Rules of
Department of Social Services
Division 70—Division of Medical Services
Chapter 26—Federally-Qualified Health Center Services

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Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
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13 CSR 70-26.010 Medicaid Program Benefits for Federally-Qualified Health Center Services

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

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency's headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.

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

(2) General Principles.

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

(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.

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

(D) FQHCs must use the Medicare cost report forms and abide by Medicare cost principles, limitations and/or screens as though the FQHC was certified for Medicare participation as a federally funded health clinic (FFHC).

(E) FQHCs which are not certified for participation as an FFHC must provide an independent audit annually to the Division of Medical Services which is also consistent with the principles and procedures applied by Medicare in satisfying its audit responsibilities.

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

(A) Grants, gifts and income from endowments will be deducted from total operating costs, with the following exceptions:

1. Public Health Service Grants under sections 329, 330 or 340 of the Public Health Services Act; and

2. Grants received from the Missouri Primary Care Association (MPCA) in accordance with contractual agreements between the Division of Medical Services and MPCA;

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

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

(D) Return on equity capital.

(4) Interim Payments.

(A) FQHC services shall be reimbursed on an interim basis up to ninety-seven percent (97%) of charges for covered services billed to the Medicaid program. Interim billings will be processed in accordance with the claims processing procedures for the applicable programs.

(B) An FQHC in a Medicaid managed care (MC+) region shall be eligible for supplemental reimbursement of up to ninety-seven percent (97%) of MC+ charges. This reimbursement shall make up the difference between ninety-seven percent (97%) of the FQHC's MC+ charges for a reporting period, and payments made by the MC+ health plans to the FQHC for covered services rendered to MC+ patients during that period. The supplemental reimbursement shall occur pursuant to the schedule agreed to by the division and the FQHC, but shall occur no less frequently than every four (4) months. Supplemental reimbursement shall be requested on forms provided by the division. Supplemental reimbursement for MC+ charges shall be considered interim reimbursement of the FQHC's Medicaid costs.

(5) Final Settlement.

(A) An annual desk review will be completed following submission of the Medicare cost report (Health Care Financing Administration (HCFA)-242) and supplemental Missouri Medicaid schedules. The Division of Medical Services will make an additional payment to the FQHC when the allowable reported Medicaid costs exceed interim payments made for the cost-reporting period. The FQHC must reimburse the division when its allowable reported Medicaid costs for the reporting period are less than interim payments.

(B) 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.

AUTHORITY: sections 208.153 and 208.201, RSMo 2000. Emergency rule filed June 4, 1990, effective July 1, 1990, expired Oct. 28, 1990. Original rule filed June 4, 1990, effective Nov. 30, 1990. Amended: Filed Sept. 4, 1991, effective Jan. 13, 1992. Amended: Filed July 30, 2002, effective Jan. 30, 2003.*

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991 and 208.201, RSMo 1987.*