| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-02 Medicare Benefit Policy | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 13600** | **Date: February 20, 2026** |
| | **Change Request 14363** |

**SUBJECT: Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Medicare Benefit Policy Manual Chapter 13 Update for Calendar Year (CY) 2026**

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to update Chapter 13 to reflect payment policies finalized for CY 2026.

**EFFECTIVE DATE: January 1, 2026**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: March 23, 2026**

***Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.***

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 13/50.1/RHC Services |
| R | 13/120.1/Provision of Incident to Services and Supplies |
| R | 13/120.2/Incident to Services and Supplies Furnished in the Patient's Home or Location Other than the RHC or FQHC |
| R | 13/140/Services and Supplies Furnished Incident to NP, PA, and CNM Services |
| R | 13/160/Services and Supplies Incident to CP, CSW, MFT and MHC Services |
| R | 13/170/Mental Health Visits |
| R | 13/200/Telehealth Services |
| R | 13/220.1/Preventive Health Services in RHCs |
| R | 13/220.3/Preventive Health Services in FQHCs |
| R | 13/230/Care Coordination Services (formerly Care Management Services) |
| R | 13/230.2.10/Advanced Primary Care Management Services |
| R | 13/230.3/Payment for Care Coordination Services |
| R | 13/230.4/Psychiatric Collaborative Care Model (CoCM) Services |
| R | 13/240/Virtual Communication Services |

**III. FUNDING:**

**For Medicare Administrative Contractors (MACs):**
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**IV. ATTACHMENTS:**

**Business Requirements**
**Manual Instruction**

# Attachment - Business Requirements

| Pub. 100-02 | Transmittal: 13600 | Date: February 20, 2026 | Change Request: 14363 |
|---|---|---|---|

**SUBJECT: Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Medicare Benefit Policy Manual Chapter 13 Update for Calendar Year (CY) 2026**

**EFFECTIVE DATE: January 1, 2026**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: March 23, 2026**

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to update Chapter 13 to reflect payment policies finalized for CY 2026.

## II. GENERAL INFORMATION

**A. Background:** The 2025 update of the Medicare Benefit Policy Manual, Chapter 13 - RHC and FQHC Services provides information on requirements and payment policies for RHCs and FQHCs, as authorized by Section 1861(aa) of the Social Security Act.

**B. Policy:** Chapter 13 of the Medicare Benefit Policy Manual has been revised to include payment policy for RHCs and FQHCs as finalized in the Calendar Year (CY) 2026 Physician Fee Schedule. All other revisions serve to clarify existing policy.

## III. BUSINESS REQUIREMENTS TABLE

*"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.*

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | MAC | FISS | MCS | VMS | CWF | |
| 14363.1 | Contractors shall be aware of the updates to the Medicare Benefit Policy Manual - Chapter 13. | X | | | | | | | | |

## IV. PROVIDER EDUCATION

None

**Impacted Contractors:** None

## V. SUPPORTING INFORMATION

**Section A: Recommendations and supporting information associated with listed requirements:** N/A

*"Should" denotes a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|

**Section B: All other recommendations and supporting information:** N/A

## VI. CONTACTS

**Post-Implementation Contact(s):** Contact your Contracting Officer's Representative (COR).

## VII. FUNDING

**Section A: For Medicare Administrative Contractors (MACs):**
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**ATTACHMENTS: 0**

# Medicare Benefit Policy Manual

## Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services

**Table of Contents**

*(Rev. 13600; Issued: 02-20-26)*

## 50.1 - RHC Services

***(Rev. 13600; Issued: 02-20-26; Effective: 01-01-26; Implementation:03-23-26)***

RHC services include:

- Physicians' services, as described in section 110;
- Services and supplies incident to a physician's services, as described in section120;
- Services of NPs, PAs, and CNMs, as described in section 130;
- Services and supplies incident to the services of NPs, PAs, and CNMs, asdescribed in section 140;
- CP and CSW services, as described in section 150;
- MFT and MHC services, as described in section 150;
- Services and supplies incident to the services of CPs and CSWs, as described in section 160;
- Services and supplies incident to the services of MFTs and MHCs, as described in section 160;
- Visiting nurse services to patients confined to the home, as described in section 190;
- Certain care *coordination* services, as described in section 230;
- Certain virtual communication services, as described in section 240*; and*
- *Intensive Outpatient Program (IOP) Services, as described in section 250.*

RHC services also include certain preventive services when specified in statute or whenestablished through the National Coverage Determination (NCD) process and not specifically excluded (see section 220 – Preventive Health Services). These services include:

- Influenza, Pneumococcal, Hepatitis B, COVID-19 vaccinations, and covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19;
- IPPE;
- Annual Wellness Visit (AWV); and
- Medicare-covered preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) with a grade of A or B, as appropriate for the individual.
- Drugs Covered as Additional Preventive Services (DCAPS) and related supply and administration fees.

The professional component of the IPPE, AWV, and other qualified preventive services is paid based on the AIR.

## 120.1 - Provision of Incident to Services and Supplies

***(Rev. 13600; Issued: 02-20-26; Effective: 01-01-26; Implementation:03-23-26)***

Incident to services and supplies can be furnished by auxiliary personnel. All services and supplies provided incident to a physician's visit must result from the patient's encounter with the physician and be furnished in a medically appropriate timeframe.
More than one incident to service or supply can be provided as a result of a single physician visit.
Incident to services and supplies must be provided by someone who has an employment agreement or a direct contract with the RHC or FQHC to provide services. Services or supplies provided by individuals who are not employed by or under direct contract with the RHC or FQHC, even if provided on the physician's order or included in the RHC or FQHC's bill, are not covered as incident to a physician's service. Services that are not considered incident to include the services of an independently practicing therapist who forwards his/her bill to the RHC or FQHC for inclusion in the entity's statement of services, services provided by an independent laboratory or a hospital outpatient department, services furnished by a

nurse, medical assistant, or other auxiliary personnel who is not an employee of or working under contract to the RHC or FQHC, including services provided by a third party under contract, etc.

