RHC Regulatory and Operational Update

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Learning objectives for today's session

- Learn about the new legislative changes for RHCs concerning payments
- Evaluate strategies for managing under the new RHC reimbursement limitations
- Understand issues and risk regarding the unknowns related to the new legislation

Today's agenda

I. Rural Health Clinic Changes

II. Advocacy Initiatives

III. Strategies under the New RHC payment methodology

IV. Additional Considerations

Rural Health Clinic Changes

Consolidated Appropriations Act, 2021

- Section 130 includes:
  - Steadily increased reimbursement limitations for independent RHCs and those with hospitals greater than 50 beds over the next 8 years, beginning April 1, 2021.
  - New reimbursement limitations will apply to all new RHCs (both independent and provider-based).
  - Existing provider-based RHCs will be subject to new RHC-specific limitations determined on a 2020 “base rate” indexed annually by MEI.
  - Allows for RHC to bill for hospice services beginning in 2022.

Consolidated Appropriations Act, 2021

- Section 130 also includes:
  - New limitations for independent RHCs, those with hospitals greater than 50 beds, and all "new" provider-based RHCs.

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)

Consolidated Appropriations Act, 2021: Section 130

- Definition of what is considered a new provider-based RHC:

  "A RHC described in this subparagraph is a RHC that, as of December 31, 2019, was—

  (i) in a hospital with less than 50 beds; and

  (ii) enrolled under section 1866(j)."

- On April 14, 2021, President Biden signed into law H.R. 1868, which includes provisions that:
  - Correct the date to December 31, 2020
  - Allow under-50-bed hospital entities that submitted, and Medicare received, by December 31, 2020, their 855A applications to become an RHC to be grandfathered in

Consolidated Appropriations Act, 2021: Section 130

- Definition of what is considered the "base rate" for an existing provider-based RHC (reflects H.R. 1868 signed into law on April 14, 2021):

"(3)(A) In establishing limits under subsection (a) on payment for RHC services furnished on or after April 1, 2021, by an RHC described in subparagraph (B), the Secretary shall establish such limit, with respect to each such RHC, for services provided—

(i) in 2021, after March 31, at an amount equal to the greater of—

(I) with respect to an RHC that had a per-visit payment amount established for services furnished in 2020—

(aa) the per-visit payment amount applicable to such RHC for RHC services furnished in 2020, increased by the percentage increase in the MEI applicable to primary care services furnished as of the first day of 2021; or

(bb) the limit described in paragraph (2)(A); and

(II) with respect to an RHC that did not have a per-visit payment amount established for services furnished in 2020—

(aa) the per-visit payment amount applicable to such RHC for RHC services furnished in 2021; or

(bb) The limit described in paragraph (2)(A);"

Advocacy Initiatives

Advocacy Initiatives

Medicare Modernization Initiatives Supported by National Rural Health Association

https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/Advocacy/Government%20affairs/2021/01-11-21-NRHA-section-130-RHC-modernization-summary.pdf

