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 publication of the entire text of the material that 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 not exceed the Medicare cost principles set forth in 42 *Code of Federal Regulations* (CFR) Parts 405 and 413, except the Medicare cost limits or caps imposed under 42 CFR 405.2462 will not apply to the prospective rates calculated by the MO HealthNet Division.

(C) Non-allowable Costs. Costs not related to PBRHC services shall not be included. Non-allowable cost areas include, but are not limited to, the following:

1. Federal Reimbursement Allowance (FRA) Tax;
2. Bad debts, charity care, and courtesy allowances;
3. Capital cost increases due solely to changes in ownership;
4. Amortization on intangible assets, such as goodwill, leasehold rights, covenants, but excluding organizational costs;
5. Attorney fees related to litigation involving state, local, or federal governmental entities and attorney's fees that are not related to the provision of PBRHC services, such as litigation related to disputes between or among owners, operators, or administrators;
6. Central office or pooled costs not attributable to the efficient and economical operation of the PBRHC;
7. 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;
8. Late charges and penalties;
9. Finders fees;
10. Fund-raising expenses;
11. Interest expense on intangible assets;
12. 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;
13. Research costs;
14. Salaries, wages, or fees paid to non-working officers, employees, or consultants;
15. Value of services (imputed or actual) rendered by non-paid workers or volunteers; and
16. 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 participants.

(2) Definitions.

(A) Alternative Prospective Payment System (APPS) rate. A reimbursement rate that is an alternative to the standard Prospective Payment System (PPS) rate established in accordance with section 1902(bb) of the Social Security Act.

(B) Audit. The division's or its authorized contractor's audit of a hospital's Medicaid cost report.

(C) Base Years FY 1 and FY 2 for current providers. Fiscal years 1999 and 2000.

(D) Base Years FY 1 and FY 2 for new providers who do not have a 1999 and 2000 cost report. Two (2) fiscal years subsequent to the first year of business as a PBRHC.

(E) Change in scope of service. A change in the type, intensity, duration, or amount of service.

(F) 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.

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

(H) Fourth prior year cost report. The Medicaid cost report for the fourth year prior to the SFY that the rate is effective (i.e., for SFY 2025, the fourth prior year cost report is the FY 2021 cost report).

(I) 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.

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

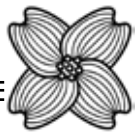
1. 42 CFR Chapter IV, Part 405, which is incorporated by reference and made part of this rule as published by the Office of the Federal Register, 800 North Capitol St. NW, Suite 700, Washington, DC 20408, October 1, 2023, and available at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-405. This rule does not incorporate any subsequent amendments or additions.
2. 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, October 1, 2023, and available at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413. This rule does not incorporate any subsequent amendments or additions.
3. 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, October 1, 2024, and available at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-491. This rule does not incorporate any subsequent amendments or additions.
4. The *Rural Health Clinic Provider 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, September 1, 2023, and available at https://mydss.mo.gov/media/pdf/rural-health-clinic-provider-manual. This rule does not incorporate any subsequent amendments or additions.

(K) Medicaid Cost Report. Shall be the cost report defined in 13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Methodology, and Missouri's supplemental cost report schedules. Each PBRHC shall be individually listed on the hospital's Medicaid cost report.

(L) Medicare Economic Index (MEI). Percentage increase for primary care services.

1. SFY 2024 = 3.8%
2. SFY 2025 = 4.6%
3. SFY 2026 = 3.5%

(M) 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 Parts 405 and 491, and operates with other departments of a hospital.

(N) Prospective Payment System (PPS) Rate. A reimbursement rate established in accordance with section 1902(bb) of the Social Security Act.

(O) 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.

(P) Third prior year cost report. The Medicaid cost report for the third year prior to the SFY that the rate is effective (i.e., for SFY 2025, the third prior year cost report is the FY 2022 cost report).

(Q) 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.

(3) Reimbursement Methodologies. Effective for dates of service on or after January 1, 2025, PBRHCs shall be reimbursed for covered services furnished to eligible Missouri Medicaid participants under a prospective payment system (PPS). An alternative prospective payment system (APPS) will also be determined for each PBRHC. The payment amount determined under this methodology is agreed to by the division and the PBRHCs and results in a payment to the PBRHC of an amount which is at least equal to the PPS rate, with no retrospective settlement.

