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Federally Qualified Health Center

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

What's Changed?

- We permanently adopted the definition of direct supervision to include supervision through audio-visual telecommunications technology (page 5)
- We updated the CY 2026:
  - Intensive outpatient program rates (page 5)
  - Federally Qualified Health Center (FQHC) market basket and Prospective Payment System base payment rates (page 8)
  - Telehealth originating site fee (page 14)
- We added 3 new optional add-on HCPCS codes for behavioral health integration and psychiatric Collaborative Care Model (CoCM) services when you provide advanced primary care management services (pages 10 and 11)
- We discontinued use of:
  - HCPCS code G0512 for psychiatric CoCM services, and we'll allow rural health clinics to report codes 99492, 99493, 99494, and G2214 instead (page 12)
  - HCPCS code G0071 for virtual communication services (page 15)
- We added a new resource link to the latest telehealth information (pages 14 and 16)
- FQHCs may continue to bill medical telehealth services using HCPCS code G2025 and serve as a distant site telehealth provider through December 31, 2026 (pages 14 and 15)

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

FQHCs and their staff must comply with all licensure and certification laws and regulations. Medicare pays FQHCs based on the FQHC Prospective Payment System (PPS) for qualified primary and 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)

The COVID-19 public health emergency (PHE) ended at the end of the day on May 11, 2023. View Infectious diseases for a list of waivers and flexibilities that were in place during the PHE.

FQHC Patient Services

FQHCs provide:

- Physician services.
- Services and supplies incident to physician services, like taking blood pressure or giving 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.

We permanently adopted the definition of direct supervision, which allows the supervising practitioner to provide supervision through a virtual presence using real-time, audio-visual communications technology, excluding audio-only.

- 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 agencies. Check eligibility before providing visiting nurse services to make sure the patient isn't already under a home health 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.
- Virtual communication services, like communication-based technology and remote evaluation services.
- Mental health services using telehealth. You may provide mental health visits using interactive, real-time telecommunications technology.
- 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 the Medicare Benefit Policy Manual, Chapter 6, section 70.4 for details. We base the IOP payment rates on the amount of IOP services you provide per day. For CY 2026, the IOP payment rates are:
  - $319.38 for 3 or fewer services per day
  - $418.45 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 to 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
- Meet **all** section 330 of the Public Health Service Act requirements, including:
  - Serve a designated medically underserved area or medically underserved population
  - 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 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
- A facility with specific requirements that exclude 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 an initial preventive physical exam (IPPE) and a separate medical or mental health visit on the same day, or both
- 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.
  - Based on historical data through the second quarter of 2025, the FQHC market basket for CY 2026 is 2.5%
  - For CY 2026, the FQHC PPS base payment rate is $207.72
- 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 apply to the FQHC PPS base payment rate:

- FQHC geographic adjustment factor
- New patient adjustment
- IPPE 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

Care coordination services include:

- Transitional care management (TCM)
- Chronic care management (CCM)
- Advanced primary care management (APCM)
- Behavioral health integration (BHI)
  - General BHI
  - Psychiatric collaborative care model (CoCM)
- Principal care management (PCM)
- Chronic pain management (CPM)
- Remote monitoring
  - Remote physiological monitoring
  - Remote therapeutic monitoring (RTM)
- Community health integration (CHI)
- Principal illness navigation (PIN)
- PIN-Peer Support (PIN-PS)

Care Coordination Requirements

- We pay for care coordination services either alone or with other payable services.
- You can bill TCM services with CCM, remote physiological monitoring, and RTM care coordination services.
- The 20% coinsurance is based on the lesser of the submitted charges or the individual HCPCS code's national non-facility rate for care coordination services.
- 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.
- We don't require face-to-face services to bill for FQHC care coordination services. Auxiliary personnel may provide them under general supervision.
- Starting January 1, 2026, we added 3 new optional, add-on HCPCS codes when you provide general BHI and psychiatric CoCM services in the same month as APCM services:
  - You must report an APCM base code (G0556, G0557, and G0558) in the same month as the optional add-on codes
  - HCPCS add-on codes G0568 and G0569 are for psychiatric CoCM services you deliver to patients also receiving APCM services
  - HCPCS add-on code G0570 is for general BHI services you deliver to patients also receiving APCM services
- We pay for care coordination services and their associated add-on codes at the national, non-facility Physician Fee Schedule (PFS) payment rate.

