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39th Annual Oregon
Rural Health Conference

OPPORTUNITY Just knock.

The Rural Health Clinic Workshop Presents
Getting Back to Normal: What to Expect After the PHE Ends

Speaker:
Jeff Harper, CHC, inQuiseek, LLC Consulting

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WHAT CHANGES WILL HAPPEN FOR RHCS WHEN THE PHE ENDS?

RHC Workshop - 39th Annual Oregon Rural Health Conference by Jeff Harper of InQuiseek Consulting

COVID-19 PUBLIC HEALTH EMERGENCY

The COVID-19 (SARS-Cov-2) Public Health Emergency (PHE) is currently in effect through this week. The PHE was extended for 90 more days by HHS Secretary Xavier Becerra on July 15, 2022. Until this extension or subsequent extensions expire, all blanket waivers are also in effect. The PHE may be extended in 90-day increments. CMS has communicated that the PHE will not end without a 60 advanced notice.

*"Silence from the administration means that the public health emergency will almost certainly be extended into **January 2023,"** said Larry Levitt, executive vice president for health policy at Kaiser Family Foundation*

Then, WHAT?

THESE BLANKET WAIVERS FOR RHCS WILL END:

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

- **Certain Staffing Requirements.** 42 CFR 491.8(a)(6). CMS is waiving the requirement in the second sentence of § 491.8(a)(6) that a nurse practitioner, physician assistant, or certified nurse-midwife be available to furnish patient care services at least 50 percent of the time the RHC operates. CMS is not waiving the first sentence of § 491.8(a)(6) that requires a physician, nurse practitioner, physician assistant, certified nurse-midwife, clinical social worker, or clinical psychologist to be available to furnish patient care services at all times the clinic or center operates. This will assist in addressing potential staffing shortages by increasing flexibility regarding staffing mixes during the PHE.

- **Physician Supervision of NPs in RHCs and FQHCs.** 42 CFR 491.8(b)(1). We are modifying the requirement that physicians must provide medical direction for the clinic's or center's health care activities and consultation for, and medical supervision of, the health care staff, only with respect to medical supervision of nurse practitioners, and only to the extent permitted by state law. The physician, either in person or through telehealth and other remote communications, continues to be responsible for providing medical direction for the clinic or center's health care activities and consultation for the health care staff, and medical supervision of the remaining health care staff. This allows RHCs and FQHCs to use nurse practitioners to the fullest extent possible and allows physicians to direct their time to more critical tasks.

THESE BLANKET WAIVERS WILL END:

- **Temporary Expansion Locations.** CMS is waiving the requirements at 42 CFR §491.5(a)(3)(iii) which require RHCs and FQHCs be independently considered for Medicare approval if services are furnished in more than one permanent location. Due to the current PHE, CMS is temporarily waiving this requirement removing the location restrictions to allow flexibility for existing RHCs/FQHCs to expand services locations to meet the needs of Medicare beneficiaries. This flexibility includes areas which may be outside of the location requirements 42 CFR §491.5(a)(1) and (2) but will end when the HHS Secretary determines there is no longer a PHE due to COVID-19.

https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

THIS MEANS: NO STAFFING WAIVERS AFTER THE PHE ENDS.

- The staffing requirements in 42 CFR § 491 must be in place:
  - NP or PA must be staffed at least 50% of all RHC Patient Care Hours as posted.
  - The RHC must have a designated Medical Director (Physician) who is responsible for the medical direction of the clinic and who performs chart audits to determine if NPP are following the medical management policies. The medical director must be able to see patients and provide medical services. The RHC Medical Director role is separate and distinct from any state required collaborative or supervisory role.
  - The flexibility for RHC providers to be working from home or alternate locations will end. RHC providers must provide face-to-face services in an approved encounter location.

THIS MEANS: NO SATELLITE OR OFF SITE RHC LOCATIONS WHICH ARE NOT INDEPENDENTLY CERTIFIED AS NEW RHCS AFTER THE PHE ENDS.

