Section 130: RHC Modernization

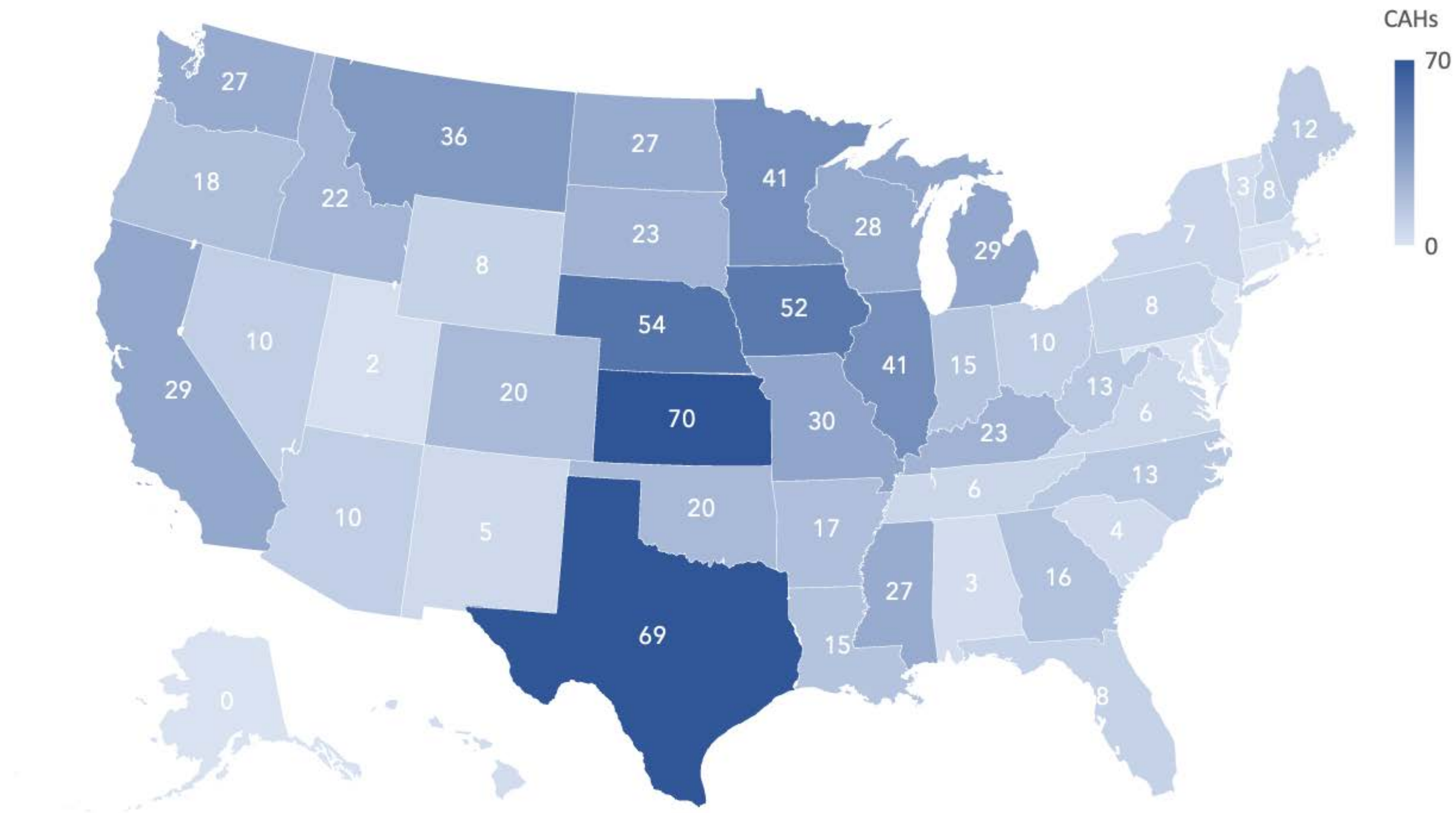
Consolidated Appropriations Act, 2021

Analysis and Findings

Lilypad®

CAHs with Provider-based RHCs by State

Map A: State Comparison of CAHs that Own Provider-based Rural Health Clinics (2019)



890

In 2019, there were approximately **1,350** Critical Access Hospitals in the US. Among those organizations, **890** owned and operated at least one Provider-based Rural Health Clinic. Collectively, these CAHs owned **1,649** PB-RHCs. The distribution of PB-RHCs largely reflected the distribution of CAHs across rural America, with a large percentage of PB-RHCs located in the Midwest.

