OREGON OFFICE of RURAL HEALTH

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CAH Finance and Operations Webinars

August 15, 2024

Behavioral Health: Leveraging RHCs to Expand an Essential Service

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The Oregon Office of Rural Health's vision statement is to serve as a state leader in providing resources, developing innovative strategies and cultivating collaborative partnerships to support Oregon rural communities in achieving optimal health and well-being.

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- Stay tuned for another series of six webinars in 2025
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Rob Bloom is a Principal at Wintergreen. Prior to joining Wintergreen as a Principal, Rob served as CFO for Carthage Area Hospital for over a decade. He previously held positions with the Hospital as Administrator of Primary Care Services and Interim Chief Financial Officer. In addition to his role as CFO at Carthage, Rob also served concurrently (2021-2022) as Chief Financial Officer at Claxton Hepburn Medical Center and Orleans Community Hospital in addition to providing consultative services to several other hospitals in rural New York.

Behavioral Health: Leveraging RHCs to Expand an Essential Service

August 15 2024

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Objectives

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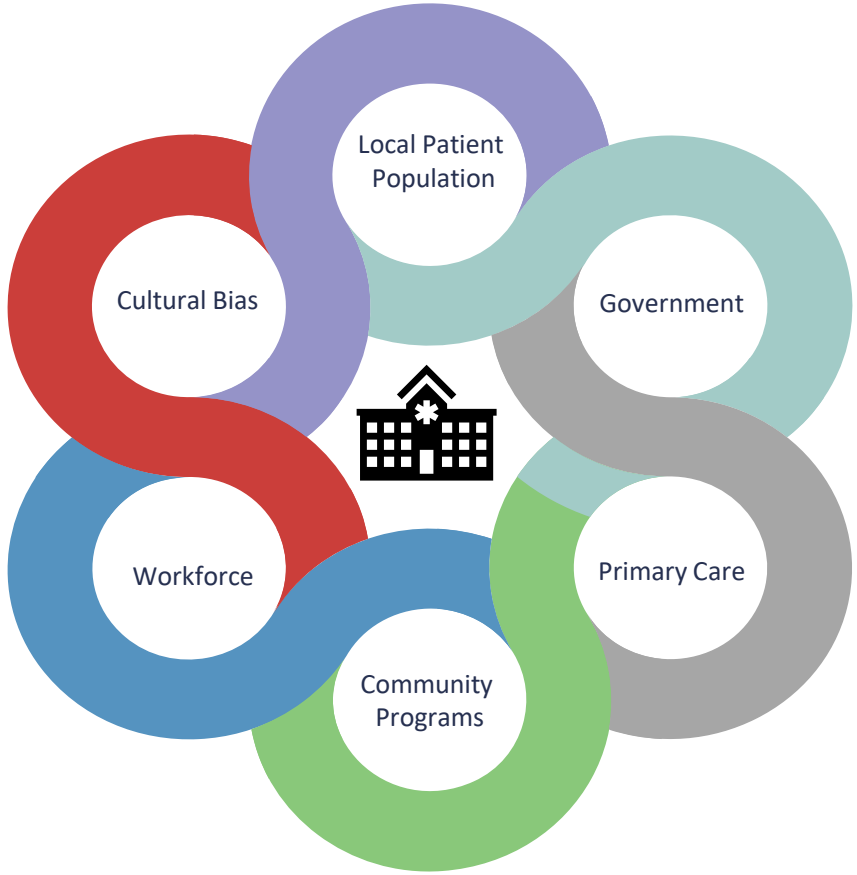
- Discuss the impact and integration of behavioral health in rural healthcare
- State recent federal changes and the opportunities related to these changes
- List opportunities related to services and provider types
- Examine strategy opportunities for implementation of behavioral health

Overview

Environment

- Behavioral Health is one of the most underserved needs in rural communities due to lack of access to care and confusion surrounding how care should be provided

  - Treatment modalities
  - Qualified professional staff
  - Regulatory environment
  - Reimbursement
  - Stigma
  - Scalability



Conflicts and Confusion

Drivers of health are dominated by behavioral health factors, and providers increasingly are paid based on population health – but our strategies and systems of care are misaligned

Conflicts

What happens when the most important and effective means of manufacturing community-based health and wellness does not have a direct, explicit nor defensible business proposition?

Confusion

What happens when an arcane, opaque and fluid regulatory environment meets with a mission-based service line that has chronic provider shortages and impenetrable reimbursement models?

The net result has been rural providers that **don’t know where to start**, how to expand nor link behavioral health delivery to growth and profitability

Providers and Sites

Outcomes and Wellness

Primary Care

Education fosters knowledge, skills, integration, and reduces stigma

Inpatient

Inpatient services assist those individuals whose need for help requires full time intervention, for both mental health and substance abuse

Outpatient

Outpatient services provide the access to care to prevent escalation of problems that may impact work and home life

Community

Providers and Sites

Any one individual can have as their professional portfolio more than one discipline and ability to provide more than one service

Provider Types

A broad variety of provider types are required and can be utilized as the build blocks of an effective BH Program

- Primary Care Physicians
- Psychiatrist
- Psychologist
- Counselors/Therapists
- Social Workers
- Nurse Practitioners/Physician Assistants
- Registered Nurses
- Clerical Support

Treatment Sites

Similarly, diverse treatments sites are both needed and available

- Hospitals
- Provider Based Clinics/RHCs
- Independent RHCs/Community Clinics
- Outpatient Substance Abuse Centers
- Residential Treatment Facilities

Provider Imperatives

Are we providing the right services?

