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**Texas Association of Rural Health Clinics**

Quality Health Care for Rural Texas

2008

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## Rural Health Clinic Payment Rates to Increase

Change Request (CR) #6218 dated October 31, 2008, from the **Centers for Medicare and Medicaid Services (CMS)** announced that the upper payment limit (independent RHC capped rate) for RHCs is increased from \$75.63 to \$76.84 effective January 1, 2009, through December 31, 2009, (i.e. Calendar Year 2009). The 2009 rate reflects a 1.6 percent increase over the 2008 payment limit in accordance with the rate increase in the Medicare Economic Index (MEI) as authorized by the Social Security Act (Section 1833(f)).

The **Texas Health and Human Services Commission (HHSC)** held a rate hearing to receive public comments on November 21<sup>st</sup> for the Medicaid proposed payment rates for RHCs. The proposal determines that RHCs will receive a MEI rate increase of 1.6 percent to their current Medicaid RHC encounter rates. This proposal will be effective January 1, 2009, on the same clinic payment rate change schedule as the **Texas Medicaid & Healthcare Partnership (TMHP)** Medicaid Auditor has made in the past.

The official instruction, CR 6218, issued to the Fiscal Intermediaries (FI) and the A/B Medicare Administrative Contractors (MAC) regarding the change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1626CP.pdf> on the **CMS** website.

## EPO CHIP Areas to Change to the CHIP Rural Service Area Managed Care Organization

The **Children's Health Insurance Program Exclusive Provider Organization (CHIP EPO)** network contract bid proposal that was released to the public on July 1, 2008, with submitted proposals due to HHSC on October 1, 2008, was amended on October 2<sup>nd</sup>. The amendment changed the **EPO CHIP** coverage in the 170 rural counties in Texas from one contracted network vendor to two contracted network vendors, each covering the entire Rural Service Area. HHSC will accept proposals from exclusive provider benefit plans, health maintenance organizations, and approved non-profit health corporations. The proposal bids will be due to HHSC not later than February 5, 2009, and the operational start of the **CHIP** coverage in Rural Service Areas will begin April 1, 2010.

Until the contracts are awarded to the bidders selected to provide these **CHIP** services, providers are encouraged to sign letters of intent (LOI) saying they will become network providers only if the vendor is selected by HHSC to provide **CHIP** services in the Rural Service Areas. HHSC will accept the LOIs for purposes of evaluating the adequacy of the vendor's proposed network. However, the selected vendor must enter into contracts with all network providers no later than 120 days after the contract's effective date. Currently Texas True Choice is the **EPO CHIP** provider network administrator and Superior Health Plan is the claims adjudicator. Their contract to provide services will continue until the start-up date in 2010 for the **CHIP Rural Service Area Managed Care Organization** implementation, at which time the **CHIP** services will be provided by two vendors for the entire Rural Service Area. This gives a choice to the **CHIP** beneficiaries. **CHIP** members will be allowed to change health plans once every 12 months at renewals unless there is a "good cause" reason.

## CMS Issues Interim Guidance Regarding Survey and Certification of RHCs

On November 21, 2008 CMS published a Memorandum (S&C-09-14) to State Survey Agency Directors <http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter09-14.pdf>

The memorandum provides guidance regarding regulatory requirements located at 42 CFR Part 405, Subpart X, Section 2401 and 42 CFR part 491, Subpart A, applying to RHCs and FQHCs. It essentially provides an overview of previous changes and clarifies the current RHC and FQHC regulatory requirements.

On December 24, 2003, the **Centers for Medicare and Medicaid Services (CMS)** published a final rule which revised certification and payment requirements for RHCs and FQHCs. Many of the amendments in that published rule were required by the Balanced Budget Act (BBA) of 1997 or the Omnibus Budget Reconciliation Act of 1989 (OBRHA 89).

CMS later determined that this final rule was subject to Section 902 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, which requires adoption of a final rule no later than 3 years after publication of the initial rule proposal. The RHC/FQHC rule established in December 2003 exceeded the 3-year statutory timeframe. Therefore on September 22, 2006, CMS published an interim final rule that suspended the effectiveness of the amendments adopted in 2003 and restored the previous version of the rule (71 FR 55341). However, CMS noted in the preamble to the 2006 rule that any statutory self-implementing provisions (that is, provisions which do not require any additional discretionary activity on the part of the Secretary) on which CMS had previously issued guidance continue in effect. This is the case even when the regulatory language

that was reinstated differs from the self-implementing provisions of the law.