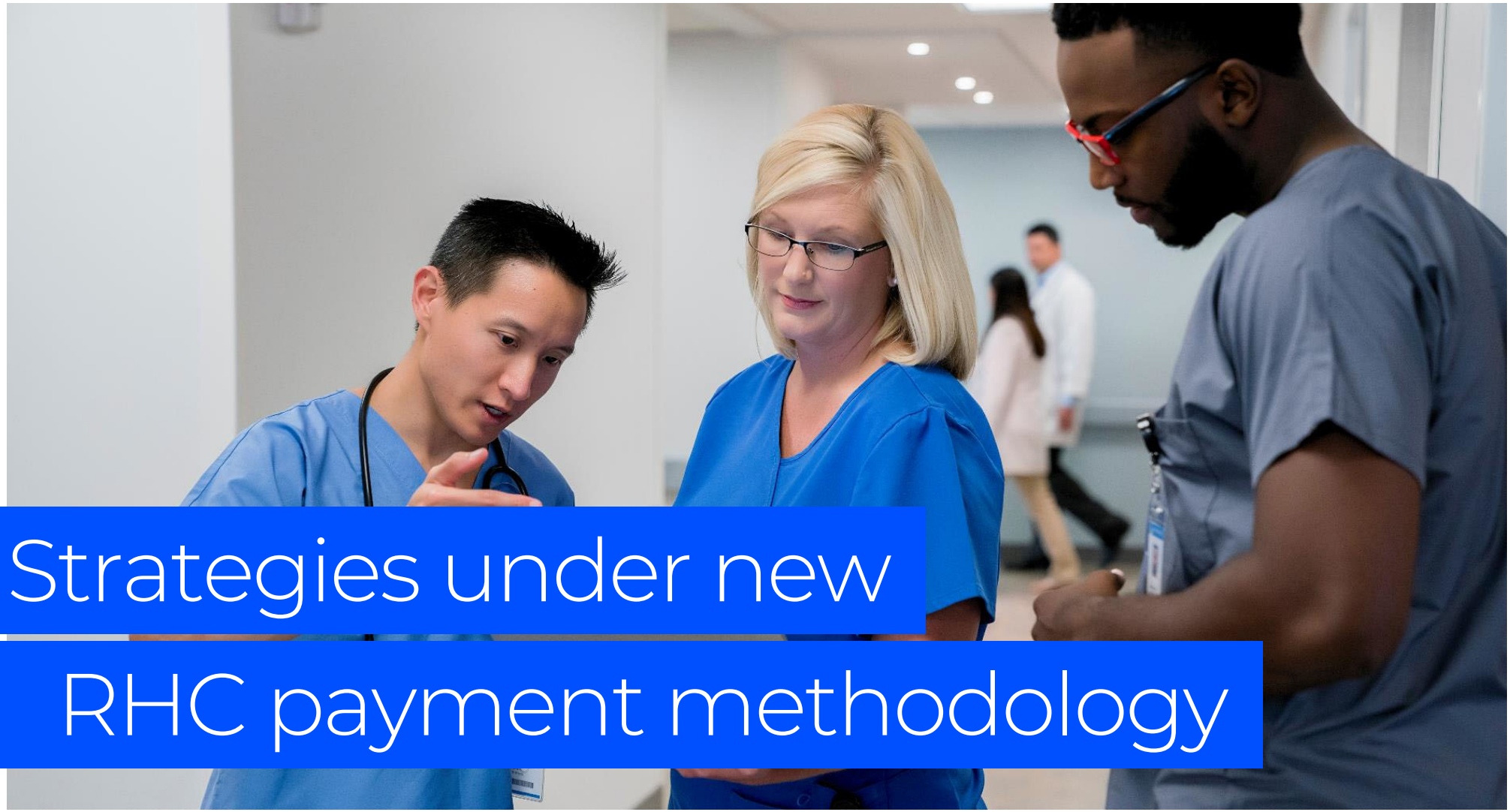
- Change grandfather date Make RHC telehealth benefit permanent, and count telehealth visits as RHC encounters.
- Flexible physician, PA, and NP requirements consistent with State and local laws
- No cap on provider-based RHCs in exchange for quality reporting.
- Low-volume exceptions for provider-based designations.
- Allow contracting with all PAs and NPs (remove employment requirement).
- Remove outdated laboratory requirements.

Advocacy Initiatives

Medicare Modernization Initiatives Supported by National Association of Rural Health Clinics

https://www.narhc.org/narhc/NARHC_ADVOCACY.asp

- Change grandfather date from 12/31/2019 to December 31, 2020.
- Expand grandfathering to “mid-build” or “in process” RHCs with small hospitals.



Strategies under new RHC payment methodology

Observation – Grandfathered RHCs

For existing (grandfathered) provider-based RHCs:

- Future costs vs. base year AIR + MEI rate going forward
  - No change in future reimbursement if the actual cost per visit is less than the base rate plus MEI.
  - Base year rate may be derived from 2020 cost report, which should include a productivity waiver and higher cost per visit than past or future.

Observation – RHCs > 50 beds

Some Capped RHCs Will Experience Increased Rates

- Favorable to Hospitals Currently Subject to the RHC Medicare Cap (> 50 beds):
  - Why?
    - Hospitals that have RHCs with more than 50 available beds will be subject to a higher Medicare RHC free-standing cap ($87.52 for 2021) as the limit is increasing approximately $13 a visit per year
    - $87.52 until March 31, 2021.
    - $100 for rest of 2021; $113 in 2022; $126 in 2023 . . .
    - A RHC that had 3,000 Medicare RHC visits would gain approximately $100,000 from 2021 to 2023 (*assuming the costs per visit was at the 2023 limit).*

Observation – Medicare Advantage

Medicare Advantage (HMO) rates may be tied to traditional Medicare AIR

- Fastest component for new Medicare enrollees.
- For those MA plans that adopt the traditional Medicare AIR, rates will be impacted.
- May have flexibility to adopt a rate other than traditional Medicare AIR.

Who is at risk?

