

CAPITOL ASSOCIATES

Moderator: Bill Finerfrock
April 20, 2012
1:00 pm CT

Operator: Good day and welcome to the Rural Health Clinics Technical Assistance National Teleconference Series, RHC Accreditation. Today's conference is being recorded.

At this time, I would like to turn the conference over to Mr. Bill Finerfrock. Please go ahead, sir.

Bill Finerfrock: Thank you, Operator and I want to welcome everyone to today's teleconference on RHC Accreditation. My name is Bill Finerfrock and I'm the Executive Director of the National Association of Rural Health Clinics and I'll be the moderator for today's call.

Traditionally, for a clinic to enter into a provider agreement with a Medicare program as a rural health clinic, the facility has to first be certified by the State Survey Agency as complying with the RHC condition. Federal law has long allowed accreditation by a nationally recognized accreditation program as a substitute for initial and ongoing state review.

If an accrediting organization can demonstrate that its program meets or exceeds all applicable federal Medicare conditions, CMS may deem that entity as having met the certification requirements. A national accrediting organization has to provide CMS with reasonable assurance that they require the accrediting entity to meet the requirements that are at least as stringent as Medicare conditions.

Until now there's been no alternative to state compliance surveys for RHC accreditation or certification. But recently, Centers for Medicare and Medicaid Services announced that the first RHC accreditation organization had met the CMS requirements for deemed status for RHCs.

Our speaker for today's program is Jeff Percy, Executive Director of the American Association for Accreditation of Ambulatory Surgical Facilities, AAAASF or Quad A, as we like to call them. Jeff's presentation will consist of about a 45 minute program on information about this new program, what it means for existing RHCs as well as those facilities preparing to become RHCs, and then the remaining 15 minutes will be reserved for questions.

This is a series - the RFC Technical Assistance is a series of teleconference calls sponsored by the Health Resources and Services Administration's Federal Office of Rural Health Policy in conjunction with the national association of Rural Health Clinics. The purpose of the call series is to provide RHC staff with valuable technical assistance, and RHC specific information.

Today's call is the 47th in the series which began in late 2004. During that time, over 12,000 individuals have participated on the bi-monthly RHC National Teleconference calls. As you all know, there's no charge to participate in this series, and we encourage you to refer others who might benefit from the information to sign up and receive announcements regarding dates, topics and speaker presentations.

The email address, or the Web site address - I apologize, is www.hrsa.gov/ruralhealth - one word, [/policy/confcall/index.html](http://policy/confcall/index.html). During the Q&A period we request that callers please provide their name, city and state prior to asking your question. In the future if you have questions or have suggestions for topics, please send them to Info, I-N-F-O at narhc.org, and put RHCTA Question or Topic in the subject line.

With that, I'd like to again take this opportunity to introduce our speaker, and thank Jeff for taking the time with us today to talk about the new RHC Accreditation Program, what it is and what that means. So Jeff, the floor is yours, and have at it.

Jeff Pearcy: Thank you, Bill. And Bill, thank you for the opportunity today to address a significant portion of the RHC community about what we consider to be a very exciting new program for us and we hope that meets some of the needs in the Rural Health Clinic community.

And this is has been a long process, it's - Bill and I first met, I think, about 2-1/2 years ago. And at that time when we were talking about the possibility of moving forward with this program, he asked the question, how long do you think it will take for this to be completed? And I said it'd be about six months.

And that's about what it would have taken, had we not been dealing with the federal government. And now this, with delays and requests for delays and a number of things, it finally has come to fruition, and we hung in there through that full process along with people from the National Association of Rural Health Clinics, and it's actually a reality now.

I'll be going through slides that were provided to you. I'll try to, whenever possible, say I'm going to move to the next slide or something like that. The first slide that you should be looking at is the accreditation process that identifies me as the speaker, the Executive Director of the Rural Health Clinic Accreditation Program. Next slide.

A little bit about who we are, we've been in business since the early 80s. We were formed originally by a group of plastic surgeons at a time when surgery was migrating out of the hospitals and into the ambulatory surgery environments and even into doctors' offices.

