Title 23: Division of Medicaid

Part 212: Rural Health Clinics

Chapter 1: General

Rule 1.4: Reimbursement Methodology

A. The Division of Medicaid uses the Prospective Payment System (PPS) method and an alternate payment methodology of reimbursement for Rural Health Centers (RHCs) which include:

1. A PPS rate per encounter as described below:

a) 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.

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

c) 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.

d) 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 RHC, 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 one hundred percent (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 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. 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.

2. An alternate payment methodology, effective November 1, 2013, which is an additional fee for certain services 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.A.2 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.A.2. 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:

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

      2) Occurs outside of 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 RHC established office hours.

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

3. An additional fee per completed transmission, for telehealth services provided by the RHC acting as the originating site, which meets the requirements in Miss. Admin. Code Part 225, Chapter 1, effective January 1, 2015.

B. 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.

C. 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 five percent (5%) increase or decrease in the clinic's PPS rate for the calendar year in which the change in scope of service took place.

1. 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 including:

a) The addition of a new service, including, but not limited to dental, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), optometry, obstetrics/gynecology (OB/GYN), laboratory, radiology, pharmacy, outreach, case management, transportation, which were not previously provided by the RHC, and/or

b) The elimination of an existing service provided by the RHC.

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.

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

4. It is the responsibility of the RHC to notify the Division of Medicaid of any change in the scope of service(s) and provide required documentation to support the rate change. Such required documentation should 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 may 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 may also request additional information as it sees fit in order to sufficiently determine whether any change in scope of service(s) has occurred.

D. 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.

Source: OBRA (1990) § 4161; 42 CFR §§ 440.20 (b) - (c), 447.371, Part 491; Miss. Code Ann. § 43-13-121; SPA 2013-033; SPA 15-003.

History: Added Miss. Admin. Code Part 212, Rule 1.4.A.3. to correspond with SPA 15-003 (eff. 01/01/2015) eff. 12/01/2015; Revised to correspond with SPA 2013-033 (eff. 11/01/13) eff. 06/01/2015.

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