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), (10), (11), and (12).

PURPOSE: This amendment provides for a rebasing of nursing facility and HIV nursing facility per diem rates using a more current cost report year, changes the resident classification system used to determine the case mix index, updates the value based purchasing per diem adjustment, provides for a facility size and occupancy rate adjustment, describes the process for reviewing information used in determining the case mix index and mental illness diagnosis add-on, clarifies data used for determining the mental illness diagnosis add-on, clarifies capital rate used in the interim rate, clarifies when an independent audit is required, and provides for reviews to be done on minimum data set submissions and adjustments to the reimbursement rate based on the MDS reviews, effective for dates of service beginning July 1, 2024. These revisions correspond to the state fiscal year 2025 appropriation for nursing facilities and are contingent upon approval by the Centers for Medicare and Medicaid Services (CMS).

PUBLISHER'S NOTE: The secretary of state has determined that publication of the entire text of the material that is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more that the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(4) Definitions.

(N) Case Mix Index (CMI). Weight or numeric score assigned to a resident classification system (e.g. Resource Utilization Group (RUG), Patient-Driven Payment Model (PDPM), etc.) grouping to reflect the relative resources predicted to care for a resident. The average acuity level of patients in a facility can be determined and expressed by calculating an average of the individual CMI values for each resident. Resident classifications are determined from information derived from the Minimum Data Set (MDS) evaluations for a given period.

1. Resident Classification Systems Used to Determine CMI.

A. RUG IV. Effective for dates of service from July 1, 2022, through June 30, 2024, the Resource Utilization Group (RUG) IV, 48 groups, Logic Version 1.03, CMI Set F01 (48-Grp) (i.e., RUG IV 48 group model classification system) is used to determine the CMIs used in this regulation and is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid services (CMS) at its website https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation, June 29, 2022. Applicable files are RUG-IV DLL Package V1.04.1 Final.zip and RUG III Files & RUG IV Files.zip. This rule does not incorporate any subsequent amendment or additions;

B. PDPM. Effective for dates of service beginning July 1, 2024, the Patient Driven Payment Model (PDPM) nursing component case mix groups (CMG) and case mix index table effective October 1, 2023, as listed in the final SNF PPS payment rule for FY 2024, as published by the Office of the Federal Register at 7 G Street NW, Suite A-734, Washington DC 20401, August 7, 2023, and is used to determine the CMIs used in this regulation and is incorporated by reference and made a part of this rule. This rule does not incorporate any subsequent amendment or additions;

*[1]***2**. Individual CMIs are calculated as follows:

A. *[The RUG IV, 48 groups, Logic Version 1.03, CMI Set F01 (48-Grp) (i.e., RUG IV 48 group model classification system) is used to determine the CMIs used in this regulation and is incorporated by reference and made*

a part of this rule as published by the Centers for Medicare & Medicaid services (CMS) at its website https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation, June 29, 2022. Applicable files are RUG-IV DLL Package V1.04.1 Final.zip and RUG III Files & RUG IV Files.zip. This rule does not incorporate any subsequent amendment or additions;

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

[C. The] **B. An** index maximizing methodology is used to calculate the individual CMI **for RUG classifications.** The index maximizing classification system will select the RUG with the highest CMI for individuals that qualify for multiple RUGs.

C. A hierarchical methodology is used to determine the individual CMI for the PDPM nursing component classifications.

I) The hierarchical classification system will work through the PDPM nursing classifications in order and select the first group for which the patient qualifies.

II) The nursing classification hierarchical order includes—

a) Extensive Services;

b) Special Care High;

c) Special Care Low;

d) Clinically Complex;

e) Behavioral Symptoms and Cognitive Performance; and

f) Reduced Physical Function.

(III) The first of the twenty-five (25) individual PDPM nursing groups for which the patient qualifies, is the assigned PDPM nursing classification.