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Data Source: December 2020 Medicare Cost Report release for hospital and RHC fiscal year 2019; and December 2020 CMS Provider of Services (POS) data file. Refer to the Data Management slide of this document for more details.

State Analysis: CAHs with PB-RHCs

Table A: Top 5 States by Count of CAHs with PB-RHCs

STATE	CAHs w RHCs	CAHs	Pct
Kansas	70	83	84%
Texas	69	86	80%
Nebraska	54	64	84%
Iowa	52	82	63%
Minnesota	41	77	53%
Illinois	41	51	80%

Table B: Top 5 States* by Percentage of CAHs with PB-RHCs

STATE	CAHS w RHCs	CAHs	Pct
Mississippi	27	31	87%
Missouri	30	35	86%
Nebraska	54	64	84%
Kansas	70	83	84%
Kentucky	23	28	82%

* Note: *State must have greater than 10 CAHs to be included in the analysis*

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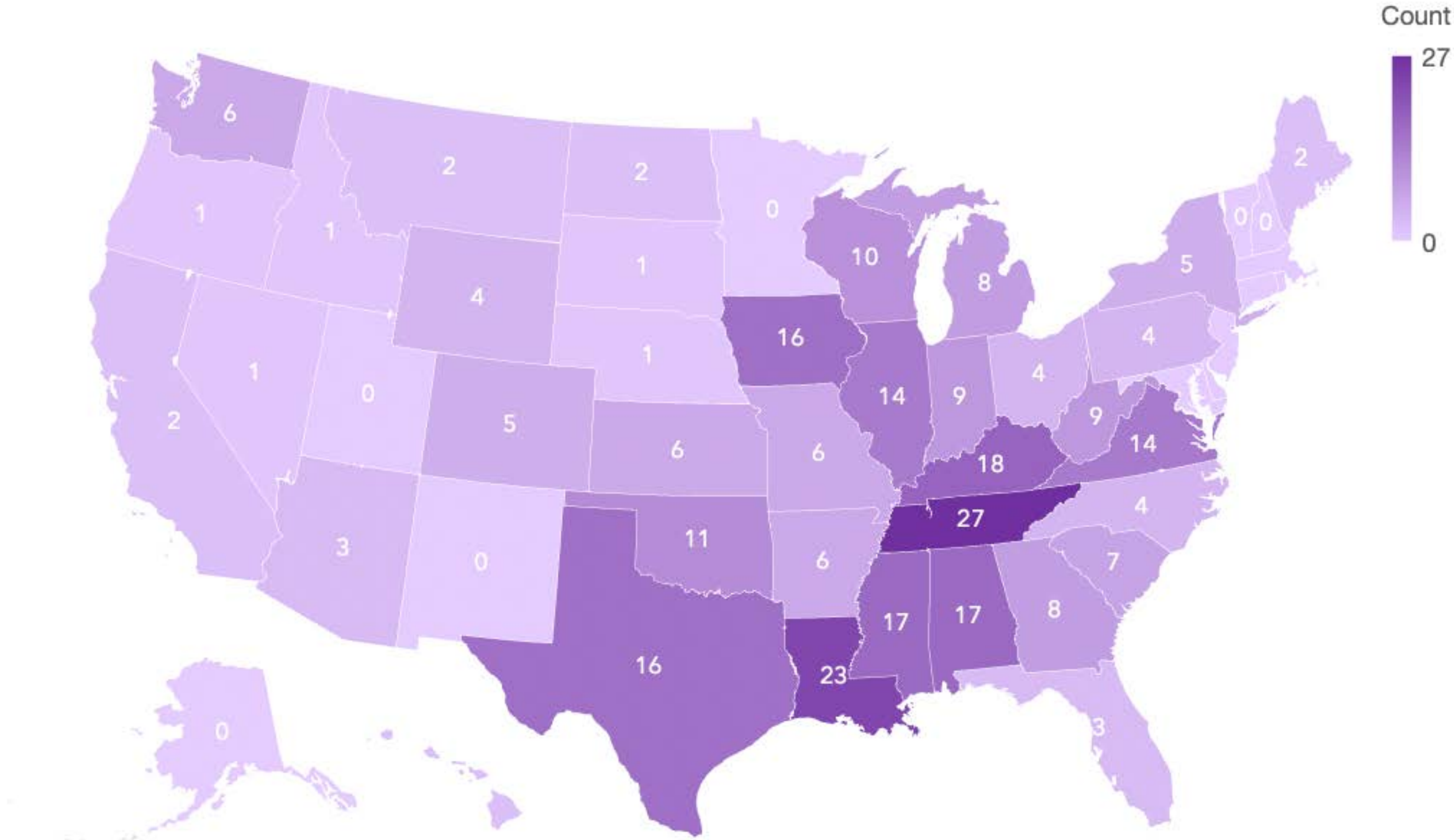
RHCs Established After 12/31/2019 by State

