



**Medicare Critical Access Hospital
Astria Health Custom Version**

**KEY CONCEPTS OUTLINE
Module 13: Basic Reimbursement Principles for
Rural Health Clinic Services**

I. The All-Inclusive Rate (AIR)

- A. A rural health clinic (RHC) is paid an all-inclusive rate (AIR) for each qualifying visit and covered items and services provided incident to that visit with a qualified RHC practitioner. <See *Medicare Benefit Policy Manual*, Chapter 13 § 70.1; see *Medicare Claims Processing Manual*, Chapter 9 § 20.1>

In general, the AIR is an interim payment rate, specific to the RHC, estimating the RHC's average costs for services and supplies related to a qualifying visit as reported on the prior year's cost report. At the end of the year, these interim payments are reconciled based on a final cost report for the year.

B. Submission of Cost Report and Reconciliation

1. An RHC must submit an annual Medicare cost report with allowable costs, visit data and other significant statistical information to their MAC to determine their final payment rate, to reconcile interim payments and determine a new interim visit rate. <See *Medicare Benefit Policy Manual*, Chapter 13, §§ 70.1, 80.1>
2. With prior approval of the MAC, an RHC with more than one site may file a consolidated cost report and may not revert to individual cost reporting without prior approval of the MAC. <See *Medicare Benefit Policy Manual*, Chapter 13 § 80.2>

- a. New RHCs enrolled on or after January 1, 2021 are only permitted to file consolidated cost reports with non-grandfathered RHCs (i.e., independent RHCs, new provider-based RHCs, and existing RHCs that are provider-based to hospitals with more than 50 beds). Grandfathered provider-based RHCs will be discussed later in this module. <See *Medicare Benefit Policy Manual*, Chapter 13 § 80.2>

3. Reconciliation

- a. The MAC determines a final total payment amount for the cost report period and compares it to the AIR payments made to the RHC for the same period and the difference is considered the reconciliation amount. <42 *C.F.R.* 405.2466(b)(2)>

Final total payment amount =
 [(Average Cost per Visit X # of Medicare Visits) – Medicare deductibles] X 80%

Average Cost per Visit* = Total Allowable Costs/Total Visits

*subject to productivity, reasonableness, and payment limitations

- i. In general, the final total payment amount is the Medicare share of costs less deductibles incurred by Medicare patients multiplied by 80%. <42 *C.F.R.* 405.2466(b)(1)>
- b. If the reconciliation amount is an underpayment, the MAC pays the RHC in a lump sum or if an overpayment, the RHC may repay in a lump sum or through offset against future payments. <42 *C.F.R.* 405.2466(d)>

C. Calculation of the RHC Specific AIR

1. The AIR is calculated by the MAC based on the RHC's allowable costs, as reported on the annual cost report, divided by the total number of visits for all patients during the cost reporting period. <See *Medicare Benefit Policy Manual*, Chapter 13 § 70.1>
 - a. The AIR is subject to a payment limitation, discussed in more detail later in this module.
2. If an RHC is in its initial reporting period, the clinic submits a budget that estimates the allowable costs and number of visits expected during the first reporting period. <See *Medicare Benefit Policy Manual*, Chapter 13 § 80.1; see *Medicare Claims Processing Manual*, Chapter 9 § 20.2>

- a. The MAC calculates an interim payment rate based on the expected expenses and volume of visits.

D. Allowable Costs

- 1. Allowable costs are reasonable and necessary costs incurred by the RHC for practitioner compensation, overhead, equipment, space, supplies, personnel, and other costs incident to the delivery of RHC services. <See *Medicare Benefit Policy Manual*, Chapter 13, § 70.1>

Medicare principles of reimbursement for allowable costs are stated in 42 CFR 413 and in the Medicare Provider Reimbursement Manual, 15-1.

Information on cost report forms and the reporting process can be found in the Medicare Provider Reimbursement Manual, 15-2.

- a. Costs for non-RHC services, including space, equipment, supplies, facility overhead, and personnel, must be excluded from allowable costs reported on the cost report. <See *Medicare Benefit Policy Manual*, Chapter 13 § 60>
 - i. Non-RHC services include items or services that are not usually covered under the Medicare program (e.g., self-administered drugs, routine physical exams), the technical component of diagnostic tests, laboratory services, durable medical equipment, and practitioner services for non-RHC visits. <See *Medicare Benefit Policy Manual*, Chapter 13 § 60.1>
- b. An RHC can claim bad debt for unpaid deductible and coinsurance if the RHC establishes reasonable collection efforts. <See *Medicare Benefit Policy Manual*, Chapter 13 § 80.1>
 - i. Coinsurance and deductibles that are waived due to statutory waiver or a sliding fee scale may not be claimed as bad debt or allowable costs. <See *Medicare Benefit Policy Manual*, Chapter 13 § 80.1>
- c. Influenza, pneumococcal, and COVID-19 vaccines and their administration are reported on the cost report but are excluded from the AIR calculation and instead paid at 100 percent of reasonable cost. <See *Medicare Benefit Policy Manual*, Chapter 13 § 80.1; 42 *C.F.R.* 405.2466>

- i. Monoclonal antibody products for COVID-19 and their administration are paid at 100 percent of reasonable cost through the cost report, similar to COVID vaccines, until the end of the calendar year in which the Emergency Use Authorization (EUA) declaration for the product ends, after which they are paid through the AIR. <See *Medicare Benefit Policy Manual*, Chapter 13 § 80.1>

E. Total Visits

1. The MAC will calculate the AIR based on the total number of visits as reported on the cost report, adjusted by an established productivity standard (i.e., expected number of visits) if the number of physician and non-physician practitioner (NPP) visits does not meet the established productivity standard. <See *Medicare Benefit Policy Manual*, Chapter 13 § 80.4>
 - a. The total number of visits includes visits for all patients, not just Medicare patients, and includes visits by physicians, non-physician practitioners (NPPs), clinical psychologists, clinical social workers, and visiting nurse visits. <*Provider Reimbursement Manual, Part 2*, Chapter 29 § 2907.1; Worksheet B Visits and Overhead Costs for RHC/FQHC Services>
2. Productivity Standards
 - a. Productivity standards only apply to physician and NPP services. The number of physician and NPP visits included in the total is the greater of the actual number of physician/NPP visits or the combined physician/NPP productivity standard. <*Provider Reimbursement Manual, Part 2*, Chapter 29 § 2907.1; Worksheet B Visits and Overhead Costs for RHC/FQHC Services>
 - i. To get the combined physician/NPP productivity standard, the number of physician full-time equivalents (FTEs) are multiplied by 4,200 and the number of NPP FTEs are multiplied by 2,100 and the results are combined. <See *Medicare Benefit Policy Manual*, Chapter 13 § 80.4; Worksheet B Visits and Overhead Costs for RHC/FQHC Services>
 - ii. To determine the number of FTEs, count time providers spend seeing patients or scheduled to see patients, but do not include administrative time. <See *Medicare Benefit Policy Manual*, Chapter 13 § 80.4>
 - iii. Physician services provided on a short-term or irregular basis purchased under an agreement are not subject to productivity standards and instead are subject to what Medicare would otherwise pay under the Physician Fee Schedule. <See *Medicare Benefit Policy Manual*, Chapter 13 § 80.4>

