Federal Policy Update

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Agenda

Legislative

- 2024 Congressional Activity
- NARHC Legislative Priorities
  - RHC Burden Reduction Act
  - Telehealth
  - Medicare Advantage

Regulatory

- CMS Proposed Rules Calendar Year 2025
  - Changes to Required Labs & Productivity Standards
  - Care Management Billing Changes
  - Proposals to clarify "primarily engaged in primary care"
- Other New Regulations

NARHC Overview

> *"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:

- Intro to RHCs
- Certified Rural Health Clinic Professionals (CRHCP)

Technical Assistance Webinars

- Mobile Units and Your RHC – Is this a good fit?
- RHC Billing 101

Conferences

Legislative & Regulatory Advocacy:

NARHC serves as the primary resource to Congress, federal agencies, and the Administration on federal RHC issues. Aim to:

- *Increase access to care*
- *remove unnecessary regulatory burdens*
- *protect the integrity of the RHC program, &*
- *enhance reimbursement policies that support rural, outpatient health care services.*

NARHC Advocacy Letters and Comments

NARHC often communicates with Congress and the Administration on issues of importance to the Rural Health Clinic community. The following is an archive of official communications we have sent advocating on behalf of the Rural Health Clinic Program. We have also included some communications and letters that NARHC has signed but were not authored by NARHC.

June 26, 2024 - Statement for the Record CMMI Hearing

June 18, 2024 - Statement for the Record 340B Oversight Hearing

May 30, 2024 - Joint Letter to Energy and Commerce Leadership

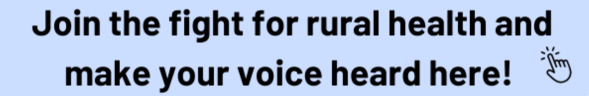
May 30, 2024 - Statement for the Record, Senate Finance Committee Rural Health Hearing

May 29, 2024 - CMS Medicare Advantage Data Request for Information Response

May 28, 2024 - RFI Response - Rural Definition Proposed Changes - FORHP Grants

April 25, 2024 - MedPAC April Public Meeting Statement for the Record

March 28, 2024 - CPT Category II ~ Letter to the Administrator

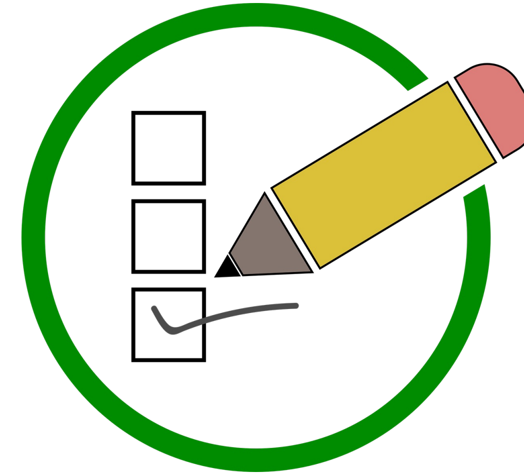


1st NARHC Policy Summit Overview!

- Shout out to Liberty Pertiwi from Samaritan Medical Group who represented Oregon at the Policy Summit!
- Webinar Debrief

2024 RHC Policy Survey Results

- RHCs provide care for **38.7 million Americans** (over 62% of people living in rural areas)



- **Payer Mix:**
  - 30% Medicaid/CHIP
  - 22% traditional Medicare
  - 12% Medicare Advantage
  - 31% commercially insured
  - 6% uninsured

- **Medicare Advantage:**
  - 31% say MA plans reimburse approximately the same as traditional Medicare
  - 18.4% say MA plans reimburse slightly less than traditional
  - 29.5% say MA plans reimburse significantly less than traditional