(A) Prospective Payment System (PPS). Effective for dates of service on or after January 1, 2025, a PPS rate will be set for each PBRHC according to the methodology outlined below:

1. Determination of final PPS base rate.

A. The final PPS base rate for each PBRHC that has base years FY 1 and FY 2 for current providers will be calculated using the Medicaid cost report as follows:

(I) Total allowable cost equals the allowable cost from base year FY 1 for current providers plus the allowable cost from base year FY 2 for current providers;

(II) Total allowable visits equal the allowable visits from base year FY 1 for current providers plus the allowable visits from base year FY 2 for current providers; and

(III) The final PPS base rate equals total allowable cost divided by total allowable visits.

B. The final PPS base rate for each PBRHC that has base years FY 1 and FY 2 for new providers will be calculated using the Medicaid cost report as follows:

(I) Total allowable cost equals the allowable cost from base year FY 1 for new providers plus the allowable cost from base year FY 2 for new providers;

(II) Total allowable visits equal the allowable visits from base year FY 1 for new providers plus the allowable visits from base year FY 2 for new providers; and

(III) The final PPS base rate equals total allowable cost divided by total allowable visits.

C. The division shall adjust the final PPS rate –

(I) By the percentage increase in the MEI applicable to the PBRHC services on July 1 of each year;

(II) In accordance with subsection (3)(C) below –

(a) Upon request and documentation by a PBRHC that there has been a change in scope of services;

(b) Upon review and determination by the division that there has been a change in scope of services; and

2. Determination of interim PPS base rate for a new PBRHC.

A. Until a final PPS rate is established, the division shall calculate an interim PPS rate based on the average final PPS rates based on the managed care organization region where the PBRHC is located.

(B) Alternative Payment Methodology (APM). Effective for dates of service on or after January 1, 2025, PBRHCs may be paid an APPS rate. PBRHCs must agree to the APM in order to receive payment in accordance with the APM and the amount paid under the APM must be at least equal to the PPS rate. To choose this method, the PBRHC must make this selection on the written memorandum form provided by the division.

1. Determination of APPS base rate.

A. The final APPS base rate will be calculated for each PBRHC as follows:

(I) Total allowable cost equals the allowable cost from the third prior year Medicaid cost report plus the allowable cost from the fourth prior year Medicaid cost report;

(II) Total allowable visits equal the allowable visits from the third prior year Medicaid cost report plus the allowable visits from the fourth prior year Medicaid cost report; and

(III) PPS base rate equals total allowable cost divided by total allowable visits.

B. The division shall adjust the final APPS rate –

(I) By the percentage increase in the MEI applicable to the PBRHC services on July 1 of each year;

(II) In accordance with subsection (3)(C) below –

(a) Upon request and documentation by a PBRHC that there has been a change in scope of services;

(b) Upon review and determination by the division that there has been a change in scope of services; and

(III) If necessary, as a result of a desk review or audit.

C. The final APPS rate will be rebased every five (5) years (i.e., SFY 2030 will be the first year of rebasing).

2. Determination of interim APPS base rate for a new PBRHC.

A. Until a final APPS rate is established, the division shall calculate an interim APPS rate based on the average final APPS rates based on the managed care organization region where the PBRHC is located.

(C) Change in scope of service.

1. To receive a PPS rate adjustment for a proposed increase or decrease in the scope of covered PBRHC services in a future FY as compared to the current year, a provider shall be required to submit a proposal which should include enough information to facilitate an evaluation of the proposed change and its effect on the rate. Any rate change would be effective on the first of the month following the division's decision.

2. To receive an APPS rate adjustment for a proposed increase or decrease in the scope of covered PBRHC services in a future FY as compared to the current year, a provider shall be required to submit a proposal which should include enough information to facilitate an evaluation of the proposed change and its effect on the rate. Any rate change would be effective on the first of the month following the division's decision. In addition to a change of scope, PBRHCs will have the opportunity to submit a request to increase the APPS rate if costs exceed the APPS rate by fifteen (15) percent or more. Again, documentation must be provided to determine the case for reconsideration of the APPS rate. Any rate change would be effective on the first of the month following the division's decision.

3. A change in scope of service shall be restricted to –

A. Adding or terminating a covered service;

B. Increasing or decreasing the intensity of a covered service; or

C. A statutory or regulatory change that materially

impacts the costs or visits of a PBRHC.