- b. The MAC has discretion to make an exception to the productivity standards in individual circumstances. <See *Medicare Benefit Policy Manual*, Chapter 13 § 80.4>
 - i. During the COVID-19 Public Health Emergency (PHE), CMS allowed MACs to proactively grant exceptions to productivity standards to RHCs who experience disruptions in staffing and services due to the PHE. RHCs should contact their MAC for further direction if the RHC anticipates needing an exception to the productivity standards. <COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing, updated 08/26/2020; *MLN Matters SE20016*, revised January 13, 2022>

II. National Payment Limitation and Exceptions

A. National Per Visit Payment Limit

1. The RHC specific AIR is subject to a national per visit payment limit, unless the RHC is considered grandfathered. <See *Medicare Benefit Policy Manual*, Chapter 13 §§ 70.2.1, 70.2.2>

The Consolidated Appropriations Act of 2021 made updates to the RHC per visit payment limit and provided an alternate methodology for the per visit payment limit for grandfathered RHCs effective April 1, 2021. For more information on the national payment limit prior to April 1, 2021, see the *Medicare Benefit Policy Manual*, Chapter 13 § 70.2.

2. An RHC, that is not grandfathered, receives the *lesser of* their RHC specific AIR or the national per visit payment limit. <See *Medicare Benefit Policy Manual*, Chapter 13 § 70.2.1>
3. The types of RHCs not grandfathered and subject to the national per visit payment limit are:
 - a. Independent RHCs (stand-alone or freestanding clinics);
 - b. RHCs enrolled with Medicare on or after January 1, 2021; and
 - c. RHCs that are provider-based to a hospital with 50 or more beds. <See *Medicare Benefit Policy Manual*, Chapter 13 § 70.2.1>

4. The national per visit payment limit is a set dollar figure each calendar year through CY2028 and beginning in CY2029 the payment limit for each subsequent year will be updated by the percentage increased in the Medicare Economic Index (MEI) for the applicable year. <See *Medicare Benefit Policy Manual*, Chapter 13 § 70.2.1>
 - a. The national per visit payment limit is applicable per calendar year so RHCs with cost report periods (i.e., fiscal years) that do not match the calendar year will have different payment limits during their fiscal year.

Per Visit Payment Limits:

- CY2023 - \$126 per visit
- CY2024 - \$139 per visit
- CY2025 - \$152 per visit
- CY2026 - \$165 per visit
- CY2027 - \$178 per visit
- CY2028 - \$190 per visit

B. Grandfathered RHCs

1. A grandfathered RHC is an RHC that is provider-based and meets the following requirements:
 - a. The RHC is provider-based to a hospital with less than 50 beds as of December 31, 2020 and the hospital continues to have less than 50 beds (not including any temporary increase pursuant to a waiver during the COVID-19 PHE) and:
 - (i) Was enrolled in Medicare as of December 1, 2021 (including temporary enrollment during the COVID-19 PHE); or
 - (ii) Submitted an application for enrollment in Medicare (or a request for temporary enrollment during the COVID-19 PHE) received not later than December 31, 2020. <See *Medicare Benefit Policy Manual*, Chapter 13 § 70.2.2>
2. Payment to grandfathered RHCs
 - a. January 1 – March 31, 2021, payment was based on the RHC's specific AIR.
 - b. April 1 – December 31, 2021:

- (i) For grandfathered RHCs *with* an established AIR for 2020, payment was based on the *greater of*:
 - (a) The RHC specific AIR applicable for services furnished in 2020, increased by the MEI for primary care services for CY 2021; or
 - (b) The national per visit payment limit applicable to non-grandfathered RHCs in CY2021 (\$100); and
- (ii) For grandfathered RHCs *without* an established AIR for 2020, payment was based on the *greater of*:
 - (a) The RHC specific AIR applicable for services furnished in 2021, or
 - (b) The national per visit payment limit applicable to non-grandfathered RHCs in CY2021 (\$100). <See *Medicare Benefit Policy Manual*, Chapter 13 § 70.2.2.1, 70.2.2.2>
- c. For CY2022 and later, payment is based on the *greater of*:
 - (i) The RHC specific AIR for the previous year, increased by the MEI for primary care services for the applicable year (e.g., 3.8 for CY2023); or
 - (ii) The national per visit payment limit applicable to non-grandfathered RHCs for the applicable year (e.g., \$126 for CY2023). <See *Medicare Benefit Policy Manual*, Chapter 13 § 70.2.2.1, 70.2.2.2>

3. Hospital 50 Bed Limit

- a. A grandfathered RHC will lose its grandfathered status if the hospital increases its bed capacity to 50 or more beds. <See *Medicare Benefit Policy Manual*, Chapter 13 § 70.2.2>
 - (i) If a grandfathered RHC loses its grandfathered status, the RHC will become subject to the national per visit payment limit. <See *Medicare Benefit Policy Manual*, Chapter 13 § 70.2.2>
- b. During COVID-19 PHE
 - (i) For RHCs that were grandfathered, but the hospital increased bed-size during the PHE, the MACs are instructed to use the number of beds from the cost report period before the PHE until the end of the PHE. <*MLN Matters SE20016*, revises February 23, 2023; Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): CMS Flexibilities to Fight COVID-19, updated 02/24/2023>

III. Deductible and Coinsurance

A. Deductible

1. Each calendar year, a deductible is applicable to Part B services, including RHC services. <42 C.F.R. 405.2410>
 - a. For CY 2023, the Part B deductible is \$226.00.
2. Medicare payment for RHC services is made only after the beneficiary incurs the Part B deductible. <42 C.F.R. 405.2410>

NOTE: The Medicare Claims Processing Manual, Chapter 9 § 40.1 states “RHC services are subject to an annual deductible of twenty percent of charges for covered services”. This appears to be an error based on the applicable regulation that does not apply a limit to the deductible applicable to RHC services, but rather states payment is only made after the deductible is satisfied. If there are questions about how the deductible was applied to the RHC claim, the RHC should seek clarification from their MAC.

3. The RHC may collect the patient’s deductible or the portion of the patient’s deductible that has not already been met at the time of the visit. <See *Medicare Claims Processing Manual*, Chapter 9 § 40.1>
 - a. Once an RHC has billed the MAC, it may not collect or accept any additional money from the patient until the MAC notifies the RHC of how much of the deductible has been met. <See *Medicare Claims Processing Manual*, Chapter 9 § 40.1>

B. Coinsurance

1. After the deductible is met, the patient is responsible for a coinsurance amount of 20% of the remaining RHC total charges. <See *Medicare Claims Processing Manual*, Chapter 9 § 40.2; see *Medicare Benefit Policy Manual*, Chapter 13 § 90; see *MLN Booklet Rural Health Clinic*, January 2022>
2. For RHC services paid under the MPFS (i.e., CCM, PCM, BHI, CoCM, VCS, and telehealth originating site fee), the calculation of coinsurance is based on 20% of the MPFS allowed amount.

3. When an independent RHC bills the Part B MAC on a 1500 claim form for non-RHC services, the coinsurance amount is usually based on 20% of the MPFS allowed amount. For more information, see *Medicare Claims Processing Manual*, Chapter 12.
4. When a provider-based RHC (or the parent provider) bills the Part A MAC on the UB-04 claim form for non-RHC services, the coinsurance amount is based on the rules applicable to the parent provider and type of bill (e.g., TOB 0851 CAH or TOB 131 OPPTS). For more information, see the *Medicare Claims Processing Manual*, Chapter 4.

C. Exceptions to Application of the Deductible and Coinsurance

1. Certain preventive services are not subject to deductible or coinsurance based upon statutory waivers. <See *Medicare Claims Processing Manual*, Chapter 9 § 40.2; see *Medicare Benefit Policy Manual*, Chapter 13 § 90; see *MLN Booklet Rural Health Clinic*, January 2022>
 - a. Charges for services not subject to the deductible and coinsurance should not be included in the RHC visit charge to ensure deductible and coinsurance amounts are not applied. <See *Medicare Claims Processing Manual*, Chapter 9 § 70.1>
2. An RHC may waive deductible and coinsurance after a good faith determination that the patient is in financial need, if these waivers are not routinely offered and are not advertised. <See *Medicare Benefit Policy Manual*, Chapter 13 § 90.1>

IV. Calculating Patient Responsibility and Medicare Payment Amount

A. The patient's responsibility is calculated by adding:

1. Any unmet deductible amount, and
2. The amount determined by subtracting the unmet deductible from the RHC visit charge and multiplying by 20%. <See *Medicare Claims Processing Manual*, Chapter 9 § 40.2; see *Medicare Benefit Policy Manual*, Chapter 13 § 90>

B. The Medicare payment amount is calculated as follows:

1. For non-grandfathered RHCs, the *lesser of*
 - a. 80% of (the RHC specific AIR less any applicable deductible), **or**
 - b. 80% of the applicable national per visit payment limit;

2. For grandfathered RHCs, the *greater of*
 - a. 80% of (the RHC specific AIR less any applicable deductible), **or**
 - b. 80% of the applicable national per visit payment limit. <See *Medicare Benefit Policy Manual*, Chapter 13 § 70.1>
3. For separately payable preventative services not subject to the deductible or coinsurance, payment is based on 100% (rather than 80%) of the AIR, subject to the national payment limit if applicable. <See *MLN Matters SE1611*, revised January 13, 2022>

See the case studies that follow for examples pertaining to the calculation of a patient's deductible and coinsurance amounts, the AIR payment, and the related RHC payment limit.

V. Sliding Fee Scale

- A. An RHC may establish a sliding fee scale if it is applied equally to all patients. <See *Medicare Benefit Policy Manual*, Chapter 13 § 90.2>
 1. The charges for services furnished to Medicare beneficiaries must be the same as the charges for services furnished to non-Medicare beneficiaries.
 2. The payment policy must be posted so that all patients are aware of the policy.
 3. Income information must be obtained and documentation retained to determine that a patient qualified for the reduced charge.
 - a. Copies of wage statements or income tax returns are not required. Self-attestations are an acceptable means for making the determination.

Case Study 1

Facts: The MAC calculated the AIR for a grandfathered RHC to be \$220.00 in CY 2023, including the MEI adjustment for 2023. A patient presents to the RHC on February 1st with a chief complaint of pain in his right calf. The NP documents the services for a new patient level 4 (99204). No other services were provided during the visit. After examination, the patient was referred to the CAH for an ultrasound. The total charge for the RHC visit was \$245 which was billed on TOB 0711 under revenue code 0521. The patient had fully satisfied their Part B deductible prior to the visit.

NOTE: The RHC national per visit payment limit for CY 2023 is \$126.00.

Using the worksheet below, calculate the patient's total financial responsibility, the payment from Medicare, and the total payment to the RHC from the patient and Medicare.

Part B RHC Reimbursement Calculation Worksheet

Patient's Financial Liability Calculation

Total visit charge	\$	
Patient's unmet deductible amount	- \$	_____
	\$	(remaining charge)

Coinsurance (remaining charge X 20%)	\$	
Patient's unmet deductible amount	+ \$	_____
	\$	Total patient responsibility

Medicare's Reimbursement Calculation

RHC's AIR	\$	
Patient's unmet deductible amount	- \$	_____
	\$	(remaining AIR)

Payment is the **greater of**

80% of the RHC's remaining AIR	\$	
or		
80% of the per visit payment limit	\$	
	\$	_____ Medicare Payment

Total payment from the patient and Medicare = _____

Refer to *Medicare Claims Processing Manual*, Chapter 9 § 40.1.

Case Study 2

Facts: Same facts as in Case Study 1 (grandfathered RHC), except prior to the qualifying visit, the patient had partially met his CY 2023 Part B deductible (\$226.00) and had paid \$100 out of pocket towards the deductible prior to the qualifying visit.

NOTE: The RHC national per visit payment limit for CY 2023 is \$126.00.

Using the worksheet below, calculate the patient's total financial responsibility, the payment from Medicare, and the total payment to the RHC from the patient and Medicare.

Part B RHC Reimbursement Calculation Worksheet

Patient's Financial Liability Calculation

Total visit charge	\$	
Patient's unmet deductible amount	- \$	_____
	\$	(remaining charge)

Coinsurance (remaining charge X 20%)	\$	
Patient's unmet deductible amount	+ \$	_____
	\$	Total patient responsibility

Medicare's Reimbursement Calculation

RHC's AIR	\$	
Patient's unmet deductible amount	- \$	_____
	\$	(remaining AIR)

Payment is the **greater of**

80% of the RHC's remaining AIR	\$	
or		
80% of the per visit payment limit	\$	
	\$	_____ Medicare Payment

Total payment from the patient and Medicare = _____

Refer to *Medicare Claims Processing Manual*, Chapter 9 § 40.1.

Case Study 3

Facts: The MAC calculated the AIR for an independent RHC to be \$130.00 in CY 2023. An established patient presents to the RHC on March 1st with a chief complaint of an uncomplicated laceration of the thumb. The NP documents a simple laceration repair (12001). No other services were provided during the visit. The total charge for the RHC visit was \$280 which was billed on TOB 0711 under revenue code 0521. The patient had fully satisfied their Part B deductible prior to the visit.

NOTE: The RHC national per visit payment limit for CY 2023 is \$126.00.

Using the worksheet below, calculate the patient's total financial responsibility and the total payment to the RHC from Medicare.

