

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. 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.

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 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 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 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 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.

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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.

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 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 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

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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

RHCs acting in the role of a telehealth originating site provider with no other separately identifiable service being provided will only be paid the 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/#.

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.

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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).