Technical Assistance Office Hours

Consolidated Appropriations Act of 2021: RHC Program Payment Methodology Changes

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National Organization of **State Offices of Rural Health**

What is Office Hours?

An informal gathering for discussion, sharing, questions answered, and identifying resource needs on mutually relevant topics

Planned topics:

January 5 - SPECIAL - RHC Payment Methodology Changes

Wednesday, February 17 - Rural EMS & Primary Care

Tuesday, April 20 - SORH Value

Wednesday, June 23 - Workforce

All at 2 PM ET
Call information to come!

Context

Only focusing on the RHC Payment Methodology change today

National Association of Rural Health Clinics (NARHC)

- Working on this for a long time
- Webinar 12/30 - Find recording and slides HERE

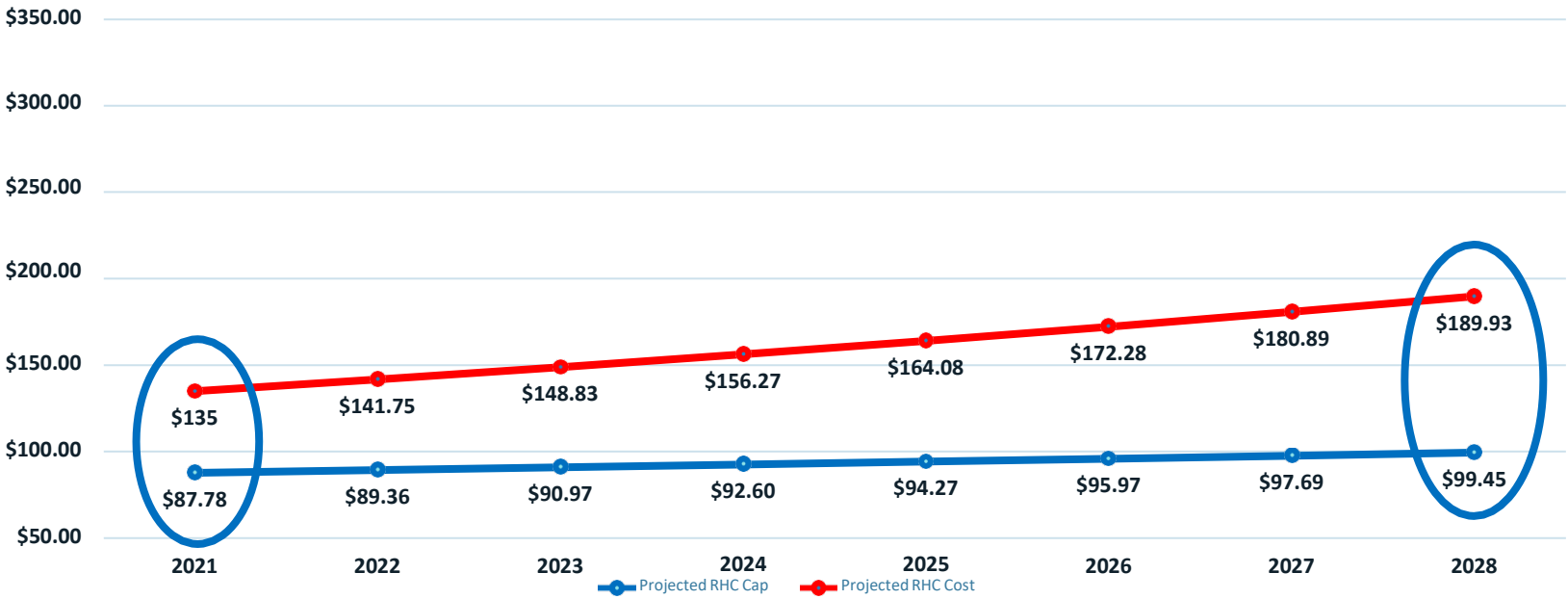
Nathan Baugh, Director of Government Affairs was kind enough to share his slides from the NARHC webinar for our discussion today

