Rural Health Clinic Regulatory and Legislative Update

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National Association of Rural Health Clinics

Agenda

- **The National Association of Rural Health Clinics (NARHC)**
- **Legislative Updates**
  - RHC Burden Reduction Act (S.198/H.R.3730)
    - Legislative Pathways
  - Telehealth Policy
  - Medicare Advantage
- **Regulatory Updates / From the Administration**
  - Good Faith Estimate
  - 2024 Medicare Physician Fee Schedule
  - 2024 Outpatient Prospective Payment System (OPPS)
  - Rural Health Clinic Behavioral Health Initiative

The National Association of Rural Health Clinics (NARHC)

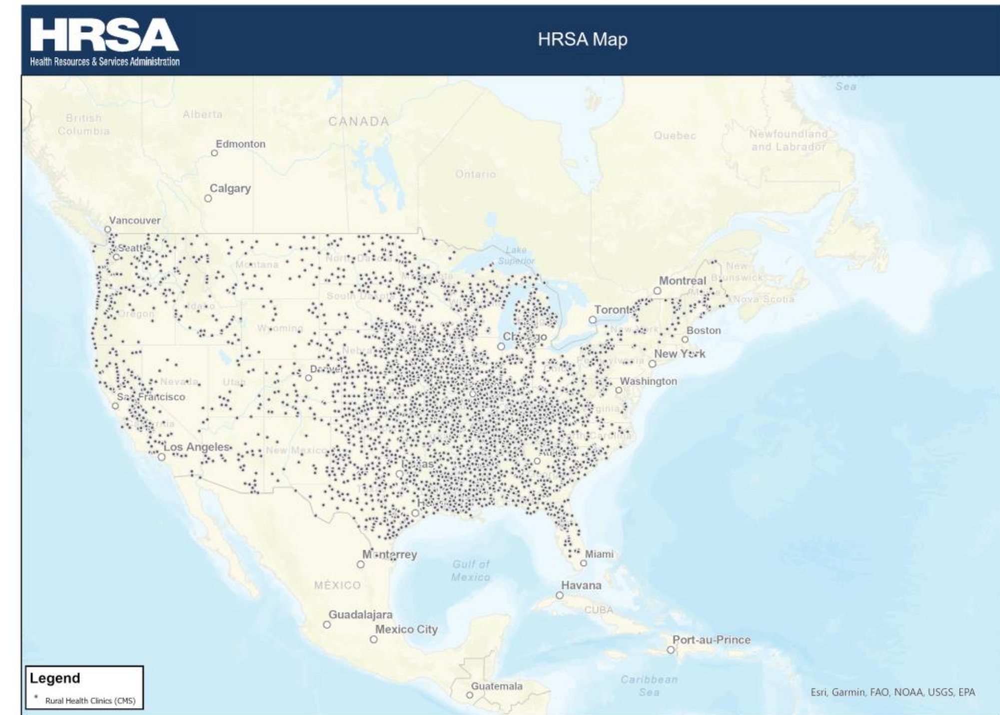
- The National Association of Rural Health Clinics mission is to educate and advocate for Rural Health Clinics, enhancing their ability to deliver cost-effective, quality health care to patients in rural, underserved communities.

- **Education:** Technical Assistance, Conferences, NARHC Academy *(Intro to RHCs, Certified Rural Health Clinic Professionals (CRHCP))*
- **Advocacy:** Regulatory and Legislative; Fellowship

2 E. Main St, Fremont, MI 49412 | 866-306-1961 | NARHC.org

Sixty Percent of Rural Americans Served by Rural Health Clinics

- NARHC survey data shows that the RHC program, as a whole, serves approximately **37.7 million patients per year** which is more than 11% of the entire population and approximately **62% of the 60.8 million Americans that live in rural areas.**
  - **5,376 RHCs in 46 states**
  - **119 RHCs in Oregon**



RHC Burden Reduction Act (S.198/H.R.3730)

Medical Director

Align RHC physician supervision requirements with the state scope of practice laws governing Nurse Practitioners and Physician Associates

Laboratory Services

Allow RHCs to satisfy onsite laboratory requirements if they provide "prompt access" to the required lab services

Employment/Contracting

Allow RHCs to employ or contract with their NPs and PAs

Location

Fix "urbanized area" issue in the statute

Maintain status quo of areas with less than 50,000 being eligible for RHCs

Interim Policy

Behavioral Health

Allow RHCs to provide over 49% behavioral health services if they are located in a mental health-Health Professional Shortage Area (HPSA)

