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RURAL HEALTH CLINIC

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

Learn about these Rural Health Clinic (RHC) topics:

- Background
- RHC services
- Medicare certification as an RHC
- RHC visits
- RHC payments
- Cost reports
- Annual reconciliation
- Resources
- Lists of helpful websites and Regional Office Rural Health Coordinators

BACKGROUND

The Rural Health Clinic Services Act of 1977 (Public Law 95-210) was enacted to address an inadequate supply of physicians serving Medicare patients in rural areas and to increase the use of non-physician practitioners, such as nurse practitioners (NPs) and physician assistants (PAs) in rural areas. RHCs are paid an all-inclusive rate (AIR) for medically-necessary primary health services and qualified preventive health services furnished by an RHC practitioner. Currently, about 4,100 RHCs nationwide furnish primary care and preventive health services in rural and underserved areas. For a State-by-State list of Medicare certified RHCs within each region, refer to the Current Listing of Rural Health Clinics.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
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RHC 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 an NP, PA, CNM, and CP
- Medicare Part B-covered drugs furnished by and "incident to" services of an RHC practitioner 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 AN RHC

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

- A non-urbanized area, as defined by the U.S. Census Bureau
- An area currently designated within the previous 4 years by the Health Resources and Services Administration as **one** of these 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

RHCs must:

- Employ an NP or PA (RHCs may contract with NPs, PAs, CNMs, CPs, and CSWs when at least one NP or PA is employed by the RHC)
- Have an 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 treating emergencies
- Furnish all of these laboratory tests on site:
  - 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
- Post their days and hours of operation
- 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

RHC VISITS

RHC visits are medically-necessary face-to-face medical or mental health visits or qualified preventive visits between the patient and a physician, NP, PA, CNM, CP, or CSW during which a qualified RHC service is furnished. A Transitional Care Management (TCM) service can also be an RHC visit. In certain limited situations, RHC visits may also include a visit by a registered professional nurse or a licensed practical nurse to a homebound patient.

RHC visits may take place:

- In the RHC
- At the patient's residence (including an assisted living facility)
- In a Medicare-covered Part A Skilled Nursing Facility or
- At the scene of an accident

RHC visits may not take place at:

- An inpatient or outpatient hospital (including a Critical Access Hospital) or
- A facility which has specific requirements that preclude RHC visits

Encounters with more than one RHC practitioner on the same day, regardless of the length or complexity of the visit, or multiple encounters with the same RHC practitioner on the same day, constitute a single visit, except when the patient has any of these:

- An illness or injury requiring additional diagnosis or treatment subsequent to the first encounter (for example, he or she sees the practitioner in the morning for a medical condition and later in the day has a fall and returns to the RHC)
- A qualified medical visit and a qualified mental health visit on the same day
- An Initial Preventive Physical Examination (IPPE) and a separate medical and/or mental health visit on the same day

RHC PAYMENTS

The AIR is subject to a maximum payment per visit that is established by Congress and updated annually based on the percentage change in the Medicare Economic Index and subject to annual reconciliation. The per-visit limit does not apply to RHCs determined to be an integral and subordinate part of a hospital with fewer than 50 beds. Laboratory tests (excluding venipuncture) and technical components of RHC services are paid separately.

The coinsurance for Medicare patients is 20 percent of total charges, except for certain preventive services. Patient cost-sharing requirements for most Medicare-covered preventive services are waived, and Medicare pays 100 percent of the costs for these services. No coinsurance or deductible is required for the IPPE, Annual Wellness Visit, and any covered preventive services recommended with a grade of A or B by the U.S. Preventive Services Task Force. For more information about preventive services, including coinsurance and deductible requirements, refer to the Rural Health Clinic (RHC) Preventive Services Chart.

The Part B deductible applies to RHC services and is based on total charges. Non-covered expenses do not count toward the deductible. After the deductible has been satisfied, RHCs are paid 80 percent of the AIR for each RHC visit, with the exception of any preventive services reimbursed by Medicare at 100 percent of cost.

Effective January 1, 2018, RHCs can receive payment for:

- Chronic Care Management (CCM) or general Behavioral Health Integration (BHI) services when 20 minutes or more of CCM or general BHI services are furnished and RHCs bill HCPCS code G0511 either alone or with other payable services. For CCM services furnished on or before December 31, 2017, RHCs bill CPT code 99490 alone or with other payable services on an RHC claim.
- Psychiatric Collaborative Care Model (CoCM) services when 70 minutes or more of initial psychiatric CoCM services or 60 minutes or more of subsequent psychiatric CoCM services are furnished and RHCs bill HCPCS code G0512 either alone or with other payable services on an RHC claim.

