

Moderator: Bill Finerfrock
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2:53 pm CT

Operator: Thanks so much for holding everyone. Welcome to the Rural Health Clinic technical assistance call. Just a quick reminder, today's call is being recorded.

And at this time, I'll turn things over to our host, Mr. Bill Finerfrock. Please go ahead, sir.

Bill Finerfrock: Thank you, operator, and welcome everyone to today's Rural Health Clinic technical assistance call, Medicare administrative contractors transition. What does it mean for Rural Health Clinics. I want to welcome our callers and participants to today's presentation.

My name, as I said, is Bill Finerfrock and I'm the Executive Director of the National Association of Rural Health Clinics and I'll be the moderator of today's call. Our presenters today are Mark Zobel and Chris Klots with the Division of MAC Strategy and Development at the Centers for Medicare and Medicaid Services.

They are going to discuss the MAC transition schedule for the RHC community and they and some others from CMS will be available to answer questions following the presentation. Today's program is scheduled for 1 hour. We will have the presentation, which will likely last around 30 minutes and then we'll open it up for questions at the end.

This call series is sponsored by the Health Resources and Services Administrations Federal Office of Rural Health Policy in conjunction with the National Association of Rural Health Clinics.

The purpose of this series is to provide Rural Health Clinic staff with valuable technical assistance and RHC specific information. Today's call is the 29th call in the series, which began in late 2004. There is no charge to participate in this series.

We encourage you to refer others who might benefit from the series to sign up to receive the announcements and they can do that by going to www.ruralhealth.hrsa.gov/rhc.

During the question and discussion segment of the call, we ask that you identify yourself by name and location before answering or asking your question. In the future, if you have questions you can e-mail them to info@narhc.org and put RHC technical assistance question in the subject line.

All questions we will try to get to. I want to remind you to follow along in the slides that hopefully you received prior to today's call.

At this point, I'd like to turn the call over to Chris Klots from the Center for Medicare and Medicaid Services. Chris, it's all yours.

Chris Klots: Thank you, Bill. This is Chris Klots with CMS and as Bill mentioned, I'm joined by my colleague, Mark Zobel, and I also wanted to mention that we are joined by at least two of our CMS Regional Rural Health Coordinators, Becky Peal-Sconce and Alma Hardy as well, who are available in case some of the questions at the end touch on matters that they can be of assistance on.

At any rate, the purpose of our call today is to give the Rural Health community an update on CMS's progress in implementing the Medicare administrative contractors and then following sort of a global update sort of focus in on the aspects of the transition that are of most significant import for the Rural Health Clinic community.

And we'll sort of do that in two parts. We'll talk about the part of the community that's already in place and billing the Medicare program today and then we will also discuss what this means for Rural Health Clinics that may be established in the future. So that's sort of the basic structure of our presentation.

OK, so just a walk backwards a little bit to what is the big picture of what's happening.

In 2003, Congress directed that CMS as part of the Medicare Modernization Act proceed with awarding through competitive processes – competitive procurement processes that are applicable to all federal programs all the workloads serviced at that time by fiscal intermediaries and carriers in the Medicare program.

And prior to that time, many of the contracts had been in place all the way back to the beginning of the program in 1966 and their terms and conditions had evolved only very, very slowly and the contracts were renewed on a non-competitive basis from year-to-year.

And there were various other issues with the way the contracts worked previously and Congress was essentially directing the agency to mainstream the way it does contracting and to award Medicare workloads through these competitive procedures.

And in 2005, the agency brought forth to Congress and to the public its overall vision for implementing this provision and the sort of cornerstone of the agency's plan was we announced that we were going to setup 15 geographic jurisdictions each comprised of several states that would service Medicare fee for service workloads.

And the new contractors, which are known as Medicare Administrative Contractors or MACs would administer both Part A fiscal intermediary-type claims from institutional providers, as well as Part B claims from physicians, practitioners and other suppliers.

The durable medical equipment workloads were going to continue to be processed by separate contractors, but most Medicare claim types were going to be brought together

into these Medicare Administrative Contractors or MACs of which there would be 15, and I believe on the second slide of the slide deck, we have the 15 AB MAC jurisdictions laid out.

Now these jurisdictions, while the agency's desire is to bring the vast majority of Medicare claims workloads within these service areas, it was also recognized that the agency would have to work around issues like multi-state healthcare systems and certain types of specialty providers and so provision was made in our planning for that kind of activity.

Since 2005, we've been in the process of putting out competitive procurements on a full and open basis for the contracting community to respond to and presently we have made initial awards on each of these 15 contracts, but there are some asterisks that go there in terms of not all of these contracts are in place yet.

We actually have six or seven of the MACs in place, seven I believe, but two MACs are currently in the midst of being implemented, one of which is Jurisdiction 10 and we'll talk about that in more detail in a minute, and the other of which is Jurisdiction 14, which covers many of the New England states.

Two of the MACs, Jurisdiction 2, the Pacific Northwest, and Jurisdiction 7, which is the Mississippi Delta area, we had made initial awards to National Heritage Insurance Corporation and Pinnacle Business Systems respectively.

However, following Government Accountability Office (GAO) review of those procurements, the agency decided that it needed to do some additional work on those procurements and reopened negotiations with the offerors.

And then finally, four of the contracts that we recently awarded have been subject of bid protests and those reviews are currently in place by the Government Accountability Office.

I won't read you know jurisdiction by jurisdiction the exact content of the second slide, which is basically a map that lays out the jurisdictions, and the third slide, which lays out the contract awards that have been made but we will sort of focus a little bit on the fourth slide here.

Again, at the beginning of January the agency had announced that it was moving forward with five contract awards, Jurisdiction 6, 8, 11 and 15, which essentially span the area from the upper Midwest; Minnesota, Wisconsin, Illinois and going southeast all the way down to the Virginias and the Carolinas.

Those contracts had been protested by unsuccessful bidders. By federal law, if a protest is filed timely, there's a mandatory stay of performance. The Government Accountability Office reviews the agency's procurement actions to verify compliance with the federal statute that governs government contracting called the Competition in Contracting Act.

