

Title 23: Division of Medicaid

Part 211: Federally Qualified Health Centers

Part 211 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.
- E. The Division of Medicaid does not enroll out-of-state providers to provide FQHC services, except in those circumstance 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; Miss. Code Ann. §§ 43-13-117, 43-13-118, 43-13-121.

History: Revised to correspond with SPA 2018-0012 (eff. 07/01/2018) eff. 06/01/2019. Revised eff. 06/01/2015. Revised eff. 07/01/2014.

Rule 1.2: Service Limits

- A. The Division of Medicaid limits reimbursement to a Federally Qualified Health Center (FQHC) 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, Licensed Clinical Social Worker (LCSW), or other health professional for mental health services.
- B. An exception to Miss. Admin. Code Part 211, 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. Part 491; 42 C.F.R. § 440.230; Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 2018-0012, SPA 2013-032.

History: Revised to correspond with SPA 2018-0012 (eff. 07/01/2018) eff. 06/01/2019. Revised to correspond with SPA 2013-032 (eff. 11/01/2013) eff. 06/01/2015.

Rule 1.3: Covered Services and Non-Covered Services

- A. The Division of Medicaid defines a Federally Qualified Health Center (FQHC) 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 FQHC's encounter rate covers the beneficiary's visit to the FQHC, 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 FQHC 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 FQHC'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. Do not count toward monthly prescription drug limits applicable to covered outpatient drugs.
- C. The Division of Medicaid covers ambulatory services performed by an FQHC employee or contractual worker for an FQHC beneficiary at multiple sites, including, but not limited to:
1. The FQHC,
 2. A skilled nursing facility,
 3. A nursing facility, or
 4. Other institution used as a beneficiary's home.
- D. The Division of Medicaid covers an outside laboratory for lab services separate from the encounter rate.
- E. The Division of Medicaid does not cover FQHC services when performed in an inpatient or outpatient hospital setting.
- F. Diabetes Self-Management Training (DSMT) is covered in the encounter rate for a core service for an FQHC but an encounter is not covered solely for DSMT.

Source: 42 C.F.R. Part 491; Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 2018-0012.

History: Revised to correspond with SPA 2018-0012 (eff.07/01/2018) eff. 06/01/2019. Revised eff. 06/01/2015.

Rule 1.4: 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; Miss. Code Ann. §§ 43-13-117, 43-13-121;

SPA 2013-0019.

History: Revised to correspond with SPA 13-0019 (eff. 01/01/2014) eff. 06/01/2015.

Rule 1.5: Reimbursement Methodology

The Division of Medicaid reimburses Federally Qualified Health Center (FQHC) providers at a prospective payment rate (PPS) per encounter and/or an alternative payment methodology (APM).

- A. The Division of Medicaid uses the PPS methodology for reimbursement to FQHC 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 FQHC's reasonable costs of providing Medicaid covered services during fiscal years 1999 and 2000. The average rate will be computed from the FQHC Medicaid cost reports by applying a forty percent (40%) weight to fiscal year 1999 and a sixty percent (60%) weight to fiscal year 2000 and adding those rates together. If an FQHC first qualifies 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 FQHC 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 FQHC is entitled to the payment amount, on a per visit basis, to which the FQHC 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 FQHC during that calendar year. The rate will be retroactively adjusted to reflect the MEI.
 4. New centers that qualify for the FQHC program after January 1, 2001, will be reimbursed the initial PPS rate which will be based on the rates established for other FQHCs located in the same or adjacent area with a similar caseload. In the absence of a comparable FQHC, the rate for the new provider will be based on projected costs. After the FQHC's initial year, a Medicaid cost report must be filed in accordance with the State Plan. The cost report will be desk reviewed and a rate will be calculated in an amount equal to one hundred percent (100%) of the FQHC's reasonable costs of providing Medicaid covered services. The FQHC may be subject to a retroactive adjustment based on the difference between projected and actual allowable costs. Claims payments will be adjusted retroactive to the effective date of the original 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 (4th) 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 211, 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 (APM) is an additional fee for certain services provided by the FQHC.
 - 1. The Division of Medicaid reimburses an FQHC 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 211, Rule 1.5.B.1. as "office hours".
 - b) To set regularly scheduled office hours outside of the Division of Medicaid's definition of office hours, referred to in Miss. Admin. Code, Part 211, Rule 1.5.B.1. as "FQHC established office hours".
 - c) The FQHC must maintain records indicating FQHC established office hours and any changes including:
 - 1) The date of the change,
 - 2) The FQHC established office hours prior to the change, and
 - 3) The new FQHC established office hours.
 - d) The Division of Medicaid reimburses a fee in addition to the encounter rate when the encounter occurs:
 - 1) During the FQHC's established office hours which are set outside of the Division of Medicaid's definition of office hours, or
 - 2) Outside of the Division of Medicaid's office hours or the FQHC'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 FQHC established office hours.

