Administrative Code

Title 23: Medicaid
Part 212
Rural Health Clinics

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Part 212: Rural Health Clinics

Part 212 Chapter 1: General

Rule 1.1: Provider Enrollment Requirements

A. To participate as a Rural Health Clinic (RHC) in the Medicaid program, an organization must be approved by the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) as an RHC.

B. RHC providers must comply with the requirements set forth in Miss. Admin. Code Part 200, Rule 4.8 for all providers in addition to the specific provider type requirements outlined below:

1. National Provider Identifier (NPI), verification from the National Plan and Provider Enumeration System (NPPES),

2. A copy of the interim rate notice or current rate letter from CMS,

3. Copy of the nurse practitioner's protocol and license to practice. If the nurse practitioner is not enrolled with the Division of Medicaid as a provider, the nurse practitioner must complete a provider application and obtain an individual provider number, and

4. Clinical Laboratory Improvement Amendments (CLIA) Information form and current CLIA certificate, if applicable.

C. Medicaid payments may not be made to any organization prior to the date of approval and execution of a valid Medicaid provider agreement.

D. The effective date of the Medicaid provider enrollment will be:

1. The date of Medicare certification if the provider requests enrollment in the Medicaid program within one hundred twenty (120) days from the date the Medicare Tie-in Notice was issued to the provider, or

2. The first day of the month in which the Division of Medicaid receives the provider's completed enrollment packet if the provider requests enrollment after one hundred twenty (120) days of the issuance of the Medicare Tie-in Notice.

E. The Division of Medicaid does not enroll out-of-state providers to provide RHC services, except in those circumstances specified in federal regulation.

Source: 42 C.F.R. Part 455, Subpart E; 42 C.F.R. Part 491; 42 C.F.R. §§ 431.52, 440.20; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with SPA 18-0013 (eff. 07/01/2018) eff. 06/01/2019. Revised eff. 07/01/2014. Updated Miss. Admin. Code Part 212, Rule 1.1A. 05/01/13 to include 04/01/2012 compilation omission.

Rule 1.2: Service Limits

A. The Division of Medicaid limits reimbursement to a Rural Health Clinic (RHC) to no more than four (4) encounters per beneficiary per day, provided that each encounter represents a different provider type, as the Division of Medicaid only reimburses for one (1) medically necessary encounter per beneficiary per day for each of the following provider types:

   1. A physician, physician assistant, nurse practitioner, or nurse midwife,

   2. A dentist,

   3. An optometrist, or

   4. A clinical psychologist, a Licensed Clinical Social Worker (LCSW), or Licensed Professional Counselors (LPCs) and/or Board Certified Behavior Analysts (BCBAs).

B. An exception to Miss. Admin. Code Part 212, Rule 1.2.A. is when the beneficiary suffers an injury or illness requiring additional diagnosis or treatment subsequent to the first encounter.

Source: 42 C.F.R. § 440.230; Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 18-0013, SPA 2013-033.

History: Revised to correspond with SPA 2018-0013 (eff. 07/01/2018) eff. 06/01/2019. Revised to correspond with SPA 2013-033 (eff. 11/01/2013) eff. 06/01/2015.

Rule 1.3: Covered and Non-Covered Services

A. The Division of Medicaid defines a Rural Health Clinic (RHC) encounter as a face-to-face visit for the provision of services provided by Mississippi licensed physicians, physician assistants, nurse practitioners, nurse midwives, dentists, optometrists, clinical psychologists, Licensed Clinical Social Workers (LCSWs), Licensed Professional Counselors (LPCs) and/or Board Certified Behavior Analysts (BCBAs) acting within their scope of practice.

   1. An RHC's encounter rate covers the beneficiary's visit to the RHC, which is inclusive of all services and supplies and drugs and biologicals which are not usually self-administered by the beneficiary, furnished as an incident to a professional service.

   2. The RHC cannot refer the beneficiary to another provider that will bill the Division of Medicaid for the covered service, supply, drug or biological which is included in the RHC's encounter.