And then renders a decision, which then can either lead to the agency moving forward with the contract or having to revisit some part of its process. Those decisions on those contracts are expected in early May.

And as soon as we get those decisions we will be providing information to the relevant provider communities so that they know their status, whether we're moving forward with an implementation or having to do additional procurement work.

And as I mentioned a minute ago, in Jurisdictions 2 and 7 there is some additional procurement work already taking place. We expect also around that time in April or May to be making announcements on those contracts.

So the reason to give this sort of global overview is because many members of the Rural Health Clinic community are provider-based entities and perhaps they have a parent provider that's a hospital or skilled nursing facility, and the MAC that services the parent provider has been by policy in the past and will be in the future the MAC that services the provider-based Rural Health Clinic.

And so just to take an example, if for instance in Pennsylvania there's a provider-based Rural Health Clinic, in the past it was serviced by Highmark. Highmark happened to win that AB MAC Jurisdiction contract. CMS was able to move forward with that particular implementation. Now that contract is fully implemented, the parent provider and the provider-based Rural Health Clinic are now serviced by Highmark.

Of the contracts that we awarded at the beginning of January, the one that we are able to move forward on at this time is the MAC Jurisdiction 10 contract, and that contract is scoped around providers located in Alabama, Georgia, and Tennessee.

But in general, the Jurisdiction 10 MAC is absorbing the workloads of the contractors that formerly serviced those areas. So the workloads of Cahaba as an intermediary and carrier are being absorbed by the MAC. Well, in that case the change is very minimal because the MAC that was awarded the Jurisdiction 10 contract is Cahaba Government Benefits Administrator.

In Georgia, of course Cahaba was serving as carrier, but the Medicare offices of Blue Cross Blue Shield of Georgia were serving as a fiscal intermediary and their workloads will be transferred to Cahaba through the implementation process that is now moving forward.

And then for Tennessee, Riverbend is presently the fiscal intermediary and its workload will be absorbed by Cahaba, as will the carrier workload for Tennessee that's presently serviced by CIGNA Government Services.

So those are the contract workloads that are affected by the Jurisdiction 10 contract award, and we've tried to outline sort of the viewpoint as it affects freestanding Rural

Health Clinics that have been serviced by several different contractors, four different contractors in the past, but the vast majority by Riverbend and that's on our fifth slide.

The Rural Health Clinics that were serviced by TrailBlazer as a fiscal intermediary, freestanding Rural Health Clinics have been cut over to TrailBlazer under the Jurisdiction 4 Medicare Administrative Contract or MAC, which TrailBlazer was awarded about a year and a half ago - that contract is now fully operational.

The freestanding Rural Health Clinics that were serviced by Highmark have, as in my notional example of a minute ago, been cut over to the Jurisdiction 12 MAC, which is Highmark. And Highmark now is servicing a broad set of providers largely from the states of Pennsylvania, New Jersey, Maryland Delaware, and D.C. and that transition is completed.

Up in New England, I mentioned that we had a MAC contract moving forward there, Jurisdiction 14. National Government Services supports some freestanding Rural Health Clinics there and their new MAC as the prime contractor would be National Heritage Insurance Corporation NHIC, and that workload cutover will take place on May 15 of this year.

That workload cutover refers to the point in time when the operations of the outgoing contractor are transferred in a very orderly way to the incoming contractor.

In the case of Jurisdiction 14 however, it should be pointed out that National Government Services is a subcontractor on the NHIC team and so our belief is that many of the personnel who've formerly been servicing the Rural Health Clinics in New England will be part of that contract effort moving forward.

So now we get to Jurisdiction 10, and Riverbend has been servicing a very large workload of Rural Health Clinics and those existing freestanding Rural Health Clinics serviced by Riverbend right now will be transferred over to Cahaba over the next several months.

It's really an implementation process with the workload cutover occurring on August 3, and so that information that I just went through is summarized on the fifth slide.

Riverbend and Cahaba will actually be having a meeting in the next week where folks will go over the transition plan and will start to develop all the concrete details that the RHC community will want to have about exactly how the transition will take place, and when the communications will take place to the community. If there are actions that the providers now serviced by Riverbend now need to take, they'll be advised of what they need to do and when they need to do it by Cahaba.

Some of these details are summarized again on the sixth slide. As indicated, the Riverbend Part A workload is moving to Jurisdiction 10 on August 3. The freestanding Rural Health Clinics currently serviced in that workload will be moved to Cahaba, and

the arrangement that will be put in place in August will apply to at least the near-term and mid-term.

Down the road, the agency has a vision of distributing among the MACs the Rural Health Clinic workload. We believe that supports our beneficiary centered vision for Medicare fee for service operations.

However, that will not take place until all the MACs are up and running and until CMS has implemented a number of other mandates that are on its plate to implement, ranging from things like ICD 10 implementation to getting this accounting system in place that we are plugging into all the Medicare Administrative Contractor workloads.

It's called the Healthcare Integrated General Ledger Accounting System. So there's a lot of program and systems-related events that need to take place. So we do not anticipate getting to a place where we'll be distributing the Rural Health Clinics to the other MACs for at least a couple of years and that process will take place in a very structured and appropriate way.

Right now our primary concern is ensuring that Rural Health Clinics are able to work with the new MAC and properly conduct their billing and cost reporting and receive their appropriate benefit administration services between now and August and after August.

The agency does have a very structured approach to managing contractor implementations. We have within our group a particular division that gets assigned accountability for overseeing each implementation.

There's a project officer that oversees – a CMS project officer that oversees the implementation efforts of the MAC. And there's a designated CMS contact person who ensures that the incoming and outgoing contractor work well together and make appropriate progress on the transition plan.

We also have a structured process for ensuring that the contractors provide advanced notice of the changes that need to take place. We try to minimize changes, but these providers are given advance notice as early as possible about what they need to do and when they need to do it.

And a lot of these steps are laid out, not all of them will apply, but a lot of these steps are laid out in an MLM article SE0837, which is available from the CMS Web site. In fact, on the very last slide of our slide deck there's a Web site URL that links over to these articles.

