Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 94—Rural Health Clinic Program

PROPOSED AMENDMENT

13 CSR 70-94.020 Provider-Based Rural Health Clinic The division is amending sections (1), (2), (3), (4), (5), and (6) and removing sections (7), (8), (9), (10), and (11).

PURPOSE: This amendment changes the reimbursement methodology for Provider-Based Rural Health Clinics.

(1) General Principles.

(A) The MO HealthNet program shall reimburse Provider-Based Rural Health Clinics (PBRHC) based on the reasonable cost incurred by the PBRHC to provide covered services, within program limitations, related to the care of MO HealthNet participants less any copayment or other third party liability amounts that may be due from the MO HealthNet-eligible individual.

(B) *[Reasonable costs shall be determined by the division based on a review of the applicable cost reports.]*Reasonable costs shall not exceed the Medicare cost principles set forth in 42 *Code of Federal Regulations* (CFR) parts 405 and 413**, except the Medicare cost limits or caps imposed under 42 CFR 405.2462 will not apply to the prospective rates calculated by the MO HealthNet Division**.

(C) *[The Medicaid charges used to determine the cost, and the payments used to determine the final settlement, will be the charges and payments extracted from the Medicaid paid claims history for reimbursable services paid on a percentage basis.]***Non-allowable Costs. Costs not related to PBRHC services shall not be included. Non-allowable cost areas include, but are not limited to, the following:**

1. Federal Reimbursement Allowance (FRA) Tax;

2. Bad debts, charity care, and courtesy allowances;

3. Capital cost increases due solely to changes in ownership;

4. Amortization on intangible assets, such as goodwill, leasehold rights, covenants, but excluding organizational costs;

5. Attorney fees related to litigation involving state, local, or federal governmental entities and attorney's fees that are not related to the provision of PBRHC services, such as litigation related to disputes between or among owners, operators, or administrators;

6. Central office or pooled costs not attributable to the efficient and economical operation of the PBRHC;

7. Costs such as legal fees, accounting costs, administration costs, travel costs, and the costs of feasibility studies that are attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition or merger for which any payment has been previously made under the program;

8. Late charges and penalties;

9. Finders fees;

10. Fund-raising expenses;

11. Interest expense on intangible assets;

12. Religious items or supplies, or services of a primarily religious nature performed by priests, rabbis, ministers, or other similar types of professionals. Costs associated with portions of the physical plant used primarily for religious functions are also non-allowable;

13. Research costs;

14. Salaries, wages, or fees paid to non-working officers, employees, or consultants;

15. Value of services (imputed or actual) rendered by non-paid workers or volunteers; and

16. Costs of services performed in a satellite clinic, which does not have a valid MO HealthNet participation agreement with the Department of Social Services for the purpose of providing PBRHC services to MO HealthNet participants.

(2) Definitions. *[The following definitions shall apply for the purpose of this rule:]*

(A) *["Audit" refers to the division's or its authorized contractor's audit of a hospital's Medicaid cost report;]***Alternative Prospective Payment System (APPS) Rate. A reimbursement rate that is an alternative to the standard Prospective Payment System (PPS) rate established in accordance with section 1902(bb) of the Social Security Act.**

(B) *[Division. Unless otherwise designated, "division" refers to the MO HealthNet Division, a division of the Department of Social Services charged with the administration of the MO HealthNet program;]***Audit. The division's or its authorized contractor's audit of a hospital's Medicaid cost report.**

(C) *[Cost-to-Charge Ratio (CCR). The CCR is determined by dividing the PBRHC cost by the PBRHC charges from the hospital's Medicaid Cost Report Worksheet C Part I;]* **Base Years FY 1 & FY 2 for current providers. Fiscal years 1999 and 2000.**

(D) *[Fiscal Year (FY). The clinic's fiscal reporting period that corresponds with the fiscal year of the hospital where the clinic is based;]* **Base Years FY 1 & FY 2 for new providers who do not have a 1999 and 2000 cost report. Two (2) fiscal years subsequent to the first year of business as a PBRHC.**

(E) *[PBRHC. A clinic that is an integral part of a hospital, eligible for certification as a Medicare rural health clinic in accordance with 42 CFR 405 and 491, and operates with other departments of a hospital;]* **Change in Scope of Service. A change in the type, intensity, duration, or amount of service.**

(F) *[Generally Accepted Accounting Principles (GAAP). Accounting conventions, rules, and procedures necessary to describe accepted accounting practice at a particular time promulgated by the authoritative body establishing those principles;]* **Division. Unless otherwise designated, division refers to the MO HealthNet Division, a division of the Department of Social Services charged with the administration of MO HealthNet program.**

