CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10780	**Date: May 4, 2021**
	Change Request 12185

Transmittal 10679, dated March 16, 2021, is being rescinded and replaced by Transmittal 10780, dated, May 4, 2021 to revise the background and policy sections. This correction also revises Business Requirement (BR) 12185.2 and adds BR 12185.2.1. All other information remains the same.

SUBJECT: Update to Rural Health Clinic (RHC) Payment Limits

I. SUMMARY OF CHANGES: This Change Request updates the payment limit for Rural Health Clinics (RHCs) in Chapter 9, Section 20.2 - "Payment Limit under the AIR" of the Claims Processing Manual effective April 1, 2021.

EFFECTIVE DATE: April 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 5, 2021

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:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 10780	Date: May 4, 2021	Change Request: 12185

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SUBJECT: Update to Rural Health Clinic (RHC) Payment Limits

EFFECTIVE DATE: April 1, 2021
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I. GENERAL INFORMATION

A. Background: As authorized by section 1833(f) of the Social Security Act (the Act), Medicare Part B payment to independent RHCs is 80 percent of the All-Inclusive Rate (AIR), subject to a payment limit for medically necessary medical, mental, and qualified preventive face-to-face visits with a RHC practitioner and a Medicare beneficiary for RHC services. The payment limits for subsequent years are increased in accordance with the rate of increase in the Medicare Economic Index (MEI).

In addition, under section 1833(f) of the Act, an RHC that is provider-based to a hospital with fewer than 50 beds is exempt from the statutory payment limit per visit. That is, a provider-based RHC's AIR (also referred to as per visit payment amount) is based on their average allowable costs determined at cost report settlement.

In the interim final rule (IFC) with comment, published in the May 8, 2020 Federal Register (85 FR 27550-27569), CMS implemented a policy that excludes temporarily added surge capacity beds due to the Public Health Emergency (PHE) for the COVID–19 pandemic (defined at § 400.200) from a hospital's bed count (discussed at § 412.105(b)) for the purposes of determining whether an RHC that is provider-based to that hospital is exempt from the statutory payment limit per visit.

Effective January 1, 2021, the RHC payment limit per visit for Calendar Year (CY) 2021 is $87.52. This payment limit applies to independent RHCs and RHCs that are provider-based to a hospital with 50 or more beds. This payment limit was implemented through Change Request 12035, Transmittal 10413, entitled "Update to Rural Health Clinic (RHC) All Inclusive Rate (AIR) Payment Limit for Calendar Year (CY) 2021".

Division CC, section 130 of the Consolidated Appropriations Act of 2021(P. L. 116-260), signed December 27, 2020, updated §1833(f) of the Act by restructuring the payment limits for RHCs beginning April 1, 2021.

Section 2 of H.R.1868 (P. L. 117-7), signed April 14, 2021, provided a technical correction to §1833(f). The amendments made by this technical correction take effect as if included in the enactment of the Consolidated Appropriations Act of 2021(P. L. 116-260).

B. Policy:
1. Independent RHCs and provider-based RHCs in a hospital with 50 or more beds

Beginning April 1, 2021, in accordance with section 1833(f)(2) of the Act, RHCs will begin to 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 MEI applicable to primary care services furnished as of the first day of that year.

The RHC payment limit per visit over an 8-year period is as follows:

- in 2021, after March 31, at $100 per visit;
- in 2022, at $113 per visit;
- in 2023, at $126 per visit;
- in 2024, at $139 per visit;
- in 2025, at $152 per visit;
- in 2026, at $165 per visit;
- in 2027, at $178 per visit; and
- in 2028, at $190 per visit.

2. Provider-Based RHCs in a hospital with less than 50 beds

a. Provider-based RHCs that are Determined to be Grandfathered

Beginning April 1, 2021, provider-based RHCs that meet the criteria in section 1833(f)(3)(B) of the Act are entitled to special payment rules, as described in section 1833(f)(3)(A) of the Act.