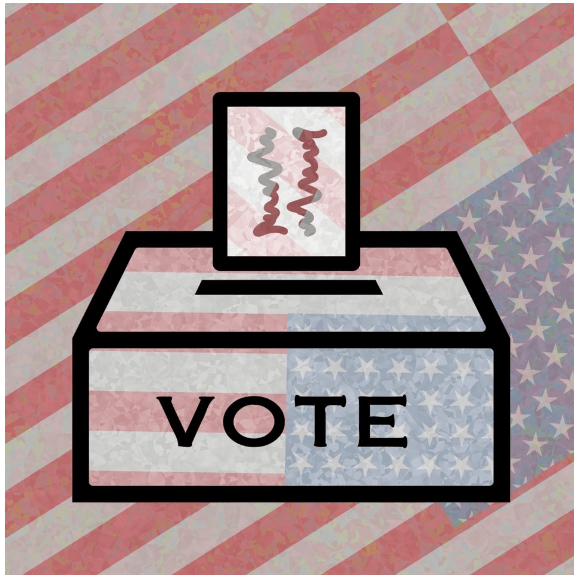
Activity of the 118th Congress Thus Far

- Divided Government
- Historically Unproductive
- Not much is moving
  - 16,317 bills introduced
  - 67 have become law
  - Compare to 117th Congress -- 365 bills signed into law!

In 2024 Congress Must…

- Campaign!
- Fund the government
  - Government's Fiscal Year begins in October
  - Need something to get us through the rest of FY 24 and through the first part of FY 25
  - These "must pass" bills are often seen as the place for other "policy riders"
  - Majority of federal healthcare policy changes in the past 10 years have been passed as "policy riders"
- Congress must extend Medicare coverage of telehealth if it is to continue beyond 2024 (which we expect)

"Nothing will happen because they are all focused on the election"



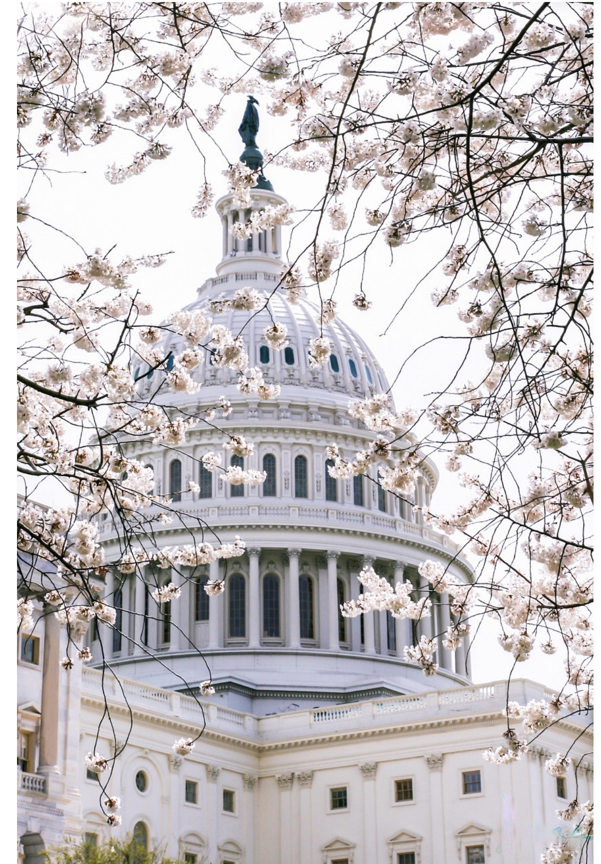
- Congress still must govern (and more specifically fund the government)
- Lame duck session sometimes provides a unique opportunity to pass policy
- "Socialization" of the RHC program and RHC issues still matters
  - **This is a prime opportunity for YOU to advocate, as well!**
- Biggest policy change of the last 20 years for RHCs happened in a lame duck session after a presidential election as a part of the FY 2021 appropriations mega-package

NARHC Priorities- 118th Congress

RHC Burden Reduction Act

Telehealth

Medicare Advantage



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 Co-Sponsors

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)
- Rep. Harshbarger (TN-01)
- Rep. Green (TN-07)
- Rep. Barr (KY-06)
- Rep. Mann (KS-01)
- Rep. Boebert (CO-03)
- Rep. Pappas (NH-01)
- Rep. Carl (AL-01)
- Rep. Zinke (MT-01)
- Rep. Cherfilus-McCormick (FL-20)
- Rep. Baird (IN-04)
- Rep. Yakym (IN-02)
- Rep. Mooney (WV-02)
- Rep. Hageman (WY)
- Rep. Vasquez (NM-02)
- Rep. Flood (NE-01)
- Rep. Higgins (LA-03)