So basically CMS makes every effort to manage the implementations carefully and we have already identified to the CMS staffer involved in this effort and to the contractors involved, both the outgoing contractor at Riverbend and the incoming contractor at Cahaba, that the management of this particular transition needs to be done well.

Because of some of the unique characteristics of the Rural Health Clinic Program, the transition will need to be managed very carefully and with an eye to ensuring that RHCs have appropriate information about what is changing and how to ensure that their bills and cost reporting processes and other activities work well once the cutover occurs.

So that's sort of an overview of the big picture where CMS is with the Medicare Administrative Contract implementation, which is being done in keeping with the statutes set out by Congress in 2003.

And an overview of where we are with the award of a new contract and with particular focus on the ones that are significant for the freestanding Rural Health Clinic community.

But of course this affects all the Rural Health Clinics, because even in the cases where you're with a different contractor because that's where the parent provider has been billing, that contractor may or may not be changed through the process – the competitive process of bidding the 15 AB MACs.

So at this point, I'd kind of like to shift gears here and turn the discussion over to Mark Zobel, who will talk through a somewhat different approach that the agency is taking for the new Rural Health Clinics that are being setup sort of on a go forward basis.

Mark Zobel: Thank you, Chris. I just want to pick up on the background and what is driving some of these changes. It will be helpful to describe the upcoming slides a little bit. Also part of the Medicare Modernization Act of 2003 served to remove the agency's ability to let providers migrate to concentrations within regional or national fiscal intermediaries or MACs.

That ability has been replaced with the geographic assignment rule that Chris alluded to earlier. There will no longer be a national or regional MAC for the RHC community.

Instead a freestanding Rural Health Clinic is going to join – that is joining the Medicare program for the first time will submit its 855 enrollment application with, and will enroll with the fiscal intermediary or MAC that covers the state where the Rural Health Clinic is located.

And this is something that has been policy for a little while already about 12 months, and shortly there will be a change request, which will give more formal instructions to the contractor community both fiscal intermediaries and the MACs that are already on board, to instruct them on where to re-route 855 applications that are filed at the wrong place that are not filed with the geographic MAC or FI.

Where do you find out which fiscal intermediary or newly implemented MAC – where do you find their address to send the 855 application? Well, there's a link across the bottom of slide 8. And I went to that link a little earlier today, and currently an older edition of the enrollment contact chart is up there.

And we're working with the folks in our Division of Provider and Supplier Enrollment to adjust that so that it reflects a line for RHCs, FQHCs and ESRD facilities that will give you the correct line and the correct address.

Right now if you go to that site, and some of you may be at your computers right now. What you want to do is look to the fiscal intermediary line on that chart for the state in which the Rural Health Clinic is located and that'll give you the correct address to send the enrollment application to. Of course, the fiscal intermediary will service all the Part A providers and RHCs are among those Part A providers.

Moving over to slide 8, a provider-based Rural Health Clinic is joining the Medicare program for the first time and going right into a provider-based relationship will want to file its enrollment application with the FI or the MAC that services the main provider.

So if there's an upstream hospital to which the Rural Health Clinic is provider-based to, then we just need to determine where that main provider hospital is currently enrolled and who is servicing its claims, and that's the address you want to send your 855 enrollment application to.

Bill Finerfrock: Mark, can I stop you for a second here because this has been an area of some confusion. The designation as to provider-based facility would typically occur – does not necessarily occur when the provider enrolls in the Medicare program.

In other words, you have to be enrolled in the Medicare Program and seeing patients before you become a Rural Health Clinic and then also your provider-based designation. So can you tell me how that would necessarily work?

Mark Zobel: Sure. So what we've got is a freestanding Rural Health Clinic that is moving into a provide-based relationship with an upstream hospital or some other Part A provider type. What the Rural Health Clinic needs to do is a couple of things. Let's focus first on where that upstream hospital is currently serviced.

Let's say that upstream hospital is currently serviced in the NGS Maine workload, which has not yet been transferred over to the MAC. It probably will be soon. The schedule is available and I think that it's coming up some time in May or June. We would want to file an 855 enrollment application together with the provider-based attestation materials with NGS Maine.

At the same time, you'd need to be communicating with the fiscal intermediary or MAC that currently services the freestanding RHC in the previous arrangement. You need to close that record out. And as for the mechanics of that, I may have to defer to some of our regional rural health coordinators to explain the exact paperwork.

I think Becky and I worked through a case of this about a year ago and had some help from some one there in the regional office in Dallas. Becky, are you available to help and help us remember what that filing is with the RHC's previous fiscal intermediary?

Becky Peal-Sconce: Well, the timing I think is key. And probably you would need to contact your regional office person for assistance for that. I'm not a provider enrollment specialist. Most regional offices do not have provider enrollment specialists. But if you contact your Regional Rural Health Coordinator, they can work with the survey and certification folks and the Medicare contractor to help you.

Mark Zobel: I think most likely, Bill, it's going to be another 855. It's a little bit cumbersome, but there would be an 855 filed with the outgoing contractor, an 855 filed with the incoming contractor, and the provider-based attestation materials are filed with the incoming contractor.

Let's go ahead and talk about slide 10 and this question has been a great back door slide 10. If an RHC needs to go ahead and update its Medicare enrollment record in one fashion or another, perhaps it's just there's been a change of ownership and a new organization owns it.

Or there have been some changes in the key personnel that are listed on the 855 application, then you need to update that with the fiscal intermediary or the MAC that currently services the RHC if you're not moving into a provided-based relationship as we just discussed. So just file that 855 to update your enrollment record with the contract that currently services your claims and takes care of your cost report.

Then finally, we're about to get to questions and answers, slide 11 those four links, the top one that says contracting reform Web pages, it's a great site that if you go directly to that link, look along the left-hand margin, there a whole bunch of buttons and among them is one that says "What's New?" and in there you can find some updates on recent MAC awards, on the progress of some of the protests.

That material is constantly changing and along with some other buttons you can find maps and narrative write-ups on the MAC jurisdictions and the providers that are in those jurisdictions.

The second link is to 42 CFR 421.404. It's a regulation that became final in November of 2006. That regulation is what comes after the Congress gives us the Medicare Modernization Act and wipes out the provider nomination privileges.

