## Table of Contents

**State/Territory Name: MO**

**State Plan Amendment (SPA) #: 24-0019**

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 S3-14-28
Baltimore, Maryland 21244-1850

**Financial Management Group**

December 4, 2024

Robert Knodell, Director
Missouri Department of Social Services
P.O. Box 1527
Jefferson City, MO 65102-1527

RE: TN 24-0019

Dear Mr. Knodell:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Missouri state plan amendment (SPA) to Attachment 4.19-D, MO 24-0019, which was submitted to CMS on September 30, 2024. This plan amendment provides for a rebasing and other updates for nursing facility and HIV nursing facility per diem rates.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 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. CMS has identified concerns that the state's use of revenues derived from its Federal Reimbursement Allowance (FRA) tax program as a source of Missouri's non-federal share for this state plan amendment may not comply with certain health care-related tax requirements in section 1903(w)(4) of the Social Security Act and implementing regulations in 42 CFR 433.68(f)(3). Approval of this state plan amendment does not constitute an approval of the non-federal share funded by the FRA or NFRA taxes.

Based upon the information provided by the state, we have approved the amendment with an effective date of July 1, 2024. 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 Fred Sebree at fredrick.sebree@cms.hhs.gov.

Sincerely,

Rory Howe
Director
Financial Management Group

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: 24-0019

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
July 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447 Subpart C

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ 20,674,682
b. FFY 2025 $ 81,747,450

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Att. 4.19D
Pages: 73, 73-A, 74, 74-A, 76, 76-A, 77, 78, 78-A, 91, 94, 94-A, 96, 97, 98, 102, 102-A, 102-B, 108-A, 109, 109-A, 111, 115-A

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Att. 4.19D
Pages: 73, 74, 76, 77, 78, 91, 94, 96, 97, 98, 102, 109, 111

9. SUBJECT OF AMENDMENT

This amendment rebases nursing facility and HIV nursing facility per diem rates, changes the resident classification system used to determine the case mix index (CMI), updates the value based purchasing (VBP) per diem adjustment, provides for a facility size and occupancy rate adjustment, describes the process for reviewing information used for the CMI and mental illness (MI) add-on, clarifies data used for MI add-on, clarifies capital rate used in the interim rate, clarifies when an independent audit is required, and provides for reviews to be done on Minimum Data Set (MDS) submissions and adjustments to the reimbursement rate based on the MDS reviews.

10. GOVERNOR'S REVIEW *(Check One)*

(●) GOVERNOR'S OFFICE REPORTED NO COMMENT JAF
( ) 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
Director

14. DATE SUBMITTED
9-30-24

15. RETURN TO

Todd Richardson
MO HealthNet Division
P.O. Box 6500
Jefferson City, MO 65102-6500

**FOR CMS USE ONLY**

16. DATE RECEIVED
9/30/2024

17. DATE APPROVED
December 4, 2024

**PLAN APPROVED - ONE COPY ATTACHED**

18. EFFECTIVE DATE OF APPROVED MATERIAL
7/1/2024

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS

11/27/2024 - State updated block 15 with contact and address

(N) Case Mix Index (CMI). Weight or numeric score assigned to a resident classification system (e.g. Resource Utilization Group (RUG), Patient-Driven Payment Model (PDPM), etc.) grouping to reflect the relative resources predicted to care for a resident. The average acuity level of patients in a facility can be determined and expressed by calculating an average of the individual CMI values for each resident. Resident classifications are determined from information derived from the Minimum Data Set (MDS) evaluations for a given period.

1. Resident Classification Systems Used to Determine CMI.

A. RUG IV. Effective for dates of service from July 1, 2022 through June 30, 2024, the Resource Utilization Group (RUG) IV, 48 groups, Logic Version 1.03, CMI Set F01 (48-Grp) (i.e., RUG IV 48 group model classification system) is used to determine the CMIs used in this regulation and is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid services (CMS) at its website https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation, June 29, 2022. Applicable files are RUG-IV DLL Package V1.04.1 Final.zip and RUG III Files & RUG IV Files.zip. This rule does not incorporate any subsequent amendment or additions;
rsingHomeQualityInits/NHQIMDS30TechnicalInformation, June 29, 2022. Applicable files are RUG-IV DLL Package V1.04.1 Final.zip and RUG III Files & RUG IV Files.zip. This rule does not incorporate any subsequent amendment or additions;

