Appropriations Act of 2021—and Boy is it a Doozy

Late in December, Congress passed the Appropriations Act of 2021, which was then signed by the President even later. It includes continued appropriations, some Medicare extenders, some wording related to the paycheck protection loans, added dollars and rules for the provider relief funds, changes the payment caps for RHCs, made up rural emergency hospitals, and several health care provider and insurer rules around surprise billing and helping patients know what the cost of their services will be. Oh, and also stimulus funds. Point is, there's a lot wrapped up in this bill. I've read only about 1 percent of it and have summarized below even less than that. But let's get started!

RHC Payment System

Currently, RHCs are paid their full cost-per-encounter (subject to productivity), or, in the case of a free-standing RHC (not provider-based to a hospital) and an RHC provider-based to a hospital with more than 50 beds, an upper payment limit. In 2020, this upper payment limit was $86.31. It has been clear for a while that this rate needed to be raised—the Medicare Economic Index (MEI) increases each year have not kept up with inflation. When the pandemic hit and RHCs were allowed to be telehealth distant site providers, the disparity of this rate was further highlighted as telehealth visits were paid at $92.

Congress has increased the upper payment limit for these RHCs in addition to subjecting new RHCs provider-based to hospitals with fewer than 50 beds to the limits listed below. For RHCs (this is you, CAHs) that as of December 31, 2019, are provider-based to hospitals with fewer than 50 beds, the cap is the greater of the rate for "services provided in 2020" and the rates below. The 2020 rate will be increased by the MEI just like the other caps. The caps are in effect for services on or after April 1, 2021.

I read this to mean if your rate was, say, $350 in 2020, but in 2021 your calculated cost-per-visit was $250, you'd receive the $250 rate rather than the $350. Your payment could still hit your cost amount but couldn't go over that amount. RHC rates follow:

- 2021 = $100
- 2021 = $113
- 2023 = $126
- 2024 = $139
- 2025 = $152
- 2026 = $165
- 2027 = $178
- 2028 = $190
- 2029 and thereafter MEI increases

Provider Relief Funds

Congress appropriated an additional $3 billion of these funds. New funds expended will go through an application process whereby the requestor will need to include a statement "justifying the need of the provider for the payment."

They also made a couple of changes to the uses of these funds.

Firstly, they're allowing for funds to be shared amongst related parties. This was always allowed, just not for the targeted funds. Now, it's allowed for both.

Secondly, they're allowing for lost revenue to be calculated based on budget-to-actual as long as the budget was established and approved before March 27, 2020. While it is really good news, it will be up to HHS to make rules around the change. For example, will it still be quarter to quarter? Can it be service line by services line? I'm guessing it will follow the established quarterly reporting and that an increase in one department will decrease the loss in another, but I'm most certainly not at the craps table for a reason.

Miscellaneous Extenders

Sequester— Due to the pandemic, the 2 percent Medicare sequester was removed for service through December 31, 2020. Congress has extended that through March 31, 2021.

Rural Community Hospital Program— This program has been extended for another five years.

Geographic Floor of One— This relates to the way Medicare physician fee schedule amounts are calculated. Medicare considers the location of the practice and calculates an index, which can be greater or less than one. For years now, though, there has been a floor amount whereby if the calculated factor was below one, one was used anyways. This policy is extended through January 1, 2024, (it had expired December 20, 2020).

Medicare Physician Fee Schedule Increases— In calendar year 2021, we will see a 3.75 percent increase (this was originally slated to be a zero percent increase for years 2020 through 2025). The increase is for calendar year 2021 **only** and will not be included in the rate increases for future years (e.g. 2022 will revert back to 2020 base rates). This increase falls under support for COVID-19, which means if you're calculating an increase in your per-unit cost for clinic visits, you will have to take out the add-on amount, as it's being paid to help cover COVID-related costs (and therefore cannot also be claimed as PRFs).