In other words, that's the regulation talking about the geographic assignment rule and tells us that generally each provider is going to be assigned to the MAC that covers the state where it's located with a few limited exceptions that aren't really applicable to Rural Health Clinics.

The third link is to an article that paints the larger landscape of the transition of workload from Legacy Fiscal Intermediaries to the MACs, and finally the fourth link is to that article that Chris referenced a moment ago that's more oriented toward the micro landscape.

The landscape of the individual provider as the individual provider is going through the process of transitioning from one contractor's workload to another - moving from a Legacy FI to a MAC.

So with that, Bill, I'll say thank you for giving us the time to present this material and we are ready to answer some questions.

Bill Finerfrock: Great. Operator, do you want to give the instructions for folks who want to ask calls?

Operator: My pleasure, sir. Ladies and gentlemen, at this time if you do have any questions or comments, simply press star 1. Just a quick reminder, if you are joining us this afternoon using a speakerphone, please make sure the mute function is turned off to allow your signal to reach our equipment. Again star 1 please and we'll pause for just a moment.

Ladies and gentlemen, we'll take our first question this afternoon.

Bill Finerfrock: Go ahead caller and please identify what state you're calling from.

(Mary Peterson): (Mid-West Clinic), Wisconsin.

Bill Finerfrock: (Mary Peterson).

(Mary Peterson): Yes. My question is, it appears that we are going to be penalized and we're going to have to move from Riverbend to Cahaba Government Benefit Administrators and then eventually we're going to have to go back to whoever the MAC is going to be in Jurisdiction 6. That doesn't seem very wise.

Chris Klots: Thank you for the feedback. It is in CMS's judgment the best way to proceed at this time and every effort will be made to make sure that the transition goes as smoothly as possible.

Mark Zobel: The reason for that is, it sounds like you are currently enrolled with Riverbend, am I correct about that?

(Mary Peterson): That's correct.

Mark Zobel: And you are located in the State of Wisconsin so your destination workload is eventually going to be Jurisdiction 6.

(Mary Peterson): Right. Hopefully, WPS.

Mark Zobel: I have no idea who it's going to wind up being right now. The award was announced for, I guess, was that Noridian Jurisdiction 6?

(Mary Peterson): Yes.

Mark Zobel: The reason that we are not able to move you to directly to the Jurisdiction 6 at this point has to do with the ability of CMS systems to scrape out individual claims histories and individual provider enrollment records and move them in a shotgun approach to the various 15 AB MAC jurisdictions - is that ability doesn't exist right now.

Our systems are currently absorbed with moving large chunks of the legacy fiscal intermediary workload over to the MAC that's coming in and taking it over. In other words, Cahaba as a Jurisdiction 10 MAC is going to take over the providers currently serviced by Part A and Part B Tennessee, and Part A and Part B Georgia, and Part B and Part A, I guess the third one is Alabama.

Since you happen to be currently serviced in one of those workloads, we're not able pick you up and move you to a different MAC at this point.

(Mary Peterson): But why wouldn't it be feasible to ask Riverbend to continue to process who they're processing right now until we are ready to go to our MAC?

Chris Klots: Riverbend is basically at the point of transferring its workloads over to Cahaba. There will be significant operational risk and cost issues with servicing the Rural Health Clinic community, and the agency is going to move forward with transferring the workload to Cahaba. In that way we can best assure that Medicare benefit administration services for RHCs will continue as uninterrupted as possible through the transition.

(Mary Peterson): Well, I guess I just hope CMS understands the great grief we go through with all this change over. This costs us a lot of money as well, and it doesn't work as smoothly as I think sometimes CMS thinks it does. I mean, if you can tell me that this is going to be transparent, as the buzzword of today says, that would be great. But it looks like there's a lot of responsibility on our shoulders in small rural health clinics.

Chris Klots: Well, we will make the process as least burdensome as we can and we certainly would like to come back as the transition proceeds and ensure that Cahaba's part of that conversation and so that they are focused in on the needs of the community.

Bill Finerfrock: Mark or Chris, you mentioned that there are individuals within CMS who are assigned to oversee this process. If the Rural Health Clinics are encountering problems or some difficulties, is there a contact person or what should they do if things are not going smoothly for them?

Chris Klots: We'll be providing probably within a few weeks the names of those contact people and a number of channels for you to get those kinds of concerns in and get them addressed.

Bill Finerfrock: Those will be individuals at CMS, at the regional office or central office?

Chris Klots: Both. Now, I have to stress that the first point of contact is always going to be the incoming contractor. So we would expect Cahaba to provide information to the Rural Health Clinic community to explain the transition process and what needs to be done and to provide contact points.

But if a Rural Health Clinic runs into difficulty in terms of getting redress through Cahaba, then, of course, CMS will be ready to step in.

(Mary Peterson): One final question we have, and just to...

Bill Finerfrock: Sorry, we have other people on the line, can we get on, I apologize, but we have other folks who have been waiting. Can we go onto another question?

Operator: Sure, we'll move to our next question.

Bill Finerfrock: If we have time we can come back around. Operator?

Operator: Caller, if you hear the voice prompt, you're line is open.

Shannon Berumen: Yes, my name is Shannon Berumen and I'm calling from Battle Mountain General Hospital in Nevada, and I'm calling to find out about the Jurisdiction 1 transition.

On the map that we had seen before, it does show that it has been awarded to Palmetto GBA, but we are still currently submitting to WPS for our Part A.

Chris Klots: Well, and that's because the WPS, which absorbed the Mutual of Omaha workload a couple of years ago when Mutual of Omaha decided to sell its Medicare Division to WPS. That workload was originally set up as a contractor to serve providers that, for whatever reason, were not assigned to the geographic fiscal intermediary.

And I'm taking it that you're with a parent provider that at some point or another chose to be serviced by Mutual of Omaha and that turned into being serviced by WPS.

Shannon Berumen: Correct. We have our Rural Health Clinic, and then we also have a critical access hospital. But we do submit our Part B to Palmetto.

