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(4) Services and supplies must be furnished in accordance with applicable State law; and

(5) Furnished under the direct supervision of a clinical psychologist or clinical social worker.

(b) The direct supervision requirement in paragraph (a)(5) of this section is met only if the clinical psychologist or clinical social worker is permitted to supervise such services under the written policies governing the FQHC.

[43 FR 8261, Mar. 1, 1978, as amended at 78 FR 74810, Dec. 10, 2013; 79 FR 25477, May 2, 2014; 79 FR 68001, Nov. 13, 2014]

PAYMENT FOR RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES

SOURCE: 57 FR 24976, 24977, June 12, 1992, unless otherwise noted.

§ 405.2460 Applicability of general payment exclusions.

The payment conditions, limitations, and exclusions set out in subpart C of this part, part 410 and part 411 of this chapter are applicable to payment for services provided by RHCs and FQHCs, except that preventive primary services, as defined in § 405.2448, are statutorily authorized for FQHCs and not excluded by the provisions of section 1862(a) of the Act.

[79 FR 25477, May 2, 2014]

§ 405.2462 Payment for RHC and FQHC services.

(a) *Payment to independent RHCs that are authorized to bill under the reasonable cost system.* (1) RHCs that are authorized to bill under the reasonable cost system are paid on the basis of an all-inclusive rate, subject to a payment limit per visit determined in paragraph (b) of this section, for each beneficiary visit for covered services. This rate is determined by the Medicare Administration Contractor (MAC), in accordance with this subpart and general instructions issued by CMS.

(2) The amount payable by the MAC for a visit is determined in accordance with paragraphs (i)(1) and (2) of this section.

(b) *RHC payment limit per visit.* (1) In establishing limits on payment for rural health clinic services provided by

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rural health clinics the limit for services provided prior to April 1, 2021:

(i) In 1988, after March 31, at \$46 per visit; and

(ii) In a subsequent year (before April 1, 2021), at the limit established for the previous year increased by the percentage increase in the Medicare Economic Index (MEI) (as defined in section 1842(i)(3) of the Act) applicable to primary care services (as defined in section 1842(i)(4) of the Act) furnished as of the first day of that year.

(2) In establishing limits on payment for rural health services furnished on or after April 1, 2021, by rural health clinics or any rural health clinic that is enrolled on or after January 1, 2021 under section 1866(j) of the Act), the limit for services provided:

(i) In 2021, after March 31, at \$100 per visit;

(ii) In 2022, at \$113 per visit;

(iii) In 2023, at \$126 per visit;

(iv) In 2024, at \$139 per visit;

(v) In 2025, at \$152 per visit;

(vi) In 2026, at \$165 per visit;

(vii) In 2027, at \$178 per visit; and

(viii) In 2028, at \$190 per visit.

(ix) In a subsequent year, at the limit established for the previous year increased by the percentage increase in MEI applicable to primary care services furnished as of the first day of such year.

(3) In establishing limits on payment for rural health services furnished on or after April 1, 2021, by provider-based rural health clinics as described in section (c)(4) of this part, the limit for services provided:

(i) In 2021, after March 31, at an amount equal to the greater of:

(A) For rural health clinics that had an all-inclusive rate established for services furnished in 2020—

(I) The all-inclusive rate applicable to the rural health clinic for services furnished in 2020, increased by the percentage increase in the MEI applicable to primary care services furnished as of the first day of 2021, or

(2) The payment limit per visit applicable in paragraph (b)(2) of this section.

(B) For rural health clinics that did not have an all-inclusive rate established for services furnished in 2020—

(1) The all-inclusive rate applicable to the rural health clinic for services furnished in 2021, or

(2) The payment limit per visit applicable in paragraph (b)(2) of this section.

(ii) In a subsequent year, at an amount equal to the greater of:

(A) The amount established under paragraph (b)(3)(i)(A) or (B) of this section, as applicable for the previous year, increased by the percentage increase in MEI applicable to primary care services furnished as of the first day of such subsequent year, or

(B) The payment limit per visit applicable under paragraph (b)(2) of this section for such subsequent year.