- e) The Division of Medicaid reimburses only the appropriate encounter rate for an encounter scheduled during office hours or FQHC's established office hours but not occurring until after office hours or FQHC established office hours.
2. The Division of Medicaid reimburses an FQHC a fee per completed transmission, for telehealth services provided by the FQHC acting as the originating site provider, which meets the requirements in Miss. Admin. Code Part 225, Chapter 1, effective January 1, 2015. The FQHC 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.

D. Fee-For-Service

1. FQHCs acting in the role of an originating site provider with no other separately identifiable service being 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 FQHC 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 FQHC'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 FQHC 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 FQHC 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 shall occur if:
 - a) The FQHC has added or has dropped any services that meets the definition of an FQHC 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 FQHC 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 FQHC 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 service. The Division of Medicaid will adjust an FQHC PPS rate if the following criteria are met:
- a) The FQHC 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 FQHC PPS rate for the calendar year in which the change in scope of service took place.
4. An FQHC must submit a request for an adjustment to its PPS rate no later than one hundred eighty (180) days after the settlement date of FQHC Medicare final settlement cost report for the FQHC'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 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 federal regulations.
5. It is the responsibility of the FQHC to notify the Division of Medicaid of any change in the scope of service 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 FQHC's PPS rate as a result of the change in scope of service. 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 service(s) has occurred.

The instructions and forms for submitting a request due to a change in scope of services located 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.

G. Cost Reports

1. All FQHCs 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 (5th) month following the close of its Medicare cost reporting year. All filing requirements must 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 policy for reimbursement of FQHCs. The FQHC's cost report must include information on all satellite FQHCs.
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 FQHC 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: 42 U.S. Code § 1396d; 42 C.F.R. Part 491; Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 2018-0012, SPA 2016-0013, SPA 15-003, SPA 2013-032.

History: Revised to correspond with SPA 2018-0012 (eff. 07/01/18) eff. 06/01/2019. Added Miss. Admin. Code Part 212, Rule 1.5.A.3. to correspond with SPA 15-003 (eff. 01/01/2015) eff. 12/01/2015; Revised to correspond with SPA 2013-032 (eff. 11/01/2013) eff. 06/01/2015.

Rule 1.6: Documentation Requirements

The Division of Medicaid requires Federally Qualified Health Centers (FQHCs) to maintain auditable records that substantiate the services provided. At a minimum, the records must contain

the following on each beneficiary:

- 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; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 06/01/2019; Revised eff. 06/01/2015.

Rule 1.7: 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: 42 C.F.R. Part 491; 42 C.F.R. § 440.345; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 06/01/2019.

Title 23: Division of Medicaid

Part 211: Federally Qualified Health Centers

Part 211 Chapter 1: General

Rule 1.1: Provider Enrollment Requirements

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- 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.
- E. The Division of Medicaid does not enroll out-of-state providers to provide FQHC services, except in those circumstance 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; Miss. Code Ann. §§ 43-13-117, 43-13-118, 43-13-121.

History: Revised to correspond with SPA 2018-0012 (eff. 07/01/2018) eff. 06/01/2019. Revised eff. 06/01/2015. Revised eff. 07/01/2014.

