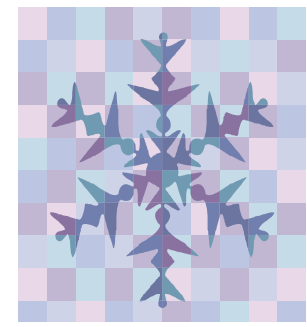


RHC Newsletter

Issue 34
December 2009– January 2010



Provider-Based RHCs excluded from EHR Incentive

CMS released its proposed rule for the electronic health record incentive program December 30, 2009. Only physicians in independent RHCs will qualify for the Medicare or Medicaid eligible professional incentives, most likely Medicaid.

Summary

According to Louis Wenzlow, Rural Wisconsin Health Cooperative, eligible professionals who qualify for the incentives is as follows:

- Eligible professionals that practice in **RHCs** and **FQHCs** are not eligible for Medicare incentives. They are eligible for Medicaid incentives if they have at least 30% patient volume attributable to “needy” patients.
- Eligible professionals that practice in clinics designated as “**provider-based**” are not eligible for either Medicare or Medicaid incentives
- Eligible professionals that practice in **independent** or **non-provider-based hospital-owned** clinics (that use place of service code 11 on their 1500s) are eligible for the Medicare incentives. They are also eligible for the Medicaid incentives if they have at least 30% Medicaid volume (20% if they are Pediatricians). But they can participate in only one of the two (Medicare or Medicaid) programs
- See next sections for language and rationale supporting this interpretation

The impact of this incentive structure is that all physicians practicing in “provider-based” clinics will be unfairly excluded from much needed incentives. The National Association of Rural Health recommends that CMS revise the proposed rule to distinguish between hospital-based physicians, e.g. pathologists and ER physicians, and physicians that practice in clinics, including the provider-based clinics that primarily use a physician’s clinic EHR.

Key ARRA Language

ARRA states that “No incentive payment may be made under this paragraph in the case of a *hospital based eligible professional* ... a *hospital-based eligible professional* means, with respect to *covered professional services* furnished by an eligible professional during the EHR reporting period for a payment year, an eligible professional, such as a pathologist, anesthesiologist, or emergency physician, who furnishes substantially all of their services in a hospital setting (whether inpatient or outpatient) and through the use of the facilities and equipment, including qualified electronic health records, of the hospital. The determination of whether an eligible professional is a hospital based EP shall be made on the basis of the site of service (as defined by the Secretary) and without regard to any employment or billing arrangement between the eligible professional and any other provider.”

In ARRA, *covered professional services* are defined as “the meaning given such term in (k)(3).” 1848 (k)(3) of the Social Security Act established RBRVS (Resource-Based Relative Value Scale) in which physicians bill Medicare on the 1500 forms. Those clinics that do not bill with 1500s will be excluded from the ARRA Medicare incentive.

A Medicare eligible professional is a physician as defined in Section 1861 (r) of the Social Security Act: Doctor of Medicine or Osteopathy, Doctor of Dental Surgery or of Dental Medicine, Doctor of Podiatric Medicine, Doctor of Optometry, Chiropractor.

A Medicaid eligible professional is a physician, dentist, certified nurse midwife, nurse practitioner, and physician assistant (practicing in a rural health clinic that is led by a physician assistant).

Key CMS Proposed Rule Language

“In our proposed approach, a hospital-based eligible professional, would be ineligible to receive an EHR incentive payment under either Medicare or Medicaid, regardless of the type of service provided, if more than 90 percent of their services are identified as being provided in places of service classified under place of service codes 21, 22, or 23.”

Implications for RHCs and FQHCs

Rural Health Clinics bill using USB04s rather than 1500s, so physicians practicing in RHCs and FQHCs are not eligible for **Medicare** incentives. However, RHC physicians that have at least 30% of their volume attributable to needy (Medicaid, sliding fee, uncompensated care, or Title XXI) individuals are specifically mentioned as eligible for **Medicaid** incentives. Physicians practicing in RHCs that do not meet this threshold of “needy” care do not qualify for any federal incentives.

