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The Rural Health Clinic Workshop Presents
Washington Update

Speaker:

Nathan Baugh, Executive Director, National Association of Rural Health Clinics

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Washington Update

Nathan Baugh
Executive Director
National Association of Rural Health Clinics

Agenda

- **Medicare Payment Reform**
- **NARHC Legislative Priorities**
  - Telehealth Policy Post PHE
  - Behavioral Health – President's Budget
  - RHC Modernization Act of 2022
- **Federal COVID-19 Funding for RHCs**
- **Regulatory Updates**
  - Mental Health via Telehealth
  - Hospice; Vaccine Administration
  - Vaccine Mandate
  - 2023 Medicare Physician Fee Schedule
- **Big Picture Considerations**

Medicare Payment Reform

Consolidated Appropriations Act of 2021

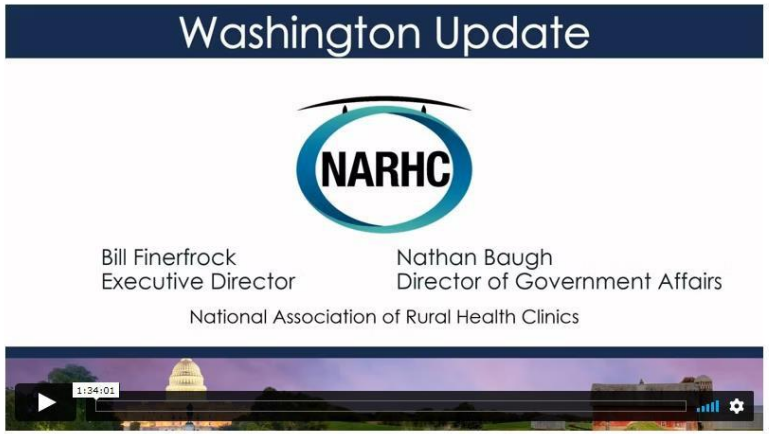
- Significant Medicare RHC payment reform
- All RHCs are now subject to an upper payment limit or cap
  - Old dynamic:
    - capped RHCs (independent RHCs and 50+ bed hospital owned RHCs)
    - uncapped provider-based RHCs (owned by hospitals with less than 50 beds)
  - New dynamic:
    - grandfathered RHCs (uncapped RHCs, in operation or with applications submitted by end of 2020)
    - RHCs subject to national cap

Why did NARHC Support These Changes?

- **Uncapped payments were growing at a rate that was not sustainable**
- Average payment for uncapped RHCs was $176 in 2015, $245 in 2020
- RHC cap went from $80.44 in 2015 to $86.31 in 2020
- Acted proactively to protect PBRHCs from site neutral cuts
  - President Trump's last budget had proposed a site neutral payment policy for all RHCs based on FQHC payments
- Grandfathered RHCs will now want to ensure that their cost-per visit increases around the same rate as the Medicare Economic Index (MEI)

Rural Health Clinics Modernization Policy Explained

Updated 12/31/20

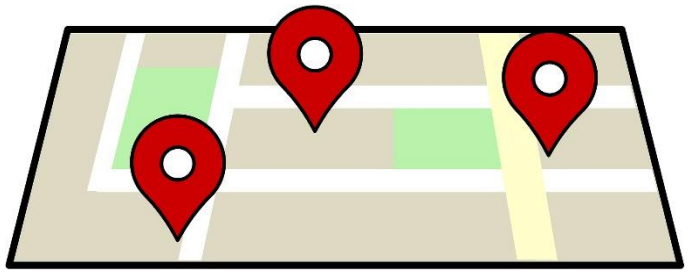


RHC Reimbursement (National Statutory Cap)

