

## **CAPITOL ASSOCIATES**

**Moderator: Bill Finerfrock**  
**June 30, 2011**  
**1:00 pm CT**

Operator: Good day and welcome to the Rural Health Clinic's Technical Assistance National Teleconference. Today's conference is being recorded. At this time, I would like to turn the call over to Mr. Bill Finerfrock. Please go ahead, sir.

Bill Finerfrock: Thank you, Operator and I want to welcome everyone to today's Rural Health Clinics' National Teleconference call. Today we'll be talking - doing a regulatory update on a couple of different rules that are in various stages of development or conclusion that are of interest to the RHC community.

Joining me today in presenting information will be Gail Nickerson. Gail is the Vice President of the National Association of Rural Health Clinics and she also serves as a representative on a negotiated rule making committee that Gail is going to be talking about a little bit later.

I want to welcome everyone to today's call. And I appreciate you taking the time to be with us. My name is Bill Finerfrock and I'm the Executive Director of the National Association of Rural Health Clinics. I will be providing remarks in addition to Gail.

The format for today's program will consist of about 45 minutes for presentation and then Gail and I will be available to take questions. If we run short that means we'll just have a little bit more time for questions.

This series of calls is sponsored by the Health Resources and Services Administration's Federal Office of Rural Health Policy and is held in conjunction with the National Association of Rural Health Clinics.

The purpose of this series is to provide Rural Health Clinic staff with valuable technical assistance in RHC specific information. Today's call is the 41st in the series which began in late 2004.

And during that time over 11,000 individuals have participated in the bi-monthly RHC National Teleconference calls.

As you all know, there's no charge to participate in this series and we encourage you to refer others who might benefit from the information to sign up to receive announcements regarding dates, topics and speaker presentations.

You can direct folks to [www.HRSA.gov/RuralHealth/Policy/CONFCALL/Index.html](http://www.HRSA.gov/RuralHealth/Policy/CONFCALL/Index.html). During the Q&A period we do ask that you identify yourself by name as well as the city and state that you're calling from.

If you have questions after the call or you want to recommend topics for future calls you can send those via email to Info, I-N-F-O at N-A-R-H-C dot org and put R-H-C-T-A question in the subject line. I would - that concludes the opening remarks.

So I will kick it off here first and I wanted to update you all on a couple of regulations that are of particular interest to the Rural Health Clinics community.

First, by way of background, some of you may know that in June of 2008, specifically June 27, 2008 the Centers for Medicare and Medicaid Services issued a very wide ranging and extensive proposed rule making a number of changes in the Rural Health Clinics programs.

Not least of which was language which would have allowed the Secretary to decertify Rural Health Clinics that were no longer located in rural areas or in shortage areas whether they be health professional shortage areas, medically underserved areas or an

area that was designated by the governor as underserved that were no longer valid or were out of date.

The rule - the proposed rule - would have also established a mechanism by which clinics in those situations could have sought a waiver of that decertification by demonstrating to the Secretary that the clinic continued to be essential to the availability of care in that community despite the fact that it was no longer designated as either rural or underserved.

In addition, the proposed rule would have established a mandatory quality assurance program improvement initiative, made changes in the program relative to the calculation of Rural Health Clinic payments and how they are affected by the beneficiary's copay and deductible from Medicare and made other technical or conforming changes to the Rural Health Clinic program to reflect statutory changes that have been made over the years. As I said, that proposed rule was issued on June 27, 2008.

Federal law requires that in order for the Centers for Medicare and Medicaid Services to publish a final rule subsequent to the issuance of a proposed rule, that final rule has to be released and finalized within three years of the date of the issuance of the proposed rule.

That means that the proposed rule that was issued on June 27, 2008 had to be finalized by June 27, 2011, this past Monday.

That did not occur. Consequently, the proposed rule that had been put forward, that we at NARHC and others had commented on and had been tracking and monitoring very closely, has been rescinded and is now dead.

There are no longer any proposed changes pending with regard to the Rural Health Clinic program and any changes will have to - the Centers for Medicare and Medicaid Services will have to go back to the drawing board and seek to potentially develop a new proposed rule which would then at some point be published in the Federal Register.

We don't know when that may occur. We don't anticipate that that will occur any time soon but that is somewhat speculative on our part.

As you can imagine, if you do the math 2008 was the very end of the Bush Administration.

The Obama Administration was not particularly, it seems, enamored with some of the proposals that were put forth by the Bush Administration. And in many cases we think that that had an impact on the decision not to issue this final rule.

So anyone who - clinics who are out there who are worried about the possibility of being decertified because you're no longer in a shortage area or being decertified because you're no longer in a rural area, that is not looming over your head in the immediate future.

And so - because the statute which authorized the Secretary to establish a mechanism for decertification also stipulated that that authority could not be exercised until such time as the Secretary put rules in place by which clinics could seek designation as an essential provider.

