Priority Health	BILLING POLICY No. 178
FACILITY RATE CHANGE LETTERS	
Date of origin: 02/2026	**Review dates: 08/2026**

POLICY OVERVIEW

This policy provides guidelines for facility rate change letters submission to Priority Health, ensuring claims are processed according to contractual agreements and industry standards.

DEFINITION

A facility rate change letter issues by the Centers for Medicare and Medicaid Services (CMS) Fiscal Intermediary (FI) details interim rate changes to payment structures, timing, and compliance regulation for various facility types such as Critical Access Hospitals (CAH), Children's Hospitals, Cancer Hospitals, Rural health Clinics (RHC), and Federally Qualified Health Centers (FQHC).

POLICY SPECIFIC INFORMATION

Facilities required to submit CMS rate letters include:

- Critical Access Hospitals (CAH)
- Children's Hospitals
- Cancer Hospitals
- 'Rural Health Clinics (RHC)
- Federally Qualified health Centers (FQHC)

Priority Health requires the CMS rate letter for initial contract agreements and for all in and out of network facilities. This reimbursement information is utilized to determine facility rates for accuracy in payment.

Priority Health requires the facilities outlined below to submit their CMS rate letter no less than every 12 months or within 30 days of the date of receiving an interim rate change notification letter (whichever is earlier). We will apply the new rates to the dates of service either on the 1st or 15th of the month based on date of receipt of a fully completed rate change notification form with submitted rate change letter. Facilities should allow 30 days for processing of this change. We will not utilize the effective date detailed in the CMS rate letter.

Failure to submit the CMS interim rate letter and applicable rate change letters will result in claims processing at the last verified rate change letters. Claims may be reprocessed retrospectively back 12 months if there is a decrease in payment.

Rate letters should be submitted as noted below:
The typical process is for facilities to submit the rate change documentation to Contracting. Contracting then uploads the documentation into EVIPs, which initiates the workflow to the appropriate teams to review and complete any necessary system updates. EVIPs is the contract management platform where our contracting team saves our agreements.

Notification should include the National Provider identifier (NPI) associated with the Provider Number/Provider Transactions Access Number (PTAN) along with the contact information for this facility.

Submissions with missing requirements will be returned to the facility for completion.

Related policies

FQHC, RHC and THC billing | Priority Health

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
02/2026	Policy Created
08/2026	Policy Overview, Definitions and Rate letter submission guidelines added.