

§ 405.2464

42 CFR Ch. IV (10–1–23 Edition)

(ii) Has a medical visit and a mental health visit on the same day.

[79 FR 68001, Nov. 13, 2014, as amended at 80 FR 71372, Nov. 16, 2015; 86 FR 65661, Nov. 19, 2021; 87 FR 70222, Nov. 18, 2022]

§ 405.2464 Payment rate.

(a) *Payment rate for RHCs that are authorized to bill under the reasonable cost system.*

(1) Except as specified in paragraphs (d) and (e) of this section, an RHC that is authorized to bill under the reasonable cost system is paid an all-inclusive rate that is determined by the MAC at the beginning of the cost reporting period.

(2) The rate is determined by dividing the estimated total allowable costs by estimated total visits for RHC services.

(3) The rate determination is subject to any tests of reasonableness that may be established in accordance with this subpart.

(4) The MAC, during each reporting period, periodically reviews the rate to assure that payments approximate actual allowable costs and visits and adjusts the rate if:

(i) There is a significant change in the utilization of services;

(ii) Actual allowable costs vary materially from allowable costs; or

(iii) Other circumstances arise which warrant an adjustment.

(5) The RHC may request the MAC to review the rate to determine whether adjustment is required.

(b) *Payment rate for FQHCs that are authorized to bill under the prospective payment system.* (1) Except as specified in paragraphs (d) and (e) of this section, a per diem rate is calculated by CMS by dividing total FQHC costs by total FQHC daily encounters to establish an average per diem cost.

(2) The per diem rate is adjusted as follows:

(i) For geographic differences in the cost of inputs according to § 405.2462(c)(1).

(ii) When the FQHC furnishes services to a new patient, as defined in § 405.2462(c)(2).

(iii) When a beneficiary receives either of the following:

(A) A comprehensive initial Medicare visit (that is, an initial preventive

physical examination or an initial annual wellness visit).

(B) A subsequent annual wellness visit.

(c) *Payment for care management services.* For chronic care management services furnished between January 1, 2016 and December 31, 2017, payment to RHCs and FQHCs is at the physician fee schedule national non-facility payment rate. For care management services furnished on or after January 1, 2018, payment to RHCs and FQHCs is at the rate set for each of the RHC and FQHC payment codes for care management services.

(d) *Payment for FQHCs that are authorized to bill as grandfathered tribal FQHCs.* Grandfathered tribal FQHCs are paid at the outpatient per visit rate for Medicare as set annually by the Indian Health Service for each beneficiary visit for covered services. There are no adjustments to this rate.

(e) *Payment for communication technology-based and remote evaluation services.* For communication technology-based and remote evaluation services furnished on or after January 1, 2019, payment to RHCs and FQHCs is at the rate set for each of the RHC and FQHC payment codes for communication technology-based and remote evaluation services.

[79 FR 25478, May 2, 2014, as amended at 80 FR 71372, Nov. 16, 2015; 83 FR 60073, Nov. 23, 2018]

§ 405.2466 Annual reconciliation.

(a) *General.* Payments made to RHCs or FQHCs that are authorized to bill under the reasonable cost system during a reporting period are subject to annual reconciliation to assure that those payments do not exceed or fall short of the allowable costs attributable to covered services furnished to Medicare beneficiaries during that period.

(b) *Calculation of reconciliation for RHCs or FQHCs that are authorized to bill under the reasonable cost system.* (1) The total reimbursement amount due the RHC or FQHC for covered services furnished to Medicare beneficiaries is based on the report specified in § 405.2470(c)(2) and is calculated by the MAC as follows: