**R414. Health, Health Care Financing, Coverage and Reimbursement Policy.**

**R414-9. Federally Qualified Health Centers.**

**R414-9-1. Introduction and Authority.**

 (1) This rule establishes Medicaid payment methodologies for federally qualified health centers (FQHCs) and Rural Health Clinics (RHCs).

 (2) This rule is authorized by 42 CFR Subpart X, and Sections 26-18-2.1, 26-18-2.3, UCA.

**R414-9-2. Definitions.**

 In addition to the definitions in R414-1, the following definitions apply to this rule:

 (1) "Federally Qualified Health Center" (FQHC) means an entity that is a Federally Qualified Health Center under the provisions of 42 CFR Subpart X.

 (2) "Rural Health Clinic" (RHC) means an entity that is a Rural Health Clinic under the provisions of 42 CFR Subpart X.

 (3) “Scope of Services Change” (SSC) means having a change in type, intensity, duration and/or amount of services.

**R414-9-3. Payment Choices for FQHCs.**

 See Utah State Plan, Attachment 4.19-B

**R414-9-4. Prospective Payment System.**

 See Utah State Plan, Attachment 4.19-B

**R414-9-5. Alternate Payment Method.**

 See Utah State Plan, Attachment 4.19-B

**R414-9-6. Rural Health Clinics.**

 See Utah State Plan, Attachment 4.19-B

**R414-9-7. Scope of Service Changes.**

Providers wanting an SSC change rate consideration must provide the required documentation, meet the SSC requirements, and have a qualifying event. All documentation must be emailed to MedicaidHealthCenter@utah.gov.

1. Documentation needed from FQHC/RHCs. All documentation must clearly detail the change in the type, intensity, duration and/or amount of services and include additional documentation the FQHC/RHC would have to support the request. An FQHC/RHC must submit to DIH the following:
2. The most recently completed Medicare cost report(s) which include the before and after SSC showing:
	* 1. Cost by service type and totals from Worksheet A
		2. Calculation of total allowable billable visits from Worksheet S3, Part 1
3. A supplemental cost report to collect other needed data may be requested to gather information that may not be available on the Medicare cost reports (e.g., dental encounters).
4. For prospective SSC, prospective cost reports for one future period discreetly showing:
	* 1. Costs of change in SSC
		2. Anticipated hiring of new staff
		3. New expenses estimated for the future (including new sites); and
		4. A description as to how the estimates were determined to be reasonable
5. A detailed description of the change in SSC
6. A detailed calculation of the change in SSC
7. SSC Requirements
	1. It is the responsibility of the FQHC/RHC to notify the agency of any increases or decreases.
	2. General requirements for FQHC/RHCs to complete a SSC change include the following:
		1. Timing of review – a complete request documentation package must be received at least six months prior to the end of the FQHC/RHC fiscal year to change the next fiscal year’s PPS rate. When an SSC change is submitted without complete documentation, the request is returned without processing. The FQHC/RHC provider is required to resubmit the entire request including the additional documentation. The date in which a complete request, with all necessary supporting documentation is received will be the submission date used for the SSC change.
		2. Effective Date – the effective date will be the first day of the provider's fiscal year following the year in which the SSC was submitted, subject to the terms of 2.b.i
		3. Threshold – the PPS rate change from the SSC must exceed a 5% increase or decrease threshold from the FQHC’s current PPS Medicaid rate
		4. Frequency of requests for review – the FQHC/RHC may not submit a request for a SSC change more than every two years. An exception may be allowable for the following:
			1. HRSA approved new access point, or
			2. The SSC exceeds a 10% increase or decrease threshold
		5. Requests to review SSC changes back more than eight years will be denied. Effective January 1, 2025, requests to review SSC changes back more than two years will be denied.
8. Qualifying Event
	1. FQHC/RHCs must have a qualifying event to trigger an SSC change. The following are considered a qualifying event if a covered Utah Medicaid service:
		1. Medical – increasing primary care and medical specialties (i.e., cardiology, dermatology, etc.)
		2. Case management or care coordination for non-billable work – adding or supplementing these services
		3. Dental – adding preventive dental or adding restorative, dental surgery, etc.
		4. X-ray – directly provided (includes ultrasound), but not through referral arrangement
		5. Medication Assisted Treatment
		6. Behavioral Health
			1. Adding behavioral health services and providers
			2. Supplanting care team with behavioral health staff who may not generate additional billable visits [e.g., community health workers (CHW), behaviorists, etc.]
		7. Substance Use Disorder – adding substance use disorder treatment services
		8. Lab – adding beyond rapid and CLIA-waived, but would include COVID rapid tests
		9. OB/GYN
		10. Social Determinants of Health Interventions where distinct staff and services were added
		11. Enabling services – adding new service (i.e., interpretation, financial counseling, diabetes, education, etc.)
		12. Optometry – directly provided
		13. Chronic pain management – adding new or certified staff
		14. Pharmacy – include clinical pharmacists
		15. Chiropractic Care
		16. Physical Therapy
		17. Complementary and Alternative Medicine
		18. An amendment to the Utah State Plan to remove a service that a FQHC/RHC had offered.
	2. FQHC/RHCs having a change in intensity, amount, or duration of the following services, if covered by Utah Medicaid, would be considered a qualifying event:
		1. Services provided (e.g., those listed in addition or deletion of new type of service)
		2. Telehealth
		3. EMR – first time implementation
		4. EMR Modules – new modules
		5. Remote Patient Monitoring
		6. Regulatory Compliance – implementation of new rules and for building compliance infrastructure
		7. Population (e.g., homeless, HIV/AIDS, other chronic diseases, elderly)
		8. HRSA approved change in scope of project – addition of new site
		9. Provider mix (e.g., psychiatrist, infectious disease specialist, etc.)
		10. Public Health Emergencies
		11. Changing capital costs from a remodel, relocation or establishing a new site
		12. Technology – new service or infrastructure not replacement service or infrastructure
		13. Costs associated with a teaching health center
	3. If above SSC change was otherwise reimbursed, then only the net cost of the SSC would be considered.