

Centers for Medicare and Medicaid Services  
Rural Health  
Open Door Forum  
Moderator: Jill Darling  
Thursday, June 28, 2018  
2:00 p.m. ET

Operator: Good afternoon, my name (Kelly), and I'll be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Rural Health Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star, then the number one on your telephone keypad. If you would like to withdraw your question, please, press the pound key.

Thank you. Mr. Jill Darling may begin your conference.

Jill Darling: Thank you (Kelly). Good morning and good afternoon everyone. I'm Jill Darling CMS Office of Communications, and thank you for today for the Rural Health Open Door Forum.

Before we began, one brief announcement, this open-door forum is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in, but please refrain from asking questions during the Q&A portion of the call. If you have any inquiries, please contact CMS at [press@cms.hhs.gov](mailto:press@cms.hhs.gov).

And now, I'll hand the call up to John Hammarlund.

John Hammarlund: Thanks very much. Hi everybody. Thank you for joining us today on the call. We have a relatively short agenda, but important topics to discuss. And

there's nothing wrong with short that just means we get more time for some Q&A which sometimes we don't have time for.

So – but the topics are important. In a little while, you'll be hearing from (Devon Trolley), one of her colleagues in Baltimore headquarters about what our agency is doing in response to really one of the – the most important health crises that's facing our country in decades and that's the opioid crisis. And so, we're really pleased to have (Devon) join us today and talk a little about what CMS is trying to do to tackle this critical public health issue.

But first, we're going to have David Wright who is from our clinical standards folks in headquarters, to talk about the CAH distance requirements. We have discussed this topic on previous open-door form calls, and generally the discussions have elicited lots of feedback and correspondence with us after the discussion.

So, we thought we would bring David in who is – and he doesn't mind me telling you this – he's the proverbial horse's mouth on this topic to, hopefully, provide sort of a definitive answer. And David has agreed to hang around and answer questions because you may have some for instances. So, we're delighted to have David on.

And before I handed back to Jill, and our speakers, I'll just simply say that our Co-chair Carol Blackford is intended to join us today, but was unable to at the last minute. But, she sends her hellos to everybody.

And I know that she would be sure to let you know that as always, we very much value your thoughts and inputs on what she should be discussing on these calls. We hold the calls about, roughly, every six weeks.

And we're certainly happy developing the agenda, based on the most current policy issues that are occurring at the agency in our own judgment about what we think would be useful for you to hear.

But, we may sometimes not get it right or we may be missing some topics that are important to you. So, please, please, please do reach out to us and let us

know what sort of things you would like to discuss on future calls. We would be very happy to set up that for an agenda item and bring the right speaker.

So, at the end of the call, Jill, we'll let you know how you can reach out to us via e-mail to dialogue with us about future agenda. So, again, thank you for joining. Hello from my Co-chair, Carol Blackford, and now I'll have it back to Jill, so she can then hand it off to David and to (Devon). Thanks.

Jill Darling: Thank you, John. Our speaker, David Wright, will go to the CAH distance requirements.

David Wright: All right. Thank you, Jill, very much. This is David Wright; I'm the Director of the Quality Safety and Oversight Group here at CMS, formally serving certification group.

And there have been some discussion, I understand, with regard to CAH distance requirements and specifically with regard to off-campus provider-based facilities, and how to calculate measurement and what the measurement goes to.

You all are aware, I would assume, that the distance requirements for CAHs, generally, are 35 miles from another hospital or 15 miles, when there's mountainous terrain or secondary roads.

Distance and requirement also applies to off-campus facilities, off-campus provider-based facilities of a CAH; that they too have to maintain that distance buffer of 35 miles from a hospital, or 50 miles with the mountainous roads.

And the intent is that the CAHs aren't extending into an area that would – gets into the territory or area, if you will, of another hospital. I think the confusion just to be very clear is that, the measurement is from the off-campus provider-based facility of the CAH to the main campus of the hospital.

So, if the hospital that's within – that's being measured against – has an off-campus provider-based facility, we don't measure to that, we measure to the

main campus of the hospital or if its another CAH in the area, that's what this the distance requires based off of.