(c) *Payment to provider-based RHCs that are authorized to bill under the reasonable cost system.* (1) An RHC that is authorized to bill under the reasonable cost system is paid in accordance with parts 405 and 413 of this subchapter, as applicable, if the RHC is—

(i) An integral and subordinate part of a hospital, skilled nursing facility or home health agency participating in Medicare (that is, a provider of services); and

(ii) Operated with other departments of the provider under common licensure, governance and professional supervision.

(2) An RHC, described in paragraph (c)(1) of this section, is paid on the basis of an all-inclusive rate, subject to a payment limit per visit, described in paragraphs (b)(1) and (2) of this section, for each beneficiary visit for covered services when in a hospital with greater than 50 beds as determined in § 412.105(b) of this subchapter. This all-inclusive rate is determined by the MAC, in accordance with this subpart and general instructions issued by CMS. The amount payable by the MAC for a visit is determined in accordance with paragraphs (i)(1) and (2) of this section.

(3) Prior to April 1, 2021, an RHC, described in paragraph (c)(1) of this section, is paid on the basis of an all-inclusive rate and is not subject to a payment limit per visit described in paragraphs (b)(1) and (2) of this section for each beneficiary visit for covered services when in a hospital with less than 50 beds as determined in § 412.105(b) of

this subchapter. This all-inclusive rate is determined by the MAC, in accordance with this subpart and general instructions issued by CMS. The amount payable by the MAC for a visit is determined in accordance with paragraphs (i)(1) and (2) of this section.

(4) On or after April 1, 2021, an RHC, described in paragraph (c)(1) of this section, is paid on the basis of an all-inclusive rate, subject to a payment limit per visit, described in paragraph (b)(3) of this section, for each beneficiary visit for covered services when it meets the specified qualifications in paragraph (d) of this section. This all-inclusive rate is determined by the MAC, in accordance with this subpart and general instructions issued by CMS. The amount payable by the MAC for a visit is determined in accordance with paragraphs (i)(1) and (2) of this section.

(d) *Specified qualifications.* A provider-based rural health clinic must meet the following qualifications to have a payment limit per visit established in accordance with paragraph (b)(3) of this section.

(1) As of December 31, 2020, was in a hospital with less than 50 beds (as determined in § 412.105(b) of this subchapter) and after December 31, 2020, in a hospital that continues to have less than 50 beds (not taking into account any increase in the number of beds pursuant to a waiver during the COVID-19 Public Health Emergency (PHE)); and one of the following circumstances:

(i) As of December 31, 2020, was enrolled under section 1866(j) of the Act (including temporary enrollment during the COVID-19 PHE); or

(ii) Submitted an application for enrollment under section 1866(j) of the Act (or a request for temporary enrollment during the COVID-19 PHE) that was received not later than December 31, 2020.

(2) [Reserved]

(e) *Payment to FQHCs that are authorized to bill under the PPS.* A FQHC that is authorized to bill under the PPS is paid a single, per diem rate based on the prospectively set rate for each beneficiary visit for covered services. Except as noted in paragraph (f) of this section, this rate is adjusted for the following:

(1) Geographic differences in cost based on the Geographic Practice Cost Indices (GPCIs) in accordance with section 1848(e) of the Act and 42 CFR 414.2 and 414.26 are used to adjust payment under the physician fee schedule during the same period, limited to only the work and practice expense GPCIs.

(2) Furnishing of care to a beneficiary that is a new patient with respect to the FQHC, including all sites that are part of the FQHC. A new patient is one that has not been treated by the FQHC's organization within the previous 3 years.

(3) Furnishing of care to a beneficiary receiving a comprehensive initial Medicare visit (that is an initial preventive physical examination or an initial annual wellness visit) or a subsequent annual wellness visit.