Part B RHC Reimbursement Calculation Worksheet

Patient's Financial Liability Calculation

Total visit charge	\$	
Patient's unmet deductible amount	- \$	_____
	\$	(remaining charge)

Coinsurance (remaining charge X 20%)	\$	
Patient's unmet deductible amount	+ \$	_____
	\$	Total patient responsibility

Medicare's Reimbursement Calculation

RHC's AIR	\$	
Patient's unmet deductible amount	- \$	_____
	\$	(remaining AIR)

Payment is the **lesser of**

80% of the RHC's remaining AIR	\$
or	
80% of the per visit payment limit	\$

\$_____ **Medicare Payment**

Total payment from the patient and Medicare = _____

Refer to *Medicare Claims Processing Manual*, Chapter 9 § 40.1.

Case Study 4

Facts: Same facts as in Case Study 3 (*independent RHC*), except the patient had partially met his CY 2023 Part B deductible (\$226.00) and has paid \$126 out of pocket towards the deductible prior to the qualifying visit.

Using the worksheet below, calculate the patient's total financial responsibility and the total payment to the RHC from Medicare.

Part B RHC Reimbursement Calculation Worksheet

Patient's Financial Liability Calculation

Total visit charge	\$	
Patient's unmet deductible amount	- \$	_____
	\$	(remaining charge)

Coinsurance (remaining charge X 20%)	\$	
Patient's unmet deductible amount	+ \$	_____
	\$	Total patient responsibility

Medicare's Reimbursement Calculation

RHC's AIR	\$	
Patient's unmet deductible amount	- \$	_____
	\$	(remaining AIR)

Payment is the **lesser of**

80% of the RHC's remaining AIR	\$	
or		
80% of the per visit payment limit	\$	
	\$	_____ Medicare Payment

Total payment from the patient and Medicare = _____

Refer to *Medicare Claims Processing Manual*, Chapter 9 § 40.1.

CASE STUDIES WITH ANALYSIS

Case Study 1

Facts: The MAC calculated the AIR for a grandfathered RHC to be \$220.00 in CY 2023, including the MEI adjustment for 2023. A patient presents to the RHC on February 1st with a chief complaint of pain in his right calf. The NP documents the services for a new patient level 4 (99204). No other services were provided during the visit. After examination, the patient was referred to the CAH for an ultrasound. The total charge for the RHC visit was \$245 which was billed on TOB 0711 under revenue code 0521. The patient had fully satisfied their Part B deductible prior to the visit.

NOTE: The RHC national per visit payment limit for CY 2023 is \$126.00.

Using the worksheet below, calculate the patient's total financial responsibility, the payment from Medicare, and the total payment to the RHC from the patient and Medicare.

Part B RHC Reimbursement Calculation Worksheet

Patient's Financial Liability Calculation

Total visit charge	\$ 245.00	
Patient's unmet deductible amount	- \$ 0.00	
	\$ 245.00	(remaining charge)

Coinsurance (remaining charge X.20)	\$ 49.00	(\$245 X .20)
Patient's unmet deductible amount	+ \$ 0.00	
	\$ 49.00	Total patient responsibility

Medicare's Reimbursement Calculation

RHC's AIR	\$ 220.00	
Patient's unmet deductible amount	- \$ 0.00	
	\$ 220.00	(remaining AIR)

Payment is the *greater of*

80% of the RHC's remaining AIR \$ 176.00 (\$220 X .80)

or

80% of the per visit payment limit \$ 100.80 (\$126 X .80)

\$ 176.00 Medicare Payment

Total payment from the patient and Medicare = \$225.00 (\$49.00 + \$176.00)

Case Study 2

Facts: Same facts as in Case Study 1 (*grandfathered RHC*), except prior to the qualifying visit, the patient had partially met his CY 2023 Part B deductible (\$226.00) and had paid \$100 out of pocket towards the deductible prior to the qualifying visit.

NOTE: The RHC national per visit payment limit for CY 2023 is \$126.00.

Using the worksheet below, calculate the patient's total financial responsibility, the payment from Medicare, and the total payment to the RHC from the patient and Medicare.

Part B RHC Reimbursement Calculation Worksheet

Patient's Financial Liability Calculation

Total visit charge	\$ 245.00	
Patient's unmet deductible amount	- \$ 126.00	
	\$ 119.00	(remaining charge)

Coinsurance (remaining charge X .20)	\$ 23.80	(\$119 X .20)	
Patient's unmet deductible amount	+ \$ 126.00		
	\$ 149.80		Total patient responsibility

Medicare's Reimbursement Calculation

RHC's AIR	\$ 220.00	
Patient's unmet deductible amount	- \$ 126.00	
	\$ 94.00	(remaining AIR)

Payment is the *greater of*

80% of the RHC's remaining AIR	\$ 75.20	(\$94 X .80)
<i>or</i>		
80% of the per visit payment limit	\$ 100.80	(\$126 X .80)

\$ 100.80 Medicare Payment

Total payment from the patient and Medicare = \$250.60 (149.80 + 100.80)

Case Study 3

Facts: The MAC calculated the AIR for an independent RHC to be \$130.00 in CY 2023. An established patient presents to the RHC on March 1st with a chief complaint of an uncomplicated laceration of the thumb. The NP documents a simple laceration repair (12001). No other services were provided during the visit. The total charge for the RHC visit was \$280 which was billed on TOB 0711 under revenue code 0521. The patient had fully satisfied their Part B deductible prior to the visit.

Using the worksheet below, calculate the patient's total financial responsibility and the total payment to the RHC from Medicare.

Part B RHC Reimbursement Calculation Worksheet

Patient's Financial Liability Calculation

Total visit charge	\$ 280.00	
Patient's unmet deductible amount	- \$ <u>0.00</u>	
	\$ 280.00	(remaining charge)

Coinsurance (remaining charge X 20%)	\$ 56.00	(\$280 X .20)
Patient's unmet deductible amount	+ \$ <u>0.00</u>	
	\$ 56.00	Total patient responsibility

Medicare's Reimbursement Calculation

RHC's AIR	\$ 130.00	
Patient's unmet deductible amount	- \$ <u>0.00</u>	
	\$ 130.00	(remaining AIR)

Payment is the *lesser of*

80% of the RHC's remaining AIR	\$ 104.00	(\$130 X .80)
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or

80% of the per visit payment limit	\$ 100.80	(\$126 X .80)
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\$ 100.80 Medicare Payment

Total payment from the patient and Medicare = 156.80 (\$56 + \$100.80)

Case Study 4

Facts: Same facts as in Case Study 3 (*independent RHC*), except the patient had partially met his CY 2023 Part B deductible (\$226.00) and has paid \$126 out of pocket towards the deductible prior to the qualifying visit.

NOTE: The RHC national per visit payment limit for CY 2023 is \$126.00.

Using the worksheet below, calculate the patient's total financial responsibility and the total payment to the RHC from Medicare.