- No RHC services can be performed off-site or at temporary or satellite locations.
  - Each location must be certified at a qualified location with its own CCN number.
  - Each location must be in a currently designated Primary Care Healthcare Shortage Area or in a currently designated Medically Underserved Area.
  - Each location must be in a rural area as defined by the Census Bureau.
  - If the temporary location is in the process of becoming certified but is not certified at the time that the PHE ends, the services at that location are not considered RHC services until the new certification is obtained.
  - No expansion site services can be held out as services of the main RHC after the PHE ends.

WHAT ABOUT MEDICAL TELEHEALTH AFTER THE PHE ENDS?

- The flexibilities given to provide telehealth will end 151 days after the end of the PHE.
- RHCs will no longer be able to provide distant site telehealth after the 151-grace period. CMS may offer more clarification on this for RHCs since most of what has been published about the grace period applies to Part B Fee for Service telehealth.
- Remember that distant site services occur when the provider is in the RHC and the patient is somewhere else.
- Originating site telehealth services occur when the patient is in the RHC (hosted by the RHC) and the provider is a non-RHC provider located somewhere else. Originating site services will pay the RHC a fee for services amount for hosting the patient.

WHAT ABOUT MENTAL/BEHAVIORAL TELEHEALTH AFTER THE PHE ENDS?

- Mental and Behavioral Health services provided via telehealth are now recognized as RHC encounters and reimburse the AIR. This was a provision of the 2022 MPFS Final Rule.
- The end of the PHE does NOT change this.
- CMS is expected to give further clarification on whether these services must be distant site or if originating site services are also included. To pay the AIR we would expect the services to be distant site; however, CMS has not been clear on this.
- Billing guidance for these mental health telehealth services can be found in SE 22001.

https://www.cms.gov/files/document/se22001-mental-health-visits-telecommunications-rural-health-clinics-federally-qualified-health.pdf

