DC Update Oregon Office of Rural Health

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DARYL CAGLE
MSNBC.COM

Overview

- New Services RHCs can provide
  - Virtual Care Communication
- Latest regulatory documents
  - SOM Appendix G
  - Medicare Benefit Manual Chapter 13
- Regulatory Relief Proposed Rules
- NARHC Legislative Efforts
  - RHC Modernization Act of 2019

Rural Health Clinic Services Act ~ 1977

PUBLIC LAW 95-210—DEC. 13, 1977 91 STAT. 1485

Public Law 95-210
95th Congress

An Act

To amend titles XVIII and XIX of the Social Security Act to provide payment for rural health clinic services, and for other purposes.

Dec. 13, 1977
[H.R. 8422]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Social Security Act, amendment.

MEDICARE AMENDMENTS

SECTION 1. (a) Section 1832(a) of the Social Security Act is amended— 42 USC 1395k.

(1) by striking out "paragraph (2)(B)" in paragraph (1) and

Rural Health Clinic ~ Purpose?

- President Carter's Statement on December 13, 1977 signing the Rural Health Clinics Services Act into law:
- "At its best the American health care system is unsurpassed. But its uneven distribution leaves millions of our people without access to adequate care. This problem effects both urban and rural areas but is more wide-spread in the latter. Two thirds of the people in areas without adequate health care live in rural America. One of the most sensible and efficient ways to cope with this problem is to enable Physician Assistants and Nurse Practitioners to provide regular and high quality care in small convenient outpatient clinics. Through such programs as the National Health Service Corps and the Appalachian Regional Commission, the federal government has helped to start and support these clinics and train the highly skilled professions who operate them. But there has been a major obstacle to the healthy growth of these clinics in the areas that need them. That is the failure of public and private health insurance programs to support them. The legislation that I am signing today will correct this defect in our public health insurance programs by requiring that the Medicare and Medicaid programs pay for the services of Physician Assistants and Nurse Practitioners in clinics and rural areas without adequate care. This reform will guarantee greater financial stability for clinics already in existence and help establish new clinics were they are needed most."

Examples of new services Medicare will pay for

- Diabetes Prevention Program
- Chronic Care Management
- Remote Patient Monitoring
- Virtual Communications Services

Where are these new codes coming from?

‘(4) EVALUATION-

‘(A) IN GENERAL- The Secretary shall conduct an evaluation of each model tested under this subsection. Such evaluation shall include an analysis of--

‘(i) the quality of care furnished under the model, including the measurement of patient-level outcomes and patient-centeredness criteria determined appropriate by the Secretary; and

‘(ii) the changes in spending under the applicable titles by reason of the model.

‘(B) INFORMATION- The Secretary shall make the results of each evaluation under this paragraph available to the public in a timely fashion and may establish requirements for States and other entities participating in the testing of models under this section to collect and report information that the Secretary determines is necessary to monitor and evaluate such models.

‘(c) Expansion of Models (Phase II)- Taking into account the evaluation under subsection (b)(4), the Secretary may, through rulemaking, expand (including implementation on a nationwide basis) the duration and the scope of a model that is being tested under subsection (b) or a demonstration project under section 1866C, to the extent determined appropriate by the Secretary, if--

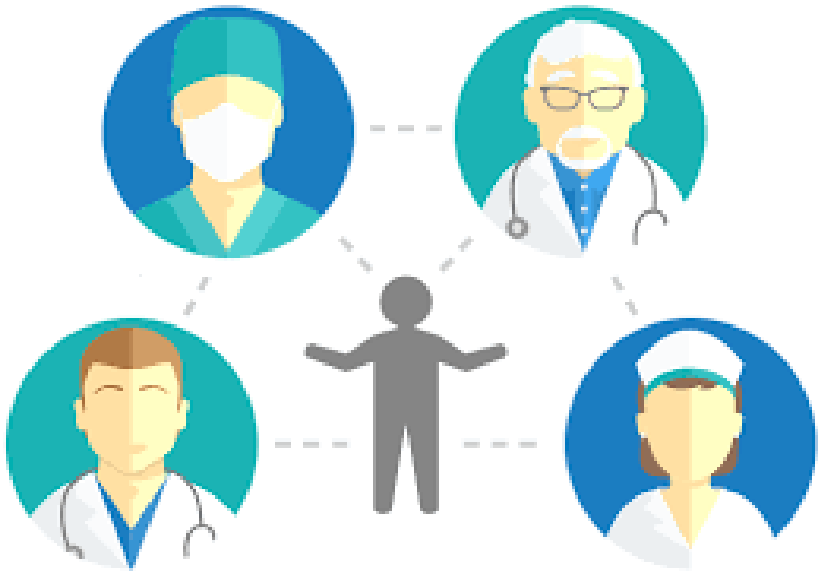
‘(1) the Secretary determines that such expansion is expected to--

‘(A) reduce spending under applicable title without reducing the quality of care; or

‘(B) improve the quality of care and reduce spending; and

‘(2) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under applicable titles.