Part B RHC Reimbursement Calculation Worksheet

Patient's Financial Liability Calculation

Total visit charge		\$ 280.00	
Patient's unmet deductible amount	-	<u>\$ 100.00</u>	
		\$ 180.00	(remaining charge)

Coinsurance (remaining charge X 20%)	\$	36.00	(\$180 X .20)
Patient's unmet deductible amount	+	<u>\$ 100.00</u>	
		\$ 136.00	Total patient responsibility

Medicare's Reimbursement Calculation

RHC's AIR		\$ 130.00	
Patient's unmet deductible amount	-	<u>\$ 100.00</u>	
		\$ 30.00	(remaining AIR)

Payment is the *lesser of*

80% of the RHC's remaining AIR	\$	24.00	(\$30 X .80)
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or

80% of the per visit payment limit	\$	100.80	(\$126 X .80)
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\$ 24.00 Medicare Payment

Total payment from the patient and Medicare = \$160.00 (\$136.00 + \$24.00)

- Screening for glaucoma;
- Cardiovascular screening blood tests; and
- Ultrasound screening for abdominal aortic aneurysm.

Influenza, pneumococcal *and COVID-19* vaccines, *and covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19* their administration are paid through the cost report, and payment for the hepatitis B vaccine and its administration is included in an otherwise billable visit. The professional component of the IPPE, AWW, and other qualified preventive services is paid based on the lesser of the FQHC's charge or the PPS rate for the specific payment code, with an adjustment for IPPE and AWW (see section 70.4 – FQHC Payment Codes).

Note: Monoclonal antibody products used for the treatment or for post-exposure prophylaxis of COVID-19 (when they are not purchased by the government) and their administration are paid through the cost report until the end of the calendar year in which the Emergency Use Authorization declaration for drugs and biological products with respect to COVID-19 ends.

50.3 - Emergency Services

(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

RHCs provide outpatient services that are typically furnished in a physician's office or outpatient clinic and generally provide only limited emergency care. Neither independent nor hospital-based RHCs are subject to Emergency Medical Treatment and Active Labor Act regulations. However, RHC practitioners are required to provide medical emergency procedures as a first response to common life threatening injuries and acute illnesses and to have available the drugs and biologicals commonly used in life-saving procedures. The definition of a "first response" is a service that is commonly provided in a physician's office.

If a patient presents at the RHC with an emergency when the RHC is not open for patient care because a physician, NP, PA, CNM, CP, or CSW is not present, other staff may attend to the patient until care of the individual can be transferred. Any care provided in this situation must be within the individual's ability, training, and scope of practice, and in accordance with state laws, and would not be considered an RHC service.

During their regular hours of operations, FQHC practitioners are required to provide medical procedures as a first response to common life threatening injuries and acute illnesses and to have available the drugs and biologicals commonly used in life-saving procedures. After their operating hours, FQHCs must provide telephone access to an individual who has the qualifications and training to exercise professional judgment in assessing a patient's need for emergency medical care, and if appropriate, to refer the patient to an appropriate provider or facility that is open.

Additional information on emergency preparedness requirements for RHCs and FQHCs can be found 42 CFR 491.12.

60 - Non RHC/FQHC Services

(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

RHCs and FQHCs must be primarily engaged in furnishing primary care services, but may also furnish certain services that are beyond the scope of the RHC or FQHC benefit, such as laboratory services or the technical component of an RHC or FQHC service. If these services are authorized to be furnished by the RHC or FQHC and are covered under a separate Medicare benefit category, the services must be billed separately (not by the RHC or FQHC) to the appropriate A/B MAC under the payment rules that apply to the service. RHCs and FQHCs must identify and remove from allowable costs on the Medicare cost report all costs associated with the provision of non-RHC/FQHC services such as space, equipment, supplies, facility overhead, and personnel.

60.1 - Description of Non RHC/FQHC Services

(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

Certain services are not considered RHC or FQHC services either because they 1) are not included in the RHC or FQHC benefit, or 2) are not a Medicare benefit. Non- RHC/FQHC services include, but are not limited to:

Medicare excluded services - Includes routine physical checkups, dental care, hearing tests, routine eye exams, etc. For additional information, see Pub. 100-02, Medicare Benefit Policy Manual, Chapter 16, General Exclusions from Coverage, at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c16.pdf>

Technical component of an RHC or FQHC service - Includes diagnostic tests such as x-rays, electrocardiograms (EKGs), and other tests authorized by Medicare statute or the NCD process. These services may be billed separately to the A/B MAC by the facility). (The professional component is an RHC or FQHC service if performed by an RHC or FQHC practitioner or furnished incident to an RHC or FQHC visit).

Laboratory services - Although RHCs and FQHCs are required to furnish certain laboratory services (for RHCs see section 1861(aa)(2)(G) of the Act, and for FQHCs see section 330(b)(1)(A)(i)(II) of the PHS Act), laboratory services are not within the scope of the RHC or FQHC benefit. When clinics and centers separately bill laboratory services, the cost of associated space, equipment, supplies, facility overhead and personnel for these services must be adjusted out of the RHC or FQHC cost report. This does not include venipuncture, which is included in the AIR when furnished in an RHC by an RHC practitioner or furnished incident to an RHC service, and it is included in the per-diem payment when furnished in an FQHC by an FQHC practitioner or furnished incident to an FQHC service.

Durable medical equipment - Includes crutches, hospital beds, and wheelchairs used in the patient's place of residence, whether rented or purchased.

Ambulance services - The ambulance transport benefit under Medicare Part B covers a medically necessary transport of a beneficiary by ambulance to the nearest appropriate facility that can treat the patient's condition, and any other methods of transportation are contraindicated. See <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c10.pdf> for additional information on covered ambulance services.

Prosthetic devices - Prosthetic devices are included in the definition of “medical and other health services” in section 1861(s)(8) of the Act and are defined as devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of such devices, and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens. Other examples of prosthetic devices include cardiac pacemakers, cochlear implants, electrical continence aids, electrical nerve stimulators, and tracheostomy speaking valves.

Body Braces – Includes leg, arm, back, and neck braces and their replacements.

Practitioner services at certain other Medicare facility – Includes services furnished to inpatients or outpatients in a hospital (including CAHs), ambulatory surgical center, Medicare Comprehensive Outpatient Rehabilitation Facility, etc., or other facility whose requirements preclude RHC or FQHC services. (**NOTE:** Covered services provided to a Medicare beneficiary by an RHC or FQHC practitioner in a SNF may be an RHC or FQHC service.)

Telehealth distant-site services - See section 200 of this chapter for additional information on telehealth services in RHCs and FQHCs.

Hospice Services (*with the exception of hospice attending physician services*) – See section 210 of this chapter for additional information on hospice services in RHCs and FQHCs.

Group Services – Includes group or mass information programs, health education classes, group therapy, or group education activities, including media productions and publications.

70 - RHC and FQHC Payment

(Rev. 252, Issued: 12-07-18, Effective: 01-01-19, Implementation: 01- 02-19)

RHCs and FQHCs must submit claims for RHC or FQHC services under the RHC or FQHC payment methodologies and are not authorized to submit claims under the Physician Fee Schedule (PFS) for RHC or FQHC services. Newly certified RHCs or FQHCs should work with their A/B MAC to ensure that all claims filed for RHC or FQHC services are paid as RHC or FQHC claims as of the date of their certification.

