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; 79 FR 25479, May 2, 2014; 79 FR 50351, Aug. 22, 2014]

§ 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 either:

(1) Under the reasonable cost payment system if the FQHC is authorized to bill under the reasonable cost payment system, or

(2) The PPS rate if the FQHC is authorized to bill under the PPS.

(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.

(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 occurs between a MA enrollee and a practitioner as set forth in § 405.2463.

[79 FR 25479, May 2, 2014]

§ 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 FQHCdoes 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.

Subpart B—Hospital Insurance Without Monthly Premiums

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