Washington Update

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Comprehensive RHC Payment Reform

As part of H.R. 133, the Consolidated Appropriations Act of 2021 (aka Covid Relief Package), Congress approved and the President signed into law the most comprehensive reforms of the Medicare RHC payment methodology since the mid-90s.

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;
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.

Why was it necessary to update and reform the RHC Payment system?

The status quo was not sustainable for either capped **or** uncapped RHCs

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

1. The Cap on Independent and Hospital-based (more than 50 beds) is well below costs and as a consequence, hundreds of RHCs were closing.
2. RHCs have a "site neutral" problem
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.

RHC Cap relative to costs

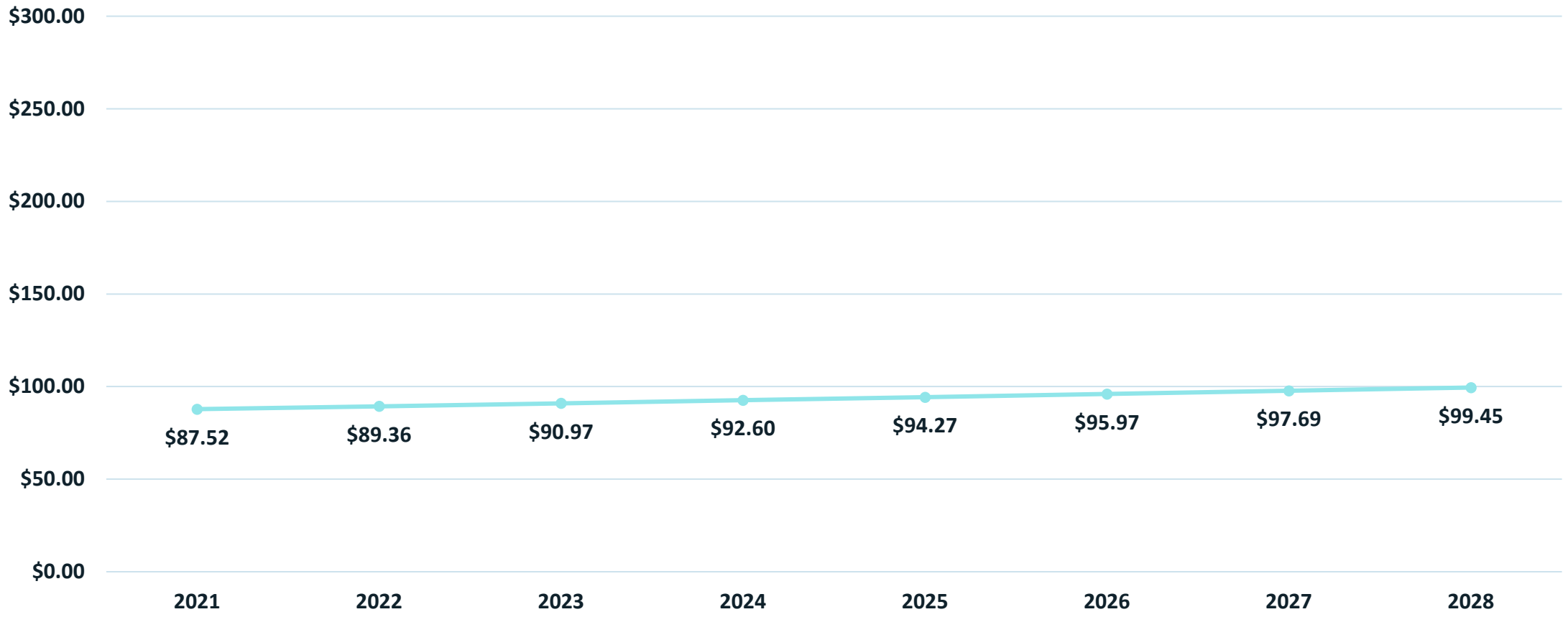
Current statutory cap is $86.31 per visit and is scheduled to go to $87.52 on January 1, 2021.

According to RHC cost reports, the average cost-per-visit for capped RHCs is over $130.00 per visit.

