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

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**Title 13—DEPARTMENT OF
SOCIAL SERVICES**

**Division 70—Division of Medical Services
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.

Editor's Note: The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State or at the headquarters of the agency and is available to any interested person at a cost established by state law.

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

(2) Qualifications. For a clinic to qualify for participation in the Medicaid 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 Missouri Medical Assistance (Medicaid) program shall reimburse independent RHC providers based on the reasonable cost of RHC-covered services related to the care of Medicaid recipients (within program limitations) less any copayment or other third party liability amounts which may be due from Medicaid recipients.

(B) Reasonable costs shall be determined by the Division of Medical Services 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 Division of Medical Services' review of a provider's cost report without on-site audit;

(B) Division. Unless otherwise designated, division refers to the Division of Medical Services, the division of the Department of Social Services charged with administration of Missouri's Medical Assistance (Medicaid) 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 noncovered services for the facility's fiscal year, shall be the Medicare cost report forms (HCFA-222 (3/83)) and all worksheets supplied by the division; and

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

(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.

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 three (3) 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 RHC and the approval of the division. The request must be received in writing by the division prior to the ninetieth day of the three (3) 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 three (3) 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 Medicaid recipients 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 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 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 RHC does not maintain records that provide an adequate basis to determine payments under Medicaid.

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 Medicaid 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 of 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 non-working 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 Medicaid participation agreement with the Department of Social Services for the pur-

pose of providing RHC services to Title XIX-eligible recipients.

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

(8) Reconciliation.

(A) The state agency shall perform an annual desk review of the Medicaid cost reports for each RHC's fiscal year and shall make indicated adjustments of additional payment or 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 Medicaid recipients is based on 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 3.A., line 7.

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

2. The total reimbursable cost is compared with total payments and third party liability made to the RHC for the reporting period.

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

(B) Notice of Program Reimbursement. The division shall send written notice to the 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 a 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 which 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 Medicaid 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 Division of Medical Services.

(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 recipients having available Medicare benefits shall be reimbursed by Medicaid to the extent of the coinsurance and deductible as imposed under Title XVIII.

(C) Where third-party payment is involved, Medicaid will be the payor 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 Medicaid 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 Medicaid liabilities.

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

AUTHORITY: section 208.201, RSMo Supp. 1987. 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.*

**Original authority 1987.*

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 Medicaid Provider-Based Rural Health Clinic (RHC) Program.

(2) Qualifications. For a clinic to qualify for participation in the Medicaid 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 Missouri Medicaid 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 Medicaid recipients less any copayment or other third party liability

amounts that may be due from the Medicaid-eligible individual.

(B) Reasonable costs shall be determined by the Division of Medical Services 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 Division of Medical Services' review of a provider's cost report without on-site audit;

(B) Division. Unless otherwise designated, division refers to the Division of Medical Services, a division of the Department of Social Services charged with the administration of Missouri's Medical Assistance (Medicaid) 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 Medicaid participation agreement in effect with the Department of Social Services for the purpose of providing RHC services to Medicaid-eligible recipients; 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 RHCs twelve (12)-month fiscal period.

2. Each provider-based RHC is required to complete and submit to the Division of Medical Services 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 three (3) 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 Missouri Division of Medical Services. The request must be received in writing by the division prior to the ninetieth day of the three (3) 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 three (3) 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 Medicaid recipients 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 Missouri Division of Medical Services 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 Medicaid.

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 Medicaid 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 non-working 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 Medicaid participation agreement with the Department of Social Services for the purpose of providing provider-based RHC services to Medicaid-eligible recipients.

(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 Medicaid, 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 by 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 Medicaid, based on the clinic's usual and customary charges multiplied by the lower of the Medicare RHC rate or the rate approved by the Division of Medical Services. Interim payments shall be reduced by copayments and other third party liabilities.

(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 Medicaid 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 Division of Medical Services.

(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 recipients having available Medicare benefits shall be reimbursed by Medicaid to the extent of the coinsurance and deductible as imposed under Title XVIII.

(C) Where third-party payment is involved, Medicaid 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 Medicaid program, the department will continue to make all the Medicaid payments directly to the entity with the RHC's current provider number and hold the entity with the current provider number responsible for all Medicaid liabilities.

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

*AUTHORITY: section 208.201, RSMo 1994. * Original rule filed June 30, 1995, effective Jan. 30, 1996. Amended: Filed May 14, 1999, effective Nov. 30, 1999.*

**Original authority: 208.201, RSMo 1987.*



Provider Number: _____

Fiscal Year: _____ to _____

Provider Name: _____

Disproportionate Share Determination Information

- 1. Total charges for hospital services furnished during your facility's fiscal period for charity care.

