Federal Policy Update for Rural Health Clinics

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AGENDA

I. Legislative Updates

- RHC Burden Reduction Act (S.198/H.R.3730)
  - What is it?
  - How can you advocate?

II. Telehealth Policy

I. Where are we now?
II. Recommendations from the MedPAC Report
III. What questions remain as Congress develops policy post 2024?

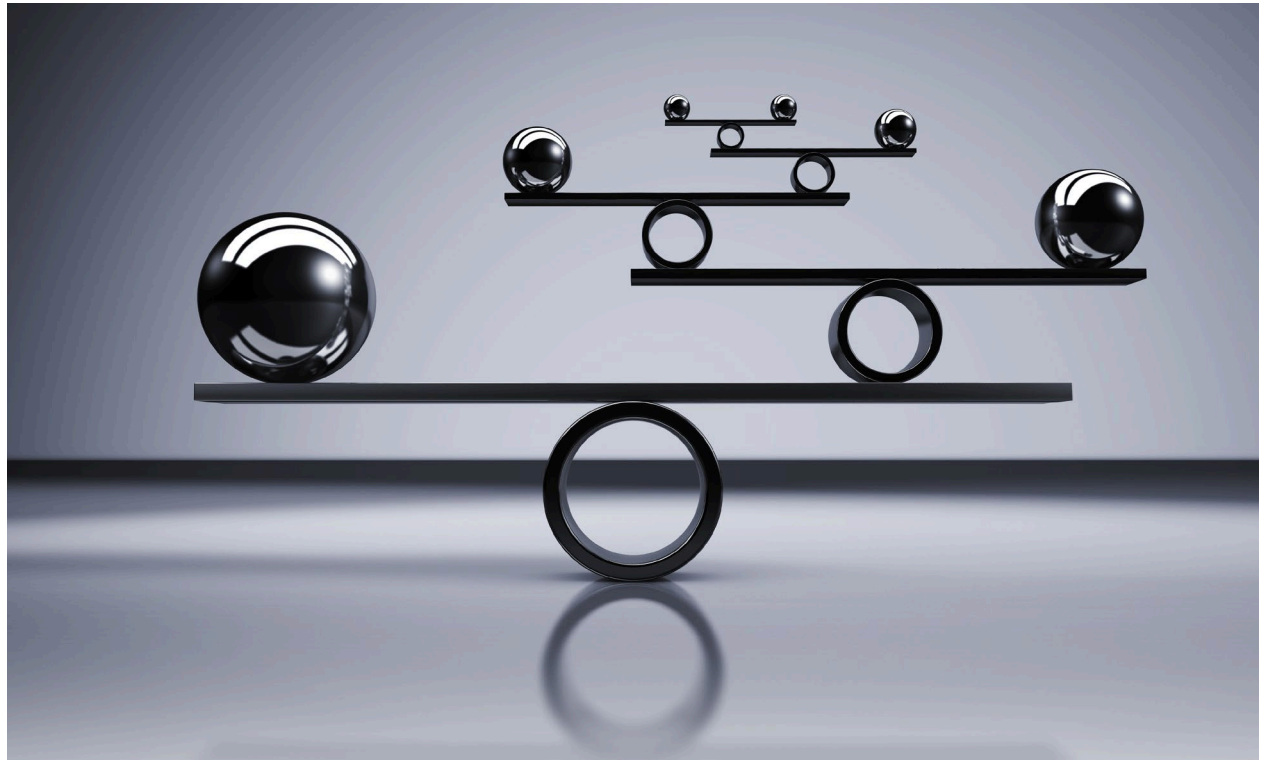
III. Regulatory Updates

I. 2024 Medicare Physican Fee Schedule
II. HPSA Withdrawal Delay

IV. Big Picture: Medicare Advantage and Value Based Care

AM Stretch

A Quick Note on Balance



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

- 8
- How many pieces of legislation have been introduced this year?
- Over 7,000

SECTION 1. SHORT TITLE.

This Act may be cited as the "Fiscal Year 2023 Veterans Affairs Major Medical Facility Authorization Act".

SEC. 2. AUTHORIZATION OF MAJOR MEDICAL FACILITY PROJECTS OF DEPARTMENT OF VETERANS AFFAIRS FOR FISCAL YEAR 2023.

(a) IN GENERAL.—The Secretary of Veterans Affairs may carry out the following major medical facility projects in fiscal year 2023 at the locations specified and in an amount for each project not to exceed the amount specified for such location:

(1) Construction of a community-based outpatient clinic and national cemetery in Alameda, California, in an amount not to exceed $395,000,000.

(2) Construction of a community living center and renovation of domiciliary and outpatient facilities in Canandaigua, New York, in an amount not to exceed $506,400,000.

(3) Construction of a new health care center in El Paso, Texas, in an amount not to exceed $700,000,000.

(4) Seismic upgrade and specialty care improvements in Fort Harrison, Montana, in an amount not to exceed $88,600,000.

(5) Realignment and closure of the Livermore campus in Livermore, California, in an amount not to exceed $490,000,000.

(6) Construction of a new medical facility in Louisville, Kentucky, in an amount not to exceed $1,013,000,000.

(7) Seismic retrofit and renovation, roadway and site improvements, construction of a new specialty care facility, demolition, and expansion of parking facilities in Portland, Oregon, in an amount not to exceed $523,000,000.

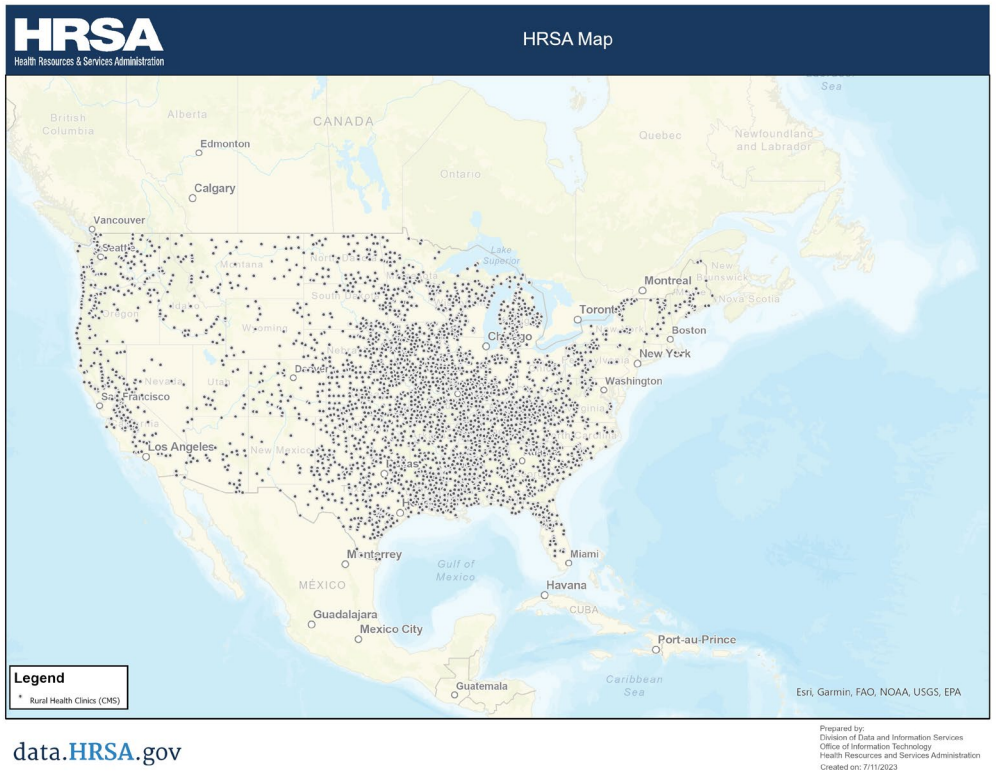
(b) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to the Secretary of Veterans Affairs for fiscal year 2023 or the year in which funds are appropriated for the Construction, Major Projects account, $3,716,000,000 for the projects authorized in subsection (a).

Modern Legislative Pathways

- Pathway 1 – Uncontroversial, generally cost-free pieces of legislation
- Pathway 2 – Bipartisan bill of substance – 60 votes in Senate
  - This does happen!
  - Examples: SUPPORT Act (Opioids), Safer Communities Act (gun control and behavioral health legislation), CHIPS act (onshoring cpu chip manufacturing), Infrastructure bill
- Pathway 3 – Must-Pass Pieces of Legislation
  - (Debt ceiling bill, appropriations bills)
- Pathway 4 – Budget Reconciliation Process
  - (Inflation Reduction Act, American Rescue Plan, Trump Tax Cuts)…generally only relevant when one party controls House/Senate/President