Finally, CMS proposed on June 27, 2008, amendments to 42 CFR Part 405, Subpart X and 42 CFR Part 491, Subpart A that would restore much of the December 2003 regulatory text (73 FR 36696).

The attachments to this memorandum can be viewed by going to <http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter09-14.pdf>

The attachments contain the current regulatory text and reflect changes from the December 2003 version of the regulation in the following areas:

- 42 CFR 405.2401 - Scope and definitions of Services for RHCs and FQHCs
- 42 CFR 491.2 - Definition
- 42 CFR 491.3 - Certification procedures
- 42 CFR 491.5 - Location of rural health clinic
- 42 CFR 491.8(a)(6) - Staffing midlevel requirements for RHCs
- 42 CFR 491.8(d) - Temporary staffing waiver [the waiver provision was eliminated]
- 42 CFR 491.11 - Program evaluation [replacing QAPI]

Appendix G of the State Operations Manual is generally consistent with the September 2006 revision to the rule that was in effect before December 2003. Surveyors may not cite an RHC for deficiencies when they are in compliance with the statutory provisions and guidance described in the attachments.

When CMS adopts a final rule concerning the amendments proposed in June 2008, they will issue guidance on its interpretation and enforcement.

## Change is in the Air: Health Reform in the Obama Administration

*Article submitted by Thomas N. Longbotham, M.A.*

While Health and Human Services (HHS) has taken back the reformulation of shortage area designation since the new RHC rules and regulations were issued on June 27, 2008, and Congress has also approved a change in RHC statutes to extend the time period of a shortage designation to be considered "current" from 3 years to 4 years; the federal rules and regulations remain in limbo during the Presidential transition.

The National Rural Health Association (NRHA) submitted a questionnaire on issues important to the rural health community to the Presidential candidates during the run-up to the election in order to assess the impact of their plans on rural health. The questions included the following topics: Health Insurance Coverage; Health Care Workforce and the Impact on Access; Preventive Care; Reimbursement and Impact on Access; Health Information Technology; Veterans Health; Specialty Care; and Health Care Infrastructure. President-elect Barack Obama sent a response to those questions in October, which are available at: <http://www.ruralhealthweb.org/go/rural-health-news/senator-obama-responds-to-nrha-questionnaire>. In addition, Obama sent a letter to the attendees of the NRHA's Rural Health Clinic and Critical Access Hospital conferences in Savannah, Georgia on October 14-15.

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The Obama-Biden administration has proposed a comprehensive rural plan to address the many challenges facing rural America and take advantage of opportunities by working with and empowering local leaders. Our healthcare system must work if we really want to create positive, substantive change for our rural economies. They will take steps to address geographic inequities, working to fix the historical disparity in Medicare and Medicaid reimbursement rates in which rural providers often get paid less than their urban counterparts. Loan forgiveness and related types of incentive programs to help attract health care providers to rural areas will be expanded. Federal capital available to build start up community health facilities will be increased. And access to health care will be increased by promoting the adoption of effective telecommunications and health information technologies is an important goal of the incoming

administration, which will bring broadband Internet access to everyone and invest \$10 billion a year over the next five years to move the U.S. health care system toward broad adoption of standards-based electronic health information systems. The Obama-Biden administration will also plans to increase the number of Veterans Affairs (VA) centers serving our rural veterans, ensuring that the VA has the tools and flexibility to contract with other health care providers in remote areas where there is inadequate access to a VA medical center or it is impractical to build one.

Change is in the air in Washington. There are new names and faces and possible policy directions. Key congressional supporters are out of office due to both retirement and electoral defeat, and the Senate Finance Committee is left with several vacancies. While the possible appointment of former Senator Tom Daschle (D-South Dakota), a friend and ally of RHCs, is good news, there are important HHS undersecretary

and CMS positions yet to be appointed.

The TARHC, NARHC, and NRHA are committed to seeking a proper adjustment of the RHC cap to reflect the importance of RHCs as a health safety net. The NRHA is holding its 2009 Rural Health Policy Institute in Washington, DC on January 26-28. [Bill Finerfrock, Executive Director of the National Rural Health Association (NARHC), will conduct an RHC breakout session at the NRHA Policy Institute.] The NRHA Policy Institute provides you an opportunity to directly participate in the American policy-making process with access to members of Congress, key public health officials and nationally known health care experts. You will be the first to know what the new Administration and Congress will mean to your local community. The RHC community has the potential to roar. Encourage one friend, one nonmember to become a member of our association and one or both national associations.