B. PDPM. Effective for dates of service beginning July 1, 2024, the Patient Driven Payment Model (PDPM) nursing component case mix groups (CMG) and case mix index table effective October 1, 2023 as listed in the final SNF PPS payment rule for FY 2024, https://www.federalregister.gov/documents/2023/08/07/2023-16249/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities#p-155, is used to determine the CMIs used in this regulation and is incorporated by reference and made a part of this rule. This rule does not incorporate any subsequent amendment or additions;

2. Individual CMIs are calculated as follows:

A. Providers should follow CMS guidelines for completing and submitting MDS assessments. No extra MDS assessments are required as a result of this plan;

B. An index maximizing methodology is used to calculate the individual CMI for RUG classifications. The index maximizing classification system will select the RUG with the highest CMI for individuals that qualify for multiple RUGs;

C. A hierarchical methodology is used to determine the individual CMI for the PDPM nursing component classifications. The hierarchical classification system will work through the PDPM nursing classifications in order and select the first group for which the patient qualifies. The nursing classification hierarchical order includes: Extensive Services, Special Care High, Special Care Low, Clinically Complex, Behavioral Symptoms and Cognitive Performance, and Reduced Physical Function.

3. Facility CMIs are calculated as follows:

A. Facility CMI calculations will be based on quarterly point-in-time data snapshots. These snapshot dates are January 1, April 1, July 1 and October 1;

B. The midnight census will determine the residents that are included in the facility's CMI;

C. The Assessment Reference Date (ARD) will be used to dete+rmine the assessment included in each quarterly CMI calculation;

D. A look-back period of one hundred eighty (180) days will be used to determine the residents included in calculating the facility CMI. The look-back period cutoff date is the day prior to the snapshot date (i.e., for the January 1 CMI calculation, the ARD would need to be December 31 or earlier).

E. The most current MDS assessment for an individual in the look-back period of one hundred eighty (180) days will be used;

F. Only assessments that are included in the MDS data sent to the State through the CMS system will be available for case mix calculations;

G. An average acuity level will be determined for each facility for each snapshot date by using a simple average of the CMI values for all residents included in the data for the snapshot date.

(I) Medicaid CMI. The average acuity level for Medicaid patients in a facility.

(a) Medicaid pending residents will be included in the facilty's Medicaid CMI calculation;

(b) Medicaid hospice residents will be included in the facility's Medicaid CMI calculation;

(c) Medicaid manage care residents will be included in the facility's Medicaid CMI calculation;

(II) Total CMI. The average acuity level for all patients in a facility.

H. When facility-specific CMI data is not available, the statewide average CMI will be used.

4. Resident Listings.

A. Nursing facilities will be provided a draft resident listing to review for accuracy and will be given a minimum of two weeks to correct resident listings that are not accurate. The draft resident listing will include resident specific information including, but not limited to, the resident's name and identification number, the payment source, the assessment reference date (ARD), the PDPM nursing code and corresponding CMI, and whether the resident has a mental illness diagnosis that qualifies for the mental illness diagnosis add-on which is used to determine the facility's Medicaid CMI and whether the facility qualifies for the Mental Illness Diagnosis Add-On. Nursing facilities will be notified when the draft resident listings are available to review and will include the due date for when all corrections must be done.

B. Facilities may submit corrections to the draft resident listings as follows:

(I) Payer Source – Corrections to the payer source for a resident should be submitted to the division or its authorized contractor;

(II) Other Corrections – Any corrections to the data other than corrections to the payer source must be submitted through the iQIES system. Chapter 5 of the Resident Assessment Instrument (RAI) Manual discusses submission and correction of MDS assessments. The RAI manual is posted on the Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual page maintained by CMS, https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual.

C. A final resident listing will be prepared based on the draft resident listing plus any corrections submitted by the facility by the due date.

D. No corrections will be accepted after the due date, unless the division or its authorized contractor has given prior approval.

E. The final resident listing will be used to determine the CMI and Mental Illness Diagnosis Add-On included in a facility's per diem rate and will be provided when the final per diem rate is determined.

F. If any of a facility's corrections that were submitted on a timely basis were not captured in the final resident listing, the facility may submit a request to the division or its authorized contractor to review. The request must include documentation supporting their claim.

(O) 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 one hundred twenty percent (120%) for patient care, one hundred twenty percent (120%) for ancillary, and one hundred ten percent (110%) for administration.

(P) Certified bed. Any licensed nursing facility or hospital based bed that is approved by the Department of Social Services to participate in the Medicaid Program.

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

(R) Charity care. Offset to gross billed charges to reduce charges for free services provided to specific types of residents, (i.e., charity care provided by a religious organization for members, etc.).

