

## **Rural Health Clinics as Essential Community Providers**

Rural Health Clinic Technical Assistance Series Call

June 11, 2:00pm EDT

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode until the question and answer session of today's conference. At that time you may press star one on your touchtone phone to ask a question and I would like to inform all parties that today's conference is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the conference over to Mr. (Bill Finerfrock). Thank you sir. You may begin.

(Bill Finerfrock): Thanks operator and thanks everyone for participating in today's call. Before we begin, I wanted to take a moment to just acknowledge someone. Today will be his last day working with us on this project and that's (Aaron Fischbach) with the Federal Office of Rural Health Policy. (Aaron)'s been the project officer on this for several years and worked very closely with the National Association of Rural Health Clinics, the National Organization of State Offices of Rural Health and many others in the rural community.

(Aaron)'s taken a new position down at the HHS main office in Washington, DC in the secretary's office and so he's going to - today will be his last day. And although you don't have the opportunity to verbalize your thanks, on behalf of everyone at rural health clinic community in general involved with this call, I just wanted to thank you (Aaron) for everything that you've done and wish you tremendous success in your next shadow of your life and that you don't forget the rural health community and know that if you ever want to come back, there's a place for you in the RHC world. So thank you for everything you've done.

As the operator said, my name is (Bill Finerfrock) and I'm the executive director for the National Association of Rural Health Clinics and I'm the moderator for today's call. Today's topic is RHC designation in the marketplace insurance plan essential community provider. It's very important for all our HC's to maintain an ECP designation and we're going to talk about that today - what you need to do, how to make sure that you are in ECP - what the benefits of that would be.

The Rural Health Clinic technical assistance (unintelligible) is sponsored by the Health Resources and Services Administration, Federal Office of Rural Health Policy in conjunction with the National Organization of State Offices of Rural Health and the National Association of Rural Health Clinics. However the series is to provide RHC staff with technical assistance and RHC specific information.

Today's call is the 65th in the series which we did in late 2004. During that time there were over 17,000 combined participants on these national teleconferences. During - there will be a Q&A period during today's call. The operator will prompt you with instructions. We ask that you give us your name, city and state that you're calling from just so we can have a sense of where people are in the country who are calling in for this program.

As I said, today's call is to talk about becoming designated as a central community provider. We're pleased to have with us (Kae Brickerd) from the Health Resources and Services Administration along with (Norma Campbell) who's also with the Health Resources and Services Administration and (Debbie Hunter) who's with the Centers for Medicare and Medicaid Services - the division called CCIIO which is the Center for Consumer Information and Insurance Oversight office.

They're each going to - they're going to talk first about the HRSA process of insuring that your RHC could qualify for ECP status. Most RHC's will qualify automatically but not necessarily and what you need to maintain that ability to be designated and then (Debbie)'s going to talk to you about how to make sure that you get the ECP designation and what you need to do to request that and petition for it if you're not (unintelligible).

So at that point I'd like to turn the meeting over to (Kae Brickerd) and (Norma Campbell) who are going to talk about the HRSA part of this process.

(Kae Brickerd): Hi everyone. This is (Kae). We are - I just wanted to let you know that we have created a new form and new procedures and revamped our website with regards to RHC's certificate of eligibility requirements and what we want to do today - those materials were provided beforehand but what we want to do today is have (Norma) explain the new process and go through it so that if you have any questions or concerns, hopefully we'll address all of those during her presentation. So with that, I'll turn it over to (Norma Campbell).

(Norma Campbell): Hello, this is (Norma). First of all I'm going to go through our office expectations such as what is the purpose of HPSAs or health professional shortage areas and also designation's branch roles and responsibilities and the application process for RHC's to obtain automatic designations. We'll also discuss some key issues for rural health clinics.

Now the purpose of our shortage designation is to identify areas of greatest need of health services and also to insure limited resources can be prioritized and directed to the people in those areas.

Our branch itself develops and implements criteria and procedures for designations of areas and populations of the medically underserved. We work closely with the primary care offices from each state, district and territory to identify these areas and populations out there.

The automatic facility HPSAs which we have two types of HPSAs. We have a regular HPSA which is your geographic low income single county prisons - different facilities. And then we have the automatic facility HPSAs which comes under the healthcare safety amendment of 2002. This allows for an automatic designation as a HPSA of a rural health clinic which if they meet certain requirements.

The key elements of these requirements are services cannot be denied to any individual unable to pay for services or those covered by Medicaid, Medicare and/or SCHIP. Sites must accept Medicare assignment and insure coverage for Medicaid and SCHIP beneficiaries. The site must have a schedule of fees and corresponding discounts adjusting for the ability to pay.

Now for National Health Service core purposes that means if you are requesting what you are designated for a loan repair or scholar, their requirements are that you must have a sliding fee and that sliding fee schedule must be posted in your window of the clinic.

Now the regular automatic HPSAs view that as not necessary. You can have a discounted allowance or anything like that but for National Service Core they stipulate that they must have a sliding fee. I just wanted to let you know.

Now the additional RHC requirements are that an entity cannot deny a request for healthcare services and shall not discriminate in the provision of services to an individual whose services are paid by Medicare, Medicaid or SCHIP.

Entities shall prepare a schedule of fees as I discussed earlier or payments consistent with locally prevailing rates or charges that your discounted allowable.

Entities shall prepare corresponding schedule of discounts including waivers to be applied to such fee or payments with adjustments made on the basis of the patient's ability to pay.

Additional requirements we have is that the entity shall make a reasonable effort to secure from patients fees and payments for services and fees should be sufficiently discounted in accordance with the schedule previously described. Entities shall also accept assignment from Medicare. Beneficiaries shall enter into agreements with state agencies that administer Medicaid and SCHIP to insure coverage of beneficiaries of these programs. Basically you're going to be serving the underserved in rural areas.