There was no accreditation standard at all at that time, and this visionary group decided that it was important to have a set of standards that they could hold them and their colleagues to. One of the things that they, early on they decided was that it had to be a peer-based survey process, so that people who were actually doing the surveys were familiar with the kind of work that was being done in the clinics.

They also decided that it would be educational and not punitive. This is not a "gotcha" kind of a program. The idea is to make sure that all clinics that meet the standards have an equal opportunity to receive the accreditation. We were, became a Medicare Deeming Authority for AFCs in 1998, and that is a process that you have to go through every three to six years, depending on how long your deeming authority has been approved for.

We, it was about three years ago that CMS talked to all of the accrediting organizations that were working in a variety of health disciplines about two programs that were out there that had approval for having an accrediting organization begin to do business, and offered the opportunity to be able to go through that accreditation process with CMS.

We decided that it fit the model and the size of clinics that we were used to accrediting under our ambulatory surgery program, and that we would begin to move forward with that. One of the first things that we did was that we needed to make sure that we had a partner in this, and that's where our outreach to the National Association of Rural Health Clinics came in.

We were finally approved in March of this year to be able to do rural health clinic accreditation. We also, this year achieved deemed status for outpatient physical therapy clinics. Next slide. Why us? Well, part of it is because, you know, we are one of four organizations that are accrediting organizations in a variety of health care disciplines, and we have a national reputation and we - the other accrediting bodies and ambulatory surgery centers are the Osteopathic Association, the Joint Commission and AAA.

We have a history that is based really strongly in responsiveness to the provider community. This goes back to the very origins of our organization and the need to make sure that it was peer-based. We have the ability to assist facilities in the certification process.

Again, we do not - we see ourselves as a quasi-governmental organization that enforces standards, but at the same time that that enforcement is going on, we make sure that there is good quality customer service to ease the process of applying for accreditation.

Early on we realized that while we were experts in doing accreditation, we didn't have any knowledge whatsoever in the rural health clinic community. So we began to search for a partner, and that's where we became involved with the National Association of Rural Health Clinics.

They were clearly the experts in the field and the people who we could go to for advice and consultation as we began to build our accreditation program. They have been a part of our, the panels that we use to assist us in doing trainings for our surveyors and reviewing standards and reviewing educational opportunities. Next slide please.

This should have a map that shows - a distribution map of where rural health clinics are across the country. Part of the reason that we drew this, or got this information from CMS was we wanted to identify where we would be in most need of potential surveyors, because we assume that the people who would be coming towards us for accreditation would mirror the areas of the country where there was currently accredited or CMS RHCs. Next slide, please.

We put our application process on line early on, and people would download the applications. We began to do a distribution map of where people were located that were downloading the application materials from us, so that we could once again identify where would be best served to locate surveyors to be able to control the cost of the accreditation process. Next slide, please.

The process to become a deeming authority is arduous. This is not - in fact, I think that there may have been a time, Bill and I have talked, one time that, is this is something that the National Association of Rural Health Clinics at one time had considered doing as a part of their member services, but recognized early on that they were much better suited being a membership organization rather than an accrediting body.

And part of the reason for that, of course, was the arduous process of (gaining) deeming authority with CMS. We had to demonstrate that we could accredit RHCs, and that we have a satisfactory surveyor training program. We had to accredit some clinics prior to getting into the process, and we had to be able to show that we had the capacity to administer the program.

We did a crosswalk with all of our standards with the Medicare conditions for coverage to be able to demonstrate that our requirements met or exceeded the Medicare requirements. Our current standards, and it was an obvious place to begin, just directly mirror the conditions for coverage so that there would be as little leeway or questions about whether our standards met those.

We are, have the capacity to have standards that exceed what CMS Medicare standards do, but we cannot have any condition for coverage that was not met. Are we harder of the certification process than going through current sets of standards? We're not any harder, but we hope to be, and what we are in our other programs is we're more consistent.

The Accreditation Survey that you will get in Michigan should be the same accreditation survey that you would get if you were in Texas. There should be less and less room for error or judgement calls based on a surveyor who is influenced by state government rather than by the CMS's conditions for coverage.

Part of the way that we reduce that kind of variation in the process is by training our surveyors in central locations so that they all have the same message, the same level of interpretation - next slide please, about RHC accreditation. It is a peer-based voluntary survey process.

