Rural Focus

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Legislative Impact on Rural Health Clinic Reimbursement

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Delivering high-quality, cost-effective healthcare remains a strategic driver for many healthcare organizations across the country. However, as the healthcare industry tries to move forward from the pandemic, healthcare entities face unprecedented cost increases, staffing and supply shortages, and service disruption. This has increased the pressure on governing boards and leadership teams across the country and brought to question the financial solvency of several healthcare providers. To combat this, rural hospital and health system boards and leadership teams must understand the changing healthcare landscape—particularly when involving changes to reimbursement methodologies.

For over 40 years, healthcare entities across the country have leveraged the Rural Health Clinic (RHC) program to increase access to primary care services in rural communities, while often receiving higher reimbursements than a practice reimbursed through the Medicare Physician Fee Schedule. However, RHCs saw a material change in the reimbursement methodology in 2021 that will directly impact the financial performance of those practices. The Consolidated Appropriations Act (CAA) of 2021 included a provision that fundamentally changed the RHC reimbursement rates and methodology. Prior to the CAA of 2021, provider-based RHCs (PB-RHCs) owned and operated by a hospital with fewer than 50 beds received uncapped cost-based reimbursement from Medicare.

First, to qualify as an RHC, an entity must meet several conditions. An RHC must be in a rural, medically underserved area and qualifies for an all-inclusive payment rate that includes the provider and practice costs. In addition to other requirements, a RHC must employ and make available an advanced practice provider at least 50 percent of the time the practice is open and ensure greater than 50 percent of the services provided are primary care.

New RHC Reimbursement Methodology

On December 27, 2020, the President signed into law the CAA of 2021, which changed the reimbursement methodology and rates for RHCs. Starting on April 1, 2021, all RHCs, regardless of whether they are independent, owned and operated by a hospital with fewer than 50 beds, or owned and operated by a hospital with 50 or more beds, began to be reimbursed based on reasonable cost with an upper payment limit set at the following rates, unless they qualified as a grandfathered PB-RHC:

- In 2021, after March 31, at $100 per visit
- In 2022, at $113 per visit
- In 2023, at $126 per visit
- In 2024, at $139 per visit
- In 2025, at $152 per visit
- In 2026, at $165 per visit
- In 2027, at $178 per visit
- In 2028, at $190 per visit
- In subsequent years, the rate will increase based on the Medicare Economic Index (MEI) for primary care services.

Practices that met the grandfathered PB-RHC conditions would have their upper payment limit set at their 2020 RHC reimbursement rate, increased by the MEI. Each year thereafter, the upper payment limit will increase by the MEI. To qualify as a grandfathered PB-RHC, the practice must have been owned and operated by

→ Key Board Takeaways

With a change in the RHC reimbursement methodology, rural hospital and health system boards will want to revisit their primary and specialty care strategies and consider the following questions:

- What is the financial impact of the new RHC reimbursement methodology on the financial performance of the RHC and system?
- Does the new RHC reimbursement methodology impact our ability to provide and or expand services?
- Have we considered an alternative practice designation instead of an RHC?
- Should we consider realigning the RHCs within the system to mitigate the change in reimbursements?

a hospital with fewer than 50 beds and been enrolled as an RHC or have applied to become an RHC by December 31, 2020. Subjecting all PB-RHCs to an upper payment limit is a material change to the reimbursement methodology that will impact healthcare entities. Going forward, all RHCs will receive the lesser of their cost-based rate or the upper payment limit.

Case Studies

The following are two case studies that highlight the net financial impact on RHCs brought forth by the CAA of 2021 from 2021 through 2028 if the practices saw a 1.4 percent MEI increase. The first case study involves a PB-RHC owned and operated by a hospital with fewer than 50 beds that experienced a 4 percent annual cost increase and no change in patient volumes or payer mix. The assessment quantified the net financial impact by subjecting the PB-RHC to an upper payment limit instead of the cost-based reimbursement received prior to the implementation of this legislation.

Exhibit 1: Case Study 1: Net Impact of CAA of 2021 on PB-RHC Owned by Hospital with Less Than 50 Beds

Category	2021	2022	2023	2024	2025	2026	2027	2028
Old RHC Rate	$178.53	$185.67	$193.10	$200.82	$208.85	$217.21	$225.90	$234.93
New RHC Rate	$172.63	$175.05	$177.50	$179.98	$182.50	$185.06	$187.65	$190.28
Variance	$(5.90)	$(10.62)	$(15.60)	$(20.84)	$(26.35)	$(32.15)	$(38.25)	$(44.66)
Medicare Visits	3,936	3,936	3,936	3,936	3,936	3,936	3,936	3,936
Net Impact	$(23,222)	$(41,818)	$(61,404)	$(82,024)	$(103,724)	$(126,550)	$(150,550)	$(175,775)

Due to the change in the reimbursement methodology, the grandfathered PB-RHC would receive less reimbursements from Medicare than under the prior methodology. Since the PB-RHC was limited to a 1.4 percent MEI, but experienced a 4 percent annual cost increase, the practice would lose over $23,000 in 2021, with the trended loss to increase to almost $176,000 in 2028. Of note, any year where the annual cost increase is more than the MEI would lead to lower reimbursements when compared to the prior methodology. Critical access hospitals must pay particular attention to the

change in the RHC reimbursement methodology due to the Medicare Cost Report and the allocation of overhead expenses to the RHCs.

The second case study involves a PB-RHC owned and operated by a hospital with more than 50 beds that experienced a 3 percent annual cost increase and no change in patient volumes or payer mix. The assessment quantified the net financial impact on the PB-RHC by increasing the upper payment limit to the new national rates established by the CAA of 2021.

Exhibit 2: Case Study 2: Net Impact of CAA of 2021 on PB-RHC Owned by Hospital with More Than 50 Beds

Category	2021	2022	2023	2024	2025	2026	2027	2028
Old RHC Rate	$87.52	$88.75	$89.99	$91.25	$92.53	$93.82	$95.13	$96.47
New RHC Rate	$100.00	$113.00	$126.00	$139.00	$148.29	$154.22	$160.39	$166.81
Variance	$12.48	$24.25	$36.01	$47.75	$55.76	$60.40	$65.26	$70.34
Medicare Visits	3,813	3,813	3,813	3,813	3,813	3,813	3,813	3,813
Net Impact	$47,586	$92,483	$137,315	$182,080	$212,632	$230,304	$248,822	$268,223

Due to the change in the reimbursement methodology, the PB-RHC owned by a hospital with more than 50 beds would receive higher reimbursements from Medicare than under the prior methodology. Since the CAA of 2021 increased the upper payment limit for all RHCs, the practice would realize around $47,500 in additional reimbursements in 2021, with the trended gains to increase to over $268,000 in 2028. Governing boards and leadership teams associated with hospitals that have more than 50 beds should evaluate the RHC program due to the more favorable reimbursements received under the new RHC upper payment limits.

Summary

As seen, the change in the reimbursement methodology and rates received will have a direct impact on the future revenues received by each RHC and, if applicable, the entities that own those RHCs. This can be positive or negative depending on the organization, and has the potential to not only impact financial sustainability but

access to primary and specialty services in rural communities across the country. Rural hospitals, health systems, and RHCs cannot continue along a path of "business as usual" and must evaluate the effect of the new reimbursement methodology and rates on each RHC. Failure to fully understand the impact of this legislation on an RHC can negatively impact access to care and a community from receiving vital resources.

The Governance Institute thanks Jonathan Pantenburg, Principal, Stroudwater Associates, for contributing this article. He can be reached at jpantenburg@stroudwater.com.