Table of Contents

State/Territory Name: Missouri

State Plan Amendment (SPA) #: 20-0025

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

August 23, 2021

Jennifer Tidball, Acting Director
Missouri Department of Social Services
P.O. Box 1527
Jefferson City, MO 65102-1527

RE: Missouri Medicaid State Plan Amendment TN: 20-0025

Dear Ms. Tidball:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 20-0025. This Medicaid State Plan Amendment (SPA) removes or replaces obsolete processes, language, and terms; clarifies plan language; allows an extension for cost report filings for good cause shown; amends when cost reports are required for terminating providers or changes in providers; amends when payments will be withheld for late cost report submissions and terminating providers; establishes a required prior authorization process for any out-of-state nursing facility to be reimbursed for nursing facility services; and, revises the methodology for determining prospective rates.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. This is to inform you that Medicaid State plan amendment 20-0025 is approved effective November 1, 2020. We are enclosing the CMS-179 and the amended plan pages.

If you have any additional questions or need further assistance, please contact Fred Sebree at fredrick.sebree@cms.hhs.gov.

Sincerely,

[redacted]

For
Rory Howe
Acting Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 20-0025
2. STATE: Missouri
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: November 1, 2020

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447 Subpart C

7. FEDERAL BUDGET IMPACT: (in thousands)
a. FFY 2021 $ 1,402
b. FFY 2022 $ 1,402

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D
Pages 1, 1a, 2, 3, 4, 5, 6, 7, 7A, 8, 9, 10, 10A, 11, 12, 14, 15, 16, 18, 20, 27, 29, 31, 32, 33, 33A, 33B, 35, 36, 61, 61A, 62, 63N, 63O (new plan page)

9. PAGE NUMBER OF THE SUPERSEDES PLAN SECTION OR ATTACHMENT (If Applicable)
Attachment 4.19-D
Pages LTC 1, LTC 1a, LTC 2, 3, 4, 5, 6, 7, 7A, 8, 9, 10, 10A, 11, 12, 14, 15, 16, 18, 20, 27, 29, 31, 32, 33, 33A, 33B, 35, 36, 61, 61A, 62, 63N

10. SUBJECT OF AMENDMENT:
This amendment removes or replaces obsolete processes, language, and terms; clarifies plan language; allows an extension for cost report filings for good cause shown; amends when cost reports are required for terminating providers or changes in providers; amends when payments will be withheld for late cost report submissions and terminating providers; establishes a required prior authorization process for any out-of-state nursing facility to be reimbursed for nursing facility services; and, revises the methodology for determining prospective rates.

11. GOVERNOR'S REVIEW (Check One)
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPE NAME: Jennifer Tidball
14. TITLE: Acting Director
15. DATE SUBMITTED: 12-16-2020

16. RETURN TO:
MO HealthNet Division
P.O. Box 6500
Jefferson City, MO 65102

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/18/2020
18. DATE APPROVED: 8/23/2021

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 11/1/2020
20. SIGNATURE OF REGIONAL OFFICIAL: [redacted] For
21. TYPED NAME: Rory Howe
22. TITLE: Acting Director, Financial Management Group

23. REMARKS:

FORM CMS-179 (07-92)

Department of Social Services
MO HealthNet Division
Nursing Home Program
Prospective Reimbursement Plan for Nursing Facility Services

Prospective Reimbursement Plan for Nursing Facility Services

(1) Authority. This plan is established pursuant to the authorization granted to the Department of Social Services (Department), MO HealthNet Division (Division).

(2) Purpose. This plan establishes a methodology for determination of reimbursement rates for nursing facilities. Subject to limitations prescribed elsewhere in this plan, a facility's reimbursement rate shall be determined by the Division as described in this plan. Any reimbursement rate determined by the Division shall be a final decision and will be implemented as set forth in the decision letter. The decisions of the division may be subject to review upon properly filing a complaint with the Administrative Hearing Commission (AHC). A nursing facility seeking review by the AHC must obtain a stay from the AHC to stop the division from implementing its final decision if the AHC determines the facility meets the criteria for a stay and so orders. If the facility appeals the division's decision it is the responsibility of the nursing facility to notify any interested parties, including but not limited to hospice providers, 11uit the rate being received is not a final rate and is subject to change. Federal financial participation is available on expenditures for services provided within the scope of the Federal Medicaid Program and made under a court order in accordance with 42 CPR 431.250.

(3) General Principles.

(A) Provisions of this reimbursement plan shall apply only to facilities certified for participation in the MO HealthNet Program.

(B) The reimbursement rates determined by this plan shall apply only to services provided on or after January 1, 1995.

(C) The effective date of this plan shall be January 1, 1995.

(D) The Medicaid Program shall provide reimbursement for nursing facility services based on:

1. The individual Medicaid eligible participant's covered days of care, within benefit limitations as determined in subsections (5)(D) and (5)(M) multiplied by the facility's Medicaid reimbursement rate;

2. Supplemental payments from enhancement payment pools that shall be calculated as a percentage determined by the Department of the aggregate difference between the Medicare Upper Limit and the per diem reimbursement for all Medicaid nursing facilities for services covered by the Missouri Medicaid program.

A. An enhancement payment pool shall be distributed quarterly to participating governmental nursing facilities based on their pro-rata share of local participation. Local participation shall be determined by calculating the pro-rata share of Medicaid patient-days of participating governmental facilities through the period ending June 30, 2005.

B. A second enhancement payment pool shall be distributed on a quarterly basis, in addition to per diem payments, to all Medicaid enrolled nursing facilities based on their pro-rata share of Medicaid days;

3. Reserved.

4. No payments may be collected or retained in addition to the Medicaid reimbursement rate for covered services, unless otherwise provided for in this plan; and

5. Where third party payment is involved, Medicaid will be the payer of last resort with the exception of state programs such as Vocational Rehabilitation and the Missouri Crippled Children's Services.

