Delta Region Community Health Systems Development (DRCHSD) Program

RHC Updates, Processes and Strategies for Leadership

National Rural Health Resource Center

The Center's Purpose

The National Rural Health Resource Center (The Center) is a nonprofit organization dedicated to sustaining and improving health care in rural communities. As the nation's leading technical assistance and knowledge center in rural health, The Center focuses on five core areas:

- Transition to Value and Population Health
- Collaboration and Partnership
- Performance Improvement
- Health Information Technology
- Workforce

DRCHSD Program Supported by FORHP and DRA

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HRSA

Federal Office of Rural Health Policy

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Diversity, Equity, Inclusion, & Anti-racism

Building a culture where difference is valued

The Center is committed to DEI and anti-racism. We create an environment that reflects the communities we live in and serve; a place where everyone feels accepted and empowered to be their full, authentic selves; and where everyone belongs.

We understand the impact of and seek to defeat racism and discrimination in ourselves, our workplace, and the world. This guides how we cultivate leaders, build our programs and resources, and deliver our technical assistance.

We are an organization that honors, celebrates, and respects all dimensions of diversity. These principles are central to our mission and to our impact.

Read more at ruralcenter.org/DEI

ruralcenter.org

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Today's Speaker:

Steve Smith, FACHE, FACMPE, CHFP, CRHCP
Director / Healthcare Performance Improvement
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RHC Updates, Processes and Strategies for Leadership

February 15, 2024

Healthcare

Meet the Presenter

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Agenda

- All Inclusive Rate Strategy
- Impact of Public Health Emergency Ending
- Legislative Updates
- Good Faith Estimates (GFE) Update
- Strategic Implications
- Questions and Answers

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RHC All-Inclusive Rate Strategy

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2021 CAA AIR Cap Rates

- Applicable to all newly certified RHCs
- Existing PB RHCs where bed availability was less than 50 beds not subject to caps
  - Rate based on finalized 2020 cost report and increases by MEI
  - If bed count exceeds 50 beds grandfathered rate is forfeited
- Periodic reviews needed to maximize benefits

Year	AIR Cap
2023	$126
2024	$139
2025	$152
2026	$165
2027	$178
2028	$190
2029 and Beyond	MEI (1% - 3%)