MENTAL HEALTH TELEHEALTH CODING & BILLING INFORMATION

RHC Claims for Mental Health Visits via Telecommunications Example

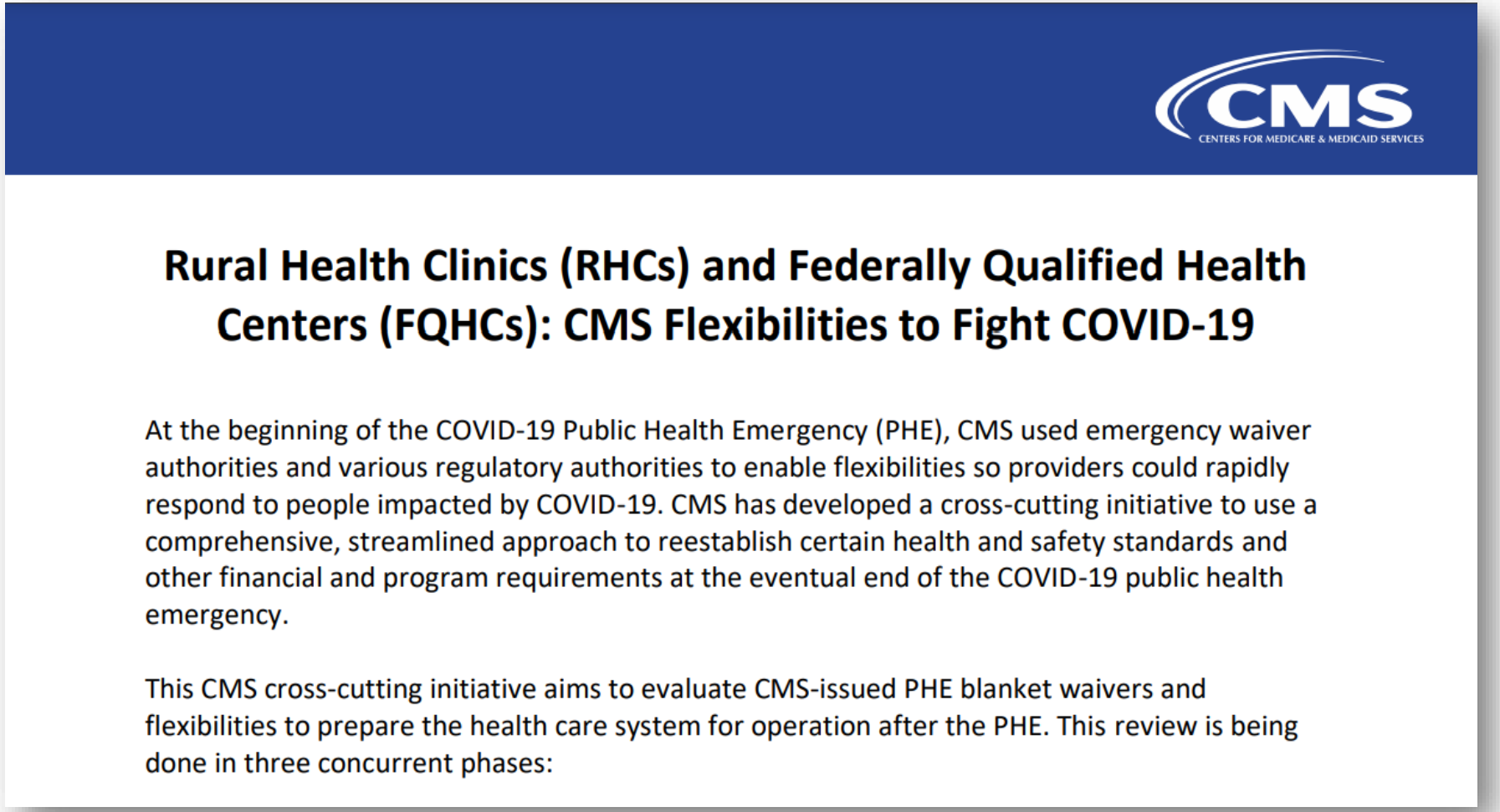
Revenue Code	HCPCS Code	Modifiers
0900	90834 (or other Qualifying Mental Health Visit Payment Code)	95 (audio-video) or FQ (audio-only) CG (required)

Mental Health Services	
HCPCS Code	**Short Descriptor**
90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvcs
90832	Psytx pt&/family 30 minutes
90834	Psytx pt&/family 45 minutes
90837	Psytx pt&/family 60 minutes
90839	Psytx crisis initial 60 min
90845	Psychoanalysis

GETTING BACK TO NORMAL WITH P & P

Processes and Procedures have been dynamic for the past two years with many changes to how RHCs do business. Many RHCs have been developed during the PHE and may not know what normal P & P should look like. Things to consider:

- Review 42 CFR §491 and other CMS Guidance to make sure you understand what is required.
- Review current processes and procedures to determine what will change back after the blanket waivers end.
- Revise internal documents including policies, procedures, training and orientation materials.
- RETRAIN staff and providers.
- Evaluate policy effectiveness and implementation.



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): CMS Flexibilities to Fight COVID-19

At the beginning of the COVID-19 Public Health Emergency (PHE), CMS used emergency waiver authorities and various regulatory authorities to enable flexibilities so providers could rapidly respond to people impacted by COVID-19. CMS has developed a cross-cutting initiative to use a comprehensive, streamlined approach to reestablish certain health and safety standards and other financial and program requirements at the eventual end of the COVID-19 public health emergency.

