**TITLE 13—DEPARTMENT OF SOCIAL SERVICES**
**Division 70—MO HealthNet Division**
**Chapter 10—Nursing Home Program**

**PROPOSED AMENDMENT**

**13 CSR 70-10.020 Prospective Reimbursement Plan for Nursing Facility and HIV Nursing Facility Services.** The division is amending sections (4), (11), and (12).

*PURPOSE: Effective for dates of service beginning July 1, 2025, this amendment amends the cost report total Case Mix Index (CMI), clarifies the MDS Review process and the resulting rate and payment adjustments, provides for replacement facilities to be designated as new or existing consistent with the criteria used for other new or existing nursing facilities, updates the value-based purchasing (VBP) quality measures and the corresponding per diem adjustments, clarifies the base rate for new facilities having their initial prospective rate set, and provides for the multiple component incentive to be recalculated with the semi-annual and annual rate updates. These revisions correspond to the state fiscal year (SFY) 2026 appropriation for nursing facilities and are contingent upon approval by the Centers for Medicare & Medicaid Services (CMS).*

(4) Definitions.

(W) Data Bank. The data from the rate base year cost reports used to determine the medians, ceilings, and per diem rates for nursing facilities.

1. A separate data bank shall be created for nursing facilities and HIV nursing facilities, as follows:

A. The data bank for nursing facilities shall include all nursing facilities except hospital based facilities and HIV facilities; and

B. The data bank for HIV nursing facilities shall only include HIV nursing facilities.

2. If a facility has more than one (1) cost report with periods ending in the rate base year, the cost report covering a full twelve- (12-) month period ending in the rate base year will be used. If none of the cost reports cover a full twelve (12) months, the cost report with the latest period ending in the rate base year will be used. Beginning with the SFY 2025 rebase, cost reports must cover more than three (3) full months to be used for rebasing. Cost reports covering three (3) months or less will not be used. If a facility does not have a cost report for the rebase year, the cost report for the year prior to the rebase year shall be used.

3. Nursing facilities that terminated from the MO HealthNet program during the rate base year shall not be included in the data bank.

4. Nursing facilities operating under an interim rate that have at least a second full year cost report after entering the Medicaid program that coincides with the rate base year may be included in the data bank. Interim rate facilities without such a cost report for the rate base year shall not be included in the data bank. Beginning with the SFY 2025 rebase, nursing facilities operating under an interim rate will not be included in the data bank.

5. The initial rate base year used for rebasing shall be 2019 and the data bank shall include cost reports with an ending date in calendar year 2019. The 2019 rebase year data shall be used to set rates effective for dates of service beginning July 1, 2022, through such time rates are rebased again or calculated on some other cost report as set forth in regulation. The 2019 year data shall be adjusted for the following and shall be used to determine the medians, ceilings, and per diem rates for the nursing facilities:

A. The following allowable salaries shall be adjusted by two percent (2%):

(I) Aides and orderlies (Line 53 of CR (3-95));

(II) Dietary salaries (Line 60 of CR (3-95));

(III) Laundry salaries (Line 85 of CR (3-95));

(IV) Housekeeping salaries (Line 91 of CR (3-95)); and

(V) Beauty & barber salaries (Line 94 of CR (3-95));

B. The total allowable costs, including the salary adjustments detailed above in subparagraph (4)(W)5.A., shall be trended through June 30, 2022, by the difference in the CMS Market Basket Index (i.e., the "Total – %MOVAVG" index for 2022:2 from the fourth-quarter 2021 publication) and the midpoint of the facility's rate setting cost report year; and

C. The total patient care costs, including the salary adjustments and trends, shall be adjusted to match the state-wide average total CMI by multiplying the total patient care costs by the quotient of the state-wide average total CMI divided by the facility cost report total CMI.

(I) A cost report total CMI is determined for each facility based on a simple average of the four (4) quarterly total CMIs covering the facility's cost report period.

