State of Mississippi
DESCRIPTION OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

2c. Federally Qualified Health Centers Services:

Federally Qualified Health Centers services are limited to those services provided in federally qualified health centers as described in the Social Security Act, Section 1861 (aa). FQHC services also include services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant, nurse practitioner or nurse midwife, and, for visiting nurse care, related medical supplies other than drugs and biologicals. Limitations on other ambulatory services furnished in the FQHC are the same limitations as defined for those services in the state plan.

A center must meet the conditions set forth in 42 CFR 491 Subpart A and have an approved agreement to participate in the Medicaid program.

Scope of Services

A. Staffing Requirements

1. The FQHC staff must include one or more physicians and one or more physician assistants or nurse practitioners.

2. The physician, physician assistant, nurse practitioner, nurse-midwife, clinical social worker, or clinical psychologist may be an owner or an employee of the clinic, or may furnish services under contract to the center.

3. The staff may also include ancillary personnel who are supervised by the professional staff. The staff must be sufficient to provide the services essential to the operation of the center.

4. The FQHC must have a physician, nurse practitioner, physician assistant, nurse-midwife, clinical social worker, or clinical psychologist available at all times to furnish patient care services during the center's hours of operation. The physician must provide medical direction for the clinic's health care activities and consultation for, and medical supervision of, the health care staff except for services furnished by a clinical psychologist, which state law permits to be provided without physician supervision.

5. The physician, in conjunction with the physician assistant and/or nurse practitioner, must participate in developing, executing, and periodically reviewing the clinic's written policies and the services provided to Medicaid beneficiaries, and must periodically review the center's patient's records, provide medical orders, and provide medical care services to the patients of the center.

6. A physician must be present for sufficient periods of time, at least once in every two week period (except in extraordinary circumstances), to provide the medical direction, medical care services, consultation and supervision and must be available through direct telecommunication for consultation, assistance with medical emergencies, or patient referral. The extraordinary circumstances are to be documented in the records of the center.

7. The FQHC program requires state licensure for physicians and nurses, as well as compliance with state law for all clinical staff credentialing.

8. The FQHC program has no requirements for hospital admitting privileges, but a practice must demonstrate that hospital services are available to patients.

B. Direct Services

Medicaid will reimburse those diagnostic and therapeutic services and supplies that are commonly furnished in a physician's office or at the entry point into the health care system. These include medical history, physical examination, assessment of health status, and treatment for a variety of medical conditions.

C. Visits

1. Encounter

A visit at a FQHC 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:

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

b. 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.

2. Hospital and Nursing Home Visits

FQHC services are not covered when performed in a hospital (inpatient or outpatient). A physician employed by a FQHC 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 FQHC PPS rate.

D. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

The Division of Medicaid covers all medically necessary services for EPSDT-eligible beneficiaries ages birth to twenty-one (21) in accordance with 1905 (a) of the Act, without regard to service limitations and with prior authorization.

Federally Qualified Health Centers (FQHCs)

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 Federally Qualified Health Centers (FQHCs) operating in the State of Mississippi. All FQHCs 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 FQHC providers at a prospective payment rate per encounter and, effective November 1, 2013, for an additional payment for certain services during extended hours.

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 federally qualified health centers 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 center'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.The average rate will be computed from 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. For centers that qualified for Medicaid participation during fiscal year 2000, their prospective payment rate will only be computed from the fiscal year 2000 Medicaid cost report.

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.

B. New Centers

For new centers that qualify for the FQHC program after January 1, 2001, the initial prospective payment (PPS) rate shall be based on the rates established for other centers located in the same or adjacent area with a similar caseload. In the absence of such a 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 this plan. The cost report will be desk reviewed and a rate shall be calculated in an amount equal to 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 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.

C. Alternate Payment Methodology

In addition to the PPS rate, FQHCs will receive an additional fee for certain services provided after normal FQHC operating hours when billing claims with codes 99050 and 99051. A listing of these services may be viewed at www.medicaid.ms.gov/FeeScheduleLists.aspx. The services will be paid at the existing fee-for-service rate on the MS Medicaid Physician Fee Schedule.

D. Change in Scope of Services

An FQHC 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 center's cost 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:

1. The addition of a new service not previously provided by the FQHC, such as, dental,

EPSDT, optometry, OB/GYN, laboratory, radiology, pharmacy, outreach, case management, transportation, etc., or

2. The elimination of an existing service provided by the FQHC.

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 FQHC 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 Health Center

PPS base year or last scope of service change: 07/01/1999 – 06/30/2000
Calendar Year in which scope of service change took place: 02/1/2009 – 12/31/2009

Cost Period	Allowable Costs	Medicaid Visits		Cost Per Visit
07/01/99 -06/30/00	$802,202	8,830	/	$90.85
02/01/09 – 01/31/2010	$867,262	9,140	/	$94.89
Increase	$65,060	310		$ 4.04

Percentage increase in costs = 7% (65,060 ÷ 867,262 × 100)

Medicaid PPS rate for January 1, 2009 through December 31, 2009:	$106.80
Increase due to Scope of Service	$ 4.04
Rate increase due to Medicare Economic Index (MEI= 1.20%)	$ 1.28
Medicaid PPS rate for January 1, 2010 thru December 31, 2010	**$112.12**

E. 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.