

EMR Stimulus Payments

As a rural health clinic administrator one of your major responsibilities for 2010 is to determine if your clinic is going to purchase an Electronic Medical Records system and pursue incentive payments as provided in the *American Recovery and Reinvestment Act of 2009*.

The Department of Health and Human Services released the initial set of standards, implementation specifications, and certification criteria for electronic health record technology as an interim final rule on January 13, 2010. The 35 pages of regulations can be accessed by going to the following link:

<http://edocket.access.gpo.gov/2010/pdf/E9-31216.pdf>

On the same day 169 pages of proposed regulations implementing the Electronic Medical Records incentive programs were released. To read these regulations go to:

<http://edocket.access.gpo.gov/2010/pdf/E9-31217.pdf>

These regulations will not be printed in your Workbook; but, are on CD in the Regulatory and Electronic Medical Records Folder and you should be familiar with them if you plan on pursuing the EMR stimulus payments.

Should our Clinic pursue EMR Stimulus Payments?

The item on your agenda is to perform an assessment of where you are in relation to EMR implementation. Some clinics have been using EMR systems for years, while others have not even thought about upgrading to EMR. It also depends on the age and comfort of your physicians/providers with technology. Many clinics with physician owners that are 55 or older may not want to go through the hassle of changing the way they record medical information or have the technical ability to make the transition. The cost of

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converting to electronic medical records includes the high cost of purchase or lease of equipment and the lost productivity when transitioning to the new system. (Some practices report that visits decrease anywhere between 25% and 40% the first year that EMR is adopted) Avalere Health LLC published a study in March, 2009 regarding the incentive payments and how they related to physician practices and their findings were as follows:

Bonus Payments Cover Only a Portion of EHR Costs

The average EHR implementation cost for a physician is about \$32,000 plus about \$1,500 in monthly upkeep costs.

A solo or small-group physician practice will spend an estimated \$124,000 over the five year period of 2011-2015 to adopt electronic health records and will receive up to \$44,000 in federal incentive payments, leaving a large bill for them to cover.

Penalties Less Than EHR Costs

In their sample scenario, the starting penalty that a solo or small group practice physician faces for non-compliance would be \$5,100 a year—far less than the costs of implementing a maintaining an EHR system.

If the penalty were raised by the Secretary to its maximum of 5%, the physician would see his/her annual Medicare payments reduced by \$8,500.

Some physicians, therefore, may find it economically beneficial to pay the penalty rather than buy EHR the system.

Avalere's findings were specific to physician practices that bill Part B the majority of their services and are not rural health clinics; so our comparison is a little apple to oranges, however, the main point that bonus payments will cover only a portion of Electronic Medical Records cost is relevant. Unfortunately, rural health clinics do not qualify for funding from Medicare. Or at least not on their core business which is billing on the UB-04 claim form and would not qualify to base incentive payments on. If a rural health clinic has a large hospital practice or bills in excess of \$25,000 in claims to

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Part B using the CMS-1500 Form then it is possible for a rural health clinic to receive incentive payments from Medicare as RHCs are not specifically 1

Medicare Incentives for EP's

Adoption year	Maximum payment							PFS* penalty
	2011	2012	2013	2014	2015	2016	TOTAL	
2011	\$18,000	\$12,000	\$8,000	\$4,000	\$2,000	\$0	\$44,000	
2012		\$18,000	\$12,000	\$8,000	\$4,000	\$2,000	\$44,000	
2013			\$15,000	\$12,000	\$8,000	\$4,000	\$39,000	
2014				\$12,000	\$8,000	\$4,000	\$24,000	
2015								-1%
2016								-2%
2017+								-3%

* PFS = Provider Fee Schedule

An EP is eligible for a 10% increase in the annual Medicare incentives if more than 50 percent of the EP's Medicare covered professional services are furnished in a geographic health professional shortage area (HPSA).

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excluded from the Medicare program it is just that the payments are based upon 75% of charges to Medicare Part B. (Rural Health Clinics are paid from the Part A Trust Fund and use the UB-04 to bill)

Medicaid is the best funding source available to rural health clinics and your clinic must have at least 30 percent (20% for pediatrics) of patient volume attributable to individuals who are: - Receiving Medicaid assistance, receiving SCHIP assistance, is furnished uncompensated care by the provider, or for whom charges are reduced by the provider on a sliding scale basis based on an individual's ability to pay. It is important to document the uncompensated care or discounted care that your clinic is providing if you are teetering at the 30% threshold for Medicaid funding. Here is a link that will help you to establish a discounted fee program for the medically needy at your clinic.