Influenza and Pneumococcal Vaccine Administration and Payment

The costs of the influenza and pneumococcal vaccines and their 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 their administration. These costs should not be reported on an RHC claim when billing for RHC services. The patient pays no Part B deductible or coinsurance for these services. When an RHC practitioner sees a patient for the sole purpose of administering these vaccinations, the RHC may not bill for a visit; however, the costs of the vaccines and their administration are included on the annual cost report and reimbursed at cost settlement.

Hepatitis B Vaccine (HBV) Administration and Payment

The cost of the HBV and its administration are covered under the RHC's AIR. If other services that constitute a qualifying RHC visit are furnished on the same day as the HBV, the charges for the vaccine and its administration should be reported on a separate line item to ensure that the deductible and coinsurance are not applied. When an RHC practitioner sees a patient for the sole purpose of administering this 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. In this instance, the charges for the HBV may be included on a claim for the patient's subsequent RHC visit.

Payment for Telehealth Services

RHCs are authorized to serve as an originating site for telehealth services if the RHC is located in a qualifying area. An originating site is the location of an eligible Medicare patient at the time the service being furnished via a telecommunications system occurs. RHCs that serve as an originating site for telehealth services are paid an originating site facility fee. Charges for the originating site facility fee may be included on a claim, but the originating site facility fee may not be included on the cost report.

RHCs are not authorized to serve as a distant site for telehealth consultations. A distant site is the location of the practitioner at the time the telehealth service is furnished.

COST REPORTS

RHCs must file a cost report annually to determine their payment rate and reconcile interim payments, including adjustments for graduate medical education payments, bad debt, and influenza and pneumococcal vaccines and their administration. Independent RHCs must complete Form CMS-222-92, Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report.

Hospital-based RHCs must complete Worksheet M of Form CMS-2552-10, Hospital and Hospital Health Care Complex Cost Report. Other provider-based RHCs must complete the appropriate set of RHC worksheets on the cost report filed by the parent provider.

To find more information about cost reports and forms, refer to the Provider Reimbursement Manual – Part 2.

ANNUAL RECONCILIATION

At the end of the annual cost reporting period, the RHC submits a report to the Medicare Administrative Contractor (MAC) that includes total allowable costs and total visits for RHC services for the reporting period and any other information that may be required. After reviewing the report, the MAC divides allowable costs by the number of actual visits to determine a final rate for the period. The MAC determines the total payment due and the amount necessary to reconcile payments made during the period with the total payment due. Both the interim and final payment rate are reviewed for productivity, reasonableness, and payment limitations. Contact your MAC if you have questions about the Medicare Program.

RESOURCES

RHC Resources

For More Information About…	Resource
RHCs	Rural Health Clinics Center CMS.gov/center/provider-type/rural-health-clinics-center.html Chapter 13 of the Medicare Benefit Policy Manual (Publication 100-02) Chapter 9 of the Medicare Claims Processing Manual (Publication 100-04) Appendix G of the State Operations Manual (Publication 100-07)
All Available Medicare Learning Network® Products	MLN Catalog
Medicare Information for Patients	Medicare.gov

Hyperlink Table

Embedded Hyperlink	Complete URL
Current Listing of Rural Health Clinics	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/rhclistbyprovidername.pdf
Rural Health Clinic (RHC) Preventive Services Chart	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Preventive-Services.pdf
Provider Reimbursement Manual – Part 2	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html
MAC	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map
Chapter 13 of the Medicare Benefit Policy Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf
Chapter 9 of the Medicare Claims Processing Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf
Appendix G of the State Operations Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c08.pdf
MLN Catalog	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf

HELPFUL WEBSITES

American Hospital Association Rural Health Care

https://www.aha.org/advocacy/small-or-rural

Critical Access Hospitals Center

https://www.cms.gov/Center/Provider-Type/Critical-Access-Hospitals-Center.html

Disproportionate Share Hospitals

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html

Federally Qualified Health Centers Center

https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html

Health Resources and Services Administration

https://www.hrsa.gov

Hospital Center

https://www.cms.gov/Center/Provider-Type/Hospital-Center.html

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http://go.cms.gov/MLNGenInfo

National Association of Community Health Centers

http://www.nachc.org

National Association of Rural Health Clinics

https://narhc.org

National Rural Health Association

https://www.ruralhealthweb.org

Rural Health Clinics Center

https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

Rural Health Information Hub

https://www.ruralhealthinfo.org

Swing Bed Providers

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SwingBed.html

Telehealth

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth

Telehealth Resource Centers

https://www.telehealthresourcecenter.org

U.S. Census Bureau

https://www.census.gov

REGIONAL OFFICE RURAL HEALTH COORDINATORS

To find contact information for CMS Regional Office Rural Health Coordinators who provide technical, policy, and operational assistance on rural health issues, refer to CMS.gov/Outreach-and-Education/Outreach/OpenDoorForums/Downloads/CMSRuralHealthCoordinators.pdf.