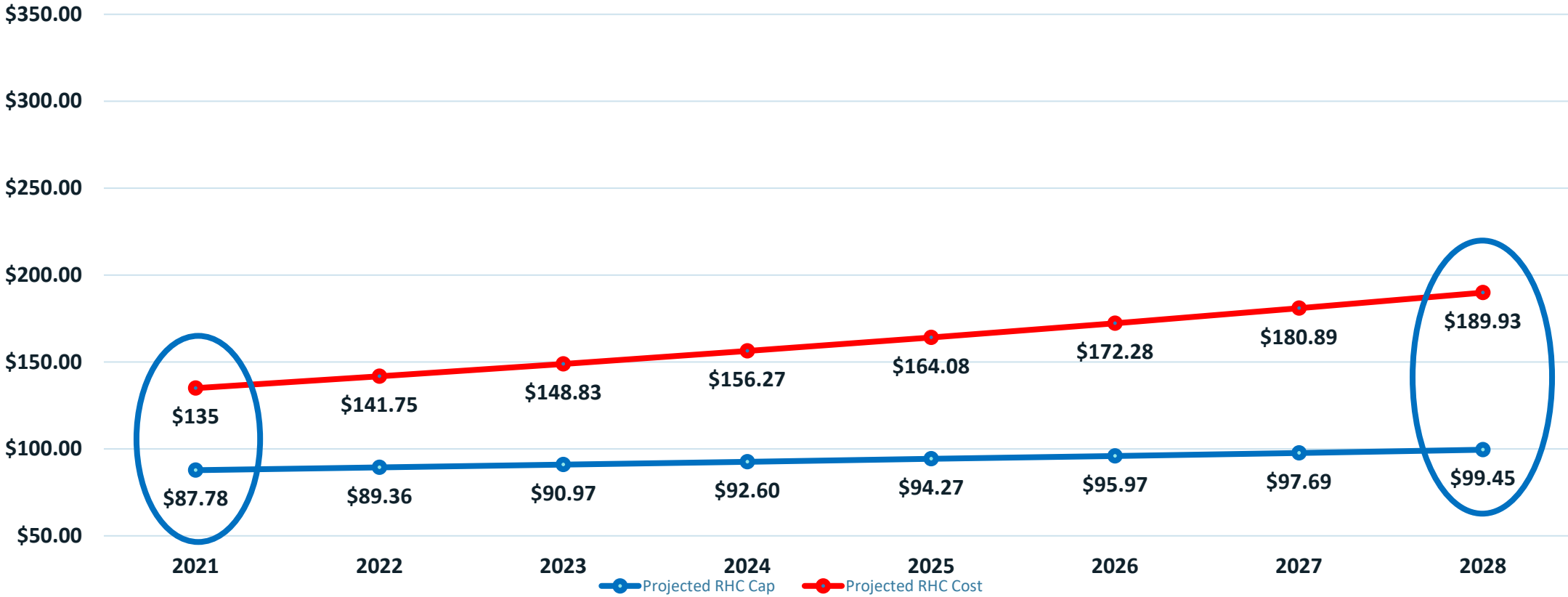
What has been happening to Capped RHCs?

Since 2012, more than **700** RHCs have closed **or** transitioned to another type of RHC.

Current Law – Capped RHCs projected



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



Based on current projections, if Congress failed to address the huge disparity between the average cost per visit and the RHC cap, the vast majority of independent RHCs and larger hospital RHCs would have closed in the next few years, leaving their communities without any source or primary care.