RHC Burden Reduction Act Outlook

- Goal is to pass S.198/H.R.3730 as a policy rider on FY24 / FY25 appropriations vehicle

- **Pros:**
  - Non-controversial, technical, common-sense legislation
  - Rural health is broadly a bipartisan, sympathetic issue
- **Cons:**
  - Simple, not "flashy enough" bill – no Member's #1 priority
  - Congress operates best on deadlines and for crisis issues
  - **This bill will not pass without Members hearing from their constituents**

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Voter Voice Advocacy

- Current advocacy priority: Have Congress include the RHC Burden Reduction Act in FY24 appropriations package
- Customize: the more personal a message is, the more weight it can carry
- NARHC Homepage > Resources > Policy and Advocacy > RHC Burden Reduction Act
- https://www.narhc.org/narhc/RHC_Burden_Reduction_Act.asp

Current Medicare Telehealth Coverage - RHCs

Medical Telehealth

- RHCs can serve as telehealth distant site providers through December 31, 2024 (at least)
- Paid $96.87 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 – Billed as G2025

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 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 we want:
  - Normal coding, cost reporting, billing, reimbursement
  - **Pay telehealth encounters through All-Inclusive Rate system**

Telehealth Legislative Outlook

- Without Congressional action, current Medicare medical telehealth flexibilities will expire on December 31, 2024
- Telehealth has significant bipartisan and widespread industry support
- Several pieces of legislation have been introduced this Congress that achieve our telehealth priorities
  - Section 105 of **S. 2016/HR 4189 -** The CONNECT for Health Act of 2023;
  - Section 2 of **H.R. 5611 -** The HEALTH Act of 2023;
  - Section 113 of **H.R. 833** - Save America's Rural Hospitals Act
  - Section 2 of **H.R.7623/S.3967** – Telehealth Modernization Act

Latest Congressional Activity

- In addition to introducing telehealth bills, relevant committees have been hosting telehealth hearings and markups.

- The House Ways & Means Committee marked up a piece of telehealth legislation that simply extends current telehealth policy (including G2025) for 2 years.

- The House Energy & Commerce Subcommittee on Health marked up a piece of telehealth legislation that **fixes** G2025 policy in a 2-year extension!

Voter Voice Advocacy

- Current advocacy priority: Have Congress extend telehealth distant site flexibilities while fixing G2025 policy (allowing RHCs to bill normally for telehealth services and receive payment parity)
- Customize: the more personal a message is, the more weight it can carry
- NARHC Homepage > Resources > Policy and Advocacy > Telehealth Policy and Resources
- https://www.narhc.org/narhc/Telehealth_Policy.asp

Medicare Advantage

Widespread Issues

- Prior authorization timelines/decisions
- Inaccurate marketing / lack of patient understanding
- Claims denials / timelines
- Administrative burden

RHC / Other Rural Provider Niche Issue

- Lower/significantly lower reimbursement than enhanced traditional Medicare reimbursement

Medicare Advantage Issues

For RHCs, each MA plan is like another commercial contract

- While some RHCs are able to negotiate for comparable reimbursement, there is **no requirement** that MA plans treat RHCs differently than any other provider (despite the RHC role in the health care safety net)
- FQHCs receive quarterly wrap payments to make up the difference between contracted rates and traditional Medicare reimbursement rates

A Few Positive Steps Forward

- CMS published a final Medicare Advantage rule in mid-January with some prior authorization reforms (beginning in 2026):
  - Require standard, non-urgent decisions within 7 days
  - Require urgent decisions within 72 hours
  - Payers must submit a specific reason for denying coverage if prior authorization is denied

- Prior legislation that aimed to reform MA prior authorization but had too high of a cost was recently re-scored by the Congressional Budget Office as a $0 cost

Medicare Advantage Advocacy

- **We cannot let Medicare Advantage plans diminish our rural safety-net**

- **Legislatively, NARHC is pursuing a floor payment (minimum) that MA plans must pay RHCs**
  - Different options for structuring and financing the floor

Medicare Advantage is still largely popular amongst Members of Congress, although this is shifting in certain ways. This is a fairly controversial, costly priority that will require RHC advocacy once text is introduced hopefully later this year.