Map B: State Comparison of RHCs Established in CY 2020



295

The Act established a retroactive grandfathering provision to be effective December 31, 2019. In the time between the grandfathering date established in the Act and the enactment date of the legislation, **295** primary care practices had been newly designated as RHCs. Among that cohort, **142** were clinics subject to the capped rate and **153** were eligible for an uncapped rate. Overall, RHCs in **38** states were established after December 31, 2019.

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Data Source: December 2020 CMS Provider of Services (POS) data file. Refer to the Data Management slide of this document for more details.

RHCs Established After 12/31/2019 by Month

Table C: RHCs Established during CY 2020

MONTH	CAPPED	UNCAPPED	TOTAL
January 2020	4	14	18
February 2020	8	8	16
March 2020	17	11	28
April 2020	11	20	31
May 2020	12	18	30
June 2020	15	25	40
July 2020	10	18	28
August 2020	27	13	40
September 2020	18	12	30
October 2020	8	8	16
November 2020	11	5	16
December 2020	1	1	2
Total	**142**	**153**	**295**

The Consolidated Appropriations Act of 2021 set a retroactive grandfather date of December 31, 2019 for Provider-based RHCs (PB-RHCs) which are RHCs owned and operated by hospitals with fewer than 50 beds.

There were **153** new PB-RHCs established in 2020 and unless a legislative fix passes, those clinics will be subject to the $100.00 Upper Payment Limit (UPL) starting on April 1, 2021

