

**State of Mississippi**

**DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF  
MEDICAL CARE AND SERVICES PROVIDED**

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**2b. Rural Health Clinic Services:**

Rural Health Clinic (RHC) services are limited to those services provided in rural health clinics as described in the Social Security Act, Section 1861 (aa). RHC services also include services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant, nurse practitioner or nurse midwife, and, for visiting nurse care, related medical supplies other than drugs and biologicals. Limitations on other ambulatory services furnished in the RHC are the same limitations as defined for those services in the state plan.

In order to participate in a Rural Health Clinic Program, a clinic must meet the certification requirements of 42 CFR 491 Subpart A and have an approved agreement to participate in the Medicaid program.

**Scope of Services**

**A. Staffing Requirements**

1. The RHC staff must include one or more physicians and one or more physician assistants or nurse practitioners.
2. The physician, physician assistant, nurse practitioner, nurse-midwife, clinical social worker, or clinical psychologist may be an owner or an employee of the clinic, or may furnish services under contract to the clinic.
3. The staff may also include ancillary personnel who are supervised by the professional staff. The staff must be sufficient to provide the services essential to the operation of the clinic.
4. The RHC must have a physician, nurse practitioner, physician assistant, nurse-midwife, clinical social worker, or clinical psychologist available at all times to furnish patient care services during the clinic's hours of operation. The RHC must also have a nurse practitioner, physician assistant, or certified nurse midwife available to furnish patient care services at least 60 percent of the time the RHC operates.
5. The physician must provide medical direction for the clinic's health care activities and consultation for, and medical supervision of, the health care staff.

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**C. Visits**

1. Encounter

A visit at an RHC can be a medical visit or an “other health” visit. A medical visit is a face-to-face encounter between a clinic patient and a physician, physician assistant, nurse practitioner, or nurse midwife. An “other health” visit is a face-to-face encounter between a clinic patient and a clinical psychologist, clinical social worker, or other health professional for mental health services. Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day and at a single location constitute a single visit, except when the following circumstances occur:

- a. After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment.
- b. The patient has a medical visit and a visit with a mental health professional, a dentist, or an optometrist. In these instances, the clinic is paid for more than one encounter on the same day.

2. Hospital and Nursing Home Visits

RHC services are not covered when performed in a hospital (inpatient or outpatient). A physician employed by an RHC and rendering services to clinic patients in a hospital must file under his own individual provider number. Nursing home visits will be reimbursed at the RHC PPS rate.

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**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 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 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 100% of the average of the clinic'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 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 clinic'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 4<sup>th</sup> quarter of the preceding calendar year. Adjustments to the PPS rate for the increase or decrease in scope of services are reflected

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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 (PPS) rate shall be based on the rates established for other clinics located in the same or adjacent area with a similar caseload. In the absence of such clinics, the rate for the new provider will be based on projected costs.

The clinic'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 100% of the clinic'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 MEI for primary care services that is published in the Federal Register in the 4<sup>th</sup> quarter of the preceding calendar year.

If a clinic'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'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.

**C. Alternate Payment Methodology**

In addition to the PPS rate, RHCs will receive an additional fee for certain services provided after normal RHC operating hours when billing claims with codes 99050 and 99051. A listing of these services may be viewed at [www.medicaid.ms.gov/FeeScheduleLists.aspx](http://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.

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**D. Change of Ownership**

When a rural health clinic 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 PPS rate as a result of a change of ownership.

**E. Change in Scope of Services**

An RHC must request an adjustment to its PPS rate whenever 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. A change in the scope of services is defined as a change in the type, intensity, duration and/or amount of services as follows:

- a. The addition of a new service not previously provided by the RHC, such as, dental, EPSDT, optometry, OB/GYN, laboratory, radiology, pharmacy, outreach, case management, transportation, etc., or
- b. The elimination of an existing service provided by the RHC.

However, 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.

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 documentation to support the rate change. 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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**Example:**

<b>Anytown Family Medical Clinic</b>			
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			
<b>Cost Period</b>	<b>Allowable Costs</b>	<b>Medicaid Visits</b>	<b>Cost Per Visit</b>
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:			<u>\$ 9.51</u>
PPS rate adjusted for scope of service change:			\$91.17
Add: Rate increase for Calendar Year 2005 (MEI = 3.1%)			<u>2.83</u>
<b>Medicaid PPS rate for January 1, 2005 thru December 31, 2005</b>			<b>\$94.00</b>

**F. Change in Status**

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

**G. Allowable Cost**

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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1. Compensation for the services of physicians, nurse practitioners, physician assistants, certified nurse midwives, visiting nurses, qualified clinical psychologists, and clinical social workers employed by the facility.
2. Compensation for the duties that a supervising physician is required to perform.
3. Cost of services and supplies incident to the services of a physician, nurse practitioner, physician assistant, certified nurse midwife, qualified clinical psychologist, or clinical social worker.
4. Overhead costs, including clinic administration, costs applicable to use and maintenance of the facility building and depreciation costs.
5. Costs of services purchased by the clinic.

Other ambulatory services provided by the facility will be included in allowable costs to the extent they are covered by the Medicaid State Plan and are reasonable.