DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®
Official CMS Information for Medicare Fee-For-Service Providers

# Rural Health Clinic

## RURAL HEALTH FACT SHEET SERIES

This publication provides the following information about Rural Health Clinics (RCH):

- RHC services;
- Medicare certification as a RHC;
- RHC visits;
- RHC payments;
- Cost reports;
- Annual reconciliation; and
- Resources.

The Rural Health Clinic Services Act of 1977 (Public Law 95-210) was enacted to address an inadequate supply of physicians serving Medicare beneficiaries and Medicaid recipients in rural areas and to increase the utilization of non-physician practitioners such as nurse practitioners (NP) and physician assistants (PA) in rural areas. There are approximately 3,800 RHCs nationwide that provide access to primary care services in rural areas.

### Rural Health Clinic Services

RHCs furnish:

- Physician services;
- Services and supplies incident to the services of a physician;
- NP, PA, certified nurse midwife (CNM), clinical psychologist (CP), and clinical social worker (CSW) services;
- Services and supplies incident to the services of a NP, PA, CNM, CP, and CSW;
- Medicare Part B covered drugs that are furnished by and incident to services of a RHC provider; and
- Visiting nurse services to the homebound in an area where the Centers for Medicare & Medicaid Services (CMS) has certified that there is a shortage of Home Health Agencies.

### Medicare Certification as a Rural Health Clinic

To qualify as a RHC, a clinic must be located in:

- An non-urbanized area, as defined by the U.S. Census Bureau; and
- An area currently designated by the Health Resources and Services Administration as one of the following types of Federally designated or certified shortage areas:
  - Primary Care Geographic Health Professional Shortage Area (HPSA) under Section 332(a)(1)(A) of the Public Health Service (PHS) Act;
  - Primary Care Population-Group HPSA under Section 332(a)(1)(B) of the PHS Act;
  - Medically Underserved Area under Section 330(b)(3) of the PHS Act; or
  - Governor-designated and Secretary-certified shortage area under Section 6213(c) of the Omnibus Budget Reconciliation Act of 1989.

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RHCs must:

- Employ a NP or PA;
- Have a NP, PA, or CNM working at the clinic at least 50 percent of the time the RHC operates;
- Directly furnish routine diagnostic and laboratory services;
- Have arrangements with one or more hospitals to furnish medically necessary services that are not available at the RHC;
- Have available drugs and biologicals necessary for the treatment of emergencies;
- Furnish onsite all of the following laboratory tests:
  - Chemical examination of urine by stick or tablet method or both;
  - Hemoglobin or hematocrit;
  - Blood sugar;
  - Examination of stool specimens for occult blood;
  - Pregnancy tests; and
  - Primary culturing for transmittal to a certified laboratory;
- Have a quality assessment and performance improvement program;
- Not be a rehabilitation agency or a facility that is primarily for the treatment of mental disease;
- Not be a Federally Qualified Health Center; and
- Meet other applicable State and Federal requirements.

## Rural Health Clinic Visits

RHC visits are medically necessary face-to-face encounters between the beneficiary and a physician, NP, PA, CNM, CP, or CSW during which a RHC service is furnished. In certain limited situations, RHC visits may also include a visit by a registered professional nurse or a licensed practical nurse to a homebound beneficiary.

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:

- The beneficiary suffers an illness or injury requiring additional diagnosis or treatment subsequent to the first encounter; or
- The beneficiary has a medical visit AND a CP or CSW visit.

## Rural Health Clinic Payments

The RHC per-visit payment limit is established by Congress and changes each year based on the percentage change in the Medicare Economic Index. RHCs receive cost-based reimbursement for a defined set of core physician and certain non-physician outpatient services. Payment is based on an all-inclusive payment methodology, subject to a maximum payment per visit and annual reconciliation. The per-visit limit does not apply to RHCs that are an integral and subordinate part of a hospital with fewer than 50 beds. Laboratory tests are paid separately.

The coinsurance for Medicare beneficiaries is 20 percent of the reasonable and customary charges except for the following services:

- Outpatient mental health treatment services – Prior to 2010, the outpatient mental health treatment limitation increased the beneficiary's copayment for mental health treatment services (not including diagnostic services) to 50 percent of the clinic's reasonable and customary charges. With enactment of the Medicare Improvements for Patients and Providers Act of 2008, the amount of the beneficiary's copayment for this service was reduced to 45 percent in 2010. On January 1, 2012, the beneficiary's copayment will be reduced to 40 percent, and it will be reduced to 35 percent on January 1, 2013. The final copayment reduction to 20 percent will be effective on January 1, 2014.
- Certain preventive services – Effective January 1, 2011, beneficiary cost-sharing requirements for most Medicare covered preventive services will be waived, and Medicare will pay 100 percent of the costs for these services. No coinsurance or deductible will be required for personalized prevention plan services and any covered preventive services that are recommended with a grade of A or B by the U.S. Preventive Services Task Force.