Entities also shall take reasonable and appropriate steps to collect all payments due for services. Okay, now how to get an automatic HPSA status. Okay, federally certified RHC's are eligible for automatic designation if they meet the requirements of section 334 of the Public Health Service Act. The RHC must be located in a non-urbanized area and an area currently designated within the last four years - designated by you - CMS.

How to get an automatic HPSA? Before HRSA can process a certificate of eligibility, the entity must complete a CMS-855A Medicare enrollment application to become a certified Medicare provider. Once the entity becomes a CMS certified RHC and is on your ECP list, the entity can now complete the certificate of eligibility which will be out on our website with the instructions on how to fill it out.

This form must be completed and sent to our office - DPSD - Division of Policy and Shortage Designation. You can send it in via fax, email, regular snail mail to the individuals listed on our website. The entity should include a certification letter from CMS along with a sliding fee scale or discounts - allowable discounts.

To be - like I said - I mentioned earlier the eligibility for National Health Service core program - if they want to become eligible for a National Service Core site, they must follow the steps that are in our website plus they have to have a sliding fee scale, not just an allowance - like a special allowance.

I have this - okay when we actually designate the RHC - basically give their certificate of eligibility - we accepted it, we processed it. We then designate provided we create a HPSA ID number and that ID number stays with that site forever and the RHC does not have to come back in every year or every four years to be re-designated. Once you're designated, you're designated until your clinic closes. But from CMS's standpoint I think it's every four years that you have to be recertified but from our standpoint, you don't. Once you're in, you're in.

Then after we designate and provide the HPSA ID numbers, we then score it. So we manually score it here in the office. We have a database of calculated functions and everything and we score based on the criteria that I will send out via the website. I'll go ahead and put the criteria in there. But the National Health Service Core - if you score a certain number - okay they have two tiers. One is tier one which is 14 and above and tier two is 13 and below and with each tier you get a certain amount of money for loan repayment and scholars.

Okay and who determines the cutoff scores would be actually National Health Service Core. But under the statute RHC's are now also qualified J1 visas so they have other options. Am I going too fast? Okay.

(Bill Finerfrock): I think you're doing fine. There's a couple of things I'm going to try and get clarified but please continue on.

(Norma Campbell): Okay. Basically the RHC's that have filled out their certificate of eligibility and have been processed by us and approved and designated, for further information they can also seek out information from their primary care offices located in each of the states. They'd be glad to help them with their scoring criteria, helping them with the application process. They're there to help you. They're there to help the RHC's as well as us here at shortage designation but your state partner will also be able to assist you in any way possible.

Okay, does anybody have any questions or the questions are later, right?

(Bill Finerfrock): We'll wait until the end for questions.

(Norma Campbell): Okay, okay.

(Bill Finerfrock): But I did want to - in terms of the automatic facility designation - if you could just - I wanted to get some clarification there before we got too far away from it. RHC's can become rural health clinics based on a health professional shortage area designation as you mentioned - geographic population. They can become designated using a medically underserved area designation or governor's designation.

(Norma Campbell): Yes.

(Bill Finerfrock): The automatic facility designation - in order to be in (unintelligible) and not to kind of cut into what (Debbie)'s going to be talking about but that becomes particularly important for the audience to understand for those RHC's that are designated as RHC's in a medically underserved area designation or a governor's designation.

(Norma Campbell): Right.

(Bill Finerfrock): So if you're going to get that facility designation not just for the national health service core participation that (Norma) talked about but that's going to be critical for your ability to be designated as an essential community provider. Those who already have those designated HPSAs the facility designation is of value but it's primarily for ECP purposes which we're trying to focus on today for those who are MUA's or governor designated because those are not being recognized for purposes of ECP designation. I just wanted to kind of make that clear, okay.

(Norma Campbell): Okay.

(Bill Finerfrock): Did you have more or do you want to go over to (Debbie) and her process?

(Norma Campbell): Yes please because we can...

(Bill Finerfrock): Okay, (Debbie). We can catch audience questions at the end. Okay.

(Debbie Hunter): Great. Hi everyone. This is (Debbie Hunter) with CCIIO. Thanks for the opportunity to speak with you today. So what I'd like to do is touch on our new process that we're rolling out that we would really appreciate your comments on with regard to our new petition that we will be using this year to update our ECP for the plan year 2017. And I know that seems like a long

way away but we're already here at the planning stage and so things are going to get really rolling pretty rapidly in October is when we're going to actually request that providers submit the petition.

So what I've done is I've sent to (Bill) an attachment with the petition and hopefully you all have been able to receive that via email and maybe if you have if you could open it if you're at your computers and I was going to walk through that petition. But before I start to do that, I would like to provide a little bit of context.

So this is in regard to our essential community provider standard that is applicable to qualified health plans operating in the marketplace and we require those issuers to contract with at least 30% of available ECPs in their plan service area. To date, that percentage threshold - the 30% threshold - has been calculated based on providers on our HHS non-exhaustive ECP list as well as qualified ECPs that an issuer writes in on their ECP template when they apply to be certified for that plan year.

Beginning in 2017, we will likely discontinue that ECP write-in process. So in order to do that though we're needing your help in strengthening our ECP list. If we're no longer going to allow issuers to write in ECPs, we need to make sure that we've, you know, done our very, very best to incorporate all of the ECPs onto our HHS list so that it will no longer be considered non-exhaustive.

And so the way in which we're doing that is to ask providers to directly submit to us their request to be either added to the list or if they're already on the list - the current list for 2016 - we'll be asking them to take a look at our ECP list and determine whether or not the data is correct like the phone number, the point of contact numbers, the address for your facility.

There are lots of different pieces of information on our ECP list about your facility if you're already on our list that unfortunately for a lot of providers that we have missing data elements and in order to remain on our list going forward - beginning in 2017 - we are requiring that providers fill in those missing data elements.