Some states may decide that they are no longer going to even do surveys, but it'll be done by the accrediting organization. Some states are so far behind that they need to have an accrediting organization into the mix to be able to give facilities an opportunity to become accredited.

The process may replace routine state certification surveys. States will continue CMS validation and complaint surveys. Nothing that we do supplants the power of the state to be able to come in and do a survey in any facility. States that license RHCs will decide whether to accept the accreditation in lieu of licensure.

In - we have seen in the ambulatory surgery program that in states that have licensure, they tend to go toward allowing accreditation in lieu of licensure. Next slide, please. Our RHC accreditation is a three-year accreditation cycle. The initial on-site survey is done, and then in the second and third year, you are actually sent a packet that is exactly the same as what the surveyor is sent.

We require that the facility fill that packet out as a self survey, and in the third - or in the fourth year, you are re-surveyed, so the - happen that the re-survey is done every three years. This is part of the requirements of CMS Medicare, and it actually reflects how we do accreditation surveys in our other programs.

There are no reciprocal surveys. In other words, you cannot - if you are a surveyor, you can't survey another surveyor's clinic and have them survey yours. There has to be some distance and arm's length in it. There's no concurrent surveys, in other words, if you are surveyed by Person X on, in one survey process, that same person will not be doing your survey the next time you're up for accreditation. Next slide.

Why choose accreditation? There's more and more trends towards accountability. This is a word that you are hearing no matter how the federal requirements for new health care plans finally come out. The word that you're hearing constantly is that there has to be accountability, pay for performance.

As more money is infused from the federal government into the process, there are more and more requirements that things be accountable. Professions that work towards self regulation actually have a better opportunity for survival than professions that decide to fight the issues that are related to accountability.

One of the things that in some states, and not in all states, in some states, once you have gotten your initial survey, you may not - while you're supposed to be resurveyed every three years, in some states that's simply not happening. In our accreditation program, when we say that you'll be resurveyed every three years, that's exactly what's meant.

The, our process is well developed. We have a well-developed cadre of inspectors, and we actually do the surveys when they're required. It's kind of interesting. One of the first clinics that applied to us, they were shocked. They applied and we had a survey team come out in the field in a couple of weeks.

And they were astounded. They said, you mean you actually are going to come out? And they were used to a system where an application didn't necessarily mean that a survey was imminent. We process applications in a very efficient manner. Next slide you'll see how quicker enrollment is done.

This is from our ambulatory surgery center data, because obviously we don't have enough data to develop a chart like this in the rural health community, but you can see that from application to

accreditation in number of days, it generally takes anywhere from 61 to 120 days towards accreditation.

The outlier groups are facilities that generally have either decided that they want to withdraw the application process or slow the application process because they didn't feel they were ready, and that's when you get some facilities that are up over 181 days. But the process is essentially an incredibly efficient process. Next slide.

Why RHC accreditation? We're incredibly responsive. We're peer-based, timely, the standards are consistently applied, and there's a focus on patient safety. We have partnered and collaborated with NARHC in a very unofficial way but a very supportive environment, and we've put people from NARHC on to our education committee and on to our standards committee.

Eventually there will be a board seat for somebody in the rural health community. We have personal attention and support for people going through the application process. If you turn to the next page you'll see some of the accreditation assistance that provide support and services in our office.

When you call our office and identify yourself that you are calling about rural health clinic accreditation you are transferred to an actual human being who will answer your questions. They are knowledgeable, and they are spread across districts, so they will be your accreditation assistant through your process. Next slide.

The CMS and the RHC enrollment process is that, the first thing is that the state agencies still determine site eligibility, and whether you fit within the catchment area of being non-urbanized and having a health care shortage area. They define that and send it to us and then we know that this a facility that meets the catchment area requirements for us to be able to go ahead and process the accreditation.

With the financial feasibility of RHC status is determined, there is a - the facility fills out an 855-A Provider Enrollment Form, and then at that point the application can be made to AAAASF and we do a survey and a recommendation. The 855 is submitted to the Fiscal Intermediary, and the facility then submits the 855-A approval to AAAASF in order to proceed with the accreditation.