Services and supplies furnished incident to physician's services are limited to situations in which there is direct physician supervision of the person performing the service, except for authorized care *coordination* services (as described in section 230) which may be furnished under general supervision. Direct supervision does not require the physician to be present in the same room. However, the physician must be in the RHC or FQHC and immediately available to provide assistance and direction throughout the time the incident to service or supply is being furnished.

Effective January 1, 2024, behavioral health services can be furnished under general supervision of the physician (or other practitioner) when these services are provided by auxiliary personnel incident to the services of a physician (or another practitioner).
When services and supplies are furnished incident to an RHC or FQHC visit, payment for the services are included in the RHC AIR or the FQHC PPS rate. An encounter that includes only an incident to service(s) is not a stand-alone billable visit for RHCs or
FQHCs

*For services provided under direct supervision, the requirement that the supervising physician or practitioner must be immediately available to provide assistance and direction throughout the procedure may be satisfied through virtual presence using real-time, interactive audio and video telecommunications.*

**120.2 - Incident to Services and Supplies Furnished in the Patient's Home or Location Other than the RHC or FQHC**
***(Rev. 13600; Issued: 02-20-26; Effective: 01-01-26; Implementation:03-23-26)***

Except for authorized care *coordination* services, services furnished incident to a physician's visit by RHC or FQHC auxiliary personnel in the patient's home or location other than the RHC or FQHC must have direct supervision by the physician. For example, if an RHC or FQHC nurse accompanies the physician to a patient's home and administers an injection, the nurse's services would be considered incident to the physician's visit. If the same nurse makes the call alone and administers an injection, the services are not incident to services since the physician is not providing direct supervision. The availability of the physician by telephone and the presence of the physician somewhere in the building does not constitute direct supervision. (This rule applies only to the incident to provision. It does not apply to visiting nursing services described in section 190.)

*For services provided under direct supervision, the requirement that the supervising physician or practitioner must be immediately available to provide assistance and direction throughout the procedure may be satisfied through virtual presence using real-time, interactive audio and video telecommunications.*

For information on supervision requirements for Part B services incident to physician services see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 60.1.

## 140 - Services and Supplies Furnished Incident to NP, PA, and CNM Services
***(Rev. 13600; Issued: 02-20-26; Effective: 01-01-26; Implementation:03-23-26)***

Services and supplies that are integral, though incident to an NP, PA, or CNM service are:

- Commonly rendered without charge or included in the RHC or FQHC payment

- Commonly furnished in an outpatient clinic setting;

- Furnished under the direct supervision of an NP, PA, or CNM, except for authorized care management services which may be furnished under general supervision; and

- Furnished by a member of the RHC or FQHC staff.

**NOTE:** The direct supervision requirement is met in the case of an NP, PA, or CNM who supervises the furnishing of the service only if such a person is permitted to exercise such supervision under the written policies governing the RHC or FQHC.

Services and supplies covered under this provision are generally the same as described in section 120 as incident to a physician's services and include services and supplies incident to the services of an NP, PA, or CNM.

*For services provided under direct supervision, the requirement that the supervising physician or practitioner must be immediately available to provide assistance and direction throughout the procedure may be satisfied through virtual presence using real-time, interactive audio and video telecommunications.*

## 160 - Services and Supplies Incident to CP, CSW, MFT and MHC Services

***(Rev. 13600; Issued: 02-20-26; Effective: 01-01-26; Implementation:03-23-26)***

Services and supplies that are integral, though incident to a CP, CSW, MFT or MHC service are:

- Commonly rendered without charge or included in the RHC or FQHC payment;
- Commonly furnished in an outpatient clinic setting;
- Furnished under the direct supervision of the CP, CSW, MFT and MHC except for authorized care management services which may be furnished under general supervision; and
- Furnished by a member of the RHC or FQHC staff.

**NOTE:** The direct supervision requirement is met in the case of a CP, CSW, MFT or MHC who supervises the furnishing of the service only if such a person is permitted to exercise such supervision under the written policies governing the RHC or FQHC. Services and supplies covered under this provision are generally the same as described in section 120 as incident to a physician's services and include services and supplies incident to the services of a CP, CSW, MFT or MHC.

*For services provided under direct supervision, the requirement that the supervising physician or practitioner must be immediately available to provide assistance and direction throughout the procedure may be satisfied through virtual presence using real-time, interactive audio and video telecommunications.*

## 170 - Mental Health Visits

***(Rev. 13600; Issued: 02-20-26; Effective: 01-01-26; Implementation:03-23-26)***

A mental health visit is a medically-necessary face-to-face encounter between an RHC or FQHC patient and an RHC or FQHC practitioner during which time one or more RHC or FQHC mental health services are rendered. Effective January 1, 2022, a mental health visit is a face-to-face encounter or an encounter furnished using interactive, real-time, audio and video telecommunications technology or audio-only interactions in cases where the patient is not capable of, or does not consent to, the use of video technology for the purposes of diagnosis, evaluation or treatment of a mental health disorder.

