Rural Health Clinics

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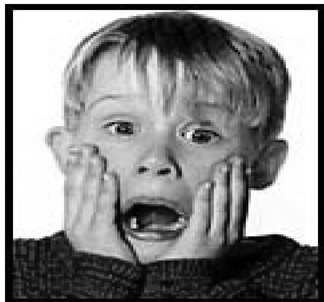
NARHC Policy Update - 2009

"Our system depends upon the fullest participation of all its citizens."

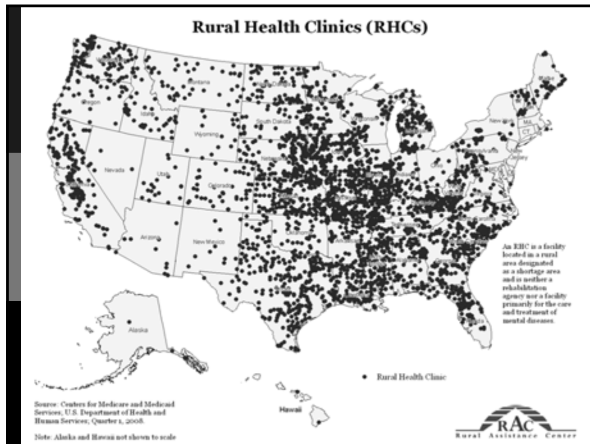
–Robert F. Kennedy



Medicare Economic Index 1.6%

RHC Upper Payment Limit for 2009
$ 76.84.

The new rate was effective as of 1/1/09



- Number of States that saw Growth in the RHC program: 35
- Number of States that saw no Growth in RHC program: 11
- Number of states that saw a decrease in the RHC program: 5

RHC Rules and Regulations

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

CMS is still reviewing all comments received. Rule is still within the agency and has not progressed beyond the staff level.

Anything developed by staff will be reviewed by in-coming Obama Administration officials to see if it fits with Obama policy and vision

Before a Final Rule can be published it must be approved by:

Obama Administration appointees at CMS
Obama Administration appointees at HHS
Obama Administration appointees at OMB

Obama Administration

HHS Secretary: Kansas Governor Kathleen Sebelius – nominated 3/2/09.

CMS Administrator - ????

HRSA Administrator: Mary Wakefield – Friend of Rural!!!

Legislation - 2008

Congress approved a change in the RHC statute that would extend the time period of a shortage area designation to be considered "current" from 3 to 4 year.

Economic Recovery (stimulus)

Reimbursement Incentive Study and Report

(1) STUDY- The Secretary of Health and Human Services shall carry out, or contract with a private entity to carry out, a study that examines methods to create efficient reimbursement incentives for improving health care quality in Federally qualified health centers, rural health clinics, and free clinics.

(2) REPORT- Not later than 2 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the appropriate committees of jurisdiction of the House of Representatives and the Senate a report on the study carried out under paragraph (1).

Economic Recovery

Authorize Incentive Payments to RHCs – through the Medicaid program – for "meaningful use" of a "Certified" EHR system.

Available to "eligible professionals" physicians, nurse practitioners, nurse midwives and some PAs who work in RHCs IF 30% of the clinics patients are "needy"

What is "Meaningful Use"?

IN GENERAL…

An eligible professional shall be treated as a meaningful EHR user for if each of the following requirements is met:

Meaningful Use

1. The eligible professional demonstrates to the satisfaction of the Secretary that during such period the professional is using certified EHR technology in a meaningful manner, which shall include the use of electronic prescribing as determined to be appropriate by the Secretary.

2. The eligible professional demonstrates to the satisfaction of the Secretary that during such period such certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination.

3. The eligible professional submits information for such period on such clinical quality measures and such other measures as selected by the Secretary.

"Needy" is defined as patients that are:

1. Medicare
2. S-CHIP
3. Uncompensated
4. Eligible to have payment calculated using a sliding fee scale

Amount RHCs can Receive

- not in excess of 85 percent of net average allowable costs for certified EHR technology (and support services including maintenance and training that is for, or is necessary for the adoption and operation of, such technology)

Who's Eligible?