Facilities will provide a copy of their Medicare tie-in letter containing their CCN to receive their certificate from us. The accreditation process on our end is very simple. You can download all the application materials from our Web site that's at the bottom of this slide.

You submit the application, the AAAASF staff reviews the survey materials and secures the survey. At the survey time the surveyor will meet with the key staff, do a walk-through through the facility, review files, interview key staff, and then at the very end does a summation conference with all the people that have been interviewed.

And at that summation conference, they actually will go through the areas where there may be deficiencies and claims and corrections need to be done. There's, again, no surprises. The idea is that it's a supportive environment in which a colleague who also is a clinician working in a rural health clinic organization is the trained surveyor who understands the issues related to doing the business that you're in.

The surveyor submits a report to us within 48 hours. You're given an opportunity to - you will receive a deficiency report and do a plan of corrections. And once that, the deficiency are completed, we confer accreditation and recommend a deeming through CMS. Next slide.

Survey report processing, RHC accreditation staff review the detailed survey report. They notify the clinic the results within 10 business days, then they send the statement of deficiency report, and they note every single deficiency that was identified by the surveyor.

The facility needs to submit a plan for correction within 10 calendar days back to the accreditation office. The surveyor may have to review the clinic's plan of correction, and finally you are issued a letter of congratulations and certificate.

The standards are organized around the basic areas that you see here that defines, you know, just the kind of organizational structure, staffing responsibilities, provision of services, how patient health records are maintained, program evaluation, et cetera. Next slide.

One of the reasons that we're so efficient at this and are able to do this is that unlike the state, we charge for the process. We worked with NARHC, the National Association of Rural Health Clinics, for a long time to identify what was the fairest way to be able to identify costs.

And at one time we were talking about volume of people - of patients coming through the clinic, but there were many reasons why that wouldn't work as a way of identifying what's a small clinic and a medium clinic and a large clinic. So we didn't want to have a process that charged the same across the board.

So the idea was floated that the best way to do this would be by full time equivalency staff, FTEs, and this is clinical staff, not support staff. And it was determined that, you know, with working with NARHC so that we could see how this could actually work out, less than two full time FTEs would be the small level. Medium level would be two to four, and over four FTEs would be considered a larger clinic.

Then the charges would be made based on that, so that if you have a person who is 0.5 in your clinic, a physician's assistant who works 0.5, and a physician that works 0.2, and somebody else - okay, I'm going to get myself confused on my math here, but once it adds up to one, then that's one FTE.

Every three years there's a survey fee in addition to the annual fee, and the survey fee covers the cost of actually having the survey team in the field. Facilities contract for a three-year cycle, so that they, you know, they may choose after three years of being accredited by us that they want to fall back under the state survey system.

That's an option they can do at that time after the three years, but if it's anything like our ambulatory surgery center environment, they prefer to work with us, the private organization that's inclined to be helpful, and we have very little attrition after that three year period. Next slide.

Our partnership with the RHC community has been rich. We have - the program could not have evolved without the support and active involvement of people from the National Association of Rural Health Clinics. Feedback was encouraged throughout the process, and our surveyors were trained and were identified to us from the National Association of Rural Health Clinics.

Surveys can be stressful. Accreditation is designed to be educational and not punitive. It's a chance for an RHC who is prepared for accreditation to actually show off. They have an opportunity to demonstrate to a colleague surveyor that they are an exemplary clinic and meet all of the requirements for accreditation. Next slide.

The value of accreditation, we perform unbiased, fair evaluations. They are less subject to interpretation because every, all the surveyors across the country are trained to the same level of consistency. Being peer-based, surveyors and uniform training, that results in the consistent application of the standards across the nation.

Clinician surveyors provide exceptional (sensitivity) to the challenges with compliance. They understand what you deal with because they deal with it also. And the corrections are reviewed by the surveyors and approved by the RHC Accreditation Committee.

I think it's important that we stress the role of the accreditation staff in differentiating that they're there to support the clinic. They do not make clinic judgement or judgements on the accreditation, and so they are there to assist the facility in being able to meet the standards for accreditation. Next slide, please.

