GETTING BACK TO NORMAL: WHAT TO EXPECT AFTER THE PHE ENDS

Louisiana Rural Health Summit | November 10, 2022 | Alexandria, LA

SESSION OBJECTIVES

- When will the PHE end?
- Which blanket waivers will end and when?
- How do you get back to "normal?"
- What are common challenges?

RENEWAL OF COVID-19 PUBLIC HEALTH EMERGENCY

HTTPS://ASPR.HHS.GOV/LEGAL/PHE/PAGES/COVID19-13OCT2022.ASPX

As a result of the continued consequences of the Coronavirus Disease 2019 (COVID-19) pandemic, on this date and after consultation with public health officials as necessary, I, Xavier Becerra, Secretary of Health and Human Services, pursuant to the authority vested in me under section 319 of the Public Health Service Act, do hereby renew, effective October 13, 2022, the January 31, 2020, determination by former Secretary Alex M. Azar II, that he previously renewed on April 21, 2020, July 23, 2020, October 2, 2020, and January 7, 2021, and that I renewed on April 15, 2021, July 19, 2021, October 15, 2021, January 14, 2022, April 12, 2022, and July 15, 2022, that a public health emergency exists and has existed since January 27, 2020, nationwide.

October 13, 2022	/s/
_____	_____
Date	Xavier Becerra

HOW MANY NEW HOSPITALS AND RHCS HAVE BEEN CERTIFIED SINCE JANUARY 2020?

THESE FACILITIES WILL HAVE ONLY OPERATED UNDER THE BLANKET WAIVERS SINCE CERTIFICATION

NEW LOUISIANA RURAL FACILITIES CERTIFIED DURING THE PHE

- New RHCs (Includes Changes in Ownership if CCN changed)
  - In 2020, 29 New RHCs
  - In 2021, 16 New RHCs
  - In 2022 YTD, 6 New RHCs
- No new CAHs
- One Rural Acute Care Hospital >50 beds

