

Section 2
Rural Health Clinics and
Federally Qualified Health Centers
Services

1	General Information.....	2
1-1	General Policy	2
2	Health Plans	2
3	Provider Participation and Requirements.....	2
4	Record Keeping	2
5	Provider Sanctions	2
6	Member Eligibility.....	2
7	Member Responsibilities.....	2
8	Program Coverage	3
8-1	Definitions.....	3
8-2	Telemedicine.....	3
8-3	Covered Services	3
9	Non-Covered Services and Limitations	4
9-1	Non-Covered Services	4
9-2	Limitations	5
10	Prior Authorization.....	5
11	Billing.....	5
12	Cost Sharing	5
13	Reimbursement	6
	References.....	7

1 General Information

All underlined words contained in this document should serve as hyperlinks to the appropriate internet resource. Email dmhfmedicalpolicy@utah.gov if any of the links do not function properly noting the specific link that is not working and the page number where the link is found.

For general information regarding Utah Medicaid, refer to [Section I: General Information](#), *Chapter 1, General Information*.

1-1 General Policy

This manual establishes the requirements for coverage and reimbursement of rural health clinic (RHC) and federally qualified health center (FQHC) services for Medicaid members receiving medically necessary covered medical services. As authorized by Section 1833, Section 1861(aa), and Section 1834(o) of the acts.

2 Health Plans

For more information about Accountable Care Organizations (ACOs), refer to [Section I: General Information](#), *Chapter 2, Health Plans*.

3 Provider Participation and Requirements

Refer to [Section I: General Information](#), *Chapter 3, Provider Participation and Requirements*.

4 Record Keeping

Refer to [Section I: General Information](#), *Chapter 4, Record Keeping*.

5 Provider Sanctions

Refer to [Section I: General Information](#), *Chapter 5, Provider Sanctions*.

6 Member Eligibility

Refer to [Section I: General Information](#), *Chapter 6, Member Eligibility*, for information about how to verify a member's eligibility, third party liability, ancillary providers, and member identity protection requirements. Medicaid members who are not enrolled in a managed care plan may receive services from any provider who accepts Medicaid and is an enrolled Utah Medicaid provider.

7 Member Responsibilities

For information on member responsibilities including establishing eligibility and co-payment requirements refer to [Section I: General Information](#), *Chapter 7, Member Responsibilities*.

8 Program Coverage

8-1 Definitions

Definitions of terms used in multiple Medicaid programs are in [Section I: General Information, Chapter 1-9, Definitions](#) and [Utah Administrative Code R414-1. Utah Medicaid Program](#).

Definitions specific to RHC and FQHC are at Title 42: Public Health, Federal Health Insurance for the Aged and Disabled, [Subpart X—Rural Health Clinic and Federally Qualified Health Center Services](#).

8-2 Telemedicine

Refer to [Section I: General Information, Chapter 8, Programs and Coverage](#).

8-3 Covered Services

Services provided at FQHCs and RHCs are primarily outpatient health care services, including routine diagnostic and laboratory services, provided by physicians, nurse practitioners, certified nurse midwives, or physician assistants. Services must be provided by a physician, or by another health professional under the supervision of a physician. Services must be provided in accordance with applicable federal, state and local laws. FQHC services include all allowable RHC services. In addition, federal law specifically lists certain services as FQHC services, including, but not limited to: preventive primary services; tests such as mammography, pelvic, diabetes, glaucoma, prostate cancer, and colorectal cancer screening tests bone mass measurement; cardiovascular screening blood tests; and ultrasound screening for abdominal aortic aneurysm; diabetes outpatient self-management services; medical nutrition therapy services.