(E) The Medicaid reimbursement rate shall be the lower of:

1. The Medicare (Title XVIII) rate, if applicable; or

2. The reimbursement rate as determined in .accordance with this plan.

(F) Medicaid reimbursements shall not be paid for services provided to Medicaid eligible participants during any time period in which the facility failed to have Medicaid participation agreement in effect. A reimbursement rate may not be established for a facility if a Medicaid participation agreement is not in effect.

(G) When a nursing facility is found not in compliance with federal requirements for participation in the Medicaid program, Sections 1919 (b), (c) and (d) of the Social Security Act (42 USC 1396r), it may be terminated from the Medicaid program or it may have imposed upon it an alternative remedy, pursuant to Section 1919 (h) of the Social Security Act (42 USC 1396r). In accordance with Section 1919 (h)(3)(D) of the Social Security Act, the alternative remedy, denial of payment for new admission, is contingent upon agreement to repay payments received if the corrective action is not taken in accordance with the approved plan and timetable. It is also required that the nursing facility establish a directed plan of correction in conjunction with and acceptable to the Department of Health and Senior Services.

(H) Upon execution of a Medicaid participation agreement, a qualified facility not previously certified for participation in the Medicaid Program shall be assigned a provider number by the Division. Facilities previously certified shall retain the same provider number and interim or prospective rate regardless of any change in ownership.

(I) Regardless of changes in control or ownership for any facility certified for participation in the Medicaid Program, the Division shall issue payments to the facility identified in the current Medicaid participation agreement. Regardless of changes in control or ownership for any facility certified for participation in Medicaid, the Division shall recover from that entity liabilities, sanctions and penalties pertaining to the Medicaid Program, regardless of when the services were rendered.

(J) Changes in ownership, management, control, operation, leasehold interest by whatever form for any facility previously certified for participation in the Medicaid program at any time that results in increased capital costs for the successor owner, management or leaseholder shall not be recognized for purposes of reimbursement;

(K) A facility with certified and non-certified beds shall allocate allowable costs related to the provision of nursing facility services on the cost report, in accordance with the cost report instructions. The methods for allocation must be supported by adequate accounting and/or statistical data necessary to evaluate the allocation method and its application.

(L) Any facility which is involuntarily terminated from participation in the Medicare Program shall also be terminated from participation in the MO HealthNet Program on the same date as the Medicare termination.

(M) No restrictions nor limitations shall, unless precluded by state plan be placed on a participant's right to select providers of his/her own choice.

(N) A nursing facility's Medicaid reimbursement rate shall not be limited by its average private pay rate.

(O) The reimbursement rates authorized by this plan shall be reevaluated in light of the provider's cost experience to determine any adjustments needed.

(P) Covered supplies, such as but not limited to, food, laundry supplies, housekeeping supplies, linens, and medical supplies, must be accounted for through inventory accounts. Purchases shall be recorded as inventory and shall be expensed in the fiscal year the items are used. Inventory shall be counted at least annually to coincide with the facility's fiscal year or the end of the cost report period, if different. Expensing of items shall be recorded by adding purchases to the beginning period inventory and subtracting the end of the period inventory. This inventory control shall begin the first fiscal year ending after the effective date of this plan.

(Q) Medicaid reimbursement will not be paid for a Medicaid eligible resident while placed in a non-certified bed in a nursing facility.

(R) All illustrations and examples provided throughout this plan are for illustration purposes only and are not meant to be actual calculations.

(S) Rebasing.

1. The division shall pick at least one (1) cost report year from cost reports with fiscal years ending in 2001 or later to compare the allowable costs from the selected desk audited and/or field audited cost report year to the reimbursement rate in effect at the time of the comparison. The rebased rates shall be determined in accordance with section(s) (20)-(21), as applicable.

2. The asset value will be adjusted annually based on the R.S. Means Construction index. The asset value as adjusted will be used only for determining reimbursement in section (11) for the year or years selected above for rebasing and as determined in sections (13)(8)6. and (13)(8)7.

(4) Definitions.

(A) Additional Beds. Newly constructed beds never certified for Medicaid or never previously licensed by the Department of Health and Senior Services.

(B) Administration. This cost component includes the following lines from the cost report:
1. version MSIR-1 (7-93): lines 105, 113-120, 122-140, 142-144, 147-150, 152-158 and amortization of organizational costs reported on line 106; and
2. version MSIR-1 (3-95): line 111-150.

(C) Age of Beds. The age is determined by subtracting the initial licensing year from 1994 for prospective rates effective January 1, 1995 set during the initial 1992 rate base year calculations or the rate setting year for prospective rates effective after January 1, 1995.

(D) Allowable Cost. Those costs which are allowable for allocation to the Medicaid Program based upon the principles established in the plan. The allowability of costs shall be determined by the MO HealthNet Division and shall be based upon criteria and principles included in this plan, the Medicare Provider Reimbursement Manual (HIM-15) and GAAP. Criteria and principles will be applied using this plan as the first source, the Medicare Provider Reimbursement Manual (HIM-15) as the second source and GAAP as the third source.

(E) Ancillary. This cost component includes the following lines from the cost report:

1. version MSIR-1 (7-93): lines 62-75, 87-95, 97-103, 145-146; and ·
2. version MSIR-1 (3-95): lines 71-101.

(F) Asset Value. The asset value is the per bed cost of construction used in calculating a facility's capital cost component per diem utilizing the Fair Rental Value System (FRV) as set forth in subsection (11){D). The asset value is determined using the RS Means Building Construction Cost publication and the median, total cost of construction per bed for nursing homes from the "S.F., C.F., and % of Total Costs" table, adjusted by the total weighted average index for Missouri cities from the "City Cost Indexes" table. The initial asset value used in setting rates effective January 1, 1995 relating to the initial 1992 base year is the value for 1994 and is thirty-two· thousand three hundred thirty dollars ($32,330). The initial asset value is adjusted annually using the estimated Historical Cost Indexes from the RS Means publication for each year and is used to set the prospective rate for new facilities. The asset value in effect at the end of the rate setting period shall be used. The asset value consists of a bed cost and a land cost. The bed cost was based upon the national average cost of a nursing facility bed, without land cost, adjusted for the city index for Kansas City and St. Louis utilizing the 1994 R.S. Means Building Construction Cost Data. The land value was based upon a study of land costs for nursing facilities being approved for construction by the Certificate of Need program in Missouri.