4. The following items individually shall not constitute a change in scope:

A. A general increase or decrease in the costs of existing services;

B. A reduction or an expansion of hours per day, days per week, or weeks per year;

C. An addition of a new site that provides the same Medicaid covered services;

D. A wage increase;

E. A renovation or other capital expenditure;

F. A change in ownership; or

G. An addition or termination of a service provided by a non-licensed professional or specialist.

5. A change in covered services shall be either —

A. An addition of a covered service restricted to the addition of a licensed professional staff member who can perform a Medicaid covered service that is not currently being performed within the PBRHC by a licensed professional employed or contracted by the PBRHC; or

B. The termination of a covered service restricted to the deletion of a licensed professional staff member who can perform a Medicaid covered service that was being performed within the PBRHC by the licensed professional staff member.

6. A change in intensity shall —

A. Increase or decrease the existing final rate by at least five (5) percent;

B. Last at least twelve (12) months; and

C. Be submitted to the division in writing.

7. A requested change in scope of service shall —

A. Increase or decrease the existing final rate by at least five (5) percent;

B. Last at least twelve (12) months; and

C. Be submitted to the division in writing.

8. A PBRHC that requests a change in scope of service shall submit the following documents to the division within six (6) months of the change in scope of service:

A. A narrative describing the change in scope of service;

B. Budgeted expenditures and change in total number of visits; and

C. A signed letter requesting the change in scope.

(D) PBRHCs that are an integral part of an out-of-state hospital shall be reimbursed a per visit rate based on the state-wide average rate of PBRHCs that are an integral part of in-state hospitals.

(4) Final Settlement Calculations. Final settlements will only be calculated for dates of service prior to January 1, 2025.

(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 (FFS) 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.

(5) 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.

(6) 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. Emergency amendment filed March 3, 2025, effective March 17, 2025, expired Sept. 12, 2025. Amended: Filed March 3, 2025, effective Sept. 30, 2025.*

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

13 CSR 70-94.030 Transformation of Rural Community Health (ToRCH)

PURPOSE: This rule establishes the Transformation of Rural Community Health (ToRCH) program. The purpose of ToRCH is to direct new resources to rural communities that commit to addressing social conditions that lead to poor health.

PUBLISHER'S NOTE: The secretary of state has determined that publication of the entire text of the material that 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) This rule implements the Transformation of Rural Community Health (ToRCH) program. ToRCH is a hub-based model that is designed to allow rural communities to have the flexibility to address health-related social needs (HRSN) among their MO HealthNet populations in a manner that focuses on improving health outcomes. ToRCH will integrate social care supports into clinical care, so that clinical outcomes are less likely to be compromised by social challenges. ToRCH will also create a new role for rural health care providers, and a new path to sustainability for these providers.

(2) Definitions. For purposes of this rule, the following words and phrases are defined as follows:

(A) "Community" shall mean a county or group of counties considered by the ToRCH entity as its core service region, and for whose health outcomes the leadership board will be held accountable;

(B) "Community Based Organization (CBO)" shall mean a public or private not-for-profit entity that provides specific services or resources to the community or targeted population within the community;

(C) "Community Health Needs Assessment" shall mean a community-wide assessment that identifies key health needs and issues through systemic, comprehensive data collection and analysis;

(D) Emergency Department Prevention Quality Indicators (ED PQIs) are measures developed by the Agency for Healthcare Research and Quality (AHRQ) that assess whether visits for a set of chronic and ambulatory care sensitive conditions that could have been more appropriately treated in a primary care setting occurred;

(E) "Health-related social needs (HRSN)" shall mean an individual's unmet, adverse social conditions that contribute to poor health. These needs can include, but are not limited to –

1. Food insecurity;
2. Housing instability;
3. Unemployment or under-employment; or
4. A lack of reliable transportation;

(F) Pediatric Quality Indicators (PDIs), also developed by AHRQ, focus on quantifying potentially preventable complications and iatrogenic events for pediatric patients treated in hospitals and on preventable hospitalizations among pediatric patients, taking into account the special characteristics of the pediatric population;

(G) Prevention Quality Indicators (PQIs) are measures developed by AHRQ. A composite measure assesses whether hospitalizations occurred as a result of complications from chronic conditions that would likely have been preventable due to better condition management;

