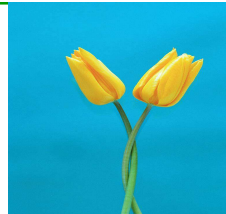




# RHC Newsletter



Issue 36

March

## Highlights of RHC and Healthcare Reform

Here are some highlights from the RHC Legislative Update which focused on Healthcare Reform. There are lots of proposal. In all, there are 160 mandates that the Secretary of the HHS would have to do.

The new HCR will cost 855 billion dollars (940 billion by other sources) over the next 10 years and proposes to expand Medicaid by \$386 billion. There are several areas that money is expected to come from to cover some of the cost for HCR:

- ◇ Tightening current health tax incentives.
- ◇ Collecting industry fees, slightly increasing Medicare Hospital Insurance tax for individuals earning more than \$200,000, couples earning more than \$250,000.
- ◇ Medicare Cuts of \$500 billion by reducing previously proposed increases in rates.
- ◇ Reduction in the FFS by \$186 billion.
- ◇ Reduction in Medicare Advantage by \$118 billion (limiting 1 plan/ county).
- ◇ Patient Protection & Affordable Care Act: proposes financial penalties for small employers (< 50 employees) who do not offer insurance and for individuals who do not acquire insurance coverage, exception for low-income individuals.
- ◇ Others: new revenues, fee on insurance companies selling high cost (Cadillac) plans, imposing insurance fees on manufacturers.
- Transparency and Program Integrity restricts physician ownership of hospitals, ownership or investment interest in a pharmaceutical or nursing home. Monitors for fraud and abuse, etc.
- Bill 2018 has the potential to include illegal immigrants.
- Insurance companies barred from deferring clients for pre-existing conditions.
- Children allowed stay on parent's insurance policy until they are 26 years old.
- On January 1, 2011, Medicare patients eligible for free annual wellness visit, no copay or deductible.
- Health insurance exchanges for small business. Tax credits to ensure individual buy insurance.
- No caps on insurance; no lifetime or annual limits on benefits.
- Free preventive care and immunizations for everyone.
- The HHS will offer grants for 5 year pilot programs; grants for medical school to collaborate with RHCs.
- FQHCs are receiving big Federal dollars. There is proposed legislation for FQHCs to contract with RHC to provide services for their patients. FQHCs would pay the RHC. Under this agreement, the RHC must accept all patients and offer a sliding fee scale; this is consistent with FQHC regulations. (see page 2).
- Within 3-6 months, changes will be considered for designations of MUAs and HPSAs.
- Medicaid will expand to include all non-elderly Americans with income below 133 percent of the Federal Poverty Level. This will benefit RHCs. It will certainly help meet the threshold for the EMR Financial Incentive requiring 30% of RHC encounters be for Medicaid.
- Creation of a nongovernmental Medicare Advisory Board. It is unsure how this could affect provider payments.
- Reduce the donut hole for patients in the Medicare Part D drug benefit this year.
- Maintain current funding for CHIP through 2015.
- Increase funding for National Health Service Corps, i.e. scholarship and loan repayment for the healthcare workforce. It includes incentives for providers serving in underserved areas.

White House summary in plain English <http://www.whitehouse.gov/sites/default/files/summary-presidents-proposal.pdf>

Awaiting more from NARHCs executive director / lobbyist for RHCs.

## Electronic Health Records Meaningful Use

HRSA presenter, Michael McNeely, was encouraging about eligibility of Provider Based RHCs owned by a CAH for EMR incentives. The overwhelming number of comments submitted by RHCs and hospitals were clearly heard. Many changes are expected in the final rule this June.

Medicaid eligible providers practice predominantly in a RHC, with more than 50% of total encounters during 6 month period in most recent calendar year. Needy individuals (30% requirement) specified in the statute include: Medicaid or CHIP enrollee, patients furnished uncompensated care by the provider; or furnished at either no cost or on a sliding fee scale.

Purdue University received \$12 million to help health-care providers adopt and use electronic health records. Purdue is one of 32 non-profit organizations receiving funding through the American Recovery and Reinvestment Act (ARRA) to support the development of regional extension centers that will assist health professionals in selecting and implementing new information technology software.

Mary Ann Sloan, director of Purdue's Healthcare Technical Assistance Program, said Purdue's center would help physicians and nurse practitioners at small practices across Indiana - with 10 or fewer doctors - and those aiding underserved populations.

For contact information and details see [www.purdue.edu/newsroom/research/2010/100216MckinnisHealthgrant.html](http://www.purdue.edu/newsroom/research/2010/100216MckinnisHealthgrant.html)

NARHC and others recommends actively researching well established EHRs companies to be ready. Do not rush to purchase. Final rules released in June 2010.