We are also requiring that even if there are no missing data elements, we are requiring any providers that are currently on the list to opt in - actively opt in and consent to remain on the list. And the reason we're doing that is some issuers are telling us that they can't meet the standard because they've contacted ECPs on our list and some of the ECPs are not even aware that they're on our list and they don't even wish to be - not that many but some of them. And so we don't want that to continue.

So we want to make sure providers are willingly being reflected on our list. We obtain the providers from our federal partners. HRSA is one of them and so some ECPs may not realize that they're on the list because they didn't actively request to be on it. So we just want to make sure that we're giving issuers a fair chance to meet that 30% standard.

So what we are soliciting public comments on right now is just the process itself. We published a PRA package - a Paperwork Reduction Act package - this past week and Bill I believe is providing you with a link but also the attachments. The petition is one of the attachments. It's the Excel spreadsheet and so within that Excel spreadsheet, which is the petition, we have embedded our preliminary draft ECP list for plan year 2017.

We are not actually requesting public comments yet on the ECP list that is embedded within that petition. The only reason why we've embedded a preliminary ECP list is because the petition - for you to be able to experience

the functionality of the petition - it requires the ECP list to be embedded in it so that the petition programming will work.

So what we're actually asking for your comments on right now is for you to look at the petition and the questions - the data elements that we have in that petition about the data collection requirements and let us know if you have any comments or if you think we could maybe phrase it a little bit differently or if you have any concerns about some of the data that we're collecting.

And we will be publishing a draft ECP list that is the official draft ECP list in October with the final version of the petition. What was published this past week in the PRA notice was a draft version of the petition and again we're collecting comments and based on those comments we will incorporate any revisions to the petition and publish the final version in October. And that's when we will be requesting that providers submit the petition for updating our list.

So in contrast to last year, this past year for plan year 2016 we published a draft ECP list and we gave I think three weeks or so for public comment back in December. And we got lots of great feedback on it and then we published the final ECP list I think the first week of February. This year, though, we're doing it much, much earlier, so that's the important message. I'm wanting to make sure that we help providers be aware that they - if they need to submit data corrections. October is the time to do it for plan year 2017. It will be October of 2015 through the petition process.

We will not be soliciting in December like we did last year and instead it will be through this petition process. So I wanted to just pretty rapidly go through the petition today and if you have it open if you're clicking on the instructions which is the first tab within the Excel spreadsheet - if you're having any

problems opening that, make sure that you - first of all, click the enable macros and the enable content. There are two buttons that should popup at the top that you have - you must click on those to be able to open the instructions in the petition.

If you're still having any problems with the instructions tab, we do have a separate PDF that's published on our PRA website that Bill can provide you as well if you don't already have it. That has the much more detailed instructions which we would prefer that you look at. In those detailed instructions in the PDF, they're the exact same instructions that are embedded in the petition which is the second tab of the Excel spreadsheet.

If you hover your cursor over each of the column headers, you'll see that the instructions are actually embedded in the column header and those instructions are pasted into the more detailed PDF version of the instructions. So you can look at either document and read the same instructions but we just wanted to put it in a couple of different formats.

So the first column is just asking for the full name of the person completing the petition and then the phone number. All of these are required columns. The phone extension of course would not be required. Email address is required, although, last year and previous years were not required - some of these have been optional.

So in order to be able to submit and validate this petition this year, you'll need to complete all of the required columns. Column E is asking if you are the listed provider. So what we're getting at here is we're not accepting third party updates. Like if an issuer who wrote you in as a provider onto their ECP list last year wants to update your information - they're not going to be able to do that.

The only way that your information can be updated is if you the petitioner who is the provider - you must be the one to update your own information. We don't want third party information being updated or third parties updating your information.

Okay so do you consent? You'll see that columns - beginning with columns G through the remainder of the spreadsheet - they're grayed out. The reason why is the first few columns A through F - it depends on how you answer those questions which columns after column F will need to be populated. We're trying to reduce burden on the provider so that they don't need to worry with the columns that are not applicable to them.

So if the petitioner - the provider in column F is saying - if you're petitioning to be added to the list then certain columns will open up after column F that will require you to complete those columns. If you are proposing to change your data on our list then other columns will open up. For instance if you're changing your data, you will then want to click on the fourth tab in the Excel spreadsheet that contains our preliminary draft ECP list and there is a row number associated with each ECP this year. Again, this is for plan year 2017 and the row number is column A.

You will want to copy that row number or you can type it in manually into the provider petition and that will be a little bit further down actually in the petition. Once you enter this row - its column Q - it asks you for the row number. Once you fill in that row number - it will auto populate some of the other cells like the provider name from our ECP list and then you don't have to retype everything. If you're already on our ECP list, you can just edit, update or make corrections, fill in any missing data elements. So that helps with reducing the burden there.

So in order to un-gray some of these columns you have to fill out the preceding columns to tell the spreadsheet which columns are applicable to you. Since you all are rural health clinics, you are handled a little bit differently than some of the other providers in the sense of your qualifications to be an ECP.

So in column H it asks if you are participating in the 340B program or if you are a rural health clinic. So you don't necessarily need to be participating in the 340B program if you're a rural health clinic. You can still qualify. Column I is asking if you are located in a low income zip code or HPSA.

You'll notice in the instructions if you hover your cursor over column I header - the column header - it says select yes only if you are located in a low income zip code or HPSA based on our zip code listing on our website, but then it says that selecting no to this question means that you do not qualify as an ECP for purposes of being added to our ECP list, unless you have been included in one of the verified data sets from our federal partners - HRSA included - and you appear on the draft ECP list or you have been certified by Medicare as a rural health clinic.