So, to try to make it very clear, the distance requirements for CAHs are evaluated based on either the main CAH campus, being 35 miles away from another hospital or the provider-based campus of that – provider-based off-campus facility of that CAH, similarly being 35 miles away from the main hospital campus.

Those are the two points that we had measured from the – both that extend out or going to the main hospital campus, not to an off-site provider-based campus of the other hospital. Hopefully, that's clear, I'm going to stick around for the Q's and A's.

But, I think the confusion before was it appear to reference that we are looking at the off-campus provider-based facility of the other hospital. In terms of doing our measurements, the state operations manual that remains unchanged, that outlines this guidance is that 2256H of the state operations manual.

And again what we're measuring from is either the CAH or the off-campus provider-based facility of that CAH, and that's to the main campus of whatever hospital may be within the area. So, hope that helps and I'll, again, stick around for questions and answers. Thanks, Jill.

Jill Darling: All right. Thank you, David. And next, we have (Devon Trolley), who has an update on the CMS opioid response activities.

(Devon Trolley): Thank you. So, my name is (Devon Trolley), and I worked at CMS. And I wanted to talk through some of the efforts that CMS has undertaken related to that opioid epidemic.

This has been a large priority, a top priority across for department of helping human services, and CMS as a payer in our programs in Medicare and

Medicaid and exchanges are really looking at all the tools that we have, within our organization, to help contribute to those efforts.

So, I'm going to highlighted a few and take a few minutes to go through some key activities and then, happy to take question at the end.

We recently (let) – in the last week or two published our road map, and I believe those links are centered around that sort of outline these activities, and those really fall into just three buckets.

The first is prevention, the second is treatment, and the third is (debit). So, I'll talk a little bit about what goes into each of those.

So – that I'm sure many people on a call are familiar this epidemic really focus – really hits every different type of place throughout the country. And so, it's really our complex problem with a lot of complex CAHs and not simple solutions. But, from (SNP's) perspective, we're looking at the tools we have to help with that.

So, the first are that we're focusing on is prevention. And in that area, we're really looking at preventing people from developing a dependent or an opioid disorder. And we see our role there in couple of different ways.

One is reducing the dependence on prescription opioids for pain management, and also the amount of prescription opioids that are used and trying to ensure that across our programs, there's adherence and alignment to the guidelines relieved by the CDC, that really work through sort of appropriate prescribing.

And in those guidelines are really focused on making sure that doctors aren't sort of overprescribing and resulting in having a lot prescription opioids out in the communities but could potentially be diverted for (misuse).

And so, some of statistic show that 40 percent of the all opioid (crisis) involve a prescription opioid, which I think really highlights the importance of this effort. And further, others pretty show that three out of four people, who use heroine misused prescription opioid first.

So, those are really sort of the underlying significance that we're looking at changing by – again, reducing the dependence on prescription opioids and then overprescribing, that I think just didn't have as much attention on it before – in that CDC guidelines and some other effort.

At the same time, we're really looking to downside with the need of some patients to have prescription opioids for pain management. We now understand that, that is a very important use of prescription opioid.

So, we just want to make sure that, that is being done in – away that is responsible for the patient, and different type of patient at undue risk of developing an opioid (use to further), and we're also looking at alternatives to prescription opioids for pain management.

See, a lot of effort going into – looking at chronic pain and (sorts of) alternatives there might be there from a covered to perspective, as well as looking at acute pain and the evidence around the whether prescription opioids are really necessary and for how long are those necessary to treat more acute pain (as well).

So – and some people might have been in April, Medicare published new regulations for the – for next year for 2019 is – and will take a fact, and those put some limits and place on prescription opioids, including a limit to seven days for initial (fill of) the prescription opioids, for people who are newly taking prescription opioids.

So, not for people who are on opioid for chronic pain, but really those more acute pain new users of prescription. And then, as we – so that – so that would be will one important piece on.

And then, recently, Congress gave Medicare a new authority to be able to limit beneficiaries to a single pharmacy and a single doctor, when it's shown that there are – when the beneficiaries are at high risk, by sort of having multiple physicians and multiple pharmacists, that are prescribing opioids and then filling them.

