



**Rules of
Department of Social Services
Division 70—MO HealthNet Division
Chapter 15—Hospital Program**

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**Title 13—DEPARTMENT OF
SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 15—Hospital Program**

**13 CSR 70-15.010 Inpatient Hospital
Services Reimbursement Methodology**

PURPOSE: This rule establishes the legal basis for the administration of the state agency's plan for reimbursement of covered inpatient hospital services in accordance with the principles and provisions described in this rule, and also establishes the legal basis for the state agency's methodology employed for reimbursement of covered outpatient hospital services.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) General Reimbursement Principles.

(A) For inpatient hospital services provided for an individual entitled to Medicare Part A inpatient hospital benefits and eligible for MO HealthNet, reimbursement from the MO HealthNet Program will be available only when MO HealthNet's applicable payment schedule amount exceeds the amount paid by Medicare. MO HealthNet's payment will be limited to the lower of the deductible and coinsurance amounts or the amount the MO HealthNet applicable payment schedule amount exceeds the Medicare payments. For all other MO HealthNet participants, unless otherwise limited by rule, reimbursement will be based solely on the individual participant's days of care (within benefit limitations) multiplied by the individual hospital's Title XIX per diem rate. As described in paragraph (5)(D)2. of this rule, as part of each hospital's fiscal year-end cost settlement determination, a comparison of total MO HealthNet-covered aggregate charges and total MO HealthNet payments will be made and any hospital whose aggregate MO HealthNet per diem payments exceed aggregate MO HealthNet charges will be subject to a retroactive adjustment.

(B) The Title XIX reimbursement for hospitals located outside Missouri and for federally-operated hospitals in Missouri will be

determined as stated in 13 CSR 70-15.190.

(C) The Title XIX reimbursement for hospitals, excluding those located outside Missouri and in-state federal hospitals, shall include per diem payments, outpatient payments, disproportionate share payments, and various MO HealthNet Add-On payments. Reimbursement shall be subject to availability of federal financial participation (FFP).

1. Per diem reimbursement is established in accordance with section (3).

2. Outpatient reimbursement is described in 13 CSR 70-15.160.

3. Disproportionate share payments are described in 13 CSR 70-15.220.

4. MO HealthNet Add-Ons are described in sections (9) and (10) of this rule and 13 CSR 70-15.015 and are in addition to MO HealthNet per diem payments. These payments are subject to the federal Medicare Upper Limit test.

(2) Definitions.

(A) Allowable costs. Allowable costs are those related to covered MO HealthNet services defined as allowable in 42 CFR chapter IV, part 413, except as specifically excluded or restricted in 13 CSR 70-15.010 or the MO HealthNet hospital provider manual and detailed on the desk-reviewed Medicare/Medicaid cost report. Penalties or incentive payments as a result of Medicare target rate calculations shall not be considered allowable costs. Implicit in any definition of allowable cost is that this cost is allowable only to the extent that it relates to patient care; is reasonable, ordinary, and necessary; and is not in excess of what a prudent and cost-conscious buyer pays for the given service or item. For purposes of calculating disproportionate share payments and to ensure federal financial participation (FFP), allowable uncompensated costs must meet definitions defined by the federal government.

(B) Bad debt. Bad debts include the costs of caring for patients who have insurance but are not covered for the particular services, procedures, or treatment rendered. Bad debts do not include the cost of caring for patients whose insurance covers the given procedures but limits coverage. In addition, bad debts do not include the cost of caring for patients whose insurance covers the procedure although the total payments to the hospital are less than the actual cost of providing care.

(C) Base cost report. Desk-reviewed Medicare/Medicaid cost report. When a facility has more than one (1) cost report with periods ending in the fourth prior calendar year, the cost report covering a full twelve- (12-) month period will be used. If none of the cost reports covers a full twelve (12) months, the

cost report with the latest period will be used. If a hospital's base cost report is less than or greater than a twelve- (12-) month period, the data shall be adjusted, based on the number of months reflected in the base cost report to a twelve- (12-) month period.

(D) Charity care. Results from a provider's policy to provide health care services free of charge or a reduction in charges because of the indigence or medical indigence of the patient.

(E) Contractual allowances. Difference between established rates for covered services and the amount paid by third-party payers under contractual agreements.

(F) Cost report. A cost report details, for purposes of both Medicare and MO HealthNet reimbursement, the cost of rendering covered services for the fiscal reporting period. The Medicare/Medicaid Uniform Cost Report contains the forms utilized in filing the cost report. The Medicare/Medicaid Cost Report version 2552-10 (CMS 2552-10) shall be used for fiscal years beginning on and after May 1, 2010.

(G) Critical access. Hospitals which meet the federal definition found in section 1820(c)(2)(B) of the Social Security Act. A Missouri expanded definition of critical access shall also include hospitals which meet the federal definitions of both a rural referral center and sole community provider and is adjacent to at least one (1) county that has a Medicaid eligible population of at least twenty-five percent (25%) of the total population of the county or hospitals which are the sole community hospital located in a county that has a Medicaid population of at least twenty-five percent (25%) of the total population of the county.

(H) Disproportionate share reimbursement. The disproportionate share payments are described in 13 CSR 70-15.220.

(I) Effective date.

1. The plan effective date shall be October 1, 1981.

2. The adjustment effective date shall be thirty (30) days after notification to the hospital that its reimbursement rate has been changed unless modified by other sections of the plan.

(J) MO HealthNet inpatient days. MO HealthNet inpatient days are paid MO HealthNet days for inpatient hospital services as reported by the Medicaid Management Information System (MMIS).

(K) Medicare rate. The Medicare rate is the rate established on the basis of allowable cost as defined by applicable Medicare standards and principles of reimbursement (42 CFR parts 405 and 413) as determined by the servicing fiscal intermediary based on yearly



hospital cost reports.

(L) Nonreimbursable items. For purposes of reimbursement of reasonable cost, the following are not subject to reimbursement:

1. Allowances for return on equity capital;
2. Amounts representing growth allowances in excess of the intensity allowance, profits, efficiency bonuses, or a combination of these;
3. Cost in excess of the principal of reimbursement specified in 42 CFR chapter IV, part 413; and
4. Costs or services specifically excluded or restricted in this plan or the MO HealthNet hospital provider manual.

(M) Per diem rates. The per diem rates shall be determined from the individual hospital cost report in accordance with section (3) of this regulation.

(N) Reasonable cost. The reasonable cost of inpatient hospital services is an individual hospital's MO HealthNet per diem cost per day as determined in accordance with the general plan rate calculation from section (3) of this regulation using the base year cost report.

(O) Specialty pediatric hospital. An inpatient pediatric acute care facility which—

1. Is licensed as a hospital by the Missouri Department of Health and Senior Services under Chapter 197 of the *Missouri Revised Statutes*;
2. Has been granted substantive waivers by the Missouri Department of Health and Senior Services from compliance with material hospital licensure requirements governing a) the establishment and operation of an emergency department, and b) the provision of pathology, radiology, laboratory, and central services; and
3. Is not licensed to operate more than sixty (60) inpatient beds.

(P) Trend factor. The trend factor is a measure of the change in costs of goods and services purchased by a hospital during the course of one (1) year.

(Q) Children's hospital. An acute care hospital operated primarily for the care and treatment of children under the age of eighteen (18) years old and which has designated in its licensure application at least sixty-five percent (65%) of its total licensed beds as a pediatric unit.

(R) FRA. The Federal Reimbursement Allowance (FRA) is identified in 13 CSR 70-15.110. Effective January 1, 1999, the assessment shall be an allowable cost.

(S) Incorporates by Reference. This rule incorporates by reference the following:

1. The Hospital Provider Manual is incorporated by reference and made a part of

this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at <http://manuals.momed.com/manuals/>, March 6, 2020. This rule does not incorporate any subsequent amendments or additions; and

2. Medicare/Medicaid Cost Report CMS 2552-10, which is incorporated by reference and made a part of this rule as published by the Centers for Medicare and Medicaid Services at website <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html>, February 18, 2020. This rule does not incorporate any subsequent amendments or additions.

(3) Per Diem Reimbursement Rate Computation. Each hospital shall receive a MO HealthNet per diem rate based on the following computation:

(A) The per diem rate shall be determined from the 1995 base year cost report in accordance with the following formula:

$$\text{Per Diem} = \frac{(\text{OC} * \text{TI})}{\text{MPD}} + \frac{\text{CMC}}{\text{MPDC}}$$

1. OC—The operating component is the hospital's total allowable cost (TAC) less CMC;

2. CMC—The capital and medical education component of the hospital's TAC;

3. MPD—Medicaid inpatient days;

4. MPDC-MPD—Medicaid patient days for capital costs as defined in paragraph (3)(A)3. with a minimum utilization of sixty percent (60%) as described in paragraph (5)(C)8.;

5. TI—Trend indices. The trend indices are applied to the OC of the per diem rate. The trend index for SFY 1995 is used to adjust the OC to a common fiscal year end of June 30. The adjusted OC shall be trended through SFY 2001;

6. TAC—Allowable inpatient routine and special care unit expenses, ancillary expenses, and graduate medical education costs will be added to determine the hospital's total allowable cost (TAC);

7. The per diem shall not exceed the average MO HealthNet inpatient charge per diem as determined from the base year cost report and adjusted by the TI;

8. The per diem shall be adjusted for rate increases granted in accordance with subsection (5)(F) for allowable costs not included in the base year cost report; and

(B) Trend Indices (TI). Trend indices starting in SFY 2016 will be determined based on the Hospital Market Basket index as pub-

lished in *Healthcare Cost Review* by Institute of Health Systems (IHS), or equivalent publication, regardless of any changes in the name of the publication or publisher, for each State Fiscal Year (SFY).

1. The per diem rate shall be reduced as necessary to avoid any negative Direct Medicaid payments computed in accordance with 13 CSR 70-15.015.

2. A facility previously enrolled for participation in the MO HealthNet Program, which either voluntarily or involuntarily terminates its participation in the MO HealthNet Program and which reenters the MO HealthNet Program, will receive the same inpatient rate and outpatient rate as the previous owner/operator. Such facility will also receive the same Direct Medicaid Add-On Payment and Uninsured Add-On Payment as the previous owner/operator if the facility reenters the MO HealthNet Program during the same state fiscal year. If the facility does not reenter during the same state fiscal year, the Direct Medicaid Add-On Payment and Uninsured Add-On Payment will be determined based on the applicable base year data (i.e., fourth prior year cost report for the Direct Medicaid Payment; see 13 CSR 70-15.220 for the applicable data for the Uninsured Add-On Payment). If the facility does not have the applicable base year data, the Direct Medicaid Add-On Payment and the Uninsured Add-On Payment will be based on the most recent audited data available and will include annual trend factor adjustments from the year subsequent to the cost report period through the state fiscal year for which the payments are being determined.

(4) Per Diem Rate—New Hospitals.

(A) In the absence of adequate cost data, a new facility's initial MO HealthNet rate shall be ninety percent (90%) of the average-weighted, statewide per diem rate for the year it became certified to participate in the MO HealthNet program until a prospective rate is determined on the facility's rate setting cost report as set forth below in paragraph (4)(A)1. The facility's rate setting cost report shall be the first full fiscal year cost report. If the facility's first full fiscal year cost report does not include any Medicaid costs, the facility shall continue to receive the initial rate, and the prospective rate will be determined from the facility's second full fiscal year cost report. If the facility's second full fiscal year cost report does not include any Medicaid cost, the initial rate shall become the facility's prospective rate and shall be effective the date the facility was enrolled in the MO HealthNet program. The effective date for facilities whose prospective rate was based on the rate setting cost report



shall be the first day of the SFY that the rate setting cost report is the base year cost report for determining the Direct Medicaid Add-On Payment as described in 13 CSR 70-15.015.

1. Prospective Per Diem Reimbursement Rate Computation. Each new hospital shall receive a MO HealthNet prospective per diem rate based on the sum of the following components:

A. Total Allowable Cost, less Graduate Medical Education cost, adjusted by the Trend Indices in subsection (3)(B) from the year subsequent to the rate setting cost report period through the state fiscal year for which the rate is being determined, divided by Medicaid Inpatient Days; plus

B. Graduate Medical Education cost divided by Medicaid Inpatient Days.

2. The per diem rate shall not exceed the average MO HealthNet inpatient charge per day as determined from the rate setting cost report as adjusted by the applicable Trend Indices.

3. The per diem rate shall be adjusted for rate increases granted in accordance with subsection (5)(F) for allowable costs not included in the rate setting cost report.

4. The per diem rate shall be reduced as necessary to avoid any negative Direct Medicaid Payments computed in accordance with 13 CSR 70-15.015.

(B) In addition to the MO HealthNet rate determined by subsection (4)(A), the MO HealthNet per diem rate for a new hospital licensed after February 1, 2007, shall include an adjustment for the hospital's estimated Direct Medicaid Add-On Payment per patient day, as determined in 13 CSR 70-15.015, until the facility's prospective rate is set in accordance with subsection (4)(A). The facility's Direct Medicaid Add-On adjustment will then no longer be included in the per diem rate but shall be calculated as a separate Add-On Payment, as set forth in 13 CSR 70-15.015.

(5) Reporting Requirements.

(A) Cost Reports.

1. Each hospital participating in the MO HealthNet program shall submit a cost report in the manner prescribed by the state MO HealthNet agency. The cost report shall be submitted within five (5) calendar months after the close of the reporting period. The period of a cost report is defined in 42 CFR 413.24(f). A single extension, not to exceed thirty (30) days, may be granted upon the request of the hospital and the approval of the MO HealthNet Division when the provider's operation is significantly affected due to extraordinary circumstances over which the provider had no control such as fire or flood.

The request must be in writing and post-marked prior to the first day of the sixth month following the hospital's fiscal year end.

2. The change of control, ownership, or termination of or by a hospital of participation in the program requires that the hospital submit a cost report for the period ending with the date of change of control, ownership, or termination within five (5) calendar months after the close of the reporting period. No extensions in the submitting of cost reports shall be allowed when a termination of participation has occurred.

A. If a provider notifies, in writing, the director of the Institutional Reimbursement Unit of the division prior to the change of control, ownership, or termination of participation in the MO HealthNet program, the division will withhold all remaining payments from the selling provider until the cost report is filed. Upon receipt of a cost report prepared in accordance with this regulation, any payment that was withheld will be released to the selling provider.

B. If the director of the Institutional Reimbursement Unit does not receive, in writing, notification of a change of control or ownership upon learning of a change of control or ownership, fifty thousand dollars (\$50,000) of the next available MO HealthNet payment, after learning of the change of control or ownership, will be withheld from the provider identified in the current MO HealthNet participation agreement until a cost report is filed. If the MO HealthNet payment is less than fifty thousand dollars (\$50,000), the entire payment will be withheld. Once the cost report prepared in accordance with this regulation is received, the payment will be released to the provider identified in the current MO HealthNet participation agreement.

C. The MO HealthNet Division may, at its discretion, delay the withholding of funds specified in subparagraphs (5)(A)2.A. and B. until the cost report is due based on assurances satisfactory to the division that the cost report will be timely filed. A request jointly submitted by the buying and selling provider may provide adequate assurances. The buying provider must accept responsibility for ensuring timely filing of the cost report and authorize the division to immediately withhold fifty thousand dollars (\$50,000) if the cost report is not timely filed.

3. All cost reports shall be submitted and certified by an officer or administrator of the provider. Failure to file a cost report, within the period prescribed in this subsection, may result in the impositions of sanctions as described in 13 CSR 70-3.030.

4. Amended cost reports or other supplemental. The division will notify hospital by

letter when the desk review of its cost report is completed. Since this data may be used in the calculation of per diem rates, direct payments, trended costs, or uninsured add-on payments, the hospital shall review the desk review data and the schedule of key data elements and submit amended or corrected data to the division within fifteen (15) days. Data received after the fifteen- (15-) day deadline will not be considered by the division for per diem rates, direct payments, trended costs, or uninsured payments unless the hospital requests in writing and receives an extension to file additional information prior to the end of the fifteen- (15-) day deadline.

(B) Records.

1. All hospitals are required to maintain financial and statistical records in accordance with 42 CFR 413.20. For purposes of this plan, statistical and financial records shall include beneficiaries' medical records and patient claim logs separated for inpatient and outpatient services billed to and paid for by MO HealthNet (excluding cross-over claims) respectively. Separate logs for inpatient and outpatient services should be maintained for MO HealthNet participants covered by managed care. All records must be available upon request to representatives, employees, or contractors of the MO HealthNet program, Missouri Department of Social Services, General Accounting Office (GAO), or the United States Department of Health and Human Services (HHS). The content and organization of the inpatient and outpatient logs shall include the following:

A. A separate MO HealthNet log for each fiscal year must be maintained by either date of service or date of payment by MO HealthNet for claims and all adjustments of those claims for services provided in the fiscal period. Lengths of stay covering two (2) fiscal periods should be recorded by date of admission. The information from the MO HealthNet log should be used to complete the Medicaid worksheet in the hospital's cost report;

B. Data required to be recorded in logs for each claim include:

(I) Participant name and MO HealthNet number;

(II) Dates of service;

(III) If inpatient claim, number of days paid for by MO HealthNet, classified by adults and peds, each subprovider, newborn, or specific type of intensive care;

(IV) Charges for paid inpatient days and inpatient ancillary charges for paid days classified by cost center as reported in the cost report or allowed outpatient services, classified by cost center as reported on cost report;



(V) Noncovered charges combined under a separate heading;

(VI) Total charges;

(VII) Any partial payment made by third-party payers (claims paid equal to or in excess of MO HealthNet payment rates by third-party payers shall not be included in the log);

(VIII) MO HealthNet payment received or the adjustment taken; and

(IX) Date of remittance advice upon which paid claim or adjustment appeared;

C. A year-to-date total must appear at the bottom of each log page or after each applicable group total, or a summation page of all subtotals for the fiscal year activity must be included with the log; and

D. Not to be included in the outpatient log are claims or line item outpatient charges denied by MO HealthNet or claims or charges paid from an established MO HealthNet fee schedule. This would include payments for hospital-based physicians and certified registered nurse anesthetists billed by the hospital on a professional services claim, payments for certain specified clinical diagnostic laboratory services, or payments for services provided by the hospital through enrollment as a MO HealthNet provider-type other than hospital outpatient.

2. Records of related organizations, as defined by 42 CFR 413.17, must be available upon demand to those individuals or organizations as listed in paragraph (5)(B)1. of this rule.

3. The MO HealthNet Division shall retain all uniform cost reports submitted for a period of at least three (3) years following the date of submission of the reports and will maintain those reports pursuant to the record-keeping requirements of 42 CFR 413.20. If an audit by, or on behalf of, the state or federal government has begun but is not completed at the end of the three- (3-) year period, or if audit findings have not been resolved at the end of the three- (3-) year period, the reports shall be retained until resolution of the audit findings.

4. The MO HealthNet Division shall maintain any responses received on this plan, subsequent changes to this plan, and rates for a period of three (3) years from the date of receipt.

(C) New, Expanded, or Terminated Services. A hospital, at times, may offer to the public new or expanded inpatient services which may require Certificate of Need (CON) approval, or may permanently terminate a service.

1. A state hospital, i.e., one owned or operated by the board of curators as provided

for in Chapter 172, RSMo, or one owned or operated by the Department of Mental Health, may offer new or expanded inpatient services to the public provided it receives legislative appropriations for the project. A state hospital may submit a request for inpatient rate reconsideration if the project meets or exceeds a cost threshold of one (1) million dollars for capital expenditures or one (1) million dollars for major medical equipment expenditures as described in 19 CSR 60-50.300.

2. Nonstate hospitals may also offer new or expanded inpatient services to the public, and incur costs associated with the additions or expansions which may qualify for inpatient rate reconsideration requests. Such projects may require a Certificate of Need (CON). Rate reconsideration requests for projects requiring CON review must include a copy of the CON program approval. Nonstate hospitals may request inpatient rate reconsiderations for projects not requiring review by the CON program, provided each project meets or exceeds a cost threshold of one (1) million dollars for capital expenditures as described in 19 CSR 60-50.300.

3. A hospital (state or nonstate) will have six (6) months after the new or expanded service project is completed and the service is offered to the public to submit a request for inpatient rate reconsideration, along with a budget of the project's costs. The rate reconsideration request and budget will be subject to desk review and audit. Upon completion of the desk review and audit, the hospital's inpatient reimbursement rates may be adjusted, if indicated. Failure to submit a request for rate reconsideration and project budget within the six- (6-) month period shall disqualify the hospital from receiving a rate increase prior to recognizing the increase through the trended cost calculation (direct Medicaid payments). Failure to submit a request shall not prohibit the division from reducing the rate in the case of a terminated service.

4. Failure to submit a budget concerning terminated services may result in the imposition of sanctions as described in 13 CSR 70-3.030.

5. The effective date for any increase granted under this subsection shall be no earlier than the first day of the month following the MO HealthNet Division's final determination on rate reconsideration.

6. Any inpatient rate reconsideration request for new, expanded, or terminated services must be submitted in writing to the MO HealthNet Division and must specifically and clearly identify the issue and total dollar amount involved. The total dollar amount must be supported by generally accepted

accounting principles. The hospital shall demonstrate the adjustment is necessary, proper, and consistent with efficient and economical delivery of covered patient care services. The hospital will be notified in writing of the agency's decision within sixty (60) days of receipt of the hospital's written request or within sixty (60) days of receipt of any additional documentation or clarification which may be required, whichever is later. Failure to submit requested information within the sixty- (60-) day period shall be grounds for denial of the request. If the state does not respond within the sixty- (60-) day period, the request shall be deemed denied.

7. Rate adjustments due to new or expanded services will be determined as total allowable project cost (i.e., the sum of annual depreciation, annualized interest expense, and annual additional operating costs) multiplied by the ratio of total inpatient costs (less skilled nursing facility (SNF) and swing bed cost) to total hospital cost as submitted on the most recent cost report filed with the agency as of the review date divided by total acute care patient days including all special care units and nursery, but excluding swing bed days.