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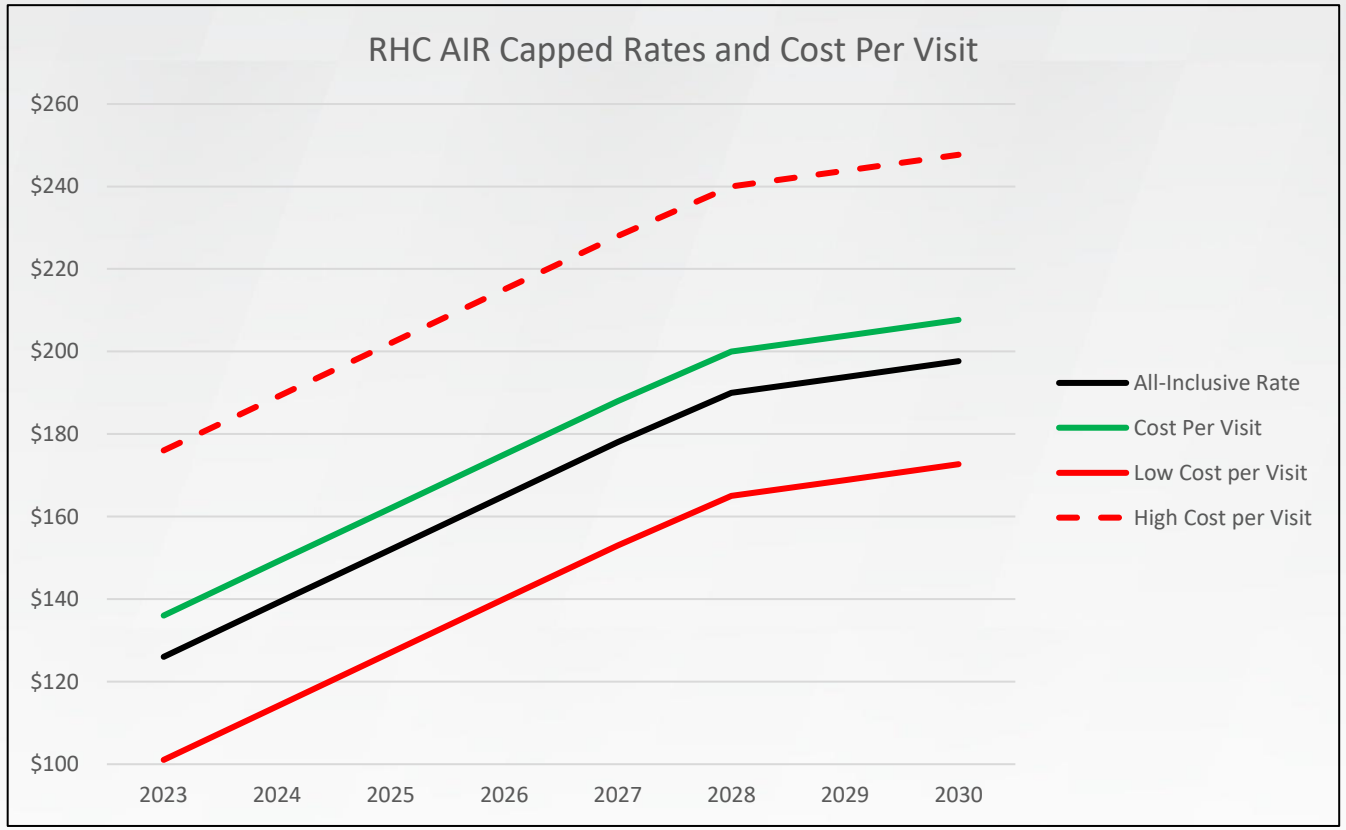
RHC AIR Strategy – Capped Rates



	2024 AIR	2024 CPV
AIR	$139	$114
Visits	5,000	5,000
Total Revenue	$695,000	$570,000
Revenue Variance		($125,000)

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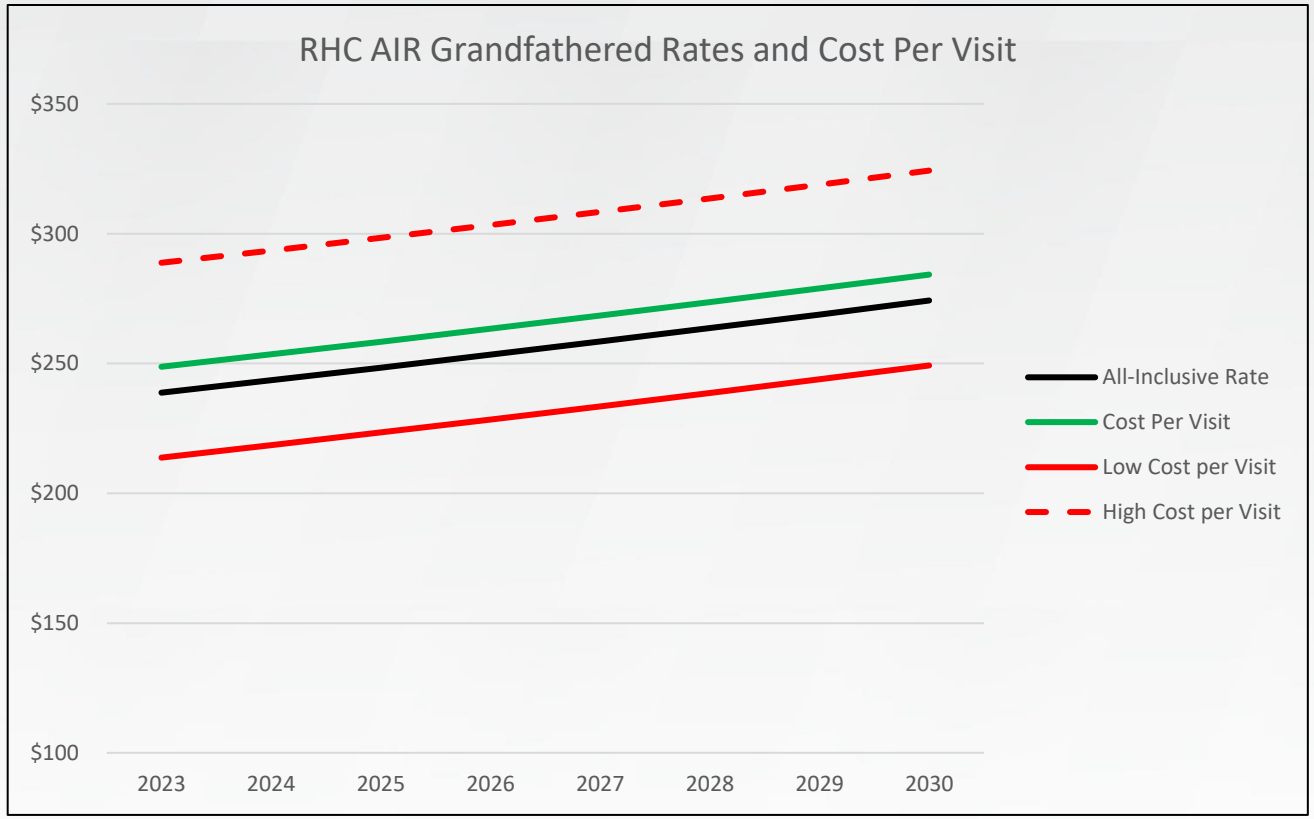
RHC AIR Strategy – Grandfathered Rates



