

SERVICES

MEDICAID PRIMARY CARE  
37.86.4401

Subchapter 44

Federally

Rural Health Clinics and  
Qualified Health Centers

37.86.4401 RURAL HEALTH CLINICS AND FEDERALLY  
QUALIFIED HEALTH CENTERS, DEFINITIONS In this subchapter  
the following definitions apply:

(1) "Category of service" means a type of medicaid covered service that is furnished in an RHC or FQHC.

(2) "Crossover claim" means a claim for services provided to medicare/medicaid dual eligibles or qualified medicare beneficiaries.

(3) "Federally qualified health center (FQHC)" means an entity which is a federally-qualified health center as defined in 42 USC 1396d(1)(2)(B) (1995 Supp.). For purposes of defining "federally qualified health center" the department hereby adopts and incorporates herein by reference 42 USC 1396d(1)(2)(B) (1995 Supp.), which is a federal statute defining "federally qualified health center" for purposes of the medicaid program. A copy of the cited statute is available upon request from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(4) "FQHC core services" means the FQHC ambulatory services defined in 42 USC 1396d(1)(2)(A) and described in 42 USC 1395x(aa)(1). For purposes of defining and describing FQHC core services, the department hereby adopts and incorporates herein by reference 42 USC 1396d(1)(2)(A) and 42 1395x(aa)(1) (1995 Supp.). The cited statutes are federal medicaid and medicare statutes defining certain FQHC services for purposes of the medicaid and medicare programs. Copies of the cited statutes are available upon request from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(5) "FQHC other ambulatory services" means ambulatory FQHC services, other than FQHC core services, that would be covered under the Montana medicaid program if provided by an individual or entity other than an FQHC in accordance with applicable medicaid requirements.

(6) "FQHC services" means FQHC core services and FQHC other ambulatory services.

(7) "Increase or decrease in the scope of service" means the addition of or elimination of a category of

service to the clinic or center or an increase or decrease in the intensity of a category of service.

(8) "Independent entity" means a rural health clinic or an FQHC that is not a provider-based entity.

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(9) "Intensity" means the increase or decrease in the cost of a category of service due to a change in the level of medical care provided to the population served by the clinic or center that may be reasonably expected to span at least 1 year.

(10) "Provider" means the entity enrolled in the Montana medicaid program as a provider of RHC or FQHC services.

(11) "Provider-based entity" means an FQHC or RHC that is an integral and subordinate part of a hospital, skilled nursing facility, or home health agency that is participating in the medicare program and that is operated with other departments of the provider under common licensure, governance and professional supervision.

(12) "Reporting period" means a period of 12 consecutive months specified by an RHC or FQHC as the period for which the entity must report its costs and utilization. The reporting period must correspond to the provider's fiscal year. The first and last reporting periods may be less than 12 months.

(13) "Rural health clinic (RHC)" means a clinic determined by the secretary of the United States department of health and human services to meet the rural health clinic conditions of certification specified in 42 CFR, part 491, subpart A.

(14) "RHC core services" means the rural health clinic services described in 42 CFR 440.20(b)(1) through (4).

(15) "RHC other ambulatory services" means other ambulatory services furnished by an RHC as described in 42 CFR 440.20(c).

(16) "Rural health clinic (RHC) services" means RHC core services and RHC other ambulatory services.

(17) "Visit" means a face-to-face encounter between a clinic or center patient and a clinic or center health professional for the purpose of providing RHC or FQHC core or other ambulatory services. Encounters with more than one clinic or center health professional, and multiple encounters with the same clinic or center health



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37.86.4406 RURAL HEALTH CLINICS AND FEDERALLY  
QUALIFIED HEALTH CENTERS, SERVICE REQUIREMENTS (1) The  
Montana medicaid program will cover and reimburse under the  
RHC or FQHC services programs only those services that are  
RHC services or FQHC services as defined in ARM 37.86.4401  
and subject to the provisions of this subchapter.

(2) The Montana medicaid program will not reimburse an  
RHC or FQHC for RHC or FQHC services that are services  
covered by a health maintenance organization for an enrolled  
recipient, as provided in ARM Title 37, chapter 86,  
subchapter 50, except as provided in ARM 37.86.4414.

(3) RHC services are covered by Montana medicaid when  
provided in accordance with these rules to a recipient at  
the clinic, the recipient's residence or a hospital or other  
medical facility.

(4) FQHC services are covered by Montana medicaid when  
provided in accordance with these rules to a recipient in an  
outpatient setting only, which may include the recipient's  
place of residence. The recipient's place of residence may  
include a skilled nursing facility or a nursing facility.  
FQHC services are not covered by Montana medicaid when  
provided to a hospital patient.

(5) The Montana medicaid program will cover and



supervision and protocol requirements, requirements for written documentation of prescription or referral, requirements for written care plans and prerequisites for receipt of a particular item or service by a particular recipient.

