How healthcare reform and national policies will impact RHCs.

Benefits/advantages of being an RHC.

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NARHC

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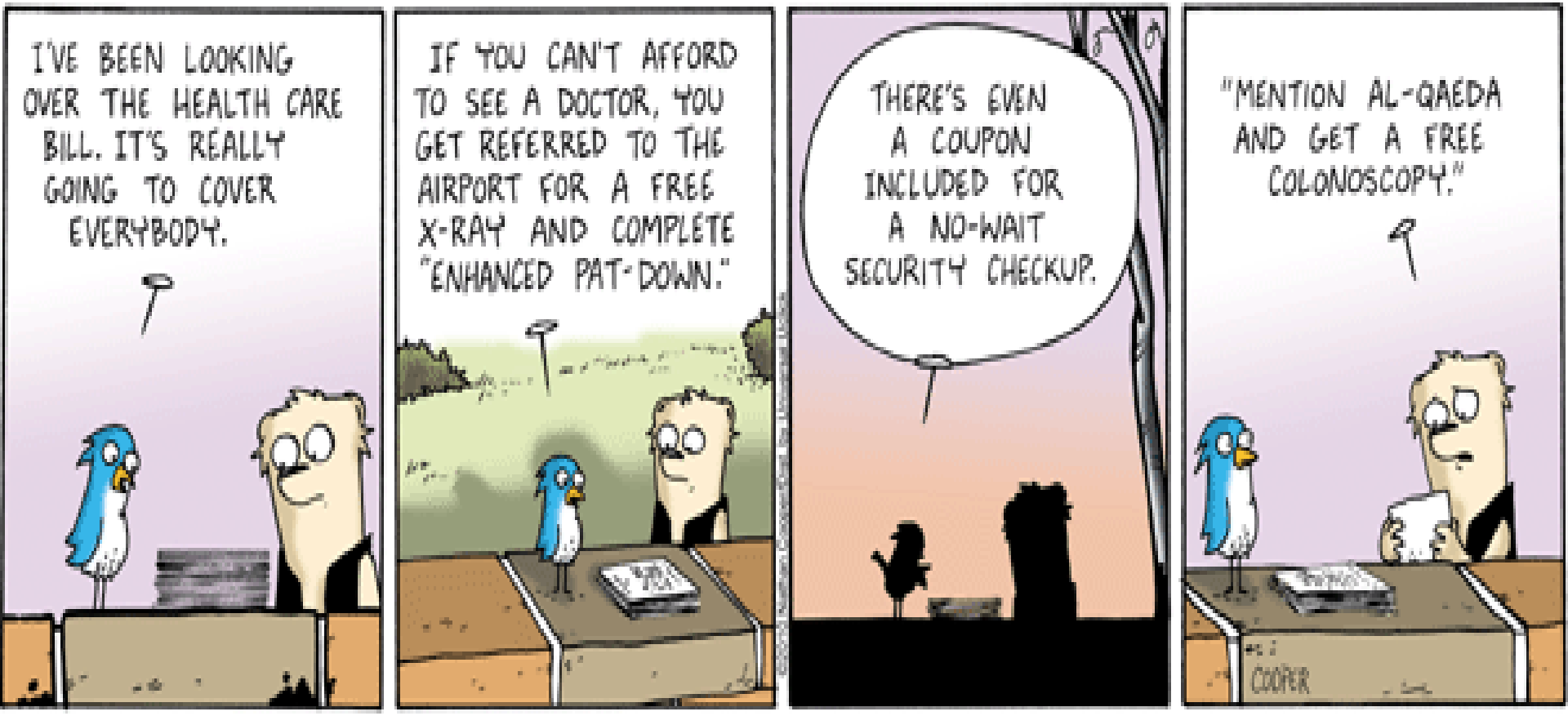

I'VE BEEN LOOKING OVER THE HEALTH CARE BILL. IT'S REALLY GOING TO COVER EVERYBODY.
IF YOU CAN'T AFFORD TO SEE A DOCTOR, YOU GET REFERRED TO THE AIRPORT FOR A FREE X-RAY AND COMPLETE "ENHANCED PAT-DOWN."
THERE'S EVEN A COUPON INCLUDED FOR A NO-WAIT SECURITY CHECKUP.
"MENTION AL-QAEDA AND GET A FREE COLONOSCOPY."
COOPER

The RHC upper payment limit per visit is increased from $77.76 to $78.07 effective January 1, 2011,

The 2011 rate reflects a 0.4 percent increase over the 2010 payment limit.

