State of Mississippi

Descriptions of Limitations as to Amount, Duration and Scope of Medical Care and Services Provided

C. Encounter

1. An encounter is also referred to as a visit. An encounter at an RHC is a face-to-face visit between a clinic beneficiary and any health professional whose services are reimbursed as one (1) of the following under the State Plan.

   a. A medical encounter is a face-to-face visit between a clinic beneficiary and a physician, physician assistant, nurse practitioner, or nurse midwife for the provision of medical services.

   b. A mental health encounter is a face-to-face visit between a clinic beneficiary and a physician, nurse practitioner, physician assistant, clinical psychologist, licensed clinical social worker, licensed professional counselor, or board certified behavior analyst for the provision of mental health services.

   c. A dental encounter is a face-to-face visit between a clinic beneficiary and a dentist for the provision of dental services.

   d. A vision encounter is a face-to-face visit between a clinic beneficiary and an ophthalmologist, optometrist, physician, nurse practitioner or physician assistant for the provision of vision services.

2. Encounters with more than one health professional for the same type of service or more than one encounter with the same health professional, which take place on the same day and at a single location constitute a single encounter, except when one of the following circumstances occur:

   a. After the first encounter, the beneficiary suffers illness or injury requiring additional diagnosis or treatment,

   b. The beneficiary has a combination of a medical encounter, mental health encounter, dental encounter, and/or vision encounter that are each a separate identifiable service. or

   c. The beneficiary has an initial preventative physical exam encounter and a separate medical, mental health, dental or vision encounter on the same day.

3. Nursing Facility and Home Encounters

a. A nursing home encounter is covered as a face-to-face visit when performed within the county or within forty (40) miles of the county where the RHC is located.

b. A home encounter is covered as a face-to-face visit when performed within the county or within forty (40) miles of the county where the RHC is located.

4. RHC Mobile Unit Encounters are covered when the mobile unit meets the following criteria:

a. Must be surveyed by the Mississippi Department of Health (MSDH) and receive an approval letter from the Centers for Medicare and Medicaid Services (CMS) prior to providing services.

b. Must meet all federal and state requirements for RHC mobile units.

c. Must have a fixed set of locations where the mobile unit is scheduled to provide services at specified dates and times.

1) Locations for RHC mobile unit services must meet the rural and shortage area requirements at the time of survey.

2) The schedule of times and locations must be posted on the mobile unit and publicized by other means so that beneficiaries will know the mobile unit's schedule in advance.

d. Must operate:

1) Within the county or within forty (40) miles of the county where the affiliated RHC has a permanent structure.

2) If the RHC has no permanent structure, within the county or within forty (40) miles of the county of the initial CMS approved locations.

3) Mobile units must have a separate Mississippi Medicaid provider number from the affiliated RHC.

D. Other Covered Ambulatory Services:

1. The following group services are covered:

a. Group Psychotherapy,

b. Group adaptive behavior services, and

c. Prenatal and postpartum education.

2. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening services are covered in a school setting, day care center or Head Start program by a physician, nurse practitioner, or physician assistant employed by the RHC.

    a. The school, day care center or Head Start program must be located within the county or within forty (40) miles of the county the RHC is located.

    b. The settings and screenings must meet the requirements as outlined in the Miss. Admin. Code Part 223.

E. Non-Covered Services

RHC services are not covered when performed in a hospital (inpatient or outpatient). A physician employed by an RHC and rendering services to beneficiaries in a hospital must file under his own individual provider number.

2b. RURAL HEALTH CLINICS (RHC)

I. Introduction

The purpose of this State Plan is to set forth policies and guidelines to be administered by the Mississippi Division of Medicaid (DOM) for Rural Health Clinics (RHCs) operating in the State of Mississippi. All RHCs are reimbursed in accordance with section 1902 of the Social Security Act as amended by section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000 (BIPA) and the principles and procedures specified in this plan.

II. Payment Methodology

This state plan provides for reimbursement to RHC providers at a prospective payment system (PPS) rate per encounter. Reimbursement is limited to a single encounter, also referred to as a "visit", per day except as described in Attachment 3.1-A exhibit 2b.

The Division of Medicaid reimburses a RHC the PPS rate for nursing home encounters.

RHC services provided by a nurse practitioner and/or a physician assistant are reimbursed the full PPS rate.