2. If a facility has more than one (1) 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. Beginning with the SFY 2025 rebase, cost reports must cover more than three (3) full months to be used for rebasing; cost reports covering three months or less will not be used. If a facility does not have a cost report for the rebase year, the cost report for the year prior to the rebase year shall be used.

3. Nursing facilities that terminated from the MO HealthNet program during the rate base year shall not be included in the data bank.

4. Nursing facilities operating under an interim rate that have at least a second full year cost report after entering the Medicaid program that coincides with the rate base year may be included in the data bank. Interim rate facilities without such a cost report for the rate base year shall not be included in the data bank. Beginning with the SFY 2025 rebase, nursing facilities operating under an interim rate will not be included in the data bank.

5. The initial rate base year used for rebasing shall be 2019 and the data bank shall include cost reports with an ending date in calendar year 2019. The 2019 rebase year data shall be used to set rates effective for dates of service beginning July 1, 2022 through such time rates are rebased again or calculated on some other cost report as set forth in plan. The 2019 year data shall be adjusted for the following and shall be used to determine the medians, ceilings, and per diem rates for the nursing facilities:

A. The following allowable salaries shall be adjusted by two percent (2%):
(I) Aides and Orderlies (Line 53 of CR (3-95));
(II) Dietary Salaries (Line 60 of CR (3-95));
(III) Laundry Salaries (Line 85 of CR (3-95));
(IV) Housekeeping Salaries (Line 91 of CR (3-95)); and,
(V) Beauty & Barber Salaries (Line 94 of CR (3-95)).

B. The total allowable costs, including the salary adjustments detailed above in (4)(W)5.A., shall be trended through June 30, 2022 by the difference in the CMS Market Basket Index (i.e., the "Total – %MOVAVG" index for 2022:2 from the Fourth-quarter 2021 publication) and the midpoint of the facility's rate setting cost report year.

C. The total patient care costs, including the salary adjustments and trends, shall be adjusted to match the statewide average total CMI by multiplying the total patient care costs by the quotient of the statewide average total CMI divided by the facility cost report total CMI.

(I) A cost report total CMI is determined for each facility based on a simple average of the four (4) quarterly total CMIs covering the facility's cost report period.

(II) The statewide total CMI is a simple average of the cost report CMIs for all nursing facilities included in the databank.

6. SFY 2025 Rebase. Effective for dates of service beginning July 1, 2024, nursing facility rates shall be rebased using a data bank with cost report ending dates in calendar year 2022, except in instances where 2022 data is not available as explained in (4)(W)2. The 2022 rebase year data shall be used to set rates effective for dates of service beginning July 1, 2024, through such time rates are rebased again or calculated on some other cost report as set forth in regulation. The 2022 base year data shall be adjusted for the following and shall be used to determine the medians, ceilings, and per diem rates for the nursing facilities:

A. The following allowable salaries shall be adjusted by two percent (2%):

(I) Aides and Orderlies (Line 53 of CR (3-95));

(II) Dietary Salaries (Line 60 of CR (3-95));

(III) Laundry Salaries (Line 85 of CR (3-95));

(IV) Housekeeping Salaries (Line 91 of CR (3-95)); and,

(V) Beauty & Barber Salaries (Line 94 of CR (3-95));

B. The total allowable costs, including the salary adjustments detailed above in (4)(W)6.A., shall be trended through June 30, 2024, by the difference in the CMS Market Basket Index (i.e., the "Total – %MOVAVG" index for 2024:2 from the first-quarter 2024 publication) and the midpoint of the facility's rate setting cost report year; and

C. The total patient care costs, including the salary adjustments and trends, shall be adjusted to match the state-wide average total CMI by multiplying the total patient care costs by the quotient of the state-wide average total CMI divided by the facility cost report total CMI.

(I) A cost report total CMI is determined for each facility based on a simple average of the four (4) quarterly total CMIs covering the facility's cost report period.

(II) The state-wide total CMI is a simple average of the cost report CMIs for all nursing facilities included in the databank.

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

(Y) 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.

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

(AA) Division. Unless otherwise specified, division refers to the MO HealthNet Division, the division of the Department of Social Services charged with administration of Missouri's MO HealthNet Program.

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

(CC) Facility asset value. Total asset value less adjustment for age of beds.