## Programs for Children

### Child Passenger Safety News - Please share this with your patients:

As many as nine out of ten car seats are not used or installed correctly. Do your families who have young children need information on installing and using car seats? A Permanent Child Safety Seat Inspection Station can provide education on the correct use and installation of car seats. Car seats may be provided to children participating in any public assistance program, based on availability. Visit <http://www.preventinjury.org/fittingStation.asp> or call 1-800-KID-N-CAR (1-800-543-6227) to locate an Inspection Station near you.

### Summer Food Service Program for Children

There is low participation in rural areas for the Summer Food Service Program. About 18 million children under the age of 18 are eligible while only 3 million receive this benefit. In some areas of our country, this program provides the only meal(s) a child will receive some days.

The USDA is looking for sponsors and sites, particularly in rural areas. Hospitals were mentioned as good sites because many have food preparation and service available. Sponsors take care of the business end of the program while sites actually feed the children.

More information: <http://www.summerfood.usda.gov>

If you are interested in becoming a site or sponsor, please contact Julie Sutton or Tina Skinner

317-232-0872; 317-232-0858    [jsutton@doe.in.gov](mailto:jsutton@doe.in.gov); [tskinner@doe.in.gov](mailto:tskinner@doe.in.gov)    Application DUE: 26-Apr

### Updated Vaccine Schedule for Rabies Post-exposure Prophylaxis

There have been updates to the Vaccine Schedule for Rabies Post-exposure Prophylaxis. The most recent MMWR concerning rabies post-exposure prophylaxis may be found at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5902a1.htm>.

The MMWR recommends that unvaccinated persons exposed to rabies receive 1 dose of HRIG and 4 doses of vaccine. HRIG should be given as soon after exposure as possible (Day 0). Vaccine should be given on Day 0, 3, 7, and 14.

The recommendations for previously vaccinated individuals have not changed.

The recommendations for persons with immunosuppression have not changed.

## Pending Legislation for RHC and FQHC Collaboration

Senate Bill 1355 and House Bill 3896

With the anticipation of more Medicaid patients, the FQHC may not have the capacity to handle the increase. Rather than invest in building larger or more facilities, a more cost effective strategy would be for the FQHC to subcontract with RHCs to care for their patients.

If a bill passes, the NARHC and the National Association of Community Health Centers will work toward a collaborative agreement to enhance local agreement possibilities.

Actions for the RHCs to consider:

- ◇ Promote sections of proposed legislation to your elected officials that allows RHCs to subcontract with FQHCs.
- ◇ Invite FQHC representatives to RHC meetings and events
- ◇ Attend FQHC meetings.
- ◇ Look for common ground.

Presenter for this presentation was Gail Nickerson, Board President of California RHC, [NickerGW@ah.org](mailto:NickerGW@ah.org)  
(916) 774-7308

## Report: CMS Update from NARHC meeting

**MACs:** Newly established independent RHCs are assigned to NGS for their Medicare payor. Those RHCs previously assigned to Riverbend are now served by Cahaba. Ultimately, these independent RHCs at Cahaba will be transitioned to the MAC within their state. (Indiana assumes that will be NGS; previously their assignment was protested.) The Medicare Modernization Act of 2003 requires that all MACs be implemented by October 2011. However, those under protest will not meet that deadline. RHCs assigned to Cahaba will not be transitioned to the MAC for their state until all the MAC contracts are fully implemented. This could take years... Meanwhile there are several strategies for becoming more acquainted with Cahaba's processes and for resolving billing issues.

**Hospitals with clinics in two different MACs:** It is permissible to send a consolidated cost report to each MAC.

### CMS Initiatives:

- Performance-based payments
- Global-episodic bundled payments
- Primary care medical home
- More money in the budget for more research
- Medical Advantage choices are to be easier for consumers to discern the significant difference in the plans, transition for beneficiaries, accountability, etc.

**Final Rules:** New RHC regulations should be out by June 2011. The new rules are being written by a different group than the previously proposed ones.

**RAC:** The Recovery Audit Contract is now a permanent program. Our region is B and the contract is with CGI Technologies and Solutions, Inc.

RACs are paid based upon payment errors that they find. If they lose on an appeal, they must return the contingency fee. There are two types of review: automated and complex (medical records are required for complex reviews). The records must be submitted within 45 days. It is recommended that RHCs ensure that the RAC knows which person to contact to prevent the oversight of their request and consequently missing the deadline.

The RAC can "look-back" to 3 years, e.g. Oct. 7, 2007. They will accept imaged medical records on CD/DVD. They are limited on number of medical record they can request.

RACs employ a physician medical director and certified coders. To review their findings, major or new issues: Office of Inspector General's website is [oig.hhs.gov](http://oig.hhs.gov)

**How to prepare for RAC:** In the audience, there were about 4 hands that went up to indicate that they have been audited. CMS regional rural health coordinator, Becky Peal-Sconce, recommended:

- Know where previous improper payments have been found...reference the OIG's RAC reports.
- Know if you are submitting claims with improper payments
- Prepare to respond to RAC medical record request
- Keep/submit proper documentation
- Appeal when necessary
- Learn from your past experiences.
- Establish a relationship with the RAC and let them know to whom they should send their correspondence to avoid delayed communication which could result in a missed deadline.
- Respond to a RAC medical record request fully and within the required 45 days.
- Call the RAC to confirm receipt of medical records.
- If you agree with the RAC, pay back the overpayment or allow offset process to take place. This is recoupment made from future payments. Or you may apply for an extended repayment plan.
- If you do not agree with the RAC determination, appeal promptly. You may send a discussion letter first, but if you still disagree be sure to appeal by the 120th day after the demand letter.

