

PROVIDER-BASED RURAL HEALTH CLINIC PROGRAM.

- (1) General Principles.
 - (A) The MO HealthNet program shall reimburse Provider-Based Rural Health Clinics (PBRHC) based on the reasonable cost incurred by the PBRHC to provide covered services, within program limitations, related to the care of MO HealthNet participants less any copayment or other third party liability amounts that may be due from the MO HealthNet-eligible individual.
 - (B) Reasonable costs shall be determined by the Division based on a review of the applicable cost reports. Reasonable costs shall not exceed the Medicare cost principles set forth in 42 Code of Federal Regulations (CFR) Part 405 and 413.
 - (C) The Medicaid charges used to determine the cost and the payments used to determine the final settlement will be the charges and payments extracted from the Medicaid paid claims history for reimbursable services paid on a percentage basis.
- (2) Definitions. The following definitions shall apply for the purpose of this rule:
 - (A) Audit. The Division's or its authorized contractor's audit of a hospital's Medicaid cost report;
 - (B) Division. Unless otherwise designated, Division refers to the MO HealthNet Division, a division of the Department of Social Services charged with the administration of the MO HealthNet program;
 - (C) Cost-to-Charge Ratio (CCR). The CCR is determined by dividing the PBRHC cost by the PBRHC charges from the hospital's Medicaid Cost Report Worksheet C Part I;
 - (D) Fiscal Year (FY). The clinic's fiscal reporting period that corresponds with the fiscal year of the hospital where the clinic is based;
 - (E) PBRHC. A clinic that is an integral part of the hospital, eligible for certification as a Medicare rural health clinic in accordance with 42 CFR 405 and 491, and operates with other departments of a hospital;
 - (F) Generally Accepted Accounting Principles (GAAP). Accounting conventions, rules and procedures necessary to describe accepted accounting practice at a particular time promulgated by the authoritative body establishing those principles;
 - (G) Medicaid Cost Report. Shall be the cost reports defined in 13 CSR 70-15.010(2)(F), 13 CSR 70-15.010(5), and Missouri's supplemental cost report schedules; and
 - (H) Provider or facility. A PBRHC with a valid MO HealthNet participation agreement in effect with the Department of Social Services for the purpose of providing PBRHC services to MO HealthNet-eligible participants.

(3) Administrative Actions.

(A) Annual Cost Report.

1. Each PBRHC shall be individually listed on the hospital's Medicaid cost report.
2. Under no circumstances will the Division accept amended cost reports for final settlement determination or adjustment after the date of the Division's notification of the final settlement amount.

(B) Records.

1. Maintenance and availability of records.

A. A provider must keep records in accordance with GAAP and maintain sufficient internal control and documentation to satisfy audit requirements and other requirements of this regulation, including reasonable requests by the Division or its authorized contractor for additional information.

B. Adequate documentation for all line items on the cost report shall be maintained by a provider. Upon request, all original documentation and records must be made available for review by the Division or its authorized contractor.

C. Records of related organizations, as defined by 42 CFR 413.17, must be available upon demand.

D. Each facility shall retain all financial information, data and records relating to the operation and reimbursement of the facility for a period of not less than five (5) years.

(4) Non-allowable Costs. Cost not related to PBRHC services shall not be included in a provider's costs. Non-allowable cost areas include, but are not limited to, the following:

- (A) Federal Reimbursement Allowance (FRA) Tax;
- (B) Bad debts, charity and courtesy allowances;
- (C) Return on equity capital;
- (D) Capital cost increases due solely to changes in ownership;
- (E) Amortization on intangible assets, such as goodwill, leasehold rights, covenants, but excluding organizational costs;
- (F) Attorney fees related to litigation involving state, local or federal governmental entities and attorneys' fees that are not related to the provision of PBRHC services, such as litigation related to disputes between or among owners, operators or administrators;

- (G) Central office or pooled costs not attributable to the efficient and economical operation of the facility;
- (H) Costs such as legal fees, accounting costs, administration costs, travel costs and the costs of feasibility studies that are attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition or merger for which any payment has been previously made under the program;
- (I) Late charges and penalties;
- (J) Finders fees;
- (K) Fund-raising expenses;
- (L) Interest expense on intangible assets;
- (M) Religious items or supplies or services of a primarily religious nature performed by priests, rabbis, ministers or other similar types of professionals. Costs associated with portions of the physical plant used primarily for religious functions are also non-allowable;
- (N) Research costs;
- (O) Salaries, wages or fees paid to non-working officers, employees or consultants;
- (P) Value of Services (imputed or actual) rendered by non-paid workers or volunteers; and
- (Q) Costs of services performed in a satellite clinic, which does not have a valid MO HealthNet participation agreement with the Department of Social Services for the purpose of providing PBRHC services to MO HealthNet-eligible participants.
- (5) Fee-for-Service (FFS) Claims Payments.
- (A) Effective for dates of service beginning July first of each year, PBRHC services that are an integral part of the hospital, unless otherwise limited by regulation, shall be reimbursed by MO HealthNet based on the clinic's usual and customary charges multiplied by the lower of one hundred percent (100%) or one hundred percent (100%) of the PBRHCs cost-to-charge ratio as determined from the third prior year audited Medicaid cost report. These payments shall be reduced by copayments and other third party liabilities.
- (6) Interim Managed Care Payments.
- (A) A PBRHC in a MO HealthNet managed care region may request an interim payment, on forms provided by the Division, prior to the final settlement calculation. This payment is limited to the 10% not reimbursed by the managed care health plans for covered services rendered to MO HealthNet managed care participants during the reporting period. The interim payment shall occur on a quarterly basis.

