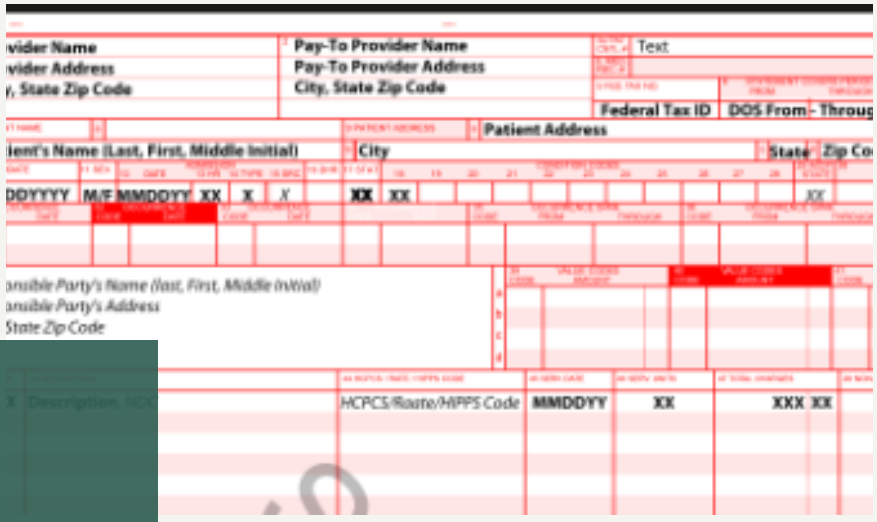

BEYOND THE ROUNDS

August 3, 2026

Demystifying Rural Health Clinic Reimbursement: The All-Inclusive Rate (AIR)

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Few concepts in rural healthcare financial management generate as much discussion, debate, and confusion as the Rural Health Clinic (RHC) All-Inclusive Rate. Whether in C-suite strategy meetings, clinical provider orientations, or daily revenue discussions, understanding how the AIR works - and how payment flows from it - remains a cornerstone of successful RHC operations.

When a medical practice becomes an RHC, it formally opts out of standard Medicare Fee-for- Service (FFS) reimbursement. In place of individual CPT-code payment, RHCs accept an All-Inclusive Rate (AIR) - a bundled, cost-based payment model designed by CMS to ensure financial stability for clinics serving rural communities.

Under FFS, clinic revenue depends on volume and specific procedures. Under the AIR model, Medicare pays a flat, encounter-based rate for every qualifying face-to-face visit, regardless of whether the encounter was a quick check-up or a complex procedure.

In this weeks Beyond the Rounds, we will dive further into the unique world of RHC reimbursement to explain exactly how the AIR is calculated, how the Medicare payment and patient coinsurance are determined, special instances where the AIR is paid at 100%, and some of the instances when payment is received outside the AIR.

1. Calculating Your AIR

Your clinic's AIR is established through your annual Medicare Cost Report. The formula is straightforward:

$$\text{All-Inclusive Rate (AIR)} = \frac{\text{Total Allowable Operational Costs}}{\text{Total Allowable Patient Visits}}$$

Total Allowable Costs: Direct clincial and operational expenses (salaries, supplies, rent, utilities, overhead)

Total Allowable Visits: Medically necessary, face-to-face encounters with an authorized RHC provider.

2. Understanding the Statutory Cap

While the AIR formula is cost-based, reimbursement is capped by a statutory Upper Payment Limit (UPL).

- **Cost ≥ UPL**: You AIR is capped at the UPL amount
- **Cost < UPL:** Your AIR is set at your actual calculated cost per visit

Enacted via the Consolidated Appropriates Act of 2021, the national statutory UPL for independent and post-2020 provider -based RHC's increases by $13 per year through 2028. Beginning in 2029, the cap will adjust annually based on the Medicare Economic Index (MEI) percentage increase.

Historically, provider-based RHC's owned by hospitals with under 50 beds enjoyed uncapped cost-based reimbursement. Legislative changes

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established two distinct rules:

Independent & Post-2020 Provider Based RHCs: Clinics established or certified on or after 12/31/2020, are subject to the national statutory UPL ($165.00 in 2026).

Grandfathered Provider-Based RHCs: Clinics certified prior to 12/31/2020, attached to hospitals with fewer than 50 beds, maintained a specialized clinic-specific cap. A grandfathered clinic's UPL is capped at its filed 2020 cost per visit, adjusted annually by the MEI.

Because interim AIR payments are reconciled against the annual cost report at year-end, keeping allowable costs aligned with or slightly above your applicable UPL ensures maximum allowable reimbursement without triggering overpayment clawbacks. However, as the statutory UPL continues to grow progressively each year toward $190.00 in 2028, it will be come increasingly difficult for some independent RHCs to reach or hit that cap. It is important to remember that even if your clinic does not reach the maximum limit, you will continue to receive reimbursement based on your clinic's actual cost per visit filed on your cost report

3. Qualifying AIR Encounters

To trigger an AIR payment, an encounter must meet key CMS criteria:

- **Face-to-Face:** Direct encounter between patient an provider (including approve mental health telehealth)
- **Medically Necessary:** Evaluates or treats a billable medical or mental health condition.
- **Allowable Provider:** Conducted by an MD/DO. NP, PA, CNM, CP, LCSW, LMFT, or MHC

RHC visits are subject to the Part B 80/20 cost-sharing benefits. For routine qualifying visits subject to cost-sharing, Medicare reimburses 80% of your current AIR, after accounting for statutory sequestration:

$$\text{Medicare Payment} = (\text{Current AIR} \times 0.80) - 2\% \text{ Sequestration}$$

The remaining 20% responsibility is paid by the patient or their secondary insurance as coinsurance. Unlike FFS where the coinsurance is based on the Medicare fee schedule, RHC patient coinsurance is based on the clinic's total actual charges reported on the line item carrying Modifier CG:

- **Bundled Charges:** All fees for services for that encounter (e.q. E&M + injections) roll up into the CG line charge. The supporting services are then reported with a fee of at least $0.01.
- **Coinsurance Base:** The MAC calculates 20% patient coinsurance strictly from the total charge amount attached to the CG line.

