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CHAPTER FORTY-EIGHT
FEDERALLY QUALIFIED HEALTH CENTERS

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Chapter 48 Federally Qualified Health Centers

Rule No. 560-X-48-.01 General

(1) Federally Qualified Health Centers (FQHCS) are defined as health care centers which meet one of the following requirements:

(a) receives a grant under Section 329, 330, 340, or 340A of the Public Health Services Act;

(b) meets the requirements for receiving such a grant as determined by the Secretary based on the recommendations of the Health Resources and Services Administration within the Public Health Service;

(c) qualifies through waivers of the requirements described above as determined by the secretary for good cause; or

(d) functions as outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638).

(2) Services provided by an FQHC include, but are not limited to medically necessary diagnostic and therapeutic services and supplies, provided by a physician, physician assistant, nurse midwife, nurse practitioner, clinical psychologist, clinical social worker, and services and supplies incidental to such services as would otherwise be covered if furnished by a physician as an incident to a physician service. Any other ambulatory service offered by the center which is included in the State Plan is covered except for home health. Home health services are excluded as an FQHC service because home health services are available on a state wide basis.

(a) Billable services must be designated by procedure codes from the Physicians Current Procedure Terminology (CPT) or by special procedure codes designated by Medicaid for its own use.

(3) Reimbursement for other ambulatory services covered by the State Plan includes but is not limited to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for individuals under age 21 family planning, prenatal, and dental for individuals under age 21. These services are subject to policies and routine benefit limitations for the respective program areas. Refer to Chapters 11, 14, 43, and 15 of the Administrative Code for details. These services are not counted in the routine benefit limits for medical encounters.

(4) FQHC clinic visits and inpatient services are subject to the same routine benefit limitations as physician visits. Refer to Chapter 6 of the Administrative Code for details.

(5) The time filing limit for FQHC Providers shall be 365 days after the date of service. Claims received after this time limit will be treated as outdated in accordance with Rule 560-X-1-.17.

Author: Carol Akin, Associate Director, Clinic/Ancillary Services

Statutory Authority: State Plan, Attachment 3.1-A; Section 6404 of the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239); Title XIX, Social Security Act.

History: Emergency Rule effective October 1, 1990. Rule effective January 15, 1991. Rule amended September 11, 1993, January 12, 1994, May 13, 1994, May 11, 1995, January 14, 1997, and December 10, 1997. Amended: Emergency Rule filed and effective March 20, 2001. Amended: Filed March 20, 2001; effective June 15, 2001.

Rule No. 560-X-48-.02 Participation

(1) In order to participate in the Title XIX Medicaid Program and to receive Medicaid payment a FQHC must:

(a) Submit a completed enrollment packet to EDS Provider Enrollment, including a list of all satellite centers and addresses.

(b) Submit appropriate documentation from the Department of Health and Human Services, Public Health Services, that the FQHC meets one of the requirements as stated in Rule No. 560-X-48-.01(1).

(c) Submit a budgeted cost report for its initial cost reporting period and thereafter when there is a change in the provider's scope of practice.

(d) Federally Funded Health Centers which are Medicare certified must also submit copies of Medicare certification.

(e) Certify compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and with the Age Discrimination Act of 1975.

(f) Be in compliance with the Clinical Laboratory Improvement Amendments of 1988 (CLIA), for all laboratory testing sites.

(2) Provider agreements are valid for the time of the grant budget period which is determined by the Public Health Services and are renewed upon proof that requirements stated in Rule No. 560-X-48-.01 and all other Medicaid requirements continue to be met.

(3) The effective date of the enrollment of an FQHC will be the first day of the month in which the enrollment application is received by Medicaid's Fiscal Agent.

(4) FQHC are required to notify Medicaid's Fiscal Agent in writing within 5 working days of any of the following changes:

(a) The FQHC loses its status as defined in Rule No. 560-X-48-.01 (1);

(b) Any changes in dates in the FQHC grant budget period; or

(c) Opening(s) and/or closing(s) of any satellite center(s).

Author: Carol Akin, Associate Director, Clinic/Ancillary Services

Statutory Authority: State Plan; Attachments 4.11, 4.13, and 7.2-A, Title XIX, Social Security Act, 42 CFR Section 431.51, 431.52, 431.107. Clinical Laboratory

Improvement Amendments of 1988 (CLIA) Public Law 100-578 (42 U.S.C. Section 263a).

History: Emergency rule effective October 1, 1990. Rule effective January 15, 1991. Rule amended April 15, 1993. Amended: Filed January 18, 2002; effective April 18, 2002.

Rule No. 560-X-48-.03 Reimbursement

(1) Federally Qualified Health Centers (FQHCs) will be reimbursed under a prospective payment system as described in Section 1902(aa) of the Social Security Act. Refer to Chapter 56 of the Administrative Code for details.

(2) Reimbursement for out-of-state FQHCs will be the lesser of their encounter rate established by their State's Medicaid Department or the average encounter rate established by Alabama Medicaid for in-state facilities.