(G) Audit. The examination or inspection of a provider's cost report, files and any other supporting documentation by the MO HealthNet Division or its authorized contractor. The MO HealthNet Division or its authorized contractor may perform the following types of audits:

1. Level I Audit - Requires a more narrow scope of review of provider cost reports, files and any other additional information requested and submitted to the MO HealthNet Division or its authorized contractor. The limited review may include items such as a comparative analysis of a provider's cost report data to industry data or a review of a provider's prior year data to determine any outliers that may warrant further review, requesting additional details of the reported information, all of which could lead to potential adjustment(s) after such further review, making any standard adjustments, etc. Level I audits may be provided off-site.

2. Level II Audit - Requires a desk review of provider cost reports, files and any other additional information requested and submitted to the MO HealthNet Division or its authorized contractor. The desk review may include review procedures in a Level I Audit plus a more detailed analysis of a provider's cost report data to identify items that would require further review including requesting additional details of the reported information, documentation to support amounts reflected in the cost report, etc. Level II audits may be provided off-site.

3. Level III Audit – Requires an in depth audit, including an on-site review, of provider cost reports, files and any other additional information requested and submitted to the MO HealthNet Division or its authorized contractor. The Level III Audit will require an in depth analysis of a provider's cost report data and an on-site verification of cost report items deemed necessary through a risk assessment or other analyses, etc. Level III audits will require some portions of the provider's records review be provided on-site.

(H) Average Private Pay Rate. The usual and customary charge for private patient determined by dividing total private patient days of care into private patient revenue net of contractual allowances and bad debt expense for the same service that is included in the Medicaid reimbursement rate. This excludes negotiated payment methodologies with State or Federal agencies such as the Veteran's Administration or the Missouri Department of Mental Health. Bad debts, charity care and other miscellaneous discounts are excluded ii) the computation of the average private pay rate.

(I) Bad debt. The difference between the amount expected to be received and the amount actually received. This amount may be written off as uncollectible after all collection efforts are exhausted. Collection efforts must be documented and an aged accounts receivable schedule should be kept. Written procedures should be maintained detailing how, when and by whom a receivable may be written off as a bad debt.

(J) Capital. This cost component will be calculated using a Fair Rental Value System (FRV). The fair rental value is reimbursed in lieu of the costs reported on the following lines of the cost report:

1. version MSIR-1 (7-93): lines 106-112, except for amortization of organizational costs; and
2. version MSIR-1 (3-95): lines 102-109.

(K) Capital Asset. A facility's building, building equipment, major moveable equipment, minor equipment, land, land improvements, and leasehold improvements as defined in HIM-15. Motor vehicles are excluded from this definition.

(L) Capital Asset Debt. The debt related to the capital assets as determined from the desk audited and/or field audited cost report.

(M) Ceiling. The ceiling is the maximum per diem rate for which a facility may be reimbursed for the patient care; ancillary and administration cost components and is determined by applying a percentage to the median per diem for the patient care, ancillary and administration cost components. The percentage is 120% for patient care, 120% for ancillary and 110% for administration.

(N) Certified Bed. Any nursing facility or hospital based bed that is certified by the Department of Health and Senior Services to participate in the Medicaid Program.

(O) Change of Ownership. A change in ownership, control, operator or leasehold interest, for any facility certified for participation in the Medicaid Program.

(P) Charity care. Offset to gross billed charges to reduce charges for free services provided to specific types of residents; i.e., charity care provided to meet Hill Burton Fund obligations or care provided by a religious organization for members, etc.

(Q) Contractual allowance. A contra revenue account to reduce gross charges to the amount expected to be received. Contractual allowances represent the difference between the private pay rate and a contracted rate which the facility contracted with an outside party for full payment of Services rendered (ie., Medicaid, Medicare, managed care organizations, etc.). No efforts are made to collect the difference.

(R) Cost Components. The groupings of allowable costs used to calculate a facility's per diem rate. They are patient care, ancillary, capital and administration. In addition, a working capital allowance is provided.

(S) Cost Report. The Financial and Statistical Report for Nursing Facilities, required attachments as specified in paragraph (10)(A)7. of this plan and all worksheets supplied by the Division for this purpose. The cost report shall I detail the cost of rendering both covered and non-covered services for the fiscal reporting period in accordance with this plan and the cost report instructions and shall be prepared on forms or diskettes provided by and/or as approved by the Division.

1. Cost Report version MSIR-1 (7-93) shall be used for completing cost reports with fiscal years ending prior to January 1, 1995 and shall be denoted as CR (7-93) throughout the remainder of this plan.
2. Cost Report version MSIR-1 (3-95) shall be used for completing cost reports with fiscal years ending on or after January 1, 1995 and shall be denoted as CR (3-95) throughout the remainder of this plan.

(T) Databank. The data from the rate base year cost reports excluding the following facilities: hospital based, state operated, pediatric, HIV, terminated or interim rate. If a facility has more than one cost report with periods ending in the rate base year, the cost report covering a full twelve (12) month period ending in the rate base year will be used. If none of the cost reports cover a full twelve (12) months, the cost report with the latest period ending in the rate base year will be used.

(U) Department. The Department, unless otherwise specified, refers to the Missouri Department of Social Services. (V) Department of Health and Senior Services. The department of the state of Missouri responsible for the survey, certification and licensure of nursing facilities as prescribed in Chapter 198, RSMo. Previously, the agency responsible for these duties was the Division of Aging within the Department of Social Services.