(II) The state-wide total CMI is a simple average of the cost report CMIs for all nursing facilities included in the databank.

6. SFY 2025 rebase. Effective for dates of service beginning July 1, 2024, nursing facility rates shall be rebased using a data bank with cost report ending dates in calendar year 2022, except in instances where 2022 data is not available as explained in paragraph (4)(W)2. of this rule. The 2022 rebase year data shall be used to set rates effective for dates of service beginning July 1, 2024, through such time rates are rebased again or calculated on some other cost report as set forth in regulation. The 2022 base year data shall be adjusted for the following and shall be used to determine the medians, ceilings, and per diem rates for the nursing facilities:

A. The following allowable salaries shall be adjusted by two percent (2%):

(I) Aides and orderlies (Line 53 of CR (3-95));

(II) Dietary salaries (Line 60 of CR (3-95));

(III) Laundry salaries (Line 85 of CR (3-95));

(IV) Housekeeping salaries (Line 91 of CR (3-95)); and

(V) Beauty and barber salaries (Line 94 of CR (3-95));

B. The total allowable costs, including the salary adjustments detailed above in subparagraph (4)(W)6.A. of this rule, shall be trended through June 30, 2024, by the difference in the CMS Market Basket Index (i.e., the Total – %MOVAVG index for 2024:2 from the first-quarter 2024 publication) and the midpoint of the facility's rate setting cost report year; and

C. The total patient care costs, including the salary adjustments and trends, shall be adjusted to match the state-wide average total CMI by multiplying the total patient care costs by the quotient of the state-wide average total CMI divided by the facility cost report total CMI.

(I) A cost report total CMI is determined for each facility based on a *[simple]* **resident-weighted** average of the four (4) quarterly total CMIs covering the facility's cost report period.

(II) The state-wide total CMI is a simple average of the cost report CMIs for all nursing facilities included in the databank.

(KK) Minimum Data Set (MDS). A standardized, primary, and comprehensive tool used to assess a patient's functional, medical, psychosocial, and cognitive status for residents of nursing facilities to participate in Medicare and Medicaid.

1. Providers should follow CMS guidelines for completing and submitting MDS assessments. No extra MDS assessments are required as a result of this rule.

2. Assessments should comply with CMS guidance as provided through the RAI Manual in effect at the time of the assessment.

3. CMS is the only source for MDS data. All MDS initial submissions, corrections, etc., must be submitted through the CMS iQIES according to CMS procedures.

4. MDS reviews. Beginning July 1, 2024, the division or its authorized contractor shall conduct reviews of a facility's MDS data to verify that residents have been properly classified and that the facility is following CMS procedures and documentation requirements.

A. *[MDS submissions that are not correct will be adjusted and will be used to recalculate the PDPM and associated CMI.*

*B.]***The general timeline is for MDS reviews to be performed on selected assessments contained in the most recently finalized resident listing at the start of the MDS review quarter, with the quarterly review periods and assessments continually being updated quarterly. For example, MDS reviews completed by the division or its authorized contractor during the January – March 2026 quarter will primarily review MDS assessments contained in the October 2025 final resident listing. MDS reviews completed by the division or its authorized contractor during the April – June 2026 quarter will primarily review MDS assessments contained in the January 2026 final resident listing.**

**B. The division or its authorized contractor will contact a facility that is the subject of an MDS review at least five (5) business days prior to the review.**

**C. An entrance conference will be held at the beginning of each day of the MDS review. The facility will be provided a list of MDS assessments to be reviewed that day which the facility must provide documentation to support the assessment.**

**(I) A facility liaison will be required to locate, navigate, or otherwise assist with medical record documentation requested by the Registered Nurse (RN) Reviewer(s).**