(3) Inpatient and outpatient surgery is reimbursed as fee for service is subject to the routine benefit limitations and policies as stated in Chapter 6 of the Administrative Code.

(4) FQHCs that are enrolled as Maternity Waiver primary contractors and/or Pharmacy providers (take home drugs) are reimbursed in accordance with routine benefit limitations and policies as stated in the Administrative Code, Chapters 45 and 16, respectively.

Author: Carol Akin, Associate Director, Clinic/Ancillary Services

Statutory Authority: State Plan, Attachment 4.19-B; Title XIX, Social Security Act; 42 C.F.R., Section 413 et seq.

History: Emergency rule effective October 1, 1990. Rule effective January 15, 1991. Rule amended April 15, 1993, December 10, 1997, and July 10, 1998. Amended: Emergency Rule filed and effective March 20, 2001. Amended: Filed March 20, 2001; effective June 15, 2001. Amended: Filed January 18, 2002; effective April 18, 2002.

Rule No. 560-X-48-.04 Change of Ownership

(1) Medicaid must be notified within thirty (30) days of the date of an FQHC ownership change. The existing contract will be automatically assigned to the new owner, and the new owner shall then be required to execute a new contract with Medicaid as soon as possible after the change of ownership, but in no event, later than thirty (30) days after notification. If the new owner fails to execute a contract with Medicaid within this time period, the contract shall terminate.

(2) The new owner may choose to accept the established reimbursement rate or submit a budgeted cost report to the Medicaid Agency. Refer to Chapter 56 of the Administrative Code for details.

Authority: State Plan, Section 4.3; Title XIX, Social Security Act; 42 C.F.R. Section 431.107. Emergency rule effective October 1, 1990. Rule effective January 15, 1991. Rule amended April 15, 1993. This amendment effective December 10, 1997.

Rule No. 560-X-48-.05 Medicare Deductible and Coinsurance

(1) Coinsurance will be paid up to the established Medicaid reimbursement rate for each FQHC.

Authority: State Plan, Attachment 3.1-A and 3.2-A; Title XIX, Social Security Act; 42 C.F.R., Section 405.2462(3). Emergency rule effective October 1, 1990. Rule effective January 15, 1991. Rule amended April 15, 1993 and December 10, 1997. Effective date of this amendment July 10, 1998.

Rule No. 560-X-48-.06 Copayment (Cost-Sharing)

(1) Medicaid and Medicare/Medicaid related recipients are required to pay and the FQHC's are required to collect the established copayment amount for each medical encounter.

(2) The cost-Sharing amount does not apply to services provided for the following:

- (a) Recipients under 18 years of age
- (b) Emergencies
- (c) Pregnancy
- (d) Family Planning
- (e) Nursing home residents
- (f) American Indians

(3) A provider may not deny services to any eligible individual based on the individual's inability to pay the copayment amount.

Author: Carol Akin, Associate Director, Clinic/Ancillary Services

Statutory Authority: State Plan, Attachment 4.18-A; Title XIX, Social Security Act; 42 C.F.R. Section 447.50, 447.53, 447.55, et seq.

History: Emergency rule effective October 1, 1990. Rule effective January 15, 1991. Amended Filed October 20, 2010; effective February 22, 2011.

Rule No. 560-X-48-.07 Billing Recipients

(1) A provider agrees to accept as payment in full the amount paid by Medicaid, plus any copayment amount required to be paid by the recipient for covered items, and further agrees to make no additional charge or charges for covered items to the recipient.

(2) Billing recipients for services not paid by Medicaid due to provider correctable errors on submitted claims or the untimely filing of claims is not permissible.

(3) A provider may bill the recipient for the copayment amount, for noncovered Medicaid services, and for services provided to a recipient who has exhausted his/her benefit limits.

Authority: 42 C.F.R. Section 447.15; State Plan, Attachment 4.18-A; Title XIX, Social Security Act; Emergency rule effective October 1, 1990. Rule effective January 15, 1991.

Rule No. 560-X-48-.08 Patient's Signature

(1) While a recipient signature is not required on individual claim forms, all providers must obtain a signature to be kept on file, e.g., release forms or sign-in-sheets, as verification that the recipient was present on the date of service for which the provider seeks payment. Exceptions to the recipient signature are listed below.

(a) Illiterate recipients may make their mark, for example, "X" witnessed by someone with their dated signature after the phrase "witnessed by."

(b) Interested parties other than the FQHC may sign claim forms for recipients who are not competent to sign because of age, mental, or physical impairment.

(c) For services rendered in a licensed facility setting, other than the provider's office, the recipient's signature on file in the facility's record is acceptable.

(d) When payment has been made on claims for which the recipient signature is not available and one of the above exceptions is not applicable, the funds paid to the provider covering this claim will be recovered.

Authority: State Plan, Attachment 4.19-A & D; Alabama State Records Commission; 42 C.F.R. Section 433.32. Rule effective April 15, 1993.