CHARITY CARE: Charity care results from a provider's policy to provide health care services free of charge or reductions in charges made by the provider of services because of the indigence or medical indigence of the patient. Standard scale (Sliding Scale) are allowable in calculating charity care. Cost of free care furnished under a Hill-Burton obligation are considered as charity allowances.

Please document this amount by submitting a copy of the trial balance page showing the amount as well as a worksheet showing any revisions.

- 2. Total cash subsidy amounts received directly from State and local governments in the fiscal period.

- 3. Please provide the hospital portion of the contractual allowances included on Worksheet G-3, Line 2.
(Do not offset your Enhanced Medicaid payments against the contractuels.)

Medicare: _____
 Medicaid: _____
 Total: _____

NOTE: *Total' includes Medicare, Medicaid, and other third party contractuels.*

- 4. Total bad debts for hospital services furnished during your facility's fiscal period, do not include the following:
 - a) Patient has insurance that covers the procedure, but the policy imposes limits on its coverage.
 - b) Patient has insurance, but total payments to the hospital are less than actual cost.
 - c) Medicare bad debts or other long term care facility bad debts.

- 5. Please provide the total payments received during the current fiscal year by your facility from out-of-state Medicaid programs for hospital services. Please provide schedule including: State; Patient Days; Payments in fiscal year.

- 6. What is the amount of your FRA tax?
Please identify the worksheet and line where this expense is recorded.
Worksheet _____ Line _____

- 7. Please identify the amount of your enhanced payments. Also state the worksheet and line where this amount is included in the cost report.
Worksheet _____ Line _____



Provider Name _____ Provider Number _____

Fiscal Period _____

(Rev. 5/95)

**SUPPLEMENTAL MM-1
Medicaid Outpatient Costs**

HCFA-2552-83
Worksheet C 2552-83

<u>Column 10</u>	<u>Total</u>	=	<u>Ratio***</u>	<u>Hospital</u>
1. Line 30	a. cost _____	=	_____	
	b. charge _____			
2. Medicaid Outpatient Hospital Charges*				_____
3. Medicaid Rural Health Clinic Charges				_____
4. Total Medicaid Allowable Outpatient Charges (line 2+3)				_____
5. Aggregate Outpatient Cost to-Charge Ratio (line 1)				_____
6. Aggregate Medicaid Hospital O/P Cost (line 4*5)				_____
7. Direct Graduate Medical Education Cost				_____
8. Total Medicaid Hospital and Rural Health Clinic O/P Cost (line 6+7)				_____
9. Medicaid Outpatient Hospital Cost (line 8 * (line 2/line 4))				_____
10. Lower of O/P Hospital Cost or Charges (lesser of line 2 or line 9) Only O/P Cost (line 9) if Nominal Charges Provider.**				_____
11. Reimbursable Cost (90% of line 10)				_____
12. Medicaid Outpatient Payments (line 2 * OP%)				_____
13. Amount Due Provider (Agency) (line 11-12)				_____

*Charges and payment for hospital services furnished to General Relief recipients, for clinical laboratory procedures, all ambulance and physician services that are paid on a fee for services basis and EPSDT payments for Speech and Occupational Therapies are not to be included. Also, do not include rejected or denied claims. Allowable Medicaid Outpatient charges currently reimbursed on your hospital specific percentage.

** Nominal Charge Providers are exempt from this limitation. Letter from Medicare attesting to facility's exempt status for the fiscal year must accompany the cost report or be on file with Medical Services, Hospital Reimbursement Unit, before exemption will be granted by Medicaid.

*** When arriving at the cost/charge ratio carry this ratio out six decimal places.



Provider Name _____ Provider Number _____

Fiscal Period

(Rev. 5/95)

SUPPLEMENTAL MM-1
Rural Health Clinic (RHC)

HCFA-2552-83
Worksheet C 2552-83

Rural Health Clinic

- 1. Medicaid O/P & Rural Health Clinic Cost (line 8, Schedule MM-1) _____
- 2. Medicaid O/P & Rural Health Clinic Charges (line 4, Schedule MM-1) _____
- 3. Medicaid Rural Health Clinic Charges (line 3, Schedule MM-1) _____
- 4. Medicaid Rural Health Clinic Cost (line 3/line 2*line 1) _____
- 5. Lower of Rural Health Clinic Cost or Charges (lesser of line 3 or line 4)
(Only Rural Clinic Cost (line 3) if Nominal Charge Provider) _____
- 6. Medicaid Rural Health Clinic Charges (line 3) * Clinic Payment Percentage _____
- 7. Amount Due Provider (Agency) (line 5-6) _____