Generally, clinic services include:

- Services and supplies furnished incident to the professional services of a physician, nurse practitioner, certified nurse midwife, physician assistant, or other licensed health professional to provide necessary medical care
- The service or supply should be:
 - Of the type commonly furnished in a physician's office and would be covered if furnished directly by the practitioner
 - Of a type rendered either without charge or included in the clinic bill
 - Furnished as an incidental, although integral, part of a physician's professional service
 - Furnished under the direct personal supervision of a physician or other professional staff by an employee of the clinic and may include non-physician services like health behavior assessments
 - Drugs and biologicals furnished incident to the practitioner's professional services, are included provided they cannot be self-administered by the recipient
- Basic laboratory services essential for the immediate diagnosis and treatment of illness or injury. To qualify for reimbursement, laboratory services must follow [CMS Clinical Laboratory Improvement Amendments \(CLIA\)](#) requirements

- Part-time or intermittent visiting nurse service and related medical supplies, other than drugs and biologicals, if the clinic is in an area in which the Secretary has determined there is a shortage of home health agencies. These visits are covered if a clinic registered nurse or licensed practical nurse provides services in the patient's place of residence in accordance with a treatment plan (reviewed every 60 days), and the services would not otherwise be available to that individual. (See also, definition of home care recipient, above.) Additional information may be found in the *Utah Medicaid Provider Manual, Home Health Services*.
- Other ambulatory services which are otherwise provided in the State Plan Amendment. Services must meet all requirements of the State Plan and provider eligibility.
- Clinics may provide emergency medical care as a first response to common life-threatening injuries and acute illness. RHCs and FQHCs provide outpatient services and are not typically set up for emergency care. However, both types of clinics must provide emergency medical procedures as a first response to common life threatening injuries and acute illnesses, and have available drugs and biologicals commonly used in life-saving procedures. RHCs and FQHCs are not subject to Emergency Medical Treatment & Labor Act (EMTALA) regulations. After hours, FQHCs must provide telephone access to an individual with the qualifications and training to exercise professional judgment in assessing a patient's need for emergency medical care, and if appropriate, to refer that patient to an appropriate provider or facility.
- Diabetes self-management training (DSMT).
- FQHCs – Offer DSMT services as a benefit. To qualify for reimbursement a face-to-face encounter is required and must be provided as part of an encounter; it cannot be billed separately.
- RHCs - Do not offer DSMT services as a benefit, but the provision of services by registered dietitians or nutrition professions might be considered incident to services in the RHC setting, provided all applicable conditions are met.
- FQHCs must provide preventive health services onsite or by arrangement with another provider, and include: well-child services, pediatric eye, ear, and dental screening, mental health and substance use referrals, services that enable individuals to use the services of the health center (including outreach and transportation services. Additional preventive services include prenatal and perinatal services, voluntary family planning services, and immunizations against vaccine-preventable diseases.
- RHCs must directly furnish routine diagnostic and laboratory services, furnish various laboratory tests on site, and have arrangements with one or more hospitals to furnish medically necessary services that are not available at the RHC. Generally, preventive health services are not within the scope of RHC benefits.

9 Non-Covered Services and Limitations

9-1 Non-Covered Services

- Personal care services are not a benefit of the Medicaid program and are not covered under visiting nurse services for RHCs or FQHCs.
- Homemaker or chore services are not covered under the Medicaid program.
- The technical component of laboratory services or use of diagnostic testing equipment is generally not covered. Some preventive services are encompassed in primary care, and these services may have a technical component such as laboratory service or use of diagnostic testing equipment.

- For FQHCs only, the technical component of certain mandated preventive services is not covered, this includes a laboratory test that is included in the FQHC visit.
- In general, if not part of the RHC or FQHC benefits, technical services (or technical components of services with both professional and technical components) are not billed on RHC/FQHC claims.
- For FQHCs, non-covered services include: preventive primary services such as group or mass information programs, health education classes, or group education activities; eyeglasses, hearing aids, and preventive dental services; also, ambulance services, prosthetic devices, and durable medical equipment.

9-2 Limitations

- RHCs and FQHCs are reimbursed for one encounter per day per patient. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day constitute a single visit. The provider may bill up to, but not exceeding, the established encounter rate.
- An individual encounter rate is established for each clinic. The encounter rate will be a blended rate of all service costs, exclusive of costs or encounters for carve-out services. If a clinic itemizes multiple services provided to a single patient at a single location on the same day, payment will be made at the established encounter rate regardless of the total claim.

10 Prior Authorization

For information regarding prior authorization, see [Section I: General Information, Chapter 10, Prior Authorization](#). Additional resources and information can be found on the [Utah Medicaid Prior Authorization](#) website.

For information on codes requiring prior authorization, manual review, or non-covered status, refer to the [Coverage and Reimbursement Code Lookup](#).

11 Billing

Billing code

The billing encounter code for RHCs and FQHCs is HCPCS T1015. In addition to the encounter rate, each procedure code must be listed on separate line.

Mobile Units

In accordance with Medicare requirement each permanent FQHC requires a separate agreement. Mobile units of an FQHC approved site are not required to enroll or bill separately, but must comply with Medicare health and safety standards.

12 Cost Sharing

The Medicaid program may require certain members to pay for services or benefits, referred to as cost sharing. Cost sharing amounts may include such items as premiums, deductibles, co-insurance, or co-payments.

Refer to Utah State Plan Attachments 4.18-A through H, for additional cost sharing information.

13 Reimbursement

There are two payment methodologies available, the prospective payment system (PPS) and the alternative payment method (APM). The FQHCs may elect to be paid under either methodology. RHCs are paid only under the prospective payment system.

Prospective Payment System

The Department pays each clinic the amount, on a per visit basis, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to consider any increase or decrease in the scope of services furnished by the clinic during that fiscal year. The PPS is a standardized rate that is the average of a clinic's reasonable costs for providing Medicaid services divided by the total number of visits by Medicaid patients to obtain an average per visit cost rate.

The Department makes supplemental payments for the difference between the amounts paid by ACO's that contract with clinics and the amounts the clinics are entitled to under the PPS as they are estimated and paid quarterly to them. The Department makes quarterly interim payments no later than thirty days after the end of the quarter based on the most recent prior annual reconciliation. As necessary, the Department settles annual reconciliations with each clinic.

Behavioral and Mental Health Services

All Medicaid members who receive behavioral health services or mental health services from a Rural Health Center or Federally Qualified Health Center in Utah should bill claims directly to Utah Medicaid. They should not be billed to the patient's PMHP. This exception applies only to mental health services.

Claims for medical services should be billed to the member's Medicaid ACO or to Utah Medicaid directly if the member is not enrolled in a Medicaid ACO.

Alternative Payment Method for FQHCs

FQHCs may also adopt an alternative payment method so long as that rate results in payments that are no less than would have been received under the PPS. If an FQHC elects to change its payment method in subsequent years, it must elect to do so no later than thirty days prior to the beginning of the FQHC's fiscal year by written notice to the Department.

An FQHC is required to calculate the Ratio of Covered Beneficiary Charges to Total Charges Applied to Allowable Cost as part of its agreement with the federal government. As part of that calculation, it allocates allowable costs to Medicaid. The Department multiplies the Medicaid allowable costs by the Medicaid charge percentage to determine the amount to pay. The Department makes interim payments based on billed charges from the FQHC, which reduce the annual settlement amount. Third party liability collections by the FQHC for Medicaid patients also reduce the final cost settlement.

An FQHC participating in the APM must provide the Department annual cost reports and other cost information required by the Department necessary to calculate the annual settlement within six months from the close of its fiscal year, including its calculations of its anticipated settlement.

The Department reviews submitted cost reports and provides a preliminary payment, if applicable, to FQHCs. Within twelve months after the end of the FQHC's fiscal year, the Department conducts a review or audit of submitted cost reports and makes a final settlement. This allows for inclusion of late filed claims and adjustments processed after the submitted cost report was prepared. If the Department overpaid an FQHC, the FQHC must repay the overpayment. If the Department underpaid an FQHC, the Department shall pay the FQHC the underpaid amount.

The Department compares the APM reimbursements with the reimbursements calculated using the PPS methodology described and pays the greater amount to the FQHC.

References

- Social Security Act, Title 19, Section 1905 (l)(1) and (2)(A)
- United States Code 42 § 254b. Health Centers [42 USC 254b]