Chris Klots: Right. So you'll continue submitting the Part B to Palmetto, which is the MAC that's in place, and then on the Part A side you'll continue submitting to WPS under that legacy contract until CMS gets to the point of distributing the workload in that contract out to the geographic MACs.

And the reasons for not just doing that immediately or overnight are for the same reasons we talked about a little while ago in terms of why the Rural Health Clinic communities cannot be immediately distributed among the geographic MACs right now. And the agency would never do that. It's going to be a more structured planned process.

However, continue to be in touch and we will be providing information on the CMS Web site and if and when the agency makes a decision and there are details firmed up in terms of transferring providers presently in Nevada or California over to the Jurisdiction 1 MAC from the WPS workload, those providers will be notified well in advance of any transfer.

Shannon Berumen: OK, but there is no timeframe for that yet?

Chris Klots: Correct.

Shannon Berumen: OK.

Bill Finerfrock: Next caller?

Operator: We'll move to next caller now.

Bill Finerfrock: Go ahead, caller, if you could identify your name and where you're calling from.

(Lisa Otham): Hi, this is (Lisa Otham) and I'm calling from Missouri. I wanted to ask you just a quick question on slide 8 and 10. On 8, if we were looking to do an initial enrollment since we are located in Missouri, which is J5, and WPS is the MAC for this jurisdiction, would we submit that to WPS between now and August 3?

Mark Zobel: Yes please. It sounds as though you've got a new initial enrollment Rural Health Clinic that is currently that is currently not enrolled in the Medicare program.

(Lisa Otham): Right.

Mark Zobel: You must submit that 855 to WPS as the Jurisdiction 5 MAC.

(Lisa Otham): OK. And then in slide 10, will...

Chris Klots: That will apply, not just between now and August 3, that'll apply from now going forward.

(Lisa Otham): OK.

Chris Klots: So if it were 5 years down the road, the enrollment in that scenario would be submitted to the Jurisdiction 5 MAC, whomever that may be.

(Lisa Otham): So WPS then would be our payer going forward? We would submit like for that RHC we would submit our cost reports to WPS?

Chris Klots: Correct, the Jurisdiction 5 MAC would be the payer going forward. I didn't touch on this in my initial presentation, but part of the statutory mandate to CMS was that we do have to re-compete the MAC contracts every few years.

And so each and every MAC that's awarded through this first cycle activity, in a few years later CMS will be re-procuring that contract and for any incumbent contractor, they might win the workload or they might not win the workload.

(Lisa Otham): OK. Then my second question for you is on slide 10. We, for instance, need to do some re-openings on some cost reports so we would go ahead and continue to submit those re-openings or any changes to our enrollment to Riverbend until August 3.

Chris Klots: Just checking; your second question refers to a facility that's currently billing Riverbend?

(Lisa Otham): Right, yes.

Chris Klots: Then the answer would be yes.

(Lisa Otham): OK. Thank you.

Bill Finerfrock: All right. Let me just take a question we got e-mailed in, and I think you covered this, but I think it's worth going over again or at least clarifying.

It's an independent Rural Health Clinic that is in Arkansas that is in the process of transitioning its ownership to a provider-based facility in Arkansas, and the effective date of the change of ownership is March 31. Do they send the 855 to TrailBlazer or do they send it Pinnacle?

Mark Zobel: Bill, the big question is where is the main provider currently serviced? Is that main provider, probably an upstream hospital, is that hospital currently in the workload serviced by Pinnacle? The Part A contractor for Arkansas and let's assume the answer to that is yes.

Then what we need to do is we need to have that Rural Health Clinic submit an 855, together with the provider-based attestation materials, to Pinnacle, Part A contractor for Arkansas, and it happens to be already, I guess that RHC is currently serviced in the Riverbend workload, is that correct?

Bill Finerfrock: Trailblazer.

Mark Zobel: The RHC would also need to also close out that enrollment record with TrailBlazer. To contact TrailBlazer's enrollment staff, you can go to that same link for

enrollment contact people, there should be a phone number and a Web site there, for TrailBlazer - the Jurisdiction 4 MAC.

That information is currently up-to-date even today. So, you need to close out the old enrollment record in cooperation with TrailBlazer, probably done through an 855, and then file the new 855 for the provider-based relationship with Pinnacle, the Part A contractor for the State of Arkansas.

Bill Finerfrock: OK.

Mark Zobel: That's where the upstream hospital is currently serviced.

Bill Finerfrock: And so for anybody else, do you really – it's where the upstream hospital is serviced is where the 855s would go. OK. All right, operator, we'll take another call.

Operator: Sure thing.

(Gale Nickerson): Hello, my name is (Gale Nickerson) I'm phoning from California. I have a question, when you're talking about provider-based Rural Health Clinics you're referring to attestations.

There are plenty of provider-based Rural Health Clinics that are based in hospitals of over 50 beds where the hospital files the RHC's cost report and so on and so forth we can't submit attestations because CMS won't review them. So we're still going to be working with the MAC for our hospitals and so forth, but I'm a little confused about the attestations part.

Mark Zobel: (Gale), it sounds like you understand more about the attestation for provider-based process than we do here. That's something that the people at the contractor can help you out with a little bit more. If what you're telling us is that if there's a bed threshold over which the attestation is not required, then I'll take you at your word for that.

(Gale Nickerson): Yes. It's not accepted, it's not that it's not required. We would submit one if it were accepted because we're still provider-based in the eyes of our state and everybody else. We'd love to be accepted that way but CMS doesn't review them any more because of the reimbursement cap.

Mark Zobel: In one fashion or another, probably through a cover letter you need to let the contractor know. It sounds like it's going to go to Palmetto, the Jurisdiction 1 MAC. Let them know with a cover letter that you're moving into a provider-based relationship so they'll understand that the downstream RHC is going to come along with the main provider.

(Gale Nickerson): OK.

Operator: We'll take our next question now.

Bill Finerfrock: Hey caller. Go ahead, caller.

Operator: Hearing no response, sir. We'll take our next question.

Bill Finerfrock: OK.

Female: This is ((inaudible)) county health services and I'm from California...

Bill Finerfrock: Can you speak up a little bit, it's hard hearing you.