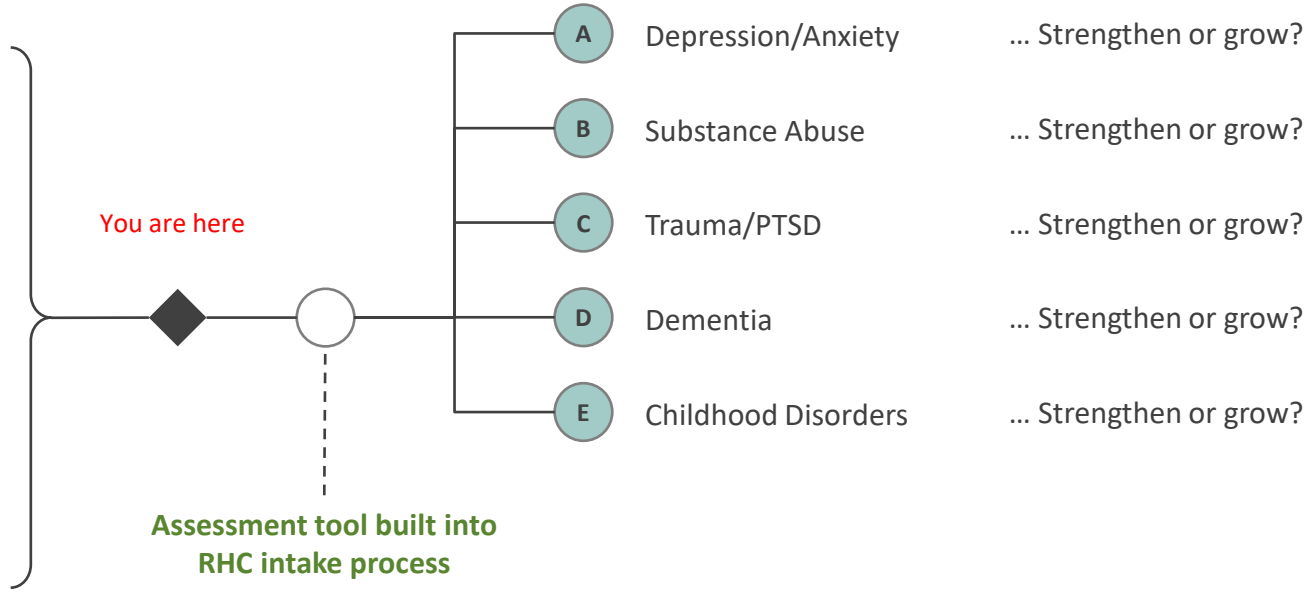
Do we get paid for the service we provide?

Are we in compliance?

How's our provider depth chart?

Are we set up for future growth and scalability?

What will competitors do?



Assessment tool built into RHC intake process

(PHQ-2, PHQ-9, GAD-7, CAGE, AUDIT, etc.)

Rural provider organizations must assess and strengthen existing programs as well as determine **supply:demand** for service growth

Get Into Behavioral Health

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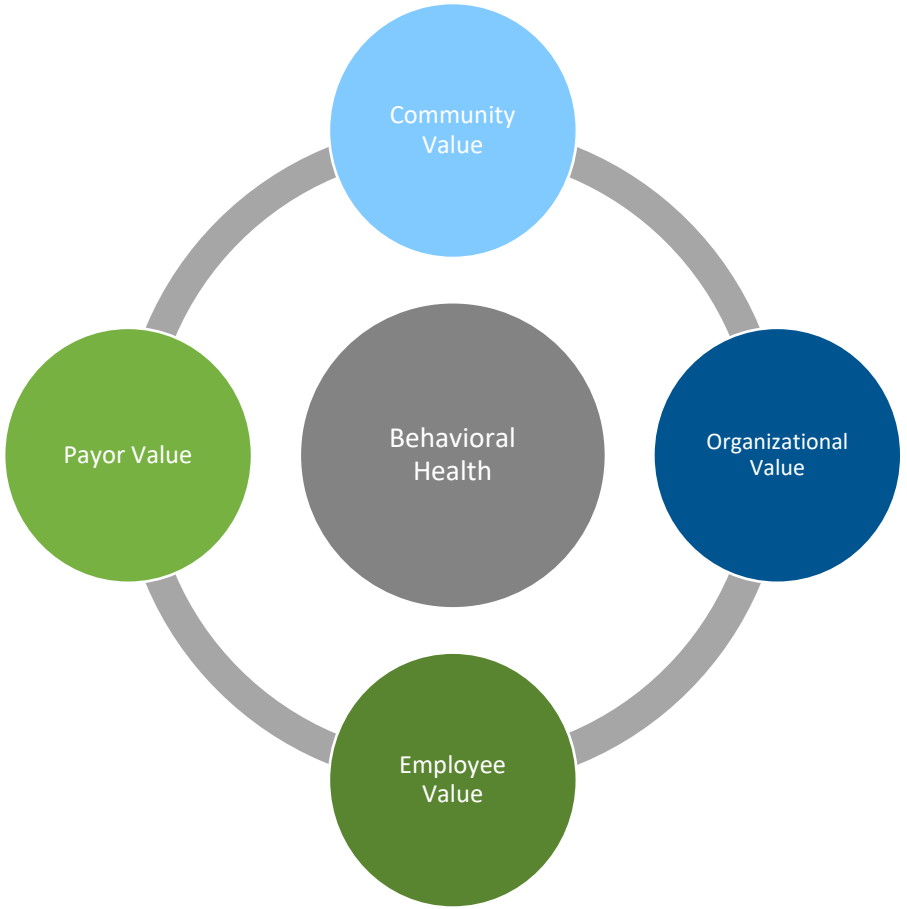
BH integration into the care continuum represents an opportunity for increased value.

Physical healthcare costs can be favorably impacted by appropriate BH intervention

Ensure payers know the intent to bring efficiency to the table as part of a holistic approach to care.