So as we stand here today there are no changes that are going to occur in the Rural Health Clinic's program based on the proposed rule that has been rescinded. There are some other rules, proposed rules, that are out there that I wanted to make you aware of.

One has to do with the ePrescribing initiative. As many of you may know, a few years ago the federal government created incentives to encourage providers to begin ePrescribing rather than using paper prescriptions.

And a bonus payment was available to providers who bill using the fee schedule could get a slight increase in their fee schedule payments if they could demonstrate that they were ePrescribers. That program will now transition to a penalty program.

And that has caused some questions with regard to the applicability of penalties to the Rural Health Clinic's program. I wanted to make people aware that in addition to the bonus payment that was available was not payable to Rural Health Clinics because RHCs do not bill using the fee schedule. By the same token, the penalty that is not going to come into play later and will not apply to Rural Health Clinics.

Rural Health Clinic services are not part of the ePrescribing program so you not only could not get the bonus but RHCs will not be subject to a reduction in payment for failure to be ePrescribers. So I just wanted to kind of make people aware of that.

Now if you have providers who are delivering services outside of the RHC for which they may bill Medicare Part B through the submission of a 1500 claim form those 1500 claim forms might potentially be subject but by-and-large that's not going to be the case because those 1500 - the services they are typically going to bill for under the 1500 claim form are also not subject to the ePrescribing penalty.

So we are fairly confident that most Rural Health Clinics and most providers in Rural Health Clinics will see no adverse impact as a result of moving from an incentive based initiative to a penalty based initiative as it relates to the physician fee schedule.

Another issue that has been looming - in late 2010 the Centers for Medicare and Medicaid Services enacted a policy stipulating that beginning in 2011 all laboratory services - Medicare would no longer pay for a laboratory service unless the requisition for that laboratory service contained the signature of a physician or a qualified non-physician such as a physician assistant, nurse practitioner or nurse midwife as a condition for payment.

That policy, shortly after it was announced, came under tremendous scrutiny and objection from the provider community.

CMS announced early in 2011 that they were going to suspend the enforcement and application of that policy, go back and reexamine that policy and make an announcement sometime later as to what they were going to do.

Yesterday CMS announced that they were rescinding the lab's signature policy and they will no longer have that policy on the books.

So it reverts back to the policy that was previously in effect which is there is no requirement for requisitions or requests for laboratory services to contain the signature of a physician, a PA, an NP or a nurse midwife as a condition for payment.

So that hassle factor if you will, which many providers saw as a hassle, is no longer out there and that policy is in the process of being rescinded. There is - they had to announce it as a proposed rule. They have to put it out there for public comment, CMS does, to give people an opportunity to comment.

The expectation is that the provider community will near universally support the decision to rescind the policy and we would expect that in sometime in September the decision to rescind will become official.

But CMS has announced that it is their intention to rescind that policy. Those are the issues Gail, I wanted to take a few minutes to update folks on.

I'd like to have - Gail is now going to talk to you about a process that is currently undergoing to look at the methodology that is being used to determine whether an area qualifies as a medically underserved area or a health professional shortage area which as you all know, is critically important to the Rural Health Clinics program.

So Gail, if you would kind of update us on that process we'd appreciate it.

Gail Nickerson: Okay. Thank you very much. My name is Gail Nickerson. I am on the Board of the National Association of Rural Health Clinics and the Vice President. I have been the alternate for this process until recently. Our original representative was Ron Nelson.

And with his illness and passing I have tried to step up. I know I can't fill his shoes but I'm trying to stand in them. And I know on our call today we also have Elia Gallardo. She's another alternate who attends every meeting. She works with the California Primary Care Association.

And there might be somebody else out there that I don't know. But I wanted to review the process for what we call HPSA, that's Health Professional Shortage Area and MUA which is Medically Underserved Area and MUP which is Medically Underserved Population.

We've been calling it the HPSA MUP negotiated rule making committee. And I would like to provide you some information on the direction of the committee and talk about some of the major factors that are being considered.

So a little bit of history - there was a negotiated rule making act in 1996 which encouraged the use of negotiation to determine complicated regulations.

And that act directed agencies and negotiated rule making committees that might be formed, to use consensus to the maximum extent possible consistent with law. So that act also set forth requirements for how such a committee, a negotiated rule making committee, would be formed.

So our negotiated rule making process for the HPSAs, MUAs and MUPs was mandated by Congress in Section 5602 of the Patient Protection and Affordable Care Act of 2010. People call that PPACA.

And that law included the, you know, expectation that this group would be set up to talk about shortage area designation. So it was created after two failed notices of proposed rule making that people call NPRMs.

One was in 1998, the other was ten years later in 2008 where regulations were put forward in NPRMs in the Federal Register and people's comments came in.

And there were so many comments and it was so complicated to try to figure out how to deal with all of that that they let both of those go and decided instead that it was time to set up a negotiated rule making committee.