Clinic Payment Percentage _____

HCFA 2552-92 REQUIREMENT FOR MEDICAID FILING

IMPORTANT NOTICE: SINCE 13 CSR 70-15.050 (19) (F) STATES THAT "...THE FEDERAL REIMBURSEMENT ALLOWANCE (FRA) ASSESSMENT DESCRIBED IN 13 CSR 70-15.110 SHALL NOT BE AN ALLOWABLE COST FOR THE DETERMINATION OF INPATIENT OR OUTPATIENT SETTLEMENTS OR RATE SETTING" THIS COST MUST BE REMOVED FROM THE COST REPORT FILED WITH THE DIVISION OF MEDICAL SERVICES.

- A. Title XIX (Medicaid) program data should be only for services provided to Missouri Medicaid recipients, unless specified otherwise such as on the questionnaire. Do not include data for services rendered to patients that were billed to Medicaid but were zero paid because of patient ineligibility, filing deadlines exceeded, third party payment exceeded Medicaid liability, service is non-covered, or because of provider billing errors.
- B. Do not include as eligible program data any claims paid under any other provider number than those mentioned in the cover letter.
- C. Record all BILLED eligible claim data for entire length of stay for admissions that occurred in the fiscal time period for which report is being filed whether the claim has been processed by Medicaid in said fiscal time period or not. Interim billings, if permitted, should be included in fiscal year of first date of service billed on claims. Days of service and ancillary charges for Missouri's Prepaid Health Program recipients are not to be included in the Missouri Medicaid Program data.
- D. LABOR/DELIVERY ROOM DAYS Please include the total number of labor and delivery room days in the hospital's total patient days for applicable Missouri Title XIX, Worksheets D, Part I, D Part III, and D-1. Please record the total number of labor and delivery room days on the Missouri questionnaire also. Because Medicaid reimburses for these days, they are to be included in the routine cost per day calculations.
- E. Do not include outpatient charges that have been reimbursed on a fee-for-service basis instead of a percentage-of-charge basis. (This includes claims paid for General Relief recipients and most lab services.)
- F. Year-end cost determinations will be done for both inpatient and outpatient services using agency data for paid claims and an audited HCFA 2552 cost report received by the Division of Medical Services from the provider's Medicare intermediary. Inpatient determinations will be calculated using the agency's data for paid days only. Under or overpayments will be determined for outpatient services. Overpayments or zero-balances will be determined for inpatient services with admissions on or after October 1, 1981; no underpayments will be determined.
- G. Interim outpatient cost settlements will be done for only those hospitals granted disproportionate share status for that year within ninety (90) days of the Division of Medical Services receipt of a COMPLETE cost report filing. The determination will be based on a desk review of the filed cost report.
- H. **DO NOT** send a check with the cost report for payment of a possible overpayment. Payments will only be expected upon the provider's receipt of an official notice of overpayment from the Division of Medical Services.

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- I. Please be sure that the following schedules have been included in your cost report that you are filing with the Division of Medical Services.
1. Signed certification
 2. Worksheet S, Parts I and II
 3. Worksheet S - 2
 4. Worksheet S - 3
 5. Worksheet A and all required supplemental worksheets
 6. Worksheet B, Parts I, II, and III
 7. Worksheet B - 1
 8. Worksheet C
 9. Worksheet D, Parts I - V for Title XVIII and XIX
 - a. Title XIX must have these calculations to comply with Federal Medicaid requirements. Use the capital cost prior to Medicare's reductions.
 - b. Swing-bed facilities must adjust inpatient routine pass through costs on Part I per Medicare instructions.
 - c. If Part V for Title XIX outpatient cannot be completed, please state on worksheet the reason for the non-completion.
 10. Supplemental Worksheet D - 4 for Title XIX
 - a. Title XIX hospital and subprovider charges and cost should not be combined on one worksheet. If this was not done in the past please start maintaining data separately.
 11. Supplemental Worksheet D - 1, Parts I, II, and III for Title XIX Hospital and Subprovider
 - a. Swing-bed costs are to be "carved out" of general inpatient routine service cost.
 - b. Lines 17 - 27 must be completed for Title XIX even if facility is PPS for Medicare.
 - c. Lines 28 - 37, if applicable.
 - d. Lines 56 - 60 do not apply to Title XIX.
 - e. Line 55 will include nursery discharges and should be so noted.

