Starting a Rural Health Clinic - A How-To Manual

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Preface

We are pleased to share with you this manual on how to start a Rural Health Clinic (RHC). This document is being produced in response to the hundreds of requests for information we have received about the RHC program over the years.

The Rural Health Clinic program presents a very real opportunity for enhancing access to health care in underserved rural areas. The following information will provide you with a description of the program requirements, and describe in easily understandable language the mechanism for becoming an RHC.

The Federal Office of Rural Health Policy has prepared this document to assist health care practitioners to better understand the process for becoming a Federally-certified Rural Health Clinic. We hope it will be useful.

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Introduction

In 1977, Congress passed the Rural Health Clinic Services Act (PL 95-210). The legislation had two main goals: improve access to primary health care in rural, underserved communities; and promote a collaborative model of health care delivery using physicians, nurse practitioners and physician assistants. In subsequent legislation, Congress added nurse midwives to the core set of primary care professionals and included mental health services provided by psychologists and clinical social workers as part of the Rural Health Clinic (RHC) benefit.

The law authorizes special Medicare and Medicaid payment mechanisms for rural health clinics and uses these special payment mechanisms as the principal incentive for becoming a Federally-certified Rural Health Clinic. For Medicare, the payment mechanism is a modified cost-based method of payment. For Medicaid, States are mandated to reimburse Rural Health Clinics using a Prospective Payment System (PPS). Federal law allows States to use an alternative payment method for Medicaid services, as long as the payment amounts are no less than the clinic would have received under the PPS method.

Improving access to primary care services in underserved rural communities and utilizing a team approach to health care delivery are still the main focuses of the RHC program.

As will be detailed later in this guide, a RHC may be a public or private, for-profit or not-for-profit entity. There are two types of RHCs: provider-based and independent. Provider-based clinics are those clinics owned and operated as an "integral part" of a hospital, nursing home or home health agency. Independent RHCs are those facilities owned by an entity other than a "provider" or a clinic owned by a provider that fails to meet the "integral part" criteria.

The mission of the RHC program has remained remarkably consistent during the lifetime of this unique benefit. Improving access to primary care services in underserved rural communities and utilizing a team approach to health care delivery are still the main focuses of the RHC program. The information found in this book is geared toward those individuals and organizations that share that mission.

There are over 3,000 Federally-certified RHC located throughout the United States. The RHC community is almost evenly split between independent clinics (52 percent) and provider-based clinics (48 percent). According to a national RHC survey conducted by the University of Southern Maine (USM), independent clinics are most commonly owned by physicians (49 percent) and provider-based clinics are most commonly owned by hospitals (51 percent). Approximately 43 percent of RHCs are located in Health Professional Shortage Areas and 40 percent are located in Medically Underserved Areas.

Also according to the University of Southern Maine, 69 percent of all RHCs are located in ZIP codes classified by the Department of Agriculture as small towns or isolated areas. A small town or isolated area is a community with fewer than 2,500 people. Another 17 percent of clinics are located in so-called "large towns". These are communities with populations between 10,000 and 49,999. The majority of the remaining clinics are located in areas defined as suburban.

Each of these clinics was located in a Federally-designated or -recognized underserved area at the time the clinic was certified. In addition, all of these facilities are located in non-urbanized areas as defined by the Bureau of the Census. Despite the tremendous growth we have seen in the RHC program over the past decade and the considerable contribution RHCs are making towards alleviating or eliminating access to care problems, thousands of rural communities continue to receive the underserved designation.

Rural communities have historically had difficulty attracting and retaining health professionals. For some rural communities, the inability to access the health care delivery system may be because there are no health care providers in the area. The lack of health professionals may be due to the fact that rural communities are disproportionately dependent on Medicare and Medicaid as the principle payers for health services. In the typical Rural Health Clinic, Medicare and Medicaid payments account for close to 60 percent of practice revenue. Consequently, ensuring adequate Medicare and Medicaid payments is essential to the availability of health care in rural underserved areas.

There was tremendous growth in the RHC program through the early '90s. Between 1990 and 1997, nearly 3,000 clinics received initial certification as a Rural Health Clinic. Since 1997, hundreds of new clinics have been certified to participate in the program, however, many clinics approved in the early '90s have chosen to discontinue participation in the program. Consequently, we have seen a slight drop in the aggregate number of clinics.

The year 1997 is considered a threshold year for the RHC community because it was this year that Congress enacted legislation to better target growth in the RHC program. While the growth in the RHC program during the early and mid-90s was not unexpected, there were some in Congress that felt that some of the clinics certified as RHCs during this period were not really appropriate for participation in a program aimed at improving health care in underserved areas.

For example, it was discovered that the Medically Underserved Area list used for participation in the RHC program had not been updated by the Federal government since the early 1980's. This meant that some communities that may no longer have been underserved were deemed eligible for participation in the program. One of the changes Congress enacted in response to this discovery was that new RHCs can no longer be certified in areas where the shortage area designation is more than three years old.

As successful as the program has been for thousands of rural communities, the fact is that the Rural Health Clinics program may not be appropriate for every rural underserved

community. While the payment methodologies available to Rural Health Clinics can be attractive, they are not magical. Indeed, depending upon the payer mix or range of services you offer or plan to offer, traditional fee for service or some other form of payment could be better. It is important, therefore, that you complete the financial assessment included in this publication to make sure that the methodologies are right for your particular practice.

The purpose of this book is to walk the reader through the steps that are required to become a Federally-certified Rural Health Clinic and complete the necessary financial audit to determine the clinic's per visit rate.

If you are looking for a way to stabilize the availability of primary care services or make primary care services available in a community that has had difficulty recruiting or retaining primary care health professionals, then we encourage you to learn more about the advantages of operating your practice or clinic as a Federally-certified Rural Health Clinic.

Chapter One

Overview of RHC Program

Chapter One - Overview

The following is an overview of the major requirements clinics must meet in order to become certified as a Rural Health Clinic. Each of the subjects addressed in this overview are discussed in further detail in this manual.

Location - Rural Health Clinics must be located in communities that are both "rural" and "underserved". For purposes of the Rural Health Clinics Act, the following definitions apply to these terms:

- **Rural Area** - Census Bureau designation as "non-urbanized"
- **Shortage Area -** A Federally-designated Health Professional Shortage Area, a Federally-designated Medically Underserved Area or an Area designated by the State's Governor as underserved.

Unlike some other programs that are not concerned about the location of the facility but rather the types of patients seen by the facility, the RHC program ties certification to the location of the facility. A non-urbanized area is any area that does not meet the Census Bureau's definition of urbanized. The Census bureau definition of an Urbanized Area can be found in Chapter 2.

Physical Plant - The Rural Health Clinic program does not place any restrictions on the type of facility that can be designated as an RHC. A Rural Health Clinic may be either a permanent location that is a stand alone building or a designated space within a larger facility. The clinic can also be a mobile facility that moves from one community to another community.

Staffing - The Rural Health Clinic program was the first Federal initiative to mandate the utilization of a team approach to health care delivery. Each Federally-certified Rural Health Clinic must have:

- One or more physicians; and
- One or more PAs, NPs or CNMs; and,
- The PA, NP or CNM **must** be on-site and available to see patients 50 percent of the time the clinic is open for patients.

Provision of Services - Each Rural Health Clinic must be capable of delivering out-patient primary care services, although Clinics are not limited to primary care services. The Clinic must also maintain written patient care policies that:

- Are developed by a physician, physician assistant or nurse practitioner, and one health practitioner who is not a member of the clinic staff.
- Describe the services provided directly by the clinic's staff or through arrangement.
- Provide guidelines for medical management of health problems.

- Provide for annual review of the policies.

A copy of a sample Policy and Procedures manual that describes this requirement has been included in Appendix D.

Direct Services - These are services that the clinic's staff must provide directly. Clinic staff must provide diagnostic and therapeutic services commonly furnished in a physician's office. Each Rural Health Clinic must be able to provide the following six laboratory tests.

- Chemical examinations of urine
- Hemoglobin or Hematocrit
- Blood sugar
- Examination of stool specimens for occult blood
- Pregnancy test
- Primary culturing for transmittal

Emergency Services - Rural Health Clinics must be able to provide "first response" services to common life-threatening injuries and acute illnesses. In addition, the clinic must have access to those drugs used commonly in life-saving procedures.

Services Provided through Arrangement - In addition to the services that clinic staff must provide directly, the Rural Health Clinic may provide other services utilizing individuals other than clinic staff. Those services that a clinic may offer that can be provided by non-RHC staff are:

- In-patient hospital care
- Specialized physician services
- Specialized diagnostic and laboratory services
- Interpreter for foreign language if indicated
- Interpreter for deaf and devices to assist communication with blind patients

Patient Health Records - Each clinic must maintain an accurate and up-to-date record keeping system that ensures patient confidentiality. A description of the Clinic's system must be included in the policy and procedures manual (see Appendix D). Clinic staff must be involved in the development of this record keeping system.

Records must include the following information:

- Identification data
- Physical exam findings
- Social data
- Consent forms
- Health status assessment
- Physicians orders
- Consultative findings
- Diagnostic and laboratory reports
- Medical history
- Signatures of the physician or other health care professionals

Protection of Record Information Policies - In addition to maintaining the confidentiality of patient information, the clinic must have written policies and procedures that govern the use, removal and release of information. The policy and procedures manual must also document the mechanism through which a patient can provide consent for the release of his or her medical records. RHCs like all other Medicare providers, must also be compliant with the HIPAA privacy standards.

Chapter Two

Getting Started

Chapter Two - Getting Started

Before engaging in the process of meeting the technical requirements of becoming a Federally-certified Rural Health Clinic, it is necessary to ensure that the site is eligible for RHC designation. There are two basic eligibility requirements for having a site designated as a Rural Health Clinic:

The facility must be located in an area:

1. that is not an urbanized area (as defined by the Bureau of the Census); and,

2. that, within the previous 3-year period,

   - has been designated by the chief executive officer of the State and certified by the Secretary as an area with a shortage of personal health services; or,

   - designated by the U.S. Secretary of Health and Human Services as either:

     # an area with a shortage of personal health services under section 330(b)(3) or 1302(7) of the Public Health Service Act; **or**,

     # a health professional shortage area described in section 332(a)(1)(A) of that Act because of its shortage of primary medical care manpower; **or**,

     # a high impact area described in section 329(a)(5) of that Act; **or**,

     # an area which includes a population group which the Secretary determines has a health manpower shortage.

According to the Census Bureau, an ***Urbanized area*** is:

"An area consisting of a central place(s) and adjacent territory with a general population density of at least 1,000 people per square mile of land area that together have a minimum residential population of at least 50,000 people. The Census Bureau uses published criteria to determine the qualification and boundaries of UAs." (Census Bureau Web site).

The agency goes on to further clarify this definition with the following additional information:

> "A densely settled area that has a census population of at least 50,000. A UA generally consists of a geographic core of block groups or blocks that have a population density of at least 1,000 people per square mile, and adjacent block groups and blocks with at least 500 people per square mile. A UA may consist of all or part of one or more incorporated places and/or census designated places, and may include area adjacent to the place(s)."

The above references to the Public Health Services Act refer to Federal Health Professional Shortage Area (HPSA) designations and Medically Underserved Area (MUA) designations. The HPSA and MUA lists are available on the Health Resources and Services Administration's Web site or by contacting the Shortage Designation Branch of the Health Resources and Services Administration's Bureau of Health Professions. The Web address and/or phone numbers for these offices are listed in Appendix F. Although the list is published in the Federal Register, the publication date is unpredictable and infrequent. To determine whether your State's executive officer has designated areas as shortage areas for purposes of establishing rural health clinics, it is recommended that you contact your State Office of Rural Health (SORH). A complete listing of SORHs, including their addresses and phone numbers, can be found in Appendix B.

Please note that by law, the shortage area designation MUST have occurred within the past three (3) years. If the shortage area designation (HPSA, MUA or Governor) is more than three years old, then the site does not qualify for RHC certification. The RHC surveyor will not conduct a survey for initial certification until that designation is updated and deemed current. If you determine that the area is not designated as either a Health Professional Shortage Area or a Medically Underserved Area, you can review the criteria for each designation (Appendix C) to ascertain whether a designation may be possible.

Once you have determined that the site is located in a "non-urbanized area" that is also a shortage area that qualifies for RHC designation, you are then ready to proceed to the next phase: Financial Feasibility Analysis.

Chapter Three

Financial Feasibility Analysis

Chapter Three - Financial Feasibility Analysis

The Rural Health Clinics program provides an opportunity for enhanced Medicare reimbursement through cost-based methodology. It is important, however, for persons considering the development or establishment of a Rural Health Clinic to ensure that the financial impact or benefits are significant enough to outweigh the cost incurred in establishing a Rural Health Clinic.

- For example, if an existing practice does not currently employ a Physician Assistant or Nurse Practitioner, the cost of the PA or NP would have to be offset by any increased revenues from participating in the program.
- It is important to determine, from a business standpoint, if this is a positive financial move.

As with any business decision, it is important that the individuals responsible for making decisions have accurate and appropriate information to determine what the impact of the RHC program will be on the financial operations of the Clinic. Many clinics make the common mistake of simply looking at the RHC Cap rate, comparing that to the Clinic's fee-for-service payments for an individual encounter (see 3-6 for definition of RHC encounter), and concluding that payments from Medicare or Medicaid will automatically be better if the clinic converts to RHC status. While it is likely that the clinic's Medicare and/or Medicaid payments will be better as a Rural Health Clinic than fee-for-service, this is not a given.

We strongly recommend that a financial feasibility analysis be conducted prior to undertaking significant costs that might result from a change to RHC status. This feasibility analysis will help to determine the financial impact of the RHC program.

For clinics that are brand new and have no financial history, a simple Financial Feasibility Analysis can be created by estimating the volume and payments from Medicare, Medicaid, and other payers. For existing facilities considering conversion, you can utilize the actual data in the practice for those same categories.

The Rural Health Clinics (RHC) program potentially enhances the reimbursement from Medicare and Medicaid - the two most critical payment areas for determining the financial impact of RHC designation.

Tables A and B in this Chapter present a summary that demonstrates the Medicare and Medicaid feasibility estimate for a clinic that is:

- A Fee-For-Service Facility (Table A)
- A Managed Care Facility (Table B)

The differences between the Managed Care Model and the Fee-For-Service Model are that, in our experience, capitated payments generally pay, on a per-visit basis, a higher amount than fee-for-service. It has also been our experience that cost-based payments are generally better than either capitation or fee-for-service when you calculate them on a per visit basis.

It is important to gather as much information as possible to accurately reflect what your current visits generate - by payer category. You cannot compare an individual Medicare visit as an RHC to a single Medicare fee-for-service visit. You need to aggregate the data in order to get an accurate assessment of the impact of converting to RHC status.

In general, we find that most RHC's will experience anywhere from 25-75 percent increased revenue in their overall annual revenues. This is based on the assumption that a minimum of 50 percent of the total visits are Medicare and Medicaid combined. When the percentage of Medicare and Medicaid patient volume drops below 50 percent as a combined number, the financial impact is usually much less. This is another reason it is important that you conduct a feasibility estimate prior to incurring significant costs and changes in the practice to determine the overall financial benefit.

Financial considerations are not the only reasons to consider RHC status. They do however tend to dominate the thinking of those considering conversion. Improved access to health care, improved patient flow via utilization of PAs and NPs and more efficient operations are other factors to consider. Also, there are often other Federal and/or State programs that you may qualify for if you are an RHC.

Finally, it is important to keep in mind that the value of a feasibility analysis is only as good as the data used to calculate that estimate. If you use data that is not accurate or, in the case of a new clinic, unrealistic, then the analysis will not be realistic. The methodology we have provided is a very simple tool. There are more complex methodologies that can be obtained from accountants or business consultants. This is only intended to give you a general perspective on the potential impact of the RHC program on practice revenues.

A blank financial feasibility chart has been included in Appendix F, page F-4.

Table A - Fee-For-Service Model

Anywhere Rural Health Clinic
1234 S. Hometown Avenue
Hometown, State 12345

FY: 2002

Feasibility Estimate

Insurance Type:	Medicare		Medicaid		Other	Total
Percent of Total Visits:	20.00 percent		30.00 percent		50.00%	5050.00%
Total Visits	2,000		3,000		5,000	10,000
Fee for Service Payments						
Average Payments	$35.00		$29.00		$65.00	
Total Payments	$70,000		$87,000		$325,000	$482,000
Rural Health Clinics						
All-Inclusive Rate (2002)	$64.78	*	$63.72	**	$65.00	
Total Payments	$129,560		$191,158		$325,000	$645,718
Increase	$59,560		$104,158		$0	$163,718
Percent Increase						**33.97%**

ASSUMPTIONS:

* Based on the assumption that the all inclusive rate is captured through cost based reimbursement for Medicare (2002 = $64.78)

** Depending on what State the RHC is located in, each State Medicaid program could have its own reimbursement policy for RHC's. In 2001, most States paid a base rate equivalent to the average of the 1999 & 2000 Medicaid per visit cost report rate. For succeeding years, the base rate will be adjusted by the Medical Economic Index (MEI).

Table B - Managed Care Model

Anywhere Rural Health Clinic
1234 S. Hometown Avenue
Hometown, State 12345

FY: 2002

Feasibility Estimate

Insurance Type:	Medicare		Medicaid		Other		Total
Percent of Total Visits:	20.00 percent		30.00 percent		50.00%		5050.00%
Total Visits	2,000		3,000		5,000		10,000
Fee for Service Payments							
Average Payments	$35.00		$36.00		$65.00		
Total Payments	$70,000		$108,000		$325,000		$503,000
Rural Health Clinics							
All-Inclusive Rate (2002)	$64.78	*	$63.72	**	$65.00		
Total Payments	$129,560		$191,158		$325,000		$645,718
Increase	$59,560		$83,158		$0		$142,718
Percent Increase							**28.37%**

ASSUMPTIONS:

* Based on the assumption that the all inclusive rate is captured through cost based reimbursement for Medicare (2002 = $64.78)

** Depending on what State the RHC is located in, each State Medicaid program could have its own reimbursement policy for RHC's. In 2001, most States paid a base rate equivalent to the average of the 1999 & 2000 Medicaid per visit cost report rate. For succeeding years, the base rate will be adjusted by the Medical Economic Index (MEI).

Explanation of the information reported on the Financial Feasibility Charts

- In order for a visit to qualify as an RHC visit, it must be a face-to-face encounter with a covered provider. For purposes of the RHC program, a covered provider is a physician, physician assistant, nurse practitioner, certified nurse midwife, psychologist (PhD.) or social worker (MSW). Visits with other providers (i.e. nurses, medical assistants, etc.) do not qualify as RHC visits and should not be counted.

- Percent of visits attributable to each payer group. As mentioned previously, it is important to understand the payer mix as this could affect the desirability of becoming an RHC. The difference between the two charts is attributable to slightly better Medicaid payments under a managed care arrangement.

- Total payments from that payer category.

- The average payment per visit is a calculation dividing total payments from that Payer category by the number of patients from that Payer category. (Line 3 divided by Line 2).

- This is the percent of revenue generated by a particular payer category. Typically the percent of revenue generated by Medicare and Medicaid patients under traditional payment methodologies is far less than will be realized under the RHC payment methodologies.

- This is an estimate. The assumption being made is that the Medicare and Medicaid RHC rates will be close to the RHC Cap rate.

- This is the amount of revenue generated using the RHC payment methodology. You multiply line 6 by line 2. The assumed Medicare and Medicaid volumes are the same as the volumes under traditional payments.

- The new breakdown of revenues based upon the alternative payment methodology. Most significant is the fact that revenues from each payer category now more

Chapter Four

How To File An RHC Application

Chapter Four - Filing the RHC Application

A practice is eligible for initial RHC certification if it is located in an area "currently" designated as a Medically Underserved Area (MUA) or Health Professional Shortage Area (HPSA) - either population or geographic. In addition, Governors are authorized to designate areas with a shortage of personal health services for purposes of obtaining RHC status. In order for a shortage area designation to be considered "current" it cannot be more than 3 years old. Once you have determined that the site is eligible for RHC designation and you have completed the Financial Feasibility Analysis, you are ready to file the RHC application.

The RHC application is broken into two parts:

- the RHC application; and,
- the CMS 855A Provider/Supplier Enrollment application

You can obtain an RHC application packet from the State agency responsible for administering the RHC program for CMS in the State in which the clinic is located. Appendix A lists the State agency for each State. The RHC application packet should include the following items although the numbers of the forms may have changed so check with CMS to ensure proper compliance. :

- CMS-29 *Request to Establish Eligibility to Participate in the Health Insurance for the Aged and Disabled Program to Provide Rural Health Clinic Services*
- CMS-1561A *Health Insurance Benefits Agreement*
- HHS-690 *Assurance of Compliance* (if participating as a Medicaid RHC).
- CMS-2572 *Statement of Financial Solvency,* and *Expression of Intermediary Preference*
- RHC Regulations (Sections 491 and 405), Section 1861(aa) of the Social Security Act and the RHC Interpretive Guidelines

Note: Please contact the CMS Regional Office nearest you to obtain these forms or to learn where to download them from the Internet. Any form numbers listed in this chapter are subject to change and it is recommended that applicants check with CMS to ensure they have the proper form numbers.

The State agency, in an effort to better assist applicants in preparing for the RHC site visit, may request additional information such as: Clinic contact name and position, clinic phone and fax numbers, travel directions to the clinic from the State agency, clinic floor plan, hours of operation, clinic organizational chart, practitioner (physician, PA, NP or CNM) resumes and work schedules, and copies of the Advisory Meeting Minutes. If your state requires that you be licensed, you must obtain this license prior to being approved as a Medicare provider.

If you are applying as an Independent RHC (i.e. not an integral and subordinate part of a hospital, skilled nursing facility, or home health agency), you will request the CMS 855A *Medicare Federal Health Care Provider/Supplier Enrollment Application* from one of the Independent RHC Fiscal Intermediaries (FI) (A list of Independent RHC Fiscal Intermediaries can be found in Appendix F). If you are applying as a Provider-based RHC (i.e. integral and subordinate part of a hospital, skilled nursing facility, or home health agency), you will request the CMS 855A *Medicare Federal Health Care Provider/Supplier Enrollment Application* from the host provider's current fiscal intermediary (FI). The application can also be obtained online at http://cms.hhs.gov/providers/enrollment/forms/

If you are considering RHC designation for more than one site, you must complete a separate RHC application and CMS 855A for each site. The exception would be for those separate services that are co-located in the same office and share resources. Consider, for example, a facility that operates a pediatric practice on one side of the facility and an OB/GYN practice on the other side of the facility. Both share a common reception area, medical records, laboratory, break areas, staff and employer identification number (EIN). For the purposes of the RHC program, this would be considered one clinic, and only one application should be filed.

Request to Establish Eligibility to Participate in the Health Insurance for the Aged and Disabled Program to Provide Rural Health Clinic Services (Please contact the CMS Regional Office to obtain this form)

I. Identifying Information

Insert the full name under which the clinic operates. A Rural Health Clinic site is the location at which health services are furnished. If a central organization operates more than one clinic site, a separate Request to Establish Eligibility Application for each rural health clinic site must be submitted. In these instances, the location of the health clinic site, rather than the central organization, will determine eligibility to participate. Also, the applicant site must be situated in a rural area, which is designated as underserved as discussed in Chapter Two. If the name of the rural health clinic site does not identify the owner(s), the name and address of the

owner(s) is to be inserted in the space provided. Otherwise, that space is to be left blank.

II. Medical Direction

Insert the name and address of the physician(s) responsible for providing medical direction for the health clinic site. The physician providing medical direction must be a member of the clinic's staff. RHC Code of Federal Regulations, sections 491.7, 491.8, 491.9, and 491.10, outline the roles and responsibilities of the Medical Director. To view these on-line, go to: www.narhc.org.

III. Clinic Personnel

(A), (B), and (C) – Personnel are to be described in terms of full-time equivalents. To arrive at full-time equivalents, add the total number of hours worked by personnel in each category in the week ending prior to the week of filing the request and divide by the number of hours in the standard work week (as determined by clinic policies). If the result is not a whole number, express it as a quarter fraction only (e.g., .00, .25, .50, or .75). Exclude all trainees and volunteers. A nurse practitioner, certified nurse midwife and/or physician assistant (mid-level provider) in addition to the physician, is required for clinic eligibility and must be shown in B and/or C respectively. (D) – Where other types of personnel are utilized (e.g., technicians, aides, nurses, etc.), the discipline, by name, is to be indicated in addition to the full-time equivalents. (Example, RN – 1.5 FTE, CMA 2.0 FTE) The mid-level providers must be available to furnish patient care services at least 50% of the time the clinic operates. Upon initial application, the clinic may not request a temporary waiver of mid-level staffing requirements.

