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## HBS Update

### July 24, 2010

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If you go to [www.ruralhealthclinic.com](http://www.ruralhealthclinic.com) you will notice big changes to our website. We have filed all the information that was previously on the home page and resulted in one long scroll of unrelated information. All the information has been categorized by subject and can be located on its corresponding page. I have included a blog page that is where I will continue to provide updates. The home page will also include the most recent posts; however, the information will be quickly filed to their appropriate page.

I hope this makes the site more useful to you and easier to find content that is of interest to you. If you have problems with tool bars on the side that help you navigate to the proper content, here are the hyperlinks to get you there.

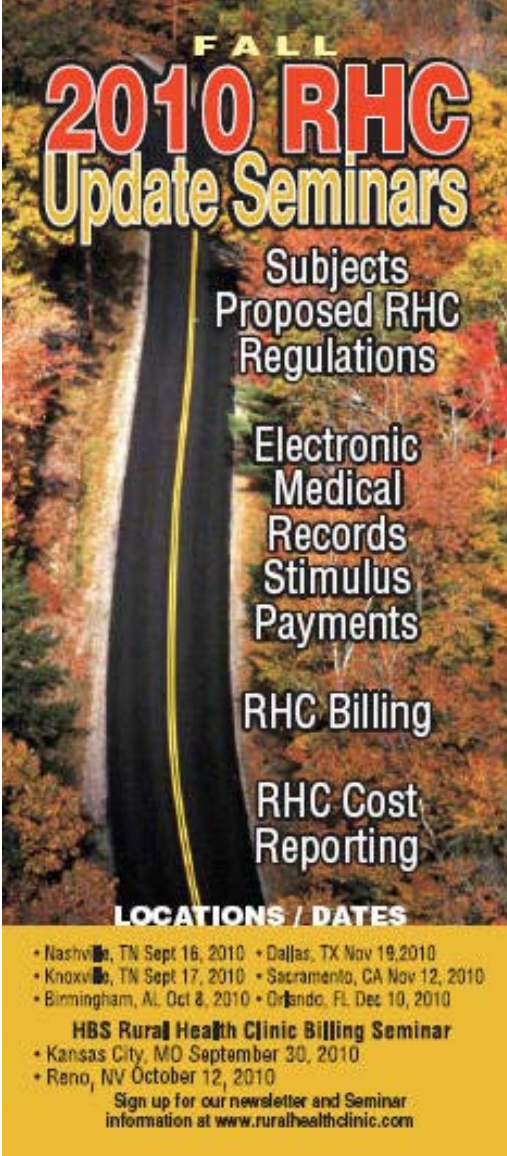
Additionally, we have started a new website that will be used for Ecommerce and it is called [www.healthcarebusinessspecialists.com](http://www.healthcarebusinessspecialists.com). We have a new email address which is [marklynn@healthcarebusinessspecialists.com](mailto:marklynn@healthcarebusinessspecialists.com) and we will use that for business communications. (I will still use [la\\_vita\\_nouva@hotmail.com](mailto:la_vita_nouva@hotmail.com) for personal purposes so you may continue to use it if you prefer.)

## Links to Information on Rural Health Clinic.com

<a href="#">About HBS</a>	<a href="#">PECOS</a>
<a href="#">Cost Report Workbook Order Form</a>	<a href="#">Rural Health Clinic Presentations</a>
<a href="#">Electronic Health Records Stimulus Payments</a>	<a href="#">RHC Billing Information</a>
<a href="#">RHC Cost Reporting Resources</a>	<a href="#">Sponsors</a>
<a href="#">RHC Classified Advertising</a>	<a href="#">What is a Rural Health Clinic</a>
<a href="#">Cost Reports</a>	<a href="#">Cost Report Contingency</a>
<a href="#">RHC Legislative and Regulatory Links</a>	<a href="#">RHC Update Workbook Order Form</a>
<a href="#">Rural Health Clinic Newsletters</a>	<a href="#">Healthcare Business Specialists - Rural Health Clinic.com</a>



## RHC Update and Billing Seminars



**FALL**  
**2010 RHC Update Seminars**

**Subjects**  
**Proposed RHC Regulations**

**Electronic Medical Records Stimulus Payments**

**RHC Billing**

**RHC Cost Reporting**

**LOCATIONS / DATES**

- Nashville, TN Sept 16, 2010 • Dallas, TX Nov 19, 2010
- Knoxville, TN Sept 17, 2010 • Sacramento, CA Nov 12, 2010
- Birmingham, AL Oct 8, 2010 • Orlando, FL Dec 10, 2010