BH Fits with Rural

- Behavioral health is an ancillary feeder service similar to other service lines
  - Labs
  - 340b
  - GI
  - Primary Care
- Value based contracts- up to 50% of ER high utilizers have BH issues
- BH has an expected growth rate of 9%; profitable if people practice at the top of their license
- Post pandemic, there has been a 25% increase in reported addiction
- BH is health, it affects everything else related: decision making, medication compliance, home life, employment, etc. Organizations cannot do value based/pop health contracts without it.



Recent Federal Changes

New Billable RHC Providers

- The Consolidated Appropriations Act of 2023 included provisions allowing RHCs to bill for Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) beginning January 1, 2024

- MFTs and MHCs becoming qualified RHC providers means they can generate a Medicare encounter that is reimbursable at the RHC's All-Inclusive Rate (AIR). MFTs and MHCs are subject to the same policies and supervision requirements as other non-physician RHC providers

- Mental health practitioners who meet all of the applicable statutory qualifications for the mental health counselor benefit category but are licensed by their State under a different title, are eligible to enroll in Medicare under the "Mental Health Counselor" category

- MFTs and MHCs will not be subject to a productivity standard in RHCs

- MFTs and MHCs were added to the regulations 491.8(a)(3) and 481.8(a)(6), allowing these provider types to serve as the RHC owner or an employee, or be under contract

- Additionally, MFTs and MHCs can fulfill the requirement that a provider must be available to furnish care at all times the clinic is open

Telehealth Services

- Pandemic-era telehealth flexibilities have only gained momentum in the past few years

- Starting in 2022, RHCs could bill and be reimbursed by Medicare for mental health services provided via telehealth and receive the RHC All-Inclusive Rate (AIR) on a permanent basis

- Permanent Medicare Changes:
  - RHCs can serve as a distant site provider for behavioral/mental telehealth services
  - There are no geographic restrictions for originating site for behavioral/mental telehealth services, including the home
  - Behavioral/mental telehealth services can be delivered using audio-only communication platforms
  - Expansion of telehealth practitioners to include Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs)
  - Social Determinants of Health Risk Assessments added to Medicare Telehealth Services List

- CY2024 Temporary Changes (through 12/31/24):
  - RHCs can serve as a distant site provider and there are no geographic restrictions for originating site for non-behavioral/mental telehealth services, allowing patients to be located at anywhere in the US during the telehealth service, including a patient's home
  - Delays the in-person requirement for mental health visits furnished via telehealth (within 6 months prior and annually thereafter)
  - Physician or practitioner "direct supervision" of incident-to services to be performed via two-way, real time-audio visual technology, as opposed to immediately available in the physical space of the RHC
  - Added health and well-being coaching services to the Medicare Telehealth Services List

Expansion of RHC Care Management Services

- Historically, RHCs have only been allowed to bill and be reimbursed for Care Management Services, including Remote Patient Monitoring, Remote Therapeutic Monitoring, or using CPT code G0511 or G0512 **once per month** per beneficiary

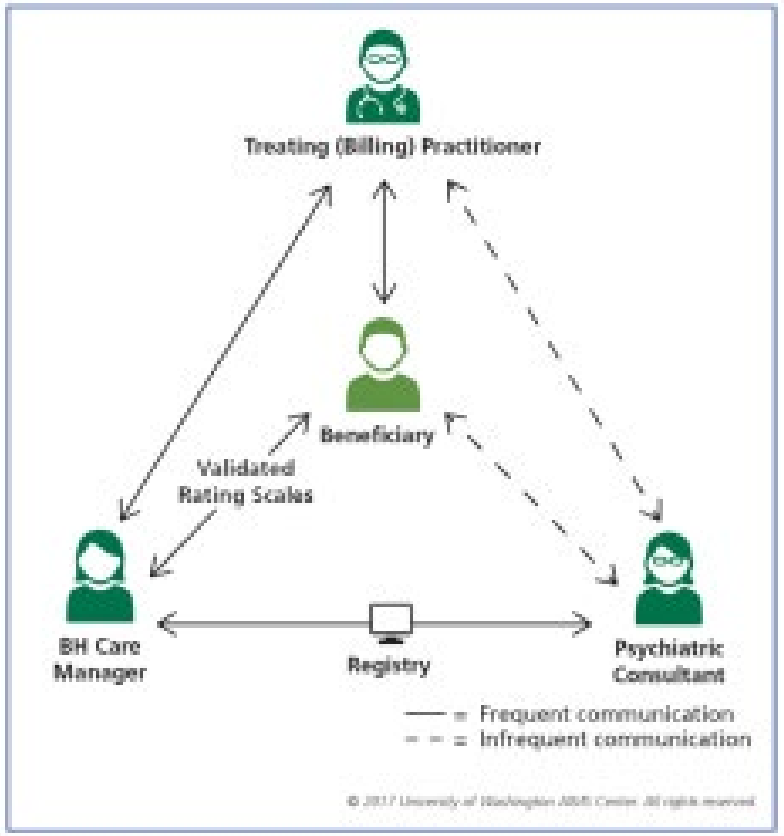
- Starting January 1, 2024, **an RHC may bill code G0511 multiple times in a calendar month** as long as all requirements are met and services are not double counted. In addition, G0511 will include coverage for the following service areas:
  - Behavioral Health Integration (BHI)
  - Chronic Care Management (CCM)
  - Principal Care Management (PCM)
  - Principal Illness Navigation (PIN)
  - Remote Patient Monitoring (RPM)
  - Remote Therapeutic Monitoring (RTM)
  - Community Health Integration (CHI)

