commenter suggested that, in addition to revising the time frame for review, CMS should also reduce the burden of this regulation by removing the requirement that someone in the group of professional personnel that reviews the policies must be from outside the clinic or center's staff.

Contact: CAPT Jacqueline Leach, USPHS, 410-786-4282

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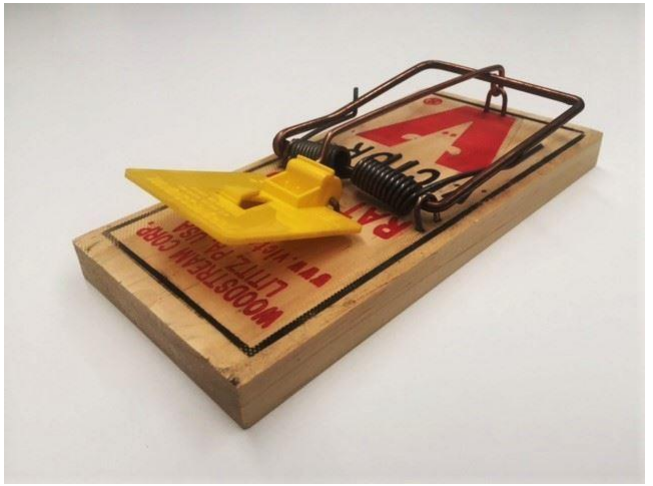
Program Evaluation is now every two years

The program evaluation and review of patient care policies requirements are reduced from annually to every two years.



Watch out for the trap

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Program Evaluation is now every two years (Continued)

Don’t forget to change your RHC Policy and Procedure Manual to reflect the new regulation as you may receive a deficiency for not following your Policy Manual

Insert the new Policy in your P & P manual

Biennial Program Evaluation Policy

Policy Number	810
Subject	Biennial Program Evaluation
Effective Date	XX/XX/XXXX
Review Date	XX/XX/XXXX

Policy:
Clinic Name carries out a biennial program evaluation of its total program drawing upon any technical assistance resources that may be available. A consultant specializing in rural health clinic delivery systems may participate in this process.

Biennial Program Evaluation Elements

1. **Utilization of Clinic Services.** The Office Manager will collect all utilization data including the number of patients served and the volume of services for the committee to review.
2. **Patient Care Guidelines.** The Medial Director and Physician Assistant/Nurse Practitioner will review the patient care policies on a biennial basis and make changes where appropriate. Policies reviewed include direct clinical services, clinic services by arrangement, guidelines for medical management of health problems and rules relating to drugs and biologicals.
3. **Chart Audit.** Open and closed clinical records will be reviewed and all changes will be communicated to the clinical providers.
4. **Review of Policy and Procedures.** The policies and procedures of the clinic will be reviewed and the need for updating will be evaluated.
5. **Walk-through of the Clinic.** There will be a walkthrough of the clinic to determine if the policies and procedures are being followed.

Biennial Program Evaluation Committee

1. Members of the Program Evaluation Committee will include the members of the Clinic Name Advisory Committee as described in Section 1 of the Policy and Procedure Manual.
2. The Medical Director will serve as the chairman of the evaluation committee. The committee will include a Physician Assistant/Nurse Practitioner, the Office Manager, and at least one community member.
3. The responsibility and purpose of the Program Evaluation Committee will include the following:
    a. Evaluation of the utilization of clinic services, including at least the number of patients served and the volume of services to determine appropriateness of utilization.
    b. Evaluation of the all policies contained in the Administrative Manual and Clinical Manual with regards to appropriateness and whether or not the policies were followed.

http://www.ruralhealthclinic.com/s/Biennial-Program-Evaluation-Policy-810-Template-Updated-10-1-2019.docx

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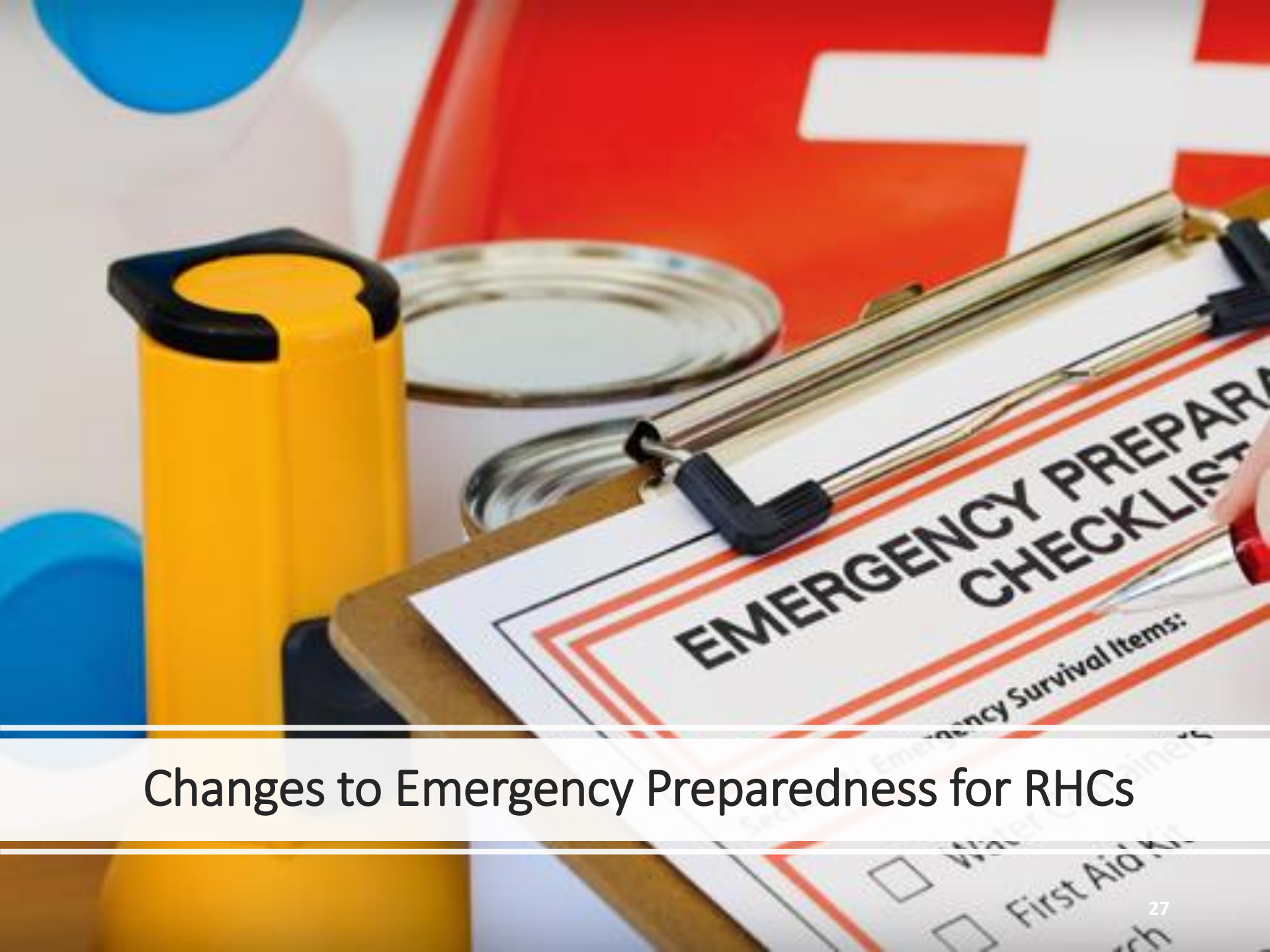
Projected Savings of Program Evaluation Changes

We discussed the burden reduction for our revision of § 491.9(b)(4) “review of patient care policies” requirements imposed on RHCs and FQHCs in the ICR section, which is an estimated savings of $7.3 million biennially, or **approximately $3.7 million annually.**

In addition, the burden reduction for our revision of § 491.11(a) “program evaluation” requirements imposed on RHCs and FQHCs in the ICR section of this rule, which is an estimated savings of $9.9 million biennially, or **approximately $5 million annually.**



Changes to Emergency Preparedness for RHCs

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The following four changes are made to the Emergency Preparedness requirements for RHCs

- *Emergency program:* decreased the requirements for RHCs to conduct an annual review of their emergency program to a biennial review.
- *Emergency plan:* Eliminating the requirement that the emergency plan include documentation of efforts to contact local, tribal, regional, State, and federal emergency preparedness officials and a facility's participation in collaborative and cooperative planning efforts;

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The following four changes are made to the Emergency Preparedness requirements for RHCs (continued)

- *Training:* Decreasing the training requirement from annually to every two years.
- *Testing:* Decreased the requirement for RHCs to conduct two testing exercises to one testing exercise annually.

- *Contact:* Kristin Shifflett, 410-786-4133, Ronisha Blackstone, 410-786-6882.

The Emergency Preparedness Regulations

P. EMERGENCY PREPAREDNESS REQUIREMENTS: REQUIREMENTS FOR EMERGENCY PLANS

- We are removing the requirements from our emergency preparedness rules for Medicare and Medicaid providers and suppliers that facilities document efforts to contact local, tribal, regional, State, and Federal emergency preparedness officials, and that facilities document their participation in collaborative and cooperative planning efforts.

RHCs are still required to work with local EMA officials

- *Response:* We would like to point out that providers would still be required at the respective emergency preparedness requirements for each provider and supplier to include a process for collaboration/cooperation with officials; however, they would not be required to document efforts to contact these officials. **Therefore, this maintains the existence of a process for collaboration with officials without posing additional documentation burdens.** Therefore, we are finalizing this requirement as proposed and eliminating the documentation requirement for collaboration with emergency preparedness officials.

The Emergency Preparedness Regulations

- **Q. EMERGENCY PREPAREDNESS REQUIREMENTS: REQUIREMENTS FOR ANNUAL REVIEW OF EMERGENCY PROGRAM**

- **We are revising this requirement so that applicable providers and suppliers review their Emergency program biennially, except for Long Term Care facilities, which will still be required to review their emergency program annually.**

Louisiana Will continue to require annual review of the EP Plans

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY
SECRETARY

State of Louisiana
Department of Health and Hospitals
Office of the Secretary

October 8, 2019

To: ESF8 Response Network

From: Cecile Castello, RN
Deputy Assistant Secretary
Health Standards Section

Subject: CMS Rule Changes

The recently released CMS rules issued September 30, 2019 relaxes the frequency of updating Emergency Preparedness plans from annually to every 2 years. Please note that LDH Health Standards' rules have not changed regarding Emergency Preparedness for annual update of the plan, the annual update of supporting components, the requirement for annual community exercises, as well as annual self-attestations for readiness as part of the annual license renewal application process

The location, scope and scale of any disaster is hard to predict. Annually updated plans, annually updated policies and procedures, and (a minimum) of annual engagement with emergency preparedness officials - prior to a disaster event - ensures that all facilities are postured for no-notice disaster events.

The frequency of severe weather to our state has increased. The nature of disasters is changing with compelling scientific evidence and studies indicating that the frequency, scope and scale of disasters is influenced by a changing climate. The last 3 years alone have demonstrated 'catastrophic' levels of disasters; namely, August 2016 flood disrupted as many homes as Katrina 2005; 2017 had 4 storms of a Category 4 or higher; and recently, Hurricane Dorian 2019 had 178mph winds (which exceeded Category 5 defined storm). Annual update of a facility's Emergency Preparedness Plan driven by exercises and drills assures that a facilities are prepared at all times.

Preparedness and Recovery is heavily dependent upon medical infrastructure being fortified and resilient. Annual community-based exercises are intended to advance preparedness at the facility and community level.

Exercises and updating the emergency plan ensures outreach to parish, state, federal and other critical stakeholders. These requirements are intended to advance transparency, as well as ensure a unified, scalable and integrated response during a time of disaster.

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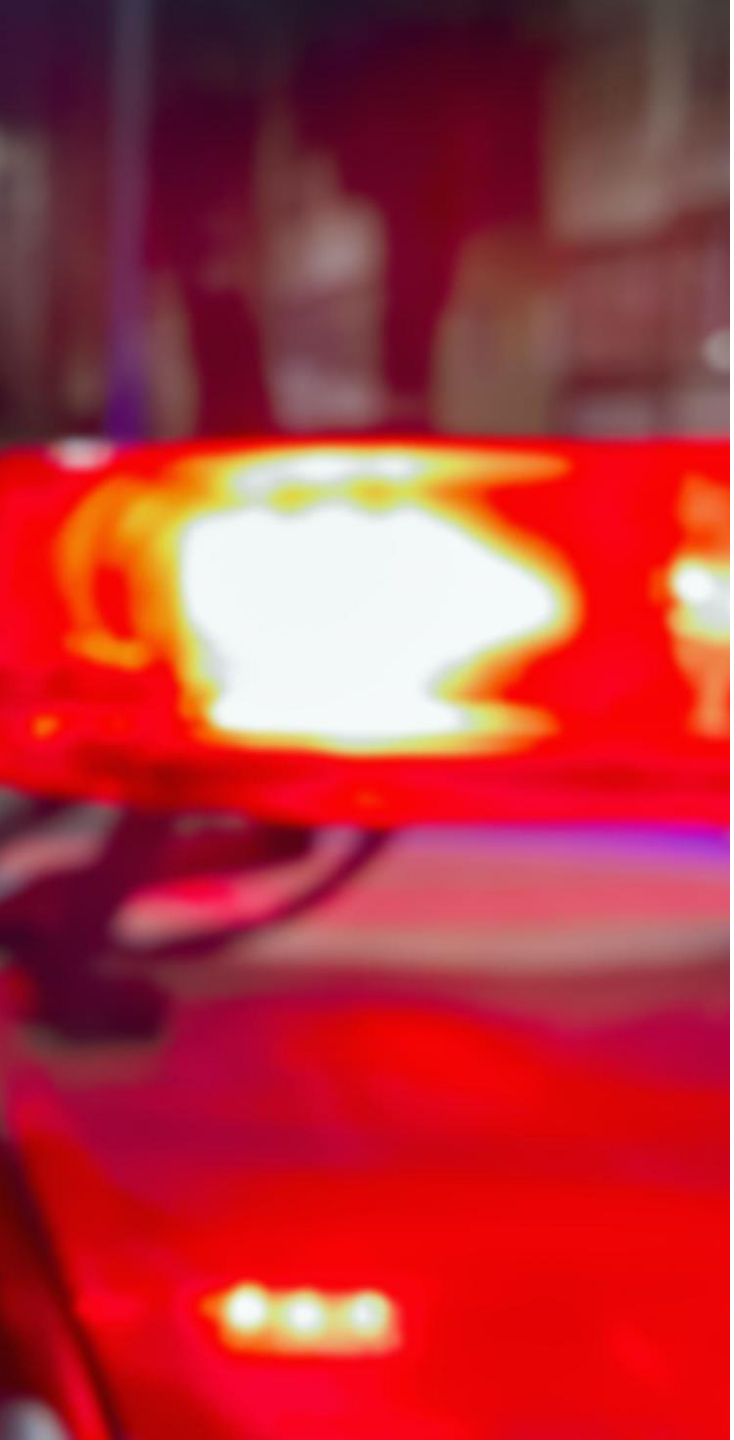


The Emergency Preparedness Regulations

- **R. EMERGENCY PREPAREDNESS REQUIREMENTS: REQUIREMENTS FOR TRAINING**

- **We are revising the requirement that facilities develop and maintain a training program based on the facility's emergency plan annually by requiring facilities to provide training biennially (every 2 years) after facilities conduct initial training for their emergency program, except for long term care facilities which will still be required to provide training annually. In addition, we are requiring additional training when the emergency plan is significantly updated.**

The Emergency Preparedness Regulations

- **S. EMERGENCY PREPAREDNESS REQUIREMENTS: REQUIREMENTS FOR TESTING**

- **For inpatient providers, we are expanding the types of acceptable testing exercises that may be conducted. For outpatient providers, we are revising the requirement such that only one testing exercise is required annually, which may be either one community-based full-scale exercise, if available, or an individual facility-based functional exercise, every other year and in the opposite years, these providers may choose the testing exercise of their choice.**

The Old Emergency Preparedness Testing Requirements

- Facilities are currently required to conduct exercises to test the emergency plan at least annually. The facility must conduct two emergency preparedness testing exercises every year. Specifically, facilities must:
- 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 facility experiences an actual natural or-man made emergency that requires activation of the emergency plan (including their communication plan and revision of the plan as needed), the facility 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;
- Conduct an additional exercise that may include either a second full-scale exercise that is community-based or individual, facility-based or a tabletop exercise that includes a group discussion led by a facilitator.

Emergency Preparedness Testing for Inpatient Services

- For providers of inpatient services (inpatient hospice facilities, Psychiatric Residential Treatment Facilities (PRTFs), hospitals, long-term care facilities (LTCFs), ICFs/IIDs, and CAHs), we proposed to retain the existing requirement for these provider and supplier types to conduct two emergency preparedness testing exercises annually.
- **We proposed to expand the testing requirement options, such that one of the two annually required testing exercises could be an exercise of their choice, which could include one community-based full-scale exercise (if available), an individual facility-based functional exercise, a drill, or a tabletop exercise or workshop that included a group discussion led by a facilitator.**

Emergency Preparedness Testing for Outpatient (RHC) Services

- For providers of outpatient services we proposed to require that providers of outpatient services conduct only one testing exercise per year.

- Furthermore, we proposed to require that these providers participate in either a community-based full-scale exercise (if available) or conduct an individual facility-based functional exercise every other year.

- In the opposite years, we proposed to allow these providers to conduct the testing exercise of their choice, which may include either a community-based full-scale exercise (if available), an individual, facility-based functional exercise, a drill, or a tabletop exercise or workshop that includes a group discussion led by a facilitator.

Emergency Preparedness – Testing Requirements

TYPES OF EXERCISES

Full Scale Exercises (FSX) require staff to "Walk Through" the event,
Tabletops (TTX) require staff to "Talk Through" the event

The Medal Count

Medal	Type of Exercise	Participation
Gold	Community-based Exercise	Representation from the clinic
Silver	Facility Based Exercise	All Employees
Bronze	Tabletop	All Employees

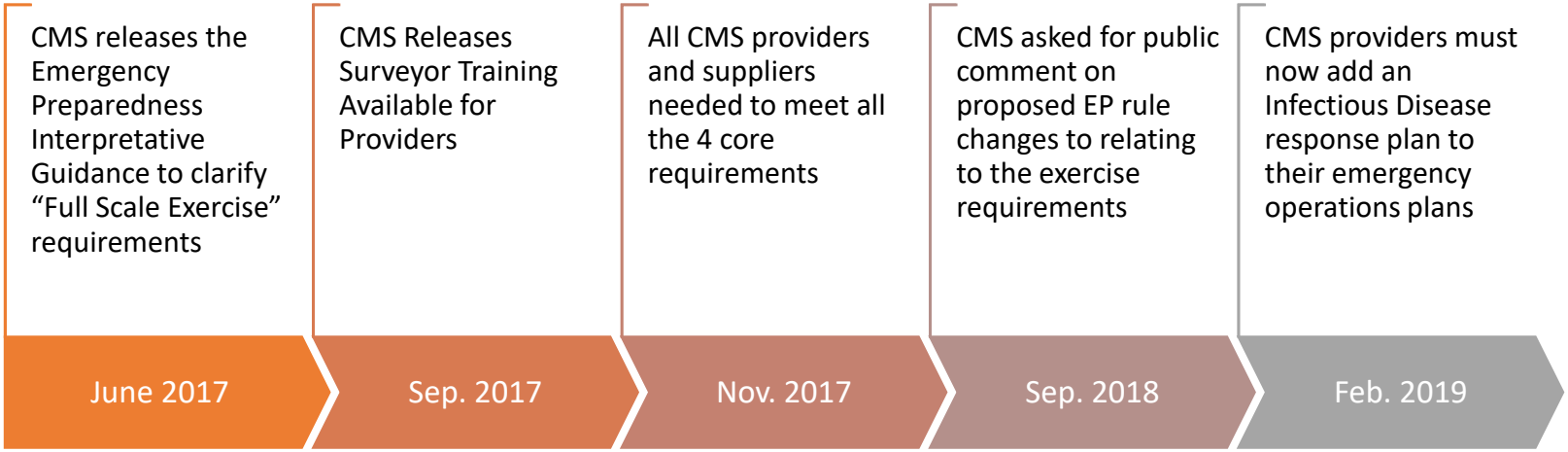
In the Event of an Emergency

- We proposed to clarify the testing requirement exemption by noting that if a provider experiences an actual natural or man-made emergency that requires activation of their emergency plan, inpatient and outpatient providers will be exempt from their next required full-scale community-based exercise or individual, facility-based functional exercise following the onset of the actual event.

How much does the Emergency Preparedness rules save annually

- *RHCs/FQHCs:* **Combined total savings of $4,284,104** (((4 hours for an administrator at $107 per hour plus 4 hours for a registered nurse at $71 per hour) × 4,160 RHCs × 50 percent) $1,480,960+ (4 hours for an administrator at $107 per hour plus 4 hours for a registered nurse at $71 per hour) × 7,874 FQHCs × 50 percent) 2,803,144.

CMS EP Rule Updates Since 2017



Great Shakeout – October 17, 2019

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SHAKEOUT HEALTHCARE ORGANIZATION RESOURCES

Great ShakeOut Earthquake Drills provide an annual opportunity for healthcare organizations and facilities to practice earthquake safety and other aspects of emergency planning along with millions of others across the United States and worldwide.

Healthcare organizations of all sizes can use the drill to get their staff, volunteers, partners, and even their patients/residents, involved and prepared for being safe during earthquakes, and ready to provide services afterwards. Furthermore, the level of your employee's personal and family preparedness will be key to their availability to support your organization's response and recovery efforts after a disaster.

To participate, first **register** in your state, territory, or region.

CMS Emergency Preparedness Rule

In 2016, new Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers were announced. Health care providers and suppliers affected by this rule must now comply and implement all regulations (see list of 17 provider and supplier types).

Your ShakeOut Drill can meet the training and plan testing requirements of the CMS Rule:

- **Training:** Conduct and document initial and annual training on your emergency preparedness policies and procedures to all staff, participants, volunteers, and contractors;
- **Exercises:** Must conduct and document two exercises annually:
  1. One must be a community-based CMS Defined Full-Scale Exercise;
  2. The other exercise can be a second Full-Scale or Tabletop Exercise.

As the term "full-scale exercise" may vary by sector, facilities are not required to conduct a full-scale exercise as defined by FEMA or DHS Homeland Security Exercise and Evaluation Program (HSEEP). Full-scale exercise is defined by CMS as:

- Any operations-based exercise (drill, functional, or full-scale exercise) that assesses a facility's functional capabilities by simulating a response to an emergency that would impact the facility's operations and their community;
- A full-scale exercise is also an operations-based exercise that typically involves multiple agencies, jurisdictions, and disciplines performing functional or operational elements.

