Title 23: Division of Medicaid

Part 211: Federally Qualified Health Centers

Chapter 1: General

Rule 1.1: Provider Enrollment Requirements

A. To participate as a Federally Qualified Health Center (FQHC) 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 FQHC.

B. FQHC 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. Written confirmation from the IRS confirming provider's tax identification number and noted Legal Business Name, and

3. Medicare Cost Report.

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.

Source: SSA § 1902; 42 CFR Part 491; Miss. Code Ann. §§ 43-13-117, 118, 121, 129.

History: Revised eff. 07/01/2014.