<http://nhsc.hrsa.gov/communities/discountedfee.pdf>

1 This slide is from a presentation by Mike Spencer, Regional Sales Consultant, KIG Healthcare Solutions, NextGen Healthcare Information

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Medicaid payments are higher than Medicare with as much as \$63,750 paid per provider as compared to a maximum of \$44,000 for Medicare.²

Medicaid Incentives for EPs (non-Pediatricians)

Calendar Year	Maximum Payments for Medicaid EPs who begin adoption in					
	2011	2012	2013	2014	2015	2016
2011	\$21,250	-----	-----	-----	-----	-----
2012	\$8,500	\$21,250	-----	-----	-----	-----
2013	\$8,500	\$8,500	\$21,250	-----	-----	-----
2014	\$8,500	\$8,500	\$8,500	\$21,250	-----	-----
2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	-----
2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250
2017	-----	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
2018	-----	-----	\$8,500	\$8,500	\$8,500	\$8,500
2019	-----	-----	-----	\$8,500	\$8,500	\$8,500
2020	-----	-----	-----	-----	\$8,500	\$8,500
2021	-----	-----	-----	-----	-----	\$8,500
TOTAL	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750

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Beginning in 2011, RHCs would be eligible for incentive payments to the extent the RHC can demonstrate that they are “meaningful users” of certified EHR. For RHCs, the EHR incentive payments will flow through the Medicaid program even though the money for the payments will come from the federal treasury.

² This slide is from a presentation by Mike Spencer, Regional Sales Consultant, KIG Healthcare Solutions, NextGen Healthcare Information

³ This information is provided by Bill Finerfrock of the National Association of Rural Health Clinics

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In order to obtain the RHC EHR incentive payments, the RHC must demonstrate that at least 30% of the RHCs patients are “needy”. This means they are on: Medicaid, S-CHIP, are uninsured or eligible for a sliding fee scale (i.e. low-income).

EHR Incentive Payments are available through the Medicaid program to:

- Physicians
- Nurse Practitioners
- Nurse Midwives
- Rural Health Clinics
- Federally Qualified Health Centers

In order for a physician, nurse practitioner or nurse midwife to be eligible for a Medicaid bonus payment, at least 30% of the physician, NP or CNM patient visits must be Medicaid recipients.

RHCs can receive bonus payments through the physicians, NPs, CNMs or PAs who practice predominantly in a rural health clinic. In the case of PAs, the clinic must be “PA led”. In addition, at least 30 percent of the RHC or FQHC providers’ patient volume must be attributable to “needy” individuals.

Who is a “Needy Individual?”

- Someone who is receiving assistance under Medicaid
- Someone who is receiving assistance S-CHIP

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- 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.

RHCs can receive an amount 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 the adoption and operation of, such technology.

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 necessary for the adoption and initial operation of such technology.

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**

Additionally, you should be assessing your ability to comply with the technical aspects of obtaining the funding and meeting the “meaningful use” threshold required for payment. An assessment of exactly where you stand on EHR should be done as soon as possible. As we stated earlier, some clinics have not started the process and some have been doing EHR for years. Finding vendors that are certified to provide services and meet the standards as defined in recent regulations and regulations still to be published is going to be a challenge as it is estimated to take an additional 40,000 people in new staff to implement and train clinics and hospitals in EHR.

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As of April 15, 2010, final regulations have not been released implementing this program and a certifying body for EHR certification for purposes of the EHR incentive payments has not been selected.⁴ “The Office of the National Coordinator of Health Information technology is just now assessing comments to the proposed standards for certifying bodies and certification standards. It is likely that there will be more than one certifying organization but to date, no decision has been made.

While there are many vendors who are CCHIT certified, this does not mean the product is certified for the EHR incentive payments. There will be new standards and new requirements and any certifying body that seeks to be recognized by ONCHIT for purposes of EHR incentive payments must demonstrate that their standards are equal to or better than the standards put forward by the Government. To date, NO EHR certifying body has been recognized by ONCHIT. In fact, ONCHIT has not even asked for any applications for recognition. It is anticipated that ONCHIT will announce the certifying organizations recognized by the federal government some time this summer.”