Rule 1.2: Service Limits

- A. The Division of Medicaid limits reimbursement to a Federally Qualified Health Center (FQHC) 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:
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 2. A dentist,
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- B. An exception to Miss. Admin. Code Part 211, 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. Part 491; 42 C.F.R. § 440.230; Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 2018-0012, SPA 2013-032.

History: Revised to correspond with SPA 2018-0012 (eff. 07/01/2018) eff. 06/01/2019. Revised to correspond with SPA 2013-032 (eff. 11/01/2013) eff. 06/01/2015.

Rule 1.3: Covered Services and Non-Covered Services

- A. The Division of Medicaid defines a Federally Qualified Health Center (FQHC) 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, and clinical psychologists, Licensed Clinical Social Workers (LCSWs), Licensed Professional Counselors (LPCs) and/or Board Certified Behavior Analysts (BCBAs) acting within their scope of practice. ~~or other health professionals for mental health services.~~
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 2. The FQHC 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 FQHC'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. Do not count toward monthly prescription drug limits applicable to covered outpatient drugs.
- C. The Division of Medicaid covers ambulatory services performed by an FQHC employee or contractual worker for an FQHC beneficiary at multiple sites, including, but not limited to:
1. The FQHC,
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- E. The Division of Medicaid does not cover FQHC services when performed in an inpatient or outpatient hospital setting.
- F. Diabetes Self-Management Training (DSMT) is covered in the encounter rate for a core service for an FQHC but an encounter is not covered solely for DSMT.

Source: 42 C.F.R. Part 491; Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 2018-0012.

History: Revised to correspond with SPA 2018-0012 (eff.07/01/2018) eff. 06/01/2019. Revised eff. 06/01/2015.

Rule 1.4: 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; Miss. Code Ann. §§ 43-13-117, 43-13-121;

SPA 2013-0019.

History: Revised to correspond with SPA 13-0019 (eff. 01/01/2014) eff. 06/01/2015.

Rule 1.5: Reimbursement Methodology

The Division of Medicaid reimburses Federally Qualified Health Center (FQHC) providers at a prospective payment rate (PPS) per encounter and/or an alternative payment methodology (APM).

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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 (4th) quarter of the preceding calendar year.

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D. Fee-For-Service

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- b) The service is included as a covered Medicaid service under the Mississippi Medicaid state plan.
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- 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 FQHC 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 service. The Division of Medicaid will adjust an FQHC PPS rate if the following criteria are met:
- a) The FQHC 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 FQHC PPS rate for the calendar year in which the change in scope of service took place.
4. An FQHC must submit a request for an adjustment to its PPS rate no later than one hundred eighty (180) days after the settlement date of FQHC Medicare final settlement cost report for the FQHC'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 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 federal regulations.
5. It is the responsibility of the FQHC to notify the Division of Medicaid of any change in the scope of service 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 FQHC's PPS rate as a result of the change in scope of service. 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 service(s) has occurred.

The instructions and forms for submitting a request due to a change in scope of services located 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.

G. Cost Reports

1. All FQHCs 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 (5th) month following the close of its Medicare cost reporting year. All filing requirements must 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 policy for reimbursement of FQHCs. The FQHC's cost report must include information on all satellite FQHCs.
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 FQHC 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: 42 U.S. Code § 1396d; 42 C.F.R. Part 491; Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 2018-0012, SPA 2016-0013, SPA 15-003, SPA 2013-032.

History: Revised to correspond with SPA 2018-0012 (eff. 07/01/18) eff. 06/01/2019. Added Miss. Admin. Code Part 212, Rule 1.5.A.3. to correspond with SPA 15-003 (eff. 01/01/2015) eff. 12/01/2015; Revised to correspond with SPA 2013-032 (eff. 11/01/2013) eff. 06/01/2015.

Rule 1.6: Documentation Requirements

The Division of Medicaid requires Federally Qualified Health Centers (FQHCs) to maintain auditable records that substantiate the services provided. At a minimum, the records must contain

the following on each beneficiary:

- 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; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 06/01/2019; Revised eff. 06/01/2015.

Rule 1.7: 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: 42 C.F.R. Part 491; 42 C.F.R. § 440.345; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 06/01/2019.