Policy Changes being pursued by NARHC during the 112th Congress

1. Raising the RHC Cap to **$92.00*** per visit.

2. **Expand Medicare and Medicaid incentives to RHCs for EHR utilization and Expand PQRI and E-prescribing**

RHCs participating in PQRI reporting would receive a $2.00 per visit bonus payment for meeting reporting requirements.

Modify the threshold to ensure that more RHC providers qualify for EHR incentives.

3. State Definition of “Rural

Certified RHCs that LOSE their “Rural” designation using federal standard would be allowed to retain RHC designation IF they were in an area defined by the STATE as “Rural”.

4. **MA organizations would be required to provide payment for rural health clinic services furnished to enrollees of the plan whether or not the services are furnished pursuant to an agreement between such organization and a rural health clinic that is ---**

4A. Not less than the RHC's Medicare payment rate (which includes the payment of an interim rate and a subsequent cost reconciliation)

OR

4B. If the rural health clinic determines appropriate, 103 percent of the applicable interim payment rate (with no reconciliation).

5. Establish a 10 state Demonstration program providing grants to RHCs to assist with covering the cost of physician, PA, NP, CNM malpractice insurance premiums

Grants would be $5,000 ($10,000 for Ob-Gyn) per provider or 50% of the premium (whichever is less).

Modify Definition of “employ” in RHC statute

Current law requires every RHC to “employ” a PA, NP or CNM. CMS interprets this to mean that the PA, NP or CNM must be an actual W-2 Employee and cannot be a 1099 independent contractor. NARHC is seeking a change that would allow RHCs to “employ” PAs, NPs or CNMs using an independent contractor model as well as a traditional employment model.

Who is the Rural Safety Net?

Medicare
Rural Health Clinic and Rural FQHC
2008

	Total Medicare Claims	Total Medicare Patients	Total Charges	Average Charge Per Claim	Average No. of Visits Per Medicare Patient	Total Claim Payment	Average Payment Per Claim	Part B Deductible Amount	Patient Co-Insurance Amount
Rural Health Clinic (RHC)	7,492,863	1,634,413	$754,276,321	$101	4.5 Visits	$489,696,104	$65	$79,259,358	$136,402,81
Rural Federally Qualified Health Centers	1,111,358	265,468	$120,928,890	$109	4.2 Visits	$92,335,118	$83	$0	$25,467,492

2008 Medicaid Data - National

	RHC Services Payments	RHC Beneficiaries	Rural FQHC Payments	Rural FQHC Beneficiaries	Rural FQHC % of all FQHC
Total	$659,962,933	2,049,171	$326,656,694.04	919,567	36.3%

Budget/Appropriations

The new GOP House leadership has announced plans to scale back federal spending to the level in place in 2008?

What, if anything, does this mean for RHCs and rural providers?

Discretionary Spending Vs. Entitlement Spending?

The Economic Stimulus Bill (ARRA) Vs. traditional appropriations?

The Affordable Care Act

Collaboration with FQHCs

The ACA has language directing that the Health Resources and Services Administration encourage great collaboration/cooperation between FQHCs and other safety net providers:

RHCs

CAHs,

Small Community Hospitals

RHC Technical Assistance Call

Contracting and Collaboration Opportunities

Monday, December 13, 2010, 2 PM EST

Go to:

http://www.hrsa.gov/ruralhealth/policy/confcall/index.html

As a result of the Affordable Care Act, claims with dates of service on or after January 1, 2010, received later than one calendar year beyond the date of service will be denied by Medicare.

Waiver of Co-insurance and Deductible for Certain Preventive Services

Effective for dates of service on or after January 1, 2011, coinsurance and deductible are waived for the IPPE, the annual wellness visit, and other Medicare covered preventive services recommended by the USPSTF with a grade of A or B. Detailed HCPCS coding is required to ensure that coinsurance and deductible are not applied to these preventive services.

Payment for the professional component of allowable preventive services is made under the all-inclusive rate when all of the program requirements are met. Lab and technical components should continue to be billed as non RHC services.

http://www.cms.gov/manuals/Downloads/bp102c13.pdf

Medicaid EHR Incentive Payments

EHR Incentive Payments

Physicians, NPs, CNMs and some PAs working in an RHC are eligible for EHR incentive payments under Medicaid.

Physicians must choose whether to receive a Medicare incentive payment OR a Medicaid incentive payment – cannot get both!

