Subpart 13. Federally-Qualified Health Centers

Chapter 103. Services

§10301. Scope of Services [Formerly §10501]

A. Medicaid reimbursement is limited to medically necessary services that are covered by the Medicaid State Plan and would be covered if furnished by a physician. The following services shall be covered:

1. services furnished by a physician within the scope of practice of his profession under Louisiana law;

2. services furnished by a:

a. physician assistant;

b. nurse practitioner;

c. nurse midwife;

d. clinical social worker;

e. clinical psychologist; or

f. dentist;

3. services and supplies that are furnished as an incident to professional services furnished by all eligible professionals;

4. other ambulatory services; and

5. diabetes self-management training (DSMT) services.

B. Effective February 20, 2011, the department shall provide coverage of diabetes self-management training services rendered to Medicaid recipients diagnosed with diabetes.

1. The services shall be comprised of one hour of individual instruction and nine hours of group instruction on diabetes self-management.

C. Effective December 1, 2011, the department shall provide coverage for fluoride varnish applications performed in the FQHC. This service shall be limited to recipients from six months through five years of age. Fluoride varnish applications may be covered once every six months per Medicaid recipient.

1. Fluoride varnish applications shall be reimbursed when performed in the FQHC by:

a. the appropriate dental providers;

b. physicians;

c. physician assistants;

d. nurse practitioners;

e. registered nurses;

f. licensed practical nurses; or

g. certified medical assistants.

2. All participating staff must review the Smiles for Life training module for fluoride varnish and successfully pass the post assessment. All staff involved in the varnish application must be deemed as competent to perform the service by the FQHC.

a. Physicians shall maintain a copy of the successfully completed post assessment certificate in their files for review, and shall provide the certificate to the department, or its fiscal intermediary, upon request.

b. Approved delegated appliers of fluoride varnish must also complete the training module and their certificates shall be retained on file locally as evidence of training.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2328 (October 2004), repromulgated LR 30:2487 (November 2004), amended LR 32:1902 (October 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:2629 (September 2011), LR 39:3076 (November 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1520 (September 2016).

§10303. Service Limits [Formerly §10503]

A. There shall be no limits placed on the number of federally qualified health center visits (encounters) payable by the Medicaid program for eligible recipients.

B. Recipients of DSMT services shall receive up to 10 hours of services during the first 12-month period beginning with the initial training date.

1. After the first 12-month period has ended, recipients shall only be eligible for two hours of individual instruction on diabetes self-management per calendar year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1902 (October 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2280 (October 2010), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:2629 (September 2011), LR 41:2637 (December 2015).

Chapter 105. Provider Participation

§10503. Standards for Participation [Formerly §10303]

A. Federally qualified health centers must comply with the applicable licensure, accreditation and program participation standards for all services rendered. If a FQHC wishes to initiate participation, it shall be responsible for meeting all of the enrollment criteria of the program. The FQHC provider shall:

1. maintain an acceptable fiscal record keeping system that readily distinguishes one type of service from another type of service that may be provided;

2. retain all records necessary to fully disclose the extent of services provided to recipients for five years from the date of service and furnish such records, and any payments claimed for providing such services, to the Medicaid Program upon request; and

3. abide by and adhere to all federal and state regulations and policy manuals.

B. If a FQHC receives approval for a satellite site, the satellite site must enter into a separate provider agreement and obtain its own Medicaid provider number.

C. In order to receive Medicaid reimbursement for DSMT services, a FQHC must have a DSMT program that meets the quality standards of one of the following accreditation organizations:

1. the American Diabetes Association;

2. the American Association of Diabetes Educators; or

3. the Indian Health Service.

D. All DSMT programs must adhere to the national standards for diabetes self-management education.

1. Each member of the instructional team must:

a. be a certified diabetes educator certified by the National Certification Board for Diabetes Educators; or

b. have recent didactic and experiential preparation in education and diabetes management.

2. At a minimum, the instructional team must consist of one of the following professionals who is a certified diabetes educator:

a. a registered dietician;

b. a registered nurse; or

c. a pharmacist.

3. All members of the instructional team must obtain the nationally recommended annual continuing education hours for diabetes management.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2328 (October 2004), repromulgated LR 30:2488 (November 2004), amended LR 32:1901 (October 2006), amended LR 37:2630 (September 2011), amended by the Department of Health, Bureau of Health Services Financing, LR 44:1253 (July 2018).

Chapter 107. Reimbursement Methodology

§10701. Prospective Payment System

A. Payments for Medicaid covered services will be made under a prospective payment system (PPS) and paid on a per visit basis.

B. A visit is defined as a face-to-face encounter between a facility health professional and a Medicaid eligible patient for the purpose of providing medically necessary outpatient services.

1. Encounters with more than one facility health professional that take place on the same day and at a single location constitute a single encounter.

2. Services shall not be arbitrarily delayed or split in order to bill additional encounters.

NOTE: Refer to the FQHC and Physician's Current Procedural Terminology (CPT) Manuals for the definition of an encounter.

3. Effective for dates of service on or after February 20, 2011, the Medicaid Program shall include coverage for diabetes self-management training services rendered by qualified health care professionals in the FQHC encounter rate.

a. Separate encounters for DSMT services are not permitted and the delivery of DSMT services alone does not constitute an encounter visit.

4. Effective for dates of service on or after December 1, 2011, the Medicaid Program shall include coverage for fluoride varnish applications in the FQHC encounter rate.

a. Fluoride varnish applications shall only be reimbursed to the FQHC when performed on the same date of service as an office visit or preventative screening. Separate encounters for fluoride varnish services are not permitted and the application of fluoride varnish does not constitute an encounter visit.

C. If an FQHC receives approval for a satellite site, the PPS per visit rate paid for the services performed at the satellite site would be the weighted average cost payment rate per encounter for all FQHCs.

D. The PPS per visit rate for a facility which enrolls and receives approval to operate shall be the weighted average cost payment rate per encounter for all FQHCs.

E. The PPS per visit rate for each facility will be increased on July 1 of each year by the percentage increase in the published *Medicare Economic Index* (MEI) for primary care services.

F. Federally qualified health center services furnished to dual eligibles will be reimbursed reasonable cost which is equivalent to the provider specific prospective payment rate.

G. Cost Reports. FQHCs shall submit cost reports when there is an increase or decrease in their scope of services.

1. *Change in Scope of Services*—an addition, removal or relocation of services sites, and the addition or deletion of specialty and non-primary care services that were not included in the base line rate calculation.

2. The final PPS rate shall be calculated using the first two years of audited Medicaid cost reports, which shall include documentation of the change in scope.

3. Cost reports shall not be accepted for rate changes without a change in the scope of service.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1902 (October 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:2630 (September 2011), LR 39:3076 (November

2013), amended by the Department of Health, Bureau of Health Services Financing, LR 44:1253 (July 2018).