2025 Proposed Rules: Medicare Physician Fee Schedule (MPFS) & Medicare Outpatient Prospective Payment System (OPPS)

Other New Regulations

New in 2024: New Medicare Billable Providers in RHCs

- Marriage and Family Therapists and Mental Health Counselors can generate a Medicare encounter, reimbursable at the RHC's All-Inclusive Rate (AIR).
- MFTs/MHCs are subject to the same policies as a PA, NP, CNM, CP, and CSW in the RHC.
- MFTs/MHCs may serve as the RHC owner or an employee, or be under contract.
- MFTs/MHCs can fulfill the requirement that a provider must be available to furnish care at all times the clinic is open.
- CMS FAQs can be found here.
- Recent NARHC webinar slides and recording.

§405.2463 What constitutes a visit.

(a) *Visit—General.*

(1) For RHCs, a visit is either of the following:

(i) Face-to-face encounter between a RHC patient and one of the following:

(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 therapist.
(J) Mental health counselor.

<u>New in 2024:</u> Intensive Outpatient Program (IOP) Services

- New behavioral health treatment category billable in RHCs
- Intended for patients with an acute mental illness (including depression, schizophrenia, substance use disorders, etc.) that need between 9-19 hours of care per week
    - Higher level of care than occasional outpatient visit; less intensive that partial hospitalization programs
    - These services are to be provided in person
- Physician must certify patient for IOP and review no less than every other month

Intensive Outpatient Program (IOP) Services

Billing and Reimbursement

Reimburses through a "special payment rule," not the AIR/encounter rate

- $259.40 per patient per day
- Reimbursement corresponds to 3* distinct, qualifying services per day
- Report condition code 92 and revenue code 0905; CG modifier
- Costs associated with IOP services must be carved out of RHC cost report

- An IOP service and a separate mental health encounter would not be eligible for same day billing (RHC All-Inclusive Rate reimbursement plus $259.40). However, RHCs could bill for IOP services and a separate medical visit for the same patient on the same day when appropriate

Three (or fewer services per day) would accommodate occasional instances when a patient is unable to complete a full day of PHP or IOP. CMS expects that days with fewer than three services would be very infrequent and intends to monitor the provision of these days among providers and individual patients. More information can be found here.

Intensive Outpatient Program (IOP) Services

One service must come from list A

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

Remaining 2 services must come from list B

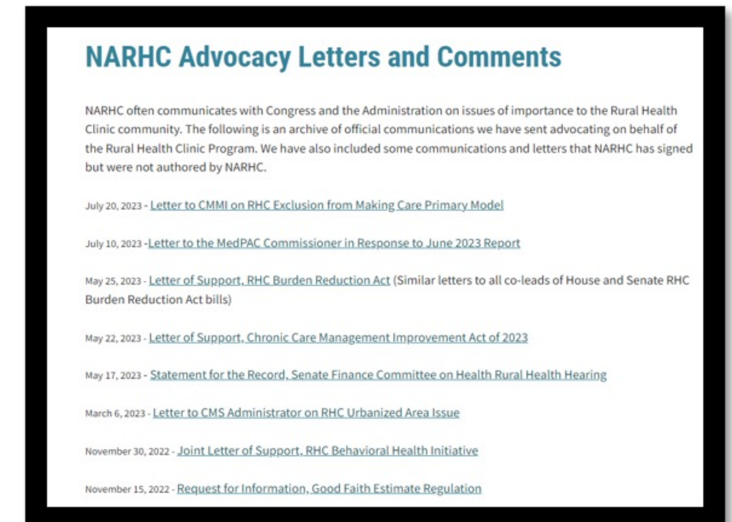
HCPCS/CPT	Short Descriptor
90785	Psytx complex interactive
90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvcs
90832	Psytx pt&/family 30 minutes
90833	Psytx pt&/fam w/e&m 30 min
90834	Psytx pt&/family 45 minutes
90836	Psytx pt&/fam w/e&m 45 min
90837	Psytx pt&/family 60 minutes
90838	Psytx pt&/fam w/e&m 60 min
90839	Psytx crisis initial 60 min
90840	Psytx crisis ea addl 30 min
90845	Psychoanalysis
90846	Family psytx w/o patient
90847	Family psytx w/patient
90849	Multiple family group psytx
90853	Group psychotherapy
90880	Hypnotherapy
90899	Psychiatric service/therapy
96112	Devel tst phys/qhp 1st hr
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
96158	Hlth bhv ivntj indiv 1st 30
96161	Admin of caregiver – focused hlth risk assmt for ben of patient

