RURAL HEALTH TRANSFORMATION

PROVIDER PAYMENTS FACT SHEET

Category B Funding for Provider Payments

Funding for Provider Payments, as described in Use of Funds Category B of the Notice of Funding Opportunity (NOFO) Use of Funds section, are **payments to healthcare providers for the *provision of healthcare items or services* not paid by insurers and/or other programs**. Provider Payments should tie directly to the strategic goals of the RHT Program, directly support initiatives described in the State's Rural Health Transformation Plan, be sustainable beyond the life of the program, and should not be duplicative of existing funding. Category B Provider Payments capture payment for services provided and are not intended to be used to pay for infrastructure needed to provide the service (e.g., intended to be used to pay for a telehealth encounter and not to pay for the computer equipment, software, and/or internet access necessary to provide telehealth services).

Provider Payments must be consistent with the RHT Program authorizing statute, Section 71401 of Public Law 119-21, and with the NOFO, including with the restrictions described in the NOFO funding policies and limitations. Additionally, allowable funding under Use of Funds Category B is limited to 15% of the total funding CMS awards a State in a given budget period.

Use of Category B Funds for Provider Incentive Payments

Category B funds may be used for provider incentive payments for quality of services provided (e.g. measures reflecting quality of care or clinical outcomes) or as part of an alternative payment model (APM). Use of Category B funds for provider incentive payments may include, for example, payments incentivizing providers to: report quality metrics and improve quality of care, reduce health care costs, and shift care to lower-cost settings as appropriate.

Note that while incentive payments to providers under Category B are subject to the 15% cap, funds used for the development of APMs, such as model infrastructure or technical assistance for model implementation, would fall under Use of Funds categories other than Category B and not be subject to the 15% cap. States can consider leveraging learnings from the CMS Innovation Center and the Health Care Payment Learning and Action Network (LAN) framework for reference on designing payment model frameworks that focus on quality and reducing total cost of care.[1]

[1] NOTE: This document contains links to non-United States Government websites. We are providing these links because they contain additional information relevant to the topic(s) discussed in this document or that otherwise may be useful to the reader. We cannot attest to the accuracy of information provided on the cited third-party websites or any other linked third-party site. We are providing these links for reference only; linking to a non-United States Government website does not constitute an endorsement by CMS, HHS, or any of their employees of the sponsors or the information and/or any products presented on the website. Also, please be aware that the privacy protections generally provided by United States Government websites do not apply to third-party sites.

Restrictions on Use of Category B Funds

There are two primary considerations when evaluating whether Provider Payments are allowable:

- **Program Duplication (universal to all grant programs):** Funding under the RHT Program does not supplant or duplicate existing funding sources and government financing streams that were either planned or already paying for healthcare items and services.
- **Sustainability of RHT Program Initiatives:** Use of funds must be consistent with RHT Program goals that initiatives are sustainable past the program period.

Provider Payments are intended for the provision of items and services not currently paid by insurance or other sources and cannot be used to enhance payment rates for currently billable items. If the item or service is not an existing billable item within the State (via Medicaid or commercial payment), it may be an allowable Provider Payment when tied to the scope of an RHT Program initiative. For example, allowable Provider Payments may be issued to a clinician providing non-reimbursed services or as payment for per member per month (PMPM) services.

Category B Provider Payments must not supplant current State funds; however, funding may be used in existing State programs and initiatives where the RHT Program funding is specifically being used to pilot new services or fund new portions of the Program (e.g., new beneficiary populations, new types of services, new geographic areas, etc.) that are then sustained beyond RHT Program through Medicaid or another payer. For all proposed uses of funds under Category B, States should consider the sustainability of initiatives past the RHT Program period.

Table 1

Examples of allowable and unallowable funding under Use of Funds Category B

Allowable Use of Category B Funds for Provider Payments	Provider Payments Potentially Allowable Under an Alternative Funding Category	Unallowable Use of RHTP Funds
• Payment to providers for nonreimbursed items and services, including services provided on a PMPM basis. • Bonus payments to providers for quality of care and process measures. • Payments to providers for performance in APMs tied to outcomes. • Payments to providers through new Medicaid Health Home Quality Incentive Payments and Medicaid Primary Care APM Incentive Payments.	• Payments to providers for relocation expenses, travel subsidies, transit costs, lodging, per diem payments, and recruitment and retention incentives. • Funding for the development of innovative models of care and APMs, such as model infrastructure or technical assistance for model implementation (e.g., system updates to support quality measurement and reporting, support for clinical workflow and operational change management, other). • Payments to allied health professionals for non-clinical services (e.g., peer recovery coaches, medical assistants, etc.)	• Enhanced payment rates for currently billable services. • Payments to employees or clinics not tied to specific quality improvements or an initiative within the scope of the RHT Program. • Uncompensated care that is not tied to a specific initiative within the State's RHT Plan.