FACT SHEET

Rural Health Clinic

THE RURAL HEALTH CLINIC Services Act of 1977 (Public Law 95-210) was established to address an inadequate supply of physicians serving Medicare beneficiaries and Medicaid recipients in rural areas and to increase the utilization of nonphysician practitioners (NPP) such as nurse practitioners (NP) and physician assistants (PA) in rural areas. To qualify as a Rural Health Clinic (RHC), a facility must be in an area determined to be non-urban and designated by the Health Resources and Services Administration as having a shortage of personal health care services or primary care medical services.

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 physicians and NPPs of the RHC; 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 facility must be located in:

- An area determined to be non-urban, as defined by the U.S. Census Bureau; and

- An area with one of the following current designations:
  - Primary Care Geographic Health Professional Shortage Area (HPSA) under Section 332(a)(1)(A) of the Public Health Service (PHS) Act;
  - Primary Care Population-Based 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.

RHCs must also:

- Employ a NP or PA;
- Have available a NP, PA, or CNM to furnish services 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 emergency cases;
- Furnish onsite 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; and
- Meet other applicable State and Federal requirements.

A facility cannot be Medicare approved concurrently as a RHC and a Federally Qualified Health Center.

Rural Health Clinic Visits

A RHC visit is defined as a medically necessary face-to-face encounter between the beneficiary and a physician, NP, PA, CNM, CP, or CSW during which a RHC service is furnished. In certain limited situations, a RHC visit 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 one of the following conditions exist:

- 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

RHCs receive cost-based reimbursement for a defined set of core physician and certain nonphysician outpatient services. Payment for RHC services furnished to Medicare beneficiaries is made on the basis of an all-inclusive payment methodology, subject to a maximum payment per visit and annual reconciliation. The per-visit payment limit to RHCs is established by Congress and is increased each year by the percentage increase in the Medicare Economic Index. Payment is made directly to the RHC for covered services. Laboratory tests are paid separately. A RHC that is an integral and subordinate part of a hospital with fewer than 50 beds can receive an exception to the payment limit. Generally, the coinsurance for RHC services is 20 percent

of the clinic's reasonable and customary charge except for psychological or psychiatric therapeutic services (generally furnished by CPs and CSWs), which are subject to the 62.5 percent outpatient mental health treatment limitation. This limit does not apply to diagnostic services. The application of the outpatient mental health treatment limitation increases the beneficiary's copayment to 50 percent of the clinic's reasonable and customary charge.

The 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 CPs and CSWs.

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 associated costs 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 associated costs 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.hhs.gov/Manuals/PBM/list.asp** on the CMS website.

Provider-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. 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.hhs.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.

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.hhs.gov/Manuals** on the CMS website.

HELPFUL RURAL HEALTH WEBSITES

CENTERS FOR MEDICARE & MEDICAID SERVICES' WEBSITES

CMS Manuals
http://www.cms.hhs.gov/Manuals

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

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

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

HPSA/PSA (Physician Bonuses)
http://www.cms.hhs.gov/hpsapsaphysicianbonuses/01_overview.asp

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

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

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

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

OTHER ORGANIZATIONS' WEBSITES

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

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

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 Assistance Center
http://www.raconline.org

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

Medicare Contracting Reform (MCR) Update
In 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. 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 and to view the list of current MACs for each jurisdiction at **http://www.cms.hhs.gov/MedicareContractingReform** on the CMS website.

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