Provider-based RHCs that meet the criteria in section 1833(f)(3)(B) of the Act are considered to be "grandfathered" into the establishment of their payment limit per visit. Meaning, those provider-based RHCs that meet the following criteria will have a payment limit per visit established (beginning with services furnished 4/1/2021) based on their AIR. A "grandfathered 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 COVID-19 PHE); and one of the following circumstances:
    - As of December 31, 2020, was enrolled in Medicare (including temporary enrollment during the COVID-19 PHE); or
    - Submitted an application for enrollment in Medicare (or a request for temporary enrollment during the COVID-19 PHE) that was received not later than December 31, 2020.

With regard to the reference of the waiver during the COVID-19 PHE, CMS will take into account the policy finalized in the interim final rule with comment, published in the May 8, 2020 Federal Register (85 FR 27550-27529). Provider-based RHCs that were exempt from the statutory payment limit per visit pursuant to section 1833(f)(3)(B) whose associated hospitals have experienced temporarily added surge capacity beds will be considered "grandfathered" in accordance with the policy set out in the May 8, 2020 IFC.

A grandfathered provider-based RHC will lose this designation if the hospital does not continue to have less than 50 beds. If this occurs, the provider-based RHC will be subject to the statutory payment limit per visit applicable for such year for RHCs (that is, section B.1. of this Change Request).

Provider-based RHCs that are new beginning January 1, 2021 and after are subject to the statutory payment limit per visit applicable for such year for RHCs (that is, section B.1. of this Change Request).

b. Establishing payment limits for Grandfathered Provider-Based RHCs

In accordance with section (f)(3)(A) of the Act, grandfathered provider-based RHCs will have a payment limit per visit based on their AIR and established in the following manner:

For provider-based RHCs that had a per visit payment amount (or AIR) established for services furnished in 2020, the payment limit per visit shall be at an amount equal to the greater of:

1. the per visit payment amount applicable to the provider-based RHC for services furnished in 2020, increased by the percentage increase in the MEI applicable to primary care services furnished as of the first day of 2021 (that is, CY 2021 MEI of 1.4 percent), or
2. the payment limit per visit applicable to RHCs ($100 as stated in section B.1. of this Change Request).

Then, in a subsequent year (that is, after 2021), the provider-based RHC's payment limit per visit will be the greater of:

1. the payment limit per visit established for the previous year, increased by the percentage increase in MEI applicable to primary care services furnished as of the first day of such subsequent year, or
2. the payment limit per visit applicable to each year for RHCs (as stated in section B.1. of this Change Request).

For provider-based RHCs that did not have a per visit payment amount (or AIR) established for services furnished in 2020, the payment limit per visit shall be at an amount equal to the greater of:

1. the per visit payment amount applicable to the provider-based RHC for services furnished in 2021, or
2. the payment limit per visit applicable to RHCs (as stated in section B.1. of this Change Request).

Then, in a subsequent year (that is, after 2022), the provider-based RHC's payment limit per visit will be the greater of:

1. the payment limit per visit established for the previous year, increased by the percentage increase in MEI applicable to primary care services furnished as of the first day of such subsequent year, or
2. the payment limit per visit applicable for such subsequent year for RHCs (as stated in section B.1. of this Change Request).

CMS plans to discuss certain policies and processes used in establishing provider-based RHC's per visit payment amount in the CY 2022 Physician Fee Schedule rules.

CMS shall continue to provide the MEI update and applicable rate updates in the Recurring Annual RHC CR.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
12185.1	Contractors shall increase the RHC payment limit per visit to $100.00 to reflect Consolidated Appropriations	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Act of 2021 updates, effective April 1, 2021 through December 31, 2021.									
12185.2	Contractors shall identify grandfathered provider-based RHCs as described in section B.2.a of this Change Request.	X								
12185.2.1	Contractors shall establish the payment limit per visit for grandfathered provider-based RHCs as described in section B.2.b of this Change Request.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12185.3	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X				

IV. 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

V. CONTACTS

Pre-Implementation Contact(s): Glenn McGuirk, 410-786-5723 or Glenn.McGuirk@cms.hhs.gov , Lisa Parker, 410-786-4949 or Lisa.Parker1@cms.hhs.gov

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

VI. FUNDING

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