- An eligible professional who practices predominantly in a rural health clinic and has at least 30 percent of the professional's patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to needy individuals

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.

Who is an eligible professional?

- The term `eligible professional' means a--
- physician
- dentist
- certified nurse mid-wife
- nurse practitioner
- physician assistant insofar as the assistant is practicing in a rural health clinic that is led by a physician assistant.

What is Average Allowable Cost?

- The term `average allowable costs' means the average costs for the purchase and initial implementation or upgrade of such technology (and support services including training that is for, or is necessary for the adoption and initial operation of, such technology.

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.

Limits on Incentive Payments

In no case shall—

* the net average allowable costs under this subsection for the first year of payment exceed **$25,000**
* the net average allowable costs under this subsection for a subsequent year of payment, exceed $10,000

Incentive Limits

- In No Case, shall payments be made for costs described in clause after 2021 OR over a period of longer than 5 years.
- Total Incentive – PER PROVIDER: $65,000 over 5 years.

The eligible professional is responsible for payment of the remaining 15 percent of the net average allowable cost

What is "Certified"

- The term `certified EHR technology' means a qualified electronic health record that meets standards adopted by the Secretary that are applicable to the type of record involved, such as an ambulatory electronic health record for office-based physicians.

S-CHIP Amendment

H.R. 2, legislation reauthorizing and expanding the State Children's Health Insurance Program (S-CHIP) mandates coverage of Rural Health Clinics under the program:

The following sections of this Act shall apply to States under this title in the same manner as they apply to a State under Medicaid:

- Section 1902(bb) (relating to payment for services provided by Federally-Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)).

Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary for fiscal year 2009, $5,000,000, to remain available until expended, for the purpose of awarding grants to States with State child health plans that are operated separately from the State Medicaid plan under title XIX of the Social Security Act for expenditures related to transitioning to compliance with the requirement to apply the prospective payment system to services provided by rural health clinics.

NARHC Legislative Agenda 111th Congress

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

Senator Charles Grassley (R-IA) recently introduced a bill (**S. 318)** that among other things, calls for raising the RHC cap to $92.00 per visit. In addition, the House and Senate Rural Health Caucus and Coalition will be introducing comprehensive rural health legislation that calls for raising the RHC cap to $92.00 per visit.

NARHC has been working with a bi-partisan group of Senators to secure the introduction of an RHC specific piece of legislation making the following changes in the RHC program

- Raising the RHC Cap to **$92.00** per visit

Diabetes Education and MNT service as covered visits (not just a service)

Extending Medicare incentives to RHCs for quality reporting, e-prescribing and EHR utilization

State Definition of “Rural”

Encouraging collaboration between RHCs and FQHCs on the delivery of care to low-income/uninsured individuals.

MA Plan payments (coordinated care – wrap around/FQHC equality)

Rural Health Clinics and Healthcare Reform

In December, 2008, Senator Max Baucus, Chairman of the Senate Finance Committee issued a "white paper" outlining his views on how to reform our nation's healthcare delivery system.

REFORMING AMERICA'S HEALTH CARE SYSTEM:A CALL TO ACTION

In his plan, Chairman Baucus outlined several key points or concepts:

1. The plan would also ensure the viability of community health centers and rural health clinics that provide vital safety net functions and serve as a true medical home for thousands of patients across the country.

2. ***Community Health Centers and Rural Health Clinics.***

Efforts to reestablish primary care as the backbone of the health care system should build on existing systems that work.

3. Mechanisms for compensating rural health clinics (RHCs) also are deficient and should be improved. In Montana and across the country, these facilities are instrumental in meeting the needs of patients when other access points to care are unavailable or inadvisable — for example, reliance on an emergency department.

4. For these reasons, health reform should include policies that bolster community Health Centers, RHCs, and FQHCs as part of the larger effort to improve patient access to critical primary care services.

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