**HBS Rural Health Clinic Billing Seminar**

- Kansas City, MO September 30, 2010
- Reno, NV October 12, 2010

Sign up for our newsletter and Seminar information at [www.ruralhealthclinic.com](http://www.ruralhealthclinic.com)

We are sending out a postcard next week on our rural health clinic and billing seminars so look for it in the mail. We have added dates in Dallas, Orlando, and Sacramento so look for those dates as well. Here is the link to the postcard that will be in the mail. The update seminars will feature information on medical homes, bundled payment, and accountable health organizations as well as the latest information on the Electronic Health Records Stimulus payments. The morning session will be all legislative changes and Electronic Health Records and the afternoon sessions are related to RHC Billing, Cost Reporting, and Annual Evaluations. If you would like to only attend the morning session, the fee is \$150.00 or the afternoon session the fee is \$150.00 as well. You do not have to be a rural health clinic to benefit from the information presented in the morning session. Here is the link:

[2010 RHC Seminar Postcard for Update and Billing Seminars.pdf](#)



Here are the links to register for the seminars. Let us know if you have a problem with any of them. Thank you and we hope to see you at one of the seminars.

[RHC Update Seminar in Nashville, TN on September 16, 2010](#)

[RHC Update Seminar in Knoxville, TN on September 17, 2010](#)

[RHC Update Seminar in Birmingham, AL on October 8, 2010](#)

[RHC Update Seminar in Sacramento, CA on November 12, 2010](#)

[RHC Update Seminar in Dallas, TX on November 19, 2010](#)

[RHC Update Seminar in Orlando FL on December 10, 2010](#)

[Kansas City, MO RHC 101 Billing Seminar](#)

[Reno, NV RHC 101 Billing Seminar](#)

<i>Date</i>	<i>Location</i>	<i>Subject</i>	<i>Time</i>
<i>Thursday, Sept. 16</i>	Nashville, TN	RHC Update	9:30 to 4:00
<i>Friday, September 17</i>	Knoxville, TN	RHC Update	9:30 to 4:00
<i>Friday, October 8</i>	Birmingham, AL	RHC Update	9:30 to 4:00
<i>Thursday, Sept. 30</i>	Kansas City, MO	RHC Billing	9:30 to 4:00
<i>Tuesday, October 19</i>	Reno, NV	RHC Billing	9:30 to 4:00
<i>Friday, November 12</i>	Sacramento, CA	RHC Update	9:30 to 4:00
<i>Friday, November 19</i>	Dallas, TX	RHC Update	9:30 to 4:00
<i>Friday, December 10</i>	Orlando, FL	RHC Update	9:30 to 4:00

**H B S**

Healthcare Business Specialists



## Electronic Health Records Regulations Finalized

The Centers for Medicare & Medicaid Services (CMS) announced a final rule to implement provisions of the American Recovery and Reinvestment Act of 2009 (Recovery Act) that provide incentive payments for the meaningful use of certified EHR technology. The Medicare EHR incentive program will provide incentive payments to eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) that are meaningful users of certified EHR technology. The Medicaid EHR incentive program will provide incentive payments to eligible professionals and hospitals for efforts to adopt, implement, upgrade or meaningfully use certified EHR technology.

CMS has a website that summarizes all the changes to EMR

<https://www.cms.gov/EHRIncentivePrograms/>

Some of the key changes in the final CMS rule include:

- Greater flexibility with respect to eligible professionals and hospitals in meeting and reporting certain objectives for demonstrating meaningful use. The final rule divides the objectives into a “core” group of required objectives and a “menu set” of procedures from which providers may choose any five to defer in 2011-2012. This gives providers latitude to pick their own path toward full EHR implementation and meaningful use.
- An objective of providing condition-specific patient education resources for both EPs and eligible hospitals and the objective of recording advance directives for eligible hospitals, in line with recommendations from the Health Information Technology Policy Committee.
- A definition of a hospital-based EP as one who performs substantially all of his or her services in an inpatient hospital setting or emergency room only, which conforms to the Continuing Extension Act of 2010
- CAHs within the definition of acute care hospital for the purpose of incentive program eligibility under Medicaid.