Payment to Physician Assistants— Beginning on January 1, 2022, and thereafter, payment can be made directly to a physician assistant as opposed to the employer.

Attending Physicians for Hospice Services— If the attending physician for a hospice patient is an RHC physician and not employed directly by the hospice, starting January 1, 2022, these services can be billed as RHC services and payment is the all-inclusive rate (AIR). FQHC physician can also receive their PPS payment for these services beginning with services on or after January 1, 2022.

DSH Reductions—The disproportionate share payments you may get from the state were set to have reductions in 2021 through 2023; however, Congress has eliminated those reductions. Keep in mind these were meant to pay for the affordable care act, so I like to call this one "how do we prove the ACA is unsustainable? We take away what we used to paid for it."

State Supplemental Payments—Speaking of other financing mechanisms, Congress has mandated reporting requirements for states that pay out supplemental payments to their providers. CMS is to have their plan ready for states to submit their reports by October 1, 2021. While the reporting shouldn't fall on the hospitals' shoulders, it's possible total supplemental payments could decrease because of the reporting.

Paycheck Protection Act Changes

This section of the Act does a few things, including adding items you can spend the funds on (like sneeze barriers) and the covered period for these loans.

The added items probably do not affect hospitals as much as they would, say, a restaurant, since hospitals have the added items already covered by provider relief funds. But a restaurant could now use the funds to put up plexiglass barriers between my table and the next.

The covered period was **either** 8 weeks or 24 weeks and recipients of these funds could choose which. However, now you can choose any amount of time **between** 8 and 24 weeks (start date is still when the loan was approved). For example, you could apply for a 9.245 week period for forgiveness. Those of you who have not requested forgiveness of your loan will want to focus on costs and a time period barely covering the loan and could not be claimed as PRFs.

The Act also allows for eligible recipients who either did not have the full amount forgiven or requested less than the maximum amount they were originally approved for, the ability to request back up to the original approved amount.

Entities may also be eligible for a second draw loan. The second draw loans are capped at $2,000,000. To qualify for the second draw, a recipient must have fewer than 300 employees and be able to show at least a 25 percent reduction in gross receipts during any quarter of 2020. My guess is this means you hospitals and clinics do not qualify for the second round.

Rural Emergency Hospitals (REH)

Well, it happened. Congress has authorized rural emergency hospitals as an option for critical access hospitals. If you're interested in giving up your inpatient services and focusing on outpatient only paid at outpatient hospital rates (PPS) plus 5 percent, this may be the program for you! Actually, the add on would be 4 percent (80 percent of 5 percent) because that's only on the amount Medicare pays, not the patient. The program is slated to start January 1, 2023.

I lied a *little* about the payment—there's also a monthly additional facility payment amount, calculated using 2019 data. It compares the CAH payment to what they would have been paid if they were paid under PPS and averages a "per CAH amount" (e.g. divides that by the number of CAHs). That add-on amount will be paid in monthly installments in 2023; in 2024 and thereafter, it's inflated forward using the MEI.

Essentially, they are paying you not to provide inpatient services while also paying a PPS hospital down the road to provide the same services. One day you'll see me in the streets explaining CAHs should be expanded (always at capacity) rather than shrunk. We're already paying for the cost; let's use that! It's like paying the cost of a complete gym at home and then saying if you don't use that gym, we'll continue to pay you for the cost of that gym and the monthly fee at the gym we want you to use.

The average per-patient length of stay for these facilities is 24 hours, meaning they can keep an observation patient, but the patient must be discharged or transferred within 24 hours.

The REH must have a transfer agreement with a level I or II trauma center.

Although I directed this at CAHs, really any hospital that is rural with fewer than 50 beds could choose this option.

You can provide ambulance services and skilled nursing services (not swing bed, although frankly it is mute on swing bed).

Closing

We at DZA wish you all a great new year. May we focus on the good of 2020 and make a better 2021 for us all. If you have question, my direct line is 509.321.9485.