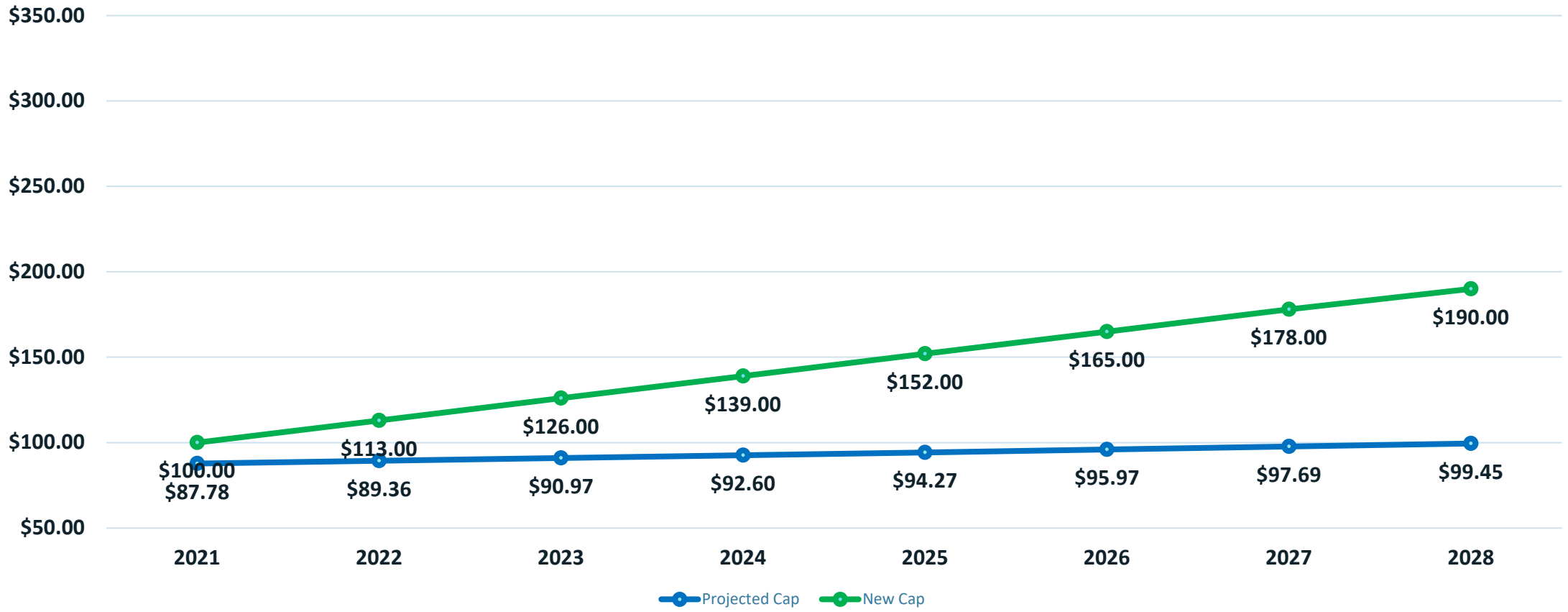
Increasing the per visit Upper Limit (Cap)