(W) Director. The Director, unless otherwise specified, refers to the Director, Missouri Department of Social Services.

(X) Division. Unless otherwise specified, Division refers to the MO HealthNet Division (formerly Division of Medical Services), the Division of the Department of Social Services charged with administration of Missouri's Medical Assistance (Medicaid) Program.

(Y) Entity. Any natural person, corporation, business, partnership or any other fiduciary unit.

(Z) Facility Asset Value. Total asset value less adjustment for age of beds.

(AA) Facility Fiscal Year. A facility's twelve (12) month fiscal reporting period covering the same twelve (12) month period as its federal tax year.

(BB) Facility Size. The number of licensed nursing facility beds as determined from the desk audited and/or field audited cost report which has been verified with Department of Health and Senior Services records.

(CC) Fair Rental Value System. The methodology used to calculate the reimbursement of capital.

(DD) Generally Accepted Accounting Principles (GMP). Accounting conventions, practices, methods, rules and procedures necessary to describe accepted accounting practice at a particular time as established by the authoritative body establishing such principles.

(EE) HCFA Market Basket Index. An index showing nursing home market basket indexes. The index is published quarterly by ORI/McGraw Hill. The table used in this plan is titled "DRI Health Care Cost - National Forecasts, HFCA Nursing Home without Capital Market Basket." HCFA became known as the Center for Medicare and Medicaid Services (CMS) and the table name changed accordingly. The publication and publisher have also changed names but the publication still provides essentially the same information. The publication is known as the HealthCare Cost Review and it is published by Global Insight. The same or comparable index and table shall continue to be used, regardless of any changes. in the name of the publication, publisher or table.

(FF) Hospital Based. Any nursing facility bed licensed and certified by the Department of Health and Senior Services, Section for Health Facilities Regulation, which is physically connected to or located in a hospital.

(GG) Interim Rate. The interim rate is the sum of 100% of the patient care cost component ceiling, 90% of the ancillary and administration cost component ceilings, 95% of the median per diem for the capital cost component, and the working capital allowance using the interim rate cost component. The median per diem for capital will be determined from the capital component per diems of providers with prospective rates in effect on January 1, 1995 for the initial rate base year; July 1, 2004 for the 2001 rebased year; and March 15, 2005 for the revised rebase calculations effective for dates of service beginning April 1, 2005 and for the per diem rate calculation effective for dates of service beginning July 1, 2005 forward.

(HH) Licensed Bed. Any Skilled Nursing Facility or Intermediate Care Facility bed meeting the licensing requirement of the Missouri Department of Health and Senior Services.

(II) Median. The median cost is the middle value in a distribution, above and below which lie an equal number of values. The distribution for purposes of this plan includes the per diems calculated for each facility based on or derived from the data in the data bank. The per diem for each facility is the allowable cost per day which is calculated by dividing the facility's allowable costs by the patient days. For the administration cost component, each facility's· per diem included in the data bank and used to determine the median shall include the adjustment for minimum utilization set forth in (7) (0) by dividing the facility's allowable costs by the greater of the facility's actual patient days or the calculated minimum utilization days.

(JJ) Miscellaneous discounts/ other revenue deductions. A contra revenue account to reduce gross charges to the amount expected to be received. These deductions represent other miscellaneous discounts not specifically defined as a bad debt. Written policies must be maintained detailing the circumstances under which the discounts are available and must be uniformly applied.

(KK) Nursing Facility (NF). Effective October 1, 1990, Skilled Nursing Facilities, Skilled Nursing Facilities/Intermediate Care Facilities and Intermediate Care Facilities as defined in Chapter 198 RSMo participating in the Medicaid Program will all be subject to the minimum Federal requirements found in section 1919 of the Social Security Act.

(LL) Occupancy Rate. A facility's total actual patient days divided by the total bed days for the same period as determined from the desk audited and/or field audited cost report. For a distinct part facility that completes a worksheet one of cost report, version MSIR (7-93) or (3-95), determine the occupancy rate from the total actual patient days from the certified portion of the facility divided by the total bed days from the certified portion for the same period, as determined from the desk audited and/or field audited cost report.

(MM) Patient Care. This cost component includes the following lines from the cost report:
1. version MSIR-1 (7-93): lines 45-60, 77-85; and
2. version MSIR-1 (3 95): lines 46-70.

(NN) Patient Day. The period of service rendered to a patient between the census-taking hour on two (2) consecutive days. Census shall be taken in all facilities at midnight each day and a census log maintained in each facility for documentation purposes. "Patient day" includes the allowable temporary leave-of-absence days per subsection (5)(0) and hospital leave days per subsection (S)(M). The day of discharge is not a patient day for reimbursement unless it is also the day of admission.

(OO) Per Diem. The daily rate calculated using this plan's cost components and used in the determination of a facility's prospective and/or interim rate.

(PP) Provider or Facility. A nursing facility with a valid Medicaid participation agreement with the Department of Social Services for the purpose of providing nursing facility services to Title XIX eligible participants.

(QQ) Prospective Rate. The rate determined from the rate setting cost report.

(RR) Rate Setting Period. The period in which a facility's prospective rate is determined. The cost report that contains the data covering this period will be. used to determine the facility's prospective rate and is known as the rate setting cost report. The rate setting period for a facility is determined from applicable plans on or after July 1, 1990.

(SS) Reimbursement Rate. A prospective or interim rate.

(TT) Related Parties. Parties are related when any one (1) of the following circumstances apply:

1. An entity where, through its activities, one (1) entity's transactions are for the benefit of the other and such benefits exceed those which are usual and customary in such dealings.