Rural Health Clinic and EHR Incentive Payments

Eligible Professionals must delivery a majority of the care they provide to patients in an RHC in order to be eligible for the incentive payment.

In the case of PAs, the clinic must be “PA led”.

Who is a “Needy Individual”

- Someone who is receiving assistance under Medicaid
- Someone who is receiving assistance S-CHIP
- Someone who is furnished un-compensated care by the provider;
- Someone for whom charges are reduced by the provider on a sliding scale basis based on an individual's ability to pay.

What is PA led?

A “PA led” Clinic is,

(1) When a PA is the primary provider in a clinic (for example, an RHC with a part-time physician and full-time PA, would be considered “PA led”); **or**

(2) When a PA is a clinical or medical director at a clinical site of practice; **or**

(3) When a PA is an owner of an RHC

Double dipping?

An eligible professional shall not qualify as a Medicaid provider under this subsection unless any right to payment under Medicare with respect to the eligible professional has been waived.

Healthcare Reform – Timeline

The Challenge of Change

Provisions already implemented

Provide dependent coverage for adult children up to age 26 for all individual and group policies.

This provision takes effect on September 23rd . However, companies do not have to make this available until the scheduled renewal of the company's policy.

Pre-Existing Condition Insurance Program (PCIP)

The PCIP initiative is in place in all 50 states and the District of Columbia.

This is either a state-run initiative or in the absence of a state program, a federally enrolled product. GEHA – Government Employees Health Association

Provisions already implemented

Individual and group health plans are prohibited from placing lifetime limits on the dollar value of coverage. Plans may only impose annual limits on coverage as determined by the Secretary.

Insurers are prohibited from rescinding coverage except in cases of fraud and they are prohibited from imposing pre-existing condition exclusions for children.

Provisions already implemented

Small Employer Tax Credit

Small employers (those with no more than 25 employees and average annual wages of less than $50,000 that purchase health insurance for employees) are eligible for a federal tax credit to help cover the cost of providing health insurance for their employees.

Small Employer Tax Credit

- **Maximum Amount.** The credit is worth up to 35 percent of a small business' premium costs in 2010. On Jan. 1, 2014, this rate increases to 50 percent.
- **Phase-out.** The credit phases out gradually for firms with average wages between $25,000 and $50,000 and for firms with the equivalent of between 10 and 25 full-time workers.

Provisions already implemented

Eligibility Rules

- **Providing health care coverage.** A qualifying employer must cover at least 50 percent of the cost of health care coverage for some of its workers based on the single rate.
- **Firm size.** A qualifying employer must have less than the equivalent of 25 full-time workers (for example, an employer with fewer than 50 half-time workers may be eligible).
- **Average annual wage.** A qualifying employer must pay average annual wages below $50,000.

IRS Information Available

www.irs.gov/newsroom/article/0,,id=221511,00.html

The Politics and Legality of Healthcare Reform


THE FUTURE OF
OBAMACARE
NOW LIES IN THE HANDS OF...
NINE EMPLOYEES COVERED BY THE FEDERAL HEALTH INSURANCE PLAN.

Legal Challenges

28 states have filed suit challenging the constitutionality of the Affordable Care Act.

