FACT SHEET

Rural Health Clinic

THE RURAL HEALTH CLINIC (RHC) PROGRAM was established in 1977 to address an inadequate supply of physicians who serve Medicare and Medicaid beneficiaries in rural areas. The program provides qualifying Clinics located in rural and medically underserved communities with payment on a cost-related basis for outpatient physician and certain nonphysician services. For RHC purposes, any area that is not defined by the U.S. Census Bureau as urbanized is considered non-urbanized. RHCs are located in areas that are designated or certified by the Secretary of the Department of Health and Human Services as Health Professional Shortage Areas (HPSA) or Medically Underserved Areas (MUA). A Clinic cannot be Medicare approved concurrently as a RHC and a Federally Qualified Health Center.

Rural Health Clinic Services

RHCs furnish the following:

- Physicians' services;
- Services and supplies incident to the services of physicians;
- Services of registered dietitians or nutritional professionals for diabetes training services and medical nutrition therapy (the costs of such services are covered but not as a billable RHC visit);
- Otherwise covered drugs that are furnished by, and incident to, services of physicians and nonphysician practitioners of the RHC;
- Services of nurse practitioners (NP), physician assistants (PA), certified nurse midwives (CNM), clinical psychologists (CP), and clinical social workers (CSW);
- Services and supplies incident to the services of NPs, PAs, CNMs, CPs, and CSWs; and
- Visiting nurse services to the homebound in an area where the Centers for Medicare & Medicaid Services (CMS) has certified a shortage of home health agencies exists.

Rural Health Clinic Designation

To qualify as a Rural Health Clinic, a Clinic must be located in:

- A non-urbanized area, as defined by the U.S. Census Bureau, and in an area with one of the following current designations:
  - MUA;
  - Geographic or population-based HPSA; or
  - Governor-designated and Secretary-certified shortage area.

A shortage or underserved designation must have been designated or redesignated in the current year or in one of the previous three years. A RHC must also:

- Employ a midlevel practitioner who is available to furnish services at least 50 percent of the time the Clinic is furnishing services;
- Furnish routine diagnostic and laboratory services;
- Establish arrangements with providers and suppliers to furnish medically necessary services not available at the Clinic; and
- Furnish first response emergency care.

Rural Health Clinic Payments

Payment for RHC services furnished to Medicare patients is made on the basis of an all-inclusive rate per covered visit with the exception of psychological or psychiatric therapeutic services. All therapeutic services furnished by CSWs and CPs are subject to the outpatient mental health treatment limitation. This limit does not apply to diagnostic services. A visit is defined as a face-to-face encounter between the patient and one of the following practitioners, during which a RHC service is furnished:

- A physician;
- NP;
- PA;
- CNM;
- CP;
- CSW; or
- Visiting nurse (in very limited cases).

The cost of the influenza and pneumococcal vaccines and related administration are separately reimbursed at annual cost settlement. There is a separate worksheet on the Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report to report the cost of these vaccines and related administration. These costs should never be reported on the claim when billing for RHC services. There is no coinsurance or deductible for these services; therefore, when these vaccines are administered, the charges for the vaccines and related administration are never included with the visit charges when calculating coinsurance or deductible for the visit. When a RHC physician, PA, NP, or CNM sees a beneficiary for the sole purpose of administering these vaccinations, the RHC may not bill for a visit; however, the associated costs should still be included on the annual cost report.

The cost of the Hepatitis B vaccine and related administration are covered under the RCH's all-inclusive rate. If other services that constitute a qualifying RHC visit are furnished at the same time as the Hepatitis B vaccination, the charges for the vaccine and related administration can be included in the charges for the visit when billing and in calculating the coinsurance and/or deductible. When a physician, NP, PA, or CNM sees a beneficiary for the sole purpose of administering a Hepatitis B vaccination, he or she may not bill for a visit; however, the associated costs should still be included on the annual cost report. Charges for the Hepatitis B vaccine may be included on a claim for the beneficiary's subsequent RHC visit and in calculating co-insurance and/or deductible.

Encounters at a single location on the same day with more than one health professional and multiple encounters with the same health professional constitute a single visit, except when one of the following conditions exist:

- The patient suffers an illness or injury requiring additional diagnosis or treatment subsequent to the first encounter; or
- The patient has a medical visit AND a clinical psychologist or clinical social worker visit.

Payment is made directly to RHCs for covered services furnished to a patient at the Clinic, the patient's place of residence, or elsewhere (e.g., the scene of an accident). Laboratory tests are paid separately.

The Medicare Part B deductible applies to RHC services and is based on billed charges. Noncovered expenses do not count toward the deductible. After the deductible has been satisfied, RHCs will be paid 80 percent of the all-inclusive interim encounter payment rate for each RHC visit with the exception of all psychological or psychiatric therapeutic services furnished by CSWs and CPs.

Independent RHCs must complete Form CMS-222-92, Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report, in order to identify all incurred costs applicable to furnishing covered Clinic services including RHC direct costs and any shared costs applicable to the RHC. An independent RHC is limited to the yearly national RHC per-visit payment ceiling for its encounter rate. Form CMS-222-92 can be found at **www.cms.hhs.gov/CMSForms/CMSForms/list.asp** on the CMS website.