Rural Health Clinic Burden Reduction Act

S.198

- **Senator Barrasso (WY)**
- **Senator Smith (MN)**
- **Senator Blackburn (TN)**
- **Senator Bennet (CO)**
- Senator Lummis (WY)
- Senator Rosen (NV)
- Senator Durbin (IL)
- Senator Sinema (AZ)

H.R.3730

- **Rep. Smith (NE-03)**
- **Rep. Blumenauer (OR-03)**
- **Rep. Tokuda (HI-02)**
- **Rep. Armstrong (ND)**
- Rep. Valadao (CA-22)
- Rep. Ciscomani (AZ-06)
- Rep. Finstad (MN-01)
- Rep. Nehls (TX-22)
- Rep. Costa (CA-21)

How many pieces of legislation have been signed into law this year?

- 13

- How many pieces of legislation have been introduced this year?

- Over 8,800

Modern Legislative Pathways

Option 1	Option 2	Option 3	Option 4

Unanimous Consent / Suspension of the rules
• Non-controversial bills; cost free
• Example: naming post offices
	Bipartisan Individual Bill of Substance
	• Semi-targeted
	• 60 votes in the Senate
	• Examples: *Bipartisan Safer Communities Act (gun control & behavioral health)*
		Must Pass Legislation
		• Debt Ceiling, Appropriations
		  • Examples: *Consolidated Appropriations Act (insert year)*
			Budget Reconciliation Process
			• Generally, only relevant when one party controls House/Senate/ President
			  • Examples: *Inflation Reduction Act, American Rescue Plan*

How can you effectively advocate?

Rural Health Clinic Burden Reduction Act

Signed into law by President Jimmy Carter in 1977, the rural health clinics (RHC) program was designed to improve access to health care in rural, underserved areas. Over forty-five years later, we are pleased to report that there are over 5,300 RHCs providing quality care to rural and underserved patients. However, as healthcare evolves, several program policies are in need of modernization to reflect the changing world. The Rural Health Clinic Burden Reduction Act would accomplish this through the following provisions:

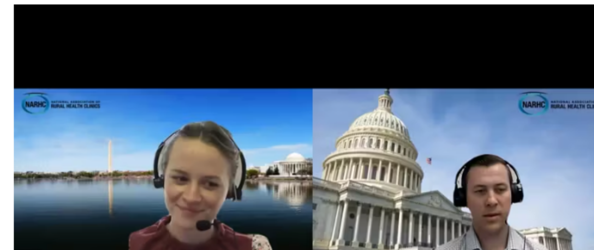
1. Modernizes RHC physician supervision requirements by aligning them to state scope of practice laws governing PA and NP practice.
2. Removes the requirement that RHCs must "directly provide" certain lab services on site and allows RHCs to instead offer "prompt access" to these services.
3. Allows RHCs the flexibility to contract with or employ PAs and NPs.
4. Maintains status quo location eligibility, allowing RHCs to be located in an area that is not in an urban area of 50,000 or more, given that the Census Bureau no longer utilizes the term "urbanized area."
5. Removes a regulatory barrier that limits RHCs provision of behavioral health services in areas experiencing a shortage of such services.

S.198 was introduced in the Senate by rural health champions Senators John Barrasso (WY), Tina Smith (MN), Marsha Blackburn (TN), and Michael Bennet (CO). Additional cosponsors include Senator Cynthia Lummis (WY), with Senator Jacky Rosen (NV), and Senator Dick Durbin (IL).

H.R. 3730 was introduced in the House of Representatives by rural health champions Representatives Adrian Smith (NE-03), Earl Blumenauer (OR-03), Jill Tokuda (HI-02), and Kelly Armstrong (ND). Additional co-sponsors include Representative David Valadao (CA-22).

To continue this momentum, **we need your help!** We strongly encourage you to reach out to your Senators and Representatives, sharing your support for the bill and how it will benefit your RHCs, ultimately asking them to co-sponsor the legislation. If Members of Congress never hear from their own constituents that passing this law is important, they are much less likely to support the bill! Please watch the brief video below for an overview of the bill and how to use our messaging software available on the right side of this webpage. Simply type in your contact information and then modify the message to explain why this legislation matters to your RHC!

