PROVIDER REQUIREMENTS

Location

Each FQHC that receives Public Health Service (PHS) 330 grant funding must be located, as appropriate, to make services accessible to the residents of a designated medically underserved area or medically underserved population.

Shortage Area Designation

In order for FQHCs to be eligible for a Health Professional Shortage Area (HPSA) facility designation, the center shall:

- Not deny requested health care services, and shall not discriminate in the provision of services to an individual who is unable to pay for services or whose services are paid by Medicare, Medicaid, or the Children's Health Insurance Program,
- Prepare a schedule of fees consistent with locally prevailing rates or charges,
- Prepare a corresponding schedule of discounts (including waivers) to be applied to such fees or payments, with adjustments made on the basis of the patient's ability to pay,
- Make every reasonable effort to secure from patients the fees and payments for services, and fees should be sufficiently discounted in accordance with the established schedule of discounts,
- Enter into agreements with the State Medicaid agency to ensure coverage of beneficiaries, and
- Take reasonable and appropriate steps to collect all payments due for services.

NOTE: Location in an HPSA alone or government designated shortage area does not meet the shortage area requirement for the FQHC program.

Staffing

FQHC primary care services are to be provided by licensed physicians, licensed physician assistants, nurse practitioners, or nurse-midwives operating under the direct supervision of the FQHC physician and within the scope of the physician extender's licensure or certification.

Direct supervision does not mean that the physician must be in the same room when services are rendered: however, the physician must be immediately available (at least by telephone) to provide direction or assistance when necessary.

Services of licensed clinical psychologists and clinical social workers are not required, but can be considered an FQHC service when these personnel provide diagnosis and treatment of mental illness.

Medicaid Enrollment Criteria

To be eligible for enrollment in the Louisiana Medicaid Program, the FQHC must be an entity receiving a Public Health Service grant under the following:

- The Consolidated Health Center Programs (Community Health Center (CHC), Migrant Health Center (MHC), Health Care for the Homeless (HCH), Public Housing Primary Care (PHPC) and Healthy Schools, Healthy Communities (HSHC) Programs authorized under Section 330 of the Public Health Service (PHS) Act as amended.

  OR

- Be designated by the U.S. Department of Health and Human Services (DHHS) to meet the requirements to be receiving such a grant as a "look-a-like" entity.

The entity must provide a copy of the Health Resources and Services Administration (HRSA) Notice Grant Award designating the center as a grantee under the applicable section of the Public Health Services Act or the CMS notification letter designating the FQHC look-a-like with its enrollment packet. Only the entity designated as the grantee on the Notice of Grant Award/CMS notification letter may enroll in Louisiana Medicaid as a FQHC.

The FQHC must provide to the fiscal intermediary's (FI's) provider enrollment unit a list of the names of all physicians and other practitioners who will be providing medical services at the center and include the practitioners':

- National Provider Identifier (NPI), and

- Assigned Medicaid provider number, if they are enrolled in Medicaid.

All enrollments of any practitioner in any Medicaid category of service, other than the FQHC program, must be submitted to the FI's provider enrollment unit.

NOTE: The FI's provider enrollment unit must be notified immediately of any change in the above. Failure to maintain current information with the provider enrollment unit may result in a loss of reimbursement for services provided by those practitioners not identified as FQHC staff.

All practitioners providing patient services must be enrolled with the fiscal intermediary's (FI) provider enrollment unit and be linked to the FQHC at the time of enrollment in order for the facility to receive reimbursement.

Since the grant awards are time-limited by budget years, the Medicaid provider agreement is time-limited, depending on the approval periods.

After enrollment, the FQHC must provide a copy of the current Notice of Grant Award each year to the Bureau of Health Services Financing. Failure to supply the notice within 30 calendar days from the effective date of the renewal of the grant will result in termination of the center's enrollment as a provider of Medicaid services. (See Appendix A for contact information)

NOTE: The effective date of enrollment shall not be prior to the date of receipt of the completed enrollment packet.