70.1 - RHC Payment

(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Medicare pays 80 percent of the RHC AIR, subject to a payment limit, for medically-necessary medical, and qualified preventive, face-to-face (one-on-one) visits with an RHC practitioner (as defined in section 30) for RHC services (as defined in section 50.1), unless otherwise noted. The rate is subject to a payment limit, except for RHCs that have an exception to the payment limit (see section 70.2). An interim rate for newly certified RHCs is established based on the RHC’s anticipated average cost for direct and supporting services. At the end of the reporting period, the A/B MAC determines the total payment due and reconciles payments made during the period with the total payments due.

In general, the AIR for an RHC is calculated by the A/B MAC by dividing total allowable costs by the total number of visits for all patients. Productivity, payment limits, and other factors are also considered in the calculation. Allowable costs must be reasonable and

necessary and include practitioner compensation, overhead, equipment, space, supplies, personnel, and other costs incident to the delivery of RHC services.

Services furnished incident to an RHC professional service are included in the AIR and are not billed as a separate visit. The professional component of a procedure is usually a covered service, but is not a stand-alone billable visit. The costs of covered services provided incident to a billable visit may be included on the RHC cost report. To receive payment for qualified services, HCPCS coding is required on all claims.

70.2 - RHC Payment Limit

(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

Prior to April 1, 2021, the RHC payment limit was set by Congress in 1988 and was adjusted annually based on the Medicare Economic Index (MEI). The payment limit was released annually via Recurring Update Notifications.

Prior to April 1, 2021, a provider-based RHC that is an integral and subordinate part of a hospital (including a CAH), as described in regulations at 42 CFR 413.65, could receive an exception to the per-visit payment limit if:

- the hospital *had* fewer than 50 beds as determined at 42 CFR 412.105(b); or
- the hospital's average daily patient census count of those beds described in 42 CFR 412.105(b) *did* not exceed 40 and the hospital meets both of the following conditions:
 - it *was* a sole community hospital as determined in accordance with 42 CFR 412.92 or an essential access community hospital as determined in accordance with 42 CFR 412.109(a), and
 - it *was* located in a level 9 or level 10 Rural-Urban Commuting Area (RUCA). (For additional information on RUCAs, see <http://depts.washington.edu/uwruca/>.)

The exception to the payment limit *applied* only during the time that the RHC *met* the requirements for the exception.

70.2.1 – Payment Limits Applicable to Independent RHCs, Provider-Based RHCs in a Hospital with 50 or More Beds, and New RHCs

(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

Beginning April 1, 2021, independent RHCs, provider-based RHCs in a hospital with 50 or more beds, and RHCs enrolled under Medicare on or after January 1, 2021 will receive a prescribed national statutory payment limit per visit increase over an 8-year period for each year from 2021 through 2028.

The national statutory payment limit for RHCs over the 8-year period is as follows:

- *In 2021, after March 31, at \$100 per visit;*
- *In 2022, at \$113 per visit;*

- In 2023, at \$126 per visit;
- In 2024, at \$139 per visit;
- In 2025, at \$152 per visit;
- In 2026, at \$165 per visit;
- In 2027, at \$178 per visit; and
- In 2028, at \$190 per visit.

Beginning in 2029 and each year thereafter the limit established for the previous year is increased by the percentage increase in MEI applicable to primary care services furnished as of the first day of such year.

We note that new RHCs are those that have submitted an application and are enrolled under Medicare on or after January 1, 2021.

70.2.2 – Payment Limits Applicable to Provider-Based RHCs in a Hospital with Less than 50 Beds

(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

Beginning April 1, 2021, provider-based RHCs that meet a specified criteria are entitled to special payment rules that establish a payment limit based on the provider-based RHC's per visit payment amount (or AIR) instead of the national statutory payment limit. For purposes of this section of the manual, we use the term "specified" interchangeably with the term "grandfathered" since those RHCs that meet the specified criteria are considered to be "grandfathered" into the establishment of their payment limit per visit.

The specified criteria that an RHC must meet in order to be eligible for the special payment rules are as follows:

- *As of December 31, 2020, was in a hospital with less than 50 beds (not taking into account any increase in the number of beds pursuant to a waiver during the Public Health Emergency (PHE) for COVID-19); and one of the following circumstances:*
 - *As of December 31, 2020, was enrolled in Medicare (including temporary enrollment during the PHE for COVID-19); or*
 - *Submitted an application for enrollment in Medicare (or a request for temporary enrollment during the PHE for COVID-19) that was received not later than December 31, 2020.*

Medicare Administrative Contractors (MACs) will calculate the payment limit per visit for specified provider-based RHCs (that is, grandfathered RHCs) as discussed in sections 70.2.2.1 and 70.2.2.2 below.

A grandfathered provider-based RHC will lose this designation if the hospital does not continue to have less than 50 beds. If this occurs, the provider-based RHC will be subject to the statutory payment limit per visit applicable for such year for RHCs discussed in section 70.2.1 of this manual.

70.2.2.1 – Determining Payment Limits for Specified Provider-Based RHCs with an AIR Established for RHC Services Furnished in 2020

(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

Beginning April 1, 2021, specified provider-based RHCs that had a per visit payment amount (that is, AIR) established for services furnished in 2020, the payment limit per visit shall be set at an amount equal to the greater of:

1. *the per visit payment amount applicable to such RHC for 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*
2. *the national statutory payment limit for RHCs per visit (see section 70.2.1 of this chapter).*

For subsequent years, the specified provider-based RHC's payment limit per visit shall be set at an amount equal to the greater of:

1. *the payment limit per visit established 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; or*
2. *the national statutory payment limit for RHCs (see section 70.2.1 of this chapter).*

Note: For purposes of establishing the payment limit effective April 1, 2021 for specified provider-based RHCs defined in section 1833(f)(3)(A)(i)(I) of the Act, that is, had an AIR established for services furnished in 2020, MACs shall use the cost report ending in 2020 that reports costs for 12-consecutive months. If the RHC does not have a 12-consecutive month cost report ending in 2020, the MACs shall use the next available 12-consecutive month cost report that reports costs for RHC services furnished in 2020. MACs should not combine cost report data to equal a 12-consecutive month cost report.