Care Management Services

- **<u>General Behavioral Health Integration (BHI)</u>**
  - BHI is a team-based, collaborative approach to care that focuses on integrative treatment of patients with primary care and mental or behavioral health conditions
  - RHCs can receive payment when at least 20 minutes of qualifying BHI services are provided during a calendar month
  - General BHI services include:
    - An initial assessment and ongoing monitoring using validated clinical rating scales;
    - Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
    - Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
    - Continuity of care with a designated member of the care team

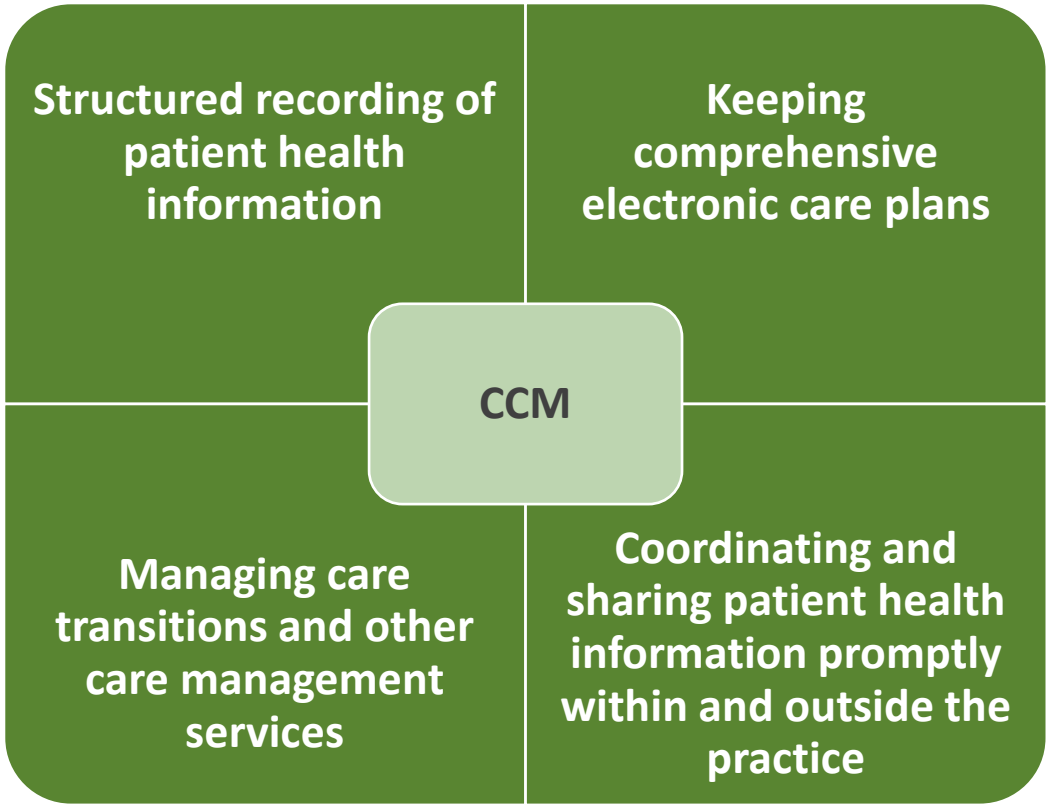
Care Management Services

- **Psychiatric Collaborative Care Model (CoCM)**
- Psychiatric CoCM is a specific model of care provided by a primary care team consisting of a primary care provider and a health care manager who work in collaboration with a psychiatric consultant to integrate primary health care services with care management support for patients receiving behavioral health treatment and includes the following:
- Regular psychiatric inter-specialty consultations with primary care team
- Regular review of treatment plan by primary care team
- Specific requirements for the RHC providers, behavioral health care manager, and psychiatric provider
- At least 70 minutes in the first calendar month, and at least 60 minutes in subsequent calendar months, of psychiatric CoCM services must have been furnished in order to bill for this service
- Only services furnished by an RHC or FQHC practitioner or auxiliary personnel that are within the scope of service elements can be counted toward the minimum 60 minutes
- Does not include administrative activities such as transcription or translation services
- Psychiatric CoCM services furnished on or after January 1, 2019, are paid at the average of the national non-facility PFS payment rate for CPT codes 99492 and CPT code 99493 when psychiatric CoCM HCPCS code, G0512, is on an RHC claim, either alone or with other payable services



Care Management Services

- **Chronic Care Management (CCM)**
  - CCM is for members with two or more chronic conditions and includes the management of medications, appointments, and services managed by one healthcare provider
    - Providers can receive payment when at least 20 minutes of qualifying CCM services are provided during a calendar month
  - General CCM services furnished outside of face to face include:
    - Continuous patient relationship with chosen care team member
    - Supporting patients with chronic diseases in achieving goals
    - 24/7 patient access to care and health information
    - Patient receiving preventative care
    - Patient and caregiver engagement
    - Prompt sharing and using patient health information



Care Management Services

- **Principal Illness Navigation**
  - Covers principal illness navigation services for patients with a serious condition that is expected to last at least 3 months and puts them at high risk for one or more of the following:
    - Hospitalization
    - Nursing home placement
    - A sudden worsening of preexisting symptoms
    - Physical or mental decline
    - Death
  - PIN is a type of care management service that helps patients understand their medical condition or diagnosis and guides them through the healthcare system, examples of conditions applicable:
    - Severe mental illness
    - Substance abuse disorders
    - Chronic conditions such as COPD, CHF, and cancer

Remote Patient Monitoring/Therapeutic Monitoring

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RPM

- Collection and analysis of patient physiologic data that is used to develop and manage a treatment plan related to a chronic or acute health illness or condition
    - For example, weight loss related to behavioral health medications

RTM

- Use of Medical devices to monitor a patient's health response to treatment using non-physiological data
    - For example, monitoring medication adherence and response treatment in behavioral health patients

Community Health Integration

Medicare Part B covers community health integration services to address needs and help the provider diagnosis and treat medical conditions when it is determined by a healthcare provider through a social determinants of health risk assessment that there are social needs that are impacting the patient's health or access to care

