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117TH CONGRESS
1ST SESSION

H. R. 5883

To establish a value-based care program to exempt eligible rural health clinics from certain payment limitations, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 4, 2021

Ms. SEWELL (for herself and Mr. SMITH of Nebraska) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To establish a value-based care program to exempt eligible rural health clinics from certain payment limitations, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Rural Health Fairness in Competition Act''.

SEC. 2. MEDICARE RURAL HEALTH CLINIC VALUE-BASED CARE PROGRAM.

(a) MEDICARE RURAL HEALTH CLINIC VALUE-BASED PROGRAM.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Health and Human Services (hereinafter referred to as the ''Secretary'') shall establish a Medicare Rural Health Clinic Value-Based Care Program under which an eligible clinic (as defined in subsection (b)(1)(B)) shall be exempt from any limitation on payment established under section 1833(a) of the Social Security Act (42 U.S.C. 1395l(a)) if such clinic submits reports required under subsection (b)(2).

(b) PROGRAM REQUIREMENTS.—

(1) APPLICATION.—

(A) IN GENERAL.—The Secretary shall establish a process by which an eligible clinic may apply for participation in the program described in subsection (a).

(B) ELIGIBLE CLINIC.—For purposes of this section, an eligible clinic is a rural health clinic (as defined in section 1861(aa)(2) of the Social Security Act (42 U.S.C. 1395x(aa)(2))) that—

(i) is owned or operated by a hospital, including a critical access hospital, with less than 50 beds;

(ii) is enrolled under section 1866(j) of such Act (including temporary enrollment during the emergency period described in section 1135(g)(1)(B) of such Act); and

(iii) meets the reporting requirements established under paragraph (2); or

(iv) is participating in a Medicare quality program, including the National Committee for Quality Assurance Patient-Centered Medical Home Recognition Program, or another value-based care program as determined by the Secretary.

(2) REPORTS.—

(A) IN GENERAL.—Not later than the end of the first calendar year in which an eligible clinic participates in the program described under subsection (a), and annually thereafter, each eligible clinic shall submit to the Administrator of the Centers for Medicare & Medicaid Services a report on the quality measures described in subsection (c)(1).

(B) SUBSEQUENT YEARS.—Not later than the end of the third calendar year in which an eligible clinic has participated in the program described under subsection (a), and annually thereafter, such eligible clinic shall submit to the Administrator a report containing the information required under subparagraph (A), and may submit additional information with respect to performance measures (described in subsection (c)(2)) as the Administrator may require.

(C) PUBLICATION OF REPORTS.—Not later than 90 days after the last day of each calendar year for which an eligible clinic has submitted a report pursuant to this paragraph, the Administrator shall make such report publicly available on the website of the Centers for Medicare & Medicaid Services.

(3) DURATION.—The exemption from payment limitations under section 1833(a) shall apply for as long as an eligible clinic meets the requirements set forth in this subsection.

(c) SELECTION OF QUALITY MEASURES; PERFORMANCE STANDARDS.—

(1) SELECTION OF QUALITY MEASURES.—Not later than 90 days after the date of the enactment of this Act, the Secretary shall select quality measures for purposes of the reporting requirements under subsection (b)(2). In selecting quality measures, the Secretary shall select such measure that are—

(A) used in existing programs;

(B) focused on primary care; or

(C) based on input from stakeholders.

(2) PERFORMANCE STANDARDS.—Not later than 2 years after the date of the enactment of this Act, the Secretary may establish performance measurements standards for purposes of the reporting requirements under subsection (b)(2).

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