2. An entity has an ownership or controlling interest in another entity; and the entity, or one (1) or more relatives of the entity, has an ownership or controlling interest in the other entity, For the purposes of this paragraph, ownership or controlling interest does not include a bank, savings bank, trust company, building and loan association, savings and loan association, credit union, industrial loan and thrift company, investment banking firm or insurance company unless the entity directly, or thr01.1gh a subsidiary, operates a facility,

3. As used in this plan, the following terms mean:

   A. Indirect ownership/interest means an ownership interest in an entity that has an ownership interest in another entity. This term includes an ownership interest in any entity that has an indirect ownership interest in an entity;

C. Relative means person related by blood, adoption or marriage to the fourth degree of consanguinity.

(UU) Replacement Beds. Newly constructed beds never certified for Medicaid or previously licensed by the Division of Aging or the Department of Health and put in service in place of existing Medicaid beds. The number of replacement beds being certified for Medicaid shall not exceed the number of beds being replaced.

(VV) Renovations/Major Improvements. Capital cost incurred for improving a facility excluding replacement beds and additional beds.

(WW) Restricted Funds. Funds, cash, cash equivalents or marketable securities, including grants, gifts, taxes and income from endowments which must only be used for a specific purpose designated by the donor.

(XX) Total Facility Size. Facility size plus increases minus decreases of licensed nursing facility beds plus calculated bed equivalents for renovations/major improvements.

(YY) Unrestricted Funds. Funds, cash, cash equivalents or marketable securities, including grants, gifts, taxes and income from endowments that are given to a provider without restriction by the donor as to their use.

(5) Covered Supplies, Items and Services. All supplies, items and services covered in the reimbursement rate must be provided to the resident as necessary. Supplies and services that would otherwise be covered in a reimbursement rate but which are also billable to the Title XVII Medicare Program must be billed to that program for facilities participating in the Title XVII Medicare Program. Covered supplies, items and services include, but are not limited to, the following:

(A) Services, items and covered supplies required by federal or state law or plan that must be provided by nursing facilities participating in the Title XIX Program;

(B) Semi-private room and board;

(C) Private room and board when it is necessary to isolate a participant due to a medical or social condition examples of which may be contagious infection, loud irrational speech;

(D) Temporary leave of absence days for Medicaid participants, not to exceed twelve (12) days for the first six (6) calendar months and not to exceed twelve (12) days for the second six (6) calendar months. Temporary leave of absence days must be specifically provided for in the participant's plan of care and prescribed by a physician. Periods of time during which a participant is away from the facility visiting a friend or relative are considered temporary leaves of absence;

(E) Provision of personal hygiene and routine care services furnished routinely and uniformly to all residents;

(F) All laundry services, including personal laundry;

(G) All dietary services, including special dietary supplements used for tube feeding or oral feeding. Dietary supplements prescribed by a physician are also covered items;

(H) All consultative services required by federal or state law or plans;

(I) All therapy services required by federal or state law or plans;

(J) All routine care items including, but not limited to, those items specified in Appendix A to this plan;

(K) All nursing services and supplies including, but not limited to, those items specified in Appendix A to this plan;

(L) All non-legend antacids, non-legend laxatives, non-legend stool softeners and non-legend vitamins. Providers may not elect which non-legend drugs in any of the four (4) categories to supply; any and all must be provided to residents as needed and are included in a facility's reimbursement rate; and

(M) Hospital leave days as defined in 13 CSR 70-10.070.

(6) Non-Covered Supplies, Items and Services. All supplies, items and services which are either not covered in a facility's reimbursement rate or are billable to another program in Medicaid, Medicare or other third-party payer. Non-covered supplies, items and services include, but are not limited to, the following:

(A) Private room and board unless it is necessary to isolate a participant due to a medical or social condition, examples of which may be contagious infection, loud irrational speech, etc. Unless a private room is necessary due to such a medical or social condition, a private room is a non-covered service and a Medicaid participant or responsible party may therefore pay the difference between a facility's semi-private charge and its charge for a private room. Medicaid participants may not be placed in private rooms and charged any additional amount above the facility's Medicaid reimbursement rate unless the participant or responsible party specifically requests in writing a private room prior to placement in a private room and acknowledges that an .additional amount not payable by Medicaid will be charged for a private room;

(B) Supplies, items and services for which payment is made under other Medicaid Programs directly to a provider or providers other than providers of the nursing facility services; and

(C) Supplies, items and services provided non-routinely to residents for personal comfort or convenience.

2. For purposes of this. plan, any asset or improvement costing greater than one thousand dollars ($1,000) and having a useful life greater than one (1) year in accordance with American Hospital Association depreciable guidelines, shall be capitalized.

3. In addition to the American Hospital Association depreciable guidelines, mattresses shall be considered a capitalized asset and shall have a three (3) year useful life.

(D) Vehicle Costs. Costs related to allowable vehicles shall be accounted for as set forth below. Allowable vehicles are vehicles that are a necessary part of the operation of a nursing facility and are limited as follows: One (1) vehicle per sixty (60) licensed beds is allowable. For example, one (1) vehicle is allowed for a facility with zero to sixty (0-60) licensed beds, two (2) vehicles are allowed for a facility with sixty-one to one hundred twenty (61-120) licensed beds, and so forth. Vehicles subject to the limit include cars, trucks, vans, sport utility vehicles (SUVs), and shuttle busses; golf carts, utility terrain vehicles (UTVs), all-terrain vehicles (ATVs), etc. shall not be included in the total vehicle count for the limit. Costs related to vehicles that are disallowed shall also be disallowed and adjustments made accordingly.

1. Depreciation.
   A. An appropriate allowance for depreciation on allowable vehicles is reported on line 139 of the cost report, version MSIR-1 (7-93) and on line 133 of CR (3- 95),

   B. The depreciation must be identifiable and recorded in the provider's accounting records, based on the basis of the vehicle and prorated over the estimated useful life of the vehicle in accordance with American Hospita,1 Association depreciable guidelines using the straight line method of depreciation from the date initially put into service.

