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RURAL HEALTH CLINIC

CONSOLIDATED APPROPRIATIONS ACT AND JUNE 2020 FAQS AFFECTING RHCS

SOURCE DOCUMENTS

December 22, 2020

Healthcare Business Specialists

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Section 1
RHC Provisions in the CAA

HISTORIC DAY FOR RHCS

December 22, 2020: Congress passed the Consolidated Appropriations Act, 2021 (CAA) and the 5,593 page document is going to the President for signature. This $900 Billion bill includes Section 130 Improving Rural Health Clinic Payments which increases the Medicare cap for independent RHCs to $100 per visit and increases the rate until the maximum rate is up to $190 per visit in 2028 and the rate will be increased by the Medicare Economic Index thereafter. This does not mean RHCs will get these higher rates. If the RHCs rate is less than the cap, then the clinic is paid the lessor of the two. There is a cost to getting this higher rate. Provider-based RHCs (less than 50 beds) certified after 12/31/2019 that were not subject to a cap will now be subject to this cap. Provider-based RHCs (less than 50 beds) certified on or before 12/31/2019 are grandfathered and will not be subject to these limitations. Here are some links to help you understand the rules.

- Consolidated Appropriations Act, 2021 (5,593 page PDF)

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DECEMBER 21, 2020

RULES COMMITTEE PRINT 116–68

TEXT OF THE HOUSE AMENDMENT TO THE SENATE AMENDMENT TO H.R. 133

[Showing the text of the Consolidated Appropriations Act, 2021]

In lieu of the matter proposed to be inserted by the Senate, insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Consolidated Appropriations Act, 2021".

SEC. 2. TABLE OF CONTENTS.

(c) FUNDING.—Subsection (g)(1) of such section 123 is amended—

(1) in subparagraph (A)—

(A) by striking "IN GENERAL" and inserting "INITIAL PERIOD"; and

(B) by inserting "with respect to the initial period" before the period at the end; and

(2) by adding at the end the following new subparagraph:

"(C) EXTENSION PERIOD.—The Secretary shall provide for the transfer of $10,000,000, in appropriate part from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), to the Centers for Medicare & Medicaid Services for the purposes of carrying out its duties under the demonstration project under this section with respect to the extension period.".

SEC. 130. IMPROVING RURAL HEALTH CLINIC PAYMENTS.

Section 1833(f) of the Social Security Act (42 U.S.C. 1395l(f)) is amended—

(1) in paragraph (2)—

(A) by inserting "(before April 1, 2021)" after "in a subsequent year"; and

(B) by striking "this subsection" and inserting "this paragraph";

(2) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively;

(3) in the matter preceding subparagraph (A), as redesignated by paragraph (2)—

(A) by inserting "(1)" after "(f)"; and

(B) by inserting "prior to April 1, 2021" after "services provided"; and

(4) by adding at the end the following new paragraphs:

"(2) In establishing limits under subsection (a) on payment for rural health clinic services furnished on or after April 1, 2021, by a rural health clinic (other than a rural health clinic described in paragraph (3)(B)), the Secretary shall establish such limit, for services provided—

"(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; and

"(I) in a subsequent year, at the limit established under this paragraph for the previous year increased by the percentage increase in the MEI applicable to primary care services furnished as of the first day of such subsequent year.

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

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

"(I) the per visit payment amount applicable to such rural health clinic for rural health clinic 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

"(II) the limit described in paragraph (2)(A); and

"(ii) in a subsequent year, at an amount equal to the greater of—

"(I) the amount established under clause (i)(I) or this subclause for the previous year with respect to such rural health clinic, increased by the percentage increase in the MEI applicable to primary care services furnished as of the first day of such subsequent year; or

"(II) the limit established under paragraph (2) for such subsequent year.

"(B) A rural health clinic described in this subparagraph is a rural health clinic that, as of December 31, 2019, was—

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

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

SEC. 131. MEDICARE GME TREATMENT OF HOSPITALS ESTABLISHING NEW MEDICAL RESIDENCY TRAINING PROGRAMS AFTER HOSTING MEDICAL RESIDENT ROTATORS FOR SHORT DURATIONS.

(a) REDETERMINATION OF APPROVED FTE RESIDENT AMOUNT.—Section 1886(h)(2)(F) of the Social Security Act (42 U.S.C. 1395ww(h)(2)(F)) is amended—

(1) by inserting "(i)" before "In the case of"; and

(1) in subsection (o), by adding at the end the following new paragraph:

"(4) PAYMENT FOR ATTENDING PHYSICIAN SERVICES FURNISHED BY FEDERALLY QUALIFIED HEALTH CENTERS TO HOSPICE PATIENTS.—In the case of services described in section 1812(d)(2)(A)(ii) furnished on or after January 1, 2022, by an attending physician (as defined in section 1861(dd)(3)(B), other than a physician or practitioner who is employed by a hospice program) who is employed by or working under contract with a Federally qualified health center, a Federally qualified health center shall be paid for such services under the prospective payment system under this subsection."; and

(2) by adding at the end the following new subsection:

"(y) PAYMENT FOR ATTENDING PHYSICIAN SERVICES FURNISHED BY RURAL HEALTH CLINICS TO HOSPICE PATIENTS.—In the case of services described in section 1812(d)(2)(A)(ii) furnished on or after January 1, 2022, by an attending physician (as defined in section 1861(dd)(3)(B), other than a physician or practitioner who is employed by a hospice program) who is employed by or working under contract with a rural health clinic,

a rural health clinic shall be paid for such services under the methodology for all-inclusive rates (established by the Secretary) under section 1833(a)(3), subject to the limits described in section 1833(f).".

SEC. 133. DELAY TO THE IMPLEMENTATION OF THE RADIATION ONCOLOGY MODEL UNDER THE MEDICARE PROGRAM.

Notwithstanding any provision of section 1115A of the Social Security Act (42 U.S.C. 1315a), the Secretary of Health and Human Services may not implement the radiation oncology model described in the rule entitled "Medicare Program; Specialty Care Models To Improve Quality of Care and Reduce Expenditures" (85 Fed. Reg. 61114 et seq.), or any substantially similar model, pursuant to such section before January 1, 2022.

SEC. 134. IMPROVING ACCESS TO SKILLED NURSING FACILITY SERVICES FOR HEMOPHILIA PATIENTS.

(a) IN GENERAL.—Section 1888(e)(2)(A)(iii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(iii)) is amended by adding at the end the following:

"(VI) Blood clotting factors indicated for the treatment of patients with hemophilia and other bleeding disorders (identified as of July 1, 2020, by HCPCS codes J7170,

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Section 2

Provider Relief Funds (Lost Revenue) Provisions in the CAA

The CAA again changed the definition of lost revenue. This week's definition reverts to the June 2020 definition of lost revenue which includes the used of budgeted income and expenses if the budget was approved prior to March 27, 2020.

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a statement justifying the need of the provider for the payment and the eligible health care provider shall have a valid tax identification number: *Provided further*, That for any reimbursement by the Secretary from the Provider Relief Fund to an eligible health care provider that is a subsidiary of a parent organization, the parent organization may, allocate (through transfers or otherwise) all or any portion of such reimbursement among the subsidiary eligible health care providers of the parent organization, including reimbursements referred to by the Secretary as "Targeted Distribution" payments, among subsidiary eligible health care providers of the parent organization except that responsibility for reporting the reallocated reimbursement shall remain with the original recipient of such reimbursement: *Provided further*, That, for any reimbursement from the Provider Relief Fund to an eligible health care provider for health care related expenses or lost revenues that are attributable to coronavirus (including reimbursements made before the date of the enactment of this Act), such provider may calculate such lost revenues using the Frequently Asked Questions guidance released by the Department of Health and Human Services in June 2020, including the difference between such provider's budgeted and actual revenue budget if such budget had been established and approved prior to March 27, 2020: *Provided*