*[2]***3**. Facility CMIs are calculated as follows:

A. Facility CMI calculations will be based on quarterly point-in-time data snapshots. These snapshot dates are January 1, April 1, July 1, and October 1;

B. The midnight census will determine the residents that are included in the facility's CMI;

C. The Assessment Reference Date (ARD) will be used to determine the assessment included in each quarterly CMI calculation;

D. A look-back period of one hundred eighty (180) days will be used to determine the residents included in calculating the facility CMI. The look-back period cutoff date is the day prior to the snapshot date (i.e., for the January 1 CMI calculation, the ARD would need to be December 31 or earlier);

E. The most current MDS assessment *[generating a RUG classification]* for an individual in the look-back period of one hundred eighty (180) days will be used;

F. Only assessments that are included in the MDS data sent to the state through the CMS system will be available for case mix calculations; and

G. An average acuity level will be determined for each facility for each snapshot date by using a simple average of the CMI values for all residents included in the data for the snapshot date.

(I) Medicaid CMI. The average acuity level for Medicaid patients in a facility.

(a) Medicaid pending residents will be included in the facility's Medicaid CMI calculation.

(b) Medicaid hospice residents will be included in the facility's Medicaid CMI calculation.

(c) Medicaid manage care residents will be included in the facility's Medicaid CMI calculation.

(II) Total CMI. The average acuity level for all patients in a facility.

H. When facility-specific CMI data is not available, the statewide average CMI will be used.

4. Resident Listings.

A. Nursing facilities will be provided a draft resident listing to review for accuracy and will be given a minimum of two (2) weeks to correct resident listings that are not accurate.

I. The draft resident listing will include resident specific information including but not limited to:

(a) The resident's name and identification number;

(b) The payment source;

(c)The ARD;

(d) The PDPM nursing code and corresponding CMI;

(e) Whether the resident has a mental illness diagnosis that qualifies for the mental illness diagnosis add-on which is used to determine the facility's Medicaid CMI; and

(f) Whether the facility qualifies for the mental illness diagnosis add-on.

(II) Nursing facilities will be notified when the draft resident listings are available to review and will include the due date for when all corrections must be done.

B. Facilities may submit corrections to the draft resident listings as follows:

(I) Payer Source. Corrections to the payer source for a resident should be submitted to the division or its authorized contractor;

(II) Other Corrections. Any corrections to the data other than corrections to the payer source must be submitted through the iQIES system. Chapter 5 of the Long-term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual discusses submission and correction of MDS assessments. The RAI manual is incorporated by reference in this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Blvd., Baltimore, MD 21244, October 1, 2024. This rule does not incorporate any subsequent amendments or additions.

C. A final resident listing will be prepared based on the draft resident listing plus any corrections submitted by the facility by the due date.

D. No corrections will be accepted after the due date unless the division or its authorized contractor has given prior approval.

E. The final resident listing will be used to determine the CMI and mental illness diagnosis add-on included in a facility's per diem rate and will be provided when the final per diem rate is determined.

F. If any of a facility's corrections that were submitted on a timely basis were not captured in the final resident listing, the facility may submit a request to the division or its authorized contractor to review. The request must include documentation supporting their claim.

(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 (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 paragraph (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 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.

(II) Interim rate. The interim rate is the sum of one hundred percent (100%) of the patient care cost component ceiling, ninety percent (90%) of the ancillary and administration cost component ceilings, and ninety-five percent (95%) of the median per diem for the capital cost component.

1.The median per diem for capital will be determined from the capital component per diems of providers with prospective rates in effect on July 1, 2022, for the initial 2019 rate base year.

2. Beginning with the SFY 2025 rebase, the median per diem for capital will be determined from the capital component per diems of providers included in the data bank.

(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. 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.

(10) Provider Reporting and Record Keeping Requirements.

(A) Annual Cost Report.

1. Each provider shall adopt the same twelve- (12-) month fiscal period for completing its Medicaid cost report as is used for its Medicare cost report, if the facility also participates in the Medicare program. If the provider does not participate in Medicare, the Medicaid cost report should have the same twelve- (12-) month fiscal year consistent with the facility's accounting and reporting period.

2. Each provider is required to complete and submit to the division or its authorized contractor an annual cost report, including all worksheets, attachments, schedules, and requests for additional information from the division or its authorized contractor. The cost report shall be submitted on forms provided by the division or its authorized contractor for that purpose. Any substitute or computer generated cost report must have prior approval by the division or its authorized contractor.

3. All cost reports shall be completed in accordance with the requirements of this regulation and the cost report instructions. Financial reporting shall adhere to GAAP, except as otherwise specifically indicated in this regulation.