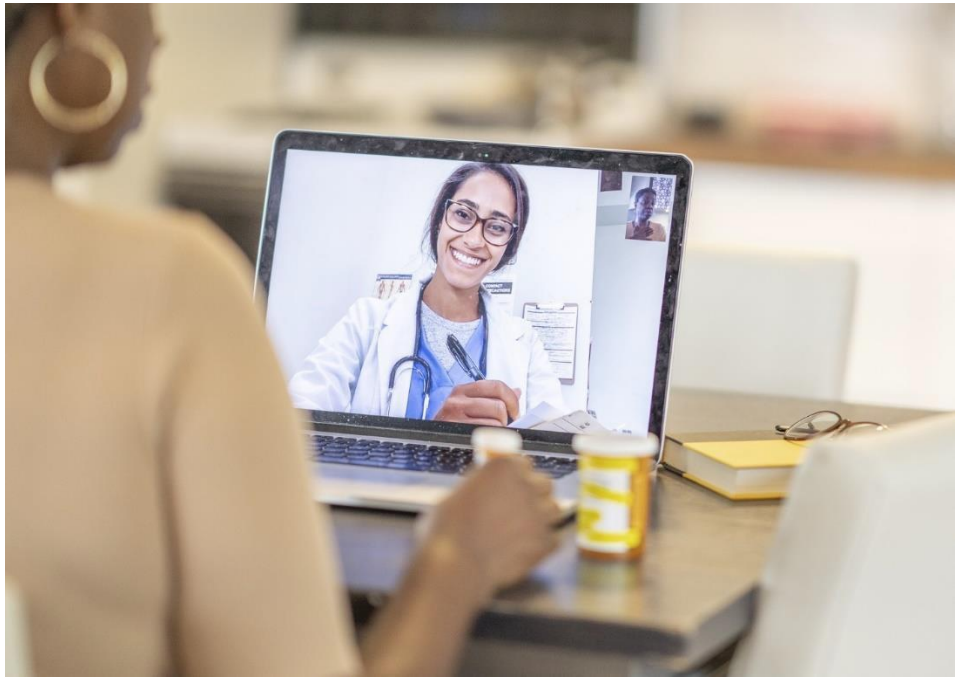
- On April 1, 2021 the RHC upper payment limit increased from $87.52 to $100. The cap then increases each year as follows:
  - 2022 $113.00
  - 2023 $126.00
  - 2024 $139.00
  - 2025 $152.00
  - 2026 $165.00
  - 2027 $178.00
  - 2028 $190.00
- After 2028, the cap will increase according to the Medicare Economic Index (MEI)

Regulatory Clarifications

- 2022 Medicare Physician Fee Schedule finalized that Changes in Ownership (when the CCN is retained) and changes of address (so long as RHC location requirements are met) will not result in a loss of grandfathering status



- 2023 Medicare Physician Fee Schedule clarifies that MACs should use the cost report ending in 2020 (or 2021 if applicable) only if the cost reporting period is a full **12-consecutive months** in determining clinic-specific upper payment limits (grandfathered RHCs)



Legislative Updates – Telehealth Policy Post-PHE

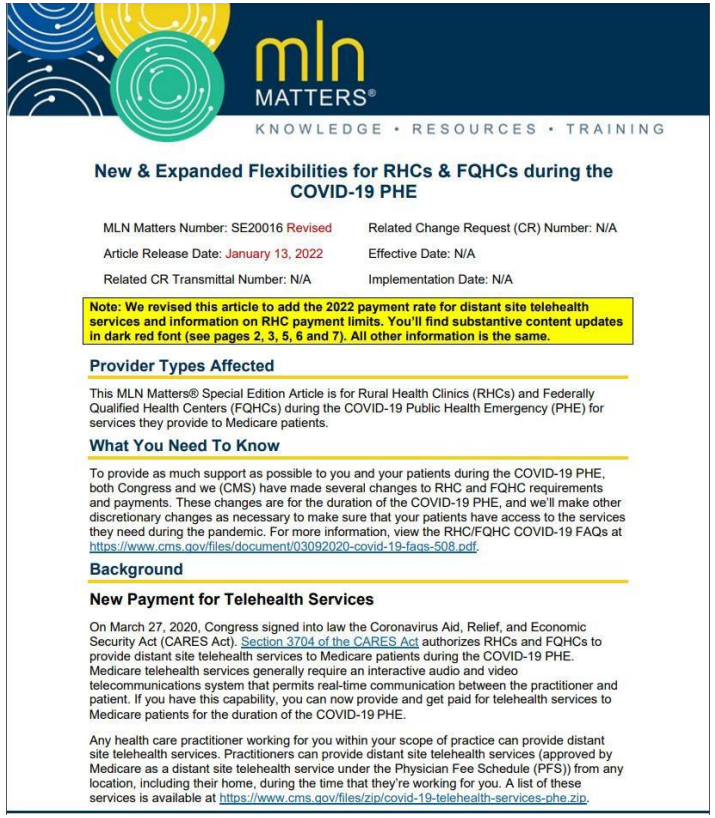
Current Medicare Telehealth Billing Policies

