Clinic Connection

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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 .

Forget January 3, 2011– PECOS Date Moved 6 Months Closer

Physicians and "eligible" providers received a jolt in the May 5, 2010, Federal Register as the date for enrollment in PECOS was moved up six months (pending the comment period and any changes resulting from the public comment period) for providers that order or supply Durable Medical Equipment (DME) for Medicare patients. Instead of the January 3, 2011, date previously announced by the Centers for Medicare and Medicaid Services (CMS), the Patient Protection and Affordable Care Act (Affordable Care Act or PPACA) has provisions to move the "go-date" to July 6, 2010, now less than a couple of weeks away.

What does that mean to you? Unless something changes based on public comments, beginning July 6, 2010:

- Providers with a National Provider Identifier (NPI) must include it on their Medicare and Medicaid enrollment applications and claims.
- Providers of medical items/other items/services and suppliers that qualify for a National Provider Identifier (NPI) must include their NPI on all applications to enroll in the Medicare and Medicaid programs AND on all claims for payment submitted under the Medicare and Medicaid programs.
- The ordering/referring supplier must be a physician or an eligible professional with an approved enrollment record in the Provider Enrollment Chain and Ownership System (PECOS) thus changing the previously reported January 3, 2011 date given by CMS.
- Claims that do not meet these requirements will be rejected by Medicare contractors.

RHCs have to do a paper enrollment for the PECOS program so that their enrollment is on file and the suppliers and referred services can get paid by Medicare.

Red Flags Rule – New Change to Enforcement Date

On May 28th, the Federal Trade Commission (FTC) announced that the enforcement of the Red Flags Rule will now begin January 1, 2011, instead of June 1, 2010. At the request of several members of Congress, the FTC announced it was delaying enforcement of the "Red Flags Rule" through December 31, 2010, while Congress considers legislation that would affect the scope of entities covered by the Rule.

Texas Medical Board (TMB) Proposes Rule Concerning Physician Assistants

TMB published a propose rule in the Texas Register (35 Tex. Reg. 4301) concerning physician assistants. Among other things, the proposed rule: 1) provides that the Physician Assistant Board may revoke a temporary license when necessary; 2) clarifies that a physician may supervise more than five physician assistants if granted a waiver by TMB; establishes requirements for probable cause hearings relating to physical or mental impairment

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examinations; and 4) sets out requirements of physician assistants to report certain events to the Physician Assistant Board with thirty days of their occurrence. Comments are due to TMB by June 25, 2010.

Transition of Part A WPS Workload to Texas J4 MAC (CMS Change Request 6902)

The Centers for Medicare and Medicaid Services (CMS) will transition all title XVIII workloads to an A/B Medicare Administrative Contractor (MAC) by October 1, 2011. The transition of providers to the appropriate A/B MAC will occur jurisdiction by jurisdiction.

Wisconsin Physician Service (WPS) currently processes Part A/B Title XVIII workload (at one time it was about 20 RHCs in Texas) that includes providers who fall under the geographic jurisdiction of all 15 A/B MAC jurisdictions. This is known as the WPS legacy workload.

Providers currently processed by WPS, whose claims should be processed by the Jurisdiction 4 A/B MAC, will transition to TrailBlazer, the J4 A/B MAC responsible for the states of Colorado, New Mexico, Oklahoma, and Texas. The J4 transition is currently scheduled to take place in October 2010.

Texas Awarded $35.7 Million to Implement Electronic Medical Records

The U.S. Department of Health and Human Services announced an award of $35,709, 106 to four Health Information Technology Texas Regional Extension Centers (RECs) to assist physicians and healthcare professionals implement statewide electronic medical records.

The four Texas Regional Extension Centers (TxRECs) were awarded:

- North Texas Regional HIT Extension Center Consortium - $8,488,513
- West Texas - $6,666,296
- CentrEast Regional Extension Center - $5,279,970
- Gulf Coast HITECH Extension Center - $15,274,3267

The four funded TxRECs will jointly review EMR vendor proposals and perform product testing in preparation for assisting practitioners with the selection of health technology systems. Early adopters of EMR technology may be eligible for up to $44,000 in American Recovery and Reinvestment Act funds to assist in the purchase and implementation of EMR systems. The TxRECs will draw upon the "meaningful use" guidance provided by the Department of Health and Human Services to create EMR system recommendations.

Census Bureau Releases 2009 State Characteristics Population Estimates

The U.S. Census Bureau released on June 10th population estimates as of July 1, 2009, for the nation, each state, and the District of Columbia by age, sex, race, and Hispanic origin.

The new estimates are not 2010 Census population counts. Rather, they are based on 2000 Census data and updated by using administrative records to estimate components of population change – namely births, deaths, and domestic and international migration. Annual estimates for the 2000 to 2009 period are provided. These are the last state estimates to use the 2000 Census results as a base. The 2011 population estimates will be the first in the estimates to be based on the 2010 Census population counts. In December, the Census Bureau will deliver the 2010 Census state population counts to the president, to be used in apportion seats in the U.S. House of Representatives. By April 2011, the Census Bureau must release counts by race and Hispanic origin for counties, cities and other small geographic areas so that states can proceed with re-districting in accordance with Public Law 94-171.

