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 .

Texas DSHS RHC Survey and Certification Duties Consolidated Under One Office

All the Department of State Health Services (DSHS) Facility and Compliance Zone offices have forwarded their rural health clinic records and files to Charles Peck at the Central Facility Compliance Office located at 8407 Wall Street in East Austin. He has established his office and is building a staff to handle all RHC certifications, re-surveys, and changes of ownership in the state out of this one office location. His telephone number is (512) 834-6650, extension 2639; and his fax is (512) 834-6653. His email is charles.peck@dshs.state.tx.us All RHC certification requests are to be directed to him.

2011 RHC Medicare Upper Payment Limit

Effective January 1, 2011, the new Medicare upper payment limit for RHCs will be $78.07 per visit through December 31, 2011. The 2011 rate reflects a 0.4 percent increase over the 2010 payment limit in accordance with the rate of increase of the Medicare Economic Index (MEI) as authorized by Section 1833 of the Social Security Act. This is the maximum rate for freestanding (independent) RHCs and provider-based RHCs whose hospital owners have 50 beds or more. Understand that this new payment rate will only be given to a RHC after it has submitted its annual cost report to the auditing staff at the Fiscal Intermediary (or MAC) and the report has been finalized establishing its new encounter rate established based on the cost report. The new payment limit is not paid until the annual cost report is filed and the auditors have finished their part. The payments are not retroactive to the beginning of the calendar year but are paid the new rate when the encounter rate is established for each clinic.

Texas Medicaid Wellness Program

To reflect the whole person management approach of a new health management program for Medicaid, the Texas Medicaid Enhanced Care Program by McKesson is being re-branded. Beginning February 1, 2011, the program will be known as the Texas Medicaid Wellness Program. Client and provider materials will reflect the new name. The key features will include:

- Client letters are more concise and easier to understand
- Individualized educational fulfillment based on specific health issues
- Wider selection of educational topics to reflect whole-person approach
- Will incorporate materials already being used in Texas
- Increased value and frequency of gift-card incentive
- Clients will have access to support and resources on a client portal

This whole person care management concept will be open to all high cost-high risk individuals – no disease exclusions. The clients will be identified via predictive modeling.
The proposed staffing structure will have Esteban Lopez, MD as the medical director esteban.lopez@mckesson.com. He has been the current medical director of the Texas

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Medicaid Enhanced Care Program for the past six years when the program was first initiated. The Austin- based program manager will be Richard Lawlor DC, MBA, Richard.lawlor@mckesson.com , who joined the program as McKesson's Texas Government Programs Manager a little over a year ago after relocating from Washington D.C. where he had worked, during President Bush's two terms of office, for the US Department of Health and Human Services (he was a DHHS staffer with the CMS Open Door Forum conference programs and has worked with Bill Finerfrock from NARHC on RHC questions in conjunction with the CMS Rural Health Open Door Forum presentations.)

At the final Provider Advisory Board meeting on December 11, 2010, the organization said that their annual reconciliation review showed a cumulative net savings of $43 million since beginning six years ago and they reported to Texas Health and Human Services Commission (HHSC) a return rate on investment to the state of Texas of 2.1:1.

During the program's sixth year's second quarter (Feb –Apr 2010) they decreased the inpatient admits by 20.6% for their enrolled program clients with high risk health conditions (asthma, CAD, CHF, COPD, and diabetes) and shortened the inpatient average length of stay by 4.5%. On the reverse side - their tracking of emergency room visits (baseline per thousand established six years ago was 1,577.2 versus the program-to-date figure of 1,875.4 visits) showed an increase of 18.9%. Likewise for physician office visits (per 1000 with an established baseline of 21, 033 versus the 2nd quarterly period program-to-date results of 24, 832.5) was an increase of 16.6%. What that means is the higher health care cost services, such as hospitalization, went down while the lower costing health care office visit services increased , i.e. number of health care provider office visits went up for those who are now better informed patients in the program. The office visit is a much cheaper patient service rather than an in-patient admission to the hospital if the patient is doing a better job of taking care of themselves by self awareness and the program closely monitoring them to identify serious health problems quicker.

The program will be looking to establish a new Provider Advisory Board when it starts next year with the Texas Medicaid Wellness Program. If you are interested in participating with this board, please contact Richard Lawlor or Dr. Esteban Lopez. Over these past six years we have had RHC representatives serve on this advisory board and on at least one occasion had Dr. Lopez speak at our annual RHC conference. The Saturday quarterly meetings are rotated between San Antonio and Austin with attendee's travel expenses taken care of by McKesson.