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.**



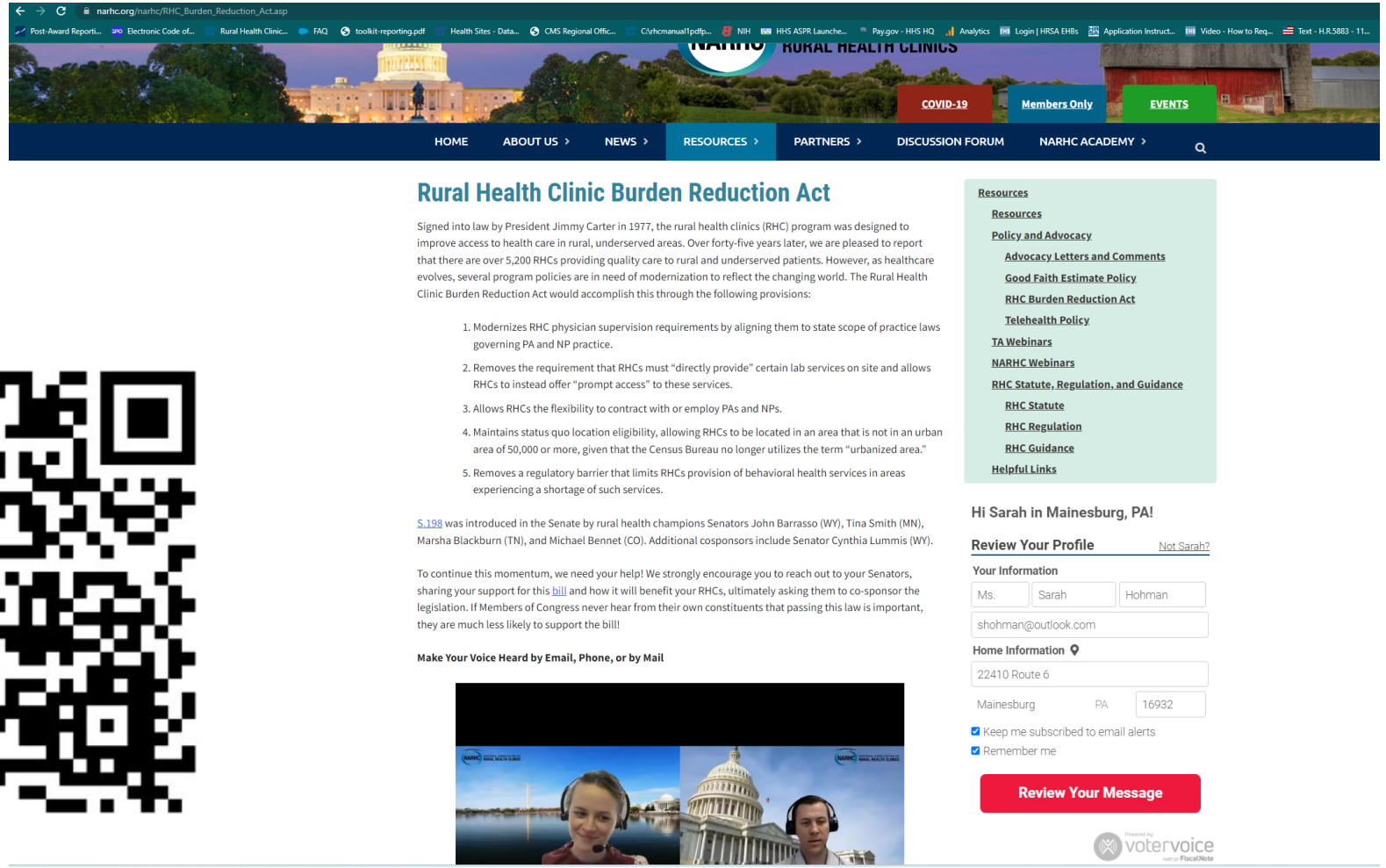
2023 Rural Health Clinic Priorities

Pass the Rural Health Clinic Burden Reduction Act	Establish Medicare Advantage Floor Reimbursement	Achieve Telehealth Parity for Safety Net Providers
S.198/H.R.3730 modernize five non-controversial, cost-neutral provisions of the RHC statute first written in 1977 to better reflect care delivery in 5,300 RHCs across the country.	There is no statutory requirement around RHC Medicare Advantage reimbursement and with RHC's limited negotiating power, low MA reimbursement is threatening the health care safety net.	Permanent coverage of Medicare telehealth and a revision of the RHC/FQHC payment policy assure continued access and ensure that RHCs do not experience a disparity in reimbursement as compared to their fee-for-service counterparts.

