

§ 405.2469

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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

per visit basis and the payment rate as determined in § 405.2462(j), 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 January 1, 2025, 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 physician 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; 88 FR 79525, Nov. 16, 2023; 88 FR 82176, Nov. 22, 2023]

§ 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