PUBLIC NOTICE

April 14, 2016

Pursuant to 42 C.F.R. Section 447.205, public notice is hereby given to the submission of a Medicaid State Plan Amendment (SPA). The Division of Medicaid, in the Office of the Governor, is submitting SPA 16-0013 Federally Qualified Health Centers (FQHC) Scope of Service to clarify the definition of a change in scope of service and the procedure for submitting a request for a rate adjustment due to a change in scope of service with an effective date of May 1, 2016. This proposed SPA also includes language for the reimbursement of telehealth services in an FQHC as approved in SPA 15-003 Telehealth Services effective January 1, 2015, our Transmittal #16-0013.

1. Mississippi Medicaid SPA 16-0013 FQHC Scope of Service clarifies the definition of a change in the scope of service and the procedure for submitting a request for a rate adjustment due to a change in the scope of service. This proposed SPA also includes language for the reimbursement of telehealth services in an FQHC as approved in SPA 15-003 Telehealth Services.

2. The expected annual aggregate expenditure is $0.00.

3. This SPA is being submitted in order to comply with federal Medicaid regulations. 42 C.F.R. § 447.201 requires the Division of Medicaid to submit a SPA describing the policy and methods used in setting payment rates for each type of service included in the Mississippi State Plan.

4. A copy of the proposed SPA will be available in each county health department office and in the Department of Human Services office in Issaquena County for review.

5. Written comments will be received by the Division of Medicaid, Office of the Governor, Office of Policy, Walter Sillers Building, Suite 1000, 550 High Street, Jackson, Mississippi 39201, or Margaret.Wilson@medicaid.ms.gov for thirty (30) days from the date of publication of this notice. Comments will be available for public review at the above address and on the Division of Medicaid's website at www.medicaid.ms.gov.

6. A public hearing on this SPA will not be held.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPES OF CARE

Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes

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 Federally Qualified Health Centers (FQHCs) and FQHC look-alikes operating in the State of Mississippi. All FQHCs and FQHC look-alikes shall be 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 FQHC and FQHC look-alike providers at a prospective payment rate per encounter and~~, effective November 1, 2013, for~~ an additional ~~payment~~ fee for certain services ~~during extended hours~~.

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 provide for payment for core services and other ambulatory services provided by ~~federally qualified health centers~~FQHCs or FQHC look-alikes at a prospective payment rate per encounter. The rate shall be calculated (on a per visit basis) in an amount equal to one hundred percent (100%) of the average of the center's 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.The average rate will be computed from FQHC and 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. For centers that qualified for Medicaid participation during fiscal year 2000, their prospective payment rate will only be computed from the fiscal year 2000 Medicaid cost report.

For services furnished during calendar year 2002 and each subsequent calendar year, the payment rate shall be 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 (4^{th}) 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 Centers

For new centers that qualify for the FQHC and FQHC look-alike program after January 1, 2001, the initial prospective payment (PPS) rate shall be based on the rates established for other centers located in the same or adjacent area with a similar caseload. In the absence of such a FQHC or FQHC look-alike, the rate for the new provider will be based on projected costs. After the FQHC or FQHC look-alike's initial year, a Medicaid cost report must be filed in accordance with this plan. The cost report will be desk reviewed and a rate shall be calculated in an amount equal to one hundred percent (100%) of the FQHC 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 shall be 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 (4^{th}) quarter of the preceding calendar year.

C. Alternate Payment Methodology

In addition to the PPS rate, FQHCs and FQHC look-alikes will receive an additional fee for the following services:

1. C~~c~~ertain services provided during or after ~~after normal~~ the FQHC or FQHC look-alike established office hours, which are set outside of the Division of Medicaid's definition of office hours ~~operating hours~~ when

billing claims with codes 99050 ~~and~~ or 99051 according to Miss. Admin. Code Part 211.

2. Telehealth services provided by the FQHC or FQHC look-alike as the originating site provider. The FQHC or FQHC look-alike will receive the originating site facility fee per completed transmission when billing claims with code Q3014. The FQHC or FQHC look-alike may not bill for an encounter visit unless a separately identifiable service is performed.

A listing of these services may be viewed at www.medicaid.ms.gov/ FeeScheduleLists.aspx. The services will be paid at the existing fee-for-service rate on the MS Medicaid Physician Fee Schedule.

D. Change in Scope of Services

The Division of Medicaid may adjust ~~A~~a~~n~~ FQHC or FQHC look-alike's ~~must request an adjustment to its~~ PPS rate whenever there is a valid and 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 5% increase or decrease in the center's cost for the calendar year in which the change in scope of service took place.~~ A change in the scope of services is defined as the occurrence of one or more of the following qualifying events: ~~a change in the type, intensity, duration and/or amount of services as follows:~~

1. A change in the type of health care services that the FQHC or FQHC look-alike provides due to:

   a) ~~1.~~ The addition of a new service not previously provided by the FQHC or FQHC look-alike, ~~such as,~~including, but not limited to, dental, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), optometry, obstetrics and gynecology (OB/GYN), laboratory, radiology, pharmacy, outreach, case management, or transportation, ~~etc.,~~ or

   b) ~~2.~~ The elimination of an existing service provided by the FQHC or FQHC look-alike.

2. A change in the intensity of health care services demonstrated by an increase or decrease in the total quantity of labor and materials consumed by an individual client during an average encounter or a change in the types of patients served.

3. A change in the duration of health care represented by an increase or decrease in the length of an average encounter.

4. A change in the amount of health care services provided by the FQHC or FQHC look-alike in an average encounter.

~~However, a~~ 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 constitute a change in the scope of services. Also, a change in the cost of a service is not considered in and of itself a change in the scope of services.

FQHCs and FQHC look-alikes must submit a request for an adjustment to its PPS rate no later than one hundred eighty (180) days after the close of the FQHC or FQHC look-alike's first full fiscal year of operation with the change in scope of services. The request must include the first cost report that includes twelve (12) months of costs for the new service. The adjustment may 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 FQHC or FQHC look-alike'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 42 CFR Part 405, Subpart X, or applicable federal regulation.

It is the responsibility of the FQHC or FQHC look-alike to notify the Division of Medicaid of any change in the scope of services and provide ~~the~~ 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 FQHC or FQHC look-alike's PPS rate as a result of the change in scope of services. The Division of Medicaid will require the

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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 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 cannot exceed the cost per visit from the most recent audited cost report.

Example:

~~Anytown Family Health Center~~

~~PPS base year or last scope of service change: 07/01/1999 – 06/30/2000~~
~~Calendar Year in which scope of service change took place: 02/1/2009 – 12/31/2009~~

~~Cost Period~~	~~Allowable Costs~~	~~Medicaid Visits~~		~~Cost Per Visit~~
~~07/01/99–06/30/00~~	~~$802,202~~	~~8,830~~	~~/~~	~~$90.85~~
~~02/01/09 – 01/31/2010~~	~~$867,262~~	~~9,140~~	~~/~~	~~$94.89~~
~~Increase~~	~~$65,060~~	~~310~~		~~$ 4.04~~

~~Percentage increase in costs = 7% (65,060 ÷ 867,262 × 100)~~

~~Medicaid PPS rate for January 1, 2009 through December 31, 2009:~~	~~$106.80~~
~~Increase due to Scope of Service~~	~~$ 4.04~~
~~Rate increase due to Medicare Economic Index (MEI= 1.20%)~~	~~$ 1.28~~
~~**Medicaid PPS rate for January 1, 2010 thru December 31, 2010**~~	~~**$112.12**~~

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Anytown Family Health Center
Rate Adjustment Due To Scope of Service Change

Change in scope of service implemented January 1, 2013
Fiscal year prior to change in scope of services: 10/1/2011 - 9/30/2012
First full fiscal year of operation with the new service: 10/1/2013 - 9/30/2014

	Fiscal year prior to change in scope	Full year of costs for new service	Prior year cost + cost of new service
	FYE 9/30/2012	**FYE 9/30/2014**	
Total Allowable Costs	730,145	194,084	924,229
Total Visits	9,200	1,200	10,400
Cost per visit	$ 79.36		$ 88.87
Increase in cost per visit	$ 9.51		
Medicaid PPS rate for Calendar Year 2014 (existing PPS rate)	$ 87.43		
Percentage increase in existing PPS rate	**10.88%**		

Medicaid PPS Rate for January 1, 2014 through December 31, 2014	$	87.43
Increase in cost per visit due to scope of service change		9.51
Amended Medicaid PPS Rate for January 1, 2014 through December 31, 2014	**$**	**96.94**

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