Building a Better Rural Health Clinic

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Learning Objectives

- Understand Rural Health Clinic's (RHCs') role in rural health care systems
- Review the evolving primary care environment as a context for understanding RHC challenges
- Review strategies to help RHCs thrive in the changing healthcare environment and better address rural needs
  - Quality and performance reporting
  - Care management
  - Integrated mental health and substance use programs
  - Telehealth
  - Team-based care

Role of RHCs in Rural Health Care Systems

Sound Familiar?

- Rural primary care access issues in 1977:
  - Access barriers for rural Medicare and Medicaid enrollees
  - Inadequate supply of primary care physicians in rural areas
  - Difficulty recruiting and retaining providers in rural areas
  - Medicare/Medicaid fees schedules problematic for low-volume practices
  - Rural populations older, poorer, sicker
  - Primary care workforce production not aligned with demand
- More recent rural challenges:
  - Rural residents have higher rates of un/under insurance
  - Coverage typical involves higher co-pays and deductibles
  - Many insured working poor are functionally “uninsured” until out-of-pocket cost requirements are met

Is the RHC Program Still Relevant?

- **YES**: Same challenges still plague rural areas
- Changes are needed:
  - Distinguish between access and availability
  - Better target program benefits to areas of greatest need
  - Collect data to quantify the extent to which RHCs are improving/access and serving vulnerable populations
  - Review participation of RHCs located in areas no longer designated as shortage areas or non-urbanized areas
    - Protect clinics that are using program benefits to expand access for vulnerable populations
    - De-certify clinics that may not be using program benefits to expand access for vulnerable populations

Concerns About the RHC Program

- Questions about the extent to which the Program is:
  - Improving access and serving vulnerable populations
  - Relevant to needs of rural communities (GAO 1996; OIG 1996 & 2005)
- Failure to implement provisions of BBA 97
- Increasing safety net demands
- Push back against cost-based reimbursement
- Demands of health reform and practice transformation
- Calls for accountability and transparency
- Limited data to explain and support program

Safety Net Challenges Facing RHCs

- Medicaid has filled coverage gaps in expansion states
- Rural residents (Kaiser Family Foundation, 4/25/17):
  - Are less likely to be employed & more likely to be low-income
  - Face significant access barriers including provider shortages, rural hospital closures, and long travel distances to providers
  - Are less likely to have employer-based coverage and more likely to be under-insured (high co-pays and deductibles)
- Greater demand for free/discounted care - reductions in provision of such care by private physicians (CSHSC 2011)
- Provision of charity care draws costs away from Medicare on cost report

Are RHCs Part of the Safety Net?

- **YES** - given their location in rural, underserved areas and their service to uninsured, self-pay, Medicaid/SCHIP, and elderly patients, many (but not all) RHCs are safety net providers
- Most are not core safety net providers (per IOM definition)
- Limitation – hard evidence on the amount of free/discounted care provided and magnitude of services to vulnerable populations is not available
- Note: RHC Program was designed to address geographic, not financial access

Understanding the Primary Care Environment

The Challenges of Primary Care

- Primary care's role has declined over the past 40 years:
  - Primary care physicians have lower incomes and higher practice overhead than most specialists
  - Much of their work involves preventive care and simple diagnoses that can be handled safely by PAs, NPS, and APNs
  - They are expected to take on care coordination & population health without adequate reimbursement or IT support
  - Projections (National Center for Workforce Analysis, 11/16):
    - Supply of PCPs will grow more slowly than demand
    - Supply of NPs and PAs will outpace demand
    - Distribution is still a problem in rural areas

Demand for Primary Care Is Rising

- 46% of Americans have one or more chronic conditions
- Sustainability of hospitals and health systems depends on the strength of their primary care systems
- Primary care plays an central role in practice transformation initiatives:
  - CMS's Medicare Shared Savings Program, readmission penalty, and hospital value-based purchasing programs
  - PCMHs and ACOs
  - Chronic care management and behavioral health integration
- PCPs are called upon to provide services that specialty providers are not providing in rural communities

Building Blocks of High Performing Primary Care

- Leadership - practice-wide vision, goals, and objectives
- Data driven improvement using HIT to track operational, clinical, and patient experience metrics
- Empanelment–patients linked to PCP & care team
- Team-based care – clinical and non-clinical staff
  - Physicians, PAs/NPs/APNs, pharmacists, behavioral health clinicians, nutritionists, nurses, care mgrs, medical assistants
  - Building teams for preventive services, chronic care, acute care
- Template of the Future
  - Reduced reliance on 15 minute in-person visits, use of e-visits, group appointments, telephone encounters

(Bodenheimer, Ghorob, Willard-Grace, Grumbach, *The 10 Building Blocks of Primary Care.* Annals of Family Medicine, 12(2), March/April 2014, pp: 166-171.)