Name of Telehealth Service	Brief Description	How to Bill	Amount (2022)
Virtual Check-In or Virtual Care Communications	Remote evaluation – G2010 Brief communication with patient (5 min) – G2012	G0071 No modifier necessary Rev Code 052X	$23.88
Chronic Care Management	**99484**, 99487, 99490, 99491, **99424**, and **99425** = G0511 99492, 99493 = G0512	G0511 – Care Management G0512 – Psychiatric Care Management	G0511 - $79.25 G0512 - $151.23
Digital e-visits	Online digital evaluation and management 99421-99423	G0071 No modifier Rev Code 052X	$23.88
Telehealth Visits	One to one substitutes for in-person services/visits List of allowable services maintained by CMS	**G2025** Modifier 95 optional Modifier CS (for services where cost sharing is waived) Rev Code 052X Costs and encounters carved out of cost report	$97.24
Mental Health Telehealth Visits	CPT Codes that can be billed with 0900 revenue code	Rev Code 0900 Use proper mental health CPT code Modifier CG always Modifier 95 if audio-video Modifier FQ if audio-only Count costs and encounters on cost report	All-Inclusive Rate

These codes are not new but fall within the telehealth umbrella!

G2025 Policy Established – April 17, 2020

- MLN Matters SE20016
- Special Payment Rule from the CARES Act is interpreted by CMS to be one payment rate and code **for all telehealth services**
- RHCs to bill G2025 for any of 200+ CPT codes that FFS providers can bill as a telehealth visit listed here
- Costs and encounters associated with telehealth visits must be carved out of the cost report



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KNOWLEDGE • RESOURCES • TRAINING

New & Expanded Flexibilities for RHCs & FQHCs during the COVID-19 PHE

MLN Matters Number: SE20016 Revised | Related Change Request (CR) Number: N/A

Article Release Date: January 13, 2022 | Effective Date: N/A

Related CR Transmittal Number: N/A | Implementation Date: N/A

Note: We revised this article to add the 2022 payment rate for distant site telehealth services and information on RHC payment limits. You'll find substantive content updates in dark red font (see pages 2, 3, 5, 6 and 7). All other information is the same.

Provider Types Affected

This MLN Matters® Special Edition Article is for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) during the COVID-19 Public Health Emergency (PHE) for services they provide to Medicare patients.

What You Need To Know

To provide as much support as possible to you and your patients during the COVID-19 PHE, both Congress and we (CMS) have made several changes to RHC and FQHC requirements and payments. These changes are for the duration of the COVID-19 PHE, and we'll make other discretionary changes as necessary to make sure that your patients have access to the services they need during the pandemic. For more information, view the RHC/FQHC COVID-19 FAQs at https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf.

Background

New Payment for Telehealth Services

On March 27, 2020, Congress signed into law the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). Section 3704 of the CARES Act authorizes RHCs and FQHCs to provide distant site telehealth services to Medicare patients during the COVID-19 PHE. Medicare telehealth services generally require an interactive audio and video telecommunications system that permits real-time communication between the practitioner and patient. If you have this capability, you can now provide and get paid for telehealth services to Medicare patients for the duration of the COVID-19 PHE.

Any health care practitioner working for you within your scope of practice can provide distant site telehealth services. Practitioners can provide distant site telehealth services (approved by Medicare as a distant site telehealth service under the Physician Fee Schedule (PFS)) from any location, including their home, during the time that they're working for you. A list of these services is available at https://www.cms.gov/files/zip/covid-19-telehealth-services-phe.zip.

Concerns with G2025 System

- Payment of $97.24 is less than AIR for vast majority of RHCs
  - May disincentive RHCs from providing telehealth as a replacement for in-person encounters
- Carve-out process presents administrative challenges
- Disguises the actual service provided causing a number of downstream problems such as:
  - Hard (Impossible?) to identify AWV done via telehealth
  - G2025 is not eligible for risk adjustment for ACOs or Medicare Advantage
  - Without descriptions of the services provided, there are challenges in gathering good data

March 11th "Omnibus" bill

- De-links Medicare telehealth waivers from PHE
- Telehealth waivers (coverage) extended for 151 days (5-months) post PHE
  - Mental health via telehealth is permanently covered; in-person requirements waived for PHE +151 days

H.R. 4040

- Passed the House in July
- Extends G2025 payment policy through 2024
- NARHC and NRHA got letters entered into the record by Rep. Adrian Smith thanking Congress for continuing telehealth policies but expressing disappointment with the continuation of the special payment rule

