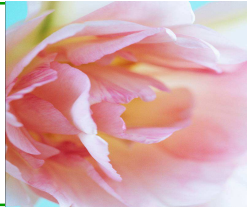




RHC Newsletter



Issue 27

May
2009

EHR Incentive

The following is a summary of the May 26, 2009 EHR Incentive Payment presentation given by Bill Finerfrock, Executive Director for National Association of Rural Health Clinics. Slides of the presentation were sent to each RHC in Indiana. A transcript and copy of slides will be available in about a week at www.ruralhealth.hrsa.gov/rhc

In 2011 the Independent Rural Health Clinics will be eligible for EHR incentives under Medicaid (not Medicare). Non-RHC physicians will be eligible for either Medicare or Medicaid incentives; however, not both. Eligibility for the Medicaid bonus payment includes having a patient volume of at least 30% that could be classified as “needy” individuals, e.g. Medicaid, S-CHIP, or un-compensated care by a RHC provider.

If the RHC is a provider based clinic, it is assumed that the hospital owns and maintains the system. Consequently, the physicians of provider-based RHCs will not be considered. The Hospitals and Critical Access Hospitals that own the PB RHCs are eligible for Medicare incentive payments if they demonstrate “meaningful use” of an EHR system. Hospitals would receive \$2 million plus \$200 per discharges until they reach a threshold of 1,149 discharges. The CAH’s reimbursement is a complex accounting process which we will leave to the accountants! Both types of hospitals will be penalized by a reduction in their Medicare payments if they do not adopt an EHR by 2015.

Requirements for eligibility include being a “meaningful user” and having a “certified” EHR system. Presently, “meaningful user” has not been fully defined by the Secretary. It is expected that the Secretary will post definitions for “meaningful use” and there will be a comment period at which time the NARHC and IRHA will communicate the information to their constituencies. The necessary contact information for making comments will be passed on to the RHCs to ensure that the definition is appropriate for them.

“Certified” refers to a system that is appropriate for its users, e.g. an ambulatory electronic health record for office-based physicians. It will have to include **e-prescribing** and be **interoperable** with all other EHRs. Interoperability ensures sharing of patient records from one site to another:

- to improve the quality of health care
- for coordination of care
- for availability to a hospital while patient is on vacation or forced to leave due to a disaster.

In 2011 it will be necessary to demonstrate that your system is an “interoperable, certified” EHR system. Therefore if you are shopping for an EHR, make sure the system that you are considering has this capability. If you have already purchased one, be talking to your vendor about what they are doing to meet this criteria by 2011.

Physicians practicing in a HPSA could receive an additional 10% EHR bonus payment. RHCs will receive the full 5 year incentive payments which will be made quarterly or in a lump sum. The incentive payment will be based upon estimates of allowed charges.

Eligible RHCs can receive up to 85% of the net average allowable costs for the “certified” EHR technology, e.g. adoption costs, technical support, maintenance, and training.

(continued page 4)

Register for IRHA’s Annual Conference June 10-11

Marriott East Indianapolis

RHC Preconference Program & Exhibits June 9th.

Incident Command System (ICS) 100 for Health Care Professionals. Free Session. RHC reimbursement for staff time and travel for this session. 8 am – 11:30 am

Rural Health Clinic Workshop
1pm – 5pm EST :

- Regulatory Update: new accreditation / survey options, current situation on CMS proposed rules, Transitioning from FI to the new MAC assignment
- RHC Policy Manual – CEO and RHC consultant Charles James
- Preparing for Initial Survey or Resurvey - RHC Consultant Joanie Perkins
- Billing/Coding - RHC Consultant Joanie Perkins
- Scope of Practice for the NP and PA Panel:
RHC Consultant Charles James
IN Professional Licensing Agency:
Kristen Kelley for the PA
Sean Gorman for the NP

Tuesday Night Events:

4-7 pm Guest Reception for Networking

Dinner at 7 pm for Preconference Registrants!

Wednesday Morning Full Conference Begins

To register online and view a full agenda <http://www.indianaruralhealth.org/>

CDC H1N1 Influenza Update 5/26/09

The novel influenza A (H1N1), a new flu virus of swine origin, was first detected in April, 2009. The virus continues to spread from person-to-person mostly through sneezing and coughing from infected persons.

New guidance for face masks were posted on the www.cdc.gov/H1N1/flu website May 27, 2009. The following are excerpts from this guidance.

Use of facemasks or respirators is not recommended for workers in non-healthcare occupational settings for general work activities. In the occupational healthcare setting respiratory protection is recommended. Because respiratory protection is not perfect, healthcare workers at higher risk may consider a temporary alternative assignment to avoid exposure.