Opportunities to address unmet needs:

Improve participation in public reporting systems

Chronic care management

Team-based care

Mental health/substance use

Telehealth

RHC Data Collection Issues

Improve RHC Participation in Public Reporting

- Quality reporting
  - RHCs are exempt from participation in MIPS
  - A core element of practice transformation, pay-for-performance, state Medicaid programs, and commercial payers
  - Allows RHCs to concretely demonstrate quality
  - Key – select a set of quality measures and promote wide-spread use by RHCs for public reporting and performance improvement
- Financial and operational reporting
  - MGMA and other data sets are not focused on rural primary care practices

Need for a National RHC Data Strategy

- Lack of data is a big challenge to the RHC Program
  - Difficult to create a national advocacy and support strategy
  - Hard to develop support for legislative change
- May be left out of health reform/transformation
- Safety net role of RHCs is under appreciated in the absence of evidence documenting their contribution
- Current contact database of RHC owners does not exist
- Need for a consistent advocacy voice
- Encourage greater RHC participation in research

RHC Core Quality Measures

- Based on National Quality Forum definitions
- 18–Controlling High Blood Pressure
- 28–Tobacco Use Assessment and Cessation Intervention
- 38–Childhood Immunization Status
- 59–Diabetes: Hemoglobin A1c poor control
- 419–Documentation of current medications, adult/geriatric

RHC Optional Quality Measures

- 24–Body Mass Index – Pediatric
- 36–Asthma – use of appropriate medications
- 41–Influenza Immunization
- 43–Pneumonia vaccines – older adults
- 56–Diabetes: foot exam – adult/geriatric
- 57–Diabetes: Hemoglobin A1c testing
- 61–Diabetes: Blood Pressure Management
- 62–Diabetes: Urine protein screening
- 63– Diabetes: Lipid profile
- 68–Ischemic Vascular Disease, aspirin use, adult/geriatric
- 73–IVD: Blood Pressure Management – adult/geriatric
- 75-IVD: Complete Lipid Profile, LDL-C Control <100 mg/dL
- 421–BMI screening and follow-up – adults

RHC Quality Reporting Initiatives

- Maine Rural Health Research Center Pilot Test of RHC quality measures – identified relevant quality measures for RHCs
- NOSORH/Lilypad partnership on the Practice Operations National Database (POND) program, a web-based data collection, reporting and benchmarking application for rural primary care providers
- Quality Health Improvement (QHi), a web-based quality benchmarking program designed, developed and driven by small rural hospitals and rural health clinics to compare selected quality measures with other similar hospitals and clinics
- Michigan's Rural Health Clinic Quality Network is an initiative started by dedicated RHCs throughout Michigan and the Michigan Center for Rural Health with a goal to measure and improve the quality of care in Michigan RHCs

Need for Financial/Operational Data

- Limited data specific to RHC finance and operations
  - Other physician data sets (e.g., MGMA) are less focused on primary care practices
- Some state RHC associations and other organizations are working with RHCs at state and regional levels
- No national "picture" of RHC operations/performance
- No current resources for research and performance improvement
- Challenge – minimizing reporting burden through the use of cost reports and claims data

Cost Report Data

- Benefits
  - Available nationally for all RHCs
  - Can be linked to other sources of data
  - Provides opportunity for peer grouping
  - Available for longitudinal analysis back to 2009
  - No additional costs burden on RHCs
- Weaknesses
  - Good for trend analysis, not day to day management
  - Does not allow calculation at the individual level
  - No balance sheet and income statement data
  - Does not allow calculation of traditional measures and ratios