3. Drugs are included in the encounter rate, if purchased at a discounted price through a discount agreement except for Clinician Administered Drugs and Implantable Drug System Devices (CADD).

B. The Division of Medicaid defines Clinician Administered Drugs and Implantable Drug System Devices (CADD) as certain physician-administered drugs, with limited distribution or limited access for beneficiaries and administered in an appropriate clinical setting, which may be reimbursed under the pharmacy benefit to the extent the CADDs were not included in the calculation of the FQHC's encounter rate, as determined by the Division of Medicaid.

1. The Division of Medicaid covers certain CADD drugs which are listed on the Division of Medicaid's website.

2. CADD drugs do not count toward monthly prescription drug limits applicable to covered outpatient drugs.

C. The Division of Medicaid covers ambulatory services performed by an RHC employee or contractual worker for an RHC beneficiary at multiple sites, including, but not limited to:

1. The RHC,

2. A skilled nursing facility,

3. A nursing facility, or

4. Other institution used as a beneficiary's home.

D. An RHC must provide the following six (6) laboratory services on site. These services are included in the encounter rate:

1. Chemical examinations of urine by stick or tablet method or both, including urine ketones,

2. Hemoglobin or hematocrit,

3. Blood glucose,

4. Examination of stool specimens for occult blood,

5. Pregnancy tests, and

6. Primary culturing for transmittal to a certified laboratory.

E. If the RHC performs only the six (6) tests listed in Miss. Admin. Code Part 212, Rule 1.3.D., a waiver certificate from the regional Clinical Laboratory Improvement Amendments (CLIA) office must be obtained. If an RHC provides other laboratory tests on site, the RHC must

comply with all CLIA requirements for the laboratory services actually provided.

F. The Division of Medicaid reimburses an outside laboratory for laboratory services not listed in Miss. Admin. Code Part 212, Rule 1.3.D. separate from the encounter rate.

G. The Division of Medicaid does not cover RHC services when performed in an inpatient or outpatient hospital setting.

H. Diabetes Self-Management Training (DSMT) is a covered service that is included in the encounter rate for a core service for an RHC, but is not considered a core service.

Source: OBRA (1990) § 4161; 42 C.F.R. Part 491; 42 C.F.R. § 440.20; Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 18-0013, SPA 2013-033.

History: Revised to correspond with SPA 2018-0013 (eff. 07/01/2018) eff. 06/01/2019. Revised eff. 06/01/2015.

Rule 1.4: Reimbursement Methodology

The Division of Medicaid reimburses Rural Health Clinic (RHC) providers at a prospective payment rate (PPS) per encounter and/or alternative payment methodology.

A. The Division of Medicaid uses the PPS methodology for reimbursement to RHC providers per encounter as described below:

1. For services provided on and after January 1, 2001, during calendar year 2001, payment for services 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 the Division of Medicaid covered services during fiscal years 1999 and 2000. If an RHC first enrolls during fiscal year 2000, the rate will only be computed from the fiscal year 2000 Medicaid cost report. The PPS baseline calculation shall include the cost of all Medicaid covered services including other ambulatory services that were previously paid under a fee-for-service basis. This rate will be adjusted to take into account any increase or decrease in the scope of services furnished by the RHC during fiscal year 2001.

2. Payment rates may be adjusted by the Division of Medicaid pursuant to changes in federal and/or state laws or regulations.

3. Beginning in calendar year 2002, and for each calendar year thereafter, the RHC is entitled to the payment amount, on a per visit basis, to which the RHC was entitled to in the previous year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services for that calendar year, and adjusted to take into account any increase or decrease in the scope of services furnished by the RHC during that calendar year. The rate will be retroactively adjusted to reflect the MEI.

4. New clinics that qualify for the RHC program after January 1, 2001, will be reimbursed the initial PPS rate which will be based on the rates established for other RHCs located in the same or adjacent area with a similar caseload. In the absence of comparable 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 will be equal to the rate established in the preceding calendar year, increased by the percentage increase in the MEI for primary care services that is published in the Federal Register in the fourth (4^{th}) quarter of the preceding calendar year.