8. Total acute care patient days (excluding nursery and swing bed days) must be at least sixty percent (60%) of total possible bed days. Total possible bed days will be determined using the number of licensed beds times three hundred sixty-five (365) days. If the days, including neonatal units, are less than sixty percent (60%), the sixty percent (60%) number plus newborn days will be used to determine the rate increase. This computation will apply to capital costs only.

9. Major medical equipment costs included in rate reconsideration requests shall not include costs to replace current major medical equipment if the replacement does not result in new or expanded inpatient services. The replacement of inoperative or obsolete major medical equipment, by itself, does not qualify for rate reconsideration, even if the new equipment costs at least one (1) million dollars.

(D) Audits.

1. A comprehensive hospital audit program shall be established in cooperation with the Missouri Medicare fiscal intermediary. Under the terms of the Common Audit Agreement, the Medicare intermediary shall perform the following:

A. Desk review all hospital cost reports;

B. Determine the scope and format for on-site audits;

C. Perform field audits when indicated in accordance with Title XIX principles;



and

D. Submit to the state agency the final Title XVIII cost report with respect to each provider.

(E) Adjustments to Rates. The prospectively determined individual hospital's reimbursement rate may be adjusted only under the following circumstances:

1. When information contained in the cost report is found to be intentionally misrepresented. The adjustment shall be made retroactive to the date of the original rate. This adjustment shall not preclude the MO HealthNet Division from imposing any sanctions authorized by any statute or rule; or

2. When rate reconsideration is granted in accordance with subsection (5)(F).

(F) Rate Reconsideration.

1. Rate reconsideration may be requested under this subsection for changes in allowable cost which occur subsequent to the base period described in subsection (3)(A). The effective date for any increase granted under this subsection shall be no earlier than the first day of the month following the MO HealthNet Division's final determination on rate reconsideration.

2. The following may be subject to review under procedures established by the MO HealthNet Division:

A. New, expanded, or terminated services as detailed in subsection (5)(C);

B. When the hospital experiences extraordinary circumstances which may include, but are not limited to, an act of God, war, or civil disturbance; and

C. Per diem rate adjustments for critical access hospitals.

(I) Critical access hospitals meeting either the federal definition or the Missouri expanded definition may request per diem rate adjustments in accordance with this subsection. The per diem rate increase will result in a corresponding reduction in the direct Medicaid payment.

(a) Hospitals which meet the federal definition as a critical access hospital will have a per diem rate equal to one hundred percent (100%) of their estimated MO HealthNet cost per day as determined in 13 CSR 70-15.015.

(b) Hospitals which meet the Missouri expanded definition as a critical access hospital will have a per diem rate equal to seventy-five percent (75%) of their estimated MO HealthNet cost per day as determined in 13 CSR 70-15.015. This includes new hospitals meeting the Missouri expanded definition as a critical access hospital whose interim MO HealthNet rate was calculated in accordance with subsection 13 CSR 70-15.015.

3. The following will not be subject to review under these procedures:

A. The use of Medicare standards and reimbursement principles;

B. The method for determining the trend factor;

C. The use of all-inclusive prospective reimbursement rates; and

D. Increased costs for the successor owner, management, or leaseholder that result from changes in ownership, management, control, operation, or leasehold interests by whatever form for any hospital previously certified at any time for participation in the MO HealthNet program, except a review may be conducted when a hospital changes from nonprofit to proprietary or vice versa to recognize the change in its property taxes, see paragraph (5)(E)4.

4. As a condition of review, the MO HealthNet Division may require the hospital to submit to a comprehensive operational review. The review will be made at the discretion of the MO HealthNet Division and may be performed by it or its designee. The findings from any such review may be used to recalculate allowable costs for the hospital.

5. The request for an adjustment must be submitted in writing to the MO HealthNet Division and must specifically and clearly identify the issue and the total dollar amount involved. The total dollar amount must be supported by generally acceptable accounting principles. The hospital shall demonstrate the adjustment is necessary, proper, and consistent with efficient and economical delivery of covered patient care services. The hospital will be notified in writing of the agency's decision within sixty (60) days of receipt of the hospital's written request or within sixty (60) days of receipt of any additional documentation or clarification which may be required, whichever is later. Failure to submit requested information within the sixty- (60-) day period shall be grounds for denial of the request. If the state does not respond within the sixty- (60-) day period, the request shall be deemed denied.

(G) Sanctions. Sanctions may be imposed against a provider in accordance with 13 CSR 70-3.030 and other applicable state and federal regulations.

(6) Outlier Adjustment for Children Under the Age of Six (6).

(A) Effective for admissions beginning on or after July 1, 1991, outlier adjustments for medically necessary inpatient services involving exceptionally high cost or exceptionally long lengths of stay for MO HealthNet-eligible children under the age of six (6) will be made to hospitals meeting the

criteria under this plan and, for MO HealthNet-eligible infants under the age of one (1), will be made to any other MO HealthNet hospital except for specialty pediatric hospitals.

1. The following criteria must be met to be eligible for outlier adjustments for children one (1) year of age to children under six (6) years of age:

A. If the facility offered nonemergency obstetric services as of December 21, 1987, there must be at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to these services under the Missouri Medicaid plan. In the case of a hospital located in a rural area (area outside of a metropolitan statistical area, as defined by the federal Executive Office of Management and Budget), the term obstetrician includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. This section does not apply to hospitals either with inpatients predominantly under eighteen (18) years of age or which did not offer nonemergency obstetric services as of December 21, 1987;

B. As determined from the fourth prior year desk-reviewed cost report, the facility must have either—

(I) A Medicaid inpatient utilization rate (MIUR) at least one (1) standard deviation above the state's mean MIUR for all Missouri hospitals. The MIUR will be expressed as the ratio of total Medicaid days (TMD) provided under a state plan divided by the provider's total number of inpatient days (TNID). The state's mean MIUR will be expressed as the ratio of the sum of the total number of the Medicaid days for all Missouri hospitals divided by the sum of the total patient days for the same Missouri hospitals. Data for hospitals no longer participating in the program will be excluded;

$$\text{MIUR} = \frac{\text{TMD}}{\text{TNID}}$$

or

(II) A low-income utilization rate (LIUR) in excess of twenty-five percent (25%). The LIUR shall be the sum (expressed as a percentage) of the fractions, calculated as follows:

(a) Total MO HealthNet patient revenues (TMPR) paid to the hospital for patient services under a state plan plus the amount of the cash subsidies (CS) directly received from state and local governments, divided by the total net revenues (TNR) (charges, minus contractual allowances, discounts, and the like) for patient services plus the CS; and



(b) The total amount of the hospital's charges for patient services attributable to charity care (CC) (care provided to individuals who have no source of payment, third-party, or personal resources) less CS directly received from state and local governments in the same period, divided by the total amount of the hospital's charges (THC) for patient services. The total patient charges attributed to CC shall not include any contractual allowances and discounts other than for indigent patients not eligible for MO HealthNet under a state plan;

$$LIUR = \frac{TMPR + CS}{TNR + CS} + \frac{CC - CS}{THC}$$

C. As determined from the fourth prior year desk-reviewed cost report, the hospital—

(I) Has an un-sponsored care ratio of at least ten percent (10%). The un-sponsored care ratio is determined as the sum of bad debts and CC divided by TNR and also meets either of the criteria in subparagraph (6)(A)1.B.; or

(II) Ranks in the top fifteen (15) in the number of Medicaid inpatient days provided by that hospital compared to Medicaid patient days provided by all hospitals, and the hospitals also have a Medicaid nursery utilization ratio greater than thirty-five percent (35%) as computed by dividing Title XIX nursery and neonatal days by total nursery and neonatal days; or

(III) Operated a neonatal intensive care unit with a ratio of Missouri Medicaid neonatal patient days to Missouri Medicaid total patient days in excess of nine percent (9%) reported or verified by the division from the fourth prior year cost report;

D. As determined from the fourth prior year desk-reviewed cost report—

(I) The acute care hospital has an un-sponsored care ratio of at least sixty-five percent (65%) and is licensed for less than fifty (50) inpatient beds; or

(II) The acute care hospital has an un-sponsored care ratio of at least sixty-five percent (65%) and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of more than forty percent (40%); or

(III) The hospital is owned or operated by the Board of Curators as defined in Chapter 172, RSMo, or their successors; or

(IV) The hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental disorders; and

E. As determined from the fourth prior year desk-reviewed cost report, hospitals which annually provide more than five

thousand (5,000) Title XIX days of care and whose Title XIX nursery days represent more than fifty percent (50%) of the hospital's total nursery days.

2. The following criteria must be met for the services to be eligible for outlier review:

A. The patient must be a MO HealthNet-eligible infant under the age of one (1) year, or for hospitals that meet the criteria under paragraph (6)(A)1. a MO HealthNet-eligible child under the age of six (6) years, for all dates of service presented for review;

B. Hospitals requesting outlier review for children one (1) year of age to children under six (6) years of age must have qualified under paragraph (6)(A)1. for the state fiscal year corresponding with the fiscal year end of the cost report referred to in paragraph (6)(A)6.; and

C. One (1) of the following conditions must be satisfied:

(I) The total reimbursable charges for dates of service as described in paragraph (6)(A)4. must be at least one hundred fifty percent (150%) of the sum of total third-party liabilities and MO HealthNet inpatient claim payments for that claim; or

(II) The dates of service must exceed sixty (60) days and less than seventy-five percent (75%) of the total service days was reimbursed by MO HealthNet.

3. Claims for all dates of service eligible for outlier review must—

A. Have been submitted to the MO HealthNet Division fiscal agent or the managed care health plan in their entirety for routine claims processing, and claim payment must have been made before the claims are submitted to the division for outlier review; and

B. Be submitted for outlier review with all documentation as required by the MO HealthNet Division no later than ninety (90) days from the last payment made by the fiscal agent or the managed care health plan through the normal claims processing system for those dates of service.

4. Information for outlier reimbursement processing will be determined from claim charges and MO HealthNet payment data, submitted to the MO HealthNet Division fiscal agent or managed care health plan, by the hospital through normal claim submission. If the claim information is determined to be incomplete as submitted, the hospital may be asked to provide claim data directly to the MO HealthNet Division for outlier review.

5. The claims may be reviewed for—

A. Medical necessity at an inpatient hospital level-of-care;

B. Appropriateness of services pro-

vided in connection with the diagnosis;

C. Charges that are not permissible per the MO HealthNet Division; policies established in the hospital provider manual and hospital bulletins; and

D. If the hospital is asked to provide claim information, the hospital will need to provide an affidavit vouching to the accuracy of final payments by the MO HealthNet Division, managed care health plans, and other third-party payors. The calculation of outlier payments will be based on the standard hospital payment defined in subparagraph (6)(A)7.B.

6. After the review, reimbursable costs for each claim will be determined using the following data from the most recent Medicaid hospital cost report filed by June 1 of each year:

A. Average routine (room and board) costs for the general and special care units for all days of the stay eligible per the outlier review;

B. Ancillary cost-to-charge ratios applied to claim ancillary charges determined eligible for reimbursement per the outlier review; and

C. No cost will be calculated for items such as malpractice insurance premiums, interns and residents, professional services, or return on equity.

7. Each state fiscal year, outlier adjustment payments for each hospital will be made for all claims submitted before March 1 of the preceding state fiscal year which satisfy all conditions in paragraphs (6)(A)1.-5. The payments will be determined for each hospital as follows:

A. Sum all reimbursable costs per paragraph (6)(A)6. for all applicable outlier claims to equal total reimbursable costs;

B. For those claims, subtract third-party payments and MO HealthNet payments, which includes both per diem payments and Direct Medicaid Add-On payments, from total reimburseable costs to equal excess cost; and

C. Multiply excess costs by fifty percent (50%).

(B) Effective for admissions beginning on or after July 1, 1997, outlier adjustments shall also be made for MO HealthNet participants enrolled in managed care. All criteria listed under subsection (6)(A) applies to managed care outlier submissions.

(C) Effective for admissions beginning on or after May 1, 2017, outlier adjustments will only be made for the fee for service claims. All criteria listed under subsection (6)(A) will continue to be applied to the fee for service outlier submissions.



(7) Payment Assurance. The state will pay each hospital, which furnishes the services in accordance with the requirements of the state plan, the amount determined for services furnished by the hospital according to the standards and methods set forth in the rules implementing the Hospital Reimbursement Program.

(8) Inappropriate Placements.

(A) The hospital per diem rate as determined under this plan and in effect on October 1, 1981, shall not apply to any participant who is receiving inpatient hospital care when s/he is only in need of nursing home care.

1. If a hospital has an established intermediate care facility/skilled nursing facility (ICF/SNF) or SNF-only MO HealthNet rate for providing nursing home services in a distinct part setting, reimbursement for nursing home services provided in the inpatient hospital setting shall be made at the hospital's ICF/SNF or SNF-only rate.

2. No MO HealthNet payments will be made on behalf of any participant who is receiving inpatient hospital care and is not in need of either inpatient or nursing home care.

(9) MO HealthNet GME Add-On—A MO HealthNet Add-On determined for Graduate Medical Education (GME) costs shall be allocated based on the estimated effect of implementation of a MO HealthNet managed care system in accordance with this section.

(A) The MO HealthNet GME Add-On for MO HealthNet participants covered under a Managed Care Plan shall be determined using the base year cost report and paid in quarterly installments. The base year cost report shall be the fourth prior fiscal year (i.e., the base year for SFY 1999 is the FY 1995 cost report). The hospital per diem shall continue to include a component for GME related to MO HealthNet participants not included in a managed care system.

1. Total GME cost shall be multiplied by a managed care allocation factor which incorporates the estimated percentage of the hospital's MO HealthNet population included in a managed care system and the estimated implementation date for a managed care system. For example: If a hospital has 1) an annual GME cost of one hundred thousand dollars (\$100,000), 2) forty percent (40%) of their MO HealthNet days are related to MO HealthNet participants eligible for MO HealthNet managed care, and 3) the projected implementation date for managed care is October 1, 1995; the prorated GME Add-On is thirty thousand dollars (\$30,000).

2. The annual GME Add-On shall be paid in quarterly installments.

(10) Enhanced Graduate Medical Education (GME) Payment. An enhanced GME payment shall be made to any acute care hospital that provides graduate medical education (teaching hospital).

(A) The enhanced GME payment shall be computed in accordance with subsection (10)(B). The payment shall be made following the end of the state fiscal year. The enhanced GME payment for each state fiscal year shall be computed using the most recent cost data available when the enhanced GME payment is computed. If the cost report is less than or more than a twelve- (12-) month period, the cost report data will be adjusted to reflect a twelve- (12-) month period. The state share of the enhanced GME payment to a hospital that has cash subsidies shall come from funds certified by the hospital.

(B) The enhanced GME payment will be computed by first determining the percentage difference between the McGraw-Hill CPI index for hospital services and Medicare update factors applied to the per resident amounts from 1986 to the most recent SFY. For example, the percentage difference has been computed to be eighty-five and sixty-two one-hundredth percent (85.62%) for SFY 2000. The percentage difference is then multiplied by the MO HealthNet share of the aggregate approved amount reported on worksheet E-4 of the Medicare cost report (CMS 2552-10) for the fourth prior fiscal year and trended to the current state fiscal year. The resulting product is the enhanced GME payment.

(11) Hospital Mergers. Hospitals that merge their operations under one (1) Medicare and MO HealthNet provider number shall have their MO HealthNet reimbursement combined under the surviving hospital's (the hospital whose Medicare and MO HealthNet provider number remains active) MO HealthNet provider number.

(A) The disproportionate share status of the merged hospital provider shall be—

1. The same as the surviving hospital's status was prior to the merger for the remainder of the state fiscal year in which the merger occurred; and

2. Determined based on the combined desk-reviewed data from the appropriate cost reports for the merged hospitals in subsequent fiscal years.

(B) The per diem rate for merged hospitals shall be calculated—

1. For the remainder of the state fiscal year in which the merger occurred by multiplying each hospital's estimated MO HealthNet paid days by its per diem rate, summing the estimated per diem payments

and estimated MO HealthNet paid days, and then dividing the total estimated per diem payments by the total estimated paid days to determine the weighted per diem rate. The effective date of the weighted per diem rate will be the date of the merger. This merged rate will also be used in fiscal years following the effective date.

(C) The Direct Medicaid Payments, Uninsured Add-On Payments, and GME payments, if the surviving facility continues the GME program, shall be—

1. Combined under the surviving hospital's MO HealthNet provider number for the remainder of the state fiscal year in which the merger occurred; and

2. Calculated for subsequent state fiscal years based on the combined data from the appropriate cost report for each facility.

AUTHORITY: sections 208.153, 208.201, and 660.017, RSMo 2016, and section 208.152, RSMo Supp. 2020. This rule was previously filed as 13 CSR 40-81.050. Original rule filed Feb. 13, 1969, effective Feb. 23, 1969. Emergency rescission and rule filed Sept. 21, 1981, effective Oct. 1, 1981, expired Jan. 13, 1982. Rescinded and re-adopted: Filed Sept. 21, 1981, effective Jan. 14, 1982. Emergency amendment filed June 21, 1982, effective July 1, 1982, expired Oct. 10, 1982. Amended: Filed June 21, 1982, effective Oct. 11, 1982. Emergency amendment filed July 21, 1982, effective July 30, 1982, expired Nov. 27, 1982. Emergency amendment filed June 21, 1983, effective July 1, 1983, expired Oct. 12, 1983. Amended: Filed June 21, 1983, effective Oct. 13, 1983. Amended: Filed Sept. 13, 1983, effective Dec. 11, 1983. Emergency amendment filed Dec. 21, 1983, effective Jan. 1, 1984, expired April 11, 1984. Emergency amendment filed March 14, 1984, effective March 28, 1984, expired June 10, 1984. Amended: Filed March 14, 1984, effective June 11, 1984. Emergency amendment filed June 21, 1984, effective July 1, 1984, expired Oct. 10, 1984. Amended: Filed July 12, 1984, effective Oct. 11, 1984. Amended: Filed Sept. 12, 1984, effective Jan. 12, 1985. Amended: Filed Jan. 15, 1985, effective May 27, 1985. Amended: Filed May 16, 1985, effective Sept. 1, 1985. Emergency amendment filed June 20, 1985, effective July 1, 1985, expired Oct. 28, 1985. Amended: Filed June 20, 1985, effective Oct. 1, 1985. Amended: Filed Sept. 4, 1985, effective Dec. 1, 1985. Emergency amendment filed Oct. 17, 1985, effective Oct. 27, 1985, expired Jan. 11, 1986. Amended: Filed Oct. 17, 1985, effective Feb. 13, 1986. Amended: Filed Dec. 16, 1985, effective April 1, 1986. Amended: Filed Feb. 14,*



1986, effective May 11, 1986. Amended: Filed March 17, 1986, effective June 28, 1986. Amended: Filed April 2, 1986, effective July 1, 1986. Amended: Filed Aug. 1, 1986, effective Oct. 11, 1986. Emergency amendment filed Sept. 19, 1986, effective Oct. 1, 1986, expired Jan. 15, 1987. Emergency amendment filed Sept. 24, 1986, effective Oct. 4, 1986, expired Jan. 29, 1987. Emergency amendment filed Oct. 22, 1986, effective Nov. 1, 1986, expired Feb. 1, 1987. Amended: Filed Nov. 4, 1986, effective Jan. 30, 1987. Amended: Filed Nov. 12, 1986, effective Feb. 2, 1987. Amended: Filed Nov. 14, 1986, effective Jan. 30, 1987. Emergency amendment filed June 19, 1987, effective July 1, 1987, expired Oct. 29, 1987. Amended: Filed Aug. 18, 1987, effective Oct. 25, 1987. Amended: Filed Jan. 5, 1988, effective March 25, 1988. Amended: Filed March 2, 1988, effective May 12, 1988. Emergency amendment filed April 15, 1988, effective April 25, 1988, expired Aug. 22, 1988. Emergency amendment filed May 17, 1988, effective May 27, 1988, expired Sept. 23, 1988. Amended: Filed May 17, 1988, effective Aug. 11, 1988. Amended: Filed June 2, 1988, effective Aug. 25, 1988. Emergency amendment filed June 21, 1988, effective July 1, 1988, expired Oct. 28, 1988. Amended: Filed June 28, 1988, effective Sept. 29, 1988. Emergency amendment filed July 15, 1988, effective July 25, 1988, expired Nov. 21, 1988. Amended: Filed July 15, 1988, effective Oct. 29, 1988. Emergency amendment filed Aug. 5, 1988, effective Aug. 15, 1988, expired Dec. 13, 1988. Amended: Filed Oct. 18, 1988, effective Jan. 13, 1989. Emergency amendment filed Dec. 16, 1988, effective Jan. 1, 1989, expired May 1, 1989. Amended: Filed Aug. 16, 1989, effective Nov. 11, 1989. Amended: Filed Sept. 26, 1989, effective Dec. 28, 1989. Emergency amendment filed Dec. 1, 1989, effective Jan. 1, 1990, expired April 29, 1990. Amended: Filed Dec. 1, 1989, effective Feb. 25, 1990. Amended: Filed Dec. 1, 1989, effective May 11, 1990. Amended: Filed Jan. 10, 1989, effective April 12, 1990. Amended: Filed Feb. 5, 1990, effective May 11, 1990. Amended: Filed Feb. 16, 1990, effective April 26, 1990. Emergency amendment filed May 30, 1990, effective July 1, 1990, expired Oct. 28, 1990. Amended: Filed May 30, 1990, effective Sept. 28, 1990. Emergency amendment filed May 30, 1990, effective July 1, 1990, expired Oct. 28, 1990. Amended: Filed May 30, 1990, effective Sept. 28, 1990. Amended: Filed Oct. 2, 1990, effective Feb. 14, 1991. Emergency amendment filed Oct. 15, 1990, effective Nov. 1, 1990, expired Feb. 28, 1991. Amended: Filed Oct. 15, 1990, effective Feb. 14, 1991.

