Rules of
Department of Social Services
Division 70—MO HealthNet Division
Chapter 94—Rural Health Clinic Program

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

13 CSR 70-94.010 Independent Rural Health Clinic Program

PURPOSE: This rule establishes the regulatory basis for Title XIX Medicaid payment for Independent Rural Health Clinic Services.

(1) Authority. This is the payment methodology used to reimburse providers in the MO HealthNet Independent Rural Health Clinic (RHC) program.

(2) Qualifications. For a clinic to qualify for participation in the MO HealthNet independent RHC program, the clinic must be an independent facility, which means that the clinic may not be part of a hospital. However, a clinic may be located in the same building as a hospital, as long as there is no administrative, organizational, financial, or other connection between the clinic and the hospital.

(3) General Principles.

(A) The MO HealthNet program shall reimburse independent RHC providers based on the reasonable cost of RHC-covered services related to the care of MO HealthNet participants (within program limitations) less any copayment or other third party liability amounts which may be due from MO HealthNet participants.

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

(4) Definitions. The following definitions shall apply for the purpose of this rule:

(A) Desk review. The MO HealthNet Division's review of a provider's cost report without on-site audit;

(B) Division. Unless otherwise designated, division refers to the MO HealthNet Division, the division of the Department of Social Services charged with administration of the MO HealthNet program;

(C) Facility fiscal year. A facility's twelve- (12-) month fiscal reporting period;

(D) 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;

(E) Medicaid cost report. The documents used for the purpose of reporting the cost of rendering both covered and non-covered services for the facility's fiscal year shall be the Medicare cost report forms CMS-222-92 and all worksheets supplied by the division. If the Medicare CMS-222-92 is superseded by an alternate Medicare developed cost reporting tool during a facility's fiscal year, that tool must be used for the facility's fiscal year; and

(F) Provider or facility. An independent RHC with a valid MO HealthNet participation agreement in effect with the Department of Social Services for the purpose of providing RHC services to Title XIX eligible participants.

(5) Administrative Actions.

(A) Annual Cost Report.

1. Each independent RHC shall complete a Medicaid cost report for the RHC's twelve- (12-) month fiscal period.

2. Each RHC is required to complete and submit to the division an Annual Cost Report, including all worksheets, attachments, schedules, and requests for additional information from the division. The cost report shall be submitted on forms provided by the division for that purpose.

A. An independent RHC may be exempt from filing a Medicaid cost report if there is no MO HealthNet reimbursement for the reporting period and the facility does not plan to bill the MO HealthNet program for any claims for the 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 MHD for review and approval:

(I) 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

(II) Worksheet S series of the Medicare Cost Report. The applicable parts of the Worksheet S must be completed and signed by an officer or administrator.

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

4. The cost report shall be submitted within five (5) calendar months after the close of the reporting period. An extension may be granted upon the request of the RHC and the approval of the division with an agreed upon date of completion. The request must be received in writing by the division prior to the end of the five (5) calendar-month period after the close of the reporting period.

5. In a change of ownership, the cost report for the closing period must be submitted within forty-five (45) calendar days of the effective date of the change of ownership, unless the change in ownership coincides with the seller's fiscal year end, in which case the cost report must be submitted within five (5) months after the close of the reporting period. No extensions in the submitting of cost reports shall be granted when a change in ownership has occurred.

6. Cost reports 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.

7. Authenticated copies of agreements and other significant documents related to the provider's operation and provision of care to MO HealthNet participants must be attached to 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:

A. Audit, review, or compilation statement prepared by an independent accountant, including disclosure statements and management letter;

B. Contracts or agreements involving the purchase of facilities or equipment during the past five (5) years if requested by the division, the department, or its agents;

C. Contracts or agreements with owners or related parties;

D. Contracts with consultants;

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

F. Documentation of expenditures, by line item, made under all restricted and unrestricted grants, gifts, or endowments;

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

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

I. Management contracts;

J. Provider of service contracts; and

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

8. Under no circumstance will the division accept amended cost reports for final

settlement determination or adjustment after the date of the division's notification of the final settlement amount.

(B) Records.

1. Maintenance and availability of records.

A. A provider must keep records in accordance with GAAP and maintain sufficient internal control and documentation to satisfy audit requirements and other requirements of this 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 independent RHCs 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 will 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 RHC does not maintain records that provide an adequate basis to determine payments under MO HealthNet.

B. The suspension or reduction continues until the RHC demonstrates to the division's satisfaction that it does, and will continue to, maintain adequate records.

(C) 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.

(D) 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.

(6) Nonallowable Costs. Cost not reasonably related to RHC services shall not be included in a provider's costs. Nonallowable cost areas include, but are not limited to, the following:

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

(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 attorney's fees which are not related to the provision of RHC 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 and administration costs, travel costs, and the costs of feasibility studies which 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 nonallowable;

(N) Research costs;

(O) Salaries, wages, or fees paid to nonworking officers, employees, or consultants;

(P) Value of services (imputed or actual) rendered by nonpaid 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 RHC services to Title XIX-eligible participants.

