

**State of Mississippi  
RURAL HEALTH CLINICS**

**STATE OF MISSISSIPPI  
OFFICE OF THE GOVERNOR  
DIVISION OF MEDICAID**

**STATE PLAN**

**GUIDELINES FOR THE REIMBURSEMENT  
OF COSTS FOR SERVICES  
TO MEDICAL ASSISTANCE RECIPIENTS  
FOR  
RURAL HEALTH CLINICS**

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TN No. 2010-030  
Supersedes  
TN No. 2001-07

Date Received \_\_\_\_\_  
Date Approved \_\_\_\_\_  
Date Effective \_\_\_\_\_

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**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. Basic Requirements**

In order to participate in the Mississippi Medicaid program, a clinic must be approved to provide rural health clinic services under the Medicare program by the Centers for Medicare and Medicaid Services. A clinic's participation in the Medicaid program is entirely voluntary. However, if a provider chooses to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid except for the allowable co-pays.

**III. Scope of Services**

**1. Staffing Requirements**

1. The RHC 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 clinic.
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 clinic.
4. The RHC 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 clinic's hours of operation. The RHC must also have a nurse practitioner, physician assistant, or certified nurse midwife available to furnish patient care services at least 60 percent of the time the RHC operates.
5. The physician must provide medical direction for the clinic's health care activities and consultation for, and medical supervision of, the health care staff.

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6. 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 clinic's patient's records, provide medical orders, and provide medical care services to the patients of the clinic.
7. 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 clinic or center.
8. The RHC program requires state licensure for physicians and nurses, as well as compliance with state law for all clinical staff credentialing. In addition, the clinic should establish written clinical protocols for managing healthcare problems. These protocols should be approved by the State Board of Nursing.
9. The RHC program has no requirements for hospital admitting privileges, but a practice must demonstrate that hospital services are available to patients.

**2. 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. In addition, the RHC must provide the following basic laboratory services on site:

1. Chemical examination of urine by stick or tablet
2. Hemoglobin or hematocrit
3. Blood sugar
4. Examination of stool specimens for occult blood
5. Pregnancy tests
6. Primary cultures for transmittal to a certified lab

**IV. 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.

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**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 4<sup>th</sup> 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 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

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TN No. 2010-030  
Supersedes  
TN No. 2002-12

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Date Received \_\_\_\_\_  
Date Approved \_\_\_\_\_  
Date Effective \_\_\_\_\_

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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:**

| <b>Anytown Family Medical Clinic</b>                           |                                 |          |                                   |          |                                     |
|----------------------------------------------------------------|---------------------------------|----------|-----------------------------------|----------|-------------------------------------|
| 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) |                                 |          |                                   |          |                                     |
| <b>Cost Reporting Period</b>                                   | <b>Allowable Cost Per Visit</b> | <b>X</b> | <b>Annualized Medicaid Visits</b> | <b>=</b> | <b>Annualized Medicaid Payments</b> |
| 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 4<sup>th</sup> 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, supplemental payments will be made quarterly to the clinic for the difference between the payment amounts paid by the managed care

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organization and the amount to which the clinic is entitled under the prospective payment system.

**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.

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.

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TN No. 2010-030  
Supercedes  
TN No. 2001-007

Date Received \_\_\_\_\_  
Date Approved \_\_\_\_\_  
Date Effective \_\_\_\_\_

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**Example:**

| <b>Anytown Family Medical Clinic</b>                                             |                        |                        |                       |
|----------------------------------------------------------------------------------|------------------------|------------------------|-----------------------|
| 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 |                        |                        |                       |
| <b>Cost Period</b>                                                               | <b>Allowable Costs</b> | <b>Medicaid Visits</b> | <b>Cost Per Visit</b> |
| 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% ( $194,084 \div 730,145 \times 100$ )         |                        |                        |                       |
| Medicaid PPS rate for January 1, 2004 thru December 31, 2004:                    |                        |                        | \$81.66               |
| PPS rate including scope of service change:                                      |                        |                        | <u>\$ 9.51</u>        |
| PPS rate adjusted for scope of service change:                                   |                        |                        | \$91.17               |
| Add: Rate increase for Calendar Year 2005 (MEI = 3.1%)                           |                        |                        | <u>2.83</u>           |
| <b>Medicaid PPS rate for January 1, 2005 thru December 31, 2005</b>              |                        |                        | <b>\$94.00</b>        |

**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:

TN No. 2010-030  
 Supercedes  
 TN No. 2001-007

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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.