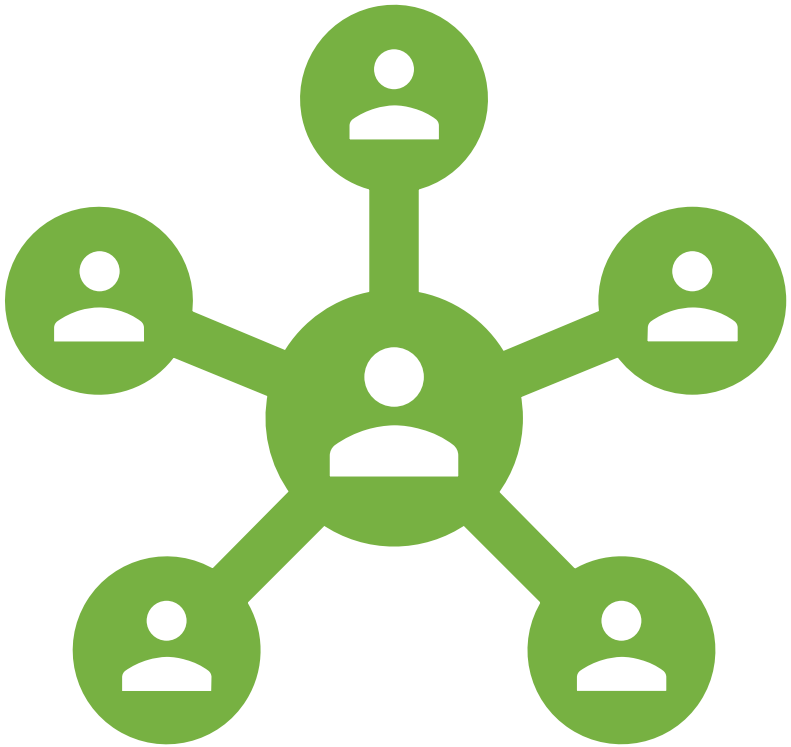
Some community health integration services include:

- An assessment to better understand the patient's life story
- Care coordination
- Health education
- Patient self-advocacy training
- Health system navigation
- Social and emotional support

IOP Details

Intensive Outpatient Program (IOP)

- Starting January 1, 2024, Section 4124(c) of the Consolidated Appropriations Act of 2023 (CAA, 2023) establishes Medicare coverage and payment for IOP services that FQHCs and RHCs provide for people with mental health needs.
- An IOP is a distinct and organized outpatient program of psychiatric services provided for patients who have an acute mental illness, which includes, but isn't limited to, conditions such as depression, schizophrenia, and substance use disorders.
- CMS will pay for IOP services provided at the same payment rate as if it were provided by a hospital. Also, costs associated with IOP services you provide won't be used to determine payment amounts under the RHC all-inclusive rate (AIR) methodology.

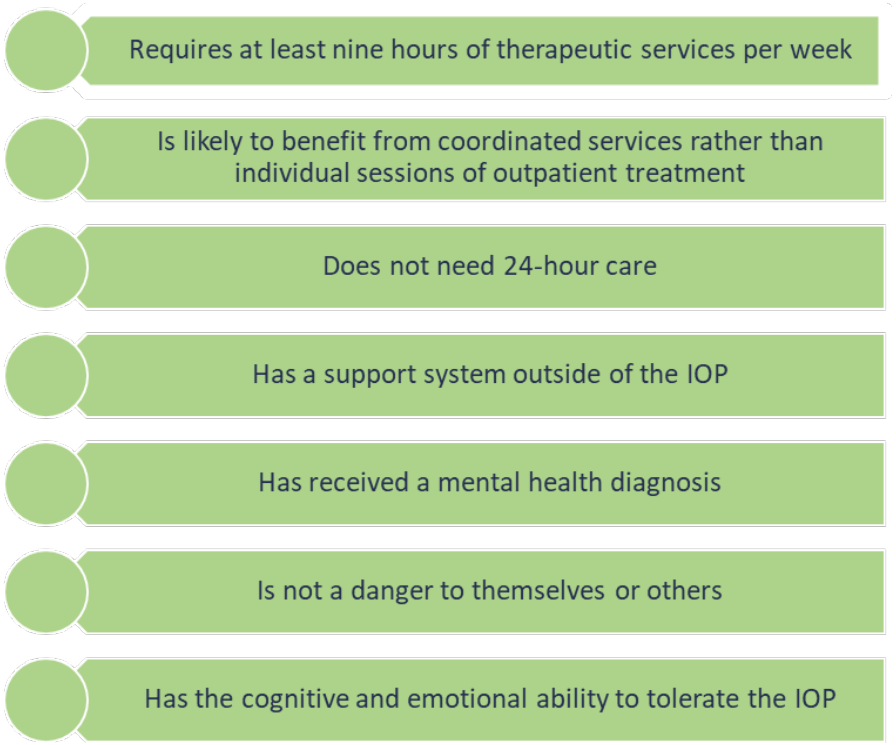


Intensive Outpatient Program (IOP)

- Services eligible to be provided and reimbursed under an IOP may include:
  - Individual and group therapy with physicians, psychologists, and other mental health professionals as available under state law
  - Occupational therapy
  - Furnishing of drugs and biologicals for therapeutic purposes that are not self-administered
  - Family counseling (as part of treatment of the patient's condition)
  - Patient training and education
  - Individualized activity therapies
  - Diagnostic services
  - Other related services for diagnosis and active treatment intended to improve or maintain the patient's condition and function

Intensive Outpatient Program (IOP)

- Qualifications for IOP Services
  - To quality a patient for IOP services, a physician is required to certify that a patient needs behavioral health services for at least nine, but no more than 19 hours per week
  - That certification must be completed by a physician at least once every other month for the patient to continue to qualify for services and the plan of care must demonstrate that the patient:



Intensive Outpatient Program (IOP)

- IOP services are not reimbursed at the RHC's AIR, but rather under a special rule that would allow for a flat payment currently at **$259.13 (note, this is the hospital 3 services per day rate)**.