**(II) Only the original legal medical record supported documentation will be accepted.**

**(III) Creating or altering original legal medical record supporting documentation before, during, or after the Case Mix Review is not permissible. Suspected intentional alteration of or creation of supporting documentation after MDS assessments have been completed and transmitted or during the Case Mix Review shall be reported to the Missouri Department of Social Services and referred to the Medicaid Fraud Control Unit of the Attorney General's Office of Missouri for investigation of possible fraud. Such an investigation could result in a felony or misdemeanor criminal conviction. In addition, the State may exercise the right to complete an additional review.**

**D. An exit conference will be held at the end of each day of the MDS review to discuss the preliminary results of the review completed that day.**

**(I) No new, additional information will be accepted for MDS assessments completed that day after the exit conference begins.**

**E. Informal Reconsideration Request. If a facility disagrees with the MDS review findings, a written request for an informal reconsideration must be submitted to the division or its authorized contractor within fifteen (15) business days following the close of the MDS review (i.e., after the last exit conference). Otherwise, the results of the MDS review findings are considered final.**

**(I) If an informal reconsideration request is submitted, it must contain specific details surrounding which MDS review findings the facility disagrees with and the reasons or justifications behind those disagreements.**

**(II) Only documentation submitted during the initial review may be considered in the reconsideration request and no new documentation may be presented.**

**(III) Reconsiderations of MDS review findings not filed in accordance with the above timeline, and only filed at the issuance of the recalculated per diem rate or posting of the revised final resident listing, will not be considered.**

**(IV) The division or its authorized contractor will review the facility's informal reconsideration request within fifteen (15) business days of receipt of the request and will send written notification of the final results of the reconsideration to the facility.**

**F. After the close of the MDS review, the division or its authorized contractor shall submit its findings in an MDS Review Summary letter to the facility within twenty (20) business days following the final exit conference date. If the facility submitted an informal reconsideration request, the MDS Review Summary letter may be delayed.**

**G. Validation Improvement Plan (VIP). If the results of the MDS review indicate a substantial percentage of unsupported assessments, the facility may be required to complete a *Validation Improvement Plan* (VIP). If required, the details and guidelines for a VIP will be outlined in the MDS Review Summary Letter. Should a facility not follow the VIP requirements, additional action may be taken by the division, such as an expedited subsequent MDS review.**

**H. MDS submissions that are not correct will be adjusted and will be used to recalculate the PDPM and associated CMI. A revised final resident listing with the corrected PDPM assessment classification and recalculated CMI for the period under MDS review will be prepared and issued to the facility upon completion of the MDS review process, or upon completion of the informal reconsideration process, if applicable.**

**I. Rate Adjustments.**

**(I)** A facility's per diem rate will be adjusted based on the revisions to the PDPM and associated CMI after the initial training and education period, as set forth below in section (12) of this rule.

**(II) MDS reviews completed on assessment data contained in the January and April final resident listings may impact July 1 per diem rates.**

**(III) MDS reviews completed on assessment data contained in the July and October final resident listings may impact January 1 per diem rates.**

(PP) Nursing facility (NF). Effective October 1, 1990, skilled nursing facilities, skilled nursing facilities/intermediate care facilities, and intermediate care facilities as defined in Chapter 198, RSMo, participating in the Medicaid Program will all be subject to the minimum federal requirements found in section 1919 of the Social Security Act.

1. HIV nursing facility. A nursing facility that operates exclusively for persons with the human immunodeficiency virus (HIV) that causes acquired immunodeficiency syndrome (AIDS) and that was granted an exemption from Certificate of Need under section 197.316, RSMo.

