NATIONAL ASSOCIATION OF
RURAL HEALTH CLINICS

Washington Update
Oregon Office of Rural Health

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Overview

- Regulatory Update
  - 2019 PFS Proposed Rule
- Legislative Update
  - Modernizing RHC Program
  - Raising the RHC Cap

New State Operations Manual-Appendix G

CMS released a long update to SOM Appendix G

- Worth a read if you feel like you will be surveyed soon
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-18-09.pdf

While not legally binding, it can be used by surveyors to justify non-compliance

2019 PFS Proposed Rule – CCM Provisions

- Proposed payment methodology for HCPCS code G0511 would be the average of the 4 national non-facility PFS payment rates for
  - -CPT 99490 (20 minutes or more of CCM services)
  - -CPT 99487 (60 minutes or more of complex CCM services)
  - -CPT 99484 (20 minutes or more of BHI services)
  - -CPT 994X7 (30 minutes or more of CCM furnished by a physician or other qualified health care professional)
- Proposed payment rate for 994X7 is $74.26
- Average of the four is around $65

2019 Physician Fee Schedule – Communication Technology-Based Services

- At least 5 minutes of communications-based technology or remote evaluation services
- Furnished by an RHC practitioner
- To a patient that has been seen in the RHC within the previous year
- May be billed when the medical discussion or remote evaluation is for a condition not related to an RHC service provided within the previous 7 days, and
- Does not lead to an RHC service within the next 24 hours or at the soonest available appointment (since in those situations the services are already paid as part of the RHC AIR)

Proposed Billing and Payment for Communication Technology-Based Services

- New Virtual Communications G code for use by RHCs (and FQHCs) only
- Payment rate set at the average of the PFS national non-facility payment rates for HCPCS code GVCI1(communication technology-based services) and HCPCS code GRAS1 (remote evaluation services)
- Payment around $14

- Many of the details will need to be worked out in final rule and accompanying guidance from CMS

Legislative Update ~ Senate Finance Hearing

https://www.finance.senate.gov/hearings/rural-health-care-in-america-challenges-and-opportunities

2 hour 28 min mark

Senator Wyden

"We have been at it for almost two and a half hours. You all have been terrific, but what I am struck by is I don't think we have mentioned, over the course of two and a half hours, what is really the backbone of rural health care. Literally, from sea-to-shining-sea, and that is **RURAL HEALTH CLINICS…**"

115TH CONGRESS
2D SESSION

S. ______

To amend title XVIII of the Social Security Act to modernize provisions relating to rural health clinics under Medicare.

IN THE SENATE OF THE UNITED STATES

______________ introduced the following bill; which was read twice and referred to the Committee on ______________

A BILL

To amend title XVIII of the Social Security Act to modernize provisions relating to rural health clinics under Medicare.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 **SECTION 1. SHORT TITLE.**
4 This Act may be cited as the "Rural Health Clinic
5 Modernization Act of 2018".
6 **SEC. 2. MODERNIZING PHYSICIAN, PHYSICIAN ASSISTANT,**
7 **AND NURSE PRACTITIONER UTILIZATION RE-**
8 **QUIREMENTS.**
9 (a) IN GENERAL.—Section 1861(aa) of the Social Se-
10 curity Act (42 U.S.C. 1395x(aa)) is amended—

RHC Modernization Act of 2018 – What does it do?

Designed to pass, not to make a statement

Uncontroversial and cost free provisions

Sec. 2 ~ Modernizing Physician, Physician Assistant, and Nurse Practitioner Utilization Requirements.

Modernizes physician supervision requirements in RHCs by aligning scope of practice laws with state law. Allows PAs and NPs to practice up to the top of their license without unnecessary federal supervision requirements that apply only because the PA or NP is practicing in a RHC.

Sec. 3 ~ Removing Outdated Laboratory Requirements

Removes a requirement that RHCs maintain certain lab equipment on site, and allows RHCs to satisfy this certification requirement if they have *prompt access* to lab services.

Sec. 4 ~ Allowing Rural Health Clinics to Determine the Drugs and Biologicals Necessary for Emergency Cases.

Allows the professional personnel responsible for the RHCs policies and procedures, instead of the Secretary of Health and Humans Services, to determine the drugs and biologicals necessary for emergency cases in each specific RHC.

Sec. 5 ~ Allowing Rural Health Clinics the Flexibility to Contract with Physician Assistants and Nurse Practitioners.

Removes a redundant requirement that RHCs employ a PA or NP (as evidenced by a W2) and allows RHCs to satisfy the PA, NP, or CNM utilization requirements through a contractual agreement if they chose to do so.

RHC Modernization Act of 2018 – What does it do?

Cost Provisions

Sec. 6 ~ Raising the Cap on Rural Health Clinic Payments.

Increases the upper limit (or cap) on RHC reimbursement to:

-$100 in 2019

-$105 in 2020

-$110 in 2021

-$115 in 2022

-And by MEI each year thereafter.

Sec. 7 ~ Allowing Rural Health Clinics to be the Distant Site for a Telehealth Visit.

Allows RHCs to offer telehealth services as the distant site (where the provider is located) and bill for such telehealth services as RHC visits.