Texas' population increased by nearly 20 percent and grew increasingly diverse in the last decade - a trend the Census Bureau estimate release showed on June 10th. Texas now has about 24.8 million residents, an increase of 3.9 million since 2000 and trails only California in proportion of its residents who identify themselves as Hispanic (37 percent).

Among the 2009 estimate highlights:

- Texas added 480, 000 new residents from 2000 to 2009, more that any other state. Harris County added 62,000 Hispanic residents alone during that period.

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- Texas' border counties lead the nation in the proportion of Hispanic residents. Only 3 percent of residents in Staff County, for example, aren't Hispanic.
- The state has the third larges - largest black and Asian populations in the country: 2.8 million and 850, 000 respectively.
- Texas is younger than all but two other states, with a medium age of 33, and is aging more slowly than the rest of the nation. Only Utah and Alabama have younger populations. Webb County which includes the city of Laredo has the nation's second-highest proportion of residents under the age of five: 12 percent.

Medicare Advantage Outlook for 2011: Fewer Expansions, More Cost Sharing

Industry actuaries and consultants say they expect to see fewer bids for new Medicare Advantage Service areas and products than in recent years. They are also seeing generally small increases in planned cost sharing and slight declines in benefits for next year to compensate for payment cuts and rising costs.

The big complication that plans faced in preparing for 2011 bids are specific new CMS policies. They cover such key arenas that discourage service-area expansions by plans that are under scrutiny for quality deficiencies, ensuring that there are "meaningful differences" in the premiums and features of plans offered by the same sponsor, and enforcing mandatory out-of-pocket limits for beneficiaries. Those factors seem to be limiting aggressive decisions by many MA plans but none of the consultants envision Major MA plan exits other that those caused by the end of "deeming" for private-fee-for-service (PFFS) products in most counties at the end of this year. There are complications related to the end of PFFS deeming in most counties in the county by December 31, 2010. To the extent that PFFS plans are unsuccessful in network contracting (direct contracts with providers), there may be a lot of PFFS members looking for new plans for 2011. Medicare Advantage Plans. Local HMOs and local PPOs contract with provider networks to deliver Medicare benefits.

Private Fee-For-Service plans (PFFS) are not currently required to establish networks, report quality measures or have Medicare review and negotiate premiums. However, the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 requires PFFS plans to comply with new quality reporting requirements, and beginning in 2011, create provider networks in certain counties.

Special Needs Plans (SNPs), mainly HMOs, are restricted to beneficiaries who are dually eligible for Medicare and Medicaid, live in long-term care institutions, or have certain serve and disabling chronic conditions. MIPPA reauthorized SNPs through 2010, but prohibits the entry of new SNPs until 2011.

Regional PPOs were established under the Medicare Modernization Act of 2003 (MMA) to provide rural beneficiaries greater access to Medicare Advantage plans and provided stabilization fund to encourage entry of regional PPOs. That fund was eliminated under MIPPA. In 2009, regional PPOs accounted for only 3% of all Medicare Advantage enrollees.

Medical Savings Account plans (MSAs) combine a high deductible health plan with a MSA into which Medicare makes annual deposits on behalf of enrollees. Beneficiaries draw from these funds to pay for qualified health care expenses until they meet the deductible at which point the plan pays for all the Medicare covered services. In 2009, MSA plans had only 1,866 enrollees.

National Rural Heath Association (NRHA) RHC Representation Needed!

Tommy Barnhart, the outgoing chair of the NRHA RHC Constituency Group, told the Executive Director of TARHC during NRHA's Annual Conference last month that there has been an increase in NRHA members selecting the RHC Constituency Group (CG) as their chief interest group. This will allow several more seats representing RHCs in the NRHA Rural Congress which identifies priority rural healthcare issues and develops healthcare policy for the organization to send to the federal Government and to Congress.

NRHA asks its members to affiliate with its constituency groups. NRHA's broad membership represents people from a variety of professions and interests, including doctors , nurses, administrators, clinicians, non-physician providers, academicians, researchers, mental health care providers, hospitals , rural health clinics, students, and many other subgroups. All of these individuals and organizations bring their own interests and agenda to the common goal of ensuring affordable and accessible quality health care for rural populations.

Through its constituency groups, NRHA is structured to represent these individual concerns as well as the more encompassing interests of the entire membership. Each group elects a chair to serve on NRHA's Board of Trustees and in

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the Rural Health Congress. In addition, constituency groups are allowed one representative on the Rural Health Congress for each 50 affiliated votes, with the chair representing the first 100 votes (RHC CG members). For several years the RHC CG has had only the RHC CG chair and one other elected representative. However, this year there has been an increase in NRHA members selecting the RHC CG as their particular interest group and Tommy says that in this year's Fall elections the RHC CG will be authorized four elected representatives. If you are a NRHA member and want to have a greater voice in RHC causes and to help in determining RHC policies and direction, contact Tommy Barnhart to learn more about this opportunity. Do it soon since ballots for the autumn elections will be prepared before summer months are out. We need Texans on the ballot for these RHC CG representative positions. *Contact Tommy at Tommy L. Barnhart, CPA, Partner, Dixon Hughes, PLC, One W. Fourth Street, Suite 700, Winston Salem, NC 27101-3818; Phone 336.714.8100 Fax: 336.722.9199;* tbarnhart@dicon-hughes.com.

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