

Centers for Medicare & Medicaid Services, HHS

§ 405.2430

(5) During a PHE, as defined in § 400.200 of this chapter, an area typically served by the RHC, and an area that is included in the FQHC's service area plan, is determined to have a shortage of home health agencies, and no request for this determination is required.

(b) The nursing care covered by this section includes the following:

(1) Services that must be performed by a registered professional nurse or licensed practical nurse if the safety of the patient is to be assured and the medically desired results achieved.

(2) Personal care services, to the extent covered under Medicare as home health services. These services include helping the patient to bathe, to get in and out of bed, to exercise and to take medications.

(c) This benefit does not cover household and housekeeping services or other services that would constitute custodial care.

(d) For purposes of this section, *homebound* means an individual who is permanently or temporarily confined to his or her place of residence because of a medical or health condition. The individual may be considered homebound if he or she leaves the place of residence infrequently. For this purpose, "place of residence" does not include a hospital or long term care facility.

[43 FR 8261, Mar. 1, 1978, as amended at 79 FR 25475, May 2, 2014; 85 FR 19285, Apr. 6, 2020]

§ 405.2417 Visiting nurse services: Determination of shortage of agencies.

A shortage of home health agencies exists if the Secretary determines that the RHC or FQHC:

(a) Is located in a county, parish, or similar geographic area in which there is no participating home health agency or adequate home health services are not available to patients of the RHC or FQHC.

(b) Has (or expects to have) patients whose permanent residences are not within the area serviced by a participating home health agency.

(c) Has (or expects to have) patients whose permanent residences are not within a reasonable traveling distance,

based on climate and terrain, of a participating home health agency.

[43 FR 8261, Mar. 1, 1978, as amended at 79 FR 25476, May 2, 2014]

FEDERALLY QUALIFIED HEALTH CENTER SERVICES

SOURCE: 57 FR 24978, June 12, 1992, unless otherwise noted.

§ 405.2430 Basic requirements.

(a) *Filing procedures.* (1) In response to a request from an entity that wishes to participate in the Medicare program, CMS enters into an agreement with an entity when all of the following occur:

(i) HRSA approves the entity as meeting the requirements of section 330 of the PHS Act.

(ii) The entity assures CMS that it meets the requirements specified in this subpart and part 491 of this chapter, as described in § 405.2434(a).

(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 FQHC, 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) *Prior HRSA FQHC determination.* An entity applying to become a FQHC must do the following:

(1) Be determined by HRSA as meeting the applicable requirements of the PHS Act, as specified in § 405.2401(b).

(2) Receive approval by HRSA as a FQHC under section 330 of the PHS Act (42 U.S.C. 254b).

(c) *Appeals.* An entity is entitled to a hearing in accordance with part 498 of