(DD) Facility fiscal year. A facility's twelve- (12-) month fiscal reporting period. If the facility is also participating in the Title XVIII Medicare (Medicare) program, the Medicaid cost report period shall be the same as the Medicare cost report period. If the provider does not participate in Medicare, the Medicaid cost report should have the same twelve- (12-) month fiscal year consistent with the facility's accounting and reporting period.

(EE) Facility size. The number of licensed nursing facility beds as determined from the cost report.

(FF) Fair rental value (FRV) system. The methodology used to calculate the reimbursement of capital.

(GG) Generally accepted accounting principles (GAAP). 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.

(HH) Hospital based. Any nursing facility bed licensed and certified which is physically connected to or located in a hospital.

(II) Interim rate. The interim rate is the sum of one hundred percent (100%) of the patient care cost component ceiling, ninety percent (90%) of the ancillary and administration cost component ceilings, and ninety-five percent (95%) of the median per diem for the capital cost component.

1. The median per diem for capital will be determined from the capital component per diems of providers with prospective rates in effect on July 1, 2022 for the initial 2019 rate base year.

2. Beginning with the SFY 2025 rebase, the median per diem for capital will be determined from the capital component per diems of providers included in the data bank.

(JJ) Licensed bed. Any skilled nursing facility or intermediate care facility bed meeting the licensing requirement of the Missouri Department of Health and Senior Services.

(KK) Minimum Data Set (MDS). A standardized, primary and comprehensive tool used to assess a patient's functional, medical, psychosocial, and cognitive status for residents of nursing facilities to participate in Medicare and Medicaid.

1. Providers should follow CMS guidelines for completing and submitting MDS assessments. No extra MDS assessments are required as a result of this rule;

2. Assessments should comply with CMS guidance as provided through the Resident Assessment Instrument (RAI) Manual in effect at the time of the assessment. The RAI manual is posted on the Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual page maintained by CMS, https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual.

3. CMS is the only source for MDS data. All MDS initial submissions, corrections, etc. must be submitted through the CMS Internet Quality Improvement & Evaluation System (iQIES) according to CMS procedures.

4. MDS Reviews. Beginning July 1, 2024, the division or its authorized contractor shall conduct reviews of a facility's MDS data to verify that residents have been properly classified and that the facility is following CMS procedures and documentation requirements.

A. MDS submissions that are not correct will be adjusted and will be used to recalculate the PDPM and associated CMI.

B. A facility's per diem rate will be adjusted based on the revisions to the PDPM and associated CMI after the initial training and education period, as set forth below in Section (12).

(LL) Minimum utilization days. Calculated number of patient days, based on the minimum utilization percentage, which will be used in the determination of the facility's administration and capital cost component per diems if the facility's occupancy is below the minimum utilization percent set forth in subsection (7)(N). Minimum utilization days are calculated by multiplying the facility's bed days by the minimum utilization percent set forth in subsection (7)(N).

(MM) 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.

(NN) Median. 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 subsection (7)(N) by dividing the facility's allowable costs by the greater of the facility's actual patient days or the calculated minimum utilization days.

(OO) Medicare Provider Reimbursement Manual (CMS Publications 15-1 and 15-2). Guidelines and policies to implement Medicare (Title VIII) regulations which set forth principles for determining the reasonable cost of provider services.

1. The Medicare Provider Reimbursement Manual (CMS Publications 15-1 and 15-2) is incorporated by reference and made a part of this plan as published by the Centers for Medicare & Medicaid Services (CMS) at its website https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929 and https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.

2. The federal regulations 42 CFR 413 forming the basis of the Medicare Provider Reimbursement Manual (CMS Publications 15-1 and 15-2) is incorporated by reference and made a part of this plan as published by CMS at its website https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413?toc=1.

3. The Medicare Provider Reimbursement Manual (CMS Publications 15-1 and 15-2) shall be referred to as the Medicare PRM throughout this plan.

(9) Revenue Offsets.

(A) Other revenues must be identified separately in the cost report. These revenues are 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;

14. Medicare Part B revenues.

A. Revenues received from Part B charges through Medicare will be offset.

B. For purposes of determining reimbursement, the total therapy revenues reported on Schedule A, lines 12, 13, and 16, that are offset shall not exceed the total therapy expenses reported on Schedule B, lines 72 -75 and lines 78-79.

15. Personal services;

16. Activity income; and

17. Revenue recorded for donated services and commodities.

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 may not be 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. The division may waive the cost report filing requirement for the twelve- (12-) month terminating cost report or the last twelve- (12-) month fiscal year end cost report resulting from a change of control, ownership, or termination of participation in the MO HealthNet program if the old/terminating provider can show financial hardship in providing the cost report. The old/terminating provider must submit a request to the division, indicating and providing documentation for the financial hardship caused by filing the cost report.

(I) If a cost report for a year that is used to calculate per diem rates is not submitted, the cost report for the year prior to the rate setting year shall be used to determine the per diem rate, consistent with (4)(W).

(II) The new provider may obtain the data needed to prepare a cost report that covers the period that the old/terminating provider operated the facility and may submit a cost report as follows:

(a) The new provider may prepare and submit a cost report that covers the old/terminating provider's cost report period, or

(b) The new provider may combine the data from the old/terminating provider with the data from the new provider and submit a twelve- (12-) month cost report that covers the new provider's cost report period, if it occurs in the same year as the old owner.

(c) The new provider must notify the division of its intention to complete a cost report covering the old provider's cost report period including the cost report period that will be submitted.

(d) The cost report is due by the first day of the sixth month following the close of the cost report period, consistent with (10)(A)5., regardless of whether the cost report covers only the old/terminating provider's cost report period or it covers the new provider's cost report period.

(e) It is the new provider's responsibility to determine if the old/terminating provider will submit a cost report and to obtain any information it needs.

C. New MO HealthNet facility or Re-certified MO HealthNet facility. The first (1st) cost report for a new facility enrolled in the MO HealthNet program or a facility that had terminated from participation in the MO HealthNet program and was re-certified in the MO HealthNet program may not be required if it is a short period cost report. A short period cost report covers three (3) months or less of nursing facility services for MO HealthNet participants, relative to the facility's fiscal year.

(I) If the provider participates in the Medicare program, the provider must complete the MO HealthNet cost report covering the same period as the Medicare cost report unless a short period cost report would still be required by Medicare but is not required by MO HealthNet because it covers three (3) months or less. For example:

(a) Example A: A facility enters the Medicaid/Medicare program on December 20 and has a December 31 fiscal year end. If Medicare requires that the December 20 – December 31 period be combined with the subsequent year cost report, then the MO HealthNet cost report should cover the same period.

(B) Certification of Cost Reports.

1. The accuracy and validity of the cost report must be certified by the provider. Certification must be made by a person authorized by one (1) of the following: for an incorporated entity, an officer of the corporation; for a partnership, a partner; for a sole proprietorship or sole owner, the owner or licensed operator; or for a public facility, the chief administrative officer of the facility. Proof of such authorization shall be furnished upon request.

2. The following statement must be signed on each cost report to certify its accuracy and validity:

Certification Statement: Misrepresentation or falsification of any information contained in this cost report may be punishable by fine and/or imprisonment under state and federal law.

Certification of Officer or Administrator of Provider

I hereby certify that I have read the above statement and that I have examined the accompanying cost report and supporting schedules prepared by (provider name) for the cost report period beginning (date/year) and ending (date/year), and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

_____
*Authorized Signature*

_____
*(Title)*

_____
*(Date)*

(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 MO HealthNet 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 MO HealthNet 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 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 full twelve- (12-) month cost report**.** If a provider terminates prior to the date that the independent audit is due, the independent audit is not required.

(E) Joint Use of Resources.

1. If a provider has business enterprises in addition to the nursing facility, the revenues, expenses, statistical, and financial records of each separate enterprise shall be clearly identifiable.

2. When the facility is owned, controlled or managed by an entity(ies) that own, control, or manage one (1) or more other facilities, records of central office and other costs incurred outside the facility shall be maintained so as to separately identify revenues and expenses of, and allocations to, individual facilities. Direct allocation of cost, such as RN consultant, which can be directly identifiable in the central office/home office cost and directly allocated to a facility by actual amounts or actual time spent. These direct costs shall be reported on the appropriate lines of the cost report. Allocation of central office/home office or management company costs to individual facilities should be consistent from year-to-year. If a desk audit or field audit establishes that records are not maintained so as to clearly identify information required by this plan, those commingled costs shall not be recognized as allowable costs in determining the facility's Medicaid reimbursement rate. Allowability of these costs shall be determined in accordance with the provisions of this plan.

(11) Prospective Rate Determination. The division will use the rate setting cost report described in (11)(I) to determine the nursing facility's prospective rate, as detailed in (11)(A)-(I) below.

(A) Patient Care. Each nursing facility's patient care per diem shall be calculated as follows –

1. The base patient care per diem shall be the lower of the —

A. Allowable cost per patient day for patient care as determined by the division from the rate setting cost report, including applicable adjustments and trends; or

B. Per diem ceiling of one hundred twenty percent (120%) of the patient care median determined by the division from the data bank.