Congress Passes Bill Exempting Physicians From Red Flag Rule

On December 2nd the US Senate passed a bill to exempt physicians and other professionals from the red flag rule. Four days later, on December 6th, the House of Representatives also passed the bill and sent it to President Obama for signing into law.

The red flag rule required any creditor who held financial data on clients to install identity theft detection and monitoring programs. The rule is the result of the Federal Trade Commission's (FTC) interpretation of the Fair and Accurate Transactions Act of 2003, which was intended to tighten security of financial data held by banks and credit card companies.

On November 1, 2008, The FTC said physicians were covered under the red flag rule because they bill people for services after they are provided, and because they allow payment plans.

Under the Health Insurance Portability and Accountability Act, physicians are responsible for ensuring the confidentiality and security of patient's medical information. Many health care provider organizations have said this Red Flag Rule is redundant with what is required by HIPAA and constitutes an unfunded mandate that creates unnecessary bureaucracy and has little, if any, public benefit. The FTC has delayed these red flag rules five times for physician practices because of legal delays from the many provider organizations who sought to stop this unnecessary requirement.

Remember to share this newsletter with your colleagues.

Electronic Health Records Incentive Payments with Medicaid for Texas RHCs

Next year physicians, Nurse Practitioners (NP), Certified Nurse Midwives, and certain Physician Assistants (PA) working in Rural Health Clinics will be eligible for electronic health record (EHR) incentive payments if they can meet the meaningful use criteria and their EHR system the clinic uses is certified. In addition, in order to be eligible for the incentive payments, the clinic and/or the individual providers must meet a threshold test by demonstrating that at least 30 percent of the patient visits are delivered to "needy" patients. A "needy" patient is one who is covered by Medicaid or S-CHIP or if the patient is eligible for free or reduced cost care based on a sliding fee scale established by the RHC.

Texas Medicaid Healthcare Partnership (TMHP) and the Texas Health and Human Services Commission (HHSC) have been meeting with your association to research some of

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the Medicaid polices that will be used to implement this program for RHCs in Texas. There is an association webcast being developed that will be held Thursday, January 20, 2011, from 2:00pm to 3:00pm Central Time to discuss this EHR incentive program. The cost to participate is anticipated to be $45 per caller and it will feature representatives from TMHP, HHSC, and the four Regional Extension Centers (RECs). The purpose it to offer initial guidelines for the Texas Medicaid implementation to RHCs on the aspects of this program. Webcast registration and information will be offered on the TARHC calendar website and it will be made available through messages on the RHC Forum List Serve and with correspondence delivered by the US Post Office.

Texas Rural Health Advocacy Days at the State Capitol

With the Texas Legislature going back into session in January, it is time to turn our attention to our state-level issues. Rural Health Advocacy Days are set for February 21-22, 2011, in Austin. Plan to make this a priority for yourself and other rural community providers to participate in this important event. This event is a collaboration between the Texas Organization of Rural & Community Hospitals (TORCH) and the Texas Rural Health Association (TRHA) to carry rural health issues to our elected state Representatives and Senators. February 21st will be an afternoon program consisting of: a discussion of advocacy issues; overview of 82nd Legislative Session; a keynote presentation; and a reception for attendees and legislators with their staff. The 22nd will start with a morning orientation and briefing of the visit to the Capitol, followed by appointments with legislators. **Watch your mail for brochures from TARHC with complete program information.**

IS THERE A RATIONAL, LOW RISK EMR SOLUTION STRATEGY?

YES, SO PLEASE READ ON

You are an owner/operator of a Rural Health Clinic. You and your staff practice medicine on the front lines of health care where access due to distances is difficult for patients. Many of your patients are subject to coverage limitations of Medicare or Medicaid or are indigent and limited by financial resources. You are required to coordinate specialty care with limited leverage to access and control that care or maintain minimal information about that care.

You are located in a rural area of Texas with some limitations of technology infrastructure that practices in urban areas do not have to deal with; and that includes knowledgeable support vendors, telecommunications access needed to accomplish electronic information exchange for example. Your office functions with multiple systems and application platforms that have been toggled together with less than complete "documentation" and implementation planning.

Now, you are being moved to acquire and implement an electronic medical record application system through a government initiated "carrot and stick" initiative. You are asked to make a decision on the implementation of an application that is one of the most sophisticated ever developed. These EMRs require the highest level of sophistication of Information Technology as the user (you) as well as your system administrator (your staff) to implement and operate.