4. The cost report submitted must be based on the accrual basis of accounting. Governmental institutions operating on a cash or modified cash basis of accounting may continue to report on that basis, provided appropriate treatment for capital expenditures is made under GAAP.

5. Cost reports shall be submitted by the first day of the sixth month following the close of the fiscal period. A provider may request, in writing, a reasonable extension of the cost report filing date if there has been an extension granted for its Medicare cost report, if applicable, or for circumstances that are beyond the control of the provider and that are not a product or result of the negligence or malfeasance of the nursing facility. Such circumstances may include public health emergencies; unavoidable acts of nature such as flooding, tornado, earthquake, lightning, hurricane, natural wildfire, or other natural disaster; or, vandalism and/or civil disorder. The division may, at its discretion, grant the extension.

6. If a cost report is more than ten (10) days past due, payment may be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with this regulation, the payments that were withheld will be released to the provider. For cost reports which are more than ninety (90) days past due, the department may terminate the provider's MO HealthNet participation agreement and if terminated retain all payments which have been withheld pursuant to this provision.

7. Copies of signed agreements and other significant documents related to the provider's operation and provision of care to MO HealthNet participants must be attached (unless otherwise noted) to the cost report at the time of filing unless current and accurate copies have already been filed with the division or its authorized contractor. Material which must be submitted or available upon request includes but is not limited to the following:

A. Audit prepared by an independent accountant, including disclosure statements and management letter or SEC Form 10-K;

B. Contracts or agreements involving the purchase of facilities or equipment during the last seven (7) years if requested by the division, the department, or its authorized contractor;

C. Contracts or agreements with owners or related parties;

D. Contracts with consultants;

E. Documentation of expenditures, by line item, made under all restricted and unrestricted grants;

F. Federal and state income tax returns for the fiscal year, if requested by the division, the department, or its authorized contractor;

G. Leases and/or rental agreements related to the activities of the provider, if requested by the division, the department, or its authorized contractor;

H. Management contracts;

I. Medicare cost report, if applicable;

J. Review and compilation statement;

K. Statement verifying the restrictions as specified by the donor, prior to donation, for all restricted grants;

L. Working trial balance actually used to prepare the cost report with line number tracing notations or similar identifications; and

M. Schedule of capital assets with corresponding debt.

8. Cost reports must be fully, clearly, and accurately completed. All required attachments must be submitted before a cost report is considered complete. If any additional information, documentation, or clarification requested by the division or its authorized contractor is not provided within fourteen (14) days of the date of receipt of the division's request, payments may be withheld from the facility until the information is submitted.

9. Under no circumstances will the division accept amended cost reports for rate determination or rate adjustment after the date of the division's notification of the final determination of the rate.

10. Exceptions. A cost report *[is]* **may** not **be** required for the following:

A. Hospital based providers which provide less than one thousand (1,000) patient days of nursing facility services for Missouri Title XIX participants, relative to their fiscal year;

B. Change in provider status. The cost report filing requirement for the cost report relating to the terminating provider from a change of control, ownership, or termination of participation in the MO HealthNet program is not required, unless the terminating cost report is a full twelve- (12-) month cost report. The division may waive the cost report filing requirement for the twelve- (12-) month terminating cost report or the last twelve- (12-) month fiscal year end cost report resulting from a change of control, ownership, or termination of participation in the MO HealthNet program if the old/terminating provider can show financial hardship in providing the cost report. The old/terminating provider must submit a request to the division, indicating and providing documentation for the financial hardship caused by filing the cost report*[; and]***.**

(I) If a cost report for a year that is used to calculate per diem rates is not submitted, the cost report for the year prior to the rate setting year shall be used to determine the per diem rate, consistent with subsection (4)(W) of this rule.