2. New MO HealthNet nursing facility. A qualified facility not previously certified for participation in the Medicaid Program within the last twenty-four (24) months. A new MO HealthNet nursing facility shall be given an interim reimbursement rate until a prospective rate is established on its rate setting cost report. A facility previously Medicaid certified within the last twenty-four (24) months (i.e., a facility that terminated participation in the MO HealthNet program and subsequently re-enrolled in the MO HealthNet program) is not considered to be a new MO HealthNet nursing facility regardless of any changes, including but not limited to a change of ownership, change of operator, tax identification change, merger, bankruptcy, name change, address change, payment address change, Medicare number change, National Provider Identifier (NPI) change, or facilities/offices that have been closed and reopened at the same or different locations. *[A replacement facility, whether it is at the same location or a different location, and whether the Medicare number is retained or if a new Medicare number is issued, is not considered to be a new MO HealthNet nursing facility. These facilities shall be given the prospective rate they had prior to terminating from the MO HealthNet program, plus any applicable adjustments set forth in the regulation between the termination date and the re-certification date.]***This includes replacement facilities, which are newly constructed facilities with beds never certified for Medicaid or previously licensed by the Department of Health and Senior Services and put in service in place of existing Medicaid beds.**

(11) Prospective Rate Determination. The division will use the rate setting cost report described in subsection (11)(I) to determine the nursing facility's prospective rate, as detailed in subsections (11)(A)-(I) below.

(F) Special Per Diem Adjustments. Special per diem rate adjustments may be added to a qualifying facility's rate without regard to the cost component ceiling if specifically provided as described below.

1. Patient care incentive. Each facility with a prospective rate on or after July 1, 2022, shall receive a per diem adjustment equal to four and seventy-fifths percent (4.75%) of the facility's patient care per diem determined in paragraph (11)(A)1. subject to a maximum of one hundred thirty percent (130%) of the patient care median when added to the patient care per diem as determined in paragraph (11)(A)1. This adjustment will not be subject to the cost component ceiling of one hundred twenty percent (120%) for the patient care median.

2. Multiple component incentive. Each facility with a prospective rate on or after July 1, 2022, and which meets the following criteria shall receive a per diem adjustment:

A. If the sum of the facility's patient care per diem and ancillary per diem, as determined in subsections (11)(A) and (11)(B), is greater than or equal to seventy percent (70%), rounded to four (4) decimal places (.6985 would not receive the adjustment) of the facility's total per diem, the adjustment is as follows:

| **Patient Care & Ancillary Percent of Total Rate** | **Incentive** |
|---|---|
| < 70% | $0.00 |
| > or = 70% but < 75% | $0.10 |
| > or = 75% but < or = 80% | $0.15 |
| > 80% | $0.20 |

B. A facility shall receive an additional incentive if it receives the adjustment in subparagraph (11)(F)2.A. and if the facility's Medicaid utilization percent is greater than eighty-five percent (85%), rounded to four (4) decimal places (.8485 would not receive the adjustment). The adjustment is as follows:

| **Medicaid Utilization Percent** | **Incentive** |
|---|---|
| < 85% | $0.00 |
| > or = 85% but < 90% | $0.10 |
| > or = 90% but < 95% | $0.15 |
| > or = 95% | $0.20 |

3. Value Based Purchasing (VBP) Incentive. Each facility with a prospective rate on or after July 1, 2022, and which meets the following criteria shall receive a per diem adjustment:

A. The facility shall receive a per diem adjustment for each Quality Measure (QM) Performance threshold that it meets. The threshold for each QM is based on national cut-points used by CMS in its Five Star Rating System. Each threshold is the maximum QM value a facility can have in order to receive the per diem adjustment. These thresholds are listed in Table A3 of the *Five-Star Quality Rating System: Technical Users' Guide* dated January 2017. The thresholds listed in Table A3 have been rounded to the nearest tenth for purposes of determining the VBP Incentive. Table A3 of the *Five-Star Quality Rating System: Technical Users' Guide* dated January 2017 is incorporated by reference and made a part of this rule as published by CMS and available at https://dss.mo.gov/mhd/providers/nursing-home-reimbursement-resources.htm. This rule does not incorporate any subsequent amendments or additions.