If you have not started, yet it is imperative that you identify a vendor or two and get started in the evaluation process.

Additionally, if you have already started using the electronic medical records and you know you meet the 30% threshold you may want to start focusing on the proposed meaningful use regulations

A couple of things that make these regulations difficult to comply for rural health clinics are the inclusion of the Provider Quality Reporting Initiative data as one of the criteria. Since rural health clinics do not get paid an incentive for this; very few have implemented this program to date. As a rural health clinic, you may want to scrape your annual evaluation process and start a quality improvement plan using the PQRI as your model for development. PQRI is a voluntary individual reporting program that provides an incentive

⁴ This information is provided by Bill Finerfrock of the National Association of Rural Health Clinics via List-Serve on April 16, 2010.

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payment to identified eligible professionals (EPs) who satisfactorily report data on quality measures.

Additionally E-prescribing is important in achieving your goal of documenting meaningful use. At least 75% of all permissible prescriptions written by the provider must be transmitted electronically to demonstrate meaningful use; however, based upon a conference call on April 15th, 2010 the 75% threshold is being scrapped and now a provider must only bill 25 different times in a year to be eligible for the E-prescribing bonus. We assume that would apply to this program as well.

It is important to know that in order to obtain Medicaid funding in 2011, your clinic must show meaningful use for at least a 90 day continuous period for the calendar year. That means that RHC must have their EHR systems up and functional by October 1, 2011 to receive funding for 2011. Meaningful use will mean different things during the process. At first, meaningful use guidelines will not be as stringent; however, they will get more difficult to achieve as the process nears completion. The key is not to be intimidated by the language. As they say, "Rome was not built in a Day". With that in mind vendors and EHR providers are going to be stressed to meet that deadline; so the sooner you put time into the process the better.

To help you process this information we have prepared an action plan table, which while not all inclusive gives you something to start the planning process.

See Next Page for Table

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Electronic Medical Records Incentive Action Plan

Step	Description	Start Date
1	Determine if physicians/providers are interested in pursuing EMR conversion and EMR incentive payments if you are currently not using an EMR system.	May, 2010
2	Access current usage of EMR including system capabilities and if it can be upgraded to meet the EMR incentive standards.	May, 2010
3	Determine if your clinic will most likely qualify for Medicare or Medicaid incentives. (RHCs will most likely be Medicaid)	May, 2010
4	Determine if your Medicaid volume and medically needy patients are well over the 30% threshold (20% for pediatrics) and if not; implement a discounted fee schedule and monitor volume closely.	May, 2010
5	Identify EMR vendors that would fit your practice size, location, and specific needs and develop an implementation schedule with them.	June, 2010
6	Review and implement Provider Quality Reporting Initiative process as prescribed in the meaningful use regulations.	January, 2011
7	Review and implement E-Prescribing as provided in the meaningful use regulations.	January, 2011
8	If you are planning on receiving the first of the Electronic Medical Records incentive payments, have your system functional enough to meet the first round of meaningful use criteria.	October 1, 2011

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Selecting an Electronic Medical Records System

The National Association of Rural Health Clinics and HRSA sponsored a teleconference on purchasing an Electronic Health record/medical system in 2008. If you are starting the process of purchasing an EMR system this information would be a great place to start as it is specific to rural health clinics. Here are the links to the information.

Selecting an EHR; Now What? (First session)

- **January 8, 2008, 2 pm ET**
- If you are thinking about purchasing an Electronic Health Record/Medical Record system, you are encouraged to listen to this presentation.
- [Slides for this teleconference](#)
- [Transcript](#)
- [Audio](#) (MP3, 6.5 MB)

Selecting an EHR; Now What? (Second session)

- **February 5, 2008, 2 pm ET (1 hour)**
- If you have questions about the steps for implementing an Electronic Health Record/Medical Record system, you are encouraged to listen to this presentation
- [Slides for this teleconference](#)
- [Transcript](#)
- [Audio](#) (MP3, 6.3 MB)

Comments on Specific Vendors

We have summarized many of the comments regarding specific vendors of EMR on the National Association of Rural Health Clinics Listserve as we thought it might provide a tool for you to evaluate the effectiveness of each of the systems. We left the contact information and addresses when possible so that you could have contact with that person if you felt follow up was warranted.

