

(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.