CMS Training and Testing FAQs (download the full set of FAQs from here)

Suggestions for having your Shakeout participation count as a CMS full-scale exercise:

- Coordinate your ShakeOut Exercise with others in your community;
- Physically evacuate your facility;
- Activate your Emergency Plan and Incident Command Team at your facility;
- Communicate with the other facilities about the possibility of moving clients/patients/residents to other facilities or accepting clients/patients/residents in your facility;
- Evaluate your exercise based on your exercise objectives;
- Document your exercise and what was noted as improvement items. i.e. After-Action Report.

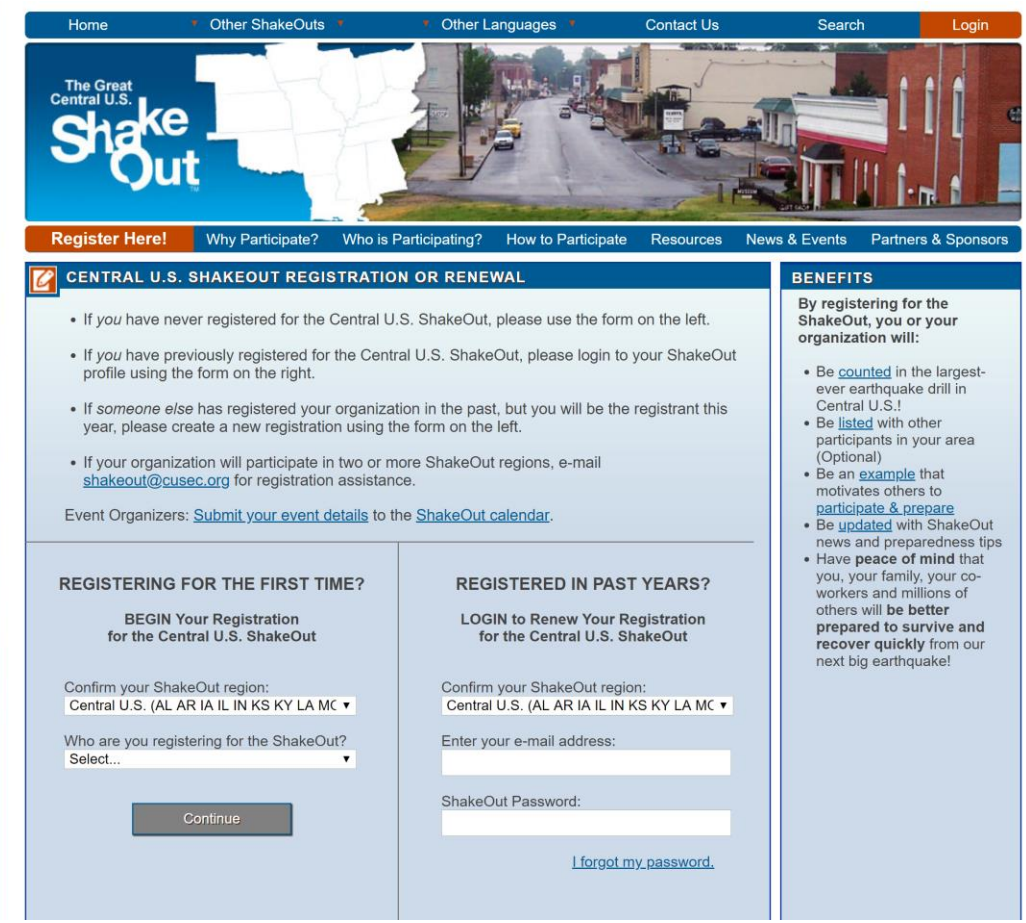
Webinar: ***Shakeout Your CMS Emergency Preparedness Exercise Requirements***
This webinar was presented on August 28, 2019 by Mark Benthien (Global Coordinator, ShakeOut) and Nora O'Brien (CEO, Connect Consulting Services):

- PowerPoint Presentation (PDF)
- View recording of the webinar

https://www.shakeout.org/healthcare/index.html?fbclid=IwAR0PW4ocf7LGU86WrxFtGia_4T_Ou32Fsol14UWZvg2Ka63IaPh85dxsUVo

The Great Shakeout Facility Drill – October 17, 2019

https://www.shakeout.org/centralus/register/



FEMA

ToDo –Earthquake Drill

- Register for the Shake out Drill at the following website: https://www.shakeout.org/centralus/ and include the Registration documentation in Tab 7 of your Emergency Preparedness Manual.
- Review the Shakeout Exercise Manual provided in EP Manual.
- Have all of your staff watch this introductory video. https://www.fema.gov/el/media-library/assets/videos/79032
- Have all of your staff watch this video on what to do in case of an earthquake. https://www.youtube.com/watch?v=6Rjyt7XAZrA
- Everyone should participate in the following drill. It will last one minute. https://www.youtube.com/user/greatshakeout
- Have everyone sign and date the sign in sheet.
- Include all documentation in Tab 7 of your Emergency Preparedness Policy and Procedure Manual and you MUST PREPARE AN AFTERACTION PLAN.

FEMA

How Can Your Shakeout Exercise Participation Count Towards your CMS Full-Scale Exercise Requirement?

- Coordinate your ShakeOut Exercise with others in your community
- Physically evacuate your facility
- Activate your Emergency Plan and Incident Command Team at your facility
- Evaluate your exercise based on your exercise objectives
- Document your exercise and what was noted as improvement items. i.e. After-Action Report (AAR)
- Implement your Improvement Plan (IP)

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To Count as an Emergency Preparedness Drill, you need an After-Action Report

[Exercise Name]

After-Action Report/Improvement Plan

[Date]

The After-Action Report/Improvement Plan (AAR/IP) aligns exercise objectives with preparedness doctrine to include the National Preparedness Goal and related frameworks and guidance. Exercise information required for preparedness reporting and trend analysis is included; users are encouraged to add additional sections as needed to support their own organizational needs.

Rev. April 2013
HSEEP-IP01

EXERCISE OVERVIEW

Exercise Name	[Insert the formal name of exercise, which should match the name in the document header]
Exercise Dates	[Indicate the start and end dates of the exercise]
Scope	This exercise is a [exercise type], planned for [exercise duration] at [exercise location]. Exercise play is limited to [exercise parameters].
Mission Area(s)	[Prevention, Protection, Mitigation, Response, and/or Recovery]
Core Capabilities	[List the core capabilities being exercised]
Objectives	[List exercise objectives]
Threat or Hazard	[List the threat or hazard (e.g. natural/hurricane, technological/radiological release)]
Scenario	[Insert a brief overview of the exercise scenario, including scenario impacts (2-3 sentences)]
Sponsor	[Insert the name of the sponsor organization, as well as any grant programs being utilized, if applicable]
Participating Organizations	[Insert a brief summary of the total number of participants and participation level (i.e., Federal, State, local, Tribal, non-governmental organizations (NGOs), and/or international agencies). Consider including the full list of participating agencies in Appendix B. Delete Appendix B if not required.]
Point of Contact	[Insert the name, title, agency, address, phone number, and email address of the primary exercise POC (e.g., exercise director or exercise sponsor)]