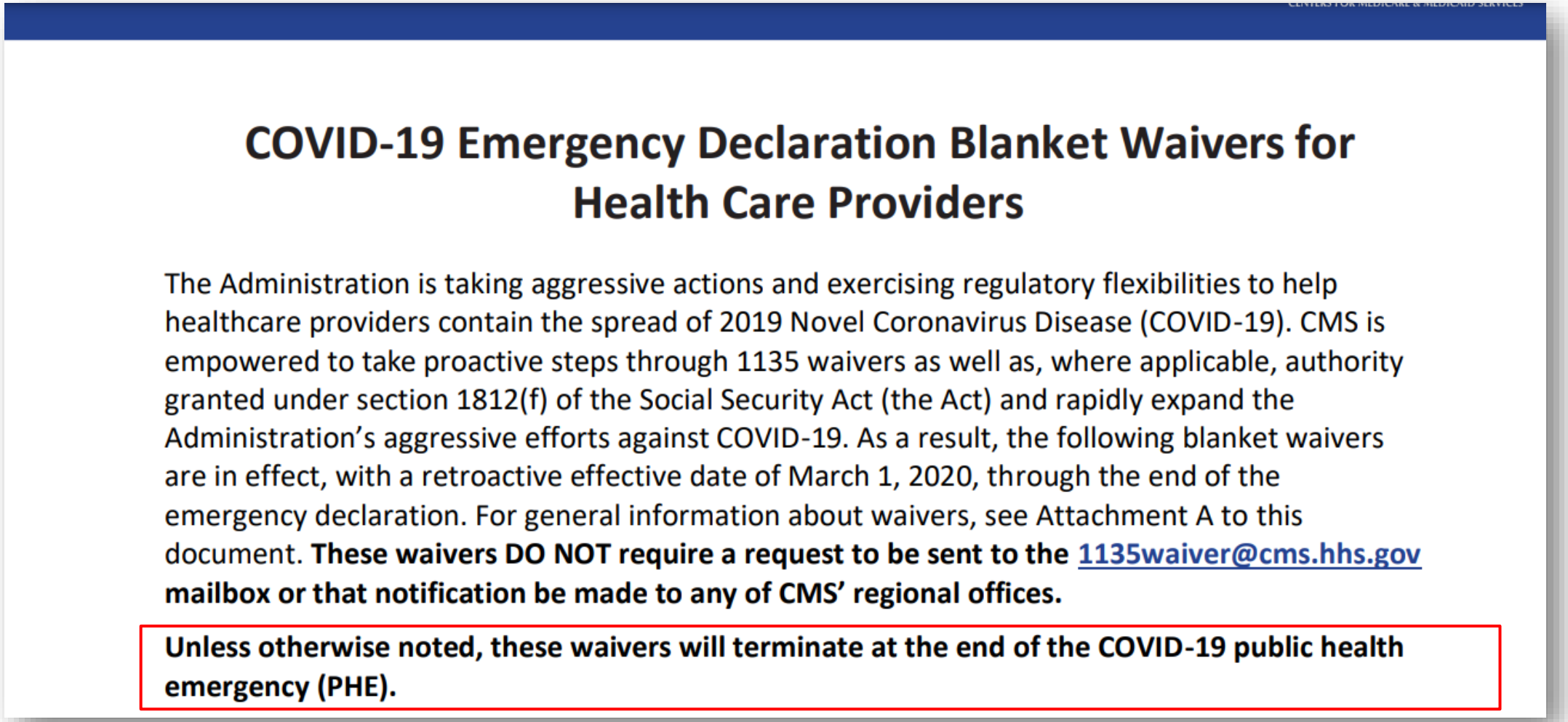
ALL BLANKET WAIVERS WILL END WITH THE PHE

FLEXIBILITIES FOR TELEMEDICINE WILL BE PHASED OUT PENDING FUTURE LEGISLATION

CRITICAL ACCESS HOSPITAL BLANKET WAIVERS

MOST WILL END WHEN THE PUBLIC HEALTH EMERGENCY END

https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf



COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers

The Administration is taking aggressive actions and exercising regulatory flexibilities to help healthcare providers contain the spread of 2019 Novel Coronavirus Disease (COVID-19). CMS is empowered to take proactive steps through 1135 waivers as well as, where applicable, authority granted under section 1812(f) of the Social Security Act (the Act) and rapidly expand the Administration's aggressive efforts against COVID-19. As a result, the following blanket waivers are in effect, with a retroactive effective date of March 1, 2020, through the end of the emergency declaration. For general information about waivers, see Attachment A to this document. **These waivers DO NOT require a request to be sent to the 1135waiver@cms.hhs.gov mailbox or that notification be made to any of CMS' regional offices.**

Unless otherwise noted, these waivers will terminate at the end of the COVID-19 public health emergency (PHE).

THESE BLANKET WAIVERS FOR CAHS WILL END:

- **Emergency Medical Treatment & Labor Act (EMTALA).** CMS is waiving the enforcement of section 1867(a) of the Act. This will allow critical access hospitals(CAHs)to screen patients at a location offsite from the hospital's campus to prevent the spread of COVID-19, so long as it is not inconsistent with a state's emergency preparedness or pandemic plan.
- **Verbal Orders.** CMS is waiving the requirements of 42 CFR §485.635(d)(3) to provide additional flexibility related to verbal orders where read- back verification is required, but authentication may occur later than 48 hours. This will allow more efficient treatment of patients in surge situations. Specifically, the following requirements are waived:

  Although the regulation requires that medication administration be based on a written, signed order, this does not preclude the CAH from using verbal orders. A practitioner responsible for the care of the patient must authenticate the order in writing as soon as possible after the fact.

THESE BLANKET WAIVERS FOR CAHS WILL END:

- **Sterile Compounding.** CMS is waiving requirements (also outlined in USP797) at 42 CFR §485.635(a)(3) in order to allow used face masks to be removed and retained in the compounding area to be re-donned and reused during the same work shift in the compounding area only. This will conserve scarce face mask supplies. CMS will not review the use and storage of face masks under these requirements.

- **Detailed Information Sharing for Discharge Planning for CAHs.** CMS is waiving the requirement 42 CFR §482.43(a)(8), §482.61(e), and §485.642(a)(8) to provide detailed information regarding discharge planning,. The CAH must assist patients, their families, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, home health agency (HHA), skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), and long-term care hospital (LTCH) quality measures and resource use measures. The hospital must ensure that the post acute care data on quality measures and resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.

THESE BLANKET WAIVERS FOR CAHS WILL END:

- **Flexibility in Patient Self Determination Act Requirements (Advance Directives).** CMS is waiving the requirements at sections 1902(a)(58) and 1902(w)(1)(A) of the Act(for Medicaid); 1852(i) of the Act (for Medicare Advantage); and 1866(f) of the Act and 42 CFR §489.102 (for Medicare), which require CAHs to provide information about their advance directive policies to patients. CMS is waiving this requirement to allow staff to more efficiently deliver care to a larger number of patients.

- **Physical Environment.** CMS is waiving certain physical environment requirements under the Medicare conditions of participation at 42 CFR §485.623 to allow for increased flexibilities for surge capacity and patient quarantine at critical access hospitals (CAHs) as a result of COVID-19. CMS will permit facility and non-facility space that is not normally used for patient care to be utilized for patient care or quarantine, provided the location is approved by the state (ensuring that safety and comfort for patients and staff are sufficiently addressed) and is consistent with the state's emergency preparedness or pandemic plan. This allows for increased capacity and promotes appropriate co-horting of COVID-19 patients. States are still subject to obligations under the integration mandate of the Americans with Disabilities Act, to avoid subjecting persons with disabilities to unjustified institutionalization or segregation.

THESE BLANKET WAIVERS FOR CAHS WILL END:

Telemedicine. CMS is waiving the provisions related to telemedicine at 42 CFR §485.616(c) for CAHs, making it easier for telemedicine services to be furnished to the hospital's patients through an agreement with an off-site hospital. This allows for increased access to necessary care for hospital and CAH patients, including access to specialty care.

Anesthesia Services. CMS is waiving requirements under 42 CFR §485.639(c) (2), that a certified registered nurse anesthetist (CRNA) is under the supervision of a physician in paragraph §485.639(c)(2). CRNA supervision will be at the discretion of the hospital and state law. These waivers will allow CRNAs to function to the fullest extent of their licensure and may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.

THESE BLANKET WAIVERS FOR CAHS WILL END:

- **Emergency Preparedness Policies and Procedures.** CMS is waiving 42 CFR §485.625(b), which requires the CAH to develop and implement emergency preparedness policies and procedures, and §485.625(c)(1)–(5) which requires that the emergency preparedness communication plans for CAHs to contain specified elements with respect to the surge site. The requirement under the communication plan requires CAHs to have specific contact information for staff, entities providing services under arrangement, patients' physicians, other hospitals and CAHs, and volunteers. This would not be an expectation for the surge site. This waiver applies to both hospitals and CAHs, and removes the burden on facilities to establish these policies and procedures for their surge facilities or surge sites.
- **Quality Assessment and Performance Improvement Program.** CMS is waiving 42 CFR §485.641(a), (b), and (d), which provide details on the scope of the program, the incorporation, and setting priorities for the program's performance improvement activities, and integrated Quality Assurance & Performance Improvement programs (for hospitals that are part of a hospital system). These flexibilities may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan. We expect any improvements to the plan to focus on the Public Health Emergency (PHE). While this waiver decreases burden associated with the development of a CAH QAPI program, the requirement that CAHs maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program will remain.