So if you're a rural health clinic that's not located in a low income zip code or HPSA, no worries there. You're sort of exempt to some degree from that requirement so long as you are a Medicare-certified a rural health clinic. Okay and column J - do you agree to accept patients regardless of ability to pay and offer a sliding fee schedule? Column K - do you agree to accept patients regardless of coverage source? And we have in parentheses there - Medicare, Medicaid, SCHIP, private health insurance.

Column L says do you agree to be listed in a consumer facing directory of ECPs? That's the issuer's consumer facing listing on their website. That's what we're referring to there.

Column M as in Mary - we're asking what is the number of FTEs representing MDs, DOs, PAs, MPs authorized by the state to independently treat and prescribe within the listed facility. Okay so that's for medical providers. For dental providers - Column N - we asked about DMDs and DDSs dentists - how many FTEs representing DMDs and DDSs are participating or practicing at your facility.

So for column M if you are a medical provider, you would enter a number. But in column N, you would enter zero if you have no dentists. If you don't offer both types of providers at your facility, you must still enter some number in both columns M and N. You must enter a number even if it's zero.

If you are a dental provider, then you would - in the reverse - in column M you would put zero and a number in column N as in Nancy. The reason why we're collecting that information is to help us credit the issuers properly if they're contracting with one versus all of the providers at that facility. Preferably, we've been really strongly encouraging issuers to contract with the entire facility but there have been some reasons why issuers legitimately have not been able to do that, so we are trying to design a policy that respects that.

Okay, so column O - number of contracts executed with QHP issuers. This is going to help us collect information on the success of the contract offers - how many have been accepted - because in column P we ask about the actual offers received that you've rejected. So this gives us an idea to some degree about the good faith efforts of the offers being extended.

And then the rest of the columns - Q through the remainder of the spreadsheet - column AS - is really on the data elements that are on the ECP list itself. And again, if you're already on our list, it will auto populate those fields if you enter the correct row number for your facility in column Q. If you're not already on our ECP list, then you would need to enter that information - that data - directly into those columns.

And now some folks have asked well what if my provider name is not correct on the ECP list and I need to change the provider name. You'll see that in this petition there is no place for provider name. It just says site name. That's because the provider name - it is directly linked to the site name so that if you need to make a correction to your provider name, you can just enter that in the site name and it will automatically update the provider name, so no worries about that.

And for the site street address you'll see that's in column V as in Victor - valentine - you'll see that you'll need to enter a street address that is not a PO box. Otherwise, you will see that an error code is generated. So for any of these columns - these data fields that you might enter an invalid entry - let's say a phone number only three digits in it - an error code will pop up and let you know that you need to try again. Or let's say you enter a PO box in column V as in Victor, it will pop up to let you know that a PO box is a valid entry.

And all of the error codes will show up in the third tab at the bottom of the spreadsheet once you click the validate button.

Okay so at the end once you've completed the entire spreadsheet, you'll want to scroll back horizontally to the left to the beginning of the petition and there is a button at the top right underneath columns A and B that says validate

provider petition. Once you click that, it will let you know if there are any errors. And in the errors out tab, which is the third tab at the bottom, it will let you know what you need to correct before you submit the petition.

So what we're collecting comments on - just to sort of recap briefly - is the process itself - these questions, the petition itself, any suggestions for additional information that you think we should be collecting - that sort of thing. And we are collecting comments through August the 4th and there are several comment periods. This is the first period - the 60 day period. There is a 30 day comment period after this one. But for purposes of the ECP list itself if you need to correct your own provider data - we're not collecting those comments just yet. That will be in October and that will be through this petition process.

So I think that pretty much wraps up my presentation. Again there are detailed instructions that we've posted on our PRA website that Bill can also provide to you that go into a bit more detail. There's also a supporting statement that describes what we believe to be the provider burden and some background context for why we're redesigning the process to update the ECP list this year.

And we'd be delighted to have all of you review these documents and provide your feedback to us to make this ECP list a stronger resource for issuers to use to contract with you all. And again I just want to emphasize that if you're already on the ECP list, to remain on the list, you still must submit a petition to consent to remain on the list. And that will be around October 23rd through November 23rd the window to submit these petitions.

So okay, I think I'll hand it back over to Bill and HRSA as well for Q&A.

(Bill Finerfrock): Yes. Operator, we'll go ahead and start taking questions if people want to get lined up. I wanted to try and, you know, before we open up the line - kind of bring this all around for - many of our ECPs are aware but there may be folks on the call who are not, you know.

Essential community provider is a really important designation that you will want to pursue in my opinion because what it will do is establishes you as a very important provider with whom the qualified health plans are going to want to contract.

Under the federal requirements in order for a plan to be able to be sold on the exchanges, they have to demonstrate that they have contracted with or offered contracts to a minimum percentage of ECPs. For this coming plan year - 2016 - it'll be a 30% threshold. They'll have to demonstrate that they have contracted with at least 30% of the available ECPs within the service area that that plan will cover.

Rural health clinics are designated as an ECP and recognized as an ECP though plans will be looking to establish contracts with the ECPs in order to establish - to meet those requirements. In addition, there are what are called categories of ECPs and the plans in addition to meeting the percentage threshold will have to offer a contract with at least one ECP in each category in each county where they are offered for 2016.

So for 2016, rural health clinics are classified in the category of "other ECPs. Other types of facilities in that "Other ECPs" category are STD clinics, TB clinics, hemophilia treatment centers, black lung community mental health centers and then - as I said - rural health clinics.

So if there are none of those others in your county - an STD clinic, a TB clinic, a hemophilia treatment clinic - then any issuer that wants to sell a plan or be authorized to sell a plan in your county is going to have to offer you a contract to be part of their network and they're going to have to offer it to you on terms no worse than what they've offered to similarly situated providers.

Beginning in 2017, the ECP designation becomes even more important because for 2017 rural health clinics will likely be their own category. As I mentioned, right now you're in the other category along with the STD, TB, and etcetera. For 2017, rural health clinics will likely be their own category.