The RHC program was facing a triple threat to the future of the program

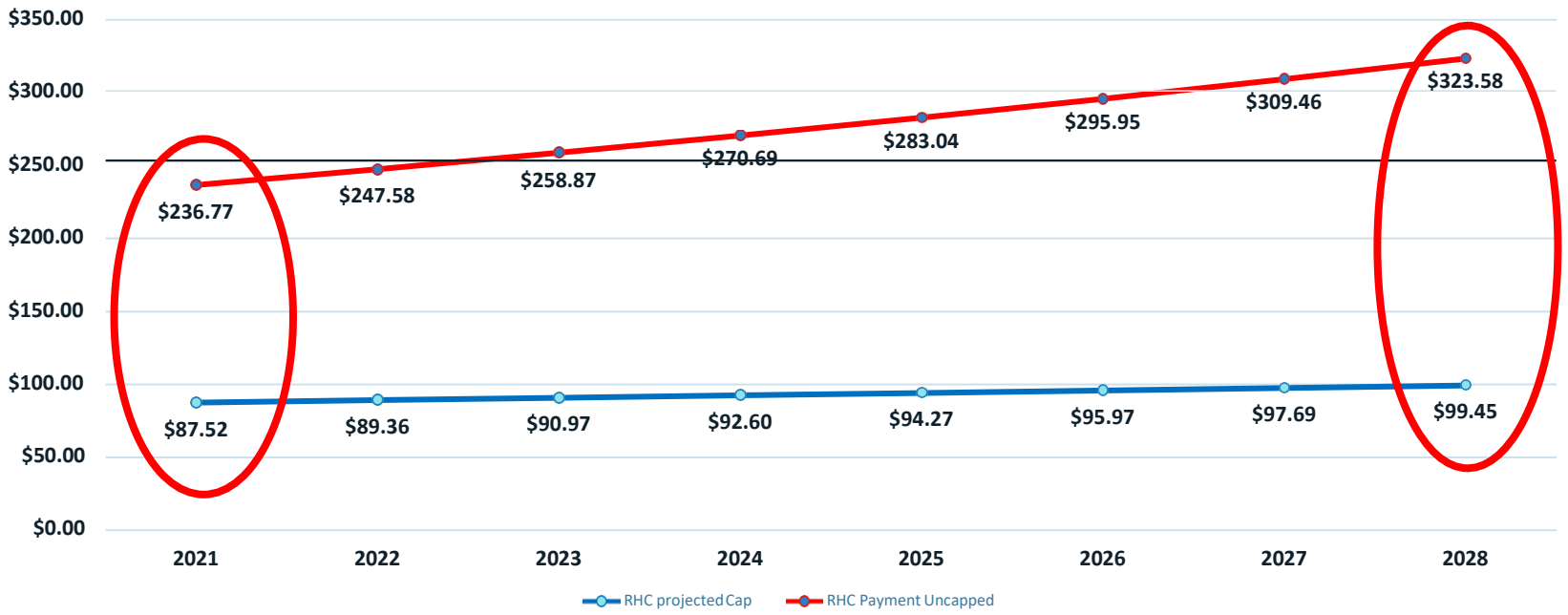
1. The Cap ($87.52 as of 1/1/21) on Independent and Hospital-based (more than 50 beds) is well below costs (~$130 average cost per encounter) and as a consequence, hundreds of RHCs were closing.
2. RHCs have a "site neutral" problem

   Under site-neutral payment policies Medicare should pay roughly the same for a particular service regardless of the place of service. (Bipartisan support since ~2015)
3. There was a strong push by proponents of a site-neutral policy to create a single rate (PPS) for **All** RHCs comparable to the FQHC PPS system.

Projected RHC Cap Compared to Projected Cost, based upon **current law**



Current Law Capped and Average Uncapped RHCs



The Government Accountability Office (GAO) and the HHS Inspector General (OIG) have both recommended a single, national cap for ALL RHCs

In a recent Federal Appellate Court ruling in favor of CMS and against the American Hospital Association, the court determined that CMS has **unilateral** authority to cut provider payments when the agency determines that payments are **inequitable**.

… the **agency** (CMS)can alter the reimbursement rate for a particular service under its authority to make "adjustments it determines to be necessary to ensure **equitable payments**,"

What's New?

Comprehensive RHC Payment Reform

1. Phase-in steady increases in the RHC statutory cap over an eight-year period
2. Subjects all "new" RHCs to the new per-visit cap (date issue);
3. Controls the annual rate of growth for uncapped RHCs whose payments are above the new cap; and,
4. Allows Rural Health Clinics (RHCs) to furnish and bill for hospice attending physician* services when RHC patients become terminally ill and elect the hospice benefit beginning January 1, 2022.

The term "attending physician" means, the physician, the nurse practitioner or the physician assistant whom the individual identifies as having the most significant role in the determination and delivery of medical care to the individual at the time the individual makes an election to receive hospice care.