*The requirement that* there must be an in-person mental health service furnished within 6 months prior to the furnishing of the mental health service furnished via telecommunications and that an in-person mental health service (without the use of telecommunications technology) 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 *will not apply to services furnished before January 31, 2026.*

RHCs and FQHCs are instructed to append modifier 95 (Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System) in instances where the mental health visit was furnished using audio-video communication technology and to append modifier 93 (Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System) in cases where the service was furnished using audio only communication.

Mental health services that qualify as stand-alone billable visits in an FQHC are listed on the FQHC center website, http://www.cms.gov/Center/Provider-Type/FederallyQualified-Health-Centers-FQHC-Center.html. Services furnished must be within the practitioner's state scope of practice.

Medicare-covered mental health services furnished incident to an RHC or FQHC visit are included in the payment for a medically necessary mental health visit when an RHC or

FQHC practitioner furnishes a mental health visit. Group mental health services do not meet the criteria for a one-one-one, face-to-face encounter in an FQHC or RHC.

*Note:* Beginning January 1, 2024, group therapy with physicians or psychologists or other mental health professionals to the extent authorized under State law may be covered and paid under the IOP benefit (see section 250 of this chapter).

A mental health service should be reported using a valid HCPCS code for the service furnished, a mental health revenue code, and for FQHCs, an appropriate FQHC mental health payment code. For detailed information on reporting mental health services and claims processing, see Pub. 100-04, Medicare Claims Processing
Manual, chapter 9, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c09.pdf

Medication management, or a psychotherapy "add on" service, is not a separately billable service in an RHC or FQHC and is included in the payment of an RHC or FQHC medical visit. For example, when a medically-necessary medical visit with an RHC or FQHC practitioner is furnished, and on the same day medication management or a psychotherapy add on service is also furnished by the same or a different RHC or FQHC practitioner, only one payment is made for the qualifying medical services reported with a medical revenue code. For FQHCs, an FQHC mental health payment code is not required for reporting medication management or a psychotherapy add on service furnished on the same day as a medical service.

## 200 - Telehealth Services

***(Rev. 13600; Issued: 02-20-26; Effective: 01-01-26; Implementation:03-23-26)***

On March 27, 2020, Congress signed into law the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). Section 3704 of the CARES Act authorized RHCs and FQHCs to provide distant site telehealth services to Medicare patients during the COVID-19 PHE. Section 4113 of the Consolidated Appropriations Act, 2023, extended this authority through December 31, 2024 *and section 2207(c) of the Full- Year Continuing Appropriations and Extensions Act, 2025 amended section 1834(m)(8) of the Act to continue payment for RHC and FQHC services as Medicare telehealth services through September 30, 2025. Most recently, section 6208 of the Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026 extended these services through January 30, 2026.*

*However, through regulation, CMS provides payment to* RHCs and FQHCs *when they furnish non-behavioral health visits via telecommunication technology, through December 31, 2026. That is,* on a temporary basis, *RHCs and FQHCs are paid* under the methodology that has been in place for these services during and after the COVID-19 PHE through December 31, *2026*. Specifically, RHCs and FQHCs can bill for RHC and FQHC services furnished using telecommunication technology by reporting HCPCS code G2025 on the claim, including services furnished using audio-only communications technology through December 31, *2026*. *P*ayment for *HCPCS code G2025* is based on the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS. *RHC and FQHC p*ractitioners can provide distant site telehealth services – approved by Medicare as a distant site telehealth service under the physician fee schedule (PFS) – from any location in the United States (see 42 CFR 411.9(a)(1)), including their home, during the time that they're employed by or under contract with the RHC or FQHC.

## 220.1 - Preventive Health Services in RHCs

***(Rev. 13600; Issued: 02-20-26; Effective: 01-01-26; Implementation:03-23-26)***

**Influenza (G0008), Pneumococcal (G0009), and COVID-19 (90480) Vaccines, and Certain COVID-19 Monoclonal Antibody Products**

Prior to July 1, 2025, influenza, pneumococcal, COVID-19 vaccines, and their administration were not paid at the time of service and were paid at 100 percent of reasonable cost through the cost report.

Effective for dates of service on or after July 1, 2025, RHCs shall report all Part B preventive vaccines and their administration – pneumococcal, influenza, and COVID-19 on the claim at the time of service. A visit/encounter is not required for these services; however, if reported on the same day, the vaccines and administrations shall receive a separate payment. Coinsurance and deductible do not apply to these vaccines or their administration.

Although paid at the time of service, payments for these services must be annually reconciled with the RHC's actual vaccine and vaccine administration costs, to ensure these services are ultimately reimbursed at 100% of reasonable costs through the cost report.

Each year, CMS updates the Seasonal Influenza Vaccines Pricing webpage: https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/vaccine-pricing to reflect the seasonal influenza virus vaccines and their applicable payment allowances that are effective August 1 through July 31 of the following year. RHCs must refer to this webpage to ensure they are billing the appropriate HCPCS codes for the applicable influenza season.

Note: An additional payment for influenza, pneumococcal, COVID-19 vaccine administration in the home can be made, provided that a home visit meets all the requirements of both part 405, subpart X, for RHC services provided in the home, and § 410.152(h)(3)(iii) for the in-home additional payment for Part B preventive vaccine administration. See Pub. 100-02, Chapter 15, Section 50.4.4.2.E.

Covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19 and their administration are paid at 100 percent of reasonable cost through the cost report. Monoclonal antibody products used for the treatment or for post-exposure prophylaxis of COVID-19 (when they are not purchased by the government) and their administration are paid through the cost report until the end of the calendar year in which the Emergency Use Authorization declaration for drugs and biological products with respect to COVID-19 ends.