- RHCs are allowed to perform up to three services per day and, to qualify for the special payment, at least one of the three services must be from the Partial Hospitalization and Intensive Outpatient Primary Services table shown at right.

- Costs associated with IOP services are not currently used to determine payment under the AIR. There will be revisions to cost reporting instructions.

- IOP services are separately payable if a patient has a medical visit on the same day.

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

New Provider Type Opportunity

Address Upper Payment Limit Challenges

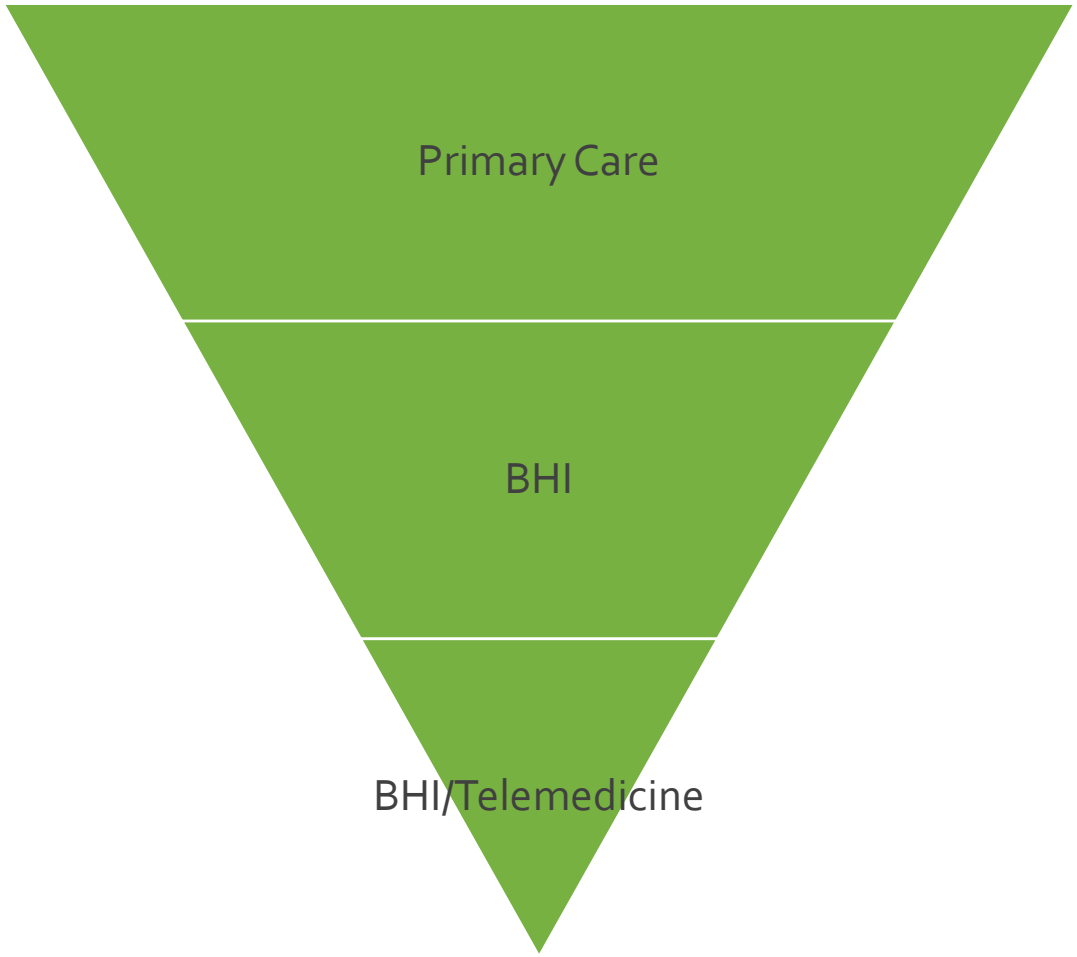
- **Trended UPL Comparison**
  - The following table presents the adjusted cost-based rates (applying the annualized cost-based increases seen by each of the RHCs from FY17 – FY21) and compares to the new UPL established through the CAA of 2021 from 2021 through 2028
    - The MEI used was 2.1% from 2022 – 2028 and a variation in the MEI will impact actual net impact
    - Wintergreen used an average cost increase for each cohort
    - The green-shaded rates reflects the average rate used for each cohort for 2021 through 2028

Location	Rate	2021	2022	2023	2024	2025	2026	2027	2028
PB-RHCs	Adj. Cost-Based Rate	$ 253.23	$ 267.58	$ 282.76	$ 298.79	$ 315.73	$ 333.63	$ 352.55	$ 372.54
	UPL	242.24	247.33	252.52	257.83	263.24	268.77	274.41	280.18
	Variance	(10.98)	(20.25)	(30.23)	(40.96)	(52.49)	(64.86)	(78.13)	(92.36)
Non-PB-RHCs	Adj. Cost-Based Rate	$ 128.28	$ 132.12	$ 136.07	$ 140.14	$ 144.33	$ 148.64	$ 153.09	$ 157.66
	Capped RHC Rate	87.52	89.36	91.23	93.15	95.11	97.10	99.14	101.22
	UPL	100.00	113.00	126.00	139.00	152.00	165.00	178.00	190.00
	Variance	12.48	23.64	34.77	45.85	56.89	67.90	78.86	88.78

Data Source: December 2022 Medicare Cost Report release for hospital and RHC fiscal year 2021; and December 2022 CMS Provider of Services (POS) data file.