(f) *Payment to grandfathered tribal FQHCs.* (1) A “grandfathered tribal FQHC” is a FQHC that:

(i) Is operated by a tribe or tribal organization under the Indian Self-Determination Education and Assistance Act (ISDEAA);

(ii) Was billing as if it were provider-based to an IHS hospital on or before April 7, 2000; and

(iii) Is not operating as a provider-based department of an IHS hospital.

(2) A grandfathered tribal FQHC is paid at the Medicare outpatient per visit rate as set annually by the IHS.

(3) The payment rate is not adjusted:

(i) By the FQHC Geographic Adjustment Factor;

(ii) For new patients, annual wellness visits, or initial preventive physical examinations; or

(iii) Annually by the Medicare Economic Index or a FQHC PPS market basket.

(4) The payment rate is adjusted annually by the IHS under the authority of sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C. 248 and 249(b)), Pub. L. 83–568 (42 U.S.C. 2001(a)), and the Indian Health Care Improvement Act (25 U.S.C. 1601 *et seq.*).

(g)(1) Except for preventive services for which Medicare pays 100 percent under § 410.152(l) of this chapter, Medicare pays—

(i) Eighty (80) percent of the lesser of the FQHC's actual charge or the PPS

encounter rate for FQHCs authorized to bill under the PPS; or

(ii) Eighty (80) percent of the lesser of a grandfathered tribal FQHC's actual charge, or the outpatient rate for Medicare as set annually by the IHS for grandfathered tribal FQHCs that are authorized to bill at this rate.

(2) No deductible is applicable to FQHC services.

(h) For RHCs visits, payment is made in accordance with one of the following:

(1) If the deductible has been fully met by the beneficiary prior to the RHC visit, Medicare pays 80 percent of the all-inclusive rate.

(2) If the deductible has not been fully met by the beneficiary before the visit, and the amount of the RHC's reasonable customary charge for the services that is applied to the deductible is less than the all-inclusive rate, the amount applied to the deductible is subtracted from the all-inclusive rate and 80 percent of the remainder, if any, is paid to the RHC.

(3) If the deductible has not been fully met by the beneficiary before the visit, and the amount of the RHC's reasonable customary charge for the services that is applied to the deductible is equal to or exceeds the all-inclusive rate, no payment is made to the RHC.

(i) To receive payment, the RHC or FQHC must do all of the following:

(1) Furnish services in accordance with the requirements of subpart X of part 405 of this chapter and subpart A of part 491 of this chapter.

(2) File a request for payment on the form and manner prescribed by CMS.

(3) *HCPCS coding.* FQHCs and RHCs are required to submit HCPCS and other codes as required in reporting services furnished.

[79 FR 25477, May 2, 2014, as amended at 80 FR 71371, Nov. 16, 2015; 83 FR 60073, Nov. 23, 2018; 86 FR 65660, Nov. 19, 2021]

§ 405.2463 What constitutes a visit.

(a) *Visit—General.* (1) For RHCs, a visit is either of the following:

(i) Face-to-face encounter (or, for mental health disorders only, an encounter that meets the requirements under paragraph (b)(3) of this section) between an RHC patient and one of the following:

(A) Physician.
 (B) Physician assistant.
 (C) Nurse practitioner.
 (D) Certified nurse midwife.
 (E) Visiting registered professional or licensed practical nurse.
 (G) Clinical psychologist.
 (H) Clinical social worker.
 (ii) Qualified transitional care management service.
 (2) For FQHCs, a visit is either of the following:
 (i) A visit as described in paragraph (a)(1)(i) or (ii) of this section.
 (ii) A face-to-face encounter between a patient and either of the following:
 (A) A qualified provider of medical nutrition therapy services as defined in part 410, subpart G, of this chapter.
 (B) A qualified provider of outpatient diabetes self-management training services as defined in part 410, subpart H, of this chapter.
 (b) *Visit—Medical.* (1) A medical visit is a face-to-face encounter between a RHC or FQHC patient and one of the following:
 (i) Physician.
 (ii) Physician assistant.
 (iii) Nurse practitioner.
 (iv) Certified nurse midwife.
 (v) Visiting registered professional or licensed practical nurse.
 (2) A medical visit for a FQHC patient may be either of the following:
 (i) Medical nutrition therapy visit.
 (ii) Diabetes outpatient self-management training visit.
 (3) *Visit—Mental health.* 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, including an in-person mental health service, beginning 152 days after the end of the COVID-19 public health emergency, furnished within 6 months prior to the furnishing of the telecommunications service 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 tele-