Your decision on an EMR is probably the most major both clinical and business decision you will ever make in your career. Your entire practice enterprise is put at risk as you make this decision. Are you prepared and do you have the necessary support locally to implement this decision and achieve clinical efficiency to meet your patient needs in a reasonable amount of time? Do you have the necessary financial capital in reserves to manage adverse issues that may arise from this significant change to your practice's operations both clinical and business?

You may be getting consulting assistance in your EMR system selection process. You may have your office manager attending sessions about the incentive program initiating this change to your practice. You are probably spending some significant time hoping that everything works out once you make a decision about an EMR selection.

But here are the facts you will face. As a primary care clinic, your patient records are long and extensive since your patients see you regularly over long years of care. As a rural health clinic, you most likely have been in practice for more than 5 years in that community. Most EMRs are built for specialty care practices where patient records are for acute care over short time periods with focus on one medical condition. For a specialty practice, the ability to implement an EMR and quickly eliminate dependence on existing paper history charts is viable. For a rural primary care clinic, that is not the case so for you, practicing with both paper and electronic records can go on for 12 or more months and in many cases that can extend to 18 months. And that one issue can and will cause you to lose clinical efficiency. And that one issue will adversely affect your patient's care and increase your staff's stress.

And when you make that decision to purchase and implement an EMR, the standard solution available will look like - $25,000 to $40,000 purchase price per practitioner in the practice for the software; training of staff will take 7 to 14 days at a cost of $1,000+ per day; acquisition of a server and user hardware for another $10,000+; interface between the new EMR

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and your Practice System OR conversion of your practice management application to the new EMR vendors practice system at an average cost of $10,000+; likely an annual maintenance fee for upgrades etc. that can range in the $5,000 per annum; and finally a likely loss of efficiency in patient care of from 20% to 40% for a period of from minimally 9 months to 18 months.

The result is a per practitioner hard costs ranging from $47,000 to $65,000 and an implementation period of several months. The soft costs from lost efficiency is difficult to calculate, but assume you see an average of 25 patients per day, a 20% efficiency drop means building a 5 patient per day backlog of patient needs build-up. From a cash flow standpoint, if you take your average reimbursement per patient visit times 5 patient visits per day times the number of practice days over the next 6 months you will get some idea of what the cost will be to your practice.

Finally, you will be required to sign a long term purchase agreement to acquire this technology so you are now tied to this decision for perhaps 3 years. You will make these financial investments NOW. Your government incentive payments will be made is partial payments starting next year and paid out over the next 5 years.

So, now that we have given you all this gloom and doom, what is your solution?

We have a solution that takes the total business and clinical risk equation into consideration. With web based technology and new security technologies for web based applications, there are web based EMR solutions that are available. These are not "ASP" solutions, but true web based solutions requiring only broadband web access and newest version of browser on the user hardware. The EMR developer we have vetted was built by an MD that has experience in a critical care environment. The financial model this developer adopted is a "Google" model. Using sponsorship financing, Mitochon EMR can be provided to a practice at no cost for software purchase with no long term agreement – basically access to a HIPAA compliant and secured EMR application and database free – that is guaranteed to meet all use requirements to have you eligible for the government incentive payments.

Our solution additionally includes a turnkey process that will scan and digitalize your current year's patient charts and then lifting necessary patient demographic and clinical data to "pre-populate" the Mitochon database so that when you begin using the EMR, your patient records are already available in the application. This one service will reduce your efficiency losses by 75% and reduce time to full efficiency to less than 3 months. The cost for this for an average primary care practitioner is $19,000. However, by doing this, your practice will be able to eliminate paper chart pulling and filing, eliminate file storage since the digitalized historical records are digitally stored and backed up for you.

Training of staff is available via webcast and can be scheduled by you and your staff to meet your business requirements. We have vetted the "ease of use" through existing clinical users and know that this is one of the most intuitive user experiences which reduce training time significantly.

You will need access to a broadband web access and we know of options available even in the most remote rural locations that you can likely access if you don't have that available to you currently. Regardless of what EMR you decide to access, meaningful use requirements make it necessary that you achieve that capability to exchange patient records.

Your hardware costs are relatively small as you do not need to purchase servers, routers etc. nor is there a "hosting" cost for your application to be accessed via an "ASP" solution which will require broadband capability also. The only hardware costs will be for the type of hardware you want to use for access during the day and there are many options available with cost decisions you control.