**Hepatitis B Vaccine (G0010)**

Prior to January 1, 2025, hepatitis B vaccine and its administration was included in the RHC visit and was not separately billable. The cost of the vaccine and its administration could be included in the line item for

the otherwise qualifying visit. A visit could not be billed if vaccine administration was the only service the RHC provides. The beneficiary coinsurance and deductible were waived.

Effective January 1, 2025, payment for the hepatitis B vaccine and its administration is through the cost report and no longer included in the RHC AIR.

Effective for dates of service on or after July 1, 2025, RHCs shall report all Part B preventive vaccines and their administration – including hepatitis B on the claim at the time of service. A visit/encounter is not required for these services; however, if a visit occurs on the same day, the vaccines and administrations shall receive a separate payment. Coinsurance and deductible do not apply to these vaccines or their administration.

Note: An additional payment for hepatitis B vaccine administration in the home can be made, provided that a home visit meets all the requirements of both part 405, subpart X, for RHC services provided in the home, and § 410.152(h)(3)(iii) for the in-home additional payment for Part B preventive vaccine administration. See Pub. 100-02, Chapter 15, Section 50.4.4.2.E for more information.

Although paid at the time of service, payments for these services must be annually reconciled with the RHC's actual vaccine and vaccine administration costs, to ensure these services are ultimately reimbursed at 100% of reasonable costs through the cost report.

**Initial Preventive Physical Exam (G0402)**

The IPPE is a face-to-face one-time exam that must occur within the first 12 months following the beneficiary's enrollment. The IPPE can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If an IPPE visit is furnished on the same day as another billable visit, two visits may be billed. The beneficiary coinsurance and deductible are waived.

**Annual Wellness Visit (G0438 and G0439)**

The AWV is a face-to-face personalized prevention visit for beneficiaries who are not within the first 12 months of their first Part B coverage period and have not received an IPPE or AWV within the past 12 months. Advance Care Planning (ACP) *and administration of a standardized, evidence-based assessment of physical activity and nutrition* can be furnished as a part of the AWV. The AWV can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If the AWV is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible are waived.

More information regarding *ACP and an evidence-based assessment of physical activity and nutrition as an optional AWV element* is available on the CMS website: *https://www.cms.gov/medicare/coverage/preventive-services/medicare-wellness-visits/annual-wellness-visit*

**Diabetes Self-Management Training (G0108) and Medical Nutrition Therapy (97802 and 97803)**

Diabetes self-management training or medical nutrition therapy provided by a registered dietician or nutritional professional at an RHC may be considered incident to a visit with an RHC practitioner provided all applicable conditions are met. DSMT and MNT are not billable visits in an RHC, although the cost may be allowable on the cost report. RHCs cannot bill a visit for services furnished by registered dieticians or nutritional professionals. However, RHCs are permitted to become certified providers of DSMT services and report the cost of such services on their cost report for inclusion in the computation of their AIR. The beneficiary coinsurance and deductible apply.

**Screening Pelvic and Clinical Breast Examination (G0101)**

Screening pelvic and clinical breast examination can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible are waived.

**Screening Papanicolaou Smear (Q0091)**

Screening Papanicolaou smear can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible are waived.

**Prostate Cancer Screening (G0102)**
Prostate cancer screening can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible apply.

**Glaucoma Screening (G0117 and G0118)**

Glaucoma screening for high risk patients can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible apply.

**Lung Cancer Screening Using Low Dose Computed Tomography (LDCT) (G0296)**

LDCT can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible are waived.

**Drugs Covered as Additional Preventive Services (DCAPS)** DCAPS drugs, and any supply and administration fee, are paid at 100 percent of the Medicare payment amount. The Medicare payment amount for DCAPS drugs, and any supply and administration fee, is described in the Medicare Claims Processing Manual (100-04), Chapter 18, Section 250. The beneficiary coinsurance and deductible are waived.

These services are separately billable and are paid on a claim-by-claim basis. Therefore, they do not affect any other claims billed on the same day.

Coding for DCAPS drugs and related supply and administration fees is listed on the CMS webpage:

• The coding and other guidance for Part B coverage and payment of PrEP for HIV is located at https://www.cms.gov/medicare/coverage/prep. The HCPCS code for the injection of PrEP for HIV is G0012.

**NOTE**: Hepatitis C Screening (G0472) is a technical service only and therefore it is not paid as part of the RHC visit.

## 220.3 - Preventive Health Services in FQHCs

***(Rev. 13600; Issued: 02-20-26; Effective: 01-01-26; Implementation:03-23-26)***

FQHCs must provide preventive health services on site or by arrangement with another provider. These services must be furnished by or under the direct supervision of a physician, NP, PA, CNM, CP, CSW, MFT or MHC. Section 330(b)(1)(A)(i)(III) of the Public Health Service (PHS) Act required preventive health services can be found at http://bphc.hrsa.gov/policies regulations/legislation/index.html, and include:

- prenatal and perinatal services;
- appropriate cancer screening;
- well-child services;

- immunizations against vaccine-preventable diseases;
- screenings for elevated blood lead levels, communicable diseases, and cholesterol;
- pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care; • voluntary family planning services; and
- preventive dental services.

NOTE: The cost of providing these services may be included in the FQHC cost report but they do not necessarily qualify as FQHC billable visits or for the waiver of the beneficiary coinsurance.

**Influenza (G0008), Pneumococcal (G0009), and COVID-19 (90480) Vaccines and Certain COVID-19 Monoclonal Antibody Products**

Prior to July 1, 2025, influenza, pneumococcal, and COVID-19 vaccines and their administration were not paid at the time of service and were paid at 100 percent of reasonable cost through the cost report. The cost was included in the cost report and no visit was billed. FQHCs must have included these charges on the claim if furnished as part of an encounter. The beneficiary coinsurance was waived.