(d) Providers must bill for RHC or FQHC services using the revenue codes specified in the department's RHC/FQHC services provider manual. The department must provide 30 days prior written notice to providers of any changes in revenue codes.

(e) RHCs and FQHCs must comply with requirements for medicaid program authorization prior to provision of services or prior to payment, as applicable to the particular category of services being provided.

(f) Reimbursement will be made to RHCs and FQHCs for RHC and FQHC services as provided in ARM 37.86.4412 through 37.86.4414 and 37.86.4420, rather than as provided in the rules applicable to the particular category of services. This rule shall not be construed to provide that reimbursement of services provided by health professionals will be made under ARM 37.86.4412 through 37.86.4414 and 37.86.4420 when the services are not provided as an RHC or FQHC service and when the health professional is separately enrolled in and providing services under a particular medicaid service category, subject to the rules applicable to the particular service category.

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(6) A provider must notify the department, in writing, of an addition or elimination of a category of service offered by the RHC or FQHC to medicaid recipients. The department will determine an increase or decrease in the intensity of services upon request of a provider.

(a) As a condition of approval, the department may require the provider to submit documentation and information necessary to demonstrate compliance with requirements applicable to the category of service or documentation and information necessary to determine the cost of the service.



of ARM 37.85.414 in addition to the requirements of this rule.

(2) A provider must make and maintain adequate financial and statistical records in accordance with generally accepted accounting principles, as defined by the American institute of certified public accountants. The provider's records must be sufficient to allow the department and its agents to determine payment for the RHC or FQHC services provided to medicaid recipients and to provide a record that is auditable through the application of generally accepted auditing standards. Such records must be maintained for a period of 6 years, 3 months after a cost report is filed with respect to the period covered by such records or until such cost report is finally settled, whichever is later.

(3) The records described in (2) must be available at the provider facility at all reasonable times and shall be subject to inspection, review and audit by the department or its agents, the United States department of health and human services, the general accounting office, the Montana legislative auditor, and other governmental agencies as authorized by law.

(4) Upon failure or refusal of the provider to make available and allow access to such records, or to report a change in scope of services, the department may recover in full all payments made to the provider during the reporting period to which such records relate and may suspend any further payments to the provider until such time as the provider fully complies with this rule.

(5) No later than 30 days prior to the beginning of its initial reporting period as a new provider or following a change in ownership, a provider must submit to the department or its agent an estimate of budgeted costs and visits for RHC or FQHC services for the reporting period in the form and detail required by the department and such other information as the department may require to establish a rate as provided at ARM 37.86.4413. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1998 MAR p. 2045, Eff. 7/31/98; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 2043, Eff. 10/12/01.)

Rules 08 through 11 reserved

37.86.4412 RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS, REIMBURSEMENT (1) This subchapter specifies requirements applicable to provision of and reimbursement for (RHC) and (FQHC) services. These rules are in addition to requirements generally applicable to medicaid providers as otherwise provided in state and federal statute, rules, regulations and policies.

(2) Unless otherwise provided in these rules, this subchapter applies to rate years beginning on or after January 1, 2001. Reimbursement and other substantive RHC and FQHC requirements for earlier periods are subject to the laws, regulations, rules and policies then in effect. Procedural and other non-substantive provisions of these rules are effective upon adoption.

(3) All RHCs and FQHCs will be reimbursed on a prospective payment system beginning January 1, 2001 and each succeeding calendar year. The prospective payment system will apply equally to provider based and independent RHCs and FQHCs.

(4) The payment for RHCs and FQHCs will be as described in section 1902(a)(2)(B) and (C) of the Social Security Act 42 USC 1396a. For services furnished on or after January 1, 2001, payment for services for an RHC or FQHC shall be calculated on a per visit basis. This payment shall be equal to 100% of the average of the allowable costs of the RHC or FQHC furnishing such services during the RHC's or FQHC's fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services. This rate will be adjusted to take into account any increase or decrease in the scope of such services, as determined by the department, furnished by the RHC or FQHC during fiscal year 2001. Reasonableness shall be determined using the same methodology used under section 1833(a)(3) of the Social Security Act and using medicare allowable cost principles as set forth in 42 CFR 405.2468, HCFA manual provisions applicable to RHCs or FQHCs, including the Medicare Provider Reimbursement Manual, HCFA Pub. 15 and HCFA Pub. 27. The RHC or FQHC shall report any increase or decrease in the scope of services for fiscal year 2001 to date by notifying the department within 60 days of receipt of their estimated prospective payment worksheet from the department. Other changes through the end of calendar year 2001 shall be as in ARM 37.86.4406(6).

(a) The formula for calculating this base per visit rate is: the total cost of core and other ambulatory services for fiscal year 1999 and fiscal year 2000 divided by the total core and other ambulatory visits for fiscal year 1999 and fiscal year 2000, as reported on the providers filed medicaid fiscal year 1999 and fiscal year 2000 cost reports. This base cost per visit rate may be adjusted by a percentage of the total cost increase/decrease due to changes in scopes of services for fiscal year 2001 to date.