And the purpose of the committee is to make sure that the areas, populations and entities that are going to get designated under the rules and then they become eligible for a variety of federal programs and other resources, we want to make sure that they're truly underserved and/or they have workforce shortages so that our resources are devoted to the places that need them the very most.

So the committee has a neutral facilitator. Those folks are from HRSA, the Health Resources and Services Administration. And the committee is attempting to reach that consensus which is defined as unanimous acceptance. Everybody has to at least be able to live with the decision.

The focus of the group is primary care HPSAs, MUAs and MUPs. We're not talking about mental health HPSAs or dental HPSAs at this point. We're just working on the primary care side of it.

And if the committee does reach consensus on all or some of the aspects of the rule then it will recommend them through Mary Wakefield, she's the HRSA administrator.

And Mary would recommend to the Secretary of Health and Human Services that they adopt the committee consensus as the basis for an interim final rule. The meetings have been held in the Washington, DC area since September of last year, of 2010.

The original goal was to submit the final report by July. I sat in by telephone on these meetings, lots of subcommittees formed to deal with details. Anyway, the timelines kind of ran through and has been now extended and the revised work plan is to complete the final report by October of this year.

The next meeting will be held in Alexandria, Virginia on July 20th and 21st. Meetings are open to the public and there is a timeframe in every meeting for public comment if somebody has that to provide. So in terms of committee membership I think there are currently 28 members of the committee.

Members were chosen for their abilities to represent various interests that are going to be significantly affected by the rule like Rural Health Clinics.



Or they're also on there because they have technical expertise that'll be helpful in either defining medical underservice or health professional shortage. So I wanted to kind of give you a picture of what that diverse group is.

It includes physicians and other clinicians, the National Association of Rural Health Clinics (NARHC), the National Association of Community Health Centers (NACHC), the National Rural Health Association (NRHA), the American Hospital Association (AHA), the American Academy of Family Physicians (AAFP).

There are also representatives from counties, from state health and primary care offices and also advocates for special interest groups such as racial and ethnic groups, the disabled, the elderly, patients with HIV or AIDS and Lesbian Gay Bisexual Transgendered, what we call LGBT.

There are also a variety of subcommittees that report back to the committee and these include groups that are discussing barriers, the weighting of the different factors that we're looking at, implementation if we do get to an agreement how do we put that in place, and also discussions about workforce.

So we have 12 questions that were set out in the PPACA bill that we're addressing. And here are those questions. The first question was: are these objectives of MUA and MUP and HPSA clearly different? Do we need to have two separate processes for medically underserved and health professional shortage?

The next question is the HPSA and MUA/MUP statutes require inclusion of factors that are indicative of health status, ability to pay, access and availability of health professionals as well as need. So what should be included? How should it be defined? To what extent should national data sources be used versus state and local resources? What data sources are accurate and reliable enough to use? So what is the provider availability resource? What economic factors influence access? How do we measure that? What health status indicators should be included? What demographic indicators should be included if there should be any?

Then the next question is what methodologies should we use to incorporate the impact of underservice indicators? Should they be combined in the same way for MUA, MUP and HPSA or should it be different?

How about provider availability? Who should we count? Do we include nurse practitioners, physician assistants and certified nurse midwives? They haven't been included before. If we do include them how do we define FTE? Is everybody the same? Are doctors different from other providers? How does that work? Should providers in a federal program be counted in the process or should they be excluded?

How do we define rational service areas, what we call RSAs? What population groups should we be considering? What's the role of the facility designations? Right now there are facility designations that different FQHCs, Rural Health Clinics, correctional facilities have a special facility designation.

Perhaps their area isn't considered underserved but the facility itself is. And how are we going to figure all that out? How should the threshold levels of various indicators be identified to separate those areas such as population groups and facilities that are found to qualify?

So, you know, right now we have the threshold I think for the population to provider is one to 3500. And for underserved populations it's one to 3000. But if we're going to include other providers then the thresholds will change. And, you know, where do we put those? And what's the right place for all of that?

How can the process be designed to reduce the burden of the application and the update process for the states and local entities? Right now everybody has to go through a process of reestablishing the HPSAs anyway, on a four year basis. And there's a lot of work that's involved with that. How can we make that as simple as possible? How can the committee assess the impact of the revised methodologies?

How are we going to tell okay, if we change it this way how is that going to affect the people that I'm working with or my area or my state or, you know, the people that I'm working for? How do we best summarize and display the impact of these methodologies?

They're starting to show us maps of - that kind of compare the different thresholds and measures. And how can this new methodology be implemented in a manner that would minimize disruption and access?

We don't want to suddenly just disqualify a whole bunch of services because then probably we'll have underservice again. And so those are those 12 questions. The four factors that are being considered obviously provider supply is the health professions, the population to provider ratio (P2P).

And then there's also health status, outcome and need. The health status is kind of social determinants. The direct measures of health like low birth weight, chronic disease like who has diabetes or COPD and also the barriers, just general access, distance to service.

Ability to pay is important as clearly a barrier even if there are services but you don't - you can't access them because you can't pay. And social barriers that, you know, could include racial and ethnic and LGBT and other groups that find it difficult to access service because of certain barriers.

So that's pretty much where we are at this point. We are hoping to see the testing come back to show us. Right now they are using counties as the rational service areas because that's where most of the dependable data is available. That's a little problematic for those that are west of the Mississippi because counties start to get very large as we go west. And they include, you know, cities and frontier areas all in the same county.

So it's going to be a little hard to take a look at that and we're all wondering how it's all going to play out, whether we're going to be able to put our thumbs up or not. But hopefully by October we will have information and we can come up with a consensus.

I think that's pretty much my report Bill. If you want to take...

Bill Finerfrock: I have a couple of questions for you Gail before we open it up to the listeners. Well can you give us any kind of more insight into some of the thinking with regard to the professionals being counted?

Does there seem to be an emerging consensus with respect to including providers other than physicians in the ratios?

Gail Nickerson: I would say yes. I think that there is some agreement. Exactly at what FTE level is still under question. Obviously a person who is a nurse practitioner and works hard all day says, you know, I'm working full time here.

But that may not exactly pan out in terms of what can be expected in terms of the services that they can provide.

I'm not sure, you know, and we're not wanting to insult anybody and wanting to respect everybody's hard work but still wanting to make sure that we're not going to punish areas that have a lot of nurse practitioners and physician assistants.

Now I think that there is a basic agreement that when these redesignations or designations happen that Rural Health Clinic and FQHC providers will not be included in the calculation.

Bill Finerfrock: And that - that was the other thing I wanted to ask you to elaborate on. Because I know when we've talked with some groups about this and we mentioned that there's a strong likelihood that PAs and NPs in particular would be included in the count.

Immediately people started doing the calculations and say well gee, you know, we'll no longer be a shortage area and we'll lose our Rural Health Clinic designation. Can you

elaborate a little bit more on this notion that certain providers would not be counted as part of this new formula?

Gail Nickerson: Well, yes. Because we're trying to affect what you've called the yo-yo effect for years we don't want to set up a situation where a place loses its designation because it's managed to bring in, you know, a Rural Health Clinic or an FQHC and is actually serving the needs of the population.

But if they went away the needs wouldn't be met anymore. So we're - it sounds like, you know, from what I hear, that the conversation is that when we do these calculations we're going to remove these people from the formula so that we're not including the services that could go away if suddenly the area lost its designation.

Bill Finerfrock: Okay.

Gail Nickerson: So that - so far I understand that to be basically RHCs, FQHCs, J-1 visa doctors...

Bill Finerfrock: National Health Service Corps?

Gail Nickerson: Yes. National Health Service Corps.

Bill Finerfrock: Okay. You - in talking about the process and the mechanism for achieving consensus, one of the things - how does that affect the National Association of Rural Health Clinics in the event that you do achieve consensus? As I understand it - let me back up a second.

As I understand it you will make recommendations to the administrator, you mentioned Mary Wakefield. Mary in turn will then make recommendations to the Secretary based on the conclusions of the negotiated rule making committee.

And then the Secretary will publish in the Federal Register a notice of proposed rule making that we assume will largely reflect the recommendations of the committee.

Gail Nickerson: Right. They actually call it an interim final rule. I'm not sure whether that's a little bit different or not.

Bill Finerfrock: It is. It gives it a little bit greater weight in the process as opposed to a negotiated...

Gail Nickerson: A proposal.

Bill Finerfrock: ...a notice of proposed rule making. A notice of proposed rule making for the audience, is really the government is putting it out there and saying, you know, here are our ideas. We want your ideas or we want your reaction.

When they do an interim final rule they are indicating that they've really got a lot more invested and this is really pretty close to what they want to adopt. But they do want to give the public an opportunity to comment on it. But the likelihood of the outside world making changes may be limited.

And part of that - one of the requirements when any RHC agreed to participate as did all of the negotiations under the negotiated rule making when this comes out as a proposed rule what is our ability or can we comment on that? Or what do we - are our hands tied?

Gail Nickerson: I think that our - part of the deal is that if we come to consensus then we don't get to argue about it afterward.

Bill Finerfrock: Okay. So we don't get the apple?

Gail Nickerson: I also want to say that each person at the table does have the right to veto consensus if they truly don't support it, can't support it, can't live with it they can say that. That's also a...

Bill Finerfrock: That was the other point I wanted to get at. That because each organization at the table has the ability to veto, the fact that you didn't exercise that veto when you had

the opportunity kind of precludes you from commenting on it when it comes out as that interim final rule.

Gail Nickerson: Correct.

Bill Finerfrock: Okay. That's been extremely helpful. Did you have anything - before we open up the lines for questions did you have anything else you wanted to add Gail?