Again looking – trying to look at that total dose of prescription opioid, that someone might be receiving and trying to make sure that, that is – we had insight into – well, one person might be receiving and how we can make sure that, that was reasonable amount.

Another activity that we've done in prevention has been monitoring Medicare data and we identify patterns of providers that are prescribing much higher than the recommendations.

We're sending out letters to them, just to make sure they understand that they're prescribing is a lot higher than their peers and in that guidelines, again, to try to use information and data to influence their behavior by help – by having them sort of understand where they fit in that context.

So, the second key bucket that we are – that we are focused on is treatment. And that's really looking at people, who already have developed an opioid use disorder. So, our prevention is really trying to decrease the number of people who get to that point.

Treatment is a – we acknowledge that a lot of people, or whether it's through prescription opioid or other opioid use that are elicit drug use or not have developed an opioid use disorder.

And so we're really been looking at our programs to see, "How can we bring evidence-based treatment onto those people to really help them recover from that opioid use to sort or – and sort of regain functionality in our lives, whether that's they're working or through families." So, that's really the goal of the treatment – the treatment bucket.

And what we're focused on there is looking at medication as the said treatment, which have been shown to be a very effective or shown to be an effective way of having people regain functionality and sort of removing of the debilitating aspects of an opioid use disorder.

However, research shows that only about 20 percent of people actually receive that treatment, that type of treatment. So, our treatment bucket is really focused on how do we, expand access to that.

So, we're looking across, again, our Medicare Medicaid and exchange programs that are private (insurance), to look what levers we have our direct or indirect, whether it's payment policy or education, best practices, to incentivize a broader coverage of that treatment.

And I think and – there's many components that go into that, including looking at how that plays out in rural areas and the unique considerations there, versus areas that tend to have more access to providers, generally, that are non-rural.

And a big component of our efforts on treatment has been on Medicaid space. And some of you may be familiar in your space. There are a few different types of waivers and demonstrations available to states to focus on substance use disorder, including opioid use disorder.

So, there are – some states have used the health home demonstration project to increase treatment capacity for opioid use disorder. And specifically, we have several states who come in at this point using an 1115 substances disorder waiver to really expand the amount of treatment that is available and sort of build-up that capacity within their states. So – and we continue to have states coming in, to take advantage of those flexibility, so, we think that, that is promising as well.

So, the last bucket is data, and that's really – we have – really focused on how do take the data we have and use that to target our prevention and treatment effort?

So, on the Medicare side, we have published a prescribing (hit) map that shows variation across the country and prescribing patterns. And the intent of this is – excuse me. The intent of this is really allow local communities – local communities to identify where they might be the most right opportunity or targeting prevention (at) – again also treatment efforts. OK.

So, I think that we – across these efforts, we’re really looking to move the dial. And I think we’ve been encouraged by some of the efforts that we have seen and – at the state in the Federal level – to make a difference in this issue.

For example in Virginia, they increased reimbursement, which led a 49 percent increase in the number of people accessing opioid treatment; services, and its 39 percent decrease in opioid-related emergency department, such as in the first five months.

We’ve also seen some success from our – (conditions) focused on best practices. And in Colorado, our CMS quality improvement orientation worked to achieve a 36 percent reduction in the use of opioids, about 35,000 fewer administrations of opioid in the emergency department and they increased in alternative medications by 31 percent.

So, we like to build on the successes that we’ve been so far and really replicate those across, as many situations as possible to really, take a comprehensive look at this issue.

So, those are our main activities so far. I think we continue to (see) feedback from a whole range of stakeholders on this issues, to make sure we’re doing as much as we really can. So, I welcome your questions and feedback on our activities so far.

Jill Darling: All right. Thank you, (Devon), and thank you to David. So, (Kelly), we’ll open the line for our Q&A, please.

Operator: Certainly. As a reminder, ladies and gentlemen, if you would like to ask a question, please press star then one on your telephone keypad. If you would like to withdraw your question, please press the pound key.

