

Title 23: Division of Medicaid

Part 212: Rural Health Clinics

Part 212 Chapter 1: General

Rule 1.1: Definitions

The Division of Medicaid defines:

- A. Rural Health Clinic as a provider that has been designated a Rural Health Clinic by the Centers for Medicare and Medicaid Services (CMS) and for purposes of this policy includes both provider-based rural health clinics and freestanding rural health clinics.
 - 1. Free Standing Rural Health Clinic as an independent clinic owned by a provider or a provider entity that does not qualify for, or have not sought, provider-based status, as designated by CMS.
 - 2. Provider-Based Rural Health Clinic as a rural health clinic that is owned and operated as an essential part of a hospital, nursing home, or home health agency, as designated by CMS.
- B. A Rural Health Clinic (RHC) encounter as a face-to-face visit for the provision of services provided by physicians, physician assistants, nurse practitioners, nurse midwives, dentists, optometrists, clinical psychologists, Licensed Clinical Social Workers (LCSWs), Licensed Professional Counselors (LPCs), Licensed Marriage and Family Therapists (LMFTs), and Board Certified Behavioral Analysts (BCBAs).
- C. An encounter rate as a prospective payment system (PPS) rate per encounter.
- D. 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 were not included in the calculation of the RHC's PPS rate, as determined by the Division of Medicaid.
- E. 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 meet the definition of an RHC service as provided in federal regulations.
 - b) The service is included as a covered Medicaid service under the Mississippi Medicaid State Plan.
 - c) A change in the intensity is a change in the amount of health care services provided by

the RHC during 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.
- 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.

F. Allowable costs as costs that:

1. Result from providing covered services,
2. Are reasonable in amount and are necessary for the efficient delivery of those services,
3. Include the direct cost center component (i.e., salaries and supplies) of providing the covered services, and
4. Are an allocated portion of overhead (i.e., administration and facility).

G. Co-mingling as the simultaneous operation of an 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.

H. Off-site screening as a screening that is provided by employees of a medical facility at a location other than the medical facility's permanent physical address.

I. Medical facility as an RHC.

1. The medical facility is limited to an RHC and must have:
 - a) A permanent location, and

b) A published telephone number.

2. The RHC must have regularly scheduled hours of operation which are posted in the facility.

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 20-0007 (eff. 08/01/2020) eff. 11/01/2020; 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: Provider 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.

a) 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.

b) If the RHC provides other laboratory tests on site, the RHC must comply with all CLIA requirements for the laboratory services actually provided.

C. An RHC must provide the following six (6) laboratory services on site which are included in the PPS 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.
- D. The Division of Medicaid does not allow co-mingling.
- E. Physicians and non-physician practitioners cannot operate a private Medicare or Medicaid practice during RHC hours of operation using the RHC's resources.
- F. 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.
- G. The Division of Medicaid does not enroll out-of-state providers to provide RHC services, except as described in Miss. Admin. Code Part 200, Rule 4.2 B.
- H. RHC mobile units must be surveyed by the Mississippi Department of Health (MSDH) and receive an approval letter from the Centers for Medicare and Medicaid Services (CMS) prior to providing services.
1. All federal and state requirements for RHC mobile units must be met.
 2. The mobile unit must have a fixed set of locations where the unit is scheduled to be providing services at specified dates and times.
 - a) Locations for RHC mobile unit services must meet the rural and shortage area requirements at the time of survey.
 - b) The schedule of times and locations must be posted on the mobile unit and publicized by other means so that beneficiaries will know the mobile unit's schedule in advance.
 3. NPs must remain within a seventy-five (75) mile distance from the primary physician.
- I. Off-site Early, Periodic Screening, Diagnosis and Treatment (EPSDT) screening providers must submit the following information to the Division of Medicaid and cannot begin at an off-site location until an approval has been authorized in writing by the Division of Medicaid:

1. A completed and signed secondary location form documenting the off-site provider's ability to complete all age appropriate components of EPSDT screenings.
2. An attestation that the EPSDT screenings will be completed by an approved EPSDT screening provider who has completed the Division of Medicaid's EPSDT provider agreement and that all required equipment and supplies are available at the off-site location.
3. A signed agreement between the off-site location authority including, but not limited to, a school superintendent, principal, day care director, and the screening provider.
4. A list of all physical addresses of the off-site locations where the EPSDT screenings will be provided and a monthly schedule for each location designating the dates and times the EPSDT screenings will be offered.
5. Information packet materials including, but not limited to, letters, consent forms, and examples of anticipatory guidance information sheets to be provided which must be prior approved by the Division of Medicaid.
6. A copy of the provider's Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or CLIA number.

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

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Rule 1.3: Covered Services

- 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 type of visit, as the Division of Medicaid only reimburses for one (1) medically necessary encounter per beneficiary per day for each of the following visit:
1. Medical,
 2. Mental health,
 3. Dental, or
 4. Vision.

- B. Visits with more than one (1) health professional and multiple visits with the same health professional that take place on the same day at a single location constitute a single encounter, except when the beneficiary:
 - 1. Suffers an illness or injury subsequent to the first visit that requires additional diagnosis or treatment on the same day, or
 - 2. Has multiple visit types on the same day.
- C. An RHC's PPS 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.
 - 1. 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.
 - 2. Drugs are included in the PPS rate, if purchased at a discounted price through a discount agreement except for Clinician Administered Drugs and Implantable Drug System Devices (CADD).
- D. The Division of Medicaid covers CADD drugs separately from an RHC encounter.
 - 1. CADD drugs 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.
 - 3. CADD drugs do not have a copay.
- E. The Division of Medicaid covers ambulatory services performed by an RHC employee or contractual worker for an RHC beneficiary at the following sites:
 - 1. The RHC,
 - 2. A skilled nursing facility,
 - 3. A nursing facility, or
 - 4. Beneficiary's residence.
- F. The Division of Medicaid covers the services of an outside laboratory for laboratory services not listed in Miss. Admin. Code Part 212, Rule 1.2.C. separate from the encounter rate.
- G. The Division of Medicaid covers the delivery of RHC services in a school-based clinic operated by an RHC and staffed with a physician, nurse practitioner and/or physician assistant.

H. The Division of Medicaid covers off-site Early and Periodic Screening, Diagnosis and Treatment (EPSDT) well-child screenings at a school, daycare center, or head start center when the following are met:

1. Must be performed by a physician, nurse practitioner, and/or nurse practitioner employed by the RHC,
2. Provided only within the county or within forty (40) miles of the county where the RHC is located,
3. Develop and adhere to confidentiality policies that are approved by the Division of Medicaid.
4. Ensure medical personnel performing the physical examination are limited to Mississippi Medicaid enrolled physicians, nurse practitioners or physician assistants employed by the RHC.
5. Complete all age appropriate components of the EPSDT well-child screening during one (1) visit or encounter.
6. Have a designated well-lit private room to perform the EPSDT screening assessments which must be in close proximity to:
 - a) Hot and cold running water, and
 - b) A bathroom.
7. Obtain written parental/guardian consent:
 - a) The written consent must contain the following statements:
 - 1) Parent/guardian's right to be present during EPSDT screenings,
 - 2) The physical examination will be unclothed,
 - 3) The EPSDT screenings will take the place of the yearly wellness exam performed at the beneficiary's primary care provider's office, and
 - 4) Vaccines will be administered, if applicable,
 - b) Must include a space for the parent/guardian signature and date giving approval for the EPSDT screenings to be performed, and
 - c) Must be received within sixty (60) days prior to the EPSDT screenings.