Gail Nickerson: I think that's, you know, it's been quite an uphill kind of learning curve for me and I'm still working on it. But I certainly welcome any questions and if I don't know the answer I can try to find out.

Bill Finerfrock: Well on behalf of the association and the Rural Health Clinics community I want to thank you for stepping up and taking on a much more active role than we had anticipated when this process began. Obviously Ron's passing has created a void as you noted.

But I want to thank Gail for really having to go the extra mile literally last week. She was - had previously organized a meeting for the California Association of Rural Health Clinics that overlapped with the meeting of the Negotiated Rule Making Committee.

And got on a Red Eye flight from California to travel to Washington, DC to be able to participate in person. I'd also like to thank John Gill who has now stepped into the role of alternate.

Because Gail could not make the first day Ron - John traveled from Florida to be able to make sure that our seat was occupied on the first day of the committee meetings. This represents a significant investment of time and effort on the part of the individuals who have been involved in this.

And I just want to thank you on behalf of the association and the Rural Health Clinics community for giving up so much of your free time and your work time to be at the table and representing the interest of the Rural Health Clinics community.

Operator at this point we'd be - we'd like to open it up to questions. And if you would give the instructions and we'll take whatever questions folks may have.

Operator: Very good. If you would like to ask a question at this time, please press star followed by the number 1 on your telephone keypad. Please make sure that your mute function is turned off to allow your signal to reach our equipment. A voice prompt on your phone line will request that you record your name for the Q&A session. We ask that you please record your name and location clearly so we may identify your line so you may pose your question. Once again, that is star followed by the number 1 to ask a question. And we will pause for one moment to assemble the queue.

Bill Finerfrock: And if there's a regulation that I didn't touch on or a policy issue that we didn't touch on that you'd like to raise, certainly feel free. And if we can, we'll try and address questions on something that - a regulatory issue that we didn't cover here.

Operator: You do have one question at this time. That comes from (Ralph West). Sir, if you could please state your location before asking your question.

(Ralph West): Yes. My name's (Ralph West) and I'm calling from Blackfoot, Idaho. Bill, earlier in the presentation today you mentioned that the ePrescribing requirement - well two things, that it won't be an RHC penalty but that's still in force and they're now into the penalty phase.

We just received some information last week from a consultant that stated that the ePrescribing rule had been moved back to 2014. So I'm - where am I up in the night on this?

Bill Finerfrock: No. They recently issued some proposed changes to the ePrescribing program to allow for additional exemptions for various categories of providers or types of services. But it is still going into effect on January.



The penalties will be applied to services provided after January 1 and it will be based on your reporting of ePrescribing that has occurred between January 1, 2011 through today.

(Ralph West): Right.

Bill Finerfrock: If you - you have to report your data that six months. And then the findings of that data will determine whether or not you will be subject to a penalty on your fee schedule payments beginning next January.

(Ralph West): Okay. Where can I get maybe something in writing on that, that I can get to some people here at my work? What's a good source?

Bill Finerfrock: The proposed rule and the changes and the additional exemptions that would apply or...

(Ralph West): Yes. Well and something that states that it still is enforced. Because like I said, this - our consultant told us last week you don't need to worry about it. It's been moved back to 2014. And so everybody was breathing a sigh of a relief and so...

Bill Finerfrock: I'd go back to your consultant and ask you for documentation to that effect. I mean because...

(Ralph West): Perfect.

Bill Finerfrock: ...what you're asking me to do is prove a negative.

(Ralph West): Okay.

Bill Finerfrock: I can't send you something that doesn't exist because the date hasn't been changed.

(Ralph West): Got you. Got you. Thank you so much.

Bill Finerfrock: Okay.

Operator: Our next question comes from (Michael Bevins). Sir, once again if you could please state your location before asking your question.

(Michael Bevins): South Bend, Washington. I have a question. We live in a rural area as do most Rural Health Clinics. And we're finding it more and more difficult to recruit midlevels to complete the necessity of the rule that you have a midlevel half time.

Are there any regulatory changes coming down the road to help our clinics that are finding it almost impossible to recruit midlevels when midlevels leave?

Bill Finerfrock: Well there's already a mechanism in place that any RHC supported and has been in place for several years. If you are a clinic that loses your PA or your nurse practitioner or your nurse midwife you have an initial 90 day period to replace that individual.

If at the end of that 90 day period you are unsuccessful what the regulations and the statute allow is for a waiver of that staffing requirement. And you can obtain a waiver for up to one year in time.

So you get to - as you're approaching your 90 day period and you're not successful you contact your state survey and certification agency and let them know that you would like to get a waiver of the PA, NP nurse midwifery staffing requirement.

Those are generally approved as a routine matter. During the course of the year or whatever timeframe that you use of that year you have to be able to demonstrate that you have been seeking to actively recruit to fill that position.

If at the end of the one year waiver period you still have not been able to find a PA or NP or nurse midwife. There is no opportunity to extend the waiver and you may be asked to show and document what steps you took during the 12 month waiver period to actively recruit.

So you do have a fair amount - you can get a fairly lengthy waiver because of the difficulty recruiting. This is something that NARHC actively sought and got approved several years ago. So you really have 15 months to be able to fill that position.

And I think the expectation is that, you know, within 15 months you should be able to fill a position presuming that you're offering a competitive salary and that you have actively recruited in places where it's likely to be able to find a PA, a nurse practitioner or a nurse midwife.

(Michael Bevins): Thank you so much.

Bill Finerfrock: Okay.

Operator: And at this time, there are no questions remaining in the queue. Once again, that is star followed by the number 1 if anyone else would like to ask a question.

Bill Finerfrock: We did such a good job and people are in such shock over the fact that the Rural Health Clinic rule has died that they were popping champagne corks all over the place. Well if - if we're not getting anymore questions we don't need to...

Operator: Well we - I'm sorry; we have had a few more questions...

Bill Finerfrock: Okay.

Operator: ...come in.

Bill Finerfrock: Okay.

Operator: Our next question comes from (Joel Vicewiner).

Bill Finerfrock: Go ahead (Joel).

(Joel Vicewiner): Hi. This is (Joel)...

Bill Finerfrock: Oh, (Joel). I'm sorry.

(Joel Vicewiner): ...from Wadena, Minnesota. Gail, your comment that in looking at future HPSA and MUA/MUP evaluations there won't be utilizing the position or provider count in existing Rural Health Clinics and FUHCs seems to almost ensure the - that in our most frontier and rural areas that they will be perpetual HPSAs.

Because I look at our area - the - our rational service area we are essentially a sole source clinic. We are a Rural Health Clinic. There are no non Rural Health Clinic providers in the whole county. So the process seems to then guarantee perpetuity. Am I missing something?

Gail Nickerson: Well it sounds like it. I'm kind of waiting to see the testing to see what that shows. The other issue is that it may not be strictly provider to population ratio anymore. Right now HPSAs are strictly the provider to population ratio. They're talking about factoring in health status indicators of other types.

We've had a lot of discussion about how much weight that should have. That's one of the things that we're getting ready to look at. I don't totally know the answer. I don't think we have a guarantee.

But I would agree with you that if you truly have an area that doesn't have a lot of providers, you know, unless everybody's in stellar health, the chances are that you would still maintain your certification.

Bill Finerfrock: And (Joel), one of the things...

Gail Nickerson: As well as your shortage area designation.

Bill Finerfrock: (Joel), one of the things - well first of all, do you think that that would be a bad thing that you would never lose your shortage area designation?

(Joel Vicewiner): No. That's a good thing. But I - it feels...

Gail Nickerson: Another champagne cork to pop.

(Joel Vicewiner): It feels too good to be true. That's why I'm wondering if we're missing something.

Bill Finerfrock: Yes. One of the things that we've also talked about in the context of that because it would create that possibility is, you know, what would preclude then - let's say you have two Rural Health Clinics in the county and they're the only providers.

And then suddenly a third and a fourth and a fifth and a sixth Rural Health Clinic in theory could come in there and suddenly you have a proliferation of providers all of whom are in Rural Health Clinics.

But because of the way the formula is established the area would still be designated and could have an eighth, a ninth, a tenth. And what we've said is that to give consideration to creating what we would call a level five HPSA.

It's an area that is a shortage area but for the existence of those Rural Health Clinics or FQHCs. And if they were to lose any of those they would, you know, fall back into a true HPSA if you will that in those instances the government would not look to put additional resources into that area.

So, you know, there were two Rural Health Clinics there and that was - you did your account and you found that the area was no longer qualified.

But because they are Rural Health Clinics we take them out of the account. Well we wouldn't look to put a third Rural Health Clinic. We wouldn't look to put an FQHC in there.

We wouldn't look to recruit additional National Health Service Corps but instead turn and try to direct those resources to areas that don't have providers and so you'd create - you don't create another type of problem in order to prevent what Gail described as the yo-yo effect.

(Joel Vicewiner): Okay. That makes sense. Thank you.

Bill Finerfrock: Yes. Next question Operator?

Operator: Yes. Our next question comes from (Libby Hoyt). And once again, if you could please state your location.

(Libby Hoyt): Redfield, Iowa.

Bill Finerfrock: I could have told you that.

(Libby Hoyt): Hi Bill. I just wondered - I am drinking - I don't have champagne, I have beer, but that's okay, to the expiration of the rules on Monday. But my concern is do you have any idea does CMS see that after the negotiated rule making for HPSAs and MUAs and MUPs is completed that they will move on towards more rules that would lead to some decertifications into the future or not?

Bill Finerfrock: Well I think that there's a certain level of frustration and fatigue on the part of certain folks at the federal level who have been working on these issues for a long time.

(Libby Hoyt): Right.