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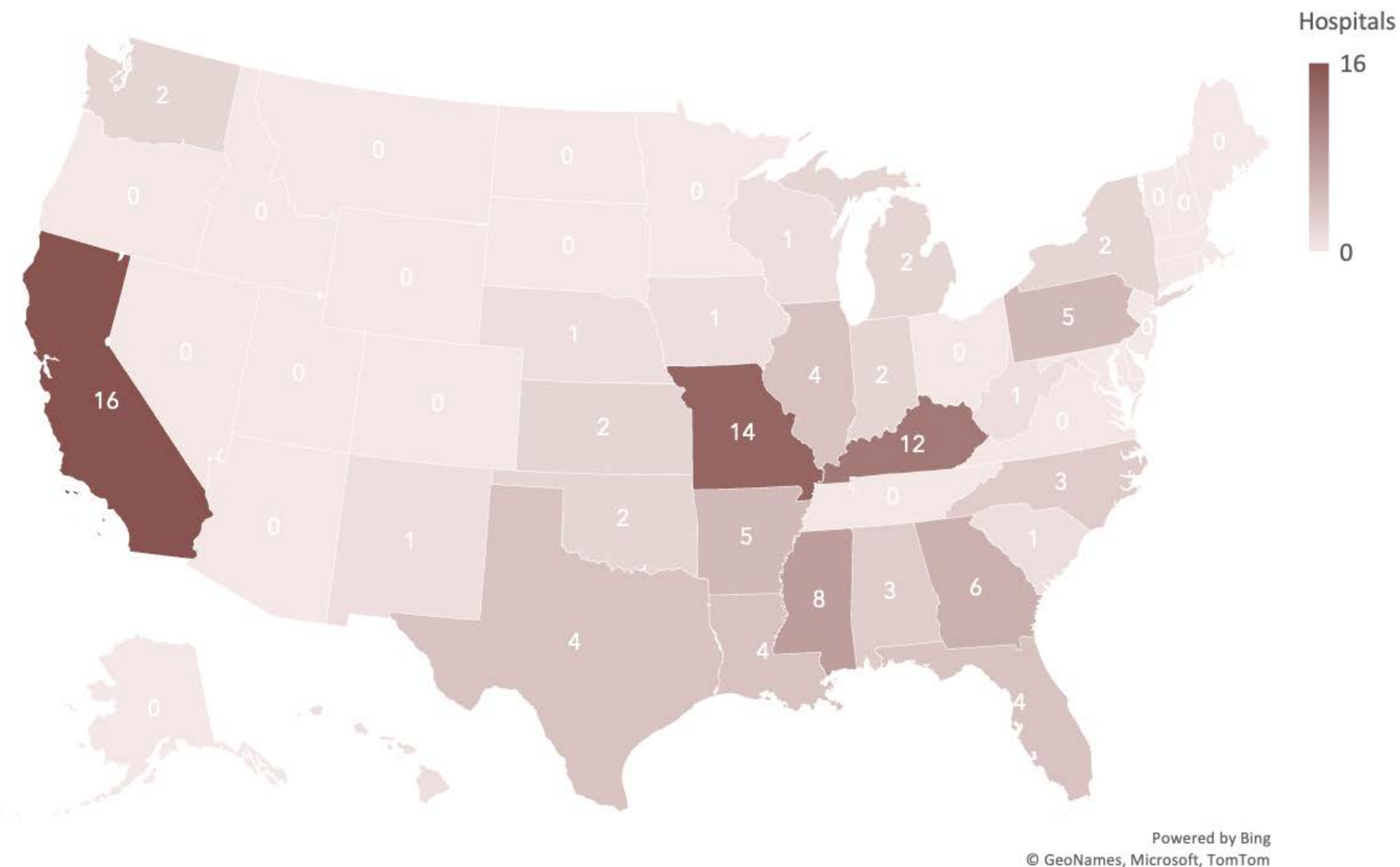
Data Source: December 2020 CMS Provider of Services (POS) data file. Refer to the Data Management slide of this document for more details.

Hospitals with 50+ Beds with RHCs by State

Map C: State Comparison of Hospitals with Greater than 50 Beds that Own RHCs



107

While the majority of hospital-owned RHCs are operated by Critical Access Hospitals and PPS hospitals with fewer than 50 beds , there are **249** RHCs in the US that are owned by **107** hospitals with greater than 50 beds representing **26** states. Below is a list of the Top 5 states with the count of hospitals with 50 or more beds that own RHCs:

STATE	Hospitals
California	16
Missouri	14
Kentucky	12
Mississippi	8
Georgia	6

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RHCs with Cost Per Visit Rates >$250

Table D: Summary All RHC Cost Per Visit Rates with $250 Threshold (FY 2019)

PAYMENT	>$250	<$250	TOTAL
Capped Rate	115	1,235	1,350
Uncapped Rate	1,085	1,819	2,904
Total	**1,200**	**3,054**	**4,254**

In FY 2019, nearly three-quarters of all RHCs had a per-visit cost less than $250.00 ***(3,054** of **4,254** RHCs or **72**%)*

*Note that **4,254** RHCs had complete, accurate and traceable cost report submissions*

1,200

Prior to the Act, PB-RHCs were eligible for an **uncapped** payment rate while RHCs that are owned and operated by hospitals with 50 beds or greater, as well as Independent RHCs, were subject to a **capped** per visit payment rate.