Amended: Filed Oct. 15, 1990, effective Feb. 14, 1991. Emergency amendment filed Dec. 21, 1990, effective Jan. 1, 1991, expired March 31, 1991. Emergency amendment filed Jan. 3, 1991, effective Jan. 15, 1991, expired May 13, 1991. Amended: Filed Feb. 14, 1991, effective July 8, 1991. Emergency amendment filed March 4, 1991, effective March 14, 1991, expired May 13, 1991. Emergency amendment filed March 7, 1991, effective March 17, 1991, expired July 14, 1991. Amended: Filed March 7, 1991, effective Aug. 30, 1991. Emergency amendment filed June 20, 1991, effective July 1, 1991, expired Oct. 28, 1991. Emergency amendment filed June 20, 1991, effective July 1, 1991, expired Oct. 28, 1991. Amended: Filed June 18, 1991, effective Oct. 31, 1991. Emergency amendment filed July 5, 1991, effective July 15, 1991, expired Aug. 15, 1991. Amended: Filed July 2, 1991, effective Dec. 9, 1991. Amended: Filed July 2, 1991, effective Dec. 9, 1991. Emergency amendment filed Aug. 8, 1991, effective Aug. 18, 1991, expired Dec. 15, 1991. Amended: Filed Aug. 5, 1991, effective Jan. 13, 1992. Emergency amendment filed Oct. 11, 1991, effective Oct. 21, 1991, expired Feb. 17, 1992. Emergency amendment filed Oct. 18, 1991, effective Oct. 28, 1991, expired Feb. 24, 1992. Amended: Filed Oct. 18, 1991, effective April 9, 1992. Emergency amendment filed Nov. 15, 1991, effective Dec. 3, 1991, expired April 1, 1992. Emergency amendment filed March 13, 1992, effective April 2, 1992, expired July 30, 1992. Amended: Filed Nov. 15, 1991, effective April 9, 1992. Emergency amendment filed Feb. 3, 1992, effective Feb. 18, 1992, expired June 16, 1992. Emergency amendment filed Feb. 7, 1992, effective Feb. 19, 1992, expired June 17, 1992. Emergency amendment filed March 13, 1992, effective April 2, 1992, expired July 30, 1992. Emergency amendment filed April 2, 1992, effective April 18, 1992, expired Aug. 15, 1992. Emergency amendment filed Aug. 6, 1992, effective Aug. 16, 1992, expired Dec. 13, 1992. Amended: Filed April 2, 1992, effective Feb. 26, 1993. Emergency amendment filed Sept. 21, 1992, effective Oct. 1, 1992, expired Jan. 28, 1993. Emergency amendment filed Sept. 21, 1992, effective Oct. 1, 1992, expired Jan. 28, 1993. Emergency amendment filed Nov. 3, 1992, effective Nov. 20, 1992, expired March 19, 1993. Emergency amendment filed Nov. 3, 1992, effective Nov. 20, 1992, expired March

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13 CSR 70-15.011 Reimbursement for Essential Disproportionate Share Hospitals

Emergency rule filed April 21, 1995, effective May 1, 1995, expired June 30, 1995.

13 CSR 70-15.015 Direct Medicaid Payments

PURPOSE: This rule provides for the calculation of the Direct Medicaid payments made on or after July 1, 2019.



(1) Direct Medicaid Qualifying Criteria.

(A) An inpatient hospital provider may qualify as a Disproportionate Share Hospital (DSH) based on the following criteria. Hospitals shall qualify as a Disproportionate Share Hospital for a period of only one (1) state fiscal year (SFY) and must requalify at the beginning of each SFY to continue their DSH classification—

1. If the facility offered nonemergency obstetric services as of December 21, 1987, there must be at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to these services under the Missouri Medicaid plan. In the case of a hospital located in a rural area (area outside of a metropolitan statistical area, as defined by the federal Executive Office of Management and Budget), the term obstetrician includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. This section does not apply to hospitals either with inpatients predominantly under eighteen (18) years of age or which did not offer nonemergency obstetric services as of December 21, 1987;

2. As determined from the fourth prior year desk-reviewed cost report, the facility must have either—

A. A Medicaid inpatient utilization rate (MIUR) at least one (1) standard deviation above the state’s mean MIUR for all Missouri hospitals. The MIUR will be expressed as the ratio of total Medicaid days (TMD) provided under a state plan divided by the provider’s total number of inpatient days (TNID). The state’s mean MIUR will be expressed as the ratio of the sum of the total number of the Medicaid days for all Missouri hospitals divided by the sum of the total patient days for the same Missouri hospitals. Data for hospitals no longer participating in the program will be excluded;

$$MIUR = \frac{TMD}{TNID}$$

or

B. A low-income utilization rate (LIUR) in excess of twenty-five percent (25%). The LIUR shall be the sum (expressed as a percentage) of the fractions, calculated as follows:

(I) Total MO HealthNet patient revenues (TMPR) paid to the hospital for patient services under a state plan plus the amount of the cash subsidies (CS) directly received from state and local governments, divided by the total net revenues (TNR) (charges, minus contractual allowances, discounts, and the like) for patient services plus the CS; and

(II) The total amount of the hospital’s charges for patient services attributable to charity care (CC) (care provided to individuals who have no source of payment, third-party, or personal resources) less CS directly received from state and local governments in the same period, divided by the total amount of the hospital’s charges (THC) for patient services. The total patient charges attributed to CC shall not include any contractual allowances and discounts other than for indigent patients not eligible for MO HealthNet under a state plan;

$$LIUR = \frac{TMPR + CS}{TNR + CS} + \frac{CC - CS}{THC}$$

3. As determined from the fourth prior year desk-reviewed cost report, the hospital—

A. Has an unsponsored care ratio of at least ten percent (10%). The unsponsored care ratio is determined as the sum of bad debts and CC divided by TNR and also meets either of the criteria in paragraph (1)(A)2.; or

B. Ranks in the top fifteen (15) in the number of Medicaid inpatient days provided by that hospital compared to Medicaid patient days provided by all hospitals, and the hospitals also have a Medicaid nursery utilization ratio greater than thirty-five percent (35%) as computed by dividing Title XIX nursery and neonatal days by total nursery and neonatal days; or

C. Operated a neonatal intensive care unit with a ratio of Missouri Medicaid neonatal patient days to Missouri Medicaid total patient days in excess of nine percent (9%) reported or verified by the division from the fourth prior year cost report;

4. As determined from the fourth prior year desk-reviewed cost report—

A. The acute care hospital has an unsponsored care ratio of at least sixty-five percent (65%) and is licensed for less than fifty (50) inpatient beds; or

B. The acute care hospital has an unsponsored care ratio of at least sixty-five percent (65%) and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of more than forty percent (40%); or

C. The hospital is owned or operated by the Board of Curators as defined in Chapter 172, RSMo, or their successors; or

D. The hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental disorders; and

5. As determined from the fourth prior year desk-reviewed cost report, hospitals which annually provide more than five thousand (5,000) Title XIX days of care and whose Title XIX nursery days represent more than fifty percent (50%) of the hospital’s total nursery days.

(B) Those hospitals which meet the criteria established in paragraphs (1)(A)1., (1)(A)2., and (1)(A)4. shall be deemed safety net hospitals. Those hospitals which meet the criteria established in paragraphs (1)(A)1. and (1)(A)3. shall be deemed first tier Disproportionate Share Hospitals (DSH). Those hospitals which meet only the criteria established in paragraphs (1)(A)1. and (1)(A)2. or (1)(A)1. and (1)(A)5. shall be deemed second tier DSH.

(2) Direct Medicaid Payments.

(A) Direct Medicaid Payments. Direct Medicaid payments will be made to hospitals for the following allowable MO HealthNet costs not included in the per diem rate as calculated in 13 CSR 70-15.010(3):

1. The increased MO HealthNet costs resulting from the Federal Reimbursement Allowance (FRA) assessment becoming an allowable cost on January 1, 1999;

2. The unreimbursed MO HealthNet costs applicable to the trend factor which is not included in the per diem rate;

3. The unreimbursed MO HealthNet costs for capital and medical education not included in the trended per diem cost as a result of the application of the sixty percent (60%) minimum utilization adjustment in 13 CSR 70-15.010(3)(A)4.;

4. The increased cost per day resulting from the utilization adjustment. The increased cost per day results from lower utilization of inpatient hospital services by MO HealthNet participants now covered by a managed care health plan;

5. The poison control adjustment shall be determined for hospitals which operated a poison control center during the base year and which continues to operate a poison control center in a MO HealthNet managed care region; and

6. The increased cost resulting from including out-of-state Medicaid days in total projected MO HealthNet days.

(B) The MO HealthNet Division will calculate the Direct Medicaid payment as follows:

1. The MO HealthNet share of the inpatient FRA assessment will be calculated by dividing the hospital’s inpatient Medicaid patient days by the total inpatient hospital patient days from the hospital’s base cost report to arrive at the inpatient Medicaid utilization percentage. This percentage is then



multiplied by the inpatient FRA assessment for the current SFY to arrive at the increased allowable MO HealthNet costs for the inpatient FRA assessment. The MO HealthNet share of the outpatient FRA assessment will be calculated by dividing the hospital's outpatient MO HealthNet charges by the total outpatient hospital charges from the base cost report to arrive at the MO HealthNet utilization percentage. This percentage is then multiplied by the outpatient FRA assessment for the current SFY to arrive at the increased allowable MO HealthNet costs for the outpatient FRA assessment.

A. Effective for payments made on or after May 1, 2017, only the Fee-for-Service and Out-of-State components of the MO HealthNet share of both the inpatient and outpatient FRA assessment will be included in the Direct Medicaid add-on payment.

2. The unreimbursed MO HealthNet costs are determined by subtracting the hospital's per diem rate from its trended per diem costs. The difference is multiplied by the estimated MO HealthNet patient days for the current SFY plus the out-of-state days from the fourth prior year cost report trended to the current SFY. The FFS days are determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior SFY. The managed care days are based on the FFS days determined from the regression analysis, as follows: The FFS days are factored up by the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report. The difference between the FFS days and the FFS days factored up by the FFS days' percentage are the managed care days.

A. Effective for payments made on or after May 1, 2017, the estimated MO HealthNet patient days for the SFY shall be determined by adjusting the FFS days from the state's MMIS for the second prior Calendar Year (CY) (i.e., for SFY 2017, second prior CY would be 2015) by—

(I) The trend determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior CY; and

(II) The days estimated to shift from FFS to managed care effective May 1, 2017. The estimated managed care days for populations added to managed care beginning May 1, 2017 will be subtracted from the trended FFS days to yield the estimated MO HealthNet patient days.

B. Effective for payments made on or after July 1, 2018, the estimated MO HealthNet patient days for the SFY shall be determined by adjusting the FFS days from

the state's MMIS for the second prior Calendar Year (CY) (i.e., for SFY 2019, second prior CY would be 2017) by—

(I) The trend determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior CY;

(II) A percentage adjustment shall be applied to the regression due to statewide managed care;

(III) The FFS days are factored up by the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report to yield the estimated MO HealthNet patient days; and

(IV) From the total estimated MO HealthNet patient days, remove the SFY 2019 estimated managed care days to yield the estimated MO HealthNet FFS patient days.

C. Effective for payments made on or after July 1, 2019, the estimated MO HealthNet patient days for the SFY shall be determined by adjusting the FFS days from the state's MMIS for the second prior Calendar Year (CY) (i.e., for SFY 2020, second prior CY would be 2018) by—

(I) The trend determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior CY;

(II) A percentage adjustment shall be applied to the regression due to statewide managed care;

(III) The FFS days are factored up by one (1) of the following:

(a) For hospitals that are in a managed care extension region or a Psychiatric hospital, the lower of the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report or from the hospital's second prior year cost report to yield the estimated MO HealthNet patient days; or

(b) For hospitals that are not in a managed care extension region or a Psychiatric hospital, the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report to yield the estimated MO HealthNet patient days; and

(IV) The difference between the FFS days and the FFS days factored up by the FFS days' percentage are the managed care days.

D. Effective for payments made on or after July 1, 2020, the estimated MO HealthNet patient days for the SFY shall be determined by adjusting the FFS days from the state's MMIS for the second prior Calendar Year (CY) (i.e., for SFY 2021, second prior CY would be 2019) by—

(I) The trend determined from a quadratic regression analysis of the hospital's FFS days from February 1999 through December of the second prior CY;

(II) The FFS days are factored up by one (1) of the following:

(a) For hospitals that are in a managed care extension region or a Psychiatric hospital, the lower of the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report or from the hospital's third prior year cost report to yield the estimated MO HealthNet patient days; or

(b) For hospitals that are not in a managed care extension region or a Psychiatric hospital, the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report to yield the estimated MO HealthNet patient days; and

(III) The difference between the FFS days and the FFS days factored up by the FFS days' percentage are the managed care days.

E. The trended cost per day is calculated by trending the base year costs per day by the trend indices as defined in 13 CSR 70-15.010(3)(B), using the rate calculation in 13 CSR 70-15.010(3)(A).

F. For hospitals that meet the requirements in paragraphs (1)(A)1., (1)(A)2., and (1)(A)4. of this rule (safety net hospitals), the base year cost report may be from the third prior year, the fourth prior year, or the fifth prior year. For hospitals that meet the requirements in paragraphs (1)(A)1. and (1)(A)3. of this rule (first tier Disproportionate Share Hospitals), the base year cost report may be from the third prior year, or the fourth prior year. The MO HealthNet Division shall exercise its sole discretion as to which report is most representative of costs. For all other hospitals, the base year cost report is the fourth prior year. For any hospital that has both a twelve- (12-) month cost report and a partial year cost report, its base period cost report for that year will be the twelve- (12-) month cost report.

G. The trended cost per day does not include the costs associated with the FRA assessment, the application of minimum utilization, the utilization adjustment, and the poison control costs computed in paragraphs (2)(B)1., 3., 4., and 5.;

3. The minimum utilization costs for capital and medical education is calculated by determining the difference in the hospital's cost per day when applying the minimum utilization, as identified in 13 CSR 70-15.010(5)(C)4., and without applying the minimum utilization. The difference in the



cost per day is multiplied by the estimated MO HealthNet patient days for the SFY;

4. The utilization adjustment cost is determined by estimating the number of MO HealthNet inpatient days the hospital will not provide as a result of the managed care health plans limiting inpatient hospital services. These days are multiplied by the hospital's cost per day to determine the total cost associated with these days. This cost is divided by the remaining total patient days from its base period cost report to arrive at the increased cost per day. This increased cost per day is multiplied by the estimated MO HealthNet days for the current SFY to arrive at the MO HealthNet utilization adjustment.

A. Effective July 1, 2011, the utilization adjustment will no longer apply to any hospital other than safety net hospitals as defined in subsection (1)(B), children's hospitals as defined in 13 CSR 70-15.010(2)(Q), and specialty pediatric hospitals as defined in 13 CSR 70-15.010(2)(O). Children's hospitals and specialty pediatric hospitals will continue to receive fifty percent (50%) of the adjustment calculated in accordance with paragraph (2)(B)4. Safety net hospitals will continue to receive one hundred percent (100%) of the adjustment calculated in accordance with paragraph (2)(B)4.;

5. The poison control cost shall reimburse the hospital for the prorated MO HealthNet managed care cost. It will be calculated by multiplying the estimated MO HealthNet share of the poison control costs by the percentage of managed care participants to total MO HealthNet participants; and

6. Effective July 1, 2006, the costs for including out-of-state Medicaid days is calculated by subtracting the hospital's per diem rate from its trended per diem cost and multiplying this difference by the out-of-state Medicaid days as determined from the regression analysis performed using the out-of-state days from the fourth, fifth, and sixth prior year cost reports.

(C) For new hospitals that do not have a base cost report, Direct Medicaid Payments shall be estimated as follows:

1. Hospitals receiving Direct Medicaid Payments shall be divided into quartiles based on total beds;

2. Direct Medicaid Payments shall be individually summed by quartile and then divided by the total beds in the quartile to yield an average Direct Medicaid Payment per bed;

3. The number of beds for the new hospital without the base cost report shall be multiplied by the average Direct Medicaid Payment per bed to determine the hospital's estimated Direct Medicaid Payment for the

current state fiscal year;

4. For a new hospital licensed after February 1, 2007, estimated total Direct Medicaid Payments for the current state fiscal year shall be divided by the estimated MO HealthNet patient days for the new hospital's quartile to obtain the estimated Direct Medicaid adjustment per patient day. This adjustment per day shall be added to the new hospital's MO HealthNet rate as determined in 13 CSR 70-15.010(4), so that the hospital's Direct Medicaid Payment per day is included in its per diem rate, rather than as a separate Add-On Payment. When the hospital's per diem rate is determined from its first full year cost report in accordance with 13 CSR 70-15.010(1)–(3), the facility's Direct Medicaid Payment will be calculated in accordance with subsection (2)(B) and reimbursed as an Add-On Payment rather than as part of the per diem rate. If the hospital is defined as a critical access hospital, its MO HealthNet per diem rate and Direct Medicaid Payment will be determined in accordance with 13 CSR 70-15.010(5)(F); and

5. A facility previously enrolled for participation in the MO HealthNet Program, which either voluntarily or involuntarily terminates its participation in the MO HealthNet Program and which reenters the MO HealthNet Program, shall have its Direct Medicaid Payments determined in accordance with 13 CSR 70-15.010(3)(B)2.

AUTHORITY: sections 208.153, 208.201, and 660.017, RSMo 2016, and section 208.152, RSMo Supp. 2020. This rule was previously filed as part of 13 CSR 70-15.010. Emergency rule filed April 30, 2020, effective May 15, 2020, expired Feb. 24, 2021. Original rule filed April 30, 2020, effective Nov. 30, 2020.*

**Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1981, 1986, 1988, 1990, 1992, 1993, 2004, 2005, 2007, 2011, 2013, 2014, 2015, 2016, 2018; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

13 CSR 70-15.020 Procedures for Admission Certification, Continued Stay Review and Validation Review of Hospital Admissions

PURPOSE: The MO HealthNet Division establishes admission certification and validation procedures on which hospitals furnishing inpatient care to MO HealthNet participants will be reviewed to determine that admissions are medically necessary and appropriate for inpatient care.

(1) The following definitions will be used in administering this rule:

(A) Admission. Admission means the act of registration and entry into a general medical and surgical, psychiatric, or rehabilitation hospital on the order of a qualified medical practitioner or medical professional having privileges of admission for the purpose of providing inpatient hospital services under the supervision of a physician member of the hospital's medical staff;

(B) Admission certification. Admission certification means the determination by the medical review agent, as transmitted to the hospital/physician and the fiscal agent, that the admission of a participant for inpatient hospital services is approved as medically necessary, reasonable, and appropriate as to placement at an acute level of care;

(C) Admitting diagnosis. Admitting diagnosis means the physician's tentative or provisional diagnosis of the participant's condition as a basis for examination and treatment when the admission certification is requested;

(D) Admitting medical professional. Admitting medical professional means a physician or other person authorized by state licensure law to order hospital services and who has admission privileges to order the participant's inpatient admission to the hospital;

(E) Certification number. Certification number means the number issued by the medical review agent that establishes that, based upon information furnished by the provider, a participant's admission for inpatient hospital services is approved as medically necessary;

(F) Department. Department means the Missouri Department of Social Services;

(G) Emergency admission. Emergency admission means an admission in which the medical condition manifests itself by acute symptoms of sufficient severity (including severe pain) that absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily function or serious dysfunction of any bodily organ or part;

(H) Fee for service. Fee for service refers to participants and/or services not included in the MO HealthNet Managed Care program or other prepaid health plans;

(I) Inpatient hospital service. Inpatient hospital service means a service provided by or under the supervision of a medical professional after a participant's admission to a hospital and furnished in the hospital for the care and treatment of the participant;

(J) Managed Care. Managed Care is a program under which some MO HealthNet participants are enrolled with a health plan who



contracts with the department to provide a package of MO HealthNet benefits for a monthly fee per enrollee;

(K) Medical record. Medical record means all or any portion of the medical record as requested by the medical review agent;

(L) Medical review agent. Medical review agent means the state's representative who is authorized to make decisions about admission certifications and validation reviews;

(M) Medically necessary. Medically necessary means an inpatient hospital service that is consistent with the participant's diagnosis or condition and is in accordance with the criteria as specified by the department;

(N) Nurse reviewer. Nurse reviewer means a person who is employed by or under contract with the medical review agent and who is licensed to practice professional nursing in Missouri;

(O) Pertinent information. Pertinent information means any information that the physician, hospital, or participant feels may justify or qualify the hospitalization;

(P) Physician reviewer. Physician reviewer means a physician who is a peer of the admitting/attending physician or who specializes in the type of care under review. Exceptions will be made only if the efficiency or effectiveness of the review would be compromised, but in every situation the review will be performed by a physician;

(Q) Readmission. Readmission means an admission that occurs within fifteen (15) days of a discharge of the same participant from the same or a different hospital. The fifteen-(15-) day period does not include the day of discharge or the day of readmission;

(R) Participant. Participant means a person who has applied and been determined eligible for MO HealthNet benefits;

(S) Reconsideration. Reconsideration means a review of a denial or withdrawal of admission certification;

(T) Required information. Required information means the information to be provided by the medical professional or hospital to obtain a preadmission or post-admission certification, which includes participant, medical professional, and hospital identifying information, admission date, admission diagnosis, procedures, surgery date, indications for inpatient setting, and plan of care;

(U) Transfer. Transfer means the movement of a participant after admission from one (1) hospital directly to another or within the same facility;

(V) Urgent admission. Urgent admission means a case which requires prompt admission to the hospital to prevent deterioration of a medical condition from an urgent to an emergency situation;

(W) Utilization review assistant. Utilization review assistant means a person who is employed by or is under contract with the medical review agent who is the preliminary reviewer to assess the need for nurse review when the Milliman Care Guidelines is not immediately met; and

(X) Validation review. Validation review means a review conducted after admission certification has been approved. The review is focused on validating the admitting information and confirming the determination of medical necessity of the admission.