Make Your Voice Heard by Email, Phone, or by Mail



- Resources
  - Resources
  - Policy and Advocacy
    - Advocacy Letters and Comments
    - Good Faith Estimate Policy
    - RHC Burden Reduction Act
    - Telehealth Policy
  - RHC Statute, Regulation, and Guidance
    - RHC Statute
    - RHC Regulation
    - RHC Guidance
  - Webinars
    - TA Webinars
    - NARHC Webinars
  - Helpful Links

Hi Sarah in Mainesburg, PA!

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Your Information

Ms. | Sarah | Hohman

shohman@outlook.com

Home Information

Send me email alerts

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Review Your Message

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Hi Sarah in Mainesburg, PA!

Compose Your Message

- Senator Bob Casey Jr.
- Senator John Fetterman

Hello RHC community! Thank you for participating in this advocacy campaign to make your voice heard on important RHC legislation, S.198.

Below you will see a sample message to send to your Senators. While simply sending this template is a great first step, your unique perspectives as to **why** this legislation matters to your clinics and the patients you serve is most significant. We encourage you to introduce yourself and your role within the RHC community, and to highlight a specific provision that will be uniquely impactful for your RHC.

Please visit NARHC.org for additional details on the bill, and contact Sarah.Hohman@narhc.org with any questions!

Subject

Support S.198 - Rural Health Clinic Burden Rec

Message Body

These provisions will modernize and strengthen the RHC program and better enable RHCs like mine to continue our mission of providing health care in the rural and underserved regions of our country.

Send Message

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Options:

- **Just click "send message," or, even better….**
- **Personalize the message**
  - This legislation came from the RHC community and will impact the RHC community
  - Introduce your RHC and the patients/community you serve
  - Pick a provision with implications for your clinic and write **one sentence** as to why it's important

TELEHEALTH POLICY

Current Medicare Telehealth Coverage - RHCs

Medical Telehealth

- RHCs can continue to be distant site providers through December 31, 2024 (at least)
- Paid $98.27 for all services on Medicare's telehealth list (200+ codes)
  - Including many via audio-only
  - Do not count as encounters; costs and visits carved out of cost report

Mental Health Telehealth

- Permanent coverage in the RHC setting, reimbursed at All-Inclusive Rate, counted as a visit
- In-person requirements are waived until January 1, 2025
  - Occasional requirement (6 months prior to furnishing telehealth; at least once per year)
- CPT codes billable with 0900 revenue code

NARHC Telehealth Policy Position

- Three primary concerns with current G2025 system:
  - Limited data can be gathered by billing 1 single code for a variety of services
  - The payment rate disincentivizes investment in telehealth technology
  - Entirely new billing and cost reporting rules increase administrative burden

- What NARHC wants for RHCs:
  - Normal coding, cost reporting, billing, reimbursement
  - **Pay telehealth encounters through All-Inclusive Rate system**

NARHC

TELEHEALTH GOOD NEWS/BAD NEWS

GOOD NEWS	BAD NEWS
• Several pieces of legislation introduced already in this Congress that will achieve our policy priority • It is the industry expectation that Congress will continue coverage of telehealth	• Unlikely to get much movement on any telehealth legislation until we are close to a "telehealth cliff" at the end of 2024 • Probable that Congress will pass more temporary extensions, not permanent policy (unanswered questions and no pay-for)

MedPAC Report – June 2023

MedPAC recommended that if Congress decides to permanently cover distant-site telehealth services in RHCs, that they continue to reimburse at the rate **"based on PFS rates for comparable telehealth services,"** which is effectively an endorsement of the current G2025/special payment rule.