Concerns About RHC Payment Cap

- The payment cap was originally applied only to independent clinics
- GAO and OIG reports raised concerns about the high ACPVs paid to provider-based clinics
- RHCs have long argued that their ACPVs exceeded the payment cap and the rate of growth has not kept pace with the cap applied to FQHCs
- The Secretary's National Advisory Committee raised this issue in its December 2017 report

Options to Create a National RHC Database

- Use independent and provider-based RHC costs reports
- Engage state licensing agencies in collecting and reporting a core set of RHC data
- Encourage CMS to collect core RHC data
- Use Medicare claims data to generate claims-based quality and utilization measures
- Engage key stakeholders in encouraging RHCs to participate in data collection efforts
- Build on existing efforts
  - Michigan RHC Quality Network
  - NOSORH/POND collaboration
  - Qhi Quality Portal

Chronic Care Management

Chronic Care Management

- Care management services in RHCs include:
  - Transitional care management (TCM)
  - Chronic care management (CCM)
  - General behavioral health integration (BHI)
  - Psychiatric Collaborative Care Model (CoCM)
- Care management is considered an RHC service
- Coinsurance/deductibles apply to care mgt services
- Except for TCM, if care mgt services are billed on the same claim as an RHC visit, both are paid
- Care mgt services are reported with revenue code 052x.
- The service period for care management services is a calendar month

Requirements for Chronic Care Management

- Services can be furnished by auxiliary personnel under general supervision of the RHC practitioner
  - Direct supervision of auxiliary personnel has been waived for RHCs. RHC practitioner is not required to be in the same building or immediately available.
- Elements within scope of service may be counted toward the required billing time if measured/documented
- An initiating visit with an RHC practitioner is required before CCM services can be furnished within one year of coordinating services (E&M, annual wellness, or initial preventive physical exam visits)
- Patient consent is required before time is counted toward care management services, consent may be verbal but must be document in the patient's record

Payment for CCM Services

- CCM services are non-face-to-face care management and coordination services for Medicare beneficiaries with two or more chronic conditions
- CCM services can be billed by adding the general care management G code, G0511, to an RHC claim, either alone or with other payable services
- Payment is the average of the national PFS payment rate for CPT codes 99490, 99487, 99491, and 99484
- CCM or General BHI (HCPCS code G0511) services are paid at the rate of $67.03 for 2019
- A minimum of 20 minutes of CCM or general BHI services must be furnished within the calendar month

Payment for TCM Services

- TCM services support patient's transition from inpatient, SNF, inpatient rehab, outpatient observation or partial hospitalization settings to home or community settings
- TCM services can be billed by adding CPT code 99495 or 99496 to an RHC claim
- If it is the only medical service provided on that day with an RHC practitioner, it is paid as a stand-alone visit
- If it is furnished on the same day as another visit, only one visit is paid
- For 2019, TCM (CPT code 99495 or 99496) is paid the same as an RHC Visit

Payment for General BHI Services

- General BHI is a defined model of care that focuses on integrative treatment of patients with primary care and mental or behavioral health conditions
- General BHI services can be billed by adding the general care management G code, G0511, to an RHC claim, either alone or with other payable services
- Payment is the average of the national non-facility PFS payment rate for CPT codes 99490, 99487, and 99484
- CCM or General BHI (HCPCS code G0511) services are paid at the rate of $67.03 for 2019
- A minimum of 20 minutes of CCM or general BHI services must be furnished within the calendar month

Psychiatric CoCM Services

- CoCM is a specific model in which services are provided by a primary care team of a PCP and a BH care manager working in collaboration with a psychiatric consultant
  - Care is directed by the team with structured care mgt, regular assessments of clinical status, and modification of treatment
  - The psychiatric consultant reviews the clinical status and care of patients and make recommendations the team
  - Services billed by adding psychiatric CoCM G code, G0512, to an RHC claim, either alone or with other payable services
  - Payment is the average of the national PFS payment rate for CPT codes 99492 and 99493
  - For psychiatric CoCM services, the 2019 rate is $145.96
  - A minimum of 60 minutes of psychiatric CoCM services are required to be furnished within the calendar month