IV. Type of Control

Identify the RHC in terms of its control by checking the appropriate part of A – Individual (Profit or Non-profit), B – Corporate (Profit or Non-profit), C – Partnership (Profit or Non-profit), or D – Government (State, Local or Federal). Non-profit status is based on Internal Revenue Service tax exemption interpretation, i.e., Section 501 of the Internal Revenue Code of 1954. If the RHC is applying as a Provider-based clinic then you must include the Medicare number of the host entity on line (RH 11). By doing so, you are indicating: 1) that both the RHC and the host entity are licensed as a single health entity; 2) that the RHC and the host entity are subject to the bylaws and operating decisions of the same governing body; and 3) that the medical personnel of the RHC are considered by the governing body to be subject to the rules of the host entity's medical staff.

V. Signature

An authorized official of the organization must sign the form (e.g., owner, Practice Manager, CEO, CFO, Board President.)

CMS 1561A Health Insurance Benefits Agreement

Two originals of this form must be completed, signed and included in the RHC application packet. Once the clinic has successfully passed the RHC certification survey and enrolled in the RHC Medicare program, the Secretary of Health and Human Services will sign the originals and one will be sent back to the clinic for their files.

HHS 690 Assurance of Compliance

An RHC is required to comply with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, and the Age Discrimination Act of 1975, if it chooses to participate in Medicaid as an RHC. If RHC status is chosen only for Medicare, compliance with the Civil Rights Act is not required. Some States have not required this signed assurance as part of the RHC application. Be aware that it is a requirement and you may be asked to complete the form.

CMS 2572 Statement of Financial Solvency

This is for the purpose of establishing eligibility for payment under Title XVIII of the Social Security Act. The provider of services States that they have not been adjudged insolvent or bankrupt in a State or Federal court; and that a court proceeding to make a judgment of bankruptcy or insolvency with respect to the provider of services is not pending in a State or Federal court. While some States have not required this signed declaration as part of the RHC application, be aware that you may be asked to complete the form.

Once the RHC application documents have been completed, signed and dated, submit them to the responsible State agency. Remember to retain a copy of documents for your file.

CMS 855A Medicare Federal Health Care Provider/Supplier Enrollment Application

The CMS 855A was implemented on January 1, 2002, as part of changes mandated by the BBA (Balanced Budget Act) of 1997. This form, although much simpler than previous versions, is best understood by following the accompanying instructions. It is important to understand that several sections of the form do not apply to the initial enrollment and can be skipped. See the table for Sections that must be completed by an RHC site filing an

initial application. Once completed, submit the CMS 855A with attachments to the FI for review and approval.

CMS 855A Related RHC Sections

General Section	A	B	C	D	E	F	G	H
1. General Application Information	**X**							
2. Provider Identification	**X**	**X**	**X**	**X**			**X**	
3. Adverse legal Actions and Overpayments	**X**	**X**						
4. Current Practice Locations(s)	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
5. Ownership Interest and/or Managing Control Information (Organizations)*	**X**	**X**	**X**					
6. Ownership Interest and/or Managing Control Information (Individuals)**	**X**	**X**						
7. Chain Home Office Information	**X**	**X**	**X**	**X**	**X**	**X**		
8. Billing Agency	**X**	**X**	**X**					
9. Electronic Claims Submission Information	**X**	**X**	**X**					
10. Staffing Company	**X**	**X**	**X**					
11. Surety Bond Information	**X**							
12. Capitalization Requirements for Home Health Agencies (HHAs)	**X**							
13. Contact Person(s)	**X**	**X**						
15. Certification Statement		**X**						
16. Delegated Official (Optional)	**X**	**X**						
17. Attachments								

* This section is to be completed with information about all organizations that have 5 percent or more (direct or indirect) ownership interest of, or any partnership interest in, and/or managing control of the provider identified in this application, as well as any information on adverse legal actions that have been imposed against that organization. If there is more than one organization, copy and complete this section for each.

** This section is to be completed with information about any individual that has a 5 percent or greater (direct or indirect) ownership interest in, or any partnership interest in the provider identified in this application. All officers, directors, and managing employees of the provider must also be reported in this section. In addition, any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each.

Once both packets have been submitted to their respective agency, they will be reviewed simultaneously (see RHC Application Matrix). The RHC packet will be reviewed by the State agency and the CMS 855A will be reviewed by the appropriate FI. Once the FI has approved the CMS 855A, a letter will be sent to the provider and the State agency informing them of the recommendation of approval. The provider will also be informed in their letter that the State agency will be contacting them regarding their date of readiness for the RHC survey. Once the State agency has received the recommendation letter from the FI and they have reviewed the RHC application packet for completeness, a letter will be issued to the provider informing them that they are eligible for the RHC program. The State agency may, but is not required to, instruct the provider to respond back to them in writing regarding their date of readiness for the RHC survey. When you respond with your date of readiness, you are indicating to the State agency, that as of that date, you believe you are, to the best of your ability, in compliance to with the RHC program regulations. You must be in operation and providing services to patients when surveyed. This means at the time of the survey the clinic functions as a RHC, and is serving a sufficient number of patients so that compliance with all requirements can be determined. This may be as few as one (1) patient, but only if, in the surveyor's judgement, compliance can be determined.

Currently CMS expects the state survey agencies to attempt to schedule initial surveys within 90 days of receiving notification that the 855 process is complete, assuming the provider is open and operating.

The State agency does have the option, under certain circumstances, of giving clinics a 48-hour notice of the scheduled survey. Some States, however, will not exercise this option and the survey will be unannounced.

Clinics are encouraged to begin collecting the information needed for completing the cost report. Although this report will not be filed until after the clinic is certified, you can use this time to make preliminary preparations so as to expedite the filing once certification is granted.

Chapter Five
Preparing for the RHC Certification Inspection

Chapter Five - Preparing for the RHC Certification Inspection

There is a saying with runners, "the race is easy, it's the preparation that will kill you." The same can be said for preparing for the RHC Certification Survey. If you prepare thoroughly, then the survey can be uneventful. This chapter is designed to assist you in the preparation. We believe you will find this information useful, but it is not possible to address every situation that may arise during the survey. There are four key elements to preparing for the RHC Certification Survey they are: 1) Policy and Procedure Manual Review, 2) Medical Records Review, 3) Facility Inspection, and 4) Program Evaluation.

The RHC Policy and Procedure Manual

The policy and procedure manual should cover key human resource policies, administrative policies, clinical procedures and protocols, and medical guidelines per RHC Code of Federal Regulations (CFR) §491.7(a)(2). A sample Policy and Procedure manual has been included in Appendix D. It should be noted that this is an example. Each clinic's policy and procedures manual should be drafted with that clinic in mind. This document should be an accurate reflection of how the clinic truly intends to operate.

The Policy and Procedures Manual section of the RHC Interpretive Guidelines States, "Written policies should consist of both administrative and patient care policies. Patient care policies are discussed under 42 CFR 491.9(b). In addition to including lines of authority and responsibilities, administrative policies may cover topics such as personnel, fiscal, purchasing, and maintenance of building and equipment. Topics covered by written policies may have been influenced by requirements of the founders of the clinic, as well as agencies that have participated in supporting the clinic's operation."

When looking at developing human resource policies, there are several laws, administrative rules, acts, and regulations that must be considered: RHC Code of Federal Regulations, RHC Interpretative Guidelines, State and Federal Laws, State Public Health Code, and Professional Practice Standards.

The Human Resource policies should include:

- job descriptions
- benefits, compensation and pay practice
- employment criteria and conditions of employment
- smoking, drug use/possession and distribution
- appointment of providers/credentialing
- confidentiality
- personnel files (organization, management, and access)
- harassment, and employee privacy

The Code of Federal Regulations for the RHC program and the RHC Interpretive Guidelines (both are available on the website of the National Association of Rural Health Clinics - www.narhc.org) are often the best place to start when developing RHC policies. CFR Section 491.8 *Staffing and staff responsibilities,* outlines some of the program requirements for physician assistants, nurse practitioners and certified nurse midwives. The regulations State that, "A nurse practitioner or a physician assistant is available to furnish patient care services at least 50 percent of the time the clinic operates." When developing the job description of the PA/NP/CNM, part of their responsibilities should include the following: "The PA/NP/CNM will be scheduled in the clinic and available to provide patient care services for at least 50 percent of the time the clinic operates."

As you develop your Administrative section, you will want to consider the following resources: RHC Code of Federal Regulations and Interpretative Guidelines, State and Federal Laws, State Court Rules, Federal and State OSHA Standards, Medicare and Medicaid reimbursement policy, State Public Health Code, Administrative rules, and the Freedom of Information Act.

Administrative policies should include:

- Life safety
- Confidentiality
- Exposure control plan
- Hazardous materials
- Health services
- Informed consent
- Medical records (storage, release of information, documentation standards)
- Reporting of suspected child neglect/abuse and abandonment
- TB screening for health care workers
- Medical waste management
- Organizational structure
- Personal accident/incident
- Physical plant and environment
- Patient compliant-grievance procedure
- Performance improvement plan
- Preventative maintenance
- Patient rights and responsibilities
- Quality assurance
- Medicare bad debt
- Cleaning

Again when developing your Administrative section, the best place to start is with the Code of Federal Regulations (CFR). An example of an Administrative policy would be Preventive Maintenance. CFR Section 491.6(b) States, "The clinic has a preventive maintenance program to ensure that: (1) All essential mechanical, electrical and patient-care equipment is maintained in safe operating condition." The RHC Interpretive Guideline for this regulation defines the requirement further, "A program of preventive maintenance should be followed by the clinic. This includes inspection of all clinic equipment at least

yearly, or as the type, use, and condition of equipment dictates." By using these two resources the preventive maintenance policy could contain the following

Statements:

1. All Clinic equipment will be inspected at least yearly, or as the type, use, and condition of equipment dictates. Each time an inspection or repair occurs, an entry will be made in the Inspection and Maintenance Log and signed by the service person to verify the event.

2. The medical/clinical assistant prior to each use must inspect all equipment.

3. An electrician or bio-medical engineer will inspect each piece of bio-medical equipment. The inspection will ensure that the equipment is in proper operating condition, is safe to use, and is calibrated properly.

When developing clinical procedures/protocols, it is helpful to keep in mind that this section refers to those procedures that are performed by support personnel, e.g., nurse, certified medical assistant, registered radiologic technologist, clinical assistant, etc. Resources that you would want to consider as you develop this section are: RHC Regulations and Interpretive Guidelines, manufacturer recommendations, professional practice standards, pharmacy regulations and administrative rules, American Heart Association, Federal and State OSHA standards, CLIA regulations, CDC, State Public Health Code, American Academy of Pediatrics, and PHS Standards for Pediatric Immunization Practices.

Clinical policies should include:

- Administration of Sub-Q, IM, or IV Medications
- Policies for all invasive procedures performed
- Vaccine administration, handling and storage
- Procedures for the operation of all medical equipment
- Medications (stock and sample)
- Laboratory services
- Communicable disease care
- HIV testing
- Universal Precautions
- Diagnostic tracking
- Adverse drug reactions
- Policies that address the testing and quality control of all lab/diagnostic test(s) performed
- Storage of sterile supplies, sterilization of sterile supplies and instruments

As with the Human Resources and Administrative sections, the first resources to consider are the Code of Federal Regulations and the Interpretive Guidelines. Using the Code you

can easily start to put together your clinical procedures/protocol section. For example, CFR Section 491.6(b)(2) States, "The clinic has a preventive maintenance program to ensure that drugs and biologicals are appropriately stored." Based on this regulation, the medication policy could contain the following Statements (among others):

1. Medications will be refrigerated as necessary and will be kept separate from any food substances. Refrigerator and freezer temperatures will be obtained and recorded on a daily basis.
2. On a monthly basis, medications will be checked for expiration dates and those which are outdated will be discarded in the following manner: Given back to drug representative or discarded via the biohazard container. A log will be maintained to indicate when monthly checks are done and by whom.
3. All medications stored on the Clinic premises will be kept in cabinets, shelves, drawers, and/or refrigerators and locked during non-patient care hours.

Finally, the RHC program requires that the clinic have guidelines for the medical management of health problems which include the conditions requiring medical consultation and/or patient referral, the maintenance of health care records, and procedures for the periodic review and evaluation of the services furnished by the clinic. Acceptable guidelines may follow various formats.

Some guidelines are collections of general protocols, arranged by presenting symptoms; some are Statements of medical directives arranged by the various systems of the body (such as disorders of the gastrointestinal system); some are standing orders covering major categories such as health maintenance, chronic health problems, common acute self-limiting health problems, and medical emergencies.

Even though approaches to describing guidelines may vary, acceptable guidelines for the medical management of health problems must include the following essential elements:

- They are comprehensive enough to cover most health problems that patients usually see a physician about;
- They describe the medical procedures available to the nurse practitioner, certified nurse-midwife, and/or physician assistant; and
- They are compatible with applicable State laws.

The professional organizations of the health professionals typically found in an RHC (physician, PA, NP and CNM) have published a number of patient care guidelines. Should a clinic choose to adopt such guidelines (or adopt them essentially with noted modifications), this would be acceptable if the guidelines include the aforementioned essential elements.

Often the regulations will over lap and you need to be aware of the areas where this occurs. Policy and procedure development is one area. The physician and PA, NP or CNM responsibilities include participation in developing, executing, and periodic reviewing of the clinic's written policies. Additionally, the policies are developed with the advice of a group of professional personnel that includes one or more physicians and one or more physician assistants or nurse practitioners. At least one member of the advisory group must not be a member of the clinic staff.

Medical Records

The RHC program has been recognized for its emphasis on documented patient care. This is the direct result of the requirements and expectations clearly stated in the Code of Federal Regulations. The clinic has written policies and procedures of how it will maintain confidentiality of patient health records and provide a safeguard against: loss, destruction, or unauthorized use of patients' health record. CFR Section 491.10 *Patient health records* of the Code, outlines expectations for medical record confidentiality, maintenance, organization, content, protection, release and retention. As part of the Certification Survey process, a representative sample of the clinic's medical records will be reviewed. The focus should be on Medicare and Medicaid records only. The clinic may have the opportunity to select the records for review. If not,
it will be the surveyor who determines the records to be reviewed.

Documentation must include but is not limited to:

- Identification and social data, evidence of consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition and instructions to the patient;
- Reports of physical examinations, diagnostic and laboratory test results and consultative findings;
- All provider orders, reports of treatments and medications and other pertinent information necessary to monitor the patient's progress; and
- Signatures of the provider and other health care professionals.

In addition to these program expectations, the clinic must also comply with reimbursement policy, legal expectations, and standard of practice guidelines. Remember, if it wasn't documented, it wasn't done.

Facility

Preparing the facility is not only a requirement of the RHC program but may also be a requirement for compliance with local, State and Federal laws. An inspection of the physical plant is one of the key elements of the survey process. Some of the regulations, laws, rules, and standards that impact the facility are: RHC Code of Federal Regulations, Clean Indoor Air Act, OSHA Hazardous Communication Standard, local building, zoning and, fire ordinances, and State laws for storage and disposal of medical waste.

To insure the safety of patients, personnel, and the public, the physical plant should be maintained consistent with appropriate State and local building, fire, and safety codes. Reports prepared by State and local personnel responsible for insuring that the appropriate codes are met should be available for review. The facility must have safe access and be free from hazards that may affect the safety of patients, personnel, and the public. The clinic must also be constructed, arranged, and maintained to insure access to and safety of patients, and provide adequate space for the provision of direct services. The clinic must provide laboratory services directly to its patients. Each clinic must have, at a minimum, its own CLIA certificate of waiver. Provider-based RHCs may not use the CLIA certificate of the parent hospital. The clinic must have a preventive maintenance program to ensure that all essential mechanical, electrical, and patient-care equipment is maintained in safe operating condition. The clinic must make provisions for the appropriate storage of drugs and biologicals and the premises must be clean and orderly. The clinic is responsible for assuring the safety of patients in case of non-medical emergencies that include, placing exit signs in appropriate locations and taking other appropriate measures that are consistent with the particular conditions of the area in which the clinic is located.

Program Evaluation

An evaluation of the clinic's total operation including the overall organization, administration, policies and procedures covering personnel, fiscal and patient care areas must be done at least annually. This evaluation may be done by the clinic; an outside group of professional personnel that includes one or more physicians and one or more physician assistants or nurse practitioners and at least one individual who is not part of the clinic staff; or through arrangement with other appropriate professionals. The State survey does not constitute any part of this program evaluation.

The total evaluation does not have to be done all at once or by the same individuals. It is acceptable to do parts of it throughout the year, and it is not necessary to have all parts of the evaluation done by the same staff person. However, if the evaluation is not done all at once, no more than one year should elapse between evaluating the same parts. For example, a clinic may have its organization, administration, and personnel and fiscal policies evaluated by a health care administrator(s) at the end of the fiscal year; and its utilization of clinic services, clinic records, and health care policies evaluated six months

later by a group of health care professionals.

If the facility has been operational for at least a year at the time of the survey and has not completed an evaluation of its total program, the surveyor must report this as a deficiency. If the facility has been operational for less than one year or is in the start-up phase, it is not required to complete a program evaluation. However, the clinic should have a written plan that specifies who is to do the evaluation, when it is to be done, how it is to be done, and what will be covered in the evaluation.

The evaluation must include a review of the following:

- Utilization of clinic services (including at least the number of patients served and the volume of services)
- A representative sample of both active and closed clinical records, and
- The clinic's health care policies

The purpose of the evaluation is to determine whether: the utilization of services was appropriate; the established policies were followed; and whether any changes are needed.

The clinic staff or a group of professional personnel must consider the findings of the evaluation and take corrective action if necessary. The Balanced Budget Act of 1997 requires RHCs to have a clinical quality assurance plan. However as of the writing of this manual, CMS had not published the rules outlining how RHCs can meet this requirement. Many State surveyors expect to see such a plan in the policy and procedures manual.

Once the clinic submits its Letter of Readiness to the State agency, the State agency has 90 days in which to schedule the RHC Certification Survey. Some clinics may experience a delay in the process depending on national initiatives and budget constraints.

The State agency does have the option, under certain conditions, of giving clinics a 48-hour notice of the scheduled survey. Some States, however, will not exercise this option and the survey will be unannounced. To ensure a successful survey, have a plan and prepare ahead. The following documents should be prepared and available to the surveyor.

Policy and Procedure Manual	MSDS Manual
All Professional Group, Staff, and Provider mtg. minutes	Minimum of 10 medical records (Medicare/Medicaid only) – mix of all life cycles and providers
Fire and Evacuation Training logs	CLIA Certificate
Exposure Control and Blood borne Pathogen Training	Quality Assurance and Performance Improvement Activity
Personnel Files	Preventative Maintenance Reports
X-ray Certificate (if applicable)	Laboratory Control Logs
Sample Drug Log	Diagnostic Results Tracking System

When the Certification Survey results in no deficiencies, the State agency has ten (10) calendar days to prepare the Survey Packet for the CMS Regional Office (RO) with a recommendation of approval. The RO has 60 days to review and approve the survey packet and issue the Medicare Provider Letter to the clinic. For those clinics that file their application as a Provider-based entity, the provider-based request must be submitted to the RO with the survey packet. The RO will make the Provider-based determination and will notify the appropriate Fiscal Intermediary via the Medicare Tie-In Notice.

Should the survey result in deficiencies or citations, a Statement of Deficiencies will be sent to the clinic by the State agency within ten (10) days of the survey. The clinic will have 10 days to develop a Plan of Correction (POC) and submit the POC back to the State agency. An initial applicant to the Medicare program cannot be certified or approved unless they are in compliance with the Conditions for Coverage. If in the judgement of the surveyor, the deficiencies evince non-compliance at the Condition level, then the applicant cannot be approved until those deficiencies have been corrected and the corrections have been verified through a follow-up survey. If there are deficiencies but they do not constitute non-compliance at the condition level, then the facility can be approved for participation with an approved plan of correction in place. A sample "Plan of Correction with Deficiencies" appears at the end of this chapter. The State agency will then review the POC for completeness.

Key elements to a POC include: it must be doable or realistic, it must have completion dates, it must specifically address the citation, and if appropriate, the clinic must be able to document proof of compliance. There are no time constraints placed on the State agency when reviewing a POC. Once the State agency has found the POC to be acceptable, they will submit the survey packet with recommendations to the RO. The RO has 60 days to review and approve the survey packet and issue the Medicare Provider Letter to the clinic. For those clinics that file their application as a Provider-based entity, the provider-based request must be submitted to the RO with the survey packet. The RO will make the Provider-based determination and will notify the Fiscal Intermediary via the Medicare Tie-In Notice.

Once the Medicare Provider Letter has been received by the clinic, the clinic is eligible to file a projected cost report and have their Medicare Rate determined. This will be covered in greater detail in the next chapter.

30 Most Common RHC Survey/Certification Deficiencies

Surveyor Code	CFR Section	Summary of Requirement
J20	491.6(a)	The clinic is constructed, arranged, and maintained to ensure access to and safety of patients, and provides adequate space for the provision of direct services.
J22	491.6(b)(1)	The clinic has a preventive maintenance program to ensure that all essential mechanical, electrical and patient-care equipment is maintained in safe operating condition.
J23	491.6(b)(2)	The clinic has a preventive maintenance program to ensure that drugs and biologicals are appropriately stored.
J24	491.6(b)(3)	The clinic has a preventive maintenance program to ensure that the premises are clean and orderly.
J26	491.6(c)(1)	The clinic assures the safety of patients in case of non-medical emergencies by training staff in handling emergencies.
J28	491.6(c)(3)	The clinic assures the safety of patients in case of non-medical emergencies by taking other appropriate measures that are consistent with the particular conditions of the area in which the clinic is located.
J32	491.7(a)(2)	The organization's policies and it's lines of authority and responsibilities are clearly set forth in writing.
J41	491.8(a)(6)	A physician, nurse practitioner, or physician's assistant is available to furnish patient care services at all times during the clinic's regular hours of operation. A nurse practitioner or a physician's assistant is available to furnish patient care services during at least 50 percent of the clinic's regular hours of operation.
J47	491.8(b)(2)	Physician responsibilities: In conjunction with the physician assistant and/or nurse practitioner member(s), the physician participates in developing, executing and periodically reviewing the clinic's written policies and the services provided to Federal program patients.
J48	491.8(b)(3)	Physician responsibilities: The physician periodically reviews the clinic's patient records, provides medical orders, and provides medical care services to the patients of the clinic.
J51	491.8(c)	Physician assistant and the nurse practitioner responsibilities. The physician assistant and the nurse practitioner members of the clinic's staff: I. Participate in the development, execution and periodic review of the written policies governing the services the clinic furnishes; II. Provide services in accordance with those policies; III. Arrange for, or refer patients to, needed services that cannot be provided at the clinic; IV. Assure that adequate patient health records are maintained and transferred as required when patients are referred; and V. Participate with a physician in a periodic review of the patient's health records.
J55	491.9(b)(1)	The clinic's health care services are furnished in accordance with appropriate written policies, which are consistent with applicable State law.

J56	491.9(b)(2)	The patient care policies are developed with the advice of a group of professional personnel that includes one or more physicians and one or more physician's assistants or nurse practitioners. At least one member of the group is not a member of the clinic's staff.
J57	491.9(b)(3)(iii)	The policies include guidelines for the medical management of health problems, which include the conditions requiring medical consultation and/or patient referral, the maintenance of health care records, and procedures for the periodic review and evaluation of the services furnished by the clinic.
J58	491.9(b)(4)	These policies are reviewed at least annually by the group of professional personnel as required under 491.9(b)(2), and reviewed as necessary by the clinic.
J61	491.9(c)(2)	The clinic provides basic laboratory services essential to the immediate diagnosis and treatment of the patient, including: 32. Chemical examinations of urine by stick or tablet methods or both (including urine ketones); 33. Hemoglobin or hematocrit; 34. Blood sugar; 35. Examination of stool specimens for occult blood; 36. Pregnancy tests; and 37. Primary culturing for transmittal to a certified laboratory.
J62	491.9(3)	The clinic provides medical emergency procedures as a first response to common life-threatening injuries and acute illness, and has available the drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids.
J70	491.10(a)(3)	For each patient receiving health care services, the clinic maintains a record that includes, as applicable: 1. Identification and social data, evidence of consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and brief summary of the episode, disposition, and instructions to the patient; 2. Reports of physical examinations, diagnostic and laboratory test results, and consultative findings; 3. All physician's orders, reports of treatments and medications and other pertinent information necessary to monitor the patient's progress; 4. Signatures of the provider or other health care professional.
J72	491.10(b)(1)	The clinic maintains the confidentiality of record information and provides safeguards against loss, destruction, or unauthorized use.
J76	491.11	Program evaluation
J77	491.11(a)	The clinic carries out, or arranges for, an annual evaluation of its total program.
J78	491.11(b)	Reviews included in evaluation
J79	491.11(b)(1)	The evaluation includes review of the utilization of clinic services, including at least the number of patients served and the volume of services.