### Trying to Start a RHC but Hindered by the Tier Rating Status of RHC Initial Surveys?

On November 7, 2007 CMS sent a letter to all state survey agency directors informing them that federal resources were highly constrained because the President's proposed budget for Survey and Certification (S&C) had not been fully funded for the previous three years and being short of funding, new providers applying to participate in the Medicare program for the first time would be placed on a revised survey priority list. These four priority levels, or tiers, are:

Tier I – consists of statutory mandates, such as surveys of existing nursing home and home health agency, and ICF/MR providers.

Tier II - includes all complaint investigations.

Tier III - includes ERSD facilities, transplant centers, hospitals without an accrediting organization (AO), and facilities with special psychiatric conditions.

Tier IV - Initial surveys for ambulatory surgical centers, home health agencies, hospices, hospitals, critical access hospitals, and all others which include comprehensive outpatient rehabilitation facilities, long term care units in hospitals, nursing homes that do not participate in Medicaid outpatient physical therapy, and rural health clinics.

Then on March 7, 2008, CMS sent a letter to all States and CMS Regions informing them that because of Congress's appropriation on part of the increase in Medicare Survey and Certification funds requested in the President's proposed FY 2008 Budget, it permitted CMS to raise initial surveys of RHCs and SNFs to Tier III (3). For initial surveys assigned to Tier 3 priority status, States may prioritize the initial surveys within Tier 3.

There may be a way to move your initial RHC application a little closer to being inspected for certification. There has always been the option of requesting a priority exception for the initial survey but it has not been widely understood by the RHC community and those wanting to establish a new RHC. **It is for access to care reasons.** Providers may apply to the State survey agency for CMS consideration to grant an exception to the priority assignments of the initial survey if lack of Medicare certification would cause significant access-to-care problems for beneficiaries served by the provider. The State

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survey agency may choose whether to make a recommendation to CMS before forwarding the request to the CMS Regional Office (RO).

There is no special form required to make a priority exception request. However, the burden is on the applicant to provide data and other evidence that effectively establishes the probability of serious, adverse beneficiary health care access consequences if the provider is not enrolled to participate in Medicare. CMS will not endorse any request that fails to provide such evidence and fails to establish special circumstances surrounding the provider's request.

In speaking to Vicki Seabolt, (214) 767-4474, CMS Region VI Division of Survey and Certification Operations, she said she normally holds a review committee meeting weekly to act on these requests for exception to the priority listing. If a RHC exception request is approved, the State is notified to move the RHC's application to a Tier 2 level and conduct the initial survey from that Tier II priority listing during the state agency's scheduled visits in the RHC's geographic area.

New RHC applicants need to realize that it is their submission of the CMS Form 855 application to become a RHC that is necessary to start the process. State survey offices and the CMS Regional Office can not act on a request for priority exceptions until they have received the word from the Fiscal Intermediary that your 855 has cleared the initial stage and is ready for further processing by the state survey office. It is during this time of the 855 processing that you should send a letter with your request to the state survey office so that when TrailBlazer notifies them that your 855 cleared, they can then act on your request for a priority exception.

## New Developments Coming in RHC Survey and Certification

*Report on the November 19, 2008, introductory meeting between NARHC and AAAASF by Thomas N. Longbotham, M.A.*

All health care providers (hospitals, Rural Health Clinics, home health agencies, skilled nursing facilities, ambulatory surgical centers, etc.) are required to meet the Medicare Conditions of Participation or Certification applicable to that particular provider. In lieu of formally meeting the Medicare Conditions, many providers can be accredited by a private accrediting agency whose standards are "deemed" equal to or better than Medicare's conditions. The RHC program is one of the few provider categories for which a private accrediting program is not currently available. There are tremendous delays in the initial certification of RHCs, wide variability in state interpretation of the RHC Conditions and inconsistent application of standards. There would be tremendous value to the RHC community and the patients we serve if a credible private accreditation agency could establish an accreditation program for RHCs that would be deemed by Medicare for certification and recertification of RHCs.