Bill Finerfrock: Gail alluded to the fact that the shortage area designation review process has been going on for over ten years. The Rural Health Clinic rule for those who have been around long enough, all of this emanates from a statutory change that was done in 1997 so it really goes back 14 years.

(Libby Hoyt): Right.

Bill Finerfrock: And there are federal employees who have literally been working on some of these things for that long. And they are very frustrated. They're - and they're kind of, you know, almost throw their hand up to say I don't know what to do, I don't know where to go.

I don't want to spend, you know, hours and hours and a lot of my work to see it all just, you know, go down the drain. So I think there's going to be a period of time for decompression and reflection to figure out where do we go from here.

NARHC believes that there are areas that are still in need of change in terms of the regulation. We're looking at - we've just started having some discussions about, you know, should we go back and relook at the '97 statutory changes to whether or not they perhaps went too far?

Would there be an opportunity to make some modifications to those so that in the event that there was still a desire to have a mechanism to decertify Rural Health Clinics it might not be as onerous to clinics who have been in the program for a long time.

We're looking at our options. I don't think anybody knows. I do think though that having the Rural Health Clinic process now the rule making kind of set aside and giving us the opportunity to see what the shortage area designation rewrite may show is really a better sequencing of the process.

That once - assuming that the shortage area designation process is able to go to completion we'll then have a better idea of what the implications are of the decertification. How many clinics would lose their shortage area designation area under the process?

And we may find that many clinics that are in jeopardy under the current methodology would be safe under a new methodology.

(Libby Hoyt): Right. I just want to thank the National Association of Rural Health Clinics because I think they have really been a beacon of light in this whole process.

And have been very helpful for all of us who run small, little clinics that we think are essential for our communities and I must say that getting true the rule making process and not having to deal with that issue.

And now we can start looking at EHR and some of the other things that I think will only strengthen the program so thank you very much Bill.

Bill Finerfrock: Well thanks for those kind comments (Libby). The check's in the mail. Tell (Ed) we say hey.

Operator: Our next question comes from (Teresa Ulrich).

Bill Finerfrock: Hey (Teresa).

(Teresa Ulrich): Hi Bill. And you know me, it's (Terry). Anyway, my question relates to the EHR incentive that (Libby) just mentioned the EHRs so I'll follow up with a question.

A recent consultant told me that the EHR incentive for Medicare is totally tied to Part B and therefore RHCs are not eligible and I want clarification on that.

Bill Finerfrock: Your consultant is correct that the Medicare part of the EHR incentive program is linked to claims submitted using the 1500 claim form.

So much as I was saying earlier with some other things with the ePrescribing, if your physician - whatever services he - so in your case, your husband, provides in your Rural Health Clinic, those services that are billed as Rural Health Clinic services even though they are for Medicare patients, are not eligible to be used for an EHR calculation because you bill using UB.

However, to the extent that your husband who is a physician, generates Part B for non RHC services delivered to a Medicare patient - so for example, he goes to see a patient in the hospital or he provides other RHC services - I'm sorry, other Medicare services Part B that are not RHC.

Those claims could be used for generating an EHR incentive payment through the Medicare program.

But we're - our expectation is that the bulk of the Rural Health Clinic providers will qualify for an EHR incentive payment through the Medicaid part of the EHR incentive where there is a specific program geared for providers who work in Rural Health Clinics.



(Teresa Ulrich): Okay. That was my understanding too but I wanted your expertise on it.

Thank you. And I second her in telling everyone what a wonderful organization NARHC is and I'm a strong supporter.

Bill Finerfrock: Well thank you.

(Teresa Ulrich): You're welcome.

Bill Finerfrock: Take care.

Operator: And we have one question remaining in queue at this time and that comes from  
(Ron Rain).

Bill Finerfrock: Hi. Go ahead (Ron).

(Ron Rain): Hi. This is (Ron Rain) in Colville, Washington. Hey. I got on the call a little bit late and I just wanted - I understand about the EHR incentive payments on the Medicare side. On the Medicaid side I'm just making sure that the threshold is still 30% Medicaid patients.

Bill Finerfrock: It's actually 30% needy, not 30% Medicaid for Rural Health Clinic providers...

(Ron Rain): Okay.

Bill Finerfrock: ...which is a combination of your Medicaid, your S chip, your - any patients that you see for whom you provide free care based upon their ability to pay or any patients you provide reduced cost care based on a sliding fee scale that you've established for individuals based on their income.

(Ron Rain): Do you know how many people are going to be - what's your sense on the number of people that are going to be able to qualify for that?

Bill Finerfrock: There's been a sporadic - what we're finding is that it's varying from state to state. Gail for example, is in California. They have - she's with Adventist. They have a large network of I believe in excess of 30 Rural Health Clinics in three different states Gail?

Gail Nickerson: Yes.

Bill Finerfrock: And how many of your clinics - I think you had told me you thought they would all qualify?