(7) Final Settlement Calculations

(A) For cost reports with a FY ending in 2021 and forward, the final settlement is calculated as follows:

1. The audited Medicaid cost report that includes each PBRHC's fiscal year shall be used to calculate the final settlement, in order that the PBRHC's net reimbursement shall equal reasonable costs as described in this section.
2. Fee-for-Service Section
 - A. The Division takes the PBRHC's allowable Medicaid charges from services paid on a percentage basis multiplied by the PBRHC's cost-to-charge ratio to determine the PBRHC's cost. From this cost, the PBRHC claims payments are subtracted. The difference is either an overpayment or an underpayment.
3. Managed Care Section
 - A. The Division takes the Missouri's supplemental cost report schedules and associated detail for the PBRHC facility to determine charges. Charges are multiplied by the PBRHC's cost-to-charge ratio to determine the PBRHC's cost. From this cost, the PBRHC payments associated with above charges are subtracted. If applicable then subtract any interim payments paid prior to the final settlement. The difference is either an overpayment or an underpayment.
4. Final Settlement amount
 - A. The Division adds together the overpayment or underpayment from the FFS Section and the Managed Care Section and then subtracts any advanced settlement payments, if applicable, to come up with a total overpayment or underpayment which will be the final settlement amount.

(B) For cost reports with a FY ending in 2020 and prior, the final settlement is calculated as follows:

1. The audited Medicare Notice of Program Reimbursement (NPR) cost report that includes each PBRHC's fiscal year shall be used to calculate the final settlement, in order that the PBRHC's net reimbursement shall equal reasonable costs as described in this section. The provider shall provide the NPR upon request from the Division.
2. Fee-for-Service Section
 - A. The Division takes the PBRHC's allowable Medicaid charges from services billed under 13 CSR 70-94.020 multiplied by the PBRHC's Medicare NPR cost-to-charge ratio to determine the PBRHC's cost. From this cost, the PBRHC claims payments are subtracted. The difference is either an overpayment or an underpayment.

3. Managed Care Section

- A. The Division takes the Missouri's supplemental cost report schedules and associated detail for the PBRHC facility to determine charges. Charges are multiplied by the PBRHC's Medicare NPR cost-to-charge ratio to determine the PBRHC's cost. From this cost, the PBRHC payments associated with above charges are subtracted. If applicable then subtract any interim payments paid prior to the final settlement. The difference is either an overpayment or an underpayment.

4. Final Settlement amount

- A. The Division adds together the overpayment or underpayment from the FFS Section and the Managed Care Section and then subtracts any advanced settlement payments, if applicable, to come up with a total overpayment or underpayment which will be the final settlement amount.

(8) Reconciliation.

- (A) The Division shall send written notice to the hospital, of which the PBRHC is an integral part, of the following:
1. Underpayments. If the total reimbursement due the PBRHC exceeds the interim payments made for the reporting period, the Division makes a lump-sum payment to the PBRHC to bring total interim payments into agreement with total reimbursement due to the PBRHC; and/or
 2. Overpayments. If the total interim payments made to the PBRHC for the reporting period exceed the total reimbursement due from the PBRHC for the period, the Division arranges with the PBRHC for repayment through a lump-sum refund, or if that poses a hardship for the PBRHC, through offset against subsequent interim payments or a combination of offset and refund.

(9) Sanctions.

- (A) The Division may impose sanctions against a provider in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services or any other sanction authorized by state or federal law or regulation.
- (B) Overpayments due the MO HealthNet program from a provider shall be recovered by the Division in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services.

- (10) Payment Assurance. The state will pay each PBRHC, which furnishes the services in accordance with the requirements of the state plan, the amount determined for services furnished by the PBRHC according to the standards and methods set forth in the regulations implementing the PBRHC Reimbursement Program

DIABETIC EDUCATION AND SUPPLIES

The state agency will establish rates for reimbursement as defined and determined by the Division of Medical Services in accordance with 42 CFR 447 Subpart D. Reimbursement will be made at the lower of:

- (1) The provider's billed charge for the service or
- (2) The Medicaid maximum allowable fee for the service.

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