Legal Challenges to ACA

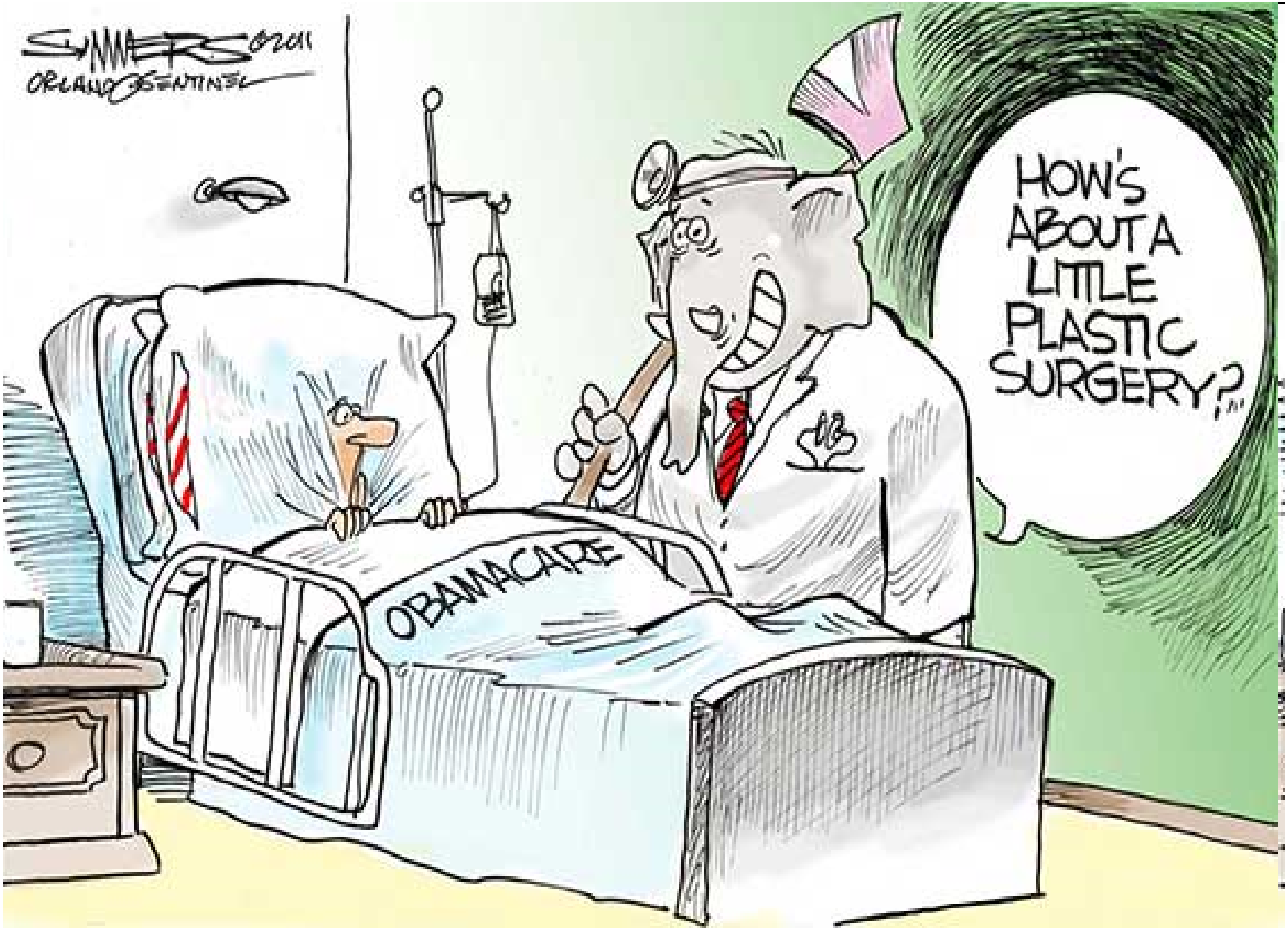
Two Key issues raised by the States:

1. Can the federal government require people to purchase health insurance
2. Can the federal government mandate expansion of the Medicaid program as directed under the ACA?

Repeal, Replace?

- On January 19th, the House passed a bill repealing the Patient Protection and Affordable Care act by a vote of 245-189.

- Subsequent to the House vote, the U.S. Senate rejected a proposal to repeal the Patient Protection and Affordable Care Act.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HOW'S ABOUT A LITTLE PLASTIC SURGERY?
OBAMACARE

New Deliver Models

Shared Savings?

Accountable Care Organizations (ACOs)

Are ACOs just a dressed up version of HMOs?

Will ACOs lead to the “Walmartization” of American Health Care or truly reform the healthcare delivery system in a way that is beneficial to patients?

How Will ACOs affect RHCs and other safety net providers?

- Rural Health Clinics can be part of an ACO.
- Rural Health Clinics that are part of an ACO can continue to receive cost-based reimbursement from Medicare.
- However, How patients will be “assigned” or “attributed” to an ACO could affect RHC participation.

General Medicare Update

Medicare Cuts in the ACA

Implementing the cuts included in the ACA extends the life of the Medicare Hospital Insurance Trust Fund by 12 years from 2017 to 2029, more than doubling the time before the exhaustion of the Trust Fund.

Medicare savings document published by CMS, Summer, 2010

The SMI (Supplementary Medical Insurance or Part B) Trust Fund is adequately financed over the next 10 years and beyond because premium and general revenue income for Part B is reset each year to match expected costs.

The Medicare Trustees

However, Congressional overrides of scheduled physician fee reductions (SRG cuts) could jeopardize Part B solvency and require UNUSUAL measures to avoid asset depletion.

The Medicare Trustees

Unless Congress intervenes, Part B premiums in 2011 and 2012 for new enrollees, high-income enrollees and State Medicaid program payments (on behalf of low-income enrollees) will have to be raised SIGNIFICANTLY above normal requirements to offset the loss of revenues.