communications technology for diagnosis, evaluation, or treatment of mental health disorders, unless, for a particular 12-month period, the physician or practitioner and patient agree that the risks and burdens outweigh the benefits associated with furnishing the in-person item or service, and the practitioner documents the reasons for this decision in the patient's medical record, between an RHC or FQHC patient and one of the following:

(i) Clinical psychologist.
 (ii) Clinical social worker.
 (iii) Other RHC or FQHC practitioner, in accordance with paragraph (b)(1) of this section, for mental health services.

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

(i) Suffers an illness or injury subsequent to the first visit that requires additional diagnosis or treatment on the same day;

(ii) Has a medical visit and a mental health visit on the same day; or

(iii) Has an initial preventive physical exam visit and a separate medical or mental health visit on the same day.

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

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

(4) For FQHCs billing under the PPS, and grandfathered tribal FQHCs that are authorized to bill as a FQHC at the outpatient per visit rate for Medicare as set annually by the Indian Health Service—

(i) Suffers an illness or injury subsequent to the first visit that requires additional diagnosis or treatment on the same day; or

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(ii) Has a medical visit and a mental health visit on the same day.

[79 FR 68001, Nov. 13, 2014, as amended at 80 FR 71372, Nov. 16, 2015; 86 FR 65661, Nov. 19, 2021; 87 FR 70222, Nov. 18, 2022]

§ 405.2464 Payment rate.

(a) *Payment rate for RHCs that are authorized to bill under the reasonable cost system.*

(1) Except as specified in paragraphs (d) and (e) of this section, an RHC that is authorized to bill under the reasonable cost system is paid an all-inclusive rate that is determined by the MAC at the beginning of the cost reporting period.

(2) The rate is determined by dividing the estimated total allowable costs by estimated total visits for RHC services.

(3) The rate determination is subject to any tests of reasonableness that may be established in accordance with this subpart.

(4) The MAC, during each reporting period, periodically reviews the rate to assure that payments approximate actual allowable costs and visits and adjusts the rate if:

(i) There is a significant change in the utilization of services;

(ii) Actual allowable costs vary materially from allowable costs; or

(iii) Other circumstances arise which warrant an adjustment.

(5) The RHC may request the MAC to review the rate to determine whether adjustment is required.

(b) *Payment rate for FQHCs that are authorized to bill under the prospective payment system.* (1) Except as specified in paragraphs (d) and (e) of this section, a per diem rate is calculated by CMS by dividing total FQHC costs by total FQHC daily encounters to establish an average per diem cost.

(2) The per diem rate is adjusted as follows:

(i) For geographic differences in the cost of inputs according to § 405.2462(c)(1).

(ii) When the FQHC furnishes services to a new patient, as defined in § 405.2462(c)(2).

(iii) When a beneficiary receives either of the following:

(A) A comprehensive initial Medicare visit (that is, an initial preventive

physical examination or an initial annual wellness visit).

(B) A subsequent annual wellness visit.

(c) *Payment for care management services.* For chronic care management services furnished between January 1, 2016 and December 31, 2017, payment to RHCs and FQHCs is at the physician fee schedule national non-facility payment rate. For care management services furnished on or after January 1, 2018, payment to RHCs and FQHCs is at the rate set for each of the RHC and FQHC payment codes for care management services.