HCPCS/CPT	Short Descriptor
96164	Hlth bhv ivntj grp 1st 30
96167	Hlth bhv ivntj fam 1st 30
96202	Multiple-family group behavior management/modification training for parent(s) guardian(s) caregiver(s) with a mental or physical health diagnosis up to 60 minutes
96203	Multiple-family group behavior management/modification training for parent(s) guardian(s) caregiver(s) with a mental or physical health diagnosis each addtl 15 minutes
97151	Bhv id assmt by phys/qhp
97152	Bhv id suprt assmt by 1 tech
97153	Adaptive behavior tx by tech
97154	Grp adapt bhv tx by tech
97155	Adapt behavior tx phys/qhp
97156	Fam adapt bhv tx gdn phy/qhp
97157	Mult fam adapt bhv tx gdn
97158	Grp adapt bhv tx by phy/qhp
97550	Caregiver training 1st 30 min
97551	Caregiver training ea addl 15
97552	Grp caregiver training
G0023	Navigate srv 60 min per m
G0024	Navigate srv add 30 min per m
G0129	PHP/IOP service
G0140	Nav srv peer sup 60 min pr m
G0146	Nav srv peer sup add 30 pr m
G0176	Opps/php/IOP; activity thrpy
G0177	Opps/php/IOP; train & educ
G0410	Grp psych PHP/IOP 45-50
G0411	Interactive grp psyc PHP/IOP
G0451	Development test interpt&rep

CMS Rulemaking Process

July – MPFS and OPPS Proposed Rules Released

- What's in the proposed rules for RHCs webinar upcoming on August 15



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July 20, 2023 - Letter to CMMI on RHC Exclusion from Making Care Primary Model

July 10, 2023 -Letter to the MedPAC Commissioner in Response to June 2023 Report

May 25, 2023 - Letter of Support, RHC Burden Reduction Act (Similar letters to all co-leads of House and Senate RHC Burden Reduction Act bills)

May 22, 2023 - Letter of Support, Chronic Care Management Improvement Act of 2023

May 17, 2023 - Statement for the Record, Senate Finance Committee on Health Rural Health Hearing

March 6, 2023 - Letter to CMS Administrator on RHC Urbanized Area Issue

November 30, 2022 - Joint Letter of Support, RHC Behavioral Health Initiative

November 15, 2022 - Request for Information, Good Faith Estimate Regulation

September – Comments Due

November – Final Rules Released

January – Provisions go into effect

<u>Newly *Proposed* in 2025:</u> Quick Overview

- Major reforms to RHC care management
  - Currently, RHCs bill G0511 instead of the individual 20+ allowable CPT codes when those individual code requirements are met
  - CMS is instead proposing for RHCs to bill individual care management codes

- Modifications to RHC lab requirements
  - Removing hemoglobin / hematocrit from required on-site labs
  - Requires RHCs to have the ability to collect specimens for transfer to outside lab, instead of requiring ability to do primary culturing on-site

- Proposes to eliminate productivity standards

Newly *Proposed* in 2025: Quick Overview

- Proposal to allow RHCs to bill for administration of part B preventive vaccines at time of service, instead of fully a lump sum cost report settlement

- Proposal to still require provision of primary care services but no longer enforce "primarily engaged in furnishing primary care services"

- Maintains that RHCs cannot be "primarily engaged in the treatment of mental diseases," but seeks comment on how to define "mental diseases"

<u>Newly *Proposed* in 2025:</u> Quick Overview OPPS

- Proposes REH quality reporting program

- Proposes new Conditions of Participation (CoPs) for CAHs and other hospitals for obstetrical services, such as staff training, quality assessment and performance improvement, and standards for staffing, delivery of care, etc.

