Administrative Code

Title 23: Medicaid
Part 211
Federally Qualified Health Centers (FQHC)

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Part 211: Federally Qualified Health Centers

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Rule 1.1: Provider Enrollment Requirements

A. To participate as a Federally Qualified Health Center (FQHC) or FQHC look-alike in the Medicaid program, an organization must be approved by the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) as an FQHC or FQHC look-alike.

B. FQHC or FQHC look-alike providers must comply with the requirements set forth in Miss. Admin. Code Part 200, Rule 4.8 for all providers in addition to the specific provider type requirements outlined below:

National Provider Identifier (NPI), verification from the National Plan and Provider Enumeration System (NPPES),

2. Written confirmation from the IRS confirming provider's tax identification number and noted Legal Business Name, and

3. Medicare Cost Report.

C. Medicaid payments may not be made to any organization prior to the date of approval and execution of a valid Medicaid provider agreement.

D. The effective date of the Medicaid provider enrollment will be:

1. The date of Medicare certification if the provider requests enrollment in the Medicaid program within one hundred twenty (120) days from the date the Medicare Tie-in Notice was issued to the provider, or

2. The first day of the month in which the Division of Medicaid receives the provider's completed enrollment packet if the provider requests enrollment after one hundred twenty (120) days of the issuance of the Medicare Tie-in Notice.

Source: 42 USC § 1396a; 42 CFR Part 491; Miss. Code Ann. §§ 43-13-117, 43-13-118, 43-13-121, 43-13-129.

History: Revised eff. 06/01/2015. Revised eff. 07/01/2014.

Rule 1.2: Service Limits

A. The Division of Medicaid limits reimbursement to an FQHC and FQHC look-alike to no more than four (4) encounters per beneficiary per day, provided that each encounter represents a different provider type, as the Division of Medicaid only reimburses for one (1) medically necessary encounter per beneficiary per day for each of the following provider types:

1. A physician, physician assistant, nurse practitioner, or nurse midwife,

2. A dentist,

3. An optometrist, or

4. A clinical psychologist or clinical social worker.

B. An exception to Miss. Admin. Code Part 211, Rule 1.2.A. is when the beneficiary suffers an injury or illness requiring additional diagnosis or treatment subsequent to the first encounter.

Source: 42 CFR § 440.230; Miss. Code Ann. § 43-13-121; SPA 2013-032.

History: Revised to correspond with SPA 2013-032 (eff. 11/01/2013) eff. 06/01/2015.

Rule 1.3: Covered Services and Non-Covered Services

The Division of Medicaid defines an FQHC or FQHC look-alike encounter as a face-to-face visit for the provision of services provided by physicians, physician assistants, nurse practitioners, clinical psychologists, dentists, optometrists, ophthalmologists and clinical social workers.

1. An FQHC's or FQHC look-alike's encounter rate covers the beneficiary's visit to the FQHC or FQHC look-alike, which is inclusive of all services and supplies and drugs and biologicals which are not usually self-administered by the beneficiary, furnished as an incident to a professional service.

2. The FQHC or FQHC look-alike cannot refer the beneficiary to another provider that will bill the Division of Medicaid for the covered service, supply, drug or biological which is included in the FQHC's or FQHC look-alike's encounter.

3. Drugs are included in the encounter rate, if purchased at a discounted price through a discount agreement.

B. The Division of Medicaid covers ambulatory services performed by an FQHC or FQHC look-alike employee or contractual worker for an FQHC or an FQHC look-alike beneficiary at multiple sites, including, but not limited to:

1. The FQHC or FQHC look-alike,

2. A skilled nursing facility,

3. A nursing facility, or

4. Other institution used as a beneficiary's home.

C. The Division of Medicaid covers an outside laboratory for lab services outside the encounter rate.

D. The Division of Medicaid does not cover:

1. FQHC or FQHC look-alike services when performed in an inpatient or outpatient hospital setting.

2. The cost of a subdermal implant as a separate service.

Source: 42 CFR Part 491; Miss. Code Ann. 43-13-121.

History: Revised eff. 06/01/2015.

Rule 1.4: Pregnancy-Related Eligibles

The Division of Medicaid covers women who are eligible for Medicaid only because of pregnancy for full Medicaid benefits during the course of their pregnancy and for sixty (60) days following delivery including any remaining days in the month in which the sixtieth (60th) day occurs.

