Rules of

Department of Social Services

Division 70—MO HealthNet Division

Chapter 26—Federally-Qualified Health Center Services

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Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 26—Federally-Qualified Health Center Services

13 CSR 70-26.010 MO HealthNet Program Benefits for Federally-Qualified Health Center Services

PURPOSE: This rule implements the payment methodology for federally-qualified health center services pursuant to section 6404 of the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239).

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which 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 than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Pursuant to the Omnibus Reconciliation Act of 1989, this regulation provides the payment methodology used to reimburse federally-qualified health centers (FQHCs) the allowable costs which are reasonable for the provision of FQHC-covered services to MO HealthNet participants.

(2) General Principles.

(A) The MO HealthNet program shall reimburse FQHC providers based on the reasonable cost of FQHC-covered services related to the care of MO HealthNet participants (within program limitations) less any copayment or deductible amounts which may be due from MO HealthNet participants effective for services on and after July 1, 1990.

(B) Reasonable costs shall be determined by the MO HealthNet Division based on desk reviews of the applicable cost reports and may be subject to adjustment based on field audits. Reasonable costs shall not exceed the Medicare cost principles set forth in 42 CFR Part 413.

(C) Reasonable costs shall be apportioned to the MO HealthNet program based on a ratio of covered charges for MO HealthNet participants to total charges. Charges mean the regular rate for various services which are established uniformly for both MO HealthNet participants and other patients. MO HealthNet charges shall include MO HealthNet managed care charges for covered services.

(D) An FQHC shall submit a MO HealthNet cost report in the manner prescribed by the state MO HealthNet agency. The cost report shall be submitted within five (5) months after the close of the FQHC's reporting period. An extension may be granted upon the request of the FQHC and the approval of the MO HealthNet Division with an agreed upon date of completion. The request must be in writing and postmarked prior to the first day of the sixth month following the FQHC's fiscal year end.

1. An FQHC may be exempt from filing a Missouri Medicaid Title XIX Cost Report if MO HealthNet reimbursement is twenty-five thousand dollars ($25,000) or less for the facility's reporting period. The facility must submit a request to the division to waive the cost report filing requirement within five (5) calendar months after the close of the facility's reporting period. To request an exemption for the cost report filing requirement, the following information must be submitted to the division for review and approval:

A. A Low or No Missouri Medicaid Utilization Waiver Request Form. This form may be obtained from the division. The form must be fully completed and signed by an officer or administrator; and

B. Worksheet S series of the Medicare Cost Report. The Worksheet S must be completed and signed by an officer or administrator.

(E) An FQHC cost report shall be submitted and certified by an officer or administrator of the provider. Failure to file a cost report within the prescribed period, except as expressly extended in writing by the state agency, may result in the imposition of sanctions as described in 13 CSR 70-3.030.

(F) Authenticated copies of agreements and other significant documents related to the provider's operation and provision of care to MO HealthNet participants must be included with the cost report at the time of filing unless current and accurate copies have already been filed with the division. Material which must be submitted includes, but is not limited to, the following as applicable:

1. Audited financial statements prepared by an independent accountant and submitted to the MO HealthNet Division when available, including explanatory notes, disclosure statements, and management letter;

2. Contracts or agreements involving the purchase of facilities or equipment during the cost reporting period if requested by the division, the department, or its agents;

3. Contracts or agreements with related parties;

4. Schedule A detailing all grants, gifts, donations, and income from endowments, including amounts, restrictions, and use;

5. Explanations of grants, gifts, donations, or endowments for which related expenses have not been offset on Worksheet 1-B of the MO HealthNet Division FQHC cost report. If subsequently requested by the division or its contracted agents, documentation of related expenditures will also be submitted;

6. Leases or rental agreements, or both, related to the activities of the provider;

7. Management contracts; and

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

(G) Records.