Smoothing the AIR

- Therapist based positions are generally lower cost that many legacy provider types:
  - PA
  - NP
  - MD
- Providers can drive down per visit costs by leveraging access to new provider types and service additions.
- BH telehealth visits currently count as a visit.



On The Horizon

Access Challenges Are on the Radar

On the Horizon

- Addition of Clinical Psychologists and Licensed Clinical Social Workers as specialty eligible for the 10-percentage point telehealth credit.
- Amend general access to services standards to include explicitly behavioral health services
- Clarify that emergency behavioral health services must not be subject to prior authorization
- Require MA organizations to establish care coordination programs, including coordination of community, social, and behavioral health services to help move towards parity between behavioral health and physical health services and advance whole-person care.

Glimpse into the Future

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Upcoming insights

- Innovation in Behavioral Health (IBH) Model
  - Address Medicare/Medicaid disproportionately high rates of mental health conditions and substance use disorder
  - Increase access to care
  - Promote interoperability
  - Notice of Funding Opportunity now open, closes 9/9/24
- CMS Behavioral Health Strategy
  - SUD prevention
  - Effective pain treatment and management
  - Improving mental healthcare and services

Workforce impacts present and future

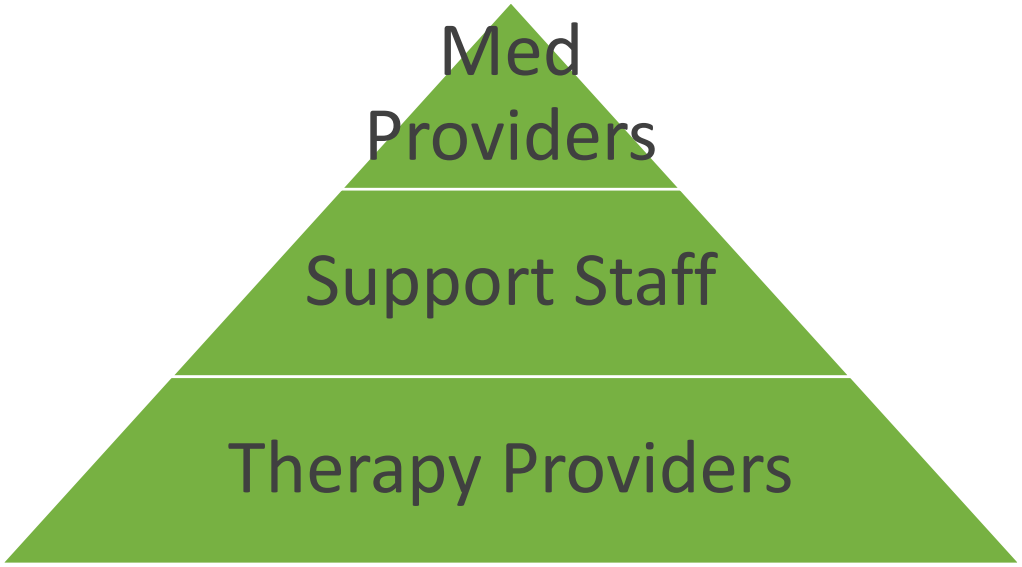
- Increased ability to use Mental Health Counselors etc. in addition to Social Workers
  - Bends the cost curve through substation effect
  - Increases growth opportunity
- Imperative to ensure substance use is an integrated part of treatment
  - Future need for Recovery Coaches?
  - Expansion of Medication Assisted Treatment capabilities?
  - Even more demand for workforce?

Adjusting the Model

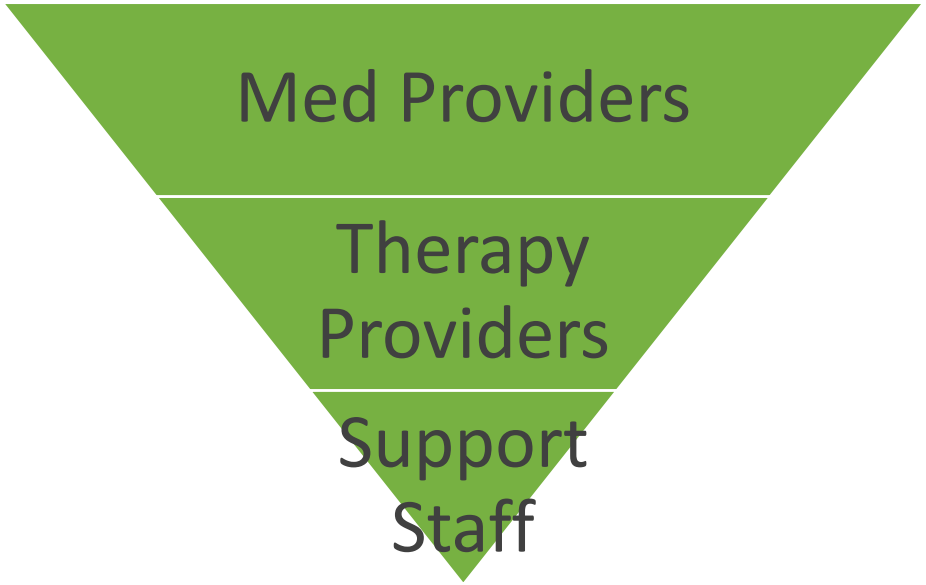
Stratification Matters

Proper staffing models are essential to financial viability. All to often, the model on the right is the norm. This forces medical providers to practice below their license and all licensed professionals to perform clerical work.