(II) The new provider may obtain the data needed to prepare a cost report that covers the period that the old/terminating provider operated the facility and may submit a cost report as follows:

(a) The new provider may prepare and submit a cost report that covers the old/terminating provider's cost report period;

(b) The new provider may combine the data from the old/terminating provider with the data from the new provider and submit a twelve- (12-) month cost report that covers the new provider's cost report period, if it occurs in the same year as the old owner;

(c) The new provider must notify the division of its intention to complete a cost report covering the old provider's cost report period including the cost report period that will be submitted;

(d) The cost report is due by the first day of the sixth month following the close of the cost report period, consistent with paragraph (10)(A)5. of this rule, regardless of whether the cost report covers only the old/terminating provider's cost report period or it covers the new provider's cost report period; and

(e) It is the new provider's responsibility to determine if the old/terminating provider will submit a cost report and to obtain any information it needs.

C. New MO HealthNet facility or Recertified MO HealthNet facility. The first (1st) cost report for a new facility enrolled in the MO HealthNet program or a facility that had terminated from participation in the MO HealthNet program and was recertified in the MO HealthNet program may not be required if it is a short period cost report. A short period cost report covers three (3) months or less of nursing facility services for MO HealthNet participants, relative to the facility's fiscal year.

(I) If the provider participates in the Medicare program, the provider must complete the MO HealthNet cost report covering the same period as the Medicare cost report unless a short period cost report would still be required by Medicare but is not required by MO HealthNet because it covers three (3) months or less. For example—

(a) Example A: A facility enters the Medicaid/Medicare program on December 20 and has a December 31 fiscal year end. If Medicare requires that the December 20 – December 31 period be combined with the subsequent year cost report, then the MO HealthNet cost report should cover the same period; and

(b) Example B: A facility enters the Medicaid/Medicare program on October 20 and has a December 31 fiscal year end. If Medicare requires that a cost report be submitted for October 20 through December 31, the facility may request that the division waive that cost report for MO HealthNet since it is within the three (3) month short period. The division must approve the request to waive the cost report.

(II) If the facility does not participate in Medicare, the facility must contact the division regarding the treatment of the short period cost report and the division must approve such treatment. The provider may—

(a) Submit the short period cost report; or

(b) Combine the short period with the cost report for the subsequent year; or

(c) Choose not to submit information relating to the short period either on a stand-alone cost report basis or combined with the subsequent year cost report.

11. Notification of change in provider status and withholding of funds for a change in provider status. A provider shall notify the Institutional Reimbursement Unit of the division via email at IRU.NursingFacility@dss.mo.gov prior to a change of control, ownership, or termination of participation in the MO HealthNet program. The division may withhold funds due to a change in provider status as follows:

A. If the division receives notification prior to the change of control, ownership, or termination of participation in the MO HealthNet program, the division may withhold funds from the old/terminating provider's remaining payments for any amounts owed to the division including but not limited to unpaid NFRA, overpayments, and system claim adjustment credits. If the division can determine the amount the provider owes, the division may withhold that amount from the old/terminating provider's remaining payments. If the division cannot determine the amount a provider owes, it may withhold a minimum of thirty thousand dollars ($30,000) of the remaining payments from the old/terminating provider. After six (6) months, any payments withheld will be released to the old/terminating provider, less any amounts owed to the division, including but not limited to unpaid NFRA, overpayments, and system claim adjustment credits; or

B. If the division does not receive notification prior to a change of control or ownership, the division may withhold funds from the provider identified in the current MO HealthNet participation agreement for any amounts owed to the division from the old/terminating provider, including but not limited to unpaid NFRA, overpayments, and system claim adjustment credits. If the division can determine the amount the old/terminating provider owes, the division may withhold that amount from the current provider's payments. If the division cannot determine the amount the old/terminating provider owes, it may withhold a minimum of thirty thousand dollars ($30,000) of the next available MO HealthNet payment from the provider identified in the current MO HealthNet participation agreement. If the MO HealthNet payment is less than thirty thousand dollars ($30,000), the entire payment will be withheld. After six (6) months, any payments withheld will be released to the provider identified in the current MO HealthNet participation agreement, less any amounts owed to the division, including but not limited to unpaid NFRA, overpayments, and system claim adjustment credits.

(B) Certification of Cost Reports.

1. The accuracy and validity of the cost report must be certified by the provider. Certification must be made by a person authorized by one (1) of the following: for an incorporated entity, an officer of the corporation; for a partnership, a partner; for a sole proprietorship or sole owner, the owner or licensed operator; or for a public facility, the chief administrative officer of the facility. Proof of such authorization shall be furnished upon request.