2019 PFS Final 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 99491 (30 minutes or more of CCM furnished by a physician or other qualified health care professional)
- Proposed payment rate for 99491 is $74.26
- Average of the four is $67.03
- Psychiatric CoCM G0512 pays $145.96
- FAQ: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

2019 Physician Fee Schedule – Communication Technology-Based Services

- At least 5 minutes of communications technology-based 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
- G0071
- Payment rate set at the average of the PFS national non-facility payment rates for HCPCS code G2012 (communication technology-based services) and HCPCS code G2010 (remote evaluation services)
- Payment around $14
- FAQ link: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf

2020 PFS Proposed Rule

- CMS is adding an additional care management services
- RHCs are ineligible because we don't have a billing mechanism
- "Principal Care Management" or PCM
- G0511 billing and G0071 structure will remain the same

- Will we continue to create work-arounds or should we redefine what constitutes a RHC "visit" to allow for the non-face-to-face services of the future?

Regulatory Relief Proposed Rule (Now Finalized)

Released Sep. 20 of 2018

Finalized Sep. 26th (Publication expected Sep. 30) Goes into effect 60 days after publication

- Changing the annual review of patient care policies and program evaluations to an every-other-year requirement.
- Allowing facilities to review their Emergency Preparedness program every other year instead of every year.
- Eliminating the requirement that RHCs must document their communication with emergency preparedness officials.
- Allowing facilities to train their staff on emergency preparedness every other year.
- Reducing the number of emergency preparedness exercises required per year to one.

Burden Reduction Rule Finalized

- https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-20736.pdf
- 491.9 (b)(4) These policies are reviewed at least biennially by the group of professional personnel required under paragraph (b)(2) of this section and reviewed as necessary by the RHC or FQHC.
- 491.11 (a) The clinic or center carries out, or arranges for, a biennial evaluation of its total program.
- 491.12 (a) Emergency plan. The RHC or FQHC must develop and maintain an emergency preparedness plan that must be reviewed and updated at least every 2 years. The plan must do all of the following:

- (2) Testing. The RHC or FQHC must conduct exercises to test the emergency plan at least annually. The RHC or FQHC must do the following:
  - (i) Participate in a full-scale exercise that is community-based every 2 years; or
    - (A) When a community-based exercise is not accessible, an individual, facility-based functional exercise every 2 years; or.
    - (B) If the RHC or FQHC experiences an actual natural or man-made emergency that requires activation of the emergency plan, the RHC or FQHC is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.
  - (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to following:
    - (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or
    - (B) A mock disaster drill; or
    - (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
  - (iii) Analyze the RHC or FQHC's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the RHC or FQHC's emergency plan, as needed.

Appendix G Revision!

- Previously, RHCs were required to stock drugs and biologicals from each of the following categories: 1-Analgesics; 2-Local Anesthetics; 3-Antibiotics; 4-Anticonvulsants; and 5-Antidotes, emetics, serums & toxoids. However, as of September 3rd, 2019, RHCs will only be required to consider each category when they craft their written policies. This means that RHCs will not be required to stock snake antidote, emetics, or anticonvulsants! Here is the key line from the new policy:
- *While each category of drugs and biologicals must be considered, all are not required to be stored…*
- We will still be required to store drugs and biologicals for emergencies, but now, CMS is allowing us to determine which drugs and biologicals are most appropriate for our communities:
- *…when determining which drugs and biologicals it has available for purposes of addressing common life-threatening injuries and acute illnesses, the RHC should consider, among other things, the community history, the medical history of its patients and accepted standards of practice. The clinic should have written policies and procedures for determining what drug/biologicals are stored and that address the process for determining which drugs/biologicals to store, including identifying who is responsible for making this determination.*
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO-19-18-RHC.pdf

