



Administrative Code

Title 23: Medicaid Part 211 Federally Qualified Health Centers (FQHC)

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Title 23: Division of Medicaid

Part 211: Federally Qualified Health Centers

Part 211 Chapter 1: General

Rule 1.1: Provider Enrollment/Requirements

- A. The Division of Medicaid must receive a copy of the letter and Provider Tie-in Notice from the Department of Health and Human Services, Centers for Medicare and Medicaid (CMS), which states approval of the center before an agreement can be established.
- B. FQHC providers must comply with the requirements set forth in Part 200, Chapter 4, Rule 4.8 for all providers in addition to the specific provider type requirements outlined below:
 - 1. National Provider Identifier (NPI), verification from the National Plan and Provider Enumeration System (NPPES),
 - 2. Written confirmation from the IRS confirming provider's tax identification number and noted Legal Business Name, and
 - 3. Medicare Cost Report.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 43-13-129; 42 CFR § 491

Rule 1.2: Service Limits

Medicaid covers a total of twelve (12) visits per state fiscal year in any office, nursing facility, or clinic setting. When a beneficiary has exhausted these visits, payment will no longer be made for services provided in the office or clinic setting.

Source: Miss. Code Ann. § 43-13-121

Rule 1.3: Covered Services

- A. Medicaid defines an encounter as services provided by physicians, physician assistants, nurse practitioners, clinical psychologists, dentists, optometrists, ophthalmologists and clinical social workers. A clinic's encounter rate covers the beneficiary's visit to the clinic, including all services and supplies, such as drugs and biologicals that are not usually self-administered by the patient, furnished as an incident to a professional service. When services, supplies, drugs or biologicals are included in the clinic's encounter rates, the clinic cannot send the beneficiary to another provider that will bill Medicaid for the covered service, supply, drug or biological.
- B. When a beneficiary sees more than one (1) provider type, either medical, dental, optometry, or mental health at the same Federally Qualified Health Center on the same date, the clinic

will be reimbursed as outlined below:

1. Physician, nurse practitioner, and/or nurse midwife are allowed one (1) medical encounter per day,
 2. Dentist is allowed one (1) dental encounter per day,
 3. Optometrist is allowed one (1) optometry encounter per day, and
 4. Clinical psychologist and/or clinical social worker are allowed one (1) mental health encounter per day.
- C. The maximum number of encounters that can be paid to the same FQHC for the same beneficiary on the same date is four (4). An exception shall be made when:
1. The beneficiary has visits with all the core service types on the same day, and
 2. The beneficiary has to return to the clinic for an injury or illness requiring additional diagnosis or treatment.
- D. Medicaid will reimburse the FQHC another medical encounter when the exceptions in Part 211, Rule 1.3 C 1 and 2 apply.
- E. All ambulatory services performed by a center employee or contractual worker for a center patient are covered. This includes services provided in the clinic, skilled nursing facility, nursing facility or other institution used as a patient's home. Medicaid covers for visits at multiple places of service for a beneficiary. Services performed by an outside lab are covered for the outside lab.
- F. Non – covered services
1. Federally Qualified Health Center services are not covered when performed in a hospital, inpatient or outpatient.
 2. Medicaid does not pay fee-for-service rates for services, same or separate dates, in an FQHC.
 3. Drugs are included in the encounter rate if purchased at a discounted price through a discount agreement.
 4. Medicaid does not cover the cost of a subdermal implant as a separate service.

Source: Miss. Code Ann. § 43-13-121; 42 USC § 254b; 42 CFR § 491

Rule 1.4: Pregnancy-Related Eligibles

- A. Women who are eligible for Medicaid only because of pregnancy are covered only for those services which are related to:
 - 1. Pregnancy, including prenatal, delivery, postpartum, and family planning services, and
 - 2. Other conditions which may complicate pregnancy.
- B. Dental and eyeglass services are not covered for women in the eligibility categories in Rule 1.4 A 1 and 2.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 491; 42 USC § 254b