J80	491.11(b)(2)	The evaluation includes review of a representative sample of both active and closed clinical records.
J81	491.11(b)(3)	The evaluation includes review of the clinic's health care policies.
J82	491.11(c)	Purpose of the evaluation
J83	491.11(c)(1)	The purpose of the evaluation is to determine whether the utilization of services was appropriate.
J84	491.11(c)(2)	The purpose of the evaluation is to determine whether the established policies were followed.
J85	491.11(c)(3)	The purpose of the evaluation is to determine whether any changes are needed.
J86	491.11(d)	The clinic staff considers the findings of the evaluation and takes corrective action if necessary.

Department of Health and Human Services
Center for Medicare and Medicaid Services

Form Approved

OMB No. 0938-0391

Statement of Deficiencies and Plan of Correction	(X1) Provider/Supplier/CLIA Identification Number	(X2) Multiple Construction A. Building_____________ B. Wing_______________	(X3) Date Survey Complete

Name of Facility	Street Address, City, State, Zip Code
Bartlett Tree Rural Health Clinic	123 Pear Street Fruitville, Pennsylvania 19026

(X4)ID Prefix Tag	Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LSC identifying information)	ID Prefix Tag	Providers's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)	(X)5 Completion Date

J 070	491.10(a) Element of Standard: Record System For each patient receiving health care services, the clinic maintains a record that includes (i) identification and social data, evidence of consent form, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient, and/or (ii) reports of physical examinations, diagnostic and laboratory test results, and consultative finds, and/or (iii) all physician's orders, reports of treatments and medications and other pertinent information necessary to monitor the patient's progress, and/or (iv) signature of the physician or other health care professional. This ELEMENT is not met as evidenced by: Ten records were reviewed. The following deficiencies are reflective of that review: Record #200 Social Data and Past Medical History was noted to be missing from the Record.	J 070	A social data, medical history form will be given to all patients	2/23/01

SAMPLE SAMPLE SAMPLE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans for correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Provider's Representative's Signature	Title	(X6) Date

SAMPLE

Department of Health and Human Services
Center for Medicare and Medicaid Services

Form Approved
OMB No.
0938-0391

SAMPLE

Statement of Deficiencies and Plan of Correction	(X1) Provider/Supplier/CLIA Identification Number	(X2) Multiple Construction A. Building____________ B. Wing______________	(X3) Date Survey Complete

Name of Facility	Street Address, City, State, Zip Code
Bartlett Tree Rural Health Clinic	123 Pear Street Fruitville, Pennsylvania, 19026

(X4)ID Prefix Tag	Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LSC identifying information)	ID Prefix Tag	Providers's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)	(X)5 Completion Date
J 070	12/04/00 - Complete vital signs were missing from the visit and the nursing entry was initialed not signed. It is standard nursing practice for entries made in the record to be signed with the first initial and last name, example: B. Pridnia, RN.	J 070	Vital signs will be taken on all patients. Nursing entries will be signed with first initial and full last name and title.	2/23/01
	Coumadin 2.5 MG QOD was ordered by the physician but not entered on the medication flow sheet		Problem lists will be updated. All medications will be entered onto the medication flow sheet.	2/23/01
	12/19/00 - Coumadin 2 MG QD except Monday was ordered by the physician, but not entered on the medication flow sheet.			
	Record #2001 12/10/00 - Medication persatine 75MG TID was called in to the pharmacy by the nurse practitioner and the verbal order was not countersigned by the physician.		All verbal orders will be signed by the physician.	2/23/01
	01/11/01 - Complete vital signs were missing from the visit and the nursing entry was initialed not signed. Diabeta ii 10MG BID was ordered by the physician but not entered on the medication flow sheet.		Problem list and medication flow sheet will be updated.	2/23/01

SAMPLE SAMPLE SAMPLE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans for correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Provider's Representative's Signature	Title	(X6) Date

SAMPLE

SAMPLE

SAMPLE

SAMPLE

Chapter Six

Completing the RHC Cost Report

Chapter Six – Completing the RHC Cost Report

This chapter will discuss the rural health clinic cost report, the process for filing the cost report, and an example of a completed cost report. It is intended to provide you with an overall summary of the cost reporting process. By also providing you with definitions of terms and a sample of a cost report, we hope to give you a better understanding of how the process works.

We cannot emphasize enough the importance of getting expert advice. Expert advice should be from individuals with experience with cost reports and specifically with the CMS-222 (or Schedule M) Cost Report, as it relates to issues such as calculation of FTE, reassignment of costs, and the completion of an independent or provider-based RHC Cost Report.

While it is possible for individual practices without significant experience to complete the cost report, in many instances there are multiple errors that occur and this is often to the financial detriment of the clinic. In addition, it is important to acknowledge that the accuracy of the data provided can have a significant financial impact on the year-end cost report. We, therefore, recommend getting appropriate expert advice when attempting to complete a Medicare Cost Report.

Form 222, the Medicare RHC cost report, (schedule M of the hospital, nursing home or home health cost report), is a required form that is completed on an annual basis by all rural health clinics.

The cost report is a statement of costs and provider utilization that occurred during the time period covered by the cost report. The cost report is the means by which Medicare determines how much money is due to the provider, or due back from the provider, for RHC services rendered to Medicare beneficiaries during the cost reporting period. The cost report typically covers a twelve (12) month period of time and is due five (5) months from the date of the end of the fiscal year of the RHC.

There are exceptions to the twelve (12) month period covered by a cost report. The exceptions would be due to the sale of the RHC or a change in ownership of the RHC during the twelve (12) month period; leaving a shorter time period than twelve (12) months that would be covered by the cost report. If a clinic experiences a change of ownership or decides to discontinue operation as an RHC, a cost report is due 150 days from the date of ownership change or RHC termination.

On July 26, 2002, the Centers for Medicare and Medicaid Services (CMS) published a proposed rule that, if adopted, would have required electronic submission of all RHC cost reports for cost reporting periods ending after December 31, 2002. As of the publication

of this book, that rule has not be finalized. The proposed rule indicated that exceptions would be available for providers who can demonstrate that electronic submission would represent a hardship. However, no details of the exception process were provided. The authors anticipate the proposed rule will be finalized and electronic submission of RHC costs reports will be mandatory at some point.

The maximum time period that can be covered by a filed cost report is thirteen (13) months. There are no extensions to file cost reports except under special circumstances, such as a natural disaster (i.e. flood, earthquake, fire, etc.). The Fiscal Intermediary generally will grant this type of extension. You can find a listing of the Fiscal Intermediaries for the independent RHC community in Appendix F.

As has been previously noted, there are two types of RHC's - Independent and Provider-based. Each must file a cost report, but the cost report is different for each of the two types of RHC's.

All Rural Health Clinics are presumed to be independent unless the clinic requests designation as a provider-based facility. Whereas, an independent RHC can be owned by any type of entity authorized under State law to own a medical practice: physicians; physician assistants; nurse practitioners; certified nurse midwives; hospitals; skilled nursing facilities; home health agencies; for-profit corporations; not-for-profit corporations; or government entities; only those entities recognized by Medicare as a "provider" can own a provider-based RHC. Entities designated by Medicare as providers are: hospitals, skilled nursing facilities, and home health agencies. Although this chapter will focus on the filing of an independent RHC cost report, the provider-based RHC cost report is very similar. A provider-based cost report is filed as a part of the sponsoring provider's cost report. It is prepared on Schedule M.

The following chart contains the title and explanation of each worksheet contained in the RHC cost report and gives an overview of Form HCFA-222.

Worksheet Title	Worksheet Description
Worksheet S	This is the statistical data and certification statement (requires original signature when submitted). The statistical data includes information such as: whether the cost report is based on actual or projected cost, time period covered, provider name, Medicare number, location, provider numbers of physicians/PAs/NPs/CNMs, operational control, hours of operation, etc.
Worksheet A Columns 1 & 2	Worksheet A is used to record the trial balance of expense accounts from the provider books and records for the cost reporting period stated. The total dollar amount of Column 1 and 2 should tie to the records of the provider for total expenses. (Column 1 is for compensation amounts, while column 2 reports amounts other than compensation). Column 3 is the total of Column 1 & 2. This worksheet also provides for the necessary reclassifications (Column 4) and adjustments (Column 6) to certain accounts.
Worksheet A-1 Column 4	This worksheet provides for reclassification of any amounts in order to reflect the proper cost allocation in a given cost center. This worksheet "moves" certain amounts from one cost center to another cost center. Supporting documentation is needed for each reclassification made on this worksheet.
Worksheet A-2 Column 6	This worksheet provides for adjustments, which are necessary under the Medicare principles of reimbursement. Types of items to be entered on this Worksheet are 1) those needed to adjust expenses incurred {accrual accounting} 2) those that represent recovery of expenses through refunds, sales, etc. 3) those needed to adjust expenses that are non-allowable for Medicare purposes 4) those needed to adjust expenses in accordance with offsets from "other/miscellaneous" income received. Supporting documentation is needed for each adjustment made on this worksheet.
Worksheet A-2-1 Column 6 Flows thru Worksheet A-1	This worksheet flows into the above worksheet A-2 at the net amount of the total adjustment. It provides for information and amounts on related parties of the organization including costs applicable to services, facilities, and supplies furnished to providers by a related organization or by common ownership. This worksheet allows for any adjustments that are needed to reduce related party transactions amounts to allowable Medicare amounts.
Worksheet B	This worksheet is used to summarize the number of facility visits to be used in the rate determination. The visits include the visits furnished by the provider's health care staff and any physicians under agreement. This worksheet also calculates the overhead cost incurred which applies to the services.
Worksheet B-1	The cost and administration of Pneumococcal and Influenza vaccines to Medicare beneficiaries are 100 percent reimbursable by Medicare. This worksheet calculates the cost per injection of each of these vaccines and determines the total amount of reimbursement for the vaccines administered to Medicare beneficiaries.
Worksheet C	This worksheet provides for the determination of the provider's cost per visit and calculates the total amount due the provider or due the intermediary. Part I calculates the cost per visit and Part II determines the total Medicare payment due the provider for services furnished to Medicare beneficiaries. This worksheet also allows the provider to claim reimbursement for bad debts related to uncollectible Medicare deductible and coinsurance amounts.

The following is information that needs to be gathered in order to complete a rural health clinic cost report.

1. Financial statements for the cost reporting period; to include the trial balance.

2. Total number of visits for the cost reporting period for each of the following health care providers (individual by name):

   A. Physicians
   B. PAs/NPs/CNMs
   C. Any Other Health Care Providers (list on worksheet by name and title)

   Total visits broken down by the following, per health care provider listed above (See Table 6-1 for a sample visit log worksheet).

   I. Medicare Visits
   II. Regular Medicaid Fee-For-Service Visits
   III. Crossover Visits (Medicare Primary and Regular Medicaid Secondary)
   IV. Medicaid HMO (Qualified Health Plan) Visits per each HMO Crossover Visit (Medicare Primary and Medicaid HMO Secondary per each HMO)
   V. Private Visits (workers' comp., commercial, self pay, sliding fee, etc.)

Table 6-1

Sample Visit Log Worksheet

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7	Column 8	Column 9	Column 10
Name of Provider	Medicare Visits (1)	Regular FFS Medicaid Visits (2)	Medicare Primary & FFS Medicaid Secondary (3)	Medicaid HMO #1 (4)	Medicare Primary & Medicaid HMO #1 Secondary (5)	Medicaid HMO #2 (4)	Medicare Primary & Medicaid HMO #2 Secondary (5)	Private Visits (6)	TOTAL
Dr. A	843	101	15	416	0	215	0	2,583	4,158
Dr. B	992	183	22	521	0	201	0	2,995	4,892
PA A	375	51	11	126	0	99	0	1,199	1,850
TOTALS	2,210	335	48	1,063	0	515	0	6,777	10,900

3. The clinic's hours of operation per week.

4. Individual average hours worked per week for the following health care providers:
   1. Physicians
   2. PA/NP's
   3. Any Other Health Care Providers

5. Total average hours worked per week for each of the above health care providers (See Table 6-2 for a sample time log worksheet) broken down by the following:
   1. Administrative hours

2. Patient Care hours
3. Inpatient hours

Table 6-2

	Column 1	Column 2	Column 3	Column 4	Column 5	Column6
Name of Provider	Administrative Hours Worked per week	Patient Care Hours Worked per week	Inpatient Hours Worked per week	Total Hours Worked pr week (sum of Column 1, 2, & 3)	Number of months worked in the cost reporting year	FTE Calculation
Dr. A	11.0	34.0	0.0	45.0	12	0.85
Dr. B	5.0	40.0	0.0	45.0	12	1.00
PA A	8.0	32.0	0.0	40.0	12	0.80
Total FTE.						2.65

Note: To calculate the FTE for each provider, multiply Patient Care Hours Worked (Column 2) by 52 weeks in the year. Multiply this number by the number of months worked by the provider during the cost reporting year (Column 5). You then divide this number by number of months in the cost reporting period (typically 12) and then divide this number by 2,080 working hours in the year.

For Dr. A in the example, the calculation would be:

1.	34.0 x 52	=	1,768
2.	1,768 x 12	=	21,216
3.	21,216/12	=	1,768
4.	1,768/2,080	=	.85

Job titles and wages should be broken down for all employees of the RHC for the cost reporting period. Be specific for those employees related to a lab technician job description for actual hours worked as “lab tech” and other hours worked.

Please see #12 for detailed information related to “Lab Tech” wages and time.

Fringe Benefits and Employer related payroll taxes of each employee.

6. Total number of vaccines given for the following vaccinations for all insurances totaled together:
   A. Pneumovax
   B. Influenza

   Total number of above vaccines given - broken down by the following:

   I. Medicare vaccines given for Pneumo and Influenza listed separately.
   I. Medicaid vaccines given for Pneumo and Influenza listed separately.
   II. Vaccine logs for Medicare Pneumovax and Influenza vaccines to include Patients name, HIC Number, and Date of Injection to support the above Medicare vaccinations.
   III. Cost per dose of each vaccine.

7. Payments Received for the following:

   A. Medicare Payments
   B. Medicaid Straight or Regular FFS Payments
   C. Medicaid HMO Payments per each HMO
   D. Medicare Crossover Payments made by Medicare
   E. Medicaid Crossover Payments made by Medicare
   F. Medicaid Other Third Party Payments (i.e. primary insurance's, besides Medicare, that have paid when Medicaid is the secondary insurance)
   G. Medicare Beneficiary Deductible Received (Payments made by the Medicare Patient)

8. Any new assets purchased? If so, submit the following:

   A. Date Asset Purchased
   B. Description of Asset
   C. Cost of Asset
   D. Depreciation Schedule to match depreciated expenses in Financial Statement

9. Listing of Medicare Bad Debts with Medicare Patients, to include the following information:

   A. Beneficiary Name
   B. Beneficiary HIC Number
   C. Date(s) of Service
   D. Date of First Bill
   E. Medicare Paid Date
   F. Date of Write-Off
   G. Amount of Debt
   H. Medicare Deductible and Coinsurance amount
   I. Medicaid Payment Amount

   In order to be considered "allowable bad debt", debt must be written off during cost reporting period.

   NOTE: Reasonable collection efforts may be waived for Medicare indigent patients. A Medicare beneficiary who also qualifies for Medicaid may be considered indigent automatically. For other Medicare beneficiaries, the provider should apply its customary practices for determining indigency. Please refer to PRM Section 312 for the factors, which should be incorporated into the provider's indigency guidelines. The bad debt for an indigent patient may be written off and claimed upon discharge or upon the determination of indigency, whichever is later. If indigency is determined, please indicate Medicaid number of recipient, if applicable, to claim as bad debt to Medicare.

10. Copy of PSR from Medicare Fiscal Intermediary to compare clinic visit and payment information for the cost reporting period.

11. Listing of each Medicaid HMO (QHP) contracted with to include the following information:

A. Name of Medicaid HMO (QHP)
B. Address of Medicaid HMO (QHP)
C. Contact and phone number of HMO (QHP)
D. Provider Number of HMO (QHP)
E. Total the number of members assigned per each HMO (QHP) for each month of the cost reporting period – these numbers are then added up to make one complete total for the entire year.
F. Visits and Payments broken down per Medicaid HMO (QHP) by capitation payments and FFS payments.

12. **Please Note:** Information is needed for any "Lab Tech" personnel employed/contracted by the clinic not solely considered a lab tech and who provides services outside of lab tech services; please break hours down for the year based on description of job performed by lab tech duties vs. all other RHC duties (2 categories needed): Other duties include, but are not limited to; billing, administrative, nursing, medical assistant, etc. This is only needed for lab tech's that perform other job functions other than lab technician services, as any cost beginning January 1, 2001 related to lab tech services is a non-allowable RHC cost. See Program Memorandum A-00-30 in Appendix F. Please be advised that Program Memos are updated regularly so you should make sure that policies have not been changed since the publication of this manual.

SAMPLE

FORM APPROVED
OMB NO: 0938-0107

INDEPENDENT RURAL HEALTH CLINIC/FREESTANDING FEDERALLY QUALIFIED HEALTH CENTER WORKSHEET STATISTICAL DATA AND CERTIFICATION STATEMENT

WORKSHEET S - PART I

For intermediary Use

Date Received

This report is required by law (42 USC. 1395g: CFR 413.20(b)). Failure to report can result in all payments made during the reporting period being deemed overpayments (42 (USC 1395g).

Intermediary Number

PART I - STATISTICAL DATA [ ] Projected Cost Report [X] Actual/Final Cost Report

1. Facility Name and Address *Rose Hips RHC*
123 Main St.
Anywhere, USA

1a. County *Cork*

2. Facility Number 12-3456

3. Designation *Rural*

4. Reporting Period From *01/01/2002* To *12/31/2002*

5. Type of Control (Check One) *Proprietary Corporation*

A. Voluntary Non Profit
[ ] Corporation
[ ] Other (specify)

B. Proprietary
[ ] Individual
[ ] Partnership
[*X*] Corporation
[ ] Other (specify)

C. Government
[ ] Federal
[ ] County
[ ] State
[ ] Other
[ ] City

6. Source of Federal Funds	GRANT AWARD NUMBER	DATE
A. Community Health Center (Section 330(d), Public Health Service Act)		
B. Migrant Health Center (Section 329(d), PHS Act)		
C. Health Services for the Homeless (Section 340(d), PHS Act)		
D. Appalachian Regional Commission		
E. Look-Alikes		
F. Other (Specify)		

7. Names of Physicians Furnishing Services At the Health Facility or Under Agreement (As described in Instructions) And Medicare Billing Numbers (Include All Part B Billing Numbers)

Name	Billing Number
Dr. A	*123456*
Dr. B	*654321*

8. Supervisory Physicians

Name	Hours of Supervision For Reporting Period
Dr. A	*572*
Dr. B	*260*

SAMPLE
SAMPLE
SAMPLE
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SAMPLE
SAMPLE
SAMPLE
SAMPLE
SAMPLE

INDEPENDENT RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER WORKSHEET
STATISTICAL DATA AND CERTIFICATION STATEMENT

WORKSHEET S
PART I (Cont.) &
PART II

PART I (CONTINUED) - STATISTICAL DATA

9. If the facility operates as other than an RHC or FQHC (i.e. as a physician office, independent laboratory, etc.) check yes and specify what type of operation and what days and house RHC/FQHC services and other than RHC or FQHC services are provided at the facility as instructed below.

YES [**X**] NO [ ]

Type of Operation ______Private Physician Office______________________

Identify days and hours by listing the time the facility operates as an RHC or FQHC next to the applicable days

Sunday			Thursday	Start: 900	End: 1700
Monday	Start: 0900	End : 1700	Friday		
Tuesday	Start: 0900	End: 1700	Saturday		
Wednesday	Start: 0900	End: 1700			

Identify days and hours by listing the time the facility operates as other than an RHC or FQHC next to the applicable day(s)

Sunday	Thursday			
Monday	Friday	Start: 900	End: 1700	**see ↑ below**
Tuesday	Saturday			
Wednesday				

PART II - CERTIFICATION BY OFFICER OR ADMINISTRATOR

Misrepresentation or Falsification of Any Information Contained in this Cost Report May Be Punishable by Criminal, Civil and Administrative Action, Fine And/or Imprisonment under Federal Law. Furthermore, If Services Identified in this Report Were Provided or Program Through the Payment Directly or Indirectly of a Kickback or Where Otherwise Illegal, Criminal, Civil and Administrative Action, Fines And/or Imprisonment May Result.

CERTIFICATION BY OFFICER OR ADMINISTRATOR

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report prepared by _______*Rose Hips RHC, Inc., 12-3456*_________(Provider Name and Number) for the Cost report period beginning _____*1/1/02*______ and ending _____*12/31/02*______ and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the Provider in accordance with the laws and regulations regarding the Provider in accordance with the laws and regulations regarding the provision of health care services and that the services identified in this cost report are provided in compliance with such laws and regulations.