Provider-based RHCs must complete Worksheet M of Form CMS-2552-96, Hospital Cost Report, in order to identify all incurred costs applicable to furnishing covered Clinic services and the RHC's appropriate share of the parent provider's overhead costs. A RHC that is provider-based to a hospital with less than 50 beds is not subject to the national per-visit payment ceiling and has an encounter rate that is based on its full reasonable cost. If a RHC is in its initial reporting period, the all-inclusive visit rate is determined on the basis of a budget the RHC submits. The budget estimates the allowable cost that will be incurred by the RHC during the reporting period and the number of visits for RHC services expected during the reporting period. Form CMS-2552-96 can be found in the Provider Reimbursement Manual–Part 2 (Pub. 15-2), Chapter 36, which can be found at **www.cms.hhs.gov/Manuals/PBM/list.asp** on the CMS website.

To determine the payment rate for new RHCs and for those that have submitted cost reports, the Fiscal Intermediary (FI) applies screening guidelines and the maximum payment per-visit limitation as described below. For subsequent reporting periods, the all-inclusive visit rate is determined, at the discretion of the FI, on the basis of a budget or the prior year's actual costs and visits with adjustments to reflect anticipated changes in expenses or utilization.

In general, the payment rate is calculated by dividing the total allowable cost by the number of total visits for RHC services. At the end of the annual cost reporting period, RHCs submit a report to the FI that includes actual allowable costs and actual visits for RHC services for the reporting period and any other information that may be required. After reviewing the report, the FI divides actual allowable costs by the number of actual visits to determine a final rate for the period. Both the final rate and the interim rate are subject to screening guidelines for evaluating the reasonableness of the Clinic's productivity, payment limit, and mental health treatment limit.

Annual Reconciliation

At the end of the annual cost reporting period, the FI determines the total payment due and the amount necessary to reconcile payments made during the period with the total payment due.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003

Section 410 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 states that professional services furnished on or after January 1, 2005, by physicians, PAs, NPs, and CPs who are affiliated with RHCs are excluded from the Skilled Nursing Facility Prospective Payment System, in the same manner as such services would be excluded if furnished by individuals not affiliated with RHCs.

HELPFUL RURAL HEALTH WEBSITES

CENTERS FOR MEDICARE & MEDICAID SERVICES' WEBSITES

CMS Forms
www.cms.hhs.gov/CMSForms/CMSForms/list.asp

CMS Mailing Lists
www.cms.hhs.gov/apps/mailinglists

Critical Access Hospital Provider Center
www.cms.hhs.gov/center/cah.asp

Federally Qualified Health Centers Provider Center
www.cms.hhs.gov/center/fqhc.asp

Hospital Provider Center
www.cms.hhs.gov/center/hospital.asp

HPSA/PSA (Physician Bonuses)
www.cms.hhs.gov/HPSAPSAPhysicianBonuses

Internet-Only Manuals
www.cms.hhs.gov/Manuals/IOM/list.asp

Paper-Based Manuals
www.cms.hhs.gov/Manuals/PBM/list.asp

Medicare Learning Network
www.cms.hhs.gov/MLNGenInfo

Medicare Modernization Update
www.cms.hhs.gov/MMAUpdate/MMU/list.asp

MLN Matters Articles
www.cms.hhs.gov/MLNMattersArticles

Physician's Resource Partner Center
www.cms.hhs.gov/center/physician.asp

Regulations & Guidance
www.cms.hhs.gov/home/regsguidance.asp

Rural Health Center
www.cms.hhs.gov/center/rural.asp

Telehealth
www.cms.hhs.gov/Telehealth

OTHER ORGANIZATIONS' WEBSITES

American Hospital Association Section for Small or Rural Hospitals
www.aha.org/aha/key_issues/rural/index.html

Government Printing Office—Code of Federal Regulations
www.gpoaccess.gov/cfr/index.html

Health Resources and Services Administration
www.hrsa.gov

National Association of Community Health Centers
www.nachc.org

National Association of Rural Health Clinics
www.narhc.org

National Rural Health Association
www.nrharural.org

Rural Assistance Center
www.raconline.org

U.S. Census Bureau
www.census.gov

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The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at **www.cms.hhs.gov/MLNGenInfo/** on the CMS website.

Medicare Contracting Reform (MCR) Update
Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Congress mandated that the Secretary of the Department of Health and Human Services replace the current contracting authority under Title XVIII of the Social Security Act with the new Medicare Administrative Contractor (MAC) authority. This mandate is referred to as Medicare Contracting Reform. Medicare Contracting Reform is intended to improve Medicare's administrative services to beneficiaries and health care providers. Currently, there are three Durable Medical Equipment (DME) MACs that handle the processing of DME claims and one A/B MAC (Jurisdiction 3) to handle the processing of both Part A and Part B claims for those beneficiaries located within the states included in Jurisdiction 3. All Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by the new A/B MACs by 2011. Providers may access the most current MCR information to determine the impact of these changes at **www.cms.hhs.gov/MedicareContractingReform** on the CMS website.

June 2007 ICN: 006398