70.2.2.2 – Determining Payment Limits for Specified Provider-Based RHCs that did not have an AIR Established for RHC Services Furnished in 2020

(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

Beginning April 1, 2021, specified provider-based RHCs that did not have a per visit payment amount (that is, AIR) established for services furnished in 2020, the payment limit per visit shall be at an amount equal to the greater of:

1. *the per visit payment amount applicable to the provider-based RHC for services furnished in 2021; or*
2. *the national statutory payment limit for RHCs (see section 70.2.1 of this chapter).*

For subsequent years, the provider-based RHCs payment limit per visit shall be set at an amount equal to the greater of:

- 1. the payment limit per visit established for the previous year, increased by the percentage increase in MEI applicable to primary care services furnished as of the first day of such subsequent year; or*
- 2. the national statutory payment limit for RHCs (see section 70.2.1 of this chapter).*

Note: For purposes of establishing the payment limit effective April 1, 2021 for specified provider-based RHCs defined in section 1833(f)(3)(A)(i)(II) of the Act (that is, those that did not have an AIR established for services furnished in 2020), the MACs shall use the cost report ending in 2021 that reports costs for 12 consecutive months. If the RHC does not have a 12-consecutive month cost report ending in 2021, the MACs shall use the next most-recent final settled cost report that reports cost for 12- consecutive months. MACs should not combine cost report data to equal a 12-consecutive month cost report.

70.3 - FQHC PPS Payment Rate and Adjustments

(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Medicare pays 80 percent of the lesser of the FQHC's charge or the FQHC PPS payment rate for the specific payment code, unless otherwise noted. Except for grandfathered tribal FQHCs, the FQHC PPS payment rate reflects a base rate that is the same for all FQHCs, a geographic adjustment based on the location where services are furnished, and other applicable adjustments as described below. The 2015 and 2016 FQHC PPS base rates were updated by the MEI. Beginning in 2017, the FQHC PPS rate is updated annually by the FQHC market basket. To receive payment for qualified services, HCPCS coding is required on all claims.

Geographic Adjustment: The PPS base rate is adjusted for each FQHC based on its location by the FQHC Geographic Adjustment Factor (FQHC GAF). The PPS payment rate is the PPS base rate multiplied by the FQHC GAF for the location where the service is furnished. Since the FQHC GAF is based on where the services are furnished, the FQHC payment rate may differ among FQHC sites within the same organization. FQHC GAFs are updated periodically and can be found at: <https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html>.

New Patient Adjustment: The PPS payment rate is adjusted by a factor of 1.3416 when an FQHC furnishes care to a patient who is new to the FQHC. A new patient is someone who has not received any Medicare-covered professional health service (medical or mental health) from any site within the FQHC organization, or from any practitioner within the FQHC organization, within the past 3 years from the date of service.

IPPE and AWW Adjustment: The PPS payment rate is adjusted by a factor of 1.3416 when an FQHC furnishes an IPPE or an AWW to a Medicare beneficiary.

NOTE: These adjustments do not apply to grandfathered tribal FQHCs.

70.4 - FQHC Payment Codes

(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

FQHCs set their own charges for services they provide and determine which services are included in the bundle of services associated with each FQHC G code based on a typical bundle of services that they would furnish per diem to a Medicare beneficiary. The FQHC should maintain records of the services included in each FQHC G code and the charges

associated with the service at the time the service was furnished. Each FQHC decides what documentation is appropriate to record the services included in each G-code pursuant to its own determination. Charges must be reasonable and uniform for all patients, regardless of insurance status. G code services and charges can be changed by the FQHC, but must be the same for all patients and cannot be changed retrospectively.

FQHCs must include one or more of the FQHC payment codes listed below on claims to receive payment for services furnished:

1. G0466 – FQHC visit, new patient: A medically-necessary medical, or a qualified preventive health, face-to-face encounter (one-on-one) between a new patient (as defined in section 70.3), and an FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an FQHC visit.
2. G0467 – FQHC visit, established patient: A medically-necessary medical, or a qualifying preventive health, face-to-face encounter (one-on-one) between an established patient and an FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an FQHC visit.
3. G0468 – FQHC visit, IPPE or AWV: An FQHC visit that includes an IPPE or AWV and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV.
4. G0469– FQHC visit, mental health, new patient: A medically-necessary, face-to-face mental health encounter (one-on-one) between a new patient (as defined in section 70.3), and an FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.
5. G0470 – FQHC visit, mental health, established patient: A medically-necessary, face-to-face mental health encounter (one-on-one) between an established patient and an FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.

80 - RHC and FQHC Cost Reports

(Rev. 220, Issued: 01-15-16, Effective: 02-01-16, Implementation: 02-01-16)

80.1 - RHC and FQHC Cost Report Requirements

(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

RHCs are required to file a cost report annually in order to determine their payment rate and reconcile interim payments, including adjustments for GME payments, bad debt, and influenza, pneumococcal *and COVID-19* vaccines, and *covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19* and their administration. If in its initial reporting period, the RHC submits a budget that estimates the allowable costs and number of visits expected during the reporting period. The A/B MAC calculates an interim rate based on a percentage of the per-visit limit, which is then adjusted when the cost report is filed.

FQHCs are required to file a cost report annually and are paid for the costs of GME, bad debt, and influenza, pneumococcal *and COVID-19* vaccines, and *covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19* and their administration through the cost report. All FQHCs, including an FQHC that does not have GME costs, bad debt, or costs associated with influenza, pneumococcal *and COVID-19* vaccines, *or covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19* and their administration, must file a cost report.

The RHC and FQHC cost reports were updated to reflect costs related to COVID-19 shots and COVID-19 monoclonal antibody products and their administration.

Note: Until the end of the calendar year in which the Emergency Use Authorization (EUA) declaration for drugs and biological products with respect to COVID-19 ends, CMS covers and pays for these infusions or injections the same way it covers and pays for COVID-19 vaccines when furnished consistent with the EUA. That is, for RHCs and FQHCs COVID-19 monoclonal antibody products (when purchased from the manufacturer) and their administration are paid at 100 percent of reasonable cost through the cost report. Effective January 1 of the year following the year in which the EUA declaration ends, CMS will cover and pay for monoclonal antibody products used for the treatment or for post-exposure prophylaxis of COVID-19 in the same way we pay for other Part B drugs and biological products. For RHCs, payment is through the All-Inclusive Rate and for FQHCs payment is through the FQHC Prospective Payment System.

RHCs and FQHCs must maintain and provide adequate cost data based on financial and statistical records that can be verified by qualified auditors.

RHCs and FQHCs are allowed to claim bad debts in accordance with 42 CFR 413.89. RHCs may claim unpaid coinsurance and deductible, and FQHCs may claim unpaid coinsurance. RHCs and FQHCs that claim bad debt must establish that reasonable efforts were made to collect these amounts. Coinsurance or deductibles that are waived, either due to a statutory waiver or a sliding fee scale, may not be claimed.

80.2 - RHC and FQHC Consolidated Cost Reports

(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

RHCs and FQHCs with more than one site may file consolidated cost reports if approved by the A/B MAC in advance of the reporting period for which the consolidated report is to be used. Once having elected to use a consolidated cost report, the RHC or FQHC may not revert to individual reporting without the prior approval of the A/B MAC.

New RHCs (enrolled under section 1866(j) of the Act on or after January 1, 2021) are permitted to file consolidated cost reports with:

- *New RHCs that are provider-based,*
- *New RHCs that are independent,*
- *Existing independent RHCs, and/or*
- *Existing provider-based RHCs that are in a hospital that has more than 50 beds.*

In addition, specified provider-based RHCs are not allowed to file a consolidated cost report with a new RHC.

