RURAL HEALTH CLINICS

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 following PPS methodology and does not provide for an alternative payment methodology for RHC providers.

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 4th quarter of the preceding calendar year. 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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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 assigned by the provider's Medicare intermediary will be used as an interim rate (on a per visit basis).

If the Medicare rate is used to set an interim rate, then 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 rate 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, using the annualized Medicaid visits from the clinic's initial cost report period, DOM will compare the annualized Medicaid payments based on the initial period Medicare final settlement cost report and the annualized Medicaid payments based on the first full year Medicare final settlement cost report. If the annualized Medicaid payments using the first full year cost report differs from the annualized Medicaid payments using the initial period cost report by $10,000 or more, then the rate from the first full year cost report will be used as the clinic's base rate.

Example:

Anytown Family Medical Clinic

Initial Cost Reporting Period: 6/1/2002 – 12/31/2002
Total Medicaid visits *(6/1/2002 – 12/31/2002)* = 750
Annualized Medicaid Visits = 1286 *(750 visits ÷ 7 months × 12)*

Cost Reporting Period	Allowable Cost Per Visit	X	Annualized Medicaid Visits	=	Annualized Medicaid Payments
6/1/2002 – 12/31/2002	$83.00	X	1286	=	$106,738.00
1/1/2003 – 12/31/2003	$75.00	X	1286	=	$ 96,450.00
Difference					$ 10,288.00
PPS Base Rate					$ 75.00

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 4th 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. Clinics Participating In a Managed Care Organization

In the case of a rural health clinic that participates in a managed care organization for Mississippi Medicaid services, the managed care organization shall reimburse the rural health clinic at the same encounter rate that the clinic is entitled to under the prospective payment system. In addition, if the rural health clinic is entitled to a rate adjustment based on a final settlement cost report or a change in scope of services, the managed care organization shall retroactively adjust the clinic's rate for the applicable rate period and adjust claims accordingly.

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

A 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.

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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.

Example:

Anytown Family Medical Clinic

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

Cost Period	**Allowable Costs**	**Medicaid Visits**	**Cost Per Visit**
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:	$ 9.51
PPS rate adjusted for scope of service change:	$91.17
Add: Rate increase for Calendar Year 2005 (MEI = 3.1%)	2.83
Medicaid PPS rate for January 1, 2005 thru December 31, 2005	**$94.00**

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 Costs

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:

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.

H. Visits

Encounter

A visit at a 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:

1. After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment.

2. 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.

Hospital and Nursing Home Visits
RHC services are not covered when performed in a hospital (inpatient or outpatient). A physician employed by a 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.

III. Reporting Requirements

Each RHC participating in the Medicaid program shall submit an electronic copy of their "as filed" Medicare cost report in PDF format to the Division of Medicaid. The cost report should be postmarked on or before the last day of the fifth month following the close of its Medicare cost reporting year. The year-end adopted for this plan shall be the same as for Title XVIII. All other filing requirements shall be the same as for Title XVIII. Should the due date fall on a weekend, a State of Mississippi holiday or a federal holiday, the due date shall be the first business day following such weekend or holiday. Extensions of time for filing the cost report will only be granted by the Division of Medicaid for those extensions supported by written notification granted by Title XVIII.

The Medicare cost report should be mailed to:

Bureau of Reimbursement
Division of Medicaid
Suite 1000, Walter Sillers Building
550 High Street
Jackson, Mississippi 39201

If the Medicare cost report is not received within thirty (30) days of the due date, payment of claims may be suspended until receipt of the required report.

To satisfy the reporting requirement, the clinic may submit an amended cost report, only if the report has been accepted by its Medicare intermediary.

IV. Audits of Financial Records

The Division of Medicaid will conduct on-site audits as necessary to verify the accuracy and reasonableness of the financial and statistical information contained in the cost report. Audit adjustments (whether in the provider's favor or not) will be made, if necessary. All adjustments will include written descriptions of the line number on the cost report being adjusted, the reason for the adjustment, the amount of the adjustment, and the applicable section of the State Plan or CMS Pub.15-1.

Overpayments and underpayments that are determined by financial audits of cost reports will result in adjustments for those periods where the PPS rate will be affected.

Overpayments and Underpayments

An overpayment is an amount which is paid by the DOM to a provider in excess of the amount that is correct. Overpayments must be repaid to the DOM within sixty (60) days after the date of discovery. Discovery occurs either (1) on the date the DOM first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery, or (2) on the date a provider acknowledges an overpayment to the DOM in writing, whichever date is earlier. Failure to repay an overpayment to the Division of Medicaid may result in sanctions as described in the following section.