The Medicare Trustees

As a result, the Medicare Trustees have issued a “Funding Warning” that the Part B program is becoming overly reliant on general revenue financing.

For these reasons, the financial projections shown in this report for Medicare do not represent a reasonable expectation for actual program operations in either the short-term or the long range.

5010 Standards

- **December 31, 2010 -** Internal testing of Version 5010 must be complete to achieve Level I Version 5010 compliance

- **January 1, 2011** - Payers and providers should begin external testing of Version 5010 for electronic claims

- CMS begins accepting Version 5010 claims but Version 4010 claims continue to be accepted.

- **January 1, 2012** – All covered entities must be fully compliant and must be able to conduct electronic transactions using the 5010 standards.

RHC Rules and Regulations

Proposed changes in RHC Rules and Regulations Issued on June 27 2008.

Final Rule MUST be issued by June 27, 2011 or the package must be rescinded.

It is not a certainty that CMS will move to release the RHC FINAL rule by June 28, 2011.

Issues that were raised in the Proposed Rule

Growth of the RHC Program

Medically Underserved/Shortage Area Designations

Expansion of Eligible Designations for RHC Certification

Commingling

Staffing Requirements, Waivers, and Contracts

1. Staffing Requirements
2. Temporary Staffing Waivers

Contractual Arrangements & Payment Issues

1. Payment Methodology for RHC and FQHCs
2. Exceptions to the Per Visit Payment Limit

RHC Location Requirements and Exceptions

1. RHC Location Requirements
2. Essential Provider Requirements
3. Location Exception Criteria
4. Process for Essential Providers Status and Timeline

Shortage Area Designation Proposed Changes

In 2008, the Health Resources and Services Administration issued a proposed rule proposing numerous changes in the way the federal government designates underserved areas.

Due to the controversial nature of that proposal, the agency withdrew the proposal and went back to the drawing board.

The Patient Protection and Affordable Care Act (Healthcare Reform) legislation, mandated that the Secretary of HHS appoint a “Negotiated Rulemaking” Committee to consider possible changes in the methodology used to designate areas as medically underserved or health professional shortage areas.

In May, Ron Nelson, PA-C, Associate Executive Director of NARHC was appointed as the NARHC representative to the Negotiated Rulemaking Committee.

NARHC Board Member Gail Nickerson has been appointed as the “alternate” representative in the even Ron is unable to attend a meeting or participate in any of the discussions/deliberations.

Negotiated Rulemaking Committee

Issues under consideration:

- How to define a rational service area?
- What is the proper ratio/threshold?
- What Providers get Counted?

Negotiated Rulemaking Committee Update

- Time Line
- Process
  - Consensus
  - Public Comment

Linking Quality and Payment in RHCs

The Patient Protection and Affordable Care Act directed the Secretary of HHS to analyze and make recommendations to Congress on how to link payments to RHCs, FQHCs and Free clinics to quality incentives/quality outcomes.

George Washington University has been awarded the contract to do this research and NARHC Executive Director Bill Finerfrock has been appointed to the GW Advisory Committee as a Subject Matter Expert.

New Medicare Enrollment Fee

Effective Friday, March 25, 2011, all NEW providers enrolling in Medicare will be required to pay an application fee as a condition for enrolling in Medicare.

The application fee is $505.00. RHC can seek a waiver of the fee base on "hardship". CMS has not issued guidelines for qualifying for a hardship exception.

RHC Technical Assistance

NARHC in conjunction with the Federal Office of Rural Health Policy conducts RHC Technical Assistance teleconference calls on topics of specific interest to the RHC community.

In addition, ORHP support the maintenance of the RHC Listerve (NARHC News)

To view transcripts or download audio recordings of previous calls

http://www.hrsa.gov/ruralhealth/policy/confcall/index.html

To sign up for both the RHC TA listserve as well as the NARHC NEWS listserve, go to:

Send an email to info@narhc.org from the email address you would like to get the messages and we will get you signed up.


WHAT FAIRY TALE WILL IT BE TONIGHT, DADDY?
LOW-COST GOVERNMENT HEALTH CARE
WIZARD OF OZ
ALICE IN WONDERLAND
LITTLE ENGINE THAT COULD
MOTHER GOOSE
SLEEPING BEAUTY
WINNIE THE POOH
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If you think health care is expensive now, wait until you see what it costs when it's free.

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