(2) As required by Title 42, Code of Federal Regulations (CFR) part 456, admissions of MO HealthNet participants to MO HealthNet participating hospitals in Missouri and bordering states are subject to admission certification procedures and validation review with the following exceptions:

(A) Admissions of participants enrolled in a MO HealthNet Managed Care health plan;

(B) Admissions of participants eligible for both Part A Medicare and MO HealthNet;

(C) Admissions for deliveries;

(D) Admissions for newborns; and

(E) Admissions for certain pregnancy-related diagnoses. The diagnoses codes for deliveries, newborns, and pregnancy-related conditions are as published in the ICD (Internal Classification of Diseases, Clinical Modification) code book. Admissions with diagnoses codes for missed abortion, pregnancy with abortive outcome, and postpartum condition or complication will continue to require admission certification and validation review.

(3) The admission certification procedure and validation review will be performed by a medical review agent. The confidentiality of all information shall be adhered to in accordance with section 208.155, RSMo and Title 42, CFR part 431, subpart F. The medical review agent's decisions related to certification or non-certification of MO HealthNet admissions are advisory in nature. The department is the final payment authority. The medical review agent's review decisions will be used as the basis for MO HealthNet reimbursement.

(4) The types of certification and review include:

(A) Prospective (Preadmission) certification of nonemergency (elective) admissions of MO HealthNet participants with established eligibility on date of admission;

(B) Admission (Initial) certification of emergency and urgent admissions of MO HealthNet participants with established eligibility on date of admission and obtained prior

to discharge;

(C) Continued Stay Review (CSR) to add days to an existing certification. This review is done prior to discharge or within fourteen (14) days after discharge;

(D) Retrospective certification (post discharge) is only appropriate if participant's or provider's eligibility is not established prior to the patient's discharge date. Other retrospective certification requests are reviewed on a case-by-case basis. Retrospective reviews are not allowed for requests that were initiated while inpatient but failed to include sufficient clinical information to obtain certification;

(E) Retrospective validation review of statistically valid sample cases to assure information provided during admission certification is substantiated by documentation in the medical record; and

(F) A review of quality will be performed for those cases selected as part of the focused and random validation and Certification of Need Samples. Potential quality issues that represent a minor or less than serious risk to a patient will not be pursued. However, potentially serious quality issues will proceed through three (3) levels of specialty physician review if the issue is upheld by the physician reviewers at the first and second level physician review.

(5) Time requirements for the certification procedures are as follows:

(A) Medical professional or hospital notification to the medical review agent of a planned elective admission must occur no later than two (2) full working days prior to the date of the planned admission;

(B) Medical professional or hospital notification to the medical review agent of the occurrence of an emergency or urgent admission is required by the end of the first full working day after the date of the actual admission or prior to discharge, whichever comes first;

(C) Medical professional or hospital notification to the medical review agent of the need for a continued stay review must occur prior to discharge or within fourteen (14) working days after discharge;

(D) The medical review agent will determine the medical necessity of admissions specified in subsections (4)(A) and (B) at the time the request is made or by the end of the next working day after receipt of all required information from the medical professional or hospital;

(E) The hospital shall submit, at its own expense, the participant's medical record to the medical review agent for retrospective certification cases specified in subsection (4)(D); and



(F) After receipt of all the required medical record information, the medical review agent will determine medical necessity of admissions specified in subsection (4)(D) within thirty (30) calendar days. Cases submitted for physician review must be completed within this same thirty- (30-) day period.

(6) The criteria to be used in the admission certification and validation review are as follows:

(A) Milliman Care Guidelines includes adult and pediatric criteria for general medical care admissions;

(B) Supplemental criteria sets are included for adult and child psychiatric care, rehabilitation care and alcohol/drug abuse treatment;

(C) Ambulatory procedure screening is done within the Milliman Care Guidelines. If the procedure meets criteria to be done in the outpatient setting versus inpatient, the case will be reviewed by a physician for final determination which may result in denial of the certification request; and

(D) Urgent/emergency criteria are used as guidelines for determination of type of admission and are defined in section (1).

(7) The admission certification procedure is as follows:

(A) Certification requests can be made in the following manner:

1. For prospective, initial admission, and continued stay reviews, the medical professional or hospital submits the request through CyberAccess Web tool or contacts the medical review agent to provide the required information to obtain certification; or

2. For retrospective certification the hospital submits, at its own expense, the participant's medical record to the medical review agent to obtain certification which is to include the emergency room record; history and physical; any operative, pathology, or consultation reports; the first three (3) days of physician or other medical professional orders including the inpatient admitting orders, progress notes, nurses' notes, graphic vital signs, medication sheets, and diagnostic testing results;

(B) Initial screening of information for reviews in paragraph (7)(A)1. is conducted through the online CyberAccess Web tool, by utilization review assistants or by nurse reviewers using the criteria in section (6) as appropriate to the case under review;

(C) Initial screening of information for reviews in paragraph (7)(A)2. is conducted by a utilization review assistant or nurse reviewer using the criteria in section (6) as appropriate to the case under review;

(D) If the medical information submitted

regarding the patient's condition and planned services meets the applicable criteria in section (6), the approval decision and a unique certification number are communicated to the medical professional and hospital via the CyberAccess Web tool;

(E) If the applicable criteria in section (6) are not met, the nurse reviewer refers the case to a physician reviewer for a medical necessity determination. The physician reviewer is not bound by any criteria and makes the determination based on medical facts in the case using his/her medical judgment;

(F) If the physician reviewer approves the admission, the approval determination and unique certification number are communicated to the medical professional and hospital via the CyberAccess Web tool;

(G) The attending medical professional will be contacted prior to a denial determination and allowed the opportunity to provide additional information. This additional information will be considered by the physician reviewer prior to a determination to approve or deny admissions. Determination decisions will be communicated as follows:

1. If the admission is approved, the approval determination and unique certification number are communicated to the medical professional and hospital via the CyberAccess Web tool; and

2. Denial determinations are communicated via mail to the medical professional, hospital, and participant. The status can also be found on the CyberAccess Web tool;

(H) The medical professional, hospital, or participant who is dissatisfied with an initial denial determination is entitled to a reconsideration review by the medical review agent as outlined in section

(8); and

(I) If inpatient admission is approved and surgery is planned, day of surgery admission will be required unless the physician reviewer approves a preoperative day for evaluating concurrent medical conditions or other risk factors.

(8) Reconsideration Review Requests. The medical review agent's denial decisions relate to medical necessity and appropriateness of the inpatient setting in which services were furnished or are proposed to be furnished. The procedure to request reconsideration of an initial denial determination is as follows:

(A) Time Requirements;

1. To request a reconsideration review for a patient for a prospective admission or for a patient still in the hospital, the provider should telephone a request to the medical review agent. In either of these situations, the request for reconsideration must be received within

three (3) working days of receipt of the written denial notice. In order to expedite the process, the provider must indicate that this is a request for a reconsideration review. The medical review agent will complete the reconsideration review and issue a determination within three (3) working days of receipt of the request and all pertinent information; and

2. If the patient has been discharged from the hospital, the provider must submit a request for reconsideration in writing or by facsimile (fax). This reconsideration cannot be requested by telephone. The request must be made within sixty (60) calendar days of receipt of the written denial notice. The medical review agent will complete the reconsideration review within thirty (30) calendar days after receipt of the request for reconsideration review, medical records, and all pertinent information. A written notice will be issued to the participant, medical professional, and hospital within three (3) working days after the reconsideration review is completed. This information may also be accessed through the CyberAccess Web tool;

(B) The reconsideration review shall consist of a review of all medical records and additional documentation submitted by any one of the parties receiving the initial denial notice;

(C) The reconsideration will be conducted by a physician reviewer who has had no previous involvement in the case;

(D) Reconsideration determination by the medical review agent is the final level of the review for the provider. The division will accept the medical review agent's decision; and

(E) If the participant disagrees with a reconsideration denial by the medical review agent, s/he has the right to a fair hearing under sections 208.080, RSMo, and 208.156, RSMo.

(9) Validation Sample of Approved Admissions.

(A) A quarterly validation sample of approved admissions will be selected to ensure that the information provided during the certification process is substantiated by documentation and clinical findings in the medical record.

(B) The sample size will be a statistically valid number of certified admissions.

(C) For admissions subject to a validation review, the medical review agent will request medical records. Providers have thirty (30) calendar days from the date of written request to submit documentation. At rates determined by state statute 191.227, RSMo, provider costs associated with submission of requested documentation will be reimbursed regardless of the medium used for submission. Records



not received within the thirty (30) days will result in the admission being denied and claim payment recouped.

(D) Admission certification is not a guarantee of MO HealthNet payment. If the information provided during the certification process cannot be validated in the medical record by a nurse reviewer using the criteria in section (6), or was false, misleading or incomplete, the case will be referred to a physician reviewer for a medical necessity determination. The physician reviewer is not bound by any criteria and makes the determination based on medical facts in the case using his/her medical judgment.

(E) The medical professional or hospital will be allowed an opportunity to respond to a proposed denial prior to issuance of a final denial notice.

(F) If the physician reviewer determines the admission was not medically necessary, a denial notice will be issued to all parties. Reconsideration review procedures in section (8) apply to this review.

(G) A validation review determination of denial will result in recovery of MO HealthNet payments in accordance with 13 CSR 70-3.030. Overpayment determinations may be appealed to the Administrative Hearing Commission within thirty (30) days of the date of the notice letter if the sum in dispute exceeds five hundred dollars (\$500).

(H) Review of the quality of care will also be performed on the validation review sample. Potentially serious quality of care issues identified by the nurse reviewer will be referred to a physician of the medical review agent.

(10) As specific in relation to administration of the provisions of this rule and not otherwise inconsistent with participant liability as determined under provisions of 13 CSR 70-4.030, participant liability issues for admission certification and validation review are as follows:

(A) The participant is liable for inpatient hospital services in the following circumstances:

1. When the prospective request for certification is denied and the participant is notified of the denial but the participant chooses to be admitted, s/he is liable for all days;

2. When an admission request for certification is denied, the participant is liable for those days of inpatient hospital service provided after the date of the denial notification to him/her;

3. When the participant's eligibility was not established on or by the date of admission and the request for certification is denied, the participant is liable for all days; and

4. When the participant has signed a

written agreement with the provider indicating that MO HealthNet is not the intended payer for the specific item or service, s/he is liable for all days. The agreement must be signed prior to receiving the services. In this situation, the participant accepts the status and liabilities of a private pay patient in accordance with 13 CSR 70-4.030; and

(B) The participant is not liable for inpatient hospital services in the following circumstances:

1. When the provider fails to comply with prospective certification requirements, the participant is not liable for any days;

2. When an admission request for certification of an admission is denied, the participant is not liable for those days of inpatient hospital service provided prior to and including the date of the notification to him/her of the denial; and

3. When the medical review agent performs a validation review as provided in section (9) of this rule and determines an admission was not medically necessary for inpatient services, the participant is not liable for any days.

(11) Continued stay reviews, when necessary, will be performed for all fee-for-service MO HealthNet participants subject to admission certification to determine that services are medically necessary and appropriate for inpatient care. The continued stay review procedure is as follows:

(A) When extended hospitalization is indicated beyond the initial length of stay assigned by the medical review agent for prospective or admission certification, the hospital and attending medical professional are required to provide additional medical information to warrant the continued hospital stay as well as request the number of additional days needed prior to discharge or within fourteen (14) working days after discharge. If the request for continued stay review is received fifteen (15) or more working days post discharge, it is considered a retrospective review and the requirements mentioned in subsection (5)(E) will apply;

(B) For continued stay reviews, either initiated via the CyberAccess Web tool or the telephone, the Milliman Care Guidelines will be applied to any additional diagnosis or surgical procedures indicated. The medical professional and/or hospital may also upload any additional supporting documentation into the CyberAccess Web tool;

(C) A physician will review cases when continued stay is requested beyond the Milliman Care Guidelines. The physician reviewer shall approve or deny the continued stay days;

(D) The requesting medical professional and hospital are notified in cases of denial only. All others are found on the CyberAccess Web tool; and

(E) Information contained in sections (8)–(10) of this rule also apply to continued stay reviews.

(12) Continued stay reviews will be performed for diagnoses relating to alcohol and drug abuse to determine that services are medically necessary and appropriate for inpatient care. The continued stay review procedure for alcohol and drug abuse detoxification services is as follows:

(A) At the time of admission certification, as described in section (7) of this rule, the hospital or attending medical professional shall specify the anticipated medically necessary length-of-stay;

(B) If the applicable criteria in section (6) of this rule is met, the utilization review assistant or nurse reviewer shall assign a number of days not to exceed three (3) days;

(C) If an extension of services is required, the hospital or attending medical professional shall contact the medical review agent either by the CyberAccess Web tool or by telephone to request additional days for inpatient hospital care. If the applicable criteria in section (6) of this rule is met, the utilization review assistant or nurse reviewer shall assign a total length-of-stay days not to exceed five (5) days;

(D) If either the applicable criteria in section (6) of this rule is not met or the total length-of-stay exceeds five (5) days, the case shall be referred to a physician reviewer. The physician reviewer is not bound by the criteria in section (6) of this rule and makes the determination based on medical facts in the case using his/her medical judgment. The physician reviewer shall approve or deny the admission or continued stay days; and

(E) The medical professional and hospital are notified of the review decision as stated in section (7) of this rule.

(13) The MO HealthNet program, in accordance with 191.710, RSMo, will request that hospital providers report all re-hospitalizations of infants born premature at earlier than thirty-seven (37) weeks gestational age within their first six (6) months of life.

(14) Large case management will be performed for fee-for-service participants with potentially catastrophic conditions whenever specific trigger diagnoses or other qualifying events are met.

(A) Large case management procedures for fee-for-service participants are as follows:

1. Preadmission review nurses identify



patients who may qualify and benefit from case management, and refer these cases to a case manager of the medical review agent. Cases include, but are not limited to, the following:

A. Patients with high costs or anticipated high costs; or

B. Patients with repeated admissions or unusually long lengths-of-stay; or

C. Patients who encounter significant variances from the intervention or from expected outcomes associated with a clinical path; or

D. Patients who meet one (1) or more of the indicators on the Trigger Diagnosis/Qualifying Events list;

2. The medical review agent will complete an initial screening which will include a review of the medical information and interviews with the health care providers and patient, if needed or feasible;

3. An in-depth assessment will be conducted, which will include evaluation of the patient's health status, health care treatment and service needs, support system, home environment, and physical and psychosocial functioning. The assessment will be used to recommend one (1) of the following:

A. Reassessment later; or

B. No potential for case management; or

C. Active monitoring in anticipation of a future plan for alternative treatment; or

D. An alternative treatment plan is indicated;

4. If an alternative treatment plan is indicated, the medical review agent will collaborate with the patient's attending medical professional to develop an alternative treatment plan. The attending medical professional is responsible for implementation of the alternative treatment plan; and

5. The medical review agent will monitor and assess the effectiveness of the case management and will report to the state.

AUTHORITY: section 208.201, RSMo Supp. 2013. Emergency rule filed Oct. 20, 1989, effective Nov. 1, 1989, expired Feb. 28, 1990. Original rule filed Nov. 2, 1989, effective Feb. 25, 1990. Amended: Filed June 18, 1991, effective Jan. 13, 1992. Amended: Filed July 2, 1992, effective Feb. 26, 1993. Amended: Filed July 1, 1996, effective Feb. 28, 1997. Amended: Filed Feb. 1, 2008, effective Aug. 30, 2008. Amended: Filed Oct. 15, 2015, effective April 30, 2016.*

**Original authority: 208.201, RSMo 1987, amended 2007.*

13 CSR 70-15.030 Payment and Payment Limitations for Inpatient Hospital Care

PURPOSE: This rule establishes payment and payment limitations for all inpatient hospital admissions. Information is provided for hospital inpatient admissions that are exempt from certification.

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

(1) For inpatient hospital admissions that do not require certification as specified in 13 CSR 70-15.020, the number of days which MO HealthNet will cover for each admission can be located at the following website: <http://dss.mo.gov/providers/pdf/exempt-diagnosis-table.pdf>. All other admissions require certification per 13 CSR 70-15.020.

(A) The MO HealthNet program shall be administered by the Department of Social Services, MO HealthNet Division. The services covered and not covered, the limitations under which services are covered, and the maximum allowable fees for all covered services shall be determined by the division and shall be included in the MO HealthNet provider manuals, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website dss.mo.gov/mhd, June 15, 2016. This rule does not incorporate any subsequent amendments or additions.

(2) The counting of days which may be reimbursed per inpatient stay shall be from the beginning date of admission for a continuous period of hospitalization, unless conditions described in subsection (2)(A) or (B) apply.

(A) If the participant's beginning date of eligibility is later than the date of admission, the counting of days which may be allowable will be from the beginning eligibility date.

(B) If the participant has exhausted Title XVIII inpatient benefits, the counting of days which may be allowable will be from the date

following the date on which the Title XVIII benefits are exhausted.

(3) Reimbursement shall be made at the applicable per diem rate in effect as of the initial date of admission and for only allowable days during which the participant is eligible.

AUTHORITY: section 208.152, RSMo Supp. 2014, and sections 208.153 and 208.201, RSMo Supp. 2013. This rule was previously filed as 13 CSR 40-81.051. Emergency rule filed April 7, 1981, effective April 20, 1981, expired July 10, 1981. Original rule filed April 7, 1981, effective July 11, 1981. Emergency amendment filed July 15, 1981, effective Aug. 1, 1981, expired Oct. 10, 1981. Emergency amendment filed Aug. 21, 1981, effective Sept. 1, 1981, expired Dec. 10, 1981. Amended: Filed July 15, 1981, effective Oct. 11, 1981. Emergency amendment filed Nov. 20, 1981, effective Dec. 1, 1981, expired March 10, 1982. Amended: Filed Aug. 21, 1981, effective Dec. 11, 1981. Amended: Filed Nov. 20, 1981, effective March 11, 1982. Amended: Filed April 14, 1982, effective July 11, 1982. Emergency amendment filed Nov. 24, 1982, effective Dec. 4, 1982, expired March 10, 1983. Amended: Filed Nov. 24, 1982, effective March 11, 1983. Emergency amendment filed April 8, 1983, effective April 18, 1983, expired July 10, 1983. Amended: Filed April 8, 1983, effective July 11, 1983. Emergency amendment filed Dec. 21, 1983, effective Jan. 1, 1984, expired April 11, 1984. Emergency amendment filed March 14, 1984, effective March 28, 1984, expired June 10, 1984. Amended: Filed March 14, 1984, effective June 11, 1984. Amended: Filed Oct. 15, 1984, effective Feb. 11, 1985. Amended: Filed Jan. 15, 1985, effective April 11, 1985. Amended: Filed April 2, 1986, effective Sept. 1, 1986. Amended: Filed June 17, 1986, effective Sept. 1, 1986. Emergency amendment filed Sept. 17, 1986, effective Sept. 27, 1986, expired Jan. 25, 1987. Amended: Filed Aug. 1, 1986, effective Oct. 11, 1986. Amended: Filed Nov. 14, 1986, effective Jan. 30, 1987. Amended: Filed May 4, 1987, effective July 23, 1987. Amended: Filed Jan. 5, 1988, effective March 25, 1988. Amended: Filed April 4, 1988, effective July 1, 1988. Emergency amendment filed Dec. 1, 1989, effective Jan. 1, 1990, expired April 29, 1990. Amended: Filed Dec. 1, 1989, effective Feb. 25, 1990. Amended: Filed Dec. 4, 1989, effective Feb. 25, 1990. Emergency amendment filed June 18, 1991, effective July 15, 1991, expired Oct. 28, 1991. Amended: Filed March 18, 1991, effective Aug. 30, 1991.*



Emergency amendment filed June 20, 1991, effective July 1, 1991, expired Oct. 28, 1991. Emergency amendment filed Oct. 15, 1991, effective Oct. 29, 1991, expired Feb. 6, 1992. Emergency amendment filed Oct. 15, 1991, effective Oct. 29, 1991, expired Feb. 6, 1992. Amended: Filed June 18, 1991, effective Oct. 31, 1991. Amended: Filed June 15, 2005, effective Dec. 30, 2005. Amended: Filed July 16, 2007, effective Feb. 29, 2008. Amended: Filed Sept. 16, 2013, effective March 30, 2014. Amended: Filed May 5, 2016, effective Nov. 30, 2016.

**Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1981, 1986, 1988, 1990, 1992, 1993, 2004, 2005, 2007, 2011, 2013, 2014; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012; and 208.201, RSMo 1987, amended 2007.*

13 CSR 70-15.040 Inpatient Hospital and Outpatient Hospital Settlements

PURPOSE: *This regulation defines the specific procedures used to calculate the final or amended settlements for hospital providers. These settlements are authorized in 13 CSR 70-15.010.*

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

(1) General. This regulation defines the specific procedures used to calculate inpatient and outpatient settlements for Missouri in-state hospitals participating in the Missouri Medicaid program. Although inpatient and outpatient settlements are calculated at the same time, an overpayment for outpatient services shall not be offset against an underpayment for inpatient services. Outpatient settlement shall not be determined for cost reports periods ending after December 31, 1998 except for recently closed hospitals, new hospitals, and nominal charge providers as provided for in paragraph (4)(E)4. and hospitals that had a change in ownership or merged

operation in paragraph (4)(E)5. and elect to stay under the retrospective payment system.

(A) The hospital's settlement will be determined after the division receives a Medicare/Medicaid cost report from the Medicare fiscal intermediary with a Notice of Provider Reimbursement (NPR). The cost report used for the settlement shall be the one with the latest NPR at the time the settlement is calculated. The data used, except for Medicaid data, shall be as reported in the cost report unless adjusted by this regulation. The current version of the cost report is HCFA 2552-92, and references in this regulation are from this cost report. However, the division will use the version of the report received from the fiscal intermediary, which may change the references.

(B) The Medicaid data used in the final settlements will be from the division's paid claims history. This data includes only claims on which Medicaid made payment.

(2) Definitions.