Implications for Provider-Based Clinics

Even though they bill using 1500s, clinics with the designation “provider-based” use the place of service code 22 (Outpatient Hospital), so physicians practicing in “provider-based” clinics are not eligible for either the Medicare or Medicaid incentives.

Implications for Independent and Non-Provider-Based Hospital-Owned Clinics

Independent and non-provider-based hospital-owned clinics bill using 1500s and use the place of service code 11 (office), so physicians practicing in such clinics are eligible for the Medicare incentives.

EPs in these clinics are also eligible for Medicaid Incentives if the Medicaid provider is an eligible professional who: (1) has at least 30% patient volume attributable to Medicaid patients, (2) is a pediatrician that has at least 20% patient volume attributable to Medicaid patients.

These eligible professionals may choose to participate in either the Medicare or the Medicaid incentives but not both.

“In summary, NARH proposes that EPs that provide substantially all of their professional services in the inpatient hospital setting, in any type of outpatient hospital setting, or in any combination of inpatient and outpatient hospital settings, be considered hospital-based EPs...

“We propose to consider the use of place of service (POS) codes on physician claims to determine whether an EP furnishes substantially all of their professional services in a hospital setting and is, therefore, hospital-based...

“In our proposed approach, a hospital-based eligible professional, would be ineligible to receive an EHR incentive payment under either Medicare or Medicaid, regardless of the type of service provided, if more than 90 percent of their services are identified as being provided in places of service classified under place of service codes 21, 22, or 23. Accordingly, for both Medicare and Medicaid incentive payment purposes, we propose that a hospital-based eligible professional is defined as an EP who furnishes 90 percent or more of their covered professional services in any of the above listed places of service.”

(Most excerpts from Rural Health Voices, online news and opinion publication from the NARH.)

Submit your comments before March at <http://h184435wp.setupmyblog.com/2010/01/cms-excludes-%E2%80%9Cprovider-based%E2%80%9D-clinics-from-all-ehr-incentives/>

Care of Special & Vulnerable Patients during an Outbreak

To maximize protection from a pandemic strain of influenza and to be ready to provide prophylaxis in the event of a biological terrorist attack, extra thought and planning is needed to ensure that we reach those with special needs and those most vulnerable. Oversight of these individuals would harm them as well as for those caring for and interacting with them. Economic, social or medical situations can present challenges in reaching some of these special groups.

People in vulnerable and hard-to-reach populations may never receive important health messages because they are not connected to mainstream communication networks or because they cannot understand English. Access or the perceived cost of health care is a barrier for some. ¹ Each community is unique; therefore, thoughtful planning is of utmost importance. There have been varied attempts to categorize these special groups based upon their needs; consequently, the National Response Framework devised a set of five common functional needs to define special needs groups. Below is a list to help identify which members of your community might need extra assistance. Hopefully some of the suggested strategies will help you recognize services and agencies that you already have that you can draw from as well as inspire new ideas.