____
(Signed)

Officer or Administrator of Facility Title Date

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a request of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0107. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare and Medicaid Services, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

FORM CMS-222-92 (10/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB.15-11, SECTIONS 2903 AND 2903.2)

Sample

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES	Facility No. *12-3456*	Reporting Period From *1/1/02* To *12/31/02*	WORKSHEET A Page 1

	COST CENTER	Compen-sation	Other	Total (Col. 1+2)	Reclassi fications	Reclassified Trial Balance (Col. 3+/-4)	Adjustments Increases (Decreases	Net Expenses (Col. 5+/-6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	430,000		430,000	-127,090	302,910		302,910	1
2	Physician Assistant	78,000		78,000	-24,960	53,040		53,040	2
3	Nurse Practitioner								3
4	Visiting Nurse								4
5	Other Nurse	92,000		92,000	-18,400	73,600		73,600	5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Technician	9,000		9,000	-9,000				8
9	Other (Specify)								9
10									10
11									11
12	Subtotal-Facility Health Care Staff Costs	609,000		609,000	-179,450	429,550		429,550	12
	COSTS UNDER AGREEMENT								
13	Physician Services Under Agreement								13
14	Physician Supervision Under Agreement								14
15									15
16	Subtotal Under Agreement (Lines 13-15)								16
	OTHER HEALTH CARE COSTS								
17	Medical Supplies		51,000	51,000	-4,400	46,600		46,600	17
18	Transportation (Health Care Staff)		1,000	1,000	-200	800		800	18
19	Depreciation-Medical Equipment		12,000	12,000	-2,400	9,600		9,600	19
20	Professional Liability Insurance		8,500	8,500	-1,700	6,800		6,800	20
21	Other (Specify)								21
22									22
23									23
24	Subtotal-Other Health Care Costs (Line 17-23)		72,500	72,500	- 8,700	63,800		63,800	24
25	Total Cost of Services (Other than Overhead and Other RHC/FQHC Services) Sum of Lines 12, 16, And 24	609,000	72,500	681,500	-188,150	493,350		493,350	25
	FACILITY OVERHEAD-FACILITY COST								
26	Rent		90,000	90,000		90,000	-90,000		26
27	Insurance		5,500	5,500		5,500		5,500	27
28	Interest On Mortgage Or Loans		500	500		500	2,200	2,700	28
29	Utilities		4,500	4,500		4,500		4,500	29

Sample

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES	Facility No. *12-3456*	Reporting Period From *1/1/02* To *12/31/02*	WORKSHEET A Page 2

Line	COST CENTER	Compen-sation	Other	Total (Col. 1+2)		Reclassifications		Reclassified Trial Balance (Col. 3+/-4)	Line
		1	2	3	4	5	6	7	
30	Depreciation - Buildings And Fixtures						8,500	8,500	30
31	Depreciation - Equipment								31
32	Housekeeping And Maintenance		22,500	22,500		22,500		22,500	32
33	Property Tax						3,000	3,000	33
34	Other (Specify)								34
35									35
36									36
37	Subtotal - Facility Costs (Lines 26-36)		123,000	123,000		123,000	- 76,300	46,700	37
	FACILITY OVERHEAD-ADMINISTRATIVE COSTS								
38	Office Salaries	143,000		143,000	92,045	235,045		235,045	38
39	Depreciation-Office Equipment		4,500	4,500		4,500		4,500	39
40	Office Supplies		21,500	21,500		21,500		21,500	40
41	Legal		4,500	4,500		4,500		4,500	41
42	Accounting		32,000	32,000		32,000		32,000	42
43	Insurance (Specify)		8,700	8,700		8,700		8,700	43
44	Telephone		9,000	9,000		9,000		9,000	44
45	Fringe Benefits and Payroll Taxes		75,000	75,000	-42,095	32,905		32,905	45
46	Other (Specify) *Consulting*		2,500	2,500		2,500		2,500	46
47	*meeting expenses*		550	550		550		550	47
48	*answering services*		3,000	3,000		3,000		3,000	48
48 1	*transcription*		1,500	1,500		1,500		1,500	48 1
49	Subtotal - Administrative Costs (Lines 38-48)	143,000	162,750	305,750	49,950	355,700		355,700	49
50	Total Overhead (Lines 37-49)	143,000	285,750	428,750	49,950	478,700	-76,300	402,400	50
	COST OTHER THAN RHC/FQHC SERVICES								
51	Pharmacy								51
52	Dental								52
53	Optometry								53
54	Other (Specify) *X-Ray Costs*	10,000	11,000	21,000		21,000		21,000	54
55	*EKG Costs*	10,000	5,000	15,000		15,000		15,000	55
56									56
57	Subtotal-Cost Other than RHC/FQHC (Lines 5-56)	20,000	16,000	36,000		36,000		36,000	57
	NON-REIMBURSABLE COSTS (Specify)								
58	*Non-RHC Lab Services*				10,500	10,500		10,500	58
59	*Non-RHC Private Practice*				127,700	127,700		127,700	59
60									60
61	Subtotal Non-Reimbursable Costs (Lines 58-60)				138,200	138,200		138,200	61
62	TOTAL COSTS (Sum Of Lines 25,50,57, AND 61) see Ï below	772,000	374,250	1,146,250		1,146,250	- 76,300	1,069,950	62

FORM CMS 222-93 (3/93) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-11, SECTION 2904)

Reclassification	Facility No. *12-3456*	Reporting Period From *1/1/02* To *12/31/02*	WORKSHEET A-1

Explanation of Entry	Code (1)	Increase	Decrease

Sample

			Cost Center	Line No.	Amount (2)	Cost Center	Line No.	Amount (2)	
		1	2	3	4	5	6	7	
1	Non-RHC Private Physician Recl	A	Non-RHC Private Practice	59	86,000	Physician	1	86,000	1
2	Non-RHC Private Physician Recl	B	Non-RHC Private Practice	59	15,600	Physician Assistant	2	15,600	2
3	Non-RHC Private Physician Recl	C	Non-RHC Private Practice	59	18,400	Other Nurse	5	18,400	3
4	Non-RHC Private Physician Recl	D	Non-RHC Private Practice	59	3,400	Medical Supplies	17	3,400	4
5	Non-RHC Private Physician Recl	E	Non-RHC Private Practice	59	200	Transportation - Health Care Staff	18	200	5
6	Non-RHC Private Physician Recl	F	Non-RHC Private Practice	59	2,400	Depreciation - Medical Equipment	19	2,400	6
7	Non-RHC Private Physician Recl	G	Non-RHC Private Practice	59	1,700	Professional Liability Insurance	20	1,700	7
8	Reclass Non-RHC Lab Reallocation	H	Non-RHC Lab Allocation	58	9,000	Laboratory Technician	8	9,000	8
9	Reclass Non-RHC Lab Reallocation	I	Non-RHC Lab Allocation	58	500	Fringe Benefits and Payroll Taxes	45	500	9
10	Reclass Non-RHC Lab Reallocation	J	Non-RHC Lab Allocation	58	1,000	Medical Supplies	17	1,000	10
11	Reclass Dr. A Admin. Wages	K	Office Salaries	38	52,556	Physician	1	52,556	11
12	Reclass Dr. B Admin Wages	L	Office Salaries	38	23,889	Physician	1	23,889	12
13	Reclass PA Admin Wages	M	Office Salaries	38	15,600	Physician Assisstant	2	15,600	13
14	Reclass Pt. Care of FB/Payroll	N	Physician	1	16,244	Fringe Benefits and Payroll Taxes	45	16,244	14
15	Reclass Pt. Care Portion of FB	O	Physician	1	19,111	Fringe Benefits and Payroll Taxes	45	19,111	15
16	Reclass Pt. Care Portion of FB	P	Physician Assistant	2	6,240	Fringe Benefits and Payroll Taxes	45	6,240	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34
35									35
36	TOTAL RECLASSIFICATION (Sum of Column 4 must equal sum of Column 7)				271,840			271,840	36

(1) A Letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
(2) Transfer to Worksheet A, Col 4, line as appropriate.

FORM CMS-222-92 (3/930 (3/93) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-11, SECTION 2905

Sample

ADJUSTMENTS TO EXPENSES	Facility No. *12 - 3456*		Reporting Period From *1/1/02* To *12/31/02*	WORKSHEET A-2
Description (1)	Basis for Adjustment (2)	Amount	Expense Classification of Worksheet A from which amount is to be deducted or to which the amount is to be added — Cost Center	Line No.
	1	2	3	4
1 Investment Income on commingled restricted and unrestricted funds (chapter 2)				
2 Trade, quantity and time discounts on purchases (chapter 8)	B			
3 Rebates and refunds of expenses (chapter 8)	B			
4 Rental of building or office space to others				
5 Home office costs (chapter 21)				
6 Adjustment resulting from transactions with related organizations (chapter 10)	From Supp. Wkst. A-2-1	-76,500		
7 Vending machines				
8 Practitioner Assigned by National Health Service Corps				
9 Depreciation - Buildings and Fixtures			Depreciation	30
10 Depreciation - Equipment			Depreciation	31
11 Other (Specify) *Interest Income*	B	200	Interest on Mortgage or Loans	28
12 Total		- 76,300		

(1) Description - all line references in this column pertain to CMS Pub. PRM 15-1.
(2) Basis for Adjustment (SEE INSTRUCTIONS)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined.

FORM CMS-222-92 (3/93) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTION 2906)

Sample

VISITS AND OVERHEAD COST FOR RHC/FQHC SERVICES	Facility No. *12-3456*	Reporting Period From *1/1/02* To *12/31/02*	WORKSHEET B PARTS I & II

PART I VISITS AND PRODUCTIVITY	Part A - Visits and Productivity				
	1	2	3	4	5
Positions	Number of FTE Personnel	Total Visits see Ð below	Productivity Standard	Minimum Visits Col. 1 X Col. 3	Greater of Col. 2 or Col. 4
1. Physicians see Ñ below	1.85	9,050	4200	7,770	
2. Physician Assistants see Ñ below	.80	1,850	2100	1,680	
3. Nurse Practitioners			2100		
4. Subtotal (Sum of Lines 1 - 3)	2.65	10,900		9,450	10,900
5. Visiting Nurse					
6. Clinical Psychologists					
7. Clinical Social Worker					
8. Total Staff	2.65	10,900			10,900
9. Physician Services Under Agreement					

PART II - DETERMINATION OF TOTAL ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10. Cost of RHC/FQHC Services - excluding overhead - (W/S A, Col. 7, Line 25)	493,350
11. Cost of Other than RHC/FQHC Services - Excluding overhead (W/S A, Col. 7, Sum of Lines 57 and 61	174,200
12. Cost of All Services - excluding overhead - (Sum of Lines 10 and 11)	667,550
13. Ratio of RHC/FQHC Services (Line 10 Divided by Line 12)	0.739046
14. Total Overhead - (W/S A, Col. 7, Line 50)	402,400
15. Overhead applicable to RHC/FQHC Services (Line 13 x Line 14)	297,392
16. Total Allowable Cost of RHC/FQHC Services (Sum of Lines 10 and 15)	790,742

Sample

FORM CMS-222-92 (8/94) INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-11 SECTIONS 2907 THRU 2907.2

DETERMINATION OF MEDICARE REIMBURSEMENT	Facility No. *12-3456*	Reporting Period From *1/1/02* To *12/31/02*	WORKSHEET C PART 1

	PART I - DETERMINATION OF RATER FOR RHC/FQHC SERVICES			Amount	
1	Total Allowable Cost (Worksheet B, Part II, Line 16			790,742	1
2	Cost of Pneumococcal and Influenza Vaccine and Its (their) Administration (From Supplemental Worksheet B-1, Line 15)			7,982	2
3	Total Allowable Cost Excluding Pneumococcal and Influenza Vaccine (Line 1 - Line 2)			782,760	3
4	Greater of Minimum Visits or Actual Visits by Health Care Staff (Worksheet B, Part 1, Column 5, Line 8)			10,900	4
5	Physicians Visits Under Agreement				5
6	Total Adjusted Visits (Line 4 + Line 5)			10,900	6
7	Adjusted Cost Per Visit (Line 3 divided by Line 6)			71.81	7
		1	2	3	8
8	Maximum Rate Per Visit (See Instructions)	64.78	0.00		
9	Rate For Medicare Covered Visits (Lessor of Line 7 or Line 8)	64.78	0.00		9

Sample Sample Sample Sample Sample Sample Sample

DETERMINATION OF MEDICARE PAYMENT		Facility No. *12-3456*	Reporting Period From *1/1/02* To *12/31/02*	WORKSHEET C PART II	
PART II - DETERMINATION OF TOTAL PAYMENT		1	2	3	
10	Rate for Medicare Covered Visits (Part 1, Line 9)	64.78	0.00		10
11	Medicare Covered Visits Excluding Mental Health Services (From Intermediary Records)	2,210		2,210	11
12	Medicare Cost Excluding Costs for Mental Health Services (Line 10 multiplied by Line 11)	143,164		143,164	12
13	Medicare Covered Visits for Mental Health Services (From Intermediary Records)				13
14	Medicare Covered Costs for Mental Health Services (Line 10 multiplied by Line 13)				14
15	Limit Adjustment (Line 14 multiplied by 62 ½ percent) (see instructions)				15
16	Total Medicare Cost (Line 12 plus Line 15)	143,164		143,164	16
17	Less: Beneficiary Deductible (From Intermediary Records)	14,430		14,430	17
18	Net Medicare Cost Excluding Pneumococcal and Influenza vaccine and its (their) Administration (Line 16 minus line 17)	128,734		128,734	18
19	Reimbursable Cost of RHC/FQHC Services, Other than Pneumococcal and Influenza Vaccine (80 percent multiplied by line 18, Column 3)			102,987	19
20	Medicare Cost of Pneumococcal and Influenza Vaccine and its (their) Administration (From Supp. Worksheet B-1, Line			2,927	20
21	Total Reimbursable Medicare Cost (Line 19 plus Line 20)			105,914	21
22	Less Payments to RHC/FQHC During Reporting Period			71,582	22
23	Balance Due To/From the Medicare Program Exclusive of Bad Debts (Line 21 less Line 22)			34,332	23
24	Total Reimbursable Bad Debts, Net of Bad Debt Recoveries (From Provider Records)			555	24
25	Total Amount Due To/From the Medicare Program (Line 23 plus Line 24)			34,887	25

FORM CMS-222-93 (10/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTIONS 3908 AND 2908.2

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS	Facility No. *12-3456*	Reporting Period From *1/1/02* To *12/31/02*	SUPPLEMENTAL WORKSHEET A-2-1 PARTS I-III

Part I. Are there any costs included on Worksheet A which resulted from transactions with related organizations as defined in the Provider Reimbursement Manual, Part I, Chapter 10?

[**X**] Yes [ ] No (If "Yes", complete Parts II and III)

Part II Costs incurred and adjustments required as result of transactions with related organizations:

LOCATION AND AMOUNT INCLUDED ON WORKSHEET A, COLUMN 6					AMOUNT ALLOWABLE IN COST **See Ò below**	NET ADJUSTMENT (COL. 4 MINUS COL. 5)	
	Line No.	Cost Center	Expense Items	AMOUNT			
	1	2	3	4	5	6	
1	26	Rent	Rent	90,000		90,000	1
2	33	Property Tax	Property Tax		3,000	-3,000	2
3	30	Depreciation - Bldg	Depreciation - Bldg		8,500	-8,500	3
4	28	Interest on Mortgage	Interest		2,000	-2,000	4
5	Totals (sum of lines 1-4) Transfer col. 6, line 1-4 to Wkst. A, col. 6 as appropriate) (Transfer col. 6, line 5 to Wkst. A-2, col. 2, line 6, Adjustment to Expenses)			90,000	13,500	75,500	5

Part II Interrelationship of facility to related organization (s):

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires the

provider to furnish the information requested on Part III of this worksheet.

This information is used by the Centers for Medicare & Medicaid Services and its intermediaries in determining that the costs applicable to services, facilities, and supplies by organizations related to you by common
ownership or control, represent reasonable costs as determined under section 1861 of the Social Security Act.
If the provider does not provide all or any part of the requested information, the cost report is considered
incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

	SYMBOL (1)	Name	Percentage of Ownership	RELATED ORGANIZATION (S) Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
1	A	Dr. A	50.00	Rose Hips RHC, Inc.		Private Practice	1
2	A	Dr. B	50.00	Rose Hips RHC, Inc.		Private Practice	2
3							3
4							4

(1) Use the following symbols to indicate interrelationship to related organizations

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in the provider;
B. Corporation, partnership, or other organization has financial interest in the provider;
C. Provider has financial interest in corporation, partnership, or other organization(s);
D. Director, officer, administrator, or key person of the provider or relative of such person has financial interest in related organization;
E. Individual is director, officer, administrator, or key person of the provider and related organization;
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in the provider;
G. Other (financial or non-financial) specify ___________________________________

FORM CMS-222-92 (3/93) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2909

CALCULATION AND TOTAL OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Facility No. *12-3456*	Reporting Period From *1/1/02* To *12/31/02*	SUPPLEMENTAL WORKSHEET B-1

	PART 1 - CALCULATION OF COST	PNEUMOCOCCAL	INFLUENZA	
1	Health Care Staff Cost (Worksheet A, Column 7, Line 12)	429,550	429,550	1
2	Ratio of Pneumococcal and Influenza Vaccine Staff Time to Total Health Care Staff Time (see Ó below)	.009071		2

3	Pneumococcal and Influenza Vaccine Health Care Staff Cost (Line 1x Line 2)	3,896		3
4	Medical Supplies Cost - Pneumococcal and Influenza Vaccine (From Your Records)	500		4
5	Direct Cost of Pneumococcal and Influenza Vaccine (Sum of Lines 3 & 4)	4,396		5
6	Total Direct Cost of the Facility (Worksheet A, Column , Line 50)	493,350	493,350	6
7	Total Facility Overhead (Worksheet A, Column 7, Line 50)	402,400	402,400	7
8	Ratio of Pneumococcal and Influenza Vaccine Direct Cost to Total Direct Cost (Line 5 divided by Line 6)	.008911		8
9	Overhead Cost - Pneumococcal and Influenza Vaccine (Line 7 x Line 8)	3,586		9
10	Total Pneumococcal and Influenza Vaccine Cost and Its (Their) Administration (Sum of Lines 5 & 9)	7,982		10
11	Total Number of Pneumococcal and Influenza Vaccine Injections (From Provider Records)	300		11
12	Cost Per Pneumococcal and Influenza Vaccine Injection (Line 10 divided by Line 11)	26.61		12
13	Number of Pneumococcal and Influenza Vaccine Injections Administered to Medicare beneficiaries	110		13
14	Medicare cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration (Line 12 Multiplied by Line 13)	2,927		14
15	Total Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration (Sum of Line 10, Columns 1 and 2) Transfer to Wkst. C, Part I, Line 2		7,982	15
16	Total Medicare Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration (Sum of Line 14, Columns 1 and 2) Transfer to Wkst. C, Part II, Line 20		2,927	16

A-1 RECLASSIFICATION SUPPORTING DOCUMENTATION

- Note: Below are the calculations to support the A-1 reclassifications on the reclassification page of the cost report. When filing a cost report with your fiscal intermediary, supporting calculations must be submitted on a separate, clearly identified document.

Rural Health Clinic hours (9-5 M-TH)	32.00 hours	80.00 percent RHC Hours
Private Physician Hours (9-5 F)	8.00 hours	20.00 percent Non RHC Hours
Total Clinic Hours	40.00 hours	100.00 percent Total Hours

Expense from column 1 & 2:	Amount	Percent Non-RHC	Amount Non-RHC
Physicians Compensation	$430,000	20.00 percent	$ 86,000
Physician Assistant	78,000	20.00 percent	15,600
Other Nurse	92,000	20.00 percent	18,400
Medical Supplies	17,000	20.00 percent	3,400
Transportation	1,000	20.00 percent	200
Depreciation	12,000	20.00 percent	2,400
Professional Liability Insurance	8,500	20.00 percent	1,700
	-------------		-------------
	$638,500		$127,700

As of January 1, 2001 all costs associated with Laboratory are Non-RHC costs	$ 9,000
As of January 1, 2001 all costs associated with Laboratory are Non-RHC costs	500
As of January 1, 2001 all costs associated with Laboratory are Non-RHC costs	1,000

	Total Hours Per Week	Admin Hours Per Week	Pt. Care Hours Per Week	Total Gross Wage	Total Fringe Benefit	Portion of Total = Administrative
Dr. A	45.00	11.0 (24.44 percent)	34.0	$ 215,000		$ 52,556
Dr. B	45.00	5.0 (11.11 percent)	40.0	$ 215,000		$ 23,889
C, PA	40.00	8.0 (20.00 percent)	32.0	$ 78,000		$ 15,600

	Total Hours Per Week	Admin Hours Per Week	Pt. Care Hours Per Week	Total Gross Wage	Total Fringe Benefit	Portion of Total = Administrative
Dr. A	45.00	11.0 (24.44 percent)	34.0		$ 21,500	$ 16,244
Dr. B	45.00	5.0 (11.11 percent)	40.0		$ 21,500	$ 19,111
C, PA	40.00	8.0 (20.00 percent)	32.0		$ 7,800	$ 6,240

The following explanations are provided so you can see how some of the various numbers were calculated.

1 With respect to the care of Medicare beneficiaries, an RHC may not function concurrently as an RHC and a private practitioner's office during the same hours of operation. Specific dates and/or times can be designated as either RHC or private practitioner (as shown above). The concurrent use of personnel, space, services and/or supplies for Medicare patients for both RHC and non-RHC purposes is referred to as commingling.

2 Total Expenses - Total expenses of $1,146,250 tie directly to the provider's accounting records (i.e. general ledger/trial balance).

3 Total visits reported above should only include face-to-face encounters with the physician, physician assistant, nurse practitioner, nurse midwife, clinical psychologist, clinical social worker for the cost reporting period. You should include all the visits that take place in the clinic during rural health clinic hours, as well as home visits and nursing home (non SNF) visits made to clinic patients. Total visits should not include inpatient hospital services.

4 FTE Calculations

Dr. A - 34.0 patient care hours worked per week, multiplied by 52 weeks in the year, multiplied by 12 months worked in the year, divided by 12 months available in the cost reporting year, divided by 2,080 hours available to work in the year = .85 FTE

Dr. B - 40.0 patient care hours worked per week, multiplied by 52 weeks in the year, multiplied by 12 months worked in the year, divided by 12 months available in the cost reporting year, divided by 2,080 hours available to work in the year = 1.00 FTE

C, PA - 32.0 patient care hours worked per week, multiplied by 52 weeks in the year, multiplied by 12 months worked in the year, divided by 12 months available in the cost reporting year, divided by 2,080 hours available to work in the year = .80 FTE

5 Related Party Transactions

Related Party Transactions must be reduced to cost. In this example, Dr. A & Dr. B are 50 percent shareholders of the clinic. Both Drs. Own the building in which the clinic is located and rent the building to the clinic.

Rent	$90,000.00

<u>Cost of Ownership to the Doctors:</u>

Property Taxes	$ 3,000.00
Depreciation	$ 8,500.00
Interest on Mortgage	$ 2,000.00
Total Ownership Cost	$ 13,500.00
Total Allowable Cost	$ 13,500.00

6 Vaccine Ratio Calculation

* 2,080 hours a year = full time equivalent (40 hours per week)
* Time to give an injection = 10 minutes
* Total Injections - 300 (Line 11, page 29-312)
* Total health care staff hours (2,080 X 2.65 FTEs = 5,512 hours available to give injections
* 10 minutes /60 minutes = .1667 X 300 = 50 Hours
* Total Hours 50 divided by 5,512 (total health care staff hours) = .009071

This glossary explains terms found within this document as well as on the web site of the Centers for Medicare and Medicaid Services (www.cms.hhs.gov). This is not a legal document and these definitions should be not used in a legal context.

Terms Defined:

Beneficiary:

The name for a person who has health insurance through the Medicare and Medicaid program.

Capitation:

A specified amount of money paid to a health plan or doctor. This is used to cover the cost of the health plan members' health care services for a certain length of time.

Coinsurance:

The percent of the Medicare-approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the original Medicare Plan, the coinsurance payment is a percentage of the approved amount for the service (like 20 percent).

Commingling:

The simultaneous operation of an RHC and another entity. It is the concurrent use of personnel, space, services, and/or supplies for both RHC and non-RHC purposes. An RHC may not function concurrently as a RHC and a private practitioners office, for example, during the same hours of operation. Specific dates and/or times can be designated as either RHC or private practitioner.

Cost Report:

The report required from providers on an annual basis in order to make a proper determination of amounts payable under the Medicare Program.

Deductible:

The annual amount payable by the beneficiary for covered services before Medicare makes reimbursement.

Encounter:

A face to face encounter between the patient and a physician, physician assistant, nurse practitioner, nurse midwife, specialized nurse practitioner, visiting nurse, clinical psychologist, or clinical social worker during which a medically necessary RHC service is rendered.

<u>Fiscal Intermediary:</u>

A private company that has a contract with Medicare to pay Part A and some Part B bills. (Also called "Intermediary").

<u>HMO:</u>

Health Maintenance Organization (State Plan defined) – A public or private organization that contracts on a prepaid Capitated risk basis to provide a comprehensive set of services and is Federally qualified.

<u>Medicare Economic Index:</u>

An index often used in the calculation of the increases in the prevailing charge levels that help to determine allowed charges for physician charges. In 1992 and later, this index is considered in connection with the update factor for the physician fee schedule.

<u>Reopening:</u>

An action taken, after all appeal rights are exhausted, to reexamine or question the correctness of a determination, a decision, or cost reports otherwise final.

<u>Rural Health Clinic:</u>

An outpatient facility that is primarily engaged in furnishing physicians' and other medical and health services and that meets the requirements designated to ensure the health and safety of individuals served by the clinic. The clinic must be located in a medically under-served area that is not urbanized as defined by the U.S. Bureau of Census.

General cost reporting tips, issues and common pitfalls

- Collect as much information as possible on an ongoing basis.
- Set up accounting procedures to collect as much financial data in the form and level of detail required for year-end reporting.
- Check the cost report for mathematical accuracy.
- Be consistent from year to year.
- Complete all of the required forms for the cost report and supporting data, as this may delay the cost report process once submitted.
- Use correct and current forms.
- Review cost report for reasonableness.
- Keep an ongoing log of visits that are totaled daily, monthly, and annually for supporting documents of the cost reported figures.
- Issues and pitfalls to consider when completing a cost report for an RHC for maximizing the calculation of the rate per visit:

Reliable Visit Count	Accrual Basis of Accounting
FTE Calculation; i.e. Administrative time vs. Patient Care time	Depreciation Threshold Guidelines and Medicare Depreciable Guidelines
Reasonableness of Provider Salaries	Laboratory Time and Services (non-RHC allocations)
Pneumococcal and Influenza Vaccine Logs for Medicare	Medicare Bad Debt and Supporting Documentation

Prepared by People with Experience

Medicare GME Reimbursement

Effective for that portion of cost reporting periods occurring on or after January 1, 1999, if an RHC or an FQHC incurs "all or substantially all" of the costs for the training program in the nonhospital setting as defined in Sec. 413.85(b) of this chapter, the RHC or FQHC may receive direct graduate medical education payment for those residents.

Direct graduate medical education costs are not included as allowable cost under Sec. 405.2455(b)(l)(i), and therefore, are not subject to the limit on the all-inclusive rate for allowable costs.