Please limit your questions to one question and one follow-up to allow other participant’s time for question. If you require any further follow-up, you may press star again to rejoin the queue.

Our first question comes from (Mark Lin) from (Healthcare Business), please go ahead.

(Mark Lin): Hi. This is (Mark Lin) from Healthcare Business, specialist in Chattanooga, Tennessee. And I have a comment in the question about the recruitment by Palmetto GBA of paid RHC and hospital claims dating back as long as four years ago.

In a matter of time, (get you around me) to comment, I can only generalize. But the vast majority that claims were valid claims for services rendered to RHC patients. They were paid for but Cahaba GBA instead of the Medicare – the Advantage plan that the patient had joined.

That patient failed to notify the RHC and Medicare had failed to notify CMS that the patient had joined or Cahaba (edits) did not catch that the patient had joined a Medicare Advantage plan.

And simply because the money was paid by the wrong Medicare contractor, Palmetto is going back and recouping all these payments from RHCs and hospitals going back for years. The RHCs and hospitals are then expected to be on the Medicare Advantage plans for the money to them.

However, the vast majority of these claims are now unplayable due to filing issues – due – timely filing issues, that CMS and the Medicare Advantage plans have set out.

Palmetto and their FAQs have said that CMS is not going to make Medicare Advantage plans, provide a timely filing exception for these RHCs and hospitals.

Even though the error that caused these payments from the wrong contractor was (luckily) committed either by the Medicare Advantage plan or Cahaba, at least culpable and, ultimately, at least (prior) into these (mean) RHCs and hospital are the ones who have injured in this set the game of three-card (monty).

Some RHCs and hospitals will surely close, due to this payback – due to these paybacks and the financial losses that will incur.

My question is, can CMS not demand that these Medicare Advantage contractors, that really come out – not having the pay claims for services they were paid for provide us – some – a timely filing exception?

Can CMS put pressure on them; because, this is financially devastating to a lot of small rural hospitals and lot of small rural (house) clinics out there? And if we don't get to bill these Medicare claims to these Medicare Advantage plans, then we're going to lose a lot of excesses to care in a lot of rural areas. So, that's my question.

John Hammarlund: So – yes. So, this is John Hammarlund. I'm just going to interject for a moment say, thank you very much for your question and your comment.

We are very much aware of this phenomenon, obviously. And for that reason, we tried to get somebody who might be able to speak definitively about the issue today on this call in the event that some questions came through.

So, let's see. Amy, are you on? And are you able to address the question, if not comment?

Amy Drake: Yes, this is Amy Drake, and I am the Contracting Officer Representative for Palmetto, and I am on the phone

And we have heard this concern and we are still looking into this. And once a definitive answer has been – come to where we will probably be looping back around. But, we are – we are fully aware of this concern and we are working on it.

John Hammarlund: OK. Thank you. Thank you, and we're delighted you're on it.

So, that's – an answer to that, we often have to (get), which is we aware of this, we're working on it, and we will have more to say, once we can sort of get it all disentangled. But we certainly appreciate the comment, the question, as well as the impacts that you're discussing. So, thanks for raising it today.

(Mark Lin): OK, thank you very much. I appreciate it.

Operator: Your next question comes from the line of Jeremy Levin from Rural Wisconsin. Please go ahead.

Jeremy Levin: Hi, Jeremy Levin from Rural Wisconsin. I have a question to David Wright.

I appreciate the citation of the (point 2256 age and state) operations manual. Just wanting to try and figure out sort of, I guess, maybe a (can of worms) that this is and clarify that it – this off-campus provider-based facility is registered as a RHC, it would not be counted.

And also it looks like if any off-campus provider-based clinic, regardless of whether the CAH was a necessary provider and that would also be at risk. Is the correct?

David Wright: It doesn't apply to those CAHs that were in operation, prior to January 1st, 2008. The off-campus provider-based does not apply to rural health clinics either.

Jeremy Levin: OK, thanks. Then to clarify too, in operation, can be – though the entity of – they would have had to do a relocation, the operation with the (then) before July 2008, it would not apply to those, even if they've relocated since?