About RHC participation, note - there really is no method for terminating existing RHCs from the program for losing non-urban status. Once you have identified that you are in a rural health clinic catchment area and go through the process, that provider number is yours. Provider-based ownership must be clearly in evidence.

Staff includes one or more physicians that are present at least every two weeks, and one or more physician's assistants or nurse practitioners, certified nurse-midwives that are available more than 50% of the time. I think that the requirement still states 60%, but in reality the enforceable guideline is 50%. Next slide, please.

As you go through the process of accreditation, my staff is available to you at any time to answer questions about the accreditation process. We're available on line, through email, through the ability to call in, a human being answers the phone and answers your questions.

This, there's - if it turns out that you are dissatisfied with something that my staff does or the surveyor does or the survey process and don't feel that you're being listened to, the number that you see there for me is my personal cell phone, so that if you're struggling with us I want to know about it.

I've left more time for questions than we had allotted. I tend to talk pretty fast, and so my 45 minutes is in chunks of 30, and that's usually a pretty good sign people enjoy the speaker more. Bill? Bill? Hello?

Bill Finerfrock: Yes, sorry, I had to unmute my line, sorry about that. I started talking and it's like, wait a minute. So thank you Jeff. I appreciate that. I have a couple of things. I have a - before we open it up for questions from the participants, a couple of things I want to mention is, there, we are anticipating that perhaps at least one other organization will seek this deemed status.

They're in the process of trying to put together their initiative, and we have indicated to them that we will give them all the same access and assistance in achieving deemed status as we did with the AAAASF folks that NARHC's view is that, you know, the more choices, the more options people have, the better.

So, you know, there may be even more news to report in the future, and when that time is appropriate we will do that. The couple questions I had, to just kind of go back perhaps and clarify, you mentioned about the state and they can come in and do a validation survey. Is that, does the state, can they reject your accreditation and insist on state certification in addition to anything that you do?

And could you talk a little bit - what is that validation survey process you talked about?

Jeff Percy: Well, if it's - similar to what was experienced in our ambulatory surgery center environment, the state can come in and do a validation survey. And partly what they're doing there is to make sure that we are surveying with enough rigor to be able to confer accreditation.

If they find deficiencies or interpret something as a deficiency that we didn't, the facility still has to meet the state requirements. They trump us at every point. So whether we found the deficiency or the state found the deficiency, the facility has to do a plan of corrections and correct the deficiency.

Bill Finerfrock: Okay, all right. You know, what about - one of the issues that has come up is, as you know, there is variability in state laws, particularly maybe governing P.A.s and nurse practitioner scope of practice, things of that nature, or some individual state laws.

Are your surveyors, will be, you know, you will have a process for keeping abreast of any changes and keeping current with the unique aspects of what may occur at a state level, given that there are areas where there could be some level of variability?

Jeff Pearcy: The way that's handled by us is that there's an attestation that the facility director signs that the facility meets all state requirements. So, you know, the onus is really on the facility to be sure that they're meeting the state requirements. Our surveyors are not trained to be state surveyors or to know the nuances of state or local laws.

Bill Finerfrock: Okay, all right. Very good, those were just some of the questions that folks had posed to me when they had heard about it, and I wanted to just try and make sure we got those onto the table. Operator, if you would let folks know the process if they'd like to ask a question, how to get in the queue and what we'd like them to do. Why don't we go ahead and open up the phone lines for questions?

Operator: Certainly. If you would like to ask a question, please signal by pressing star 1 on your telephone keypad. If you're using a Speakerphone, please make sure your Mute function is turned off to allow your signal to reach our equipment. Please be aware that a voice prompt on your phone line will indicate when your line is open.

At that point please state your name and where you're calling from before posing your question. Once again, press star1 to be placed in the queue.

Jeff Pearcy: Bill, while we're waiting for the first question, one of the items that came up here recently was on cost. And CMS Medicare has informed us that the cost of the accreditation process is a recoverable cost.

Bill Finerfrock: Right, that it's allowable on the RHC's cost reports...

Jeff Pearcy: Right.

Bill Finerfrock: ...so ultimately there would be a mechanism for recoupment of a significant portion of that cost...

Jeff Pearcy: Right.

Bill Finerfrock: ...relative to your Medicare costs, correct.