Appendix Z Updated in Feburary, 2019

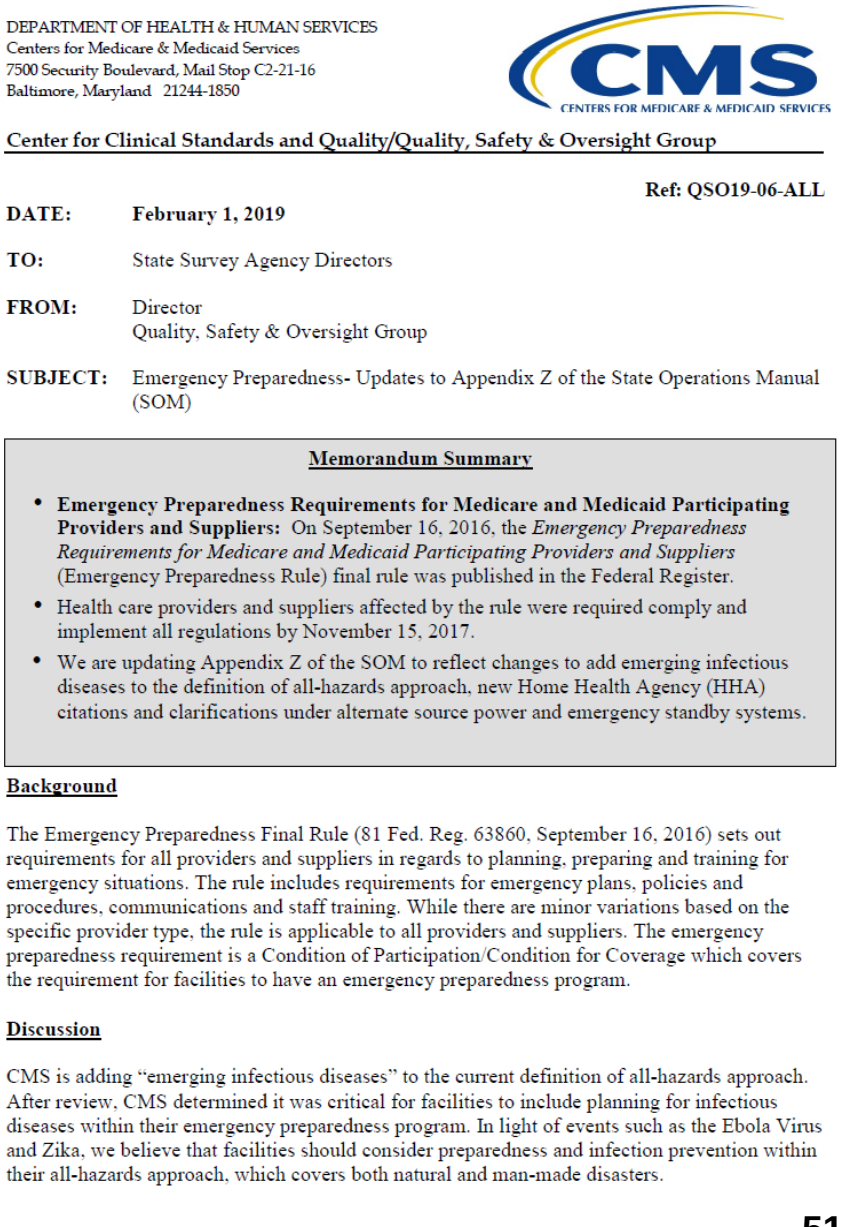
Appendix Z Revised on 2/1/2019

- **Appendix Z updated as of 2/1/2019. The red italics show the changes made with this revision (see downloads section). For the full Appendix Z, please see**
- **https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_z_emergprep.pdf**

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO19-06-ALL.pdf

Revisions and Updates to Appendix Z

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO19-06-ALL.pdf



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO19-06-ALL

DATE: February 1, 2019

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Emergency Preparedness- Updates to Appendix Z of the State Operations Manual (SOM)

Memorandum Summary

- **Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers:** On September 16, 2016, the *Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers* (Emergency Preparedness Rule) final rule was published in the Federal Register.
- Health care providers and suppliers affected by the rule were required comply and implement all regulations by November 15, 2017.
- We are updating Appendix Z of the SOM to reflect changes to add emerging infectious diseases to the definition of all-hazards approach, new Home Health Agency (HHA) citations and clarifications under alternate source power and emergency standby systems.

Background

The Emergency Preparedness Final Rule (81 Fed. Reg. 63860, September 16, 2016) sets out requirements for all providers and suppliers in regards to planning, preparing and training for emergency situations. The rule includes requirements for emergency plans, policies and procedures, communications and staff training. While there are minor variations based on the specific provider type, the rule is applicable to all providers and suppliers. The emergency preparedness requirement is a Condition of Participation/Condition for Coverage which covers the requirement for facilities to have an emergency preparedness program.

Discussion

CMS is adding "emerging infectious diseases" to the current definition of all-hazards approach. After review, CMS determined it was critical for facilities to include planning for infectious diseases within their emergency preparedness program. In light of events such as the Ebola Virus and Zika, we believe that facilities should consider preparedness and infection prevention within their all-hazards approach, which covers both natural and man-made disasters.

Include Infectious Diseases in All Hazards Risk Assessment & Develop a Policy

- **CMS is adding "emerging infectious diseases" to the current definition of all-hazards approach. After review, CMS determined it was critical for facilities to include planning for infectious diseases within their emergency preparedness program. In light of events such as the Ebola Virus and Zika, we believe that facilities should consider preparedness and infection prevention within their all-hazards approach, which covers both natural and man-made disasters.**
- **http://www.ruralhealthclinic.com/s/2019-Master-Infectious-Disease-Policy-E50-to-add-to-the-Emergency-Preparedness-Policy-and-Procedure.docx**
- **http://www.ruralhealthclinic.com/s/2019-Emergency-Preparedness-Forms-Infectious-Disease-Forms.pdf**

CMS Relaxes Policy on Emergency Drugs and Biologicals for RHCs

NARHC is happy to report that CMS is significantly altering their guidance policy regarding emergency drugs and biologicals required in Rural Health Clinics. This change is effective immediately.

Previously, RHCs were required to stock drugs and biologicals from each of the following categories: 1-Analgesics; 2-Local Anesthetics; 3-Antibiotics; 4-Anticonvulsants; and 5-Antidotes, emetics, serums & toxoids. **However, as of September 3rd, 2019, RHCs will only be required to consider each category when they craft their written policies.** This means that RHCs will not be required to stock snake antidote, emetics, or anticonvulsants!

https://www.web.narhc.org/News/28058/CMS-Relaxes-Policy-on-Emergency-Drugs-and-Biologicals-for-RHCs

Appendix G - Emergency Drugs and Biologicals for RHCs

- *"While each category of drugs and biologicals must be considered, all are not required to be stored…*

- We will still be required to store drugs and biologicals for emergencies, but now, CMS is allowing us to determine which drugs and biologicals are most appropriate for our communities:

- *…when determining which drugs and biologicals it has available for purposes of addressing common life-threatening injuries and acute illnesses,* ***the RHC should consider, among other things, the community history, the medical history of its patients and accepted standards of practice. The clinic should have written policies and procedures*** *for determining what drug/biologicals are stored and that address the process for determining which drugs/biologicals to store, including identifying who is responsible for making this determination."*

Appendix G – Revision Dated September 3, 2019

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality /Quality, Safety & Oversight Group

Ref: QSO-19-18- RHC

DATE: September 3, 2019

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Revised Rural Health Clinic (RHC) Guidance Updating Emergency Medicine Availability—State Operations Manual (SOM) Appendix G- Advanced Copy

Memorandum Summary

- ***RHC Appendix G Revision:*** The Centers for Medicare & Medicaid Services (CMS) is updating the medical emergency guidance as it pertains to the availability of drugs and biologicals commonly used in life saving procedures.

Background

On December 22, 2017, CMS issued a comprehensive revision to the SOM, Appendix G for RHCs. As part of the revision, we provided additional guidance pertaining to the medical emergency requirements which are codified at 42 CFR 491.9(c)(3). The regulation requires RHCs to provide medical emergency procedures as a first response to common life-threatening injuries and acute illness. In addition, it requires RHCs to have available the drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids. Since the regulation utilizes the term "such as" when identifying the types of drugs/biologicals the RHC must have available, there have been questions as to whether the RHC must maintain items from *each category type* listed or if the categories were provided as examples. Additionally, it has been brought to our attention that the example provided in the current guidance implies all RHCs are required to store snake bite anti-venom, regardless of whether or not there was a specific risk in the RHC's geographic area.