**Internet-based PECOS Enrollment** - Use for provider enrollment. Can not use to file 855A initial application or changes of information/ownership.

**Maintaining Records:** Keep patient orders and referral documentation for seven years.

**30 days to report:** To notify change in ownership or control, change in location, final adverse action. **Failure to report could result in loss of RHC designation.**

**90 days to report:** Change in practice status (e.g. retirement); changes in business structure, legal business name or taxpayer ID number; change of banking arrangements or payment information; change in correspondence or special payments address; change of clinic manager; change in billing services; and other changes.

Indiana's CMS regional rural health coordinator is Christine Davidson, (312) 886-3642.

CMS MAC Webpage <http://www.cms.hhs.gov/RAC/>  
CMS RAC email [RAC@cms.hhs.gov](mailto:RAC@cms.hhs.gov)

## Indiana Rural Health Association

2901 Ohio Blvd. Suite 110  
Terre Haute, IN 47803

Phone 812-478-3919

## Upcoming Events

### National Public Health Week Conference

April 6-7, IUPUI Campus Center

### NIMS—ICS 100 for Healthcare

South - Washington April 14

Central - Greenfield April 21

North - Bremen April 28

### RHC Update & Billing

Healthcare Business Specialists

April 23, Indianapolis

Cost: Registration \$200, Manual \$100

[www.ruralhealthclinic.com](http://www.ruralhealthclinic.com)

### IMPACT 2010 (AAPA)

Date: May 29 - June 3

Location: Atlanta, GA

The American Academy of Physician Assistants - 38th Annual PA Conference connects colleagues with the tools needed to evolve as a PA in every practice area. Nearly 200 CME sessions, new social and networking experiences, and information on new technologies. Pre-registration closes April 16, 2010. Continuing Medical Education credits will be available.

<http://www.aapa.org/upcoming-events/annual-conference>

**13th Annual Indiana Rural Health Conference**  
June 15 and 16, 2010  
Indianapolis Marriott East

## Cahaba Webinar Training Opportunities

These webinars accommodate a limited number, so register soon.

[https://www.cahabagba.com/apps/course\\_registration/al/calendar.jsp](https://www.cahabagba.com/apps/course_registration/al/calendar.jsp)

**4/8** Using the Cahaba GBA Voice Interactive Response System

**4/13** Medicare 101: Learning the Basics of Medicare Part A

**4/22** Medicare Billing Session "Completing UBO4 Claim Form"

### Telehealth Webinar - FREE

Thursday, April 22, 2010

1pm CT (2pm ET)

MidWest Health Education presents Nina Antoniotti, RN, MSN, PhD via a webinar addressing business planning and return on investment for TeleHealth success. This program will provide an opportunity for TeleHealth programs, individuals and organizations to learn about sound business planning principles and elements for developing a successful return on investment. Financial and strategic models will be reviewed and specific examples will be used.

If your interested in TeleHealth you don't want to miss this webinar. Complete the process to Register with Midwest Health to view free programming from the convenience of your computer. Reserve for your spot! [www.midwesthealthed.org](http://www.midwesthealthed.org)

### Emergency Preparedness Training: Incident Command Training Offered Regionally

During April, Indiana Rural Health Association and Indiana Primary Health Care Association will jointly offer the ICS 100 for Healthcare to all Community Health Centers and Rural Health Clinics. This is a required training for healthcare agencies that are first responders receiving federal funding for emergency or disaster preparedness.

Dana Stidham, IRHA, and Jenifer Nelson, IPHCA are providing this valuable training in an interactive classroom setting. Participants will learn how to respond to a community wide emergency as well as how to apply the ICS guidance to planning an event, e.g. health fair, fund raiser, or community influenza clinic. Courses are also available on FEMA website.

FEMA offers CEUs for this training as well as 1 college credit hour.

Travel is compensated with gift card.

To register, visit [www.indianaruralhealth.org](http://www.indianaruralhealth.org)

Southern Indiana	Daviess Community Hospital 1314 E. Walnut St., Washington, IN	Wed. April 14 <sup>th</sup>	9:30 am - 2 pm
Central Indiana	Real Life Church 971 W. US HWY 40, Greenfield, IN	Wed. April 21 <sup>st</sup>	9:30 am - 2 pm
Northern Indiana	Community Hospital of Bremen 1020 High Rd., Bremen, IN	Wed. April 28 <sup>th</sup>	9:30 am - 2 pm