(H) "Rural community health hub" shall mean a partnership among the ToRCH entity, primary care, behavioral health, and community-based organizations, to provide community-level care management services, including but not limited to strategic coordination of community-based services;

(I) "ToRCH entity" shall mean the leader of a rural community health hub that will provide community-level care management services, i.e., strategic coordination of community-based services that primary care partners are then able to utilize in a systematic way to more fully achieve the goals of primary care case management on an individual patient level. A ToRCH entity shall be located in a county deemed eligible for rural-targeted funding by the Federal Office of Rural Health Policy at the time of its application. Selection criteria for ToRCH entities are specified in section (4); and

(J) "ToRCH model" shall encompass the ToRCH entity and its partners, operating a rural community health hub, making strategic and data-informed decisions in order to earn value-based payments as described in this rule.

(3) ToRCH entities shall provide primary care case management (PCCM) services as defined at 42 U.S.C. section 1396d(t) (2011), as well as utilize a waiver under the *Social Security Act*, section 1915(b) (1921) to address HRSN at a rural community level. This includes but is not limited to –

(A) The strategic coordination of community-based services to allow primary care providers to utilize these services in a systematic way to more fully support positive health outcomes on the individual patient level;

(B) Engaging Community Based Organization (CBO) partners to participate in a Community Information Exchange (CIE) platform;

1. The purpose of the CIE platform is, in part, to allow ToRCH entities to locate HRSN services that case managers and other screening providers can use to better coordinate HRSN services across multiple CBOs, and to monitor enrolled participants in need of these services;

2. Furthermore, the CIE platform is designed to send referrals for HRSN services from medical or clinical providers to CBOs and track the resolution of each referral, to aggregate referral activity at the community level, to pre-screen for eligibility, to manage ToRCH model invoicing, and to assess ToRCH model performance; and

3. ToRCH entities shall agree to use the CIE platform designated by MHD; and

(C) Paying for HRSN services that correlate with better health outcomes and reductions in health care spending.

(4) ToRCH entity selection criteria.

(A) A ToRCH entity shall be located in a county deemed eligible for rural-targeted funding by the Federal Office of

Rural Health Policy at the time of its application.

(B) A ToRCH entity shall be a hospital, a federally qualified health center, a rural health clinic, or a local public health agency.

(C) A prospective ToRCH entity shall apply to participate by submitting a Preparation, Approach, and Implementation Plan based on the following criteria:

1. Provide a well-thought-out plan for the creation of a Leadership Board to oversee and administer all aspects of the ToRCH model at the rural community level.

A. This plan shall identify the organizations and the individuals who the provider intends to participate in the Leadership Board.

B. The Leadership Board shall include hospital leaders necessary to successfully administer the program, as approved by the division.

C. The Leadership Board shall consist of organizations across all domains (hospital, primary care, behavioral health, local public health agency (LPHA), and social care organizations).

D. The Leadership Board shall have a defined structure that includes voting policies for decisions related to ToRCH, defined meeting frequency, recording of minutes, and other procedures common to similar types of bodies and which acknowledges the fiduciary responsibility and risk-bearing status of the ToRCH entity.

E. The purpose of the Leadership Board shall be to harness the members' knowledge of their community and their clinical expertise to strategically focus on HRSN services likely to have the greatest influence on hospital outcomes and population health;

2. Provide a list of existing and potential partners with strong letters of support from at least one (1) from each domain: primary care, behavioral health, CBOs, and local public health agencies;

3. Demonstrate CBOs' current readiness and anticipated needs for support, including technical assistance;

4. Use a Community Health Needs Assessment (or other similar report) to identify the challenges and unmet needs of the community, demonstrating understanding of local population health concerns and providing a preliminary indication of which population health goals the community health hub may wish to prioritize through the ToRCH model;

5. Provide a written statement of commitment to data sharing among clinical partners, and indicate how data will be shared at the individual or aggregate level; and

6. Demonstrate a strong commitment by leadership through one (1) or more letters of support that —

A. Express a vision and enthusiasm for the model and a willingness to be held accountable;

B. Discuss the team (with relevant skills) who will be running the model;

C. Describe current efforts to screen/address Social Determinants of Health (SDoH) in the community; and

D. Describe insights gained from the interactive Community Information Exchange (CIE) demonstration or other data sources.