THESE BLANKET WAIVERS FOR CAHS WILL END:

- **Nursing Care Plans.** CMS is waiving the requirements at 42 CFR §485.635(d)(4)), which requires the nursing staff to develop and keep current a nursing care plan for each patient. These waivers allow nurses increased time to meet the clinical care needs of each patient and allow for the provision of nursing care to an increased number of patients. In addition, we expect that hospitals will need relief for the provision of inpatient services and as a result, the requirement to establish nursing-related policies and procedures for outpatient departments is likely of lower priority. These flexibilities apply to CAHs §485.635(d)(4) and may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.
- **CAH Personnel Qualifications.** CMS is waiving the minimum personnel qualifications for clinical nurse specialists at paragraph 42 CFR §485.604(a)(2), nurse practitioners at paragraph §485.604(b)(1)–(3), and physician assistants at paragraph §485.604(c)(1)–(3). Removing these Federal personnel requirements will allow CAHs to employ in decidual in these roles who meet state licensure requirements and provide maximum staffing flexibility. These flexibilities should be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.

THESE BLANKET WAIVERS FOR CAHS WILL END:

- **CAH Staff Licensure.** CMS is deferring to staff licensure, certification, or registration to state law by waiving 42 CFR §485.608(d) regarding the requirement that staff of the CAH be licensed, certified, or registered in accordance with applicable federal, state, and local laws and regulations. This waiver will provide maximum flexibility for CAHs to use all available clinicians. These flexibilities may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.

- **CAH Status and Location.** CMS is waiving the requirement at 42 CFR §485.610(b) that the CAH be located in a rural area or an area being treated as being rural, allowing the CAH flexibility in the establishment of surge site locations. CMS is also waiving the requirement at §485.610(e) regarding the CAH's off-campus and co-location requirements, allowing the CAH flexibility in establishing temporary off-site locations. In an effort to facilitate the establishment of CAHs without walls, these waivers will suspend restrictions on CAHs regarding their rural location and their location relative to other hospitals and CAHs. These flexibilities may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.

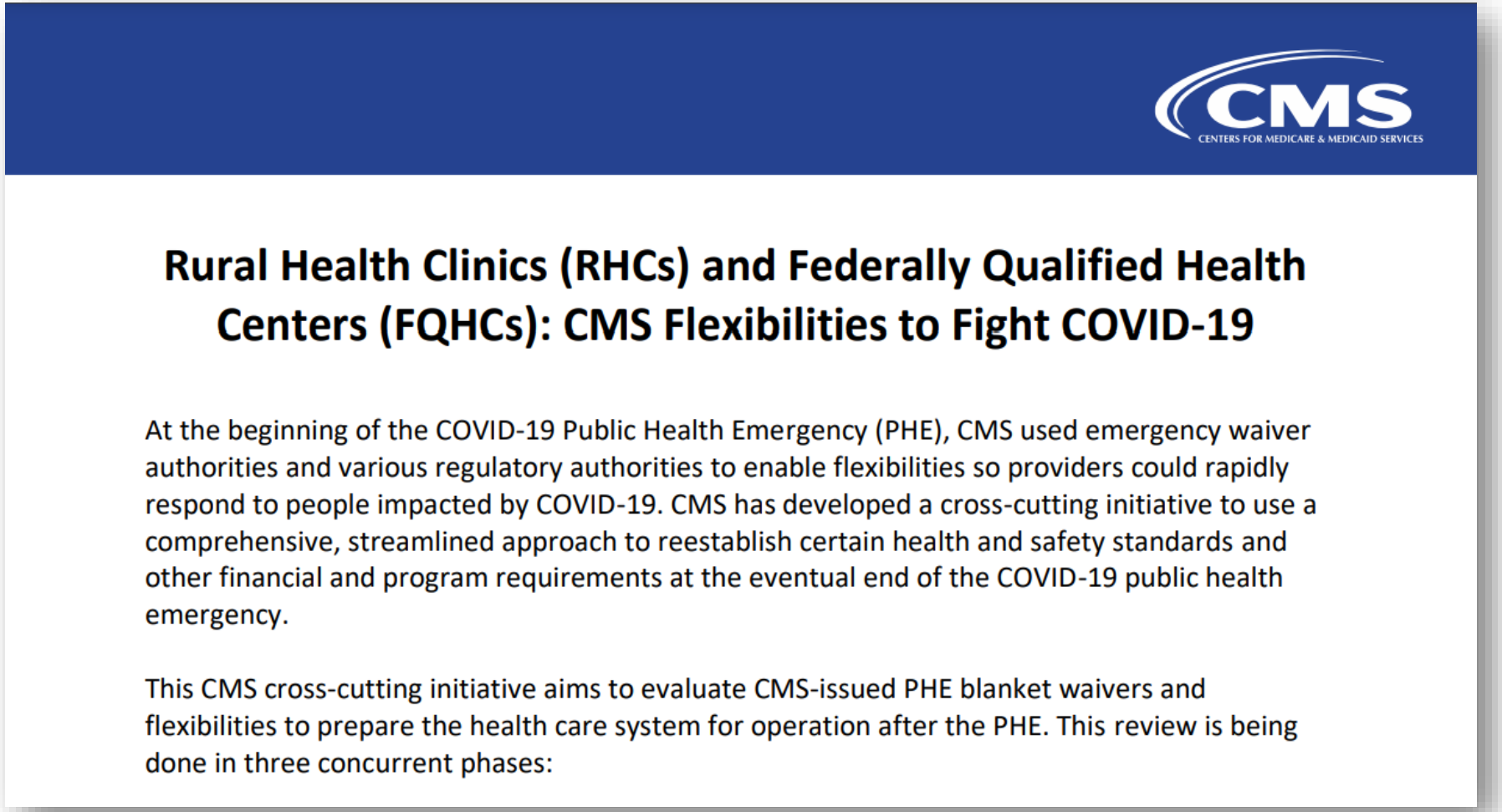
THESE BLANKET WAIVERS FOR CAHS WILL END:

- **Responsibilities of Physicians in Critical Access Hospitals (CAHs).** 42 CFR § 485.631(b)(2). CMS is waiving the requirement for CAHs that a doctor of medicine or osteopathy be physically present to provide medical direction, consultation, and supervision for the services provided in the CAH at § 485.631(b)(2). CMS is retaining the regulatory language in the second part of the requirement at § 485.631(b)(2) that a physician be available "through direct radio or telephone communication, or electronic communication for consultation, assistance with medical emergencies, or patient referral." Retaining this longstanding CMS policy and related longstanding subregulatory guidance that further described communication between CAHs and physicians will assure an appropriate level of physician direction and supervision for the services provided by the CAH. This will allow the physician to perform responsibilities remotely, as appropriate. This also allows CAHs to use nurse practitioners and physician assistants to the fullest extent possible, while ensuring necessary consultation and support as needed.

- **3-Day Prior Hospitalization for SNFs.** Using the authority under Section 1812(f) of the Act, CMS is waiving the requirement for a 3-day prior hospitalization for coverage of a SNF stay, which provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who experience dislocations, or are otherwise affected by COVID-19. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period (this waiver will apply only for those beneficiaries who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have occurred under normal circumstances).

THESE BLANKET WAIVERS FOR CAHS WILL END:

42 CFR §485.623(b) for CAHs require these facilities and their equipment to be maintained to ensure an acceptable level of safety and quality. CMS is temporarily modifying these requirements to the extent necessary to permit these facilities to adjust scheduled inspection, testing and maintenance (ITM) frequencies and activities for facility and medical equipment.



Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): CMS Flexibilities to Fight COVID-19

At the beginning of the COVID-19 Public Health Emergency (PHE), CMS used emergency waiver authorities and various regulatory authorities to enable flexibilities so providers could rapidly respond to people impacted by COVID-19. CMS has developed a cross-cutting initiative to use a comprehensive, streamlined approach to reestablish certain health and safety standards and other financial and program requirements at the eventual end of the COVID-19 public health emergency.

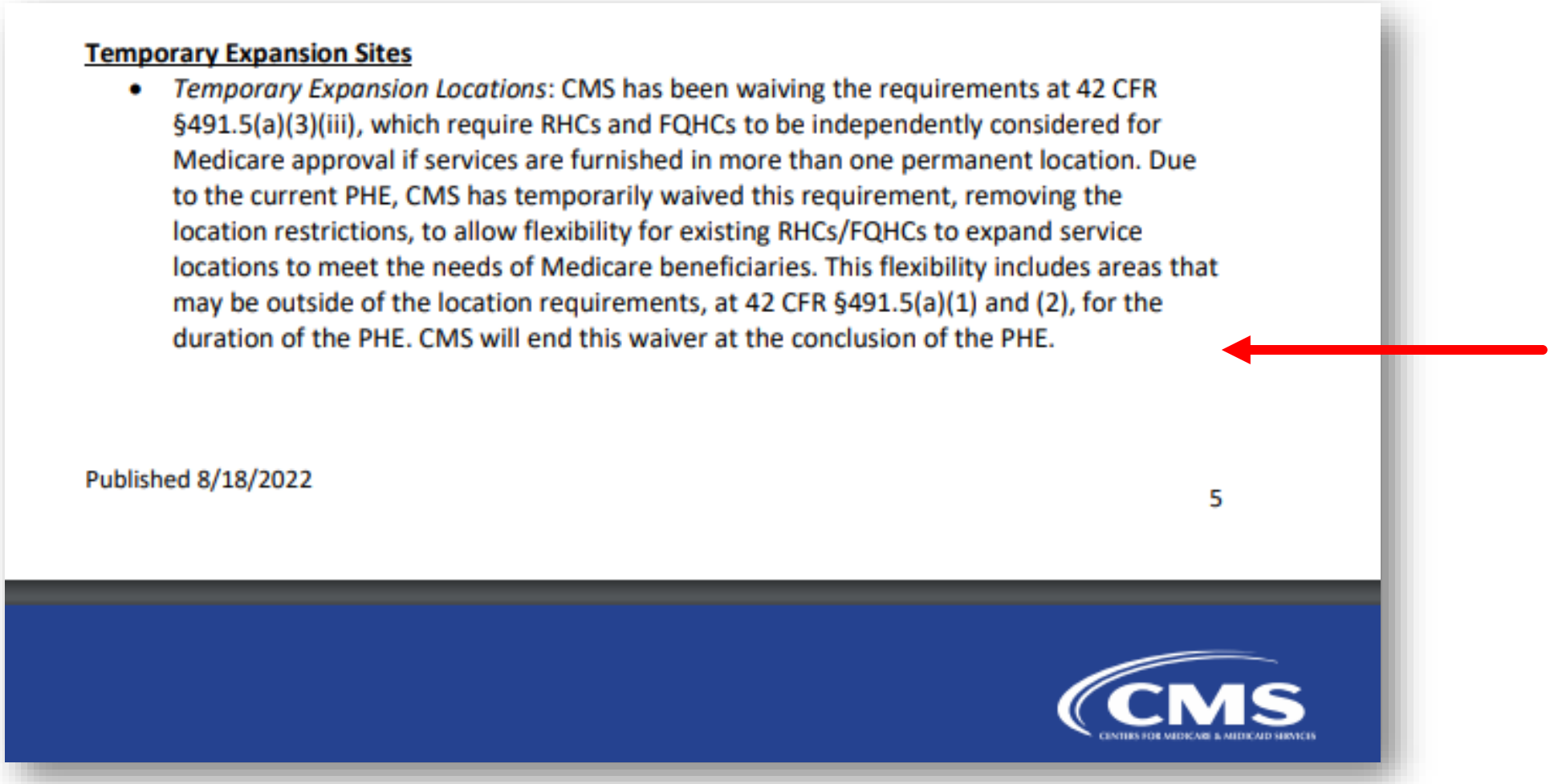
This CMS cross-cutting initiative aims to evaluate CMS-issued PHE blanket waivers and flexibilities to prepare the health care system for operation after the PHE. This review is being done in three concurrent phases:

https://www.cms.gov/files/document/rural-health-clinics-and-federally-qualified-health-centers-cms-flexibilities-fight-covid-19.pdf

Waivers or Flexibilities That Have Already Ended are indicated in red text

- *Provider Enrollment*: During the PHE, CMS has established toll-free hotlines for physicians, non-physician practitioners, and Part A certified providers and suppliers who have established isolation facilities to enroll and receive temporary Medicare billing privileges. **When the PHE ends, the hotlines will be shut down.** Additionally, CMS has provided the following flexibilities for provider enrollment:
    - *Screening requirements:*
        - Site Visits: CMS waived provider enrollment site visits for moderate and high-risk providers/suppliers. ***(This waiver terminated on 07-06-2020 and CMS, in accordance with 42 C.F.R. §§ 424.517 and 424.518, resumed all provider enrollment site visits.)***
        - *Fingerprint-based criminal background checks:* CMS waived the requirement for fingerprint-based criminal background checks for 5% or greater owners of newly enrolling high risk categories of providers and suppliers (e.g., newly-enrolling Home Health Agencies, DMEPOS suppliers, Medicare Diabetes Prevention Programs, Opioid Treatment Programs). ***(This waiver terminated on 10/31/2021 and CMS, in accordance with 42 C.F.R. § 424.518, resumed requesting fingerprints for all newly enrolling high risk providers and suppliers.)***
    - *Application Fees:* CMS waived the collection of application fees for institutional providers who are initially enrolling, revalidating, or adding a new practice location. ***(This waiver terminated on 10/31/2021 and CMS, in accordance with 42 C.F.R. § 424.514, resumed collecting application fees.)***

The document has been revised and updated to include information about when the waiver will end or how it will be transitioned.



Temporary Expansion Sites

- *Temporary Expansion Locations*: CMS has been waiving the requirements at 42 CFR §491.5(a)(3)(iii), which require RHCs and FQHCs to be independently considered for Medicare approval if services are furnished in more than one permanent location. Due to the current PHE, CMS has temporarily waived this requirement, removing the location restrictions, to allow flexibility for existing RHCs/FQHCs to expand service locations to meet the needs of Medicare beneficiaries. This flexibility includes areas that may be outside of the location requirements, at 42 CFR §491.5(a)(1) and (2), for the duration of the PHE. CMS will end this waiver at the conclusion of the PHE.

Published 8/18/2022

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

THESE BLANKET WAIVERS FOR RHCS WILL END:

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

- **Certain Staffing Requirements.** 42 CFR 491.8(a)(6). CMS is waiving the requirement in the second sentence of § 491.8(a)(6) that a nurse practitioner, physician assistant, or certified nurse-midwife be available to furnish patient care services at least 50 percent of the time the RHC operates. CMS is not waiving the first sentence of § 491.8(a)(6) that requires a physician, nurse practitioner, physician assistant, certified nurse-midwife, clinical social worker, or clinical psychologist to be available to furnish patient care services at all times the clinic or center operates. This will assist in addressing potential staffing shortages by increasing flexibility regarding staffing mixes during the PHE.

- **Physician Supervision of NPs in RHCs and FQHCs.** 42 CFR 491.8(b)(1). We are modifying the requirement that physicians must provide medical direction for the clinic's or center's health care activities and consultation for, and medical supervision of, the health care staff, only with respect to medical supervision of nurse practitioners, and only to the extent permitted by state law. The physician, either in person or through telehealth and other remote communications, continues to be responsible for providing medical direction for the clinic or center's health care activities and consultation for the health care staff, and medical supervision of the remaining health care staff. This allows RHCs and FQHCs to use nurse practitioners to the fullest extent possible and allows physicians to direct their time to more critical tasks.

THESE BLANKET WAIVERS WILL END:

- **Temporary Expansion Locations.** CMS is waiving the requirements at 42 CFR §491.5(a)(3)(iii) which require RHCs and FQHCs be independently considered for Medicare approval if services are furnished in more than one permanent location. Due to the current PHE, CMS is temporarily waiving this requirement removing the location restrictions to allow flexibility for existing RHCs/FQHCs to expand services locations to meet the needs of Medicare beneficiaries. This flexibility includes areas which may be outside of the location requirements 42 CFR §491.5(a)(1) and (2) but will end when the HHS Secretary determines there is no longer a PHE due to COVID-19.

https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

THIS MEANS: NO STAFFING WAIVERS AFTER THE PHE ENDS.