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



What about the Uncapped RHCs

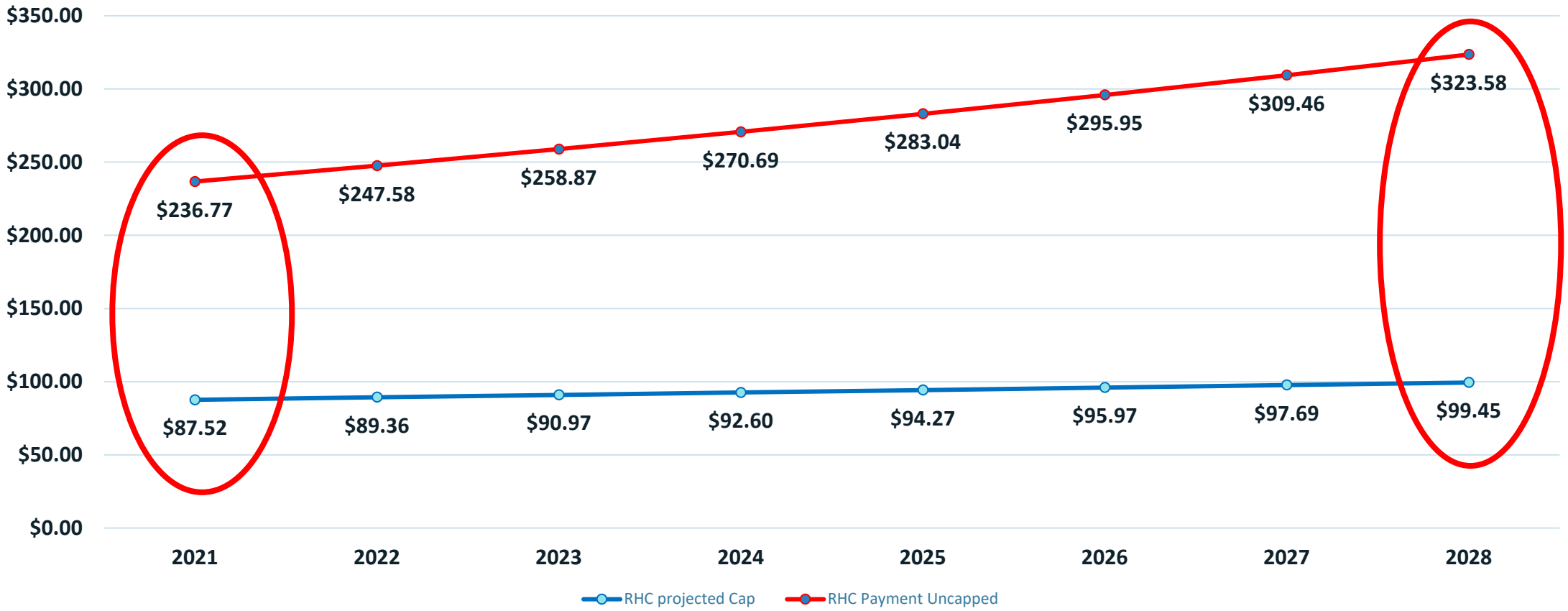
Uncapped RHCs were not suffering from below-cost reimbursement. Why was it necessary to make any changes to how uncapped RHCs are paid?

Uncapped RHCs have been under the public policy microscope for the past several years. The growing disparity between the RHC payment rates for uncapped and capped RHCs had caught the attention of CMS, the Medicare Payment Advisory Commission, The Government Accountability Office (GAO), the HHS Inspector General and some in Congress.

Uncapped RHCs

For ease of discussion, we use the average per visit payment for uncapped RHCs. In reality, the payment rates for uncapped RHCs vary tremendously. There are uncapped RHCs with per visit rates as low as **$130.00** per visit and uncapped RHCs with per visit rates as high as **$600.00** per visit.

Current Law Capped and Average Uncapped RHCs



We had a site neutral problem

What is a site neutral problem?

Since 2015 bi-partisan majorities in the House and Senate, with the support and encouragement of both the Obama and Trump administrations, have been promoting so-called "site-neutral" Medicare payment policies.

Under site-neutral payment policies, proponents argue, Medicare should pay roughly the same for a service regardless of the site of service.

For example, an Evaluation and Management service provided in an off-campus hospital outpatient department, should be paid roughly the same as what Medicare would pay for that same service if provided in a physician's office.

This is a site neutral problem

For the past several years, NARHC has been warning the uncapped RHC community that we faced a site-neutral problem and we have spoken about this at numerous national and state forums over for the past four years.

Over this time period, NARHC examined various site neutral options (including a single rate PPS) but in the end, we concluded that it would not be possible to set the PPS rate high enough to cover the cost of most uncapped RHCs.

How serious was this threat?

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

GAO ---

For those RHCs that continue to be reimbursed on a cost-reimbursement basis, the Secretary of HHS should direct the Administrator to:

Revise Medicare payment policy to hold facility-based RHCs to the same payment limits and cost-reporting requirements as independent RHCs and

The OIG stated in a report to Congress:

The current reimbursement cap for independent RHCS should be examined for reasonableness. Consideration should also be given to the use of a cap for provider-based RHCS.

We believe you should consider whether the cap for provider-based RHCS should be the same or different from that used for independent RHCS.

In February, the Trump Administration proposed site neutral payment policy for RHCs in the 2021 Budget it submitted to Congress

Modernize Payment for Rural Health Clinics

"CMS has been limited to annual updates to the cap on Medicare payments to many rural health clinics based on increases in the Medicare Economic Index for many years, raising concerns that payments are inadequate."