Female: Yes, I'm calling because we're a freestanding Rural Health Clinic, and is our jurisdiction going to change again from Riverbend?

Bill Finerfrock: Where are you from please?

Female: California.

Chris Klots: OK. So you're a freestanding Rural Health Clinic that currently is serviced...

Female: By Riverbend.

Chris Klots: OK. You will be transferred over the next few months leading up to August 3 to Cahaba Government Benefits Administrator, and very shortly Cahaba should be putting up on its transition Web site and so forth information that will advise you how that process will work.

Female: OK. Thank you.

Bill Finerfrock: But they will not always be with Cahaba. At some point they'll go through another transition, correct?

Chris Klots: That's the agency's plan and but as discussed, that activity is not scheduled yet and we don't see it being scheduled within the next 2 years.

Bill Finerfrock: Right.

Female: So it's going to change again in 2 years?

Chris Klots: No, it might change later than that. As we described earlier on the call, there are a lot of other things that need to be put in place before we will move through the process of distributing the Rural Health Clinics among the geographic MACs, including but not least of which is actually getting all the MACs up and running.

They are not all up and running at this time. But also we need get a lot of enrollment and accounting and cost reporting systems coordinated to be able to do that activity in a way that would be effective and minimally disruptive.

Female: OK. Is this only affecting Rural Health Clinics or is it going to affect like mental health services also because we provide those at another facility?

Chris Klots: And in that situation who are you billing at this time?

Female: Palmetto.

Chris Klots: OK. So serving as the Jurisdiction 1 MAC?

Female: Yes.

Chris Klots: Well, that facility will continue to bill Palmetto as the Jurisdiction 1 MAC. You've been assigned into that workload and that's your endpoint. The only thing that could happen, as I alluded to a little while ago, is we do have a mandate to compete again the contracts every few years.

And so when the appropriate time comes that MAC workload will be re-competed, it could be Palmetto that is successful in winning that or it could be another contractor. That is a part of the competitive process, but for right now for that provider you're securely with Palmetto and that's the MAC that you'll be assigned to.

Female: OK. Thank you.

Operator: We'll take our next question now.

Bill Finerfrock: Go ahead, caller. Your name and where you're calling from?

Angie Roberts: Hi, this is Angie Roberts with Mercy Medical Services in Sioux City, Iowa, and I have a question regarding the initial enrollment. Right now presently we have 13 independent Rural Health Clinics in both Nebraska and Iowa and we submit a group cost report between those 13 clinics.

I'm currently in the process of bringing on a new Rural Health Clinic in Nebraska. I'm assuming because we file as a group to Riverbend we would continue to send that 855 to Riverbend to be completed prior to August 3.

Mark Zobel: No. Angie, what you want to do is send the 855 for the initial enrollment that's coming on board and joining the rest of your facilities - you'll want to file that 855 with the MAC that covers the state where the RHC is located in Nebraska or Iowa - that would be the Jurisdiction 5 MAC. You can continue to file a common cost report across all of your facilities, and it sounds like Riverbend currently audits that cost report?

Angie Roberts: Yes.

Mark Zobel: Yes, Riverbend will continue to audit the cost report. So for this new one coming on board, its cost report will be audited by Riverbend, then eventually Cahaba after August 3, and claims will be paid by the Jurisdiction 5 MAC.

Angie Roberts: The WPS?

Mark Zobel: Correct.

Angie Roberts: That's going to be extremely messy.

Mark Zobel: In what respect?

Angie Roberts: We're going to have to submit a cost report to WPS and then to Cahaba because our fiscal year ends June 30.

Mark Zobel: No. Let me help you out again on that. If you're filling one common cost report, as I understand the manuals permit, you can have that facility that you're bringing on board part of it – file as part of that common cost report that goes to Riverbend that is audited by Riverbend and eventually Cahaba.

Meanwhile, the claims will be paid by the local geographically assigned MAC Jurisdiction 5 WPS.

Angie Roberts: Once I submit that 855 to WPS then what they're going to take a look is at the cost report that we've submitted for this last year and then they will put us at the current rate that we already exist in under our other clinics, correct, because it is a common cost report.

Chris Klots: Are you currently given an interim rate that's the same across all the clinics?

Angie Roberts: Yes.

Chris Klots: Then I believe that the same approach will be taken in your case.

Angie Roberts: OK.

Chris Klots: In the – just to take an analogy that occurs often in the home health and hospice world, many providers bill their claims to the regional home health and hospice intermediary that's in place.

And then meanwhile they're in a provided-based relationship with a provider that submits its cost report to a different fiscal intermediary, and CMS coordinates with the fiscal

intermediary that services the parent provider with the contractor that processes the claims.

Bill Finerfrock: OK.

Angie Roberts: OK. Thank you.

Bill Finerfrock: Do we have more questions, operator?

Operator: We do, Mr. Finerfrock. Do you want to take those now?

Bill Finerfrock: How many do we have in the queue?

Operator: Sir, we have six remaining.

Bill Finerfrock: How much time do you guys have there at CMS? Can we try and take those questions or do you need to go?

Chris Klots: Let's take at least two or three of them and see how things are going.

Bill Finerfrock: OK, great. Operator, next question.

Operator: Thank you, sir.

Bill Finerfrock: Go ahead, caller. Your name and where you're calling from.

(Zinn): (Zinn) from (Chapada) Indian Health Program in California. Will there be a separate region for IHS?

Mark Zobel: Yes, it'll be Jurisdiction 4, a contract currently held by TrailBlazer.

(Zinn): OK.

Mark Zobel: All qualified Indian health facilities are going to eventually be billing to Jurisdiction 4.

(Zinn): OK.

Mark Zobel: Are you currently assigned to the Jurisdiction 1 MAC?

(Zinn): Yes. Palmetto, yes.

Mark Zobel: Becky, I know you've been of help in the past, as we've narrowed down the definition of which set of Indian health providers are going to be assigned to Jurisdiction 4. Is there some way we can help Zinn figure out if her facility is going to meet that definition?

Becky Peal-Sconce: Sure. Are you a Rural Health Clinic?

(Zinn): Yes.