Provider Relief Funds

Lost Revenue

further, That of the amount made available in the third paragraph under this heading in Public Law 116–136, not less than 85 percent of (i) the unobligated balances available as of the date of enactment of this Act, and (ii) any funds recovered from health care providers after the date of enactment of this Act, shall be for any successor to the Phase 3 General Distribution allocation to make payments to eligible health care providers based on applications that consider financial losses and changes in operating expenses occurring in the third or fourth quarter of calendar year 2020, or the first quarter of calendar year 2021, that are attributable to coronavirus: *Provided further*, That, not later than 3 years after final payments are made under this paragraph, the Office of Inspector General of the Department of Health and Human Services shall transmit a final report on audit findings with respect to this program to the Committees on Appropriations of the House of Representatives and the Senate: *Provided further*, That nothing in this section limits the authority of the Inspector General or the Comptroller General to conduct audits of interim payments at an earlier date: *Provided further*, That not later than 60 days after the date of enactment of this Act, the Secretary of Health and Human Services shall provide a report to the Committees on Appropriations of the House of Representatives and the Senate on

obligation of funds, including obligations to such eligible health care providers, summarized by State of the payment receipt: *Provided further,* That such reports shall be updated and submitted to such Committees every 60 days until funds are expended: *Provided further,* That the amounts repurposed in this paragraph that were previously designated by the Congress as an emergency requirement pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985 are designated by the Congress as an emergency requirement pursuant to section 251(b)(2)(A)(i) of the Balanced Budget and Emergency Deficit Control Act of 1985: *Provided further,* That such amount is designated by the Congress as being for an emergency requirement pursuant to section 251(b)(2)(A)(i) of the Balanced Budget and Emergency Deficit Control Act of 1985.

GENERAL PROVISIONS—DEPARTMENT OF HEALTH AND HUMAN SERVICES

SEC. 301. Funds appropriated by this title may be used by the Secretary of the Department of Health and Human Services to appoint, without regard to the provisions of sections 3309 through 3319 of title 5 of the United States Code, candidates needed for positions to perform critical work relating to coronavirus for which—

(1) public notice has been given; and

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Section 3
Provider Relief Funds FAQs - June 2020

As a refresher here is the June 2020 FAQs:

- Provider Relief Funds FAQ from June 2020 (the new Lost Revenue Definition)

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FAQs
June, 2020

CARES Act Provider Relief Fund
Frequently Asked Questions

CARES Act Provider Relief Fund Frequently Asked Questions

Provider Relief Fund General Information FAQs

Overview

What is HHS doing with payments that are returned to the Provider Relief Fund? (Added 6/30/2020)
HHS will allocate returned payments to future distributions of the Provider Relief Fund.

New or Recently Updated

specific to treating COVID-19. Recipients of funding must still comply with the Terms and Conditions related to permissible uses of Provider Relief Fund payments.

If a provider secures COVID-19-related funding separate from the Provider Relief Fund, such as the Small Business Administration's Paycheck Protection Program, does that affect how they can use the payments from the Provider Relief Fund? Does accepting Provider Relief Fund payments preclude a provider organization from seeking other funds authorized under the CARES Act? ***(Added 5/29/2020)***
There is no direct ban under the CARES Act on accepting a payment from the Provider Relief Fund and other sources, so long as the payment from the Provider Relief Fund is used only for permissible purposes and the recipient complies with the Terms and Conditions. By attesting to the Terms and Conditions, the recipient certifies that it will not use the payment to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse.

How will HHS recoup funds from providers that are required to repay all or part of a Provider Relief Fund payment? ***(Added 5/29/2020)***
HHS has not yet detailed how recoupment or repayment will work. However, the Terms and Conditions associated with payment require that the Recipient be able to certify, among other requirements, that it was eligible to receive the funds (e.g., provides or provided after January 31, 2020, diagnoses, testing, or care for individuals with possible or actual cases of COVID-19) and that the funds were used in accordance with allowable purposes (e.g., to prevent, prepare for, and respond to coronavirus). Additionally, recipients must submit all required reports as determined by the Secretary. Non-compliance with any term or condition is grounds for the Secretary to direct recoupment of some or all of the payments made. HHS will have significant anti-fraud monitoring of the funds distributed, and the Office of Inspector General will provide oversight as required in the CARES Act to ensure that Federal dollars are used appropriately.