Discussion

The current guidance clarifies that an RHC must maintain a supply of drugs and biologicals adequate to handle the volume and type of emergencies it typically encounters for *each of the listed categories*. It further states, if an RHC generally handles only a small volume/type of a specific emergency, it is appropriate for the RHC to store a small volume of a particular drug/biological. As an example, we used snake bites as a medical emergency to which storing a small volume of an antidote would be acceptable.

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO-19-18-RHC.pdf

RHCs are required to disclose ownership, medical direction & Principal Direction and Operation in the Lobby

Dunder Mifflin Medical Associates

Ownership

Dunder Mifflin Medical Associates

100 Main Street

Scranton, Pennsylvania

Medical Direction

Marcus Welby, MD

Principal Direction and Operation

Michael Scott

http://www.ruralhealthclinic.com/s/2019-Certification-Master-Signage-with-Ownership-Medical-Direction-and-management-to-be-placed-in-lo.docx

Updated RHC Fact Sheet – May, 2019

RURAL HEALTH CLINIC

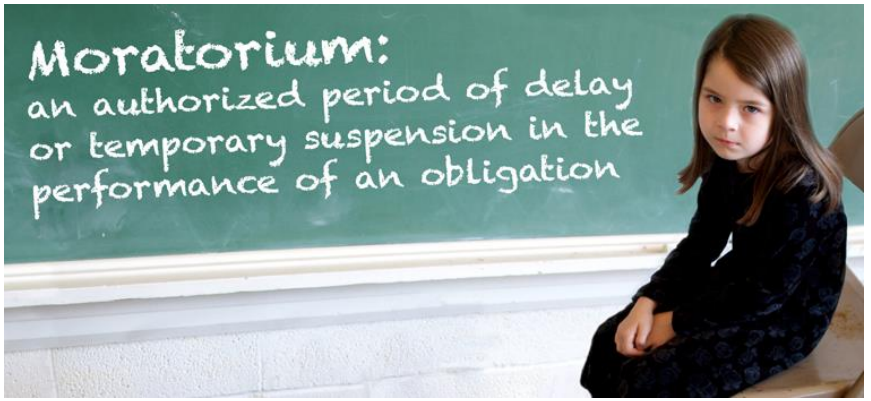
The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

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

Questions before we move on Tenncare

The Moratorium Lifted Effective October 1, 2019

TennCare



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Tenncare Moratorium Lifted

As of October 1, 2019, TennCare is lifting the moratorium on new RHCs registering as Medicaid RHCs
They have posted a memo and FAQ concerning Final Rate Setting and the Moratorium on their website at:

https://www.tn.gov/tenncare/moratorium-on-rural-health-centers.html

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Moratorium on Rural Health Centers and Final Rate Setting

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 2019, the federal government approved a moratorium extension that runs through October 25, 2019. 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 proposed TennCare rules and associated state plan amendment have been withdrawn by TennCare.

As of October 1, 2019, TennCare is lifting the moratorium and moving forward with setting final rates for all clinics that are still on interim rates. For more information about this, please see the following two documents:

Memo on RHC Moratorium and FQHC/RHC Final Rate Setting
FAQ on RHC Moratorium and FQHC/RHC Final Rate Setting

Tenncare Memorandum on Final Rate Setting

https://www.tn.gov/content/dam/tn/tenncare/documents/RateAndMoratoriumMemo.pdf

TN Division of TennCare

To: Administrators of Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
From: Zane Seals, Deputy Chief Financial Officer
Date: September 26, 2019
Subject: Final Rate Setting and Moratorium on FQHCs and RHCs

As you may already be aware, TennCare has elected to withdraw the proposed rule to govern rate-setting and payment processes for the prospective payment system (PPS) for FQHCs and RHCs. This decision was made in response to a lack of clarity from CMS regarding the rule and associated state plan amendment. TennCare is also withdrawing the proposed state plan amendment. Because the rule and proposed state plan amendment will not be going into effect, TennCare would like to clarify several issues regarding rate setting and reimbursement that affect the provider community.

Moratorium on RHCs

In October of 2017, TennCare gained approval from CMS to implement a moratorium on the registration of new RHCs with TennCare. Beginning on October 1, 2019, TennCare will lift the moratorium on new RHCs registering as Medicaid RHCs. This means that clinics that have already received their federal RHC designation will be able to change their provider type to RHC, and new clinics that obtain RHC status from the federal government will be able to immediately register with TennCare as an RHC. See the attached FAQ on how to register with TennCare as an RHC. All of these clinics will receive a final rate as specified below.

Setting of Final Rates

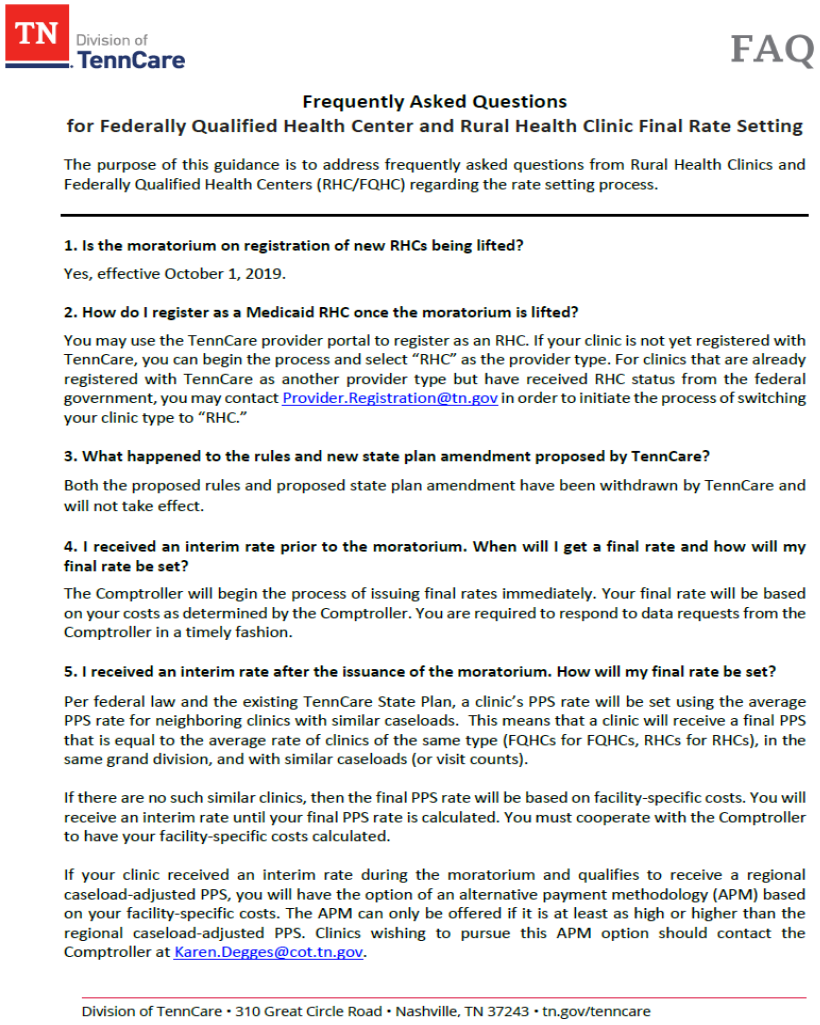
Clinics (FQHCs and RHCs) that are receiving an interim rate set prior to the moratorium will receive a final PPS rate based on their costs as set by the Comptroller. Clinics impacted by the moratorium (those receiving an interim rate after the issuance of the moratorium) will receive a final PPS rate that is equal to the average of adjacent clinics with similar caseloads. This means that a clinic will receive a final PPS that is equal to the average rate of clinics of the same type (FQHCs for FQHCs, RHCs for RHCs) in their grand division, with a separate average being calculated for clinics of varying caseloads. If there are no such similar clinics, then the facility will receive a cost-based PPS, as explained in the attached FAQ document. These clinics affected by the moratorium will also be given an option of an alternative payment methodology (APM) based on cost data. Clinics must timely respond to data requests from the Comptroller in order to receive final PPS and if applicable, APM rates.