- The staffing requirements in 42 CFR § 491 must be in place:
  - NP or PA must be staffed at least 50% of all RHC Patient Care Hours as posted.
  - The RHC must have a designated Medical Director (Physician) who is responsible for the medical direction of the clinic and who performs chart audits to determine if NPP are following the medical management policies. The medical director must be able to see patients and provide medical services. The RHC Medical Director role is separate and distinct from any state required collaborative or supervisory role.
  - The flexibility for RHC providers to be working from home or alternate locations will end. RHC providers must provide face-to-face services in an approved encounter location.

THIS MEANS: NO SATELLITE OR OFF SITE RHC LOCATIONS WHICH ARE NOT INDEPENDENTLY CERTIFIED AS NEW RHCS AFTER THE PHE ENDS.

- No RHC services can be performed off-site or at temporary or satellite locations.
  - Each location must be certified at a qualified location with its own CCN number.
  - Each location must be in a currently designated Primary Care Healthcare Shortage Area or in a currently designated Medically Underserved Area.
  - Each location must be in a rural area as defined by the Census Bureau.
  - If the temporary location is in the process of becoming certified but is not certified at the time that the PHE ends, the services at that location are not considered RHC services until the new certification is obtained.
  - No expansion site services can be held out as services of the main RHC after the PHE ends.

WHAT ABOUT MEDICAL TELEHEALTH AFTER THE PHE ENDS?

- The flexibilities given to provide telehealth will end 151 days after the end of the PHE.
- RHCs will no longer be able to provide distant site telehealth after the 151-grace period. CMS may offer more clarification on this for RHCs since most of what has been published about the grace period applies to Part B Fee for Service telehealth.
- Remember that distant site services occur when the provider is in the RHC and the patient is somewhere else.
- Originating site telehealth services occur when the patient is in the RHC (hosted by the RHC) and the provider is a non-RHC provider located somewhere else. Originating site services will pay the RHC a fee for services amount for hosting the patient.

WHAT ABOUT MENTAL/BEHAVIORAL TELEHEALTH AFTER THE PHE ENDS?

- Mental and Behavioral Health services provided via telehealth are now recognized as RHC encounters and reimburse the AIR. This was a provision of the 2022 MPFS Final Rule.
- The end of the PHE does NOT change this.
- CMS is expected to give further clarification on whether these services must be distant site or if originating site services are also included. To pay the AIR we would expect the services to be distant site; however, CMS has not been clear on this.
- Billing guidance for these mental health telehealth services can be found in SE 22001.

https://www.cms.gov/files/document/se22001-mental-health-visits-telecommunications-rural-health-clinics-federally-qualified-health.pdf

MENTAL HEALTH TELEHEALTH CODING & BILLING INFORMATION

RHC Claims for Mental Health Visits via Telecommunications Example

Revenue Code	HCPCS Code	Modifiers
0900	90834 (or other Qualifying Mental Health Visit Payment Code)	95 (audio-video) or FQ (audio-only) CG (required)

Mental Health Services	
HCPCS Code	**Short Descriptor**
90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvcs
90832	Psytx pt&/family 30 minutes
90834	Psytx pt&/family 45 minutes
90837	Psytx pt&/family 60 minutes
90839	Psytx crisis initial 60 min
90845	Psychoanalysis

WHAT ABOUT THE VACCINE MANDATE?

COVID VACCINE MANDATE

- The COVID vaccine mandate WILL NOT end with the PHE.
- Staff must be fully vaccinated 10 days prior to beginning work or have been granted a valid exemption.
- The mandate is written into the CFR for all certified healthcare facilities. It will need to be changed by Congress to be removed.
- If you have exempt staff, you must accommodate those individuals.
- Accommodation can include masking, periodic testing, relocation of workspace, etc.
- Masking may be required even if CDC guidelines or screening guidelines change.

STEPS TO GETTING BACK TO NORMAL

STEP 1: REVIEW YOUR CURRENT POLICIES, PROCESSES AND PROCEDURES

- Review your current policies, processes and procedures identifying what may have been added or revised during the PHE.
- Will those changes remain in effect after the end of the PHE or will you need to revert back to original policies? Will you require additional revisions to meet post-PHE compliance?
- Review you administrative processes for compliance and workflow. Will you be in compliance after the blanket waivers are terminated? Interview staff to get an accurate picture of how you are doing business right now.
- Make adjustments to workflow as needed to resume full compliance. Allow time to make revisions. Check with your state agency or accreditor to make ensure compliance with PHE-related changes to conditions for certification, licensure or accreditation.

TIMELINE

January 13, 2023

Current PHE is expected to end on January 13, 2023. All blanket waivers end. Staffing must be restored to pre-PHE levels. NP or PA 50% of all patient care hours. No temporary expansion sites.

June 13, 2023

The 151-day grace period for phasing out distant site telehealth and telehealth flexibilities ends. Expect more clarification on this from CMS concerning the grace period.

On-going

Mental Health via Telehealth continues for RHCs after the PHE ends. Refer to CMS guidance on coding and billing. Expect clarification between distant site and originating site.

WHAT DO YOU NEED TO REVIEW?

What Services are being Performed?

Who is Performing Services?

How are services being performed?

Where are services being performed?

What has changed in regulatory compliance?

What internal processes need changing?

Federal RHC/FQHC Regulations

- **42 CFR §491**

Conditions for certification

- **42 CFR §405**

Subpart X

- **42 CFR §413.65**

Provider Based Status

Federal Regulations
Critical Access Hospitals

- **<u>42 CFR §485</u>**

Subpart F

Conditions of Participation

Federal Hospital Regulations

- **42 CFR §482**

Conditions of Participation

- **42 CFR §412**

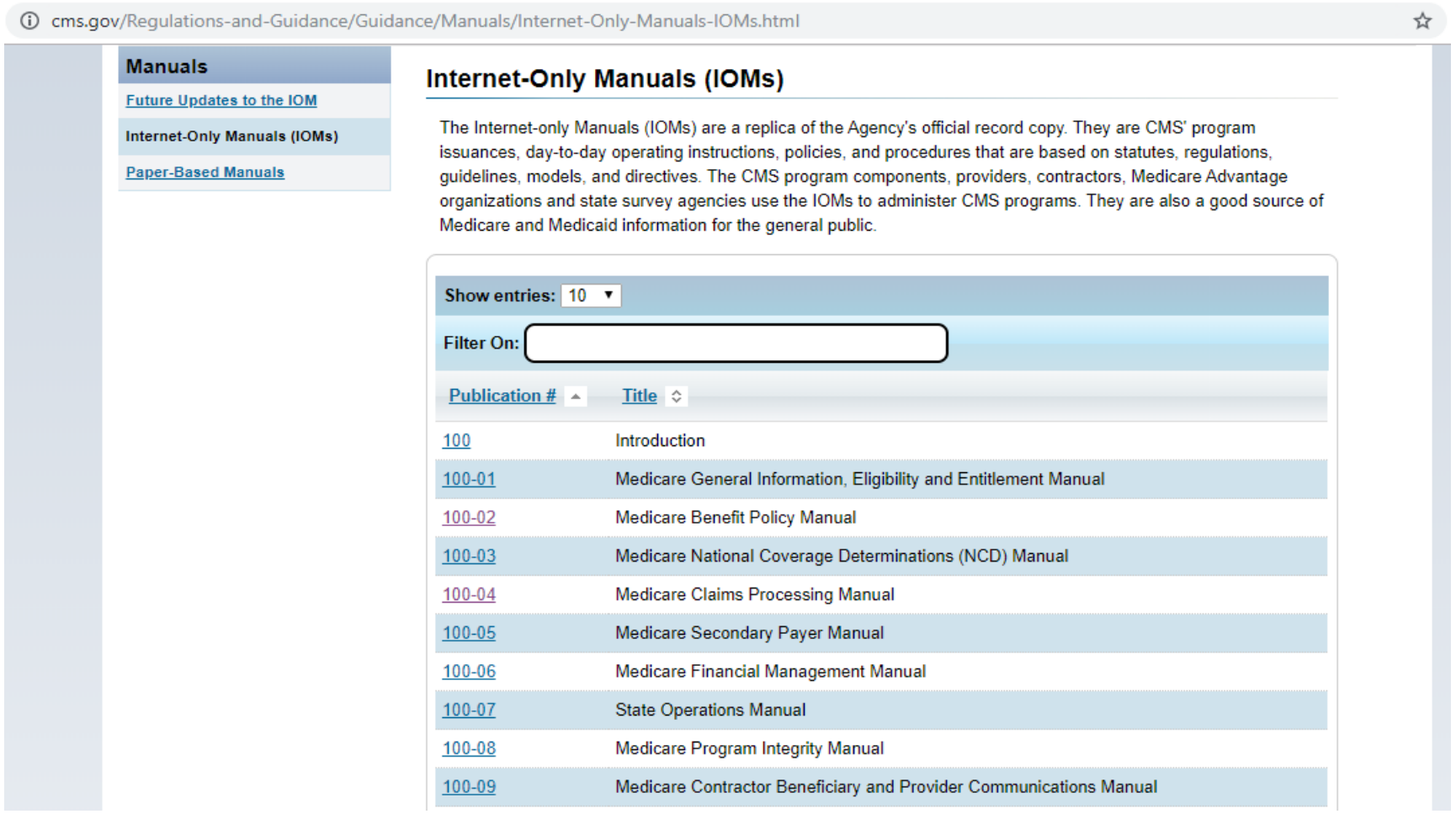
Inpatient PPS System

- **42 CFR §419**

Outpatient PPS System

https://www.ecfr.gov/cgi-bin/ECFR?page=browse

CMS Internet-Only Manuals



https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html

State Operations Manual

Appendix G - Guidance for Surveyors: Rural Health Clinics (RHCs)

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(Rev. 200, 02-21-20)

https://www.cms.gov/files/document/appendix-g-state-operations-manual

State Operations Manual

Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs

(Rev. 200, 02-21-20)

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf

State Operations Manual
Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals

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(Rev. 200, 02-21-20)

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

OIG EXCLUSIONS

Additional state LDH checks are required for unlicensed staff working in an RHC. This includes Medical Assistants.

STEP 2: EDUCATE AND EMPOWER YOUR STAFF

- Once you have identified any needed changes in policies or workflow, retrain both administrative and clinical staff on what regulatory changes will be necessary at the end of the PHE.
- This may include changes in how services are performed, case management, admission criterion, coding/billing, staff responsibilities, quality functions or recordkeeping.
- Don't assume that everyone will automatically know how to operate post-PHE.
- Empower your team to make these changes and give them ownership of compliance within their scope.

STEP 3: CALL ON YOUR BRAIN TRUST/PARTNERS

- Get input from your consultants, auditors and cost report preparers to ensure that the strategic or operational changes you are making will optimize performance and compliance post-PHE.
- With reimbursement changes due to the RHC Modernization Act and the 2023 Final Rules, you many need to analyze where and how services are provided between your CAH and RHC to allocate costs appropriately.
- If in doubt, ASK.

