

## § 405.2460

(4) Services and supplies must be furnished in accordance with applicable State law; and

(5) Furnished under the direct supervision of a clinical psychologist or clinical social worker.

(b) The direct supervision requirement in paragraph (a)(5) of this section is met only if the clinical psychologist or clinical social worker is permitted to supervise such services under the written policies governing the FQHC.

[43 FR 8261, Mar. 1, 1978, as amended at 78 FR 74810, Dec. 10, 2013; 79 FR 25477, May 2, 2014; 79 FR 68001, Nov. 13, 2014]

### PAYMENT FOR RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES

SOURCE: 57 FR 24976, 24977, June 12, 1992, unless otherwise noted.

#### § 405.2460 Applicability of general payment exclusions.

The payment conditions, limitations, and exclusions set out in subpart C of this part, part 410 and part 411 of this chapter are applicable to payment for services provided by RHCs and FQHCs, except that preventive primary services, as defined in § 405.2448, are statutorily authorized for FQHCs and not excluded by the provisions of section 1862(a) of the Act.

[79 FR 25477, May 2, 2014]

#### § 405.2462 Payment for RHC and FQHC services.

(a) *Payment to independent RHCs that are authorized to bill under the reasonable cost system.* (1) RHCs that are authorized to bill under the reasonable cost system are paid on the basis of an all-inclusive rate, subject to a payment limit per visit determined in paragraph (b) of this section, for each beneficiary visit for covered services. This rate is determined by the Medicare Administration Contractor (MAC), in accordance with this subpart and general instructions issued by CMS.

(2) The amount payable by the MAC for a visit is determined in accordance with paragraphs (i)(1) and (2) of this section.

(b) *RHC payment limit per visit.* (1) In establishing limits on payment for rural health clinic services provided by

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rural health clinics the limit for services provided prior to April 1, 2021:

(i) In 1988, after March 31, at \$46 per visit; and

(ii) In a subsequent year (before April 1, 2021), at the limit established for the previous year increased by the percentage increase in the Medicare Economic Index (MEI) (as defined in section 1842(i)(3) of the Act) applicable to primary care services (as defined in section 1842(i)(4) of the Act) furnished as of the first day of that year.

(2) In establishing limits on payment for rural health services furnished on or after April 1, 2021, by rural health clinics or any rural health clinic that is enrolled on or after January 1, 2021 under section 1866(j) of the Act), the limit for services provided:

(i) In 2021, after March 31, at \$100 per visit;

(ii) In 2022, at \$113 per visit;

(iii) In 2023, at \$126 per visit;

(iv) In 2024, at \$139 per visit;

(v) In 2025, at \$152 per visit;

(vi) In 2026, at \$165 per visit;

(vii) In 2027, at \$178 per visit; and

(viii) In 2028, at \$190 per visit.

(ix) In a subsequent year, at the limit 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 year.

(3) In establishing limits on payment for rural health services furnished on or after April 1, 2021, by provider-based rural health clinics as described in section (c)(4) of this part, the limit for services provided:

(i) In 2021, after March 31, at an amount equal to the greater of:

(A) For rural health clinics that had an all-inclusive rate established for services furnished in 2020—

(I) The all-inclusive rate applicable to the rural health clinic 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, or

(2) The payment limit per visit applicable in paragraph (b)(2) of this section.

(B) For rural health clinics that did not have an all-inclusive rate established for services furnished in 2020—

(1) The all-inclusive rate applicable to the rural health clinic for services furnished in 2021, or

(2) The payment limit per visit applicable in paragraph (b)(2) of this section.

(ii) In a subsequent year, at an amount equal to the greater of:

(A) The amount established under paragraph (b)(3)(i)(A) or (B) of this section, as applicable 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

(B) The payment limit per visit applicable under paragraph (b)(2) of this section for such subsequent year.

(c) *Payment to provider-based RHCs that are authorized to bill under the reasonable cost system.* (1) An RHC that is authorized to bill under the reasonable cost system is paid in accordance with parts 405 and 413 of this subchapter, as applicable, if the RHC is—

(i) An integral and subordinate part of a hospital, skilled nursing facility or home health agency participating in Medicare (that is, a provider of services); and

(ii) Operated with other departments of the provider under common licensure, governance and professional supervision.

(2) An RHC, described in paragraph (c)(1) of this section, is paid on the basis of an all-inclusive rate, subject to a payment limit per visit, described in paragraphs (b)(1) and (2) of this section, for each beneficiary visit for covered services when in a hospital with greater than 50 beds as determined in § 412.105(b) of this subchapter. This all-inclusive rate is determined by the MAC, in accordance with this subpart and general instructions issued by CMS. The amount payable by the MAC for a visit is determined in accordance with paragraphs (i)(1) and (2) of this section.

(3) Prior to April 1, 2021, an RHC, described in paragraph (c)(1) of this section, is paid on the basis of an all-inclusive rate and is not subject to a payment limit per visit described in paragraphs (b)(1) and (2) of this section for each beneficiary visit for covered services when in a hospital with less than 50 beds as determined in § 412.105(b) of

this subchapter. This all-inclusive rate is determined by the MAC, in accordance with this subpart and general instructions issued by CMS. The amount payable by the MAC for a visit is determined in accordance with paragraphs (i)(1) and (2) of this section.