"Rural health clinics subject to the cap are disproportionately likely to close compared to other clinics."

Trump Administration Prospective Payment Initiative

This proposal calls for the establishment of a new single rate Medicare prospective payment system for rural health clinics similar to the single rate payment system for Federally Qualified Health Centers.

This new payment system would "ensure **equitable** payment for these health clinics."

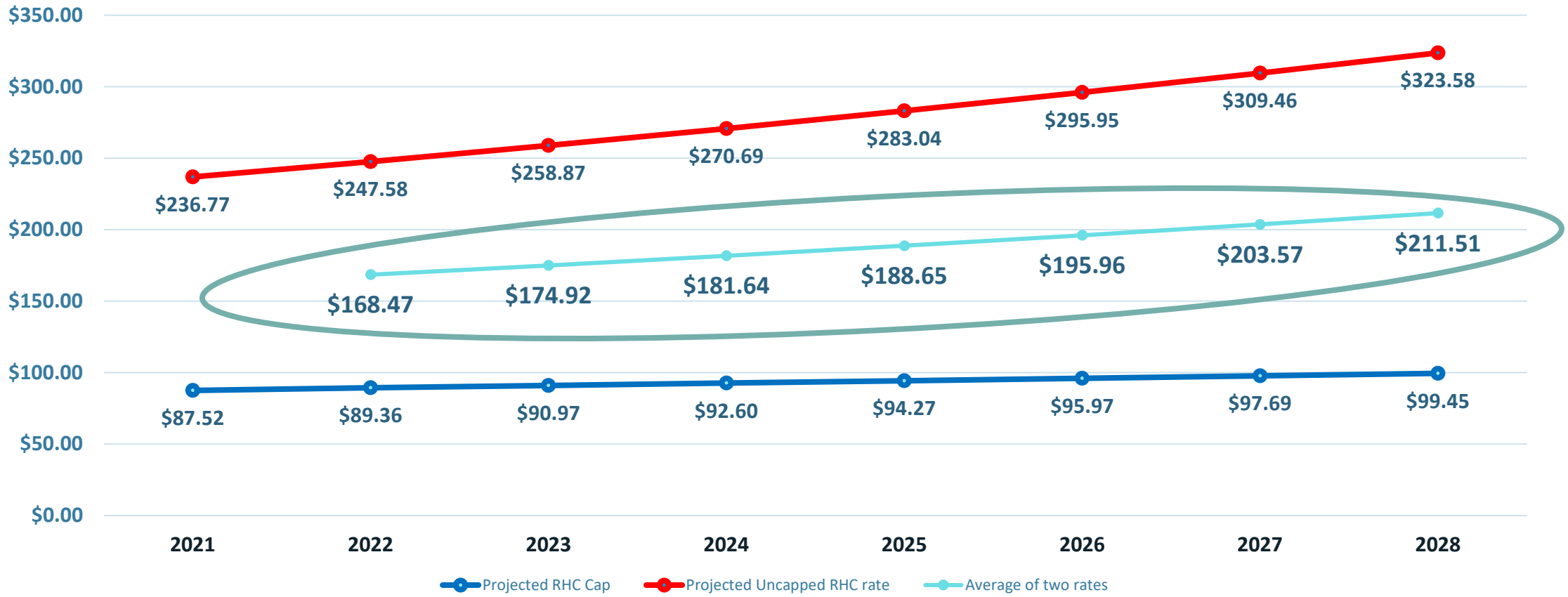
Trump Administration Budget Estimate for RHC PPS/Site Neutral Policy

(in millions)

	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	Total 2021 - 2030
Establish a single PPS payment rate for all RHCs	- $20	- $60	- $80	- $110	- $160	- $200	- $230	- $290	- $ 290	- $350	**- $ 1,790**

The Trump Administration estimated that adoption of this single rate PPS policy would save the government, **$1.8 Billion** over 10 years.

In order to achieve the budget savings projected by the Trump Budget, what might this look like?



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**.

Appellate Court ruled…

… the **agency** 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 was it CMS said when justifying a single rate PPS?

> This new payment system would "ensure **equitable** payment for these health clinics."