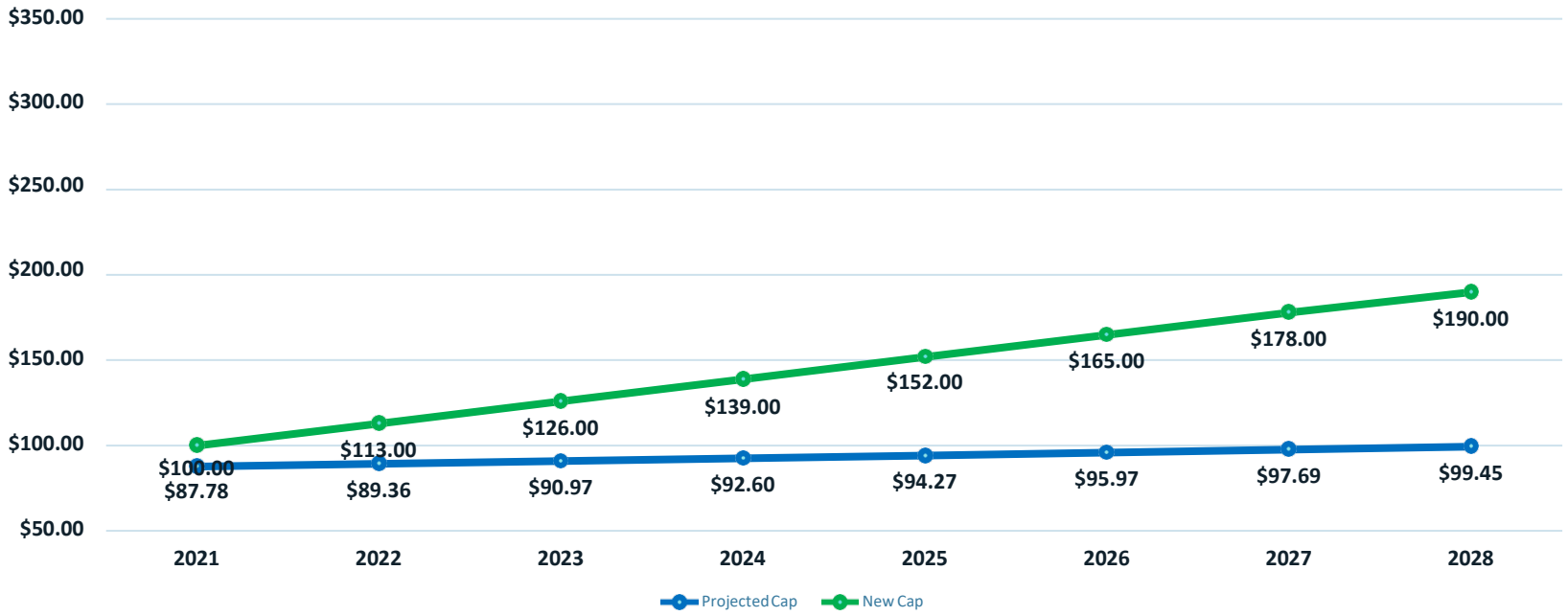
Increasing the per visit Upper Limit (Cap)

January 1 – March 31 $87.52. On April 1, the cap goes to $100.00 per visit. It then rises at statutorily set increases as follows:

2022	$113.00
2023	$126.00
2024	$139.00
2025	$152.00
2026	$165.00
2027	$178.00
2028	$190.00

After 2028 and in subsequent years, the cap goes up by the Medicare Economic Index (MEI)