(A) Reimbursable cost. Reimbursable costs are the costs which are identified as reimbursable in 13 CSR 70-15.010 and the *Hospital Provider Manual*.

(B) Labor/delivery room day. A labor/delivery room day is a day where the mother enters the hospital prior to the census hour but is not admitted to the hospital until the next day after she delivers.

(C) Medicaid payments. Medicaid payments included in the settlement include actual Medicaid claims payments, partial insurance payments on claims, patient liability amounts for coinsurance and deductibles and outlier claim payments. If the insurance payments exceed the Medicaid liability, the claim will not be considered a Medicaid claim.

(D) Inpatient service costs. The reimbursable costs for inpatient services or costs which will be included in the final settlement are those services or costs which are provided to the Medicaid beneficiary after being admitted to the hospital. Services or costs provided prior to admission as an inpatient should be billed as outpatient services, except for cost associated with labor and delivery room days.

(E) Outpatient services/cost. Reimbursable outpatient services or costs are services or costs that are provided prior to the patient being admitted to the hospital. Only outpatient services or cost which are reimbursed on a percentage of charge as defined in 13 CSR 70-15.160 will be included in the final settlement, unless they are excluded elsewhere in this regulation.

(F) Routine cost center. A routine cost center is an adult and peds unit, subprovider

unit, nursery unit or special care unit.

(G) Special care unit. A special care unit is a hospital unit that furnishes services to critically ill inpatients. Examples are Intensive Care Units (ICU), Coronary Care Unit (CCU), or Neonatal Care Unit. The ICU unit may be for only one (1) type of patient or for all critically ill patients.

(H) Paid days. Paid days are the actual number of days paid for inpatient services on claims with the first date of service within the fiscal period of the cost report.

(I) Routine charges. Routine charges are the charges billed by the hospital for the care provided to the patient in a routine care center. These services are normally provided to all patients in the hospital.

(J) Ancillary charges. Ancillary charges are the charges billed by the hospital for services that are not routinely provided in the routine care center and are not provided to all patients.

(K) Private room day. A private room day is a day when due to the patient's medical condition it is determined that the patient should be alone in a room.

(L) Incorporation by Reference. This rule adopts and incorporates by reference the provisions of the—

1. Current Medicare/Medicaid cost report forms that have a Notice of Provider Reimbursement (NPR) from the Medicare fiscal intermediary; and

2. *Missouri Medicaid Institutional (Hospital) Manual*.

(3) Inpatient settlements will be calculated based on paid day hospital services after the Medicare/Medicaid cost report is received from the fiscal intermediary. Based on this settlement the division shall make any recoupments necessary to ensure that Title XIX Medicaid payments for inpatient services do not exceed the allowable inpatient Medicaid charges. This settlement shall not result in additional payment to the hospital if its cost exceeds its payments. This settlement will be determined in the following manner:

(A) Data will be gathered from the Medicaid inpatient claim history for paid days by routine cost center; private room days; routine charges; charges for each ancillary cost center; and inpatient payments for claims with first date of service in the cost report period;

(B) The division will extract the following data from the cost report received from the fiscal intermediary:

1. The total patient days from worksheet S-3 for each routine cost center and observation bed days. The total patient days for adults and peds may be adjusted for labor



and delivery room days reported on questionnaire, if not included on worksheet S-3;

2. The total cost from worksheet D-1 for adults and peds, after removing swing-beds and private room cost differential, and if the hospital has a subprovider, the total cost from worksheet D-1 for the subprovider after removing the private room cost differential. These costs are before the Respiratory Therapy/Physical Therapy (RT/PT) limit and Reasonable Compensation Equivalent (RCE) disallowance;

3. The total cost from worksheet D-1 for special care units and nursery unit. These costs are before RT/PT limit adjustment and RCE disallowance;

4. The cost-to-charge ratio for each covered ancillary service from worksheet C Part I column 7;

5. The Direct Graduate Medical Education (GME) amount reported on worksheet E-3 Part IV line 3;

6. If the hospital is proprietary, the equity ratio from worksheet F-5 Part I line 4 column 1; and

7. The private room cost differential per diem from worksheet D-1 for adults and peds and subproviders, if provided;

(C) The inpatient Medicaid reimbursable cost will be determined as follows:

1. The Medicaid routine cost for adults and peds and subprovider units will be calculated by taking the total routine cost from paragraph (3)(B)2. From this cost will be removed the cost of observation bed days from subparagraph (3)(C)1.A. This total cost will be divided by the total patient days for adults and peds not including observation days (adjusted for labor and delivery room days if not included on worksheet S-3) plus patient days for any subprovider unit. This cost per day will be multiplied by the Medicaid paid days for adults and peds and subprovider units to determine Medicaid routine adult and peds cost. The cost of private room days will be added to this cost.

A. Observation cost will be determined by dividing the routine cost for adults and peds from paragraph (3)(C)2., by adult and peds days, adjusted by labor and delivery room days if not included, plus observation bed days. This cost per day is multiplied by the observation bed days reported on worksheet S-3 column 6 line 19 to determine the observation cost.

B. If the hospital reports medically necessary Medicaid private room days on worksheet D-1 line 14 and the data from the division's paid claim history reports private room days, the private room cost will be calculated by multiplying the private room cost differential per diem from worksheet D-1 line

35 by the lower of Medicaid private room days from the division's claims data or the private room days reported on worksheet D-1;

2. The routine inpatient cost for each special care unit will be determined by dividing the routine cost for the special care unit by the total patient days for that special care unit to determine the unit's cost per day. This cost per day will be multiplied by Medicaid paid days for that special care unit from the division's paid claim history to determine Medicaid cost (If the hospital has more than one (1) ICU unit with Medicaid days reported on the cost report, the Medicaid patient days for ICU from the division's records will be prorated based on the Medicaid days reported on the cost report.);

3. The routine cost for the nursery unit will be determined by dividing total nursery cost by total nursery days to determine the nursery cost per day. This cost per day will be multiplied by the Medicaid paid days to determine Medicaid nursery cost (Nursery days will not be prorated between nursery and neonatal. The hospital must use the proper room accommodation revenue code to bill neonatal days.);

4. The ancillary cost for each ancillary cost center will be determined by multiplying the Medicaid ancillary cost center's charges by its cost-to-charge ratio from paragraph (3)(B)4. (Based on the information in the cost report and in the division's data some ancillary accounts on the division's data may be combined.);

5. The Medicaid inpatient portion of the GME will be determined using the methodology on worksheet E-3 part IV from the Medicare/Medicaid cost report by substituting Medicaid data in place of the Medicare data;

6. If the hospital is a proprietary hospital it may be entitled to a return on equity. This cost would be determined by multiplying the equity ratio from paragraph (3)(B)6., by the Medicaid cost in paragraphs (3)(C)1.-4.; and

(D) Comparison of Inpatient Medicaid Cost to Inpatient Medicaid Payments.

1. The total inpatient Medicaid cost will be determined as the sum of the cost in paragraphs (3)(C)1.-6.

2. The Medicaid inpatient payments include the following amounts:

A. Partial payments made by third party payers (that is, insurance companies, HMO, etc);

B. Coinsurance and deductibles, which are the responsibility of the patient whether or not they were actually collected;

C. Inpatient claims payments made by

the Medicaid program; and

D. Outlier claim payments with service dates within the cost report period.

3. The total payments from subparagraph (3)(D)2.A.-D., will be subtracted from the lesser of the total cost in paragraph (3)(D)1., or the Medicaid charges from subsection (3)(A) (except hospitals identified by Medicare as a nominal charge provider for that fiscal year shall have their settlements based on cost). If the lesser of cost or charge exceeds the payment, no additional payment is due the hospital. (The inpatient settlement is zero (0) under the prospective payment plan.) If these payments exceed the charges the difference will result in an overpayment which will be due from the hospital (Disproportionate share payments are waived from the overpayment determination).

(4) Outpatient Hospital Settlements, Provider Based Rural Health Clinic (PBRHC) settlements or Provider Based Federally Qualified Health Centers (PBFQHC) settlements will be calculated after the division receives the Medicare/Medicaid cost report with a NPR from the hospital fiscal intermediary.

(A) The Division of Medical Services shall adjust the hospital's outpatient Medicaid payments, PBRHC or PBFQHC Medicaid payments to conform with the percent of cost paid on an interim basis under 13 CSR 70-15.160 for the appropriate time period (except for those hospitals that qualify under subsection (4)(B), whose payments will be based on the percent of cost in paragraph (4)(A)1., 2., or 3.) for—

1. Services prior to January 5, 1994, the lower of eighty percent (80%) of the outpatient share of the costs from subsection (4)(D), or eighty percent (80%) of the outpatient charges from paragraph (4)(C)1.;

2. Services after January 4, 1994 and prior to April 1, 1998, the lower of ninety percent (90%) of the outpatient share of the cost from subsection (4)(D), or ninety percent (90%) of the outpatient charge from paragraph (4)(C)1.;

3. Services after March 31, 1998, included in cost reports ending prior to January 1, 1999, the lower of one hundred percent (100%) of the outpatient share of the cost from subsection (4)(D), or one hundred percent (100%) of the outpatient charge from paragraph (4)(C)1.; and

4. PBRHC and PBFQHC shall be reimbursed one hundred percent (100%) of its share of the cost in paragraph (4)(E)2.

(B) A facility that meets the Medicare criteria of nominal charge provider for the fiscal period shall have its net cost reimbursement based on its cost in paragraph (4)(A)1., 2., or



3.

(C) The Medicaid charges used to determine the cost, and the payments used to determine the settlement will be—

1. For outpatient services the charges and payments extracted from the Medicaid outpatient claims history for reimbursable services paid on a percentage basis under 13 CSR 70-15.160.

2. For PBRHC and PBFQHC the charges and payments will be for services billed under 13 CSR 70-94.020.

(D) The Medicaid hospital's outpatient, cost will be determined by multiplying the overall outpatient cost-to-charge ratio, determined in accordance with paragraph (4)(D)1., by the Medicaid charges from paragraph (4)(C)1. To this product will be added the Medicaid outpatient share of GME. The GME will be determined using the methodology on worksheet E-3 part IV from the Medicare/Medicaid cost report (HCFA 2552-92) by substituting Medicaid data in place of Medicare data.

1. The overall outpatient cost-to-charge ratio will be determined by multiplying the reported total outpatient charges for each ancillary cost center, excluding PBRHC or PBFQHC, on the supplemental worksheet C column 10 (HCFA 2552-83) or substitute schedule by the appropriate cost-to-charge ratio from worksheet C (HCFA 2552-92) column 7 part I of the fiscal intermediary's audited Medicare/Medicaid cost report to determine the outpatient cost for each cost center reimbursed on a percentage of charge basis by Medicaid under 13 CSR 70-15.160. Total the outpatient costs from each cost center and total the outpatient charges from each cost center. Divide the total outpatient costs by the total outpatient charges to arrive at the overall outpatient cost-to-charge ratio.

(E) The Medicaid outpatient final settlement for cost reports ending prior to January 1, 1999, unless the hospital closed or had a change in ownership or merger prior to July 1, 2002, will determine either an overpayment or an underpayment for the hospital's outpatient services.

1. The outpatient Medicaid cost determined in subsection (4)(D) is multiplied by the percent of cost allowed in paragraph (4)(A)1., 2., or 3., to determine the reimbursable cost for outpatient services. (If a cost report covers both periods the outpatient Medicaid charges will be split to determine the reimbursable cost for each time period.) From this cost subtract the outpatient payments made on a percentage of charge basis under 13 CSR 70-15.010 for the time period. (Medicaid payments include the actual payment by Medicaid, third party payments,

coinsurance and deductibles.) The difference is either an overpayment (negative amount) due from provider or underpayment (positive amount) due to provider;

2. Closed facilities. Hospitals which closed after January 1, 1999 but before July 1, 2002 will have final settlements for cost reports ending during this time period calculated in accordance with 13 CSR 70-15.040(4)(E)1.;

3. New hospitals which do not have a fourth, fifth, and sixth prior year cost report necessary for establishment of a prospective rate will have final settlement calculated for their initial three (3) cost report periods;

4. Hospitals who qualify as nominal charge providers in accordance with 42 CFR 413.13(f) will have final settlements calculated for all cost report periods; and

5. Hospitals which had a change in ownership or merged with another hospital between January 1, 1997 and June 30, 2002 will have a final settlement calculated in accordance with this regulation for the first three (3) cost report periods after the change in ownership or merger after which it will be reimbursed under the prospective outpatient hospital reimbursement methodology unless it elects to be reimbursed under the prospective payment methodology starting July 1, 2002.

(F) The Medicaid PBRHC or PBFQHC final settlement will determine either an overpayment or an underpayment for the hospital's PBRHC or PBFQHC services. For PBRHC or PBFQHC services multiply the PBRHC or PBFQHC Medicaid charges from paragraph (4)(C)2., by the cost center's cost-to-charge ratio to determine PBRHC or PBFQHC cost. From this cost, the PBRHC or PBFQHC payments associated with charges from paragraph (4)(C)2., are subtracted. The difference is either an overpayment (negative amount) due from provider or an underpayment (positive amount) due to provider.

(5) Reopened cost reports received after the division has completed a final settlement will be calculated in the same manner as the original settlement. The division will not reopen any cost report when the amended NPR is received more than five (5) years after the hospital's fiscal year end unless the reopening is due to the provider submitting false or fraudulent information to its cost report. If the amended cost report changes the previous settlement by less than one hundred dollars (\$100) the cost report will not be reopened. If the prior settlement(s) resulted in an overpayment on the inpatient side, then an underpayment, up to the amount of the net inpatient recoupment, may be made.

AUTHORITY: sections 208.152, 208.153, 208.201, RSMo 2000 and 208.471, RSMo Supp. 2001. Original rule filed June 2, 1994, effective Dec. 30, 1994. Amended: Filed June 3, 1997, effective Dec. 30, 1997. Amended: Filed May 14, 1999, effective Nov. 30, 1999. Amended: Filed June 15, 1999, effective Dec. 30, 1999. Amended: Filed Aug. 24, 2001, effective March 30, 2002. Emergency amendment filed June 20, 2002, effective July 1, 2002, expired Feb. 27, 2003. Amended: Filed June 14, 2002, effective Jan. 30, 2003.*

**Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1981, 1986, 1988, 1990, 1992, 1993; 208.153, RSMo 1967, amended 1973, 1989, 1990, 1991; 208.201, RSMo 1987; and 208.471, RSMo 1992, 2001.*

13 CSR 70-15.070 Inpatient Hospital Psychiatric Services for Individuals Under Age Twenty-One

PURPOSE: This rule provides the legal basis where inpatient hospital psychiatric services provided eligible individuals under the age of twenty-one might be afforded coverage for purposes of vendor payment under the Title XIX Medicaid program.

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

(1) Pursuant to provisions of section 208.161, RSMo, Medicaid program coverage will be afforded eligible individuals under age twenty-one (21) for inpatient psychiatric hospital services provided under the following conditions:

(A) Under the direction of a physician;

(B) In a psychiatric hospital facility or an inpatient program in a psychiatric facility, either of which is accredited by the Joint Commission on Accreditation of Hospitals and meets the qualification definition in section (2); and



(C) For claimants under the age of twenty-one (21) or, if receiving the services immediately before attaining the age of twenty-one (21), not to extend beyond the earlier of the date—

1. Services are no longer required; or
2. Individual reaches the age of twenty-two (22).

(2) For purposes of administration of inpatient psychiatric hospital services coverage for individuals under age twenty-one (21), the Division of Family Services defines a qualified psychiatric hospital facility or inpatient program in a psychiatric facility as follows:

(A) The facility or program within the facility is currently accredited as a psychiatric hospital by the Joint Commission on Accreditation of Hospitals;

(B) The psychiatric facility is currently licensed by the hospital licensing authority of Missouri; and

(C) A psychiatric facility which is operated as a public institution and exempt from the hospital licensing law, must be operated by the Missouri Department of Mental Health.

(3) Inpatient psychiatric hospital services which are provided within a licensed acute care general hospital are not subject to the provisions and conditions of coverage as expressed in this rule, even though provided within an inpatient program or a part of the general hospital facility which is separately accredited as a psychiatric hospital by the Joint Commission on Accreditation of Hospitals. These inpatient psychiatric services shall be subject to the same provisions of coverage and the same benefits and limitations for inpatient hospital services as apply to all Medicaid-eligible recipients.

(4) Reimbursement for inpatient psychiatric hospital services, as provided for in this rule, shall be made in accordance with the provisions for inpatient hospital care reimbursement at 13 CSR 70-15.010 as rescinded effective October 1, 1981, for services prior to October 1, 1981, and at 13 CSR 70-15.010 as a readopted rule effective October 1, 1981, for services on or after October 1, 1981.

(5) A written and signed certification of need for services must be completed for every admission reimbursed by Medicaid that attests to—

(A) Ambulatory care resources available in the community do not meet the treatment needs of the youth;

(B) Inpatient treatment under the direction

of a physician is needed; and

(C) The services can reasonably be expected to improve the patient's condition, or prevent further regression, so that the services will no longer be needed.

(6) The certifications of need for care shall be made by different teams depending on the status of the individual patients as follows:

(A) For an individual who is receiving Medicaid at the time of admission, the certification of need shall be made by an independent team of health professionals at the time of admission. A team member cannot be employed by the admitting hospital or be receiving payment as a consultant on a regular and frequent basis. The team must include a licensed physician who has competence in diagnosis and treatment of mental illness preferably in child psychiatry, and has knowledge of the patient's situation and one (1) other mental health professional who is licensed, if a part of a licensed discipline;

(B) For an individual who applies for Medicaid while in the facility, the certification of need shall be made by the treatment facility interdisciplinary team responsible for the individual's plan of care as specified in section (7). The certification of need is to be made before submitting a Medicaid claim for payment and must cover any period for which Medicaid claims are made; or

(C) For an individual who undergoes an emergency admission, the certification of need shall be made by the treatment facility interdisciplinary team responsible for the individual's plan of care as specified in section (7) within fourteen (14) days after admission.

(7) The treatment facility's interdisciplinary team shall be a team of physicians and other personnel who are employed by, or provide services to patients in, the facility.

(A) The team shall include, as a minimum, either:

1. A board-eligible or board-certified psychiatrist who is a licensed physician;

2. A clinical psychologist who has a doctoral degree and is licensed, if required by the state, and a physician licensed to practice medicine or osteopathy; or

3. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology and is licensed, if required by the state or, if licensure is not required by the state, who has been certified by the state or by the state psychological association.

(B) The team also shall include one (1) of the following:

1. A psychiatric social worker who is licensed, if required by the state;

2. A licensed registered nurse with specialized training or one (1) year's experience in treating mentally ill individuals;

3. An occupational therapist who is licensed, if required by the state, and who has specialized training or one (1) year of experience in treating mentally ill individuals; or

4. A psychologist who has a master's degree in clinical psychology and is licensed, if required by the state or, if licensure is not required by the state, who has been certified by the state or by the state psychological association.

(C) The team must be capable of performing the following responsibilities:

1. Assessing the individual's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;

2. Assessing the potential resources of the individual's family;

3. Setting treatment objectives; and

4. Prescribing therapeutic modalities to achieve the plan of care objectives.

(8) Inpatient psychiatric services shall include active treatment which means implementation of a professionally developed and supervised individual plan of care, as described in section (9), that meet the following requirements:

(A) Developed and implemented no later than fourteen (14) days after admission; and

(B) Designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

(9) An individual plan of care is a written plan developed for each recipient to improve his/her condition to the extent that inpatient care is no longer necessary. The plan of care shall—

(A) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care;

(B) Be developed by a team of professionals specified under section (7) in consultation with the recipient; and his/her parents, legal guardians or others in whose care s/he will be released after discharge;

(C) State treatment objectives;

(D) Prescribe an integrated program of therapies, activities and experiences designed to meet objectives;



(E) Include, at an appropriate time, post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school and community upon discharge; and

(F) Be reviewed every thirty (30) days by the treatment facility interdisciplinary team specified in section (7) to provide the following requirements:

1. Determine that services being provided are or were required on an inpatient basis; and

2. Recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient.

(10) Before admission or before authorization for payment, the team described in section (6) of this rule must make medical, psychiatric and social evaluations of each applicant's or recipient's need for care in the hospital. Each medical evaluation must include the following elements:

(A) Diagnoses;

(B) Summary of present medical findings;

(C) Medical history;

(D) Mental and physical functional capacity;

(E) Prognoses; and

(F) A recommendation by a licensed physician concerning admission to the mental hospital or continued care in the mental hospital for individuals who apply for Medicaid while in the mental hospital.

(11) Audits to monitor hospital compliance shall be performed by a medical review agent as authorized by the Division of Medical Services. Hospital admissions of July 1, 1991, and after, that will be subject to audits which may include up to one hundred percent (100%) of Medicaid admissions. Documentation of certification of need, medical/psychiatric/social evaluations, plan of care and active treatment shall be a part of the individual's medical record. All required documentation must be a part of the medical record at the time of audit to be considered during the audit. Failure of the medical record to contain the required documents at the time of audit shall result in recoupment. The medical review agent's audit process is as follows:

(A) The hospital has thirty (30) calendar days from the date of the request to furnish medical records for desk audits. At rates determined by the medical review agent, provider costs associated with submission of records will be reimbursed. Records not received within thirty (30) days will result in the services being denied and the Medicaid

payment recouped;

(B) Review of the certification of need, medical/psychiatric/social evaluations and plan of care documentation is performed to determine compliance with this rule;

(C) A sample of claims will be reviewed for quality of care using the Health Care Financing Administration (HCFA) psychiatric generic quality screens;

(D) An initial review of the medical record information for active treatment is performed by either a nurse who is licensed or social worker reviewer who is licensed using the Child and Adolescent Assessment Psychiatric Treatment screening criteria;

(E) If the medical record documentation regarding the patient's condition and planned services meet the criteria in subsection (11)(D) of this rule, the services are approved by either the nurse or social worker reviewer;

(F) If the criteria in subsection (11)(D) of this rule is not met, the nurse or social worker reviewer refers the case to a physician reviewer who is a licensed physician for a determination of documentation and medical necessity. The physician reviewer is not bound by criteria used by the nurse or social worker reviewer. The physician reviewer uses his/her medical judgment to make a determination based on the documented medical facts in the record;

(G) If the physician reviewer denies the admission or days of stay, the attending physician and hospital shall be notified. The hospital may request of the medical review agent a reconsideration review. The hospital is notified of the medical review agent's reconsideration determination;

(H) Reconsideration determination is the final level of review by the medical review agent. The division will accept the medical review agent's decision;

(I) Hospitals are notified by the Division of Medical Services if an adjustment of Medicaid payments is required as a result of audit findings;

(J) The following Medicaid policies apply for calculation of Medicaid payments:

1. Medicaid shall reimburse nursing facility care provided in the inpatient hospital setting in accordance with 13 CSR 70-15.010;

2. No Medicaid payment shall be made on behalf of any recipient who is receiving inpatient hospital care and is not in need of either inpatient or nursing facility care. No payment will be made for outpatient services rendered on an inpatient basis; or

3. Medicaid shall not pay for admissions or continued days for social situations, placement problems, court commitments or abuse/neglect without medical risk; and

(K) Overpayment determinations may be appealed in accordance with section 208.156, RSMo.