THEN

CMS Proposed single rate payment for RHC telehealth visits

Subsequent to the release of the Trump budget proposing a single rate PPS payment for RHCs, the COVID-19 pandemic hit and there was a need to expand telehealth policy to allow RHCs to be the distant site for a telehealth visit avoiding the need for patients to come to the office for non-COVID related care.

CMS informed Congress that they would support such a policy but **ONLY** if Congress approved a single rate payment for all RHCs. Congress approved this policy and established the precedent of a single rate payment for RHC services, regardless of RHC type.

What does this all mean?

NARHC came to the conclusion that it was highly likely that either Congress or CMS would make a significant push to establish a single rate PPS type payment rate for **all** RHCs in the near future.

As the President's budget shows, moving to a single rate PPS would not only establish a site neutral policy, but it would save Billions of dollars. The money currently projected to be spent on RHCs over the next 10 years could be "repurposed" to go to other Medicare providers (i.e. higher hospital DRG payments or physician fee schedule payments).

The time to act was now

In talking with our allies in Congress, we felt that if we had any hope of preventing this from happening, the time to act was NOW.

The RHC community could either try to control the destiny of the RHC program by preventing a single rate PPS and keeping money projected to be spent on RHCs continue flowing to RHCs, or have others control the destiny of the RHC program and send money projected for RHCs to go elsewhere.

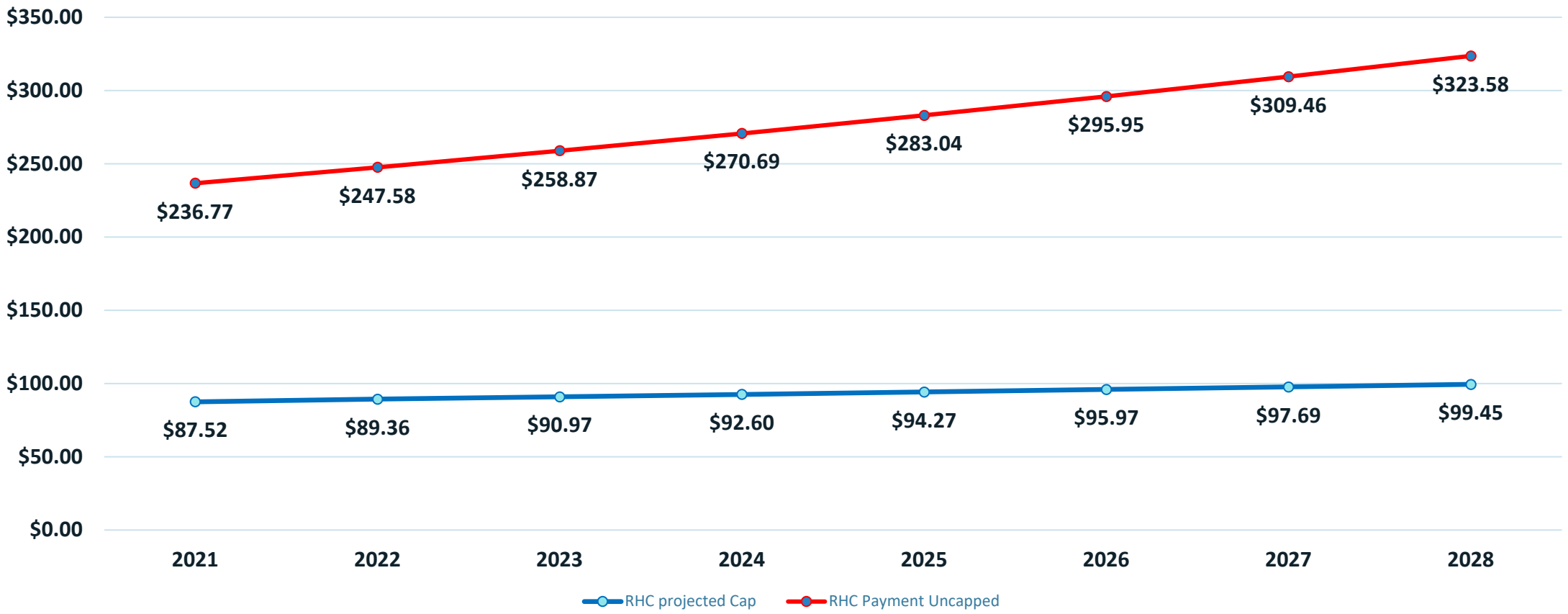
And if others controlled our destiny, the outcome would not be pretty.

