Program Memorandum Intermediaries

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal A-02-044 **Date: MAY 29, 2002**

This Program Memorandum re-issues Program Memorandum A-01-49, Change Request 1600 dated April 5, 2001. The only change is the discard date; all other material remains the same.

CHANGE REQUEST 1600

SUBJECT: Announcement of Medicare Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Payment Rate Increases, Changes to the RHC Benefit Made by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 and Clarification Regarding Drugs Furnished by RHCs/FQHCs.

Change in FQHC and RHC Payment Rates

RHCs:

For calendar year (CY) 2001, the Medicare RHC upper payment limit per visit is increased to $63.14 effective January 1, 2001 through December 31, 2001. The 2001 rate reflects a 2.1 percent increase over the 2000 payment limit in accordance with the rate of increase in the Medicare Economic Index (MEI) as authorized by §1833(f) of the Social Security Act (the Act).

FQHCs:

For CY 2001, the Medicare FQHC upper payment limit per visit for urban FQHCs is increased to $98.03 effective January 1, 2001 through December 31, 2001, and the maximum Medicare payment limit per visit for rural FQHCs is increased to $84.28 effective January 1, 2001through December 31, 2001. The 2001 FQHC rates reflect a 2.1 percent increase over the 2000 rates, in accordance with the rate of increase in the MEI.

The effective date of January 1, 2001, is necessary in order to update FQHC and RHC payment rates in accordance with §1833(f) of the Act. To avoid unnecessary administrative burden, the intermediary should not retroactively adjust individual RHC/FQHC bills paid at previous upper payment limits.

The intermediary does, however, retain the discretion to make adjustment 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. (See §504.2 of CMS Pub. 27, *The Medicare Rural Health Clinic and Federally Qualified Health Center Manual*.)

BIPA and Provider-based RHCs

Under the Balanced Budget Act (BBA) of 1997, the independent RHC all-inclusive payment methodology and annual payment limit is also used for provider-based RHCs. This BBA provision also provided an exception to the RHC payment limit for those RHCs based in small rural hospitals.

The CMS implemented this provision effective January 1, 1998, by releasing a program memorandum which directed Medicare intermediaries to use the bed definition at 42 CFR 412.105(b) and the rural definition at 42 CFR 412.62(f)(1)(ii)(A) to determine which RHCs are eligible for the exception. CMS's hospital bed definition is based on available bed days and the rural definition is based on the Office of Management and Budget's metropolitan statistical area (MSA) method.

Effective July 1, 2001, §224 of BIPA expanded the eligibility criteria for receiving an exception to the RHC annual payment limit. Specifically, this section of BIPA extends the exemption to RHCs based in small urban hospitals. Thus, all hospitals of less than 50 beds are now eligible to receive an exception from the per visit payment limit for their RHCs.

Use the above bed size and MSA definition, effective July 1, 2001, to determine which provider-based RHCs are eligible for an exception to the payment limit. Specifically, grant exceptions from the RHC payment cap to clinics based in hospitals located in MSAs that are operating with less than 50 available beds.

Medicare Covered Drugs Furnished by RHCs/FQHCs

In light of recent inquiries regarding the payment for Medicare covered drugs, we are clarifying drug coverage and payment policies under RHC/FQHC benefits.

RHC services include, in accordance with §1861(aa)(1) of the Act, physician and non-physician services and any services and supplies incident to their professional services. Section 406 of the RHC/FQHC Manual, CMS Pub. 27, elaborates on the coverage definition of supplies and services incident to a physician's professional services.

Medicare covers drugs which are not usually self-administered by the patient as services and supplies incident to a physician's professional services. Consequently, if Medicare covered drugs are furnished by physicians and non-physician practitioners of the RHC/FQHC to Medicare patients, the drugs must be covered and paid for as RHC/FQHC services. The cost of such drugs are allowable costs and are part of the clinic's all-inclusive rate calculation.

Promptly notify all RHCs/FQHCs of these changes and clarifications.

The effective dates for this Program Memorandum (PM) are various dates as stated in the PM.

The implementation date for this PM is various dates as specified below:

Change in FQHC and RHC Payment Rates – at tentative or final cost settlement.

BIPA and Provider-based RHCs – July 1, 2001.

Medicare Covered Drugs Furnished by RHC/FQHCs – April 5, 2001.

For questions pertaining to payment and coverage, please contact David Worgo, on (410) 786-5919. For questions concerning claims processing, contact Gertrude Saunders (410) 786-5888.

This PM may be discarded after May 31, 2003.