AUTHORITY: section 208.201, RSMo Supp. 1987. This rule was previously filed as 13 CSR 40-81.053. Emergency rule filed Sept. 24, 1981, effective Oct. 4, 1981, expired Jan. 13, 1982. Original rule filed Sept. 24, 1981, effective Jan. 14, 1982. Emergency amendment filed Sept. 13, 1991, effective Oct. 2, 1991, expired Jan. 29, 1992. Amended: Filed June 18, 1991, effective Dec. 9, 1991.*

**Original authority: 208.201, RSMo 1987.*

13 CSR 70-15.080 Payment Method for General Relief Recipient Hospital Outpatient Services

(Rescinded December 30, 2005)

AUTHORITY: section 207.020, RSMo 1986. This rule was previously filed as 13 CSR 40-81.180. Emergency rule filed July 15, 1981, effective Aug. 1, 1981, expired Oct. 10, 1981. Original rule filed July 15, 1981, effective Oct. 11, 1981. Rescinded: Filed June 15, 2005, effective Dec. 30, 2005.

13 CSR 70-15.090 Procedures for Evaluation of Appropriate Inpatient Hospital Admissions and Continued Days of Stay

(Rescinded May 30, 2020)

AUTHORITY: sections 208.153 and 208.201, RSMo 2016. This rule was previously filed as 13 CSR 40-81.162. Original rule filed May 3, 1985, effective Sept. 1, 1985. Amended: Filed Nov. 15, 1988, effective Feb. 11, 1989. Amended: Filed April 4, 1989, effective June 29, 1989. Rescinded: Filed Nov. 2, 1989, effective Jan. 26, 1990. Emergency rule filed June 4, 1990, effective June 28, 1990, expired Oct. 25, 1990. Readopted: Filed June 4, 1990, effective Nov. 30, 1990. Amended: Filed Nov. 3, 2017, effective June 30, 2018. Rescinded: Filed Oct. 25, 2019, effective May 30, 2020.

13 CSR 70-15.100 Unreimbursed Care Payment Methodology

Emergency rule filed May 4, 1992, effective May 15, 1992, expired Sept. 11, 1992.

13 CSR 70-15.110 Federal Reimbursement Allowance (FRA)

PURPOSE: This rule establishes the formula



for determining the Federal Reimbursement Allowance each hospital, except public hospitals which are operated primarily for the care and treatment of mental disorders and any hospital operated by the Department of Health, is required to pay for the privilege of engaging in the business of providing inpatient health care in Missouri.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Federal Reimbursement Allowance (FRA). FRA shall be assessed as described in this section.

(A) Definitions.

1. Bad debts—Amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. Allowable bad debts include the costs of caring for patients who have insurance, but their insurance does not cover the particular service procedures or treatment rendered.

2. Base cost report—Desk-reviewed Medicare/Medicaid cost report. The Medicare/Medicaid Cost Report version 2552-96 (CMS 2552-96) shall be used for fiscal years ending on or after September 30, 1996. The Medicare/Medicaid Cost Report version 2552-10 (CMS 2552-10) shall be used for fiscal years beginning on and after May 1, 2010. When a hospital has more than one (1) cost report with periods ending in the base year, the cost report covering a full twelve- (12-) month period will be used. If none of the cost reports covers a full twelve (12) months, the cost report with the latest period will be used. If a hospital's base cost report is less than or greater than a twelve- (12-) month period, the data shall be adjusted, based on the number of months reflected in the base cost report, to a twelve- (12-) month period.

3. Charity care—Those charges written off by a hospital based on the hospital's policy to provide health care services free of charge or at a reduced charge because of the indigence or medical indigence of the patient.

4. Contractual allowances—Difference between established rates for covered services and the amount paid by third-party payers under contractual agreements. The Federal

Reimbursement Allowance (FRA) is a cost to the hospital, regardless of how the FRA is remitted to the MO HealthNet Division, and shall not be included in contractual allowances for determining revenues. Any redistributions of MO HealthNet payments by private entities acting at the request of participating health care providers shall not be included in contractual allowances or determining revenues or cost of patient care.

5. Department—Department of Social Services.

6. Director—Director of the Department of Social Services.

7. Division—MO HealthNet Division, Department of Social Services.

8. Engaging in the business of providing inpatient health care—Accepting payment for inpatient services rendered.

9. Federal Reimbursement Allowance (FRA)—The fee assessed to hospitals for the privilege of engaging in the business of providing inpatient health care in Missouri. The FRA is an allowable cost to the hospital.

10. Fiscal period—Twelve- (12-) month reporting period determined by each hospital.

11. Gross hospital service charges—Total charges made by the hospital for inpatient and outpatient hospital services that are covered under 13 CSR 70-15.010.

12. Hospital—A place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment, or care for not fewer than twenty-four (24) hours in any week of three (3) or more nonrelated individuals suffering from illness, disease, injury, deformity, or other abnormal physical conditions; or a place devoted primarily to provide, for not fewer than twenty-four (24) hours in any week, medical or nursing care for three (3) or more nonrelated individuals. The term hospital does not include convalescent, nursing, shelter, or boarding homes as defined in Chapter 198, RSMo.

13. Hospital revenues subject to FRA assessment effective July 1, 2008—Each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues subject to the FRA assessment will be determined as follows:

A. Obtain "Gross Total Charges" from Worksheet G-2, Line 25, Column 3 from CMS 2552-96, or Worksheet G-2, Line 28, Column 3 from CMS 2552-10, of the third prior year cost report (i.e., FRA fiscal year cost report) for the hospital. Charges shall exclude revenues for physician services. Charges related to activities subject to the Missouri taxes assessed for outpatient retail pharmacies and nursing facility services shall also be excluded. "Gross Total Charges" will be reduced by the following:

(I) "Nursing Facility Charges" from Worksheet C, Part I, Line 35, Column 6 from CMS 2552-96, or Worksheet C, Part I, Line 45, Column 6 from CMS 2552-10;

(II) "Swing Bed Nursing Facility Charges" from Worksheet G-2, Line 5, Column 1 from CMS 2552-96, or Worksheet G-2, Line 6, Column 1 from CMS 2552-10;

(III) "Nursing Facility Ancillary Charges" as determined from the Department of Social Services, MO HealthNet Division, nursing home cost report. (Note: To the extent that the gross hospital charges, as specified in subparagraph (1)(A)13.A. above, include long-term care charges, the charges to be excluded through this step shall include all long-term care ancillary charges including skilled nursing facility, nursing facility, and other long-term care providers based at the hospital that are subject to the state's provider tax on nursing facility services.);

(IV) "Distinct Part Ambulatory Surgical Center Charges" from Worksheet G-2, Line 22, Column 2 from CMS 2552-96, or Worksheet G-2, Line 25, Column 2 from CMS 2552-10;

(V) "Ambulance Charges" from Worksheet C, Part I, Line 65, Column 7 from CMS 2552-96, or Worksheet C, Part I, Line 95, Column 7 from CMS 2552-10;

(VI) "Home Health Charges" from Worksheet G-2, Line 19, Column 2 from CMS 2552-96, or Worksheet G-2, Line 22, Column 2 from CMS 2552-10;

(VII) "Total Rural Health Clinic Charges" from Worksheet C, Part I, Column 7, Lines 63.50–63.59 from CMS 2552-96, or Worksheet C, Part I, Column 7, Line 88 and subsets from CMS 2552-10; and

(VIII) "Other Non-Hospital Component Charges" from Worksheet G-2, Lines 6, 8, 21, 21.02, 23, and 24 from CMS 2552-96, or Worksheet G-2, Lines 5, 7, 9, 21, 24, 26, and 27 from CMS 2552-10;

B. Obtain "Net Revenue" from Worksheet G-3, Line 3, Column 1. The state will ensure this amount is net of bad debts and other uncollectible charges by survey methodology;

C. "Adjusted Gross Total Charges" (the result of the computations in subparagraph (1)(A)13.A.) will then be further adjusted by a hospital-specific collection-to-charge ratio determined as follows:

(I) Divide "Net Revenue" by "Gross Total Charges"; and

(II) "Adjusted Gross Total Charges" will be multiplied by the result of part (1)(A)13.C.(I) to yield "Adjusted Net Revenue";

D. Obtain "Gross Inpatient Charges" from Worksheet G-2, Line 25, Column 1 from



CMS 2552-96, or Worksheet G-2, Line 28, Column 1 from CMS 2552-10, of the most recent cost report that is available for a hospital;

E. Obtain “Gross Outpatient Charges” from Worksheet G-2, Line 25, Column 2 from CMS 2552-96, or Worksheet G-2, Line 28, Column 2 from CMS 2552-10, of the most recent cost report that is available for a hospital;

F. Total “Adjusted Net Revenue” will be allocated between “Net Inpatient Revenue” and “Net Outpatient Revenue” as follows:

(I) “Gross Inpatient Charges” will be divided by “Gross Total Charges”;

(II) “Adjusted Net Revenue” will then be multiplied by the result to yield “Net Inpatient Revenue”; and

(III) The remainder will be allocated to “Net Outpatient Revenue”; and

G. The trend indices, if greater than 0%, will be determined based on the Health Care Costs index as published in *Healthcare Cost Review* by Institute of Health Systems (IHS), or equivalent publication, regardless of any changes in the name of the publication or publisher, for each State Fiscal Year (SFY). The trend indices listed below will be applied to the apportioned inpatient adjusted net revenue and outpatient adjusted net revenue in order to inflate or trend forward the adjusted net revenues from the FRA fiscal year cost report to the current state fiscal year to determine the inpatient and outpatient adjusted net revenues subject to the FRA assessment.

(I) SFY 2016 =

(a) Inpatient Adjusted Net Revenues—0%

(b) Outpatient Adjusted Net Revenues—3.90%

(II) SFY 2017 =

(a) Inpatient Adjusted Net Revenues—0%

(b) Outpatient Adjusted Net Revenues—4.10%

(III) SFY 2018 =

(a) Inpatient Adjusted Net Revenues—0%

(b) Outpatient Adjusted Net Revenues—0%

(IV) SFY 2019 =

(a) Inpatient Adjusted Net Revenues—0%

(b) Outpatient Adjusted Net Revenues—0%

(V) SFY 2020 =

(a) Inpatient Adjusted Net Revenues—0%

(b) Outpatient Adjusted Net Revenues—2.9%

(VI) SFY 2021 =

(a) Inpatient Adjusted Net Revenues—3.2%

(b) Outpatient Adjusted Net Revenues—0%

(B) Each hospital engaging in the business of providing inpatient health care in Missouri shall pay an FRA. The FRA shall be calculated by the Department of Social Services.

1. The FRA shall be as described beginning with section (2) and going forward.

2. If a hospital does not have a third prior year base cost report, inpatient and outpatient adjusted net revenues shall be estimated as follows:

A. Hospitals required to pay the FRA, except safety net hospitals, shall be divided in quartiles based on total beds;

B. The inpatient adjusted net revenue shall be summed for each quartile and divided by the total beds in the quartile to yield an average inpatient adjusted net revenue per bed. The number of beds for the hospital without the base cost report shall be multiplied by the average inpatient adjusted net revenue per bed to determine the estimated inpatient adjusted net revenue; and

C. The outpatient adjusted net revenue shall be summed for each quartile and divided by the number of facilities in the quartile to yield an average outpatient adjusted net revenue per facility which will be the estimated outpatient adjusted net revenue for the hospital without the base cost report.

3. Beginning January 1, 2015, if a hospital does not have a third prior year cost report on which to determine the hospital revenues subject to FRA assessment as set forth in paragraph (1)(A)13., inpatient and outpatient adjusted net revenues shall be based upon the projections included with its Certificate of Need (CON) application on the “Service-Specific Revenues and Expenses” form (CON projections) required in a full CON review as described in 19 CSR 60-50.300. If the hospital did not go through a full CON review, it must submit a completed “Service-Specific Revenues and Expenses” form that has been verified by an independent auditor.

A. The hospital must provide the division with the breakdown of the inpatient and outpatient revenues that tie to the CON projections.

B. The CON projections and the breakdown of the inpatient and outpatient revenues are subject to review and validation by the division.

C. If the facility does not provide the CON projections, the breakdown of the inpatient and outpatient revenues, or any other additional information requested by the division within thirty (30) days of the division’s request, the inpatient and outpatient adjusted

net revenues shall be based upon the quartile method set forth in paragraph (1)(B)2.

D. Direct Medicaid and Uninsured Add-On Payments shall be included in the estimated inpatient and outpatient adjusted net revenues.

E. Once the facility has a third prior year cost report, the assessment shall be based on the actual inpatient and outpatient adjusted net revenues from such cost report.

4. The FRA assessment for hospitals that merge operation under one (1) Medicare and MO HealthNet provider number shall be determined as follows:

A. The previously determined FRA assessment for each hospital shall be combined under the active MO HealthNet provider number for the remainder of the state fiscal year after the division receives official notification of the merger; and

B. The FRA assessment for subsequent fiscal years shall be based on the combined data for both facilities.

5. A hospital which either voluntarily or involuntarily terminates its license and which becomes relicensed will be assessed the same inpatient and outpatient assessment as the previous hospital owner/operator if the hospital becomes relicensed during the same state fiscal year. If the hospital does not become relicensed during the same state fiscal year, the inpatient and outpatient assessment will be determined based on the applicable base year data (i.e., third prior year). If the hospital does not have the applicable base year data, the inpatient and outpatient assessment will be based on the most recent cost report data available and will include annual trend factor adjustments from the year subsequent to the cost report period through the state fiscal year for which the assessments are being determined.

(C) The division shall prepare a confirmation schedule of the information from each hospital’s third prior year cost report and provide each hospital with this schedule. Each hospital required to pay the FRA shall review the confirmation schedule confirm the information is correct or provide correct information within fifteen (15) days of receiving the confirmation schedule. If the hospital fails to submit the corrected data within the fifteen-(15-) day time period, the hospital shall be barred from submitting corrected data later to have its FRA assessment or the add-on payments from 13 CSR 70-15.010, 13 CSR 70-15.015, and 13 CSR 70-15.220 adjusted.

1. The FRA will be offset against any Missouri Medicaid payment due the hospital. The FRA Assessments shall be allocated and deducted over the applicable period.

2. A letter will be sent to the hospital



indicating the FRA balance due after offset, if any, at the end of each state fiscal quarter. The FRA balance due shall be remitted by the hospital to the MO HealthNet Division as stated in the letter.

(D) In accordance with sections 621.055 and 208.156, RSMo, hospitals may seek a hearing before the Administrative Hearing Commission from a final decision of the director of the department or division.

(2) Beginning July 1, 2010, the FRA assessment shall be determined at the rate of five and forty-five hundredths percent (5.45%) of each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues as set forth in paragraph (1)(A)13. The FRA assessment rate of five and forty-five hundredths percent (5.45%) will be applied individually to the hospital's inpatient adjusted net revenues and outpatient adjusted net revenues. The hospital's total FRA assessment is the sum of the assessment determined from its inpatient adjusted net revenue plus the assessment determined for its outpatient adjusted net revenue.

(3) Beginning October 1, 2011, the FRA assessment shall be determined at the rate of five and ninety-five hundredths percent (5.95%) of each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues as set forth in paragraph (1)(A)13. The FRA assessment rate of five and ninety-five hundredths percent (5.95%) will be applied individually to the hospital's inpatient adjusted net revenues and outpatient adjusted net revenues. The hospital's total FRA assessment is the sum of the assessment determined from its inpatient adjusted net revenue plus the assessment determined for its outpatient adjusted net revenue.

(4) Beginning July 1, 2017, the FRA assessment shall be determined at the rate of five and seventy hundredths percent (5.70%) of each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues as set forth in paragraph (1)(A)13. The FRA assessment rate of five and seventy hundredths percent (5.70%) will be applied individually to the hospital's inpatient adjusted net revenues and outpatient adjusted net revenues. The hospital's total FRA assessment is the sum of the assessment determined from its inpatient adjusted net revenue plus the assessment determined for its outpatient adjusted net revenue.

(A) If the reduction of disproportionate share hospital allotments for federal fiscal year 2018 is implemented as provided in section 1923(f)(7) of the Social Security Act, the

FRA assessment shall be set, effective on the date of such reduction, at the rate of five and fifty hundredths percent (5.50%) of each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues as set forth in paragraph (1)(A)13. The FRA assessment rate of five and fifty hundredths percent (5.50%) will be applied individually to the hospital's inpatient adjusted net revenues and outpatient adjusted net revenues. The hospital's total FRA assessment is the sum of the assessment determined from its inpatient adjusted net revenue plus the assessment determined for its outpatient adjusted net revenue.

(5) Beginning July 1, 2018, the FRA assessment shall be determined at the rate of five and sixty hundredths percent (5.60%) of each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues as set forth in paragraph (1)(A)13. The FRA assessment rate of five and sixty hundredths percent (5.60%) will be applied individually to the hospital's inpatient adjusted net revenues and outpatient adjusted net revenues. The hospital's total FRA assessment is the sum of the assessment determined from its inpatient adjusted net revenue plus the assessment determined for its outpatient adjusted net revenue.

(6) Beginning July 1, 2020, the FRA assessment shall be determined at a rate of five and seventy-five hundredths percent (5.75%) of each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues as set forth in paragraph (1)(A)13. The FRA assessment rate will be applied individually to the hospital's inpatient adjusted net revenues and outpatient adjusted net revenues. The hospital's total FRA assessment is the sum of the assessment determined from its inpatient adjusted net revenue plus the assessment determined for its outpatient adjusted net revenue.

AUTHORITY: sections 208.201, 208.453, 208.455, and 660.017, RSMo 2016. Emergency rule filed Sept. 21, 1992, effective Oct. 1, 1992, expired Jan. 28, 1993. Emergency rule filed Jan. 15, 1993, effective Jan. 25, 1993, expired May 24, 1993. Original rule filed Sept. 21, 1992, effective June 7, 1993. Emergency amendment filed Sept. 2, 1993, effective Sept. 18, 1993, expired Jan. 15, 1994. Amended: Filed Oct. 15, 1993, effective June 6, 1994. Emergency amendment filed Sept. 23, 1994, effective Oct. 3, 1994, expired Feb. 1, 1995. Emergency amendment filed Jan. 20, 1995, effective Jan. 31, 1995, expired May 30,*

1995. Emergency amendment filed Feb. 9, 1995, effective Feb. 20, 1995, expired June 19, 1995. Amended: Filed Feb. 9, 1995, effective Aug. 30, 1995. Emergency amendment filed June 20, 1995, effective July 1, 1995, expired Oct. 28, 1995. Emergency amendment filed July 31, 1995, effective Aug. 10, 1995, expired Dec. 7, 1995. Amended: Filed May 19, 1995, effective Dec. 30, 1995. Emergency amendment filed Nov. 27, 1995, effective Dec. 8, 1995, expired June 4, 1996. Amended: Filed Nov. 27, 1995, effective June 30, 1996. Emergency amendment filed June 21, 1996, effective July 1, 1996, expired Dec. 27, 1996. Amended: Filed April 15, 1996, effective Nov. 30, 1996. Emergency amendment filed June 21, 1996, effective July 1, 1996, expired Dec. 31, 1996. Emergency amendment filed Sept. 13, 1996, effective Oct. 1, 1996, expired March 29, 1997. Amended: Filed Sept. 13, 1996, effective April 30, 1997. Emergency amendment filed June 3, 1997, effective July 1, 1997, expired Dec. 27, 1997. Amended: Filed June 3, 1997, effective Dec. 30, 1997. Emergency amendment filed March 2, 1998, effective April 1, 1998, expired Sept. 28, 1998. Amended: Filed March 2, 1998, effective Sept. 30, 1998. Emergency amendment filed Aug. 31, 1998, effective Sept. 10, 1998, expired March 8, 1999. Amended: Filed Jan. 14, 1999, effective July 30, 1999. Emergency amendment filed March 29, 1999, effective April 8, 1999, expired Oct. 4, 1999. Amended: Filed Aug. 16, 1999, effective March 30, 2000. Amended: Filed March 3, 2000, effective Oct. 30, 2000. Emergency amendment filed June 8, 2001, effective June 18, 2001, expired Dec. 8, 2001. Amended: Filed June 8, 2001, effective Nov. 30, 2001. Amended: Filed Sept. 11, 2001, effective March 30, 2002. Emergency amendment filed May 28, 2002, effective June 6, 2002, expired Dec. 2, 2002. Amended: Filed April 29, 2002, effective Nov. 30, 2002. Emergency amendment filed April 29, 2003, effective May 9, 2003, terminated Sept. 18, 2003. Amended: Filed April 29, 2003, effective Nov. 30, 2003. Emergency amendment filed Sept. 8, 2003, effective Sept. 18, 2003, expired March 15, 2004. Amended: Filed Sept. 8, 2003, effective March 30, 2004. Emergency amendment filed June 7, 2004, effective June 17, 2004, expired Dec. 13, 2004. Amended: Filed June 7, 2004, effective Dec. 30, 2004. Emergency amendment filed Sept. 10, 2004, effective Sept. 20, 2004, expired March 18, 2005. Amended: Filed Sept. 27, 2004, effective March 30, 2005. Emergency amendment filed June 7, 2005, effective June 17, 2005, expired Dec. 13, 2005. Amended: Filed June 15, 2005, effective Dec. 30, 2005. Emergency



amendment filed May 10, 2006, effective May 20, 2006, expired Nov. 15, 2006. Emergency amendment filed June 15, 2006, effective July 1, 2006, expired Dec. 28, 2006. Amended: filed May 10, 2006, effective Nov. 30, 2006. Emergency amendment filed June 20, 2007, effective July 1, 2007, expired Dec. 27, 2007. Amended: Filed June 20, 2007, effective Jan. 30, 2008. Emergency amendment filed June 18, 2008, effective July 1, 2008, expired Dec. 28, 2008. Amended: Filed July 1, 2008, effective Jan. 30, 2009. Emergency amendment filed June 19, 2009, effective July 1, 2009, expired Dec. 28, 2009. Amended: Filed July 1, 2009, effective Jan. 30, 2010. Emergency amendment filed Dec. 1, 2009, effective Jan. 1, 2010, expired June 29, 2010. Amended: Filed Dec. 1, 2009, effective June 30, 2010. Emergency amendment filed June 17, 2010, effective July 1, 2010, expired Dec. 27, 2010. Amended: Filed June 17, 2010, effective Jan. 30, 2011. Emergency amendment filed Sept. 20, 2011, effective Oct. 1, 2011, expired March 28, 2012. Amended: Filed July 1, 2011, effective Jan. 30, 2012. Emergency amendment filed June 20, 2012, effective July 1, 2012, expired Dec. 28, 2012. Amended: Filed July 2, 2012, effective Jan. 30, 2013. Emergency amendment filed June 20, 2013, effective July 1, 2013, expired Dec. 28, 2013. Amended: Filed July 1, 2013, effective Jan. 30, 2014. Emergency amendment filed June 20, 2014, effective July 1, 2014, expired Dec. 27, 2014. Amended: Filed July 1, 2014, effective Jan. 30, 2015. Emergency amendment filed June 19, 2015, effective July 1, 2015, expired Dec. 28, 2015. Amended: Filed July 1, 2015, effective Jan. 30, 2016. Emergency amendment filed June 20, 2016, effective July 1, 2016, expired Dec. 27, 2016. Amended: Filed June 23, 2016, effective Jan. 30, 2017. Emergency amendment filed June 20, 2017, effective July 1, 2017, expired Feb. 22, 2018. Amended: Filed June 20, 2017, effective Jan. 30, 2018. Emergency amendment filed June 21, 2018, effective July 1, 2018, expired Feb. 28, 2019. Amended: Filed June 21, 2018, effective Jan. 30, 2019. Amended: Filed April 30, 2020, effective Nov. 30, 2020.

