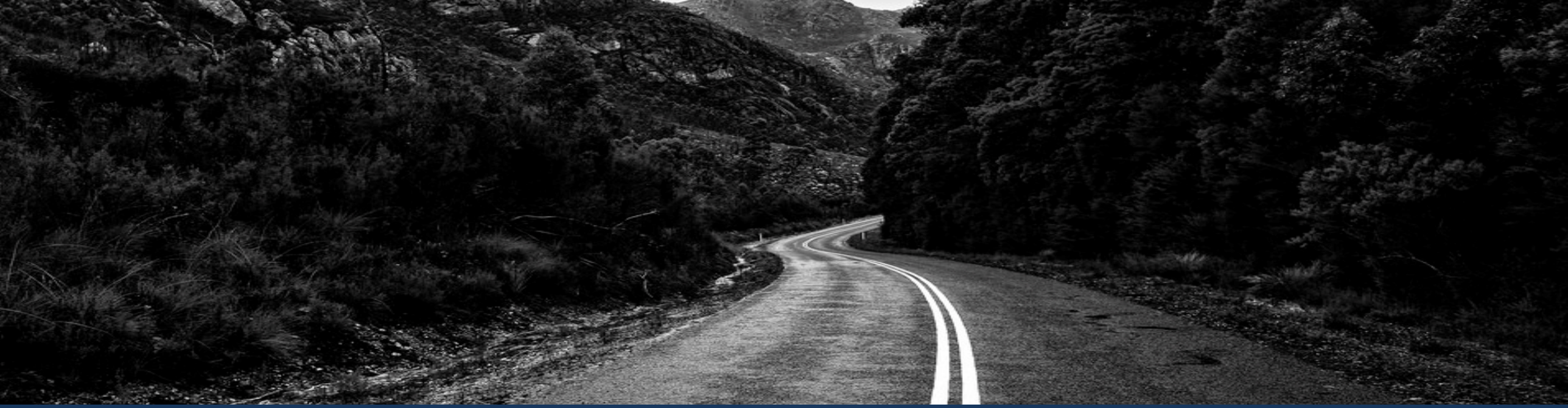

West Virginia
RHC Legislative Impact

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Overview

- Overview
- Definitions / Regulations
- Impact to RHCs and Hospitals
- Questions

DEFINITIONS / REGULATIONS

New RHC Reimbursement Methodology

- On December 27, 2020, the President signed into law, the "*Consolidated Appropriations Act, 2021 (CAA)"* which changed the reimbursement methodology for Rural Health Clinics (RHC) starting on April 1, 2021
  - Starting on April 1, 2021, all new RHCs established after December 31, 2019, 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 greater than 50 beds, shall be reimbursed based on reasonable cost with an upper payment limit (UPL) set at the following rates:
    a) In 2021, after March 31, at $100 per visit;
    b) In 2022, at $113 per visit;
    c) In 2023, at $126 per visit;
    d) In 2024, at $139 per visit;
    e) In 2025, at $152 per visit;
    f) In 2026, at $165 per visit;
    g) In 2027, at $178 per visit;
    h) In 2028, at $190 per visit;
    i) In subsequent years, the rate will increase based on the Medicare Economic Index (MEI) for primary care services
  - RHCs owned and operated by a hospital with fewer than 50 beds and established on or before December 31, 2019, will use their 2020 rate to establish a clinic-specific grandfathered UPL that will then be increased each year based on the MEI
- Since the final legislation varied greatly from the RHC Modernization Act and due to the impact on provider-based RHCs (PB-RHC), efforts are underway to change certain provisions
  - The removal of the un-capped cost-based reimbursement rate for RHCs owned and operated by hospitals with fewer than 50 beds will jeopardize the financial solvency of many hospitals

IMPACT TO RHCs and HOSPITALS

RHC Grandfathered UPL

- The Consolidated Appropriations Act, 2021 set a grandfathered date of December 31, 2019 for RHCs owned and operated by hospitals with fewer than 50 beds; however, this has brought forth issues

