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# Federally Qualified Health Center





CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

**What's Changed:**

- Added advanced primary care management services (page 5)
- New payment rate when you provide 4 or more intensive outpatient program services on the same day (page 5)
- Added specified dental services (pages 5 and 7)
- Federally Qualified Health Center (FQHC) market basket update (page 7)
- Updates to billing for care coordination services (page 9)
- Preventive vaccine billing and payment changes (page 10)
- Coverage of pre-exposure prophylaxis (PrEP) for HIV drugs at FQHCs (page 11)
- Extended some telehealth flexibilities through September 30, 2025 (pages 11, 12, and 14)
- Added coding information for mental telehealth visits (page 14)

Substantive content changes are in dark red.

# Table of Contents

Federally Qualified Health Centers (FQHCs) are safety net providers that provide services in an outpatient clinic setting. Section 1861(aa) of the Social Security Act allows additional FQHC Medicare payments.

FQHCs may be in rural or urban areas and include:

- Community health centers
- Migrant health centers
- Homeless health centers
- Public housing primary care centers
- Health center program "look-alikes"
- Outpatient health programs or facilities operated by a tribe or tribal organization or an urban Indian organization

**Note:** The information in this publication may not apply to Historically Excepted Tribal FQHCs (formerly known as Grandfathered Tribal FQHCs).

## Practitioners

You and your staff must comply with all licensure and certification laws and regulations. We pay FQHCs based on the FQHC Prospective Payment System (PPS) for medically necessary, primary health services, and qualified preventive health services from an FQHC practitioner, including:

- Nurse practitioners (NPs)
- Physician assistants (PAs)
- Certified nurse-midwives (CNMs)
- Clinical psychologists (CPs)
- Clinical social workers (CSWs)
- Marriage and family therapists (MFTs)
- Mental health counselors (MHCs)

## FQHC Patient Services

FQHCs provide:

- Physician services.
- Services and supplies incident to physician services like taking blood pressure or administering shots.
- Services and supplies incident to NP, PA, CNM, CP, CSW, MHC, and MFT services.
- Medicare Part B-covered drugs supplied incident to FQHC practitioner services.
- Medicare patient homebound visiting nurse services when a registered nurse (RN) or licensed practical nurse (LPN) provides them in an area we certify as having a shortage of home health (HH) agencies. Check eligibility before providing visiting nurse services to make sure the patient isn't already under an HH plan of care.
- Outpatient diabetes self-management training (DSMT) and medical nutrition therapy (MNT) from qualified DSMT and MNT practitioners in a 1-on-1, face-to-face visit for patients with diabetes or renal disease.
- Certain care coordination services like transitional care management (TCM), chronic care management (CCM), advanced primary care management (APCM), general behavioral health integration (BHI), principal care management (PCM), chronic pain management (CPM), psychiatric collaborative care model (CoCM) services, remote physiologic monitoring (RPM), remote therapeutic monitoring (RTM), community health integration (CHI), principal illness navigation (PIN), and PIN-Peer Support (PIN-PS).
- Virtual communication services like communication-based technology and remote evaluation services.
- Mental health telehealth services.
- Hospice attending physician services from an FQHC physician, an NP, or a PA employed or working under contract for an FQHC, instead of employed by a hospice program. During a hospice election, attending physician services can take place at the patient's home, a Medicare-certified hospice freestanding facility, skilled nursing facility (SNF), or hospital.
- Intensive outpatient program (IOP) services, which provide treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation but less intense than a partial hospitalization program. See CR 13496 for details.
- For CY 2025, we're implementing a new payment rate for when you provide 4 or more IOP services per day in an FQHC. The IOP payment rate is:
  - $269.19 for 3 services per day
  - $408.55 for 4 or more services per day
- Dental services that are inextricably linked to other covered medical services, including when FQHCs provide these services during separate visits on the same day.

## Certification

To qualify as an FQHC, you must meet **1** of these requirements:

- Get a grant under section 330 of the Public Health Service Act or be funded by the same grant contracted to the recipient
- Get a grant as an FQHC "look-alike" based on a Health Resources & Services Administration (HRSA) recommendation
- Be treated by the HHS Secretary as a comprehensive federally funded health center since January 1, 1990, under Part B
- Operate as an outpatient health program or tribe or tribal organization facility under the Indian Self-Determination and Education Assistance Act or as an urban Indian organization getting funds under Title V of the Indian Health Care Improvement Act

Health Center Program Look-Alikes are HRSA-designated health centers that provide comprehensive, culturally competent, high-quality primary health care services while meeting all Health Center Program requirements, but they don't receive federal award funding.