Effective for dates of service on or after July 1, 2025, FQHCs shall report all Part B preventive vaccines and their administration – pneumococcal, influenza, and COVID-19 -- on the claim at the time of service. A visit/encounter is not required for these services; however, if a visit occurs on the same day, the vaccines and administrations shall receive a separate payment. Coinsurance does not apply to these vaccines or their administration.

Although paid at the time of service, payments for these services must be annually reconciled with the FQHC's actual vaccine and vaccine administration costs, to ensure these services are ultimately reimbursed at 100% of reasonable costs through the cost report.

Each year, CMS updates the Seasonal Influenza Vaccines Pricing webpage: https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/vaccine-pricing to reflect the seasonal influenza virus vaccines and their applicable payment allowances that are effective August 1 through July 31 of the following year. FQHCs must refer to this webpage to ensure they are billing the appropriate HCPCS codes for the applicable influenza season.

Note: An additional payment for influenza, pneumococcal, COVID-19 vaccine administration in the home can be made, provided that a home visit meets all the requirements of both part 405, subpart X, for FQHC services provided in the home, and § 410.152(h)(3)(iii) for the in-home additional payment for Part B preventive vaccine administration. See Pub. 100-02, Chapter 15, Section 50.4.4.2.E.

Covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19 and their administration are paid at 100 percent of reasonable cost through the cost report. Monoclonal antibody products used for the treatment or for post-exposure prophylaxis of COVID-19 (when they are not purchased by the government) and their administration are paid through the cost report until the end of the calendar year in which the Emergency Use Authorization declaration for drugs and biological products with respect to COVID-19 ends.

**Hepatitis B Vaccine (G0010)**

Prior to January 1, 2025, hepatitis B vaccine and its administration was included in the FQHC visit and was not separately billable. The cost of the vaccine and its administration could be included in the line item for the otherwise qualifying visit. A visit could not be billed if vaccine administration was the only service the FQHC provides. The beneficiary coinsurance was waived.

Effective January 1, 2025, payment for the hepatitis B vaccine and its administration is through the cost report and no longer included in the FQHC PPS rate.

Effective for dates of service on or after July 1, 2025, FQHCs shall report all Part B preventive vaccines and their administration – including hepatitis B, on the claim at the time of service. A visit/encounter is not required for these services; however, if a visit occurs on the same day, the vaccines and administrations shall receive a separate payment. Coinsurance does not apply to these vaccines.

Although paid at the time of service, payments for these services must be annually reconciled with the FQHC's actual vaccine and vaccine administration costs, to ensure these services are ultimately reimbursed at 100% of reasonable costs through the cost report.

Note: An additional payment for hepatitis B vaccine administration in the home can be made, provided that a home visit meets all the requirements of both part 405, subpart X, for FQHC services provided in the home, and § 410.152(h)(3)(iii) for the in-home additional payment for Part B preventive vaccine administration. See Pub. 100-02, Chapter 15, Section 50.4.4.2.E for more information.

**Initial Preventive Physical Exam (G0402)**

The IPPE is a face-to-face one-time exam that must occur within the first 12 months following the beneficiary's enrollment. The IPPE can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If an IPPE visit is furnished on the same day as another billable visit, FQHCs may not bill for a separate visit. These FQHCs will have an adjustment of 1.3416 to their PPS rate. The beneficiary coinsurance is waived.

**Annual Wellness Visit (G0438 and G0439)**

The AWV is a personalized face-to-face prevention visit for beneficiaries who are not within the first 12 months of their first Part B coverage period and have not received an IPPE or AWV within the past 12 months. Advance Care Planning (ACP) *and administration of a standardized, evidence-based assessment of physical activity and nutrition* can be furnished as a part of the AWV. The AWV can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If the AWV is furnished on the same day as another medical visit, it is not a separately billable visit. FQHCs that are authorized to bill under the FQHC PPS will have an adjustment of 1.3416 to their PPS rate. The beneficiary coinsurance is waived.

*More information regarding ACP and an evidence-based assessment of physical activity and nutrition as an optional AWV element is available on the CMS website:*
*https://www.cms.gov/medicare/coverage/preventive-services/medicare-wellness-visits/annual-wellness-visit*

**Diabetes Self-Management Training (G0108) and Medical Nutrition Therapy (97802 and 97803)**

DSMT and MNT furnished by certified DSMT and MNT providers are billable visits in FQHCs when they are provided in a one-on-one, face-to-face encounter and all program requirements are met. Other diabetes counseling or medical nutrition services provided by a registered dietician at the FQHC may be considered incident to a visit with an FQHC provider. The beneficiary coinsurance is waived for MNT services and is applicable for
DSMT.

DSMT must be furnished by a certified DSMT practitioner, and MNT must be furnished by a registered dietitian or nutrition professional. Program requirements for DSMT services are set forth in 42 CFR 410 Subpart H for DSMT and in Part 410, Subpart G for MNT services, and additional guidance can be found at Pub. 100-02, chapter 15, section 300.

**Screening Pelvic and Clinical Breast Examination (G0101)**

Screening pelvic and clinical breast examination can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance is waived.

**Screening Papanicolaou Smear (Q0091)**

Screening Papanicolaou smear can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance is waived.

**Prostate Cancer Screening (G0102)**

Prostate cancer screening can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance applies.