*Original authority: 208.201, RSMo 1987, amended 2007; 208.453, RSMo 1992, amended 1994, 2010; 208.455, RSMo 1992, amended 1993, 1994, 1995; and 660.017, RSMo 1993, amended 1995.

13 CSR 70-15.150 Enhancement Pools (Rescinded September 30, 2018)

AUTHORITY: sections 208.153 and 208.201, RSMo 2000. Emergency rule filed April 9, 2001, effective April 19, 2001, expired Oct.

15, 2001. Original rule filed April 9, 2001, effective Sept. 30, 2001. Rescinded: Filed March 2, 2018, effective Sept. 30, 2018.

13 CSR 70-15.160 Outpatient Hospital Services Reimbursement Methodology

PURPOSE: This rule establishes the payment methodology for outpatient hospital services.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Prospective Outpatient Hospital Services Reimbursement Percentage for Hospitals Located Within Missouri.

(A) Outpatient hospital services shall be reimbursed on a prospective outpatient payment percentage effective July 1, 2002, except for services identified in subsection (1)(C). The prospective outpatient payment percentage will be calculated using the Medicaid overall outpatient cost-to-charge ratio from the fourth, fifth, and sixth prior base year cost reports regressed to the current State Fiscal Year (SFY). (If the current SFY is 2003, the fourth, fifth, and sixth prior year cost reports would be the cost report filed in calendar year 1997, 1998, and 1999). As part of the regression analysis, a facility's outpatient payment percentage is limited to a downward adjustment of fifteen percent (15%) from the previous year with no limit on the upward swing, unless the facility chose the lower upward and downward swing option. For SFYs 2007–2010, the lower upward and downward swing option was three percent (3%) and beginning with SFY 2011 the lower upward and downward swing option is six percent (6%). Once a facility has chosen an option, it shall be fixed and applied beginning with the year it is selected. If a facility has not chosen an option, the default is the downward adjustment of fifteen percent (15%) from the previous year with no limit on the upward swing. The prospective outpatient payment percentage shall not exceed one hundred percent (100%) and shall not be less than twenty percent (20%).

(B) Outpatient cost-to-charge ratios will be

as determined in the desk review of the base year cost reports. If adjustments are not made during the desk review, adjustments will be made to remove the cost and charges for services reimbursed on a fee schedule when calculating the cost-to-charge ratios used to determine the outpatient percentage rate.

1. Costs and charges for laboratory and radiology services reimbursed on a fee schedule shall be excluded when calculating the outpatient cost-to-charge ratios used to determine outpatient percentage rates.

2. Costs and charges for outpatient surgical procedures reimbursed on a fee schedule shall be excluded when calculating the outpatient cost-to-charge ratios used to determine outpatient percentage rates. Adjustments shall be made by the division starting with the calculation of the outpatient percentage rate for the SFY after the surgical procedures are moved to a fee schedule:

A. Exception. A hospital may request a revised calculation of the outpatient percentage rate prior to the adjustment made by the division in paragraph (1)(B)2. of this regulation. The hospital must provide the charges and cost-to-charge ratios by cost center for both Medicaid and Total (i.e., all payor types). The hospital must provide a breakdown of the amounts reimbursed on a fee schedule using a template developed by the division and available upon request. The template must be submitted to the division by April 1 of the current SFY for which the revised calculation of the outpatient percentage rate is requested. The hospital may be notified in writing of the revised outpatient percentage rate within sixty (60) days of receipt of the hospital's written request or within sixty (60) days of receipt of any additional documentation or clarification which may be required. If an adjustment is not otherwise limited or prohibited, the effective date of the change in the hospital's outpatient percentage rate shall be the first day of the month following the date of the division's final determination.

3. Costs and charges for the telehealth originating site fee reimbursed on a fee schedule shall be excluded when calculating the outpatient cost-to-charge ratios used to determine outpatient percentage rates starting with the calculation of the outpatient percentage rate for the SFY after the telehealth originating site fee is moved to a fee schedule.

4. Costs and charges for outpatient drugs reimbursed in accordance with the methodology described in 13 CSR 70-20.070 shall be excluded when calculating the outpatient cost-to-charge ratios used to determine outpatient percentage rates beginning February 1, 2019.



(C) Outpatient Hospital Services Reimbursement Limited by Rule.

1. Certain clinical diagnostic laboratory procedures will be reimbursed from a Medicaid fee schedule which shall not exceed a national fee limitation.

2. The technical component of outpatient radiology procedures will be reimbursed from a Medicaid fee schedule.

A. Effective for dates of service beginning October 1, 2011, through December 31, 2018, the technical component of outpatient radiology procedures, will be reimbursed according to the outpatient Medicaid fee schedule. These rates are based on one hundred twenty-five percent (125%) of the Medicare Physician fee schedule rate using Missouri Locality 01. The Medicaid outpatient radiology fee schedule for the calendar years of 2016, 2017, and 2018 is published on the MO HealthNet website. This fee schedule is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at <https://dss.mo.gov/mhd/providers/files/outpatient-hospital-radiology-fee-schedule18.pdf>, December 4, 2018. This rule does not incorporate any subsequent amendments or additions.

B. Effective for dates of service beginning January 1, 2019, the technical component of outpatient radiology procedures will be reimbursed according to the outpatient Medicaid fee schedule. These rates are based on ninety percent (90%) of the Medicare Physician fee schedule rate, effective January 1, 2018, using Missouri Locality 01. The Medicaid outpatient radiology fee schedule for the calendar years of 2017, 2018, and 2019 is published on the MO HealthNet website. This fee schedule is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at <https://dss.mo.gov/mhd/providers/files/outpatient-hospital-radiology-fee-schedule.pdf>, December 4, 2018. This rule does not incorporate any subsequent amendments or additions.

3. Effective for dates of service beginning January 1, 2019, outpatient surgical procedures are reimbursed according to the outpatient Medicaid fee schedule. These rates are based on the 2018 Medicare Hospital Prospective Payment System Addendum B. The list of outpatient surgical procedure codes are reimbursed according

to the Medicaid fee schedule. This fee schedule is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at <https://dss.mo.gov/mhd/providers/files/outpatient-hospital-surgical-procedure-fee-schedule.pdf>, November 30, 2018. This rule does not incorporate any subsequent amendments or additions.

4. Effective for dates of service beginning January 1, 2019 telehealth originating site fee is paid at the lesser of the billed amount or the outpatient fee schedule amount.

5. Effective for service dates beginning April 1, 2019, outpatient drugs are reimbursed in accordance with the methodology described in 13 CSR 70-20.070.

6. Services of hospital-based physicians and certified registered nurse anesthetists are reimbursed from a Medicaid fee schedule or the billed charge, if less.

7. Outpatient hospital services provided for those recipients having available Medicare benefits shall be reimbursed by Medicaid to the extent of the deductible and coinsurance as imposed by Medicare.

8. Reimbursement of Medicare/Medicaid crossover claims (crossover claims) for Medicare Part B and Medicare Advantage/Part C outpatient hospital services, except for public hospitals operated by the Department of Mental Health (DMH), shall be determined as follows:

A. Crossover claims for Medicare Part B outpatient hospital services in which Medicare was the primary payer and the MO HealthNet Division (MHD) is the payer of last resort for cost-sharing (i.e., coinsurance, copay, and/or deductibles) must meet the following criteria to be eligible for MHD reimbursement:

(I) The crossover claim must be related to Medicare Part B outpatient hospital services that were provided to MO HealthNet participants also having Medicare Part B coverage;

(II) The crossover claim must contain approved outpatient hospital services which MHD is billed for cost-sharing; and

(III) The Other Payer paid amount field on the claim must contain the actual amount paid by Medicare. The MO HealthNet provider is responsible for accurate and valid reporting of crossover claims submitted to MHD for payment regardless of how the claim is submitted. Providers submitting crossover claims for Medicare Part B outpatient hospital services to MHD must be

able to provide documentation that supports the information on the claim upon request. The documentation must match the information on the Medicare Part B plan's remittance advice. Any amounts paid by MHD that are determined to be based on inaccurate data will be subject to recoupment;

B. Crossover claims for Medicare Advantage/Part C (Medicare Advantage) outpatient hospital services in which a Medicare Advantage plan was the primary payer and MHD is the payer of last resort for cost-sharing (i.e., coinsurance, copay, and/or deductibles) must meet the following criteria to be eligible for MHD reimbursement:

(I) The crossover claim must be related to Medicare Advantage outpatient hospital services that were provided to MO HealthNet participants who also are either a Qualified Medicare Beneficiary (QMB Only) or Qualified Medicare Beneficiary Plus (QMB Plus);

(II) The crossover claim must be submitted as a Medicare UB-04 Part C Professional Crossover claim through the MHD online billing system;

(III) The crossover claim must contain approved outpatient hospital services which MHD is billed for cost-sharing; and

(IV) The Other Payer paid amount field on the claim must contain the actual amount paid by the Medicare Advantage plan. The MO HealthNet provider is responsible for accurate and valid reporting of crossover claims submitted to MHD for payment. Providers submitting crossover claims for Medicare Advantage outpatient hospital services to MHD must be able to provide documentation that supports the information on the claim upon request. The documentation must match the information on the Medicare Advantage plan's remittance advice. Any amounts paid by MHD that are determined to be based on inaccurate data will be subject to recoupment;

C. MHD reimbursement for approved outpatient hospital services. MHD will reimburse seventy-five percent (75%) of the allowable cost-sharing amount; and

D. MHD will continue to reimburse one hundred percent (100%) of the allowable cost-sharing amounts for outpatient services provided by public hospitals operated by DMH as set forth above in paragraph (1)(C)4.

(2) Exempt Hospitals. Exempt Hospital Outpatient payment percent will be set as follows and will include:



(A) New Medicaid providers which do not have a fourth, fifth, and sixth prior year cost report.

1. Interim payment percentage. An interim outpatient payment percentage for new Medicaid hospital providers will be set at seventy-five percent (75%) for the first three (3) state fiscal years in which the hospital operates. The cost reports for these three (3) years will have a cost settlement calculated in accordance with 13 CSR 70-15.040.

2. Outpatient percentage. The outpatient payment percentage for the fourth and fifth year in which the hospital operates will be based on the overall Medicaid cost-to-charge ratio from its fourth prior year cost report.

(B) Hospitals who qualify as nominal charge providers under 42 CFR 413.13(f) or meet the definition of nominal charge provider in subsection (4)(D) shall be reimbursed on an interim basis by Medicaid at the lesser of seventy-five percent (75%) of usual and customary charges as billed by the provider for covered services or one hundred percent (100%) of the facility's Medicaid-allowable outpatient cost-to-charge ratio as determined from the most recent desk-reviewed cost report. Reimbursement at the applicable percentage shall be effective July 1 of each SFY for all providers.

(C) A hospital which had a change-in-ownership or merged its operation with another hospital between January 1, 1997 and June 30, 2002, and does not have a 1997 cost report filed by new owner, shall have the option to delay its entry into prospective outpatient payment methodology or enter the prospective outpatient payment methodology identified in subsection (1)(A) of this regulation. The hospital must notify the division of its decision by March 3, 2003. A hospital which chooses to delay its entry into the prospective outpatient payment methodology will receive an outpatient payment percentage starting July 1, 2002, and may have final settlements calculated in accordance with paragraphs (2)(C)1., and 2. The transfer to the prospective outpatient payment percentage will occur as follows:

1. A hospital which does not have a fourth prior year cost report (for SFY 2003 cost report would be 1999) filed by new owner will have its retrospective outpatient payment percentage based on the overall outpatient cost-to-charge ratio from the most current desk-reviewed cost report, either prior or current owner. All cost reports for prior and current owner ending in the SFY prior to the year the new owner receives a prospective outpatient payment percentage in accordance with paragraph (2)(C)2., will have a final settlement calculated in accordance with 13 CSR 70-15.040; and

2. A hospital which has a fourth prior year cost report filed by current owner will have its prospective outpatient payment percentage based on the overall outpatient cost-to-charge ratio from its fourth prior year cost report for the fourth and fifth SFY after the change-in-ownership or merger which occurred prior to July 1, 2002. For the sixth SFY the hospital's rate will be established in accordance with subsection (1)(A) of this regulation.

Chart for prospective rates for change in ownership or merger:

1 st cost report filed calendar year	Settlement calculated	SFY	SFY Prospective rate granted	Cost reports used for prospective rate
1998	Yes	1998	No	
1999	Yes	1999	No	
2000	Yes	2000	No	
2001	No	2001	No	
2002	No	2002	No	
2003	No	2003	Yes	1999
N/A	No	2004	Yes	1998, 1999, & 2000
N/A	No	2005	Yes	1999, 2000, & 2001

(D) Hospital Mergers. Hospitals that merge their operations under one (1) Medicare and MO HealthNet provider number shall have their outpatient percentage rate calculated under the surviving hospital's (the hospital whose Medicare and MO HealthNet provider number remains active) MO HealthNet provider number. The outpatient percentage rate of the surviving entity for the remainder of the state fiscal year in which the merger occurred is determined from combining the cost report data for the applicable cost report periods for the merged facilities. The effective date of the merged rate is the date of the merger. The surviving entity's outpatient percentage rate will be calculated for subsequent state fiscal years using the combined cost report data from the appropriate cost report periods for the merged facilities.

(E) A hospital that has failed to file one (1) of the cost reports used to determine their prospective outpatient payment percentage for the year, whether it be the fourth, fifth, or sixth prior year cost report, will have their prospective outpatient payment percentage based on the two (2) cost reports that are on file with the division plus the average of those two (2) cost reports to be used in place of the missing cost report. For example, if the division does not have on file a fourth prior year cost report, but has the fifth and sixth prior year cost reports, an average of the fifth and sixth prior year cost reports would be used in

place of the fourth prior year cost report. This average along with the fifth and sixth prior year cost reports would then be used to calculate the prospective outpatient payment percentage.

(3) Closed Facilities. Hospitals which closed after January 1, 1999, but before July 1, 2002, will have final settlements for cost reports ending during this time period calculated in accordance with 13 CSR 70-15.040.

(4) Definitions.

(A) Base cost report. Desk-reviewed Medicare/Medicaid cost report. When a facility has more than one (1) cost report with periods ending in the fourth prior calendar year, the cost report covering a full twelve-(12-) month period will be used. If none of the cost reports covers a full twelve (12) months, the cost report with the latest period will be used. If a hospital's base cost report is less than or greater than a twelve-(12-) month period, the data shall be adjusted, based on the number of months reflected in the base cost report to a twelve- (12-) month period.

(B) Cost report. A cost report details, for purposes of both Medicare and Medicaid reimbursement, the cost of rendering covered services for the fiscal reporting period. The Medicare/Medicaid Uniform Cost Report contains the forms utilized in filing the cost



report. The Medicare/Medicaid Cost Report version 2552-96 (CMS 2552-96) shall be used for fiscal years ending on or after September 30, 1996. The Medicare/Medicaid Cost Report version 2552-10 (CMS 2552-10) shall be used for fiscal years beginning on and after May 1, 2010.

(C) Effective date.

1. The plan effective date shall be July 1, 2002.

2. New prospective outpatient payment percentages will be effective July 1 of each SFY.

(D) Nominal charge provider. A nominal charge provider is determined from the fourth prior year desk-reviewed cost report. The hospital must meet the following criteria:

1. An acute care hospital with an unsponsored care ratio of at least sixty-five percent (65%) and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of more than forty percent (40%). The unsponsored care ratio is determined as the sum of bad debts and charity care divided by total net revenue. The hospital must meet one (1) of the federally mandated Disproportionate Share qualifications; or

2. The hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental disorders.

(5) *Outpatient Simplified Fee Schedule* (OSFS) Payment Methodology.

(A) Definitions. The following definitions will be used in administering section (5) of this rule:

1. Ambulatory Payment Classification (APC). Medicare's ambulatory payment classification assignment groups of Current Procedural Terminology (CPT) or Healthcare Common Procedures Coding System (HCPCS) codes. APCs classify and group clinically similar outpatient hospital services that can be expected to consume similar amounts of hospital resources. All services within an APC group have the same relative weight used to calculate the payment rates;

2. APC conversion factor. The unadjusted national conversion factor calculated by Medicare effective January 1 of each year, as published with the Medicare Outpatient Prospective Payment System (OPPS) Final Rule, and used to convert the APC relative weights into a dollar payment. The Medicare OPPS Final Rule is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at <https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action>, December 9, 2020.

This rule does not incorporate any subsequent amendments or additions;

3. APC relative weight. The national relative weights calculated by Medicare for the Outpatient Prospective Payment System;

4. Current Procedural Terminology (CPT). A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies, and accreditation organizations;

5. Dental procedure codes. The procedure codes found in the Code on Dental Procedures and Nomenclature (CDT), a national uniform coding method for dental procedures maintained by the American Dental Association;

6. Federally-Deemed Critical Access Hospital. Hospitals that meet the federal definition found in section 1820(c)(2)(B) of the Social Security Act;

7. HCPCS. The national uniform coding method maintained by the Centers for Medicare and Medicaid Services (CMS) that incorporates the American Medical Association (AMA) Physicians CPT and the three (3) HCPCS unique coding levels, I, II, and III;

8. Medicare Inpatient Prospective Payment System (IPPS) wage index. The wage area index values are calculated annually by Medicare, published as part of the Medicare IPPS Final Rule;

9. Missouri conversion factor. The single, statewide conversion factor used by the MO HealthNet Division (MHD) to determine the APC-based fees, uses a formula based on Medicare OPPS. The formula consists of: sixty percent (60%) of the APC conversion factor, as defined in paragraph (5)(A)2. multiplied by the St. Louis, MO Medicare IPPS wage index value, plus the remaining forty percent (40%) of the APC conversion factor, with no wage index adjustment;

10. Nominal charge provider. A nominal charge provider is determined from the fourth prior year audited Medicaid cost report. The hospital must meet the following criteria:

A. A public non-state governmental acute care hospital with a low income utilization rate (LIUR) of at least fifty percent (50%) and a Medicaid inpatient utilization rate (MIUR) greater than one (1) standard deviation from the mean, and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of at least forty percent (40%). The hospital must meet one (1) of the federally mandated Disproportionate Share qualifications; or

B. The hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental

disorders; and

C. A hospital physically located in the State of Missouri;

11. Outpatient Prospective Payment System (OPPS). Medicare's hospital outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 (BBRA) and the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act (BIPA) of 2000; and

12. Payment level adjustment. The percentage applied to the Medicare fee to derive the OSFS fee.

(B) Effective for dates of service beginning July 20, 2021, outpatient hospital services shall be reimbursed on a predetermined fee-for-service basis using an OSFS based on the APC groups and fees under the Medicare Hospital OPPS. When service coverage and payment policy differences exist between Medicare OPPS and Medicaid, MHD policies and fee schedules are used. The fee schedule will be updated as follows:

1. MHD will review and adjust the OSFS annually on July 1 based on the payment method described in subsection (5)(D); and

2. The OSFS is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at <https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action>, July 20, 2021. This rule does not incorporate any subsequent amendments or additions.