Participation in GME training should not affect any FQHC's or RHC's ability to meet the productivity standards outlined in section 503 of the Medicare Rural Health Clinic and Federally Qualified Health Centers Manual. Therefore, we are proposing that, where payment is available under section 1886(k) of the Act for residents working in either an FQHC or an RHC, the FQHC's and RHC's do not need to include residents as health care staff in the calculation of productivity standards under section 503 of the manual.

The following costs are not included as allowable graduate medical education costs–

(A) Costs associated with training, but not related to patient care services.
(B) Normal operating and capital-related costs.
(C) The marginal increase in patient care costs that the RHC or FQHC experiences as a result of having an approved program.
(D) The costs associated with activities described in Sec. 413.85 (d) of this chapter.

Effective January 1, 1999, for FQHC's and RHC's that incur "all or substantially all" of the costs for the training program in the nonhospital setting, the direct GME costs are not subject to the existing per visit payment caps for reimbursement under sections 505.1 and 505.2 of the Medicare Rural Health Clinic and Federally Qualified Health Centers Manual.

The following costs are included in allowable direct graduate medical education costs to the extent that they are reasonable–

(A) The costs of the residents' salaries and fringe benefits (including travel and lodging expenses where applicable).
(B) The portion of teaching physicians' salaries and fringe benefits that are related to the time spent teaching and supervising residents.
(C) Facility overhead costs that are allocated to direct graduate medical education.

In order to receive the direct GME payment, the Medicare+Choice organization must produce a contractual agreement between itself and the nonhospital patient care site, including freestanding clinics, nursing homes, and physicians' offices in connection with approved programs. The contract between the Medicare+Choice organization and the nonhospital site must indicate that, for the time that residents spend in the nonhospital site, the Medicare+Choice organization agrees to pay for the cost of residents' salaries and fringe benefits spends in the nonhospital setting, not based upon a Capitated rate for the delivery of physician services.

The contact must stipulate the portion of each teaching physician's time that will be spent training resident in the nonhospital setting. Moreover, the contract must indicate that the Medicare+Choice organization agrees to identify an amount for the cost of the teaching physician's salary based on the time that the resident spends in the nonhospital setting, not based upon a Capitated rate for the delivery of physician services.

Chapter Seven

RHC Coding and Billing Issues

Chapter Seven - RHC Coding and Billing Issues

The Rural Health Clinics program created a unique opportunity for clinics that meet Federal standards to be paid on a cost-per-visit basis. This payment system is frequently misunderstood by policy makers, and others, as it is believed that one can compare cost-based reimbursement rates with fee-for-service rates. This is incorrect.

The RHC program provides the opportunity for clinics to take the total allowable costs for RHC services divided by allowable visits provided to RHC patients receiving core RHC services. From this equation, the clinic determines an interim payment rate. This interim payment rate is paid throughout the clinic's fiscal year and then reconciled at the end of the fiscal year through the cost reporting methodology. When looking at RHC billing issues, it should be acknowledged that Rural Health Clinics essentially provide Part B services with the payment for those services determined by utilizing a Part A payment methodology.

In order to understand RHC billing, it is important to understand RHC terminology. Therefore, outlined below are explanations of many of the most common terms and issues that are encountered in billing for RHC services. Following these explanations, we provide you with an overview of some of the issues that you will face when attempting to bill for RHC services.

RHC Terms and Explanations

Rural Health Clinic – A facility the meets the standards of the RHC program and regulations as it relates to survey and certification, policy and procedure, as well as staffing (described elsewhere in this publication). A Rural Health Clinic must receive official approval after survey, by an approved State agency. The approval is provided by CMS and the fiscal intermediary that is designated to serve the RHC program within the State in which the RHC is located.

Centers for Medicare and Medicaid Services (CMS) - The Federal agency responsible for overseeing the operation of both the Medicare and Medicaid programs. CMS selects the Fiscal Intermediaries and Carriers and oversees the enforcement of all RHC rules and regulations.

Physician – A licensed physician (MD or DO) who provides services and is authorized by the State in the practice of medicine to provide services to Medicare beneficiaries.

PA, NP or CNM – This refers to the other professional staff required to be in a Rural Health Clinic. A physician assistant (PA), nurse practitioner (NP), or certified nurse midwife (CNM) must be on-site and available to see patients at least 50 percent of the hours the clinic is open and available for patient care. Each State has specific definitions related to the scope of practice for each of these practitioners. Anyone considering the RHC program must become aware of the rules and regulations governing utilization of PAs, NPs or CNMs in their State. Medicare defers to the State as it relates to licensure, certification, and the scope of practice for PAs, NPs or CNMs that are approved for utilization in a Rural Health Clinic.

UPIN – This is the **u**nique **p**rovider **i**dentification **n**umber which is issued after application to Medicare Part B to receive the Medicare Provider Number. It is a requirement under Medicare regulations that whenever services are provided to Medicare beneficiaries, the UPIN number of the provider that is ordering or performing the service shall be provided to the referring facility. The UPIN number is also commonly used by private insurers to identify and track practitioners providing services.

Provider Identification Number – This is a unique number that is issued by payers to each provider to identify that provider as a credentialed and approved provider. In addition, it is used to generate payments under the name and credentials of an individual practitioner. It is appropriate and encouraged that Rural Health Clinics apply and obtain Medicare provider identification numbers and UPIN numbers for all practitioners employed/utilized by the RHC: physicians, certified nurse midwives, nurse practitioners, physician assistants, social workers, and psychologists.

UB92 – Refers to the billing form utilized for billing Medicare for RHC services. It is generally utilized as a hospital outpatient billing format. This requires use of revenue codes for the purposes of generating billing and/or payments.

HCFA-1500 – Part B billing format that is utilized to submit to the carrier to receive payment for Medicare services. This form has frequently been adopted by many State Medicaid programs, and is commonly the uniform format for submitting claims to commercial carriers.

Fiscal Intermediary (FI) – The entity that has been designated by CMS to process RHC claims and make payment for RHC services. The FI will also reconcile costs based on a submitted cost report. Traditionally, the Fiscal Intermediaries processed Medicare Part A claims.

Carrier – Entity that has been designated by CMS to process Medicare Part B claims and make payment for Medicare covered services provided to Medicare beneficiaries. Traditionally the Carrier is focused on Part B services.

Medicaid, Title XIX – This program was developed to provide services to the poor and disadvantaged. Every State has variations within its Medicaid program. It is important to understand your Medicaid program's payment methodology. Does the State utilize a managed care, fee-for-service or some variation of the two? The RHC program allows for cost reimbursement or prospective payment under the Medicaid program.

Medicare, Title XVIII – Provides services to the aged and disabled. This program is designed to provide coverage for the elderly. Medicare also pays based upon full cost for RHC services and the physician fee schedule for Part B services.

RHC Core Services – Rural Health Clinic Core Services are defined within the Rural Health Clinic Manual (referred to as HCFA-Publication 27, US Department of Health and Human Services). Generally, the core RHC services are services that would typically be provided to Medicare beneficiaries in a primary care physician's office, the beneficiary's home, or to Medicare beneficiaries in skilled nursing facilities who are under a non-Part A stay. The RHC Manual defines physician services; services and supplies "incident-to" physician services; services of nurse practitioners, physician assistants, and clinical nurse mid-wives; services and supplies "incident-to" the services of nurse practitioners, physician assistants, and clinical nurse mid-wives; clinical psychologist and clinical social worker services as defined in Section 419; visiting nurse services to home-bound patients with special circumstances; and, services and supplies "incident-to" clinical psychologists and clinical social worker services. A link to the RHC manual is available on the NARHC website: www.narhc.org .

Non-RHC Services – These are services that are covered by Medicare Part B but not considered part of the RHC core services. These services are typically billed to Medicare, however, they are billed to Medicare Part B. Non-RHC services would include inpatient services, services provided to Medicare beneficiaries in a Part A skilled nursing facility, and diagnostic tests such as laboratory and x-ray. These non-RHC services will be paid under the Medicare fee schedule. The RHC manual provides a more exhaustive list of examples of non-RHC services.

Incident-To – This is the mechanism Medicare utilizes to define services that are provided incident-to a professional service of an approved Medicare provider. These might include dressings, supplies and support staff assisting with the provision of a professional service. In order to qualify as "incident-to", the service must generally be provided in a physician's office or a patient's home and be provided under the

direct supervision of the Medicare approved provider. Furthermore, the individual providing the incident-to service must be under the control, either through common employment or contractual relationship, of the Medicare provider who is delivering a "physician" service to the Medicare beneficiary. Although non-RHC practices can generally submit a claim for an incident-to service, this is not the case for the Rural Health Clinic. An incident-to service, by definition, cannot meet the RHC test for an "encounter".

Supervision – For the purposes of the Rural Health Clinic program, supervision is defined as a requirement of the physician to ensure that the quality of care is being maintained. The physician must be on-site and physically present a sufficient amount of time to see patients in the clinic and to interact with the Rural Health Clinic's PAs, NPs or CNMs on a regular basis. The minimum Federal requirement for on-site availability is one day every two weeks, unless more frequent availability is required as part of the PA/NP or CNM State practice Act.

Interim Payment Rate – This is the Medicare all-inclusive rate that is established by the Medicare program. The RHC receives this amount for each Medicare covered RHC visit (face-to-face encounter) throughout the Clinic's Fiscal Year. The Interim Rate is determined by calculating the Medicare allowable costs, divided by the number of Medicare allowable encounters. This mathematical equation determines the average Medicare cost per visit. At the end of each Fiscal Year, this Interim Rate is recalculated based upon the previous year's allowable costs and allowable visits. If the clinic's cost-per-visit rate is different from the rate established 12 months previous, the FI reconciles the new rate and uses this to set the interim rate for the next 12 months.

Encounter – An encounter for the RHC program constitutes a <u>medically necessary</u> face-to-face visit between a Medicare approved RHC provider (i.e. physician, PA, NP, CNM, psychologist, or social worker) and a Medicare beneficiary. Please note that the encounter must be both medically necessary AND face-to-face. The test of medical necessity is no different for an RHC service than it is for any other service covered by Medicare. A face-to-face visit with a physician may not necessarily be medically necessary. If it is not medically necessary, it does not meet the standard for an RHC encounter. A face-to-face encounter with a nurse (RN) may be medically necessary; however, a nurse is not a Medicare approved RHC provider, therefore, a nurse-only visit does not meet the standard for an RHC encounter.

Independent Rural Health Clinic – This is a facility that meets the requirements of the Rural Health Clinic program, however, it functions independent of any Medicare provider. Independent RHCs are subject to payment and cost report reconciliation through the identified Rural Health Clinic Fiscal Intermediary. The major RHC Fiscal Intermediaries include Riverbend Government Benefits Administrator, Veritus Medicare Services, and TrailBlazer Health Enterprises, LLC. All independent RHCs are reimbursed by Medicare on their all-inclusive rate (AIR), however, the AIR is subject to a cost-per-visit cap. The cap is set by statute and adjusts each year to reflect medical inflation. Consult the appropriate Fiscal Intermediary to ascertain the current RHC cap.

Provider-Based Rural Health Clinic – This designation refers to a Rural Health Clinic that is an intricate and subordinate part of another provider, such as a hospital, home health agency, or skilled nursing facility. In order to be considered "provider-based", the clinic need not be physically located on the campus of the parent provider. However, to meet the provider-based requirements generally means complying with extensive regulations. Provider-based RHCs must not only demonstrate that they are an integral part of the hospital, but must also serve the same service area as the parent provider. The provider-based designation changes some of the billing and payment methodology and requires billing and cost reconciliation through the fiscal intermediary of the provider. In addition, some provider-based RHCs are exempt from the per visit cap applicable to all independent RHCs and most provider-based RHCs.

Cost Report – This is a document prepared by every Federally-certified Rural Health Clinic at the end of the Clinic's fiscal year. The cost report must be submitted within 5 months of the end of the Clinic's fiscal year in order to reconcile RHC allowable costs and allowable visits with RHC payments. There are two forms of the RHC Cost Report. The Independent RHC cost report is the HCFA-RHC222 and is submitted electronically to the fiscal intermediary. Schedule M of the Parent Provider's cost report is the Provider-Based RHC cost report. Schedule M is similar to the HCFA-RHC222 Form and is an attachment to the parent provider's cost report.

BILLING FOR RHC SERVICES

Generally, billing for RHC services has been referred to as a process that is easier than traditional Part B billing because of the ability to collapse CPT codes into a single Revenue Code (See chart below).

Rural Health Clinic Billing Procedure Codes

Billed on UB-92 to Fiscal Intermediary as an RHC Service:

Procedure Description	CPT Code	Rev Code
Surgery	10000-69999	520
Medicine (Psych)	90801-90815	520
E&M – New	99201-99205	520
E&M – Established	99211-99215	520
Office Consults	99241-99245	520
Preventive Health	90381-90397	
Nursing Home Visits *	99302-99316	551
Domiciliary	99321-99333	551
Gyn Exams	G0101	520
OMT Therapy	98925-98929	520

* In Non-Skilled Facility or in Skilled Facility NOT paid by Part A (1st 100 days)

Billed on CMS-1500 to Part B Carrier:

Procedure Description	CPT Code	Rev Code
Radiology	70000-79999	N/A
Laboratory	80000-89999	N/A
Infusion (Chemotherapy)	96400-96520, plus JXXXX	N/A
Infusion (Remicade)	90780-90781, plus J1745	N/A
Injection (Synvisc)	90782, plus J7320	N/A
Part A Nursing Home Visits	99302-99316	N/A
Hospital Visits	99221-99239	N/A

Although you collapse codes into a single revenue code, it is still important to list the appropriate CPT codes as part of the billing process. These codes will be used to determine medical necessity and will be useful in determining what happened during the encounter.

It is also important to know that not all Medicare covered services provided to Medicare beneficiaries in an RHC are defined as Rural Health Clinic services. It is likely that you will provide services that are covered by Medicare Part B that are non-RHC services. These services are billable under the fee schedule to Medicare Part B. To further clarify the billing responsibilities, it is important to discuss the various components and methodologies of how RHC's bill for services.

For Rural Health Clinic Core Services (see definition above)**:** Medicare uses a Part A payment methodology which includes the professional component (physician, PA, NP, etc.) of services provided in the Rural Health Clinic and those services provided "incident-to" that visit. In the independent Rural Health Clinic, this includes ancillary services, such as injections, dressings, etc. However, in a provider-based Rural Health Clinic, this is not the case. Because of the implementation of the Medicare hospital outpatient payment system (OPPS), the provider-based RHC does not bill for anything as a core service except the professional component of the visit. Provider-based Rural Health Clinics only bill for the face-to-face encounter, as an RHC service. Ancillary services provided during a Provider-Based RHC visit are billed to Medicare Part B under the fee schedule where allowable.

Part-B Billing for Non-RHC Services provided in the RHC: Part B billing for non-RHC services includes the technical component of services that may be provided within an RHC and those services that are provided outside of the Rural Health Clinic. Examples of services that are billable to Part B would include diagnostic tests, such as laboratory tests, lab draws, x-rays, EKGs, pulmonary function testing and technical components of x-ray services. Billing for diagnostic tests requires that you utilize the Part B billing format (HCFA/CMS-1500 Form). You will bill for the technical component to Part B, capturing

the professional component as part of the RHC billing. Only the professional costs associated with these tests are captured on the RHC cost report.

Medicare Part B Services Provided in a Hospital: Medicare Part B Services provided in a Hospital are not Core RHC Services, therefore they are billed under the Medicare Part B fee schedule. It is important to recognize that you must bill for these services according to the Medicare billing guidelines for that particular practitioner. For example, if an RHC physician visits a patient in the hospital and provides Medicare Part B covered services, the physician bills for that service using the physician's individual provider number. It is extremely important that ALL costs associated with the delivery of inpatient services being paid to the RHC through Medicare Part B would have to be appropriately allocated out of the RHC cost center for cost reporting purposes. Failure to make this accounting adjustment would result in duplicate payments from Medicare.

Medicare Part B Services Provided in a Skilled Nursing Facility: Payment regulations require the bundling of payment for those Skilled Nursing Facility patients that are under a Part A stay. For these patients it is necessary for the RHC to carve out of the RHC cost report the time associated with the Medicare Part B covered services provided to the Part A stay patient. These services are billed to Medicare Part B.

Medicare covered services provided to non-Part A stay Medicare beneficiaries in skilled nursing facilities, which make up the majority of skilled nursing facility visits, should be billed to the RHC FI as RHC encounters. These will be paid based upon the RHC encounter rate.

Obtaining Provider Numbers: Three specific provider numbers could be utilized when billing for a Rural Health Clinic:

RHC Provider/Billing Number
UPIN Number
Individual Practitioner Provider Number

When you are initially approved as an RHC, you will receive a Rural Health Clinic Billing Number, which is a 6-digit number issued by the Medicare Part A RHC Fiscal Intermediary. This number is utilized when billing for all RHC services.

In addition, it is frequently required that the UPIN number of the Medicare approved practitioner within the RHC must also be included on the billing. The UPIN number, defined above, is a unique provider identification number issued to all Medicare approved practitioners and must be utilized when billing for Medicare services.

The Individual Practitioner Provider Number, which is issued by Medicare Part B Carriers, is necessary to bill for non-RHC Medicare Part B services. When billing Medicare Part B

for the technical component of diagnostic services, payment is not reduced or changed simply because the test was provided by an RHC physician, PA or NP.

To apply for and obtain the Individual Provider Number, it is necessary to complete the CMS-855A application form. This form should be submitted to the Medicare carrier and will subsequently be processed within 60 days. At the end of the application process, the Carrier will issue an Individual Practitioner Provider Number. Subsequently a UPIN number will be issued for that Medicare provider. Assignment of payment should be to the Rural Health Clinic for those Part B payment numbers.

BILLING FOR HOSPITAL SERVICES

All Part B services provided in a hospital are defined as non-RHC services and must be billed under Medicare Part B. If the service provided to the Medicare beneficiary in the hospital is provided by a PA, NP or CNM, the approved charge will be the lesser of the actual charge or 85 percent of the physician fee schedule amount for that service. Services that might be provided in the hospital include surgery, outpatient visits such as the emergency department, inpatient care, and obstetrical deliveries. It is important to remember that Rural Health Clinics can bill and receive payment from Medicare Part B for non-RHC services, however, the clinic must allocate the costs (i.e. time and any overhead) associated with the delivery of non-RHC services out of their total costs when completing their cost report.

MEDICAID BILLING FOR RHC's

All State Medicaid programs are required to recognize Rural Health Clinic services. Each State Medicaid plan must define how it will pay for the services provided by a Rural Health Clinic. While minimum Federal requirements exist, States can seek to either waive those requirements or establish a unique Medicaid payment mechanism for RHCs in their State.

In 2000 Congress changed the way Medicaid must pay RHCs from a cost-based system to a prospective payment system (PPS). Included in that legislation was the ability of States to develop an alternative payment methodology, however each RHC in the State must individually agree to the alternative. In no case can the alternative payment methodology result in payments that are less than the payments the clinics would have received under the PPS methodology.

Therefore, Medicaid billing for RHC's is often a unique and sometimes complex story. It is important that you contact your State Medicaid office and obtain basic information on how Medicaid pays for RHC services in your State.

The initial Federally mandated PPS rate is based on an average of the 1999 and 2000 RHC cost reports. Each year, the PPS rate is to reflect changes in the Medicare Economic

Index. If a clinic did not exist during 1999 and 2000, then the State is required to develop a methodology for determining any new clinics' initial Medicaid PPS rate. It is important to note that States have chosen to use different methodologies for calculating the initial Medicaid PPS rate. That's why it is important for you to understand how your Medicaid is paying for RHC services.

Generally, State Medicaid agencies have the ability to cover additional services that are not normally considered RHC services. This would include such services as dental and other types of ambulatory services. Medicaid may choose to full-cost reimburse diagnostic services as well, including laboratory and x-ray. It is important that you look at the State Medicaid Plan to determine what are appropriate covered services within the RHC for billing purposes. It is also important that you obtain a copy of the Medicaid Billing Instructions to understand the specific methodology under which your State Medicaid agency will pay. At the time this document is being written, dozens of different methodologies have been established. These range from quarterly wrap-around payments to paying an interim rate with reconciliation at year-end.

Conclusion

The Rural Health Clinics program has become the largest (based on the number of clinics) primary care service delivery program in rural, underserved communities in the country. This program and its emphasis on insuring adequate reimbursement in the rural and underserved areas for Medicare and Medicaid beneficiaries has grown to over 3,000 facilities. It is important when looking at billing for RHC services that one obtain appropriate advice and counsel from individuals with experience and knowledge in the area of Rural Health Clinic billing.

The issues that face Rural Health Clinics are unique in that RHC staff are expected to understand not only traditional Medicare regulations as they relate to coding and documentation, but also to understand the unique characteristics and requirements of billing for RHC services. Therefore, RHC staff must be able to bill two distinctly different programs, while still maintaining the integrity and compliance with Medicare requirements related to coding and documentation.

This manual will not answer every question you might have about the Rural Health Clinics program but it is the hope of the authors that it will answer many. Several resources and contacts have been listed in the Appendix F. The individuals and/or organizations identified in Appendix E may be able to answer more detailed questions not covered by this manual.

