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

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 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 RHC providers at a prospective payment rate per encounter and~~, effective November 1, 2013, for~~ an additional ~~payment~~ fee for certain services~~. during extended hours not to overlap the hours of the physician's practice office hours co-located within the RHC.~~

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 RHCs~~rural health clinics~~ 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 ~~clinic's~~ RHC'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. For ~~clinics~~ RHCs that qualified for Medicaid participation during fiscal year 2000, their prospective payment rate for fiscal year 2001 shall be calculated (on a per visit basis) in an amount equal to one hundred percent (100%) of the average of the ~~clinic's~~ RHC's 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 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 Clinics

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

The ~~clinic~~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 ~~clinic's~~ 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 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.

If an ~~clinic~~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 ~~clinic~~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.

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C. Alternate Payment Methodology

In addition to the PPS rate, RHCs will receive an additional fee for the following services:

1. Ceertain services provided ~~after normal RHC operating hours~~ during or after the RHC established office hours, which are set outside of the Division of Medicaid's definition of office hours when billing claims with codes 99050 ~~and~~ or 99051 according to Miss. Admin. Code Title 23, Part 212.

2. 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.

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 of Ownership

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

E. Change in 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 ~~An RHC must request an adjustment to its~~ PPS rate ~~whenever~~ if the following criteria are met: ~~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 5% increase or decrease in the clinic's PPS rate for the calendar year in which the change in scope of service took place.~~

- The RHC can demonstrate that there is a valid and documented change in the scope of services.
- 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.
- All previous changes in scope of services were properly reported to the Division of Medicaid by the RHC.

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 RHC provides due to:

   a) ~~a.~~The addition of a new service not previously provided by the RHC, ~~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) ~~b.~~The elimination of an existing service provided by the RHC.

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.

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4. A change in the amount of health care services provided by the RHC 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.

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 42 CFR Part 405, Subpart X, or applicable federal regulation.

It is the responsibility of the RHC 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 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 cannot exceed the cost per visit from the most recent audited cost report.

Example:

Anytown Family Health Clinic experienced one of the qualifying events outlined in II. E. above and submitted the appropriate supporting documentation.

~~Anytown Family Medical Clinic~~

~~Fiscal Year Prior to Scope of Service Change: 1/1/2003 – 12/31/2003~~
~~Calendar Year in which scope of service change took place: 1/1/2004 – 12/31/2004~~

~~Cost Period~~		~~Allowable Costs~~	~~Medicaid Visits~~	~~Cost Per Visit~~
~~1/1/2003~~	~~12/31/2003~~	~~$730,145.00~~	~~9,200~~	~~$79.36~~
~~1/1/2004~~	~~12/31/2004~~	~~$924,229.00~~	~~10,400~~	~~$88.87~~
~~Increase~~		~~$194,084.00~~	~~1,200~~	~~$ 9.51~~

~~Percentage increase in costs = 27% (194,084 ÷ 730,145 × 100)~~

~~Medicaid PPS rate for January 1, 2004 thru December 31, 2004:~~	~~$81.66~~
~~PPS rate including scope of service change:~~	~~$ 9.51~~
~~PPS rate adjusted for scope of service change:~~	~~$91.17~~
~~Add: Rate increase for Calendar Year 2005 (MEI = 3.1%)~~	~~2.83~~
~~Medicaid PPS rate for January 1, 2005 thru December 31, 2005~~	**~~$94.00~~**

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Anytown Family Health Clinic
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

Ln #		*Column 1*	*Column 2*	*Column 3*
		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**	
1	Total Allowable Costs	730,145	194,084	924,229
2	Total Visits	9,200	1,200	10,400
3	Cost per visit	$ 79.36		$ 88.87
4	Increase in cost per visit *(column 3 - column 1)*			$ 9.51
5	Medicaid PPS rate for Calendar Year 2014 *(existing PPS rate)*			$ 87.43
	Percentage increase in existing PPS rate *(Ln 4 / Ln 5)**			**10.88%**

**Meets 5% threshold required for rate adjustment.*

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**

F. Change in Status

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

G. 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). The following types and items of cost are included in allowable costs to the extent that they are covered and reasonable:

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II. Payment Methodology

This state plan provides for reimbursement to RHC providers at a prospective payment rate per encounter and an additional fee for certain services.

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 RHCs 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 RHC'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. For RHCs that qualified for Medicaid participation during fiscal year 2000, their prospective payment rate for fiscal year 2001 shall be calculated (on a per visit basis) in an amount equal to 100% of the average of the RHC's reasonable costs of Medicaid covered services provided during fiscal year 2000.

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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 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 rate for the new provider will be based on projected costs.

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