Table 1. General Care Coordination Service Codes

Care Coordination Services	HCPCS or CPT Codes	Add-On Codes
CCM	99487, 99490, 99491	99437, 99439, 99489
TCM	99495, 99496	N/A
PCM	99424, 99426	99425, 99427
APCM	G0556, G0557, G0558	G0568, G0569, G0570
CPM	G3002	G3003
General BHI	99484, G0323	N/A
Psychiatric CoCM	99492, 99493, G2214	99494
Remote Physiological Monitoring	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.

See the Medicare Benefit Policy Manual, Chapter 13, section 230 for more information on care coordination services.

Psychiatric CoCM

- Starting January 1, 2026, FQHCs will report the individual CPT and HCPCS codes (99492, 99493, 99494, and G2214) describing psychiatric CoCM services instead of HCPCS code G0512.
- We pay for psychiatric CoCM service codes at the national non-facility PFS payment rate:
  - CPT code 99492 (70 minutes or more of initial psychiatric CoCM services)
  - CPT code 99493 (60 minutes or more of subsequent psychiatric CoCM services)
  - CPT code 99494 (Add-on each additional 30 minutes per calendar month, any calendar month)
  - HCPCS code G2214 (Initial or subsequent 30 minutes of behavioral health care manager time per calendar month)
- 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.
- The coinsurance is 20% of the submitted charges or the individual HCPCS code's payment rate for psychiatric CoCM services.
- You can bill 99493 once per month per patient when you deliver at least 60 minutes of psychiatric CoCM services and 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.

Part B Vaccines & Administration

We pay for flu, hepatitis B, pneumococcal, and COVID-19 shots and their administration at 100% of their reasonable cost. Effective July 1, 2025, FQHCs must bill and we'll pay for these Part B vaccines and their administration at the time of service.

- We pay for these preventive vaccine products at 95% of the average wholesale price and their administration based on the National Vaccine Administration Fee Schedule
- You'll reconcile these rates annually with your facility's actual vaccine cost on your cost report
- Coinsurance and deductible don't apply to these vaccine products or their administration

FQHCs must report the vaccine and the administration code on the claim using type of bill 77X. You don't need to bill a qualifying visit code to bill for these services. See MLN Matters® article MM13923 for more information.

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 doesn't depend 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

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 generally 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.

Visit the CMS Telehealth webpage for the latest information. It's intended to help physicians, practices, and health systems navigate changes to Medicare telehealth policy.

You may continue to bill for telehealth services using HCPCS code G2025. We'll base the payment amount using the national average amount payment rates for comparable services under the PFS through December 31, 2026.

You may use 2-way, interactive, audio-only technology for 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.

Originating Site

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.

For behavioral and mental telehealth services, 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.

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. For CY 2026, the originating site fee is $31.85.

Distant Site

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 a distant site provider. For non-behavioral and non-mental health services, FQHCs can serve as distant site providers through December 31, 2026.

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 FQHCs 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. There are 2 ways to provide virtual communication services:

1. Through communication-based technology (CPT code 98016)
2. With remote evaluation services (HCPCS codes G2010 and G2250)

Starting January 1, 2026, FQHCs will report individual CPT and HCPCS codes (98016, G2010, and G2250) describing virtual communication services instead of HCPCS code G0071.

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

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

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 Care Coordination & Virtual Communication Services

We require patient consent for all services, including non-face-to-face services. This means that someone working under your general supervision can get patient consent, and we don't require direct supervision to get consent. In general, auxiliary personnel under general supervision of the billing 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. You may also 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 or 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 another 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.

Visit the CMS Telehealth webpage for the latest information. It's intended to help physicians, practices, and health systems navigate changes to Medicare telehealth policy.

Resources

- CY 2025 Medicare PFS Fee Schedule Final Rule fact sheet
- CY 2026 Medicare PFS Fee Schedule Final Rule fact sheet
- FQHC Center
- Medicare Benefit Policy Manual, Chapter 13
- Medicare Claims Processing Manual, Chapter 9

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.