   C. The basis of vehicle cost at the time placed in service shall be the lower of:

      (I) the book value of the provider;
      (II) fair market value at the time of acquisition; or
      (Ill) the recognized IRS tax basis.

(F) Interest and Borrowing Costs on Capital Asset Debt. Allowable interest and borrowing costs, as set forth below, are reimbursed as part of the capital cost component per diem detailed in (11)(D).

1. Interest will be reimbursed for necessary loans for outstanding capital asset debt from the rate setting cost report at the prime rate plus two percentage (2%) points, as set forth in paragraph (11)(D)3.

2. Loans (including finance charges, prepaid costs and discounts) must be supported by evidence of a written agreement that funds were borrowed and repayment of the funds are required. The loan costs must be identifiable in the provider's accounting records, must be related to the reporting period in which the costs are claimed, and must be necessary for the acquisition and/or renovation of the provider's facility.

3. Necessary means that the loan be incurred to satisfy a financial need of the provider and for a purpose related to participant care. Loans which result in excess funds or investments are not considered necessary.

4. A provider shall capitalize borrowing costs and amortize them over the life of the loan on a straight line basis. Borrowing costs include loan costs (i.e., lender's title and recording fees, appraisal fees, legal fees, escrow fees, and other closing costs), finance charges, prepaid interest and discounts. Finder's fees are not allowed.

5. If loans for capital asset debt exceed the facility asset value the interest and borrowing costs associated with the portion of the loan or loans which exceeds the facility asset value shall not be allowable.

(H) Federal, state or local income and excess profit taxes, including any interest and penalties paid thereon;

(I) Late charges and penalties;

(J) Finder's fees;

(K) Fund-raising expenses;

(L) Interest expense on loans for intangible assets;

(M) Legal fees related to litigation involving the Department and attorneys fees which are not related to the provision of nursing facility services, such as litigation related· to disputes between or among owners, operators or administrators;

(N) Life insurance premiums for officers and owners and related parties except the amount relating to a bona fide nondiscriminatory employee benefits plan;

(0) Non-covered supplies, services and items as defined in section (6);

(P) Owner's Compensation in excess of the applicable range of the most recent survey of administrative salaries paid to individuals other than owners for proprietary and non-proprietary providers as published in the updated Medicare Provider Reimbursement Manual. Part 1, Section 905.2 and based upon the total number of working hours.

1. The applicable range will be determined as follows:

   A. The number of licensed beds owned or managed.

   B. Owners acting as administrators will be adjusted on the basis of the high range. Owners included in home office costs or management company costs will be adjusted on the high range. All others will be calculated on the median range;

(9) Revenue Offsets

(A) Revenues other than room and board shall be classified as other revenues and must be identified separately in the cost report and offset against expenses. Such revenues include, but are not limited to, the following:

1. Income from telephone services;

2. Sale of employee and guest meals;

3. Sale of medical abstracts;

4. Sale. of scrap and waste food or materials;

5. Cash, trade, quantity, time and other discounts;

6. Purchase rebates and refunds;

7. Recovery on insured loss;

8. Parking lot revenues;

9. Vending machine commissions or profits;

10. Sales from supplies to individuals other than nursing facility participants;

11. Room reservation charges other than covered therapeutic home leave days and hospital leave days;

12. Barber and beauty shop revenue;

13. Private room differential;

(10) Provider Reporting and Record Keeping Requirements.

(A) Annual Cost Report. The cost report (version MSIR-1 (3-95)) and cost report instructions (revised 3/95) are incorporated by reference and made a part of this rule published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109. This State Plan does not incorporate any subsequent amendments or additions.

1. Each provider shall adopt the same twelve (12) month fiscal period for completing its cost report as is used for federal income tax reporting.

2. Each provider is required to complete and submit to the Division or its authorized contractor an annual cost report, including all worksheets, attachments, schedules and requests for additional information from the Division or its authorized contractor. The cost report shall be submitted on forms provided by the Division or its authorized contractor for that purpose. Any substitute or computer generated cost report must have prior approval by the Division or its authorized contractor.

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

4. The cost report submitted must be based on the accrual basis of accounting. Governmental institutions operating on a cash or modified cash basis of accounting may continue to report on that basis, provided appropriate treatment for capital expenditures is made under GAAP.

5. Cost reports shall be submitted by the first day of the sixth month following the close of the fiscal period. A provider may request, in writing, a reasonable extension of the cost report filing date for circumstances that are beyond the control of the provider and that are not a product or result of the negligence or malfeasance of the nursing facility. Such circumstances may include public health emergencies; unavoidable acts of nature such as flooding, tornado, earthquake, lightning, hurricane, natural wildfire, or other natural disaster; or, vandalism and/or civil disorder. The division may, at its discretion, grant the extension.

6. If a cost report is more than ten (10) days past due, payment may be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with this plan, the payments that were withheld will be released to the provider. For cost reports which are more than ninety (90) days past due, the Department may terminate the provider's Medicaid participation agreement and if terminated retain all payments which have been withheld pursuant to this provision.

7. Copies of signed agreements and other significant documents related to the provider's operation and provision of care to Medicaid recipients- must be attached (unless otherwise noted) 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 or available upon request includes the following, but may include other documents to assist the Division's understanding of the submitted cost report.

A. Audit prepared by an independent accountant, including disclosure statements and management letter or SEC Form 10-K;

B. Contracts or agreements involving the purchase of facilities or equipment during the last seven (7) years if requested by the Division, the Department or its authorized contractor;

C. Contracts or agreements with owners or related parties;

D. Contracts with consultants;

E. Documentation of expenditures, by line item, made under all restricted and unrestricted grants;

F. Federal and state income tax returns for the fiscal year, if requested by the Division, the Department or its authorized contractor;

G. Leases and/or rental agreements related to the activities of the provider if requested by the Division, the Department or its authorized contactor;

H. Management contracts;

I. Medicare cost report, if applicable;

J. Review and compilation statement;

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

L. Working trial balance actually used to prepare the cost report with line number tracing notations or similar identifications; and

M. Schedule of capital assets with corresponding debt.

8. Cost reports must be fully, clearly and accurately completed. All required attachments must be submitted before a cost report is considered complete. If any additional information, documentation or clarification requested by the Division or its authorized contractor is not provided within fourteen (14) days of the date of receipt of the Division's request, payments may be withheld from the facility until the information is submitted.