B. The Division of Medicaid reimburses no more than four (4) encounters per beneficiary per day, provided that each encounter represents a different provider type, as the Division of Medicaid only reimburses for one (1) medically necessary encounter per beneficiary per day for each of the provider types listed in Miss. Admin. Code, Title 23, Part 212, Rule 1.2.A. except if the beneficiary experiences an illness or injury requiring additional diagnosis or treatment subsequent to the first encounter.

C. An alternative payment methodology is an additional fee for certain services provided by the RHC.

1. The Division of Medicaid reimburses an RHC a fee in addition to the encounter rate when certain services are provided outside the Division of Medicaid's regularly scheduled office hours.

a) The Division of Medicaid defines regularly scheduled office hours as the hours between 8:00 a.m. and 5:00 p.m., Monday through Friday, excluding Saturday, Sunday and federal and state holidays, referred to in Miss. Admin. Code, Part 212, Rule 1.4.B.1. as "office hours".

b) The Division of Medicaid permits RHCs to set regularly scheduled office hours outside of the Division of Medicaid's definition of office hours, referred to in Miss. Admin. Code, Part 212, Rule 1.4.C.1. as "RHC established office hours".

c) The RHC must maintain records indicating RHC established office hours and any changes including:

1) The date of the change,

2) The RHC established office hours prior to the change, and

3) The new RHC established office hours.

d) The Division of Medicaid reimburses a fee in addition to the encounter rate when the encounter occurs:

1) During the RHC's established office hours which are set outside of the Division of Medicaid's office hours, or

2) Outside of the Division of Medicaid's office hours or the RHC's 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.

e) The Division of Medicaid reimburses only the appropriate encounter rate for an encounter scheduled during office hours or RHC's established office hours but not occurring until after office hours or RHC established office hours.

2. The Division of Medicaid reimburses an RHC a fee per completed transmission, for telehealth services provided by the RHC acting as the originating site provider, which meets the requirements in Miss. Admin. Code Part 225, Chapter 1, effective January 1, 2015. The RHC may not bill for an encounter visit unless a separately identifiable service is performed. The originating site facility fee will be paid at the existing fee-for-service rate.

3. If an RHC's base year cost report is amended, the RHC's PPS base rate will be adjusted based 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

1. RHCs acting in the role of a telehealth originating site provider with no other separately identifiable service provided will only be paid the telehealth originating site facility fee per completed transmission and will not receive reimbursement for an encounter. The originating site facility fee will be paid at the existing fee-for-service rate.

2. The Division of Medicaid reimburses an RHC the encounter rate for the administration, insertion, and/or removal of certain categories of physician administered drugs (PADs), referred to as Clinician Administered Drug and Implantable Drug System Devices (CADDs), reimbursed under the pharmacy benefit to the extent the CADDs were not included in the calculation of the RHC's encounter rate.

a) CADDs are located on the Division of Medicaid's website.

b) CADDs not included on the Division of Medicaid's list of CADD-classified drugs will be denied if billed through the pharmacy point-of-sale (POS).

E. All services provided in an inpatient hospital setting, outpatient hospital setting, or a hospital's emergency room will be reimbursed on a fee-for-service basis. If a physician employed by an RHC provides physician services at an inpatient, outpatient, or emergency room hospital setting, the services must be billed under the individual physician's Medicaid provider number and payment will be made directly to the physician. The financial arrangement between the physician and the RHC must be handled through an agreement.

F. The Division of Medicaid defines a change in the scope of service as a change in the type, intensity, duration and/or amount of services.

1. A change in the scope of services occurs if:

a) The RHC has added or has dropped any services that meets the definition of an RHC service as provided in federal regulations, and

b) The service is included as a covered Medicaid service under the Mississippi Medicaid state plan.

c) A change in the intensity could be a change in the amount of health care services provided by the RHC in an average encounter.