Becky Peal-Sconce: And you're a tribal clinic, not really paid by IHS, correct?

(Zinn): Yes.

Becky Peal-Sconce: OK, then you should be with the California jurisdiction. Only the IHS hospitals and provider-based entities to IHS hospitals go to the J4 MAC. Rural Health Clinics are not part of the IHS workload.

(Zinn): OK. Thank you.

Becky Peal-Sconce: So you're where you need to be.

Bill Finerfrock: OK, (Zinn).

(Zinn): Thank you.

Operator: We'll move to our next question.

Bill Finerfrock: Next question, go ahead caller. Where you're call – name and where are you calling from?

Marty Bennett: Marty Bennett from Riverside Family Medicine in South Louisiana.

Bill Finerfrock: Riverside where?

Marty Bennett: Family Medicine in south Louisiana.

Bill Finerfrock: Louisiana, OK, thank you. Go ahead.

Marty Bennett: My question pertains to some confusion in that I was working with a clinic that was filing an 855 as a new practice and they were instructed – I'm sorry, we're in Jurisdiction 7 or are supposed to be, but currently administrated by TrailBlazers.

So the last 855 we filed went to TriSpan and a little bit later when you were talking about slide 8, you had referenced – I think it was slide 8 – what is going to happen to Jurisdiction 7, so are we staying with Trailblazer? Is TriSpan in it at all?

Mark Zobel: Marty, if you are currently serviced by TrailBlazer, the Jurisdiction 4 MAC, you're going to remain in that relationship for the time being. You're going to continue to have your claims serviced by TrailBlazer, the Jurisdiction 4 MAC.

And inasmuch as you're located in the State of Louisiana, we know that your destination workload would be the Jurisdiction 7 MAC, but as we've talked about earlier in this call, we have no schedule for when we're going to move those out-of-jurisdiction providers to their destination workloads. So for now, you're going to stay with TrailBlazer Jurisdiction 4.

Marty Bennett: And Jurisdiction 7 is definitively going to be Pinnacle or is that still in debate, too?

Chris Klots: That is a contract that was originally awarded to Pinnacle. However, there was a bid protest filed and through the course of the GAO review, it was determined that the agency needed to conduct some additional negotiations with the offerors and we're kind of in the middle of that process now.

Marty Bennett: OK.

Chris Klots: Shortly, we'll be hopefully making an announcement about what is happening with that contract, but we cannot comment any further than that.

Marty Bennett: Thank you. I appreciate your time.

Operator: We'll take our next question now.

(Candice): Hi, this is (Candice) with (Childs) Area Health Center in Idaho. We were wondering what MAC has been assigned to our state.

Chris Klots: Idaho falls within the jurisdiction of the Jurisdiction 2 MAC. There was a contract award made initially to National Heritage Insurance Company, but the same situation that I alluded to with Jurisdiction 7, arose there. There was a bid protest, subsequent to which the agency and the Government Accountability Office determined that some additional procurement steps needed to be taken.

We're in the middle of conducting discussions with all those offerors and hope to make a contract announcement in the near future and obviously, we will be putting out that information to the provider community when we can.

(Candice): Because we were under the understanding that Cahaba was awarded this.

Chris Klots: Are you talking about the Jurisdiction 2 MAC?

(Candice): Yes, for Idaho.

Mark Zobel: Can you tell us where you saw that information? Maybe we can get it corrected, (Candice).

(Candice): It was actually our administrator, who's not here today, had heard that and I'm sure exactly from where.

Chris Klots: (Candice), are you an independent Rural Health Clinic?

(Candice): No, we're a provider-based rural health group.

Chris Klots: And who do you – who do you presently bill?

(Candice): Riverbend.

Chris Klots: You presently bill Riverbend even though you are provider-based. OK. I take it that means that your parent provider is assigned to Riverbend as well. And yes, your workload will move over to Cahaba for the time being when the transition takes place.

Mark Zobel: That's not the permanent MAC for that reason. It's just that Cahaba is the transitional intermediary.

Chris Klots: They have to provide services for at least a couple of years.

(Candice): So we will go to Cahaba for up to a couple of years and then it could switch again to National Heritage possibly?

Chris Klots: Or to whomever is the eventual awardee for Jurisdiction 2.

(Candice): So Cahaba is not a permanent...

Chris Klots: Cahaba is the awardee for MAC Jurisdiction 10, but they are absorbing the workload presently administered by Riverbend.

(Candice): OK. Well, do you know if we'll be able to bill the same way that we bill to Riverbend?

Chris Klots: And what way is that?

(Candice): It's electronically through I don't know which program. But it's all sent electronically. Do you know if any of that will change?

Chris Klots: I know that Cahaba will setup electronic data interchange opportunities to bill electronically and they'll be aggressive about it as possible. Whether or not the exact arrangement you presently have will be supported, I do not know that without having further details about what you do and Cahaba's plan.

Bill Finerfrock: All right. Thank you, (Candice). A couple more here. Go ahead next caller. Go ahead caller, your name and where you're calling from?

Operator: Caller, if you heard the voice prompt your line is open.

Bill Finerfrock: OK. We may have lost that caller.

Operator: Getting no response, so we'll move on to the next question, sir.

Bill Finerfrock: OK. Caller, name and where you're calling from.

(Carol Fron): (Carol Fron) from State of Wisconsin. I have a question.

Bill Finerfrock: Did we get you in there?

(Carol Fron): Yes, you did. I have a question regarding the 855 for an existing facility independent rural health. Are we required to file a new one or only if there is a change?

Mark Zobel: What kind of transaction are you undertaking, (Carol)?

(Carol Fron): We're not undertaking a transaction. My question is do we have to file a new – on slide 10, do we have to file a new 855 if there is no change happening, no change in ownership, no change in principle, people, or employees?

Mark Zobel: (Carol), now I understand your question and the answer is no. If you're simply being moved and en masse together with the other Part A workload from Riverbend to Cahaba, then you don't need to file an 855. We'll move that workload en masse. There will be a few things that you'll need do to - EFT agreements and other electronic connections, a little claims testing here and there. But all those requirements will be set forth to you well in advance of the transition date, August 3. So you don't have to file a new 855 in this process.