CMS' and ONC's final rules complement two other recently issued HHS rules. On June 24, 2010, ONC published a final rule establishing a temporary certification program for health information technology. And on July 8, 2010 the Office for Civil Rights announced a proposed rule that would strengthen and expand privacy, security, and enforcement protections under the Health Insurance Portability and Accountability Act of 1996.

As part of this process, HHS is establishing a nationwide network of Regional Extension Centers to assist providers in adopting and using in a meaningful way certified EHR technology.

“Health care is finally making the technology advances that other sectors of our economy began to undertake years ago,” Dr. Blumenthal said. “These changes will be challenging for clinicians and hospitals, but the time has come to act. Adoption and meaningful use of EHRs will help providers deliver better and more effective care, and the benefits for patients and providers alike will grow rapidly over time.”

A technical fact sheet on ONC's standards and certification criteria final rule is available at <http://healthit.hhs.gov/standardsandcertification>.

#### **Links to Rules via Federal Register:**

[http://www.ofr.gov/OFRUpload/OFRData/2010-17207\\_PI.pdf](http://www.ofr.gov/OFRUpload/OFRData/2010-17207_PI.pdf)

[http://www.ofr.gov/OFRUpload/OFRData/2010-17210\\_PI.pdf](http://www.ofr.gov/OFRUpload/OFRData/2010-17210_PI.pdf)

Here is a good summary of the regulations if you are not in the mood to read over 1,000 pages of final regulations.

<http://insurancenewsnet.com/article.aspx?id=209125>





In addition The New England Journal of Medicine produced an excellent article on meaningful use including listing the required core items and the optional menu of requirements. Here is the link to the article and a snapshot of the key chart on core and menu requirements.

<http://healthcarereform.nejm.org/?p=3732>

Summary Overview of Meaningful Use Objectives.*	
Objective	Measure
<b>Core set†</b>	
Record patient demographics (sex, race, ethnicity, date of birth, preferred language, and in the case of hospitals, date and preliminary cause of death in the event of mortality)	More than 50% of patients' demographic data recorded as structured data
Record vital signs and chart changes (height, weight, blood pressure, body-mass index, growth charts for children)	More than 50% of patients 2 years of age or older have height, weight, and blood pressure recorded as structured data
Maintain up-to-date problem list of current and active diagnoses	More than 80% of patients have at least one entry recorded as structured data
Maintain active medication list	More than 80% of patients have at least one entry recorded as structured data
Maintain active medication allergy list	More than 80% of patients have at least one entry recorded as structured data
Record smoking status for patients 13 years of age or older	More than 50% of patients 13 years of age or older have smoking status recorded as structured data
For individual professionals, provide patients with clinical summaries for each office visit; for hospitals, provide an electronic copy of hospital discharge instructions on request	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days; more than 50% of all patients who are discharged from the inpatient department or emergency department of an eligible hospital or critical access hospital and who request an electronic copy of their discharge instructions are provided with it
On request, provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, and for hospitals, discharge summary and procedures)	More than 50% of requesting patients receive electronic copy within 3 business days
Generate and transmit permissible prescriptions electronically (does not apply to hospitals)	More than 40% are transmitted electronically using certified EHR technology
Computer provider order entry (CPOE) for medication orders	More than 30% of patients with at least one medication in their medication list have at least one medication ordered through CPOE
Implement drug–drug and drug–allergy interaction checks	Functionality is enabled for these checks for the entire reporting period
Implement capability to electronically exchange key clinical information among providers and patient-authorized entities	Perform at least one test of EHR's capacity to electronically exchange information
Implement one clinical decision support rule and ability to track compliance with the rule	One clinical decision support rule implemented
Implement systems to protect privacy and security of patient data in the EHR	Conduct or review a security risk analysis, implement security updates as necessary, and correct identified security deficiencies
Report clinical quality measures to CMS or states	For 2011, provide aggregate numerator and denominator through attestation; for 2012, electronically submit measures
<b>Menu set‡</b>	
Implement drug formulary checks	Drug formulary check system is implemented and has access to at least one internal or external drug formulary for the entire reporting period
Incorporate clinical laboratory test results into EHRs as structured data	More than 40% of clinical laboratory test results whose results are in positive/negative or numerical format are incorporated into EHRs as structured data
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach	Generate at least one listing of patients with a specific condition
Use EHR technology to identify patient-specific education resources and provide those to the patient as appropriate	More than 10% of patients are provided patient-specific education resources
Perform medication reconciliation between care settings	Medication reconciliation is performed for more than 50% of transitions of care
Provide summary of care record for patients referred or transitioned to another provider or setting	Summary of care record is provided for more than 50% of patient transitions or referrals
Submit electronic immunization data to immunization registries or immunization information systems	Perform at least one test of data submission and follow-up submission (where registries can accept electronic submissions)
Submit electronic syndromic surveillance data to public health agencies	Perform at least one test of data submission and follow-up submission (where public health agencies can accept electronic data)
<b>Additional choices for hospitals and critical access hospitals</b>	
Record advance directives for patients 65 years of age or older	More than 50% of patients 65 years of age or older have an indication of an advance directive status recorded
Submit of electronic data on reportable laboratory results to public health agencies	Perform at least one test of data submission and follow-up submission (where public health agencies can accept electronic data)
<b>Additional choices for eligible professionals</b>	
Send reminders to patients (per patient preference) for preventive and follow-up care	More than 20% of patients 65 years of age or older or 5 years of age or younger are sent appropriate reminders
Provide patients with timely electronic access to their health information (including laboratory results, problem list, medication lists, medication allergies)	More than 10% of patients are provided electronic access to information within 4 days of its being updated in the EHR