NARHC NATIONAL ASSOCIATION OF RURAL HEALTH CLINICS

July 26, 2022

The Honorable Nancy Pelosi
Speaker
United States House of Representatives
Washington, DC 20515

The Honorable Kevin McCarthy
Republican Leader
United States House of Representatives
Washington, DC 20515

Dear Speaker Pelosi and Leader McCarthy:

The National Association of Rural Health Clinics (NARHC) is grateful that the House of Representatives is considering extending Medicare coverage of telehealth through 2024 but we are concerned that the current language in H.R. 4040 will perpetuate inequitable payment policies for safety-net providers.

Presently, our peers in traditional office settings are able to bill for telehealth services as if the service was provided physically in the office. In other words, they have coding and reimbursement parity between telehealth services and in-person services.

On the other hand, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) do not use their normal coding and reimbursement rules for telehealth. RHCs and FQHCs instead have a "special payment rule" that requires them to bill a single code, G2025, for all telehealth services which is then reimbursed at a single nationwide rate (currently $97.24).

We are concerned with this "special payment rule" methodology for a whole host of reasons. First and foremost, the payment is significantly less than what most RHCs and FQHCs would receive for providing the same service in person, disincentivizing safety-net providers from offering the service via telehealth. Second, the current rules require RHCs and FQHCs to "carve-out" all telehealth costs from their cost report, which adds significant administrative burden to the cost-reporting process. Third, the use of a single telehealth code, G2025, has prevented RHCs from tracking annual wellness visits and other services provided via telehealth severely hindering their ability to properly participate in ACOs and other quality programs.

Complicating matters is the fact that for mental health services provided via telehealth, RHCs and FQHCs do use their normal coding and reimbursement mechanisms. This policy is working well, and we believe that it should work this way for all services, not just mental health services.

NARHC strongly believes that the best way to encourage telehealth usage in underserved communities is to create parity between in-person and telehealth policies. We strongly encourage Congress to amend H.R. 4040 to include the payment policy enumerated in Section 9 of H.R. 7876, the Connecting Rural Telehealth to the Future Act introduced by Representative Adrian Smith and Representative Terri Sewell.

Please feel free to contact me if you would like to discuss this issue further.

Sincerely,

Nathan Baugh
Executive Director
National Association of Rural Health Clinics
(202) 543-0348

What does Medicare telehealth coverage look like in the future?

- It is evident that telehealth is here to stay, but the details remain undecided
  - What telehealth waivers will be rescinded, modified, and kept?
    - Ex. Will HIPAA compliant platforms be required again?
    - Ex. Will providers need to be in specified distant site locations?
    - Ex. Will Medicare pay parity with in-person visits?
    - Ex. Will audio-only telehealth be allowed? What services can be done audio-only?
    - Ex. Will there be in-person requirements for all telehealth?

MedPAC Study Due June 2023

- Consolidated Appropriations Act of 2022 (March 11th bill) directed MedPAC to analyze telehealth policy
- The legislation mandates that the study analyzes:
  - "The utilization of telehealth services under the Medicare program…
  - Medicare program expenditures…
  - Medicare payment policy for telehealth services and alternative approaches to such payment policy, including for federally qualified health centers and rural health clinics."
- There is speculation that Congress will extend telehealth waivers until they get more information, particularly from this study

Cost Analysis

- Does telehealth save Medicare money or does telehealth cost Medicare money?
- Does a telehealth visit replace an in-person visit or does it increase volume?

- The MedPAC study and others will provide data to begin answering these questions, but ultimately the analysis from the Congressional Budget Office (CBO) will have the greatest impact…

Moving Forward

- Likely to be a series of temporary extensions of Medicare telehealth policy as questions are answered
- Each extension provides Congress with an opportunity to tweak aspects of the telehealth policy

- **There is bipartisan agreement and industry wide expectations that Medicare telehealth policy will not revert to the very limited pre-COVID rules.**

Behavioral Health Provisions in President Biden's Proposed Budget

RHC Provisions – March 2020

RHC Behavioral Health Initiative

- $10 million for a RHC grant program – funding RHCs where there is no behavioral health provider *("fund the salary of a behavioral health provider, address provider burnout, and expand the availability of services such as mental health screenings, counseling, and therapy.")*

