# Clinic Connection

June/July 2009
Volume 17, Issue 3

THIS NEWSLETTER IS A PUBLICATION OF THE

Texas Association of Rural Health Clinics

Quality Health Care for Rural Texas



Clinic Connection, www.tarhc.org, is published by the TEXAS ASSOCIATION OF RURAL HEALTH CLINICS located at 505 E. Huntland Drive, Suite 150, Austin, Texas 78752; telephone 512/873-0045; fax 512/873-0046. Articles are prepared by and comments should be sent to Ramsey Longbotham, Executive Director, ramsey@tarhc.org .

## RURAL HEALTH CLINICS IN THE UNITED STATES

The **Rural Health Clinic** program has shown its importance to increasing healthcare access to rural communities throughout the country in just about every State of the Union. The only States that currently do not have an operational **Rural Health Clinic** (RHC) are: Connecticut, Delaware, and Maryland.

The States having about a hundred or more existing **RHCs** are: California (249 clinics); Florida (132 clinics); Illinois (197 clinics); Iowa (130 clinics); Kansas (165 clinics); Kentucky (113 clinics); Michigan (143 clinics); Mississippi (127 clinics); Missouri (270 clinics); Nebraska (99 clinics); **Texas (328 clinics)**; and Washington (130 clinics).

The States with the least number of **RHCs** are: Hawaii (2 clinics); Massachusetts (1 clinic); and Rhode Island (1 clinic).

Although some people may argue that there has not been an appreciable increase of access to care for the majority of underserved Medicare and Medicaid beneficiaries in the nation, the **RHC** program has brought healthcare providers to a number of rural communities and sustained their staying power in those communities whereas the economic situation would indicate from a business's profit and loss viewpoint that a provider could do better elsewhere. There are 3,407 **certified rural health clinics** in the United States participating in the federal **RHC** Program that provide vital healthcare services to patients in rural medical underserved areas of the country.

**Guess where the rural health clinic in Massachusetts is located? The answer will be further in this newsletter, so keep reading!**

## HAVE PATIENCE AND WE WILL PREVAIL IN THE TEXAS LEGISLATURE

What started as a **RHC** legislative suggestion at the beginning of 2007 by **Kenneth Lowrance, FNP-C from the Clifton Medical Clinic in Clifton**, – has finally become a reality at the closing of the 2009 Texas 81st Legislation with the passage of Senate Bill 1984 that was sent to the Governor's Office on June 1, 2009, for signing into law effective September 1, 2009.

The concept of this bill was to allow **RHC** non-physician practitioners (physician assistants, nurse practitioners, and certified nurse mid-wives) the authority to certify a disabled person as meeting the criteria and eligibility for the **Texas Department of Transportation (TXDOT)** permanent (blue) and temporary (red) handicapped permits. The **TXDOT** rules for these permits only allow Texas licensed physicians and Veterans Administration healthcare providers the authority to certify people as handicapped and meeting the approval criteria for these parking permits. The original intent of the suggestion was to allow non-physician **RHC** providers to make the handicapped determination and thus lessen the application processing time for patients waiting for an approval to apply for the **TXDOT** handicapped permits in our Texas **RHC** communities.

In 2007, **Senator Glenn Hegar (Senate District 18) from Katy and Representative Geanie Morrison (House District 30)** from Victoria submitted companion bills SB 985 and HB 2370 with the Senate Bill passing and the House Bill unfortunately getting caught in committee and not meeting the deadline suspense to get on the House floor for a vote. The **80th Texas Legislative Session** ended with only 1,480 bills passing out of 6,500 bills filed during that legislature.

*(Continued on page 2)*

*(Continued from page 1)*

In 2008, the Association coordinated with Senator Hegar's and Representative Morrison's staff to again submit bills that would allow **RHC** non-physician practitioners the authority to certify people as eligible for the **TXDOT** handicapped permits. These two offices were instrumental in moving the initiative forward. In 2009, Senate Bill 1984 sponsored by **Senator Carlos Uresti (San Antonio, Senate District 19) co-sponsored by Senator Hegar**; and an identical bill, House Bill 4349, by **Representative Tracy O. King (Eagle Pass, House District 80)** were both voted into law by the legislature and sent to the Governor's Office for signature.