Appendix A

State RHC Survey & Certification Contacts

State RHC Survey and certification contacts

State	Agency Name and Address	Phone & Fax numbers
Alabama	Division of Licensure and Certification Department of Public Health PO Box 303017 Montgomery, Alabama 36130-3017	Phone (334) 206-5077 Fax (334) 206-5088
Alaska	Medical Assistance Health Facilities Licensing and Certification 4730 Business Park Blvd, Suite 18, Bldg H Anchorage, Alaska 99503-7137	Phone (907) 561-8081 Fax (907) 561-3011
Arizona	Assurance/Licensure Health/Child Care Rev Svcs Department of Health Services 1647 East Morten Avenue, Suite 220 Phoenix, Arizona 85020	Phone (602) 674-4200 Fax (602) 861-0645
Arkansas	Health Facilities Services Department of Health Freeway Medical Twr, 5800 W 10th Street, Suite 400 Little Rock, Arkansas 72204 OR Office of Long Term Care, Medical Services Department of Human Services PO Box 8059, Slot #402 Little Rock, Arkansas 72203-8059	Phone (501) 661-2201 Fax (501) 661-2165 Phone (501) 682-8486 Fax (501) 682-6171
California	Licensing and Certification Division Department of Health Services PO Box 942732, 1800 3rd Street, Suite 210 Sacramento, California 94234-7320	Phone (916) 445-3054 Fax (916) 445-6979
Colorado	Health Facilities Div., Bldg A, 2nd Floor Dept of Public Health & Environment 4300 Cherry Creek Drive, South Denver, Colorado 80222-1530	Phone (303) 692-2819 Fax (303) 782-4883

State	Agency Name and Address	Phone & Fax numbers
Connecticut	Division of Health Systems Regulation Department of Public Health 410 Capitol Avenue, MS#12HSR Hartford, Connecticut 06134-0308	Phone (860) 509-7400 Fax (860) 509-7543
Delaware	Office of Health Facilities Lic. and Cert. 2055 Limestone Road, Suite 200 Wilmington, Delaware 19808	Phone (302) 995-8521 Fax (302) 577-6672
Florida	Division of Health Quality Assurance Agency for Health Care Administration 2727 Mahan Drive, Room 200 Tallahassee, Florida 32308-5403	Phone (850) 487-2527 Fax (850) 487-6240
Georgia	Office of Regulatory Services Department of Human Resources 2 Peachtree Street NW, 21st Floor, Ste 21-325 Atlanta, Georgia 30303-3167	Phone (404) 657-5700 Fax (404) 657-5708
Hawaii	State Department of Health Office of Health Care Assurance 601 Kamokila Blvd. Room 395 Kapolei, Hawaii 96707	Phone (808) 692-7420 Fax (808) 692-7447
Idaho	Bur. of Facility Standards, Div. of Medicaid Department of Health and Welfare 450 West State Street, 3rd Floor Boise, Idaho 83720-0036 OR Laboratory Improvement Section, Division of Health Department of Health and Welfare 2220 Old Penitentiary Road Boise, Idaho 83712-8299	Phone (208) 334-1864 Fax (208) 332-1888 Phone (208) 334-2235 x245 Fax (208) 334-2382
Illinois	Office of Health Care Regulation Department of Public Health 525 West Jefferson Street, 5th Floor Springfield, Illinois 62761	Phone (217) 782-2913 Fax (217) 524-6292

State	Agency Name and Address	Phone & Fax Numbers
Indiana	Health Care Regulatory Services Commission State Department of Health 2 North Meridian Street, Section 3B Indianapolis, Indiana 46204	Phone (317) 233-7022 Fax (317) 233-7053
Iowa	Health Facilities Division Department of Inspections and Appeals 3rd Floor, Lucas State Office Building Des Moines, Iowa 50319-0083	Phone (515) 281-4233 Fax (515) 242-5022
Kansas	Bureau of Health Facility Regulation, Div of Health Dept of Health and Environment Landon State Ofc Bldg 900 SW Jackson, Suite 1001 Topeka, Kansas 66612-1290	Phone (913) 296-1240 Fax (913) 296-1266
Kentucky	Division of Licensing and Regulation Cabinet for Human Resources 275 East Main Street, 4E-A Frankfort, Kentucky 40621-0001	Phone (502) 564-2800 Fax (502) 562-6546
Louisiana	Health Standards Section Department of Health and Hospitals PO Box 3767 Baton Rouge, Louisiana 70821-3767	Phone (225) 342-0415 Fax (225) 342-5292
Maine	Division of Licensing and Certification Department of Human Services - BMS 11 State House Station, 35 Anthony Avenue Augusta, Maine 04333-0011	Phone (207) 624-5443 Fax (207) 624-5378
Maryland	Office of Licensing and Certification Programs Dept. of Health and Mental Hygiene 55 Wade Ave. Baltimore, Maryland 21228	Phone (410) 402-8001 Fax (410) 402-8215
Massachusetts	Division of Health Care Quality Department of Public Health 10 West Street, 5th Floor Boston, Massachusetts 02111	Phone (617) 753-8100 Fax (617) 753-8125

State	Agency Name and Address	Phone & Fax Numbers
Michigan	Dept. of Consumer & Industry Svcs Bureau of Health Systems Division of Health Facility Licensing & Cert. PO Box 30664 525 W Ottawa, 5th Floor Lansing, Michigan 48909	Phone (517) 241-2626 Fax (517) 241-2629
Minnesota	Facility and Provider Compliance Division Department of Health PO Box 64900 St Paul, Minnesota 55164-0900	Phone (651) 215-8715 Fax (651) 215-8710
Mississippi	Health Facilities Licensure and Certification State Department of Health PO Box 1700 Jackson, Mississippi 39215-1700	Phone (601) 354-7300 Fax (601) 354-7230
Missouri	Division of Health Standards and Licensure Department of Health PO Box 570 912 Wildwood Drive Jefferson City, Missouri 65102-0570 OR Institutional Services, Division of Aging Department of Social Services PO Box 1337 615 Howerton Court Jefferson City, Missouri 65102-1337	Phone (573) 751-6271 Fax (573) 526-3621 Phone (573) 526-0721 Fax (573) 751-8493
Montana	Quality Assurance, Certification Bureau Department of Health and Human Services 2401 Colonial Dr., 2nd Floor PO Box 202953 Helena, Montana 59620-2953	Phone (406) 444-2099 Fax (406) 444-3456
Nebraska	Health Facility Licensure and Inspection Department of Health PO Box 95007 Lincoln, Nebraska 68509-5007	Phone (402) 471-0179 Fax (402) 471-0555

State	Agency Name and Address	Phone & Fax Numbers
Nevada	Bureau of Licensure and Certification/EMS Department of Human Resources 1550 E College Parkway, Suite 158 Carson City, Nevada 89710 OR Bureau of Licensure and Certification/EMS Department of Human Resources 4220 South Mary Parkway, Suite 810 Las Vegas, Nevada 89119	Phone (702) 687-4475 Fax (702) 687-6588 Phone (702) 486-6815 Fax (702) 486-6520
New Hampshire	Prog Support, Licensing & Regulation Svcs Health Facilities Administration Dept of Health & Human Services 129 Pleasant Street, Brown Bldg. Concord, New Hampshire 03301	Phone (603) 271-4966 Fax (603) 271-5590
New Jersey	Long Term Care Assessment and Survey Division of Long Term Care Systems Development and Quality Department of Health & Senior Services P.O. Box 367 Trenton, New Jersey 08625-0367 OR Inspections, Compliance and Enforcement Division of Health Care Systems Analysis Department of Health and Senior Services P.O. Box 360 Trenton, New Jersey 08625-0360	Phone (609) 633-8980 Fax (609) 633-9060 Phone: (609)-341-3005 Fax (609)-943-3013
New Mexico	Bureau of Health Facility Licensing and Certification New Mexico Department of Health 525 Camino de Los Marquez, Suite 2 Santa Fe, New Mexico 87501	Phone (505) 827-4200 Fax (505) 827-4203

State	Agency Name and Address	Phone & Fax Numbers
New York	Office of Continuing Care Department of Health 161 Delaware Avenue Delmar, New York 12054 OR Health Care Standards and Surveillance Department of Health Hedley Park Place, 433 River Street, Suite 303 Troy, New York 12180 OR Office of Managed Care Empire State Plaza, Corning Tower Building Room 2001 Albany, New York 12237	Phone (518) 474-7055 Fax (518) 478-1014 Phone (518) 402-1045 Fax (518) 402-1042 Phone (518) 474-5737
North Carolina	Division of Facility Services Certification Section Department of Human Resources PO Box 29530 Raleigh, North Carolina 27626-0530	Phone (919) 733-7461 Fax (919) 733-8274
North Dakota	Health Resources Section Div of Health Facilities Dept of Health & Consolidated Labs 600 East Boulevard Avenue Bismarck, North Dakota 58505-2352	Phone (701) 328-2352 Fax (701) 328-1890
Ohio	Division of Quality Assurance Department of Health 246 N. High Street Columbus, Ohio 43266-0118	Phone (614) 466-7857 Fax (614) 644-0208
Oklahoma	Special Health Services - 0237 Department of Health 1000 N.E. Tenth Street Oklahoma City, Oklahoma 73117-1299	Phone (405) 271-4200 Fax (405) 271-3442

State	Agency Name and Address	Phone & Fax Numbers
Oregon	Health Care Licensure and Cert. Section Health Department PO Box 14450 Portland, Oregon 97214-0450 OR Client Care Monitoring Unit Senior and Disabled Services Department of Human Resources 500 Summer Street, 2nd Floor Salem, Oregon 97310-1015	Phone (503) 731-4013 Fax (503) 731-4080 Phone (503) 945-6456 Fax (503) 373-7902
Pennsylvania	Bureau of Quality Assurance Department of Health P.O. Box 90 Harrisburg, Pennsylvania 17108	Phone (717) 787-8015 Fax (717) 787-1491
Puerto Rico	Regulation and Accreditation of Health Facilities Department of Health Ruiz Soler Former Hospital Bayamon, Puerto Rico 00959	Phone (809) 781-1066 Fax (809) 782-6540
Rhode Island	Division of Facilities Regulation Rhode Island Department of Health 3 Capitol Hill Providence, Rhode Island 02908-5097	Phone (401) 222-2566 Fax (401) 222-3999
South Carolina	Bureau of Certification Department of Health & Environmental Control 2600 Bull Street Columbia, South Carolina 29201-1708	Phone (803) 737-7205 Fax (803) 737-7292
South Dakota	Office of Health Care Facilities Licensure and Certification Health Systems Development and Regulation Department of Health 615 East 4th Street Pierre, South Dakota 57501-5070	Phone (605) 773-3356 Fax (605) 773-6667
Tennessee	Division of Health Care Facilities Department of Health Cordell Hull Building, 1st Floor 426 5th Avenue North Nashville, Tennessee 37247-0508	Phone (615) 741-7221 Fax (615) 741-7051

State	Agency Name and Address	Phone & Fax Numbers
Texas	Health Facility Compliance Division Department of Health 1100 West 49th Street Austin, Texas 78756 OR Long Term Care - Regulatory Department of Human Services 701 West 51st Street, P.O. Box 149030 Austin, Texas 78751	Phone (512) 834-6752 Fax (512) 834-6653 Phone (512) 834-6696 Fax (512) 834-6756
Utah	Medicare/Medicaid Prgm Cert/Resident Assessment Division of Health Systems Improvement PO Box 16990 Salt Lake City, Utah 84114-2905	Phone (801) 538-6559 Fax (801) 538-6163
Vermont	Division of Licensing and Protection Department of Aging and Disabilities 103 South Main Street Waterbury, Vermont 05671-2306	Phone (802) 241-2345 Fax (802) 241-2358
Virginia	The Center for Quality Health Care Services and Consumer Protection Department of Health 3600 West Broad Street, Suite 216 Richmond, Virginia 23230	Phone (804) 367-2102 Fax (804) 367-2149
Washington	Facilities and Services Licensing PO Box 47852 Olympia, Washington 98504-7852 OR Residential Care Services Department of Social & Health Services PO Box 45600 Olympia, Washington 98504-5600	Phone (360) 705-6652 Fax (360) 705-6654 Phone (360) 493-2560 Fax (360) 438-7903
West Virginia	Office of Health Facility Licensure and Cert. Dept of Health and Human Resources 1900 Kanawha Boulevard East, Building 3, Suite 550 Charleston, West Virginia 25304	Phone (304) 558-0050 Fax (304) 558-2515

State	Agency Name and Address	Phone and Fax Numbers
Wisconsin	Bureau of Quality Assurance Dept of Health and Family Services PO Box 2969 Madison, Wisconsin 53701-2969	Phone (608) 267-7185 Phone (608) 266-8847 Fax (608) 267-0352
Wyoming	Health Facilities Program Department of Health First Bank Building, 8th Floor Cheyenne, Wyoming 82002-0480	Phone (307) 777-7121 Fax (307) 777-5970

Appendix B

State Offices of Rural Health

State Offices of Rural Health

ALABAMA Office of Rural Health Department of Public Health RSA Tower, Suite 840 201 Monroe St Montgomery, AL 36130-3017 Phone: 334-206-5396 Fax: 334-206-5434	ALASKA Center for Rural Health/ICHS University of Alaska Anchorage Diplomacy Bldg., Suite 530 3211 Providence Dr. Anchorage, AK 99508 Phone: 907-786-6579 Fax: 907-786-6576
ARIZONA Rural Health Office Family and Community Medicine University of Arizona 2501 East Elm Street Tucson, AZ 85716 Phone: 520-626-7946 Fax: 520-326-6429	ARKANSAS Office of Rural Health Arkansas Dept. of Rural Health 5800 West 10th Street, #401 Little Rock, AR 72227 Phone: 501-661-2375 Fax: 501-280-4706
CALIFORNIA Office of Primary and Rural Health Care California Dept. of Health Services 714 P Street, Room 550 Sacramento, CA 95814 Phone: 916-654-0348 Fax: 916-654-5900	COLORADO Colorado Rural Health Center 225 E 16th Ave., Suite 1050 Denver, CO 80203-1604 Phone: 303-832-7493 Fax: 303-832-7496
CONNECTICUT Office of Rural Health Northwestern CT Community-Technical College Park Place East Winsted, CT 06098-1798 Phone: 860-738-6378 Fax: 860-738-6443	DELAWARE Office of Primary Care & Rural Health Delaware Division of Public Health PO Box 637, Jesse Cooper Bldg. Dover, DE 19903 Phone: 302-739-4735 Fax: 302-739-6653

<table>
<tr><td>FLORIDA
Office of Rural Health
Florida Dept. of Health
4052 Bald Cypress Way, Bin C-15
Tallahassee, FL 32399-1735

Phone: 850-245-4340
Fax: 850-414-6470</td><td>GEORGIA
Office of Rural Health - Services
Georgia Department of Community Health
PO Box 310 (272 7th St. N.)
Cordele, GA 31010-0310

Phone: 229-401-3092
Fax: 229-401-3077</td></tr>
<tr><td>HAWAII
Hawaii Department of Health
State Office of Rural Health
1250 Punchbowl St, Rm 340
Honolulu, HI 96801

Phone: 808-586-4188
Fax: 808-586-4193</td><td>IDAHO
Rural Health Program
Idaho Dept. of Health and Welfare
PO Box 83720 - 450 W State St., 4th Fl.
Boise, ID 83720

Phone: 208-332-7212
Fax: 208-334-6581</td></tr>
<tr><td>ILLINOIS
Center for Rural Health
Illinois Dept. of Public Health
535 West Jefferson
Springfield, IL 62761

Phone: 217-782-1624</td><td>INDIANA
Indiana State Office of Rural Health
Indiana State Dept. of Health
2 North Meridian Street, 8B
Indianapolis, IN 46204-3003

Phone: 317-233-7679
Fax: 317-233-7761</td></tr>
<tr><td>IOWA
Bureau of Rural Health & Primary Care
Iowa Department of Public Health
321 East 12th Street
Des Moines, IA 50319-0075

Phone: 515-281-7224
Fax: 515-242-6384</td><td>KANSAS
Office of Local and Rural Health Systems
Kansas Department of Health & Environment
Landon State Office Bldg
900 SW Jackson, Rm 1051
Topeka, KA 66612-1200

Phone: 785-296-1200
Fax: 785-296-1231</td></tr>
</table>

KENTUCKY	LOUISIANA
Kentucky Office of Rural Health University of Kentucky Center for Rural Health 100 Airport Gardens Road, Suite 10 Hazard, KY 41701-9529 Phone: 606-439-3557 Fax: 606-436-8833	Office of Rural Health Louisiana Dept. of Health & Hospitals 1201 Capitol Access Road, PO Box 1349 Baton Rouge, LA 70821-1349 Phone: 225-342-9513 Fax: 225-342-5839

MAINE Office of Rural Health Maine Dept. of Human Services 35 Anthony Avenue 11 State House Station Augusta, ME 04333-0011 Phone: 207-624-5427 Fax: 207-624-5431	MARYLAND Office of Primary Care and Rural Health Maryland Dept. of Health 201 West Preston St., Room 430B Baltimore, MD 21201 Phone: 410-767-5942 Fax: 410-333-7501
MASSACHUSETTS Office of Rural Health Massachusetts Dept. of Public Health 180 Beaman Street West Boylston, MA 01583 Phone: 508-792-7880 Fax 508-792-7706	MICHIGAN Center for Rural Health-Michigan State University C 219 Fee Hall East Lansing, MI 48824-1316 Phone: 517-432-1066 Fax: 517-432-007
MINNESOTA Office of Rural Health and Primary Care Minnesota Dept. of Health Metro Square Building 121 East 7th Place, Suite 400 St. Paul, MN 55101 Phone: 651-282-6348 Fax: 651-297-5808	MISSISSIPPI Office of Rural Health Mississippi Dept. of Health 2423 N. State St., PO Box 1700 Jackson, MS 39215-1700 Phone: 601-576-7874 Fax: 601-576-7530
MISSOURI Office of Rural Health Missouri Dept. of Health 920 Wildwood Drive, PO Box 570 Jefferson City, MO 65102-0570 Phone: 573-751-6219 Fax: 573-528-402	MONTANA Office of Rural Health Montana Area Health Education Center Montana State University 304 Culbertson Hall Bozeman, MT 59717-0540 Phone: 406-994-5553 Fax: 406-994-5653

NEBRASKA Office of Rural Health Nebraska Dept. of Health 301 Centennial Mall South Lincoln, NE 68509-5044 Phone: 402-471-2337 Fax: 402-471-0180	NEVADA Office of Rural Health School of Medicine, University of Nevada SAVITT Medical Building Room 53, Mail Stop 150 Reno, NV 89557-0046 Phone: 775-784-4841 Fax: 775-784-4544
NEW HAMPSHIRE Primary Care and Rural Health Services New Hampshire Dept. of Health 6 Hazen Drive Concord, NH 03301 Phone: 603-271-4638 Fax: 603-271-4506	NEW JERSEY Office of Rural Health c/o New Jersey Primary Care Association 14 Washington Road, #211 Princeton Junction, NJ 08550-1030 Phone: 609-275-8886 Fax: 609-936-7247
NEW MEXICO Office of Rural Health New Mexico Dept. of Health 625 Selver SW, Suite 201 Albuquerque, NM 87102 Phone: 505-841-5871 Fax: 505-841-5885	NEW YORK Office of Rural Health New York Dept. of Health Empire State Plaza Corning Tower, Room 1656 Albany, NY 12237 Phone: 518-474-5565 Fax: 518-473-6195
NORTH CAROLINA Office of Research, Demonstrations, and Rural Health Development 2009 Mail Service Center Raleigh, NC 27699-2009 Phone: 919-733-2040 Fax: 919-733-8300	NORTH DAKOTA UND Center for Rural Health School of Medicine and Health Sciences University of North Dakota 501 North Columbia Road, PO Box 9037 Grand Forks, ND 58202-9037 Phone: 701-777-3848 Fax: 701-777-2389

OHIO Office of Rural Health Primary Care and Rural Health Ohio Dept. of Health 246 North High Street Columbus, OH 43215 Phone: 614-644-8508 Fax: 614-644-9850	OKLAHOMA Office of Rural Health Oklahoma State Dept. of Health 100 NE 10th St., 5th Floor Oklahoma City, OK 73117-1299 Phone: 405-271-8750 Fax: 405-271-8877
OREGON Office of Rural Health Oregon Health Sciences University, L-593 3181 SW Sam Jackson Park Road Portland, OR 97201-3098 Phone: 503-494-4450 Fax: 503-494-4798	PENNSYLVANIA Office of Rural Health Pennsylvania State University 203 Beecher-Dock House University Park, PA 16802-2315 Phone: 814-863-8214 Fax: 814-865-4688
RHODE ISLAND Office of Rural Health Rhode Island Dept. of Health 3 Capitol Hill, Cannon Bldg. Providence, RI 02908-5097 Phone: 401-222-1171 Fax: 401-222-4415	SOUTH CAROLINA Office of Rural Health SC Office for Recruitment & Retention of Health Professions 220 Stone Ridge Drive, Suite 402 Columbia, SC 29210 Phone: 803-771-2810 Fax: 803-771-4213
SOUTH DAKOTA Office of Rural Health South Dakota Dept. of Health 600 East Capitol Avenue Pierre, SD 57501-2536 Phone: 605-773-3364 Fax: 605-773-5904	TENNESSEE Office of Rural Health Tennessee Dept. of Health 425 Fifth Avenue, North Cordell Hull-5th Floor Nashville, TN 37247-5245 Phone: 615-741-0418 Fax: 615-741-1063

TEXAS Center for Rural Health Initiatives 211 E. 7th St., Suite 915 PO Drawer 1708 Austin, TX 78767 Phone: 512-479-8891 Fax: 512-479-8898	UTAH Utah Dept. of Health Bureau of Primary Care and Rural Health Systems 288 North 1460 West, Second Floor PO Box 142005 Salt Lake City, UT 84114-2005 Phone: 801-538-6113 Fax: 801-538-6387
VERMONT Office of Rural Health Vermont Dept. of Health 108 Cherry St., PO Box 70 Burlington, VT 05402 Phone: 802-863-7513 Fax: 802-651-1634	VIRGINIA Center for Rural Health Virginia Dept. of Health 1500 E Main Street, Room 213 Richmond, VA 23219 Phone: 804-786-4891 Fax: 804-371-0116
WASHINGTON Office of Community and Rural Health P.O. Box 47834 Olympia, WA 98504-7834 Phone: 360-705-6762 Fax: 360-664-9273	WEST VIRGINIA Office of Rural Health Policy West Virginia Dept. of Health 1411 Virginia Street, East Charleston, WV 25301 Phone: 304-558-1327 Fax: 304-558-1437
WISCONSIN Wisconsin Rural Health Assoc. Inc. c/o WI Office of Rural Health Rm. 109 Bradley Memorial 1300 University Avenue Madison, WI 53706 Phone: 608-265-3608 Fax: 608-265-4400	WYOMING Office of Rural Health Wyoming Dept. of Health 1st Floor Hathaway Bldg., Room 117 Cheyenne, WY 82002 Phone: 307-777-6918 Fax: 307-777-7439

Appendix C

Criteria for Designation as a HPSA or MUA

The following are the Health Professional Shortage Area Guidelines and the Medically Underserved Area Guidelines. Please note the legislation was signed into law in October, 2002 mandating that these guidelines be revised to better reflect shortages.

In order to get the most up-to-date information on HPSA/MUA criteria, go to the website of the Office of Shortage Designation:

http://bhpr.hrsa.gov/shortage/

To check on-line to see if a specific community qualifies as a HPSA or MUA, you can go to:

HPSA: http://belize.hrsa.gov/newhpsa/newhpsa.cfm
MUA: http://bphc.hrsa.gov/databases/newmua/

Guidelines for Primary Care Health Professional Shortage Area Designation

Part I -- Geographic Areas

A. Criteria

A geographic area will be designated as having a shortage of primary medical care professionals if the following three criteria are met:

1. The area is a rational area for the delivery of primary medical care services.

2. One of the following conditions prevails within the area:

   (a) The area has a population to full-time-equivalent primary care physician ratio of at least 3,500:1.

   (b) The area has a population to full-time-equivalent primary care physician ratio of less than 3,500:1 but greater than 3,000:1 and has unusually high needs for primary care services or insufficient capacity of existing primary care providers.

3. Primary medical care professionals in contiguous areas are overutilized, excessively distant, or inaccessible to the population of the area under consideration.

B. Methodology

In determining whether an area meets the criteria established by paragraph A of this part, the following methodology will be used:

1. Rational Areas for the Delivery of Primary Medical Care Services.

   (a) The following areas will be considered rational areas for the delivery of primary medical care services:

      (i) A county, or a group of contiguous counties whose population centers are within 30 minutes travel time of each other.

      (ii) A portion of a county, or an area made up of portions of more than one county, whose population, because of topography, market or transportation patterns, distinctive population characteristics or other factors, has limited access to contiguous area resources, as measured generally by a travel time greater than 30 minutes to such resources.

(iii) Established neighborhoods and communities within metropolitan areas which display a strong self-identity (as indicated by a homogeneous socioeconomic or demographic structure and/or a tradition of interaction or interdependency), have limited interaction with contiguous areas, and which, in general, have a minimum population of 20,000.

(b) The following distances will be used as guidelines in determining distances corresponding to 30 minutes travel time:

(i) Under normal conditions with primary roads available: 20 miles.

(ii) In mountainous terrain or in areas with only secondary roads available: 15 miles.

(iii) In flat terrain or in areas connected by interstate highways: 25 miles.

Within inner portions of metropolitan areas, information on the public transportation system will be used to determine the distance corresponding to 30 minutes travel time.

2. Population Count.

The population count used will be the total permanent resident civilian population of the area, excluding inmates of institutions with the following adjustments, where appropriate:

(a) The effect of transient populations on the need of an area for primary care professional(s) will be taken into account as follows:

(i) Seasonal residents, i.e., those who maintain a residence in the area but inhabit it for only 2 to 8 months per year, may be included but must be weighted in proportion to the fraction of the year they are present in the area.

(ii) Other tourists (non-resident) may be included in an area's population but only with a weight of 0.25, using the following formula: Effective tourist contribution to population = 0.25 x (fraction of year tourists are present in area) x (average daily number of tourists during portion of year that tourists are present).

(iii) Migratory workers and their families may be included in an area's population, using the following formula: Effective migrant contribution to population = (fraction of year migrants are present in area) x (average daily number of migrants during portion of year that migrants are present).

3. Counting of Primary Care Practitioners.

(a) All non-Federal doctors of medicine (M.D.) and doctors of osteopathy (D.O.) providing direct patient care who practice principally in one of the four primary care specialities -- general or family practice, general internal medicine, pediatrics, and obstetrics and gynecology -- will be counted. Those physicians engaged solely in administration, research, and teaching will be excluded. Adjustments for the following factors will be made in computing the number of full-time-equivalent (FTE) primary care physicians:

(i) Interns and residents will be counted as 0.1 full-time equivalent (FTE) physicians.

(ii) Graduates of foreign medical schools who are not citizens or lawful permanent residents of the United States will be excluded from physician counts.

(iii) Those graduates of foreign medical schools who are citizens or lawful permanent residents of the United States, but do not have unrestricted licenses to practice medicine, will be counted as 0.5 FTE physicians.

(b) Practitioners who are semi-retired, who operate a reduced practice due to infirmity or other limiting conditions, or who provide patient care services to the residents of the area only on a part-time basis will be discounted through the use of full-time equivalency figures. A 40-hour work week will be used as the standard for determining full-time equivalents in these cases. For practitioners working less than a 40-hour week, every four (4) hours (or ½ day) spent providing patient care, in either ambulatory or inpatient settings, will be counted as 0.1 FTE (with numbers obtained for FTE's rounded to the nearest 0.1 FTE), and each physician providing patient care 40 or more hours a week will be counted as 1.0 FTE physician. (For cases where data are available only for the number of hours providing patient care in office settings, equivalencies will be provided in guidelines.)