1. There were 295 new RHCs established in 2020, of which 153 were PB-RHCs, and unless a legislative fix passes, those clinics will be subject to the $100 UPL starting on April 1, 2021
   - As passed, this changed the rules of the game after several practices received their RHC designation
     - Granted, discussions are under way to change this date; however, this will require legislation

2. Several hospitals have already filed their 855As (in process), but have not yet been surveyed, and will be subject to the new UPL
   - This will require hospitals and systems to reevaluate their strategies to determine if the RHC program remains a viable option to maintain services

3. Several hospitals have capital projects underway and the change in the PB-RHC reimbursement methodology may jeopardize the future solvency of those hospitals due to the capped rates
   - The unanticipated and under-communicated change in the reimbursement methodology may lead to the termination of capital projects and a decline in rural community investment

4. CMS used site-neutrality in the 2019 OPPS Final Rule (US Court of Appeals, DC ruled in their favor) to reduce APC payments received by off-campus provider-based practices that were grandfathered through the Bipartisan Budget Act of 2015
   - *See next slide for additional information*

RHC Grandfathered Rule – 2019 OPPS Final Rule

- The Bipartisan Budget Act (BBA) of 2015 identified excepted provider-based items and services as those permitted to bill for items and services under OPPS after January 1, 2017, as the following:
  1. By a dedicated emergency department;
  2. By an off-campus provider-based department (PBD) that was billing for covered outpatient department (OPD) services furnished prior to November 2, 2015, that has not impermissibly relocated or changed ownership; or
  3. In a PBD that is "on the campus," or within 250 yards, of the hospital or a remote location of the hospital.

- Through the 2019 OPPS Final Rule, to save the Medicare program and beneficiaries a combined $380m in 2019, CMS removed the grandfathering provision identified in the BBA of 2015 that applied to off-campus PBDs billing for covered OPD services furnished prior to November 2, 2015
  - Under the final rule, CMS would make payments for clinic visits site-neutral by reducing the payment rate for hospital outpatient clinic visits provided at off-campus provider-based departments by 60% with a two-year phase-in of this policy in 2019 and 2020

On July 20, 2020, the U.S. Court of Appeals for the D.C. Circuit upheld the CMS volume control site-neutrality payment policy for off-campus hospital clinic sites

CONSIDERATION: Are grandfathered PB-RHCs at risk in the future due to the outcome of the OPPS site-neutral suit?

Critical Access Hospital Reimbursement

- Critical Access Hospitals (CAH) are paid for most inpatient and outpatient services at 101 percent of Reasonable Cost
  - Medicare does not include CAHs in the hospital Inpatient Prospective Payment System (IPPS) nor the hospital Outpatient Prospective Payment System (OPPS)
  - Medicare pays CAH services according to Part A and Part B deductible and coinsurance amounts and does not limit most of the 20 percent CAH Part B outpatient services copayment changes by the Part A inpatient deductible amount[1]

- Roughly 890 of the 1,350 CAHs own and operate at least one RHC which represents 66% of the total number of CAHs across the country
  - Those 890 CAHs own and operate roughly 1,650 RHCs
  - Under the prior RHC reimbursement methodology, PB-RHCs owned and operated by a CAH would receive un-capped cost-based reimbursement from Medicare which is in line with most of the other essential, core safety net services offered at the CAH
    - Un-capped cost-based reimbursement subject to meeting the RHC minimum productivity threshold and allowable cost assumptions

- The change in PB-RHC reimbursement methodology means CAHs will no longer receive cost-based reimbursement for a business unit that may represent a large portion of the business and a cornerstone of their rural community's healthcare delivery system
  - Based on FY19 cost report data, roughly 750 RHCs owned and operated by a CAH saw annual cost increases in excess of the 1.4% 2021 Medicare Economic Index (MEI) which will negatively impact the financial performance of those CAHs
    - From 2017 to 2019, the capped RHC rate increased between 1.2% to 1.9% per year
    - The 750 RHCs referenced have been in operation for at least 3 years