MedPAC Rationale

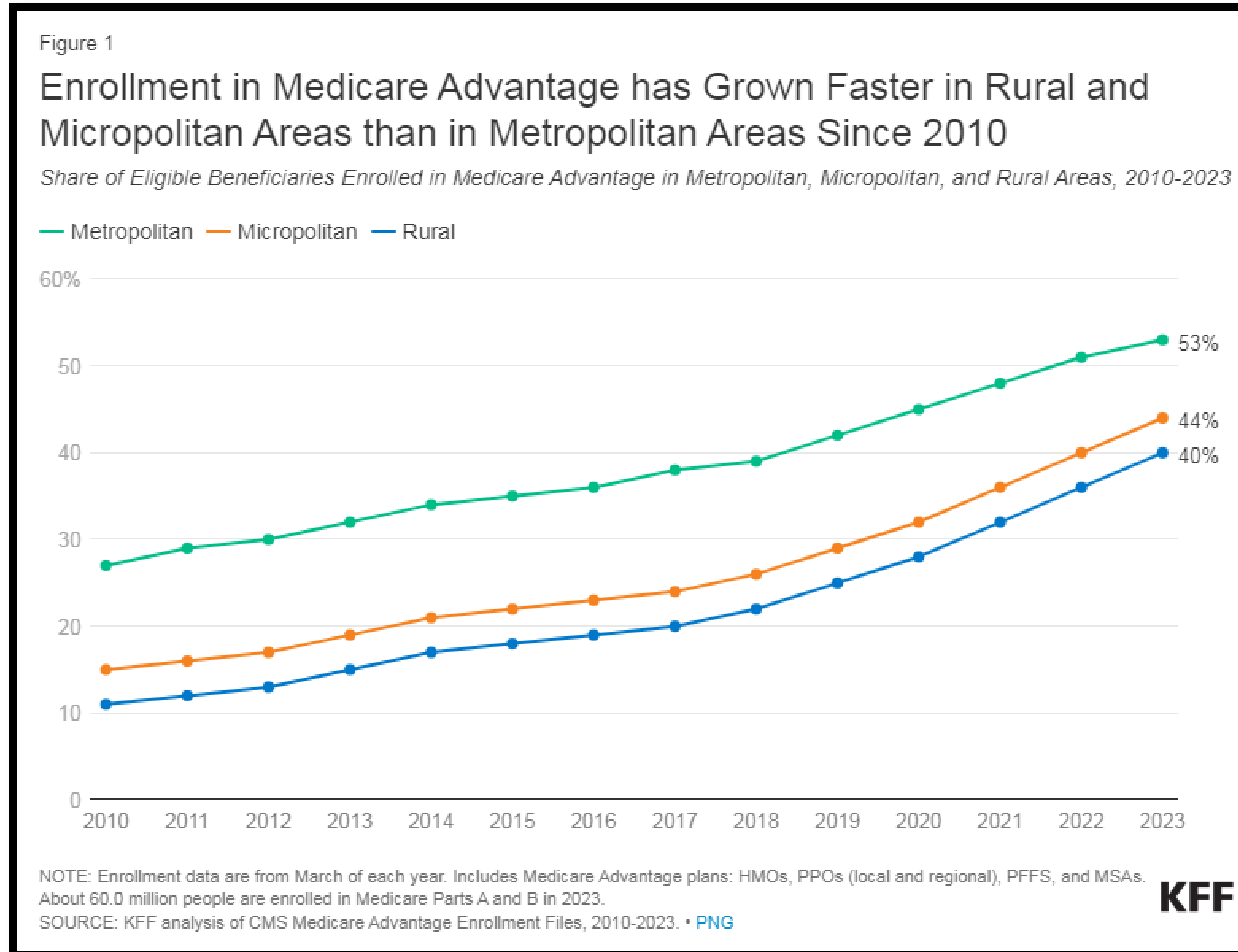
- Paying parity between in-person and telehealth visits would cost the Medicare program more money and disincentivize providing in-person care
  - **NARHC response:**
    - RHC Medicare spending for telehealth was just 2% in 2021 (unlikely to significantly increase spending)
    - Guardrails could be established to protect the integrity of the telehealth benefit

IS TELEHEALTH A THREAT?

- Does telehealth fundamentally alter what it means to have “access” to healthcare?
  - Will physical proximity to a provider mean less?

- Will RHCs find themselves competing with city-based entities offering telehealth services to their patient-base?

Medicare Advantage



Medicare Advantage in Rural

KFF

1. 2010: 11% of eligible rural beneficiaries are enrolled in an MA plan
   - Beneficiaries could choose between ~9 plans

2. 2023: 40% of eligible rural beneficiaries are enrolled in an MA plan
   - Beneficiaries can choose between ~27 plans

Medicare Advantage in Rural

- Prior authorization, marketing practices, and other administrative burden concerns, **PLUS**
- RHC specific - low reimbursement concerns
  - For RHCs, each MA plan is like another commercial contract
    - While some RHCs can negotiate for comparable reimbursement, there is no requirement that MA plans treat RHCs differently than any other provider
  - FQHCs have a quarterly “wrap- around” payment that ensures that they receive no less than what they would make from traditional Medicare

Medicare Advantage Advocacy

"Wrap" Payment (Similar to FQHCs)	Establishing a "Floor" MA Plans Must Pay
Pros:	**Pros:**
• Established policy for FQHCs	• Holds MA plans accountable for supporting rural safety net
Cons:	**Cons:**
• Doesn't hold MA plans accountable • Paid by the Medicare Trust Fund	• Challenges/limitations to Congress requiring certain practices/reimbursement from MA plans

Regulatory Updates:

- Good Faith Estimate
- 2024 Medicare Physician Fee Schedule
- 2024 Medicare Outpatient Prospective Payment System

Good Faith Estimate Resources

NARHC Webinars

- (December 2021 and December 2022)

NARHC Resource Guide

Regulations

CMS Overview

Patient Initiated Independent Dispute Resolution Process

Templates

CMS Webinar

CMS FAQs: 1 and 2 and 3 and 4

CMS Rulemaking Process

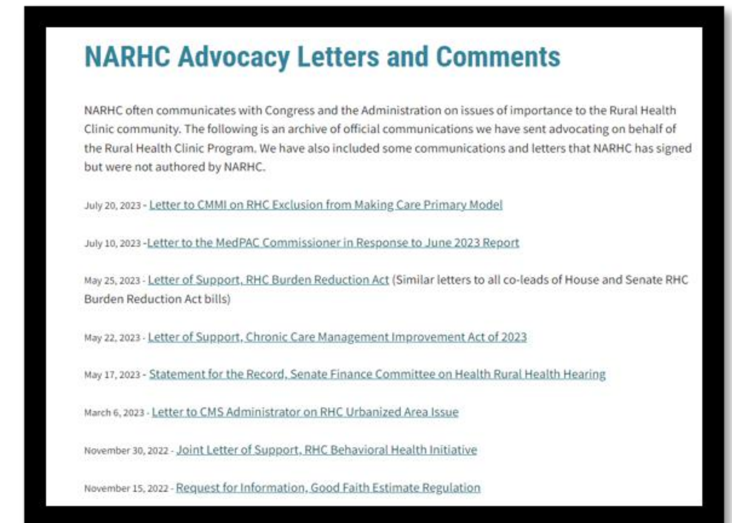
July – MPFS and OPPS Proposed Rules Released

- What's in the proposed rules for RHCs webinar

September – Comments Due

November – Final Rules Released

January – Provisions go into effect

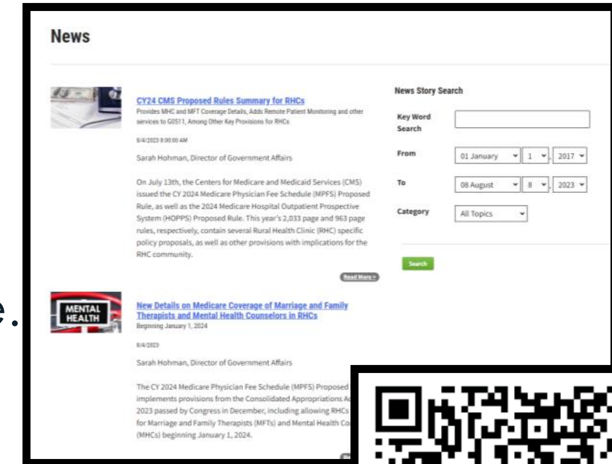


2024 MPFS Relevant Provisions

Beginning January 1, 2024

New Billable Providers in RHCs - §405.2463

- (A) Physician.
- (B) Physician assistant.
- (C) Nurse practitioner.
- (D) Certified nurse midwife.
- (E) Visiting registered professional or licensed practical nurse.
- (G) Clinical psychologist.
- (H) Clinical social worker.
- (I) Marriage and Family Therapists
- (J) Mental Health Counselors



2024 MPFS Relevant Provisions

Beginning January 1, 2024

CMS proposed to add Remote Patient Monitoring, Remote Therapeutic Monitoring, Community Health Integration, and Principal Illness Navigation Services as billable services under general care management code – G0511

- **RPM/RTM**: services are intended to help providers monitor their patients' conditions remotely through various digital technologies
- **Community Health Integration:** services provided by a Community Health Worker or other similarly certified/trained auxiliary members of the care team under general supervision of the billing provider (care coordination, health education, other tailored supports)
- **Principal Illness Navigation:** individualized help by a peer specialist, or other similar auxiliary staff, to the patient in navigating the complex health care and social support system (for patients with serious, high-risk disease)

