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Rural Health Clinic All-Inclusive Rate: CY 2023 Update

MLN Matters Number: MM12999 Related Request (CR) Number: 12999

Related CR Release Date: November 23, 2022 Effective Date: January 1, 2023

Related CR Transmittal Number: R11718CP Implementation Date: January 3, 2023

Related CR Title: Update to Rural Health Clinic (RHC) All Inclusive Rate (AIR) Payment Limit for Calendar Year (CY) 2023

Provider Types Affected

This MLN Matters Article is for RHCs billing Medical Administrative Contractors (MACs) for services provided to Medicare patients.

Provider Action Needed

Make sure your billing staff knows about:

- RHC per-visit payment limit for CY 2023
- Specified (grandfathered) provider-based RHC payment limits
- Cost report data requirements

Background

Section 1833(f)(2) of the Social Security Act (the Act) requires CMS to increase the payment limit per visit RHCs get for an 8-year period (from 2021-2028). Medicare's Part B payment to RHCs is 80% 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 patient for RHC services.

We update the limit by the percentage increase in the Medicare Economic Index (MEI) applicable to primary care services provided as of the first day of that year.

Starting April 1, 2021, provider-based RHCs that met the qualifications in Section 1833(f)(3)(B) of the Act are entitled to special payment rules that set a payment limit based on the specified provider-based RHC's per visit AIR payment amount instead of the national statutory payment limit.

For entitlement to the special payment rules, a specified provider-based RHC (grandfathered

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RHC) is an RHC that:

- As of December 31, 2020, was in a hospital with less than 50 beds and
- After December 31, 2020, was 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 Public Health Emergency (PHE), and 1 of the following circumstances:
  - As of December 31, 2020, was enrolled in Medicare (including temporary enrollment during the PHE) or
  - Submitted a Medicare enrollment application (or a request for temporary enrollment during the PHE) that we got before January 1, 2021.

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

Note: We use the term specified the same as the term grandfathered in CR 12999 and CR 12185.

Policy for CY 2023

The RHC payment limit per visit for CY 2023 is $126.00 for independent RHCs and provider-based RHCs in a hospital with 50 or more beds

Specified (grandfathered) provider-based RHCs with an April 1, 2021, established payment limit that continue to meet the qualifications in Section 1833(f)(3)(B) of the Act, the payment limit per visit for CY 2023 is an amount equal to the greater of:

- The payment limit per visit starting January 1, 2022, increased by the MEI 3.8% for primary care services provided as of the first day of CY 2023 (3.8 %*), or
- The RHC national statutory payment limit per visit for CY 2023 ($126 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 2023 is the national statutory payment limit per visit for CY 2023 ($126 per visit)

Specified provider-based RHCs that don't have an April 1, 2021, established payment limit due to a pending final settled cost report:

- Under Section 1833(f)(3)(A) of the Act, specified provider-based RHCs that didn't have a per-visit payment amount (or AIR) set for services provided in CY 2020 will have a payment limit per visit based on their AIR and set at an amount equal to the greater of:
  - The per-visit payment amount applicable to the provider-based RHCs for services provided in 2021, or
  - The RHC national statutory payment limit per visit for CY 2023 ($126 per visit)

Cost Report Data Requirements and Applicability of the 2021 MEI Percentage Increase

CR 12999 clarifies the timing of cost reports used to establish the payment limit for specified provider-based RHCs. MACs will use 12 consecutive month final settled cost reports and not final settled short period cost reports (less than 12 consecutive months).

For specified provider-based RHCs defined in Section 1833(f)(3)(A)(i)(I) of the Act who had an AIR for services provided in 2020, MACs will use the cost report ending in 2020 that reports costs for 12 consecutive months. If the RHC doesn't have a 12 consecutive month cost report ending in 2020, MACs will use the next available 12 consecutive month cost report that reports costs for RHC services provided in 2020. For example, a cost reporting period from October 1, 2020, through September 30, 2021, would be acceptable.

For specified provider-based RHCs defined in Section 1833(f)(3)(A)(i)(II) of the Act that didn't have an AIR for services provided in 2020, MACs will use the cost report ending in 2021 that reports costs for 12 consecutive months. If the RHC doesn't have a 12 consecutive month cost report ending in 2021, MACs will use the next most recent final settled cost report that reports cost for 12 consecutive months. When deciding the per-visit payment amount applicable to the provider-based RHCs for services in 2021, we won't apply the 2021 MEI percentage increase.

Note: MACs won't combine cost report data to equal a 12-consecutive month cost report.

More Information

We issued CR 12999 to your MAC as the official instruction for this change.

For more information, find your MAC's website.

Document History

Date of Change	Description
November 29, 2022	Initial article released.