(4) On or after April 1, 2021, an RHC, described in paragraph (c)(1) of this section, is paid on the basis of an all-inclusive rate, subject to a payment limit per visit, described in paragraph (b)(3) of this section, for each beneficiary visit for covered services when it meets the specified qualifications in paragraph (d) of this section. This all-inclusive rate is determined by the MAC, in accordance with this subpart and general instructions issued by CMS. The amount payable by the MAC for a visit is determined in accordance with paragraphs (i)(1) and (2) of this section.

(d) *Specified qualifications.* A provider-based rural health clinic must meet the following qualifications to have a payment limit per visit established in accordance with paragraph (b)(3) of this section.

(1) As of December 31, 2020, was in a hospital with less than 50 beds (as determined in § 412.105(b) of this subchapter) 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 Public Health Emergency (PHE)); and one of the following circumstances:

(i) As of December 31, 2020, was enrolled under section 1866(j) of the Act (including temporary enrollment during the COVID-19 PHE); or

(ii) Submitted an application for enrollment under section 1866(j) of the Act (or a request for temporary enrollment during the COVID-19 PHE) that was received not later than December 31, 2020.

(2) [Reserved]

(e) *Payment to FQHCs that are authorized to bill under the PPS.* A FQHC that is authorized to bill under the PPS is paid a single, per diem rate based on the prospectively set rate for each beneficiary visit for covered services. Except as noted in paragraph (f) of this section, this rate is adjusted for the following:

(1) Geographic differences in cost based on the Geographic Practice Cost Indices (GPCIs) in accordance with section 1848(e) of the Act and 42 CFR 414.2 and 414.26 are used to adjust payment under the physician fee schedule during the same period, limited to only the work and practice expense GPCIs.

(2) Furnishing of care to a beneficiary that is a new patient with respect to the FQHC, including all sites that are part of the FQHC. A new patient is one that has not been treated by the FQHC's organization within the previous 3 years.

(3) Furnishing of care to a beneficiary receiving a comprehensive initial Medicare visit (that is an initial preventive physical examination or an initial annual wellness visit) or a subsequent annual wellness visit.

(f) *Payment to grandfathered tribal FQHCs.* (1) A “grandfathered tribal FQHC” is a FQHC that:

(i) Is operated by a tribe or tribal organization under the Indian Self-Determination Education and Assistance Act (ISDEAA);

(ii) Was billing as if it were provider-based to an IHS hospital on or before April 7, 2000; and

(iii) Is not operating as a provider-based department of an IHS hospital.

(2) A grandfathered tribal FQHC is paid at the Medicare outpatient per visit rate as set annually by the IHS.

(3) The payment rate is not adjusted:

(i) By the FQHC Geographic Adjustment Factor;

(ii) For new patients, annual wellness visits, or initial preventive physical examinations; or

(iii) Annually by the Medicare Economic Index or a FQHC PPS market basket.

(4) The payment rate is adjusted annually by the IHS under the authority of sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C. 248 and 249(b)), Pub. L. 83–568 (42 U.S.C. 2001(a)), and the Indian Health Care Improvement Act (25 U.S.C. 1601 *et seq.*).

(g)(1) Except for preventive services for which Medicare pays 100 percent under § 410.152(l) of this chapter, Medicare pays—

(i) Eighty (80) percent of the lesser of the FQHC's actual charge or the PPS

encounter rate for FQHCs authorized to bill under the PPS; or

(ii) Eighty (80) percent of the lesser of a grandfathered tribal FQHC's actual charge, or the outpatient rate for Medicare as set annually by the IHS for grandfathered tribal FQHCs that are authorized to bill at this rate.

(2) No deductible is applicable to FQHC services.

(h) For RHCs visits, payment is made in accordance with one of the following:

(1) If the deductible has been fully met by the beneficiary prior to the RHC visit, Medicare pays 80 percent of the all-inclusive rate.

(2) If the deductible has not been fully met by the beneficiary before the visit, and the amount of the RHC's reasonable customary charge for the services that is applied to the deductible is less than the all-inclusive rate, the amount applied to the deductible is subtracted from the all-inclusive rate and 80 percent of the remainder, if any, is paid to the RHC.

(3) If the deductible has not been fully met by the beneficiary before the visit, and the amount of the RHC's reasonable customary charge for the services that is applied to the deductible is equal to or exceeds the all-inclusive rate, no payment is made to the RHC.

(i) To receive payment, the RHC or FQHC must do all of the following:

(1) Furnish services in accordance with the requirements of subpart X of part 405 of this chapter and subpart A of part 491 of this chapter.

(2) File a request for payment on the form and manner prescribed by CMS.

(3) *HCPCS coding.* FQHCs and RHCs are required to submit HCPCS and other codes as required in reporting services furnished.

[79 FR 25477, May 2, 2014, as amended at 80 FR 71371, Nov. 16, 2015; 83 FR 60073, Nov. 23, 2018; 86 FR 65660, Nov. 19, 2021]

**§ 405.2463 What constitutes a visit.**

(a) *Visit—General.* (1) For RHCs, a visit is either of the following:

(i) Face-to-face encounter (or, for mental health disorders only, an encounter that meets the requirements under paragraph (b)(3) of this section) between an RHC patient and one of the following: