Utah Department of
Health & Human Services
Integrated Healthcare

Utah Medicaid Provider Manual

Rural Health Clinics and Federally Qualified Health Centers Services

Division of Integrated Healthcare

Updated January 2025

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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.

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 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.

For more information about Prepaid Mental Health Plans (PMHPs), refer to Section I: General Information Chapter 2-8, Prepaid mental health plans, and the Behavioral Health Services Provider Manual.

Two individual tabs on the Medicaid website, Managed Care: Accountable Care Organizations and Prepaid Mental Health and Substance Use Disorder Plans, identify which ACOs and PMHPs Medicaid has a contract with that allow those organizations to provide health care services to Medicaid members.

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 verifying a member's eligibility, third party liability, ancillary providers, and member identity protection requirements. Medicaid members 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 l: 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. FQHC or RHC rendering these services must comply with all applicable federal, state, and local laws. While FQHC can perform all allowable services to an RHC, federal law explicitly lists certain services as FQHC services. These services include, but are not limited to:

1. primary preventive services,
2. diagnostic testing such as mammography, pelvic, diabetes, glaucoma, prostate cancer, and colorectal cancer screening tests,
3. bone mass measurement,
4. blood tests for cardiovascular screening, and
5. ultrasound screening for abdominal aortic aneurysm,
6. diabetes outpatient self-management services,
7. medical nutrition therapy services.

Clinic services include:

1. 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.
2. The service or supply should be:
   a) Of the type commonly furnished in a physician's office and would be covered if delivered directly by the practitioner
   b) Of a type rendered either without charge or included in the clinic bill
   c) Provided as an incidental, although integral, part of a physician's professional service
   d) Drugs and biologicals furnished incident to the practitioner's professional services are included provided they cannot be self-administered by the member
3. Basic laboratory services for the immediate diagnosis and treatment of illness or injury. Coverage of laboratory services must comply with the

CMS Clinical Laboratory Improvement Amendments (CLIA) requirements.

4. Part-time or intermittent visiting nurse service and related medical supplies, other than drugs and biologicals, if the clinic is in an area where the Secretary has determined there is a shortage of home health agencies. These visits are covered if a registered nurse or licensed practical nurse provides services in the member's residence following a treatment plan. Additionally, a review of the treatment plan must occur every 60 days. and the services would not otherwise be available to that individual. Additional information for these services is in the Home Health Services provider manual.
5. Other ambulatory services which are otherwise provided in the State Plan Amendment. Services must meet all requirements of the State Plan and provider eligibility.
6. Clinics may provide emergency medical care as a first response to common life-threatening injuries and acute illness. Additionally, they must 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. However, FQHCs must provide telephone access, including after hours, to an individual with the qualifications and training to exercise clinical 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.
7. Diabetes self-management training (DSMT).
    a) FQHCs – Offer DSMT services. A face-to-face encounter is required and must be provided as part of an encounter to qualify for coverage. Therefore, FQHC cannot report these services separately.
    b) RHCs - Do not offer DSMT services. Nevertheless, registered dieticians' or nutrition professionals' services might be considered incidental to services in the RHC setting.
8. FQHCs must provide preventive health services onsite or by arrangement with another provider and include:
    a) well-child services,
    b) pediatric eye, ear, and dental screening,

c) mental health and substance use referrals,
d) services that enable individuals to use the services of the health center (including outreach and transportation services,
e) prenatal and perinatal services,
f) voluntary family planning services, and
g) immunizations against vaccine-preventable diseases.

9. While preventive health services are not generally within the scope of RHC, they must provide:
   a) direct routine diagnostic and laboratory services,
   b) various laboratory tests onsite, and
   c) arrangements with one or more hospitals to deliver medically necessary services that are not available at the RHC.

8-3.1 Dental coverage

A member's eligibility type restricts which providers can perform dental services. For information concerning dental coverage and provider restrictions see Dental, Oral Maxillofacial, and Orthodontia Services provider manual, Chapter 8 Programs and coverage.

9 Non-covered services and limitations

Certain services are non-covered by Medicaid because medical necessity, appropriateness, and cost-effectiveness cannot be readily determined or justified for medical assistance under Title XIX of the federal Social Security Act and Title 42 of the Code of Federal Regulations (CFR).

For more information on non-covered services and limitations, see R414-2A. Inpatient Hospital Services, Rule R414-3A. Outpatient Hospital Services, Utah Administrative Code R414-1. Utah Medicaid Program, and Section I: General Information, Chapter 9, Non-covered services and limitations.

9-1 Non-covered services

The following services are not covered for RHC or FQHCs:

1. Personal care services for visiting nurses,
2. Homemaker or chore

3. The technical component of laboratory services or the use of diagnostic testing equipment is not covered. However, exceptions may be related to some preventive services encompassed in primary care. These services may have a technical component, such as laboratory service or diagnostic testing equipment.
4. In general, if not part of the RHC or FQHC benefits, technical services are not reportable on RHC/FQHC claims; this includes technical components of services with professional and technical components.
5. For FQHCs only:
    a) The technical component of mandated preventive services, together with laboratory tests included in the FQHC visit,
    b) preventive primary services such as group or mass information programs,
    c) health education classes,
    d) group education activities,
    e) eyeglasses,
    f) hearing aids,
    g) ambulance services,
    h) prosthetic devices, and
    i) durable medical equipment.

9-2 Limitations

Reporting encounters for RHCs and FQHCs is limited to one encounter per day per patient. Encounters with more than one health professional or multiple visits with the same health professional 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. For example, if a clinic itemizes multiple services provided to a single patient at a single location on the same day. In that case, reimbursement is made at the established encounter rate regardless of the total claim.

10 Prior authorization

Providers must verify prior authorization requirements before rendering services. Claims must be submitted with the prior authorization number that was issued to the provider. Charges will not be paid when prior authorization is required and there is no valid prior authorization approval on file. For information regarding prior authorization, see Section I: General Information, Chapter 10, Prior authorization. Additional resources and information may 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

Refer to Section I: General Information, Chapter 11, Billing Medicaid, for more information about billing instructions.

11-1 Billing code

Delivered services must be reported using the appropriate CPT codes.

11-2 Mobile units

In accordance with Medicare requirements, 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.

11-3 Obstetrical Care

Antepartum and postpartum services should be reported using an appropriate evaluation and management code for each visit with the TH modifier (Obstetrical treatment/services, prenatal and postpartum) appended to the appropriate service line. The TH modifier indicates the service was related to obstetrical care.

For labor and delivery, report the appropriate CPT code describing the mode of delivery only.

For inpatient postpartum care, report the appropriate evaluation and management CPT code for post-delivery and discharge services with the TH modifier.

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 Attachments 4.18-A through H of the Utah State Plan 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 reimbursement under either method. However, RHCs are paid only under PPS.

13-1 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. In addition, the Department makes quarterly interim payments no later than 30 days after the end of the quarter based on the most recent prior annual reconciliation. Finally, as necessary, the Department settles annual reconciliations with each clinic.

13-2 Behavioral and mental health services

All Medicaid members who receive behavioral health services or mental health services from a RHC or FQHC in Utah should submit claims directly to Utah Medicaid.

Providers should not submit claims to the patient's prepaid mental health plan (PMHP). This exception applies only to mental health services.

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

13-3 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 30 days before 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 with its annual cost reports and other cost information 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 12 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 process 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 must pay the FQHC the underpaid amount.

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

14 References

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