Gail Nickerson: We think that...

Bill Finerfrock: All of your providers in your Rural Health Clinics would qualify?

Gail Nickerson: Some of them work in other locations as well, but that...

Bill Finerfrock: Okay.

Gail Nickerson: ...would be our main variant because we see lots of Medicaid patients.

Bill Finerfrock: Okay. Yes, we've heard from providers in other states where either the Medicaid program is not as robust or they don't see large numbers of uninsured or uncompensated care where they may have difficulty meeting the threshold.

The University of Southern Maine is currently doing an analysis to try and come up with better data on how many rural health clinics will be able to qualify on the 30% needy threshold. We at the national level are looking at whether or not there's an opportunity to modify the threshold.

Either to lower the threshold to a different number, something lower than 30% or that the threshold would be raised but allow you to calculate your Medicare populations into a higher threshold. So those are some things that are being looked at.

So one other thing I would say is I would encourage folks to look very closely at the opportunity this presents to establish a sliding fee scale.

The - there are no parameters on the type of sliding fee scale that you establish and there's no limitation on how high of a sliding fee scale that you can establish nor the amount of the discount that you provide particularly to individuals who are on the upper end of the sliding fee scale.

So for example, you could establish a sliding fee scale that made a discount available to individuals in your community who had income up to 400% of poverty which mirrors some of the provisions that are in the affordable care act.

And you can provide them with a relatively small discount, you know, two, three, four, five percent on that upper end of your sliding fee scale. And at 400% of poverty for a family of four you would be allowing individuals to qualify for a small discount who are making close to \$100,000 a year.

So that by providing a very small financial discount those individuals would then all be able to be counted towards meeting your 30% needy threshold and potentially create an opportunity for you to be able to qualify.

So look at - don't just look at your Medicaid and your chip patients but look to see whether or not there's an opportunity to establish a sliding fee scale.

Certainly that would be robust for your low income, those individuals who are below 100% of poverty for whom you may already be providing a discount or not aggressively seeking to obtain payment. But that would also allow individuals on higher levels of the income scale, to qualify.

But for whom the financial hit - the amount of the discount if you will that you would be giving them on your sliding fee scale, would be relatively small such that you would be able to qualify because now more patients could be counted towards that 30% threshold.

(Ron Rain): And that would have to be with - they would need to be uninsured. Correct?

Bill Finerfrock: No. They don't have to be uninsured.

(Ron Rain): Oh okay. So you could do the sliding scale even if they have insurance?

Bill Finerfrock: As long as - yes, whatever you set it up that you would say for example, my charges are \$100 and you have to have consistent charges. But if you're at 400% of poverty we will accept 98% of charges, so...

(Ron Rain): Okay.

Bill Finerfrock: ...your insurance company - their insurance company pays whatever it pays - the copay instead of it being \$20 you'd collect \$18 in a copay. So they'd qualify for your sliding fee scale. You lost \$22 - I'm sorry, you lost \$2.00 but you may have enough patients now suddenly you reach your 30% threshold.

And now you're going to qualify for \$64,000 per provider for an EHR incentive.

(Ron Rain): Now you're talking. Okay. Good idea. Now the next thing is on the ePrescribing payments, the - basically the penalty. I was just kind of following up on a previous question. Now that was really for non Rural Health Clinic visits as well, right?

Bill Finerfrock: I'm sorry? Say your question again. The ePrescribing...

(Ron Rain): On the ePrescribing basically this penalty that's coming about, you know, we have to do a lot of...

Bill Finerfrock: That is all tied to claims that are submitted using a 1500 claim form.

(Ron Rain): Perfect. The last thing is 340B pricing programs. Is there any opportunity for us to get RHCs on the 340B pricing?

Bill Finerfrock: Well that would require - that requires a legislative change. We have had those conversations with several members of Congress. I think there is some sympathy within

the Congress. I will tell you that the pharmaceutical industry is very much opposed to further expansion of the 340B program.

So we will continue to have it as a, you know, something on our wish list but I would say that the likelihood of it happening is not very high.

(Ron Rain): Okay. Thank you very much. You're doing fine work out there.

Bill Finerfrock: Well thank you. I appreciate the kind comments.

(Ron Rain): Bye-bye.

Bill Finerfrock: Any other questions Operator?

Operator: There are no further questions at this time.

Bill Finerfrock: Okay. Well I think we're right up on our hour so we did a good job of stretching this out. So I want to thank everybody for taking the time to participate.

If there was a topic, as I said, that we didn't cover here in terms of the regulatory send me a question to Info, I-N-F-O at N-A-H-R-C dot org with your questions or if you have a suggestion for a topic for the future.

We want to thank everyone for your participation and wish you a wonderful day and keep providing great quality care to your communities and doing the wonderful job you're doing. Thank you all.

Gail Nickerson: Happy holiday.

Operator: And this does conclude today's conference call. We thank you for your participation and have a wonderful day.

END