1: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CritAccessHospfctsht.pdf

CAH Overhead Cost Allocation

- The Medicare Cost Report is a systematic method of cost accounting that determines both allowable costs and the costs allocated to each department (such as Med/Surg, ED, PB-RHC, etc.)
  - Since CAHs receive cost-based reimbursement for most other services, the allocation of costs to each department is of importance and the CAH settlement can have a material impact on the financial statements

- Since the Medicare cost-report allocation methodology requires the inclusion of provider compensation when determining the overhead costs allocated to the PB-RHC, PB-RHCs can distribute a disproportionate amount of overhead costs to a now non-cost-based program
  - The following example illustrates the impact of a PB-RHC on the allocation of costs under a CAH:

	Direct Cost	Adjustment	Adjusted Cost	Overhead Allocation	Fully Allocated Cost
PBC	$ 2,123,292	$ (962,156)	$ 1,161,136	$ 518,696	$ 1,679,832
PB-RHC	$ 2,123,292		$ 2,123,292	$ 622,867	$ 2,746,159
				$ 104,171	

  - In the example provided, operating the practice as a PB-RHC led to a $104K increase in overhead cost allocation to the PB-RHC which will negatively impact reimbursements received for other cost-based services

West Virginia Specific Impact

- Based on the 2020 Provider of Service (POS) file, WV had 59 RHCs with a being 28 independent and 31 being hospital-based
  - Of that total, the following 9 RHCs were established in 2020, with 7 being PB-RHCs subject to the new $100 UPL unless a legislative fix occurs:

Hospital Owner	Hospital Designation	Clinic Name	Clinic Town	Clinic Designation	Designation Date
		VALLEY HEALTH FAMILY MEDICINE INWOOD	INWOOD	RHC	11/5/2020
Pleasant Valley Hospital	STAC	PLEASANT VALLEY HOSPITAL REGIONAL HEALTH CENTER	POINT PLEASANT	PB-RHC	9/24/2020
Potomac Valley Hospital	CAH	FORT ASHBY RURAL HEALTH CLINIC OF POTOMAC VALLEY H	FORT ASHBY	PB-RHC	8/12/2020
Potomac Valley Hospital	CAH	MINERAL COUNTY RURAL HEALTH CLINIC OF POTOMAC VALL	KEYSER	PB-RHC	8/12/2020
St. Josephs Hospital Of Buckhannon	CAH	ST JOSEPH'S CLINIC	BUCKHANNON	PB-RHC	7/29/2020
St. Josephs Hospital Of Buckhannon	CAH	BRUSHY FORK CLINIC	BUCKHANNON	PB-RHC	7/28/2020
Pleasant Valley Hospital	STAC	BEND AREA CLINIC	MASON	PB-RHC	5/14/2020
Sistersville General Hospital	CAH	ST MARYS EXPRESS CARE	SAINT MARYS	PB-RHC	3/10/2020
		SUMMERSVILLE PEDIATRICS, INC	WEBSTER SPRINGS	RHC	1/20/2020

- It is unknown the exact number of practices, whether independent or hospital-based, that were “in process” in WV when the RHC reimbursement methodology changed
  - Even though clinics and or hospitals may have expended capital resources to transition to an RHC, those entities must evaluate whether the RHC designation still makes sense

- In 2020, there were 14 WV CAHs that owned and operated 25 RHCs that will now be subject to the annual UPL increase
  - 5 of those RHCs were established in 2020 and would be subject to the $100 UPL in 2020 unless legislation passes to change the grandfathering date
  - This does not include the clinics converted in 2020 that had not yet received their Medicare CCN

RHC Specific Impact – Grandfathered

- With a change in the reimbursement methodology, hospitals must evaluate and understand the net impact on future reimbursements
  - Critical Access Hospital (Former Un-Capped RHC Rate):
    - The following table presents the net impact on reimbursements for a CAH that operates 2 RHCs if the law went into effect in 2016 and the practices were "grandfathered":