So health plans for the 2017 plan year will be required to offer a contract to at least one rural health clinic in each county that they wish to offer a product and for many of you, you are the only provider in your county - only rural health clinic in your county. If there are non-RHC providers in your county and you're the only RHC, the plans are going to have to come to you first to offer you a contract.

So it's very important that you get - if you are already on the list as was mentioned by Debbie - to go in and verify in October when the opportunity comes to say "yes, I want to still be on this list" - that you take advantage of that opportunity. If you look at the list and you're not on that list, then you're going to want to go through this facility designation process that Norma made reference to to make sure that you can be on that list.

So when the ECP list is published and made available to the plan and they look at that and they know okay, this is who we're going to have to contract with and it'll be searchable by county. That's who they're going to look to setup their contract. So it's very, very important that rural health clinics make

sure that you're on the ECP list and you understand why it's important to be on the list. Operator, do you want to give the instructions for questions?

Coordinator: Yes, sir. Thank you and we'll now begin the question and answer session. If you would like to ask a question, please press star one, unmute your phone and record your name clearly. I will require your name to introduce your question. If you need to withdraw your question, you may press star two. Again to ask a question, please press star one and it will take a moment for questions to queue so please stand by.

Our first question comes from Mrs. (Marty Kower). Ma'am, your line is open.

(Marty Kower): Yes. Would you review the sliding fee scale that you went over - the difference between...

(Bill Finerfrock): (Marty) can I ask you to let us know where you're calling from (Marty)?

(Marty Kower): Yes, I'm calling from Richmond, Missouri.

(Bill Finerfrock): Great, thank you.

(Norma Campbell): Okay and that question is related to me, right - (Norma).

Group: Yes.

(Norma Campbell): Okay. Actually each county and each state has their own sliding fee schedule. The primary care office who is your partner in this can give you that information because they do the marketplace analysis and they do the definition of the HPSAs in the geographic local population income and stuff like that so they will have that information.

Our primary care office does not deal with our sole proprietorships of our rural health clinics. They only deal with the provider based rural health clinics in our state, not with the private owned rural health clinics.

(Bill Finerfrock): Right. So if you're a - if you're a physician owned - for example - rural health clinic and you need some assistance, is there any place there to go for any requirements?

(Norma Campbell): Well that's a very good question. I'll have to find that out because we don't usually set up the sliding fee scale for...

(Bill Finerfrock): Yes, that was - yes that was - I was a little bit - yes that was a little bit surprising to me because that was my understanding was that for purposes of a sliding fee scale - and I think you made the distinction (Norma) between what you would need to do in order to be a national health service core site versus getting the facility designation for ECP status.

(Norma Campbell): Right.

(Bill Finerfrock): For the ECP you're not required to have a sliding fee scale. Did I hear you correctly?

(Norma Campbell): That's correct. You can have some kind of different accountable allowances and stuff, yes.

(Bill Finerfrock): Right so the bar to become a facility designation for ECP purposes is lower or less stringent than the bar if you're seeking National Health Service core designation.

(Norma Campbell): Correct.

(Bill Finerfrock): So I think that that's important - an important distinction to keep in mind. Did that help at all or do you need some additional clarification?

(Marty Kower): I think that's good. Thank you.

(Bill Finerfrock): Okay. Next question caller - operator.

Coordinator: Yes, our next question comes from (Angie). Ma'am, your line is open.

(Angie): Yes sir, I'm (Angie) from McCall, Mississippi. I needed to get the website that you're referencing to find that spreadsheet.

(Bill Finerfrock): The - are you on the RHC list serve? It was distributed earlier today on the rural health clinic's list serve and we can send it out again and there's a link there. You just press that. It will take you to the document and then provide you with the - you should get it as a file. It'll take it a little bit to download. It is a large document.

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If you're not on the list serve and you didn't get it, just send an email to me - bf@narhc.org and I will send you the links so that you can download the document.

(Angie): Great. I'll send you an email. Thank you.

(Bill Finerfrock): Thank you.

Coordinator: Our next question comes from Mr. (Barry Caldwell) from Senora, California. Sir, your line is open.

(Bill Finerfrock): Hey (Barry).

(Barry Caldwell): A question - I understood you said that you have to accept services regardless of the patient's ability to pay. My question relates to patients who are being frequently discharged patients based on behavior. Is that - are we still tied to that patient permanently or are we allowed to discharge them - nothing to do with pay but based on behavior?

Woman: I'm not sure of that question. So you're a hospital clinic or...

(Barry Caldwell): We're a provider - provider clinic - hospital based clinic yes but...

Woman: Okay so you're discharging - yes that wouldn't really apply to that. The - that's a good question. That has never come up before. So you're asking me like if there's an ability...

(Barry Caldwell): If you have a patient who's threatening to staff or providers, you know, we will give them a letter of discharge saying we will provide for your medication or whatnot for the next 30 days while you find another - another PCP.

Woman: Right. You can do that. I mean that...

(Bill Finerfrock): Guys, I think the language is specifically based on their ability to pay.

Woman: Like Medicaid, Medicare.

(Barry Caldwell): Right.

(Bill Finerfrock): Yes, it doesn't preclude you - it doesn't preclude you from terminating a patient. Now you have to - you need to check with your state laws with regard to what is generally referred to as patient abandonment laws to make sure that you're not - that you are in compliance with there but I'm thinking for this designation does not take away your ability to terminate or take from your practice a patient who's disruptive, abusive. They're simply focused on you won't discriminate based on the individual's ability to pay.

(Barry Caldwell): Okay, very good.

Woman: Yes.

(Debbie Hunter): This is Debbie Hunter. I - if you don't mind I wanted to circle back to the previous question with regard to the sliding fee schedule. I think (Bill) - I think that was you speaking saying that the standards are a little different for the ECP. We actually have added in column J in the petition - we ask the question do you agree to accept patients regardless of ability to pay and offer a sliding fee schedule so that is a requirement.