2. The base patient care per diem determined in (11)(A)1. shall be adjusted by the facility's average Medicaid CMI from the two (2) preceding quarterly calculations relative to the effective date of the rate (i.e., for 2019 rebase rates effective July 1, 2022, the January 1, 2022 and April 1, 2022 CMI calculations shall be used) and shall be the facility's patient care per diem to be included in the facility's total prospective per diem rate.

(D) Capital. Each nursing facility's capital per diem shall be determined using the fair rental value system (FRV), which consists of two (2) elements — rental value and pass-through expenses. The calculation for each element, as well as the overall capital per diem, is detailed below in paragraphs (11)(D)1.–3.

1. Rental value.

A. Determine the total asset value.

(I) Determine facility size from the rate setting cost report. The changes in the number of licensed beds (i.e., increase and decreases) from the date the facility was originally licensed through the end of the rate setting cost report period should be determined and should result in the same number of licensed beds at the end of the facility's rate setting cost report.

(a) Facility Size and Occupancy Rate Adjustment. Beginning with the SFY 2025 rebase, a facility may request a facility size and occupancy rate adjustment, which provides for the number of licensed beds as of the April 1 that precedes the July 1 rate calculation to be used to determine the facility size and occupancy rate rather than the number of licensed beds at the end of the applicable cost report period.

1. Qualifying criteria. A nursing facility may qualify for a facility size and occupancy adjustment if it meets all of the following criteria:

a. The facility operated at less than its licensed bed capacity during the cost report period used to determine the facility's capital rate so that it could provide single occupancy accommodations; and

b. The facility operated as such at least from the beginning of the facility's cost report period used to determine the facility's capital rate through the April 1 that precedes the July 1 rate calculation; and

c. The facility reduced the number of licensed beds to be equal to the number of single occupancy rooms that the facility will operate with going forward. The reduction in licensed beds must be effective on or before the April 1 that precedes the July 1 rate calculation.

2. Calculation of adjusted facility size, adjusted occupancy rate, and adjusted per diem rate.

a. Adjusted facility size. The facility size as defined in subsection (4)(EE) and used in the determination of a facility's capital cost component under the fair rental value system set forth in subsection (11)(D) shall be adjusted to reflect the licensed bed capacity as of the April 1 that precedes the July 1 rate calculation.

b. Adjusted occupancy rate. The occupancy rate as defined in subsection (4)(QQ) shall be adjusted to reflect the licensed beds as of the April 1 that precedes the July 1 rate calculation rather than the licensed beds reflected on the applicable cost report. The bed days will be calculated using the licensed beds as of the April 1 that precedes the July 1 rate calculation and the adjusted occupancy rate will be calculated by dividing the facility's total actual patient days by the adjusted bed days.

c. The adjusted facility size and the adjusted occupancy rate shall be used to determine the facility's per diem rate in accordance with the remaining provisions of this regulation.

3. The facility must request in writing the facility size and occupancy rate adjustment and provide the proper documentation to show that it qualifies for the adjustment, including the following:

a. A copy of the quarterly surveys from the beginning of the applicable cost report period through the April 1 that precedes the July 1 rate calculation showing that the facility's number of available beds was less than its full licensed bed capacity; and

b. A copy of the approved change in the number of licensed beds that includes a notation that the rooms are single occupancy; and

c. A statement from the facility that it will continue to operate single occupancy rooms; and

d. For the July 1, 2024 rate calculation, the division shall accept such written requests from facilities that qualify for this adjustment as of July 1, 2024 for up to thirty (30) days after the effective date of this amendment. The rate adjustment shall be retroactive back to July 1, 2024. For subsequent rate calculations, a facility must submit the request, including all documentation showing that they qualify for the adjustment, to the division by the May 1 that precedes the July 1 rate calculation and the rate adjustment shall be effective on July 1.

4. This adjustment shall only apply to nursing facilities with a prospective rate and shall remain in effect for all subsequent rates determined from the 2022 cost report used to rebase rates.