Team-Based Care

Team-Based Care

- Team-based care has been linked to improved patient outcomes and may also be a means to improve clinician well-being
- Closely linked with PCMHs, value-base care, and chronic care management
- Requires restructuring of clinical workflows to promote increased sharing of responsibilities across the entire team, which enhances practice efficiency while improving provider, patient, and staff engagement
- A team-based model of care seeks to meet patient needs by engaging them as participants, while encouraging health care professionals to function to the full extent of their education, certification, and experience

Characteristics and Requirements

- Key characteristics
  - Clear, compelling, and shared goals
  - An enabling social structure that facilitates teamwork
  - A supportive organizational context
  - Expert teamwork coaching
- Depends on:
  - Team members' psychological safety, defined as their ability to trust one another and feel safe enough within the team to admit a mistake, ask a question, offer new data, or try a new skill without fear of embarrassment or punishment
  - A culture that allows members to learn, teach, communicate, reason, think together, and achieve shared goals, irrespective of their individual positions or status outside the team

Action Steps

- Identify leadership for teams and build a team culture
- Develop and test a core team structure/structures
- Develop roles/responsibilities that allows each member to work to the top of their skillsets/credentials
- Enable staff to work independently – use standard work processes for common services and standing orders
- Engage patients as a member of the care team
- Provide team members with time to meet about patient care, quality improvement, and to facilitate strong working relationships
- Train staff members on working in a team environment
- Develop career ladders for staff members in all roles

Integrating Mental Health Services

Integrated Mental Health Services

- MH services provided by a doctoral-level psychiatrist or a clinical social worker are considered RHCs services and covered under the RHC's Medicare inclusive rate
- Services may also be provided by PCPs, psychiatrists, nurse practitioners, and physician assistants
- Depending on state Medicaid regulations, RHCs may also be reimbursed for other types of masters trained MH professionals - licensed professional clinical counselors
- Integrated MH services fill a vital community need and can reduce the burden on the RHC's primary care staff
- Depending on payer mix and staffing costs – integrated MH services can be self-sustaining

Functional Aspects of Integrated MH Services

- Clinical integration
  - Shared medical records
  - Shared decision making
  - Common treatment plans and models
  - Regular communication
  - Use of critical pathways or practice guidelines
  - Internal referral process
- Structural integration
  - Co-location (e.g. shared space)
  - Staffing - employed or contracted staff
  - Single medical record
  - Shared billing and scheduling systems
  - Shared risk

Where to Begin

- Decide what your goals are and prioritize them
  - Expand access to MH services for patients, improve PCP productivity?
- Determine the best ways to achieve each goal
  - Start simply and evolve with experience, avoid competition for necessary resources, explore telehealth if the resource do not exist to hire a mental health clinician
- Understand MH reimbursement policies
  - Examine MH procedure/diagnostic codes and managed care requirements -prior authorization, visit limitations, etc.
  - Hire clinicians and staff to meet the demands of the largest patient group (e.g., Medicare, Medicaid, commercial payers)
  - Focus on services that are reimbursable
  - Understand different treatment models

Telehealth

Evolving Telehealth Regulations

- CMS has provided substantial regulatory relief to allow RHCs (and other providers) to use telehealth during the COVID-19 crisis
- Questions about the extent to which these regulations will remain in place as we emerge from the pandemic
- Recommendations
  - Monitor and adapt to regulatory changes
  - Examine opportunities to incorporate telehealth as we emerge from the pandemic
  - Understand and work on clinical culture to effectively integrate telehealth into your clinic's operations

2019 Telehealth Codes in the Medicare PFS

- Current Medicare telehealth reimbursement policies
  - Services normally conducted in person but furnished via real-time, interactive communication technology
  - Limited to services furnished to beneficiaries treated in certain originating sites located in rural areas
- 2019 changes to the MPS
  - Reflect changes in the management of chronically ill patients
  - Increase access to physicians' services by recognizing a discrete set of services that are defined by and inherently involve the use of communication technology
  - CMS does not consider them to be telehealth services
  - Requires medical necessity and documentation in the record
  - These codes may be used to better serve patients and reduce out of community referrals