(Bill Finerfrock): So that is - okay and which column is that in?

(Debbie Hunter): Column J.

(Bill Finerfrock): Column J, okay. Okay, yes I was simply responding to what I thought you had said because my understanding was that they had - and what we had been telling people was the sliding fee scale. So alright, so there is a sliding fee scale. Now how the RHC - what - how high that is in terms of what percentage of poverty, the amount of discount that they offer in terms of their sliding fee scale is up to the individual clinic. You don't dictate the terms and conditions of the sliding fee scale, but simply that they have one and it is

linked to the percentage - the individual's income as a percentage of poverty.

Correct?

(Debbie Hunter): Correct.

(Debbie Hunter): That's correct, yes.

(Norma Campbell): Yes, me too.

(Bill Finerfrock): Okay, alright. Operator, next question.

Coordinator: I'm showing no additional questions at this time. Again to ask a question, please press star one.

(Bill Finerfrock): The - I did want to, you know, (Mary)'s question with regard to discrimination and I think you also said you can't discriminate against a patient who's Medicare or Medicaid. Maybe I misheard how you phrased that.

Woman: Well they can't turn them down just because they're Medicaid or Medicare. They're only going to get a certain percentage based on the fact that they're on, you know, a government program. You can't just say oh, I - I'm sorry.

(Bill Finerfrock): Go ahead.

Woman: You can't just say no, we're not going to accept them because we're not going to get enough money out of that patient and then take another one that's, you know, private pay.

(Bill Finerfrock): Right, right. Again it's the - it's based on the payment. So I think it ties into what (Barry) was saying. Sometimes there's confusion on that point. If a

patient comes in who's Medicare and has other behavior or other thing that cause that individual to be disruptive to the practice or cause some fear on the part of personnel in the clinic about their safety, the fact that they're a Medicare patient or a Medicaid patient does not preclude you from terminating that individual from your practice.

The discrimination part is simply because Medicare is the payer or Medicaid is the payer for that care is where the discrimination comes in, not the fact that, you know, because they're on Medicare that overrides any other reason that you might have wanted to terminate that patient from your practice.

Woman: That's correct.

Man: Okay. Operator, any other questions - any line up since we've been chatting?

Coordinator: We do have three additional questions in queue. The next one is from Mrs. (Joan Walker). Ma'am, your line is open.

(Joan Walker): Hi, this is (Joan) and I am from Archer, Florida and I did not receive any of the handouts or the presentation so if I could get information sent to me, I would really appreciate it or if I could get...

(Bill Finerfrock): Sure. Yes, just - as I told the previous caller - if you send an email to BF - my initials -- (Bill Finerfrock) -- @narhc.org we will send you out a link to all of the slides.

(Joan Walker): Thank you.

(Bill Finerfrock): Or all of the materials I should say the speakers made reference to today.

(Joan Walker): Thank you.

(Bill Finerfrock): And that goes for anybody else on the call. You don't need to - just go ahead and email me at that address and we'll send it out.

Coordinator: The next question is from Mrs. (Barbra Schlimmer) from Odessa, Washington. Ma'am, your line is open.

(Barbra Schlimmer): Thank you. My question is are there any different rules for provider based versus independent rural health clinics?

(Norma Campbell): No. As long as they are an ECP and they meet all of our requirements to become certified - have eligibility of certification - no. They just have to meet our requirements.

(Barbra Schlimmer): Okay, thank you.

Coordinator: Our next question comes from Mrs. (Nicole). Ma'am, your line is open.

(Nicole): Hi, this is (Nicole). I'm from Oconto Falls, Wisconsin. I have two questions. One, at the beginning of the call did you state that all RHC clinics should be ECP for a designation for ECP status?

Woman: I'm sorry. Could you repeat that, please?

(Bill Finerfrock): Well what I said was - in my opinion all RHC's should be designated but it's voluntary. You don't have to become an ECP. You're not required to be an ECP, but many of our RHCs will automatically receive the designation and they'll have to verify. Others will have to go through some additional steps in order to qualify.

My opinion is I think that there's significant value in being an ECP and that's something that each RHC should obtain that designation but ultimately it's your decision as to whether or not you want that or not.

(Nicole): And how do we know if we are ECP - by looking at this list that everyone's talking about?

(Debbie Hunter): This is Debbie Hunter again. We currently have on our CMS CCHIO website the ECP list for the plan year 2016 - the active list. However within the petition that you'll be able - once you are able to access that - in the workbook - the tab within the petition - it's the second tab. It's called - I'm sorry - it's the fourth tab. It's called the draft 2017 ECP list.

That should list you for purposes of our preliminary data for 2017. That's not the official 2017 list so again if you're not on that list, we're not collecting comments yet to add you at this moment. That will be in October.

(Nicole): Right.

(Debbie Hunter): But if you want to find out if you're currently on the 2016 plan year list, this 2017 list is built partially on that.

(Bill Finerfrock): So why don't we do a little bit of a test here. What town are you in in Wisconsin?

(Nicole): Oconto Falls but I have five clinics ranging from...

(Bill Finerfrock): I'm just trying - I'm not going to do your work for you. I'm just going to - we'll test to see if anybody - so what is it. O - how do you spell it?

(Nicole): O-C-O-N-T-O and then capital F-A-L-L-S.

(Bill Finerfrock): Okay, so I'm doing it and so what it tells me as I look, it says, you know, Oconto Falls we have CMH Oconto Falls Primary Care Clinic which is a rural health clinic in Oconto Falls. Is that you?

(Nicole): Say that again. You're very choppy when you talk. I apologize.

(Bill Finerfrock): I'm sorry. It's probably my phone. CMH Oconto Falls Primary Care Rural Health Clinic.