Trump Administration Proposal on Non-Discrimination Rules

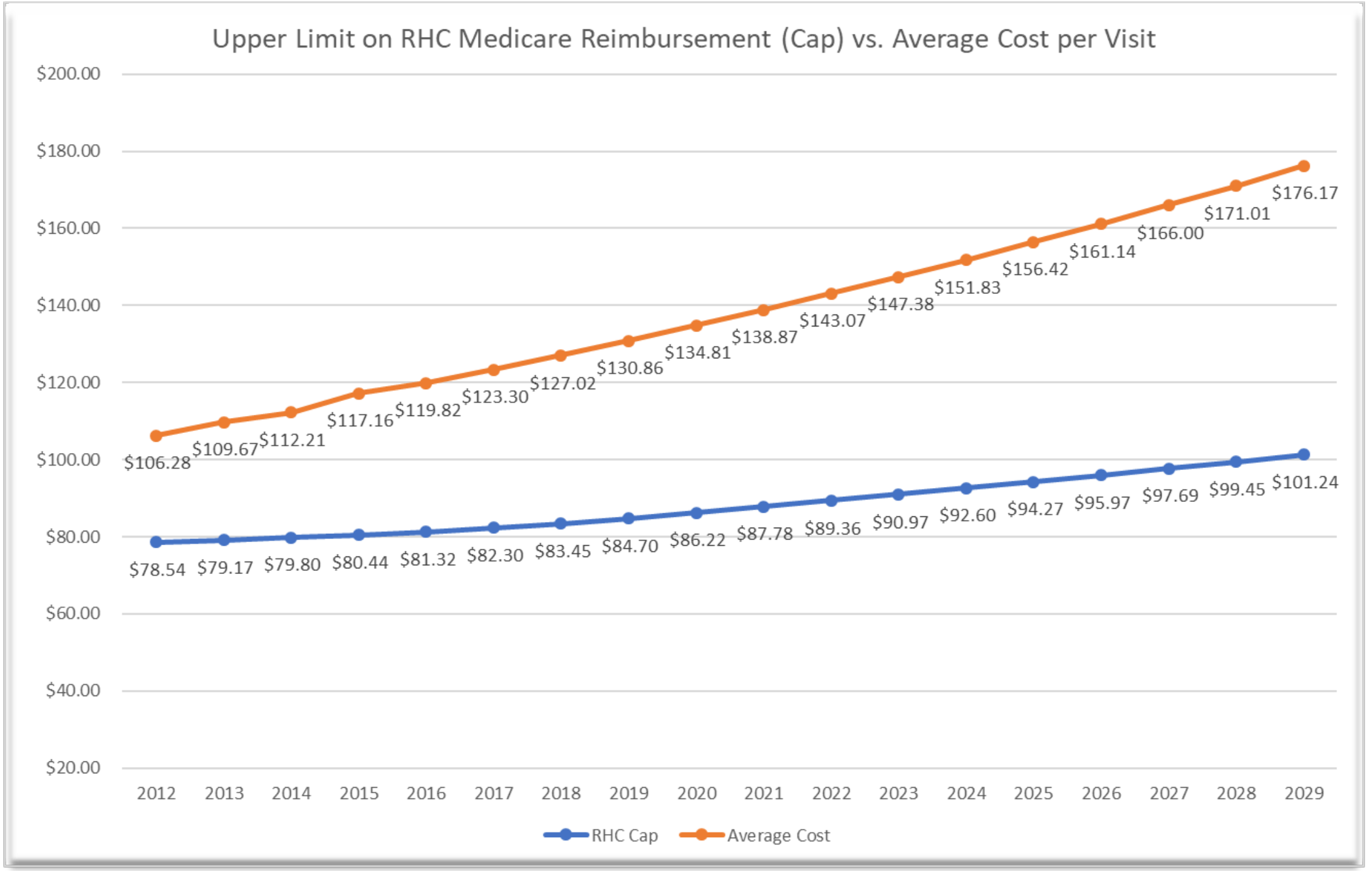
- The Department proposes to repeal *in toto* the Section 1557 provisions on taglines the use of language access plans, and notices of non-discrimination. The Department also proposes to replace the requirements for remote English-language video interpreting services with comparably effective requirements with respect to audio-based services. The current rule's provisions were not justified by need, were overly burdensome compared to the benefit provided, and created inconsistent requirements for HHS funded health programs or activities as compared to HHS funded human services programs or activities. The Department proposes to return to the language access standard previously in place under the existing Title VI regulation as interpreted by the U.S. Supreme Court and HHS and the Department of Justice in their LEP guidance documents.
- For reasons explained more fully below, the 2016 estimate of $7.2 million in onetime costs stemming from the notice and taglines requirement was a gross underestimation, and thus this proposed rule's elimination of those requirements would generate a large economic savings of approximately $3.6 billion over five years based on the proposed repeal of the notice and taglines provision.
- https://www.hhs.gov/sites/default/files/1557-nprm-hhs.pdf

Updates to Important RHC Documents

- State Operations Manual Appendix G ~ Updated 1/26/18
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf
- Update to Medicare Benefit Policy Manual Chapter 13 ~ Updated 12/7/18
- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf

Legislative Efforts

- Rural Health Clinic Modernization Act
- https://www.web.narhc.org/narhc/RHC_Modernization_Act_Advocacy.asp
- House – H.R. 2788
- Senate – S. 1037
- What are we trying to fix?