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Vendor	Comment
CPSI	I am a RHC provider based. I have 5-physicians and 2 CRNP's . The CEO of the company decided to go server based instead of a web-based. We have been EMR for 2-years now with CPSI based out of Mobile. I do not like server based because I share it with the hospital (Lake Martin Community Hospital) they have the billing side only of EMR. I can't not take a upgrade with the EMR system unless they are on the same Version which holds me back from upgrades and enhancements . I cannot print out a lot of the reports I need to give to the CEO of the company. I have to call into CPSI for help and they walk me thru a ADHOC report that has 30 or 40 steps to get the report. The system we have is so complicated . It takes the girls 17 steps to make one appointment. Just make sure you do your homework before getting a EMR system. The on and off site training was awful as well. Patty Kerr. pkerr@lakemartinhospital.com
CPSI McKesson Meditech	I consider the top three EMR systems to be for what it is worth: McKesson, CPSI, Meditech. Mary Cobos, MBA-HCM, Chief Operations Officer Office(432)336-4213 Fax (432)336-4545
. NextGen	Online EHR/PM systems are great until the internet is cut. The vendor has no responsibility to fix this. A few years ago I did a search for a replacement EMR/PM system for a Eye Clinic. NextGen and one other vendor were the final two. This was for a small practice. NextGen is pricey and not as integrated as they portray but all in all a modern system with a lot of users and support it seems. I would make sure you see how NextGen submits part A claims, get reference's, and go see them in person. I expect part B claims should not be an issue. You learn a lot face to face rather than via a phone call. Money well spent. Patty, Get your own server so that you can upgrade. They are not expensive any more (\$3-\$5K). From your writing you are spending more dollars in Time wasted than the cost of a server of your own that can be upgraded to increase your efficiency.Kenneth Watson, MBA Director of Clinic Services,,Kimball Health Services,,505 South Burg St.,Kimball, NE 69145
eClinical Works NextGen	We are looking at 2 RFP's (eClinicalWorks & NextGen) and setting up demo's for our clinics. I am brainstorming questions that I think would help us get a better understanding of what each software brings to the table. We have such a variety of clinics, reports and requirements that I'm trying to figure out what questions I've missed asking. Our clinics are nurse practitioner run with physician preceptors and additional volunteer providers. The clinics are....Independent Rural Health Clinic (1 facility),Federally Qualified Health Clinic (4 facilities) (Community Health Center for Homeless & Migrant),,School Based Health Clinic (3 facilities),University Health Clinic (1 facility),,Communicative Disorder (Audiology & Speech Language Pathology) & Physical Therapy Clinic (6 facilities)The types of reports we run are....RHC & FQHC Medicare Cost Reports,,RHC & FQHC Safety Net, RHC & FQHC PPS, State, County & City Reports, UDS. With eCW, is it better to get the additional report software Enterprise Business Optimizer or are the standard reports enough for what I need them for? How do you handle down times? Are there many and do they fix them in a timely manner? We have to run a lot of reports, can either system run reports in the "background" and allow the user to continue working? How are they handling Part A & B claims? We go through Cahaba Part A for the RHC but UGS for the FQHC's and then Cahaba for Part B. How is Customer Support & Training once you've purchased the system and "go live"? Was the training off-site, web-based, etc...? Has anyone used the RSM Services from NextGen? How would I go about setting standards to include in the contract for financial penalties if they don't meet them? For example, do I take the average of claims processed in a day/week or monies received? What type of standards could I incorporate? Odom, Lisa Renee [mailto:ODOML@mail.etsu.edu]

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eClinical Works	My independent RHC is very happy with eClinicalWorks. I understand the practice management side has not been able to handle the accounting needs of a provider-based RHC -- as recently as one year ago -- but I don't know if that is still true. Keith E. Davis, MD, email: docdavis@shoshone.net
eMDs	I use eMDs for my Rural Health Clinic. Support has been a good experience for me 99% of the time. When I purchased the software 3 years ago, the 1st 90 days we were assigned to a certain contact person which worked really well. It gave us 1 person to call. Since then, we can call the support desk (but you may be on hold for awhile) or submit a service ticket online. This seems to be the best solution for us. It does sometimes take talking to a billing specialist who is familiar with RHCs to get the issues resolved. The system seems to work well with posting and sending claims but I do send them in a separate batch from my professional claims. The only issue that I've struggled with is submitting secondary Medicare claims. We cannot submit them electronically. If that's what you need, you will have to use the PC ACE software from Medicare. They just released an update on the UB 3/15/2010 but I just sent some paper claims today so I'm not sure if they will be rejected. The last time some of the fields were supposed to be left blank but they were not. You can feel free to call me at the office. Felesha Perrigo, FNP, Family Med 101, Inc, Booneville, MS 38829, 662-720-4919
eClinical Works	Hmmm we have used eCW for 6 years and while we have had to get the system up and running with support help for RHC billing, we have been using since we became an RHC 4 years ago. We just set it so that the provider puts in the code and then it defaults to T1015. It took some work with the switch to NPI numbers and multiple providers but it works fine now. We use WEBMD mostly. One thing it doesn't do is separate into 2 claims automatically.. like if we have a visit and a lab and one goes to the RHC dept of Medicaid and the other goes to regular Medicaid. Those of you who have had problems with the RHC billing with eCW could you elaborate on what your problems were? Amy Carling, Practice Administrator, Carolina Pediatric Associates, Gaffney, SC, 864-839-4325
eClinical Works	Based upon our experience and those reporting here, for RHCs, the clearinghouse is important as, if not maybe more important than the EMR itself. Once ZirMed got our billing out, we began to look more on the positives of eClinicalWorks. Thus before choosing an EMR, strongly consider matching the correct billing clearinghouse with the software. Results being reported here with EMR/clearinghouse success combinations are a great start. Alexander D Giloff, Administrator, Western Sierra Medical Center, 3070 Camino Heights Drive, Suite B, Camino, California, 95709 TEL 530-647-9762 FAX 530-647-1961 agiloff@wsmedicalcenter.com www.WSMedicalCenter.com
Allscripts	We are using Allscripts Professional PM and have ZirMed as our clearinghouse. We did have initial implementation problems, but our overall system (including billing) is working great now. Allscripts worked with us to integrate everything with ZirMed. We love the ability to correct claims online instantaneously and to check eligibility. ZirMed also sends out our patient statements. For months we ran into major support issues with Allscripts, but this was during the buyout of Misys by Allscripts (transitional phase, I assume). Support has improved, but is still not comparable to the support we were accustomed to from Misys. Our primary concern and problem at the present time with Allscripts is the Crystal reports. We simply cannot get the information needed from the system. Support wants to charge you everytime you call for help with this, even though they initially helped you with the report. We are still working on this and have not been on the system for a year until May. The EMR with Allscripts is wonderful. Our primary concern with EMR is that we cannot keep the scanners working. The topaz is simply too slow for us to even consider using. Julie Nettles Director Community Clinics, Clarendon Health System, 50 Hospital Street, Suite 8, Manning, SC 29102, Telephone: 803-435-5270, Fax: 803-435-5259

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eClinical Works IDX	The hospital system who owns us chose eCW. I really don't know why they didn't choose IDX. Although have seen ratings of EMR's and eCW seems to be near the top of most lists. Tori Tapper, Practice Manager, Laurens Family Practice, (864) 984-0571, ext. 247
eClinical Works	We currently are using Eclinicalworks, and due to the many issues we have encountered are currently seeking another product. Right now we are looking at Allscripts, McKesson, Meditech, and IDX. I would love any feed back you could give me on any of these products. Feel free to call me at the numbers below. I would be happy to discuss our ECW issues as well. Angela Ash, Central Billing Office, Stanly Medical Services, 320 Yadkin Street , Suite B, Albemarle, NC 28001, Phone: 704-986-6307 ext 5508, Toll Free: 1-800-230-2053 angela.ash@stanly.org
eClinical Works	eClinicalWorks is actually very wonderful to work with and has a good strong product. We just found that when it came to automated RHC billing processes, eMDs already had those moves in place and eClinicalWorks had not yet implemented those features in their billing package. Unfortunately, we were unable to wait for them to make those improvements. Additionally, we found that eMDs has more experienced trainers in the special billing nuances inherent in the RHC environment. Pam Wiese, <i>Practice Administrator, Port Lavaca Clinic Associates, PA, 1200 North Virginia, Port Lavaca, TX 77979, Phone: 361.553.6567, Fax: 361.552.2863, pjwiese@plclinic.net</i>
eClinical Works	We've been using eClinicalWorks for 5 years now. The billing was a very big problem we had, since the EMRs were not build to understand RHC billing, (Institutional claims in an outpatient setting). We had many bad months move into years. We tried the built in clearinghouse Web-MD that eClinical recommended, but we didn't have the time for the finger pointing that began after the failures and ended up resorting to paper submissions. Save yourself a lot of time and go with an outside clearinghouse that knows how to integrate with the software. We use Zirmed and have had no problems. They are about \$150 to \$200 per month. It has good reporting capabilities and will do all of your payer mix. We choose to still run the Medicare through the old modem system. Our local hospital just chose eClinicalWorks as well, so we lucked out. With the future communication requirements that are to appear in the near future under Meaningful Use, I would recommend going with the same company as your hospital or the provider majority's software of choice if possible, as the cost associated with making the EMRs talk to one another will have to be paid by someone. Alexander D Giloff, Administrator, Western Sierra Medical Center, 3070 Camino Heights Drive, Suite B, Camino, California, 95709, TEL 530-647-9762, FAX 530-647-1961
Allscripts	We are on Allscripts/Tiger, and go through their clearinghouse with Rural Health Claims and have no problems. Nettie Gregory, Client Service Representative, Medical Billing P.O. Box 15409, New Bern, NC 28562 nettie.gregory@rsmi.com
Allscripts	We are Rural Health and are on Allscripts. It is working good now, but had a lot of trouble during set up of the billing. I would be glad to discuss the problems we had with you so maybe you can ward them off at the start. If you would like, please call me at 912-537-7476. Will be out of the office from 11:20 until about 1:00pm. Will be here from 1 to 5:..pm. Barbara Dismuke, Office Manager, R.T. Stanley, Sr Health Center, 110 R.T. Stanley Sr. Place, Lyons, Ga 30436, Phone 912-526-9355, Fax 912-526-4783
Allscripts	What type of trouble did you have with set up? We will be going live on Allscripts April 14th, what should I expect? We are a provider based Rural Health Clinic that will be using ePremise as the electronic clearing house. We have another clinic that we will be sharing our data base with, and they are provider based and have not sent out a good claim since January 1. Apparently Allscripts isn't meshing very well with ePremis. So I ask, what type of electronic clearing houses are any of you allscript users using? Jean Beckers, jeanbeckers@catholichealth.net

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NextGen.	We are currently beginning the implementation phase of Practice Management with NextGen. We looked at many vendors and chose them because they have a strong market share of over 75% of Arizona RHC's/FQHC's, a solid product, and the references were very positive. If NextGen is on your short list I would be glad to discuss the results of the implementation process in a couple of months. Frank Stapleton, Regional Clinics Director Cobre Valley Community Hospital, 5880 S. Hospital Drive, Globe, AZ 85501, (928) 402-1131, F (928) 425-3859
NextGen McKesson	We are a large multi-specialty independent RHC and have narrowed our search to NextGen and McKesson. We did not like RHC processing from eClinicalWorks. Some of our specialties are carved out of RHC billing so generating the correct claim in Clinic is difficult. Any thoughts on NextGen or McKesson? You can call me directly also. Mary E. Peterson, Director of Compliance and Billing, 608-847-9854
e-MDs	We too looked at eCW in our overall review. Our final decision was on e-MDs as well. Great tech support, lower price point, wonderful implementation staff, and very interested in meeting RHC needs. Marty Bennett, CFO, Riverside Family Medicine, 12489 Home Port Dr STE-D, Maurepas, LA 70449, 225-698-3435 (O), 225-337-1942 (C)
CPSI	Patty, we have CPSI also. I like it except for the facts you detailed- we have the financial side of it. I attended the user group conference in Dallas a couple of weeks ago and asked CPSI why we cannot mirror the hospital for reports because it takes forever to get to the point we need and the report numbers are never the same. I was told the platform we have is the old platform and we are now in line to get the new platform. Once this happens the reports etc will be better and the upgrades will be improved because like you said we don't really see the upgrades. Currently, our clinic is not set up with the EMR side but are planning that phase within a year. I am hoping this fixes a lot of things but I guess we shall see. So what platform are you all on the new or old one? If you are on the old platform get a sit set up with them so they can put you on the list to upgrade to the new platform. Just a suggestion because I had no idea about the platform issue until I asked. It is frustrating. I do have to say that many of the EMR's out there are very similar to CPSI. Let me add, we are happy for the most part with the billing side of CPSI, if we had the whole the deal then I think we would be a lot better off. We are working on the clinical side at this time. The hospital has the point of care side and financial side of CPSI- they like it. Mary Cobos, MBA-HCM, Chief Operations Officer, Po Box 1060, Fort Stockton, Texas 79735, Office(432)336-4213 Fax (432)336-4545, Cell (432)251-9177 or (432)940-8003
ALLSCRIPTS	ALLSCRIPTS has a rural health billing software that you can send MSP claims. Nettie Gregory, Client Service Representative, Medical Billing, P.O. Box 15409, New Bern, NC 28562, nettie.gregory@rsmi.com , 252-672-7724 phone, 252-672-7758 fax:

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Note: This is from Brock Slabach from the NRHA as it relates to provider-based clinics and it indicates that provider-based rural health clinics are eligible for Medicaid incentives.

CMS Excludes Most “Provider-Based” Clinics from All EHR Incentives (1-29-10: revised to clearly indicate that RHCs are eligible for Medicaid incentives, whether or not they are provider-based)

On December 30th, CMS released its proposed rule for the ARRA electronic health record incentive program. Among the issues that will impact rural providers is which physicians will qualify for the Medicare and Medicaid eligible professional incentives.

Summary

My interpretation of which eligible professionals (see [Key ARRA Language](#) for definitions of eligible professional) qualify for the incentives is as follows:

- Eligible professionals that practice in *RHCs* and *FQHCs* are not eligible for Medicare incentives. They are eligible for Medicaid incentives if they have at least 30% patient volume attributable to “needy” patients.
- Eligible professionals that practice in clinics designated as “*provider-based*” (except the RHCs mentioned above) are not eligible for either Medicare or Medicaid incentives
- Eligible professionals that practice in *independent* or *non-provider-based hospital-owned* clinics (that use place of service code 11 on their 1500s) are eligible for the Medicare incentives. They are also eligible for the Medicaid incentives if they have at least 30% Medicaid volume (20% if they are Pediatricians). But they can participate in only one of the two (Medicare or Medicaid) programs
- See next sections for language and rationale supporting this interpretation

The impact of this incentive structure is that all physicians practicing in non-RHC “provider-based” clinics (many of which are in rural communities) will be unfairly excluded from much needed incentives. CMS should revise the proposed rule to create a distinction between hospital-based physicians (i.e.

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physicians that predominantly use the hospital's inpatient EHR, such as pathologists and ER physicians) and physicians that practice in clinics, including provider-based clinics (i.e. physicians that predominantly use a physician clinic EHR). The latter physicians should all be eligible for incentives, with the understanding that provider-based clinics in CAHs cannot claim both eligible professional and CAH incentives for costs associated with the same EHR modules.

Key ARRA Language

ARRA states that “No incentive payment may be made under this paragraph in the case of a *hospital based eligible professional* ... a *hospital-based eligible professional* means, with respect to *covered professional services* furnished by an eligible professional during the EHR reporting period for a payment year, an eligible professional, such as a pathologist, anesthesiologist, or emergency physician, who furnishes substantially all of their services in a hospital setting (whether inpatient or outpatient) and through the use of the facilities and equipment, including qualified electronic health records, of the hospital. The determination of whether an eligible professional is a hospital based EP shall be made on the basis of the site of service (as defined by the Secretary) and without regard to any employment or billing arrangement between the eligible professional and any other provider.”

In ARRA, *covered professional services* are defined as “the meaning given such term in (k)(3).” [1848 (k)(3) of the Social Security Act established RBRVS (Resource-Based Relative Value Scale) under which physicians bill Medicare for reimbursement using 1500 forms. The implication of this is that those clinics that do not bill with 1500s do not provide eligible covered professional services and are therefore excluded from the ARRA Medicare incentive.]

A Medicare eligible professional is a physician as defined in Section 1861 (r) of the Social Security Act: Doctor of Medicine or Osteopathy, Doctor of Dental Surgery or of Dental Medicine, Doctor of Podiatric Medicine, Doctor of Optometry, Chiropractor.

