PUBLIC NOTICE

June 29, 2018

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 18-0012 Federally Qualified Health Center (FQHC) Physician Administered Drugs. Effective July 1, 2018 and contingent upon approval from the Centers for Medicare and Medicaid Services (CMS), the Division of Medicaid will begin reimbursing FQHCs outside of the encounter rate for the administration of physician administered drugs covered and reimbursed through the pharmacy benefit.

1. Mississippi Medicaid SPA 18-0012 FQHC Physician Administered Drugs is being submitted to allow FQHCs to receive reimbursement outside of the encounter rate for the administration of physician administered drugs covered and reimbursed through the pharmacy benefit.

2. The Division of Medicaid expects to realize a savings in expenditures due to the increased beneficiary access to, but not limited to, long-acting reversible contraceptives (LARCs), pregnancy maintaining agents, injectable atypical antipsychotics agents, and chemical dependency treatment agents.

3. The Division of Medicaid is submitting SPA 18-0012 to comply with 42 C.F.R. § 447.201 which requires a SPA which describes 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. A hard copy can be downloaded and printed from www.medicaid.ms.gov or may be requested at Margaret.Wilson@medicaid.ms.gov or 601-359-2081.

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.

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 reasonable costs of providing Medicaid covered services. The FQHC 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. Alternative Payment Methodology

1. The Division of Medicaid reimburses an FQHC a fee in addition to the encounter rate when billing with codes 99050 or 99051 when the encounter occurs: (1) during the FQHC'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 FQHC 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 FQHC 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 FQHC an additional fee for telehealth services provided by the FQHC as the originating site provider. The FQHC will receive the originating site facility fee per completed transmission when billing claims with code Q3014. The FQHC 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. The Division of Medicaid reimburses an FQHC an additional fee for the administration of a physician administered drug (PAD) which is covered and reimbursed under the pharmacy benefit. The FQHC may not bill for an encounter visit unless a separately identifiable service is performed. The administration fee will 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/#.

D. Fee-For-Service

1. FQHCs acting in the role of an 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 https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

2. FQHCs administering physician administered drugs covered and reimbursed through the pharmacy benefit with no other separately identifiable service being provided will only be paid the administration fee and will not receive reimbursement for an encounter. This service will 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/#.

E. 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 shall 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) of the SSA; 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 FQHC 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 FQHC PPS rate if the following criteria are met: (1) the FQHC 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 FQHC PPS rate for the calendar year in which the change in scope of service took place.

A change in the scope of services generally 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 generally 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 FQHC must submit a request for an adjustment to its PPS rate no later than one hundred eighty (180) days after the settlement date of FQHC Medicare final settlement cost report for the FQHC'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 FQHC 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 FQHC 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 FQHC PPS rate as a result of the change in scope of services. The Division of Medicaid will require the FQHC 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 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.

F. 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).

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 reasonable costs of providing Medicaid covered services. The FQHC 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. Alternative Payment Methodology

1. The Division of Medicaid reimburses an FQHC a fee in addition to the encounter rate when billing with codes 99050 or 99051 when the encounter occurs: (1) during the FQHC'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 FQHC 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 FQHC 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 FQHC an additional fee for telehealth services provided by the FQHC as the originating site provider. The FQHC will receive the originating site facility fee per completed transmission when billing claims with code Q3014. The FQHC 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. The Division of Medicaid reimburses an FQHC an additional fee for the administration of a physician administered drug (PAD) which is covered and reimbursed under the pharmacy benefit. The FQHC may not bill for an encounter visit unless a separately identifiable service is performed. The administration fee will 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/#.

D. Fee-For-Service

1. FQHCs acting in the role of an 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 https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

2. FQHCs administering physician administered drugs covered and reimbursed through the pharmacy benefit with no other separately identifiable service being provided will only be paid the administration fee and will not receive reimbursement for an encounter. This service will 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/#.

E. 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 shall 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) of the SSA; 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 FQHC 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 FQHC PPS rate if the following criteria are met: (1) the FQHC 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 FQHC PPS rate for the calendar year in which the change in scope of service took place.

A change in the scope of services generally 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 generally 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 FQHC must submit a request for an adjustment to its PPS rate no later than one hundred eighty (180) days after the settlement date of FQHC Medicare final settlement cost report for the FQHC'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 FQHC 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 FQHC 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 FQHC PPS rate as a result of the change in scope of services. The Division of Medicaid will require the FQHC 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 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.

F. 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).