The wording is a little different from what was tried in 2007 but the concept is still the same:

*The first application for a disabled parking placard submitted by a person who resides in a county with a population of 125, 000 or less. The notarized written statement or prescription may be issued by:*

1. *a person acting under the delegation and supervision of a licensed physician in conformance with Subchapter B, Chapter 157, Occupation Code; or*
2. *a physician assistant licensed to practice in this state acting as the agent of a licensed physician under Section 204.202(e), Occupations Code.*

**The Association thanks Melissa Hamilton, Senator Hegar's healthcare legislative aide, for tracking the bills and keeping us informed of their progress as they were acted on.**

## MEDICAID RULE PROPOSED FOR RHC REIMBURSEMENT

The **Texas Health and Human Services Commission (HHSC)** provided a proposed rule for our **RHC** membership's consideration that will be presented to the **Texas Medicare Advisory Council (MCAC)** on July 9, 2009. This proposal was sent to the Association on June 16th and then forwarded out to subscribers on the association's **RHC Forum (Internet) List** Serve on June 17th for comments and input.

The **RHC** changes are:

- The proposed amendment adds the detailed methodology that **HHSC** uses to set interim base rates for new **RHCs**. Currently, interim base rates for new freestanding **RHCs** and for **RHCs** with more than 50 beds is set at the lesser of the initial estimated cost report or the Medicare maximum payment rate (federal ceiling). The interim base rate for hospital based **RHCs** with 50 or fewer beds is paid at 80% of their costs from their initial estimated cost report in addition, language was added to clarify the methodology **HHSC** will use to cost-settle interim payments after determination of the final base rate.
- In addition, language was added to clarify the methodology **HHSC** will use to cost-settle interim payments after the determination of the final base rate. The rule also clarifies that any **RHC** that chooses not to file an estimated cost report has its interim base rate set at 75% of the federal ceiling rate.
- **HHSC** proposes to add language to require **RHCs** to periodically submit cost reports, at the discretion of **HHSC.** Language is also added to clarify that HHSC may place facilities on vendor hold if it fails to submit the cost report within 5 months.
- It is the intent to **HHSC** to no longer differentiate between the **PPS** and **APPS** methodologies and combine them into one methodology that applies to all **RHCs.** The new methodology will allow for interim payment cost settlement up or down based on the final base rate. As a result, duplicative language regarding the **APPS** and **PPS** rate is removed from the proposed rule.

The current existing **RHC** Medicaid reimbursement rule can be found on the Texas Secretary of State's website at http://www.sos.state.tx.us/ .Go into the link for the **Texas Administrative Code (TAC).** The **RHC** Medicaid reimbursement information is in:

| | |
|---|---|
| Title 1 | Administration |
| Part 15 | Texas Health and Human Services Commission |
| Chapter 355 | Reimbursement Rates |
| Subchapter J | Purchased Health Services |
| Division 6 | Rural Health Clinics |
| Rule .355.8101 | Reimbursement |

## DSHS SYMPOSIUM ON TREATMENT OF RABIES/TETANUS UTILIZING CDC GUIDELINES

The **Texas Department of State Health Services** is offering a Symposium on the **Prevention and Treatment of Rabies and Tetanus** through Utilization of CDC Guidelines and Statewide Resources. **The symposium is free for attendance and the registration deadline has been moved to June 29th.** The educational meeting will be conducted on **Wednesday, July 1st from 9:00 am to 12:30 pm**. It will be held at the Sheraton Austin in Austin, Texas. The program will

*(Continued on page 3)*

*(Continued from page 2)*

feature a panel of **experts** from the **American Academy of Pediatrics, Emergency Department, Poison Control Center, Infectious Disease, National Hispanic Medical Association, USDA Wildlife Services, and a local Health Director.**

*Call or email Robin Jennings at 919-545-0289 or robin@rbendeavors.com for registration information. For questions about the conference call or email Tom J. Sidwa, D.V.M. (512-458-7111, ext 6628 or email Tom.Sidwa@dshs.state.tx.us or Cindy Yager at cindyy@saboney.com or 919-881-1193.*