So, we have a solution that is low risk and rational. No upfront on ongoing cost for accessing the EMR application and a secured patient database that will meet incentive requirements enabling you to access government payments. Elimination of efficiency loss through a digitalized paper records full conversion including pre populating the EMR with your current patient data. Limited hardware costs that you have complete control over. Broadband web access that you will need regardless of the EMR solution you choose. And no long term agreement with a guarantee that if you ever want to move to another EMR, your patient records will be provided to you.

Maintaining your options by limiting your commitment to one solution, solving the efficiency issues that primary care practices encounter from complexity of existing patient records needing access after EMR implementation, solving any broadband web access issues you may be having and lowering your cost of a total solution are values that you need as a rural health care physician.

How do you pursue this option? Call Dave Strilein at 512/468-2136 or email Dave at Integration Solutions, LLC **at** daves@integrationsolutionsllc.com with your contact information. You will be contacted via phone or email and provided the necessary information for you to make a decision.

Dave Streilein, Principal
Integration Solutions, LLC
512-468-2136 (cell)
daves@integrationsolutionsllc.com

Texas Association of Rural Health Clinics

P.O. Box 14547, Austin Texas 78761 512-873-0045/Fax 512-873-0046

Membership Application

(for corporate or association members, see next page)

Date:_____

Clinic Membership:

Rural Health Clinic:_____ County:_____

Type of Clinic: ☐ Hospital-Based: ☐ Independent: Certified: ☐ Yes ☐ No Date Certified:_____

Address:_____ City:_____ Zip:_____

Designated Representative:_____ Title:_____

Phone:_____ Fax:_____ E-mail:_____
(Required in order to receive publications)

If Hospital-Based, name of hospital:_____

If Independent, indicate clinic ownership:_____

Benefit for new or current clinic members:
with completion of this application, joint membership in both Texas Association of Rural Health Clinics and National Association of Rural Health Clinics at a savings of $250! Payment can be made by check or credit card.

Types of Clinic Membership: (check one)

	Joint $500	TARHC $300	NARHC $450
Regular Membership: Single independent or hospital-based certified rural health clinic	☐	☐	☐

The following section is important! It allows us to accurately represent our membership on key policy and legislative issues. All information will be kept confidential and no clinic specific information will be released.

Clinic Specialty:_____ Sub-Specialty:_____

Current Medicare all-inclusive rate: $_____/encounter

How many days per week is your RHC open for patient care?_____

Annual Encounters (total patient encounters from most recent cost report):_____

Number of Medicare encounters:_____ Number of Medicaid encounters:_____

Please indicate the type of providers by health profession and full time/part time status providing care at the RHC:

Professional Type	Specialty (if applicable)	Number of Full Time Equivalents (FTEs)
Physician		
Physician Assistant		
Nurse Practitioner		
Certified Nurse Midwife		
Clinical Psychologist		
Social Worker		

Counties in Service Area:_____

What is the population (round to the nearest 1,000) of the town where the RHC is located?_____

What is your best estimate of the population of the RHC's service area?_____

Do you participate in Medicare Advantage? ☐ Yes ☐ No

Do you participate in a state sponsored Medicaid HMO plan? ☐ Yes ☐ No

What percentage of the RHC's patient population is uninsured?_____

Corporate or Associate Membership: (check one)

☐ Corporate $300	☐ Associate $125
Companies doing business with RHC's	Individuals interested in RHC's

Individual/Organization name: _____

Designated Representative:_____

Address:_____ City:_____ Zip:_____

Phone:_____ Fax:_____ E-mail:_____

Company Description (25 words or less)

_____

_____

_____

Thank you for your membership!

If paying by check, mail to P.O. Box 14547, Austin, TX 78761. If by credit card see below

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TARHC CREDIT CARD PAYMENT

Please Print Clearly

(fax both pages to 512-873-0046)

Total Amount Paid: $_____ Date:_____

Name as it appears on card:_____

PERSON AUTHORIZED TO CHARGE:

First Name: _____ Last Name:_____

Card Type: ☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS ☐ DISCOVER

Card Number:_____ Expiration Date:_____

Card Security Code:_____ *3-digit number on back of card, 4-digit on front for AMEX*