(c) In some cases, physicians located within an area may not be accessible to the population of the area under consideration. Allowances for physicians with restricted practices can be made, on a case-by-case basis. However, where only a portion of the population of the area cannot access existing primary care resources in the area, a population group designation may be more appropriate (see part II of this appendix).

(d) Hospital staff physicians involved exclusively in inpatient care will be excluded. The number of full-time equivalent physicians practicing in organized outpatient departments and primary care clinics will be included, but those in emergency rooms will be excluded.

(e) Physicians who are suspended under provisions of the Medicare-Medicaid Anti-Fraud and Abuse Act for a period of eighteen months or more will be excluded.

4. Determination of Unusually High Needs for Primary Medical Care Services.

An area will be considered as having unusually high needs for primary health care services if at least one of the following criteria is met:

(a) The area has more than 100 births per year per 1,000 women aged 15 - 44.

(b) The area has more than 20 infant deaths per 1,000 live births.

(c) More than 20 percent of the population (or of all households) have incomes below the poverty level.

5. Determination of Insufficient Capacity of Existing Primary Care Providers.

An area's existing primary care providers will be considered to have insufficient capacity if at least two of the following criteria are met:

(a) More than 8,000 office or outpatient visits per year per FTE primary care physician serving the area.

(b) Unusually long waits for appointments for routine medical services (i.e., more than 7 days for established patients and 14 days for new patients).

(c) Excessive average waiting time at primary care providers (longer than one hour where patients have appointments or two hours where patients are treated on a first-come, first-served basis).

(d) Evidence of excessive use of emergency room facilities for routine primary care.

(e) A substantial proportion (2/3 or more) of the area's physicians do not accept new patients.

(f) Abnormally low utilization of health services, as indicated by an average of 2.0 or less office visits per year on the part of the area's population.

6. Contiguous Area Considerations.

Primary care professional(s) in areas contiguous to an area being considered for designation will be considered excessively distant, overutilized or inaccessible to the population of the area under consideration if one of the following conditions prevails in each contiguous area:

(a) Primary care professional(s) in the contiguous area are more than 30 minutes travel time from the population center(s) of the area being considered for designation (measured in accordance with paragraph B.1(b) of this part).

(b) The contiguous area population-to-full-time-equivalent primary care physician ratio is in excess of 2000:1, indicating that practitioners in the contiguous area cannot be expected to help alleviate the shortage situation in the area being considered for designation.

(c) Primary care professional(s) in the contiguous area are inaccessible to the population of the area under consideration because of specified access barriers, such as:

(i) Significant differences between the demographic (or socio-economic) characteristics of the area under consideration and those of the contiguous area, indicating that the population of the area under consideration may be effectively isolated from nearby resources. This isolation could be indicated, for example, by an unusually high proportion of non-English-speaking persons.

(ii) A lack of economic access to contiguous area resources, as indicated particularly where a very high proportion of the population of the area under consideration is poor (i.e., where more than 20 percent of the population or the households have incomes below the poverty level), and Medicaid-covered or public primary care services are not available in the contiguous area.

Part II -- Population Groups

A. Criteria.

1. In general, specific population groups within particular geographic areas will be designated as having a shortage of primary medical care professional(s) if the following three criteria are met:

   (a) The area in which they reside is rational for the delivery of primary medical care services, as defined in paragraph B.1 of part I of this appendix.

   (b) Access barriers prevent the population group from use of the area's primary medical care providers. Such barriers may be economic, linguistic, cultural, or architectural, or could involve refusal of some providers to accept certain types of patients or to accept Medicaid reimbursement.

   (c) The ratio of the number of persons in the population group to the number of primary care physicians practicing in the area and serving the population group is at least 3,000:1.

2. Indians and Alaska Natives will be considered for designation as having shortages of primary care professional(s) as follows:

   (a) Groups of members of Indian tribes (as defined in section 4(d) of Pub. L. 94 - 437, the Indian Health Care Improvement Act of 1976) are automatically designated.

   (b) Other groups of Indians or Alaska Natives (as defined in section 4(c) of Pub. L. 94 - 437) will be designated if the general criteria in paragraph A are met.

Part III -- Facilities

Public or Non-Profit Medical Facilities.

1. Criteria.

   Public or non-profit private medical facilities will be designated as having a shortage of primary medical care professional(s) if:

   (a) the facility is providing primary medical care services to an area or population group designated as having a primary care professional(s) shortage; and

   (b) the facility has insufficient capacity to meet the primary care needs of that area or population group.

2. Methodology

   In determining whether public or nonprofit private medical facilities meet the criteria established by paragraph B.1 of this Part, the following methodology will be used:

   (a) Provision of Services to a Designated Area or Population Group.

   A facility will be considered to be providing services to a designated area or population group if either:

   (i) A majority of the facility's primary care services are being provided to residents of designated primary care professional(s) shortage areas or to population groups designated as having a shortage of primary care professional(s); or

   (ii) The population within a designated primary care shortage area or population group has reasonable access to primary care services provided at the facility. Reasonable access will be assumed if the area within which the population resides lies within 30 minutes travel time of the facility and non-physical barriers (relating to demographic and socioeconomic

characteristics of the population) do not prevent the population from receiving care at the facility.

Migrant health centers (as defined in section 319(a)(1) of the Act) which are located in areas with designated migrant population groups and Indian Health Service facilities are assumed to be meeting this requirement.

(b) Insufficient capacity to meet primary care needs.

A facility will be considered to have insufficient capacity to meet the primary care needs of the area or population it serves if at least two of the following conditions exist at the facility:

(i) There are more than 8,000 outpatient visits per year per FTE primary care physician on the staff of the facility. (Here the number of FTE primary care physicians is computed as in Part I, Section B, paragraph 3 above.)

(ii) There is excessive usage of emergency room facilities for routine primary care.

(iii) Waiting time for appointments for routine health services is more than 7 days for established patients or more than 14 days for new patients.

(iv) Waiting time at the facility is longer than 1 hour where patients have appointments or 2 hours where patients are treated on a first-come, first-served basis.

GUIDELINES FOR MUA DESIGNATION

These Guidelines are for use in applying the established Criteria for Designation of Medically Underserved Areas (MUAs) based on the Index of Medical Underservice (IMU), published in the Federal Register on October 15, 1976.

The method for designation of MUAs is as follows:

I. MUA Designation

This involves application of the Index of Medical Underservice (IMU) to data on a service area to obtain a score for the area. The IMU scale is from 0 to 100, where 0 represents completely underserved and 100 represents best served or least underserved. Under the established criteria, each service area found to have an IMU of 62.0 or less qualifies for designation as an MUA.

The IMU involves four variables - ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over. The value of each of these variables for the service area is converted to a weighted value, according to established criteria. The four values are summed to obtain the area's IMU score.

The MUA designation process therefore requires the following information:

(1) Definition of the service area being requested for designation. These may be defined in terms of:

(a) a whole county (in non-metropolitan areas);

(b) groups of contiguous counties, minor civil divisions (MCDs), or census county divisions (CCDs) in non-metropolitan areas, with population centers within 30 minutes travel time of each other;

(c) in metropolitan areas, a group of census tracts (C.T.s) which represent a neighborhood due to homogeneous socioeconomic and demographic characteristics.

In addition, for non-single-county service areas, the rationale for the selection of a particular service area definition, in terms of market patterns or composition of population, should be presented. Designation requests should also include a map showing the boundaries of the service area involved and the location of resources within this area.

(2) The latest available data on:

(a) the resident civilian, non-institutional population of the service area (aggregated from individual county, MCD/CCD or C.T. population data)

(b) the percent of the service area's population with incomes below the poverty level

(c) the percent of the service area's population age 65 and over

(d) the infant mortality rate (IMR) for the service area, or for the county or subcounty area which includes it. The latest five-year average should be used to ensure statistical significance. Subcounty IMRs should be used only if they involve at least 4000 births over a five-year period. (If the service area includes portions of two or more counties, and only county-level infant mortality data is available, the different county rates should be weighted according to the fraction of the service area's population residing in each.)

(e) the current number of full-time-equivalent (FTE) primary care physicians providing patient care in the service area, and their locations of practice. Patient care includes seeing patients in the office, on hospital rounds and in other settings, and activities such as laboratory tests and X-rays and consulting with other physicians. To develop a comprehensive list of primary care physicians in an area, an applicant should check State and local physician licensure lists, State and local medical society directories, local hospital admitting physician listings, Medicaid and Medicare provider lists, and the local yellow pages.

(3) The computed ratio of FTE primary care physicians per thousand population for the service area (from items 2a and 2e above).

(4) The IMU for the service area is then computed from the above data using the attached conversion Tables V1-V4, which translate the values of each of the four indicators (2b, 2c, 2d, and 3) into a score. The IMU is the sum of the four scores.

The following charts show how the Weighted Values are determined.

PERCENTAGE OF POPULATION BELOW POVERTY LEVEL

In the left column find the range which includes the percentage of population below the poverty level for the area being examined. The corresponding weighted value found opposite in the right column, should be used in the formula for determining the IMU.

Percent Below Poverty	Weighted Value V1
0	25.1
0.1 - 2.0	24.6
2.1 - 4.0	23.7
4.1 - 6.0	22.8
6.1 - 8.0	21.9
8.1 - 10.0	21.0
10.1 - 12.0	20.0
12.1 - 14.0	18.7
14.1 - 16.0	17.4
16.1 - 18.0	16.2
18.1 - 20.0	14.9
20.1 - 22.0	13.6
22.1 - 24.0	12.2
24.1 - 26.0	10.9
26.1 - 28.0	9.3
28.1 - 30.0	7.8
30.1 - 32.0	6.6
32.1 - 34.0	5.6
34.1 - 36.0	4.7
36.1 - 38.0	3.4
38.1 - 40.0	2.1
40.1 - 42.0	1.3
42.1 - 44.0	1.0
44.1 - 46.0	0.7
46.1 - 48.0	0.4
48.1 - 50.0	0.1
50+	

PERCENTAGE OF POPULATION AGE 65 AND OVER

In the left column find the range which includes the percentage of population age 65 and over for the area being examined. The corresponding weighted value, found opposite in the right column, should be used in the formula for determining the IMU.

Percent Age 65 and Over	Weighted Value V2
0-7.0	20.2
7.1 - 8.0	20.1
8.1 - 9.0	19.9
9.1 - 10.0	19.8
10.1 - 11.0	19.6
11.1 - 12.0	19.4
12.1 - 13.0	19.1
13.1 - 14.0	18.9
14.1 - 15.0	18.7
15.1 - 16.0	17.8
16.1 - 17.0	16.1
17.1 - 18.0	14.4
18.1 - 19.0	12.8
19.1 - 20.0	11.1
20.1 - 21.0	9.8
21.1 - 22.0	8.9
22.1 - 23.0	8.0
23.1 - 24.0	7.0
24.1 - 25.0	6.1
25.1- 26.0	5.1
26.1 - 27.0	4.0
27.1 - 28.0	2.8
28.1 - 29.0	1.7
29.1 - 30.0	0.6
30+	0

INFANT MORTALITY RATE

In the left column find the range which includes the infant mortality rate for the area being examined or the area in which it lies. The corresponding weighted value is on the right.

Infant Mortality Rate	Weighted Value V3
0-8	26.0
8.1 - 9.0	25.6
9.1 - 10.0	24.8
10.1 - 11.0	24.0
11.1 - 12.0	23.2
12.1 - 13.0	22.4
13.1 - 14.0	21.5
14.1 - 15.0	20.5
15.1 - 16.0	19.5
16.1 - 17.0	18.5
17.1 - 18.0	17.5
18.1 - 19.0	16.4
19.1 - 20.0	15.3
20.1 - 21.0	14.2
21.1 - 22.0	13.1
22.1 - 23.0	11.9
23.1 - 24.0	10.8
24.1 - 25.0	9.6
25.1 - 26.0	8.5
26.1 - 27.0	7.3
27.1 - 28.0	6.1
28.1 - 29.0	5.4
29.1 - 30.0	5.0
30.1 - 31.0	4.7
31.1 - 32.0	4.3
32.1 - 33.0	4.0
33.1 - 34.0	3.6
34.1 - 35.0	3.3
35.1 - 36.0	3.0
36.1 - 36.0	2.6
37.1 - 39.0	2.0
39.1 - 41.0	1.4
41.1 - 43.0	0.8
43.1 - 45.0	0.2
45.1 +	0

RATIO OF PRIMARY CARE PHYSICIANS PER 1,000 POPULATION

In the left column find the range which includes the ratio of primary care physicians per 1,000 population for the area being examined. The corresponding weighted value found opposite in the right column should be used in the formula for determining the IMU.

Ratio	Weighted Value V4
0 - .050	0
.051 - .100	0.5
.101 - .150	1.5
.151 - .200	2.8
.201 - .250	4.1
.251 - .300	5.7
.301 - .350	7.3
.351 - .400	9.0
.401 - .450	10.7
.451 - .500	12.6
.501 - .550	14.8
.551 - .600	16.9
.601 - .650	19.1
.651 - .700	20.7
.701 - .750	21.9
.751 - .800	23.1
.801 - .850	24.3
.851 - .900	25.3
.901 - .950	25.9
.951 - 1.000	26.6
1.001 - 1.050	27.2
1.051 - 1.100	27.7
1.101 - 1.150	28.0
1.151 - 1.200	28.3
1.201 - 1.250	28.6
over 1.250	28.7

Appendix D

Sample Policy and Procedures Manual

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Hope Medical Clinic

SAMPLE SAMPLE

POLICIES AND PROCEDURES

SAMPLE SAMPLE
SAMPLE SAMPLE
SAMPLE SAMPLE

Hope Medical Clinic
1 Pine Street
Hope, Illinois
77777

Phone 777-777-7777

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RURAL HEALTH CLINIC

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SAMPLE

RURAL HEALTH CLINIC
POLICY AND PROCEDURES
STAFF ORGANIZATION AND RESPONSIBILITIES

I. It is the policy of the Rural Health Clinic that the following lines of authority and responsibility be established:

A. Ownership

The Rural Health Clinic is owned by Hope Medical Clinic, a partnership.

B. Staffing

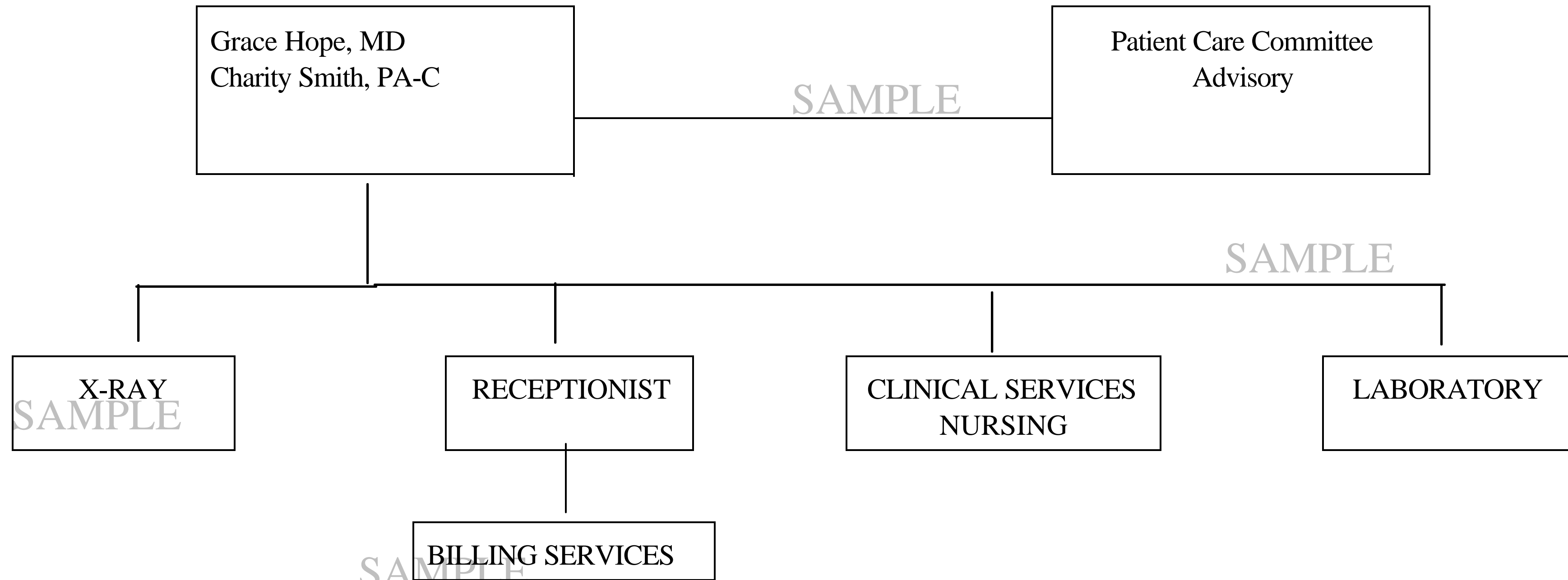
The Clinic has a Health Care Staff which includes one or more physicians, and one or more physician assistants. The staff also includes the necessary ancillary personnel who are supervised by the professional staff. The staff is sufficient at all times to provide the services essential to the operation of the clinic.

C. Physician Responsibilities

1. Provides medical direction for the clinic health care activities and consultation for, and medical supervision of, the health care staff.
2. In conjunction with the physician assistant, participates in developing, executing and periodically reviewing the clinic policies and services provided to Federal program patients. Provides medical care service to the patients of the clinic.
3. The physician is present for sufficient periods of time, at least once every two weeks, to provide medical direction, medical care services, consultation and communication for consultation, assistance with medical emergencies, and patient referral. Any extraordinary circumstances are documented in the records of the clinic.

SAMPLE

HOPE MEDICAL CLINIC
ORGANIZATIONAL CHART



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RURAL HEALTH CLINIC
POLICY AND PROCEDURES
FIRE AND DISASTER

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I. Policy

It is the policy of the Rural Health Clinic to have an effective plan for evacuation of the building in case of fire or disaster.

II. Procedures

A. Evacuation

In case of fire or disaster, the staff will help everyone in the building to leave safely using the published escape plan. Only when every person is safe will an attempt be made to rescue medical or financial records.

B. Training

All staff members will receive training in how to respond to emergencies.

C. Drills

Unannounced fire and disaster drills will be held twice a year. Results will be recorded and a log kept in the building.

D. Evacuation Drills

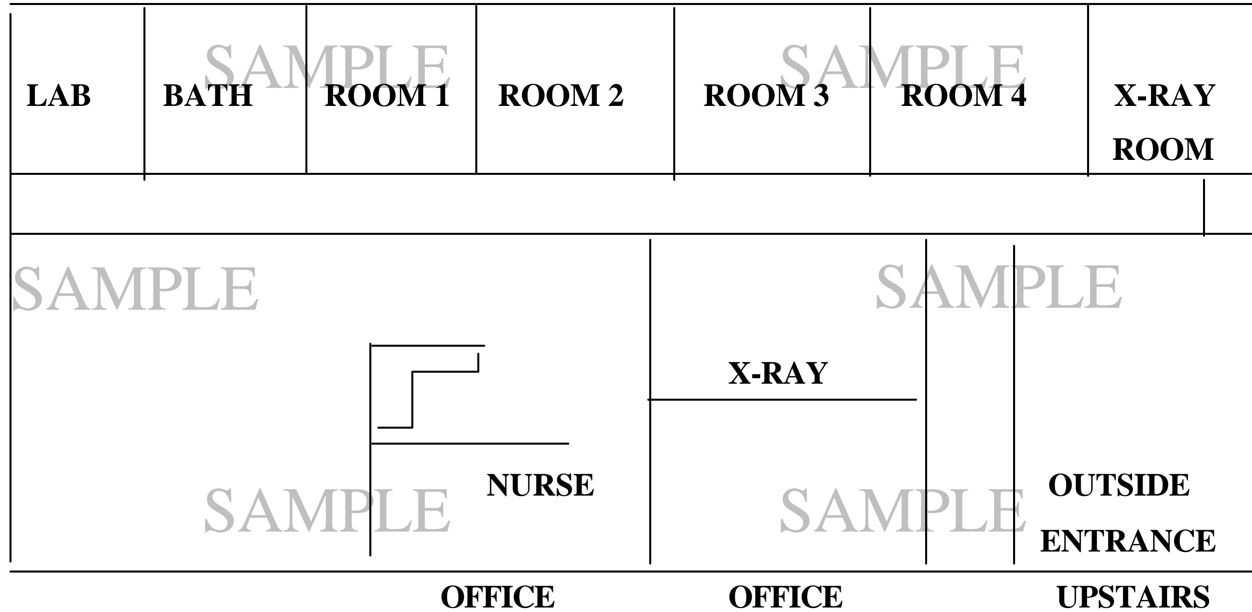
Each employee will familiarize himself/herself with the evacuation plan, as well as the location of normal and emergency exits, fire extinguishers, alarms and other pertinent information. An evacuation drill will be held and personnel will be instructed how to deal effectively with emergencies at least twice each year.

The foregoing policies and procedures were approved by the Rural Health Clinic on _______.

RURAL HEALTH CLINIC

POLICY AND PROCEDURES

SCHEMATIC DRAWING



PINE STREET

EMERGENCY EVACUATION PLAN

FIRE DEPT. NO. 911

The first person to see a fire or hear the smoke alarm should alert everyone in the building and call the fire department. Give the fire department the address, location of fire, nature of fire and name of person calling. All occupants should be evacuated in an orderly manner through the nearest and least dangerous exit. Two exits are clearly marked at the front and rear of the building. All personnel are to locate the two fire extinguishers located in the building and learn how to use them.

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RURAL HEALTH CLINIC
JOB DESCRIPTION
PHYSICIAN ASSISTANT

The physician assistant will examine patients who present to the Rural Health Clinic. Every patient entering the clinic will have the option of seeing the physician assistant or returning to the clinic at a time when the physician will be in attendance.

The duties of the physician assistant in the office will be as follows:

I. Well Child Health Care Checks

A. Take a complete detailed medical and developmental history at the routine one-week, six-week, six-month and one year health care checks. Perform the physical examination, recognize the deviations from normal, record and present the data to the primary physician.

B. Perform preschool and physical education examinations. Review the developmental history and immunization record of the patient.

C. Perform Title XIX pre-screening physicals on eligible children once each year.

D. Recognize departures from good health in the above examinations, under the supervision of the physician. Counsel regarding diet, growth and development, social habits and routine health care, according to physician's orders.

II. Ill Child

See initially and screen children with departures from good health, taking appropriate history and physical examinations. Evaluate the situation, consult with the physician when appropriate, and follow his orders in regard to instructions for the patient and treatments as outlined in Item 6 below. The physician will perform re-checks and progress examinations.

SAMPLE

III. Adult Patients

Take a complete history. Perform complete physical examinations including pelvic and rectal, where appropriate. Record history, formulate diagnosis, and treatment plan.

IV. Emergency Call

The physician assistant may take emergency calls. He/she will evaluate emergency patients.

V. Diagnostic Procedures

The physician assistant may draw venous blood, take Papanicolaou smears, collect culture specimens, perform tonometry, EKG interpretation, and other procedures commensurate with experience and training.

VI. Therapeutic Procedures

The physician assistant may routinely perform such therapeutic procedures as:

Treatment, medication, diagnosis, debridement, suture and subsequent care of wounds; removal of impacted cerumen; subcutaneous local anesthesia; nasal packing for epistaxis; cast sprains and fractures; remove casts; incise and drain localized abscesses and electrocauterize warts; and other procedures as delegated by the supervising physician.

The duties of the Physician Assistant at other sites will be as follows:

House Calls: The physician assistant may make house calls when appropriate. He will follow the orders of the physician regarding any instructions to the patient, and treatments as outlined in Item 6 above.

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RURAL HEALTH CLINIC
POLICY AND PROCEDURES
PREVENTIVE MAINTENANCE OF BIO-MEDICAL EQUIPMENT

I. Policy

It is the policy of the Rural Health Clinic to maintain all bio-medical equipment in optimal safe operating condition.

II. Procedures

A. Each piece of bio-medical equipment will be inspected by a Bio-Medical Technician. This inspection will insure the equipment is in proper operating condition, is safe to use, and is calibrated properly.

B. The x-ray machine will be inspected annually by a representative of the x-ray corporation, to insure proper operating condition, safety, and calibration.