Example Claim Scenario:
99214, CG at $275.00
J3301 at $0.01 (actual fee is $25, added above with 99214)
AIR Rate: $165.00
Medicare Pays: $129.36 (80% minus 2%)
Coinsurance: $55.00 (20% of charge)

4. When an AIR is NOT Paid

There are services that are statutorily excluded from receiving the AIR payment. Some of these services are not billable (nurse visits), some paid outside the AIR by your Part B MAC (e.g. labs, technical components) and others are paid by your Part A MAC but at a separate rate (telehealth, CCM, RPM, and Part B vaccines).

- **Nurse-Only Visits:** Injection-only, nurse blood pressure checks, or routine blood draws do not qualify as qualifying visit and are not billable alone
- **Technical Components & Labs:** Lab testing (including required RHC testing) or technical components of diagnostics (EKG and imaging) are billed separately under FFS rates
- **Medical Telehealth**: Distant site (provider located in the RHC) under current flexibilities reimbursed at $97.35 (2026). Originating site (patient located in the RHC) reimbursed at $31.85 (2026).
- **Care Management:** Chronic Care Management (CCM) and Remote Patient Monitoring (RPM) are reimbursed at current FFS rates.

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- **Part B Vaccines:** As of 7/1/2025, Part B preventative vaccines (flu, pneumonia, COVID, & Hep B) are reimbursed at Fair Market Value and then settled to 100% cost via your annual cost report. They can be billed alone or with a qualifying visit.

5. Preventative Services Exception (100% of AIR)

Certain Medicare preventative services- such as the Annual Wellness Visit (AWV), Initial Preventative Exam (IPPE), and qualifying screenings - are exempt from patient cost-sharing.

- **100% AIR Payment:** For stand-alone preventative visits, Medicare pays 100% of your AIR (minus 2% sequestration.).
- **Zero Coinsurance:** Deductibles and coinsurances are waived, leaving zero balance for the patient.
- **Reporting:** Modifier CG is still appended to preventative code to trigger AIR reimbursement

6. Same-Day Multiple Visits: What Qualifies?

As a general rule, CMS limits RHC reimbursement to one AIR payment per patient per day, regardless of how many practitioners the patient sees. However, specific exceptions allow for multiple AIR payments on the same day of service:

Receive Multiple AIR Payments:

- **Medical + Mental Health Visit:** A medical encounter and a distinct mental health encounter on the same day.
- **IPPE & Medical Visit:** Initial Preventative Physical Exam (IPPE) combined with a seperate medical or mental health visit.
- **Subsequent Unrelated Illness/Injury:** Patient leaves & returns later in the day for an unexpected, distinct medical condition (e.g., saw practitioner in morning for chronic condition, returned in afternoon for a fall/injury). This is only instance when the 59 modifier is applicable.

Does NOT Receive Multiple AIR Payments (Consolidated to 1 AIR):

- **Multiple Medical Visits:** Two routine medical visits on the same day with the same or different providers in the same RHC for related management. (e.g. visit with primary and with specialty)
- **AWV + Medical Visit:** Annual Wellness Visit combined with a medical E&M visit on the same day (cost-sharing applies only to the medical portion, but paid as 1 AIR)

Final Thought: Key Action Items for RHCs

To maximize reimbursement and protect your clinic's financial health under the All-Inclusive Rate model, leadership and operational teams should focus on three immediate priorities:

- **Actively Monitor Your Cost per Visit**: RHC leadership must regularly evaluate direct expenses against total qualifying visit volumes. Tracking your actual cost per visit throughout the fiscal year allows you to understand where your clinic sits relative to the statutory Upper Payment Limit (UPL). This ongoing monitoring prevents unexpected year-end cost report reconciliation adjustments and ensures your interim rate reflects your true cost structure.
- **Maintain Realistic Billed Fee Schedules:** Because Medicare calculates RHC patient coinsurance as 20% of the clinic's total actual billed charges on the CG modifier line—rather than a Medicare fee schedule amount—your fee schedule directly dictates patient out-of-pocket costs. Reviewing and updating your clinic's charge master ensures your billed charges remain fair, compliant, and market-appropriate while preventing artificial financial barriers for your patients.
- **Routinely Audit Medicare Claims & Remittances:** Revenue cycle teams should regularly audit outgoing claims and payment statements to verify compliance and catch billing errors. Audits should ensure all visit charges roll up correctly into the Modifier CG line, non-qualifying nurse visits (like blood pressure checks or blood draws) are not billed as AIR encounters, and same-day multiple visits are formatted properly. Routine review guarantees your clinic receives accurate reimbursement while preventing costly compliance risks.

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