**Glaucoma Screening (G0117 and G0118)**

Glaucoma screening for high risk patients can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance applies.

**Lung Cancer Screening Using Low Dose Computed Tomography (LDCT) (G0296)**

LDCT can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance is waived.

**Drugs Covered as Additional Preventive Services (DCAPS)**

DCAPS drugs, and any supply and administration fee, are paid at 100 percent of the Medicare payment amount. The Medicare payment amount for DCAPS drugs, and any supply and administration fee, is described in the Medicare Claims Processing Manual (100-04), Chapter 18, Section 250. The beneficiary coinsurance and deductible are waived.

These services are separately billable and are paid on a claim-by-claim basis. Therefore, they do not affect any other claims billed on the same day.

Coding for DCAPS drugs and related supply and administration fees is listed on the CMS webpage:

- The coding and other guidance for Part B coverage and payment of PrEP for HIV is located at https://www.cms.gov/medicare/coverage/prep. The HCPCS code for the injection of PrEP for HIV is G0012.

**NOTE:** Hepatitis C Screening (G0472) is a technical service only and therefore not paid as part of the FQHC visit.

## 230 – Care Coordination Services (formerly Care Management Services)

***(Rev. 13600; Issued: 02-20-26; Effective: 01-01-26; Implementation:03-23-26)***

Care coordination services are RHC and FQHC services and include transitional care management (TCM), chronic care management (CCM), principal care management (PCM), chronic pain management (CPM), general behavioral health integration (BHI),
Remote Patient Monitoring (RPM), Remote Therapeutic Monitoring (RTM), Community
Health Integration (CHI), Principal Illness Navigation (PIN), Principal Illness Navigation Peer Support (PIN-PS), Advanced Primary Care Management (APCM) and psychiatric collaborative care model (CoCM) services.

The RHC and FQHC face-to-face requirements are waived for these care management services. Effective January 1, 2017, care management services furnished by auxiliary personnel may be furnished under general supervision. (Note: General supervision does not require the RHC or FQHC practitioner to be in the same building or immediately available, but it does require the services to be furnished under the overall supervision and control of the RHC or FQHC practitioner.) Except for TCM services, care management services are paid separately from the RHC AIR or FQHC PPS.

*Prior to January 1, 2022,* RHCs and FQHCs *could* not bill for care management services for a beneficiary if another practitioner or facility *had* already billed for care management services for the same beneficiary during the same time period. *E*ffective January 1, 2022, RHCs and FQHCs may bill for care management and TCM services and other care management services (outside of the RHC AIR or FQHC PPS), for the same beneficiary during the same time period. Coinsurance and deductibles are applied as applicable to RHC claims, and coinsurance is applied as applicable to FQHC claims.

Effective January 1, 2025, RHCs and FQHCs are required to bill the individual codes that make up the general care management HCPCS code, G0511. RHCs and FQHCs *must* report the individual CPT/HCPCS base codes and add-on codes (as necessary) for each of the care coordination services which replace*d the reporting of* HCPCS code G0511.

*Note: Effective January 1, 2026, RHCs and FQHCs can bill care coordination services established under the Physician Fee Schedule (PFS) as designated care management services. The care coordination codes can be found in the table entitled Designated Care Management Services, which is published annually with the PFS Final Rule Addenda on the CMS website. Care coordination services are paid separately and should meet all of the billing requirements. Except for TCM services, which can be an RHC or FQHC visit (see section 230.1 of this Chapter).*

## 230.2.10 Advanced Primary Care Management Services

***(Rev. 13600; Issued: 02-20-26; Effective: 01-01-26; Implementation:03-23-26)***

Advanced Primary Care Management services combine elements of several existing care management and communication technology-based services that include essential elements such as Chronic Care Management (CCM), Transitional Care Management (TCM), and Principal Care Management (PCM). *Effective January 1, 2025,* RHCs and FQHCs can bill for APCM services once per patient per calendar month using an APCM HCPCS code when the billing requirements are met. APCM services aren't time based.

*Effective January 1, 2026, RHCs and FQHCs can bill optional add-on codes for APCM services that would facilitate providing complementary BHI or CoCM services.*

*Detailed information regarding APCM can be found on the CMS Website: https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/advanced-primary-care-management-services*

## 230.3– Payment for Care Coordination Services

***(Rev. 13600; Issued: 02-20-26; Effective: 01-01-26; Implementation:03-23-26)***

CCM services furnished between January 1, 2016, and December 31, 2017, are paid based on the PFS national average non-facility payment rate when CPT code 99490 is billed alone or with other payable services on an RHC or FQHC claim.

CCM or general BHI services furnished between January 1, 2018, and December 31, 2018, are paid at the average of the national non-facility PFS payment rate for CPT codes 99490 (30 minutes or more of CCM services), 99487 (60 minutes or more of complex CCM services), and 99484 (20 minutes or more of general behavioral health integration services), when general care management HCPCS code G0511 is on an RHC or FQHC claim, either alone or with other payable services.

CCM or general BHI services furnished on or after January 1, 2019, are paid at the average of the national non-facility PFS payment rate for CPT codes 99490, 99487, 99484, and 99491(30 minutes or more of CCM furnished by a physician or other qualified health care professional), when general care management HCPCS code G0511 is on an RHC or FQHC claim, either alone or with other payable services.

CCM, PCM or general BHI services furnished on or after January 1, 2021 are paid at the average of the national non-facility PFS payment rate for CPT codes 99490, 99487, 99484, and 99491, and CPT codes 99424 (30 minutes or more of PCM services furnished by physicians or non-physician practitioners (NPPs)) and 99426 (30 minutes or more of PCM services furnished by clinical staff under the direct supervision of a physician or NPP), when general care management HCPCS code G0511 is on an RHC or FQHC claim, either alone or with other payable services.