(d) *Payment for FQHCs that are authorized to bill as grandfathered tribal FQHCs.* Grandfathered tribal FQHCs are paid at the outpatient per visit rate for Medicare as set annually by the Indian Health Service for each beneficiary visit for covered services. There are no adjustments to this rate.

(e) *Payment for communication technology-based and remote evaluation services.* For communication technology-based and remote evaluation services furnished on or after January 1, 2019, payment to RHCs and FQHCs is at the rate set for each of the RHC and FQHC payment codes for communication technology-based and remote evaluation services.

[79 FR 25478, May 2, 2014, as amended at 80 FR 71372, Nov. 16, 2015; 83 FR 60073, Nov. 23, 2018]

§ 405.2466 Annual reconciliation.

(a) *General.* Payments made to RHCs or FQHCs that are authorized to bill under the reasonable cost system during a reporting period are subject to annual reconciliation to assure that those payments do not exceed or fall short of the allowable costs attributable to covered services furnished to Medicare beneficiaries during that period.

(b) *Calculation of reconciliation for RHCs or FQHCs that are authorized to bill under the reasonable cost system.* (1) The total reimbursement amount due the RHC or FQHC for covered services furnished to Medicare beneficiaries is based on the report specified in § 405.2470(c)(2) and is calculated by the MAC as follows:

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

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

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

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

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

(c) *Notice of program reimbursement.* The MAC notifies the RHC or FQHC that is authorized to bill under the reasonable-cost system:

(1) Setting forth its determination of the total reimbursement amount due the RHC or FQHC for the reporting period and the amount, if any, of the reconciliation; and

(2) Informing the RHC or FQHC of its right to have the determination reviewed at a hearing under the procedures set forth in subpart R of this part.

(d) *Payment of reconciliation amount—*

(1) *Underpayments.* If the total reimbursement due the RHC or FQHC that is authorized to bill under the reasonable cost system exceeds the payments made for the reporting period, the MAC makes a lump-sum payment to the RHC or FQHC to bring total payments

into agreement with total reimbursement due the RHC or FQHC.

(2) *Overpayments.* If the total payments made to a RHC or FQHC for the reporting period exceed the total reimbursement due the RHC or FQHC for the period, the MAC arranges with the RHC or FQHC for repayment through a lump-sum refund, or, if that poses a hardship for the RHC or FQHC, through offset against subsequent payments or a combination of offset and refund. The repayment must be completed as quickly as possible, generally within 12 months from the date of the notice of program reimbursement. A longer repayment period may be agreed to by the MAC if the MAC is satisfied that unusual circumstances exist which warrant a longer period.

[57 FR 24976, June 12, 1992, as amended at 61 FR 14657, Apr. 3, 1996; 79 FR 25478, May 2, 2014; 86 FR 65662, Nov. 19, 2021]

§ 405.2467 Requirements of the FQHC PPS.

(a) *Cost reporting.* For cost reporting periods beginning on or after October 1, 2014, FQHCs are paid the lesser of their actual charges or the FQHC PPS rate that does all of the following:

(1) Includes a process for appropriately describing the services furnished by FQHCs.

(2) Establishes payment rates for specific payment codes based on such appropriate descriptions of services.

(3) Takes into account the type, intensity and duration of services furnished by FQHCs.

(4) May include adjustments (such as geographic adjustments) determined by the Secretary.

(b) *Initial payments.* (1) Beginning October 1, 2014, for the first 15 months of the PPS, the estimated aggregate amount of PPS rates is equal to 100 percent of the estimated amount of reasonable costs that would have occurred for that period if the PPS had not been implemented.

(2) Payment rate is calculated based on the reasonable cost system, prior to productivity adjustments and any payment limitations.

(c) *Payments in subsequent years.* (1) Beginning January 1, 2016, PPS payment rates will be increased by the percentage increase in the Medicare economic index.

(2) Beginning January 1, 2017, PPS rates will be increased by the percentage increase in a market basket of FQHC goods and services as established through regulations, or, if not available, the Medicare economic index.