9. Under no circumstances will the Division accept amended cost reports for rate determination or rate adjustment after the date of the Division's notification of the final determination of the rate.

10. Exceptions. A cost report is not required for the following:

A. Hospital based providers which provide less than one thousand (1,000) patient days of nursing facility services for Missouri Title XIX participants, relative to their fiscal year.

B. Change in provider status. The cost report filing requirement for the cost report relating to the terminating provider from a change of control, ownership, or termination of participation in the MO HealthNet program is not required, unless the terminating cost report is a full twelve- (12-) month cost report. If a rebase is done for a year in which there is no cost report, the cost report for the year prior to the change of control, ownership, or termination shall be used in the rebase calculation. A trend from the prior year cost report to the rebase year may be applied, if applicable.

11. Notification of change in provider status and withholding of funds for a change in provider status. A provider shall provide written notification to the assistant deputy director of the Institutional Reimbursement Unit of the division prior to a change of control, ownership or termination of participation in the Medicaid program. The division may withhold funds due to a change in provider status as follows:

A. If the division receives notification prior to the change of control, ownership or termination of participation in the Medicaid program, the division will withhold a minimum of thirty thousand dollars ($30,000) of the remaining payments from the old/terminating provider. After six (6) months, any payments withheld will be released to the old/terminating provider, less any amounts owed to the division such as unpaid NFRA, overpayments, etc.

B. If the division does not receive notification prior to a change of control or ownership, the division will withhold thirty thousand dollars ($30,000) of the next available Medicaid payment from the provider identified in the current Medicaid participation agreement. If the Medicaid payment is less than thirty thousand dollars ($30,000), the entire payment will be withheld. After six (6) months, any payments withheld will be released to the provider identified in the current Medicaid participation agreement, less any amounts owed to the division such as unpaid NFRA, overpayments, etc.

(C) Adequate Records and Documentation.

1. 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 plan, including reasonable requests by the Division or its authorized contractor for additional information.

2. Each of a provider's funded accounts must be separately maintained with all account activity clearly identified.

3. Adequate documentation for all line items on the cost report shall be maintained by a provider. Upon request, all original documentation and records must be made available for review by the Division or its authorized contractor at the same site at which the services were provided or at the central office/home office if located in the State of Missouri. Copies of documentation and records shall be submitted to the Division or its authorized contractor upon request.

4.. 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 seven (7) years.

(D) Audits.

1. Any cost report submitted may be subject to a Level III Audit (also known as a field audit) by the Division or its authorized contractor.

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, other than central offices/home offices not located in the State of Missouri, the provider shall transfer the records to the same facility at which the Medicaid services were provided, or the provider must reimburse the Division or its authorized contractor 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.

4. Those providers initially entering the program shall be required to have an annual independent audit of the financial records, used to prepare annual cost reports covering at a minimum the first two (2) full twelve (12) month fiscal years of their participation in the Medicaid Program, in accordance with GAAP and Generally Accepted Auditing Standards. The audit shall include, but may not be limited to, the Balance Sheet, Income Statement, Statement of Retained Earnings and Statement of Cash Flow. For example, a provider begins participation in the Medicaid Program in March and chooses a fiscal year of October 1 to September 30. The first cost report will cover March through September. That cost report may be audited at the option of the provider. The October 1 to September 30 cost report, the first full twelve (12) month fiscal year cost report, shall be audited. The next October 1 to September 30 cost report, the second full twelve (12) month cost report, shall be audited. The audits shall be done by an independent certified public accountant. The independent audits of the first two (2) full twelve- (12-) month fiscal years may be performed at the same time. The provider may submit two (2) independent audit reports (i.e., one for each year) or they may submit one (1) combined independent audit report covering both years. The independent audit report(s) for combined audits are due with the filing of the second (2nd) full twelve- (12-) month cost report. If the independent audits are combined, the provider must notify the division of such by the due date of the first (1st) full twelve- (12-) month cost report.

(14) Exceptions

(A) Requirements for Placement of MO HealthNet Participants in Out-of-State Nursing Facilities and Reimbursement for Out-of-State Nursing Facilities.

1. In order to provide nursing facility services to MO HealthNet participants when there is no Missouri nursing facility with a suitable bed available that meets the medical needs of the participant, the division may authorize placement of a MO HealthNet participant in an out-of-state facility.
2. The division will only authorize placement of a MO HealthNet participant into an out-of-state facility if:
   A. No Missouri nursing facility bed is available that meets the medical needs of the participant,
   B. In-state alternatives for providing services have been exhausted, and
   C. Prior approval for placement into an out-of-state nursing facility is requested from and approved by the division.
3. Once a Missouri nursing facility bed meeting the medical needs of the participant is available, the participant must return to Missouri to remain eligible for Missouri Medicaid program, unless the participant's health would be endangered if required to travel to Missouri.
4. No fiscal year end Missouri Medicaid cost report will be required from the out-of-state nursing facility nor will there be any requirement for Missouri conducted periodic audits.
5. The Title XIX reimbursement rate for out-of-state providers shall be set as follows:
   A. For out-of-state providers which provided services for Missouri Title XIX participants, the reimbursement rate shall be the lower of:
      I. The weighted average MO HealthNet rate for comparable services at the beginning of the state fiscal year in which the provider enters the MO HealthNet program, or
      II. The rate paid to the out-of-state nursing facility for comparable services by the state in which the provider is located. The out-of-state provider must notify the division of any reimbursement changes made by its state Medicaid agency. The provider must also include a copy of the rate letter issued by their state Medicaid agency detailing the rate and effective date. The effective date of the rate change is as follows:

a. Rate increases: If the provider notifies the division within thirty (30) days of receipt of notification from their state of the per-diem rate increase, the effective date of the rate increase for purposes of reimbursement from Missouri shall be the same date as indicated in the issuing state's rate letter. If the division does not receive written notification from the provider within thirty (30) days of the date the provider received notification from their state of the rate increase, the effective date of the rate increase for purposes of reimbursement from Missouri shall be the first day of the month following the date the division receives notification; or

b. Rate Decreases: The effective date of the rate decrease for purposes of reimbursement from Missouri shall be the same date as indicated in the issuing state's rate letter.