FQHC certification requires you meet these requirements:

- Provide comprehensive services, including an ongoing quality assurance program and an annual review
- Meet all health and safety requirements
- Not be approved as a rural health clinic (RHC)
- Meet **all** section 330 of the Public Health Service Act requirements, including:
  - Serve a designated medically underserved area (MUA) or medically underserved population (MUP)
  - Offer people with incomes below 200% of the federal poverty guidelines a sliding fee scale
  - Be governed by a board of directors, where most members get care at the FQHC

## Visits

FQHC visits **must:**

- Be medically necessary
- Be face-to-face medical or mental health visits or qualified preventive health visits between the patient and an FQHC where the practitioner provides 1 or more qualified FQHC services
- Include an RN or LPN homebound patient visit in certain limited situations
- Meet certain conditions when a qualified practitioner offers outpatient DSMT or MNT services and the FQHC meets the requirements to provide these services

FQHC visits **can** take place at:

- An FQHC
- A patient's home, including an assisted living facility
- A Medicare-covered Part A SNF
- The scene of an accident
- A hospice facility (when an FQHC physician, an NP, or a PA who's employed or working under contract for an FQHC but isn't employed by a hospice program provides them)

FQHC visits **can't** take place at:

- An inpatient or outpatient hospital department, including a critical access hospital (CAH)
- A facility with specific requirements excluding FQHC visits

## Multiple Visits on the Same Day

Visits with more than 1 FQHC practitioner on the same day, or multiple visits with the same FQHC practitioner on the same day, count as a single visit, except when a patient:

- Returns to the FQHC to diagnose or treat an injury or illness that happened after the initial visit (for example, a patient sees their practitioner in the morning because they have flu symptoms, then later in the day they cut their finger and return to the FQHC)
- Has a qualified medical and mental health visit on the same day
- Has IOP services on the same day as a medical visit
- Has a dental visit on the same day as a medical visit

# Payments

FQHC claims must include an FQHC payment code.

- We pay claims at 80% of the lesser of the FQHC charges or the FQHC PPS rate for the specific payment code, which is the national encounter-based rate with geographic and other adjustments.
- We annually update the FQHC PPS base payment rate using the FQHC market basket.
  - We rebase the market basket every 4 years, which we last rebased in the CY 2021 Physician Fee Schedule (PFS) Final Rule
  - For CY 2025, we'll revise the market basket to reflect the 2022 base year
  - The final CY 2025 FQHC market basket update is 3.4%, reflecting a 4% increase in the 2022-based market basket, reduced by a 0.6 percentage-point productivity adjustment
- Coinsurance is 20% of the lesser of the FQHC charges or the PPS rate for the specific payment code, except for certain preventive services. We waive the Part B coinsurance and deductible for certain preventive services, including specific Medicare Wellness Visits.
- Visit the FQHC Center for more information on PPS rates.

## Payment Adjustments

These adjustments apply to the FQHC PPS base payment rate:

- FQHC geographic adjustment factor
- New patient adjustment
- Initial preventive physical exam or annual wellness visit adjustment

## Charges & Payment

FQHCs set their own service charges and decide which services to include with each FQHC G code. Patient charges must be uniform.

The FQHC Center has more information about submitting claims with FQHC PPS payment codes and lists of billable visits.

We'll pay for:

- Professional services only.
- Lab tests, excluding venipuncture, and the technical component of billable visits separately.
- Billable procedures that aren't separately in the payment of an otherwise qualified visit. If a procedure is associated with a qualified visit, include procedure charges on the visit's claim.

## Cost Reports

FQHCs must file an annual cost report that includes graduate medical education adjustments; bad debt; flu, hepatitis B, COVID-19, and pneumococcal shots; and your administration payments. Use FQHC Cost Report Form (CMS-224-14) to determine your payment rate and reconcile interim payments.

- See Telehealth to learn more about reporting telehealth costs
- See the Provider Reimbursement Manual – Part 2 for more cost reports and forms information

## Care Coordination Services

- We pay for general care coordination services either alone or with other payable services. Starting January 1, 2025, we require FQHCs to bill these services under their individual CPT or HCPCS code instead of the general care management code, G0511. We allow FQHCs a 6-month transition period (until July 1, 2025) to update their billing systems. Payment for these services and their associated add-on codes is based on the national, non-facility PFS payment rate. You can bill TCM services with other care coordination services.
- The 20% coinsurance is the lesser of the FQHC charges or the PFS rate for the specific payment code.
- You can report care coordination costs in the cost report's non-reimbursable section, and we don't consider these costs under the FQHC PPS.
- **Don't** include administrative activities like transcription or translation services.