RAMPING BACK UP AND PROTECTING YOUR RHC AIR

- Many RHCs experienced low volumes during the PHE or switched to telemedicine services. In either case, this negatively impacted the productivity standards.
- RHCs always have the option of asking for a productivity waiver for cost reporting.
- However, for PBRHCs with grandfathered AIRs, it is important to sustain the grandfathered cost per encounter. Falling below the productivity standard can jeopardize the grandfathered rate in a low-volume cost reporting period.
- Physicians should have 4,200 encounters per FTE. NPs or PAs should have 2,100 encounters per FTE. This calculation is based on the hours the provider is available to see patients. Falling below this aggregate standard will subject you to CMS using what the visits should have been as the AIR denominator instead of the actual number of encounters which can decrease the cost per encounter and lower the rate from your grandfathered upper payment limit.

STEP 4: REBUILD & RE-ENERGIZE YOUR TEAM

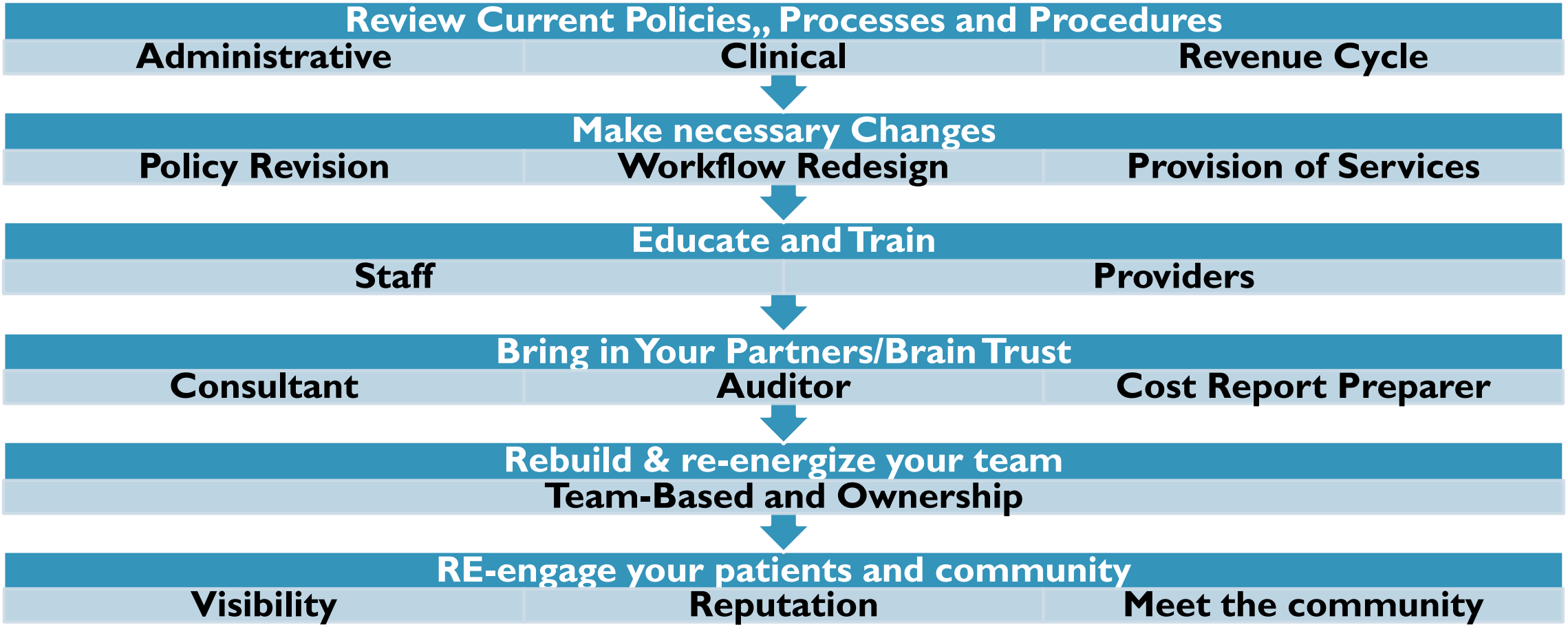
- COVID-19 and the PHE have been incredibly hard on our facilities and our workforce.
- Now, more than ever, is the time to build a cohesive team and create a team-based culture.
- Facilities have drawn on, survived on, the creativity and endurance of its staff. Rural facilities have been more nimble, more responsive during COVID than larger organizations. Don't lose this momentum by falling back into a hum-drum culture.
- Invest in your team. Empower your team. Learn from your team.
- Value your staff.

STEP 5: RE-ENGAGE YOUR PATIENTS AND COMMUNITY

- Look honesty at how your community view your hospital and RHC after COVID? Better? Worse? Indifferent?
- Are your community relationships stronger or weaker? What can you do to maintain or improve public perception and trust?
- Introduce new providers or new services to the community.
- Offer more convenient, patient-centered services to prevent out-migration.
- Use community engagement and participation to move forward.

PULLING IT ALL TOGETHER

Know Which Blanket Waivers are Ending and When



QUESTIONS OR COMMENTS

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Patty Harper is CEO of InQuiseek, LLC, a business and healthcare consulting company based in Louisiana. She has over 24 years of healthcare experience in the areas of healthcare finance & reimbursement, health information management, compliance, and practice management. She began her healthcare career as a hospital controller and reimbursement analyst. Patty holds a B.S. in Health Information Administration (cum laude) from Louisiana Tech University. She is credentialed through AHIMA as a RHIA, CHTS-IM, and CHTS-PW. Patty successfully completed AHIMA's ICD-10 Academy and has previously been recognized as an ICD-10 Trainer. She is also Certified in Healthcare Compliance (CHC®) thorough the Compliance Certification Board. Patty is a frequent speaker and contributor for national, state and regional and rural healthcare associations on these and other reimbursement-related topics. She has held memberships regional, state and national organizations throughout her healthcare career including NARHC, NRHA, AHIMA, MGMA, and HFMA. Patty currently serves on the Board of NARHC

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