8. Encourage the parent/guardian to be present during the EPSDT screenings,
9. Follow-up with the parent/guardian on the results of the screening by mail or in a one-on-one meeting.
10. Utilize the anticipatory guidance materials that are:
 - a) Age appropriate.
 - b) Mailed to the parent/guardian for beneficiaries under the age of fourteen (14).
 - c) Given to beneficiaries fourteen (14) years of age and above.
11. The settings and screenings must meet the requirements as outlined in Miss. Admin. Code Part 223.
 - I. RHC mobile units are covered services when the requirements of Miss. Admin. Code Title 23, Part 212, Rule 1.2 are met.
 - J. Diabetes Self-Management Training (DSMT) is a covered service that is included in the PPS rate for a core service for an RHC but is not considered a core service.
 - K. Vaccine administration is a covered service that is included in the PPS rate for a core service for an RHC but is not considered a core service.
 - L. The Division of Medicaid covers the following group therapy per beneficiary participating in a group therapy session:
 1. Group psychotherapy,
 2. Group adaptive behavior services, and
 3. Prenatal and postpartum education.

Source: 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 20-0007 (eff. 08/01/2020) eff. 11/01/2020; Revised to correspond with SPA 2018-0013 (eff. 07/01/2018) eff. 06/01/2019. Revised eff. 06/01/2015.

Rule 1.4: Non-Covered Services

- A. The Division of Medicaid does not reimburse an RHC for services when performed in an inpatient or outpatient hospital setting. If a physician is employed by an RHC and provides services in a hospital setting, the RHC is prohibited from billing for these services. The

physician must bill under the physician's individual Medicaid provider number or group physician Medicaid provider number.

B. The Division of Medicaid does not consider the following as an encounter:

1. Vaccine administration, and/or
2. Diabetes Self-Management Training (DSMT).

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

Rule 1.5: Reimbursement

The Division of Medicaid reimburses Rural Health Clinic (RHC) providers at a prospective payment system (PPS) rate 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 a 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 (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 212, Rule 1.2.A. except if the beneficiary experiences an illness or injury requiring additional diagnosis or treatment subsequent to the first encounter.
 - 1. Services provided by a nurse practitioner (NP) or physician assistant (PA) are reimbursed the full PPS rate.
 - 2. RHC services provided by an RHC physician, NP, or PA at a nursing facility are reimbursed as an encounter.

- C. An alternative payment methodology is an additional fee for certain services provided by the RHC.
 - 1. The Division of Medicaid reimburses a RHC a fee in addition to the PPS 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 PPS 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 PPS 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 a 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 a 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. RHCs providing EPSDT well-child screenings will be reimbursed at the lower of the RHC's PPS rate or the current applicable MS Medicaid fee-for-service rate for the screening. The provider must bill indicating the place of service is in a school.
3. The Division of Medicaid does not reimburse for services other than EPSDT well-child screenings in an off-site location.
4. The Division of Medicaid reimburses an RHC the PPS 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 PPS 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).
5. The Division of Medicaid reimburses RHCs at the current applicable MS Medicaid fee-for-service rate per beneficiary participating in a group therapy session. The following are covered group services:
- a) Group Psychotherapy,
 - b) Group adaptive behavior services, and
 - c) Prenatal and postpartum education.
- 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. Change in the Scope of Services
- 1. 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.
 - 2. 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.

3. 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.
4. 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.
5. 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 (5th) 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. Medicaid payments are not be made to any organization prior to the date of approval and execution of a valid Medicaid provider agreement.

I. The Division of Medicaid reimburses an outside laboratory for laboratory services not listed

in Miss. Admin. Code Part 212, Rule 1.2.C. separate from the PPS rate.

Source: 42 U.S.C. 1396d; 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.

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Rule 1.6: Documentation Requirements

The Division of Medicaid requires Rural Health Clinics (RHCs) to maintain auditable records that will substantiate the services provided in accordance with Miss. Admin. Code Title 23, Part 200, Rule 1.3. 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. § 440.20; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with SPA 20-0007 (eff. 08/01/2020) eff. 11/01/2020; Revised eff. 06/01/19.

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

History: Renamed rule eff. 11/01/2020.