CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13505	**Date: December 5, 2025**
	Change Request 14303

SUBJECT: Calendar Year (CY) 2026 Update to Rural Health Clinic (RHC) All Inclusive Rate (AIR) Payment Limit for CY 2026 and Payment Rates for Intensive Outpatient Program (IOP) Services for RHCs

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the CY 2026 payment limits for RHCs. This recurring update notification applies to Chapter 9, Sections 20.2 and 110 of the Claims Processing Manual.

EFFECTIVE DATE: January 1, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 5, 2026

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	**CHAPTER / SECTION / SUBSECTION / TITLE**
N/A	N/A

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification

Attachment - Recurring Update Notification

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II. GENERAL INFORMATION

A. Background: As authorized by section 1833(f) of the Social Security Act (the Act), Medicare Part B payment to RHCs is 80 percent of the AIR, subject to a payment limit for medically necessary medical, and qualified preventive face-to-face visits with a practitioner and a Medicare beneficiary for RHC services.

In accordance with section 1833(f)(2) of the Act, 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. Then, in subsequent years, the limit is updated by the percentage increase in the Medicare Economic Index (MEI) applicable to primary care services furnished as of the first day of that year.

In addition, beginning April 1, 2021, provider-based RHCs that meet the qualifications in section 1833(f)(3)(B) of the Act, are entitled to special payment rules that establish a payment limit based on the specified provider-based RHC's per visit payment amount (or AIR) instead of the national statutory payment limit. For entitlement to the special payment rules, a specified provider-based RHC is an RHC that --

--As of December 31, 2020, was in a hospital with less than 50 beds and after December 31, 2020, in a hospital that continues to have less than 50 beds (not taking into account any increase in the number of beds pursuant to a waiver during the Public Health Emergency (PHE) for Coronavirus Disease 2019 (COVID-19)); and one of the following circumstances:

--As of December 31, 2020, was enrolled in Medicare (including temporary enrollment during the PHE for COVID-19); or

--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.

CR 12185 implemented the increase in the RHC statutory payment limit per visit and established the specified provider-based RHC payment limits per visit, which went into effect on April 1, 2021.

Section 4124 of the Consolidated Appropriations Act of 2023 (CAA, 2023) established coverage and payment under Medicare for the IOP benefit, effective January 1, 2024. Section 4124(c) required payment for IOP services furnished by RHCs to be made at the same payment rate as if it were furnished by a hospital. It also required that costs associated with IOP services furnished by RHCs and Federally Qualified Health Centers to not be used to determine payment amounts under the RHC AIR methodology.

For CY 2024, CMS finalized a three (3) services per day payment rate for IOP services furnished in RHCs and for CY 2025 a four (4) or more services per day payment rate for IOP services furnished in RHCs was established.

CRs 13264 and 13580 implemented these IOP services.

B. Policy: For CY 2026:

<u>1. Independent RHCs and provider-based RHCs in a hospital with 50 or more beds</u>

The RHC payment limit per visit for CY 2026 is $165.00.

<u>2. Specified provider-based RHCs with an April 1, 2021, established payment limit</u>

For specified provider-based RHCs that continue to meet the qualifications in section 1833(f)(3)(B) of the Act, the payment limit per visit for CY 2026 is an amount equal to the greater of:

1. the payment limit per visit beginning January 1, 2025, increased by the percentage increase in MEI applicable to primary care services furnished as of the first day of CY 2026 (that is, 2.7 percent), or

2. the RHC national statutory payment limit per visit for CY 2026 (that is, $165 per visit).

For specified provider-based RHCs that no longer meet the qualifications in section 1833(f)(3)(B) of the Act, the payment limit per visit for CY 2026 is the national statutory payment limit per visit for CY 2026 (that is, $165 per visit).

3. The applicable payment rates for 3 services and 4 or more IOP services furnished in RHCs for IOP services furnished on or after January 1, 2026 are as follows:

The IOP payment rate for 3 or fewer service days is $319.38.

The IOP payment rate for 4 or more service days is $418.45.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
14303.1	Contractors shall increase the RHC payment limit per visit for independent RHCs and provider-based RHCs in a hospital with 50 or more beds to $165.00 to reflect CY 2026 rate.	X								
14303.2	Contractors shall confirm the specified provider-based RHC continues to meet the qualifications in section 1833(f)(3)(B) of the Act as	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	discussed in the Background.									
14303.2.1	Contractors shall increase the specified provider-based RHC payment limit per visit as described in the Policy section, subsection B.2. of this CR, if the specified provider based RHC continues to meet the qualifications.	X								
14303.2.2	Contractors shall set the provider-based RHC's payment limit per visit as $165.00 to reflect CY 2026 rate, if the specified provider-based RHC does not continue to meet the qualifications.	X								
14303.3	Contractors shall not retroactively adjust individual RHC bills paid at previous upper payment limits. However, contractors should make adjustments to the interim payment rate or a lump sum adjustment to total payments already made to take into account any excess or deficiency in payments to date.	X								
14303.4	Contractors shall complete these updates during their scheduled rate review.	X								
14303.5	Contractors shall update the IOP rate for RHC claims (type of bill 71X) when 3 or fewer services ($319.38) and 4 or more IOP services ($418.45) user-controlled field as established in CR 13580.	X								

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately

track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0