CURRENT MEDICARE TELEHEALTH BILLING POLICIES

Name of Telehealth Service	Brief Description	How to Bill	Amount (2023)
Virtual Check-In or Virtual Care Communications	Remote evaluation – G2010 Brief communication with patient (5 min) – G2012	G0071 No modifier necessary Rev Code 052X	$23.72
Chronic Care Management	99484, 99487, 99490, 99491, 99424, and 99425 = G0511 99492, 99493 = G0512	G0511 – Care Management G0512 – Psychiatric Care Management	G0511 - $77.94 G0512 - $146.73
Digital e-visits	Online digital evaluation and management 99421-99423	G0071 No modifier Rev Code 052X	$23.72 - **Only covered through May 11, 2023**
Telehealth Visits	One to one substitutes for in-person services/visits List of allowable services maintained by CMS **Coverage through 12/31/2024**	**G2025** Modifier 95 optional Modifier CS (for services where cost sharing is waived) Rev Code 052X Costs and encounters carved out of cost report	$98.27
Mental Health Telehealth Visits	CPT Codes that can be billed with 0900 revenue code **Permanent Coverage**	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

Name of Telehealth Service	Brief Description	How to Bill	Amount (2023)
Virtual Check-In or Virtual Care Communications	Remote evaluation – G2010 Brief communication with patient (5 min) – G2012	G0071 No modifier necessary Rev Code 052X	$23.72
Chronic Care Management	Current: 99484, 99487, 99490, 99491, 99424, and 99425 = G0511 Proposed: 99484, 99487, 99490, 99491, 99424, and 99425 **PLUS** 99453, 99454, 99457, 99458, 99091 (RPM), 98975, 98976, 98977, 98980, 98981 (RTM), GXXX1, GXXX2 (CHI), and GXXX3, GXXX4 (PHI) 99492, 99493 = G0512	G0511 – Care Management G0512 – Psychiatric Care Management	G0511 - $77.94 G0512 - $146.73
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Limitations with using G0511 for Care Management

- **For Fee-For-Service Providers:**
  - "We are proposing that the practitioner could bill separately for other care management services during the same month as PIN [and CHI], if time and effort are not counted more than once, requirements to bill the other care management services are met, and the services are medically reasonable and necessary."
  - "Practitioners may bill RPM or RTM, but not both RPM and RTM, concurrently with the following care management services: CCM/TCM/BHI, PCM, and CPM. These various codes, which describe other care management services, may be billed with RPM or RTM, for the same patient, if the time or effort is not counted twice. As specified in the CY 2023 PFS final rule, if all requirements to report each service are met, without time or effort being counted more than once, RPM or RTM (not both RPM and RTM) may be billed in conjunction with any one of CCM, TCM, BHI, PCM, or CPM codes."
- **For RHCs/FQHCs:**
  - CMS says in Medicare Claims Processing Chapter 9 and a 2019 FAQ that: "RHCs and FQHCs can only bill one care management service for an individual per month."
    - If RHCs already bill for CCM services for a patient (G0511), they can not also bill for RPM, RTM, PIN, and/or CHI services (also G0511) in the same month.

Problems with G0511

- Current rules only allow one G0511 to be billed per patient per month
- Collapsing so many services into G0511 means that RHCs are only paid for one "care management" service and cannot offer a suite of care management services to our patients (and get paid for it)
- We are forced to pick: CCM or RPM or RTM or PIN or CHI but never two types of services
- Furthermore, we are not incentivized to provide add-on code services and RPM/RTM is not as attractive because we still cannot bill for the device and setup service

2024 OPPS Relevant Provisions

Beginning January 1, 2024

Intensive Outpatient Program Treatment Category

- RHCs can begin billing for these services on January 1, 2024, and will be reimbursed under a special payment rule.