The Part B deductible applies to RHC services and is based on the reasonable and customary 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 those services subject to the mental health limitation and any preventive services that are reimbursed by Medicare at 100 percent of cost.

### *Influenza and Pneumococcal Vaccine Administration and Payment*

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 cost report to report the cost of these vaccines and related administration. These costs should not be reported on a RHC claim when billing for RHC services. The beneficiary pays no Part B deductible or coinsurance for these services. When a RHC practitioner (e.g., a physician, NP, PA, or CNM) sees a beneficiary for the sole purpose of administering these vaccinations, the RHC may not bill for a visit; however, the costs of the vaccine and its administration are included on the annual cost report and reimbursed at cost settlement.

### *Hepatitis B Vaccine Administration and Payment*

The cost of the Hepatitis B vaccine and related administration are covered under the RHC'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 deductible and/or coinsurance. When a RHC practitioner (e.g., a physician, NP, PA, or CNM) sees a beneficiary for the sole purpose of administering a Hepatitis B vaccination, the RHC may not bill for a visit; however, the costs of the vaccine and its administration are 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 used in calculating the deductible and/or coinsurance.

## Cost Reports

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 RHC services. Form CMS-222-92 can be found in the Provider Reimbursement Manual – Part 2 (Pub.15-2), Chapter 29, located at *http://www.cms.gov/Manuals/PBM/list.asp* on the CMS website.

Hospital-based RHCs must complete Worksheet M of Form CMS-2552-96, Hospital and Hospital Complex Cost Report, in order to identify all incurred costs applicable to furnishing covered RHC services. RHCs based in other types of providers must complete the appropriate set of RHC worksheets on the cost report filed by the parent provider. A RHC that is based in a hospital with less than 50 beds is not subject to the per-visit payment limit 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 expected visits 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 *http://www.cms.gov/Manuals/PBM/list.asp* on the CMS website.

## Annual Reconciliation

At the end of the annual cost reporting period, RHCs submit a report to the Fiscal Intermediary (FI) or A/B Medicare Administrative Contractor (MAC) 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 or A/B MAC divides allowable costs by the number of actual visits to determine a final rate for the period. The FI or A/B MAC determines the total payment due and the amount necessary to reconcile payments made during the period with the total payment due.

Both the final rate and the interim rate are subject to screening guidelines for evaluating the reasonableness of the RHC's productivity, payment limit, and mental health treatment limit.

## Resources

To find additional information about RHCs, see Chapter 9 of the Medicare Claims Processing Manual (Pub. 100-4) and Chapter 13 of the Medicare Benefit Policy Manual (Pub. 100-2) at *http://www.cms.gov/Manuals/IOM/list.asp* on the CMS website.

## HELPFUL WEBSITES

**American Hospital Association Rural Health Care**
http://www.aha.org/aha/key_issues/rural/index.html

**Critical Access Hospitals Center**
http://www.cms.gov/center/cah.asp

**Disproportionate Share Hospital**
http://www.cms.gov/AcuteInpatientPPS/05_dsh.asp

**Federally Qualified Health Centers Center**
http://www.cms.gov/center/fqhc.asp

**Health Resources and Services Administration**
http://www.hrsa.gov

**Hospital Center**
http://www.cms.gov/center/hospital.asp

**HPSA/PSA (Physician Bonuses)**
http://www.cms.gov/hpsapsaphysicianbonuses

**Medicare Learning Network**
http://www.cms.gov/MLNGenInfo

**National Association of Community Health Centers**
http://www.nachc.org

**National Association of Rural Health Clinics**
http://www.narhc.org

**National Rural Health Association**
http://www.nrharural.org

**Rural Health Clinics Center**
http://www.cms.gov/center/rural.asp

**Rural Assistance Center**
http://www.raconline.org

**Swing Bed Providers**
http://www.cms.gov/SNFPPS/03_SwingBed.asp

**Telehealth**
http://www.cms.gov/Telehealth

**U.S. Census Bureau**
http://www.Census.gov

## REGIONAL OFFICE RURAL HEALTH COORDINATORS

Below is a list of contact information for CMS Regional Office Rural Health Coordinators who provide technical, policy, and operational assistance on rural health issues.

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