1. Maintenance and availability of records.

A. A provider must keep records in accordance with generally accepted accounting principles (GAAP) and maintain sufficient internal control and documentation to satisfy audit requirements and other requirements of this rule, including reasonable requests by the division or its authorized agent for additional information.

B. Adequate documentation for all line items on the cost report shall be maintained by a provider. Upon request, all original documentation and records must be made available for review by the division or its authorized agent at the same site at which the services were provided. Copies of documentation and records shall be submitted to the division or its authorized agent upon request.

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

D. The division shall retain all uniform cost reports submitted by the FQHCs for seven (7) years after the final settlement relating to a cost report is finalized, including the resolution of any subsequent appeals or other administrative actions pertaining to the cost report.

E. Each facility shall retain all financial information, data, and records relating to the operation and reimbursement of the facility for seven (7) years after the final settlement relating to a cost report is finalized, including the resolution of any subsequent appeals or other administrative actions pertaining to the cost report, and shall maintain those reports pursuant to the record-keeping requirements of 42 CFR 413.20.

2. Adequacy of records.

A. The division may suspend reimbursement or reduce payments to the appropriate fee schedule amounts if it determines that the FQHC does not maintain records that

provide an adequate basis to determine payments under MO HealthNet.

B. A suspension or reduction will continue until the FQHC demonstrates, to the division's satisfaction, that it has an ongoing and current process in place to ensure the maintenance of adequate records.

(H) Audits.

1. Any cost report submitted may be subject to field audit by the division or its authorized agent.

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, the provider shall transfer the records to the same facility at which the services were provided, or the provider must reimburse the division or its authorized agent 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.

(I) Change in Provider Status. The next payment due the provider after the division has received the notification of the termination of participation in the MO HealthNet program or change of ownership may be held by the division until the cost report is filed. Upon receipt of a cost report prepared in accordance with this rule, the payments that were withheld will be released.

(3) Nonallowable Costs. Any costs which exceed those determined in accordance with the Medicare cost reimbursement principles set forth in 42 CFR Part 413 are not allowable in the determination of a provider's total reimbursement. In addition, the following items specifically are excluded in the determination of a provider's total reimbursement:

(A) Grants, gifts, and income from endowments will be deducted from total operating costs. Exceptions—

1. Grants awarded directly to an FQHC by federal government agencies, such as the Health Resources and Services Administration (HRSA) and Public Health Service;

2. Grants received by an FQHC from the Missouri Primary Care Association (MPCA) in accordance with contractual agreements between the MO HealthNet Division and MPCA;

3. Grants to FQHCs for covered services provided to uninsured patients resulting in uninsured FQHC charges that are included on Worksheet 2 of the MO HealthNet Division FQHC cost report;

4. Grants or incentive payments for the meaningful use of electronic health records (EHR) systems which are either paid directly to FQHCs or assigned to FQHCs by their performing providers; and

5. Payments to FQHCs for participation in MO HealthNet Division Medical Home initiatives.

(B) The value of services provided by non-paid workers, including members of an organization having an agreement to provide those services;

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

(D) Return on equity capital;

(E) Attorney fees related to litigation involving state, local, or federal governmental entities, and attorney fees which are not related to the provision of FQHC services;

(F) Late charges and penalties; and

(G) Research costs.

(4) Interim Payments.

(A) FQHC services shall be reimbursed on an interim basis up to ninety-two percent (92%) of charges for covered services billed to the MO HealthNet program. Interim billings will be processed in accordance with the claims processing procedures for the applicable programs.

(B) An FQHC contracted with a MO HealthNet managed care health plan shall be eligible for supplemental reimbursement of up to ninety-two percent (92%) of managed care charges. The supplemental reimbursement shall make up the difference between what the FQHC would have been paid by the division based on the FQHC's managed care charges for a reporting period and payments made to the FQHC during the reporting period by the managed care health plans for covered services rendered to managed care participants as set forth in the Managed Care contract. The supplemental reimbursement shall occur pursuant to the schedule agreed to by the division and the FQHC, but shall occur no less frequently than every four (4) months. Supplemental reimbursement shall be requested by the FQHC on forms provided by the division. Supplemental reimbursement for managed care charges shall be considered interim reimbursement of the FQHC's MO HealthNet costs.