[79 FR 25479, May 2, 2014, as amended at 80 FR 71372, Nov. 16, 2015]

§ 405.2468 Allowable costs.

(a) *Applicability of general Medicare principles.* In determining whether and to what extent a specific type or item of cost is allowable, such as interest, depreciation, bad debts and owner compensation, the MAC applies the principles for reimbursement of provider costs, as set forth in part 413 of this subchapter.

(b) *Typical RHC and FQHC costs.* The following types and items of cost are included in allowable costs to the extent that they are covered and reasonable:

(1) Compensation for the services of a physician, physician assistant, nurse practitioner, certified nurse-midwife, visiting registered professional or licensed practical nurse, clinical psychologist, and clinical social worker who owns, is employed by, or furnishes services under contract to a FQHC or RHC.

(2) Compensation for the duties that a supervising physician is required to perform under the agreement specified in § 491.8 of this chapter.

(3) Costs of services and supplies incident to the services of a physician, physician assistant, nurse practitioner, nurse-midwife, qualified clinical psychologist, or clinical social worker.

(4) Overhead costs, including RHC or FQHC administration, costs applicable to use and maintenance of the entity, and depreciation costs.

(5) Costs of services purchased by the RHC or FQHC.

(c) *Tests of reasonableness of cost and utilization.* Tests of reasonableness authorized by sections 1833(a) and 1861(v)(1)(A) of the Act may be established by CMS or the MAC with respect to direct or indirect overall costs, costs

of specific items and services, or costs of groups of items and services. For RHCs and FQHCs that are authorized to bill under the reasonable cost system, these tests include, but are not limited to, screening guidelines and payment limits.

(d) *Screening guidelines.* (1) Costs in excess of amounts established by the guidelines are not included unless the RHC or FQHC that is authorized to bill under the reasonable cost system provides reasonable justification satisfactory to the MAC.

(2) Screening guidelines are used to assess the costs of services, including the following:

(i) Compensation for the professional and supervisory services of physicians and for the services of physician assistants, nurse practitioners, and nurse-midwives.

(ii) Services of physicians, physician assistants, nurse practitioners, nurse-midwives, visiting nurses, qualified clinical psychologists, and clinical social workers.

(iii) The level of administrative and general expenses.

(iv) Staffing (for example, the ratio of other RHC or FQHC personnel to physicians, physician assistants, and nurse practitioners).

(v) The reasonableness of payments for services purchased by the RHC or FQHC, subject to the limitation that the costs of physician services purchased by the RHC or FQHC may not exceed amounts determined under the applicable provisions of subpart E of part 405 or part 415 of this chapter.

(e) *Payment limitations.* Limits on payments may be set by CMS, on the basis of costs estimated to be reasonable for the provision of such services.

(f) *Graduate medical education.* (1) Effective for portions of cost reporting periods occurring on or after January 1, 1999, if an RHC or an FQHC incurs “all or substantially all” of the costs for the training program in the nonhospital setting as defined in § 413.75(b) of this chapter, the RHC or FQHC may receive direct graduate medical education payment for those residents.

However, in connection with cost reporting periods for which “all or substantially all of the costs for the training program in the nonhospital setting” is not defined in § 413.75(b) of this chapter, if an RHC or an FQHC incurs the salaries and fringe benefits (including travel and lodging where applicable) of residents training at the RHC or FQHC, the RHC or FQHC may receive direct graduate medical education payments for those residents.

(2) Direct graduate medical education costs are not included as allowable cost under § 405.2466(b)(1)(i); and therefore, are not subject to the limit on the all-inclusive rate for allowable costs.

(3) Allowable graduate medical education costs must be reported on the RHC’s or the FQHC’s cost report under a separate cost center.

(4) Allowable graduate medical education costs are non-reimbursable if payment for these costs are received from a hospital or a Medicare Advantage organization.

(5) Allowable direct graduate medical education costs under paragraphs (f)(6) and (f)(7)(i) of this section, are subject to reasonable cost principles under part 413 and the reasonable compensation equivalency limits in §§ 415.60 and 415.70 of this chapter.