[2. Cost reports must be notarized by a commissioned notary public.

*3]***2**. The following statement must be signed on each cost report to certify its accuracy and validity:

CERTIFICATION STATEMENT:

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER STATE AND FEDERAL LAW.

CERTIFICATION OF OFFICER OR ADMINISTRATOR OF PROVIDER

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report and supporting schedules prepared by (provider name) for the cost report period beginning (date/year) and ending (date/year), and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

[_____]
[Notary Public]

_____
AUTHORIZED SIGNATURE

_____
TITLE

[My Commission Expires _____]

_____
DATE

(D) Audits.

1. Any cost report submitted may be subject to a Level III Audit (also known as a field audit) by the division or its authorized contractor.

2. A provider shall have available at the field audit location one (1) or more knowledgeable persons authorized by the provider and capable of explaining the provider's accounting and control system and cost report preparation, including all attachments and allocations.

3. If a provider maintains any records or documentation at a location which is not the same as the site where services were provided, other than central offices/home offices not located in the state of Missouri, the provider shall transfer the records to the same facility at which the Medicaid services were provided, or the provider must reimburse the division or its authorized contractor for reasonable travel costs necessary to perform any part of the field audit in any off-site location, if the location is acceptable to the division.

4. Those providers initially entering the MO HealthNet program shall be required to have an annual independent audit of the financial records, used to prepare annual cost reports covering, at a minimum, the first two (2) full twelve- (12-) month fiscal years of their participation in the MO HealthNet Program, in accordance with GAAP and generally accepted auditing standards. The audit shall include but may not be limited to the Balance Sheet, Income Statement, Statement of Retained Earnings, and Statement of Cash Flow. For example, a provider begins participation in the Medicaid program in March and chooses a fiscal year of October 1 to September 30. The first cost report will cover March through September. That cost report may be audited at the option of the provider. The October 1 to September 30 cost report, the first full

twelve- (12-) month fiscal year cost report, shall be audited. The next October 1 to September 30 cost report, the second full twelve- (12-) month cost report, shall be audited. The audits shall be done by an independent certified public accountant. The independent audits of the first two (2) full twelve- (12-) month fiscal years may be performed at the same time. The provider may submit two (2) independent audit reports (i.e., one for each year) or they may submit one (1) combined independent audit report covering both years. The independent audit report(s) for combined audits are due with the filing of the second full twelve- (12-) month cost report. If the independent audits are combined, the provider must notify the division of such by the due date of the first full twelve- (12-) month cost report. **If a provider terminates prior to the date that the independent audit is due, the independent audit is not required.**

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

(A) Patient Care. Each nursing facility's patient care per diem shall be calculated as follows –

1. The base patient care per diem shall be the lower of the —

A. Allowable cost per patient day for patient care as determined by the division from the rate setting cost report, including applicable adjustments and trends; or

B. Per diem ceiling of one hundred twenty percent (120%) of the patient care median determined by the division from the data bank.

2. The base patient care per diem determined in (11)(A)1. shall be adjusted by the facility's average Medicaid CMI *[using the RUGS IV 48 group model classification system]* from the two (2) preceding quarterly calculations relative to the effective date of the rate (i.e., for 2019 rebase rates effective July 1, 2022, the January 1, 2022, and April 1, 2022, CMI calculations shall be used) and shall be the facility's patient care per diem to be included in the facility's total prospective per diem rate.

3. Following is an illustration of the calculation of the patient care per diem:

Description		Total Allowable Cost	Ceiling	Lower of Ceiling /Per Diem
Total Patient Care Costs		$3,285,275		
Aides & Orderlies	$918,303			
Dietary Salaries	$248,776			
Total	$1,167,079			
Salary Adjustment	2%	$23,342		
Adjusted Patient Care		$3,308,617		
Trend		7.69%		
Trended Cost		$3,563,050		
Statewide Average Total CMI	.8744			
Cost Report Total CMI	.9664			
Total CMI Adjusted Costs ($3,563,050*		$3,223,852		

.8744/.9664)				
Total Patient Days		30,475		
Base Patient Care Per Diem		$105.79	$127.12	$105.79
Medicaid CMI	.8206			
Medicaid CMI Adjusted Patient Care Per Diem ($105.79* .8206/.8744)				$99.28

(D) Capital. Each nursing facility's capital per diem shall be determined using the fair rental value system (FRV), which consists of two (2) elements — rental value and pass-through expenses. The calculation for each element, as well as the overall capital per diem, is detailed below in paragraphs (11)(D)1.–3.

1. Rental value.

A. Determine the total asset value.

(I) Determine facility size from the rate setting cost report. The changes in the number of licensed beds (i.e., increase and decreases) from the date the facility was originally licensed through the end of the rate setting cost report period should be determined and should result in the same number of licensed beds at the end of the facility's rate setting cost report.

(a) Facility Size and Occupancy Rate Adjustment. Beginning with the SFY 2025 rebase, a facility may request a facility size and occupancy rate adjustment, which provides for the number of licensed beds as of the April 1 that precedes the July 1 rate calculation to be used to determine the facility size and occupancy rate rather than the number of licensed beds at the end of the applicable cost report period.

1. Qualifying criteria. A nursing facility may qualify for a facility size and occupancy adjustment if it meets all of the following criteria:

a. The facility operated at less than its licensed bed capacity during the cost report period used to determine the facility's capital rate so that it could provide single occupancy accommodations;

b. The facility operated as such at least from the beginning of the facility's cost report period used to determine the facility's capital rate through the April 1 that precedes the July 1 rate calculation; and

c. The facility reduced the number of licensed beds to be equal to the number of single occupancy rooms that the facility will operate with going forward. The reduction in licensed beds must be effective on or before the April 1 that precedes the July 1 rate calculation.

2. Calculation of adjusted facility size, adjusted occupancy rate, and adjusted per diem rate.

a. Adjusted facility size. The facility size as defined in subsection (4)(EE) of this rule and used in the determination of a facility's capital cost component under the fair rental value system set forth in subsection (11)(D) of this rule shall be adjusted to reflect the licensed bed capacity as of the April 1 that precedes the July 1 rate calculation.

b. Adjusted occupancy rate. The occupancy rate as defined in subsection (4)(QQ) of this rule shall be adjusted to reflect the licensed beds as of the April 1 that precedes the July 1 rate calculation rather than the licensed beds reflected on the applicable cost report. The bed days will be calculated using the licensed beds as of the April 1 that precedes the July 1 rate calculation and the adjusted occupancy rate will be calculated by dividing the facility's total actual patient days by the adjusted bed days.

c. The adjusted facility size and the adjusted occupancy rate shall be used to determine the facility's per diem rate in accordance with the remaining provisions of this regulation.

3. The facility must request in writing the facility size and occupancy rate adjustment and provide the proper documentation to show that it qualifies for the adjustment, including the following:

a. A copy of the quarterly surveys from the beginning of the applicable cost report period through the April 1 that precedes the July 1 rate calculation showing that the facility's number of available beds was less than its full licensed bed capacity;

b. A copy of the approved change in the number of licensed beds that includes a notation that the rooms are single occupancy;

c. A statement from the facility that it will continue to operate single occupancy rooms; and

d. For the July 1, 2024, rate calculation, the division shall accept such written requests from facilities that qualify for this adjustment as of July 1, 2024, for up to thirty (30) days after the effective date of this amendment. The rate adjustment shall be retroactive back to July 1, 2024. For subsequent rate calculations, a facility must submit the request, including all documentation showing that they qualify for the adjustment, to the division by the May 1 that precedes the July 1 rate calculation, and the rate adjustment shall be effective on July 1.

4. This adjustment shall only apply to nursing facilities with a prospective rate and shall remain in effect for all subsequent rates determined from the 2022 cost report used to rebase rates.