Upper Limit on RHC Medicare Reimbursement (Cap) vs. Average Cost per Visit
$200.00
$180.00
$160.00
$140.00
$120.00
$100.00
$80.00
$60.00
$40.00
$20.00
$106.28
$109.67
$112.21
$117.16
$119.82
$123.30
$127.02
$130.86
$134.81
$138.87
$143.07
$147.38
$151.83
$156.42
$161.14
$166.00
$171.01
$176.17
$78.54
$79.17
$79.80
$80.44
$81.32
$82.30
$83.45
$84.70
$86.22
$87.78
$89.36
$90.97
$92.60
$94.27
$95.97
$97.69
$99.45
$101.24
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025
2026
2027
2028
2029
RHC Cap
Average Cost

John Barrasso
— U.S. SENATOR ★ WYOMING —
Chairman, Senate Republican Conference

FOR IMMEDIATE RELEASE: April 4, 2019
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Molly Morrisey (Smith) – (202) 224-9857

Barrasso, Smith Introduce Bipartisan Rural Health Clinic Modernization Act

Bill provides regulatory relief for rural health clinics and improves reimbursement rates.

WASHINGTON, DC –Today, U.S. Senators John Barrasso (R-WY) and Tina Smith (D-MN) introduced the bipartisan Rural Health Clinic Modernization Act (S. 1037). The bill provides regulatory relief for rural health clinics while also improving reimbursements for these important facilities.

"As a doctor from a rural state, I want all patients to have access to high-quality care wherever they live," **Sen. Barrasso said**. "Rural health clinics have a long record of making sure that folks in rural communities receive primary care close to home. I am proud to help lead this bipartisan effort to strengthen rural health clinics so they will continue to serve patients in Wyoming and across rural America."

"We need to do everything we can to make sure that people in rural areas are able to get healthcare," **Sen. Smith said**. "While there have been significant changes in the health care system, many of the laws focusing on Rural Health Clinics haven't been updated in over 40 years. Our bipartisan bill would fix some of the old rules that are in need of these upgrades. For example, it expands the ability of physician assistants and nurse practitioners to provide care in these clinics. This legislation is really about making sure at the end of the day people are going to be able to get the vital care Rural Health Clinics provide in underserved, rural areas."

Rural Health Clinics (RHCs) were established through the Rural Health Clinic Services Act of 1977. The purpose of RHCs was to address the shortage of health care providers serving i rural communities, including advanced practice clinicians.

There are approximately 4,100 rural health clinics operating in the United States. Rural Health Clinics are an important part of the rural health care safety net, with facilities heavily dependent on Medicare and Medicaid reimbursement.

UNITED STATES CONGRESSMAN
ADRIAN SMITH
Representing the 3rd District of Nebraska

REPS. SMITH, SEWELL, MCMORRIS RODGERS, AND LOEBSACK INTRODUCE BIPARTISAN RURAL HEALTH CLINIC MODERNIZATION ACT

May 16, 2019
Press Release

WASHINGTON, D.C. - Today, U.S. Reps. Adrian Smith (R-NE-3), Terri Sewell (D-AL-07), Cathy McMorris Rodgers (R-WA-05), and Dave Loebsack (D-IA-2) introduced the Rural Health Clinic Modernization Act. This legislation provides regulatory relief for Rural Health Clinics (RHCs) and updates Medicare reimbursements to independent RHCs. The 4,100 RHCs nationwide provide essential primary care and preventative services in rural and underserved areas, either independently or affiliated with a hospital with fewer than 50 beds.

Currently, RHCs are subject to certain regulations, some of which have not been changed since the RHC program started in 1977. This legislation would remove outdated requirements for onsite laboratory equipment which is no longer used, expand the ability of Nurse Practitioners and Physician Assistants to provide care in RHCs, and improve access to telehealth in rural areas by allowing clinics to function as a distant site to provide telehealth services.

"Rural Health Clinics serve as the primary care center to many Americans living in rural areas. In Nebraska's Third District alone, there are 111 Rural Health Clinics. We must stop the trend of clinics shuttering because of outdated regulations," **said Rep. Smith**. "This bipartisan effort would enable Rural Health Clinics able to operate efficiently and safely, while keeping their doors open and ready to help those in need."