Rule 1.5: Reimbursement Methodology

- A. Medicaid uses the Prospective Payment System method of reimbursement for FQHCs and FQHC look-alikes. All ambulatory services provided in the FQHC will be reimbursed an encounter rate on a per visit basis.
- B. All services provided in an inpatient hospital setting, outpatient hospital setting or an emergency room hospital will be paid on a fee-for-service basis. Medicaid covers services provided by a physician employed by an FQHC when services are provided in a hospital, inpatient or outpatient setting. Medicaid covers that individual physician's services only.
- C. For services provided on and after January 1, 2001, during calendar year 2001, payment for services shall be calculated, on a per visit basis, in an amount equal to one hundred percent (100%) of the average of the FQHC's reasonable costs of providing Medicaid covered services during fiscal years 1999 and 2000. The average rate will be computed from the 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. If an FQHC first qualifies during fiscal year 2000, the rate will only be computed from the fiscal year 2000 Medicaid cost report. The PPS baseline calculation shall include the cost of all Medicaid covered services including other ambulatory services that were previously paid under a fee-for-service basis. This rate will be adjusted to take into account any increase or decrease in the scope of services furnished by the FQHC during fiscal year 2001.
- D. When a new provider first qualifies as an FQHC after fiscal year 2000, payment for services shall be calculated, on a per visit basis, in an amount equal to one hundred percent (100%) of the FQHCs reasonable costs of providing Medicaid covered services during such calendar year based on the rates established for other FQHCs in the same or adjacent area with a similar case load. In the absence of such an FQHC, the rate for the new provider will be based on projected costs or estimated expenditures. After the FQHC's initial year, a Medicaid cost report must be filed. The cost report will be desk reviewed and a rate shall be calculated, on a per visit basis, in an amount equal to one hundred percent (100%) of the FQHC's reasonable costs of providing Medicaid covered services. The FQHC may be subject to a retroactive adjustment based on the difference between projected and actual

allowable costs. After the initial year, payment for services shall be calculated in accordance with Rule 1.5 B above.

- E. Payment rates may be adjusted by the Division of Medicaid pursuant to changes in Federal and/or State laws or regulations.
- F. Beginning in calendar year 2002, and for each calendar year thereafter, the FQHC is entitled to the payment amount, on a per visit basis, to which the FQHC was entitled to in the previous year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services for that calendar year, and adjusted to take into account any increase or decrease in the scope of services furnished by the FQHC during that calendar year. The rate will be retroactively adjusted to reflect the MEI.
- G. A change in the scope of service is defined as a change in the type, intensity, duration and/or amount of service as follows:
 - 1. The addition of a new service, like dental, EPSDT, and optometry, not previously provided by the FQHC, and/or
 - 2. The elimination of an existing service provided by the FQHC.
- H. A change in the scope of service does not mean the addition or reduction of staff members to or from an existing service. A change in the cost of a service is not considered in and of itself a change in the scope of service.
- I. It is the responsibility of the FQHC to notify Medicaid of any change in the scope of service and provide proper documentation of said change.
- J. Cost Reports
 - 1. All FQHCs must submit to Medicaid a copy of their Medicare cost report for information purposes using the appropriate Medicare forms postmarked on or before the last day of the fifth (5th) month following the close of its Medicare cost reporting year. All filing requirements must be the same as for Title XVIII. When the due date of the cost report falls on a weekend or State of Mississippi or federal holiday, the cost report is due on the following business day. Extensions of time for filing cost reports will not be granted by the Division of Medicaid except for those supported by written notification of the extension granted by Title XVIII. Cost reports must be prepared in accordance with the policy for reimbursement of Federally Qualified Health Centers. The center's cost report must include information on all satellite clinics. A copy of the Plan is available upon written request.
 - 2. If the Medicare cost report is not received within thirty (30) days of the due date, payment of claims will be suspended until receipt of the required report. This penalty may only be waived by the Executive Director of the Division of Medicaid.

3. An FQHC that does not file a Medicare cost report within six (6) calendar months after the close of its Medicare cost reporting year may be subject to cancellation of its provider agreement at the Division of Medicaid's discretion.
4. Centers beginning operations during a reporting year must prepare the cost report from the effective date of participation to June 30th, the end of the regular reporting period.

Source: Miss. Code Ann. § 43-13-121; 42 USC § 254b; 42 CFR § 491

Rule 1.6: Documentation Requirements

Medicaid requires FQHC facilities to maintain auditable records that substantiate the services provided. At a minimum, the records must contain the following on each patient:

- A. Date of service,
- B. Patient's presenting complaint,
- C. Provider's findings,
- D. Treatment rendered, and
- E. Provider's signature.

Source: Miss. Code Ann. § 43-13-121; 42 USC § 254b; 42 CFR § 491

Rule 1.7: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121