- Which providers (uncapped RHCs) are impacted the most?
  - Clinics that have recently incurred significant capital or tenant improvement costs
  - Clinics that have added or were planning to add additional services and personnel
  - Clinics that are undergoing a change of ownership, especially when there were going to be significant capital costs/personnel costs being injected
    - Will depend on date being used for grandfathering clause
    - Will depend on Medicare payer mix

Observation – Independent RHCs

Illustration of applying the new limits

	2021	2021 (04/01)	2022	2023	2024	2025	2026	2027	2028
New RHC Upper Limit	**$87.52**	**$100.00**	$113.00	$126.00	**$139.00**	$152.00	$165.00	$178.00	$190.00
Clinic specific cost per visit	$95	$105	**$110**	**$125**	$145	**$140**	**$150**	**$160**	**$170**

- Amounts shown in red indicate that the limit is the payment amount
- Amounts shown in green indicate that the RHC's actual cost is the payment amount

Strategies – HOPD to RHC or stay as existing HOPD?

- As the Medicare cap continues to grow, it may be advantageous to convert existing hospital outpatient departments (HOPD) clinics to RHCs
  - Why? Medicare RHC rates may eventually be higher than the Medicare fee for service rates
  - RHC certification only, no hospital licensure as for HOPD in most states
- HOPD status could be advantageous depending on the service mix; specialty services are often reimbursed higher by Medicare in a HOPD
  - The 2021 increases in the Medicare physician fee schedule may be a factor

Strategy: Review the Medicaid RHC rate

- Make sure your RHC Medicaid rates are maximized
- Oregon allows for a change in scope request
- Will newly certified RHCs receive the Medicare capped rate, or will a different rate calculation be used?

Note: A loss in Medicare RHC reimbursement may be offset by a gain in Medicaid RHC reimbursement. RHC status may still make sense depending on your state's RHC reimbursement rates and your clinic's paye r mix.

Strategies – Specialty services

Use of high-cost specialists in RHC setting may be reevaluated

- General surgery and/or orthopedic surgery may be reimbursed better under Medicare physician fee schedule or in a hospital outpatient department
- Consider concentrating Medicare services, such as internal medicine, into higher-AIR, cost-limited RHCs

Place of service considerations

- Are there benefits to offering some services outside of the RHC setting:
  - High cost specialty services (i.e. orthopedics, general surgery, etc.).
  - Services not subject to cost-base reimbursement for Medicare (e.g. telehealth, care management, etc.).
  - School-based services

Strategies – Think mobile!

- Mobile RHCs for Medicare get to use an existing Medicare RHC rate
  - So, in theory, if a hospital developed a mobile RHC, it wouldn't be subject to these Medicare RHC caps
  - Mobiles could be stationary
  - And mobile RHCs may receive a Medicaid RHC rate as well; check with your state

Strategies – Consolidations

Hospitals operating multiple RHCs may consider filing consolidated cost reports

- There may be a way to select the filing RHC with the highest AIR limit.
- Perhaps a physical consolidation could be completed with the surviving RHC having the highest AIR limit.

Additional considerations

Additional Considerations

- How will the new base rate be impacted when/if RHCs are consolidated on the Medicare cost report?
- If the 2020 (or 2021) base rate is calculated from a filed/settled cost report, will it be based on cost reports beginning or ending in 2020 (or 2021 if applicable) for fiscal year filers?
- How are MACs likely to treat interim rates for 2021 given the potential for limitations on the AIR?

Additional Considerations

- What if a clinic submitted an 855A prior to 12/31/2020, but does not receive certification until 2022?
- If the clinic is certified in 2021 and submitted an 855A prior to 12/31/2020, what will the grandfathered rate be based on?
- Will a change of address cause a grandfathered clinic to lose its grandfathered rate?
- Will a change in ownership cause a grandfathered clinic to lose its grandfathered rate?

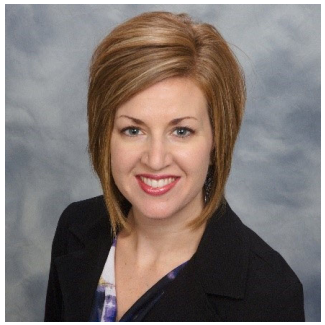
Closing Remarks

- Know the Facts!
  - RHC Modernization provisions are going to change.
  - Final revisions could affect planning for RHCs
  - Regardless, current reimbursement will change for RHCs.
  - Strategies can be implemented to mitigate the impact to clinics.

Questions?

The Wipfli Way

Your presenter:



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