Source: 42 CFR § 435.116, Part 491; Miss. Code Ann. § 43-13-121; SPA 13-0019.

History: Revised to correspond with SPA 13-0019 (eff. 01/01/2014) eff. 06/01/2015.

Rule 1.5: Reimbursement Methodology

A. The Division of Medicaid uses the Prospective Payment System (PPS) method and an alternate payment methodology of reimbursement for Federally Qualified Health Centers (FQHCs) and FQHC look-alikes which include:

1. A PPS rate per encounter as described below:

a) For services provided on and after January 1, 2001, during calendar year 2001, payment for services shall be calculated, on a per visit basis, in an amount equal to one hundred percent (100%) of the average of the FQHC's or FQHC look-alike's reasonable costs of providing Medicaid covered services during fiscal years 1999 and 2000. The average rate will be computed from the FQHC or FQHC look-alike Medicaid cost reports by applying a forty percent (40%) weight to fiscal year 1999 and a sixty percent (60%) weight to fiscal year 2000 and adding those rates together. If an FQHC or FQHC look-alike first qualifies during fiscal year 2000, the rate will

only be computed from the fiscal year 2000 Medicaid cost report. The PPS baseline calculation shall include the cost of all Medicaid covered services including other ambulatory services that were previously paid under a fee-for-service basis. This rate will be adjusted to take into account any increase or decrease in the scope of services furnished by the FQHC or FQHC look-alike during fiscal year 2001.

b) Payment rates may be adjusted by the Division of Medicaid pursuant to changes in federal and/or state laws or regulations.

c) Beginning in calendar year 2002, and for each calendar year thereafter, the FQHC or FQHC look-alike is entitled to the payment amount, on a per visit basis, to which the FQHC or FQHC look-alike was entitled to in the previous year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services for that calendar year, and adjusted to take into account any increase or decrease in the scope of services furnished by the FQHC or FQHC look-alike during that calendar year. The rate will be retroactively adjusted to reflect the MEI.

d) New centers that qualify for the FQHC or FQHC look-alike program after January 1, 2001, will be reimbursed the initial PPS rate which will be based on the rates established for other FQHCs and FQHC look-alikes located in the same or adjacent area with a similar caseload. In the absence of a comparable FQHC or FQHC look-alike, the rate for the new provider will be based on projected costs. After the FQHC's or FQHC look-alike's initial year, a Medicaid cost report must be filed in accordance with the State Plan. The cost report will be desk reviewed and a rate will be calculated in an amount equal to one hundred percent (100%) of the FQHC's or FQHC look-alike's reasonable costs of providing Medicaid covered services. The FQHC or FQHC look-alike may be subject to a retroactive adjustment based on the difference between projected and actual allowable costs. Claims payments will be adjusted retroactive to the effective date of the original rate. For each subsequent calendar year, the payment rate will be equal to the rate established in the preceding calendar year, increased by the percentage increase in the MEI for primary care services that is published in the Federal Register in the 4th quarter of the preceding calendar year.

2. An alternate payment methodology, effective November 1, 2013, which is an additional fee for certain services provided outside the Division of Medicaid's regularly scheduled office hours.

a) The Division of Medicaid defines regularly scheduled office hours as the hours between 8:00 a.m. and 5:00 p.m., Monday through Friday, excluding Saturday, Sunday and federal and state holidays, referred to in Miss. Admin. Code, Part 211, Rule 1.5.A.2. as "office hours".

b) The Division of Medicaid permits FQHCs and FQHC look-alikes to set regularly scheduled office hours outside of the Division of Medicaid's definition of office hours, referred to in Miss. Admin. Code, Part 211, Rule 1.5.A.2. as "FQHC or FQHC

look-alike established office hours".

c) The FQHCs and FQHC look-alikes must maintain records indicating FQHC and FQHC look-alike established office hours and any changes including:

1) The date of the change,

2) The FQHC and FQHC look-alike established office hours prior to the change, and

3) The new FQHC and FQHC look-alike established office hours.

d) The Division of Medicaid reimburses a fee in addition to the encounter rate when the encounter:

1) Occurs during the FQHC or FQHC look-alike established office hours which are set outside of the Division of Medicaid's definition of office hours, or

2) Occurs outside of office hours or the FQHC or FQHC look-alike 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 provider established office hours.

e) The Division of Medicaid reimburses only the appropriate encounter rate for an encounter scheduled during office hours or FQHC and FQHC look-alike established office hours but not occurring until after office hours or FQHC and FQHC look-alike established office hours.

3. An additional fee per completed transmission, for telehealth services provided by the FQHC and FQHC look-alike acting as the originating site, which meets the requirements in Miss. Admin. Code Part 225, Chapter 1, effective January 1, 2015.

B. All services provided in an inpatient hospital setting, outpatient hospital setting or a hospital's emergency room will be reimbursed on a fee-for-service basis. If a physician employed by an FQHC or FQHC look-alike provides physician services at an inpatient, outpatient, or emergency room hospital setting, the services must be billed under the individual physician's Medicaid provider number and payment will be made directly to the physician. The financial arrangement between the physician and the FQHC or FQHC look-alike must be handled through an agreement.

C. An FQHC or FQHC look-alike must request an adjustment to its PPS rate whenever there is a documented change in the scope of services. The adjustment will be granted only if the change in scope of services results in at least a five percent (5%) increase or decrease in the center's PPS rate for the calendar year in which the change in scope of service took place.

1. The Division of Medicaid defines a change in the scope of service as a change in the type, intensity, duration and/or amount of service including:

a) The addition of a new service, including, but not limited to, dental, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), optometry, obstetrics/gynecology (OB/GYN), laboratory, radiology, pharmacy, outreach, case management, transportation, which were not previously provided by the FQHC or FQHC look-alike, and/or

b) The elimination of an existing service provided by the FQHC or FQHC look-alike.

2. A change in the scope of service does not mean:

a) The addition or reduction of staff members to or from an existing service, and/or

b) An increase or decrease in the number of encounters.

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

4. It is the responsibility of the FQHC or FQHC look-alike to notify the Division of Medicaid of any change in the scope of service and provide required documentation to support the rate change. Such required documentation should include, at minimum, a detailed working trial balance demonstrating the increase or decrease in the FQHC's or FQHC look-alike's PPS rate as a result of the change in scope of service. The Division of Medicaid may require the FQHC or FQHC look-alike 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 may also request additional information as it sees fit in order to sufficiently determine whether any change in scope of service has occurred.

D. Cost Reports

1. All FQHCs and FQHC look-alikes must submit to the Division of Medicaid a copy of their Medicare cost report for information purposes using the appropriate Medicare forms postmarked on or before the last day of the fifth (5^{th}) month following the close of its Medicare cost reporting year. All filing requirements must be the same as for Title XVIII. When the due date of the cost report falls on a weekend or State of Mississippi or federal holiday, the cost report is due on the following business day. Extensions of time for filing cost reports will not be granted by the Division of Medicaid except for those supported by written notification of the extension granted by Title XVIII. Cost reports must be prepared in accordance with the policy for reimbursement of FQHCs and FQHC look-alikes. The FQHC's or FQHC look-alike's cost report must include information on all satellite FQHCs or FQHC look-alikes.

2. If the Medicare cost report is not received within thirty (30) days of the due date, payment of claims will be suspended until receipt of the required report. This penalty can only be waived by the Executive Director of the Division of Medicaid.

3. An FQHC or FQHC look-alike that does not file a Medicare cost report within six (6) calendar months after the close of its Medicare cost reporting year may be subject to cancellation of its provider agreement at the Division of Medicaid's discretion.

Source: 42 CFR Part 491; Miss. Code Ann. § 43-13-121; SPA 2013-032; SPA 15-003.

History: Added Miss. Admin. Code Part 212, Rule 1.5.A.3. to correspond with SPA 15-003 (eff. 01/01/2015) eff. 12/01/2015; Revised to correspond with SPA 2013-032 (eff. 11/01/2013) eff. 06/01/2015.

Rule 1.6: Documentation Requirements

The Division of Medicaid requires FQHCs and FQHC look-alikes to maintain auditable records that substantiate the services provided. At a minimum, the records must contain the following on each beneficiary:

A. Date of service,

B. Beneficiary's presenting complaint,

C. Provider's findings,

D. Treatment rendered, and

E. Provider's signature.

Source: 42 CFR Part 491; Miss. Code Ann. § 43-13-121.

History: Revised eff. 06/01/2015.

Rule 1.7: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121.