(Nicole): Yes, that's me. That's one of mine. Okay.

(Bill Finerfrock): Okay, so you're on that list as is Community Memorial Hospital in Oconto Falls. So as we look at the list, you're on there but as Debbie mentioned, come October you're going to want to go in and say we want to continue to be on the list or you'll want to go in and make sure that all of the information that's on this list is accurate and up to date.

(Nicole): Okay.

(Debbie Hunter): Yes, because you will drop off the ECP list if you don't opt in - actively consent to remain on the list.

(Nicole): Now someone will get an email for my facility? Is that what I'm being told right now? Is that...

(Debbie Hunter): We will publish - we'll probably have Bill again help us with the outreach to send you the link but we will publish on our website the petition - the official

petition - the final version of it and it will go out approximately give or take October 23rd with the official draft ECP list embedded in it.

(Nicole): Okay, I thought so. Is HPSA and ECP kind of correlate each other? If you're a HPSA designation that you are an ECP probably - no or am I saying that wrong?

(Debbie Hunter): No. I mean there are a lot of ECPs - I mean a lot of those providers that are within HPSAs - health professional shortage areas - have already been added to our ECP list but it's not guaranteed that you're on the ECP list just because you are in a HPSA.

(Nicole): Thank you so very much.

(Bill Finerfrock): Sure but yes, it behooves everybody to go in, take a few minutes, check the list, see if you're on there. If you're not, look at the steps for becoming an ECP and then go through that. And again I think it's really, really important. If you are on the list, that doesn't mean you don't have to do anything. But come October we will work with CMS and get the word out but you will have to go in and verify that yes, I want to remain on the list. It's an opt in, not an opt out at that point. So we will have to affirmatively say we want to opt in. We want to remain on the list.

(Nicole): Thank you.

(Bill Finerfrock): Okay.

Coordinator: Our next question comes from...

(Bill Finerfrock): Go ahead.

Coordinator: Our next question comes from Mrs. (Melinda Morton). Ma'am, your line is open.

(Melinda Morton): Yes, I wanted to - I had two questions also.

(Bill Finerfrock): Where are you from (Melinda)?

(Melinda Morton): I'm from Louisiana.

(Bill Finerfrock): Okay.

(Melinda Morton): (Unintelligible). Did I understand correctly though about the ability to pay? As long - if you have a sliding scale and but you still have patients - even insurance patients that have a large deductible that won't pay or that your sliding scale people that don't pay - if you still have to provide services to these people?

Woman: Yes, I don't think you can turn them away because you're saying - let me see if I understand what you're saying - that they have some kind of fee for service and they're private or as third party payers. The amount that they - that isn't covered under their insurance - you're saying that these patients do not pay that amount?

(Melinda Morton): Right, they won't like - if they had, you know, \$1000 deductible, they'll come and they'll come and then they won't pay and they won't pay and so but because you're saying you accept all patients then you have to accept all patients regardless of that.

I thought that I understood that as long as you had the sliding scale, you honored the sliding scale and if they filled out the stuff and, you know, they were eligible for that, we do that but if they run up a bill with you of 1000 or 1500 or some whatever odd dollars and don't pay, you're still obligated to see them?

(Norma Campbell): No, I don't remember reading that. I don't remember seeing that anywhere. I'll have to check on that but I - because basically what...

(Bill Finerfrock): As I understand it, the operative word here is ability to pay that it's a multistep process. First you've established a mechanism for what you deem to be - to determine the individual's ability to pay so that's some basis based on the level of poverty that the individual may exhibit.

And so let's say your policy is, you know, zero. You don't have to pay for anything if you're less than 100% of poverty, 10% if you're 200% or whatever it is. So the first test you're doing with the patient regardless of whether or not they have insurance is where do they fall on your scale to determine their ability to pay.

Once you determine what you consider to be their ability to pay then you bill them based on what has been deemed to be their ability to pay.

(Norma Campbell): Correct.

(Bill Finerfrock): If they fail to pay, you're not discriminating against them based on their ability and so you've determined that we think that Mr. (Jones) you can pay \$15 of the \$50 bill based on where your income is on our sliding fee scale and Mr. you know, he doesn't pay the \$15. You're now not discriminating against them based on their ability to pay but rather their failure to pay.

(Norma Campbell): That's true, yes.

(Bill Finerfrock): Okay so that's the distinction.

(Melinda Morton): Okay.

(Bill Finerfrock): You determined you discounted it down from \$50 to \$15 and you said we think that you can pay this - looking at your income, applying it to our scale, apply to all of our patients - we think you have the ability to pay \$15 based on that and so they've accepted that and now they come in and now they're not paying it so it's a different decision you're making.

Woman: Yes.

(Melinda Morton): Okay.

(Debbie Hunter): And this is (Debbie) with CCIIO. (Bill) you articulated it perfectly. We are in agreement here.

(Norma Campbell): Yes.

(Melinda Morton): Okay, okay. Well I just - that's why I just wanted to make sure because I have some patients that just kind of force you to make them do that, you know, and so I just wanted to be clear on that.

Also if we are a provider based clinic - a department of the hospital - and the hospital's on this list and we are not on this list, we need to try to get on the list, correct?

(Bill Finerfrock): Correct.

(Debbie Hunter): If you are located at a different street address then yes.

(Melinda Morton): Yes and I had to send in where we had the certification of being a provider based rural health clinic and they told me that I was scheduled to get on the list but the new updated list wasn't out. Is this the new updated list?

(Debbie Hunter): It is not if you're speaking about the ECP list. Is that what you're referencing?

(Melinda Morton): Yes, ma'am.

(Debbie Hunter): Okay, no it is not. HRSA will be providing to CMS and myself an updated list with the most current new grantees or new RHCs and that will be reflected in the October published version if you make that cut. Again, I want to emphasize even if you are appearing on that list, you still must submit a petition to consent to remain on the list or you will fall off that list even though HRSA just provided us with your data.