(6) The allowable direct graduate medical education costs are those costs incurred by the nonhospital site for the educational activities associated with patient care services of an approved program, subject to the redistribution and community support principles in § 413.85(c).

(i) The following costs are allowable direct graduate medical education costs to the extent that they are reasonable—

(A) The costs of the residents’ salaries and fringe benefits (including travel and lodging expenses where applicable).

(B) The portion of teaching physicians’ salaries and fringe benefits that are related to the time spent teaching and supervising residents.

(C) Facility overhead costs that are allocated to direct graduate medical education.

(ii) The following costs are not allowable graduate medical education costs—

(A) Costs associated with training, but not related to patient care services.

(B) Normal operating and capital-related costs.

(C) The marginal increase in patient care costs that the RHC or FQHC experiences as a result of having an approved program.

(D) The costs associated with activities described in § 413.85(h) of this chapter.

(7) Payment is equal to the product of—

(i) The RHC’s or the FQHC’s allowable direct graduate medical education costs; and

(ii) Medicare’s share, which is equal to the ratio of Medicare visits to the total number of visits (as defined in § 405.2463).

(8) Direct graduate medical education payments to RHCs and FQHCs made under this section are made from the Federal Supplementary Medical Insurance Trust Fund.

[43 FR 8261, Mar. 1, 1978. Redesignated and amended at 57 FR 24977, June 12, 1992; 60 FR 63176, Dec. 8, 1995; 61 FR 14658, Apr. 3, 1996; 63 FR 41002, July 31, 1998; 66 FR 39932, Aug. 1, 2001; 70 FR 47484, Aug. 12, 2005; 79 FR 25479, May 2, 2014; 79 FR 50351, Aug. 22, 2014]

§ 405.2469 FQHC supplemental payments.

(a) *Eligibility for supplemental payments.* FQHCs under contract (directly or indirectly) with MA organizations are eligible for supplemental payments for FQHC services furnished to enrollees in MA plans offered by the MA organization to cover the difference, if any, between their payments from the MA plan and what they would receive under one of the following:

(1) The PPS rate if the FQHC is authorized to bill under the PPS; or

(2) The Medicare outpatient per visit rate as set annually by the Indian Health Service for grandfathered tribal FQHCs.

(b) *Calculation of supplemental payment.* The supplemental payment for FQHC covered services provided to Medicare patients enrolled in MA plans is based on the difference between—

(1) Payments received by the FQHC from the MA plan as determined on a per visit basis and the FQHCs all-inclusive cost-based per visit rate as set forth in this subpart, less any amount the FQHC may charge as described in section 1857(e)(3)(B) of the Act; or

(2) Payments received by the FQHC from the MA plan as determined on a per visit basis and the FQHC PPS rate as set forth in this subpart, less any amount the FQHC may charge as described in section 1857(e)(3)(B) of the Act; or

(3) Payments received by the FQHC from the MA plan as determined on a per visit basis and the FQHC outpatient rate as set forth in this section under paragraph (a)(2) of this section, less any amount the FQHC may charge as described in section 1857(e)(3)(B) of the Act.

(c) *Financial incentives.* Any financial incentives provided to FQHCs under their MA contracts, such as risk pool payments, bonuses, or withholds, are prohibited from being included in the calculation of supplemental payments due to the FQHC.

(d) *Per visit supplemental payment.* A supplemental payment required under this section is made to the FQHC when a covered face-to-face encounter or an encounter furnished using interactive, real-time, audio and video telecommunications technology or audio-only interactions in cases where beneficiaries do not wish to use or do not have access to devices that permit a two-way, audio/video interaction for the purposes of diagnosis, evaluation or treatment of a mental health disorder occurs between a MA enrollee and a practitioner as set forth in § 405.2463. Additionally, beginning 152 days after the end of the COVID–19 public health emergency, there must be an in-person mental health service furnished within 6 months prior to the furnishing of the telecommunications service 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 physi-

cian 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.