CCM, PCM, CPM or general BHI services furnished on or after January 1, 2023 are paid at the average of the national non-facility PFS payment rate for CPT codes 99490, 99487, 99484, 99491, 99424, 99426, and G3002 (30 minutes or more of CPM services) when general care management HCPCS code G0511 is on an RHC or FQHC claim, either alone or with other payable services. The payment rate for HCPCS code G0511 is updated annually based on the PFS amounts for these codes.

CCM, PCM, CPM, general BHI, RPM, RTM, CHI or PIN services furnished on or after January 1, 2024, are paid at the weighted average of the national non-facility PFS payment rate by taking the utilization of the base code for the service furnished and any applicable add-on codes used in the same month, as well as any base code reported alone in a month, when general care management HCPCS code G0511 is on an RHC or FQHC claim, either alone or with other payable services. The actual utilization of the services that comprise G0511 will be obtained by using the most recently available data for the services paid under the PFS. The payment rate for HCPCS code G0511 is updated annually based on the PFS amounts for these codes.

RHCs and FQHCs may bill HCPCS code G0511 multiple times in a calendar month for the codes listed in the table below as long as all requirements are met and there is not double counting. For example, RHCs and FQHCs can bill HCPCS code G0511 twice for 20 minutes of qualifying CCM services and 30 minutes of qualifying PCM services, as long as, the clinical staff minutes do not overlap.

*Effective January 1, 2025,* RHCs and FQHCs *are required to bill* the individual CPT/HCPCS base codes and add-on codes for each of the care coordination services *to receive payment separate from the RHC AIR or FQHC PPS. Billing the individual codes* replace*d the reporting of* HCPCS code G0511. Care coordination services are paid at the national non-facility PFS payment rates.

*Note: CMS permitted billing of HCPCS code G0511 to continue through September 30, 2025.*

Advanced Primary Care Management Services (APCM) *furnished on or after January 1, 2025, are paid at the national non-facility PFS payment rates.*

*A list of all care coordination services for RHCs and FQHCs are available on the RHC and FQHC websites at https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center and https://www.cms.gov/medicare/payment/prospective-payment-systems/federally-qualified-health-centers-fqhc-center, respectively.*

*Coinsurance*

For FQHCs, coinsurance for care *coordination* services is 20 percent of *the* lesser of submitted charges or the *national non-facility PFS* payment rate for each individual HCPCS code.

For RHCs, coinsurance *for care coordination services* is 20 percent of the *lesser of the submitted charges* or the *national non-facility PFS* payment rate for each individual HCPCS code.

Care *coordination* costs are reported in the non- reimbursable section of the cost report and are not used in determining the RHC AIR or the FQHC PPS rate.

## 230.4 – Psychiatric Collaborative Care Model (CoCM) Services

***(Rev. 13600; Issued: 02-20-26; Effective: 01-01-26; Implementation:03-23-26)***

Psychiatric CoCM is a specific model of care provided by a primary care team consisting of a primary care provider and a health care manager who work in collaboration with a psychiatric consultant to integrate primary health care services with care management support for patients receiving behavioral health treatment. It includes regular psychiatric inter-specialty consultation with the primary care team, particularly regarding patients whose conditions are not improving. The primary care team regularly reviews the beneficiary's treatment plan and status with the psychiatric consultant and maintains or adjusts treatment, including referral to behavioral health specialty care, as needed. Patients with mental health, behavioral health, or psychiatric conditions, including substance use disorders, who are being treated by an RHC or FQHC practitioner may be eligible for psychiatric CoCM services, as determined by the RHC or FQHC primary care practitioner. A separately billable initiating visit with an RHC or FQHC primary care practitioner (physician, NP, PA, or CNM) is required before psychiatric CoCM services can be furnished. This visit can be an E/M, AWV, or IPPE visit, and must occur no more than one-year prior to commencing care management services.

Psychiatric CoCM services do not need to have been discussed during the initiating visit, and the same initiating visit can be used for psychiatric CoCM as for CCM and BHI services, as long as it occurs with an RHC or FQHC primary care practitioner within one year of commencement of psychiatric CoCM services. Beneficiary consent to receive care management services must be obtained either by or under the direct supervision of the RHC or FQHC primary care practitioner, may be written or verbal and must be documented in the patient's medical record before psychiatric CoCM services are furnished. The medical record should document that the beneficiary has been informed about the availability of care management services, has given permission to consult with relevant specialists as needed, and has been informed of all of the following:

- There may be cost-sharing (e.g. deductible and coinsurance in RHCs, and coinsurance in FQHCs) for both in-person and non-face-to-face services that are provided;
- Only one practitioner/facility can furnish and be paid for these services during a calendar month; and
- They can stop care management services at any time, effective at the end of the calendar month.

Beneficiary consent remains in effect unless the beneficiary opts out of receiving care management services. If the beneficiary chooses to resume care management services after opting out, beneficiary consent is required before care management services can resume. If the beneficiary has not opted out of care management services but there has been a period where no care management services were furnished, a new beneficiary consent is not required.