Assumes 2020 Rate of $225 and MEI of 2% per Year

	2024 AIR	2024 CPV
AIR	$244	$219
Visits	5,000	5,000
Total Revenue	$1,220,000	$1,095,000
Revenue Variance		($125,000)

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Impact of Public Health Emergency Ending

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Impacts of PHE Ending May 11, 2023

- Staffing requirements reinstated
  - NP, PA, or CNM must be available to provide patient care at least 50% of the time the RHC is open
- Temporary expansion locations no longer allowed
- Bed Count for provider-based RHCs must not exceed 50 bed or less requirement to retain grandfathered rates
- RHC recertification surveys restarted
  - Program evaluation every two years
  - Mock survey completed?
  - Emergency Operations Plan and evidence binder up to date?

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Legislative Updates

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

- Align RHC physician supervision requirements with state scope of practice laws
- Allow RHCs to satisfy onsite lab requirements if “prompt access” to services is provided
- Allow RHCs to employ **or** contract with NPs and PAs
- Permanently fix “urbanized area” issue
  - Areas with less than 50,000 being eligible for RHCs
- Allow RHCs to provide over 49% behavioral health services is located in mental health HPSA

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Telehealth Policy

Medical Telehealth

- RHCs continue to be distant site providers through December 31, 2024
- Paid $98.27 for all services on Medicare's telehealth list
  - Includes audio-only services
  - Do not count as encounters
  - Costs and visits carved out of cost report

Mental Health Telehealth

- Permanent coverage in RHC setting
  - Reimbursed at AIR
  - Counted as visit and costs included in cost report
- In-person requirements waived until January 1, 2025
  - 6 months prior to telehealth visit and at least once per year
- CPT codes billable with 0900 revenue code

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Newly Approved RHC Provider Types

- Marriage and Family Therapists (MFT) and Mental Health Counselors (MHC) are eligible as of January 1, 2024
- MHC requirements:
  - "(A) possesses a master's or doctor's degree which qualifies for licensure or certification as a mental health counselor, clinical professional counselor, or professional counselor under the State law of the State in which such individual furnishes the services described in paragraph (3);
  - (B) is licensed or certified as a mental health counselor, clinical professional counselor, or professional counselor by the State in which the services are furnished;
  - (C) after obtaining such a degree has performed at least two years of clinical supervised experience in mental health counseling; and
  - (D) meets such other requirements as specified by the Secretary."