Our Goal and that of our Congressional allies:

1. Raise the cap for capped RHCs.

2. Narrow the gap between uncapped and capped RHCs (i.e. the concept of site-neutral) but do so **without reducing payments for any existing RHC**.

Here was the starting point for the discussion



NARHC went to Congress and proposed

1. Phase-in steady increases in the RHC upper payment limit over a five – ten year period;
2. Control the annual rate of growth for **currently certified** uncapped RHCs whose payments are above the new upper limit; and
3. Subject all new RHCs to the uniform per-visit cap.

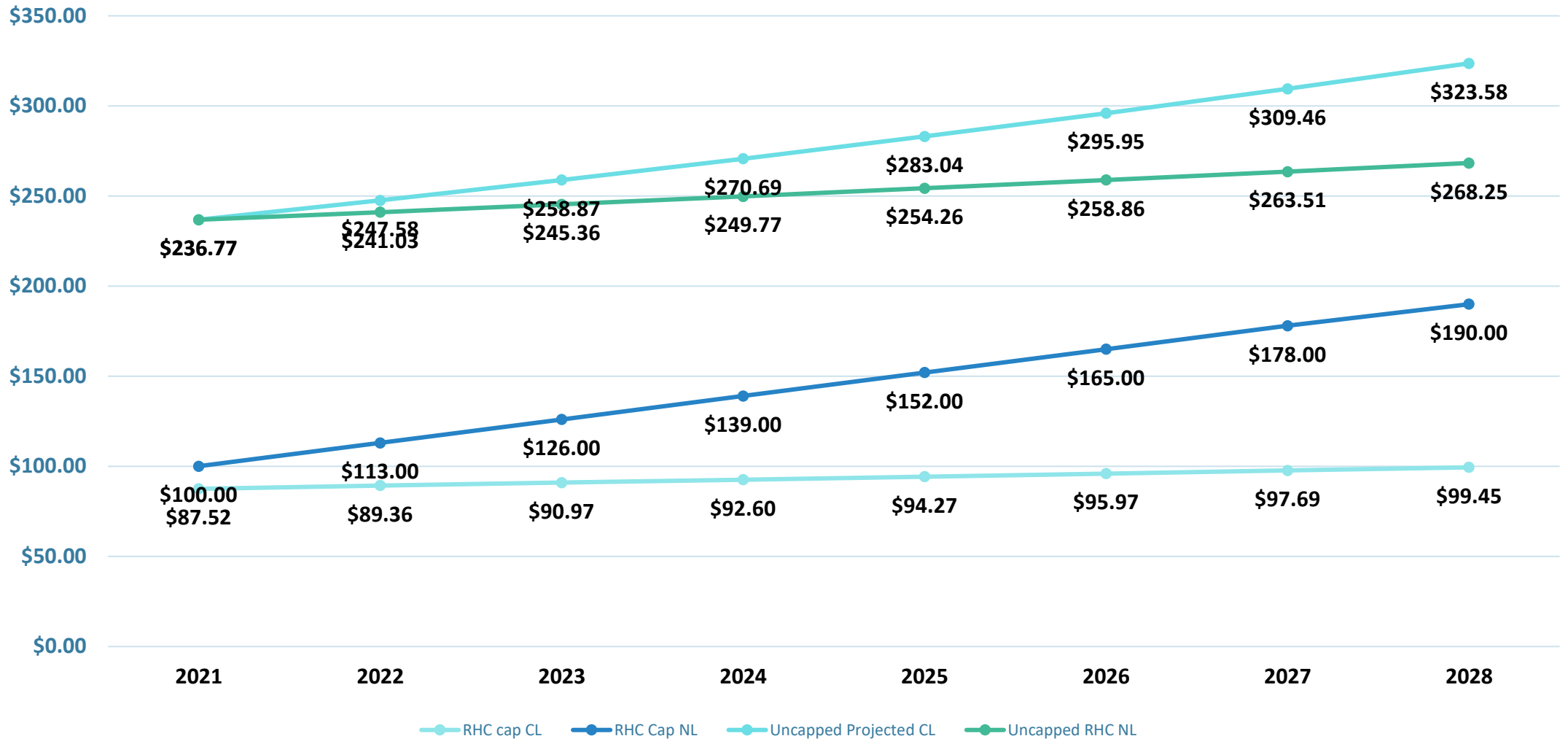
Grandfathered RHCs

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".

Rectifying date

The intent of these reforms as described in the summary and what we were promoting was to ensure that

"… no RHC would see a reduction in reimbursement."

This is only true IF:

The date is corrected to either "date of enactment" or some later date.

Because this can only be accomplished via legislation, we cannot guarantee this will be corrected but NARHC is committed to getting this fixed.

How might this Affect Medicaid Reimbursement?

- In most states, Medicaid payments are based on a PPS that is not linked to Medicare payments
- In some states, the Medicaid PPS rates are tied to the Medicare upper limit
- It will be up to states that link their Medicaid payment policy to the Medicare payment policy to allow the increased Medicare upper limit to flow through to increased Medicaid PPS payments.

Medicaid policy will vary state by state

What happens if I'm a grandfathered RHC and my AIR is above the new cap to start but within a few years, the cap is higher than my air?

Example 1 – Grandfathered RHC with a 2020 AIR of $130.00 per visit

	2020	2021	2022	2023	2024	2025	2026	2027	2028
Grandfathered RHC Upper Limit	$130.00	$132.40	$134.78	$137.20	$139.66	$152.00	$165.00	$178.00	$190.00
Updated RHC Upper Limit		$100.00	$113.00	$126.00	$139.00	$152.00	$165.00	$178.00	$190.00

Grandfathered RHCs will have a cap that is the higher of their grandfathered cap (adjusted for inflation) or the statutory cap.