- Hospitals interested in learning more about these provisions can review the CMS OPPS Fact Sheet.

Regulatory Updates with RHC Impacts

Medicaid / Medicaid Managed Care

- CMS rule requires states to publish Medicaid FFS rates online by 2026 (excludes RHCs/FQHCs)
- Establishes maximum wait times for Medicaid MCO patients
- These rules have impacts for insurers and your patients, not direct RHC impacts at this time

Dep. Of Labor and Fed. Trade Commission

- DOL rule expands overtime eligibility by increasing the salary threshold required for OT exemptions from $35,568 to $58,656
- FTC bans non-compete agreements beginning Sep. 4, 2024; existing non-competes except for senior executives are no longer enforceable

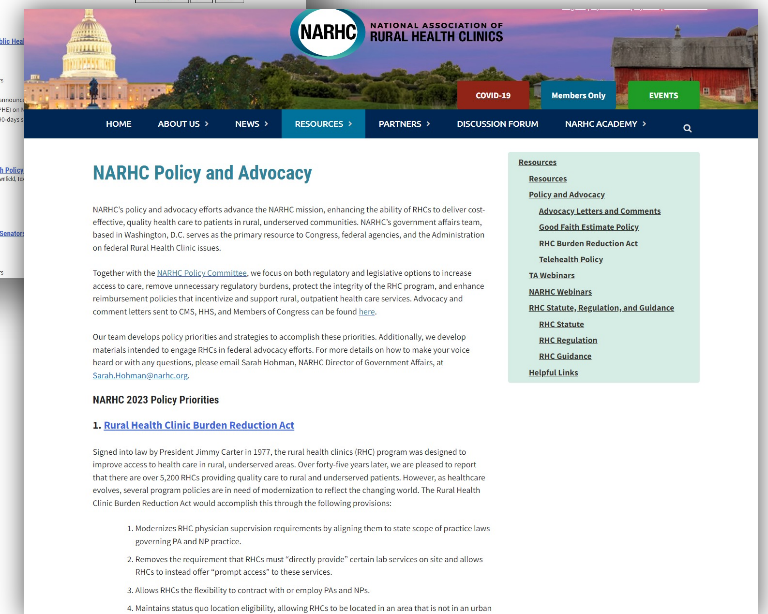
Regulatory Updates with RHC Impacts

HHS Nondiscrimination Rule

- Section 1557 of the Affordable Care Act "prohibits discrimination on the basis of race, color, national origin, sex, age, or disability" in specified health programs or activities. The rule contains a broad definition for "covered entities" which includes any healthcare provider that "receives Federal financial assistance" which in this case means any provider who receives reimbursement from Medicare, Medicaid, CHIP or any Affordable Care Act Marketplace plan.
- This final rule re-introduces specific patient notification requirements, expands nondiscrimination policies into telehealth/clinical decision support tools, and requires covered entities to both develop and train staff on Section 1557 policies and procedures.
- July 15 NARHC Webinar

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
- Federal Office of Rural Health Policy (FORHP) Weekly Updates
- RHIhub
- CMS RHC Center



NARHC Community Forum

Your resource to engage in discussions about all things Rural Health Clinics. The NARHC Community Forum serves as a valuable resource to ask questions, network with other professionals, share knowledge, and stay informed!

How to join:

- Access the registration form through this QR code!
- Sign up to create an account & verify email
- Build your Community profile
- Access the community and start interacting!

Questions? Contact us at Academy@NARHC.org

Scan to join!

Questions?

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