\* This overview is meant to provide a reference tool indicating the key elements of meaningful use of health information technology. It does not provide sufficient information for providers to document and demonstrate meaningful use in order to obtain financial incentives from the Centers for Medicare and Medicaid Services. The regulations and filing requirements that must be fulfilled to qualify for the Health IT financial incentive program are detailed at [www.cms.gov](http://www.cms.gov).

† These objectives are to be achieved by all eligible professionals, hospitals, and critical access hospitals in order to qualify for incentive payments.

‡ Eligible professionals, hospitals, and critical access hospitals may select any five choices from the menu set.

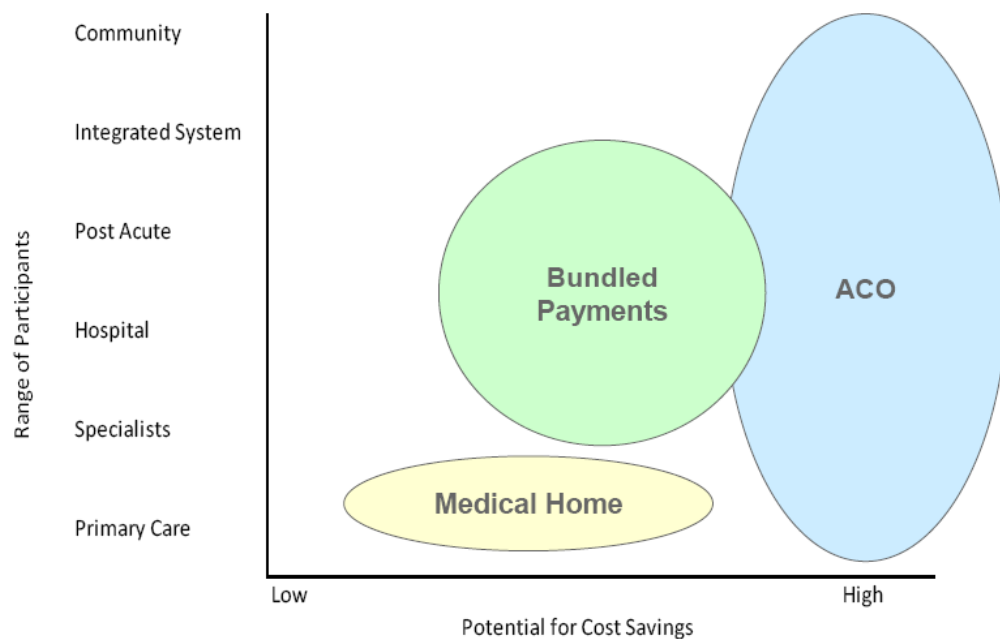


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## Are you ready for 2011

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Healthcare reform goes into high gear next year with medical home, bundled payments, and Accountable Care Organizations all the rage. Is your rural health clinic ready for the sweeping changes? Here is slide from Wipfli's CPA and Consultant's recent webinar on health reform. There are still 3 more of these seminars if you want to sign up at [wipfli.com](http://wipfli.com).