Jeff Pearcy: Correct.

Bill Finerfrock: So, yes so even though there is a charge it's, you know, there is, it is not as perhaps large as it may seem given that it is an allowable cost.

Jeff Pearcy: Right.

Bill Finerfrock: Okay. Operator, are we getting many questions?

Operator: We do have a couple of questions.

Bill Finerfrock: Why don't we go ahead and open up the phone lines, then. And again, please identify yourself, who's calling and where you're calling from. Go ahead with the first question.

Operator: Caller, if you signaled for a question, please go ahead.

(Sue Quirky): Hi, this is (Sue Quirky) in Wisconsin, and I apologize if I missed this section, but with the self eval, did you say your surveyors were coming on site, or that's just without them coming on site?

Jeff Pearcy: That's without them coming on site. Thanks a lot - nice to hear from somebody else in Wisconsin. I'm sitting here in Milwaukee right now. That's, the surveyor does not do that. We send out the packet of information that is the same that the surveyor would get, and you fill it out as the clinic.

And it does two things, number one it informs you if there's been any changes in the survey or in the requirements since your last survey, so there's no surprise the next time a surveyor actually comes out. The second thing is, is that, people work so hard to get their clinic ready for their accreditation visit, and then there can be slippage, or what we call in our profession, drift away from the standards, and it's a way of doing an analysis to make sure that drift isn't happening.

(Sue Quirky): Great, thank you.

Jeff Pearcy: Okay.

Operator: And we'll go to our next question.

Bill Finerfrock: Go ahead caller.

Mike Bell: Hey, this is Mike Bell with Whibley in Spokane, and I have a follow-up question on Bill's comment earlier. There are a number of states out there that have a backlog on surveys, and it's

primarily because they really don't want to certify any new rural health clinics so they've used funding and one thing and another as an excuse for not doing new rural health clinic surveys.

And so my question is this, if a new clinic hires your organization to do a survey, is there anything in that, in the regulations that prohibits a state from rejecting your survey and postponing their work for two or three years and pretty much just make the survey done by your organization to be just a waste and we're going to end up in the same situation we would have been had this opportunity not come along? Thanks.

Jeff Percy: As I understand it, the answer to that is no, that's what we're here for, is to provide an alternative route towards accreditation and certification than a backlogged state system. That doesn't mean that it may not happen, and we'll have to work on that issue as it occurs.

Bill Finerfrock: We have, just so you know, we have checked on that as well and we've come to the same conclusion, because you're right in the premise of your question that, Mike, that we've identified different states where because they don't want to incur some additional Medicaid costs or whatever, that they would use the survey and certification means as a way to artificially retard the growth in the program in their states, and that they shouldn't be able to intercede in this process to allow that to occur.

And should we see that, the association would certainly take whatever steps we could at the federal level to make sure that the states aren't abusing whatever authority they may have. But as Jeff said, the whole purpose of providing this type of a private process is to avoid that very problem. And CMS has said that they don't want to see that RHC program artificially prohibited from growing.

Tom Terranova: Bill, this is Tom Terranova with AAAASF. For all the attendees, I'm the Director of External and Legislative Affairs here at AAAASF. Another important distinction to keep in mind is

that the actual approval and the issuance of the CCN number is done by the Medicare Regional Office, it's not done by the state agency. The state agency carries out the survey on behalf of the regional office.

So the actual person, the office that receives our recommendation for deeming is actually the regional office.

Mike Bell: So it doesn't have to go through the state for any type of additional approval or paperwork or anything of that nature, is what you're saying.

Jeff Pearcy: The state is notified. The state agency is certainly notified so that the facility appears on whatever rosters they keep in the system. The state agency actually processes some of the, I think the 855 and some of the other paperwork, but the approval comes from the regional office.

Mike Bell: Okay.

Bill Finerfrock: Okay? Thanks, Tom. Next question, Operator, next caller?

Operator: And we'll go to our next caller.

(Susan): Hi, my name is (Susan), and I'm calling from Corydon, Iowa. We've been in touch with the staff of AAAASF, already. I have been, they've been very helpful whenever I've had a question, phone call, email, they're getting right back to me. I think my biggest dilemma right now is just the, developing the manuals and policies.

