



Medicare Critical Access Hospital

KEY CONCEPTS OUTLINE

Module 3: 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 =

$$[(\text{Average Cost per Visit} \times \text{\# of Medicare Visits}) - \text{Medicare deductibles}] \times 80\%$$

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 OPPI). 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	\$
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or

80% of the per visit payment limit	\$
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\$ _____ **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	\$
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or

80% of the per visit payment limit	\$
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\$_____ **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	- \$ <u>126.00</u>
	\$ 119.00 (remaining charge)

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

Medicare's Reimbursement Calculation

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

Payment is the *greater of*
 80% of the RHC's remaining AIR \$ 75.20 (\$94 X .80)
or
 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	- \$ 0.00	
	\$ 280.00	(remaining charge)

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

Medicare's Reimbursement Calculation

RHC's AIR	\$ 130.00
Patient's unmet deductible amount	- \$ 0.00
	\$ 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)

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10780	Date: May 4, 2021
	Change Request 12185

Transmittal 10679, dated March 16, 2021, is being rescinded and replaced by Transmittal 10780, dated, May 4, 2021 to revise the background and policy sections. This correction also revises Business Requirement (BR) 12185.2 and adds BR 12185.2.1. All other information remains the same.

SUBJECT: Update to Rural Health Clinic (RHC) Payment Limits

I. SUMMARY OF CHANGES: This Change Request updates the payment limit for Rural Health Clinics (RHCs) in Chapter 9, Section 20.2 - "Payment Limit under the AIR" of the Claims Processing Manual effective April 1, 2021.

EFFECTIVE DATE: April 1, 2021

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: April 5, 2021

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 10780	Date: May 4, 2021	Change Request: 12185
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Transmittal 10679, dated March 16, 2021, is being rescinded and replaced by Transmittal 10780, dated, May 4, 2021 to revise the background and policy sections. This correction also revises Business Requirement (BR) 12185.2 and adds BR 12185.2.1. All other information remains the same.

SUBJECT: Update to Rural Health Clinic (RHC) Payment Limits

EFFECTIVE DATE: April 1, 2021

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: April 5, 2021

I. GENERAL INFORMATION

A. Background: As authorized by section 1833(f) of the Social Security Act (the Act), Medicare Part B payment to independent RHCs is 80 percent of the All-Inclusive Rate (AIR), subject to a payment limit for medically necessary medical, mental, and qualified preventive face-to-face visits with a RHC practitioner and a Medicare beneficiary for RHC services. The payment limits for subsequent years are increased in accordance with the rate of increase in the Medicare Economic Index (MEI).

In addition, under section 1833(f) of the Act, an RHC that is provider-based to a hospital with fewer than 50 beds is exempt from the statutory payment limit per visit. That is, a provider-based RHC's AIR (also referred to as per visit payment amount) is based on their average allowable costs determined at cost report settlement.

In the interim final rule (IFC) with comment, published in the May 8, 2020 Federal Register (85 FR 27550-27569), CMS implemented a policy that excludes temporarily added surge capacity beds due to the Public Health Emergency (PHE) for the COVID-19 pandemic (defined at § 400.200) from a hospital's bed count (discussed at § 412.105(b)) for the purposes of determining whether an RHC that is provider-based to that hospital is exempt from the statutory payment limit per visit.

Effective January 1, 2021, the RHC payment limit per visit for Calendar Year (CY) 2021 is \$87.52. This payment limit applies to independent RHCs and RHCs that are provider-based to a hospital with 50 or more beds. This payment limit was implemented through Change Request 12035, Transmittal 10413, entitled "Update to Rural Health Clinic (RHC) All Inclusive Rate (AIR) Payment Limit for Calendar Year (CY) 2021".

Division CC, section 130 of the Consolidated Appropriations Act of 2021 (P. L. 116-260), signed December 27, 2020, updated §1833(f) of the Act by restructuring the payment limits for RHCs beginning April 1, 2021.

Section 2 of H.R.1868 (P. L. 117-7), signed April 14, 2021, provided a technical correction to §1833(f). The amendments made by this technical correction take effect as if included in the enactment of the Consolidated Appropriations Act of 2021 (P. L. 116-260).