Special Groups to Consider	Outreach Strategies
<p>1. Communication:</p> <ul style="list-style-type: none"> • Hearing limitations • Visual limitations • Non-English speaking • homeless • Amish 	<p>TTYs/TTDs messaging, pictorial signage, radio and TV public service announcements, cell phone text messaging, wireless network alerts.</p> <p>Braille, large print, radio and TV</p> <p>Radio and TV, information at churches, schools, and clinics, posters available in multiple languages (CDC website), coordination with ethnic media communities.</p> <p>Provide information at food banks, shelters, libraries, etc.</p> <p>Grocery, information at churches, contact the Bishop</p>
<p>Ensure verbal and written messages are simple and clear.</p>	
<p>2. Transportation or mobility limitations:</p> <ul style="list-style-type: none"> • Shut-ins / homebound on medical devices. • Homeless or individuals without a car; community without public transportation services. • Individuals who live in a group home, nursing home, some in assisted living. 	<p>Ensure caregiver transportation, door to door service, voluntary registry</p> <p>Use school busses for a prophylaxis clinic / point of medication distribution site, service agencies and volunteers</p> <p>Prior identification and planning for the facility.</p>
<p>Organize or participate in a temporary transportation option for the community. Where possible, secure written agreements for vehicles, individuals requiring assistance, which vehicles would be available, where vehicles would be staged, etc. When appropriate, establish formal agreements to alleviate legal liability issues. Plan accordingly for service animals.</p>	
<p>3. Special medical care needs:</p> <ul style="list-style-type: none"> • home bound, reliance on medical devices • acute and chronic disease management • recuperating at home from surgery or injury. 	<p>Advise caregivers on infection control for the home; ensure caregivers receive prophylaxis.</p> <p>Ensure family and care givers receive prophylaxis. Give clear definitions for priority groups.</p> <p>Advise caregivers on infection control for the home; ensure caregivers receive prophylaxis.</p>
<p>4. Supervision needs:</p> <ul style="list-style-type: none"> • children • cognitive and intellectual disabilities • impaired elderly. e.g. dementia or Alzheimer's disease • psychiatric conditions, etc. • prison 	<p>Advise caregivers on infection control for the home. Ensure family and care givers receive prophylaxis. Give clear definitions for priority groups.</p> <p>Prior identification and planning for the facility.</p>

<p>5. Maintaining independence (dependent on others):</p> <ul style="list-style-type: none"> • limited mobility • dependence on devices, people, medicine, and service animals. 	<p>Collaborate with other supportive organizations, e.g. local health departments, churches, service leagues, pharmacies, medical reserve corps, etc. to help residents needing assistance, e.g. options to pick up medication. If treatment or prophylaxis is a tablet, a family member can bring appropriate information about allergies and current prescriptions, and pick up the prophylaxis. During any office visit, discuss with the caregivers about planning for prophylaxis. Discover the best means for accomplishing it, e.g. for injections, visiting nurse, home health care staff, clinic nurse or provider, parish nurses, etc.</p>
<p>http://www.flu.gov/professional/community/cfboguidance.pdf</p>	

Pandemic Influenza: Be ready for a third wave....

The traditional flu season is just beginning and typically lasts until May. **History tells us to prepare for another serious wave of illness.** With H1N1 flu declining, a window of opportunity exists to help prevent the flu from spreading further and causing even more illness, hospitalization, and death.

The H1N1 flu vaccine is safe and effective. The H1N1 vaccine is made the same way seasonal flu vaccines are made every year. Extensive testing and monitoring have shown that the vaccine is not only safe, but also an excellent match for the H1N1 flu virus. Getting vaccinated, not only helps you, but also helps prevent further spreading of the virus.

CDC encourages people with underlying health conditions, pregnant women, children, young adults, caretakers of infants, and health care workers to get vaccinated against H1N1. Unlike the seasonal flu, H1N1 has hit children, young people, and adults under age 65 exceptionally hard. That is why we encourage you to get the H1N1 vaccine as soon as possible.

So far pediatric deaths have tripled the numbers seen by previous flu seasons. The has CDC received 255 reports of pediatric deaths associated with laboratory-confirmed 2009 H1N1 virus compared to the previous three flu seasons that averaged 74 pediatric deaths.¹ A study reported by CIDRAP found that serologic evidence suggests as many as 1 in 3 children under 15 and 1 in 5 ages 15 to 24 were infected during the first pandemic wave. "This finding is consistent with the high level of susceptibility in children and the increased potential for transmission that occurs within schools." They also found that a "substantial proportion of older adults had preexisting immunity to the pandemic virus, which experts say could result from previous exposure to antigenically similar flu viruses." The study's findings also suggested that the late October launch of the pandemic vaccine did little to mitigate the second wave of infections in the fall.² This study demonstrates the importance of getting a flu shot, especially for the children who easily transmit it at school and bring it home.