Current Law Projected Cap and New Cap



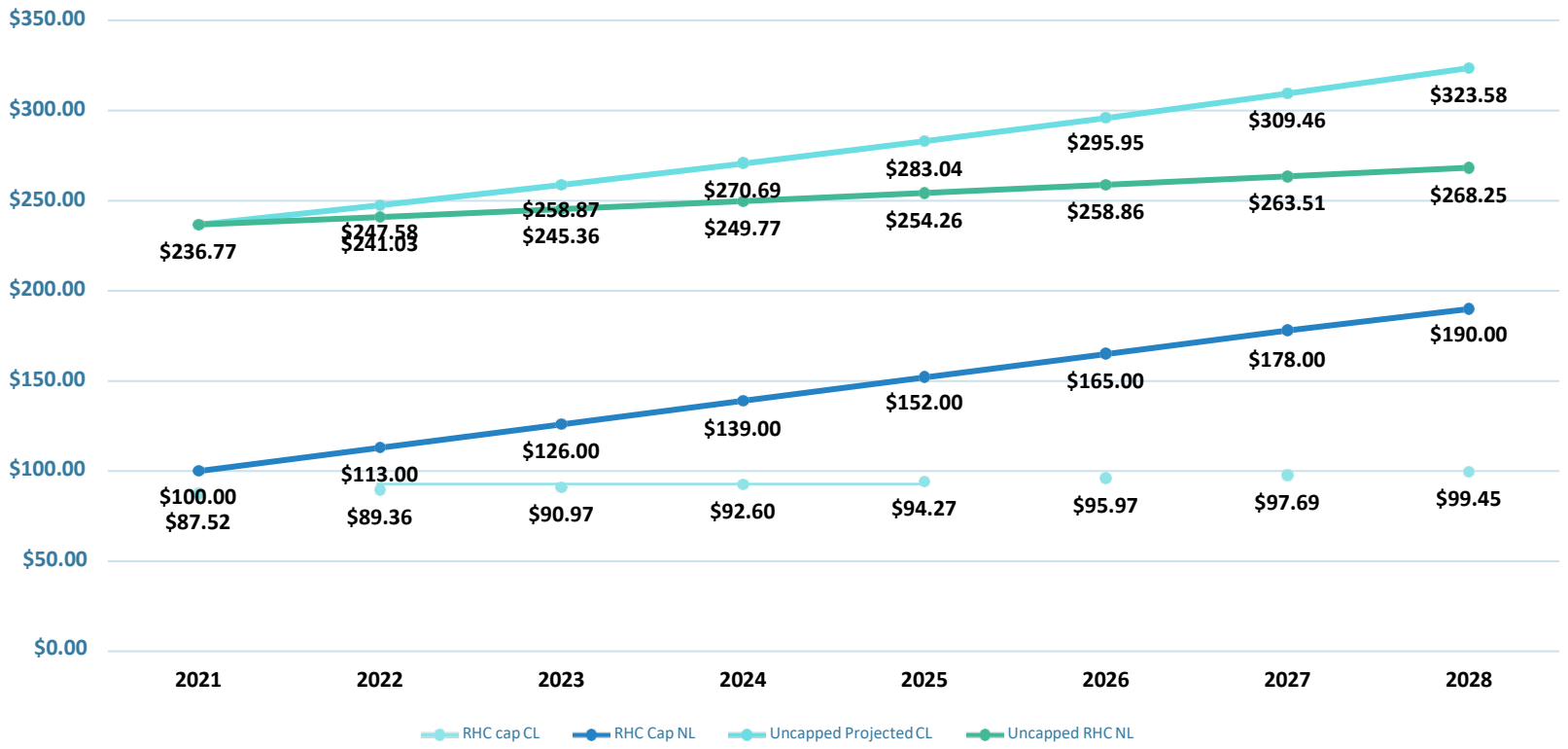
Grandfathered RHCs

Instead of being subjected to a single uniform cap, all currently uncapped RHCs enrolled in Medicare are grandfathered in at the clinic's 2020 All-inclusive rate.

Each uncapped RHC will have a clinic specific cap based on their 2020 AIR rather than being subject to the new RHC cap that will apply to all new RHCs or RHCs that were already subjected to the cap.

The clinic-specific cap for the grandfathered RHCs will grow annually at the rate of medical inflation (MEI).

RHC Payment Current Law Vs. New Law



Here is how the RHC provision was described in the summary produced by the Ways and Means Committee

This section implements a comprehensive RHC payment reform plan. It phases-in a steady increase in the RHC statutory cap over an eight-year period, subjects all new RHCs to a uniform per-visit cap, and controls the annual rate of growth for uncapped RHCs whose payments are above the upper limit. **It ensures that no RHC would see a reduction in reimbursement**.

https://gop-waysandmeans.house.gov/house-republican-provisions-in-the-2020-year-end-legislation/

The statutory language, however, is not consistent with the summary nor is it consistent with what was proposed.

The COVID relief package states:

> A rural health clinic described in this subparagraph is a rural health clinic that, as of December 31, **2019**, was in a hospital with less than 50 beds; and enrolled under section 1866(j).

This means that uncapped RHCs that were certified and enrolled in Medicare after December 31, 2019, will be treated as "new" RHCs and therefore subjected to the new Cap and are not "grandfathered".

Armed with this Information

How might SORH help RHC organizations understand and respond to…

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For Consideration

- how they might be impacted with the new payment methodology
- "Grandfathered" RHCs
- the "site neutral" challenge and how it influenced these new requirements
- the potential for RHC PPS, CMS "unilateral" authority to adjust provider payments and telehealth single rate payment establishing precedent

What's Missing?

CMS Guidance

The RHC Program is administered by CMS… when in doubt, go to the source. As of this morning, the Rural Health Clinic Center on the CMS website does not provide any reference to the upcoming changes.

What else?

Questions??

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Ongoing Assistance

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Thanks so much!
Your participation is appreciated!

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Final Thought…

Ryder & Buster