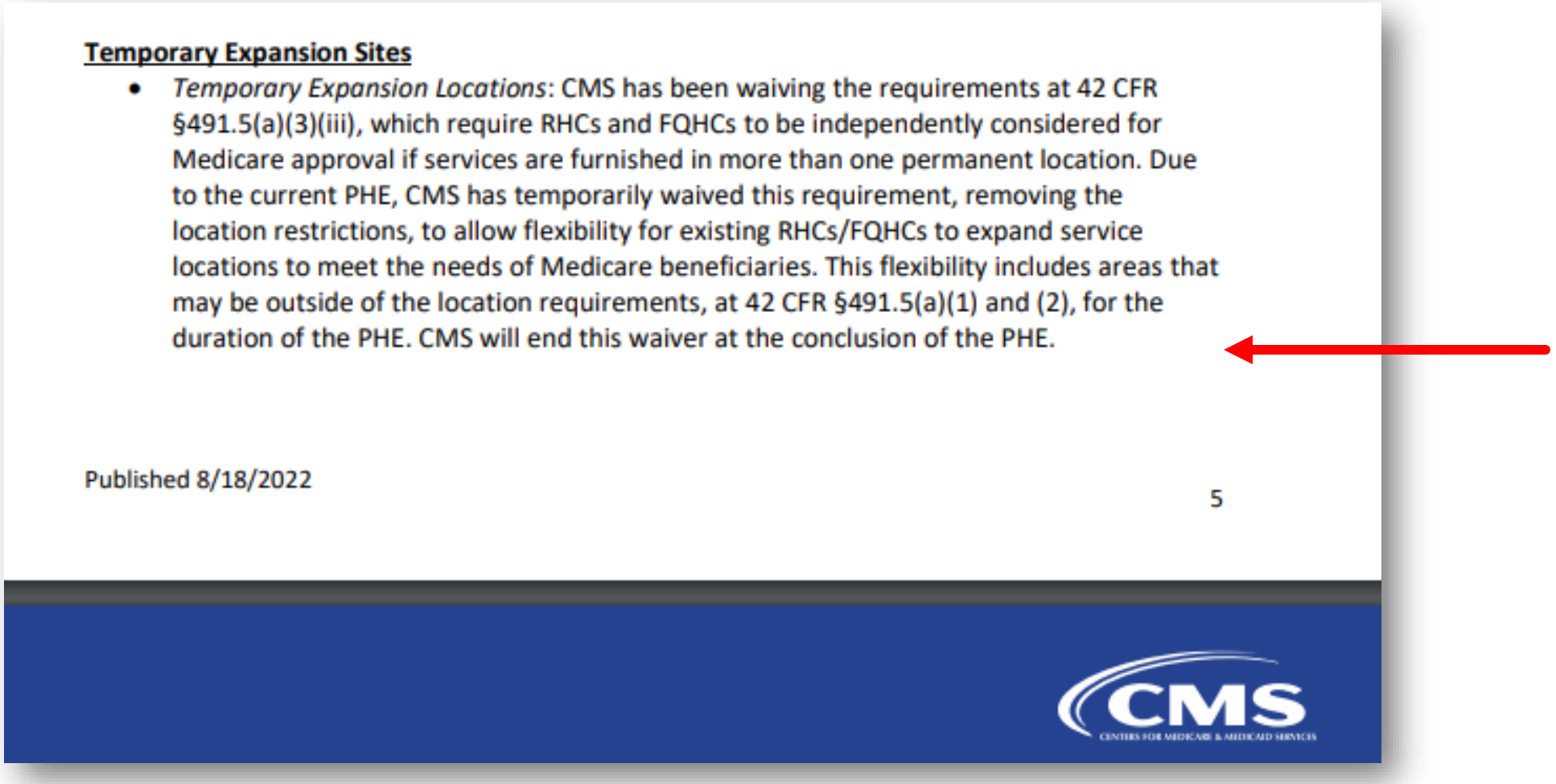
This CMS cross-cutting initiative aims to evaluate CMS-issued PHE blanket waivers and flexibilities to prepare the health care system for operation after the PHE. This review is being done in three concurrent phases:

https://www.cms.gov/files/document/rural-health-clinics-and-federally-qualified-health-centers-cms-flexibilities-fight-covid-19.pdf

