Rural Health Clinics (RHCs) Frequently Asked Questions

Topics

Rural Health Clinic (RHC) Payment Limit Per-Visit

Q: How is the RHC payment limit per-visit changing?
A: Section 130 of the CAA (as amended by P. L. 117-7) requires that beginning April 1, 2021, RHCs 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 for independent RHCs and larger provider-based RHCs. Then, in subsequent years, the limit is updated by the percentage increase in Medicare Economic Index. Also beginning April 1, 2021, section 130 of the CAA as amended requires that a payment limit per-visit be established for smaller provider-based RHCs in operation before 2021. Lastly, section 130 of the CAA subjects all newly enrolled RHCs (as of January 1, 2021, and after), both independent and provider-based, to a national payment limit per-visit.

Q: What is the effective date for the RHC payment limit per-visit increase?
A: The effective date for the RHC payment limit per-visit increase is April 1, 2021. Since the payment limits were effective April 1, 2021, Change Request 12185 was issued to instruct the Medicare Administrative Contractors to set the applicable payment limits.

Q: Does the higher payment for RHC visits mean that beneficiaries will have to pay more to access RHC services? If so, can the cost-sharing be waived? If not, will beneficiaries be able to afford them?
A. Except for certain preventive services for which the coinsurance is statutorily waived, cost sharing is applied. The coinsurance is 20 percent of the RHC's charge for covered services. We believe this legislation was implemented to bring the Medicare reimbursement for freestanding RHCs more in line with provider-based RHCs that had an exception to the payment limit. To the extent that an RHC has increased its charges, the beneficiary's coinsurance may be impacted. The legislation did not provide for a waiver of the coinsurance, however, RHCs may waive the copayment and deductible after a good faith determination has been made that the patient is in financial need, provided the waivers are not routine and not advertised. In addition,

many RHCs do have sliding fee scale policies, often set at a percentage of the federal poverty level.

Q. How are new RHCs defined for purposes of the applying the national per-visit limit and provider-based exceptions? Is it the date on the 855 enrollment form or some other date?
A. New RHCs, that is, those that enrolled on or after January 1, 2021, receive the national statutory payment limit. Some provider-based RHCs are entitled to a special payment rule; however, they needed to be, as of December 31, 2020, enrolled in Medicare (including temporary enrollment during the PHE for COVID-19) or have submitted an application for enrollment in Medicare (or a request for temporary enrollment during the PHE for COVID-19) that was received not later than December 31, 2020.

Payment for Attending Physician Services Furnished by RHCs or Federally Qualified Health Centers (FQHCs) to Hospice Patients

Q: What policy was finalized for CY 2022 for the payment of attending physician services furnished by RHCs and FQHCs during a patient's hospice election?
A: Beginning January 1, 2022, RHCs and FQHCs will be eligible to receive payment for hospice attending physician services when provided by a FQHC/RHC physician, nurse practitioner, or physician assistant who is employed or working under contract for an FQHC or RHC, but is not employed by a hospice program.

Concurrent Billing for Chronic Care Management Services (CCM) and Transitional Care Management (TCM) Services for RHCs and FQHCs

Q: What policy was finalized for CY 2022 for the billing of CCM and TCM services furnished in RHCs and FQHCs?
A: Consistent with changes made in the CY 2020 PFS final rule for care management services billed under the PFS, CMS finalized the proposal to allow RHCs and FQHCs to bill for TCM and other care management services furnished for the same beneficiary during the same service period, provided all requirements for billing each code are met.

Q: Can consent for care management services furnished by RHCs and FQHCs be obtained under general supervision after the PHE?
A: Before the PHE for COVID-19, we required that beneficiary consent be obtained either by or under the direct supervision of the primary care practitioner, RHC, and FQHC. This requirement is consistent with the conditions of payment for this service under the PFS. As a PHE flexibility, we have allowed for consent for care management services furnished to occur under general supervision. CMS will continue to evaluate consent for care management services.

COVID-19 Vaccines Furnished in RHCs and FQHCs (Technical Updates)

Q: What change is CMS finalizing for COVID-19 vaccines furnished in RHCs and FQHCs?

