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).

G. Cost Reports

All FQHCs must submit to the Division of Medicaid a copy of their Medicare cost report using the appropriate Medicare forms on or before the last day of the fifth (5th) month following the close of its Medicare cost-reporting year. All filing requirements shall be the same as for Title XVIII. Cost reports must be submitted by the specified due date, in order to avoid a penalty in the amount of fifty dollars ($50.00) per day for each day the cost report is delinquent. This penalty can only be waived by the Executive Director of the Division of Medicaid. 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 XVII. Cost reports must be prepared in accordance with the State Plan for reimbursement of FQHCs. The FQHCs cost report should include information on all satellite FQHCs.

An FQHC that does not submit its Medicare cost report within six (6) calendar months after the close of its Medicare cost reporting year may be subject to suspension of the payment of claims and termination of its provider agreement at the Division of Medicaid's discretion.

H. Where to File

The Cost report and related information must be uploaded electronically to the cost report database as designated by the Division of Medicaid.

I. Other Correspondence

Other correspondence to and from the Division of Medicaid must be uploaded electronically to the cost report database as designated by the Division of Medicaid.

J. Out-Of-State Providers

The Division of Medicaid does not enroll out-of-state providers to provide FQHC services, except in those circumstances specified at 42 CFR 431.52.

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