- Behavioral health services provided through an outpatient setting. For patients with an acute mental illness including:
  - Substance use disorders, depression, schizophrenia, and others
  - IOP is a distinct program from partial hospitalization programs (PHPs) and is understood to be less intensive than PHP; however, IOP is for patients requiring a higher level of care than isolated outpatient visits with a behavioral health provider
  - Distinct services: therapy/patient education/diagnostic services
  - RHCs will receive a flat payment per day which CMS is proposing as $284 in 2024
    - Corresponds to an anticipated 3 separate qualifying services per day

At least one service must come from this list:

HCPCS/CPT	Short Descriptor	Proposed Action
90832	Psytx pt&/family 30 minutes	
90834	Psytx pt&/family 45 minutes	
90837	Psytx pt&/family 60 minutes	
90845	Psychoanalysis	Add
90846	Family psytx w/o patient	
90847	Family psytx w/patient	
90853	Group psychotherapy	Add
90865	Narcosynthesis	Remove
90880	Hypnotherapy	
96112	Devel tst phys/qhp 1st hr	Add
96116	Neurobehavioral status exam	Add
96130	Psychological testing evaluation by physician/qualified health care professional; first hour	Add
96132	Neuropsychological testing evaluation by physician/qualified health care professional; first hour	Add
96136	Psychological/neuropsychological testing by physician/qualified health care professional; first 30 minutes	Add
96138	Psychological/neuropsychological testing by technician; first 30 minutes	Add
G0410	Grp psych partial hosp/IOP 45-50	Update
G0411	Inter active grp psych PHP/IOP	Update

Remaining services must come from this list:

HCPCS/CPT	Short Descriptor	Proposed Action
90785	Psytx complex interactive	
90791	Psych diagnostic evaluation	
90792	Psych diag eval w/med srvcs	
90832	Psytx pt&/family 30 minutes	
90833	Psytx pt&/fam w/e&m 30 min	
90834	Psytx pt&/family 45 minutes	
90836	Psytx pt&/fam w/e&m 45 min	
90837	Psytx pt&/family 60 minutes	
90838	Psytx pt&/fam w/e&m 60 min	
90839	Psytx crisis initial 60 min	Add
90845	Psychoanalysis	
90846	Family psytx w/o patient	
90847	Family psytx w/patient	
90849	Multiple family group psytx	Add
90853	Group psychotherapy	Add
90865	Narcosynthesis	Remove
90880	Hypnotherapy	
90899	Psychiatric service/therapy	Add
96112	Devel tst phys/qhp 1st hr	Add
96116	Neurobehavioral status exam	
96130	Psychological testing evaluation by physician/qualified health care professional; first hour	
96131	Psychological testing evaluation by physician/qualified health care professional; each additional hour	
96132	Neuropsychological testing evaluation by physician/qualified health care professional; first hour	
96133	Neuropsychological testing evaluation by physician/qualified health care professional; each additional hour	
96136	Psychological/neuropsychological testing by physician/qualified health care professional; first 30 minutes	
96137	Psychological/neuropsychological testing by physician/qualified health care professional; each additional 30 minutes	
96138	Psychological/neuropsychological testing by technician; first 30 minutes	
96139	Psychological/neuropsychological testing by technician; each additional 30 minutes	
96146	Psychological/neuropsychological testing; automated result only	
96156	Hlth bhv assmt/reassessment	Add
96158	Hlth bhv ivntj indiv 1st 30	Add
96164	Hlth bhv ivntj grp 1st 30	Add
96167	Hlth bhv ivntj fam 1st 30	Add
97151	Bhv id assmt by phys/qhp	Add
97152	Bhv id suprt assmt by 1 tech	Add
97153	Adaptive behavior tx by tech	Add
97154	Grp adapt bhv tx by tech	Add
97155	Adapt behavior tx phys/qhp	Add
97156	Fam adapt bhv tx gdn phy/qhp	Add
97157	Mult fam adapt bhv tx gdn	Add
97158	Grp adapt bhv tx by phy/qhp	Add
G0129	PHP/IOP service	Update
G0176	Opps/php/IOP; activity thrpy	Update
G0177	Opps/php/IOP; train & educ	Update
G0410	Grp psych PHP/IOP 45-50	Update
G0411	Interactive grp psyc PHP/IOP	Update
G0451	Development test interpt&rep	Add

Intensive Outpatient Program Patient Eligibility

- Physician certifies (at least once every other month) that a patient needs behavioral health services between 9-19 hours per week and:
  - Is likely to benefit from these coordinated services more than they would individual sessions of outpatient treatment
  - Does not need 24-hour care
  - Has a separate support system outside of the IOP
  - Has received a mental health diagnosis
  - Is not a danger to themselves or others
  - Has the cognitive and emotional ability to tolerate the IOP

What was missing from the proposed rules?