(I) SFY 2023 QM Performance Measure Table. The facility's most current twelve- (12-) month rolling average QM value as of January 21, 2022, is used to determine the per diem adjustment(s) the facility qualified to receive for the rates effective July 1, 2022. The QM Performance Measure threshold, rounded to the nearest tenth, and per diem adjustments are as follows:

| **QM Performance** | **Threshold** | **Per Diem Adjustment** |
|---|---|---|
| Decline in Late-Loss ADLs | < or = 10.0% | $1.00 |
| Decline in Mobility on Unit | < or = 8.0% | $1.00 |
| High-Risk Residents w/ Pressure Ulcers | < or = 2.7% | $1.00 |
| Anti-Psychotic Medications | < or = 6.8% | $1.00 |
| Falls w/ Major Injury | < or = 1.3% | $1.00 |
| In-Dwelling Catheter | < or = 1.1% | $1.00 |
| Urinary Tract Infection | < or = 1.9% | $1.00 |

(II) SFY 2024 QM Performance Measure Table. Effective for dates of service beginning July 1, 2023, the QM Performance Measure per diem adjustments are as follows:

| **QM Performance** | **Threshold** | **Per Diem Adjustment** |
|---|---|---|

| | | |
|---|---|---|
| Decline in Late-Loss ADLs | < or = 10.0% | $1.87 |
| Decline in Mobility on Unit | < or = 8.0% | $1.87 |
| High-Risk Residents w/ Pressure Ulcers | < or = 2.7% | $1.87 |
| Anti-Psychotic Medications | < or = 6.8% | $1.87 |
| Falls w/ Major Injury | < or = 1.3% | $1.87 |
| In-Dwelling Catheter | < or = 1.1% | $1.87 |
| Urinary Tract Infection | < or = 1.9% | $1.87 |

(III) SFY 2025 QM Performance Measure Table. Effective for dates of service beginning July 1, 2024, the QM Performance Measure per diem adjustments are as follows:

| QM Performance | Threshold | Per Diem Adjustment |
|---|---|---|
| Decline in Late-Loss ADLs | < or = 10.0% | $3.04 |
| Decline in Mobility on Unit | < or = 8.0% | $3.04 |
| High-Risk Residents w/ Pressure Ulcers | < or = 2.7% | $3.04 |
| Anti-Psychotic Medications | < or = 6.8% | $3.04 |
| Falls w/ Major Injury | < or = 1.3% | $3.04 |
| In-Dwelling Catheter | < or = 1.1% | $3.04 |
| Urinary Tract Infection | < or = 1.9% | $3.04 |

**(IV) SFY 2026 QM Performance Measure Table. Effective for dates of service beginning July 1, 2025, the QM Performance Measures and related per diem adjustments are as follows:**

| QM Performance | Threshold | Per Diem Adjustment |
|---|---|---|
| **Decline in Late-Loss ADLs (Percentage of long-stay residents whose need for help with daily activities has increased)** | **< or = 10.0%** | **$3.42** |
| **Decline in Mobility on Unit (Percentage of long-stay residents whose ability to walk independently worsened)** | **< or = 8.0%** | **$3.42** |

| | | |
|---|---|---|
| **High-Risk Residents w/ Pressure Ulcers (Percentage of high risk long-stay residents with pressure ulcers)** | **< or = 2.7%** | **$3.42** |
| **Anti-Psychotic Medications (Percentage of long-stay residents who received an antipsychotic medication)** | **< or = 6.8%** | **$3.42** |
| **Falls w/ Major Injury (Percentage of long-stay residents experiencing one or more falls with major injury)** | **< or = 1.3%** | **$3.42** |
| **In-Dwelling Catheter (Percentage of long-stay residents with a catheter inserted and left in their bladder)** | **< or = 1.1%** | **$3.42** |
| **Urinary Tract Infection (Percentage of long-stay residents with a urinary tract infection)** | **< or = 1.9%** | **$3.42** |

B. A VBP percentage will also be applied to the per diem adjustment for each facility that qualifies for a VBP Incentive. The VBP percentage will be determined by the total QM score calculated from the Five-Star Rating System scores for each of the eight (8) long-stay QMs, as follows:

(I) The eight (8) long-stay QMs included in the total QM score to determine the VBP percentage include the following:

(a) Decline in Late-Loss ADLs;
(b) Decline in Mobility on Unit;
(c) High-Risk Residents w/ Pressure Ulcers;
(d) Anti-Psychotic Medications;
(e) Falls w/ Major Injury;
(f) In-Dwelling Catheter;
(g) Urinary Tract Infection; and
(h) Physical Restraints;

(II) The facility's most current twelve- (12-) month rolling average QM value as of January 21, 2022, is used to determine the facility's QM Score and VBP percentage for the rates effective July 1, 2022;

(III) For each QM value, the corresponding number of QM points will be determined from Table A3 of the *Five-Star Quality Rating System: Technical Users' Guide* dated January 2017;

(IV) The QM points for all of the QMs will be summed to determine the facility's total QM Score; and

(V) The VBP percentage for each scoring range is listed in the following table.

| QM Scoring Tier | Minimum Score | VBP Percentage |
|---|---|---|
| 1 | 600 | 100% |
| 2 | 520 | 75% |
| 3 | 440 | 50% |
| 4 | 360 | 25% |
| 5 | 0 | 0% |

4. Mental illness (MI) diagnosis add-on. Each facility with a prospective rate on or after July 1, 2022, and which meets the following criteria shall receive a per diem adjustment:

A. If at least forty percent (40%) of a facility's Medicaid participants have the following mental illness diagnosis, the facility shall receive a per diem adjustment of five dollars ($5.00):

(I) Schizophrenia; and

(II) Bi-polar.

(G) Prospective Rate Calculation.

1. A preliminary per diem shall be calculated and is the sum of—

A. The cost component per diems as set forth in subsections (11)(A)-(11)(E); and

B. The patient care incentive and multiple component incentive set forth in paragraphs (11)(F)1. and (11)(F)2., respectively.

2. A base rate shall be determined and is the greater of—

A. The preliminary per diem; and

B. The facility's prospective rate as of June 30, 2022, excluding NFRA.

**C. The base rate for new nursing facilities operating under an interim rate whose initial prospective rate is effective on or after July 1, 2022, is the greater of:**

**(I) The preliminary per diem, and**

**(II) The facility's interim rate on the day before the effective date of the initial prospective rate, excluding NFRA.**

3. The facility's rebased rate shall be the sum of—

A. The facility's base rate; and

B. The NFRA in effect for the applicable date of service.

4. The facility's prospective rate shall be the sum of—

A. The facility's rebased rate;

B. The VBP Add-On set forth in paragraph (11)(F)3., if applicable; and

C. The Mental Illness Diagnosis Add-On set forth in paragraph (11)(F)4., if applicable.

5. The following is an illustration of how subsections (11)(A)–(G) determine a facility's prospective rate:

| **Cost Component** | **Per Diem** |
|---|---|
| Patient Care | $99.28 |
| Ancillary | $16.19 |
| Administration | $35.73 |
| Capital (FRV) | $13.25 |
| Total Cost Component Per Diem | $164.45 |
| | |
| Patient Care Incentive | $5.03 |
| Multiple Component Incentive | $0.10 |
| Total Patient Care & Multiple Component Incentives | $5.13 |
| | |
| Preliminary Per Diem | $169.58 |
| Current Prospective Rate (excluding NFRA) – June 30, 2022 | $163.98 |

| | |
|---|---|
| Base Rate - Greater of Preliminary Per Diem or June 30, 2022 Prospective Rate | $169.58 |
| | |
| NFRA – July 1, 2022 | $12.93 |
| Total Rebased Rate | $182.51 |
| VBP Incentive | $2.00 |
| VBP Payment Percent | 75% |
| VBP Add-On Per Diem Rate | $1.50 |
| | |
| Mental Illness Diagnosis Add-On | $0.00 |
| | |
| Total Prospective Rate – July 1, 2022 | $184.01 |

(H) Semi-Annual and Annual Rate Updates. Each facility with a prospective rate on or after July 1, 2022, shall have its rate updated for the following items as described below:

1. Semi-annual acuity adjustment for patient care per diem rate. Each facility's patient care per diem rate will be adjusted semi-annually using a current Medicaid CMI. The patient care per diem rate will be adjusted effective for dates of service beginning January 1 and July 1 of each year. The Medicaid CMI will be updated based on the facility's average Medicaid CMI from the two (2) preceding quarterly calculations. The allowable patient care cost per day determined in paragraph (11)(A)1. shall be adjusted by the applicable Medicaid CMI and shall be the facility's patient care per diem to be included in the facility's total prospective per diem rate, effective each January 1 and July 1. *[The patient care and multiple component incentives will not be updated based on the adjusted patient care per diem. The facility's prospective rate shall continue to include the patient care and multiple component incentives initially determined for the prospective rate.]* The applicable Medicaid CMI are as follows:

A. Effective for dates of service beginning January 1 of each year, each facility's Medicaid CMI will be updated using the average of the preceding July 1 and October 1 quarterly Medicaid CMI calculations; and

B. Effective for dates of service beginning July 1 of each year, each facility's Medicaid CMI will be updated using the average of the preceding January 1 and April 1 quarterly Medicaid CMI calculations;

2. Semi-annual adjustment for VBP Incentive. Each facility's QM Performance data shall be re-evaluated semi-annually and the per diem add-on rate shall be adjusted accordingly. The VBP will be recalculated effective for dates of service beginning January 1 and July 1 of each year. The QM Performance data will be updated based on the most current data available as of November 15 for the January 1 rate adjustment and as of May 15 for the July 1 rate adjustment. For facilities that do not have updated data as of the review date, prior period data will be carried forward. This provision will be applied to data frozen by CMS. A facility must meet the criteria set forth in paragraph (11)(F)3. each period and will lose any per diem adjustments for which it does not continue to qualify;

3. Semi-annual adjustment for mental illness diagnosis add-on. Each facility's Mental Illness Diagnosis data shall be re-evaluated semi-annually and the per diem add-on rate shall be adjusted accordingly. The Mental Illness Diagnosis will be recalculated effective for dates of service beginning January 1 and July 1 of each year. The Mental Illness Diagnosis data will be updated based on the final resident listing for October for the January 1 rate adjustment and the final resident listing for April for the July 1 rate adjustment. For facilities that do not have updated data as of the review date, prior period data will be carried forward. A facility must meet the criteria set forth in paragraph (11)(F)4. each period and will lose any per diem adjustments for which it does not continue to qualify;

4. Annual capital rate update. Each facility's capital rate will be recalculated annually by updating the rental value portion of the capital rate. The capital rate will be recalculated at the beginning of each state fiscal year (SFY), effective for dates of service beginning July 1, as follows:

A. The total facility size will be updated each year for any increases or decreases in licensed beds and capital expenditures that qualify as bed equivalencies, as follows:

(I) For SFY 2024, effective for dates of service beginning July 1, 2023, the total facility size will be updated using information from the 2020 and 2021 cost reports; and

(II) For SFY 2025 forward, the total facility size will be updated using the information from the third prior year cost report relative to the SFY (i.e., for SFY 2025, the facility size will be updated using 2022 cost report data);

B. The weighted average age of the facility shall be updated each year. The age shall be calculated from the year coinciding with the latest cost report used to update the facility size above in subparagraph (11)(A)1.A. (i.e., the age for SFY 2024 shall be calculated from 2021, the age for SFY 2025 shall be calculated from 2022, etc.); and

C. The asset value shall be updated each SFY. The asset value shall be updated for the year coinciding with the latest cost report used to update the facility size above in subparagraph (11)(A)1.A. (i.e., for SFY 2024 the 2021 asset value shall be used, for SFY 2025 the 2022 asset value shall be used, etc.); and

5. A facility's prospective rate shall be increased or decreased based upon the semi-annual and annual rate adjustments but the rate shall not be decreased below the facility's June 30, 2022, prospective rate.

(12) Adjustments to the Reimbursement. Subject to the limitations prescribed elsewhere in this regulation, a facility's reimbursement rate may be adjusted as described in this section and 13 CSR 70-10.017.

(D) Conditions for prospective rate adjustments. The division may adjust a facility's prospective rate both retrospectively and prospectively under the following conditions:

1. Fraud, misrepresentation, errors. When information contained in a facility's cost report is found to be fraudulent, misrepresented, or inaccurate, the facility's prospective rate may be both retroactively and prospectively reduced if the fraudulent, misrepresented, or inaccurate information as originally reported resulted in establishment of a higher, prospective rate than the facility would have received in the absence of such information. No decision by the division to impose a rate adjustment in the case of fraudulent, misrepresented, or inaccurate information shall in any way affect the division's ability to impose any sanctions authorized by statute or regulation. The fact that fraudulent, misrepresented, or inaccurate information reported did not result in establishment of a higher prospective rate than the facility would have received in the absence of this information also does not affect the division's ability to impose any sanctions authorized by statute or regulation;

2. Decisions of the Administrative Hearing Commission, or settlement agreements approved by the Administrative Hearing Commission;

3. Court order;

4. Disallowance of federal financial participation; and

5. MDS reviews.

A. If a facility's MDS submissions were corrected as a result of an MDS review and resulted in a revised CMI, a facility's per diem rate shall be adjusted as follows:

(I) For reviews completed between July 1, 2024, and December 31, 2025, per diem rates will only be adjusted for increases in the CMI;

(II) For reviews completed between January 1, 2026, and December 31, 2026, per diem rates will be adjusted for any changes to the CMI. The per diem rate may be increased or decreased based on the adjusted CMI; and

(III) For reviews completed after January 1, 2027, per diem rates will only be adjusted for decreases in the CMI.

**B. Per Diem Rate Adjustments and Payment Adjustments.**

**(I) The per diem rate will be recalculated using the Medicaid CMI that has been revised based on the corrected MDS submissions.**

**(II) The revised per diem rate will replace the per diem rate with the incorrect CMI for the period that the incorrect rate was in effect. The revised per diem rate will be retroactive back to the initial effective date of the rate being revised and will remain in place until the effective date of the following rate.**

**(III) The payments corresponding to the per diem rate with the incorrect CMI will be adjusted to reflect the revised per diem rate including the corrected CMI.**

**(a) Additional payments will be made to nursing facilities with increases in the per diem rate resulting from the corrected CMI.**

**(b) Payments will be recouped from nursing facilities with decreases in the per diem rate resulting from the corrected CMI.**

*AUTHORITY: sections 208.159, 208.201, and 660.017, RSMo 2016, and section 208.153, RSMo Supp. 2024.* Emergency rule filed May 16, 2023, effective May 31, 2023, expired Nov. 26, 2023. Original rule filed May 16, 2023, effective Dec. 30, 2023. Emergency amendment filed Feb. 21, 2024, effective March 6, 2024, expired Sept. 1, 2024. Amended: Filed Feb. 21, 2024, effective Aug. 30, 2024. Emergency amendment filed Jan. 21, 2025, effective Feb. 4, 2025, expired Aug. 2, 2025. Amended: Filed Jan. 21, 2025, effective Aug. 30, 2025. Amended: Filed Nov. 24, 2025.*

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012, 2024; 208.159, RSMo 1979; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

*PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions approximately three million, three hundred sixty-eight thousand ($3,368,000) annually.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, Legal Services Division-Rulemaking, P.O. Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*