A: Section 3713 of the CARES Act established Medicare Part B coverage and payment for a COVID-19 vaccine and its administration. CMS finalized the proposal to make conforming technical changes to the regulatory text related to COVID-19 vaccines for RHCs and FQHCs.

Q: Is CMS finalizing changes to how RHCs and FQHCs are paid for vaccines and their administration to allow for more prompt payment rather than based on the cost report?
A: CMS did not propose any changes to how RHCs and FQHCs are paid for vaccines and administration. Therefore, RHCs and FQHCs are paid 100 percent of reasonable cost through their cost report. Since there is a gap in time from when costs are incurred for furnishing vaccines and when payment is received, the Medicare Administrative Contractors (MACs) have been providing early payments in the form of lump sum payments to RHCs and FQHCs since March of 2021. RHCs and FQHCs can request additional lump sum payments from their MAC at any time.

Mental Health Services furnished via Telecommunications Technologies for RHCs and FQHCs

Q: What policies are being finalized for CY 2022 for RHCs and FQHCs related to use of telehealth technologies?
A: CMS is revising the current regulatory language to permit RHC or FQHC mental health visits to include visits furnished using interactive, real-time telecommunications technology. This will allow RHCs and FQHCs to report and receive payment for mental health visits furnished via real-time telecommunication technology in the same way they currently do when visits take place in-person including audio-only visits when the beneficiary is not capable of, or does not consent to, the use of video technology. CMS is also finalizing that an in-person, non-telehealth visit must be furnished at least every 12 months for these services; however, exceptions to the in-person visit requirement may be made based on beneficiary circumstances (with the reason documented in the patient's medical record) and more frequent visits are also allowed under our policy, as driven by clinical needs on a case-by-case basis.

Q: How is this policy different from the telehealth services that RHCs and FQHCs can furnish during the PHE for COVID-19?
A: During the PHE, RHCs and FQHCs are paid based on an average rate of telehealth services furnished under the PFS. Under this finalized policy, beginning January 1, 2022, RHCs and FQHCs will be paid for mental health visits furnished via telecommunications technology the same way they currently do for in-person mental health visits.

Q: When do the in-person visit requirements take effect for RHC and FQHC mental health visits furnished via telecommunications technology?

A: Consistent with policies finalized for mental health services furnished via telehealth under the Physician Fee Schedule, the in-person visit requirements for mental health services furnished via telecommunications technology will take place on or after the first day after the end of the COVID-19 public health emergency. After that time, there must be an in-person mental health service furnished within 6 months prior to the furnishing of the telecommunications service and

in general, there must be an in-person mental health service (without the use of telecommunications technology) provided at least every 12 months while the beneficiary is receiving services furnished via telecommunications technology for diagnosis, evaluation, or treatment of mental health disorders. Consistent with policies finalized for mental health services furnished via telehealth under the PFS, the in-person service requirements apply only to telehealth services furnished to a patient receiving the service at home.

Q: Can exceptions be made to the in-person visit requirements for RHC and FQHC mental health visits furnished via telecommunications technology?

A: CMS will allow for limited exceptions to the requirement that there be an in-person, non-telehealth service every 12 months based on beneficiary circumstances, in which case the basis for that decision should be documented in the patient's medical record. Specifically, if the patient and practitioner consider the risks and burdens of an in-person service and agree that, on balance, these outweigh the benefits, and the practitioner documents the basis for that decision in the patient's medical record, then the in-person visit requirement is not applicable for that 12-month period. Situations in which the risks and burdens associated with an in-person service may outweigh the benefit could include, but are not limited to, instances when an in-person service is likely to cause disruption in service delivery or has the potential to worsen the patient's condition(s). The risks and burdens associated with an in-person service could also outweigh the benefit if a patient receiving services is in partial or full remission and only requires a maintenance level of care. Other justifications include the clinician's professional judgment that the patient is clinically stable and/or that an in-person visit has the risk of worsening the beneficiary's condition, creating undue hardship on self or family, or if it is determined that the patient is at risk for disengagement with care that has been effective in managing the illness.