5. Loss of facility size adjustment and recalculation of per diem rate. If a facility's per diem rate has been calculated using an adjusted facility size and an adjusted occupancy rate and the facility ceases to operate with only single occupancy accommodations, the facility will no longer receive the adjustment to the facility size and occupancy rate in determining its per diem rate.

a. If the facility size and occupancy rate adjustment is lost, the facility's per diem rate will be recalculated using the facility size as set forth in subsection (4)(EE) and the bed days and occupancy rate as set forth in subsection (4)(QQ).

b. The facility must notify the division within thirty (30) days if it no longer qualifies for the facility size and occupancy rate adjustment.

c. If the facility notifies the division of such within thirty (30) days, the effective date of the rate recalculation will be the date that the facility stopped operating with only single occupancy accommodations.

d. If the facility does not notify the division within thirty (30) days, the effective date of the rate recalculation will be the date the facility size and occupancy rate adjustment was originally granted. The facility shall repay the division any overpayment resulting from the loss of the facility size and occupancy rate adjustment.

(II) Determine the bed equivalency for capital expenditures from the date the facility was originally licensed through the end of the rate setting cost report period by taking the cost of the capital expenditures for each year divided by the asset value per bed for the year of the capital expenditures rounded down to the nearest whole bed. The cost of the capital expenditures must be at least the asset value per bed for the year of the capital expenditures for each bed equivalency. For example, a capital expenditures done in 2009 with a cost of two hundred seventy th7ousand dollars ($270,000) is equal to five (5) beds. ($270,000/$47,948 equals 5.65 beds rounded down to 5 beds).

(III) The Total Facility Size is the sum of (I) and (II).

(VI) The Total Asset Value is the total facility size times the asset value.

B. Determine the reduction for age. The age of the beds is determined by subtracting the year the beds were originally licensed from the year relative to the rate base year. The age of bed equivalencies for capital expenditures is calculated by subtracting the year the capital expenditures were made from the year relative to the rate base year. The age of the beds for multiple licensing dates (i.e., for increases and decreases in licensed beds) and multiple bed equivalencies is calculated on a weighted average method rounded to the nearest whole year. For licensed bed decreases and replacement beds, the oldest beds are delicensed first. The reduction for age is determined by multiplying the age of the beds by one percent (1%) up to a maximum of forty percent (40%).

C. Determine the facility asset value. The facility asset value is the total asset value set forth in subparagraph (11)(D)1.A. less the reduction for age set forth in subparagraph (11)(D)1.B.

D. Determine the rental value. Multiply the facility asset value by six and three hundred seventy fifths percent (6.375%) to determine the rental value. The six and three hundred seventy fifths percent (6.375%) is comprised of two and one-half percent (2.5%), which is based on a forty- (40-) year life, plus three and eight hundred seventy fifths percent (3.875%) for a return. The three and eight hundred seventy fifths percent (3.875%) is based on the Treasury Bill thirty- (30-) year coupon rate in effect as of January 1, 2022 of one and eight hundred seventy fifths percent (1.875%) plus two percent (2%).

(III) SFY 2025 QM Performance Measure Table. Effective for dates of service beginning July 1, 2024, the QM Performance Measure per diem adjustments are as follows:

| QM Performance | Threshold | Per Diem Adjustment |
|---|---|---|
| Decline in Late-Loss ADLs | < or = 10.0% | $3.04 |
| Decline in Mobility on Unit | < or = 8.0% | $3.04 |
| High-Risk Residents w/ Pressure Ulcers | < or = 2.7% | $3.04 |
| Anti-Psychotic Medications | < or = 6.8% | $3.04 |
| Falls w/ Major Injury | < or = 1.3% | $3.04 |
| In-Dwelling Catheter | < or = 1.1% | $3.04 |
| Urinary Tract Infection | < or = 1.9% | $3.04 |

B. A VBP percentage will also be applied to the per diem adjustment for each facility that qualifies for a VBP Incentive. The VBP percentage will be determined by the total QM score calculated from the Five-Star Rating System scores for each of the eight (8) long-term QMs, as follows:

(I) The eight (8) long-stay QMs included in the total QM score to determine the VBP percentage include the following:

(a) Decline in Late-Loss ADLs;
(b) Decline in Mobility on Unit;
(c) High-Risk Residents w/ Pressure Ulcers;
(d) Anti-Psychotic Medications;
(e) Falls w/ Major Injury;
(f) In-Dwelling Catheter;
(g) Urinary Tract Infection; and
(h) Physical Restraints;

(II) The facility's most current twelve- (12-) month rolling average QM value as of January 21, 2022 is used to determine the facility's QM Score and VPB Percentage for the rates effective July 1, 2022;

(III) For each QM value, the corresponding number of QM points will be determined from Table A3 of the Five-Star Quality Rating System: Technical Users' Guide dated January 2017;

(IV) The QM points for all of the QMs will be summed to determine the facility's total QM Score.