Summary of Medicare PFS Changes

Code	Service	Originating Site
G2012	Brief Communication Technology-Based Service (Virtual Check-In)	No
G2010	Remote Evaluation of Pre-Recorded Patient Information	No
99451	Telephone, internet, EHR assessment & management by consultative provider, 5+ minutes	No
99452	ITelephone, internet, EHR assessment & management by treating/requesting provider, 30 min.	No
99446	Interprofessional Internet Consultation by consultative provider, 5-10 minutes	No
99447	Interprofessional Internet Consultation by consultative provider, 11-20 minutes	No
99448	Interprofessional Internet Consultation by consultative provider, 21-30 minutes	No
99449	Interprofessional Internet Consultation by consultative provider, 31 or more minutes	No
G0513	Prolonged Preventive Services (beyond the typical time of the primary procedure), first 30 min.	Yes
G0514	Prolonged Preventive Services each additional 30 minutes	Yes
	End Stage Renal Disease Assessments for purpose of home dialysis ESRD-related assessments	Yes
	Acute Stroke Telehealth Treatment in any hospital, CAH, mobile stroke units, or other sites	Yes
G0396	Alcohol/substance use intervention 15-30mn (Treatment for O/SUDs)	Yes
G0397	Alcohol/substance use intervention – over 30 minutes (Treatment for O/SUDs)	Yes

Brief Communication Technology-Based Service, Virtual Check-In (HCPCS Code G2012)

- Brief non-face-to-face check-in with an established patient via communication technology, to assess if the patient's condition necessitates an office visit
- Provided by physician/other qualified health care providers (QCHPs)
- Does not originate from a related E/M service provided within the previous 7 days nor lead to an E/M service within 24 hours or soonest available appointment
- 5-10 minutes of medical discussion
- Direct interaction between patient and billing provider
- Patient must consent to receiving services

Remote Evaluation of Pre-Recorded Patient Information (HCPCS Code G2010)

- Remote evaluation of recorded video and/or images submitted by an established patient (store & forward)
- Includes interpretation with follow-up with the patient within 24 business hours
- Does not originate from a related E/M service provided within previous 7 days nor lead to an E/M service within next 24 hours or soonest available appointment
- Can take place via phone call, audio/video, secure text messaging, email, or patient portal communication
- Patient must consent to receipt of service

Interprofessional Internet Consultation

- Assessment/management services conducted by telephone, internet, or HER record consultations
- Treating provider requests the opinion and/or treatment advice of a consulting specialty provider to assist with the diagnosis/management of the patient's problem
- Face-to-face contact with consultant not required
- Especially useful for managing chronic conditions
- Telephone or internet-based interactions between specialists and treating providers allowed
- Patient consent is required
- Limited to providers eligible to bill for E/M visits

Interprofessional Internet Consultation

- Codes used by consultants
  - CPT Codes 99446, 99447, 99448, and 99449
  - Telephone/internet assessment/management service provided by a consultant to patient's treating/requesting provider
  - 5 - 31 minutes of medical consultative discussion/review
  - Includes a verbal and written report
- Codes used by referring providers
  - 99451 - Telephone, internet, EHR assessment/management service, 5 or more minutes of medical consultative time with consulting provider Includes a written report to the patient's treating/requesting physician or other QHCP
  - 99452 –Similar services as 99451 with 30 minutes of medical consultative time

Opioid and Other Substance Use Disorders

- Treatment of Opioid Use and Other SUDs
- G0396 and G0397-Alcohol/SU intervention, 15-> 30 min
  - Removes originating site geographic limitations and adds the home as permissible originating sites effective 7/1/19
  - No originating site facility fee paid when the originating site is the individual's home
  - Recognition that virtual check-in services “could be used as part of a treatment regimen for O/SUDs, since several components of MAT could be done virtually, or to assess where a patient’s requires an office visit
  - Section 2005 of the SUPPORT Act establishes a new Medicare benefit category for OUD treatment services furnished by OTPs under Medicare Part B, beginning on or after January 1, 2020

Recommendations to Modernize RHC Program

- Support development of a standardized RHC data set to monitor program performance/impact
- Explore team-based reimbursement models that encourage innovative use of clinical and non-clinical staff
- Develop incentives to encourage RHC participation in MIPS and practice transformation initiatives
- Provide TA to support quality reporting, practice transformation, and implementing the building blocks of primary care
- Evaluate Medicare/Medicaid reimbursement rates
- Support/reimburse for RHC safety net activities

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