Reconciliation of Final Rates

TennCare recognizes that many clinics have been on an interim rate for a significant period of time, resulting in unique risk to these facilities once the final rate is set. In an effort to recognize this risk posed to these clinics and encourage the stability of healthcare delivery in challenged areas, TennCare will not execute a reconciliation of final rates to those clinics currently on an interim rate established prior to the moratorium, if their final rate is lower than the interim. TennCare will still perform a reconciliation for those clinics whose final rate is higher than the interim, meaning these clinics will receive additional back payments from the state. This means that if a clinic's interim rate established prior to the moratorium is higher than the final rate, TennCare will not seek reconciliation of funds.

If you have questions about any step in this process, please see the attached FAQ that is being distributed with this memo. You can also contact Rebekah Stephens at Rebekah.stephens@tn.gov or 615-687-4739.

Tenncare FAQs on Rate Setting



TN Division of TennCare

FAQ

Frequently Asked Questions
for Federally Qualified Health Center and Rural Health Clinic Final Rate Setting

The purpose of this guidance is to address frequently asked questions from Rural Health Clinics and Federally Qualified Health Centers (RHC/FQHC) regarding the rate setting process.

---

1. Is the moratorium on registration of new RHCs being lifted?

Yes, effective October 1, 2019.

2. How do I register as a Medicaid RHC once the moratorium is lifted?

You may use the TennCare provider portal to register as an RHC. If your clinic is not yet registered with TennCare, you can begin the process and select "RHC" as the provider type. For clinics that are already registered with TennCare as another provider type but have received RHC status from the federal government, you may contact Provider.Registration@tn.gov in order to initiate the process of switching your clinic type to "RHC."

3. What happened to the rules and new state plan amendment proposed by TennCare?

Both the proposed rules and proposed state plan amendment have been withdrawn by TennCare and will not take effect.

4. I received an interim rate prior to the moratorium. When will I get a final rate and how will my final rate be set?

The Comptroller will begin the process of issuing final rates immediately. Your final rate will be based on your costs as determined by the Comptroller. You are required to respond to data requests from the Comptroller in a timely fashion.

5. I received an interim rate after the issuance of the moratorium. How will my final rate be set?

Per federal law and the existing TennCare State Plan, a clinic's PPS rate will be set using the average PPS rate for neighboring clinics with similar caseloads. This means that a clinic will receive a final PPS that is equal to the average rate of clinics of the same type (FQHCs for FQHCs, RHCs for RHCs), in the same grand division, and with similar caseloads (or visit counts).

If there are no such similar clinics, then the final PPS rate will be based on facility-specific costs. You will receive an interim rate until your final PPS rate is calculated. You must cooperate with the Comptroller to have your facility-specific costs calculated.

If your clinic received an interim rate during the moratorium and qualifies to receive a regional caseload-adjusted PPS, you will have the option of an alternative payment methodology (APM) based on your facility-specific costs. The APM can only be offered if it is at least as high or higher than the regional caseload-adjusted PPS. Clinics wishing to pursue this APM option should contact the Comptroller at Karen.Degges@cot.tn.gov.

Division of TennCare • 310 Great Circle Road • Nashville, TN 37243 • tn.gov/tenncare

https://www.tn.gov/content/dam/tn/tenncare/documents/FQHCRHCFAQ.pdf

Tenncare FAQs on Rate Setting (2)

TN Division of TennCare

FAQ

6. What if my final rate is lower than my interim rate?

In order to recognize the unique risks posed to facilities who are currently on interim rates established prior to the moratorium, TennCare will not execute a reconciliation of the final rate if the final rate is lower than the interim rate. This means there will be no recoupment in applying your final rate--your final rate will only be applied prospectively.

Clinics impacted by the moratorium (those receiving interim rates after the issuance of the moratorium) and in the future will experience full reconciliations. It is important to note that clinics must still respond to data requests from the Comptroller in a timely fashion so that the Comptroller can set the final rates.

7. What if my final rate is higher than my interim rate?

If you are currently on an interim rate, including those impacted by the moratorium, then TennCare will reconcile the final rate retroactively if the final rate is higher than the interim rate. For clinics that are already registered with TennCare as an RHC, the reconciliation will cover all services on or after the date of your registration with TennCare as an RHC. For clinics that are impacted by the moratorium and are therefore not currently registered as an RHC, this reconciliation will cover all services on or after the date of receiving RHC status from the federal government (these clinics must still register with TennCare as an RHC as part of this process). This reconciliation means you will receive additional back payments from TennCare for the above described periods. It is important to note that clinics must still respond to data requests from the Comptroller in a timely fashion so that the Comptroller can set the final rates.

8. I am a new clinic entering the program after the Moratorium is lifted. Will I get an interim rate?

If there is an average PPS rate for neighboring clinics of the same type (FQHCs for FQHCs, RHCs for RHCs) with similar caseloads, then you will immediately receive that rate as your final PPS rate. If there are not adequate neighboring clinics with similar caseloads, then you will receive an average PPS rate on an interim basis until you receive a final rate based on your costs.

9. I have questions about my rate. Who can I call?

If you have questions about your rate, you can contact the Comptroller at Karen.Degges@cot.tn.gov. If you have questions about the related memo or this document, you can contact Rebekah Stephens with TennCare at Rebekah.stephens@tn.gov or 615-687-4739.

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Experienced Knowledge

Important updates

1. Is the moratorium on registration of new RHCs being lifted?

Yes, effective October 1, 2019.

3. What happened to the rules and new state plan amendment proposed by TennCare?

Both the proposed rules and proposed state plan amendment have been withdrawn by TennCare and will not take effect.

The state's refusal to expand Medicaid has left 380,000 uninsured adults who would otherwise be covered. In so doing, Tennessee is passing up an estimated $26 billion in federal payments over the next decade.

https://www.commonwealthfund.org/blog/2019/what-medicaid-block-grant-would-mean-tennessee-update

https://www.tn.gov/content/dam/tn/tenncare/documents2/TennCareAmendment42.pdf

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How to register as an RHC with Tenncare

2. How do I register as a Medicaid RHC once the moratorium is lifted?

You may use the TennCare provider portal to register as an RHC. If your clinic is not yet registered with TennCare, you can begin the process and select "RHC" as the provider type. For clinics that are already registered with TennCare as another provider type but have received RHC status from the federal government, you may contact Provider.Registration@tn.gov in order to initiate the process of switching your clinic type to "RHC."

Tennessee RHCs can be placed in Three Buckets

Final Rate Setting Process

Prior to 10/1/2017

Final Rate based upon Cost Report

From 10/1/2017 to 9/30/2019

Final Rate will be set using the average PPS rate for similar clinics unless no similar clinics.

Beginning 10/1/2019

Final Rate will be set using the average PPS for similar clinics unless no similar clinics

Tennessee RHCs can be placed in Three Buckets

Settlement Process

Prior to 10/1/2017

If final rate is lower there will be no recoupment in applying your final rate--your

final rate will only be applied prospectively. If final rate is higher the RHC will receive final settlement.