Services

The FQHC agrees to provide those primary care services typically included as part of a physician's medical practice. The FQHC must provide, either directly or by referral, a full range of primary diagnostic and therapeutic services and supplies which include:

- Medical history
- Physical examination,
- Assessment of health status and treatment of a variety of conditions amendable to medical management on an ambulatory basis by a physician or a physician extender,
- Evaluation and diagnostic services to include:
    - Radiological services and
    - Laboratory and pathology services,
- Services and supplies incident to a physician's or a physician extender's services such as:
    - Pharmaceuticals, and

- Supplies.

In addition, an FQHC can provide services related to the diagnosis and treatment of mental illness, and in certain instances, visiting nurse services.

Billing

The FQHC agrees to bill its usual and customary charge for each FQHC-related service using applicable diagnoses and procedure codes. FQHC services must be billed using the FQHC's NPI and Medicaid provider number assigned to the specific FQHC location and Tax Identification Number (TIN) of the specific FQHC location where the services were provided and/or the rendering provider is based, as required by each health plan and/or the fiscal intermediary.

"Usual and customary" is defined as the fee charged to private paying patients for the same procedure during the same period of time. Records on both Medicaid eligible and private paying patients must be maintained for a minimum of five years in order to verify compliance with this policy. The FQHC shall also furnish its authorized representative or contractual agents, with all information that may be requested regarding "usual and customary" fees.

The FQHC must ensure that no staff or contract provider will seek separate reimbursement from Medicaid for specific services that are ordered and/or performed in the FQHC and are billable under the FQHC program. Laboratory, pathology, radiological and other services ordered by the FQHC staff, but provided by an organization independent of the FQHC, must be billed by the provider of the service and not the FQHC.

Diabetes Self-Management Training

In order to receive Medicaid reimbursement for diabetes self-management training (DSMT) services, a FQHC must have a DSMT program that meets the quality standards of one of the following accreditation organizations:

- The American Diabetes Association,
- The American Association of Diabetes Educators, or
- The Indian Health Service.

All DSMT programs must adhere to the national standards for diabetes self-management education. Each member of the instructional team must:

- Be a certified diabetes educator (CDE) certified by the National Certification Board for Diabetes Educators, or

- Have recent didactic and experiential preparation in education and diabetes management.

At a minimum, the instructional team must consist of one of the following professionals who is a CDE:

- A registered dietician,
- A registered nurse, or
- A pharmacist.

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

Satellite Clinics

A satellite clinic must enter into a separate provider agreement from the parent center and obtain its own provider number for billing and reimbursement purposes.

Mobile Clinics

An FQHC is prohibited from enrolling a mobile clinic in the Louisiana Medicaid program. Services rendered at the mobile clinic must be billed using the main center's provider number.

Out of State FQHCs in Trade Areas

An FQHC located in the trade areas designated by the Department that wishes to enroll in the Louisiana Medicaid program, must meet all the provider enrollment requirements of an FQHC located in Louisiana and include a letter from the FQHCs home state verifying its reimbursement rate.

Changes

FQHCs are required to notify Medicaid in writing within seven working days of any of the following changes:

- Loss of FQHC status,
- Changes in dates of the FQHC grant budget period,

- Opening(s) and/or closing(s) of any satellite center(s), or
- Addition or termination of providers.

Change in Ownership

When there is a change in ownership, Medicaid must be notified within 30 calendar days of the date of the FQHC ownership change. The new owner is required to enter into a new provider agreement with the Louisiana Medicaid program. Failure to enter into a new provider agreement following a change in ownership will result the center's termination as a Louisiana Medicaid provider.

Cost Reports

FQHCs are required to submit cost reports with all requests for change in scope. Cost reports will not be accepted for rate changes without a change in scope of service. For more information on adjustment of rate for a change in scope, refer to Section 22.4.