

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

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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; 79 FR 25476, May 2, 2014]

§ 405.2434 Content and terms of the agreement.

Under the agreement, the FQHC must agree to the following:

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

(2) FQHCs must promptly report to CMS any changes that result in non-compliance with any of these requirements.

(b) *Effective date of agreement.* The effective date of the agreement is determined in accordance with the provisions of § 489.13 of this chapter.

(c) *Charges to beneficiaries.* (1) For non-FQHC services that are billed to Part B, the beneficiary is responsible for payment of a coinsurance amount which is 20 percent of the amount of Part B payment made to the FQHC for the covered services.

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

(3) The FQHC agrees not to charge the beneficiary (or any other person acting on behalf of a beneficiary) for any FQHC 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 FQHC had filed a request for payment in accordance with § 410.165 of this chapter), except for coinsurance amounts.

(4) The FQHC may charge the beneficiary for items and services that are not FQHC services. If the item or service is covered under Medicare Part B, the FQHC may not charge the beneficiary more than 20 percent of the Part B payment amount.

(d) *Refunds to beneficiaries.* (1) The FQHC 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 FQHC 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 FQHC’s agreement with CMS was in effect; and

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

(e) *Treatment of beneficiaries.* (1) The FQHC must agree to accept Medicare beneficiaries for care and treatment.

(2) The FQHC 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 FQHC. Failure to comply with this requirement is a cause for termination of the FQHC’s agreement with CMS in accordance with § 405.2436(d).

(3) If the FQHC 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.

[57 FR 24978, June 12, 1992, as amended at 79 FR 25476, May 2, 2014]

§ 405.2436 Termination of agreement.

(a) *Termination by FQHC.* The FQHC 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 FQHC requests that the termination take effect.

(b) *Effective date.* (1) Upon receiving a FQHC’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 FQHC 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,