(G) *[Medicaid Cost Report. Shall be the cost reports defined in 13 CSR 70-15.010(2)(F), 13 CSR 70-15.010(5), and Missouri's supplemental cost report schedules.]* **Fiscal Year (FY). The clinic's fiscal reporting period that corresponds with the fiscal year of the hospital where the clinic is based.**

(H) *[Provider or facility. A PBRHC with a valid MO HealthNet participation agreement in effect with the Department of Social Services for the purpose of providing PBRHC services to MO HealthNet-eligible participants; and]* **Fourth Prior Year Cost Report. The Medicaid cost report**

for the fourth year prior to the SFY that the rate is effective (i.e. for SFY 2025, the fourth prior year cost report is the FY 2021 cost report).

(I) *[Incorporation by reference. This rule incorporates by reference the following:*

1. 42 CFR Chapter IV, Part 405, which is incorporated by reference and made part of this rule as published by the Office of the Federal Register, 800 North Capitol St. NW, Suite 700, Washington, DC 20408, and which is located on the website of the U.S. Government Publishing Office at https://www.govinfo.gov/content/pkg/CFR-2000-title42-vol2/pdf/CFR-2000-title42-vol2-part405.pdf, October 1, 2000. This rule does not incorporate any subsequent amendments or additions.

2. 42 CFR Chapter IV, Part 491, which is incorporated by reference and made part of this rule as published by the Office of the Federal Register, 800 North Capitol St. NW, Suite 700, Washington, DC 20408, and which is located on the website of the U.S. Government Publishing Office at https://www.govinfo.gov/content/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-part491.pdf, October 1, 2011. This rule does not incorporate any subsequent amendments or additions.

3. 42 CFR Chapter IV, Part 413, which is incorporated by reference and made part of this rule as published by the Office of the Federal Register, 800 North Capitol St. NW, Suite 700, Washington, DC 20408, and which is located on the website of the U.S. Government Publishing Office at https://www.govinfo.gov/content/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-part *413.pdf, October 1, 2011. This rule does not incorporate any subsequent amendments or additions.*

4. The Rural Health Clinic Manual is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action, April 6, 2021. This rule does not incorporate any subsequent amendments or additions.] **Generally Accepted Accounting Principles (GAAP). Accounting conventions, rules and procedures necessary to describe accepted accounting practice at a particular time promulgated by the authoritative body establishing those principles.**

(J) Incorporation by reference. This rule incorporates by reference the following:

1. 42 CFR Chapter IV, Part 405, which is incorporated by reference and made part of this rule as published by the Office of the Federal Register, 800 North Capitol St. NW, Suite 700, Washington, DC 20408, October 1, 2023. This rule does not incorporate any subsequent amendments or additions.

2. 42 CFR Chapter IV, Part 413, which is incorporated by reference and made part of this rule as published by the Office of the Federal Register, 800 North Capitol St. NW, Suite 700, Washington, DC 20408, October 1, 2023. This rule does not incorporate any subsequent amendments or additions.

3. 42 CFR Chapter IV, Part 491, which is incorporated by reference and made part of this rule as published by the Office of the Federal Register, 800 North Capitol St. NW, Suite 700, Washington, DC 20408, October 1, 2024. This rule does not incorporate any subsequent amendments or additions.

4. The Rural Health Clinic Manual is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, September 1, 2023. This rule does not incorporate any subsequent amendments or additions.

(K) Medicaid Cost Report. Shall be the cost report defined in 13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Methodology, and Missouri's supplemental cost report schedules. Each PBRHC shall be individually listed on the hospital's Medicaid cost report.

(L) Medicare Economic Index (MEI). Percentage increase for primary care services.

1. SFY 2024 = 3.8%

2. SFY 2025 = 4.6%

3. SFY 2026 = 3.5%

(M) PBRHC. A clinic that is an integral part of a hospital, eligible for certification as a Medicare rural health clinic in accordance with 42 CFR 405 and 491, and operates with other departments of a hospital.

(N) Prospective Payment System (PPS) Rate. A reimbursement rate established in accordance with section 1902(bb) of the Social Security Act.

(O) Provider or facility. A PBRHC with a valid MO HealthNet participation agreement in effect with the Department of Social Services for the purpose of providing PBRHC services to MO HealthNet eligible participants.

(P) Third Prior Year Cost Report. The Medicaid cost report for the third year prior to the SFY that the rate is effective (i.e. for SFY 2025, the third prior year cost report is the FY 2022 cost report).