From 10/1/2017 to 9/30/2019

These RHCs will experience full reconciliations. If the final rate is higher then the RHC will receive settlement and if the rate is lower the RHC will have to pay Tenncare Back

Beginning

10/1/2019

These RHCs will experience full reconciliations. If the final rate is higher then the RHC will receive settlement and if the rate is lower the RHC will have to pay Tenncare Back.

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4. I received an interim rate prior to the moratorium. When will I get a final rate and how will my final rate be set?

The Comptroller will begin the process of issuing final rates immediately. Your final rate will be based on your costs as determined by the Comptroller. You are required to respond to data requests from the Comptroller in a timely fashion.

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Experienced Knowledge

6. What if my final rate is lower than my interim rate?

In order to recognize the unique risks posed to facilities who are currently on interim rates established prior to the moratorium, TennCare will not execute a reconciliation of the final rate if the final rate is lower than the interim rate. This means there will be no recoupment in applying your final rate--your final rate will only be applied prospectively.

Tennessee RHCs certified 10/1/2019 and after

Three different Interim Rate Setting Process

8. I am a new clinic entering the program after the Moratorium is lifted. Will I get an interim rate?

If there is an average PPS rate for neighboring clinics of the same type (FQHCs for FQHCs, RHCs for RHCs) with similar caseloads, then you will immediately receive that rate as your final PPS rate. If there are not adequate neighboring clinics with similar caseloads, then you will receive an average PPS rate on an interim basis until you receive a final rate based on your costs.

Three processes

1. **If similar RHCs with similar case loads the RHC will immediately receive your final PPS rate.**
2. **If there are not similar RHCs, then the RHC receives an average PPS rate as the interim rate and you will receive the final rate based upon your cost report.**
3. **APM (See Next Slide)**

Tennessee's Three Grand Divisons

West Middle East

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Experienced Knowledge

Grand Division Interim Rates

The interim rates are:

West	$141.49
Middle	$131.35
East	$137.99

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5. I received an interim rate after the issuance of the moratorium. How will my final rate be set?

Per federal law and the existing TennCare State Plan, a clinic's PPS rate will be set using the average PPS rate for neighboring clinics with similar caseloads. This means that a clinic will receive a final PPS that is equal to the average rate of clinics of the same type (FQHCs for FQHCs, RHCs for RHCs), in the same grand division, and with similar caseloads (or visit counts).

If there are no such similar clinics, then the final PPS rate will be based on facility-specific costs. You will receive an interim rate until your final PPS rate is calculated. You must cooperate with the Comptroller to have your facility-specific costs calculated.

If your clinic received an interim rate during the moratorium and qualifies to receive a regional caseload-adjusted PPS, you will have the option of an alternative payment methodology (APM) based on your facility-specific costs. The APM can only be offered if it is at least as high or higher than the regional caseload-adjusted PPS. Clinics wishing to pursue this APM option should contact the Comptroller at Karen.Degges@cot.tn.gov.

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Clinics impacted by the moratorium (those receiving interim rates after the issuance of the moratorium) and in the future will experience full reconciliations. It is important to note that clinics must still respond to data requests from the Comptroller in a timely fashion so that the Comptroller can set the final rates.

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7. What if my final rate is higher than my interim rate?

If you are currently on an interim rate, including those impacted by the moratorium, then TennCare will reconcile the final rate retroactively if the final rate is higher than the interim rate. For clinics that are already registered with TennCare as an RHC, the reconciliation will cover all services on or after the date of your registration with TennCare as an RHC. For clinics that are impacted by the moratorium and are therefore not currently registered as an RHC, this reconciliation will cover all services on or after the date of receiving RHC status from the federal government (these clinics must still register with TennCare as an RHC as part of this process). This reconciliation means you will receive additional back payments from TennCare for the above described periods. It is important to note that clinics must still respond to data requests from the Comptroller in a timely fashion so that the Comptroller can set the final rates.

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8. I am a new clinic entering the program after the Moratorium is lifted. Will I get an interim rate?

If there is an average PPS rate for neighboring clinics of the same type (FQHCs for FQHCs, RHCs for RHCs) with similar caseloads, then you will immediately receive that rate as your final PPS rate. If there are not adequate neighboring clinics with similar caseloads, then you will receive an average PPS rate on an interim basis until you receive a final rate based on your costs.

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9. I have questions about my rate. Who can I call?

If you have questions about your rate, you can contact the Comptroller at Karen.Degges@cot.tn.gov. If you have questions about the related memo or this document, you can contact Rebekah Stephens with TennCare at Rebekah.stephens@tn.gov or 615-687-4739.

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TENNCARE BILLING RESOURCES

Tenncare was granted a moratorium for paying RHCs the enhanced RHC reimbursement rate effective October 25, 2017. We have included links to many of the documents regarding the moratorium. Please click the link below:

- The Tennessean Article on Tenncare lifting the Moratorium
- Tenncare Interim Payment Memorandum lifting the Moratorium
- The Tennessean Article on payment freeze to RHCs published on December 27, 2018
- Tenncare Comments on November 27, 2018
- Tenncare Proposed Rules on November 6, 2018
- Tenncare State Plan from 2005

Tenncare Memorandum on the Moratorium on January 10, 2019

TN Division of TennCare

January 10, 2019

Re: Interim rates during Moratorium

TennCare would like to share with you an update regarding payments to Rural Health Clinics (RHCs). As you are aware, there is currently a moratorium on the registration of new RHCs into the TennCare program to allow for the creation of a new set of rules governing FQHC/RHC payments. The rules are designed to allow for clear, detailed, and robust rules for payments to FQHCs and RHCs and are not intended to limit the number of RHCs in the program. The proposed rule is currently in the rulemaking process but is not yet final. TennCare recognizes that the time it has taken to prepare diligent, complete, and fair rules has had a financial impact on new RHCs certified by CMS during the moratorium. In order to mitigate this impact, TennCare is allowing interim RHC supplemental or "wraparound" payments to be made to RHCs certified by CMS during the moratorium. Because the moratorium on new enrollment of RHCs in the TennCare program remains in place, affected RHCs will receive this temporary interim payment but will not be permitted to register with TennCare as an RHC at this time or to establish a final RHC payment rate.

Interim payments will not be based on the individual RHC's actual cost data, which is used to set the final payment rate. Rather, the interim rate for each affected RHC shall be set at the average rate for all active RHCs that (a) had already received a final payment rate from the Comptroller as of the date the moratorium began and (b) are located in the same Grand Division of the state as the affected RHC. Interim payments will be made dating back to either the effective date of a provider's certification by CMS as an RHC or the effective date of a provider's TennCare Medicaid ID number, whichever is later.[1] However, in no case will payments be made dating back earlier than October 25, 2017, which is the date the moratorium began. In addition, no payments will be made for visits prior to when an RHC entered into a participation agreement with a corresponding MCO.

Once the moratorium is lifted and the final rules are in place, TennCare will resume registration of RHCs. At that time, the final payment rate for each newly registered RHC, including those that received these interim payments, will be based on one year of its actual cost report data as required under the proposed rule. Further, at the time the final rate is set, the RHC will be offered a choice of rate methodologies as set forth in the forthcoming state rules: the RHC can choose to be paid according to the Prospective Payment System (PPS) rate or under the Alternative Payment Methodology (APM) rate.

[**IMPORTANT NOTE**] The interim rate is not based on the individual RHC's actual cost data. Therefore, there will be a reconciliation process once the final rate has been selected by the RHC under the forthcoming rules. If the RHC has been overpaid under the interim rate as compared to the final rate,

[1] TennCare recognizes that, in the normal course of business, there is typically a gap in time between a provider's certification by CMS as an RHC and their subsequent registration with the TennCare program as an RHC. However, because there is a moratorium on the enrollment of new RHCs with TennCare, TennCare will rely on the date of CMS certification solely for the purposes of establishing eligibility for this interim payment.

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Questions, Comments, Thank You

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