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| Supersedes      | Date Approved _____  |
| TN No. 2001-007 | Date Effective _____ |

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**V. 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.

**VI. 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.

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TN No. 2010-030  
Supersedes  
TN No. 2001-007

Date Received \_\_\_\_\_  
Date Approved \_\_\_\_\_  
Date Effective \_\_\_\_\_

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**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.

**VII. 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.

**VIII. 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.

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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

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- 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.

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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.

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TN No. 2010-030  
Supercedes  
TN No. 2001-007

Date Received \_\_\_\_\_  
Date Approved \_\_\_\_\_  
Date Effective \_\_\_\_\_

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**STATE PLAN**

**GUIDELINES FOR THE REIMBURSEMENT  
OF COSTS FOR SERVICES  
TO MEDICAL ASSISTANCE RECIPIENTS  
FOR  
RURAL HEALTH CLINICS**

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~~MISSISSIPPI TITLE XIX RURAL HEALTH CLINICS~~

~~REIMBURSEMENT PLAN~~

~~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 (RHC's) operating in the State of Mississippi. Each clinic that has contractually agreed to participate in the Title XIX Program will adopt the procedures set forth in this Plan and those set forth by federal regulations and/or mandates.~~

~~Payment for Services Provided by Rural Health Clinics~~

~~The reimbursement rate for both free standing and provider-based RHCs are established by the following:~~

~~(1) In General Beginning with fiscal year 2001 with respect to services furnished on or after January 1, 2001, and each succeeding fiscal year, the plan shall provide for payment for services described in section 1905(a)(2)(b) furnished by a rural health clinic in accordance with the provisions of this subsection.~~

TN No. 2010-030  
Supersedes  
TN No. 96-11

Date Received \_\_\_\_\_  
Date Approved \_\_\_\_\_  
Date Effective \_\_\_\_\_

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Date Effective \_\_\_\_\_

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~~(2) Fiscal Year 2001 Subject to paragraph (4), for services furnished on and after January 1, 2001 during fiscal year 2001, Payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the cost of the center or clinic of furnishing such services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1833(a)(3), or, in the case of services to which such regulations do not apply, the same methodology used under section 1833(a)(3), adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during fiscal year 2001.~~

~~(3) Fiscal Year 2002 and succeeding Fiscal Years Subject to paragraph (4) for services furnished during fiscal year 2002 or a succeeding fiscal year, the plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to the amount calculated for such services under this section for the preceding fiscal year.~~

~~\_\_\_\_\_ (A) \_\_\_\_\_ Increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) applicable to primary care services (as defined in section 1842(i)(4)) for that fiscal year and \_\_\_\_\_~~

~~\_\_\_\_\_ (B) \_\_\_\_\_ adjusted to take into account any increase in the scope of such services furnished by the center or clinic during that fiscal year.~~

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TN No. 2010-030  
Supercedes  
TN No. 96-11

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(4) Establishment of initial year payment amount for new centers or clinics. In any case in which an entity first qualifies as a rural health clinic after fiscal year 2000, the plan shall provide for payment for services described in section 1905(a)(2)(B) furnish by the clinic in the first fiscal year in which the clinic so qualifies in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of furnishing such services during such fiscal year based on the rates established under this subsection for the fiscal year for other clinics located in the same or adjacent area with a similar case load or, in the absence of such clinic, in accordance with the regulations and methodology referred to in paragraph (2) or based on such other tests of reasonableness as the Secretary may specify. For each fiscal year following the fiscal year in which the entity first qualifies as a rural health clinic, the plan shall provide for the payment amount to be calculated in accordance with paragraph (3).

Upon approval of Plan the State will reconcile the interim rate on claims with date of service on or after January 1, 2001 utilizing the Prospective Payment System (PPS).

Prospective Payment System (PPS)

The PPS baseline calculation will include the cost of all Medicaid covered services under 1905(a)(2)(B) and (C) to include other ambulatory services that were previously paid under a fee for service (FFS) basis. The rates will be increased by the Medicare Economic Index (MEI), and adjustments will be made for any increases/decreases in the scope of services retroactive to the beginning of the calendar year.

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TN No. 2010-030  
Supercedes  
TN No. 96-11

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**II. Basic Requirements**

In order to participate in the Mississippi Medicaid program, a clinic must be approved to provide rural health clinic services under the Medicare program by the Centers for Medicare and Medicaid Services. A clinic’s participation in the Medicaid program is entirely voluntary. However, if a provider chooses to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid except for the allowable co-pays.

**III. Scope of Services**

**A. Staffing Requirements**

1. The RHC 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 clinic.
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 clinic.
4. The RHC 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 clinic’s hours of operation. The RHC must also have a nurse practitioner, physician assistant, or certified nurse midwife available to furnish patient care services at least 60 percent of the time the RHC operates.
5. The physician must provide medical direction for the clinic’s health care activities and consultation for, and medical supervision of, the health care staff.

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~~The clinic will notify the Medicaid agency of any change in scope of service, and provide proper documentation of said change. If said change is warranted the Medicaid agency will adjust rate for that calendar year and use as base year thereafter.~~

~~While cost reports are not required the clinic should provide the Medicaid agency with a copy of their Medicare Cost Report for information purposes.~~

New Clinic

~~When a new facility that qualifies on or before FY 2000, the PPS per visit will be calculated using 100 percent of the average costs of furnishing services during those FY's. If the Clinic only participated in FY 2000, that is the only year the base for PPS rate will be calculated.~~

~~If after FY 2000 a center/clinic should qualify, the payment rate will be calculated using reasonable costs used in calculating the rates for neighboring clinic with similar caseloads. If there is no clinic located in the same or an adjacent area with a similar caseload, a rate for the new facility based on projected costs (estimated expenditures) after applying tests of reasonableness as the Secretary prescribe under section 1833(a)(3) of the Social Security Act will be used.~~

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6. 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 clinic's patient's records, provide medical orders, and provide medical care services to the patients of the clinic.
7. 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 clinic or center.
8. The RHC program requires state licensure for physicians and nurses, as well as compliance with state law for all clinical staff credentialing. In addition, the clinic should establish written clinical protocols for managing healthcare problems. These protocols should be approved by the State Board of Nursing.
9. The RHC 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. In addition, the RHC must provide the following basic laboratory services on site:

1. Chemical examination of urine by stick or tablet
2. Hemoglobin or hematocrit
3. Blood sugar
4. Examination of stool specimens for occult blood
5. Pregnancy tests
6. Primary cultures for transmittal to a certified lab

**IV. 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.

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Audits of Financial Records

~~The Division of Medicaid or its contract auditors will conduct audits, utilizing generally accepted auditing standards, to verify the accuracy and reasonableness of all financial and statistical reports.~~

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 cost.~~

Allowable Costs

~~Allowable costs are those costs that result from providing covered services, 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). Allowable costs, as set forth in 42 CFR 405.2468, include: (1) compensation for services of physicians, nurse practitioners, physician assistants, qualified clinical psychologists, and clinical social workers employed by the clinic; (2) compensation for the duties that a supervising physician is required to perform under agreement; (3) costs of services and supplies incident to~~

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**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 4<sup>th</sup> 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 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

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~~the services of a physician, nurse practitioner, physician assistant, qualified clinical psychologist, or clinical social worker; overhead costs and depreciation costs; and (4) costs of services purchased by the clinic.~~

~~The following list of allowable costs is not comprehensive, but serves a general guide and clarifies certain key expense areas. The absence of a particular cost does not necessarily mean that it is not an allowable cost. Generally, the following types and items of cost will be included in allowable costs to the extent that they are covered by the State Medicaid Plan and are reasonable:~~

- ~~a. Compensation for the services of physicians, nurse practitioners, physician assistants, certified nurse midwives, specialized nurse practitioner, visiting nurses, qualified clinical psychologists, and clinical social workers employed by the facility.~~
- ~~b. Compensation for the duties that a supervising physician is required to perform.~~
- ~~c. Cost of services and supplies incident to the services of a physician, nurse practitioner, physician assistants, certified nurse midwife, specialized nurse practitioner, qualified clinical psychologist, or clinical social worker.~~
- ~~d. Overhead Cost, including center administration, costs applicable to use and maintenance of the facility building and depreciation costs. The overhead costs directly related to patient care should be expensed in the Health care Costs cost center of the cost report. Examples of overhead costs which are directly related to patient care and depreciation expenses related to examination equipment and~~

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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:**

| <b>Anytown Family Medical Clinic</b>                           |                                 |          |                                   |          |                                     |
|----------------------------------------------------------------|---------------------------------|----------|-----------------------------------|----------|-------------------------------------|
| 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) |                                 |          |                                   |          |                                     |
| <b>Cost Reporting Period</b>                                   | <b>Allowable Cost Per Visit</b> | <b>X</b> | <b>Annualized Medicaid Visits</b> | <b>=</b> | <b>Annualized Medicaid Payments</b> |
| 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 4<sup>th</sup> 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, supplemental payments will be made quarterly to the clinic for the difference between the payment amounts paid by the managed care

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e. ~~Costs of services purchased by the center.~~

~~Other ambulatory services provided by the facility will be included in allowable costs to the extent they are covered by the State Medicaid Plan and are reasonable.~~

~~Overpayments and Underpayments~~

~~For cost reporting periods prior to January 2001, and in particular for cost reporting periods for fiscal years 1999 and 2000, overpayments and underpayments that are determined by financial audits of cost reports will result in claims adjustments for those periods where the PPS base rate will be materially affected.~~

~~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 sections.~~

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organization and the amount to which the clinic is entitled under the prospective payment system.

**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.

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.

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~~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 with sixty (60) days after the date of discovery.~~

~~Grounds for Imposition of Sanctions~~

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

- ~~A. Failure to disclose or make available to the DOM, or its authorized agent, records of services provided to Medicaid recipients and records made therefrom.~~
- ~~B. 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.~~
- ~~C. 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.~~
- ~~D. Documented practice of charging Medicaid recipients for services over and above that paid by the DOM.~~
- ~~E. 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.~~

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Example:

| <b>Anytown Family Medical Clinic</b>                                             |                        |                        |                       |
|----------------------------------------------------------------------------------|------------------------|------------------------|-----------------------|
| 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 |                        |                        |                       |
| <b>Cost Period</b>                                                               | <b>Allowable Costs</b> | <b>Medicaid Visits</b> | <b>Cost Per Visit</b> |
| 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:                                      |                        |                        | <u>\$ 9.51</u>        |
| PPS rate adjusted for scope of service change:                                   |                        |                        | \$91.17               |
| Add: Rate increase for Calendar Year 2005 (MEI = 3.1%)                           |                        |                        | <u>2.83</u>           |
| <b>Medicaid PPS rate for January 1, 2005 thru December 31, 2005</b>              |                        |                        | <b>\$94.00</b>        |

**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:

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- ~~F. Failure to meet standards required by the State or Federal law for participation.~~
- ~~G. Submission of a false or fraudulent application for provider status.~~
- ~~H. Failure to keep and maintain auditable records as prescribed by the DOM.~~
- ~~I. Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral.~~
- ~~J. Violating a Medicaid recipient's absolute right of freedom of choice of a qualified participation provider of services under the Medicaid program.~~
- ~~K. Failure to repay or make arrangements for the repayment of identified overpayments, or otherwise erroneous payments.~~
- ~~L. Presenting, or cause to be presented, for payment any false or fraudulent claims for services or merchandise.~~
- ~~M. 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).~~
- ~~N. Submitting, or causing to be submitted, false information for the purpose of meeting prior authorization requirements.~~
- ~~O. Exclusion from Medicare because of fraudulent or abusive practices.~~

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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.