B. Policy:

1. Independent RHCs and provider-based RHCs in a hospital with 50 or more beds

Beginning April 1, 2021, in accordance with section 1833(f)(2) of the Act, RHCs will begin to receive an increase in their payment limit per visit over an 8-year period, with a prescribed amount for each year from 2021 through 2028. Then, in subsequent years, the limit is updated by the percentage increase in MEI applicable to primary care services furnished as of the first day of that year.

The RHC payment limit per visit over an 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.

2. Provider-Based RHCs in a hospital with less than 50 beds

a. Provider-based RHCs that are Determined to be Grandfathered

Beginning April 1, 2021, provider-based RHCs that meet the criteria in section 1833(f)(3)(B) of the Act are entitled to special payment rules, as described in section 1833(f)(3)(A) of the Act.

Provider-based RHCs that meet the criteria in section 1833(f)(3)(B) of the Act are considered to be “grandfathered” into the establishment of their payment limit per visit. Meaning, those provider-based RHCs that meet the following criteria will have a payment limit per visit established (beginning with services furnished 4/1/2021) based on their AIR. A “grandfathered provider-based RHC” is an RHC that --

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

With regard to the reference of the waiver during the COVID-19 PHE, CMS will take into account the policy finalized in the interim final rule with comment, published in the May 8, 2020 Federal Register (85 FR 27550-27529). Provider-based RHCs that were exempt from the statutory payment limit per visit pursuant to section 1833(f)(3)(B) whose associated hospitals have experienced temporarily added surge capacity beds will be considered “grandfathered” in accordance with the policy set out in the May 8, 2020 IFC.

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 (that is, section B.1. of this Change Request).

Provider-based RHCs that are new beginning January 1, 2021 and after are subject to the statutory payment limit per visit applicable for such year for RHCs (that is, section B.1. of this Change Request).

b. Establishing payment limits for Grandfathered Provider-Based RHCs

In accordance with section (f)(3)(A) of the Act, grandfathered provider-based RHCs will have a payment limit per visit based on their AIR and established in the following manner:

For provider-based RHCs that had a per visit payment amount (or 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 2020, increased by the percentage increase in the MEI applicable to primary care services furnished as of the first day of 2021 (that is, CY 2021 MEI of 1.4 percent), or
2. the payment limit per visit applicable to RHCs (\$100 as stated in section B.1. of this Change Request).

Then, in a subsequent year (that is, after 2021), the provider-based RHC's payment limit per visit will be 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 payment limit per visit applicable to each year for RHCs (as stated in section B.1. of this Change Request).

For provider-based RHCs that did not have a per visit payment amount (or 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 payment limit per visit applicable to RHCs (as stated in section B.1. of this Change Request).

Then, in a subsequent year (that is, after 2022), the provider-based RHC's payment limit per visit will be 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 payment limit per visit applicable for such subsequent year for RHCs (as stated in section B.1. of this Change Request).

CMS plans to discuss certain policies and processes used in establishing provider-based RHC's per visit payment amount in the CY 2022 Physician Fee Schedule rules.

CMS shall continue to provide the MEI update and applicable rate updates in the Recurring Annual RHC CR.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared- System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
12185.1	Contractors shall increase the RHC payment limit per visit to \$100.00 to reflect Consolidated Appropriations	X								

Number	Requirement	Responsibility									
		A/B MAC			D M E	Shared- System Maintainers				Other	
		A	B	H H H		F I S S	M C S	V M S	C W F		
	Act of 2021 updates, effective April 1, 2021 through December 31, 2021.										
12185.2	Contractors shall identify grandfathered provider-based RHCs as described in section B.2.a of this Change Request.	X									
12185.2.1	Contractors shall establish the payment limit per visit for grandfathered provider-based RHCs as described in section B.2.b of this Change Request.	X									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A/B MAC			D M E						
		A	B	H H H							
12185.3	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X									

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
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Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Glenn McGuirk, 410-786-5723 or Glenn.McGuirk@cms.hhs.gov , Lisa Parker, 410-786-4949 or Lisa.Parker1@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

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ATTACHMENTS: 0

Version 03/15/2023
Check for Updates