Our hospital owns four clinics. One of them was designated Rural Health many years ago. We're several years past what should have been our usual survey time. We've never had a problem when they came and did a survey. I can't - the last one's been at least five years ago, maybe six.

Our manual and policies have been fairly simple, and I guess that's what I'm thinking of trying to do is develop one that covers all the facilities so it's easier to keep up. But I'm just wondering if, you know, on the survey process, am I going to be okay to just say, we have a clinic system, we have employees who might float anywhere.

Can I just reference in my manuals, see Human Resources, see Medical Staff office for copies of licensure and those type of things? I'm trying to make it as simple and, you know, so I don't have to keep four separate things up to date. I'm trying to keep them all in one. Does that sound reasonable?

Jeff Percy: It all depends. And I know that's not the answer that you were looking for. If in fact you have a centralized system in which all employees work for the same organization and, you know, we're looking at the four clinics altogether, you know, and going from one to the other to do the survey, centralized records of employees and that sort of thing, and of policies and procedures that they all subscribe to is certainly allowed.

They have to have individual, you know, patient records on each one of the sites. So there are ways that you can have economies of scale that way. Where it becomes more difficult is if the partnership is in name only, and in reality it's four really very separate clinics that have unique ownership except on paper to be able to fall underneath a single CCN number.

So, you know, in the exact situation that you gave to me, I'd say yes, that would be a, certainly a good way for you to be able to proceed.

(Susan): Okay.

Bill Finerfrock: But just, you know, it's been my experience when some of that stuff, the way that you'd present it, and I think the key there is a fact situation. If they get on site and they find out that there are different facts, then that could change the answer. I think it's...

Jeff Pearcy: So that's right.

Bill Finerfrock: ...difficult in any situation to give an absolute answer, because the facts are going to dictate the ultimate outcome.

Jeff Pearcy: That's right.

(Susan): Okay, thank you.

Operator: Once again if you have a question please press star 1, that's star 1 to ask a question. And we'll go next to our next question.

(Jack Andres): Hi, this is (Jack Andres) in Texas. I had a question for you regarding your application process. I know you have a separate application. I guess I'm just wondering why we couldn't just send you our 855-A and the attestation statement and have that be the information you need instead of, you know, more pages of paperwork.

Jeff Pearcy: You know, that's a great question. Unfortunately there's a duplication of systems that we have to do in order to satisfy Medicare, okay. And they need us to be gathering information, whether it - you know, independent of the 855 and those sorts of things. So for the present time it is what it is.

If you come back to me in three years and people are struggling with the paperwork part of the application process, we probably will have changed it by then.

(Jack Andres): Okay and, so once you get your recommendation of approval from the MAC to CMS that would be the appropriate time to start the process with AAAASF?

Jeff Pearcy: Tom, jump in there, would you?

Tom Terranova: Yes, when you submit the 855, when you receive notification that your 855 has been approved, that's really the best time for us to step in. At that time the state agency will also get your name, and they'll put you on their list of facilities to be surveyed. Obviously the reality doesn't necessarily match that. In some cases the states just can't or won't come out.

But they're, you're still theoretically on their list, and that's also the time when you would come to us with your 855 approval and your application. And then generally, what our staff does is advise you to just let the state agency know that you're going through the accreditation process, just if by some chance they, you know, they come out to your neighborhood, this way you're not surprised by them.

But yes, that's - the short answer is yes, that's the appropriate time.

(Jack Andres): Okay.

Bill Finerfrock: Okay.

Operator: And once again that is star 1 if you have a question.

Bill Finerfrock: We've taken care of all the questions in the queue, Operator?

Operator: There are no other questions at this time.

Bill Finerfrock: Okay. Why don't we give, just in case folks thought that we would have time and give them another minute or two, if they wanted to get in the queue to ask a question or clarify? But if we end early, there's nothing wrong with that. We have no problems with ending early.

All right, it doesn't look like...

Operator: We actually do have two people that queued up.

Bill Finerfrock: Okay, great.

Operator: We'll take our next question.

Bill Finerfrock: Okay, go ahead, Caller.

