

must be provided at least every 12 months while the beneficiary is receiving services furnished via telecommunications technology for diagnosis, evaluation, or treatment of mental health disorders, unless, for a particular 12-month period, the physician or practitioner and patient agree that the risks and burdens outweigh the benefits associated with furnishing the in-person item or service, and the practitioner documents the reasons for this decision in the patient's medical record, between an RHC or FQHC patient and one of the following:

- (i) Clinical psychologist.
- (ii) Clinical social worker.
- (iii) Marriage and family therapist.
- (iv) Mental health counselor.
- (v) Other RHC or FQHC practitioner, in accordance with paragraph (b)(1) of this section, for mental health services.

(c) *Visit—Multiple.* (1) For RHCs and FQHCs that are authorized to bill under the reasonable cost system, encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except when the patient—

- (i) Suffers an illness or injury subsequent to the first visit that requires additional diagnosis or treatment on the same day;
- (ii) Has a medical visit and a mental health visit or intensive outpatient services on the same day; or
- (iii) Has an initial preventive physical exam visit and a separate medical, mental health, or intensive outpatient services visit on the same day.

(2) For RHCs and FQHCs that are authorized to bill under the reasonable cost system, Medicare pays RHCs and FQHCs for more than 1 visit per day when the conditions in paragraph (c)(1) of this section are met.

(3) For FQHCs that are authorized to bill under the reasonable cost system, Medicare pays for more than 1 visit per day when a DSMT or MNT visit is furnished on the same day as a visit described in paragraph (c)(1) of this section are met.

(4) For FQHCs billing under the PPS, and grandfathered tribal FQHCs that are authorized to bill as a FQHC at the

outpatient per visit rate for Medicare as set annually by the Indian Health Service—

- (i) Suffers an illness or injury subsequent to the first visit that requires additional diagnosis or treatment on the same day; or
- (ii) Has a medical visit and a mental health visit or intensive outpatient services on the same day.

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**§ 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 between January 1, 2018 and December 31, 2023, payment to RHCs and FQHCs is at the rate set for each of the RHC and FQHC payment codes for care management services. For general care management services furnished on or after January 1, 2024, the payment amount is based on a weighted average of the services that comprise HCPCS code G0511 using the most recently available PFS utilization data.

(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.

(f) *Payment for intensive outpatient services.* Payment to RHCs and FQHCs is at the rate determined under § 405.2462(j).

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#### § 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:

(i) The average cost per visit is calculated by dividing the total allowable cost incurred for the reporting period by total visits for RHC or FQHC services furnished during the period. The average cost per visit is subject to tests of reasonableness which may be established in accordance with this subpart.

(ii) The total cost of RHC or FQHC services furnished to Medicare beneficiaries is calculated by multiplying the average cost per visit by the number of visits for covered RHC or FQHC services by beneficiaries.

(iii) The total payment due the RHC is 80 percent of the amount calculated by subtracting the amount of deductible incurred by beneficiaries that is attributable to RHC services from the cost of these services. FQHC services are not subject to a deductible and the payment computation for FQHCs does not include a reduction related to the deductible.

(iv) For RHCs and FQHCs, payment for pneumococcal, influenza, and COVID-19 vaccine and their administration is 100 percent of Medicare reasonable cost.

(2) The total reimbursement amount due is compared with total payments made to the RHC or FQHC for the reporting period, and the difference constitutes the amount of the reconciliation.

(c) *Notice of program reimbursement.* The MAC notifies the RHC or FQHC