A Medicaid eligible professional is a physician, dentist, certified nurse midwife, nurse practitioner, and physician assistant (insofar as the assistant is

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practicing in a rural health clinic that is led by a physician assistant or is practicing in a Federally Qualified Health Center that is so led).

Key CMS Proposed Rule Language

“In our proposed approach, a hospital-based eligible professional, would be ineligible to receive an EHR incentive payment under either Medicare or Medicaid, regardless of the type of service provided, if more than 90 percent of their services are identified as being provided in places of service classified under place of service codes 21, 22, or 23.”

See last section for additional CMS proposed rule language.

Implications for RHCs and FQHCs

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) bill using USB04s rather than 1500s, so physicians practicing in RHCs and FQHCs are not eligible for *Medicare* incentives.

However, RHC and FQHC physicians (whether provider based or not) that have at least 30% of their volume attributable to needy (Medicaid, sliding fee, uncompensated care, or Title XXI) individuals are specifically mentioned as eligible for *Medicaid* incentives.

Physicians practicing in RHCs and FQHCs that do not meet this threshold of “needy” care do not qualify for any federal incentives.

Implications for Provider-Based Clinics

Even though they bill using 1500s, clinics with the designation “provider-based” use the place of service code 22 (Outpatient Hospital), so physicians practicing in “provider-based” clinics (excepting those RHCs eligible for Medicaid incentives) are not eligible for either the Medicare or Medicaid incentives.

Implications for Independent and Non-Provider-Based Hospital-Owned Clinics

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Independent and non-provider-based hospital-owned clinics bill using 1500s and use the place of service code 11 (office), so physicians practicing in such clinics are eligible for the Medicare incentives.

EPs in these clinics are also eligible for Medicaid Incentives if the Medicaid provider is an eligible professional who: (1) has at least 30% patient volume attributable to Medicaid patients, (2) is a pediatrician that has at least 20% patient volume attributable to Medicaid patients.

These eligible professionals may choose to participate in either the Medicare or the Medicaid incentives but not both.

Additional Relevant CMS Proposed Rule Language

“Because that the parenthetical after the term “hospital setting” in the statutory definition of hospital-based EP specifically refers to both inpatient and outpatient hospital settings, we believe the term “hospital setting” should be defined to also include the outpatient setting. So although a “hospital” is an institution that primarily provides inpatient services, we propose to define the term “hospital setting” for purposes of the Medicare and Medicaid EHR incentive payment programs to also include all outpatient settings where hospital care is furnished to registered hospital outpatients. For purposes of Medicare payment and conditions of participation, it is CMS’s longstanding policy to consider as outpatient hospital settings include those outpatient settings that are owned by and integrated both operationally and financially into the entity, or main provider, that owns and operates the inpatient setting. For example, we consider as outpatient hospital settings all types of outpatient care settings in the main provider, on-campus and off campus provider-based departments (PBDs) of the hospital, and entities having provider based status, as these entities are defined in §413.65...

“Because, by definition of the requirements for provider-based departments and entities, EPs who furnish substantially all of their covered professional services to hospital outpatients use the hospital’s facility and equipment, including the integrated medical record system, for which payment is made by Medicare to the hospital, we believe these EPs should be considered hospital-based EPs, and thus excluded from the Medicare EP EHR incentive

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payments. This is fully consistent with the definition of hospital-based EPs in section 1848(o)(1)(C)(ii) of the Act...

“In summary, we propose that EPs that provide substantially all of their professional services in the inpatient hospital setting, in any type of outpatient hospital setting, or in any combination of inpatient and outpatient hospital settings, be considered hospital-based EPs...

“We propose to consider the use of place of service (POS) codes on physician claims to determine whether an EP furnishes substantially all of their professional services in a hospital setting and is, therefore, hospital-based...

“In our proposed approach, a hospital-based eligible professional, would be ineligible to receive an EHR incentive payment under either Medicare or Medicaid, regardless of the type of service provided, if more than 90 percent of their services are identified as being provided in places of service classified under place of service codes 21, 22, or 23. Accordingly, for both Medicare and Medicaid incentive payment purposes, we propose that a hospital-based eligible professional is defined as an EP who furnishes 90 percent or more of their covered professional services in any of the above listed places of service.”