David Wright: I don't ...

Jeremy Levin: Contingent requirements?

David Wright: ... I don't know that (blurarjay) question.

We have that – again, it – if the CAH operates in off-campus provider-based facility, except for rural health clinic and some other exceptions that was created or required on or after January 1st, 2008. And that would mean that it was part of the CAH's Medicare certification.

Jeremy Levin: OK, thank you.

Operator: Your next question comes from a line of James Mikes from Missouri Hospital. Please. Go ahead.

James Mikes: Thank you. Thanks for taking the question.

I was just curious if there will be some written guidance of that clarification? Once again, this is for David Wright.

Will their written clarification sent out, just because I think there has been some confusion on both the side of the providers in hospital and from the regional office on whether or not the provider-based clinic of a distant hospital – not the CAH – but that provider-based clinic of another hospital factors into that measurement of the requirement for mileage?

David Wright: I don't think we're going to issue any additional written guidance, because we didn't change the guidance that's there. And if we have a situation, where there's an action taken against a CAH because of the off-campus provider-based facility of the hospital from which is being measured, then we'll certainly address that, at the time.

We're not seeing that, but, again, there's not been a change to this guidance. So, we don't believe we need to issue any sort of additional guidance on it.

James Mikes: OK.

Operator: Your next question comes from a line of Paul Lee from Strategic Healthcare. Please, go ahead.

Paul Lee: Thank you very much. And this question maybe for David, again David Wright. I just want to make sure I understand this distance issue.

So, we're working with a hospital that meets all the critical access hospital requirements. They applied, including the – distance, so a 35-mile requirement.

They applied fairly recently within the last couple years to be a critical access hospital and they were denied. And the denial basically said, "Well there's a

– an off-campus so facility of another hospital,” that’s – would – it’s a physician service, that’s within 35 miles of that hospital, of that critical – or that the hospital that was making application become a critical access hospital.

So, help me understand – I’m not exactly sure why they were denied, and how this may potentially impact other hospitals?

David Wright: I don’t know why they are denied either, and it would be hard for me to really opine on all the facts of that. I would follow up with the regional office that issued that determination and make sure that, again, in keeping with 2256 (age) ...

Paul Lee: Right.

David Wright: ... that the distance was measured to the main campus of the other hospital, not to their off-campus provider-based location.

Paul Lee: Yes. And they’ve been through appeals and everything and we keep getting the same letter back from CMS basically saying, “Well, we’re sorry. It’s within 35 miles of that other hospitals off-campus facility.”

David Wright: Yes. So, again, I would circle back to the regional office and you’re welcome to send me an e-mail as well. Then, I’ll follow up with them also.

Paul Lee: Thank you, David.

David Wright: Yes. And my e-mail real quick is david.wright@cms.hhs.gov.

Paul Lee: Thank you very much.

Operator: Your next question is from a line from (Dan Liner) from RSM U.S. LLP. Please go ahead.

(Dan Liner): I’m sorry. I believe my questions already been answered. So, thank you.

Operator: Your next question comes from a line of (Debbie Mith) from – and she’s a medical specialist. Please go ahead.

- (Debbie Mith): Just want to follow-up on (Mark Lin's) comments. I understand Palmetto has recoupment. And it sounds like you all understand the effect it has on the practices. One question I have is, what responsibility does Cahaba have in this?
- Amy Drake: Hi. This is Amy – Amy Drake. And that is something that we're still working on their evaluation, their performance evaluation. And so, their performance overall will be reflected in that.
- (Debbie Mith): Amy, (can you – can I still speak)?
- Amy Drake: Yes.
- (Debbie Mith): OK. So, their evaluation, but what impact will their evaluation have on those clinics?
- Amy Drake: Well, Cahaba no longer processes the claims for those clinics that all of that work has transitioned over Palmetto.
- (Debbie Mith): Correct.
- Amy Drake: And Palmetto is now the MAC. So, Cahaba will no longer be handling any of the claims payment for any of these clinics.
- (Debbie Mith): Could Cahaba potentially be held response – financially responsible for this era?
- Amy Drake: I can't answer that. That – that's not something I can answer at this point.
- John Hammarlund: Yes. And in fact, this is John Hammarlund. Again, I don't think we have anybody on this call that could possibly answer that question today. We're still unpacking this whole issue as I explained earlier. And I don't think we're going to be able to give you the kind of definitive answers you're looking for today. Let us sort through all of the different facets first.
- (Debbie Mith): Thank you.