(Q) Cost-to-Charge Ratio (CCR). The CCR is determined by dividing the PBRHC cost by the PBRHC charges from the hospital's Medicaid Cost Report Worksheet C Part I.

(3) *[Administrative Actions.]***Reimbursement Methodologies. Effective for dates of service on or after January 1, 2025, PBRHCs shall be reimbursed for covered services furnished to eligible Missouri Medicaid participants under a prospective payment system (PPS). An alternative prospective payment system (APPS) will also be determined for each PBRHC. The payment amount determined under this methodology is agreed to by the Division and the PBRHCs and results in a payment to the PBRHC of an amount which is at least equal to the PPS rate, with no retrospective settlement.**

(A) *[Annual Cost Report.]***Prospective Payment System (PPS). Effective for dates of service on or after January 1, 2025, a PPS rate will be set for each PBRHC according to the methodology outlined below:**

1. *[Each PBRHC shall be individually listed on the hospital's Medicaid cost report.]* **Determination of final PPS Base Rate.**

A. The final PPS base rate for each PBRHC that has base years FY 1 and FY 2 for current providers will be calculated using the Medicaid cost report as follows:

(I) Total allowable cost equals the allowable cost from base year FY 1 for current providers plus the allowable cost from base year FY 2 for current providers;

(II) Total allowable visits equal the allowable visits from base year FY 1 for current providers plus the allowable visits from base year FY 2 for current providers; and

(III) The final PPS base rate equals total allowable cost divided by total allowable visits.

B. The final PPS base rate for each PBRHC that has base years FY 1 and FY 2 for new providers will be calculated using the Medicaid cost report as follows:

(I) Total allowable cost equals the allowable cost from base year FY 1 for new providers plus the allowable cost from base year FY 2 for new providers;

(II) Total allowable visits equal the allowable visits from base year FY 1 for new providers plus the allowable visits from base year FY 2 for new providers; and

(III) The final PPS base rate equals total allowable cost divided by total allowable visits.

C. The division shall adjust the final PPS rate—

(I) By the percentage increase in the MEI applicable to the PBRHC services on July 1 of each year;

(II) In accordance with subsection (3)(C) below:

(a) Upon request and documentation by a PBRHC that there has been a change in scope of services;

(b) Upon review and determination by the division that there has been a change in scope of services; and

2. *[Under no circumstances will the division accept amended cost reports for final settlement determination or adjustment after the date of the division's notification of the final settlement amount.]* **Determination of interim PPS Base Rate for a new PBRHC.**

A. Until a final PPS rate is established, the division shall calculate an interim PPS rate based on the average final PPS rates based on the managed care organization region where the PBRHC is located.

(B) *[Records.]* **Alternative Payment Methodology (APM). Effective for dates of service on or after January 1, 2025, PBRHCs may be paid an APPS rate. PBRHCs must agree to the APM in order to receive payment in accordance with the APM and the amount paid under the APM must be at least equal to the PPS rate. To choose this method, the PBRHC must make this selection on the written memorandum form provided by the division.**

1. *[Maintenance and availability of records.]* **Determination of APPS Base Rate.**

A. *[A provider must keep records in accordance with GAAP and maintain sufficient internal control and documentation to satisfy audit requirements and other requirements of this regulation, including reasonable requests by the division or its authorized contractor for additional information.]***The final APPS base rate will be calculated for each PBRHC as follows:**

(I) Total allowable cost equals the allowable cost from the third prior year Medicaid cost report plus the allowable cost from the fourth prior year Medicaid cost report;

(II) Total allowable visits equal the allowable visits from the third prior year Medicaid cost report plus the allowable visits from the fourth prior year Medicaid cost report; and

(III) PPS base rate equals total allowable cost divided by total allowable visits.

B. *[Adequate documentation for all line items on the cost report shall be maintained by a provider. Upon request, all original documentation and records must be made available for review by the division or its authorized contractor.]* **The division shall adjust the final APPS rate:**

(I) By the percentage increase in the MEI applicable to the PBRHC services on July 1 of each year;

(II) In accordance with subsection (3)(C) below—

(a) Upon request and documentation by a PBRHC that there has been a change in scope of services;

(b) Upon review and determination by the division that there has been a change in scope of services; and

(III) If necessary, as a result of a desk review or audit.

C. *[Records of related organizations, as defined by 42 CFR 413.17, must be available upon demand.]***The final APPS rate will be rebased every five (5) years (i.e. SFY 2030 will be the first year of rebasing).**

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

2. Determination of interim APPS Base Rate for a new PBRHC.

A. Until a final APPS rate is established, the division shall calculate an interim APPS rate based on the average final APPS rates based on the managed care organization region where the PBRHC is located.