Modernize Medicare Mental Health Benefits

- Allow payment to RHCs/FQHCs for Licensed Professional Counselors and Marriage and Family Therapists providing mental health services

RHC Behavioral Health Initiative Update

Outreach to Committees of Jurisdiction

- Letters to House HHS/Labor Appropriations Subcommittee, House Ways & Means, House Energy and Commerce, Senate Committee on Finance
- Joint meetings with NRHA and NOSORH
- **House Appropriations Report Included $5 million for RHC BHI**
- Senate Appropriations Report also included $5 million for RHCBHI
- Must still make it into final appropriations package for FY 2023
- Application could open sometime next Spring/Summer

RHC Modernization Act of 2022

- Working to introduce and pass new cost-free legislation that contains the "low hanging fruit" issues in the RHC statute…this bill would:
- Align RHC scope of practice with state scope of practice
- Remove the on-site lab requirements and convert them to "prompt access"
- Allow RHCs to contract with all their PAs and NPs
- Protect the definition of rural for RHCs
- Allow RHCs to be primarily engaged in behavioral health if they are in a mental health HPSA

Federal COVID-19 Funding and Supply Programs for RHCs

Funding Program	Date	Amount	Purpose	Reporting
Phase 1 General Distribution	April 10, 2020	6.2% of 2019 Medicare Reimbursement	Lost Revenue and Unreimbursed COVID Expenses	Provider Relief Fund Portal
Phase 2 General Distribution	April 24, 2020	2% of 2018 revenue minus phase 1 distribution	Lost Revenue and Unreimbursed COVID Expenses	Provider Relief Fund Portal
Phase 3 General Distribution	December 15, 2020	Variable	Lost Revenue and Unreimbursed COVID Expenses	Provider Relief Fund Portal
Rural Targeted Allocation	May 6, 2020	$103k + 3.6% operating expenses (Ind), Graduated Base Payment + 1.97% of operating expenses (PB)	Lost Revenue and Unreimbursed COVID Expenses	Provider Relief Fund Portal
RHC COVID-19 Testing Fund	May 20, 2020 + later dates	$49,461.42 per RHC	Unreimbursed COVID testing expenses	www.RHCcovidreporting.com
RHC COVID-19 Testing and Mitigation Fund	June 10, 2021 + later dates	$100,000 per RHC	Unreimbursed COVID testing and mitigation expenses	www.RHCcovidreporting.com
RHC Vaccine Confidence Grants	July 22, 2021	Approximately $49,529.00	Vaccine hesitancy work	Financial Reports through Payment Management System + Quarterly Calls
American Rescue Plan + Phase 4 General Distribution	November/December 2021	Variable	Lost Revenue and Unreimbursed COVID Expenses	Provider Relief Fund Portal

RHC COVID-19 Funding Program Reminders

- **RHC COVID-19 Testing and Mitigation (RHCCTM)**
  - $100,000 per RHC
  - Automatically awarded beginning June 2021 to reporting compliant RHCs
  - Project Period: January 1, 2021 – December 31, 2022
  - Reporting on RHCcovidreporting.com through Jan. 2023
- **Allowable Expenses**
  - Testing and testing-related
  - Mitigation and mitigation-related
  - Otherwise unreimbursed

Retention payments!

Expanding digital technologies!

Facility retrofitting!

RHC COVID-19 Vaccine Confidence Grants

- ~$49,529 per **awarded** RHC in July/August 2021 for vaccine confidence efforts
- Project Period: July 1, 2021 – June 30, 2022 (unless your RHC was granted a no-cost extension)
- Funds drawn down on Payment Management System (PMS) and managed on HRSA Electronic Handbooks (EHB)

Last day to draw down funds and **complete closeout requirements** is September 28, 2022!

HRSA COVID-19 Testing Supply and Therapeutics Program

- Free, direct supply of:
  - At-home test kits
  - Point-of-care testing supplies
  - COVID Vaccines (including Bivalent vaccines)
  - Enrollment available here!

- The newest HRSA program offers **free, direct access to COVID therapeutics**, allowing RHCs to participate in the nationwide "Test-to-Treat" program
  - Visit narhc.org for enrollment steps and to learn more!