At the 2008 NARHC Fall Institute, the association's board was addressed by Jeff Percy, the Executive Director of the American Association for Accreditation of Ambulatory Surgical Facilities, with an opportunity to consult on the privatization of RHC survey and certification. CMS has encouraged AAAASF to establish an accreditation program for RHCs. The NARHC Board members unanimously support AAAASF's initiative to establish a private RHC accreditation program and its goal of securing deemed status for purposes of Medicare certification and recertification. The AAAASF uses a peer review program and will employ RHC health professionals to survey, inspect, and certify RHCs. The NARHC Board was impressed with their emphasis on creating a credible program aimed at evaluating and improving the quality of care in RHCs using a peer review process.

The CMS staff responsible for reviewing requests for deemed status have a very high opinion of AAAASF. The AAAASF is a not-for-profit 501c6 organization established for the purpose of facility accreditation. It is currently an accrediting organization for Ambulatory Surgical Centers (ASCs) and is a deemed agency for Medicare certification and recertification of ASCs. AAAASF has been in existence for more than 20 years and has been a deemed entity for Medicare for 9 years.

In light of this it important to keep in mind that there is nothing to fear about having a survey. Surveyors are not out to get you; they don't like to write deficiencies any more than you like getting them. If your facility does get deficiencies, send in a good plan of correction and take care of the issues and you should be fine. Know the regulations. Have policies and procedures that meet the regulations. Make sure that someone is responsible for ensuring policy and procedures are monitored and followed. The following are some recommendations to make certain that you are in compliance:

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**Physical Facility Recommendations:**

- Arrange an annual fire inspection.
- Document fire and natural disaster in-service training.
- Ensure expired drugs are removed and document/schedule this activity monthly.
- Multi-use vials marked with date of opening and disposed 30 days after opening.
- Ensure Schedule II drugs are separately locked, inventoried, and limit access.
- Keep the facility clean and tidy.

**Provision of Service Recommendations:**

- An emergency kit is required – a defibrillator is not.
- Ensure the clinic can perform Hemoglobin or Hematacrit, and that supplies are current.
- The RHC must be able to admit to a hospital or have a written agreement with someone who can.

**RHC Manual Recommendations:**

- Organize the manual according to RHC regulations.
- Keep business, personnel, and medical licenses current.
- Ensure the Medical Director and NP/PA review polices and sign the manual annually.
- Make sure that patient care and administrative polices are included and current.
- Maintain organizational chart.
- Assign one person and an alternate responsibility for the manual in case of inspection.

**Medical Record Recommendations:**

- Maintain individual patient charts.
- Use problem and medication lists.
- Sheets must be attached.
- Physician writing must be legible.
- No financial data in charts other than insurance info.
- Maintain written policies regarding retention, confidentiality, and release of information.
- A designated staff member should be responsible for overseeing medical records.

**Annual To-Do List:**

- Make sure the medical director and NP/PA have signed the manual annually.
- Insert all current medical personnel licenses in manual.
- Insert current medical malpractice, building, and liability insurance certificates.
- Make sure that NP/PA hours equal at least 50% of posted clinic hours.
- Post NP/PA hours to make it official.
- Make sure personnel on organizational chart are current.
- Annual Fire Inspection if possible.
- Make sure all staff is CPR certified.
- Document annual fire/natural disaster in-service.
- Bio-medical equipment inspection - the 110% solution.
- Make sure 'crash cart' drugs are not expired.
- Drug sample storage and expirations have been reviewed and activity logged.
- Multi-use vials – mark date of opening and dispose of 30 days after opening.
- Make sure that all lab supplies are current that that all tests can be performed.
- Make sure you have Annual Evaluations/ Medical Record reviews documented.

**If you are prepared and have your policy and procedures in place and have followed the regulations, you will have a good survey.**

## Prescription Drug Coverage for Texans

The Medicare annual open enrollment period for 2009 with the Medicare prescription drug coverage (Part D) will be coming to an end on December 31, 2008. *Here are some facts for Texas that you may find interesting:*

86% of people with Medicare have prescription drug coverage (including 65% in Part D).

47% of those in Part D are receiving the low-income subsidy (LIS).

53 Medicare Prescription Drug Plans (PDPs) are available in 2009.

99.11% of people in a PDP can switch to a PDP with a lower premium in 2009.