**Table 1. General Care Coordination Service Codes**

| General Care Coordination Services | HCPCS/CPT Codes | Add-on codes |
|---|---|---|
| CCM | 99487, 99490, 99491 | 99437, 99439, 99489 |
| PCM | 99424, 99426 | 99425, 99427 |
| APCM | G0556, G0557, G0558 | N/A |
| CPM | G3002 | G3003 |
| General BHI | G0323, 99484 | N/A |
| RPM | 99091, 99453, 99454, 99457, 99474 | 99458 |
| RTM | 98975, 98976, 98977, 98980 | 98981 |
| CHI | G0019 | G0022 |
| PIN | G0023 | G0024 |
| PIN-PS | G0140 | G0146 |

**Note:** The table includes add-on codes that describe additional minutes when FQHCs perform them in conjunction with the primary service.

## Psychiatric CoCM

- We pay at the national non-facility PFS payment rate for CPT code 99492 (70 minutes or more of initial psychiatric CoCM services) and CPT code 99493 (60 minutes or more of subsequent psychiatric CoCM services) when HCPCS code G0512 is on an FQHC claim either alone or with other payable services
- You must provide at least 70 minutes in the first calendar month and at least 60 minutes in subsequent calendar months of psychiatric CoCM services to bill for this service
- 20% coinsurance is the lesser of submitted charges or G0512's payment rate for care management services coinsurance
- You can report care management costs in the cost report's non-reimbursable section, and we don't consider these costs under the FQHC PPS
- You can bill G0512 once per month per patient when you deliver at least 60 minutes of psychiatric CoCM services and when your services meet all other requirements
  - You can count only FQHC practitioner or auxiliary personnel services within the scope of service elements toward the 60-minute psychiatric CoCM billing minimum
  - **Don't** include administrative activities like transcription or translation services

# Flu, Hepatitis B, Pneumococcal & COVID-19 Shots

Influenza virus, hepatitis B, pneumococcal, and COVID-19 vaccines don't count as FQHC visits. We include the vaccine product and administration service in the cost report, but don't bill a visit for these services. FQHCs should report the vaccine and administration code on the claim using type of bill 77X if there was another reason for the visit, for informational and data collection purposes only.

Starting July 1, 2025, we pay for these preventive vaccine products at 95% of the average wholesale price and their administration at the non-facility PFS payment rate when billed on the date of service. We pay the cost for these vaccine products and their administration at 100% of reasonable cost, reconciled through the cost report.

Coinsurance and deductible don't apply to these vaccine products or their administration.

# COVID-19 Monoclonal Antibody Therapies

For **Original Medicare patients**, we pay for administering COVID-19 monoclonal antibody products and the service for their administration at 100% of reasonable cost through the cost report.

**Note:** We updated the FQHC cost report to show costs related to COVID-19 shots, COVID-19 monoclonal antibody products, and how you administer them.

For COVID-19 monoclonal antibodies used for post-exposure prophylaxis or treating COVID-19, we'll continue to pay 100% of reasonable cost through the cost report through the end of the CY in which the Emergency Use Authorization (EUA) declaration for COVID-19 drugs and biologicals ends. The EUA declaration is distinct from, and not dependent on, the COVID-19 PHE.

Starting January 1 of the year after the EUA declaration ends:

- We'll pay you for monoclonal antibody products used for **post-exposure prophylaxis or treating** COVID-19 in the same way we pay for other Part B drugs and biological products (through the FQHC PPS)
- We'll continue to pay for covered monoclonal antibody products and their administration when used as **pre-exposure prophylaxis for preventing** COVID-19 at 100% of reasonable cost through the cost report

For **Medicare Advantage (MA) patients**, submit claims for administering COVID-19 vaccines and COVID-19 monoclonal antibody products to the MA Plan. Original Medicare won't pay these claims. To learn more about billing and payment, including MA wrap-around payments, visit the FQHC Center, or review our FAQs.

## Drugs Covered as Additional Preventive Services: Pre-exposure Prophylaxis for HIV Drugs

Effective September 30, 2024, Medicare Part B covers pre-exposure prophylaxis (PrEP) for HIV drugs and other services to decrease an individual's risk of acquiring HIV without cost-sharing. Starting January 1, 2025, FQHCs bill for these services separately from the FQHC PPS. PrEP for HIV has more information.

## Telehealth

Telehealth substitutes for an in-person visit and involves 2-way, interactive technology that permits communication between the practitioner and patient. FQHCs can provide telehealth to extend care when a patient is in a different place.

During the COVID-19 PHE, we used emergency waivers and other regulatory authorities so you could provide more services to your patients via telehealth. Learn more about Medicare telehealth services, including technology and other requirements.

Through September 30, 2025:

- Medicare patients can get non-behavioral and non-mental telehealth services in their home
- You can deliver non-behavioral and non-mental telehealth services using audio-only communication platforms

You may continue to bill for telehealth services using HCPCS code G2025. We'll base the payment amount on the average amount for all Medicare telehealth services paid under the PFS, weighted by volume through December 31, 2025.

