

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.

§ 405.2417 Visiting nurse services: Determination of shortage of agencies.

A shortage of home health agencies exists if the Secretary determines that the rural health clinic:

(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 rural health clinic;

(b) Has (or expects to have) patients whose permanent residences are not within the area serviced by a participating home health agency; or

(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.

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—

(i) PHS recommends that the entity qualifies as a Federally qualified health center;

(ii) The Federally qualified health center assures CMS that it meets the Federally qualified health center requirements specified in this subpart and part 491, as described in § 405.2434(a); and

(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 Federally qualified health center, 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) *Recommendations by PHS about Federally qualified health centers.* (1) An entity must—

(i) Meet the applicable requirements of the PHS Act, as specified in § 405.2401(b); and

(ii) Be recommended by PHS to CMS as a Federally qualified health center.

(2) The PHS notifies CMS of entities that meet the requirements specified in § 405.2401(b).

(c) *Provider-based and freestanding Federally qualified health centers.* The requirements and benefits under Medicare for provider-based or freestanding Federally qualified health centers are the same, except that payment methodologies differ, as described in § 405.2462.

(d) *Appeals.* An entity is entitled to a hearing in accordance with part 498 of 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]

§ 405.2434 Content and terms of the agreement.

Under the agreement, the Federally qualified health center must agree to the following:

(a) *Maintain compliance with the requirements.* (1) The Federally qualified health center must agree to maintain