Intensive Outpatient Program (IOP) Services

- Designed for individuals who require more complex mental health care than would be accomplished during a typical office visit, but not to the extent that inpatient services would be required
  - + Acute mental illness such as depression
  - + Substance abuse disorders that require higher level of care
- Physician required to certify that a patient needs behavioral health services for at least 9, but no more than 19 hours per week
- Certification must be completed at least once every other month

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Intensive Outpatient Program (IOP) Services – continued

- Services eligible to be provided and reimbursed under 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) Services – concluded

- IOPs paid by special payment rule at approximately $280 per day
- Allowed to perform up to 3 services per day
  - + At least one service from Proposed Partial Hospitalization and Intensive Outpatient Primary Services (Table 44) of the HOPPS Proposed Rule
- Additional rulemaking expected but key considerations:
  - + Costs and visits for IOPs removed from cost report
  - + Mental health visits and potential impact to 51% primary care threshold

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Expansion of RHC Care Management

- Effective January 1, 2024, RHCs now eligible to bill for care management services multiple times per month
  - + Remote Patient Monitoring
  - + Remote Therapeutic Monitoring
  - + Community Health Integration
  - + Principal Illness Navigation
- Billed using G0511
- Must be rendered by qualified provider

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Good Faith Estimates (GFE)

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NSA – High Level Overview

1 No Surprises Act Interim Final Rule Part 1

Part 1 Released July 2021

- May not balance bill patients for emergency stabilization services
- ED Post stabilization waiver
- Protects patients from balance bills from out-of-network providers for services performed at in-network facilities (unless waiver is obtained)
- Establishes in-network cost-share for services outlined above for Providers & treatment by payers the Qualified Payment Amount (QPA)
- Public notice of compliance with state & federal balance billing regulations
- Selection of PCP & continuation of coverage

2 No Surprises Act Interim Final Rule Part 2

Part 2 Released September 2021

- Establishes the Provider-Payer dispute resolution Process & Timelines
  - Open negotiation period
  - Selection of the IDR
  - Ruling & payments
- Establishes the requirements & timelines for good faith estimates for self-pay or uninsured patients
  - Establishes the future (1/2023 but delayed) requirements for convening providers
- Establishes the Patient-Provider dispute resolution process & timelines

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“Unwinding” of Continuous Medicaid Enrollment

- 14-month process of redetermining Medicaid eligibility of 90 million Americans
  - Ineligible individuals may lose coverage or be moved to other forms of coverage (i.e. CHIP or the marketplace)
  - Begin as early as April 2023
- RHCs and other clinics need to carefully navigate with patients, staff and local stakeholders

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“Unwinding” of Continuous Medicaid Enrollment – Patient Approach

- Targeted outreach communications with Medicaid recipients about the unwinding
  - Encourage enrollees to update contact information with the state
  - Spread the news that redetermination will resume
  - Remind enrollees to complete and return and re-enrollment forms timely
- Support patients who lose coverage in understanding the options for re-enrolling or transitioning
  - 90-day Medicaid reinstatement periods for those who miss redetermination
  - Ineligible persons will qualify for marketplace special enrollment period

“Unwinding” of Continuous Medicaid Enrollment – Staff Approach

- Train direct service staff (social workers, case managers) to be champions of messaging
  - Check state eligibility systems for redetermination dates
  - Understand redetermination process and timelines
- Train registration staff to provide information to patient during clinic visits
  - Increased focus on insurance eligibility checks
- Design EMR build for renewal date alerts

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“Unwinding” of Continuous Medicaid Enrollment – Community Stakeholder Approach

- Connect with state Medicaid agencies to learn about state-specific communication, timelines, and impacted populations
- Support in messaging to members
- Work with MCOs to verify and update contact information
- Identify local application assistance agencies to refer patients to
  - Certified application counselors, state call centers, eligibility offices, etc.)

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Good Faith Estimates – The Facts

Prominently Displayed – Information regarding the availability of estimates must be prominently displayed (facility) & easily searchable via website

Verbal Notification – The convening provider must verbally inform uninsured/self-pay individuals of the availability of a good faith estimate

Written or Printable Format – Must be provided in written form either on paper or electronically (email, portal) pursuant to individuals requested method of delivery.