The relevant threshold of analysis for RHC Cost per Visit rates is **$250.00** given the current distribution of rates across the 4,254 RHCs and the projected per-visit reimbursement levels established in the RHC Modernization section of the Act.

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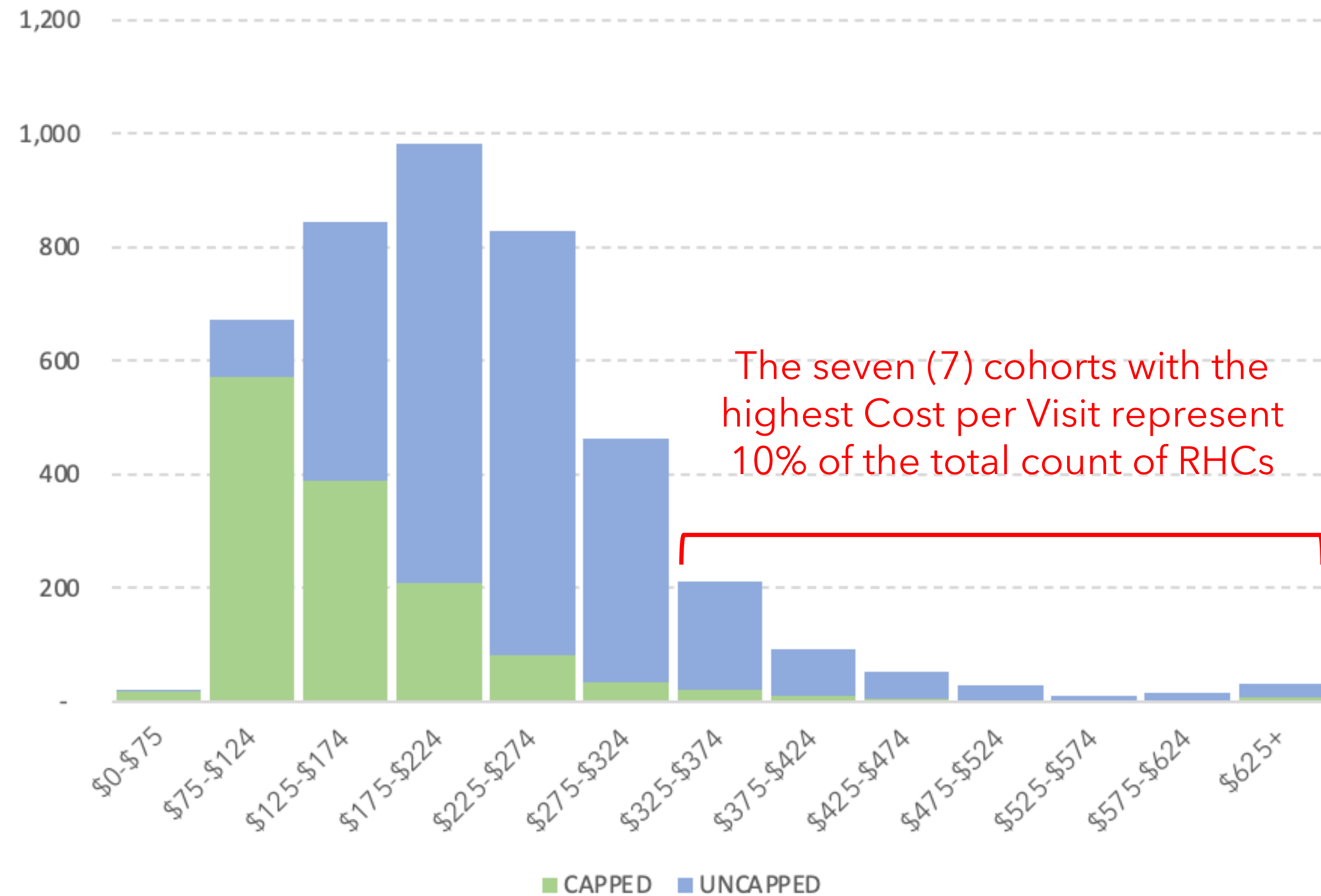
RHC Cost Per Visit Rate Bands



90%

Chart A displays cohorts based on cost per visit rates calculated as Total Costs divided by Total Visits. We constructed 13 bands based on the cost per visit rates for all RHCs for FY 2019. This analysis includes all RHCs (Independent and Hospital-owned) and excludes those clinics whose Medicare cost reports contained material errors, omissions or irregularities (n=293). For each band we calculated its percentage of total RHCs.