Groups of people at higher risk for severe illness from novel influenza A (H1N1) infection are thought to be the same as those people at higher risk for severe illness from seasonal influenza. These groups include:

- Children younger than 5 years old
- Persons aged 65 years or older
- Children and adolescents (younger than 18 years) who are receiving long-term aspirin therapy and who might be at risk for experiencing Reye syndrome after influenza virus infection
- Pregnant women
- Adults and children who have asthma, chronic pulmonary, cardiovascular, hepatic, hematological, neurologic, neuromuscular, or metabolic disorders such as diabetes;
- Adults and children who have immunosuppression (including immunosuppression caused by medications or by HIV)
- Residents of nursing homes and other chronic-care facilities.

There are important differences between facemasks and respirators. Facemasks do not seal tightly to the face and are used to block large droplets from coming into contact with the wearer's mouth or nose. Most respirators (e.g. N95) are designed to seal tightly to the wearer's face and filter out very small particles that can be breathed in by the user. For both facemasks and respirators, however, limited data is available on their effectiveness in preventing transmission of H1N1 (or seasonal influenza) in various settings.

Facemasks are labeled as surgical, dental, medical procedure, isolation, or laser masks. Facemasks help stop droplets from being spread by the person wearing them. They also keep splashes or sprays from reaching the mouth and nose of the person wearing the facemask. They are not designed to protect against breathing in very small



particle aerosols that may contain viruses. Facemasks should be used once and then thrown away in the trash.

"Respirator" refers to an N95 or higher filtering face piece respirator certified by the CDC/NIOSH. It fits snugly on the face can filter out virus-containing small particle aerosols that can be generated by an infected person, but compared with a facemask it is harder to breathe through a respirator for long periods of time. *Respirators are*

not recommended for children or people who have facial hair.

A respiratory protection program is required in occupational settings per OSHA's Respiratory Protection standard (29 CFR 1910.134). This includes fit testing, medical evaluation and training of the worker (donning masks, removing and disposing of the mask, when to wear a mask, etc.).

Further details from the CDC call:

- Patients hospitalized with pneumonia appear to have viral rather than bacterial pneumonia. If patients do not present within 48 hours, it was recommended to still treat them because they will experience some benefit.
- Avoid aspirin and products containing aspirin for children to prevent Reyes Syndrome.
- Use a combination of antivirals if not sure whether patient has seasonal or the novel H1N1 influenza.
- Some commercial labs now have H1N1 typing capabilities.
- H1N1 testing: Rapid test sensitivity is suboptimal. Testing priority is for hospitalized patients, those with underlying conditions, children, and pregnant patients.
- If patients are not very ill, office visits and testing not necessary. Treatment and testing prioritized for those with chronic illness.
- Vaccine is in development. Availability is expected in 5 months. CDC is monitoring the southern hemisphere in anticipation of our fall season.
- Very limited recommendations for pre-exposure prophylaxis due to limited availability of antivirals. Recommendation is for personal protective equipment and post exposure treatment.

CDC recommends that antiviral treatment for H1N1 be given as soon as possible after onset of symptoms for all hospitalized patients with confirmed, probable, or suspected H1N1 virus infection, including patients who seek care more than 48 hours after illness onset. (continued on page 3)

State Health Officials Ask Hoosiers to Take Steps to Prevent Mosquito Borne Illnesses

State health officials are urging Hoosiers again this year to take steps to protect themselves from mosquito borne diseases, including St. Louis encephalitis and West Nile Virus. In 2008, there were three human cases of West Nile virus in the state.

"This is a key time of the year when people should start ridding their properties of potential mosquito breeding grounds to protect themselves and their families from mosquito borne illnesses," said James Howell, DVM, state epidemiologist at the Indiana State Department of Health. "Mosquitoes lay eggs in still water, which hatch in seven to 10 days. If standing water is eliminated weekly, many mosquitoes will be kept from breeding in the first place."

St. Louis encephalitis is a viral disease that is spread to humans through the bite of infected mosquitoes. It is found throughout much of the United States. Persons infected with St. Louis encephalitis virus may exhibit no apparent illness, mild illness with headache and fever, or severe infection with headache, high fever, neck stiffness, stupor, disorientation, coma, tremors, occasional convulsions (especially in infants) and spastic (but rarely flaccid) paralysis.

The West Nile Virus can include fever, headache, body aches, swollen lymph glands, or a rash. However, a small number of individuals can develop a more severe form of the disease with encephalitis or meningitis and other neurological syndromes, including flaccid muscle paralysis. Health officials report individuals age 50 and over are at greatest risk for serious illness and even death from West Nile virus. However, people of all ages can be and have been infected with the virus.