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

- **Would align RHC physician supervision requirements with state scope of practice laws governing Nurse Practitioners and Physician Associates**
  - 26 states have granted NPs full practice authority, yet NPs practicing in RHCs in those states still have federal supervision requirements
- **Would allow RHCs to satisfy onsite laboratory requirements if they provide "prompt access" to the required lab services**
  - CMS would be directed to define "prompt access"
- **Would allow RHCs to employ or contract with their NPs and PAs**
  - Currently one NP/PA must be formally employed, as referenced by a W-2
- **Would fix "urbanized area" issue in the statute**
- **Would allow RHCs to provide over 49% behavioral health services, if they are located in a mental health-Health Professional Shortage Area (HPSA)**

How can *you* effectively advocate?



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

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 end of PHE**
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

Telehealth Services but <u>not</u> considered a telehealth "visit"

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 GOOD NEWS/BAD NEWS

GOOD 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

BAD NEWS
• Unlikely to get much movement on any telehealth legislation until we are close to "telehealth cliff" at the end of 2024 • Probable that Congress will pass more temporary extensions, not permanent policy

TELEHEALTH POLICY UNSETTLED QUESTIONS

- Where can telehealth providers be located?
- Should there be in-person requirements?
- What can be done via audio only?
- Should Medicare telehealth pay parity with in-person?

Does Medicare Save Money?

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 GROWTH

- RHCs have no formal reimbursement benefit from Medicare Advantage plans
- There are some old and relatively unclear policies that provide protections for RHCs that are Out-of-Network providers
- If an RHC agrees to a contract with the MA plan, then the RHC must bill (and be paid) according to the terms of that contract

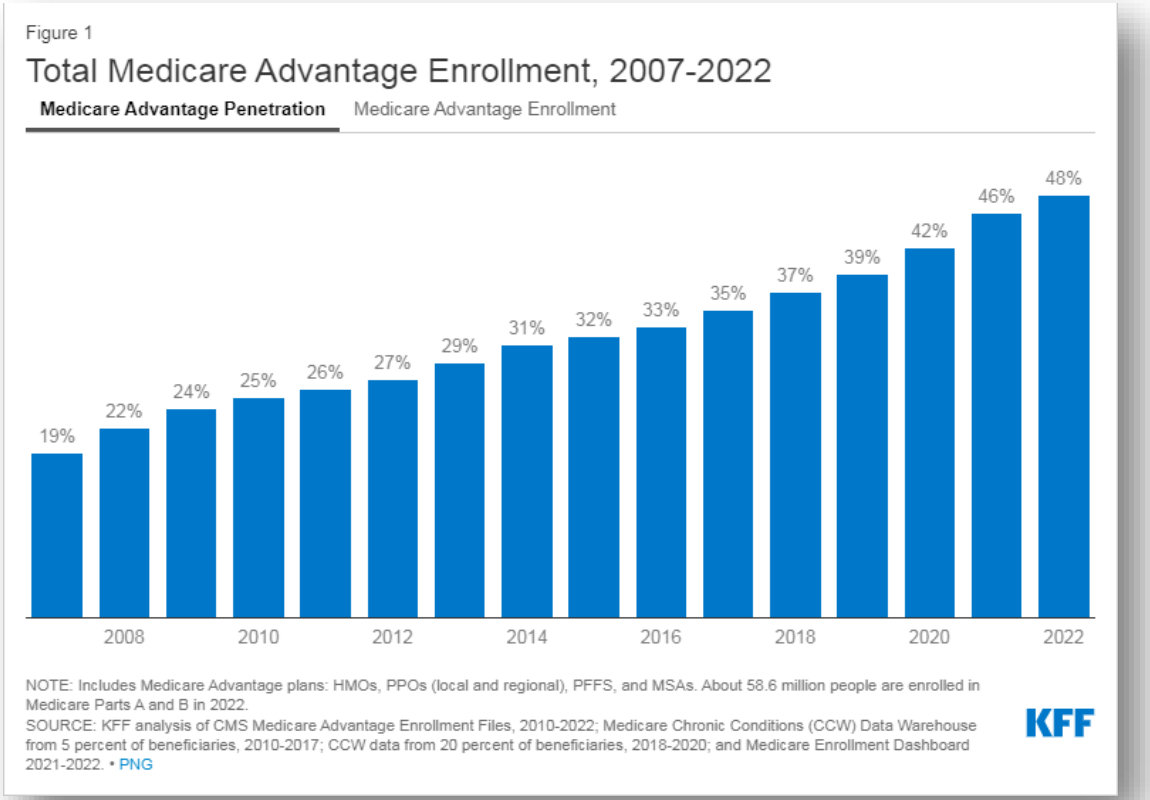
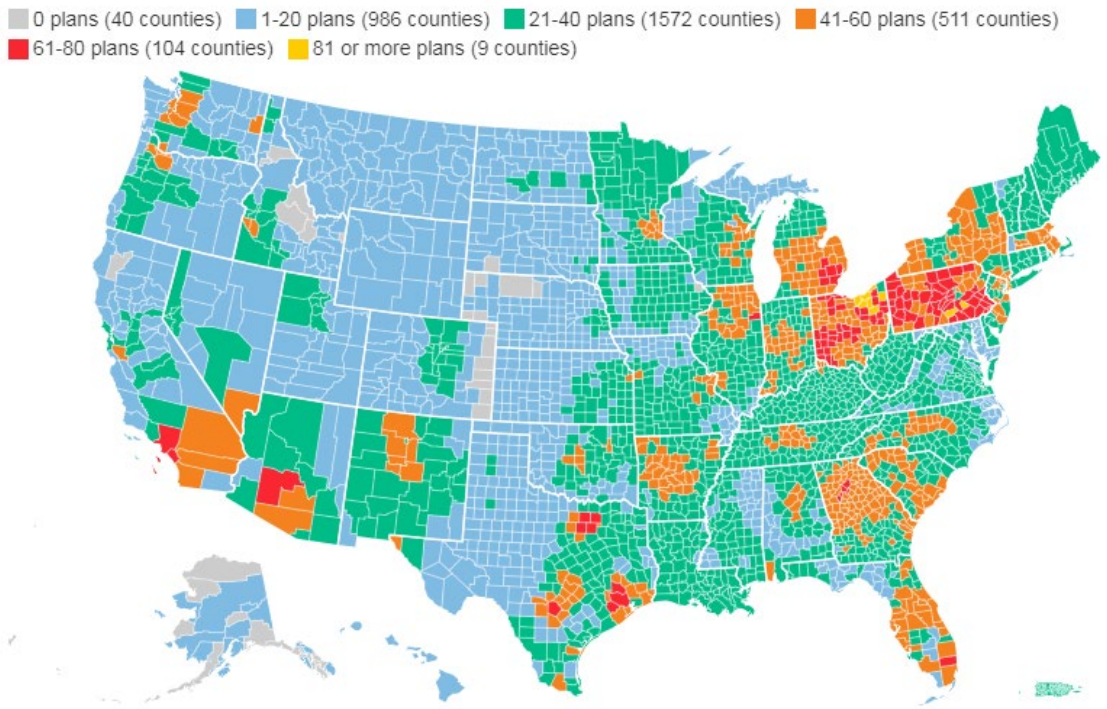