	2016	2017	2018	2019	COMBINED	Rate Increase
Cost-Based Rate	$ 154.85	$ 188.94	$ 223.91	$ 220.92		43%
Grandfathered UPL	154.85	157.01	159.21	161.44		4%
Variance	$ -	$ (31.93)	$ (64.69)	$ (59.48)	$ (39.85)	<-- AVG
Medicare Visits	4,114	4,226	4,269	4,653	17,262	
Lost Reimbursement	$ -	$ (134,927)	$ (276,183)	$ (276,757)	$ (687,867)	

  - Hospital-based RHC with > 50 Beds (Former Capped RHC Rate):
    - The following table presents the net impact on reimbursements for 2 hospital-based RHCs if the law went into effect in 2016:

	2016	2017	2018	2019	COMBINED	Rate Increase
Clinic Cost / Visit	$ 145.56	$ 126.50	$ 131.06	$ 141.35		-3%
Independent Rate	81.32	82.30	83.45	84.70		4%
New UPL RHC Rate	100.00	113.00	126.00	139.00		39%
Variance	$ 18.68	$ 30.70	$ 42.55	$ 54.30	$ 35.80	<-- AVG
Medicare Visits	2,478	2,319	2,379	2,065	9,241	
Reimbursement Gain	$ 46,289	$ 71,193	$ 101,226	$ 112,130	$ 330,838	

    - Stroudwater assumed an annual Medicare Economic Index (MEI) increase of 1.4% for both scenarios
    - Since RHCs will receive the lesser of their cost-based rate or the UPL, the green-shaded box highlights whether the practice would receive their cost-based rate or the UPL

RHC Specific Impact – New RHC

- Critical Access Hospital (Former Un-Capped RHC Rate):
  - The following table presents the net difference in reimbursements received if the CAH established the same 2 practices as new RHCs in 2016; however, the practices were subject to the new UPL:

	2016	2017	2018	2019	COMBINED	Rate Increase
Cost-Based Rate	$ 154.85	$ 188.94	$ 223.91	$ 220.92		43%
New RHC UPL Rate	100.00	113.00	126.00	139.00		39%
Variance	$ (54.85)	$ (75.94)	$ (97.91)	$ (81.92)	$ (77.96)	<-- AVG
Medicare Visits	4,114	4,226	4,269	4,653	17,262	
Lost Reimbursement	$ (225,640)	$ (320,933)	$ (417,968)	$ (381,178)	$ (1,345,719)	

- Hospital-based RHC with > 50 Beds (Former Capped RHC Rate):
  - The following table presents the net difference in reimbursements received if the hospital-based RHCs were established as new RHCs and subject to the new UPL:

	2016	2017	2018	2019	COMBINED	Rate Increase
Clinic Cost / Visit	$ 145.56	$ 126.50	$ 131.06	$ 141.35		-3%
Independent Rate	81.32	82.30	83.45	84.70		4%
New UPL RHC Rate	100.00	113.00	126.00	139.00		39%
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Service Expansion to Rural Communities

- Many hospitals and systems leveraged the RHC program to expand access to care in rural communities by partnering with rural providers
  - Specifically, the reimbursement advantage afforded to PB-RHCs owned and operated by hospitals with fewer than 50 beds incentivized larger hospitals and systems to engage smaller hospitals, expand access, and decentralize services away from urban centers
    - Increasingly, RHCs functioned as the means to expand access to behavioral health and substance abuse services in rural areas where disparities are more extreme and needs are more acute

- Since all new RHCs now receive the same rate, larger hospitals (those with > 50 beds) no longer have the same financial incentives to partner with smaller rural hospitals, including CAHs
  - With the change in the RHC reimbursement methodology (UPL increasing to $190 in 2028) and access to 340B for qualifying hospitals, larger hospitals can further leverage RHCs to target new markets, bypassing rural providers, and redirect services to those larger facilities
    - Note: The HRSA off-site outpatient facility (child-site) registration requirements do not require a CMS provider-based determination and an RHC owned and operated by a hospital with greater than 50 beds may qualify for 340B if the hospital and RHC meet the HRSA registration requirements

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