In FY 2019 for the 4,254 RHCs that had complete, reliable and traceable Medicare cost report submissions, **90%** of RHCs report a Cost per Visit rate lower than $325

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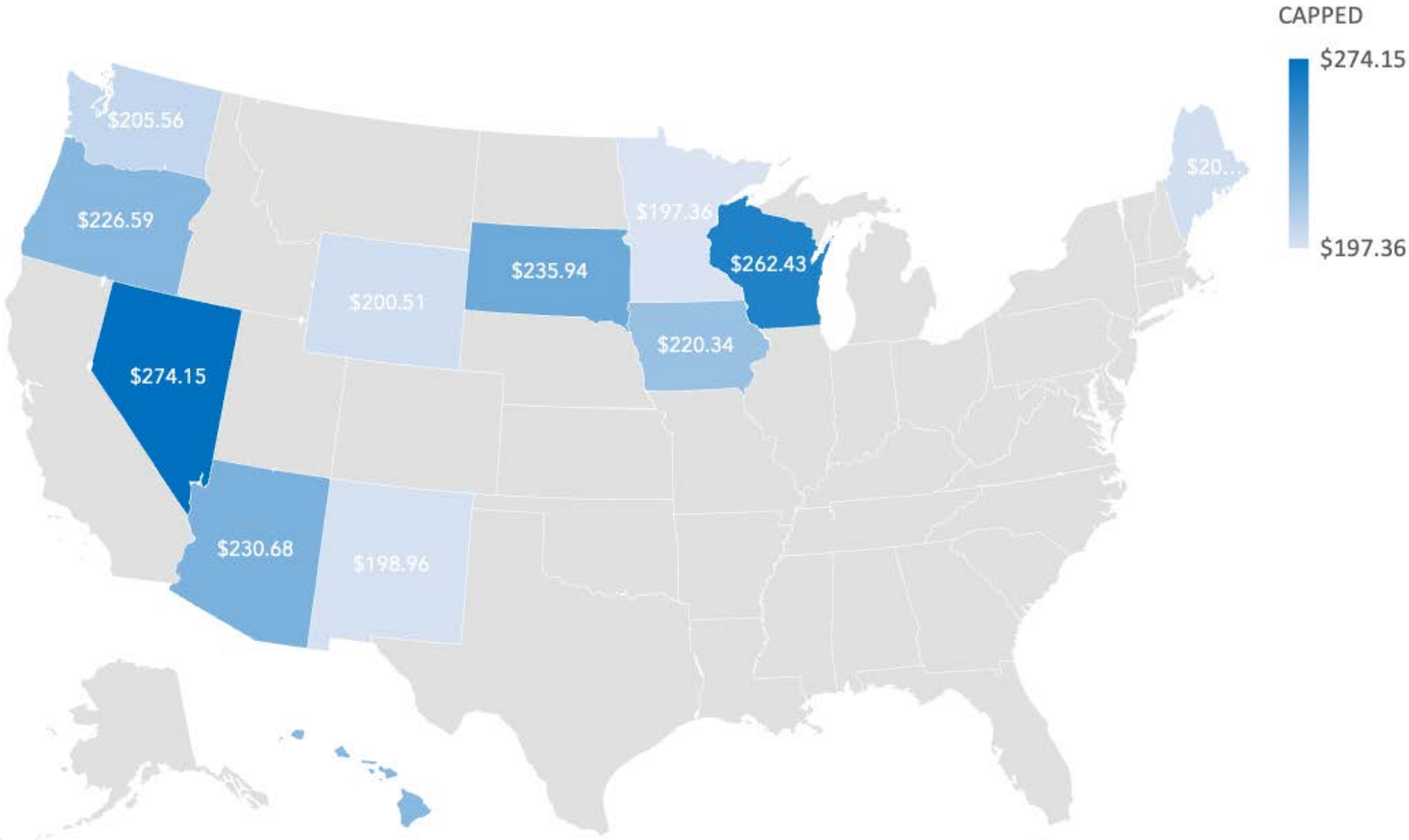
States with RHCs Subject to Capped Rate with Average Cost Per Visit >$190