Waivers or Flexibilities That Have Already Ended are indicated in red text

- *Provider Enrollment*: During the PHE, CMS has established toll-free hotlines for physicians, non-physician practitioners, and Part A certified providers and suppliers who have established isolation facilities to enroll and receive temporary Medicare billing privileges. **When the PHE ends, the hotlines will be shut down.** Additionally, CMS has provided the following flexibilities for provider enrollment:
    - *Screening requirements:*
        - Site Visits: CMS waived provider enrollment site visits for moderate and high-risk providers/suppliers. ***(This waiver terminated on 07-06-2020 and CMS, in accordance with 42 C.F.R. §§ 424.517 and 424.518, resumed all provider enrollment site visits.)***
        - *Fingerprint-based criminal background checks:* CMS waived the requirement for fingerprint-based criminal background checks for 5% or greater owners of newly enrolling high risk categories of providers and suppliers (e.g., newly-enrolling Home Health Agencies, DMEPOS suppliers, Medicare Diabetes Prevention Programs, Opioid Treatment Programs). ***(This waiver terminated on 10/31/2021 and CMS, in accordance with 42 C.F.R. § 424.518, resumed requesting fingerprints for all newly enrolling high risk providers and suppliers.)***
    - *Application Fees:* CMS waived the collection of application fees for institutional providers who are initially enrolling, revalidating, or adding a new practice location. ***(This waiver terminated on 10/31/2021 and CMS, in accordance with 42 C.F.R. § 424.514, resumed collecting application fees.)***

The document has been revised and updated to include information about when the waiver will end or how it will be transitioned.



Temporary Expansion Sites

- *Temporary Expansion Locations*: CMS has been waiving the requirements at 42 CFR §491.5(a)(3)(iii), which require RHCs and FQHCs to be independently considered for Medicare approval if services are furnished in more than one permanent location. Due to the current PHE, CMS has temporarily waived this requirement, removing the location restrictions, to allow flexibility for existing RHCs/FQHCs to expand service locations to meet the needs of Medicare beneficiaries. This flexibility includes areas that may be outside of the location requirements, at 42 CFR §491.5(a)(1) and (2), for the duration of the PHE. CMS will end this waiver at the conclusion of the PHE.

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TIMELINE

January 13, 2023

Current PHE is expected to end on January 13, 2023. All blanket waivers end. Staffing must be restored to pre-PHE levels. NP or PA 50% of all patient care hours. No temporary expansion sites.

June 13, 2023

The 151-day grace period for phasing out distant site telehealth and telehealth flexibilities ends. Expect more clarification on this from CMS concerning the grace period.

On-going

Mental Health via Telehealth continues for RHCs after the PHE ends. Refer to CMS guidance on coding and billing. Expect clarification between distant site and originating site.

RAMPING BACK UP AND PROTECTING YOUR AIR

- Many RHCs experienced low volumes during the PHE or switched to telemedicine services. In either case, this negatively impacted the productivity standards.
- RHCs always have the option of asking for a productivity waiver for cost reporting.
- However, for PBRHCs with grandfathered AIRs, it is important to sustain the grandfathered cost per encounter. Falling below the productivity standard can jeopardize the grandfathered rate in a low-volume cost reporting period.
- Physicians should have 4,200 encounters per FTE. NPs or PAs should have 2,100 encounters per FTE. This calculation is based on the hours the provider is available to see patients. Falling below this aggregate standard will subject you to CMS using what the visits should have been as the AIR denominator instead of the actual number of encounters which can decrease the cost per encounter and lower the rate from your grandfathered upper payment limit.

QUESTIONS

- ?????

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For the past forty years, Jeff Harper has been a business leader and innovator. During his emerging career, his accomplishments include: Working with Hospitals and Physician Practices in both urban and rural areas. Leading a regional CPA Firm as Managing Partner of a regional for 8 years; Providing 10 years of strategic financial leadership as CFO; Navigating and heavily negotiating through 12 mergers & acquisitions; and Serving as President of 50-million-dollar international corporation for 3 1/2 years earning INC 5000 for two consecutive years.

He presently is a principal of InQuiseek Consulting, a Louisiana-based firm that provides a wide range of consulting services across a variety of healthcare facility types. He is certified in Healthcare Compliance. Harper is in various hospitals and RHCs ever week all over the rural landscape and his diverse experience gives him a unique perspective to address opportunities for improved operational performance and cultural transformation. He has membership in NARHC, NRHA, and HFMA.

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