(C) Change in Scope of Service

1. To receive a PPS rate adjustment for a proposed increase or decrease in the scope of covered PBRHC services in a future FY as compared to the current year, a provider shall be required to submit a proposal which should include enough information to facilitate an evaluation of the proposed change and its effect on the rate. Any rate change would be effective on the first of the month following the division's decision.

2. To receive an APPS rate adjustment for a proposed increase or decrease in the scope of covered PBRHC services in a future FY as compared to the current year, a provider shall be required to submit a proposal which should include enough information to facilitate an evaluation of the proposed change and its effect on the rate. Any rate change would be effective on the first of the month following the division's decision. In addition to a change of scope, PBRHCs will have the opportunity to submit a request to increase the APPS rate if costs exceed the APPS rate by fifteen (15) percent or more. Again, documentation must be provided to determine the case for reconsideration of the APPS rate. Any rate change would be effective on the first of the month following the division's decision.

3. A change in scope of service shall be restricted to—

A. Adding or terminating a covered service;

B. Increasing or decreasing the intensity of a covered service; or

C. A statutory or regulatory change that materially impacts the costs or visits of a PBRHC.

4. The following items individually shall not constitute a change in scope:

A. A general increase or decrease in the costs of existing services;

B. A reduction or an expansion of hours per day, days per week, or weeks per year;

C. An addition of a new site that provides the same Medicaid covered services;

D. A wage increase;

E. A renovation or other capital expenditure;

F. A change in ownership; or

G. An addition or termination of a service provided by a non-licensed professional or specialist.

5. A change in covered services shall be either—

A. An addition of a covered service restricted to the addition of a licensed professional staff member who can perform a Medicaid covered service that is not currently being performed within the PBRHC by a licensed professional employed or contracted by the PBRHC; or

B. The termination of a covered service restricted to the deletion of a licensed professional staff member who can perform a Medicaid covered service that was being performed within the PBRHC by the licensed professional staff member.

6. A change in intensity shall—

A. Increase or decrease the existing final rate by at least five (5) percent;

B. Last at least twelve (12) months; and

C. Be submitted to the division in writing.

7. A requested change in scope of service shall—

A. Increase or decrease the existing final rate by at least five (5) percent;

B. Last at least twelve (12) months; and

C. Be submitted to the division in writing.

8. A PBRHC that requests a change in scope of service shall submit the following documents to the division within six (6) months of the change in scope of service:

A. A narrative describing the change in scope of service;

B. Budgeted expenditures and change in total number of visits; and

C. A signed letter requesting the change in scope.

(D) PBRHCs that are an integral part of an out-of-state hospital shall be reimbursed a per visit rate based on the state-wide average rate of PBRHCs that are an integral part of in-state hospitals.

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

(A) Federal Reimbursement Allowance (FRA) Tax;

(B) Bad debts, charity, and courtesy allowances;

(C) Return on equity capital;

(D) Capital cost increases due solely to changes in ownership;

(E) Amortization on intangible assets, such as goodwill, leasehold rights, covenants, but excluding organizational costs;

(F) Attorney fees related to litigation involving state, local, or federal governmental entities and attorneys' fees that are not related to the provision of PBRHC services, such as litigation related to disputes between or among owners, operators, or administrators;

(G) Central office or pooled costs not attributable to the efficient and economical operation of the facility;

(H) Costs such as legal fees, accounting costs, administration costs, travel costs, and the costs of feasibility studies that are attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition or merger for which any payment has been previously made under the program;

(I) Late charges and penalties;

(J) Finder's fees;

(K) Fund-raising expenses;

(L) Interest expense on intangible assets;

(M) Religious items or supplies or services of a primarily religious nature performed by priests, rabbis, ministers, or other similar types of professionals. Costs associated with portions of the physical plant used primarily for religious functions are also non-allowable;

(N) Research costs;

(O) Salaries, wages, or fees paid to non-working officers, employees, or consultants;

(P) Value of services (imputed or actual) rendered by non-paid workers or volunteers; and

(Q) Costs of services performed in a satellite clinic, which does not have a valid MO HealthNet participation agreement with the Department of Social Services for the purpose of providing PBRHC services to MO HealthNet-eligible participants.

(5) Fee-for-Service (FFS) Claims Payments.