(B) The Title XIX reimbursement rate for hospital based providers that provide services of less than one thousand (1,000) patient days for Missouri Title XIX participants, relative to their fiscal year, and that are exempt from filing a cost report as prescribed in section (10) shall be determined as follows:

12. For hospital based nursing facilities that have less than 1,000 Medicaid patient days, the rate base cost report will not be required. The prospective rate will be the sum of the ceilings for patient care, ancillary and administration, working capital allowance, and the median per diem for capital. In addition, the patient care incentive of ten percent (10%) of the patient care median will be granted.

13. For hospital based nursing facilities, that have less than 1,000 Medicaid patient days, with a provider agreement in effect on December 31,.1994, a prospective rate shall be set by one of the following:

A. The hospital based nursing facility requests, in writing, that their prospective rate be determined from their rate setting cost report as set faith in this plan; or

B. The sum of the ceilings for patient care, ancillary, administration and working capital allowance, and the median per diem for capital from the permanent capital per diem in effect January 1, 1995 for the initial rate base year; July 1, 2004 for the 2001 rebased year; and March 15, 2005 for the revised rebase calculations effective for dates of service beginning April 1, 2005 and for the per diem rate calculation effective for dates of service beginning July 1, 2005 forward. In addition, the· patient care incentive of ten percent (10%) of the patient care median will be granted.

(15) Sanctions and Overpayments.

(A) In addition to the sanctions and penalties set forth in this plan, the Division may also impose sanctions against a provider in accordance with state plan 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 plans.

(B) Overpayments due the Medicaid Program from a provider shall be recovered by the Division in accordance with state plan 13 CSR 70-3.030, Sanctions for False or Fraudulent Claims for Title XIX Services.

(16) Appeals. In accordance with sections 208.156, RSMo, and 622.055, RSMo, providers may seek hearing before the Administrative Hearing Commission of final decisions of the Director or the Division.

(17) Payment in Full. Participation in the program shall be limited to providers who accept as payment in full, for covered services rendered to Medicaid participants, the amount paid in accordance with these plans and other applicable payments.

1. If there is a 2001 cost report for the nursing facility, regardless of the owner/operator who completed the 2001 cost report, the prospective rate shall be based on the 2001 cost report in accordance with section (21).

2. If there is not a 2001 cost report for the nursing facility, the prospective rate in effect when the facility terminated from the program shall be adjusted to reflect the rate changes granted through June 30, 2004 and shall be the June 30, 2004 rate to be compared to the preliminary rebased interim rate to determine the total increase, the one-third increase and the rebased prospective rate, in accordance with section (21), consistent with the rest of the nursing facility industry.

(L) Nursing facilities who qualify to have their prospective rate set in accordance with the provisions of subsection (20)(E) shall continue to receive the rate determined from subsection (20)(E) for dates of service beginning July 1, 2005.

(22) Prospective Rate Determination Beginning November 1, 2020. Prospective rates determined on or after November 1, 2020 shall be calculated as follows:

(A) Prospective Rate Determination for Nursing Facilities Newly Medicaid Certified after June 30, 2004. As set forth in subsection (12)(F), a nursing facility never previously certified for participation in the Medicaid program shall receive an interim rate upon entering the Medicaid program. The nursing facility shall have its prospective rate set on its second full twelve- (12-) month cost report following the facility's initial date of certification, referred to as the rate setting cost report. The period to which the rate setting cost report relates is referred to as the rate setting period.

(B) The prospective rate shall be calculated in accordance with the provisions of the regulation in effect from the beginning of the facility's rate setting period through the date the prospective rate is determined, as detailed below. If industry-wide rate changes were implemented during this period the provision of the regulation relating to the effective date of the rate change shall be the governing regulation for those dates of service.

(C) The prospective rate shall be calculated using the same principles and methodology as detailed throughout sections (1)–(19) of this regulation and the updated items detailed in subsections (21)(A)-(L), except for the following:

1. Paragraphs (21)(L)2. and (21)(L)3. shall not be applied in determining the prospective rate; and,

2. The total rate determined from the rate setting cost report shall be adjusted by any global per diem adjustments granted after the beginning of the facility's rate setting period through the effective date of the prospective rate; and,

3. The effective date for a facility's prospective rate is as follows:

   A. The effective date for facilities with a rate setting cost report period that begins prior to November 1, 2020 shall be November 1, 2020; and,

   B. The effective date for facilities with a rate setting cost report period that begins after November 1, 2020 shall be the beginning of the rate setting cost report period; and

4. The total rate that has been trended shall be limited to a cap, referred to as the total rate cap. The total trended rate shall be limited to the total rate cap that is in effect on the effective date of the prospective rate, as follows:

   A. The total rate cap in effect on November 1, 2020 is $190.00; and,

   B. The total rate cap set forth above, $190.00, shall be adjusted by any global per diem adjustments granted after November 1, 2020; and,

5. Once the prospective rate is finalized, a retroactive payment shall be made back to the effective date, if applicable.

6. The prospective rate determined in (22)(C)1.-5. shall be adjusted by any global per diem adjustments set forth in 13 CSR 70-10.016 that are granted after the effective date of the prospective rate.