John Hammarlund: Apologies, yes. Thanks. We'll go on for the next question.

Operator: Your next question comes from a line of Jessica Harback from State of Michigan. Please go ahead. Jessica Harback, your line is open.

Larry Harvath: This question is for David. This is Larry Harvath in State of Michigan. I just wanted – double check out.

So, if you have critical access hospital or if you have a hospital wanting to convert to critical access in their application, do we go by their self-identified provider locations or do we look at our records to see which provider-based locations have been officially recognized by CMS? And also could you briefly talk about the secondary road condition?

David Wright: Sure. I – Larry, I would think that we're going off what we have under the Medicare certification. So, it's what we've identified as an off-campus provider-based facility that's under their Medicare certification, so it's what we would have listed.

The secondary roads requirement again is something that applies and has been in place and that is its 15 miles, if there's mountainous terrain or areas only with secondary roads, which I believe are defined as those that as less than U.S. highways, so state roads and things like that.

There's some criteria in terms of, if it's two lane or two lane divided and things like that. But, generally, not interstates and not U.S. highways is what we look at with secondary roads or (as) mountainous terrain.

It's – would qualify for the 15-mile distance requirement. Again, that's going to be a case-by-case determination by the regional office.

Larry Harvath: And then, just to – want to clarify. I'm assuming if you have that CAH in a provider-based location and the nearest hospital, it is – whichever of the two locations is closest to the near hospital. They don't get a choice.

David Wright: That's a great clarification, Larry. That's absolutely correct. (And) (inaudible).

Larry Harvath: Thank you so much.

David Wright: Yes, thanks.

Operator: Your next question comes from the line of Maggie Elehwany from National Rural Healthcare. Please, go ahead.

Maggie Elehwany: Thank you so much for this opportunity and thank you for the clarification of mileage designation issue. I think there is still confusion on it and perhaps the clarification to the different regions.

I'm looking at a letter terminating their critical access hospital status out of a CAH in Southern Oregon, Curry General Hospital, who – there was a provider-based clinic of another – rural PPS hospital located in Northern California that was less than 35 miles away.

And according to this letter, it said that Sutter Coast Health Center, which is the California Hospital, and they're a provider-based clinic, because that is less than 35 miles from Curry General Hospital in Gold Beach Oregon.

Therefore, we must terminate your designation as a CAH effective no later than April 2nd, 2019. You may choose to convert to an acute care hospital, prior to the termination date.

Now, that CAH had to spend significant legal costs trying to challenge that. We're able to prove that they were also designated to be a necessary provider. So they won that. But we think that this was an improper issued letter by the region. So, there can be clarification to what you stated today. I think that would be helpful.

David Wright: Well, we'll be in force with the regional offices, what the policy is, what the expectations. So, we're happy to do that.

Maggie Elehwany: Thank you.

Operator: Your next question comes from a line of Dale Gibson from Dale R Gibson Inc. Please go ahead.

Dale Gibson: Yes, thank you for this opportunity.

I wanted to reiterate the issue with Palmetto and Cahaba. One thing you must realize, most these patients, these manage – managed care patients do not have a supplement. So, most of these patients had to pay out of pocket for this coinsurance and deductible from these claims.

And is obvious that it was a Cahaba issue because I think I saw in writing where it was a Cahaba issue. And what Cahaba had to do is bypass these edits 'cause if they sent these claims (of common working) file, the (common working) file would've told them these patients had an HMO. So, Cahaba bypassed these edits.

You also have to think about thousands of these claims were crossed over to Medicaid, Georgia Medicaid and ERA. And Georgia Medicaid funds were expanded incorrectly. And I would like to bring up the point for years, we have been sending claims to the regional office of our claims,, hospital claims that could – that were correct, that Cahaba could not or would not pay.