(A) Effective for dates of service beginning July 1 of each year, PBRHC services that are an integral part of the hospital, unless otherwise limited by regulation, shall be reimbursed by MO HealthNet, based on the clinic's usual and customary charges multiplied by the lower of one hundred percent (100%) or one hundred percent (100%) of the PBRHC's cost-to-charge ratio as determined from the third prior year audited Medicaid cost report. These payments shall be reduced by copayments and other third party liabilities.

(6) Interim Managed Care Payments.

(A) A PBRHC in a MO HealthNet managed care region may request an interim payment, on forms provided by the division, prior to the final settlement calculation. This payment is limited to the ten percent (10%) not reimbursed by the managed care health plans for covered services rendered to MO HealthNet managed care participants during the reporting period. The interim payment shall occur on a quarterly basis.

(7)] Final Settlement Calculations. **Final settlements will only be calculated for dates of service prior to January 1, 2025.**

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

1. The audited Medicaid cost report that includes each PBRHC's fiscal year shall be used to calculate the final settlement, in order that the PBRHC's net reimbursement shall equal reasonable costs as described in this section;

2. Fee-for-Service Section.

A. The division takes the PBRHC's allowable Medicaid charges from services paid on a percentage basis multiplied by the PBRHC's cost-to-charge ratio to determine the PBRHC's cost. From this cost, the PBRHC claims payments are subtracted. The difference is either an overpayment or an underpayment;

3. Managed Care Section.

A. The division uses the PBRHC Form from the Medicaid Supplemental Packet, which is filed with the hospital cost report, and associated detail for the PBRHC facility to determine charges. These charges are multiplied by the PBRHC's cost-to-charge ratio to determine the PBRHC's cost. From this cost, the PBRHC payments associated with above charges are subtracted. If applicable**,** then subtract any interim payments paid prior to the final settlement. The difference is either an overpayment or an underpayment; and

4. Final Settlement Amount.

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

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

1. The audited Medicare Notice of Program Reimbursement (NPR) cost report that includes each PBRHC's fiscal year shall be used to calculate the final settlement, in order that the PBRHC's net reimbursement shall equal reasonable costs as described in this section. The provider shall provide the NPR upon request from the division;

2. Fee-for-Service Section.

A. The division takes the PBRHC's allowable Medicaid charges from services billed under this rule multiplied by the PBRHC's Medicare NPR cost-to-charge ratio to determine the PBRHC's cost. From this cost, the PBRHC FFS claims payments are subtracted. The difference is either an overpayment or an underpayment;

3. Managed Care Section.

A. The division uses the PBRHC Form from the Medicaid Supplemental Packet, which is filed with the hospital cost report, and associated detail for the PBRHC facility to determine charges. These charges are multiplied by the PBRHC's cost-to-charge ratio to determine the PBRHC's cost. From this cost, the PBRHC payments associated with above charges are subtracted. If applicable then subtract any interim payments paid prior to the final settlement. The difference is either an overpayment or an underpayment; and

4. Final Settlement Amount.

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

*[(8)]***(5)** Reconciliation.

(A) The division shall send written notice to the hospital, of which the PBRHC is an integral part, of the following:

1. Underpayments. If the total reimbursement due the PBRHC exceeds the interim payments made for the reporting period, the division makes a lump-sum payment to the PBRHC to bring total interim payments into agreement with total reimbursement due to the PBRHC; and/or

2. Overpayments. If the total interim payments made to the PBRHC for the reporting period exceed the total reimbursement due from the PBRHC for the period, the division arranges with the PBRHC for repayment through a lump-sum refund, or if that poses a hardship for the PBRHC, through offset against subsequent interim payments or a combination of offset and refund.

[(9) Sanctions.

(A) The division may impose sanctions against a provider in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services or any other sanction authorized by state or federal law or regulation.

(B) Overpayments due the MO HealthNet program from a provider shall be recovered by the division in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services.

(10) Appeals. In accordance with sections 208.156 and 621.055, RSMo, providers may seek hearing before the Administrative Hearing Commission of final decisions of the director, Department of Social Services or the MO HealthNet Division.

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

AUTHORITY: sections 208.201 and 660.017, RSMo 2016. Original rule filed June 30, 1995, effective Jan. 30, 1996. Amended: Filed May 14, 1999, effective Nov. 30, 1999. Amended: Filed Aug. 15, 2008, effective Feb. 28, 2009. Amended: Filed April 7, 2021, effective Nov. 30, 2021. <u>The emergency amendment was filed Feb. 28, 2025, effective March 14, 2025, and expires Sept. 14, 2025</u>. Amended: Filed Feb. 28, 2025.*

**Original authority: 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 eight hundred twenty-one thousand dollars ($821,000) in the aggregate.

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****. A public hearing will not be scheduled.*