Figure 5

About half of all Medicare beneficiaries (in 19 percent of counties) have more than 40 Medicare Advantage plans available where they live in 2023

Click on the buttons below to see number of Medicare Advantage plans across years:

2018 2023



NOTE: Excludes SNPs, EGHPs, HCPPs, PACE plans, cost plans, and MMPs.
SOURCE: KFF analysis of CMS Landscape files for 2023. • PNG

KFF

RHCs & Medicare Advantage

- Prior authorization, marketing, and other administrative burden concerns, PLUS
- Low reimbursement concerns
  - FQHCs (since 2003) have a quarterly "wrap- around" payment that ensures that they receive no less than what they would make from traditional Medicare
  - 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

Medicare Advantage Advocacy

- NARHC is advocating to create a floor payment rate for RHCs relative to MA plans
  - Different options for both setting and financing the floor
- Hoping to get Congress to introduce legislation to start the conversation
- **We cannot let Medicare Advantage plans diminish our rural safety-net**

Value Based Care

- CMS has announced goals to have 100% of providers in some type of value-based care arrangement by 2030
- Several CMMI models exclude RHCs from participating or do not work well with the RHC payment methodology

- **NARHC advocates for the creation of an RHC-specific value-based payment model based on the All-Inclusive Rate methodology.**

Regulatory Updates

2024 Medicare Physician Fee Schedule Proposed Rule / 2024 Outpatient Prospective System Proposed Rule

- **What is included?**
  - Changes to regulations to include MFTs and Mental Health Counselors as billable providers
  - Creation of Intensive Outpatient Services code and special payment rule
  - Incorporated Remote Patient Monitoring, Remote Therapeutic Monitoring, Community Health Integration, and Principal Illness Navigation Services into G0511 code.
- **Comments due September 11th; final rules published in November**

HPSA Withdrawal Delay

- If a HPSA designation is currently in proposed for withdrawal status, it will remain in this status until it is re-evaluated this fall.
  - Intended to give Primary Care Offices additional time to process HPSA data.
  - Any HPSA designations that do not meet eligibility by November 15 will be officially withdrawn in January 2024.

STAY UP TO DATE!

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