An underpayment occurs when an amount which is paid by the DOM to a provider is less than the amount that is correct. Underpayments will be reimbursed to the provider.

V. Record Keeping Requirements

Providers must maintain adequate financial records and statistical data for proper determination of costs payable under the program. Financial and statistical data must be current, accurate and in sufficient detail to support costs. All required cost reports and supporting files must be maintained for a period of five (5) years after submission. If the provider is the subject of an ongoing audit, the provider must maintain records beyond this five (5) year period. In the event of an ongoing audit, the provider must maintain all cost reports and supporting files until the audit is completed. All financial and statistical records must be made available to the DOM or its contract auditors upon request.

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VI. Appeals and Sanctions

A. Appeal Procedures

RHC providers who disagree with an adjustment to their allowable costs made as a result of an audit or a scope of service determination may file an appeal to the Division of Medicaid. The appeal must be in writing, must include the reason for the appeal, and must be made within thirty (30) calendar days after notification of the adjustment. The Division of Medicaid shall respond within thirty (30) calendar days after the receipt of the appeal.

Notices and responses shall be delivered by certified mail, return receipt requested, overnight delivery by a private carrier, or by hand delivery, and shall be deemed to have been received (a) if by certified mail or overnight mail, on the day the delivery receipt is signed, or (b) if by hand delivery, on the date delivered.

Appeals by RHC providers involving any issues other than those specified above in this section shall be taken in accordance with the administrative hearing procedures set forth in Miss. Code Ann. Section 43-13-121.

B. Grounds for Imposition of Sanctions

Sanctions may be imposed by the DOM against a provider for any one or more of the following reasons:

1. Failure to disclose or make available to the DOM, or its authorized agent, records of services provided to Medicaid recipients and records made therefrom.

2. Failure to provide and maintain quality services to Medicaid recipients within accepted medical community standards as adjudged by the DOM or the Mississippi Department of Health.

3. Breach of the terms of the Medicaid Provider Agreement or failure to comply with the terms of the provider certification as set out on the Medicaid claim form.

4. Documented practice of charging Medicaid recipients for services over and above that paid by the DOM.

5. Failure to correct deficiencies in provider operations after receiving written notice of the deficiencies from the Mississippi State Department of Health, Division of Health Facilities Licensure and Certification.

6. Failure to meet standards required by the State or Federal law for participation.

7. Submission of a false or fraudulent application for provider status.

8. Failure to keep and maintain auditable records as prescribed by the DOM.

9. Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral.

10. Violating a Medicaid recipient's absolute right of freedom of choice of a qualified participating provider of services under the Medicaid program.

11. Failure to repay or make arrangements for the repayment of identified overpayments, or otherwise erroneous payments.

12. Presenting, or causing to be presented, for payment any false or fraudulent claims for services or merchandise.

13. Submitting, or causing to be submitted, false information for the purpose of obtaining greater compensation to which the provider is legally entitled (including charges in excess of the fee schedule as prescribed by the DOM or usual and customary charges as allowed under the DOM regulations).

14. Submitting, or causing to be submitted, false information for the purpose of meeting prior authorization requirements.

15. Exclusion from Medicare because of fraudulent or abusive practices.

16. Conviction of a criminal offense relating to performance of a provider agreement with the State, or for the negligent practice resulting in death or injury to patients.

C. Sanctions

The following sanctions may be invoked against providers based on the grounds specified above:

1. Suspension, reduction, or withholding of payments to a provider;

2. Suspension of participation in the Medicaid program; and/or

3. Disqualification from participation in the Medicaid program.

Under no circumstances shall any financial loss caused by the imposition of any of the above sanctions be passed on to recipients, their families or any other third party.

D. Right to a Hearing

Within thirty (30) calendar days after the date of the notice from the Director of the DOM of the intent to sanction, the provider may request a formal hearing. Such request must be in writing and must contain a statement and be accompanied by supporting documents setting forth the facts which the provider contends places him in compliance with the DOM's regulations or his defenses thereto.

Unless a timely and proper request for a hearing is received by the DOM from the provider, the findings of the DOM shall be considered a final and binding administrative determination.
Suspension or withholding of payments may continue until such time as a final determination is made regarding the appropriateness of the claims or amounts in question.

The hearing will be conducted in accordance with the Procedures for Administrative and Fair Hearings as adopted by the DOM.