- CMS did not propose to allow for Annual Wellness Visits (other than IPPEs) to be eligible for same day billing.
  - We also believe it is within CMS authority to allow RNs to facilitate AWVs and still receive an All-Inclusive Rate for these services

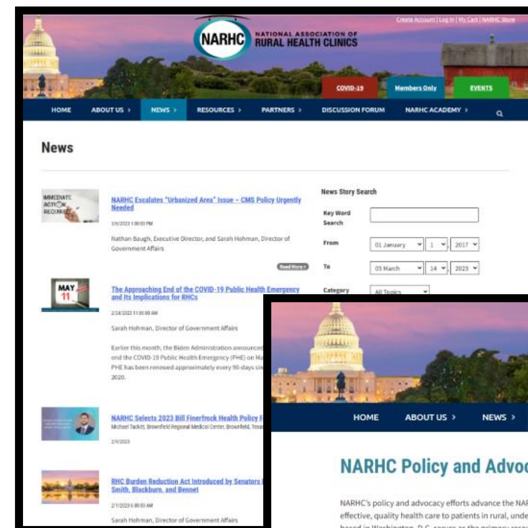
President Biden's Budget Request FY24

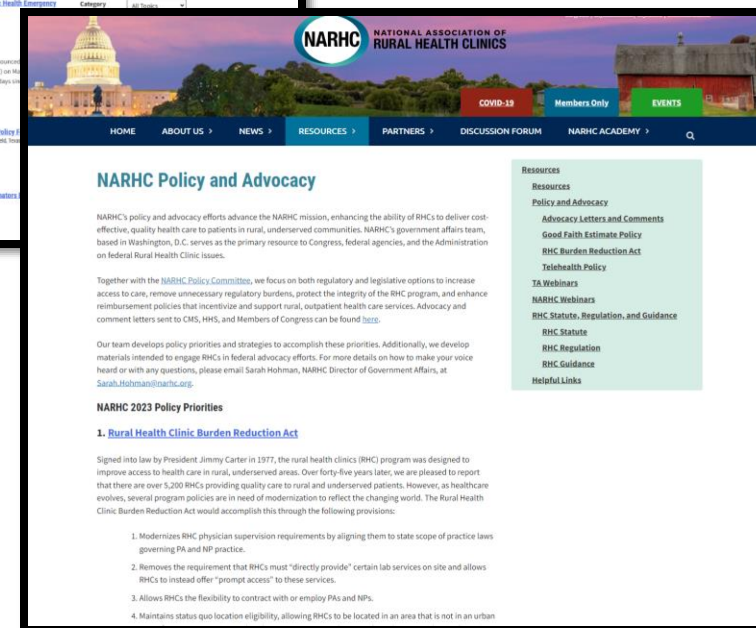
Rural Behavioral Health Initiative

"Rural areas represent nearly 60 percent of Mental Health Professional Shortage Areas, encompassing more than 25 million people who do not have adequate access to mental healthcare providers. Rural health clinics serve as a key access point for healthcare service where there is no Federally Qualified Health Center. ***The budget for rural health includes $10 million for a new Rural Health Clinic Behavioral Health Initiative to expand access to mental health services in rural communities.****"*

Stay “In the Know” on RHC Issues

- NARHC.org
  - Email Listserv
  - Discussion Forum
  - News Tab
  - Resources Tab
    - TA Webinars
    - Policy and Advocacy
- State rural health organizations & offices of rural health
- RHIhub
- CMS RHC Center





Thank You!

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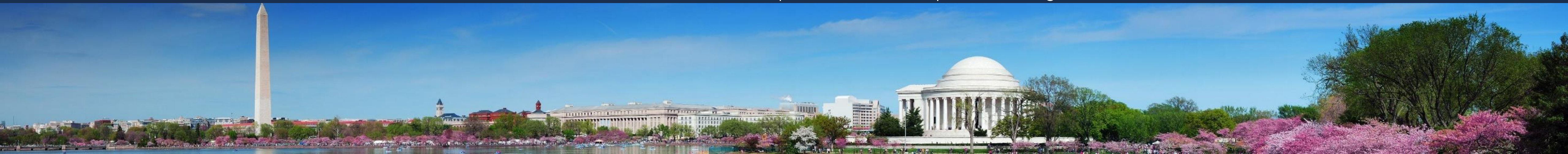

Thank You Partners!

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