A. Prospective Payment System

In accordance with Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, effective January 1, 2001, the state plan provides for payment for core services and other ambulatory services provided by RHCs at a prospective payment system (PPS) rate per encounter. The PPS rate is calculated (on a per -encounter basis) in an amount equal to one hundred percent (100%) of the average of the RHCs reasonable costs of providing Medicaid covered services provided during fiscal years 1999 and 2000, adjusted to take into account any increase or decrease in the scope of services furnished during fiscal year 2001. For RHCs that qualified for Medicaid participation during fiscal year 2000, their PPS rate for fiscal year 2001 is calculated (on a per visit basis) in an amount equal to one hundred percent (100%) of the average of the RHCs reasonable costs of Medicaid covered services provided during fiscal year 2000.

For services furnished during calendar year 2002 and each subsequent calendar year, the payment rate is equal to the rate established in the preceding calendar year increased by the Medicare Economic Index (MEI) for primary care services that is published in the Federal Register in the fourth (4th) quarter of the preceding calendar year. Adjustments to the PPS rate for the increase or decrease in scope of services are reflected in the PPS rate for services provided in the calendar year following the calendar year in which the change in scope of services took place.

B. New Clinics

For new clinics that qualify for the RHC program after January 1, 2001, the initial PPS rate is based on the rates established for other RHCs located in the same or adjacent area with a similar caseload. In the absence of such RHCs, the PPS rate for the new provider will be based on projected costs.

The RHC's Medicare final settlement cost report for the initial cost report period year will be used to calculate a PPS base rate that is equal to one hundred percent (100%) of the RHC's reasonable costs of providing Medicaid covered services. If the initial cost report period represents a full year of RHC services, this final settlement rate will be considered the base rate. If the initial RHC cost report period does not represent a full year, then the rate from the first full year cost report will be used as the clinic's base rate.

For each subsequent calendar year, the payment rate is equal to the rate established in the preceding calendar year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services that is published in the Federal Register in the fourth (4th) quarter of the preceding calendar year.

C. Alternative Payment Methodology

1. The Division of Medicaid reimburses an RHC a fee in addition to the PPS rate when billing with codes 99050 or 99051 when the encounter occurs: (1) during the RHC's established office hours but before or after the Division of Medicaid's office hours, or (2) outside of the Division of Medicaid's office hours or the RHC established office hours only for a condition which is not life-threatening but warrants immediate attention and cannot wait to be treated until the next scheduled appointment during office hours or the RHC established office hours. The Division of Medicaid's office hours are defined as the hours between 8:00 a.m. and 5 p.m., Monday through Friday, excluding Saturday, Sunday, and federal and state holidays. These codes will be paid at the existing fee-for-service rate on the MS Medicaid Physician Fee Schedule at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#.

2. The Division of Medicaid reimburses an RHC an additional fee for telehealth services provided by the RHC as the originating site provider. The RHC will receive the originating site facility fee per completed transmission when billing claims with code Q3014. The RHC may not bill for an encounter visit unless a separately identifiable service is performed. This service will be paid at the existing fee-for-service rate on the MS Medicaid Physician Fee Schedule at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

3. If an RHC's base year cost report is amended, the clinic's PPS base rate will be adjusted based

on the Medicare final settlement amended cost report. The RHC's original PPS base rate and the rates for each subsequent fiscal year will be recalculated per the payment methodology outlined above. Claims payments will be adjusted retroactive to the effective date of the original rate. The amended PPS base rate will be no less than the original base rate.

D. Fee-For-Service

1. RHCs acting in the role of a telehealth originating site provider with no other separately identifiable service being provided will only be paid the fee-for-service telehealth originating site fee per completed transmission and will not receive reimbursement for an encounter.

2. RHCs providing EPSDT well child screenings in a school setting, day care center or Head Start program are reimbursed at the lower of the RHC's PPS rate or the current applicable MS Medicaid fee-for-service rate for the EPSDT screening.

3. RHCs providing group therapy is reimbursed the current applicable MS Medicaid fee-for-service rate per beneficiary participating in a group therapy session.

Current fee-for-service rates are located on the MS Medicaid Physician Fee Schedule at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#.

4. The Division of Medicaid reimburses an RHC the PPS rate for the administration of certain categories of physician administered drugs (PADs), referred to as Clinician Administered Drug and Implantable Drug System Devices (CADDs). CADDs are reimbursed under the pharmacy benefit to the extent the CADDs were not included in the calculation of the RHC's PPS rate.

E. Change of Ownership

When an RHC undergoes a change of ownership, the PPS rate of the new owner will be equal to the PPS rate of the old owner. There will be no change to the RHC's PPS rate as a result of a change of ownership.

F. Change in Scope of Services

A change in the scope of services is defined as a change in the type, intensity, duration and/or amount of services. A change in the scope of services occurs if: (1) the clinic RHC has added or has dropped any services that meets the definition of an RHC service as provided in section 1905(a)(2)(B) and (C), and (2) the service is included as a covered Medicaid service under the Mississippi Medicaid state plan. A change in intensity could be a change in the amount of health care services provided by the RHC in an average encounter.

A change in the scope of services does not mean the addition or reduction of staff members to or from an existing service. An increase or decrease in the number of encounters does not generally

constitute a change in the scope of services. A change in the cost of a service is not considered in and of itself a change in the scope of services.

An RHC must notify the Division of Medicaid in writing of any change in the scope of services by the end of the calendar year in which the change occurred, including decreases in scope of services. The Division of Medicaid will adjust an RHC's PPS rate if the following criteria are met: (1) The RHC can demonstrate that there is a valid and documented change in the scope of services, and (2) The change in scope of services results in at least a five percent (5%) increase or decrease in the RHC's PPS rate for the calendar year in which the change in scope of service took place.

An RHC must submit a request for an adjustment to its PPS rate no later than one hundred eighty (180) days after the settlement date of the RHC's Medicare final settlement cost report for the RHC's first full fiscal year of operation with the change in scope of services. The request must include the first final settlement cost report that includes twelve (12) months of costs for the new service. The adjustment will be granted only if the cost related to the change in scope of services results in at least a five percent (5%) increase or decrease in the RHC's PPS rate for the calendar year in which the change in scope of services took place. The cost related to a change in scope of services will be subject to reasonable cost criteria identified in accordance with 45 C.F.R. Part 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards and 42 C.F.R. Part 413 Principles of Reasonable Cost Reimbursement.

It is the responsibility of the RHC to notify the Division of Medicaid of any change in the scope of services and provide proper and valid documentation to support the rate change. Such required documentation must include, at a minimum, a detailed working trial balance demonstrating the increase or decrease in the RHC's PPS rate as a result of the change in scope of services. The Division of Medicaid will require the RHC to provide such documentation in a format acceptable to the Division of Medicaid, including providing such documentation upon the Division of Medicaid's pre-approved forms. The Division of Medicaid will also request additional information as it sees fit in order to sufficiently determine whether any change in scope of services has occurred. The instructions and forms for submitting a request due to a change in scope of services can be found at http:/www.medicaid.ms.gov/resources/forms/.

Adjustments to the PPS rate for the increase or decrease in scope of services are reflected in the PPS rate for services provided in the calendar year following the calendar year in which the change in scope of services took place. The revised PPS rate generally cannot exceed the cost per visit from the most recent audited cost report.

G. Change in Ownership Status

The RHC's PPS rate will not be adjusted solely for a change in ownership status between freestanding and provider-based.

H. Allowable Costs

Allowable costs are those costs that result from providing covered services. They are reasonable in amount and are necessary for the efficient delivery of those services. Allowable costs include the direct cost center component (i.e., salaries and supplies) of providing the covered services and an allocated portion of overhead (i.e., administration and facility).

I. Out of State Providers

The Division of Medicaid does not enroll out-of-state providers to provide RHC services, except in those circumstances specified at 42 C.F.R. § 431.52.

State of Mississippi

Descriptions of Limitations as to Amount, Duration and Scope of Medical Care and Services Provided

C. ~~**Visits**1.~~Encounter

1. An encounter is also referred to as a visit. An encounter at an RHC is a face-to-face visit between a clinic beneficiary and any health professional whose services are reimbursed as one (1) of the following under the State Plan.~~can be a medical visit or an "other health" visit.~~

   a. A medical ~~visit~~ encounter is a face-to-face ~~encounter~~ visit between a clinic ~~patient~~ beneficiary and a physician, physician assistant, nurse practitioner, or nurse midwife for the provision of medical services.

   b. A~~n~~ ~~"other health"~~mental health ~~visit~~ encounter is a face-to-face ~~encounter~~visit between a clinic ~~patient~~ beneficiary and a physician, nurse practitioner, physician assistant, clinical psychologist, licensed clinical social worker, licensed professional counselor, or board certified behavior analyst for the provision of mental health services. ~~or other health professional for mental health services~~.

   c. A dental encounter is a face-to-face visit between a clinic beneficiary and a dentist for the provision of dental services.

   d. A vision encounter is a face-to-face visit between a clinic beneficiary and an ophthalmologist, optometrist, physician, nurse practitioner or physician assistant for the provision of vision services.

2. Encounters with more than one health professional for the same type of service ~~and~~ or ~~multiple encounters~~ more than one encounter with the same health professional, which take place on the same day and at a single location constitute a single ~~visit~~ encounter, except when one of the following circumstances occur:

   a. After the first encounter, the ~~patient~~ beneficiary suffers illness or injury requiring additional diagnosis or treatment,~~.~~

   b. The ~~patient~~ beneficiary has a combination of a medical ~~visit~~ encounter, mental health encounter, dental encounter, and/or vision encounter that are each a separate identifiable service. ~~and a visit with a mental health professional, a dentist, or an optometrist.~~ or

   c. The beneficiary has an initial preventative physical exam encounter and a separate medical, mental health, dental or vision encounter on the same day. ~~In these instances, the clinic is paid for more than one encounter on the same day~~.

State of Mississippi

Descriptions of Limitations as to Amount, Duration and Scope of Medical Care and Services Provided

~~2~~3. ~~Hospital and~~ Nursing Facility and Home ~~Visits~~ Encounters

~~RHC services are not covered when performed in a hospital (inpatient or outpatient). A physician employed by an RHC and rendering services to clinic patient in a hospital must file under his own individual provider number.~~

a. A n~~N~~ursing home encounter ~~visits will be reimbursed at the RHC PPS rate.~~is covered as a face-to-face visit when performed within the county or within forty (40) miles of the county where the RHC is located.

b. A home encounter is covered as a face-to-face visit when performed within the county or within forty (40) miles of the county where the RHC is located.

4. RHC Mobile Unit Encounters are covered when the mobile unit meets the following criteria:

a. Must be surveyed by the Mississippi Department of Health (MSDH) and receive an approval letter from the Centers for Medicare and Medicaid Services (CMS) prior to providing services.

b. Must meet all federal and state requirements for RHC mobile units.

c. Must have a fixed set of locations where the mobile unit is scheduled to provide services at specified dates and times.

1) Locations for RHC mobile unit services must meet the rural and shortage area requirements at the time of survey.

2) The schedule of times and locations must be posted on the mobile unit and publicized by other means so that beneficiaries will know the mobile unit's schedule in advance.

d. Must operate:

1) Within the county or within forty (40) miles of the county where the affiliated RHC has a permanent structure.

2) If the RHC has no permanent structure, within the county or forty (40) miles of the county of the initial CMS approved locations.

Descriptions of Limitations as to Amount, Duration and Scope of Medical Care and Services Provided

3) Mobile units must have a separate Mississippi Medicaid provider number from the affiliated RHC.

D. Other Covered Ambulatory Services:

1. The following group services are covered:

   a. Group Psychotherapy,

   b. Group adaptive behavior services, and

   c. Prenatal and postpartum education.

2. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening services are covered in a school setting, day care center or Head Start program by a physician, nurse practitioner, or physician assistant employed by the RHC.

   a. The school, day care center or Head Start program must be located within the county or within forty (40) miles of the county where the RHC is located.

   b. The settings and screenings must meet the requirements as outlined in the Miss. Admin. Code Part 223.

E. Non-Covered Services

RHC services are not covered when performed in a hospital (inpatient or outpatient). A physician employed by an RHC and rendering services to beneficiaries in a hospital must file under his own individual provider number.

2b. RURAL HEALTH CLINICS (RHC)

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II. Payment Methodology

This state plan provides for reimbursement to RHC providers at a prospective payment system (PPS) rate per encounter. Reimbursement is limited to a single encounter, also referred to as a "visit", per day except as described in Attachment 3.1-A exhibit 2b.

The Division of Medicaid reimburses a RHC the PPS rate for nursing home encounters.

RHC services provided by a nurse practitioner and/or a physician assistant are reimbursed the full PPS rate.

A. Prospective Payment System

In accordance with Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, effective January 1, 2001, the state plan ~~shall~~ provides for payment for core services and other ambulatory services provided by RHCs at a prospective payment system (PPS) rate per encounter. The PPS rate ~~shall be~~ is calculated (on a per ~~visit~~ -encounter basis) in an amount equal to one hundred percent (100%) of the average of the RHCs reasonable costs of providing Medicaid covered services provided during fiscal years 1999 and 2000, adjusted to take into account any increase or decrease in the scope of services furnished during fiscal year 2001. For RHCs that qualified for Medicaid participation during fiscal year 2000, their ~~prospective payment~~ PPS rate for fiscal year 2001 ~~shall be~~is calculated (on a per visit basis) in an amount equal to one hundred percent (100%) of the average of the RHCs reasonable costs of Medicaid covered services provided during fiscal year 2000.

For services furnished during calendar year 2002 and each subsequent calendar year, the payment rate ~~shall be~~ is equal to the rate established in the preceding calendar year increased by the Medicare Economic Index (MEI) for primary care services that is published in the Federal Register in the fourth (4th) quarter of the preceding calendar year. Adjustments to the PPS rate for the increase or decrease in scope of services are reflected in the PPS rate for services provided in the calendar year following the calendar year in which the change in scope of services took place.

B. New Clinics

For new clinics that qualify for the RHC program after January 1, 2001, the initial ~~prospective payment system (~~PPS~~)~~ rate ~~shall be~~ is based on the rates established for other RHCs located in the same or adjacent area with a similar caseload. In the absence of such RHCs, the PPS rate for the new provider will be based on projected costs.

The RHC's Medicare final settlement cost report for the initial cost report period year will be used to calculate a PPS base rate that is equal to one hundred percent (100%) of the RHC's reasonable costs of providing Medicaid covered services. If the initial cost report period represents a full year of RHC services, this final settlement rate will be considered the base rate. If the initial RHC cost report period does not represent a full year, then the rate from the first full year cost report will be used as the clinic's base rate.

For each subsequent calendar year, the payment rate ~~shall be~~ is equal to the rate established in the preceding calendar year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services that is published in the Federal Register in the fourth (4th) quarter of the preceding calendar year.

C. Alternative Payment Methodology

1. The Division of Medicaid reimburses an RHC a fee in addition to the ~~encounter~~ PPS rate when billing with codes 99050 or 99051 when the encounter occurs: (1) during the RHC's established office hours but before or after the Division of Medicaid's office hours, or (2) outside of the Division of Medicaid's office hours or the RHC established office hours only for a condition which is not life-threatening but warrants immediate attention and cannot wait to be treated until the next scheduled appointment during office hours or the RHC established office hours. The Division of Medicaid's office hours are defined as the hours between 8:00 a.m. and 5 p.m., Monday through Friday, excluding Saturday, Sunday, and federal and state holidays. These codes will be paid at the existing fee-for-service rate on the MS Medicaid Physician Fee Schedule at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#.

2. The Division of Medicaid reimburses an RHC an additional fee for telehealth services provided by the RHC as the originating site provider. The RHC will receive the originating site facility fee per completed transmission when billing claims with code Q3014. The RHC may not bill for an encounter visit unless a separately identifiable service is performed. This service will be paid at the existing fee-for-service rate on the MS Medicaid Physician Fee Schedule at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

3. If an RHC's base year cost report is amended, the clinic's PPS base rate will be adjusted based

on the Medicare final settlement amended cost report. The RHC's original PPS base rate and the rates for each subsequent fiscal year will be recalculated per the payment methodology outlined above. Claims payments will be adjusted retroactive to the effective date of the original rate. The amended PPS base rate will be no less than the original base rate.

D. Fee-For-Service

1. RHCs acting in the role of a telehealth originating site provider with no other separately identifiable service being provided will only be paid the fee-for-service telehealth originating site fee per completed transmission and will not receive reimbursement for an encounter. ~~This service will be paid at the existing fee-for-service rate on the MS Medicaid Physician Fee Schedule at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#.~~

2. RHCs providing EPSDT well child screenings in a school setting, day care center or Head Start program are reimbursed at the lower of the RHC's PPS rate or the current applicable MS Medicaid fee-for-service rate for the EPSDT screening.

3. RHCs providing group therapy is reimbursed the current applicable MS Medicaid fee-for-service rate per beneficiary participating in a group therapy session.

Current fee-for-service rates are located on the MS Medicaid Physician Fee Schedule at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#.

~~2~~4. The Division of Medicaid reimburses an RHC the PPS rate ~~encounter rate~~ for the administration of certain categories of physician administered drugs (PADs), referred to as Clinician Administered Drug and Implantable Drug System Devices (CADDs).~~,~~ CADDs are reimbursed under the pharmacy benefit to the extent the CADDs were not included in the calculation of the RHC's PPS ~~encounter~~ rate.

E. Change of Ownership

When an RHC undergoes a change of ownership, the PPS rate of the new owner will be equal to the PPS rate of the old owner. There will be no change to the RHC's PPS rate as a result of a change of ownership.

F. Change in Scope of Services

A change in the scope of services is defined as a change in the type, intensity, duration and/or amount of services. A change in the scope of services occurs if: (1) the clinic RHC has added or has dropped any services that meets the definition of an RHC service as provided in section 1905(a)(2)(B) and (C), and (2) the service is included as a covered Medicaid service under the Mississippi Medicaid state plan. A change in intensity could be a change in the amount of health care services provided by the RHC in an average encounter.

A change in the scope of services does not mean the addition or reduction of staff members to or from an existing service. An increase or decrease in the number of encounters does not generally constitute a change in the scope of services. A change in the cost of a service is not considered in and of itself a change in the scope of services.

An RHC must notify the Division of Medicaid in writing of any change in the scope of services by the end of the calendar year in which the change occurred, including decreases in scope of services. The Division of Medicaid will adjust an RHC's PPS rate if the following criteria are met: (1) The RHC can demonstrate that there is a valid and documented change in the scope of services, and (2) The change in scope of services results in at least a five percent (5%) increase or decrease in the RHC's PPS rate for the calendar year in which the change in scope of service took place.

An RHC must submit a request for an adjustment to its PPS rate no later than one hundred eighty (180) days after the settlement date of the RHC's Medicare final settlement cost report for the RHC's first full fiscal year of operation with the change in scope of services. The request must include the first final settlement cost report that includes twelve (12) months of costs for the new service. The adjustment will be granted only if the cost related to the change in scope of services results in at least a five percent (5%) increase or decrease in the RHC's PPS rate for the calendar year in which the change in scope of services took place. The cost related to a change in scope of services will be subject to reasonable cost criteria identified in accordance with 45 C.F.R. Part 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards and 42 C.F.R. Part 413 Principles of Reasonable Cost Reimbursement.

It is the responsibility of the RHC to notify the Division of Medicaid of any change in the scope of services and provide proper and valid documentation to support the rate change. Such required documentation must include, at a minimum, a detailed working trial balance demonstrating the increase or decrease in the RHC's PPS rate as a result of the change in scope of services. The Division of Medicaid will require the RHC to provide such documentation in a format acceptable to the Division of Medicaid, including providing such documentation upon the Division of Medicaid's pre-approved forms. The Division of Medicaid will also request additional information as it sees fit in order to sufficiently determine whether any change in scope of services has occurred. The instructions and forms for submitting a request due to a change in scope of services can be found at http:/www.medicaid.ms.gov/resources/forms/.

Adjustments to the PPS rate for the increase or decrease in scope of services are reflected in the PPS rate for services provided in the calendar year following the calendar year in which the change in scope of services took place. The revised PPS rate generally cannot exceed the cost per visit from the most recent audited cost report.

G. Change in Ownership Status

The RHC's PPS rate will not be adjusted solely for a change in ownership status between freestanding and provider-based.

H. Allowable Costs

Allowable costs are those costs that result from providing covered services. They are reasonable in amount and are necessary for the efficient delivery of those services. Allowable costs include the direct cost center component (i.e., salaries and supplies) of providing the covered services and an allocated portion of overhead (i.e., administration and facility).

I. Out of State Providers

The Division of Medicaid does not enroll out-of-state providers to provide RHC services, except in those circumstances specified at 42 C.F.R. § 431.52.