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NATIONAL RURAL HEALTH ASSOCIATION

Section 130 Rural Health Clinic Modernization

Section 130 Provision Summary

- Increases the freestanding RHC limit to $100 beginning April 1, 2021 taking it to $190 in 2028.
- Subjects all "new" (certified after 12/31/19) RHCs, both freestanding and provider-based, to the new per-visit cap.
- Eliminates the exemption of payment limit for new provider-based RHCs. Any provider-based RHC certified after 12/31/19 will be subject to the same limits as freestanding facilities, meaning no new provider-based RHCs can receive uncapped cost-based reimbursement.
- Provider-based RHCs in existence as of 12/31/19 would be grandfathered-in at their current All-Inclusive Rate (AIR) and would receive their 2020 AIR plus an adjustment for MEI (the Medicare Economic Index) or their actual costs for the year.

Technical Correction Recommendation

- Addressing provider-based RHC's who were under construction and/or in development as of date of enactment. The backdating for new provider-based RHC of the December 31, 2019 is not acceptable and should be changed to April 1, 2021, when the change goes into effect. That will give hospitals currently in the process of converting RHCs an opportunity to address their planning and complete pending conversions. In the middle of a pandemic, as much flexibility should be given to rural providers as possible.

RHC Modernization Policy Recommendations

- Permanently enable all RHCs to serve as distant-site providers for purposes of Medicare telehealth reimbursement and to set reimbursement for these services at their respective AIR. Additionally, these services should be counted as a qualified encounter on the Medicare cost report.
- Modernize physician, physician assistant, and nurse practitioner utilization requirements to allow for arrangements consistent with State and local law relative to practice, performance, and delivery of health services.
- Continue cost-based reimbursement without a per-visit cap in exchange for requiring provider-based RHCs reporting of quality measures, perhaps per the Uniform Data System (UDS) or another like system. Provider-based RHCs would use the higher rate to pay for their participation in a quality program.
- Create an option for low-volume facilities (perhaps those meeting frontier and/or volume threshold) to automatically be eligible to receive a provider-based designation exception to address low-volume issues.
- Allow RHC's the flexibility to contract with physician assistants and nurse practitioners, rather than solely employment relationships.
- Remove outdated laboratory requirements.

As of October 2020, there are 4,661 Rural Health Clinics, with 3,008 (64.5%) being provider-based RHCs and 1,655 (35.5%) being freestanding RHCs. Potential Impacts of Section 130 Policy Change include:

- **On the Rural Health Clinic Program:** The change will allow the RHC program to have a more viable Medicare reimbursement policy. Additionally, it addresses the disparity between the cap on freestanding RHCs and the average uncapped all-inclusive rate RHCs, and any associated scrutiny of the RHC program and uncapped payment rates.
- **On Provider-Based RHCs with PPS Hospitals Under 50 Beds and Critical Access Hospitals:**
    - Provider-based RHCs aligned under a hospital with fewer than 50 beds established on or before 12/31/19 would annually be paid the lower of their 2020 AIR, adjusted by the MEI, OR their actual costs for the year.
    - The limitation has significant implications on the provider-based RHC program and may require hospitals and health systems to re-evaluate their business plans as provider-based RHCs will no longer be able to accommodate annual AIR increases that exceed MEI. Additionally, hospitals and systems considering establishing new RHCs may need to re-evaluate the feasibility of investing in RHCs, potentially leading to access concerns for individuals living in rural, especially low-volume, areas.
    - One intent of the provider-based program is to provide access to care at uncapped rates that reflected costs associated with care, including the allocated hospital overhead. Many CAHs allocate overhead costs to their provider-based RHCs through the cost-report stepdown methodology, which will now potentially be limited. This required allocation methodology may dilute otherwise reimbursable costs of the CAH since the RHC AIR will be limited.
    - Despite the uncapped AIR, data suggests that CAHs with provider-based RHCs already perform less well financially than CAHs without provider-based RHCs. Since annual CAH cost increases generally outpace MEI increases, CAHs that own and operate RHCs will likely see a continued deterioration of financial performance. This may reduce hospital resources, jeopardizing the ability to sustain these safety net providers in the long-term.
- **On Provider-Based RHCs with PPS Hospitals Over 50 Beds:**
    - Provider-based RHCs aligned under a hospital with 50 beds or more established on or before 12/31/19 are already subject to the same limits as freestanding RHCs and therefore will receive an annual limit of $100 beginning April 1, 2021 taking it to $190 in 2028.
- **On Rural Emergency Hospital (REH) Model:** Impacts of the policy change could mean a newly formed Rural Emergency Hospitals may be unable to convert RHCs grandfathered-in at their current All-Inclusive Rate (AIR) and would not be able to set up a provider-based RHC at uncapped rates, thereby limiting services needed by the community.