Regulatory Updates – 2022 Physician Fee Schedule

Mental Health via Telehealth

- In December of 2020, Congress made *permanent* Medicare coverage of telehealth for mental health services but made no mention of how this might extend to safety net providers.
- CMS finalized a regulatory change to the definition of an RHC (and FQHC) mental health encounter to include telehealth encounters:
  - (3) Visit - Mental health. A mental health visit is a face-to-face encounter **or an encounter furnished using interactive, real-time, audio and video telecommunications technology or audio-only interactions in cases where the patient is not capable of, or does not consent to, the use of video technology** for the purposes of diagnosis, evaluation or treatment of a mental health disorder between an RHC or FQHC patient and one of the following…
- NARHC welcomed this policy change by CMS allowing RHCs to use normal coding, normal reimbursement, and normal cost reporting rules for mental health telehealth visits.

Mental Health via Telehealth In-Person Requirements

- In-person requirements are waived during PHE *and for 151 days after PHE ends*
- **After this period, beneficiaries must have an in-person visit within 6 months of furnishing mental health via telehealth service and an in-person service must be provided at least every 12 months thereafter.**
  - Some exceptions may be made based on patient need
  - Some of the details are unclear –
    - Does the telehealth provider need to be the provider that sees the patient for their in-person visit?

Public Health Emergency Update

- Health and Human Services (HHS) Secretary Becerra renewed the PHE on July 15, 2022.
  - Renewals can be for UP TO 90 days at a time
  - States will receive minimum 60 days notice when the PHE is set to expire / not be renewed
- Already within 60 days of mid-October and there has been no announcement so there is an expectation that it will be extended again

Other 2022 PFS RHC Provisions

Beginning January 1, 2022

- **Hospice**: RHC clinicians can provide hospice related care to a Medicare beneficiary enrolled in hospice and receive the all-inclusive rate payment for attending physician services.
- **Vaccine Administration:** RHCs should bill Medicare Advantage directly for COVID-19 vaccine administration.
- **CCM/TCM:** RHCs can bill for Transitional Care Management (TCM) and other care management services like CCM provided to the same beneficiary in the same time period, so long as all billing requirements for each code are followed.

2023 MPFS Relevant Provisions

RHC Payment Methodology

- CMS proposes that MACs use the cost report ending in 2020 (or 2021 for RHCs that don't have an AIR established for 2020 services furnished) that reports costs for **12 consecutive months**

2023 MPFS Relevant Provisions

New Care Management Codes Billable in RHCs

- Chronic Pain Management (CPM)
- General Behavioral Health Integration (GBHI)

- Billed under G0511 which is currently a consolidated fee schedule rate of 6 codes ($79.25 in 2022)
  - The addition of these codes will not change the average used to calculate the G0511 rate but it will continue to be updated annually

2023 MPFS Relevant Provisions

Medicare Economic Index (MEI) Rebasing

- Proposal to use new methodology to calculate MEI using 2017 publicly available data sources instead of 2006-based inputs
- NARHC is appreciative of the efforts to acknowledge issues with the outdated formula but 2017 data remains behind the impacts of current inflation

Regulatory Updates – Medicare Sequester

2% Medicare Sequester Back in Effect

- Beginning July 1, 2022 Medicare sequester policy was fully re-implemented
  - RHCs, and all of healthcare, should now expect to receive 78.4% of the allowable
- A similar, 4% "pay as you go" or "PAYGO" Medicare reduction is currently scheduled to kick in on January 1, 2023
  - There is industry wide expectation that Congress will again waive this payment reduction

The use of the sequester has long since been part of the games of political/budget chicken with significant impacts on things like Medicare reimbursement! For a more in-depth history, visit NARHC.org.