Map D: States with RHCs subject to Capped Rate with Average Cost per Visit Greater than $190



In 2028, the maximum per visit rate rate for RHCs will be **$190.00** with an annual MEI increase in subsequent years.

12

In FY 2019, **12** states had an average Cost per Visit rate greater than $190 for their RHCs that were subject to a capped rate. RHCs that are owned and operated by hospitals with fewer than 50 beds are eligible for an **uncapped** payment rate while RHCs that are owned and operated by hospitals with 50 beds or greater, as well as Independent RHCs, are subject to a **capped** per visit payment rate.

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Data Sources and Management

This report utilizes the CMS **December 2020 Medicare Cost Report** data release for FY 2019 performance analysis and the CMS **December 2020 Provider of Services** data release for RHC characteristics and enrollment summaries

Medicare Cost Report Data Files
Provider of Services Data Files

Lilypad warehouses Medicare Cost Reports for every Rural Health Clinic (RHC) in the United States and analyzes both provider-based and independent clinic reports.

As part of the data management process, we evaluate the integrity of each Cost Report to determine if the data furnished by CMS are complete and accurate. Cost Reports that violate our 29 proprietary integrity checks are handled separately to prevent erroneous data from corrupting the final analyses. As a result, each organization’s Cost Report data are evaluated on a field- by-field basis and data sourcing for our analyses are selected only if our integrity analysis confirms that the data are valid and reliable.

Cost Reports with omissions or errors for integral data elements are considered “Incomplete" and may not be included in certain analyses. Some selected data from these incomplete Cost Reports may be used in our analyses, or depending upon our assessment, they may be excluded entirely.

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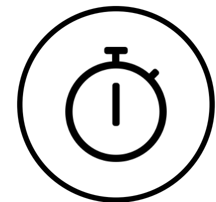
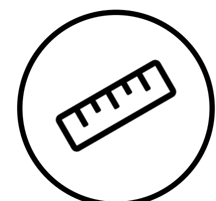
Data Considerations

Source Data Integrity. Both the CMS Provider of Services (POS) and Medicare Cost Report data files contain raw data that are made publicly available for the purpose of research and analysis. These data files reflect the source data submitted to CMS by hospitals and clinics, and are subject to data errors, omissions and inconsistencies. In all instances Lilypad has made efforts to identify, resolve, eliminate and document material errors. **This may result in some RHCs being excluded from this report's analyses**.



Timing and Synchronicity. RHCs operate with a range of fiscal year start dates. Designations and re-designations occur continuously. To harmonize these phenomena, Lilypad uses the fiscal year date on the Medicare Cost report as the time frame basis; in the case of this analysis, we used FY 2019 for every RHC. As indicated, Lilypad aggregates multiple cost reports for RHCs representing more than one parent organization. **This may result in certain summary values differing from other publicly-available findings**.



Cost Report Preparation and Compliance. The quality and completeness of Medicare cost report preparation is highly variable across different organizations. To address this variation, Lilypad implements 29 data integrity checks on every electronic cost report. Material data integrity check errors may result in some RHC cost reports being excluded from certain analyses. In addition, organizations may elect to consolidate multiple RHCs yet fail to report the identities of each RHC. Lilypad attempts to establish RHC relationships between the POS and Medicare cost report data files. **This may result in non-material variances in RHC counts and aggregated reimbursement values across different analyses in this report**.

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Lilypad is a Maine-based analytics firm that provides mobile and web-based applications for rural primary care practices. We adhere to a core business principle that accountable physicians/clinical leaders and administrators require sound data and simple, innovative tools to be successful in their roles within the emerging value-based care delivery environment.

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