

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, clinical social worker, marriage and family therapist, and mental health counselor 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, clinical social worker, marriage and family therapist, or mental health counselor.

(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, clinical social workers, marriage and family therapists, and mental health counselors.

(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 pur-

chased 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

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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.

(g) *Intensive outpatient services.* (1) For RHCs, costs associated with intensive outpatient services are not used to determine the amount of payment for RHC services under the methodology for all-inclusive rates under section 1833(a)(3) of the Act as described in § 405.2464(a).

(2) For FQHCs, costs associated with intensive outpatient services are not used to determine the amount of payment for FQHC services under the prospective payment system under section

1834(o)(2)(B) of the Act as described in § 405.2464(b).

[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; 88 FR 79525, Nov. 16, 2023; 88 FR 82176, Nov. 22, 2023]

§ 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;

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

(3) The payment rate as determined in § 405.2462(j).

(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; or

(4) Payments received by the FQHC from the MA plan as determined on a