

(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

Subpart A—General Provisions

Sec.

406.1 Statutory basis.

406.2 Scope.

406.3 Definitions.

406.5 Basis of eligibility and entitlement.

406.6 Application or enrollment for hospital insurance.

406.7 Forms to apply for entitlement under Medicare Part A.

Subpart B—Hospital Insurance Without Monthly Premiums

406.10 Individual age 65 or over who is entitled to social security or railroad retirement benefits, or who is eligible for social security benefits.

406.11 Individual age 65 or over who is not eligible as a social security or railroad retirement benefits beneficiary, or on the basis of government employment.

406.12 Individual under age 65 who is entitled to social security or railroad retirement disability benefits.

406.13 Individual who has end-stage renal disease.

406.15 Special provisions applicable to Medicare qualified government employment.

Subpart C—Premium Hospital Insurance

406.20 Basic requirements.

406.21 Individual enrollment.

406.22 Effect of month of enrollment on entitlement.

406.24 Special enrollment period related to coverage under group health plans.

406.25 Special enrollment period for volunteers outside the United States.

406.26 Enrollment under State buy-in.

406.27 Special enrollment periods for exceptional conditions.

406.28 End of entitlement.

406.32 Monthly premiums.

406.33 Determination of months to be counted for premium increase: Enrollment.

406.34 Determination of months to be counted for premium increase: Reenrollment.

406.38 Prejudice to enrollment rights because of Federal Government error.