

NARHC Update



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Agenda

Legislative

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

Regulatory

- CMS Final Rules Calendar Year 2024
 - New Behavioral Health Provider Types
 - Care Management Billing Opportunities
 - Intensive Outpatient Program Services

+ 2025 NARHC Policy Wishlist for CMS!

- New Regulations

The National Association of Rural Health Clinics (NARHC)

- The National Association of Rural Health Clinics mission is 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:** Technical Assistance, Conferences, NARHC Academy (Intro to RHCs, Certified Rural Health Clinic Professionals (CRHCP))
- **Advocacy:** Regulatory and Legislative; Fellowship

Special congratulations to the individual from Louisiana who recently became CRHCP certified!!!

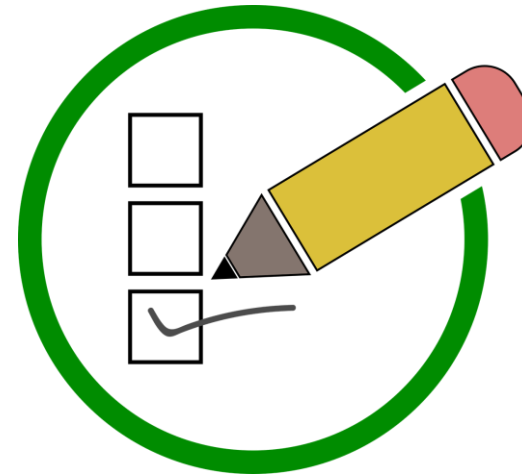


2024 RHC Policy Survey Results

- 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
- 16,677 bills introduced
- 47 have become 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
- 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

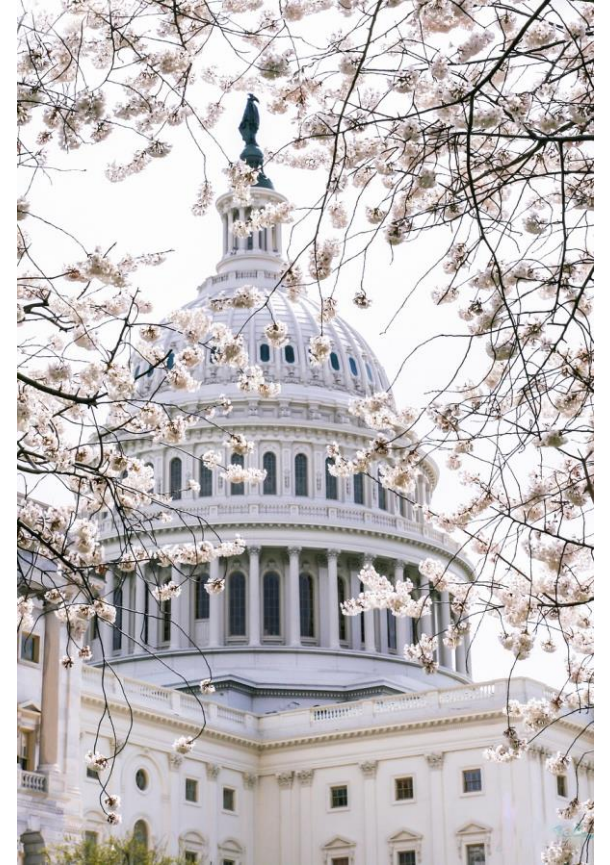


NARHC Priorities- 118th Congress

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)



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**



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.

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



Regulations



UPDATE

2024 Rules: Medicare Physician Fee Schedule (MPFS) &
Medicare Outpatient Prospective Payment System (OPPS)
2025 Wishlist
New Regulations



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.

History of Care Management

- Chronic Care Management (CCM) first created by Medicare in 2015
 - **RHCs eligible to participate in 2016**
 - Intended to support patients with chronic conditions who could benefit from services outside of traditional, face to face visits; continuous relationship; 24/7 patient access to information
- CMS created a consolidated code (G0511) that allows RHCs to bill for any care management services in the suite of codes
 - Traditional, fee-for-service Medicare providers will bill individual CPT codes
 - New codes have been added to the G0511 consolidated code every year since 2016



