Table of Contents

State/Territory Name: Missouri

State Plan Amendment (SPA) MO-24-0012

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
230 South Dearborn
Chicago, Illinois 60604

Financial Management Group

August 21, 2025

Todd Richardson
Director MO Health Net
Missouri Department of Social Services
Broadway State Office Building
PO Box 1527
Jefferson City, MO 65102

RE: TN MO-24-0012

Dear Director Richardson:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Missouri state plan amendment (SPA) to Attachment 4.19-B MO-24-0012, which was submitted to CMS on December 26th, 2024. The purpose of this plan amendment is to add a Prospective Payment System (PPS) and an Alternative Payment Method for Provider Based Rural Health Clinics (PBRHCs)

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of January 1, 2025. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Robert Bromwell at 410-786-5914 or via email at robert.bromwell@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

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: 24 — 0012
2. STATE: MO
3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: January 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION: 1902(a)(15) and 1902(bb) of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 848,944
b. FFY 2026 $ 279,212

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19 B Pages 39 - 46

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19 B Pages 39 - 46
Delete Appendix A - all pages

9. SUBJECT OF AMENDMENT
This State Plan Amendment changes the reimbursement methodology for Provider Based Rural Health Clinics (PBRHC).

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]
12. TYPED NAME: Robert J. Knodell
13. TITLE: Acting Director
14. DATE SUBMITTED: 12-20-24

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

FOR CMS USE ONLY

16. DATE RECEIVED: December 26, 2024
17. DATE APPROVED: August 21, 2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2025
19. SIGNATURE OF APPROVING OFFICIAL: [redacted]
20. TYPED NAME OF APPROVING OFFICIAL: Todd McMillion
21. TITLE OF APPROVING OFFICIAL: Director, Division of Reimbursement Review

22. REMARKS

Pen and ink change authorized via email on 7/22/2025 to block 6.b. from blank to 2026, $279,212.

PROVIDER-BASED RURAL HEALTH CLINIC ALTERNATIVE PAYMENT METHODOLOGY

I. Provider-based rural health clinics (PBRHC) shall be reimbursed for covered services furnished to eligible Missouri Medicaid participants under a prospective payment system (PPS) pursuant to section 702 of the Medicare, Medicaid, and CHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000). 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 State 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.

II. General Principles.

A. The MO HealthNet program shall reimburse PBRHCs 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 nonworking 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.

III. Definitions. The following definitions shall apply for the purpose of this rule:

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 BIPA 2000;

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 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. Medicaid Cost Report. Shall be the cost report defined in Attachment 4.19-A, and Missouri's supplemental cost report schedules. Each PBRHC shall be individually listed on the hospital's Medicaid cost report;

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

L. 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 405 and 491, and operates with other departments of a hospital;

M. Prospective Payment System (PPS) Rate. A reimbursement rate established in accordance with BIPA 2000;

N. 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; and

O. 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).

IV. Reimbursement Methods.

A. Prospective Payment System (PPS). A PPS rate will be set for each PBRHC according to the methodology outlined below:

1. Determination of final PPS Base Rate

(i) 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:

(a) Total allowable costs equal the allowable cost from base year FY 1 for current providers plus the allowable cost from base year FY 2 for current providers.

(b) 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.

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

(ii) 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:

(a) Total allowable costs equal the allowable cost from base year FY 1 for new providers plus the allowable cost from base year FY 2 for new providers.

(b) 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.

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

(iii) The division shall adjust a final PPS rate:

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

(b) In accordance with section IV.C. of this state plan:

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

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

2. Determination of PPS Base Rate for a new PBRHC

(i) Until a final PPS rate is established, the division shall calculate a PPS rate equal to one hundred percent (100%) of the reasonable cost used in calculating the PPS rates of like or similar PBRHCs located in the same or adjacent area during the same fiscal year with similar case load. If there are no like or similar PBRHCs, the division shall calculate a PPS rate equal to the average final PPS rates based on one of the four managed care organization regions in the State of Missouri where the PBRHC is located.

B. Alternative Payment Methodology (APM). Effective 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 Initial APPS Base Rate for a new PBRHC

(i) Until a final APPS rate is established, the division shall calculate an APPS rate equal to the average final APPS rates based on one of the four managed care organization regions in the State of Missouri where the PBRHC is located.

2. Determination of Final APPS Base Rate

(i) The final APPS base rate will be calculated for each PBRHC as follows:

(a) Total allowable costs equal the allowable cost from the third prior year Medicaid cost report plus the allowable cost from the fourth prior year Medicaid cost report.

(b) 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.

(c) The final APPS base rate equals total allowable cost divided by total allowable visits.

(ii) Once a final PPS rate is determined, the division will compare the final PPS rate to the APPS rate annually. If the final PPS rate is greater than the APPS rate for the new PBRHC, the division will make a payment up to what would have been paid under the PPS methodology. This review will be done annually for new PBRHCs until final rates are determined.

3. Adjustments to the Final APPS Rate:

   (i) The division shall adjust the final APPS rate:

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

      (b) In accordance with section IV.C. of this state plan:

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

         (2) Upon review and determination by the department that there has been a change in scope of services; or

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

4. The final APPS rate will be rebased and effective every five (5) years (i.e. SFY 2030 will be the first year of rebasing. The rebased rate will be effective July 1, 2029.)

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 implemented 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 implemented on the first of the month following the division's decision. In addition to change of scope, clinics 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 implemented on the first of the month following the division's decision.

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

   (i) Adding or terminating a covered service;

   (ii) Increasing or decreasing the intensity of a covered service; or

   (iii) 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 of service:

   (i) A general increase or decrease in the costs of existing services;

   (ii) A reduction or an expansion of hours per day, days per week, or weeks per year;

   (iii) An addition of a new site that provides the same Medicaid covered services;

   (iv) A wage increase;

   (v) A renovation or other capital expenditure;

   (vi) A change in ownership; or

   (vii) An addition or termination of a service provided by a non-licensed professional or specialist.

5. A change in covered services shall:

   (i) An addition of a covered service shall be 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.

   (ii) The termination of a covered service shall be 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:

   (i) Include a material change;

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

   (iii) Last at least twelve (12) months.

7. A requested change in scope of service shall:

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

   (ii) Last at least twelve (12) months; and

   (iii) 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:

   (i) A narrative describing the change in scope of service;

   (ii) Budgeted expenditures and change in total number of visits; and

   (iii) A signed letter requesting the change in scope.

V. State Supplemental Payment for PBRHC Services Furnished Under Contract with Managed Care Organizations (MCOs)

A. If a MCOs reimbursement to a PBRHC is less than what the PBRHC would receive under the applicable Section IV.A. or B., the state shall supplement the reimbursement made in a manner that:

1. Equals the difference between what the MCO reimbursed and what the reimbursement would have been if it had been made in accordance with Section IV.

2. The supplemental payment will be made no less frequently than every four months.

3. An annual reconciliation of the supplemental payments to the PPS or APPS amount will be performed.

DIABETIC EDUCATION AND SUPPLIES

I. The reimbursement will be made at the lower of:

A. The provider's billed charge for the service or

B. The Medicaid maximum allowable fee for the service.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers for the above services. The division's fee schedule rate was set as of January 1, 2001, and is effective for services provided on or after that date. The division's established fee schedule rates are published on the MO HealthNet website at https://mydss.mo.gov/mhd/cpt. To navigate the site users must agree to the licensure terms and conditions, select "Download" or "Full Search", and select "Medical Services".