You may use 2-way, interactive, audio-only technology for any telehealth visits if the distant site provider is technically capable of using an audio-video telehealth system, but the patient isn't capable of, or doesn't consent to, using video technology. You don't need any additional documentation except to append the FQ modifier on the claim.

**Note:** Section 2207 of the Full-Year Continuing Appropriations and Extensions Act, 2025 extends certain telehealth policies until September 30, 2025.

## Originating Sites

An originating site is the location where a patient gets physician or practitioner medical services through telehealth. Before the COVID-19 PHE, patients needed to get telehealth at an originating site located in a certain geographic location.

All patients can get telehealth wherever they're located. They don't need to be at an originating site, and there aren't any geographic restrictions. For non-behavioral and non-mental health services, patients can get telehealth wherever they're located through September 30, 2025.

FQHCs can be originating sites for telehealth if they're in a qualifying area. FQHCs serving as telehealth originating sites get an originating site facility fee. You may include the originating site facility fee charges on the claim. Although FQHC services aren't subject to a deductible, we don't consider the facility fee an FQHC service. You must apply the deductible when billing the telehealth originating site facility fee.

## Distant Sites

A distant site is the location where a physician or practitioner provides telehealth. Before the COVID-19 PHE, only certain types of distant site providers could provide and get paid for telehealth.

For behavioral and mental telehealth services, FQHCs can serve as distant site providers. For non-behavioral and non-mental health services, FQHCs can serve as distant site providers through September 30, 2025.

Practitioners can provide telehealth from any distant site location, including their home, during the time they're working for the FQHC, and they can provide any distant site-approved telehealth under the PFS. You can't bill the visit's cost or include it in the cost report.

## Virtual Communication Services

You can also provide virtual communication services, which you bill differently than telehealth.

Virtual communication services are services where a practitioner meets with a patient for at least 5 minutes to decide if the patient needs a visit. The 2 ways to provide virtual communication services are:

1. Through communication-based technology
2. With remote evaluation services

We pay for virtual communication services when an FQHC practitioner meets certain requirements, including the:

- Practitioner provides at least 5 minutes of billable FQHC virtual communications, either through communication-based technology or remote evaluation services
- Patient had at least 1 face-to-face billable visit within the previous year
- Virtual visit isn't related to services provided within the last 7 days
- Virtual visit doesn't lead to an in-person FQHC service within the next 24 hours or at the next appointment

When the virtual communication HCPCS code G0071 is on an FQHC claim alone or with other payable services, we require FQHCs to submit HCPCS code G2012 (communication technology-based services) or HCPCS code G2010 (remote evaluation services).

When an FQHC practitioner provides virtual communication services, they don't need to meet face-to-face, so the coinsurance doesn't apply.

See Virtual Communication Services FAQs for more information.

## Consent for Chronic Care Management & Virtual Communication Services

We require patient consent for all services, including non-face-to-face services. You may get patient consent at the same time you initially provide the services. We don't require direct supervision to get consent. In general, auxiliary personnel under general supervision of the FQHC practitioner can get patient consent for these services.

## Mental Health Visits

We pay for mental health visits using telehealth in the same way as face-to-face services. The changes also allow you to use audio-only telehealth in cases where patients can't, or don't consent to, using audio-video telehealth. You can report and get paid in the same way as in-person visits.

**Table 2. FQHC Claims for Mental Telehealth Visits**

| Revenue Code | HCPCS/CPT Code | Modifiers |
|---|---|---|
| 0900 | G0470 (or other appropriate FQHC-specific mental health visit payment code) | 95 (audio-video) or FQ or 93 (audio only) |
| 0900 | 90834 (or other FQHC PPS qualifying mental health visit payment code) | N/A |

You can provide a mental health visit and an IOP service on the same day; however, we'll only pay the IOP rate, and we'll consider the mental health visit as packaged.

42 CFR 405.2463(b)(3) states you must provide an in-person mental health service to the patient 6 months before providing telehealth, and you must provide an in-person, non-telehealth visit at least every 12 months for these services. However, we may make exceptions to the in-person visit requirement based on patient circumstances (with the reason documented in the patient's medical record), allowing more frequent visits as driven by clinical needs on a case-by-case basis.

**Note:** Section 2207 of the Full-Year Continuing Appropriations and Extensions Act, 2025 continues to delay the in-person visit requirements for mental health visits until September 30, 2025.

## Resources

- FQHC Center
- Medicare Benefit Policy Manual, Chapter 13
- Medicare Claims Processing Manual, Chapter 9
- Telehealth Policy Updates

## Regional Office Rural Health Coordinators

Get contact information for CMS Regional Office Rural Health Coordinators who offer technical, policy, and operational help on rural health issues.