2. A change in the scope of service does not mean:

a) The addition or reduction of staff members to or from an existing service, and/or

b) An increase or decrease in the number of encounters.

c) A change in the cost of a service is not considered in and of itself a change in the scope of service.

3. 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 PPS rate if the following criteria are met:

a) The RHC can demonstrate there is a valid and documented change in the scope of services, and

b) The change in scope of services results in at least a five percent (5%) increase or decrease in the RHC PPS rate for the calendar year in which the change in scope of service took place.

4. 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 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 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 federal regulations.

5. It is the responsibility of the RHC to notify the Division of Medicaid of any change in the scope of service(s) and provide the required proper and valid documentation to support the rate change. Such required documentation must include, at 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 service(s). 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 service(s) has occurred. The instructions and forms for submitting a request due to a change in scope of services can be found on the Division of Medicaid's website.

6. 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.

7. The RHC PPS rate will not be adjusted solely for a change in ownership status between freestanding and provider-based.

G. Cost Reports

1. All RHCs must submit to the Division of Medicaid a copy of their Medicare cost report for information purposes using the appropriate Medicare forms postmarked on or before the last day of the fifth (5^{th}) month following the close of its Medicare cost-reporting year. All filing requirements shall be the same as for Title XVIII. 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 XVIII. Cost reports must be prepared in accordance with the State Plan for reimbursement of RHCs. The RHC's cost report should include information on all satellite RHCs.

2. If the Medicare cost report is not received within thirty (30) days of the due date, payment of claims will be suspended until receipt of the required report. This penalty can only be waived by the Executive Director of the Division of Medicaid.

3. An RHC that does not file a Medicare cost report within six (6) calendar months after the close of its Medicare cost reporting year may be subject to cancellation of its provider agreement at the Division of Medicaid's discretion.

H. 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).

Source: OBRA (1990) § 4161; 42 U.S.C. § 1396d; 42 C.F.R. Part 491; 42 C.F.R. §§ 440.20, 447.371; 45 C.F.R. Part 75; Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 18-0013, SPA 2016-0014, SPA 2015-003, SPA 2013-033.

History: Revised to correspond with SPA 2018-0013 (eff. 07/01/18), 2016-0014 (eff. 05/01/16) eff. 06/01/2019. Added Miss. Admin. Code Part 212, Rule 1.4.A.3. to correspond with SPA 2015-003 (eff. 01/01/2015) eff. 12/01/2015; Revised to correspond with SPA 2013-033 (eff. 11/01/13) eff. 06/01/2015.

Rule 1.5: Documentation Requirements

The Division of Medicaid requires Rural Health Clinics (RHCs) to maintain auditable records that will substantiate the services provided. At a minimum, the records must contain the following on each patient:

A. Date of service,

B. Beneficiary's presenting complaint,

C. Provider's findings,

D. Treatment rendered, and

E. Provider's signature.

Source: 42 C.F.R. Part 491; 42 C.F.R. § 440.20; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 06/01/19.

Rule 1.6: Co-Mingling

A. The Division of Medicaid does not allow co-mingling which is defined as the simultaneous operation of a Rural Health Clinic (RHC) and another physician practice where the two (2) practices share:

1. Hours of operation,

2. Use of the space,

3. Professional staff,

4. Equipment,

5. Supplies, and

6. Other resources.

B. Physicians and non-physician practitioners cannot operate a private Medicare or Medicaid practice during RHC hours of operation using the RHC's resources.

Source: 42 C.F.R. Part 491; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 06/01/19

Rule 1.7: Pregnancy Related Eligibles

The Division of Medicaid covers women who are eligible for Medicaid only because of pregnancy for full Medicaid benefits during the course of their pregnancy and for sixty (60) days following delivery including any remaining days in the month in which the sixtieth (60th) day occurs.

Source: 42 C.F.R. Part 491; 42 C.F.R. §§ 435.116, 440.20; Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 2013-0019.

History: Revised to correspond with SPA 2013-0019 (eff. 01/01/2014) eff. 06/01/2015.

Rule 1.8: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121.