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12. Supplemental Worksheet E - 3, Parts III and IV for Title XIX.
13. Supplemental Worksheets D - 2, F - 1 through F - 5, Part II and all other necessary worksheets, if applicable.
14. Worksheets G, G - 2, G - 3 and a copy of the audited financial statements.
15. Complete working trial balance schedules, Mark Revenues, Revenue deductions and Expenses. Please identify which cost report cost center will include which account balance(s).
16. For Medicaid outpatient:*
 - a. Missouri Medicaid's worksheet MM - 1 (attached). Charges must be reconciled to the total on Worksheet D, Part V, Line 101.
 - b. Missouri Medicaid's worksheet MM-1 Rural Health Clinic (RHC) (attached).
 - c. HCFA 2552 (83 version) Worksheet C (attached) columns 1, 2, 3, 4 - 9 if applicable, and 10. Fill out all columns.

Costs should be taken from Column 1 before RT/PT limit adjustment and RCE disallowance. Column 1 (of the 83 version) total hospital charges should be the same as on HCFA 2552-92, Worksheet C, Column 6. Column 2 cost/charge ratios shall be the same as on Worksheet C, column 7 (HCFA 2552-92). Column 3 (83 version) shall state cost/charge for total hospital inpatient. Columns 4 - 9 (83 version) shall state cost/charge for sub-provider, SNF, ICF, and Home Health. Column 10 should report outpatient cost/charge on the Supplemental MM-1.

17. Complete Disproportionate Share Information
18. Attached questionnaire related to out-of-state Medicaid activity, labor/delivery room days and nursery discharges.

If you have any questions, please contact the hospital reimbursement unit at (314) 751-5663.

* In order to be in compliance with federal upper limit requirements, Medicaid must take into consideration the restrictions placed on claims for ambulatory surgical and radiological services. Because the new HCFA forms are not available for studies to be conducted by the Division of Medical Services, Missouri Medicaid has not developed the methodology to be applied or the applicable forms at this time.

COST CENTER		DEFINITIONAL COST DISTRIBUTION										PROVIDER NO.:		PERIOD:		WORKSHEET C
		Total (Pr- Wkst B, Part I, Col 21)	Ratio of Cost to Charges	Hospital (Col 2x3b)	Subprov. I (Col 2x4b)	Subprov. II (Col 2x5b)	SMP (Col 2x6b)	ICF & Other Long Term Care (Col 2x7b)	MHA (Col. 8)	CONF (Col 2x9b)	All Outpatient (Col 2x10b)	FROM	TO			
1	ARCILLARI SVY COST CTRS	1	2	3	4	5	6	7	8	9	10					
2	Operating Room	a														
3	Recovery Room	b														
4	Delivery Rm & Labor Rm	a														
5	Anesthesiology	b														
6	radiology--Diagnostic	a														
7	radiology--Therapeutic	b														
8	Radioisotope	a														
9	Laboratory	b														
10	Whole Blood & Packed Red Blood Cells	a														
11	Blood Storing, Processing & Transfusion	b														
12	Intravenous Therapy	a														
13	Oxygen (Inhalation) Therapy	b														
14	Physical Therapy	a														
15	Occupational Therapy	b														

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Cost Center	DEPARTMENTAL COST DISTRIBUTION					PROVIDER NO.:				PERIOD: FROM TO				MONESUBET C (Continued)	
	Total (Part I Col 21)	Ratio of Cost to Charges	Hospital (Col 2x3b)	Subprov. I (Col 2x4b)	Subprov. II (Col 2x5b)	SNP (Col 2x6b)	ICF & Other Long Term Care (Col 2x7b)	III A (Col 2x8b)	CORP (Col 2x9b)	All Outpatient (Col 2x10b)					
16 Speech Pathology	a	2	3	4	5	6	7	8	9	10					
17 Electrocardiology	a														
18 Electroencephalography	b														
19 Medical Supplies Charged to Patients	a														
20 Drugs Charged to Patients	b														
21 Renal Dialysis	a														
22	b														
23	a														
24 OUTPATIENT SVY COST CTNS	b														
25 Clinic	a														
26 Emergency	b														
27	a														
28 OTHER REIMBURSABLE COST CTNS	b														
29 Home Program Dialysis--	a														
Other	b														
30 TOTAL	a														

FORM IICFA-2552-B3

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