27 PDPs offer enhanced benefits or services.

30 PDPs have \$0 deductibles.

12 PDPs have premiums under \$25.

\$13.70 is the lowest monthly premium for a PDP.

\$53.10 is the lowest monthly premium for a PDP with any generic coverage for the Gap.

14 PDPs have a premium amount of \$0 for people who qualify for the full extra help.

98.90% of people with Medicare will have access to a Medicare Advantage plan with Drug Coverage (MA-PD) for a \$0 premium.

74 MA-PDs have a \$0 premium.

100% of people with Medicare will have access to a MA-PD with a \$0 drug deductible.



What about people who are not on Medicare, or Medicaid, or do not have employer covered insurance? Is there any relief for them? **Yes, there are programs that can help people save on prescription drugs.** One useful program is called **Together Rx Access** which under its program, most participants can save 25% to 40% on about 300 brand-name prescription drugs for such conditions as diabetes, depression, asthma, and high cholesterol. Those taking part in the program are issued a card to bring to the pharmacy when they pick up their prescriptions, the discount is immediately applied. Because **Together Rx Access** is designed to aid people who would otherwise have trouble affording their medications, there are income limits. For example, a family of three must have a household income equal to or less than \$50,000. The **Together Rx Access** card is accepted at most pharmacies in the United States. There are two ways to find out if you're eligible: you can call (800) 966-0407, or you can log on to [www.togetherrxaccess.com](http://www.togetherrxaccess.com).

Another option worth exploring is the **National Prescription Savings Card**, which was launched in the spring of 2008. Now accepted at nearly 60,000 drugstores across the United States. The program's administrators say that cardholders can save up to 20% off the retail price of most prescription drugs. Unlike the **Together Rx Access** care, there are no income requirements and even people with insurance coverage can use their free card. You don't even have to fill out an enrollment form. *To sign up, call (866) 203-7208 or visit [www.npsavings.com](http://www.npsavings.com).*

Don't forget that a lot of discount stores offer low-cost generic drugs. This began with K-Mart in 2006 and has spread to a number of other stores such as Wal-Mart, Walgreens, Target, and even H.E.B. grocery store pharmacies.

### RHC Conferences in Texas Next Year

#### **March 9-11, 2009** ---- NARHC/TARHC Rural Health Clinic 2009 Spring Institute

*Hyatt Regency Hotel in San Antonio.* Room reservations need to be made no later than February 15, 2009, to receive the conference discounted room rate of \$159.00 per night plus tax. Call 800-233-1234 and make sure to mention you are attending the *NARHC Spring Institute*. The conference program details will be posted on the events page of [www.narhc.org](http://www.narhc.org).

#### **July 28-30, 2009** ---- TARHC Annual Rural Health Clinic Conference

*AT&T Conference Center and Hotel at the University of Texas, Austin Campus.* Conference details and lodging information will be available in **April 2009** on the [www.tarhc.org](http://www.tarhc.org) website.



There is another program that will be entering the stage this coming March 2009; ***Rx 'n Go Affordable Prescription Services*** that exhibited at the National Association of Rural Health Clinics Annual Fall Conference in November of this year. ***Rx 'n Go*** is ideal for patients who pay “out-of-pocket” for their prescriptions because they are:

Uninsured  
Lack Prescription Coverage  
Hit the Medicare “donut hole”  
or have a High Deductible Plan

***Rx 'n Go*** is predictable: 3 Flat-Fee tiers; \$25, \$50, and \$100 – over 1200 meds (all therapeutic classes covered in the \$25 tier).



***I***n some cases it's less than the average insurance co-pay.

***Rx 'n Go*** is convenient: a 90 day supply of generic maintenance meds **delivered to your door.**

***Rx 'n Go*** is simple: it's available to anyone- there are no restrictions, no qualifications, & no income eligibility.

Visit [www.rxngo.com](http://www.rxngo.com) (the site may still be under construction) or call (888) 697-9646. Julie Mayer at ***Rx 'n Go*** visited with Texas delegation at the NARHC Fall Conference and is interested in hearing from Texas Rural Health Clinics as to the merits of this prescription drug program. She would like you to call her to discuss how this program could help your clinic with its patients who have trouble keeping up with their required medications due to financial problems. *Call Julie at 513-474-6250 to hear about the program.*



RETURN SERVICE REQUESTED



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