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~~P. 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.~~

Sanctions

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

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

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

~~C. 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.~~

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.~~

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**V. 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.

**VI. 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.

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~~Suspension or withholding of payments may continue until such a time as a final determination is made regarding the appropriateness of the claims or amounts in question.~~

~~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.~~

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

Visits

~~A visit is defined as a face-to-face encounter between a clinic patient and a health professional during which an RHC service is furnished. 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 for cases in which the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment.~~

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**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. An overpayment must be reported and returned by the later of either (1) the date which is 60 days after the date on which the overpayment was identified, or (2) the date any corresponding cost report is due, if applicable. Any overpayment retained by a provider after the deadline for reporting and returning the overpayment is an obligation as defined in Section 3729 (b)(3) of title 31, United States Code. 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.

**VII. 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.

**VIII. 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.

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Scope of Services

~~Services must be delivered by both physicians and midlevel practitioners. Midlevel practitioners must function under physician supervision. An RHC may be any primary care practice, i.e. Family practice, pediatric, obstetric/gynecology, or internal medicine. All RHC services must be furnished by providers authorized to provide those services.——~~

~~Basic Lab Services —An RHC is required to provide the following minimum lab services on site:~~

~~Chemical examination of urine by stick or tablet~~

~~Hemoglobin or hematocrit~~

~~Blood sugar~~

~~Examination of stool specimens for occult blood~~

~~Pregnancy tests~~

~~Primary cultures for transmittal to a certified lab~~

~~If the RHC performs only these six test, it may obtain a waiver certificate from the regional CLIA office. If an RHC provides other tests on site, it will have to comply with CLIA requirements for the lab services actually delivered.~~

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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

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Change in Scope of Service

~~A change in scope of service 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 clinic (i.e. Dental, Pharmacy, EPSDT, Optometry)~~

~~B. The eliminating of an existing service provided by the clinic.~~

~~However, a change in scope of service does not mean the addition/reduction of staff members to an existing service.~~

Inpatient Hospital and Nursing Home Visits

~~An RHC must have a written arrangement with its servicing provider(s) that the servicing provider's salary includes inpatient hospital or nursing home visits in order to be compensated for these visits. These visits will be reimbursed at the fee for service rate. If no such arrangement/agreement exists, then these visits are to be filed by the individual servicing provider.~~

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

~~Physicians Licensed in the State The RHC program requires state licensure for physicians, as well as compliance with state law for all clinical staff credentialing.~~

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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.

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TN No. 2010-030  
Supersedes  
TN No. 96-11

Date Received \_\_\_\_\_  
Date Approved \_\_\_\_\_  
Date Effective \_\_\_\_\_

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~~Written Clinical Protocols~~ Written protocols for managing health care problems are required for an RHC.

Annual Evaluations

~~As mandated by 42 CFR Section 491.11, an evaluation of a clinic's total operation including the overall organization, administration, policies and procedures covering personnel, fiscal and patient care areas must be done at least annually. This evaluation may be done by the clinic, the group of professional personnel required under 42 CFR Section 491.9(b)(2), or through arrangement with other appropriated professionals. The results of this annual evaluation are to be forwarded, as per the Provider Participation Agreement, to the Division of Medicaid. Failure to submit this information may result in cancellation of the Agreement by the Division of Medicaid.~~

Change of Ownership

~~When RHC's undergo a change of ownership, the MEDICARE agreement and reimbursement rate with the existing RHC is automatically assigned to the new owner. However, The DOM requires that the new RHC obtain a new Medicaid provider number, i.e., complete a Medicaid provider enrollment application and participation agreement.~~

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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.

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TN No. 2010-030  
Supercedes  
TN No. 96-11

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