Excerpts from the CDC website posting for January 11, 2010

1. CDC WWMR Report Jan. 22, 2009;

2. CIDRAP News "Serologic study finds H1N1 infections surged past official estimates."

IRHA joins Group Purchasing Cooperative:

IRHA has entered into a new business relationship with **FirstChoice Cooperative (FCC.)** The National Rural Health Association also selected **FirstChoice Cooperative** as their "Provider of Choice" for group purchasing services this past summer. They saw and realized the benefit that **FCC** could bring to their members through extremely aggressive pricing discounts on supplies, services, and equipment - and **cash dividends** ("patronage") **paid back to the members** annually. This could be a whole new revenue stream for you. You would not only get attractive pricing, but you also get an actual check back annually.

FirstChoice Cooperative has **no pricing tiers.** This means that pricing is the same regardless of the size of the healthcare provider. For most contracts, the item pricing is visible to any member on the FirstChoice website, and contract enrollment is done electronically from your computer or laptop. **FCC** delivers real cost savings and generates real cash dividends for all members **on an equal basis regardless of size.**

FirstChoice Cooperative has a complete contract portfolio with over 600 contracts in place to deliver the results that you deserve from your Group Purchasing Cooperative!

And here are a few more **member benefits**:

- No access fees – no enrollment or monthly fees.
 - No tiered pricing.
 - Generates a new revenue source on every contract utilized through PATRONAGE DIVIDENDS paid to your clinic or hospital if they are doing your purchasing.
 - No minimum number of contracts to use and no penalties for using other GPOs.
 - Patronage dividends are reported to each member on a monthly basis as reported to the Coop by its suppliers. This way, you'll know what to expect. No surprises.
 - Allows each member to participate and vote on which proposal to ratify- one vote per member regardless of size.
- FCC** is a Cooperative that is owned and directed by its members.
- Regularly scheduled user teleconference meetings allow you, the member, to voice your opinion as well as network with your peers. Attendance not required except for voting privileges.
 - A dedicated Region Director who will call on your facility every 6-8 weeks, to keep you apprised of new contracts, help identify savings opportunities, and perform financial analyses for you – at no cost to you.
 - Each clinic member receives a card. At this time employee discounts for Indiana include LaQuinta Hotels, car rental for Avis and Hertz, Staples, and Sherwin Williams.

Next steps:

To run a price comparison for you, our **FCC** representative, Mark Tonn, requests that you submit a list of supplies/equipment on an Excel spreadsheet with your current pricing. Prices are already established and new contract pricing is sent to members each month. He will send you comparative pricing; then you can a decision about whether to join the **Cooperative**. Mark shared with us that in many cases you will be ordering from the same sales rep and continue to receive visits from them; however, there will be an additional contract that will result in a better price from your sales reps due to an agreement between them and the **FirstChoice Cooperative**. Mark Tonn will contact you for an appointment to explain the program in more detail and the cost savings you can receive by participating.

January: A Time for Making Resolutions

Break Free from Tobacco

1-800-Quit Now

Talk to your patients and staff about quitting. The Indiana Quitline is easy to use and offers one-on-one telephone counseling with a Quit Coach 7 days a week between 8 am – 3 am EST. 24 Access to a friendly WebCoach. When the caller is ready to quit, the Quit Coach will help them devise a quit plan specifically for them. They offer tips on how to:

- Cope with cravings.
- Find ways to change daily activities that trigger smoking.
- Avoid weight gain.

Quit Coaches are available for pregnant smokers and will call after delivery to help them stay tobacco free. Encourage them for the health of their baby. Saving money spent on tobacco products is more to spend on things for them and their baby!

Resolution: Lose Weight, Again!

INHealthyWeight Initiative

63% of Indiana adults reported being either overweight or obese!

<http://www.inhealthyweight.org/>

Public Health TV Update:

The project is still moving forward. We expect placements this spring. As they say on TV, stay tuned for more!

