and part 491, as described in § 405.2434(a); and

(iii) The FQHC terminates other provider agreements, unless the FQHC assures CMS that it is not using the same space, staff and resources simultaneously as a physician's office or another type of provider or supplier. A corporate entity may own other provider types as long as the provider types are distinct from the FQHC.

(2) CMS sends the entity a written notice of the disposition of the request.

(3) When the requirement of paragraph (a)(1) of this section is satisfied, CMS sends the entity two copies of the agreement. The entity must sign and return both copies of the agreement to CMS.

(4) If CMS accepts the agreement filed by the Federally qualified health center, CMS returns to the center one copy of the agreement with the notice of acceptance specifying the effective date (see § 489.11), as determined under § 405.2434.

(b) *Recommendations by PHS about Federally qualified health centers.* (1) An entity must—

(i) Meet the applicable requirements of the PHS Act, as specified in § 405.2401(b); and

(ii) Be recommended by PHS to CMS as a Federally qualified health center.

(2) The PHS notifies CMS of entities that meet the requirements specified in § 405.2401(b).

(c) *Provider-based and freestanding Federally qualified health centers.* The requirements and benefits under Medicare for provider-based or freestanding Federally qualified health centers are the same, except that payment methodologies differ, as described in § 405.2462.

(d) *Appeals.* An entity is entitled to a hearing in accordance with part 498 of this chapter when CMS fails to enter into an agreement with the entity.

[57 FR 24978, June 12, 1992, as amended at 61 FR 14657, Apr. 3, 1996]

§ 405.2434 Content and terms of the agreement.

Under the agreement, the Federally qualified health center must agree to the following:

(a) *Maintain compliance with the requirements.* (1) The Federally qualified health center must agree to maintain compliance with the Federally qualified health center requirements set forth in this subpart and part 491, except that the provisions of § 491.3 do not apply.

(2) Centers must promptly report to CMS any changes that result in noncompliance with any of these requirements.

(b) *Effective date of agreement.* (1) Except as specified in paragraph (b)(2) of this section, the effective date of the agreement is the date CMS accepts the signed agreement, which assures that all Federal requirements are met.

(2) For facilities that met all requirements on October 1, 1991, the effective date of the agreement can be October 1, 1991.

(c) *Charges to beneficiaries.* (1) The beneficiary is responsible for payment of a coinsurance amount which is 20 percent of the amount of Part B payment made to the Federally qualified health center for the covered services. There is no coinsurance for a second or third opinion obtained in accordance with section 1164 of the Act or for pneumococcal vaccine and its administration.

(2) The beneficiary is responsible for blood deductible expenses, as specified in § 410.161.

(3) The Federally qualified health center agrees not to charge the beneficiary (or any other person acting on behalf of a beneficiary) for any Federally qualified health center services for which the beneficiary is entitled to have payment made on his or her behalf by the Medicare program (or for which the beneficiary would have been entitled if the Federally qualified health center had filed a request for payment in accordance with § 410.165 of this chapter), except for coinsurance amounts.

(4) The Federally qualified health center may charge the beneficiary for items and services that are not Federally qualified health center services. However, if the item or service is covered under Part B of Medicare, and the Federally qualified health center agrees to receive Part B payment under the assignment method, the Federally qualified health center may not

charge the beneficiary more than 20 percent of the Part B payment.

(d) *Refunds to beneficiaries.* (1) The Federally qualified health center must agree to refund as promptly as possible any money incorrectly collected from Medicare beneficiaries or from someone on their behalf.

(2) As used in this section, ''money incorrectly collected'' means any amount for covered services that is greater than the amount for which the beneficiary was liable because of the coinsurance requirements specified in part 410, subpart E.

(3) Amounts also are considered incorrectly collected if the Federally qualified health center believed the beneficiary was not entitled to Medicare benefits but—

(i) The beneficiary was later determined to have been so entitled;

(ii) The beneficiary's entitlement period fell within the time the Federally qualified health center's agreement with CMS was in effect; and

(iii) The amounts exceed the beneficiary's coinsurance liability.

(e) *Treatment of beneficiaries.* (1) The Federally qualified health center must agree to accept Medicare beneficiaries for care and treatment.

(2) The Federally qualified health center may not impose any limitations with respect to care and treatment of Medicare beneficiaries that it does not also impose upon all other persons seeking care and treatment from the Federally qualified health center. Failure to comply with this requirement is a cause for termination of the Federally qualified health center's agreement with CMS in accordance with § 405.2436(d).

(3) If the Federally qualified health center does not furnish treatment for certain illnesses and conditions to patients who are not Medicare beneficiaries, it need not furnish such treatment to Medicare beneficiaries.

§ 405.2436 Termination of agreement.

(a) *Termination by Federally qualified health center.* The Federally qualified health center may terminate its agreement by—

(1) Filing with CMS a written notice stating its intention to terminate the agreement; and

(2) Notifying CMS of the date on which the Federally qualified health center requests that the termination take effect.

(b) *Effective date.* (1) Upon receiving a Federally qualified health center's notice of intention to terminate the agreement, CMS will set a date upon which the termination takes effect. This effective date may be—

(i) The date proposed by the Federally qualified health center in its notice of intention to terminate, if that date is acceptable to CMS; or

(ii) Except as specified in paragraph (2) of this section, a date set by CMS, which is no later than 6 months after the date CMS receives the Federally qualified health center's notice of intention to terminate.

(2) The effective date of termination may be less than 6 months following CMS's receipt of the Federally qualified health center's notice of intention to terminate if CMS determines that termination on such a date would not—

(i) Unduly disrupt the furnishing of Federally qualified health center services to the community; or

(ii) Otherwise interfere with the effective and efficient administration of the Medicare program.

(3) The termination is effective at the end of the last day of business as a Federally qualified health center.

(c) *Termination by CMS.* (1) CMS may terminate an agreement with a Federally qualified health center if it finds that the Federally qualified health center—

(i) No longer meets the requirements specified in this subpart; or

(ii) Is not in substantial compliance with—

(A) The provisions of the agreement; or

(B) The requirements of this subpart, any other applicable regulations of this part, or any applicable provisions of title XVIII of the Act.

(2) *Notice by CMS.* CMS will notify the Federally qualified health center in writing of its intention to terminate an agreement at least 15 days before the effective date stated in the written notice.