## PPOs DRIVING GROWTH IN RURAL MEDICARE ADVANTAGE ENROLLMENT

A changing landscape is emerging for rural **Medicare Advantage (MA)** enrollment in 2009 as rapid growth in **preferred provider organization (PPO)** plans is coupled with a decline in the growth rate in enrollment in **private fee-for-service (PFFS)** plans. Enrollment in **MA** plans has continued to climb in 2009, but it has been impacted by slowed rate of growth in PFFS plans, which cover over half of MA enrollees in rural areas. The growth in **PPO** enrollment in recent months is likely tied to changes in policy that have encouraged the growth of the new **PPO** plans, enrollment in existing **PPO** plans, and expansions of the service areas of existing plans.

From January 2008 to May 2008, rural enrollment in **MA** and other prepaid plans grew by 16.1% while from January 2009 to May 2009 enrollment grew only by 10.3%.

Over half (57%) of rural **MA** beneficiaries were enrolled in a **PFFS** plan in May 2009: however, growth in rural **PFFS** plans is slowing. While rural **PFFS** enrollment grew by 17.2% during the 2008 open enrollment period (reflected in enrollment changes from January through May 2008) enrollment grew only by 6.1% during the 2009 open enrollment period (January to May 2009). From January 2008 through May 2009, rural enrollment in **PFFS** plans grew by 27%.

Rural **PPO** enrollment grew by 34% from January 2008 through May 2008 and by 29% during the same months in 2009. **PPO** enrollment in rural areas more than doubled from January 2008 through May 2009, with enrollment reaching 224,000 Medicare beneficiaries (17% of **MA** enrollees).

*The information above is a Rural Policy Brief, Brief No. 2009-7, June 2009 by Leah Kemper, MPH, Timothy D. McBride, PhD, and Keith Mueller, PhD. at the RUPRI Center for Rural Health Policy Analysis, www.unmc.edu/rupri health . Future CMS requirements for the **MA PFFS** plans are that they will have to develop direct network participation agreements with service providers to see their members. This will be a requirement in 2011 and will be discussed by a panel of **MA** representatives at the **National Association of RHC s (NARHC) Annual Meeting & Conference in Nashville, Tennessee in early September.***

## WHERE DID YOU SAY MASSACHUSETTS HAS A RURAL HEALTH CLINIC?

Where is it? In some quaint farming community? No, it is just a 45-minute ferry ride from the mainland. On an island that features pristine sandy beaches, golf courses, natural beauty and more than its fair share of sun-seeking celebrities. **It is in Martha's Vineyard.**

**Island Health Care (IHC)** is Massachusetts' first and only rural health clinic located on Martha's Vineyard (Dukes County) which is currently designated as a **Health Professional Shortage Area (HPSA).** Among the 15,500 year-round-population in the Vineyard, the majority have limited incomes and significant challenges accessing health services.

Approximately 22% have incomes below 200% of the **federal poverty level (FPL)** and over 50% have incomes below 400% FPL. Very high rates (almost 20%) of un-insurance (close to twice the Massachusetts' statewide rate) and a lack of access to specialty care combined with limited income creates significant barriers to health care.

**2009 Federal Poverty Guidelines** for the 48 Contiguous States are:

| *Persons in family* | *Poverty Guidelines* | *Persons in family* | *Poverty Guidelines* |
|---|---|---|---|
| 1 | $10, 830 | 5 | $25,790 |
| 2 | $14, 570 | 6 | $29,530 |
| 3 | $18,310 | 7 | $33,270 |
| 4 | $22,050 | 8 | $37,010 |

The poverty guidelines are sometimes referred to as the **"federal poverty level" (FPL)**

http://aspe.hhs.gov/poverty/09poverty.shtml .