Site Neutral Payment Policies

Section 603 of the Bipartisan Budget Act of 2015

Site Neutral Payment Policies

All newly-established (November 2, 2015) off-campus hospital outpatient departments (HOPDs) must receive the PFS rate

Because HOPDs cannot bill the PFS, CMS had to create a workaround:

-Can still bill HOPPS but CMS only pays 40%

2019 HOPPS Proposed Rule Looks at ways of expanding this policy even to those that are grandfathered-in

-Clinical Families

Site Neutral Payment Policies

CMS Administrator Seema Verma:

> "Medicare pays for things differently based on the site of care, paying more or less for the same service, but different locations. Now sometimes it makes sense, as some facilities provide a higher level of service. But other times, it creates misaligned incentives – decisions about whether a patient receives a service in a hospital or in a doctor's office is influenced by how Medicare pays.
>
> Because when we pay more for services provided in a hospital setting than in an office setting, we are encouraging the consolidation of providers around hospital systems. When consolidation gets to the point where there is only one large competitor in a market, prices will go up and the competitive forces that encourage higher quality and lower costs will disappear."

https://www.cms.gov/newsroom/press-releases/speech-medicare-remarks-cms-administrator-seema-verma-commonwealth-club-california

President Trump's FY 2019 Budget Proposal

Pay All Hospital-Owned Physician Offices Located OffCampus at the Physician Office Rate Medicare pays for services at certain off-campus hospital outpatient departments under the Physician Fee Schedule. Most off-campus facilities are exempt from this site neutral payment policy, including grandfathered off-campus hospital outpatient departments that were billing or under construction as of November 2, 2015, emergency departments, and cancer hospitals. This proposal eliminates all exemptions effective CY 2019. [$34.0 billion in savings over 10 years]

https://www.hhs.gov/sites/default/files/fy-2019-budget-in-brief.pdf

RHC Cap Model Unviable

The 2019 PFS also contains a proposal to collapse the E/M codes to one payment of approximately $93

The RHC limit on reimbursement is currently $83.45

Why would you retain RHC status if you are capped?

RHC Spending and Encounters by Provider Type

Medicare RHC Encounters	2012		2013		2014		2015		2016		CAGR
Provider Based RHCs	4,448,853	51%	4,908,748	55%	4,869,526	56%	5,193,722	59%	5,521,981	63%	5.6%
Independent RHCs	4,358,543	49%	4,086,160	45%	3,818,340	44%	3,630,444	41%	3,183,334	37%	-7.6%
Total	8,807,396	100%	8,994,908	100%	8,687,866	100%	8,824,166	100%	8,705,315	100%	-0.3%

Medicare RHC Program Spending	2012		2013		2014		2015		2016		CAGR
Provider Based RHCs	564,328,105	67%	677,957,004	72%	670,397,383	73%	735,140,187	76%	833,377,373	80%	10.2%
Independent RHCs	273,855,974	33%	258,801,030	28%	243,762,826	27%	233,626,332	24%	207,094,977	20%	-6.7%
Total	838,184,079	100%	936,758,034	100%	914,160,209	100%	968,766,519	100%	1,040,472,349	100%	**5.6%**

We saw 5.6% annual growth in Medicare spending from the 2012 to 2016 period. This was largely due to a shift from independent RHC encounters to provider-based RHC encounters. If the law is not changed, we expect this trend to continue.

- We have a “site neutral” problem. The same market shifts that caused Congress to begin this move to site neutral payment policy is occurring in the RHC space.

- To date, RHCs have been exempt from this policy; however we believe it is inevitable that Congress will seek to apply the site-neutral policy to ALL hospital-based providers, including RHCs.

Raising the RHC Cap

- Raising the RHC cap is imperative if the RHC program and access to care in underserved rural communities is going to be preserved.
- Raising the RHC Cap for those RHC subject to the cap is not only important for these clinics, but it is also critical for the survival of uncapped RHCs who, we believe, will be subject to the cap in the next few years.
- If NARHC and the RHC Community do not take a proactive approach to addressing the site neutral “problem” then others will make policy decisions for us.
- And we can almost guarantee that if those decisions are made by others, it will not be good for rural underserved communities.

What is NARHC doing?

- We have endorsed a policy whereby a new RHC CAP that would be applicable to ALL RHCs. This new cap MUST be significantly higher than the current cap ($83.45) and must result in a payment level that is sufficient to cover the cost of delivering care for MOST uncapped RHCs allowing them to remain economically viable.

- But there is no way that the new cap could be set at a level high enough to cover the current per-visit payment level for some uncapped RHCs.

2016 AIR Data

*Highest RHC AIR: $354.00 per visit

Average AIR for uncapped RHCs (adjusted for volume): $152.00

Average cost per visit (adjusted for volume) for Independent RHCs: $90.00

* With significant volume

What is NARHC doing?

- The new cap would have to be “cost neutral” to stand a realistic chance of passing.
- This means that adjusting the RHC cap must be done in a way that does not result in a net increase in Medicare spending for services provided in federally certified Rural Health Clinics.
- We believe this money should be put back into the RHC program to raise the cap for the for those RHCs that are currently capped.
- Based upon the preliminary analysis, a new, single RHC cap would be dramatically higher than the current cap (more than double).
- Most RHCs – including many uncapped RHCs – would either see a higher AIR and thus higher Medicare payments or see no change at all.
- But some RHCs will likely see a cap below their current AIR.

Mitigation strategies

Concurrent with looking at the impact of a single cap for all Rural Health Clinics, NARHC is exploring with our partners additional policy changes that could mitigate some of the negative impact of an RHC site-neutral payment policy on hospital-based RHCs.

Examples include modifications to classification and allocation of allowable costs or what constitutes an RHC visit.

Questions?

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