(D) A prospective ToRCH entity shall provide a narrative that demonstrates a full understanding of the ToRCH model as follows:

1. How the flexibility and customizability of the model will be used to address community needs that connect back to the overarching health goals;

2. The specific actions that the provider will take to achieve the health goals;

3. How data will be used to inform and guide efforts;

4. How course corrections will be made; and

5. How the strengths of the rural community will be leveraged.

(5) A ToRCH entity shall enter into a Participation Agreement with the MO HealthNet Division for the operation of a ToRCH program by the provider. The Participation Agreement (12/07/2023) is incorporated by reference in 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://mydss.mo.gov/mhd/ToRCH, on May 1, 2024. This rule does not incorporate any subsequent amendments or additions.

(A) Participation agreements shall include details on data sharing requirements and responsibilities among ToRCH hub clinical partners and with the division, as well as enumerating requirements and responsibilities for financial reporting and attestation of ToRCH model activities.

(B) A Participation Agreement shall be valid only in geographic areas in which the division has approved the ToRCH entity under this rule.

(C) A Participation Agreement may contain additional terms and conditions agreed to by the parties if the terms and conditions are consistent with the provisions of the *Social Security Act*, section 1915(b) (1981) waiver, this rule, and relevant state or federal law.

(6) Payment Methodology.

(A) Payments to a ToRCH entity in good standing will vary over time. Payments in year N are indicated as "ToRCH(N)" and are determined according to the following formula:

ToRCH(1) = CBF(1) + CSS + SB3(1)
ToRCH(2) = CBF(2) + CSS + SB3(2) + PH(2) + AV(2) + AH(2)
ToRCH(3) = CBF(3) + CSS + SB3(3) + PH(3) + AV(3) + AH(3) + SS(3)
ToRCH(4) = CBF(4) + CSS + SB3(4) + PH(4) + AV(4) + AH(4) + SS(4)
ToRCH(5+) = CSS + PH(5+) + SS(5+).

(B) The components identified in subsection (6)(A) are defined as follows:

1. CBF — Capacity Building Funds. The amount in model years one (1) and two (2) is one hundred sixty thousand dollars ($160,000) per year for a small rural county, two hundred forty thousand dollars ($240,000) for a medium rural county, and three hundred twenty thousand dollars ($320,000) for a large rural county. In year three (3), the amount is reduced by one third (1/3). In year four (4), the amount is reduced by two-thirds (2/3). In year five (5) and beyond, the amount is zero (0). These amounts are to be trended forward for inflation for additional cohorts after the first cohort and are to be awarded to local CBOs that agree to participate in the ToRCH model according to guidance established by the division. For purposes of this rule —

A. A small rural county shall mean a rural county with a population of less than fifteen thousand (15,000);

B. A medium rural county shall mean a rural county with a population from fifteen thousand (15,000) to twenty-nine thousand nine hundred ninety-nine (29,999); and

C. A large rural county shall mean a rural county with a population of at least thirty thousand (30,000);

2. CSS — Community Strategy Services. This amount is comprised of two (2) actuarily-determined components to deliver community strategy services. The first is a base allocation that supports two (2), three (3), or four (4) full-time

personnel (for small, medium, or large counties, respectively) to administer and manage the ToRCH model; the second covers screening and referral activities for MO HealthNet participants, multiplied by the most recent quarter's enrollment data for the ToRCH county or counties, and payable quarterly;

3. SB3 – Supplemental B3 services and activities. In model years one (1) and two (2), this is a budgeted amount to be used by the ToRCH entity to provide supplemental services in accordance with section 1915(b)(3) of the *Social Security Act*. In year three (3), as the funding source for these services and activities begins to transition to Shared Savings (SS), the amount is reduced by one third (1/3). In year four (4), the amount is reduced by two thirds (2/3). In year five (5) and beyond, the amount is reduced to zero (0);

4. PH – Population Health incentive payments. For each of the identified population health goals referenced in the ToRCH entity's Participation Agreement, the Supplemental HRSN services budget will be increased by two percent (2%) if the goal for the prior year is met and by three percent (3%) if the goal is exceeded. Thus, the value of PH(2) equals up to fifteen percent (15%) of SB3(1). The value of PH(3) equals up to fifteen percent (15%) of SB3(2). The value of PH(4) equals up to fifteen percent (15%) of the sum of SB3(3) and SS(3). The value of PH(5) equals up to fifteen percent (15%) of the sum of SB3(4) and SS(4). The value of PH(6+) equals up to fifteen percent (15%) of SS(5+);