5. Loss of facility size adjustment and recalculation of per diem rate. If a facility's per diem rate has been calculated using an adjusted facility size and an adjusted occupancy rate and the facility ceases to operate with only single occupancy accommodations, the facility will no longer receive the adjustment to the facility size and occupancy rate in determining its per diem rate.

a. If the facility size and occupancy rate adjustment is lost, the facility's per diem rate will be recalculated using the facility size as set forth in subsection (4)(EE) and the bed days and occupancy rate as set forth in subsection (4)(QQ) of this rule.

b. The facility must notify the division within thirty (30) days if it no longer qualifies for the facility size and occupancy rate adjustment.

c. If the facility notifies the division of such within thirty (30) days, the effective date of the rate recalculation will be the date that the facility stopped operating with only single occupancy accommodations.

d. If the facility does not notify the division within thirty (30) days, the effective date of the rate recalculation will be the date the facility size and occupancy rate adjustment was originally granted. The facility shall repay the division any overpayment resulting from the loss of the facility size and occupancy rate adjustment.

(II) Determine the bed equivalency for capital expenditures from the date the facility was originally licensed through the end of the rate setting cost report period by taking the cost of the capital expenditures for each year divided by the asset value per bed for the year of the capital expenditures rounded down to the nearest whole bed. The cost of the capital expenditures must be at least the asset value per bed for the year of the capital expenditures for each bed equivalency. For example, a capital expenditures done in 2009 with a cost of two hundred seventy thousand dollars ($270,000) is equal to five (5) beds. ($270,000/$47,948 equals 5.65 beds rounded down to 5 beds).

(III) The Total Facility Size is the sum of (I) and (II).

(VI) The Total Asset Value is the total facility size times the asset value.

B. Determine the reduction for age. The age of the beds is determined by subtracting the year the beds were originally licensed from the year relative to the rate base year. The age of bed equivalencies for capital expenditures is calculated by subtracting the year the capital expenditures were made from the year relative to the rate base year. The age of the beds for multiple licensing dates (i.e., for increases and decreases in licensed beds) and multiple bed equivalencies is calculated on a weighted average method rounded to the nearest whole year. For licensed bed decreases and replacement beds, the oldest beds are delicensed first. The reduction for age is determined by multiplying the age of the beds by one percent (1%) up to a maximum of forty percent (40%).

C. Determine the facility asset value. The facility asset value is the total asset value set forth in subparagraph (11)(D)1.A. less the reduction for age set forth in subparagraph (11)(D)1.B.

D. Determine the rental value. Multiply the facility asset value by six and three hundred seventy fifths percent (6.375%) to determine the rental value. The six and three hundred seventy-fifths percent (6.375%) is comprised of two and one-half percent (2.5%), which is based on a forty- (40-) year life, plus three and eight hundred seventy-fifths percent (3.875%) for a return. The three and eight hundred seventy-fifths percent (3.875%) is based on the Treasury Bill thirty- (30-) year coupon rate in effect as of January 1, 2022, of one and eight hundred seventy-fifths percent (1.875%) plus two percent (2%).

E. The following is an illustration of how subparagraphs (11)(D)1.A., B., C. and D. determine the rental value.

(I) The following is the determination of the total facility size and the age of the beds:

Historical Base Data *			
	Total Facility Size	Age	Age x Beds
Licensed Beds	75		
Bed Equivalents	0		
Totals	75	30	2,250

* The is the cumulative, historical data previously used to determine existing nursing facilities' prospective rates under 13 CSR 70-10.015.

Licensure History *				
Licensure Year		No. of Bed Incr/(Decr)	Age From 2019	Age x Beds
Bed Increases / Decreases:	2003	15	16	240
	2004	5	15	75
	2006	10	13	130
	2008	(5)	30	(150)
Totals (Bed Incr/(Decr thru 2019)		25		295
Total Licensed Beds (Base Data + Bed Incr/(Decr))		100		

* This is the licensure history from 2002-2019 which reflects the licensure changes subsequent to the Historical Base Data shown above.

Capital Expenditure History *					
Year	Allowable Capital Expenditures for Bed Equiv	Asset Value – Year of Capital Expenditures	Bed Equivalents	Age From 2019	Age x Beds
2002	$1,677,164	$35,325	47	17	799
2009	$170,824	$47,948	3	10	30
2014	$310,351	$52,042	5	5	25
2018	$84,308	$53,769	1	1	1
2019	$145,692	$64,701	2	0	0
Totals (Bed Equiv. through 2019)			58		855
Total Bed Equiv. (Base Data + Bed Equiv thru 2019)			58		

* This is the capital expenditure and bed equivalency history from 2002-2019 which reflects the changes subsequent to the Historical Base Data shown above.

