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. Encounter

1. An encounter is also referred to as a visit. An encounter at a FQHC is a face-to-face visit between a clinic beneficiary and any health professional whose services are reimbursed as one (1) of the following under the State Plan.

    a. A medical encounter is a face-to-face visit between a clinic beneficiary and a physician, physician assistant, nurse practitioner, or nurse midwife for the provision of medical services.

    b. A mental health encounter is a face-to-face visit between a clinic beneficiary and a physician, psychiatrist, psychiatric mental health nurse practitioner, nurse practitioner, physician assistant, clinical psychologist, licensed clinical social worker, licensed professional counselor, or board certified behavior analyst for the provision of mental health services.

c. A dental encounter is a face-to-face visit between a clinic beneficiary and a dentist for the provision of dental services.

d. A vision encounter is a face-to-face visit between a clinic beneficiary and an ophthalmologist, optometrist, physician, nurse practitioner or physician assistant for the provision of vision services.

2. Encounters with more than one health professional for the same type of service or more than one encounter with the same health professional, which take place on the same day and at a single location constitute a single encounter, except when one of the following circumstances occur:

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

   b. The beneficiary has a combination medical encounter, mental health encounter, dental encounter, and/or vision encounter that are each a separate identifiable service.

   c. The beneficiary has an initial preventative physical exam encounter and a separate medical, mental health, dental or vision encounter on the same day.

3. Nursing Facility Encounters are covered as a face-to-face visit when performed within the county or within forty (40) miles of the county where the FQHC is located.

4. FQHC Mobile Unit Encounters are covered when the mobile unit meets the following criteria:

   a. 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.

   b. Must meet all federal and state requirements for FQHC mobile units.

   c. Must have a fixed set of locations where the mobile unit is scheduled to provide services at specified dates and times.

1) Locations for FQHC mobile unit services must meet the rural and shortage area requirements at the time of survey.

2) 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.

d. Must operate:

1) Within the county or within forty (40) miles of the county where the affiliated FQHC has a permanent structure.

2) If the FQHC has no permanent structure, within the county or forty (40) miles of the county of the initial CMS approved locations.

3) Mobile units must have a separate Mississippi Medicaid provider number from the affiliated FQHC.

D. Other Covered Ambulatory Services:

1. The following group services are covered:

a. Group Psychotherapy,

b. Group adaptive behavior services, and

c. Prenatal and postpartum education.

2. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening services are covered in a school setting, day care center or Head Start program by a physician, nurse practitioner, or physician assistant employed by the FQHC.

a. The school, daycare center or Head Start program must be located within the county or forty (40) miles of the county where the FQHC is located.

b. The school setting and screenings must meet the requirements as outlined in the Miss. Admin. Code Part 223.

E. Non-Covered Services

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.

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 are 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 system (PPS) rate per encounter. Reimbursement is limited to a single encounter, also referred to as a "visit", per day except as described in Attachment 3.1-A exhibit 2c.

The Division of Medicaid reimburses a FQHC the PPS rate for a nursing home encounter.

FQHC services provided by a nurse practitioner and/or a physician assistant are reimbursed the full PPS rate.

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 provides for payment for core services and other ambulatory services provided by FQHCs at a prospective payment system (PPS) rate per encounter. The PPS rate is calculated (on a per encounter basis) in an amount equal to one hundred percent (100%) of the average of the FQHC'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 FQHC's that qualified for Medicaid participation during fiscal year 2000, their PPS 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 is 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 fourth (4^{th}) 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 PPS rate is based on the rates established for other centers located in the same or adjacent area with a similar caseload. In the absence of such an FQHC, the PPS rate for the new provider will be based on projected costs. After the FQHC initial year, a Medicaid cost report must be filed in accordance with this plan. The cost report will be desk reviewed and a rate is calculated in an amount equal to one hundred percent (100%) of the FQHC 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 PPS rate is equal to the rate established in the preceding calendar year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services that is published in the Federal Register in the fourth (4th) quarter of the preceding calendar year.

C. Alternative Payment Methodology

1. The Division of Medicaid reimburses an FQHC a fee in addition to the PPS rate when billing with codes 99050 or 99051 when the encounter occurs: (1) during the FQHC's established office hours but before or after the Division of Medicaid's office hours, or (2) outside of the Division of Medicaid's office hours or the FQHC 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 FQHC established office hours. The Division of Medicaid's office hours are defined as the hours between 8:00 a.m. and 5 p.m., Monday through Friday, excluding Saturday, Sunday, and federal and state holidays. These codes will be paid at the existing fee-for-service rate on the MS Medicaid Physician Fee Schedule at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

2. The Division of Medicaid reimburses an FQHC an additional fee for telehealth services provided by the FQHC as the originating site provider. The FQHC will receive the originating site facility fee per completed transmission when billing claims with code Q3014. The FQHC may not bill for an encounter visit unless a separately identifiable service is performed. This service will be paid at the existing fee-for-service rate on the MS Medicaid Physician Fee Schedule at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

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 fee per completed transmission and will not receive reimbursement for an encounter.