Behavioral Health Care Manager Requirements

The behavioral health care manager is a designated individual with formal education or specialized training in behavioral health, including social work, nursing, or psychology, and has a minimum of a bachelor's degree in a behavioral health field (such as in clinical social work or psychology), or is a clinician with behavioral health training, including RNs and LPNs. The behavioral health care manager furnishes both face-to-face and nonface-to-face services under the general supervision of the RHC or FQHC practitioner and may be employed by or working under contract to the RHC or FQHC. The behavioral health care manager:

- Provides assessment and care management services, including the administration of validated rating scales;
- Provides behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Provides brief psychosocial interventions;
- Maintains ongoing collaboration with the RHC or FQHC practitioner;
- Maintains a registry that tracks patient follow-up and progress;
- Acts in consultation with the psychiatric consultant;
- Is available to provide services face-to-face with the beneficiary; and
- Has a continuous relationship with the patient and a collaborative, integrated relationship with the rest of the care team.

Psychiatric Consultant Requirements

The psychiatric consultant is a medical professional trained in psychiatry and qualified to prescribe the full range of medications. The psychiatric consultant is not required to be on site or to have direct contact with the patient and does not prescribe medications or furnish treatment to the beneficiary directly. The psychiatric consultant:

- Participates in regular reviews of the clinical status of patients receiving psychiatric CoCM services;
- Advises the RHC or FQHC practitioner regarding diagnosis and options for resolving issues with beneficiary adherence and tolerance of behavioral health treatment; making adjustments to behavioral health treatment for beneficiaries who are not progressing; managing any negative interactions between beneficiaries' behavioral health and medical treatments; and
- Facilitates referral for direct provision of psychiatric care when clinically indicated.

Payment for Psychiatric CoCM

Psychiatric CoCM services furnished on or after January 1, 2019, are paid at the average of the national non-facility PFS payment rate for CPT codes 99492 (70 minutes or more of initial psychiatric CoCM services) and CPT code 99493 (60 minutes or more of subsequent psychiatric CoCM services) when psychiatric CoCM HCPCS code, G0512, is on an RHC or FQHC claim, either alone or with other payable services. This rate is updated annually based on the PFS amounts for these codes. At least 70 minutes in the first calendar month, and at least 60 minutes in subsequent calendar months, of psychiatric CoCM services must have been furnished in order to bill for this service.

Coinsurance for psychiatric CoCM services is 20 percent of the lesser of submitted charges or the payment rate for G0512. Psychiatric CoCM costs are reported in the nonreimbursable section of the cost report and

are not used in determining the RHC AIR or the FQHC PPS rate. G0512 can be billed once per month per beneficiary when all requirements have been met.

Only services furnished by an RHC or FQHC practitioner or auxiliary personnel that are within the scope of service elements can be counted toward the minimum 60 minutes that is required to bill for psychiatric CoCM services and does not include administrative activities such as transcription or translation services.

*Effective January 1, 2026, RHCs and FQHCs must report the individual CPT/HCPCS base codes and add-on codes for each of the psychiatric CoCM services. Billing of the individual codes replaced the reporting of HCPCS code G0512. Psychiatric CoCM services are paid separately at the national non-facility PFS payment rates. A claim should not contain both G0512 and the corresponding CPT/HCPCS codes. Only the individual CPT/HCPCS codes will be paid.*

## 240 – Virtual Communication Services

***(Rev. 13600; Issued: 02-20-26; Effective: 01-01-26; Implementation:03-23-26)***

Virtual communication services are RHC and FQHC services and include communications-based technology and remote evaluation services. The RHC and FQHC face-to-face requirements are waived when these services are furnished to an RHC or FQHC patient.

Effective January 1, 2019, RHCs and FQHCs receive an additional payment for the costs of communication technology-based services or remote evaluation services that are not already captured in the RHC AIR or the FQHC PPS payment when the requirements for these services are met. Coinsurance and deductibles apply to RHC claims, and coinsurance applies to FQHC claims for these services.

Requirements

The following requirements must be met for RHCs and FQHCs to bill for virtual communication services:

- At least 5 minutes of communications-based technology or remote evaluation services are furnished by an RHC or FQHC practitioner to a patient that has had a billable visit in the RHC or FQHC within the previous year; and
- The medical discussion or remote evaluation is for a condition not related to an RHC or FQHC service provided within the previous 7 days, and does not lead to an RHC or FQHC service within the next 24 hours or at the soonest available appointment.

If the discussion between the patient and the RHC or FQHC practitioner is related to a billable visit furnished by the RHC or FQHC within the previous 7 days or within the next 24 hours or at the soonest available appointment, the cost of the RHC or FQHC practitioner's time would be included in the RHC AIR or the FQHC PPS payment and is not separately billable.

Beneficiary consent to receive virtual communication services may be obtained under general supervision by auxiliary staff.

Payment for Virtual Communication Services

Virtual communication services furnished by RHCs and FQHCs on or after January 1, 2019 *through December 31, 2025*, are paid at the average of the national non-facility PFS payment rate for HCPCS code G2012 (communication technology-based services), and HCPCS code G2010 (remote evaluation services), when the virtual communication HCPCS code, G0071, is on an RHC or FQHC claim, either alone or with

other payable services. The payment rate for HCPCS code G0071 is updated annually based on the PFS amounts for these codes.

*Effective January 1, 2026, RHCs and FQHCs must report the individual CPT/HCPCS base codes and add-on codes for each of the virtual communication services. Billing of the individual codes replaced the reporting of HCPCS code G0071. Virtual communication services will be paid separately at the national non-facility PFS payment rates. A claim should not contain both G0071 and the corresponding CPT/HCPCS codes. Only the individual CPT/HCPCS codes will be paid.*

*Note: Due to the similarities between CPT code 98016 and HCPCS code G2012, HCPCS code G2012 was replaced with CPT 98016. That is, HCPCS code G2012 was terminated effective December 31, 2024.*