(5) Final Settlement.

(A) An annual desk review will be completed following submission of the FQHC's Medicaid cost report. The total reimbursement amount due the FQHC for covered services furnished to MO HealthNet participants is based on the allowable costs from the Medicaid cost report. The MO HealthNet Division will make an additional payment to the FQHC when the allowable reported MO HealthNet costs exceed interim payments made for the cost-reporting period. The FQHC must reimburse the division when its allowable reported MO HealthNet costs for the reporting period are less than interim payments.

(B) The annual desk review may be subject to adjustment based on the results of a field audit which may be conducted by the division or its contracted agents.

(C) Cost reports must be fully, clearly, and accurately completed. If any additional information, documentation, or clarification requested by the division or its contracted agents 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.

(D) Notification of Final Settlement.

1. The division will notify an FQHC by letter of a cost report final settlement after completion of the division's cost report desk review. The division's notification letter will include the desk review which details the adjustments the division made to the facility's cost report, the calculation of the final settlement, and a Settlement Agreement, which the facility will sign and return to the division indicating it agrees with the final settlement calculation. The division's written notice to the FQHC shall indicate if the final settlement results in the following:

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

B. Overpayments. If the total interim payments made to an FQHC for the reporting period exceed the total reimbursement due the FQHC for the period, the division arranges with the FQHC for repayment of the overpayment either by having it offset against the FQHC's subsequent interim payments, having the FQHC repay by sending the division a payment, or a combination of offset and payment.

2. The FQHC shall review the division's notification letter and attachments and respond with a signed Settlement Agreement indicating it has accepted the final settlement within fifteen (15) calendar days of receiving the final settlement letter. If the FQHC believes revisions to the division's desk review and/or final settlement are necessary before it can accept the settlement, it must submit additional, amended, or corrected data within the fifteen-(15-) day deadline. Data received from the

FQHC after the fifteen- (15-) day deadline may not be considered by the division in determining if revisions to the final settlement are needed unless the FQHC requests and receives an extension for submitting additional information prior to the end of the fifteen- (15-) day deadline. If the fifteen- (15-) day deadline passes without a response from the provider, the division will proceed with processing the final settlement as set forth in the division's notification letter, and the final settlement shall be deemed final. The division may not accept an amended cost report or any other additional information to revise the cost report or final settlement after the final settlement is finalized.

(6) Payment Assurance.

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

(B) FQHC services provided for those participants having available Medicare benefits shall be reimbursed by MO HealthNet to the extent of the coinsurance and deductible as imposed under Title XVIII.

(C) Where third-party payment is involved, MO HealthNet will be the payer of last resort.

(D) Regardless of changes of ownership, management, control, or leasehold interests by whatever form for any FQHC previously certified for participation in the MO HealthNet program, the division will continue to make all the Title XIX payments directly to the entity with the FQHC's current provider number and hold the entity with the current provider number responsible for all MO HealthNet liabilities.

AUTHORITY: sections 208.201 and 660.017, RSMo 2016. Emergency rule filed June 4, 1990, effective July 1, 1990, expired Oct. 28, 1990. Original rule filed June 4, 1990, effective Nov. 30, 1990. Amended: Filed Sept. 4, 1991, effective Jan. 13, 1992. Amended: Filed July 30, 2002, effective Jan. 30, 2003. Amended: Filed Jan. 14, 2005, effective July 30, 2005. Amended: Filed June 2, 2008, effective Dec. 30, 2008. Amended: Filed June 17, 2011, effective Dec. 30, 2011. Amended: Filed Sept. 18, 2018, effective May 30, 2019.*

**Original authority: 208.201, RSMo 1987, amended 2007 and 660.017, RSMo 1993, amended 1995.*