5. AV – Avoided Visits incentive payments. Based on calculations of avoidable Emergency Department visits, a pool is created across the ToRCH cohort, i.e., across all ToRCH entities that are in the same model year. Using Emergency Department Prevention Quality Indicators (ED PQIs), hospital services are probabilistically identified as potentially avoidable, and the dollar amount associated with these services is calculated at baseline and after each model year for services that occurred in the ToRCH hospital. The combined reductions achieved by all hospitals achieving reductions will comprise the Avoided Visits Pool. First, these changes are expressed as percentage changes for each hospital, negative numbers representing better performance. The percentage change for any hospital with worse performance is set to zero. Second, these percentage changes are summed to determine the total percent change across the cohort. Third, each hospital's share of the total percent change is calculated as the ratio of the above two (2) steps. Fourth, this share is multiplied by the total value of the reduction achieved across the cohort to determine a prorated share of the reduction, assuming any reductions occurred, and the Pool value is therefore positive. AV for each hospital equals its prorated share of the reduction, or zero if the Pool value is zero. Original values for the first cohort will refer to calendar year 2023 measurements. (Note: if a ToRCH entity is not a hospital, then it will not participate in the Avoided Visits Pool.);

6. AH – Avoided Hospitalization incentive payments. Based on calculations of avoidable hospitalizations, a pool is created across the ToRCH cohort, i.e., across all ToRCH entities that are in the same model year. Using Prevention Quality Indicators (PQIs) and area-level Pediatric Quality Indicators (PDIs), hospital services are identified as potentially avoidable, and the dollar amount associated with these services is calculated at baseline and after each model year for services that occurred in the ToRCH hospital. The combined reductions achieved by all hospitals achieving reductions will comprise the Avoided Hospitalizations Pool. First, these changes are expressed as percentage changes for each hospital, negative numbers representing better performance. The percentage change for any hospital with worse performance is set to zero. Second, these percentage changes are summed to determine the total percent change across the cohort. Third, each hospital's share of the total percent change is calculated as the ratio of the above two (2) steps. Fourth, this share is multiplied by the total value of the reduction achieved across the cohort to determine a prorated share of the reduction, assuming any reductions occurred, and the Pool value is therefore positive. AH for each hospital equals its prorated share of the reduction, or zero if the Pool value is zero. Original values for the first cohort will refer to calendar year 2023 measurements. (Note: if a ToRCH entity is not a hospital, then it will not participate in the Avoided Hospitalization Pool.);

7. SS – Shared Savings payments – Beginning in year three (3), ToRCH entities will be eligible for shared savings payments based upon the estimated savings that MHD calculates as occurring through reductions in all-cause hospitalization (inpatient and outpatient) among the MO HealthNet residents of the ToRCH community. The estimate will be calculated relative to the utilization of MO HealthNet residents of rural, non-ToRCH counties and will be adjusted for the demographic composition of the county, including differences in enrollment by Category of Aid. To phase in the Shared Savings component of the ToRCH model, SS(3) will be, at minimum, equal to twenty percent (20%) of the calculated amount saved between years one (1) and two (2). SS(4) will be, at minimum, forty percent (40%) of the calculated amount saved between years two (2) and three (3). SS(5) will be, at minimum, sixty percent (60%) of the calculated amount saved between years three (3) and four (4). For N>5, SS(N) will be, at minimum, sixty percent (60%) of the calculated amount saved between years N minus two (2) and N minus one (1). When the PH incentive payments are added, the total shared savings rate may be up to seventy-five percent (75%);

(C) The Participation Agreement shall include detailed examples of the methodology described above, including trend rates and algorithms used, in order to ensure clarity for the ToRCH entities.

AUTHORITY: sections 208.201 and 660.017, RSMo 2016, and section 208.153, RSMo Supp. 2024. Emergency rule filed April 22, 2024, effective May 6, 2024, expired Nov. 1, 2024. Original rule filed April 22, 2024, effective Dec. 30, 2024.*

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012, 2024; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*