(7) Interim Payments.

(A) Independent RHCs, unless otherwise limited by regulation, shall be reimbursed on an interim basis by MO HealthNet at the Medicare RHC rate. Interim payments shall be reduced by copayments and other third party liabilities.

(B) An independent RHC contracted with a MO HealthNet managed care health plan shall be eligible for supplemental reimbursement up to its interim Medicare RHC rate. The supplemental reimbursement shall make up the difference between what the independent RHC would have been paid by the division based on the independent RHC's Medicare rate and the total managed care health plan payments made to the clinic during the reporting period for covered services rendered to MO HealthNet 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 independent RHC but shall occur no less frequently than every four (4) months. Supplemental reimbursement shall be requested by the independent RHC on forms provided by the division. Supplemental reimbursement for managed care charges shall be considered interim reimbursement of the independent RHC's MO HealthNet costs.

(8) Final Settlement.

(A) Final Settlement Determination. The state agency shall perform an annual desk review of the Medicaid cost reports for each RHC's fiscal year and shall make the necessary payment adjustments (i.e., an additional payment or a recoupment), in order that the RHC's net reimbursement shall equal reasonable costs as described in this section.

1. The total reimbursement amount due the RHC for covered services furnished to MO HealthNet participants is based on the allowable costs from the Medicaid cost report and is calculated as follows:

A. The average cost per visit is calculated by dividing the total allowable cost incurred for the reporting period by total visits for RHC services furnished during this period. The average cost per visit is subject to tests of reasonableness which may be established in accordance with this rule or incorporated in the Allowable Cost per visit as determined on Worksheet C, Part I, line 9 of the cost report; and

B. The total cost of RHC services furnished to MO HealthNet participants is calculated by multiplying the allowable cost per visit by the number of MO HealthNet visits for covered RHC services.

2. The total reimbursable cost is compared to the total interim payments made to the RHC during the reporting period for MO HealthNet participants to determine the amount of the final settlement owed to or due from the RHC. The total interim payments include the amount paid by the division as determined from the division's Medicaid Management Information System (MMIS) reports, the health plan payments as set forth in the Managed Care contract, and third party liability payments.

3. The total reimbursement will be subject to adjustment based on the results of a field audit which may be conducted by the MO HealthNet Division or its contracted agents.

(B) Notification of Final Settlement.

1. The division will notify the RHC by letter of a cost report final settlement after the division completes the desk review of the cost report. The division's notification letter will include 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 RHC shall indicate if the final settlement results in the following:

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

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

2. The RHC 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 RHC believes revisions to the division's desk review and 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 RHC 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 RHC 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.

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

(9) Payment Assurance.

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

(B) RHC 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, leasehold interests by whatever form for any RHC 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 RHC'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 Aug. 20, 1993, effective Sept. 18, 1993, expired Jan. 15, 1994. Emergency rule filed Jan. 19, 1994, effective Jan. 29, 1994, expired Jan. 31, 1994. Original rule filed Aug. 20, 1993, effective Jan. 31, 1994. Amended: Filed Aug. 15, 2008, effective Feb. 28, 2009. Amended: Filed Oct. 17, 2018, effective June 30, 2019.*

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

13 CSR 70-94.020 Provider-Based Rural Health Clinic

PURPOSE: This rule establishes the regulatory basis for Medicaid payment for services provided through the Provider-Based Rural Health Clinic Program.

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) 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.

(C) The Medicaid charges used to determine the cost, and the payments used to determine the final settlement, will be the charges and payments extracted from the Medicaid paid claims history for reimbursable services paid on a percentage basis.

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

(A) "Audit" refers to the division's or its authorized contractor's audit of a hospital's Medicaid cost report;

(B) Division. Unless otherwise designated, "division" refers to the MO HealthNet Division, a division of the Department of Social Services charged with the administration of the MO HealthNet program;

(C) Cost-to-Charge Ratio (CCR). The CCR is determined by dividing the PBRHC

cost by the PBRHC charges from the hospital's Medicaid Cost Report Worksheet C Part I;

(D) Fiscal Year (FY). The clinic's fiscal reporting period that corresponds with the fiscal year of the hospital where the clinic is based;

(E) PBRHC. A clinic that is an integral part of 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;

(F) Generally Accepted Accounting Principles (GAAP). Accounting conventions, rules, and procedures necessary to describe accepted accounting practice at a particular time promulgated by the authoritative body establishing those principles;

(G) Medicaid Cost Report. Shall be the cost reports defined in 13 CSR 70-15.010(2)(F), 13 CSR 70-15.010(5), and Missouri's supplemental cost report schedules.

(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

(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-part413.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.

(3) Administrative Actions.

(A) Annual Cost Report.

1. Each PBRHC shall be individually listed on the hospital's Medicaid cost report.

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

(B) Records.

1. Maintenance and availability of records.

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

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

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

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

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

(A) Federal Reimbursement Allowance (FRA) Tax;

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

(C) Return on equity capital;

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

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

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

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

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

(I) Late charges and penalties;

(J) 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.

(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) 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) 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.*

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