

**§ 405.2434**

**42 CFR Ch. IV (10–1–23 Edition)**

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; 79 FR 25476, May 2, 2014]

**§ 405.2434 Content and terms of the agreement.**

Under the agreement, the FQHC must agree to the following:

(a) *Maintain compliance with the requirements.* (1) The FQHC must agree to maintain compliance with the FQHC requirements set forth in this subpart and part 491, except that the provisions of § 491.3 do not apply.

(2) FQHCs must promptly report to CMS any changes that result in non-compliance with any of these requirements.

(b) *Effective date of agreement.* The effective date of the agreement is determined in accordance with the provisions of § 489.13 of this chapter.

(c) *Charges to beneficiaries.* (1) For non-FQHC services that are billed to Part B, the beneficiary is responsible for payment of a coinsurance amount which is 20 percent of the amount of Part B payment made to the FQHC for the covered services.

(2) The beneficiary is responsible for blood deductible expenses, as specified in § 410.161.

(3) The FQHC agrees not to charge the beneficiary (or any other person acting on behalf of a beneficiary) for any FQHC services for which the beneficiary is entitled to have payment made on his or her behalf by the Medicare program (or for which the beneficiary would have been entitled if the FQHC had filed a request for payment in accordance with § 410.165 of this chapter), except for coinsurance amounts.

(4) The FQHC may charge the beneficiary for items and services that are not FQHC services. If the item or service is covered under Medicare Part B, the FQHC may not charge the beneficiary more than 20 percent of the Part B payment amount.

(d) *Refunds to beneficiaries.* (1) The FQHC must agree to refund as promptly as possible any money incorrectly collected from Medicare beneficiaries or from someone on their behalf.

(2) As used in this section, “money incorrectly collected” means any amount for covered services that is greater than the amount for which the beneficiary was liable because of the coinsurance requirements specified in part 410, subpart E.

(3) Amounts also are considered incorrectly collected if the FQHC believed the beneficiary was not entitled to Medicare benefits but—

(i) The beneficiary was later determined to have been so entitled;

(ii) The beneficiary’s entitlement period fell within the time the FQHC’s agreement with CMS was in effect; and

(iii) The amounts exceed the beneficiary’s coinsurance liability.

(e) *Treatment of beneficiaries.* (1) The FQHC must agree to accept Medicare beneficiaries for care and treatment.

(2) The FQHC may not impose any limitations with respect to care and treatment of Medicare beneficiaries that it does not also impose upon all other persons seeking care and treatment from the FQHC. Failure to comply with this requirement is a cause for termination of the FQHC’s agreement with CMS in accordance with § 405.2436(d).

(3) If the FQHC does not furnish treatment for certain illnesses and conditions to patients who are not Medicare beneficiaries, it need not furnish such treatment to Medicare beneficiaries.

[57 FR 24978, June 12, 1992, as amended at 79 FR 25476, May 2, 2014]

**§ 405.2436 Termination of agreement.**

(a) *Termination by FQHC.* The FQHC may terminate its agreement by—

(1) Filing with CMS a written notice stating its intention to terminate the agreement; and

(2) Notifying CMS of the date on which the FQHC requests that the termination take effect.

(b) *Effective date.* (1) Upon receiving a FQHC’s notice of intention to terminate the agreement, CMS will set a date upon which the termination takes effect. This effective date may be—

(i) The date proposed by the FQHC in its notice of intention to terminate, if that date is acceptable to CMS; or

(ii) Except as specified in paragraph (2) of this section, a date set by CMS,