Dr. Howell says throughout the summer people should:

- Dispose of old tires, tin cans, plastic containers, ceramic pots or other unused containers that can hold water
- Repair failed septic systems
- Drill holes in the bottom of recycling containers left outdoors
- Keep grass cut short and shrubbery trimmed
- Clean clogged roof gutters, particularly if leaves tend to plug up the drains
- Aerate ornamental pools, or stock them with predatory fish
- Apply insect repellent containing DEET, Picardin, or oil of lemon eucalyptus to clothes and exposed skin
- Wear long-sleeved shirts and pants

For more information, visit the ISDH Web site at <http://www.statehealth.in.gov/>.

CDC Recommendations for Treatment of H1N1 influenza continued

For maximum benefit, often this means before diagnostic test results (RT-PCR) are available. If bacterial co-infection is suspected, antibacterials should be directed at likely pathogens (e.g., *S. pneumoniae*, *S. aureus*) consistent with existing guidelines for the management of community-acquired pneumonia. Antibacterial therapy also should be initiated after appropriate diagnostic specimens are obtained, including blood, respiratory secretions (especially for intubated patients), and pleural fluid for culture and urine for pneumococcal antigen testing (in adults).

Patients who are at higher risk for seasonal influenza complications (including people 65 years and older, children younger than five years old, pregnant women, and people of any age with chronic medical conditions) are also recommended for treatment, regardless of whether they require hospitalization.

For More Information:

Antiviral Treatment for Novel Influenza A (H1N1) Virus Infection <http://www.cdc.gov/h1n1flu/recommendations.htm>

Indiana: 138 Novel H1N1 Flu Cases Confirmed. No deaths.

The breakdown of confirmed cases by age group (years), include:

- 0-4 (24)
- 5-24 (94)
- 25-64 (19)
- 65+ (1)

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Upcoming Events

June 9th

ICS 100
RHC Preconference
Marriott East Indy

June 10-11

IRHA Annual Conference
Marriott East Indy

October 21st

RHC Fall Workshop
Columbus, Indiana

Riverbend Webinars for Transition

May 28, 2 pm EST Data Entry

June 3, 2pm EST Overview of Transition

June 10, 2pm EST Review and Updates of Transition

EHR Incentive continued

There are limitations for the Medicaid Incentive Payments: a net average allowable cost for the first year is \$25,000, and subsequent years are \$10,000. Provider based RHCs can not apply for Medicaid incentive unless their hospital waives their right to the Medicare incentive. Claiming both would be viewed as double dipping. No payments will be made after 2021 or longer than 5 years. The total incentive PER PROVIDER is \$65,000 over 5 years.

If an EHR is not utilized by 2015 by the Medicare eligible practices, they will be penalized until they are able to demonstrate to the Secretary that doing so would represent a hardship. The penalty is 1% of the reimbursement rates with the greatest penalty being 96% of usual payment.

Q & A session:

Can the FTEs for part time physicians be added together for the per provider reimbursement rate? It is not clear at this time how this will be calculated.

What is the timeline for implementation of these rules? The clinic will be instructed to use appropriate codes on their claims and cost reports.

Are specialists working in the RHC eligible? Yes, they qualify; they are eligible for Medicare incentives. Recall the RHC primary care providers are only eligible for Medicaid incentives.

Are Provider Based RHCs eligible? The CAH is already getting the incentive. It is viewed that the hospital incurred the cost and maintenance of the system and the RHC is using it.

Will the RHC be penalized for not adopting an EHR? There is no penalty through the Medicaid incentive program; however, there is a penalty to those eligible for the Medicare incentive (e.g. hospitals). The Secretary has the authority to classify other Non-RHC practices.

What if the RHC can not demonstrate that 30% of their patients meet the "needy" criteria? They are not eligible.

RHC Constituency Call: The Transition from Riverbend to Cahaba

The Medicare Modernization Act of 1874A called for Medicare Contract Reform with the intent of establishing a premier health plan. On August 1st, the independent RHCs served by Riverbend will begin to transition outside of their Jurisdiction 8 to Cahaba. Due to the magnitude Riverbend's service to more than 1500 clinics in 23 states, independent clinics will be transitioned out to Jurisdiction 10, geographically outside of our area. When all MAC transitions are completed, the independent clinics in Indiana will be transitioned back into our area with National Government Services (NGS) in Indianapolis. It is anticipated that the subsequent transition to NGS will not happen for several years.

Indiana's provider based RHCs are presently assigned to the same MAC as the hospital that owns them. For Indiana, that is NGS. Consequently, PB clinics should not experience any changes. An exception is that newly designated independent RHCs are being assigned to NGS rather than going through the transitions.

Riverbend will transfer all old or unfiled claims to Cahaba. Clinics will transmit new billing claims to Cahaba. Independent clinics will need to enter into new EFT and EBI agreements. **This Riverbend website offers clear guidance, also a timeline and clinic checklist for preparing for the MAC implementation. Be sure to view J10 Q & A training webinar at: www.rgbagov.com/Transition/index.shtml**