Big Picture Issues for the RHC Program

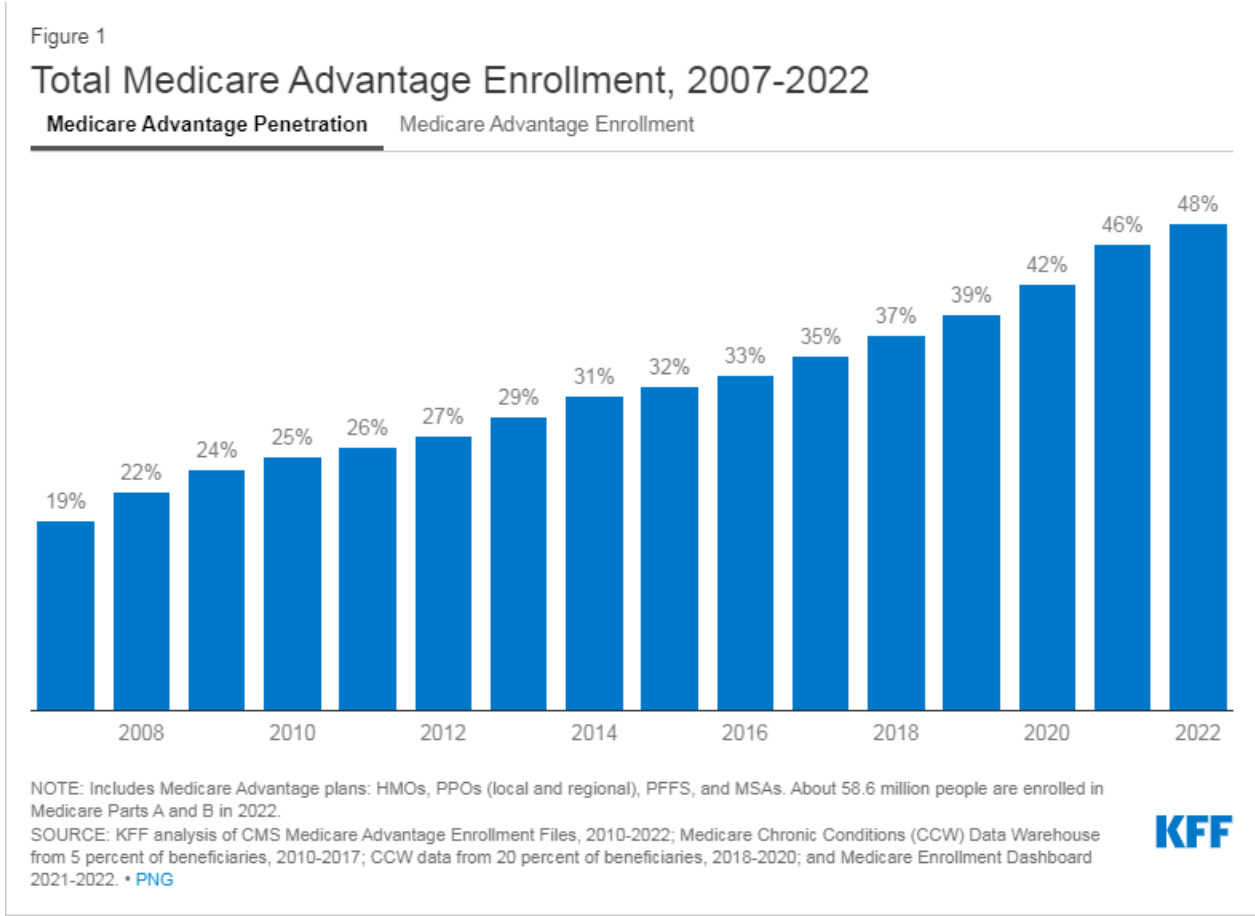
- Quality Reporting for RHCs
- Medicare Advantage Growth
- Telehealth Implications

Medicare Quality Reporting Program for RHCs with AIR as the foundation

- Legislation introduced to create a quality reporting program for RHCs in exchange for going back to uncapped rates ~ but only for Provider-based RHCs.
- NARHC supports the creation of a Medicare quality reporting program, but it must be available to ALL RHCs.
- Likely that the financial incentive will need to be revised if we want this legislation to pass
  - We believe a simple upward adjustment to AIR as a reward for quality reporting may work

Medicare Advantage Growth

- RHCs have no formal reimbursement benefit from Medicare Advantage plans
- FQHCs (since 2003) have a “wrap-around” payment that ensures that they receive no less than what they would make from traditional Medicare
- There are some old and relatively unclear policies that provide protections for RHCs that are Out-of-Network providers
- But if an RHC agrees to a contract with the MA plan, then the RHC must bill (and be paid) according to the terms of that contract



Telehealth Implications

- Short term – telehealth policy expires at the end of ~~PHE~~ *151 days after PHE*, what does Congress do?
- Medium term – what aspects of telehealth policy are made permanent? Do private payers opt to cover telehealth visits fully? How is audio-only handled?
- **Long term – does telehealth fundamentally alter what it means to have "access" to healthcare?** Will RHCs be able to compete with offices in the city with sophisticated telehealth services?

Stay "In the Know" on RHC Issues

- NARHC.org
  - Email Listserv
  - Discussion Forum
  - News Tab
  - Resources Tab
    - TA Webinars
    - Advocacy Letters and Comments

Questions?

Nathan Baugh
Executive Director
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