BUTLER UNIVERSITY

DID YOU KNOW YOU CAN MAKE A DIFFERENCE FOR YOUR PATIENTS?

The Butler University Community Health Resource Webpage is designed for use by health care professionals and patients as a resource to affordable health solutions.

Visit the page today!

www.butler.edu/community-health



**BUTLER
UNIVERSITY**

COLLEGE OF PHARMACY AND HEALTH SCIENCES

The screenshot shows the Butler University website header with the university name and a search bar. Below the header is a navigation menu with links for Home, About Butler, Admission, Academics, Athletics, Student Life, Events, and Alumni. The main content area is titled "College of Pharmacy & Health Sciences - Community Health Resource" and "Community Health Resource". It includes a sidebar with a list of links: Community Resource, Health Centers - Clinics, Health Departments, Patient Assistance, Other Cost-Saving Tips, Disposal Suggestions, Specialty Pharmacies, Medical History Form, Comments Survey, and COPHS Home. The main text states: "Butler University is committed to promoting public health. The College of Pharmacy and Health Sciences, through support from the Lily Endowment Inc., is actively involved in public health in the community. The Community Health Resource webpage is a one-stop resource for health care professionals and patients seeking information on health and medical care affordability and public health resources across the state. These resources include public health services, links to government and private programs for low income or uninsured patients, guide to low cost prescriptions, and a listing of affordable health centers and clinics." Below this text is a photograph of a young woman with blonde hair, wearing a grey shirt, assisting an older man with glasses and a green shirt. They are both looking at something in the man's hands. Below the photo is a section titled "H1N1 Information" with a "More Information" link. At the bottom of the page, there is a footer with the copyright notice: "© Butler University • 4600 Sunset Ave., Indianapolis, IN 46208 • Phone: (800) 368-6852 • CONTACT US".

The Community Health Resource webpage is a one-stop resource, which includes:

- Links to affordable public health services
- Links to government and private programs for low income or uninsured patients
- Guide to low cost prescriptions, listing of affordable health centers and clinics
- Medicare Part D information and more!

Questions or Comments?

Please Contact: Jessica Callahan

Phone: (317)940-8870 • Fax: (317)940-8901

E-mail: jacallah@butler.edu

Opportunities to Learn More about Rural Health Clinics and Network

IRHA's RHC Constituency Call

January 26th Tuesday - Noon Hour, ET
1-800-791-2345 Code: 77869 #

Topics of discussion will include:

- Overview of IRHA's Annual Policy Forum: National Perspective of Healthcare Issues by NRHA, Impact of Health Reform on Rural Health by AHA, FSSA Changes affecting Rural Health, Panel on Coordinated Mental Health Delivery System Helps Rural Populations, Senator Leising spoke on internet access for rural communities, and overview of 119th General Assembly and Rural Health.
- PECOS
- Networking with Peers
- Clinic Messaging with Electronic Posters, Don Yost

Rural Health Open Door Forum

January 27th Wednesday 11:30 am – 12:30 pm ET

The call will be broadcasting live from the National Rural Health Association Policy Institute Annual Meeting in Washington, DC. If you wish to participate, dial **1-800-837-1935** Conference ID **49621730**. At first CMS presents updates which are followed by an open opportunity for Q & A.

"Spring Into Quality" Symposium for Health Care Providers

March 4

Details and registration: www.indianaruralhealth.org

National Association of Rural Health Clinics 2010 Spring Institute

March 24-26

San Antonio, TX

Reserve room before March. 210-222-1234. They will sell out of discounted rooms.

Registration and Agenda at www.narhc.org under Events

13th Annual Indiana Rural Health Conference

June 15 - 16, 2010

Details and registration: www.indianaruralhealth.org

IRHA Leadership Seminar

Friday, August 13, 2010

French Lick Resort

French Lick, Indiana

Keynote Speaker: Quint Studer

FREE to Indiana Rural Health Association Members

Limit 3 individuals per organization

\$25 per additional individual

\$150 per individual for non IRHA members