**Send us any changes you may have had in your clinic in the past year. Please complete the following and return to us. TARHC Member Directory is COMING SOON!**

Name of Clinic _____

Street Address_____

Mailing Address_____

City_____ State_____ Zip Code_____

Phone (___)_____ Fax (___)_____

Web Site_____

Contact Person _____

**Return ASAP to either:**

**rose@torchnet.org**

**Or**

**Fax (512) 873-0046**

**Or**

**P.O. BOX 14547**
**Austin, TX**
**78761**

## MORE PRACTICES REFUSING TO ACCEPT CREDIT CARDS FROM PATIENTS:

The **American Medical Association** in its amednews.com release on June 22nd, has an article by **Bob Cook** which says that a third of physician practices in April did not accept credit cards, which is an increase of 5 points from 28% last year. **SK&A Information Services** conducted the telephone survey of 202,650 physician offices to collect the data on healthcare providers accepting credit card payments. **SK&A** said a specialty's interest in accepting credit cards seems to be linked with its reliance on patient self-pay and the age of its patient base. The highest acceptance rate was in plastic surgery, with 91% of practices open to plastic payments. Pathology, at 21% has the lowest acceptance rate. Family physicians had a credit card acceptance rate of 71%; internists had 53.1% and geriatricians had 32%.

**SK&A** said its survey did not ask practices why they were refusing to accept credit cards. But a company spokesman, echoing what practice management experts and practices themselves are saying, citing ever-increasing fees for card-transactions. Credit-card companies and the firms that service transactions take a collective 3% to 4% off the top of every payment. Many practices feel that is too much.

## SPEAKING OF CREDIT CARDS - YOU CAN NOW PAY YOUR TARHC CONFERENCE REGISTRATION BY CREDIT CARD. HAVE YOU REGISTERED YET?

The **Annual Texas Association of Rural Health Clinics' Conference and Annual Membership Meeting** will be held **from July 28th to July 30th at the AT&T Education Conference Center at the University of Texas Austin Campus**. Visit the www.tarhc.org website calendar page for registration/credit card instructions.

You don't want to miss our informative and educational programs that have been lined up for **RHCs**. The **Rural Health Clinic (AAAASF) American Association for Accreditation of Ambulatory Surgery Facilities, Inc. speaker Jeff Pearcy** will give us an update as to how close his organization is to being a deemed a non-government **RHC** certification organization. At the beginning of June, he told attendees at the **National Association of Rural Health Clinics** (**NARHC) Summer Rural Health Clinic Institute** that **CMS** had changed the criteria from sending in the results of 10 **RHC** initial certifications to now only five initial certifications but one each from five different states. How soon can his organization be given the green light to do "Official" initial certifications and re-certifications?

**Bryan Carmody, President of Public Health Television (PHTv),** can tell us how the July implementation of the **Public Health Television** clinic program is going for the 30 health centers in Tennessee. He may offer us details of having Texas become one of the startup pilot states in the country. He has already gotten the **Washington State RHC Association** to commit to becoming a pilot **RHC** program state this fall. And the newly formed **California RHC Association** has given their approval to work with him. Would there be a financial incentive for **Texas RHCs** that agree to participate in his **Public Health Television** program?

What is this "meaningful use" of **EMR** requirements we are hearing about these days? What if we don't use electronic health records in our clinics? They are too expensive and do they even interchange data between the programs? Will there be any of President's Obama's stimulus money for **RHCs** to buy that stuff? What if we don't buy into all of this **EMR** mumbo jumbo, paper records have worked and are just fine with our clinic? Who gets hurt? What is the point? Well, maybe the panel we have assembled for the conference about this subject can shed some light on it.

And you don't want to miss the big news on how to become a member of both the **Texas Association of Rural Health Clinics** and the **National Association of Rural Health Clinics** under one joint membership application that will save you $200 rather than if you were to join each separate **RHC** association individually. The **Texas Association of Rural Health Clinics** has 108 clinics as members in its group. The **National Association of Rural Health Clinics** has 517 members nation-wide with 35 Texas clinics on its membership rolls. After a couple of years of discussion and negotiating, we have finally come up with ***the plan*** that we will roll out for next year's membership drive.

See you at the July RHC Conference in Austin—it's *sizzling* with good things happening!

RETURN SERVICE REQUESTED

## June/July 2009

**In this issue . . .**



Visit www.tarhc.org


June/July 2009
Volume 17 Issue 3


# TARHC Annual Conference July 28-30, 2009 Austin, Texas

**If your administrator/ director, address, email, phone or fax number has changed, please let us know by emailing us at torch@torchnet.org .**

**Remember to share this newsletter with your colleagues.**