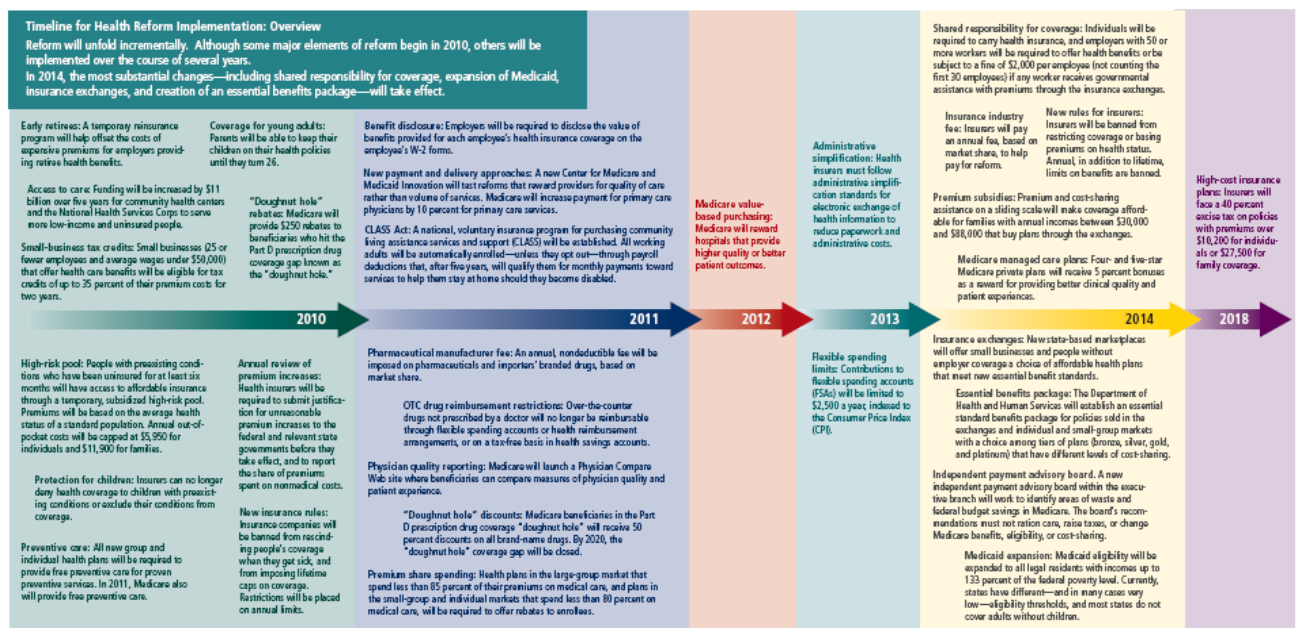


Medical home reimbursement starts in 2011 and should be the sweet spot for rural health clinics as they are primary care providers and this could be a relatively risk free method of participating in healthcare reform. (as opposed to Accountable Care Organizations which require 5,000 covered Medicare lives and the providers to manage risk and starts in 2014.)



The changes are coming fast. The Commonwealthfund has a great summary of the timing of the upcoming changes that you should review closely. Here is the link and a reduced picture of the document.

[http://www.commonwealthfund.org/Content/Publications/Other/2010/~//media/Images/Publications/Other/2010/timeline\\_print\\_1\\_legal\\_size\\_pg.pdf](http://www.commonwealthfund.org/Content/Publications/Other/2010/~//media/Images/Publications/Other/2010/timeline_print_1_legal_size_pg.pdf)



## Preventive Health out of pocket costs reduced in 2011

CMS has issued a proposed rule that would implement key provisions in the Affordable Care Act of 2010 that expand preventive services for Medicare beneficiaries, improve payments for primary care services and promote access to health care services in rural areas. The proposed policies would apply to payments under the MPFS for services furnished on or after January 1, 2011. The proposed rule would implement provisions that will eliminate out-of-pocket costs for beneficiaries for most preventive services. The proposed rule



would improve access to primary care services by implementing an incentive payment for primary care services furnished by primary care practitioners, which can include physicians, NP's, CNS's and PA's. The proposed rule would also implement a payment incentive program for general surgeons performing major surgery in areas designated HPSAs, would allow PA's to order post-hospital extended care services in SNFs, and would pay certified nurse midwives for their services under the MPFS at the same rates as physicians. To read the entire CMS press release with links to the proposed rule, [click here](#). CMS will accept comments on the proposed rule until August 24.