Retained as part of the medical record – Forms considered part of Medical Records (6-year retention)

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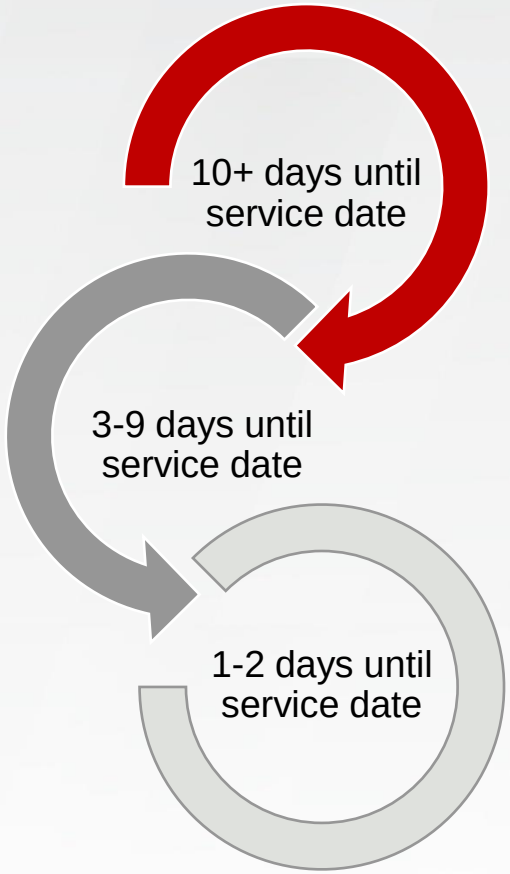
Timelines & Recommendations Related to GFEs



*GFE must be provided in **3 days** of scheduled date*

*GFE must be provided in **1 day** of scheduled date*

GFE is not required

STRATEGIES TO REDUCE BURDEN

- Integrate patient estimates into the financial clearance workflows
- Educate registration staff to double check for estimates on scheduled services for self-pay patients
- 80/20 Rule – Perform analysis to identify commonly scheduled procedures for self-pay patients

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Patient-Provider Dispute Resolution Timeline

0–120 Days

Patient Initiates Dispute Resolution

Patients may submit for dispute resolution process for up to **120 days** from receipt of original bill
$25 to file

Patient Notice Requirements

1. DOS & description
2. Copy of bill
3. Copy of GFE
4. Contact information, address, phone
5. State
6. Individual's communication preference

Additional Info

The Selected Dispute Resolution (SDR) entity will notify patient electronically or by mail. Should request be incomplete, patient will have **21 days** to submit additional information for consideration

Convening Entity 10 Days

Convening facility/provider will have **10 days** from date of receipt of notice by SDR of patient-provider dispute to submit information

Final Determination

SDR will have **30 days** after receipt of information from provider to make a determination on the amount to be paid by patient

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Strategic Implications

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Mobile RHCs

- Mobile RHCs may utilize an existing RHC provider number
  - If part of grandfathered RHC, it may not be subject to AIR caps
  - Separate certification and conditions of participation do not need to be separately met
- Service requirements
  - Provide services in rural area with current HPSA designation
  - Services provided on regular schedule and public aware of schedule

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Hospital Outpatient Department (HOPD) or RHC Status

- Continued AIR increases may create opportunities to convert existing HOPDs to RHCs
  - RHCs not subject to location and mileage requirements applicable to HOPDs
- Services rendered in HOPDs need to be evaluated
  - RHC 51% primary care threshold
  - Reimbursement for services (injections, procedures, etc.)
- Timing of possible transition
  - AIR increases
  - 340B eligibility

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Changing RHC Physical Location

- Existing RHCs may change location and retain existing AIR
  - New location must be rural and in a HPSA or MUA
    + RHC status may be lost if new location does not qualify
  - Conditions of participation must be met and survey may be required
- Suite within a building with same “parent” address can be added onto the existing enrollment

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Questions?

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Thank you!

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Assurance / Tax / Advisory

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