We have thousands of those. We have claims where we want appeals. We want appeals and Cahaba could not pay those claims.

So, if you're going to able to go back and re-processes each claims that Cahaba did incorrectly, how can we go about getting these claims that Cahaba failed to pay that were correct claims?

I would like for you also to know that over the past six years, I've been sending e-mails to the regional office. Well, over 200 e-mails to the regional office about the problem for the Cahaba.

And I think I even have one e-mail in there where I addressed the problem about Cahaba paying these managed-care claims when, in fact, this patient had coverage. So, would you like to address my thoughts there?

Amy Drake: Mr. Gibson, thank you for concerns and I think you and I have corresponded many times through e-mail as well.

And I appreciate you bringing all this to us. And if you think something has been paid in error, I would be very happy if you could bring that to us, if you don't think we're addressing at this point.

As you can see, when we realized, we had a (systemic) issue here, we have – we really have tried to address those as well as we could. I do think – I haven't heard a discussion about the Medicaid impact. And so I do am planning on exploring as well.

John Hammarlund: Yes, this is John Hammarlund. I'll add that I appreciate you're mentioning that issue as well.

Know that we are taking this very seriously. We're doing our very best, as I said earlier, to unpack this issue. We're mindful of the impacts and the importance to rural America and rural health clinics. And we're doing our very best to try to figure out how to solve this problem.

I wish we had all kinds of answers for you today, we don't. But, know that we are working diligently on this, and we hear you. And you're welcome to bring your concerns to us to this forum or by writing to us, and we're going to do the best we can.

Amy Drake: One other thing I would add, Mr. Gibson. I believe you personally have contacts at Palmetto that I would like you to send any of those concerns to. And go ahead and copy me. I know you've got my e-mail address. But, for the rest of you, it's [amy.drake@cms.hhs.gov](mailto:amy.drake@cms.hhs.gov). Thank you.

Dale Gibson: Again, one last thing, we're looking at a 15-day deadline when – and they're going to start taking the money back. So, we realize that (your clinic) figuring out want to do. But, in 15 days we lose the money.

Amy Drake: I hear you. And, again, I think what we've asked is that if you have issues, if you think that (was) – is an error, we are on that's what this additional 15 days is for to July 15th and we are also still exploring, what else we can do to help.

Dale Gibson: All right, thank you.

Operator: Your next question comes from the line Sandy Sage from HomeTown Health. Please, go ahead.

Sandy Sage: Hi. I think that most of the questions were answered, this is for Amy. Amy is there anything that you would like the hospitals to do meanwhile while you guys are trying to figure out how to handle the situation like should I send the letter somewhere? Should I fill any forms to slow or stop, to take back of this money meanwhile while you guys working on this?

Amy Drake: Yes, I believe Palmetto has shared an e-mail address where all of – anything that you think is pertinent should be submitted. And so, please go ahead and take advantage of that.

Sandy Sage: OK. The only other thing that we have had issue with is the list of the patients, only shows the claim I.D. number, but not a name or a patient I.D. number, anything like that.

It's very difficult for these really small rural hospitals to research these and find these people and for the RHCs as well, trying to figure out who the patient (seat in ours). So, is there any way to get patient list and (so their) employee numbers?

Amy Drake: Yes, actually, you should be able to – Palmetto was diligently working on system changes to help you out on that, and those have been put in. So, if you call their IVR that should be able to give you that information.

Sandy Sage: OK. Awesome. Thank you (inaudible) ...

Amy Drake: And I believe on their – on their website, they’ve even offered if you submit a spreadsheet, they’ll send one back with that information. I believe they’ve offered that as well.

Sandy Sage: All right, great. Thank you so much, I appreciate it.

Amy Drake: Thank you.

Operator: Again, if you would like to ask a question please, press star then one on your telephone keypad. Your next question comes from the line of Santana Jones from Dublin Medical. Please, go ahead.

Santana Jones: Amy, I know you’re all saying, you don’t have answer yet. We are a small office in Dublin County. I am one person. And now for the last two weeks, I’m not even able – been send out claims, having to research these.