## **GME and IME Payments for FQHCs and RHCs**

Section 5508 of PPACA and Part C of Title VII of the Public Health Service Act, as amended by Section 5303 of PPACA, provides that the Secretary may award grants to teaching health centers for the purpose of establishing new accredited or expanded primary care residency programs (i.e. family medicine, general dentistry, geriatrics, internal medicine, internal medicine-pediatrics, obstetrics and gynecology, pediatrics, pediatric dentistry and psychiatry). The definition of teaching health centers include RHCs. Grants may not exceed \$500,000 and are limited to three years. They must be used to cover the costs of establishing or expanding primary residency training programs, including costs associated with curriculum development, recruitment and training and retention of residents and faculty, accreditation by certain accreditation bodies, and faculty salaries during the development phases. In selecting recipients for grants, the Secretary shall give preference to applications that document an existing agreement with an area health education center program. Grants of more than \$35 billion have been authorized by Congress.

PPACA also provides funding of \$230 million to make GME and IME payments to teaching health centers, including RHCs, that operate GME programs. The payments will be similar to the GME and IME payments



traditionally paid to hospitals, and the Secretary is to compute for each individually qualified teaching health center a per resident amount for direct GME costs.

RHCs should consider expanding or starting new primary care residency programs. They can qualify for grants and receive Medicare GME and IME payments for these residency programs. The ability of these entities to receive grants and medical education payments directly from Medicare represents a significant reimbursement opportunity under health care reform that should not be overlooked.

<http://www.hinshawlaw.com/health-care-reform-law-changes-medicare-gme-for-hospitals-and-allows-gme-payments-for-fqhcs-and-rhcs-07-19-2010/>

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## PECOS Enforcement Delayed

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CMS has had a change of heart regarding its July 6 deadline for physician enrollment in the agency's Provider Enrollment, Chain and Ownership System, or PECOS.

According to a [June 30 news release](#), the federal regulation that requires all ordering and referring physicians to be enrolled in PECOS will still be effective as of July 6, but "CMS will, for the time being, not implement changes that will automatically reject claims based on orders, certifications and referrals made by providers that have not yet had their applications approved by July 6."





## PECOS Links

Here is a summary table of some excellent links related to PECOS.

<i>Description</i>	<i>Website</i>
Summary information related to PECOS from AAFP	<a href="http://www.aafp.org/online/en/home/publications/news/news-now/practice-management/20100720cmsmedicarehelp.html">http://www.aafp.org/online/en/home/publications/news/news-now/practice-management/20100720cmsmedicarehelp.html</a>
Special Instructions for RHCs related to PECOS	<a href="#">Medicare Enrollment Guidance for Physicians that Infrequently Receive Reimbursement from the Medicare Program</a>
Log In to PECOS System	<a href="https://pecos.cms.hhs.gov/pecos/login.do">https://pecos.cms.hhs.gov/pecos/login.do</a>
855i Paper Form	<a href="http://www.cms.gov/cmsforms/downloads/cms855i.pdf">http://www.cms.gov/cmsforms/downloads/cms855i.pdf</a>
CMS Getting Started with PECOS Guide	<a href="#">"getting started" guide</a>
CMS Reassignment of Benefits Form – 855r	<a href="http://www.cms.gov/cmsforms/downloads/cms855r.pdf">http://www.cms.gov/cmsforms/downloads/cms855r.pdf</a>
Contact List of Medicare Contracting personnel	<a href="#">state-by-state listing of Medicare contractors</a>
CMS will not enforce July 6, 2010 deadline CMS Press Release on June 30 regarding PECOS	<a href="http://www.aafp.org/online/en/home/publications/news/news-now/practice-management/20100702pecosdeadline.html">http://www.aafp.org/online/en/home/publications/news/news-now/practice-management/20100702pecosdeadline.html</a> <a href="http://www.cms.gov/apps/media/press/release.asp?Counter=3774">http://www.cms.gov/apps/media/press/release.asp?Counter=3774</a>



Thanks for reading this newsletter. I hope it was informative and helpful. I am off to Maine for the next 9 days to beat the summer heat here in Tennessee; so it will be a little quiet for the next week or so. If you need me my cell phone is (423) 243-6185. Thanks and look forward to seeing everyone at one of the seminars.

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