(Carol Fron): Great. And then the other question I have is a cost report question.

Chris Klots: To be clear, you may have to file a new electronic funds transfer agreement.

(Carol Fron): Sure. Yes, that makes sense.

Chris Klots: And new EDI billing form.

Mark Zobel: And (Carol) before we leave that all together, I know that the folks in CMS' enrollment shop often talk about the requirement that facilities of all kinds that haven't updated their enrollment record in a decade or more, I don't know exactly where the cutoff is, but they need to go in and essentially – what is the term they use, Chris, is it to "update" the enrollment record?

I think it's about that simple. So I shouldn't go too far with that admonition that you don't need to file a new 855. All providers that haven't updated their enrollment record in

quite some time need to go in and do that. But those instructions are on the CMS.gov enrollment Web site and that's not in connection with the transition of workload from a fiscal intermediary to a MAC.

Chris Klots: Just being moved from Riverbend to Cahaba does not trigger the need for a new 855.

(Carol Fron): That makes sense. And regarding the cost report, of course with transition being in the middle of the year, I wasn't quite sure how – will that be then directed by the new fiscal intermediary rather than Riverbend when we come to file 2009?

Chris Klots: When does your fiscal year end?

(Carol Fron): Our fiscal is a calendar year. So we'll have a fiscal intermediary of Riverbend for part of the year and then Cahaba for the second part of the year. And then, of course, depending on when the changeover goes to our MAC, it could also affect us in 2010.

Chris Klots: Well, speaking to this year here now, if your cost report year ends at the end of this calendar year, by then Cahaba will be servicing you and you will file your cost report with them.

(Carol Fron): So basically all the financial information that is needed when you file the cost report will be transferred from Riverbend to Cahaba and we won't even know anything different than that.

Chris Klots: The financial information will be transferred, yes.

Bill Finerfrock: How about a situation where the clinic's fiscal year is a little bit closer to when the transition is scheduled to occur? In other words, let's say I'm on a June to July, or July to June fiscal year. I submit my cost report prior to the end of the current fiscal year, but while it is still at, in this case let's say Riverbend, the transition to Cahaba occurs.

Will that occur seamlessly? Is there anything that the clinic will have to do or should do or be concerned about?

Chris Klots: Well, depending on when the cost report is due, this is part of the transition communications that will come from Cahaba and Riverbend. The guidance will be provided as to whether to file it with Cahaba or whether it's – let's say a cost report is due in May, or whatever. That would still be filed with Riverbend and then as needed be transferred over to Cahaba.

(Carol Fron): Then we should be receiving information then from Cahaba and Riverbend regarding this transition.

Mark Zobel: Absolutely.

(Carol Fron): OK. Thank you.

Mark Zobel: Bill, If we could take, if there are any more questions in the queue, if we could take one more that'll give Chris and I a chance to travel across the campus and make it to our 4:30 meeting.

Bill Finerfrock: OK. You want to take one more or that was it?

Mark Zobel: Let's do one more.

Bill Finerfrock: OK, we'll do one more.

Operator: We'll take that now, sir.

Bill Finerfrock: Go ahead, caller. What you're name is and where you're calling from.

(Charles James): Hey this is (Charles James) I'm in Missouri. And I guess my comment, I guess this is part comment, part question.

Back on (Lisa Otham's) example of transitioning from one intermediary to another, or if you're doing a transfer from a provider-based and independent or vice versa, we've had a lot of trouble getting the initial intermediary to close out the record and transfer that to the subsequent intermediary.

And they're just – it's been a very difficult process and it's kind of one of those things where we can't seem to get anyone to move on it. And so that's the comment, the question part is, and I know you said there'll be contact information, et cetera.

But will there be anyone, aside from the people at the regional offices or the newly assigned jurisdiction MACs, that will be quarterbacking this information where we have kind of a troubleshooter where we can go to and say hey you know neither the new intermediary, the old intermediary, no one will release this we can't get things done. Who's going to be quarterbacking this?

Mark Zobel: (Charles) there are six workloads that need to transfer to Cahaba the J10 MAC. There are two for Tennessee, Part A Part B, there are two for Georgia, Part A Part B, there are two for Alabama, one Part A one Part B.

For each of those transitions we set up arrangements whereby we do identify a quarterback, it's an implementation lead and that person works with the outgoing contractor, in this case Riverbend, and the incoming contractor, in this case Cahaba.

And we figure out what is – given the current situation and the current workload - what is the best way to troubleshoot any given set of items that don't transition just perfectly the

first time. So you can expect to see some more information about what those communication channels will be on the Cahaba Web site together with the Riverbend Web site.

And they'll give you some contact points there that you can make good use of should there be any problems with files or cost reports or claims testing or EFT agreements.

(Charles James): So basically that will be distributed to the intermediaries and there won't be any kind of wholesale CMS announcements coming out. We need to stay tuned with the intermediaries.

Mark Zobel: That's correct.

Chris Klots: For vast majority of communications but the CMS is always there. I believe we already discussed that the Regional Rural Health Coordinators are available to elevate issues that get to the critical point, as are the folks overseeing the MAC implementations themselves.

(Charles James): Thanks for your time.

Bill Finerfrock: Thank you guys, Mark and Chris, for all the time you spent with us today, particularly here answering questions. I don't know whether we answered everybody's questions, or hopefully we've been able to clear up some things.

I think this is a process we intend to stay on top of and look forward to keeping a good line of communication with you and with Cahaba and the other with the MACs as this process continues.

I also want to thank all of our participants today and the Office of Rural Health Policy for sponsoring this series. A transcript, as I mentioned at the outset of the call, will be available as well as a recording of the call. I want to remind you to encourage others to participate in this series and encourage them to sign up.

The next Rural Health Clinic Technical Assistance teleconference is tentatively scheduled for the second Tuesday in May at 2 o'clock. A notice will be sent by e-mail to those who registered for the series with the details on that next call.

On behalf of the National Association of Rural Health Clinics, I want to thank you for participating and look forward to your participation at the next call. Thank you very much.

Mark Zobel: Thank you, Bill. Bye-bye.

END