G0511 Billing Details



- [2024 G0511 Reimbursement - \\$72.90](#)
- RHCs bill G0511 anytime they meet the requirements to bill any of the CPT codes on slide 27
- RHCs may bill multiple G0511s per patient per month so long as resource costs are not double counted and all requirements for individual services are met
 - RHCs are not eligible to bill for additional time-based "add-on" codes



2024 Care Management Codes (G0511)

| Physician Fee Schedule Code | Description |
|-----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 99484 | General Behavioral Health Integration (BHI) |
| 99487 | Complex Chronic Care Management (over 60 minutes of care management per month) |
| 99490 | Basic Chronic Care Management (20 minutes of care management) |
| 99491 | 30 minutes or more of Chronic Care Management furnished by a physician or other qualified health professional |
| 99424 | 30 minutes or more of Principal Care Management furnished by physicians or non-physician practitioners |
| 99426 | 30 minutes or more of PCM services furnished by clinical staff under the supervision of a physician or non-physician practitioner |
| G3002 | Chronic pain management first 30 minutes |
| 99453 | Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment |
| 99454 | Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days |
| 99457 | Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes |
| 99091 | Collection and interpretation of physiologic data (e.g. Blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days |
| 98975 | Remote therapeutic monitoring (eg, therapy adherence, therapy response); initial set-up and patient education on use of equipment |
| 98976 | Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days |
| 98977 | Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days |
| 98980 | Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes |
| G0019 | Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating E/M visit |
| G0023 | Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator; 60 minutes per calendar month |
| G0140 | Principal Illness Navigation services by certified peer specialist under the direction of a physician or other practitioner, including a peer specialist; 60 minutes per calendar month |



Intensive Outpatient Program (IOP) Services

Quick Details

- New behavioral health treatment category billable in RHCs beginning January 1, 2024
- 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 than 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

- o \$259.40 per patient per day
- o Reimbursement corresponds to 3* distinct, qualifying services per day
- o Report condition code 92 and revenue code 0905; CG modifier
- o Costs associated with IOP services must be carved out of RHC cost report
- o 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 srves |
| 90832 | Psytx pt&/family 30 minutes |
| 90833 | Psytx pt&/fam w/c&m 30 min |
| 90834 | Psytx pt&/family 45 minutes |
| 90836 | Psytx pt&/fam w/c&m 45 min |
| 90837 | Psytx pt&/family 60 minutes |
| 90838 | Psytx pt&/fam w/c&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 asmt/reassessment |
| 96158 | Hlth bhv ivntj indiv 1st 30 |
| 96161 | Admin of caregiver - focused hlth risk asmt 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 asmt by phys/qhp |
| 97152 | Bhv id suprt asmt 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 1 st 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 psych PHP/IOP |
| G0451 | Development test interpt&rep |



2025 Regulatory Wishlist

Payment

CPT Category II Codes on UB-04 Claims

Annual Wellness Visits as Separate Medical Visits (Eligible for same day billing like IPPEs)

- Plus allowing Registered Nurses to perform AWWs

Allowing RHC providers to offer telehealth services outside of RHC hours of operation

Re-evaluate how to offer RHC practitioners same "add-on" code opportunities as FFS providers (additional CCM/RPM minutes; complex E&M)

Survey & Certification

Updates to guidance documents to clarify measurement of "primarily" (engaged in mental health) and "primarily engaged in primary care"

Update to 491.9(c)(2) -- Removing Hemoglobin / Hematocrit from the list of diagnostic services RHCs must provide on-site

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.



Section 1557 Provider Relevant Provisions

| Section 1557 Requirement and Description | Covered entities must comply by: |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|
| §92.7 Section 1557 Coordinator | Within 120 days of effective date (anticipated November 2, 2024) |
| §92.8 Policies and Procedures | Within one year of effective date (anticipated July 5, 2025) |
| §92.9 Training | After the creation of a covered entities P&P and no later than one year after effective date (anticipated July 5, 2025) |
| §92.10 Notice of Nondiscrimination ~ Longer notice required in English explaining Nondiscrimination rules to patients | Within 120 days of effective date (anticipated November 2, 2024) |
| §92.11 Notice of Availability ~ Shorter notice in English and top 15 foreign languages explaining the availability of translation and auxiliary aid services free of charge | Within one year of effective date (anticipated July 5, 2025) |
| §92.210 Patient Care Decision Support Tools | Within 300 days of effective date (anticipated May 1, 2025) |



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Questions?

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