(Marilyn): Yes, this is (Marilyn) from Huntsville, Texas. I'm just wondering, from the time you have the survey and you have deemed that you're accredited, from that point you then, I guess, notify CMS and from that point on, do you know long it is before you receive your CPN number?

Jeff Pearcy: That'll vary region to region, I'm sure. You know, it's at that point that we lose a bit of control over the process. You know, the - generally, Tom, do you know how long it's been taking in the AFC environment for that to happen? Is it relatively quick?

Tom Terranova: It - as you said, there's great variability, depending on the region. I can tell you that as far as the central office - Medicare is concerned, they like to see the regions turn it around in under 180 days. So if it takes longer than 180 days they sort of want to hold the region accountable, and they ask us to really kind engage in more vigorous dialogue with them to get things moving along.

In many regions, I would say in most regions it's under that 180 day threshold. I think there's still a region or two that's over it, and that wouldn't be for every facility, but they'll occasionally drift over that 180 days. The important thing is that all of your billing, from the date of recommendation, you can still bill that retroactively once you receive your number.

(Marilyn): Okay, thank you.

Operator: And we'll take our next question. Caller, go ahead.

(Patty): This is (Patty), from Iola, Kansas. We received...

Bill Finerfrock: I'm sorry, (Patty), I'm having a hard time hearing you, can you repeat that?

(Patty): Yes, I'm from Iola, Kansas.

Bill Finerfrock: Okay.

(Patty): We received our 855 CMS approval back in November of 2010. Would we have to start all over from that point? Or could we just do the application to AAAASF?

Jeff Percy: Again that, you know, that's a question I'm not prepared to answer. Tom, do you know, do those 855's sunset at some point?

Tom Terranova: I had not heard that specific question before, but my guess is that, yes because even if you're already active and you don't bill in most cases for a 12 month period, the 855 becomes dormant and you would have to re-enroll anyway. So my guess is if that's the case, then if you had an approved 855 and were never certified the same would apply.

(Patty): Okay.

Bill Finerfrock: The other tissue, too with the, you'll want to, you'll need to go back and reverify that your area qualifies, given the time lapse between when you got that and today, to make sure that your shortage area designation is current. Because you wouldn't want to, you know...

(Patty): And a short ((inaudible)).

Bill Finerfrock: I'm sorry?

(Patty): The state just didn't have anyone to send out for a survey, is what they kept telling me.

Bill Finerfrock: Okay.

Jeff Pearcy: My email is Jeff at, and then aaaasf.org. If you would email me that question, I'll be sure and find the - rather than guessing at the answer, I'll find the answer for you.

(Patty): Okay, I appreciate that.

Jeff Pearcy: Okay, yes.

(Patty): Thank you.

Bill Finerfrock: Okay.

Operator: And there are no other questions.

Bill Finerfrock: Okay, well, I think - hopefully we've given everybody an ample opportunity. If for some reason you think of a question afterwards, you've got Jeff's email, or Tom or you can send it to the National Association of Rural Health Clinics at info@narhc.org and we will make sure to get it back to Jeff and get the answer out.

As I mentioned, today's call is being recorded, and also the transcript and recording and slides are available, will be available on the ORHT Web site. I want to thank everybody for participating, and also to encourage you to notify others if the subject matter, you think would be of interest to go to the ORHT Web site and get that information, or who you think, just in general would be, find the value of these calls, to give them the information.

The next Rural Health Clinic Technical Assistance teleconference has already been scheduled. It is scheduled for Monday, May 21, 2012. And the topic will be Community Facility Loans and Grant Programs through the U.S. Department of Agriculture.

We will send out more information as we get closer, and with the number and the slides for that presentation. But if you go ahead and mark your calendars, our next call will be May 21, and that will be on the USDA's Community Facility Loans and Grants program. I want to thank Jeff and Tom and the folks at AAAASF for pursuing this process, for staying vigilant.

We are excited about the fact that there is now an alternative to a state survey and certification. We are excited about the possibility that there may even be more entrants into this environment to give folks even more choice, and we look forward to being able to present information on that if and when that becomes available.

So thank you to AAAASF, thank you for participating in today's call, and we look forward to having you all on our next call. Thank you very much.

Operator: That does conclude today's conference. We appreciate your participation.

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