[79 FR 25479, May 2, 2014, as amended at 80 FR 71372, Nov. 16, 2015; 86 FR 65662, Nov. 19, 2021; 87 FR 70222, Nov. 18, 2022]

§ 405.2470 Reports and maintenance of records.

(a) *Maintenance and availability of records.* The RHC or FQHC must:

(1) Maintain adequate financial and statistical records, in the form and containing the data required by CMS, to allow the MAC to determine payment for covered services furnished to Medicare beneficiaries in accordance with this subpart;

(2) Make the records available for verification and audit by HHS or the General Accounting Office;

(3) Maintain financial data on an accrual basis, unless it is part of a governmental institution that uses a cash basis of accounting. In the latter case, appropriate depreciation on capital assets is allowable rather than the expenditure for the capital asset.

(b) *Adequacy of records.* (1) The MAC may suspend reimbursement if it determines that the RHC or FQHC does not maintain records that provide an adequate basis to determine payments under Medicare.

(2) The suspension continues until the RHC or FQHC demonstrates to the MAC's satisfaction that it does, and will continue to, maintain adequate records.

(c) *Reporting requirements—*(1) *Initial report.* At the beginning of its initial reporting period, the RHC or FQHC must submit an estimate of budgeted costs and visits for RHC or FQHC services for the reporting period, in the form and detail required by CMS, and such other information as CMS may require to establish the payment rate.

(2) *Annual reports.* Within 90 days after the end of its reporting period, the RHC or FQHC must submit, in such form and detail as may be required by CMS, a report of:

(i) Its operations, including the allowable costs actually incurred for the

period and the actual number of visits for RHC or FQHC services furnished during the period; and

(ii) The estimated costs and visits for RHC services or FQHC services for the succeeding reporting period and such other information as CMS may require to establish the payment rate.

(3) *Late reports.* If the RHC or FQHC does not submit an adequate annual report on time, the MAC may reduce or suspend payments to preclude excess payment to the RHC or FQHC.

(4) *Inadequate reports.* If the RHC or FQHC does not furnish a report or furnishes a report that is inadequate for the MAC to make a determination of program payment, CMS may deem all payments for the reporting period to be overpayments.

(5) *Postponement of due date.* For good cause shown by the RHC or FQHC, the MAC may, with CMS's approval, grant a 30-day postponement of the due date for the annual report.

(6) *Reports following termination of agreement or change of ownership.* The report from a RHC or FQHC which voluntarily or involuntarily ceases to participate in the Medicare program or experiences a change in ownership (see §§ 405.2436–405.2438) is due no later than 45 days following the effective date of the termination of agreement or change of ownership.

(d) *Collection of additional claims data.* Beginning January 1, 2011, a Medicare FQHC must report on its Medicare claims such information as the Secretary determines is needed to develop and implement a prospective payment system for FQHCs including, but not limited to all pertinent HCPCS (Healthcare Common Procedure Coding System) code(s) corresponding to the service(s) provided for each Medicare FQHC visit (as defined in § 405.2463).

[43 FR 8261, Mar. 1, 1978, as amended at 75 FR 73613, Nov. 29, 2010; 79 FR 25479, May 2, 2014]

§ 405.2472 Beneficiary appeals.

A beneficiary may request a hearing by an intermediary (subject to the limitations and conditions set forth in subpart H of this part) if:

(a) The beneficiary is dissatisfied with a MAC's determination denying a request for payment made on his or her behalf by a RHC or FQHC;

(b) The beneficiary is dissatisfied with the amount of payment; or

(c) The beneficiary believes the request for payment is not being acted upon with reasonable promptness.

[43 FR 8261, Mar. 1, 1978. Redesignated and amended at 57 FR 24978, June 12, 1992; 79 FR 25480, May 2, 2014]

PART 406—HOSPITAL INSURANCE ELIGIBILITY AND ENTITLEMENT

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