Total Facility Size and Weighted Average Age		
Total Facility Size (Licensed Beds + Bed Equiv.)	158	3,400
Weighted Average Age (3,495 / 158)		22

(II) The total asset value is the product of the total facility size times the asset value;

Total facility size	158
x Asset value - 2019	$64,701
Total asset value	$10,222,758

(III) Facility asset value is total asset value less the reduction for age of the beds; and

Total asset value	$10,222,758
x Age of beds x 1%	22%

- Reduction for age (max 40%)	($2,249,007)
Facility asset value	$7,973,751

(IV) Rental value is the facility asset value multiplied by 6.375%—

Facility asset value	$7,973,751
x Rental value percent	x 6.375%
Rental value	$508,327

2. Pass-through expenses.

A. Add the following pass-through expenses, including applicable trends:

(I) Property insurance – line 107 of CR (3-95);

(II) Real estate taxes – line 108 of CR (3-95); and

(III) Personal property taxes – line 109 of CR (3-95);

3. Capital component per diem calculation. A per diem is calculated for each element detailed above in paragraphs (11)(D) 1.–2. which are then added together to determine the total capital cost component per diem.

A. Rental value per diem. A per diem is calculated by dividing the rental value by the computed patient days, rounded to the nearest cent. Computed patient days are equal to the total facility size (i.e., number of licensed beds plus equivalencies) determined in part (11)(D)1.A.(III) multiplied by three hundred sixty-five (365) adjusted by the greater of the minimum utilization as determined in subsection (7)(N) or the facility's occupancy from the rate setting cost report. The following is an illustration of how the rental value per diem is calculated:

	Allowable Cost	**Computed Patient Days ***	**Per Diem**
Rental Value	$508,327	46,136	$ 11.02
* Computed Patient Days:			
Total facility size		158	
x 365 days		x 365	
Subtotal		57,670	
Greater of:			
Minimum Utilization	80.00%		
Facility Occupancy **	56.63%	x 80.00%	
Computed Patient Days		46,136	

** Assumption: facility occupancy from the rate setting cost report = 56.63%

B. Pass-through expenses per diem. A per diem is calculated by dividing the pass-through expenses by the greater of the minimum utilization days as determined in subsection (7)(N) or the facility's patient days from the rate setting cost report, rounded to the nearest cent. The following is an illustration of how the pass-through per diem is calculated:

	Allowable Cost	**Patient Days ***	**Per Diem**
Pass-Through Expenses:			
Property Insurance	$23,969		
Real Estate Taxes	$61,962		
Personal Property Taxes	$3,408		
Total Pass-Through Expenses	$89,339		
Trend	7.69%		
Total Trended Pass-Through Expenses	$96,209	43,050	$2.23
* Patient days - Greater of:			
a. Facility patient days		30,475	
b. Minimum utilization days			
Beddays		53,812	
x Minimum Utilization Percent		x 80%	
Minimum utilization days		43,050	

C. The capital cost component per diem is the sum of the per diems determined in subparagraphs (11)(D)3.A. and B.

Rental value	$11.02
Pass-through expenses	$2.23
Total capital cost component per diem	$13.25

(E) The following is an illustration of how subsections (11)(A)–(D) determine the total per diem for the cost components:

Patient Care	$99.28
Ancillary	$16.19
Administration	$35.73
Capital (FRV)	$13.25
Total Cost Component Per Diem	$164.45

(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-fifth 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**

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 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.

(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 *[using the RUGS IV 48 group model classifications]* 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 *[most current data available as of November 15]* **final resident listing for October** for the January 1 rate adjustment and *[as of May 15]* **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 (3rd) 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; and

4. Disallowance of federal financial participation.

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.

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

AUTHORITY: sections 208.153, 208.159, 208.201, and 660.017, RSMo 2016. 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 January 21, 2025, effective February 4, 2025, expires August 2, 2025. Amended: Filed Jan. 21, 2025.*

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

PUBLIC COST: This emergency amendment will cost state agencies or political subdivisions approximately one hundred twenty-five million, one hundred sixty-eight thousand, three hundred fifty-five dollars ($125,168,355) in the time the emergency is effective.

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency is effective.

*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.*