80.3 – RHC and FQHC Cost Report Forms

(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

RHCs and FQHCs use one of the following cost report forms:

Independent RHCs and Freestanding FQHCs:

RHCs: Form CMS-222-17, Independent Rural Health Clinic Cost Report.

FQHCs: Form CMS-224-14, Federally Qualified Health Center Cost Report.

Provider-based RHCs and FQHCs:

Hospital-based *RHCs*: Worksheet M of Form CMS-2552-10, Hospital and Hospital Care Complex Cost Report.

Hospital-based FQHCs: Worksheet N of Form CMS-2552-10, Hospital and Hospital Care Complex Cost Report.

Skilled Nursing Facility based: Worksheet I series of form CMS-2540-10, “Skilled Nursing Facility and Skilled Nursing Facility Health Care Complex Cost Report”.

Information on these cost report forms is found in Chapters 44 *and 46; and* 40 and 41, respectively, of the “Provider Reimbursement Manual - Part 2” (Publication 15-2), which can be located on the CMS Website at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html>.

the patient’s condition without the interposition of a third person’s judgment. Direct visualization includes review of the patient’s X-rays, EKGs, tissue samples, etc.

Except for services that meet the criteria for authorized care management or virtual communications services, telephone or electronic communication between a physician and a patient, or between a physician and someone on behalf of a patient, are considered physicians’ services and are included in an otherwise billable visit. They do not constitute a separately billable visit.

Qualified services furnished at an RHC or FQHC or other authorized site by an RHC or FQHC physician are payable only to the RHC or FQHC. RHC and FQHC physicians are paid according to their employment agreement or contract (where applicable).

80.4 – RHC Productivity Standards

(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Productivity standards are used to help determine the average cost per patient for Medicare reimbursement in RHCs. The current productivity standards require 4,200 visits per full-time

equivalent physician and 2,100 visits per full-time equivalent non-physician practitioner (NP, PA, or CNM). Physician and non-physician practitioner productivity may be combined. The FTE on the cost report for providers is the time spent seeing patients or scheduled to see patients and does not include administrative time.

The A/B MAC has the discretion to make an exception to the productivity standards based on individual circumstances. All visits (Medicare, Medicaid, Managed Care, etc.) are included in determining the productivity standards for the cost report.

At the end of the cost reporting year, the A/B MAC re-calculates the AIR by dividing the total allowable costs across all patient types (i.e., the numerator) by the number of visits (as defined in section 40) for all patient types (i.e., the denominator). If fewer than expected visits based on the productivity standards have been furnished, the A/B MAC substitutes the expected number of visits for the denominator and uses that instead of the actual number of visits. The total allowable costs (numerator) would be divided by the higher, expected number of visits (denominator). In this example, this would have the effect of lowering the AIR.

Physician services that are provided on a short term or irregular basis under agreements are not subject to the productivity standards. Instead of the productivity limitation, purchased physician services are subject to a limitation on what Medicare would otherwise pay for the services under the Physician Fee Schedule (PFS), in accordance with 42 CFR 405.2468(d)(2)(v). Practitioners working on a regular, ongoing basis are subject to the productivity standards, regardless of whether they are paid as an employee or independent contractor.

FQHCs are not subject to the productivity standards.

90 - RHC and FQHC Charges, Coinsurance, Deductible, and Waivers (Rev. 252, Issued: 12-07-18, Effective: 01-01-19, Implementation: 01- 02-19)

Except for certain preventive services for which the coinsurance is statutorily waived, the beneficiary in an RHC must pay the deductible and coinsurance amount, and the beneficiary in an FQHC must pay the coinsurance amount (there is no Part B deductible in FQHCs for FQHC-covered services). For RHCs, the coinsurance is 20 percent of the total charges. For FQHCs, the coinsurance is 20 percent of the lesser of the FQHC's charge for the specific payment code or the PPS rate. For claims with a mix of waived and non-waived services, applicable coinsurance and deductibles are assessed only on the non-waived services. For both RHCs and FQHCs, coinsurance for care management and virtual communication services is 20 percent of the lesser of submitted charges or the payment rate.

90.1 - Charges and Waivers

(Rev. 220, Issued: 01-15-16, Effective: 02-01-16, Implementation: 02-01-16)

Charges for services furnished to Medicare beneficiaries must be the same as the charges for non-Medicare beneficiaries. FQHCs may waive collection of all or part of the copayment, depending on the beneficiary's ability to pay. RHCs may waive the copayment and deductible after a good faith determination has been made that the patient is in financial need, provided the waivers are not routine and not advertised. (See 42 U.S.C. 1320a-7a(6)(A))

90.2 - Sliding Fee Scale

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

RHCs may establish a sliding fee scale if it is uniformly applied to all patients. An RHC that chooses to offer a sliding fee scale must post the policy so that all patients are aware of the policy. If the payment policy is based on an individual's income, the RHC must document that income information from the patient was obtained in order to determine that the patient qualified. Copies of their wage statement or income tax return are not required, and self-attestations are acceptable.

FQHCs that are approved by HRSA are required to establish a sliding fee scale in accordance with statutory and HRSA requirements.

100 – Commingling

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Commingling refers to the sharing of RHC or FQHC space, staff (employed or contracted), supplies, equipment, and/or other resources with an onsite Medicare Part B or Medicaid fee-for-service practice operated by the same RHC or FQHC physician(s) and/or non-physician(s) practitioners. Commingling is prohibited in order to prevent:

- Duplicate Medicare or Medicaid reimbursement (including situations where the RHC or FQHC is unable to distinguish its actual costs from those that are reimbursed on a fee-for-service basis), or
- Selectively choosing a higher or lower reimbursement rate for the services.

RHC and FQHC practitioners may not furnish or separately bill for RHC or FQHC-covered professional services as a Part B provider in the RHC or FQHC, or in an area outside of the certified RHC or FQHC space such as a treatment room adjacent to the RHC or FQHC, during RHC or FQHC hours of operation.

If an RHC or FQHC practitioner furnishes an RHC or FQHC service at the RHC or FQHC during RHC or FQHC hours, the service must be billed as an RHC or FQHC service. The service cannot be carved out of the cost report and billed to Part B.

If an RHC or FQHC is located in the same building with another entity such as an unaffiliated medical practice, x-ray and lab facility, dental clinic, emergency room, etc., the RHC or FQHC space must be clearly defined. If the RHC or FQHC leases space to another entity, all costs associated with the leased space must be carved out of the cost report.

RHCs and FQHCs that share resources (e.g., waiting room, telephones, receptionist, etc.) with another entity must maintain accurate records to assure that all costs claimed for Medicare reimbursement are only for the RHC or FQHC staff, space, or other resources. Any shared staff, space, or other resources must be allocated appropriately between RHC or FQHC and non-RHC or non-FQHC usage to avoid duplicate reimbursement.