Sustainable Staffing Model



Unsustainable Staffing Model



Breaking Down Costs

- Typical model found in rural settings result in less-than-optimal efficiency as many providers are not working at the top of licensure.
  - Prescribers performing large amounts of verbal therapy (Psychiatrist, PA, NP)
  - All providers performing significant amounts of clerical work
- Total volume potential is limited, and payment is thus not optimized, particularly for commercial payers.
- This decreases the ability to generate margin by controlling per visit costs
- Common failures include:
  - Too few therapists to keep a prescriber at capacity
  - Underinvestment in clerical support staff

Therapist Staffing Calculation

	Clinical Hours	Avereage visit duration	Total Potential	No Show Rate	Expected Visits
Prescriber	39	45	53	20%	42
Therapist	30	60	30	20%	24
Therapist VT Only (40%)			12		10
Thrapist MT/VT			18		14
Minimum Therapist Requirement					**3**

Staffing Cost

	Count	Cost Per	Total Cost	Annual Vists	Cost Per Visit
Prescriber	1	$120,000	$120,000	2035	$ 58.96
Therapist	2	$ 70,000	$140,000	2304	$ 60.76
Clerical Staff	1	$ 45,000	$ 45,000		
Total	**4**		**$305,000**	**4339**	**$ 70.29**

Breaking Down Costs

As verbal therapy providers are added, the verbal therapy burden of prescribers can be decreased to create capacity for medication therapy, driving the cost per visit lower.

Therapist Staffing Calculation					
	Clinical Hours	Avereage visit duration	Total Potential	No Show Rate	Expected Visits
Prescriber	39	30	78	20%	62
Therapist	30	60	30	20%	24
Therapist VT Only (40%)			12		10
Thrapist MT/VT			18		14
Minimum Therapist Requirement					**4**

Staffing Cost					
	Count	Cost Per	Total Cost	Annual Vists	Cost Per Visit
Prescriber	1	$120,000	$120,000	2995	$ 40.06
Therapist	4	$ 70,000	$280,000	4608	$ 60.76
Clerical Staff	1	$ 45,000	$ 45,000		
Total	**6**		**$445,000**	**7603**	**$ 58.53**

Therapist Staffing Calculation					
	Clinical Hours	Avereage visit duration	Total Potential	No Show Rate	Expected Visits
Prescriber	39	15	156	20%	125
Therapist	30	60	30	20%	24
Therapist VT Only (40%)			12		10
Thrapist MT/VT			18		14
Minimum Therapist Requirement					**9**

Staffing Cost					
	Count	Cost Per	Total Cost	Annual Vists	Cost Per Visit
Prescriber	1	$120,000	$120,000	5990	$ 20.03
Therapist	9	$ 70,000	$630,000	10368	$ 60.76
Clerical Staff	1	$ 45,000	$ 45,000		
Total	**11**		**$795,000**	**16358**	**$ 48.60**

Breaking Down Costs

- Optimal results can be obtained by maximization of clinical availability and licensure.
- Versus the second model on the prior slide, note that annual visit potential increases while costs decrease.
  - More clerical staff
  - Fewer therapists
- Consider recruiting challenges within the model; non licensed personnel are in higher supply.
- The same principles will apply when adding in nurses, MAs, etc.

Therapist Staffing Calculation					
	Clinical Hours	Avereage visit duration	Total Potential	No Show Rate	Expected Visits
Prescriber	39	15	156	20%	125
Therapist	39	60	39	20%	31
Therapist VT Only (40%)			16		12
Thrapist MT/VT			23		19
Minimum Therapist Requirement					**7**

Staffing Cost					
	Count	Cost Per	Total Cost	Annual Vists	Cost Per Visit
Prescriber	1	$120,000	$120,000	5990	$ 20.03
Therapist	7	$ 70,000	$490,000	10483	$ 46.74
Clerical Staff	3	$ 45,000	$135,000		
Total	**11**		**$745,000**	**16474**	**$ 45.22**

Key Strategy Considerations

Assessing Current Processes

- Perform an inventory of nonclinical tasks
  - Components of Quality Review
  - Correspondence
  - Insurance Coordination
  - Client Advocacy Support Items
  - Schedule Management and Coordination
- Determine the appropriate level of staff necessary and adjust policies and procedures
- Recruit and retrain to fill gaps in resources

Addressing the HR Challenge

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Work to develop competitive wage and benefit packages that offer incentives not common in the market

Partner with university programs to reach prospective employees early

Update work-flows to increase the potential applicant pool

Staff Care

One of the leading causes of failure is turnover due to lack of programs to protect staff from burnout and negative impact to their own wellbeing

The Harsh Reality

Behavioral health providers are exposed to vicarious trauma which can lead to:

- Staff burnout
- Staff mental health challenges
- Decreased treatment efficacy
- Costly turnover (staff and patient panel)

Coping Mechanisms

Stable organizations employ a variety of strategies to protect stability:

- Effective supervision
- Duress monitoring and staff safety plans
- Adequate time off
- Continuing education and training

Strategies for Growth (People)

- Education must be a core competency
  - SUD education
  - De-escalation training
  - Physical health coordination training
  - Industry trends
  - Regulatory changes
  - Department of Health Advocacy
  - Reimbursement competency
  - Strategic plan education
- Staffing models must be deliberately designed
  - Profit requires practicing at the top of a provider's license
  - Evaluate staffing stratification to ensure efficiency

Rob Bloom, Principal
rbloom@wintergreenme.com
c: (315) 405-1535

ORH Announcements

Oregon Rural Quality Excellence Award | Nominations Due Aug. 31, 2025
(*More information here*)

Next Community Conversations | September 26| 12:00 p.m.
2024/2025 Tax Credit and Insurance Subsidy Programs - *Register here*

October 2-4, Bend, OR | 41st Annual Oregon Rural Health Conference
(*More information here*)

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Thank you!

Sarah Andersen
Director of Field Services
ansarah@ohsu.edu

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