Some of these, we were actually paid negative amounts for and Palmetto is trying to take positive. And I know you're saying “Send to a e-mail.”

But, is there a way we can have a open session and let’s discussed this, because we’re in the balance here and we only had 15 days. So, maybe if you guys aren’t ready for this yet, maybe we can extend it out until everybody is ready on the same page.

Amy Drake: I’m sorry. (Inaudible).

John Hammarlund: Go ahead. Go ahead, Amy.

Amy Drake: Yes. Ms. Jones, have you send those concerns to Palmetto, where it looks like what you are seeing is – disagrees to what they are seeing?

Santana Jones: Yes, I have not seen them, because actually I’m still trying to research and gather information from our old billing company that is trying to hold our (staff hostage) as well.

I did get the listed “A” from Palmetto to go in and be able to, hopefully, look it up on Palmetto. But, then again, it’s Fourth of July, one person and you guys don’t have all the answers.

So, how are we (at stake that) – as a small office to have all the answers. And this is life or death for us. I mean, we need – we need to be more only – the only thing that has been offered to us is a few extra days. We need to be on point.

Amy Drake: I hear what you’re saying. And what I would recommend is you send something to Palmetto saying, “We haven’t finished the research yet. But, so far, preliminarily we’re seeing –we’re seeing some issues here, so can you hold off?” And get that ...

Santana Jones: OK, thanks. (So we’ll get the e-mail).

Amy Drake: ... get that on record. Oh, I don’t have it in front of me. Let me – my computer just locked up, as we were talking. Let me see if I could find that e-mail address for you.

Santana Jones: I just don’t think it’s fair how we are the only ones held responsible. The patient is not held responsible for not knowing what insurance they have. Cahaba is not held responsible for not knowing. But, us, small RHCs on RHC hospitals – oh we’re responsible. So, we’re passing a book of like (duck goose) and (goose), (we’re it).

Amy Drake: I hear your concern. I’m pulling up that e-mail address right now. I know it’s right here on the – on the Palmetto website. It’s [jj.prrs@palmettogba.com](mailto:jj.prrs@palmettogba.com).

Santana Jones: OK. And just to add, why do you need to be able to be (understanding) to the managed care plans in order for us to stay out then.

Amy Drake: I hear you.

Santana Jones: Thank you.

Amy Drake: Thank you.

Operator: And there are no further questions at this time.

Jill Darling: All right. This is Jill, and I'll hand the call to John for closing remarks.

John Hammarlund: Well, thanks again, everybody, for participating today. And delighted that (Devon) could join us to talk a little bit about our opioid response. Stay tuned about that and there's information on the agenda, so you can find out more information about that

Really delighted that David could join us today and, hopefully, shed greater light on the CAH distance requirements. And then, we're really delighted that Amy Drake could be part of this today 'cause, clearly, the issue that our – a lot of our friends in rural (health) (understood) in raising is an important one. And as I said we're really trying to work as quickly as we can to resolve a very difficult situation.

So, we appreciate your patience and we appreciate your staying in touch with us. And, Amy, thank you for joining today, the call. So, Jill, you can help remind us of the way that people can write into us if they would like to have future agenda items.

Again we encourage you to stay in touch with us and let us know what things you'd like to talk about. And again, we just appreciate the active participation today.

Jill, can you remind folks of the right e-mail address to send in?

Jill Darling: Yes, sure. So, the e-mail is [ruralhealthodf@cms.hhs.gov](mailto:ruralhealthodf@cms.hhs.gov) and it is always on the agenda. It's on (past) agendas, so please feel free to e-mail any topic you'd like for us to discuss. So, thanks, everyone. Have a great day. Have a wonderful Fourth of July. Thank you.

Operator: Thank you for participating in today's Rural Health Open Door Forum Conference Call.

This call will be available for replay, beginning today at 5 P.M., Eastern Standard Time and ending at midnight July 2nd, 2018. And the conference I.D. number for the replay is 33289417. The number to dial for the replay is 855-859-2056.

This concludes today's conference calling, you may now disconnect.

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