

by total visits for rural health clinic or Federally qualified health center 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 rural health clinic or Federally qualified health center services furnished to Medicare beneficiaries is calculated by multiplying the average cost per visit by the number of visits for covered rural health clinic or Federally qualified health center services by beneficiaries.

(iii) For rural health clinics, the total reimbursement due the clinic is 80 percent of the amount calculated by subtracting the amount of deductible incurred by beneficiaries that is attributable to rural health clinic services from the cost of these services. The reimbursement computation for Federally qualified health centers does not include a reduction related to the deductible because Federally qualified health center services are not subject to a deductible.

(iv) For rural health clinics and FQHCs, payment for pneumococcal and influenza 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 clinic or center for the reporting period, and the difference constitutes the amount of the reconciliation.

(c) *Notice of program reimbursement.* The intermediary sends written notice to the clinic or center:

(1) Setting forth its determination of the total reimbursement amount due the clinic or center for the reporting period and the amount, if any, of the reconciliation; and

(2) Informing the clinic or center 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 clinic or center exceeds the payments made for the reporting period, the intermediary makes a lump-sum payment to the clinic or center to bring total payments into

agreement with total reimbursement due the clinic or center.

(2) *Overpayments.* If the total payments made to a clinic or center for the reporting period exceed the total reimbursement due the clinic or center for the period, the intermediary arranges with the clinic or center for repayment through a lump-sum refund, or, if that poses a hardship for the clinic or center, 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 intermediary if the intermediary 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]

#### § 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 intermediary applies the principles for reimbursement of provider costs, as set forth in part 413 of this subchapter.

(b) *Typical rural health clinic and Federally qualified health center 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, nurse-midwife, visiting nurse, qualified clinical psychologist, and clinical social worker who owns, is employed by, or furnishes services under contract to an FQHC. (RHCs are not paid for services furnished by contracted individuals other than physicians.)

(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 clinic or center administration, costs applicable to use and maintenance of the entity, and depreciation costs.

(5) Costs of services purchased by the clinic or center.

(c) *Tests of reasonableness for rural health clinic 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 carrier with respect to direct or indirect overall costs, costs of specific items and services, or costs of groups of items and services. Those tests include, but are not limited to, screening guidelines and payment limitations.

(d) *Screening guidelines.* (1) Costs in excess of amounts established by the guidelines are not included unless the clinic or center provides reasonable justification satisfactory to the intermediary.

(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 clinic or center personnel to physicians, physician assistants, and nurse practitioners).

(v) The reasonableness of payments for services purchased by the clinic or center, subject to the limitation that the costs of physician services purchased by the clinic or center 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 that portion 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.

(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+Choice 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 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.

[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]

**§ 405.2469 Federally Qualified Health Centers supplemental payments.**

Federally Qualified Health Centers under contract (directly or indirectly) with Medicare Advantage organizations are eligible for supplemental payments for covered Federally Qualified Health Center services furnished to enrollees in Medicare Advantage plans offered by the Medicare Advantage organization to cover the difference, if any, between their payments from the Medicare Advantage plan and what they would receive under the cost-based Federally Qualified Health Center payment system.

(a) *Calculation of supplemental payment.* (1) The supplemental payment for Federally Qualified Health Center covered services provided to Medicare patients enrolled in Medicare Advantage plans is based on the difference between—

(i) Payments received by the center from the Medicare Advantage plan as determined on a per visit basis; and

(ii) The Federally Qualified Health Center's 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.

(2) Any financial incentives provided to Federally Qualified Health Centers under their Medicare Advantage contracts, such as risk pool payments, bonuses, or withholds, are prohibited from being included in the calculation of supplemental payments due to the Federally Qualified Health Center.

(b) *Per visit supplemental payment.* A supplemental payment required under this section is made to the Federally Qualified Health Center when a covered face-to-face encounter occurs between a Medicare Advantage enrollee and a practitioner as set forth in § 405.2463.

[70 FR 70329, Nov. 21, 2005, as amended at 71 FR 9460, Feb. 24, 2006]

**§ 405.2470 Reports and maintenance of records.**

(a) *Maintenance and availability of records.* The rural health clinic or Federally qualified health center must:

(1) Maintain adequate financial and statistical records, in the form and containing the data required by CMS, to allow the intermediary 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 intermediary may suspend reimbursement if it determines that the clinic or center does not maintain records that provide an adequate basis to determine payments under Medicare.

(2) The suspension continues until the clinic or center demonstrates to the intermediary'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 clinic or center must submit an estimate of budgeted costs and visits for rural health clinic or Federally qualified health center services for the reporting period, in the form and detail required by CMS, and