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

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# 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 publication of the full text of the material that the adopting agency has incorporated by reference in this rule would be unduly cumbersome or expensive. Therefore, the full text of that material will be made available to any interested person at both the Office of the Secretary of State and the office of the adopting agency, pursuant to section 536.031.4, RSMo. Such material will be provided at the cost established by state law.*

(1) Authority. This is the payment methodology used to reimburse providers in the MO HealthNet Provider-Based Rural Health Clinic (RHC) Program.

(2) Qualifications. For a clinic to qualify for participation in the MO HealthNet Provider-Based RHC Program, the clinic must meet all of the following criteria:

(A) The clinic must be an integral part of a hospital, skilled nursing facility, or home health agency;

(B) The clinic must be eligible for certification as a Medicare rural health clinic in accordance with 42 CFR 405 and 491; and

(C) The clinic must be operated with other departments of the hospital, skilled nursing facility, or home health agency under common licensure, governance, and professional supervision.

(3) General Principles.

(A) The MO HealthNet program shall reimburse provider-based rural health providers based on the reasonable cost incurred by the RHC 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 MO HealthNet Division based on a 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 parts 405 and 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, a division of the Department of Social Services charged with the administration of the MO HealthNet program;

(C) Facility fiscal year. The clinic's twelve (12)-month fiscal reporting period that corresponds with the fiscal year of the hospital, skilled nursing facility, or home health agency where the clinic is based;

(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.

1. Hospital-based RHCs. The documents used, for the purpose of reporting the cost of rendering both covered and noncovered services for the facility's fiscal year, shall be the cost reports defined in 13 CSR 70-15.010(2)(C) and all worksheets supplied by the division.

2. Skilled nursing facility-based RHCs. The documents used, for the purpose of reporting the cost of rendering both covered and noncovered services for the facility's fiscal year, shall be the skilled nursing facility Medicare cost report forms and all worksheets supplied by the division.

3. Home health agency-based RHCs. The documents used, for the purpose of reporting the cost of rendering both covered and noncovered services for the facility's fiscal year, shall be the home health agency Medicare cost report forms and all worksheets supplied by the division;

(F) Provider or facility. A provider-based RHC with a valid MO HealthNet participation agreement in effect with the Department of Social Services for the purpose of providing RHC services to MO HealthNet-eligible participants; and

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

1. 42 *Code of Federal Regulations* (CFR) Chapter IV, Part 405

2. 42 CFR Chapter IV, Part 491

3. 42 CFR Chapter IV, Part 413

4. 42 CFR Chapter IV, Part 413.17

5. 42 CFR Chapter IV, Part 413.20

6. *Code of State Regulations* (CSR) 13 70-15.010(2)(C)

7. 13 CSR 70-3.030

8. All worksheets supplied by the division

9. Medicare cost report.

(5) Administrative Actions.

(A) Annual Cost Report.

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

2. Each provider-based RHC is required to complete and submit to the MO HealthNet 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.

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 regulation.

4. The cost report shall be submitted within five (5) calendar months after the close of the reporting period. A single extension, not to exceed thirty (30) days, may be granted upon the request of the provider-based RHC and the approval of the MO HealthNet Division. 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) calendar 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 that 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 last 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 and/or rental agreements related to the activities of the provider;

I. Management contracts;

J. Provider of service contracts; and

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

8. 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 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 organizations, as defined by 42 CFR 413.17, must be available upon demand.

D. The MO HealthNet Division shall retain all uniform cost reports submitted for a period of at least three (3) years following the date of submission of the reports and will maintain those reports pursuant to the recordkeeping requirements of 42 CFR 413.20.

E. 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. Adequacy of records.

A. The division may suspend reimbursement or reduce payments to the appropriate fee schedule amounts if it determines that the provider-based RHC does not maintain records that provide an adequate basis to determine payments under MO HealthNet.

B. The suspension or reduction continues until the provider-based 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. This person must be 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 that is different from 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 related to provider-based RHC services shall not be included in a provider's costs. Nonallowable cost areas include, but are not limited to, the following:

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

(B) Return on equity capital;

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

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

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

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

(G) 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;

(H) Late charges and penalties;

(I) Finder's fees;

(J) Fund-raising expenses;

(K) Interest expense on intangible assets;

(L) 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;

(M) Research costs;

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

(O) Value of services (imputed or actual) rendered by nonpaid workers or volunteers; and

(P) 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 provider-based RHC services to MO HealthNet-eligible participants.

(7) Interim Payments.

(A) Hospital-Based RHCs. Provider-based RHC services that are an integral part of the hospital, unless otherwise limited by regulation, shall be reimbursed on an interim basis 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 Hospital Based Rural Health Clinic's cost-to-charge ratio as determined from the audited Medicare cost report. Interim payments shall be reduced by copayments and other third party liabilities.

(B) Skilled Nursing Facility-Based RHCs and Home Health Agency-Based RHCs. Provider-based RHC services that are an integral part of the skilled nursing facility or home health agency, unless otherwise limited by regulation, shall be reimbursed on an interim basis by MO HealthNet, based on the clinic's usual and customary charges multiplied by the lower of the Medicare RHC rate or the rate approved by the MO HealthNet Division. Interim payments shall be reduced by copayments and other third party liabilities.

(C) A provider-based RHC in a MO HealthNet managed care region shall be eligible for supplemental reimbursement up to its interim MO HealthNet payment percentage. This reimbursement shall make up the difference between the provider-based MO HealthNet payment percentage and total managed care health plan payments to the clinic for managed care participants for covered services rendered to MO HealthNet managed care participants during the reporting period. The supplemental reimbursement shall occur pursuant to the schedule agreed to by the division and the provider-based RHC but shall occur no less frequently than every four (4) months. Supplemental reimbursement shall be requested on forms provided by the division. Supplemental reimbursement for managed care charges shall be considered interim reimbursement of the provider-based RHC's MO HealthNet costs.

(8) Reconciliation.

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

(B) Notice of Program Reimbursement. The division shall send written notice to the provider-based RHC of the following:

1. 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 interim payments into agreement with total reimbursement due the RHC; and

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

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

(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.

(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, or leasehold interests by whatever form for any RHC previously certified for participation in the MO HealthNet program, the department will continue to make all the MO HealthNet 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.

(12) Payment in Full. Participation in the MO HealthNet program shall be limited to providers who accept as payment in full, for covered services rendered to MO HealthNet participants, the amount paid in accordance with these regulations and applicable copayments.

*AUTHORITY: section 208.201, RSMo Supp. 2007.* 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.*

**Original authority: 208.201, RSMo 1987, amended 2007.*