

Rural Health Clinic Program Modernization

The Rural Health Clinic (RHC) program is intended to increase access to primary care services for patients in rural communities. RHCs are reimbursed an all-inclusive rate (AIR) for medically-necessary primary health services and qualified preventive health services furnished by an RHC practitioner. RHCs can be either provider-based RHCs or independently owned and operated. The majority of RHCs are provider-based and are owned and operated as an essential part of a hospital, nursing home, or home health agency participating in the Medicare program. Independent RHCs are free-standing clinics owned by a provider or a provider entity. As of October 2020, there are 4,661 RHCs, with 3,008 (64.5%) being provider-based RHCs and 1,655 (35.5%) being freestanding RHCs.

Immediate Provider-Based RHC Payment Policy Recommendations

The Consolidated Appropriations Act (CAA) of 2021 Section 130 made significant revisions to RHC payment methodology for both freestanding and provider-based RHCs. The CAA changes will have significant unintended consequences for the future of the provider-based RHC program. ([See below for further details.](#))

NRHA urges Congress to revise the RHC statute to continue cost-based reimbursement without a per-visit cap in exchange for allowing provider-based RHCs to voluntarily report quality measures. Provider-based RHCs would use the higher payment rate to support involvement in a quality program. On average, RHCs have been less involved in quality measure reporting initiatives than their urban and suburban counterparts. Through adoption of this proposal, Congress will receive data on the RHC program that has been historically unavailable. Additionally, this will keep the provider-based RHC program stable for the creation of additional RHCs to meet future need.

Long-Term RHC Modernization Policy Recommendations

In addition to the above payment changes, a number of modernizations would be beneficial for the RHC program as a whole, including:

- 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. 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.
- Allow RHC's the flexibility to contract with physician assistants and nurse practitioners, rather than solely employment relationships.
- Remove outdated laboratory requirements.

Consolidated Appropriations Act (CAA), 2021, Section 130 Provision Summary

Section 130 for the CAA 2021 increases the freestanding RHC upper payment limit (cap) to \$100 beginning April 1, 2021, increasing to \$190 in 2028. Next year's (calendar year 2022) Physician Fee Schedule proposes to implement these provisions. The provision subjects all "new" (in the CAA defined as those certified after December 31, 2019) RHCs, both freestanding and provider-based, to the new per-visit upper payment limit.

Section 130 eliminates the exemption of payment limit for new provider-based RHCs. Through significant member advocacy, Congress responded to NRHA's concerns regarding the RHC provisions by passing H.R. 1868, which, among other things, move the date for provider-based RHCs subject to the upper-payment limit from December 31, 2019, to December 31, 2020. Any provider-based RHC certified after December 31, 2020, 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 December 31, 2019, would be grandfathered-in at their current AIR and would receive their 2020 AIR plus an adjustment for the Medicare Economic Index (MEI) or their actual costs for the year. Additionally, H.R. 1868 text allowed provider-based RHCs that had filed their 855A application by December 31, 2020, to be eligible for the historically uncapped rates.

Section 130 Impact on the RHC Program

While the Section 130 payment change will allow the broader RHC program to have a more viable long-term Medicare reimbursement policy, the change has significant implications on the provider-based RHC program. 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 Critical Access Hospitals (CAH) allocate overhead costs to their provider-based RHCs through the cost-report stepdown methodology. This required allocation methodology may dilute otherwise reimbursable costs of the CAH since the RHC AIR will be limited. Even with the historically uncapped AIR, data suggests that CAHs with provider-based RHCs 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 small, rural safety net providers in the long-term. As a result, many hospitals and health systems will re-evaluate viability to provide RHCs services. Additionally, hospitals and systems considering establishing new services may need to re-evaluate the feasibility of investing in provider-based RHCs, potentially leading to access concerns for individuals living in rural, especially low-volume, areas.