Subpart 15. Rural Health Clinics

Chapter 161. General Provisions

§16101. Purpose

A. The Rural Health Clinic (RHC) Act of 1977 authorized the development of rural health clinics to encourage and stabilize the provision of outpatient primary care in rural areas through cost-based reimbursement.

B. Rural health clinic regulations distinguish between two types of rural health clinics.

1. The independent RHC is a free-standing practice that is not part of a hospital, skilled nursing facility, or home health agency.

2. The provider-based RHC is an integral and subordinate part of a hospital, skilled nursing facility, or home health agency.

C. Rural health clinics improve the health status of Louisiana residents in rural and underserved areas by working proactively to build community health systems' capacity to provide integrated, efficient and effective health care services.

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 32:1904 (October 2006), repromulgated LR 32:2266 (December 2006).

Chapter 163. Services

§16301. Scope of Services [Formerly §16501]

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 RHC. 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 RHC 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 RHC.

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 32:1905 (October 2006), repromulgated LR 32:2267 (December 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:2631 (September 2011), LR 40:83 (January 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1524 (September 2016).

§16303. Service Limits
[Formerly §16503]

A. There shall be no limits placed on rural health clinic 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 ends, 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 32:1905 (October 2006), repromulgated LR 32:2267 (December 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:2632 (September 2011), LR 41:2653 (December 2015).

Chapter 165. Provider Participation
[Formerly Chapter 163]

§16501. Provider Enrollment
[Formerly §16301]

A. In order to enroll and participate in the Medicaid Program, a RHC must submit a completed provider enrollment packet.

B. The effective date of enrollment to participate in the Medicaid Program shall not be prior to the date of receipt of the completed enrollment packet.

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 32:1904 (October 2006), repromulgated LR 32:2267 (December 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:2632 (September 2011).

§16503. Standards for Participation
[Formerly §16303]

A. Rural health clinics must comply with the applicable licensure, accreditation and program participation standards for all services rendered. If a RHC wishes to initiate participation, it shall be responsible for meeting all of the enrollment criteria of the program. The RHC 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. Medicaid enrollment can be no sooner than Medicaid's receipt of the complete enrollment packet. A

complete enrollment packet for RHCs must include a copy of the CMS provider certification letter approving rural health clinic status.

C. In order to receive Medicaid reimbursement for DSMT services, a RHC 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 (CDE) 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 the following professionals who is a CDE:

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 32:1905 (October 2006), repromulgated LR 32:2267 (December 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:2632 (September 2011).

Chapter 167. Reimbursement Methodology

§16701. 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 needed 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 RHC 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 RHC 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 RHC encounter rate.

a. Fluoride varnish applications shall only be reimbursed to the RHC 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. For an RHC which enrolls and receives approval to operate, the facility's initial PPS per visit rate shall be determined through a comparison to other RHCs in the same town/city/parish. The scope of services shall be considered in determining which proximate RHC most closely approximates the new provider. If no RHCs are available in the proximity, comparison shall be made to the nearest RHC offering the same scope of service. The rate will be set to that of the RHC comparative to the new provider.

D. 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 services.

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 32:1905 (October 2006), repromulgated LR 32:2267 (December 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:2632 (September 2011), LR 40:83 (January 2014).

§16703. Alternate Payment Methodology

A. Effective for dates of service on or after October 20, 2007, the Medicaid Program establishes an alternate payment methodology for adjunct services provided by rural health clinics (RHCs) when these professional services are rendered during evening, weekend or holiday hours. This alternate payment methodology is in addition to the Prospective Payment System methodology established for RHC services.

1. A payment for adjunct services is not allowed when the encounter is for dental services only.

B. The reimbursement for adjunct services is a flat fee, based on the Current Procedural Terminology (CPT) procedure code, in addition to the reimbursement for the associated office encounter.

C. Reimbursement is limited to services rendered between the hours of 5 p.m. and 8 a.m. Monday through Friday, on weekends and State legal holidays. Documentation relative to this reimbursement must include the time that the services were rendered.

D. Effective for dates of service on or after January 1, 2019, RHCs shall be reimbursed a separate payment outside of the prospective payment system (PPS) rate for long acting reversible contraceptives (LARCs).

1. Reimbursement for LARCs shall be at the lesser of, the rate on file or the actual acquisition cost for entities participating in the 340B program. Rural health clinics eligible for 340B pricing must bill Medicaid at their 340B actual acquisition cost for reimbursement.

E. Effective for dates of service on or after April 1, 2019, the Medicaid Program shall establish an alternative payment methodology for behavioral health services provided in RHCs by one of the following practitioners:

1. physicians with a psychiatric specialty

2. nurse practitioners or clinical nurse specialists with a psychiatric specialty

3. licensed clinical social workers; or

4. clinical psychologists

F. The reimbursement for behavioral health services will equal the all-inclusive encounter PPS rate on file for fee for service on the date of service. This reimbursement will be in addition to any all-inclusive PPS rate on the same date for a medical/dental visit.

G. Dental services shall be reimbursed at the all-inclusive PPS rate on file for fee-for-service on the date of service. This reimbursement will be in addition to any all-inclusive PPS rate made on the same date for a medical/behavioral health visit.

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HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1036 (June 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 44:1903 (October 2018), LR 44:2168 (December 2018), LR 45:435 (March 2019), amended LR 46:185 (February 2020).

§16705. Hospital-Based Rural Health Clinics

A. Effective for dates of service on or after July 1, 2008, the reimbursement methodology for services rendered by a rural health clinic that was licensed as part of a small rural hospital as of July 1, 2007 shall be as follows:

1. Hospital-based rural health clinics shall be reimbursed in the aggregate at 110 percent of reasonable costs.

2. The interim payment for claims shall be the Medicaid Benefits Improvement and Protection Act of 2000 (BIPA) Prospective Payment System (PPS) per visit rate currently in effect for each provider. Final reimbursement shall be the greater of BIPA PPS payments or the alternative payment methodology of 110 percent of allowable costs as calculated through the cost settlement process.

3. The payment received under this methodology will be compared each year to the BIPA PPS rate to assure the clinic that their payment under this alternative payment methodology is at least equal to the BIPA PPS rate. If the payment calculation at 110 percent of allowable cost is less than the BIPA PPS payments, the clinic will be paid the difference.

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, Bureau of Health Services Financing, LR 35:957 (May 2009).