2. FQHCs providing EPSDT well child screenings in a school setting, day care center or Head Start program are reimbursed at the lower of the FQHC's PPS rate or the current applicable MS Medicaid fee-for-service rate for the EPSDT screening.

3. FQHCs providing group therapy is reimbursed the current applicable MS Medicaid fee-for-service rate per beneficiary participating in a group therapy session.

Current fee-for-service rates are located on the MS Medicaid Physician Fee Schedule at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#.

4. The Division of Medicaid reimburses an FQHC the PPS rate for the administration 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 PPS rate.

E. Change in Scope of Services

A change in the scope of services is defined as a change in the type, intensity, duration and/or amount of services. A change in the scope of services occurs if: (1) the FQHC has added or has dropped any services that meets the definition of an FQHC service as provided in section 1905(a)(2)(B) and (C) of the SSA; and, (2) the service is included as a covered Medicaid service under the Mississippi Medicaid state plan. A change in intensity could be a change in the amount of health care services provided by the FQHC in an average encounter.

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 generally constitute a change in the scope of services. A change in the cost of a service is not considered in and of itself a change in the scope of services.

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 services. The Division of Medicaid will adjust an FQHC PPS rate if the following criteria are met: (1) the FQHC can demonstrate that there is a valid and documented change in the scope of services, and (2) 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.

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 45 C.F.R. Part 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards and 42 C.F.R. Part 413 Principles of Reasonable Cost Reimbursement.

It is the responsibility of the FQHC to notify the Division of Medicaid of any change in the scope of services and provide proper and valid documentation to support the rate change. Such required documentation must include, at a minimum, a detailed working trial balance demonstrating the increase or decrease in the FQHC PPS rate as a result of the change in scope of services. 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 services has occurred. The instructions and forms for submitting a request due to a change in scope of services can be found at www.medicaid.ms.gov/resources/forms/.

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.

F. 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).

G. Out-Of-State Providers

The Division of Medicaid does not enroll out-of-state providers to provide FQHC services, except in those circumstances specified at 42 C.F.R. § 431.52.

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

1. An encounter is also referred to as a visit. An encounter at a FQHC ~~can be~~ is a face-to-face visit between a clinic beneficiary and any health professional whose services are reimbursed as one (1) of the following under the State Plan.~~medical visit or an "other health" visit~~.

   a. A medical ~~visit~~ encounter is a face-to-face ~~encounter~~ visit between a clinic ~~patient~~ beneficiary and a physician, physician assistant, nurse practitioner, or nurse midwife for the provision of medical services.

   b. A~~n "other health" visit~~ mental health encounter is a face-to-face ~~encounter~~ visit between a clinic ~~patient~~ beneficiary and a physician, psychiatrist, psychiatric mental health nurse practitioner, nurse practitioner, physician assistant, clinical psychologist, licensed clinical

social worker, licensed professional counselor, or board certified behavior analyst for the provision of mental health services. ~~or other health professional for mental health services.~~

c. A dental encounter is a face-to-face visit between a clinic beneficiary and a dentist for the provision of dental services.

d. A vision encounter is a face-to-face visit between a clinic beneficiary and an ophthalmologist, optometrist, physician, nurse practitioner or physician assistant for the provision of vision services.

2. Encounters with more than one health professional for the same type of service ~~and~~ or ~~multiple encounters~~ more than one encounter with the same health professional, which take place on the same day and at a single location constitute a single ~~visit~~encounter, except when one of the following circumstances occur:

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

b. The ~~patient~~beneficiary has a combination medical ~~visit~~encounter, mental health encounter, dental encounter, and/or vision encounter that are each a separate identifiable service. ~~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.~~

c. The beneficiary has an initial preventative physical exam encounter and a separate medical, mental health, dental or vision encounter on the same day.

~~2~~3. ~~Hospital and~~ Nursing Facility ~~Home Visits~~ Encounters

~~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.~~ are covered as a face-to-face visit when performed within the county or within forty (40) miles of the county where the FQHC is located.

4. FQHC Mobile Unit Encounters are covered when the mobile unit meets the following criteria:

State of Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

a. 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.

b. Must meet all federal and state requirements for FQHC mobile units.

c. Must have a fixed set of locations where the mobile unit is scheduled to provide services at specified dates and times.

1) Locations for FQHC mobile unit services must meet the rural and shortage area requirements at the time of survey.

2) 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.

d. Must operate:

1) Within the county or within forty (40) miles of the county where the affiliated FQHC has a permanent structure.

2) If the FQHC has no permanent structure, within the county or forty (40) miles of the county of the initial CMS approved locations.

3) Mobile units must have a separate Mississippi Medicaid provider number from the affiliated FQHC.

D. Other Covered Ambulatory Services:

1. The following group services are covered:

a. Group Psychotherapy,

b. Group adaptive behavior services, and

c. Prenatal and postpartum education.

2. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening services are covered in a school setting, day care center or Head Start program by a physician, nurse practitioner, or physician assistant employed by the FQHC.

a. The school, daycare center or Head Start program must be located within the county or forty (40) miles of the county where the FQHC is located.

b. The school setting and screenings must meet the requirements as outlined in the Miss. Admin. Code Part 223.

State of Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

~~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.~~

E. Non-Covered Services

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.

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~~are 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 system (PPS) rate per encounter. Reimbursement is limited to a single encounter, also referred to as a "visit", per day except as described in Attachment 3.1-A exhibit 2c.

The Division of Medicaid reimburses a FQHC the PPS rate for a nursing home encounter.

FQHC services provided by a nurse practitioner and/or a physician assistant are reimbursed the full PPS rate.

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~~ provides for payment for core services and other ambulatory services provided by FQHCs at a prospective payment system (PPS) rate per encounter. The PPS rate ~~shall be~~is calculated (on a per ~~visit~~ encounter basis) in an amount equal to one hundred percent (100%) of the average of the FQHC'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 FQHC's that qualified for Medicaid participation during fiscal year 2000, their ~~prospective payment~~PPS 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~~ is 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 fourth (4^{th}) 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 system (~~PPS~~)~~ rate ~~shall be~~is based on the rates established for other centers located in the same or adjacent area with a similar caseload. In the absence of such an FQHC, the PPS rate for the new provider will be based on projected costs. After the FQHC 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~~ is calculated in an amount equal to one hundred percent (100%) of the FQHC 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~~ PPS rate ~~shall be~~ is equal to the rate established in the preceding calendar year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services that is published in the Federal Register in the fourth (4th) quarter of the preceding calendar year.

C. Alternative Payment Methodology

1. The Division of Medicaid reimburses an FQHC a fee in addition to the ~~encounter~~ PPS rate when billing with codes 99050 or 99051 when the encounter occurs: (1) during the FQHC's established office hours but before or after the Division of Medicaid's office hours, or (2) outside of the Division of Medicaid's office hours or the FQHC 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 FQHC established office hours. The Division of Medicaid's office hours are defined as the hours between 8:00 a.m. and 5 p.m., Monday through Friday, excluding Saturday, Sunday, and federal and state holidays. These codes will be paid at the existing fee-for-service rate on the MS Medicaid Physician Fee Schedule at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

2. The Division of Medicaid reimburses an FQHC an additional fee for telehealth services provided by the FQHC as the originating site provider. The FQHC will receive the originating site facility fee per completed transmission when billing claims with code Q3014. The FQHC may not bill for an encounter visit unless a separately identifiable service is performed. This service will be paid at the existing fee-for-service rate on the MS Medicaid Physician Fee Schedule at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

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 fee per completed transmission and will not receive reimbursement for an encounter. ~~This service will be paid at~~

~~the existing fee-for-service rate on the MS Medicaid Physician Fee Schedule at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.~~

2. FQHCs providing EPSDT well child screenings in a school setting, day care center or Head Start program are reimbursed at the lower of the FQHC's PPS rate or the current applicable MS Medicaid fee-for-service rate for the EPSDT screening.

3. FQHCs providing group therapy is reimbursed the current applicable MS Medicaid fee-for-service rate per beneficiary participating in a group therapy session.

Current fee-for-service rates are located on the MS Medicaid Physician Fee Schedule at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#.

~~2~~4. The Division of Medicaid reimburses an FQHC the ~~encounter~~ PPS rate for the administration 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~~ PPS rate.

E. Change in Scope of Services

A change in the scope of services is defined as a change in the type, intensity, duration and/or amount of services. A change in the scope of services ~~shall~~ occurs if: (1) the FQHC has added or has dropped any services that meets the definition of an FQHC service as provided in section 1905(a)(2)(B) and (C) of the SSA; and, (2) the service is included as a covered Medicaid service under the Mississippi Medicaid state plan. A change in intensity could be a change in the amount of health care services provided by the FQHC in an average encounter.

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 generally constitute a change in the scope of services. A change in the cost of a service is not considered in and of itself a change in the scope of services.

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 services. The Division of Medicaid will adjust an FQHC PPS rate if the following criteria are met: (1) the FQHC can demonstrate that there is a valid and documented change in the scope of services, and (2) 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.

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 45 C.F.R. Part 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards and 42 C.F.R. Part 413 Principles of Reasonable Cost Reimbursement.

It is the responsibility of the FQHC to notify the Division of Medicaid of any change in the scope of services and provide proper and valid documentation to support the rate change. Such required documentation must include, at a minimum, a detailed working trial balance demonstrating the increase or decrease in the FQHC PPS rate as a result of the change in scope of services. 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 services has occurred. The instructions and forms for submitting a request due to a change in scope of services can be found at www.medicaid.ms.gov/resources/forms/.

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.

F. 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).

G. Out-Of-State Providers

The Division of Medicaid does not enroll out-of-state providers to provide FQHC services, except in those circumstances specified at 42 C.F.R. § 431.52.