I'm currently an uncapped RHC and my costs per visit fluctuate, how will this affect my upper limit as a grandfathered RHC in a year when my cost per visit drops?

Example 2 – Grandfathered RHC 2020 Rate of $250.00 (assumes an MEI of 1.8%)

	2020	2021	2022	2023	2024	2025	2026	2027	2028
Grandfathered RHC Upper Limit	$250.00	$254.50	$259.08	$263.74	$268.48	$273.31	$278.22	$283.22	$288.31
Clinic specific cost per visit	$250.00	$260.00	$230.00	$265.00	$290.00	$270.00	$265.00	$285.00	$291.00

Green = A Year where clinic receives full cost per visit; Red = A year where the clinic is subject to their clinic-specific upper limit

The clinic-specific cap applicable to grandfathered RHCs is not affected by the fluctuations in your annual actual cost per visit. It will function just like the statutory cap in that it will grow each year based on the clinic-specific cap for the previous.

I am the Administrator of a small 49 bed hospital. I have wanted to increase the number of beds due to increased demand but did not do so because it would have meant that our five RHCs would be subject to the cap. With this change, does the grandfathering of our rate depend on us staying below the 50 bed threshold?

No, you can increase the number of beds in your small hospital and the grandfathered cap stays. Your payment is no longer linked to the hospital bed size so you can increase the number of beds in your hospital without jeopardizing your grandfathered cap.

A Quick Note on Medicare Telehealth Policy

- New valuation for G2025 should be coming soon
- Ability to perform telehealth may expire at end of the PHE OR the end of 2021 (Secretary now has authority to extend until the end of 2021)
- NARHC is fighting to ensure that RHCs may continue to provide telehealth services as distant site providers but we are seeking changes to the policy…
- NARHC is working to have telehealth visits counted as normal RHC encounters
  - Counts as a visit on the cost report
  - Costs do not have to be separately reported on the cost report
  - Normal coding w/ a modifier to signify telehealth visit
  - Normal reimbursement (the RHC's AIR)

Questions?

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