And the reason why is that there have been some providers that our federal partners gave us their provider data but they didn't realize it and when the issuer contacted them, they didn't know what the issuer was talking about. And so we want to make sure all the providers are aware, you know, if they have ECP status that they know that issuers are going to be contacting them to contract.

(Melinda Morton): Yes, okay. Okay so even though I've done what I think I need to do to get on the list, I should fill this out then is what you're telling me.

(Debbie Hunter): If you want to remain on the list, all providers must submit a petition. Right.

(Melinda Morton): Okay. Okay, thank you ma'am.

(Debbie Hunter): Sure.

(Bill Finerfrock): We've gone a little bit over but operator, do we have any other questions on the line?

Coordinator: We do have one final question from (Tom Rictor).

(Bill Finerfrock): Okay, why don't we make that the final question and then we'll - if our presenters are okay with taking the final question if your - I think (Kae) had to leave but (Debbie) and (Norma) if you're okay, why don't we take this last one.

(Debbie Hunter): Sure.

(Bill Finerfrock): Okay, go ahead operator.

Coordinator: The final question comes from Mr. (Tom Rictor). Sir, your line is open.

(Tom Rictor): Yes, this is (Tom Rictor) from Viborg, South Dakota. The question is where can we find a list of the QHPs in our state?

(Bill Finerfrock): The qualified health plans in your state?

(Tom Rictor): Yes.

(Debbie Hunter): So thank you for that question. This is Debbie again. We have on our website our qualified health plan landscape files - that might be the best place to go. I

can provide (Bill) with a link that maybe Bill you could send out to the list serve. Would that work - would that work well for you?

(Bill Finerfrock): Yes, that'd be fine. We'd be happy to do that.

(Debbie Hunter): Great.

(Tom Rictor): Then one side question. If we choose not to opt in in October, when is the earliest that we can decide? Do we have to just go through the whole new - the whole application process again if we decide later to become an ECP?

(Debbie Hunter): So I'm sorry. Your question was if you decide not to submit in October. Is that what you are asking?

(Tom Rictor): No. We're on the list now but if in October we decide to remove ourselves from the list and then later decide well maybe we do want to become an ECP. Is there a timeframe in which we can apply again or how does that work?

(Debbie Hunter): It would be the following year. So it would - it's an annual process. Right now it's an annual process. We may - in future years we may update the list more frequently but at this time we're only updating it once a year.

(Tom Rictor): Thank you.

(Aaron): (Bill)?

(Bill Finerfrock): Yes.

(Aaron): This is (Aaron). Could I just add a couple of things there?

(Bill Finerfrock): Sure, sure.

(Aaron): One thing is that the list that HRSA - that (Debbie) was mentioning that HRSA would be preparing every year for the gentleman from Viborg, Oregon and people in similar situations. If you qualify based on being in that primary care HPSA or in one of the auto HPSAs, we're going to put you on the list again the next year and they're going to send you a confirmation again next year to make sure. So you won't - you shouldn't have to physically do anything unless your HPSA has gone away if you're through a regular HPSA.

The other thing is if you are on the 2016 essential community provider list, actually I wouldn't encourage you because of the workload and the paperwork involved here at HRSA to actually submit the auto HPSA application at this time. You're already on the list. Unless your HPSA is going away, you will be on the list. You can just wait for CMS to send you the letter confirming it.

If your address is incorrect then you may want to send us your update so that we can get that information up so that CMS sends it to the right location. But otherwise as a workload we would ask you not to just be safe sending in an application because there's going to be a lot of work if thousands of rural health clinics submitted in.

The other thing - I may have missed it. Did anyone mention the deadline that we've asked people to send in their auto HPSA applications?

(Norma Campbell): No, that was never mentioned.

(Aaron): Okay, everybody if you do need to submit an auto HPSA application as we've been talking about all through this call, you need to do that by June 26th.

(Bill Finerfrock): So this is - this is predominantly for those RHC's that are in medically underserved areas or whose RHC designation is due to a governor's designation are going to need to get those in.

(Aaron): Right or if your HPSA - if you are through a regular primary care HPSA that has expired - if you check - if you know that - if the primary care office in your state is withdrawing your HPSA then you would also want to come in for an auto HPSA but it's that subset of people who need to go through this process to become an essential community provider and we need - and HRSA needs those applications by June 26th because - as you heard - CMS is going to want us to submit a list to them so that they have time to prepare everything and send it out to you for that October timeline.

Woman: Thank you.

(Aaron): Yes.

(Bill Finerfrock): Well thank you (Darren) and thank you to all of our speakers and it seems fitting that (Aaron) should have the last word since this is his last rural health clinic technical assistance call. Also on the call with us today has been Wakina Scott who's going to be taking over and we're going to be sitting down with her in the next couple of weeks and talking about the project moving forward.

I did want to let folks know that the TA initiative has been re-awarded for a new three year cycle and the National Association of Rural Health Clinics will continue as the sponsoring organization for this project. So you can look forward to - hopefully with money allowing - assuming the federal government doesn't shut down this project. The rural health clinic technical

assistance, the RHC list serve, the RHC news list serve, the RHC technical assistance will all be continuing.

So thank you to the Federal Office of Rural Health Policy for their support. I'd like to welcome Wakina and look forward to her participation with us in the months and the years ahead and once again thank (Aaron) for all of his hard work on behalf of rural health clinics and rural health in general.

That concludes today's call. I appreciate everyone's participation. We will probably have another call here this summer in the next few weeks and we'll get information out to you on that as soon as it's available. Since we've gone a little bit long today, I won't go through my entire closing remarks and just say thank you again for participating and looking forward to talking to you soon.

Woman: Thank you.

Coordinator: That does conclude today's conference and you may disconnect at this time.

END