"Whether they live in Birmingham or Wilcox County, Alabamians should have access to quality, affordable health care," **Rep. Sewell said**. "Alabama is home to over 100 Rural Health Clinics that provide critical services in their communities. The Rural Health Clinic Modernization Act will strengthen our Rural Health Clinics by expanding the ability of physician assistants and nurse practitioners to provide care in these clinics, increasing access to telehealth services and helping ensure clinics can keep their doors open in our rural communities."

"As co-chair of the Congressional Rural Health Coalition, ensuring access to medical care in rural communities will always be a top priority for me," **said McMorris Rodgers**. "This bipartisan legislation helps meet that goal by providing regulatory relief to Rural Health Clinics and updating Medicare reimbursements so these independent clinics can keep their doors open and serve the Eastern Washington community."

"Rural health clinics are bedrocks of their communities, providing more than just access to high quality, local health care," **Rep. Loebsack said**. "Rural health clinics help stimulate the local economy, creating jobs both in the clinic and community. Without local health care, lives and communities are lost. This bill will help rural Iowans as well as the communities where they have built their lives."

Issues:
Health Care

TINA SMITH
UNITED STATES SENATOR FOR MINNESOTA

U.S. Senator Tina Smith Introduces Bipartisan Bills to Invest in Rural Communities

Senators' Legislation Seeks to Spur Rural Broadband Expansion and Make Sure Rural Health Clinics Continue Serving Minnesotans, Americans Across the Nation

WASHINGTON D.C. [04/04/2019]— This week, U.S. Senator Tina Smith helped introduce a pair of bipartisan bills to expand investments in rural communities: one designed to help improve rural broadband, and one to improve rural health care.

Sen. Smith has been contacted by several Minnesota cooperatives—which are a vital part of the effort to build out rural broadband in the state—that are at risk of losing their tax-exempt status due to a mistake in the 2017 tax law. The mistake in the 2017 law put the tax-exempt status of co-ops at risk if they receive government grants to expand broadband or to recover from a natural disaster. The Revitalizing Underdeveloped Rural Areas and Lands (RURAL) Act, that she introduced with Sen. Rob Portman (R-Ohio) would fix that error that hinders rural broadband expansion. Their bill would ensure that co-ops can retain their tax exemptions in efforts to expand rural broadband or in providing relief from, or preparation for, a disaster or emergency.

RHC Modernization Act– 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 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.

Sec. 6 ~ Including Facilities Located in Certain Areas

Gives states authority to designate areas as rural for purposes of the RHC program.

RHC Modernization Act of 2019 – What does it do?

Cost Provisions

Sec. 5 ~ 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.

Sec. 7 ~ Raising the Cap on Rural Health Clinic Payments.

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

-$105 in 2020

-$110 in 2021

-$115 in 2022

-And by MEI each year thereafter.

What is the ask?

- Please cosponsor the RHC Modernization Act of 2019

First signed into law by President Jimmy Carter in 1977, the RHC program was designed to improve access to health care in rural, underserved areas. Over forty years later, we are happy to report that there are approximately 4,500 RHCs, providing quality care to rural and underserved patients. However, the program is in desperate need of modernization if we are to succeed for another forty years.

The rural health clinic reimbursement model is supposed to be based on costs, but due to the increasingly burdensome and outdated statutory language regarding the upper limit (often referred to as the cap), some rural health clinics are reimbursed far below their actual costs to deliver care. Since 2012, 388 rural health clinics have closed impacting around 3.87 million residents' access to care. These closures are primarily driven by this inadequate and arbitrarily low cap on reimbursement.

The Rural Health Clinics Modernization Act of 2019 makes vital changes to Medicare reimbursement policy by increasing this upper limit to a level that better reflects the cost of delivering care in rural America. If we cannot fix this policy, we fear that many more RHCs will close and millions more residents will lose access to care.

The Rural Health Clinics Modernization Act of 2019 also addresses certain outdated aspects of the RHC statute and Conditions for Certification (CfC) that are currently written with a 1977 understanding of medicine. These changes include:

- aligning federal scope of practice laws for Physician Assistants and Nurse Practitioners with state scope of practice laws;
- modernizing the currently-outdated lab and "emergency kit" requirements; and
- allowing RHCs to be the distant-site in a telehealth visit.

Together, these provisions will strengthen the RHC program and better enable RHCs to continue their mission of providing health care in the rural and underserved regions of our country.

Finance Committee

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