Signature Authorizing Charge:_____

Email Address:_____

Telephone Number:(_____)_____

BILLING ADDRESS

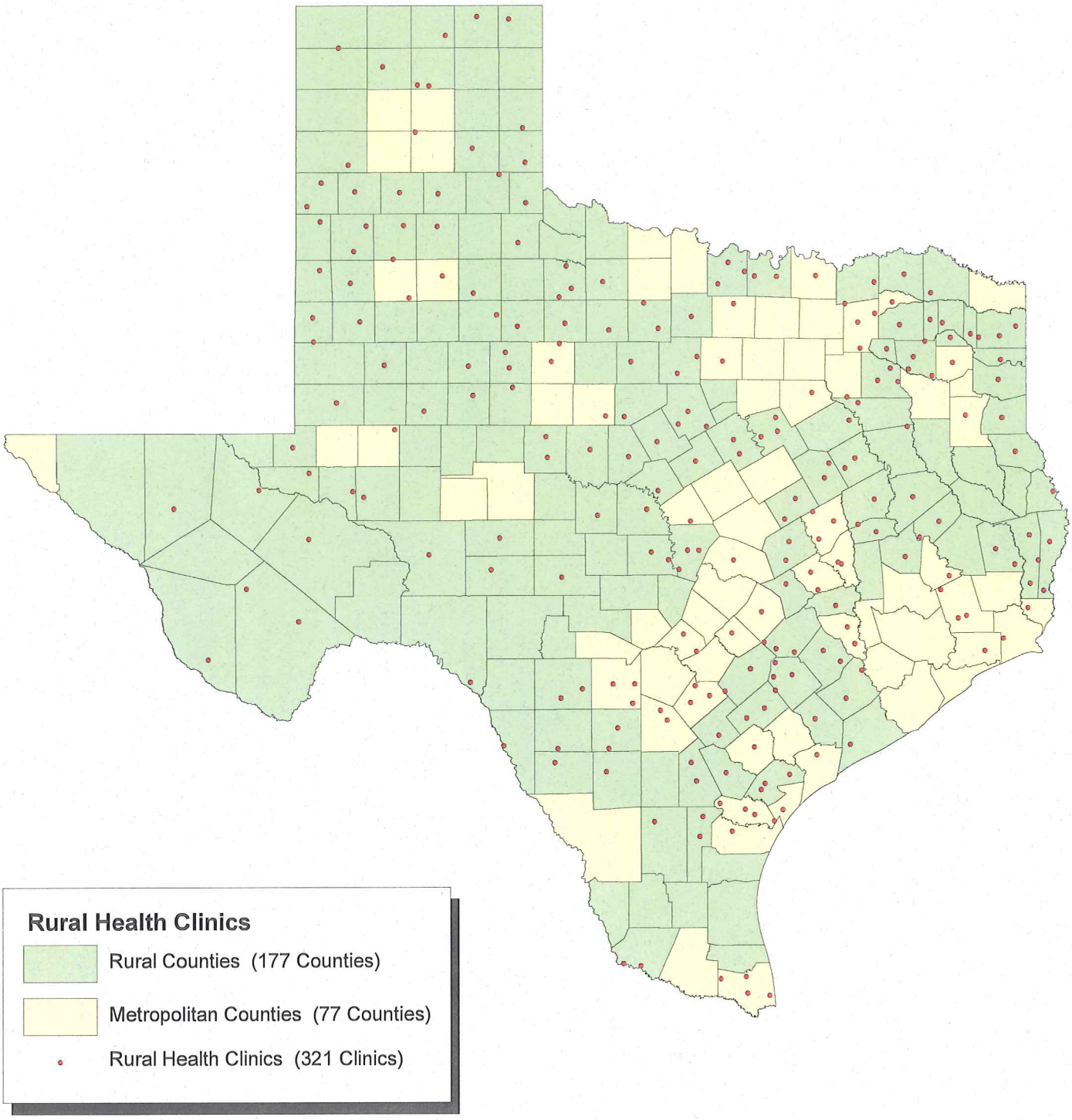
Please enter the following information exactly as it appears on your credit card statement

Address:_____

City: _____ State: _____ Zip:_____

Payment cannot be processed unless all information is provided.

RURAL HEALTH CLINICS IN TEXAS



Map Prepared By:
TEXAS DEPARTMENT OF RURAL AFFAIRS
Texas State Office of Rural Health
August, 2010.

RETURN SERVICE REQUESTED

Texas Association of Rural Health Clinics
P.O. Box 14547
Austin, TX 78761

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Visit www.tarhc.org

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TORCH ADVOCACY DAYS
February 21- 22, 2011
Omni Hotel Downtown, Austin
Austin, Texas

Merry Christmas and Happy New Year!

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