The Terms and Conditions state that Provider Relief Fund payments will only be used to prevent, prepare for, and respond to coronavirus and shall reimburse the Recipient only for healthcare-related expenses or lost revenues that are attributable to coronavirus. What expenses or lost revenues are considered eligible for reimbursement? ***(Modified 6/19/2020)***
Lost Revenue
The term "healthcare related expenses attributable to coronavirus" is a broad term that may cover a range of items and services purchased to prevent, prepare for, and respond to coronavirus, including:

- supplies used to provide healthcare services for possible or actual COVID-19 patients;
- equipment used to provide healthcare services for possible or actual COVID-19 patients;
- workforce training;
- developing and staffing emergency operation centers;
- reporting COVID-19 test results to federal, state, or local governments;
- building or constructing temporary structures to expand capacity for COVID-19 patient care or to provide healthcare services to non-COVID-19 patients in a separate area from where COVID-19 patients are being treated; and
- acquiring additional resources, including facilities, equipment, supplies, healthcare practices, staffing, and technology to expand or preserve care delivery.

Providers may have incurred eligible health care related expenses attributable to coronavirus prior to the date on which they received their payment. Providers can use their Provider Relief Fund payment for such expenses incurred on any date, so long as those expenses were attributable to coronavirus and were used to prevent, prepare for, and respond to coronavirus. HHS expects that it would be highly unusual for providers to have incurred eligible expenses prior to January 1, 2020.

The term "lost revenues that are attributable to coronavirus" means any revenue that you as a healthcare provider lost due to coronavirus. This may include revenue losses associated with fewer outpatient visits, canceled elective procedures or services, or increased uncompensated care. Providers can use Provider Relief Fund payments to cover any cost that the lost revenue otherwise would have covered, so long as that cost prevents, prepares for, or responds to coronavirus. Thus, these costs do not need to be specific to providing care for possible or actual coronavirus patients, but the lost revenue that the Provider Relief Fund payment covers must have been lost due to coronavirus. HHS encourages the use of funds to cover lost revenue so that providers can respond to the coronavirus public health emergency by maintaining healthcare delivery capacity, such as using Provider Relief Fund payments to cover:

- Employee or contractor payroll
- Employee health insurance
- Rent or mortgage payments
- Equipment lease payments
- Electronic health record licensing fees

You may use any reasonable method of estimating the revenue during March and April 2020 compared to the same period had COVID-19 not appeared. For example, if you have a budget prepared without taking into account the impact of COVID-19, the estimated lost revenue could be the difference between your budgeted revenue and actual revenue. It would also be reasonable to compare the revenues to the same period last year.

Budget

All providers receiving Provider Relief Fund payments will be required to comply with the reporting requirements described in the Terms and Conditions and specified in future directions issued by the Secretary. HHS will provide guidance in the future about the type of documentation we expect recipients to submit. Additional guidance will be posted at https://www.hhs.gov/provider-relief/index.html.

In order to accept a payment, must the provider have already incurred eligible expenses and losses higher than the Provider Relief Fund payment received? ***(Added 6/8/2020)***
No. Providers do not need to be able to prove, at the time they accept a Provider Relief Fund payment, that prior and/or future lost revenues and increased expenses attributable to COVID-19 (excluding those covered by other sources of reimbursement) meet or exceed their Provider Relief Fund payment. Instead, HHS expects that providers will only use Provider Relief Fund payments for permissible purposes and if, at the conclusion of the pandemic, providers have leftover Provider Relief Fund money that they cannot expend on permissible expenses or losses, then they will return this money to HHS. HHS will provide directions in the future about how to return unused funds. HHS reserves the right to audit Provider Relief Fund recipients in the future and collect any Relief Fund amounts that were used inappropriately.