C. If and when a malfunction occurs or is suspected, the proper service will be solicited immediately and the equipment will be put out of use until it has been returned to proper operating condition.

D. Each time an inspection or repair occurs, an entry will be made in a log and signed by the service person to verify the event.

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RURAL HEALTH CLINIC
BIO-MEDICAL EQUIPMENT
PREVENTIVE MAINTENANCE AND SERVICE LOG

SAMPLE SAMPLE SAMPLE

Instrument:____
Date:______________________ Serial No.:______________________
Service Performed:____
____

____
Service Technician Signature

Instrument:____
Date:______________________ Serial No.:______________________
Service Performed:____
____

____
Service Technician Signature

Instrument:____
Date:______________________ Serial No.:______________________
Service Performed:____
____

____
Service Technician Signature

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RURAL HEALTH CLINIC
POLICY AND PROCEDURES
DRUG STORAGE AND SECURITY

I. Policy

A. Security

All medications stored on the clinic premises will be kept in cabinets or refrigerators.

B. Expiration Dates

All drug storage areas will be inspected and inventoried every month and all medications will be disposed of properly when their expiration date is passed. A schedule will be posted in the medication storage area and the staff member performing the inspection each month will initial it.

C. Drug Shelf Life

All multiple-use vials must be disposed of one year after the date of first use. The date of first use and the date after which the vial must be disposed of will be written on the vial, even if the expiration date of the drug has not yet been reached. Medications that must be mixed will be labeled with the date when it was mixed and when it must be discarded. Such medications shall be discarded no more than six months after the drug is mixed.

D. Administration of Drugs

Injections of medications will not be administered by an R.N./L.P.N./M.A. unless a physician or physician assistant is on the premises.

E. Prescribing

The physician assistant may prescribe only non-controlled substances as listed in the current Physicians Desk Reference. Controlled substances will only be prescribed by physicians using the appropriate form. All prescriptions will be documented in the patient chart indicating drug name, strength, duration and diagnosis.

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RURAL HEALTH CLINIC
POLICY AND PROCEDURES
USE OF AUTOCLAVE AND STERILE SUPPLIES

I. Sterilizing

A. Sterilizing Equipment

1. Prepare CIDEX PLUS 28 day solution for use by first adding the entire contents of the vial of liquid activator to the solution in the plastic container. A quick shake activates solution.
NOTE: The activator contains a rust inhibitor. Do not add any other agent. Upon mixing, the colorless solution changes to a nonstaining green to denote proof of activation.

2. Clearly mark the expiration date in space provided on the jub, or on the lid of tray with a piece of tape. Expiration date is 28 days from the date of activation.

3. Thoroughly clean all instruments with a mild detergent solution to remove debris.

4. Place clean, rough-dried equipment in perforated inner tray and immerse in SIDEX PLUS Solution for desired period of time. Use covered containers to minimize odor and to prevent evaporation.

   For DISINFECTION: Immerse completely for a minimum of 10 minutes at 20°C or higher to destroy vegetative organisms including Pseudomonas aeruginosa, pathogenic fungi and viruses. (Poliovirus Type 1; Adenovirus Type 2; Herpes simplex Type 1, 2; Influenza Type A [WS/33]; Vaccinia; Coronavirus; Cytomegalovirus; Rhinovirus Type 14; Coxsackievirus B1) on inanimate surfaces.

   To destroy Mycobacterium tuberculosis on inanimate surfaces, check and ensure that solution temperature is 25°C before immersing completely for a minimum of 20 minutes.

   For STERILIZATION: Immerse completely for a minimum of 10 hours to destroy resistant spores as represented by Clostridium sporogenes and Bacillus subtilis.

5. Remove equipment from CIDEX PLUS Solution

   For DISINFECTION: Rinse equipment THOROUGHLY with quality tap water. Quality tap water is water that has been tested by a public health service and certified as safe to drink.

   For STERILIZATION: Use sterile technique when removing equipment from solution and rinse THOROUGHLY with sterile water.

6. Dry. Return to use. This solution may be used and reused for up to 28 days after activation. Do not use activated solution beyond 28 days.

B. Sterile Supplies

1. No sterile supplies will be stored on a counter or other open surface.

2. All supplies sterilized within the clinic will be labeled with date of sterilization and an expiration date.

- Items wrapped in cloth will carry an expiration date of three months following sterilization.
- Items wrapped in sterile peel packaging, plastic, and paper envelopes, and sealed with autoclave tape will carry an expiration date of six months after sterilization.

3. Sterile supplies will be inspected every two weeks. Out of date supplies will be removed, rewrapped and sterilized again. A schedule for regular inspection will be posted and the staff member inspecting the supplies will initial it.

4. No outdated sterile supplies will be used.

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RURAL HEALTH CLINIC
POLICY AND PROCEDURES
MEDICAL RECORDS

I. Policy

The policy of the Rural Health Clinic is to maintain complete medical records on each patient seen.

II. Procedures

A. Confidentiality

Patients as well as the clinic staff will be made aware the medical records and information contained in them is to be held in strict confidence. A patient must give written permission for the release of medical information from the clinic records. A parent or legal guardian must supply this permission for a minor.

B. Responsibility

At the Rural Health Clinic, maintenance, accessibility and systematic organization of medical records will be the responsibility of the physician assistant/physician.

C. Development of Medical Records

1. Each patient will have an individual medical record.
2. Clinic visit notes will be recorded on consecutively numbered pieces of lined notebook paper, one entry for each clinic visit using problem-oriented approach.
3. A medical assistant or nurse will record weight, blood pressure and temperature when appropriate.
4. Assessment of each visit will include either presumptive or definitive diagnosis.
5. Each clinic visit alone, along with history and physical examination date, will include:
   - Laboratory or x-ray results if appropriate.
   - Treatment plan, including medications, patient education, etc.
   - Return appointment if needed.

D. Personal Data Base

1. Each patient will be required to complete a patient registration form.
2. If a patient is a minor or unable to supply the necessary information, a parent or guardian will be required to provide the data.

E. Obtaining Medical Records from Previous Physician Providers

To obtain information in the form of medical records from previous physicians, providers or hospitals, the patient must sign a release of information form.

F. Miscellaneous Procedures

1. On the first visit, each patient will be questioned as to past medical history and an appropriate physical examination will be recorded on a special form to be the first page of the record.
2. A laboratory flow sheet will be used to follow laboratory reports.

G. Filing of Records

1. Each patient will have an individual medical record with name displayed on the folder.
2. Records will be filed in alphabetical order in an open-faced filing system located at the receptionist*s area with a color-coded system to reduce possibility of filing error.
3. Each pediatric chart will contain a form to record immunizations.
4. Ledger cards will be kept to maintain a record of charges and payments.
5. Medical records will be kept for seven years after the last active use of the record. If the record is not used for one year, it will be moved to an "inactive file."
6. Upon the death of a patient, the record will be moved to a deceased file.

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III. Review of Records

A. Each clinic visit note may be reviewed by the supervising physician.

B. Medical records will be formally reviewed periodically for quality control.

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RURAL HEALTH CLINIC
POLICY AND PROCEDURES
PATIENT CARE

I. Policy

The following policies were developed by the Patient Care Committee. It is the policy of the Board that the best and most appropriate services be provided to all of its patients, particularly in each of the clinical settings.

II. Procedure

It shall be the policy of the Rural Health Clinic to provide the following direct services at the clinical site, making use of the services of both a physician and physician assistant (refer to job description for the physician assistant).

A. Professional Services:

1. Office Visits
2. Patient Counseling
3. Physical Examinations
4. Blood Pressure Checks
5. Gynecological Examinations (Includes: pelvic, pap smear, breast and rectal examinations).

B. Clinical Procedures

1. Audiometry
2. Arthrocentesis
3. Catheterization (Bladder)
4. Ear Examination
5. Ear Piercing
6. Cauterization
7. Excision Large Skin Lesion
8. Excision Small Skin Lesion
9. Excision of Ingrown Toenail
10. Foreign Body Removal
11. Foreign Body Removal (Eye)
12. Fracture Care and Follow-Up
13. Incision and Drainage (Simple and Uncomplicated)
14. Laceration (Small and Large)
15. Sigmoidoscopy
16. T.B. Skin Test (or Other)
17. Tonometry (Screen)
18. Visual Acuity Test

III. Laboratory

It is the policy of the Rural Health Clinic to provide quality laboratory services appropriate to the medical needs of the patient, using the facilities of the Rural Health Clinic, and more sophisticated facilities, but with preference to local services.

A. Rural Health Clinic

1. Basic laboratory procedures will be performed at the Rural Health Clinic.
2. Laboratory services will be performed by appropriately trained clinical personnel.
3. Laboratory (on-site complete)
    - a. Blood Sugar
    - b. Hemaglobin or Hematocrit
    - c. Pregnancy Test
    - d. Gram Stain Smear
    - e. UA
    - f. Wet Prep
    - g. WBC
    - h. Cholesterol
    - i. Blood Urea Nitrogen
    - j. Mono Test
    - k. Uric Acid
    - l. Strep Screen

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4. Laboratory (on-site specimen/off-site analysis)

Automated Chemistry Panels:

a. Profile 12 Chemistry
b. Profile 20 Chemistry
c. Profile 20 Chemistry with Lipoprotein Electrophorysis
d. Electrolyte Profile
e. Executive Profile
f. Liver Profile
g. Prenatal Profile
h. Thyroid Profile
i. Weight Control Profile II
j. VDRL
k. Pap Smear
l. Culture & Sensitivity

B. Laboratory studies which are urgent and not available at the Rural Health Clinic will be done at another local facility.

C. Injections/Immunizations/Supplies

1. Allergy Shots
2. B-12
3. DT
4. Flu Shot
5. Bicillin
6. TB
7. Tetanus Toxoid
8. Tetanus Immune Globulin
9. Dressings
10. Other

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D. Guidelines for Medical Management of Health Care Problems

1. All records will be retained in the patient files for seven years after the last patient visit or upon death of the patient. All health care records will be kept updated, containing sufficient information to correctly assess and respond to medical problems which are reviewed.

2. All consultations and referrals will be made by the physician assistant or after consultation with the physician, and such consultation and/or referral will be entered on the patient records.

3. The clinic shall provide medical emergency procedures as a first response to common life-threatening injuries and acute illnesses.

E. Procedures for Emergency Care

1. Whenever an emergency medical situation such as cardiac distress, stroke, extensive burns, punctures, poison, choking, diabetic coma, insulin shock, etc., presents itself, the first person aware of the situation should alert the physician, physician assistant and the staff.

2. The procedure shall be to make certain the person whose life is threatened has:

   a. Open Airway (remove obstruction)
   b. Breathing (start oxygen/cardiopulmonary resuscitation)
   c. No Excessive Bleeding (pressure)
   d. No Broken Bones

3. As soon as the patient is stable enough to leave, one person should notify the physician by telephone and notify the ambulance to prepare for transport. The hospital should then be notified of the forthcoming emergency.

4. The following drugs and biologicals commonly used in life-saving procedures are at the Rural Health Clinic for use at the direction of the physician assistant by an R.N. or L.P.N. in such life-threatening emergencies.

   a. Lasix IV
   b. Lidocain IV
   c. Ipecac-oral
   d. Decadron Phosphate Injectable
   e. Benedryl Injection
   f. Insulin Injectable

   Other biologicals, analgesics, anesthetics, antibiotics, antidotes, emetics, serus, and toxoids, may be maintained at the discretion of the director.

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G. Referrals and Other Off-Site Services

1. It shall be the policy of the Rural Health Clinic to provide the following services through agreement or arrangement with local hospitals and or clinic centers.
   - Professional Services
   - Nursing Home Visit
   - Hospital Outpatient
   - Hospital Visit (Initial)
   - Hospital Visit (Subsequent)
   - Hospital Visit (Special Care or Comprehensive)
   - Obstetrical Care (Complete) Uncomplicated Including Antepartum Care, Delivery and Post-Partum
   - Mental Health Care
   - OB Procedures

H. The Patient Care Committee will personally review and evaluate services provided by the Rural Health Clinic.

I. Security of Medications

Administration of all drugs and biologicals (if applicable) will be performed by the physician, physician assistant, or other appropriately trained personnel, upon the order of the physician or physician assistant.

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J. Review of Policies

These patient care policies and procedures shall be reviewed semi-annually. Policies will be reviewed and approved by the Medical Director.

The foregoing policy and procedures were approved by the Rural Health Clinic Medical Director on ________________.

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RURAL HEALTH CLINIC
STATEMENT TO PERMIT PAYMENT TO THE RURAL HEALTH CLINIC FOR SERVICES AND AUTHORIZATION TO RELEASE INFORMATION

I certify that the information given by me in applying for payment under Title (18) XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Medicare Program and/or the Social Security Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I request that payment of authorized benefit be made on my behalf. This authorization and request shall apply to the period ________ to ________.

Signed ___________________________
State of Current License _________

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RURAL HEALTH CLINIC
POLICY AND PRECEDURES
NONDISCRIMINATION POLICY

It is the policy of Hope Medical Clinic to provide service to all persons without regard to race, color, national origin, handicap or age in compliance with 45 CFR Parts 80, 84, and 91 respectively. The same requirements are applied to all, and there is not distinction in eligibility for, or in the manner of providing services. All services are available without distinction to all program participants regardless of race, color, national origin, handicap or age. All persons and organizations having occasion either to refer persons for services or to recommend our services are advised to do so without regard to the person's race, color, national origin, handicap or age.

The person codesignated to coordinate compliance with Section 504 of the Rehabilitation Act of 1973 (nondiscrimination against the handicapped) is Catherine Farmer who can be reached at 777-777-7777.

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HOPE MEDICAL CLINIC
PERSONNEL

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HOPE MEDICAL CLINIC
LAB SERVICES

IN HOUSE:

REFERENCE LAB:

QUALITY ASSURANCE:

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HOPE MEDICAL CLINIC
EQUIPMENT

SAMPLE SAMPLE SAMPLE

GEMSTAR SERIAL#
Printer SERIAL#
Pipetter SERIAL#

EKG MACHINE SERIAL#

X-RAY MACHINE SERIAL#
Processor SERIAL#
Film Bin SERIAL#

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HOPE MEDICAL CLINIC
RECORDS RELEASE

SAMPLE SAMPLE

Date ___________________________

To____
____

SAMPLE SAMPLE

I hereby authorize you to release to:
____
____
____

SAMPLE SAMPLE

any information including the diagnosis and records of any treatment or examination rendered to
me during the period from _____________________ to _____________________.

____
Signature

SAMPLE SAMPLE

____
Witness

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HOPE MEDICAL CLINIC
SECTION 504 GRIEVANCE PROCEDURES

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Section 504 of the Rehabilitation Act prohibits discrimination based on handicap. In accordance with Section 504 Regulation, any program participant (patient, resident, etc.), participant representative, prospective participant, or staff member who has reason to believe that she/he has been mistreated, denied services or discriminated against in any aspect of services or employment because of handicap may file a grievance. In order to implement this policy, this agency/facility has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by the U.S. Department of Health and Human Services regulation (45 CFR Part 84) implementing Section 504 of the Rehabilitation Act of 1973 as amended (29 U.S.C. 794). Section 504 states, in part, that "no otherwise qualified handicapped individual ... shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." The law and regulations may be examined in the office of Grace Johnson, Hope Medical Clinic, 1 Pine Street, Hope, Illinois, 777-777-7777, who has been designated to coordinate the efforts of Hope Medical Clinic to comply with the regulations.

1. A grievance must be in writing, contain the name and address of the person filing it, and briefly describe the action alleged to be prohibited by the regulations.

2. A grievance must be filed in the office of the Section 504 Coordinator within 10 days after the person filing the grievance becomes aware of the action alleged to be prohibited by the regulations. This time frame may be waived by the Coordinator if extenuating circumstances existed which justify an extension.

3. The Coordinator, or his designee, shall conduct such investigation of a grievance as may be appropriate to determine its validity. These rules contemplate thorough investigation, affording all interested persons and their representatives, if any, an opportunity to submit evidence relevant to the grievance. Under Section 504 of the Rehabilitation Act, 45 CFR 84.7(b), the agency/facility need not process complaints from applicants for employment.

4. The Section 504 Coordinator shall issue a written decision determining the validity of the grievance no later than 30 days after its filing.

5. If the grievance has not been resolved at this point, the Section 504 Coordinator should forward it to Grace Johnson, P.A., Clinical Director, who shall have an additional 30 days to resolve the grievance. The clinical director shall notify the grievant in writing of the decision and list the evidence on which the decision is based.

6. If the complaint is still unresolved, the grievant may request, in writing, that the clinical director submit the grievance to the Board of Directors. The Board shall have 30 days to resolve the grievance. If the grievance is then unresolved, the grievant will be advised in writing of the right to file a complaint with the appropriate local, State and Federal civil rights offices and will be provided with the names and addresses of such offices, including the Office for Civil Rights of the U.S. Department of Health and Human Services at 105 W. Adams St., 16th Floor, Chicago, IL, 60603.

HOPE MEDICAL CLINIC
COMMUNICATION WITH LIMITED-ENGLISH-PROFICIENT PERSONS

I. Policy:

The Hope Medical Clinic shall provide for communication with limited-English-proficient persons, including current and prospective patients/clients, family, interested persons, etc., to ensure them an equal opportunity to benefit from services. The procedures outlined below will ensure that information about obligations, etc. are communicated to limited-English-proficient persons in a language which they understand. Also, it provides for an effective exchange of information between staff/employees and patient/clients and/or families while services are being provided.

II. Procedure:

Whenever a translator is needed, Grace Johnson is responsible for contacting the translator if available who speaks the needed language, e.g., Spanish. If a translator is not available or there is none for a particular language, arrangements have been made with the Health Department to provide such translators.

(If consent forms, waivers of rights and information about services, benefits, requirements, etc. are available in languages other than English, list the materials and the languages in your procedures and tell how and where they can be obtained.)

Note
Family members or friends of the limited-English-proficient person may not be used as translators unless specifically requested by that individual *after* an offer of a translator has been made by your facility/agency. Such an offer and the response must be documented in the person*s file and you may wish to develop a form for them to sign. Other patients/clients may *not* be used to translate. These restrictions are to ensure confidentiality of information and accurate communication.

*If your agency/facility operates on a 24-hour basis, procedures must cover the entire period.

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M.D.

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RESUME
P.A.

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HOPE MEDICAL CLINIC
REFERRAL PHYSICIANS

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Name: ________________________________
Specialty: _____________________________
Address: ______________________________
City/State/Zip:_________________________

Name: ________________________________
Specialty: _____________________________
Address: ______________________________
City/State/Zip:_________________________

Name: ________________________________
Specialty: _____________________________
Address: ______________________________
City/State/Zip:_________________________

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Eye

Name: ______________________________
Specialty: ___________________________
Address: ____________________________
City/State/Zip:________________________

Name: ______________________________
Specialty: ___________________________
Address: ____________________________
City/State/Zip:________________________

Dental

Name: ______________________________
Specialty: ___________________________
Address: ____________________________
City/State/Zip:________________________

Name: ______________________________
Specialty: ___________________________
Address: ____________________________
City/State/Zip:________________________

SPECIALTIES

A= Allergy
AN= Anesthesiology
C= Cardiology
D= Dermatology
GI= Gastroenterology
GP= General Practice
U=Urology
GY= Gynecology
H= Hematology
IM= Internal Medicine
NO= Neurosurgery
NS= Neurology
OB= Obstetrics

OG= OB/GYN
OH= Other Specialties
OM= Occupational Medicine
OP= Opthamology
OS= Orthopedic Surgery
OT= Otorhinolaryngology
P= Pediatrics
PD= Pulmonary Disease
PH= Pathology
PM= Physical Medicine

S= Surgery
POD= Podiatrist

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Appendix E

Other Resources

Other Resources

<table>
<tr><th colspan="2">Centers for Medicare & Medicaid Services</th></tr>
<tr><td>RHC Coverage and Payment

Randy Ricktor
CMS
7500 Security Blvd.
Room C4-25-02
Baltimore MD 21244

Phone: 410-786-4632
e-mail: rricktor@cms.hhs.gov</td><td>RHC Survey & Certification

Jacquelyn Kosh-Suber
CMS
7500 Security Blvd.
Room S2-09-16
Baltimore MD 21244

Phone: 410-786-0618
e-mail: JKoshsuber@cms.hhs.gov</td></tr>
<tr><td>RHC Cost Reporting Policy

Tom Talbott
CMS
7500 Security Blvd.
Room C5-03-13
Baltimore, MD 21244

Phone: 410-786-4592
e-mail: TTalbott@cms.hhs.gov</td><td>RHC Claims Processing

Gertrude Saunders
CMS
7500 Security Boulevard
Room C4-12-06
Baltimore MD 21244

Phone: 410-786-5888
e-mail: GSaunders@cms.hhs.gov</td></tr>
</table>

RHC Quality Assurance Standards	RHC Medicaid
Mary Collins CMS 7500 Security Boulevard S3-05-16 Baltimore MD 21244-1850 Phone: 410-786-3189 e-mail: MCollins@cms.hhs.gov	Suzan Stecklein CMS Center for Medicaid and State Operations S2-05-28 Baltimore MD 21244-1850 Phone: 410-786-3288 e-mail: Sstecklein@cms.hhs.gov

Health Resources and Services Administration

Office of Rural Health Policy
Health Resources and Services Administration
5600 Fishers Lane, 9A-55
Rockville, MD 20857

Phone: (301) 443-0835
(301) 443-2803 - Fax

Website: www.ruralhealth.hrsa.gov

Shortage Designation Branch
National Center for Health Workforce Analysis,
Bureau of Health Professions
5600 Fishers Lane, 8C-26
Rockville, MD 20857
800-400-2742

Phone: 301-594-0816
301-594-4988 - Fax
e-mail: sdb@hrsa.gov

Health Professional Shortage Areas
(http://bphc.hrsa.gov/databases/newhpsa/newhpsa.cfm)

Medically Underserved Areas
(http://bphc.hrsa.gov/databases/newmua/)

National Association of Rural Health Clinics

Bill Finerfrock
Executive Director
426 C Street, NE
Washington, D.C. 20002

Phone: (202) 543-0348
(202) 543-2565 - Fax
e-mail: info@narhc.org

Independent RHC Fiscal Intermediaries	
State(s)	RHC Fiscal Intermediary
Maine	Associated Hospital Service of Maine 2 Gannett Drive South Portland, ME 04106 (617) 689-2809
New Hampshire, Vermont	Anthem Health Plans of New Hampshire, Inc. Medicare Audit and Reimbursement 3000 Goffs Falls Road Manchester, NH 03111-0001 (603) 695-7560
Connecticut, Delaware, District of Columbia, New York, Pennsylvania, Puerto Rico, Rhode Island, Maryland Massachusetts, Virginia, West Virginia,, New Jersey, Virgin Islands	Veritus Medicare Services 120 Fifth Avenue Suite P5301 Pittsburgh, PA 15222 (412) 544-1867 www.Veritusmedicare.com
Colorado, Montana, North Dakota, Oklahoma, South Dakota, Utah, Wyoming, Texas, Arkansas, Louisiana, New Mexico	TrailBlazer Health Enterprises, LLC Medicare Operations P. O. Box 660156 Dallas, TX 75266-0156 (469) 372-7463
Kentucky, Tennessee, North Carolina, South Carolina, Mississippi, Alabama, Iowa, Georgia, Florida, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Illinois, Indiana, Ohio, Kansas, Oregon, Michigan, Minnesota, Nevada, Missouri, Nebraska, Washington, Alaska, Wisconsin	Riverbend GBA 730 Chestnut St, Rm. 3C Chattanooga, TN 37402-1790 (423)755-5124 riverbendgba.com

Fee-For-Service Model

Feasibility Analysis

FY: 200_

Feasibility Estimate

Insurance Type:	Medicare	Medicaid	Other	Total
Percent of Total Visits:				
Total Visits				
Fee for Service Payments				
Average Payments				
Total Payments				
Rural Health Clinics				
All-Inclusive Rate (200)	**	**		
Total Payments				
Increase				
Percent Increase				

ASSUMPTIONS:

* Assumption should be based on RHC cap rate for year prior to analysis. (2002 = $64.78)

** Depending on what State the RHC is located in, each State Medicaid program could have its own reimbursement policy for RHC's. In 2001, most States paid a base rate equivalent to the average of the 1999 & 2000 Medicaid per visit cost report rate. For succeeding years, the base rate will be adjusted by the Medical Economic Index (MEI).

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