(V) The VBP percentage for each scoring range is listed in the following table.

| QM Scoring Tier | Minimum Score | VBP Percentage |
|---|---|---|
| 1 | 600 | 100% |
| 2 | 520 | 75% |
| 3 | 440 | 50% |
| 4 | 360 | 25% |
| 5 | 0 | 0% |

4. Mental Illness Diagnosis Add-On. Each facility with a prospective rate on or after July 1, 2022, and which meets the following criteria shall receive a per diem adjustment:

A. If at least forty percent (40%) of a facility's Medicaid participants have the following mental illness diagnosis, the facility shall receive a per diem adjustment of five dollars ($5.00):

(I) Schizophrenia

(II) Bi-polar

(G) Prospective Rate Calculation.

1. A preliminary per diem shall be calculated and is the sum of:

A. The cost component per diems as set forth in (11)(A)-(11)(E), plus

B. The patient care incentive and multiple component incentive set forth in (11)(F)1. and (11)(F)2., respectively.

2. A base rate shall be determined and is the greater of:

A. The preliminary per diem, and

B. The facility's prospective rate as of June 30, 2022, excluding NFRA.

3. The facility's rebased rate shall be the sum of:

A. The facility's base rate, plus

B. The NFRA in effect for the applicable date of service.

(H) Semi-Annual and Annual Rate Updates. Each facility with a prospective rate on or after July 1, 2022 shall have its rate updated for the following items as described below:

1. Semi-Annual Acuity Adjustment for Patient Care Per Diem Rate. Each facility's patient care per diem rate will be adjusted semi-annually using a current Medicaid CMI. The patient care per diem rate will be adjusted effective for dates of service beginning January 1 and July 1 of each year. The Medicaid CMI will be updated based on the facility's average Medicaid CMI from the two (2) preceding quarterly calculations. The allowable patient care cost per day determined in (11)(A)1. shall be adjusted by the applicable Medicaid CMI and shall be the facility's patient care per diem to be included in the facility's total prospective per diem rate, effective each January 1 and July. The patient care and multiple component incentives will not be updated based on the adjusted patient care per diem. The facility's prospective rate shall continue to include the patient care and multiple component incentives initially determined for the prospective rate. The applicable Medicaid CMI are as follows:

A. Effective for dates of service beginning January 1 of each year, each facility's Medicaid CMI will be updated using the average of the preceding July 1 and October 1 quarterly Medicaid CMI calculations.

B. Effective for dates of service beginning July 1 of each year, each facility's Medicaid CMI will be updated using the average of the preceding January 1 and April 1 quarterly Medicaid CMI calculations.

2. Semi-Annual Adjustment for VBP Incentive. Each facility's QM Performance data shall be re-evaluated semi-annually and the per diem add-on rate shall be adjusted accordingly. The VBP will be recalculated effective for dates of service beginning January 1 and July 1 of each year. The QM Performance data will be updated based on the most current data available as of November 15 for the January 1 rate adjustment and as of May 15 for the July 1 rate adjustment. For facilities that do not have updated data as of the review date, prior period data will be carried forward. This provision will be applied to data frozen by CMS. A facility must meet the criteria set forth in (11)(F)3. each period and will lose any per diem adjustments for which it does not continue to qualify.

3. Semi-Annual Adjustment for Mental Illness Diagnosis Add-On. Each facility's Mental Illness Diagnosis data shall be re-evaluated semi-annually and the per diem add-on rate shall be adjusted accordingly. The Mental Illness Diagnosis will be recalculated effective for dates of service beginning January 1 and July 1 of each year. The Mental Illness Diagnosis data will be updated based on the final resident listing for October for the January 1 rate adjustment and the final resident listing for April for the July 1 rate adjustment. For facilities that do not have updated data as of the review date, prior period data will be carried forward. A facility must meet the criteria set forth in (11)(F)4. each period and will lose any per diem adjustments for which it does not continue to qualify.

5. MDS Reviews.

A. If a facility's MDS submissions were corrected as a result of an MDS review and resulted in a revised CMI, a facility's per diem rate shall be adjusted as follows:

(I) For reviews completed between July 1, 2024 and December 31, 2025, per diem rates will only be adjusted for increases in the CMI.

(II) For reviews completed between January 1, 2026 and December 31, 2026, per diem rates will be adjusted for any changes to the CMI. The per diem rate may be increased or decreased based on the adjusted CMI.

(III) For reviews completed after January 1, 2027, per diem rates will only be adjusted for decreases in the CMI.