(b) If the provider reports only costs of other ambulatory services and not visits on their fiscal year 1999 and/or fiscal year 2000 cost reports, the costs of the other ambulatory services shall be removed from the calculation, however, the provider may report the number of visits and have the costs and visits added back into the base cost per visit rate by notifying the department within 60 days of receipt of their estimated prospective payment worksheet from the department.

(5) The department shall reimburse the clinic or center retroactive to the effective date of January 1, 2001.

(6) On January first of each succeeding calendar year the rate shall be adjusted by the percentage increase in the medicare economic index (MEI) applicable to primary care services for that calendar year.

(7) The department will reimburse the RHC or FQHC for the rate change in (7) retroactive to the effective date of January first of the calendar year, beginning with January 1, 2002.

(8) The prospective payment per visit rate may be adjusted by a percentage of the total cost increase or decrease due to changes in scope of services as reported in ARM 37.86.4406(6). (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1998 MAR p. 2045, Eff. 7/31/98; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 2043, Eff. 10/12/01.)

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37.86.4413 RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS, ESTABLISHMENT OF INITIAL PAYMENT FOR NEW CLINICS OR CENTERS (1) To determine the initial medicaid prospective payment system base per visit rate for a newly qualified RHC or FQHC, reimbursement shall be equal to 100% of the average prospective payment system rates for other RHCs or FQHCs located in the same or adjacent area with a similar caseload. In the event that there is no such RHC or FQHC, payment shall be made in accordance with the methodology provided in (2) through (4).

(2) During the RHC's or FQHC's first two fiscal years, the RHC or FQHC will be reimbursed on a per visit basis equal to the RHC's or FQHC's total projected costs divided by the RHC's or FQHC's total projected visits. The provider must submit to the department or its agent an estimate of budgeted costs and visits for the RHC or FQHC for the reporting period in the form and detail required by the department and such other information as the department may require to establish a rate.

(3) At the end of the RHC's or FQHC's first two fiscal years, a new per visit rate shall be established that is equal to 100% of the allowable costs of the RHC or FQHC furnishing such services during the RHC's or FQHC's first two fiscal years which are reasonable and related to the cost of furnishing such services. The provider must submit to the department or its agent the costs and visits for the RHC or FQHC for the reporting period in the form and detail required by the department and such other information as the department may require to establish a rate.

(a) The formula for calculating this new base per visit rate is: the total cost of core and other ambulatory services for the first two fiscal years divided by the total

core and other ambulatory visits for the first two fiscal years. This base cost per visit rate may be adjusted by a percentage of the total cost increase/decrease due to changes in scopes of services for the third fiscal year to date.

(b) The department shall reimburse the RHC or FQHC this new base rate retroactive to the effective date of their enrollment as an RHC or FQHC.

(4) Reimbursement for the third year forward shall be as in ARM 37.86.4406(6) and 37.86.4412(7) and (8).

(History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1998 MAR p. 2045, Eff. 7/31/98; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 1476, Eff. 8/10/01; AMD, 2001 MAR p. 2043, Eff. 10/12/01.)

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37.86.4414 RURAL HEALTH CLINICS AND FEDERALLY  
QUALIFIED HEALTH CENTERS, SUPPLEMENTAL PAYMENTS IN CASE OF  
MANAGED CARE

(1) In the case of services furnished by an RHC or FQHC pursuant to a contract between the RHC or FQHC and a managed care entity (as defined in section 1932(a)(1)(B) and 1932(a)(1)(C) of the Social Security Act), payment to the RHC or FQHC shall be a supplemental payment equal to the amount (if any) by which the amount determined under medicaid prospective payment system exceeds the amount of the payments provided under the contract.

(2) The supplemental payment required shall be made quarterly. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1998 MAR p. 2045, Eff. 7/31/98; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 2043, Eff. 10/12/01.)

Rules 15 through 19 reserved

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37.86.4420 RURAL HEALTH CLINICS AND FEDERALLY  
QUALIFIED HEALTH CENTERS, ALTERNATIVE PAYMENT METHODOLOGIES

(1) In the case of a catastrophic event or extraordinary circumstance that would directly impact the cost of medical services provided by an RHC or FQHC, or upon mutual agreement of the department and the RHC or FQHC the department may provide for payment in any year to an RHC or FQHC for services described in section 1905(a)(2)(B) and (C) of the Social Security Act in an amount determined under an alternative payment methodology that:

(a) is agreed to by the department and the RHC or FQHC;  
and

(b) results in payment to the RHC or FQHC of an amount which is at least equal to the amount otherwise required to be paid to the RHC or FQHC under the medicaid prospective payment system. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1998 MAR p. 2045, Eff. 7/31/98; TRANS, from SRS, 2000

MAR p. 481; AMD, 2001 MAR p. 2043, Eff. 10/12/01.)

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