(C) Payment will be the lower of the provider's charge or the payment as calculated in subsection (5)(D).

(D) Fee schedule methodology. Fees for outpatient hospital services covered by the MO HealthNet program are determined by the HCPCS procedure code at the line level and the following hierarchy:

1. The APC relative weight or payment rate assigned to the procedure in the Medicare OPPS *Addendum B* is used to calculate the fee for the service, with the exception of the hospital observation per hour fee which is calculated based on the method described in subparagraph (5)(D)1.B. Fees derived from APC weights and payment rates are established using the Medicare OPPS *Addendum B* effective as of January 1 of each year as published by the CMS for Medicare OPPS. The Medicare OPPS *Addendum B* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at



<https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action>, December 29, 2020. This rule does not incorporate any subsequent amendments or additions.

A. The fee is calculated using the APC relative weight times the Missouri conversion factor. The resulting amount is then multiplied by the payment level adjustment of ninety percent (90%) to derive the OSFS fee.

B. The hourly fee for observation is calculated based on the relative weight for the Medicare APC (using the Medicare OPSS *Addendum A* effective as of January 1 of each year as published by the CMS for Medicare OPSS) which corresponds with comprehensive observation services multiplied by the Missouri conversion factor divided by forty (40), the maximum payable hours by Medicare. The resulting amount is then multiplied by the payment level adjustment of ninety percent (90%) to derive the OSFS fee. The Medicare OPSS *Addendum A* is incorporated by reference and made a part of this rule as published by the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at <https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action>, July 6, 2021. This rule does not incorporate any subsequent amendments or additions.

C. For those APCs with no assigned relative weight, ninety percent (90%) of the Medicare APC payment rate is used as the fee;

2. If there is no APC relative weight or APC payment rate established for a particular service in the Medicare OPSS *Addendum B*, then the MHD approved fee will be ninety percent (90%) of the rate listed on other Medicare fee schedules, effective as of January 1 of each year: *Clinical Laboratory Fee Schedule*; *Physician Fee Schedule*; and *Durable Medical Equipment Prosthetics/Orthotics and Supplies Fee Schedule*, applicable to the outpatient hospital service.

A. The Medicare *Clinical Laboratory Fee Schedule* is incorporated by reference and made a part of this rule as published by the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at <https://www.cms.gov/license/ama?file=/files/zip/21clabq1.zip>, January 5, 2021. This rule does not incorporate any subsequent amendments or additions.

B. The Medicare *Physician Fee Schedule* is incorporated by reference and made a part of this rule as published by the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at [https://www.cms.gov/medicare/medicare-fee-](https://www.cms.gov/medicare/medicare-fee)

service-paymentphysicianfeeschedpfs-carrier-specific-files/all-states-0 January 4, 2021. This rule does not incorporate any subsequent amendments or additions.

C. The Medicare *Durable Medical Equipment Prosthetics/Orthotics and Supplies Fee Schedule* is incorporated by reference and made a part of this rule as published by the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at <https://www.cms.gov/medicare/medicare-fee-service-paymentdmeoposfeescheddmeopos-fee-schedule/dme21>, December 2, 2020. This rule does not incorporate any subsequent amendments or additions;

3. Fees for dental procedure codes in the outpatient hospital setting are calculated based on thirty-eight and one half percent (38.5%) of the fiftieth percentile fee for Missouri reflected in the 2021 *National Dental Advisory Service* (NDAS). The 2021 NDAS is incorporated by reference and made a part of this rule as published by Wasserman Medical & Dental at its website at <https://wasserman-medical.com/product-category/dental/ndas/>, and available at the MO HealthNet Division, 615 Howerton Court, Jefferson, City MO 65109, April 20, 2021. This rule does not incorporate any subsequent amendments or additions;

4. If there is no APC relative weight, APC payment rate, other Medicare fee schedule rate, or NDAS rate established for a covered outpatient hospital service, then a MO HealthNet fee will be determined using the MHD *Dental, Medical, Other Medical or Independent Lab - Technical Component* fee schedules.

A. The MHD *Dental Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at <https://dss.mo.gov/mhd/providers/pages/cptagree.htm>, April 12, 2021. This rule does not incorporate any subsequent amendments or additions.

B. The MHD *Medical Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at <https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action>, July 13, 2021. This rule does not incorporate any subsequent amendments or additions.

C. The MHD *Other Medical Fee Schedule* is incorporated by reference and made a part of this rule as published by the

Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at <https://dss.mo.gov/mhd/providers/pages/cptagree.htm>, April 12, 2021. This rule does not incorporate any subsequent amendments or additions.

D. The MHD *Independent Lab—Technical Component Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at <https://dss.mo.gov/mhd/providers/pages/cptagree.htm>, April 12, 2021. This rule does not incorporate any subsequent amendments or additions;

5. In-state federally-deemed critical access hospitals will receive an additional forty percent (40%) of the rate as determined in paragraph (5)(B)2. for each billed procedure code; and

6. Nominal charge providers will receive an additional twenty-five percent (25%) of the rate as determined in paragraph (5)(B)2. for each billed procedure code.

(E) Packaged services. MHD adopts Medicare guidelines for procedure codes identified as “Items and Services Packaged into APC Rates” under Medicare OPSS *Addendum D1*. These procedures are designated as always packaged. Claim lines with packaged procedure codes will be considered paid but with a payment of zero (0). The Medicare OPSS *Addendum D1* is incorporated by reference and made a part of this rule as published by the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/cms1392fc_addendum_d1.pdf, December 29, 2020. This rule does not incorporate any subsequent amendments or additions.

(F) Inpatient only services. MHD adopts Medicare guidelines for procedure codes identified as “Inpatient Procedures” under Medicare OPSS *Addendum D1*. These procedures are designated as inpatient only (referred to as the inpatient only (IPO) list). Claim lines with inpatient only procedures will not be paid under the OSFS.

(G) Drugs. Effective for dates of service beginning April 1, 2019, outpatient drugs are reimbursed in accordance with the methodology described in 13 CSR 70-20.070.

(H) Payment for outpatient hospital services under this rule will be final, with no cost settlement.



AUTHORITY: sections 208.153, 208.201, and 660.017, RSMo 2016, and section 208.152, RSMo Supp. 2021.* Emergency rule filed June 20, 2002, effective July 1, 2002, expired Feb. 27, 2003. Original rule filed June 14, 2002, effective Jan. 30, 2003. Amended: Filed May 3, 2004, effective Oct. 30, 2004. Amended: Filed June 15, 2005, effective Dec. 30, 2005. Emergency amendment filed Sept. 21, 2010, effective Oct. 1, 2010, expired March 29, 2011. Amended: Filed Sept. 30, 2010, effective March 30, 2011. Emergency amendment filed Sept. 20, 2011, effective Oct. 1, 2011, expired March 28, 2012. Amended: Filed July 1, 2011, effective Feb. 29, 2012. Emergency amendment filed June 20, 2012, effective July 1, 2012, expired Dec. 28, 2012. Amended: Filed June 20, 2012, effective Jan. 30, 2013. Amended: Filed July 1, 2013, effective Jan. 30, 2014. Amended: Filed May 1, 2018, effective Jan. 1, 2019. Amended: Filed Jan. 8, 2019, effective July 30, 2019. Amended: Filed April 21, 2021, effective Nov. 30, 2021.

*Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1978, 1981, 1986, 1988, 1990, 1992, 1993, 2004, 2005, 2007, 2011, 2013, 2014, 2015, 2016, 2018, 2021; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.

13 CSR 70-15.170 Enhanced Disproportionate Share Payment to Trauma Hospitals for the Cost of Care to the Uninsured Provided by Physicians Not Employed by the Hospital

Emergency rule filed June 20, 2002, effective July 1, 2002, expired Feb. 27, 2003.

13 CSR 70-15.180 Grant to Trauma Hospitals for the Care Provided by Physicians Not Employed by the Hospital

Emergency rule filed June 6, 2007, effective June 16, 2007, expired Dec. 12, 2007.

13 CSR 70-15.190 Out-of-State Hospital Services Reimbursement Plan

PURPOSE: This rule establishes the method of reimbursing out-of-state hospitals for inpatient or outpatient care provided to any recipients of Missouri Medicaid, whether they are under age twenty-one (21) or age twenty-one (21) and over.

(1) Covered inpatient hospital services include those items and services allowed by the Medicaid State Plan including medically

necessary care in a semi-private room. If prior authorized Missouri Medicaid may reimburse for a private room if it is certified medically necessary by a physician to avoid jeopardizing the health of the patient or to protect the health and safety of other patients. No payment will be made for any portion of the room charge when the recipient requests and is provided a private room when the private room is not medically necessary.

(2) Payment for authorized inpatient hospital services shall be made on a prospective per diem basis for services provided outside Missouri if the services are covered by the Missouri Medical Assistance (Medicaid) Program. To be reimbursed for furnishing services to Missouri Medicaid recipients, out-of-state providers must complete a Missouri Medical Assistance Program Provider Participation Application and have the application approved by the Missouri Department of Social Services, Division of Medical Services.

(3) Determination of Payment. The payment for inpatient hospital services provided by an out-of-state provider shall be the lowest of:

(A) At the out-of-state hospital's election, the prospective inpatient payment may be based on information from the hospital's Medicare base year cost report and all financial documentation required by Missouri regulations for hospitals operating in Missouri with inflationary increases as granted by the Missouri General Assembly or the out-of-state hospital may be exempt from the cost report filing requirements if the hospital accepts the projected statewide average per diem rate for Missouri hospitals as calculated by the Department of Social Services, Division of Medical Services for the state fiscal year in which the service was provided. The effective date for any increase above the statewide average per diem rate for Missouri hospitals shall be the first day of the month following the Division of Medical Services determination of per diem rate based on information from the hospital's Medicare base year cost report and all financial documentation required by Missouri regulation for hospitals operating in Missouri;

(B) The amount of total charges billed by the hospital. The provider's billed charges must be their usual and customary charges for services; or

(C) The Medicare deductible or coinsurance, if applicable, up to the amount allowed by the Missouri Medicaid program.

(4) Per Diem Reimbursement Rate Computation. The per diem reimbursement rate computation is the same as calculated for

Missouri hospitals at 13 CSR 70-15.010(3).

(5) If a provider fails to submit all financial documentation required by Missouri regulations (Medicare cost report, working trial balance, audited financial statements, Medicaid supplemental schedules, and Worksheet C2552-83 for ancillary costs and charges) for hospitals operating in Missouri within thirty (30) days of making the election to receive payment based on information from cost reports, the payment shall be based on the projected statewide average per diem rate in Missouri as developed by the Department of Social Services, Division of Medical Services for the state fiscal year.

(6) Out-of-state hospitals shall present claims to Missouri Medicaid within three hundred sixty-five (365) days from the date of service. In no case shall Missouri be liable for payment of a claim received beyond one (1) year from the date services were rendered. Inpatient and outpatient hospital services must be submitted on the UB-92 claim form.

(7) Out-of-state hospitals are subject to the Department Concurrent Hospital Review process (utilization review) for all non-emergency services.

(8) The payment for authorized outpatient hospital services provided by an out-of-state hospital shall be the lowest of:

(A) At the out-of-state hospital's election, a prospective outpatient payment percentage calculated using the Medicaid over-all outpatient cost-to-charge ratio from the fourth, fifth, and sixth prior base year cost reports and all documentation required by Missouri regulation for hospitals operating in Missouri regressed to the current state fiscal year or the out-of-state hospital may be exempt from the cost report filing requirement if the hospital accepts the projected statewide average outpatient payment percentage as developed by the Department of Social Services, Division of Medical Services for the state fiscal year in which the service was provided. The effective date for any increase above the statewide average outpatient payment percentage shall be the first day of the month following the Division of Medical Services determination of the outpatient payment percentage based on information from the hospital's Medicare base year cost report and all financial documentation required by Missouri regulation for hospitals operating in Missouri; or

(B) The amount of total charges billed by the hospital.

(9) Outpatient Reimbursement Rate Computation. The outpatient reimbursement rate



computation is the same as calculated for Missouri hospitals at 13 CSR 70-15.160.

(10) Disproportionate Share Providers. Out-of-state hospitals do not qualify for disproportionate share (DSH) payments unless they have a low income utilization rate exceeding twenty-five percent (25%) for Missouri residents and the out-of-state hospital can demonstrate that the provision of services to Missouri residents has not been considered in establishing their DSH status in any other state.

(11) All Medicaid services are subject to program compliance reviews. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made.

(12) Regardless of changes of ownership, management, control, operation, leasehold interests by whatever form for any hospital previously certified for participation in the Medicaid program, the department will continue to make all the Title XIX payments directly to the entity with the hospital's current provider number and hold the entity with the current provider number responsible for all Medicaid liabilities.

(13) Participation in the Missouri Medicaid program shall be limited to hospitals who accept as payment in full for covered services rendered to Medicaid recipients the amount paid in accordance with Missouri statute and regulations.

(14) Definitions.

(A) The definitions from regulation 13 CSR 70-15.010 are incorporated as 13 CSR 70-15.190.

(B) Base year cost report—shall be either a 1995 Medicare cost report and Missouri's supplemental cost report schedules for those hospitals enrolled in the Missouri Medicaid program as of the effective date of this regulation or the most recent submitted cost report to Medicare and Missouri's supplemental cost report schedules for those hospitals that elect to enroll in Missouri Medicaid after the effective date of this regulation.

(C) Out-of-state—not within the physical boundaries of Missouri.

(D) Usual and customary charge—the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.

AUTHORITY: section 208.201, RSMo 2000. Original rule filed April 15, 2004, effective Oct. 30, 2004.*

**Original authority: 208.201, RSMo 1987.*

13 CSR 70-15.200 Payment Policy for a Preventable Serious Adverse Event or Hospital or Ambulatory Surgical Center-Acquired Condition
(Rescinded June 30, 2012)

AUTHORITY: section 208.201, RSMo Supp. 2008. Original rule filed Nov. 17, 2008, effective June 30, 2009. Rescinded: Filed Nov. 30, 2011, effective June 30, 2012.

13 CSR 70-15.220 Disproportionate Share Hospital Payments

PURPOSE: This rule implements a new state methodology for paying Disproportionate Share Hospital (DSH) payments in order to comply with the new federally-required DSH audit standards. The regulation provides for an interim adjustment to DSH payments and provides for final adjustment to DSH payments based upon the federally-mandated DSH audits.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) General Reimbursement Principles.

(A) In order to receive federal financial participation (FFP), disproportionate share payments are made in compliance with federal statutes and regulations. Section 1923 of the Social Security Act (42 U.S. Code) describes the hospitals that must be paid DSH payments and those that the state may elect to pay DSH payments.

(B) Federally-Deemed DSH Hospitals. The state must pay disproportionate share payments to hospitals that meet the specific obstetric requirements set forth below in paragraph (1)(B)1. and have either a Medicaid Inpatient Utilization Rate (MIUR) at least one (1) standard deviation above the state mean or a Low Income Utilization Rate (LIUR) greater than twenty-five percent (25%). The state shall not make DSH payments in excess of each hospital's estimated hospital-specific

DSH limit.

1. Obstetrics requirements and exemptions.

A. Hospitals must have two (2) obstetricians, with staff privileges, who agree to provide non-emergency obstetric services to Medicaid eligibles. Rural hospitals, as defined by the federal Executive Office of Management and Budget, may qualify any physician with staff privileges as an obstetrician.

B. Hospitals are exempt from the obstetric requirements if the facility did not offer non-emergency obstetric services as of December 22, 1987.

C. Hospitals are exempt if inpatients are predominantly under eighteen (18) years of age.

(C) State-Elected DSH Payments. The state may elect to make disproportionate share payments to hospitals that meet the obstetric requirements set forth in paragraph (1)(B)1. and have a MIUR of at least one percent (1%).

(D) Section 1923(g) of the Social Security Act (Act) limits the amount of DSH payments states can pay to each hospital and earn FFP. To be in compliance with the Act, DSH payments shall not exceed one hundred percent (100%) of the uncompensated care costs of providing hospital services to Medicaid and uninsured individuals. Hospital-specific DSH limit calculations must comply with the federal DSH rules (42 CFR 447, Subpart E and 42 CFR 455, Subpart D). If the disproportionate share payments exceed the hospital-specific DSH limit, the difference shall be deducted from disproportionate share payments or recouped from future payments.

(E) All DSH payments in the aggregate shall not exceed the federal DSH allotment within a state fiscal period. The DSH allotment is the maximum amount of DSH payments a state can distribute each year and receive FFP.

(F) The state must submit an annual independent audit of the state's DSH program to the Centers for Medicare and Medicaid Services (CMS). FFP is not available for DSH payments that are found to exceed the hospital-specific eligible uncompensated care cost limit. All hospitals that receive DSH payments are subject to the independent federal DSH audit.

(G) Hospitals qualify for DSH for a period of one (1) state fiscal year and must requalify at the beginning of each state fiscal year to continue to receive disproportionate share payments.

(2) Definitions.

(A) Annual independent DSH audit. The annual independent DSH audit is the annual independent certified audit of the state DSH payments as required by the federal DSH audit



rule 42 CFR 455.301 through 42 CFR 455.304. The annual independent DSH audit also includes the reporting requirements of 42 CFR 447.299. The annual independent DSH audit may also be referred to as the federally-mandated annual independent DSH audit or independent federal DSH audit.

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

(C) Estimated Medicaid net cost. Estimated Medicaid net cost is the cost of providing inpatient (IP) and outpatient (OP) hospital services for all Medicaid eligible individuals including dual eligible and managed care participants less payments the hospital received for claims. The estimated Medicaid net cost is determined by using Medicare cost reporting methodologies described in this rule and is calculated using data reported on the state DSH survey. Depending on the hospital's response to questions 14, 15, and 16 of the state DSH survey, versions 1, 2, and 3, the source of the Medicaid out-of-state net cost, Medicaid organ acquisition net cost, and Medicaid/Medicare crossover net cost will either be—the hospital's estimated data, an amount estimated by MHD based on the most recent annual independent DSH audit trended to the SFY the DSH payments relate to, or was determined by the hospital to be insignificant or zero.

1. The estimated Medicaid net cost determined from the state DSH surveys prior to SFY 2017 is the sum of the following estimated data from the "Settlement Calculation" tab:

- A. In-state Medicaid inpatient net cost;
- B. In-state Medicaid outpatient net cost;
- C. Out-of-state Medicaid inpatient net cost;
- D. Out-of-state Medicaid outpatient net cost;
- E. Medicaid organ acquisition net cost; and
- F. Medicaid/Medicare crossover net cost.

2. Beginning with SFY 2017 interim DSH payments, the estimated Medicaid net cost is determined from the state DSH survey using the "Report Summary" tab and is calculated as follows:

- A. Total Cost of Care for Medicaid IP/OP Services;
- B. Less Regular IP/OP Medicaid FFS Rate Payments (excluding any other Medicaid payments as defined in subsection (2)(S));
- C. Less IP/OP Medicaid MCO Payments;

D. Equals the Estimated Medicaid Net Cost; and

E. The Estimated Medicaid Net Cost shall be trended as set forth in subsection (2)(Y).

(D) Estimated uninsured net cost. Estimated uninsured net cost is the cost of providing inpatient and outpatient hospital services to individuals without health insurance or other third party coverage for the hospital services they receive during the year less uninsured payments received on a cash basis for the applicable Medicaid state plan year. The costs are to be calculated using Medicare cost report costing methodologies described in this rule and should not include costs for services that were denied for any reason.

1. The estimated uninsured net cost determined from the state DSH survey prior to SFY 2017 is calculated as the sum of the following:

- A. Uninsured inpatient net cost; and
- B. Uninsured outpatient net cost.

2. Beginning with SFY 2017 interim DSH payments, the estimated uninsured net cost is determined from the state DSH survey using the "Report Summary" tab and is calculated as follows:

- A. Total IP/OP Uninsured Cost of Care;
- B. Less Total IP/OP Indigent Care/Self-Pay Revenues;
- C. Equals the Estimated Uninsured Net Cost.

(E) Estimated uninsured uncompensated care cost (UCC).

1. The estimated uninsured uncompensated care cost from the state DSH survey prior to SFY 2017 is the estimated uninsured net cost less Section 1011 payments.

2. Beginning with SFY 2017 interim DSH payments, the estimated uninsured uncompensated care cost is determined from the state DSH survey using the "Report Summary" tab and is calculated as follows:

- A. Estimated Uninsured Net Cost, as defined in subsection (2)(D);
- B. Less Total Applicable Section 1011 Payments;
- C. Equals the Estimated Uninsured Uncompensated Care Cost; and

D. The Estimated Uninsured Uncompensated Care Cost shall be trended as set forth in subsection (2)(Y).

(F) Federal DSH allotment. The maximum amount of DSH a state can distribute each year and receive federal financial participation (FFP) in the payments in accordance with 42 CFR 447.297 and 42 CFR 447.298.

(G) Hospital DSH liability. The hospital DSH liability is the amount of DSH overpayments subject to recoupment. It is the lesser

of the total longfall or the DSH payments paid during the SFY. The source for this calculation is as follows:

1. Actual hospital DSH liability. The actual hospital DSH liability is determined from the final annual independent DSH audit; and

2. Estimated hospital DSH liability. The estimated hospital DSH liability is calculated by the state using data from the state DSH survey, other Medicaid payments, and data provided in the most recent independent DSH audit, if applicable, which is used in determining the interim DSH payment adjustments for SFY 2011.

(H) Hospital-specific DSH limit. The hospital-specific DSH limit is the sum of the Medicaid uncompensated care cost plus the uninsured uncompensated care cost and is calculated each year. The source for this calculation is as follows:

1. Actual hospital-specific DSH limit. The actual hospital-specific DSH limit is determined from the final annual independent DSH audit; and

2. Estimated hospital-specific DSH limit. The estimated hospital-specific DSH limit is calculated by the state using data from the state DSH survey, other Medicaid payments, and data provided in the most recent independent DSH audit, if applicable, which is used in determining the interim DSH payments.

(I) Individuals Without Health Insurance or Other Third Party Coverage.

1. Individuals who have no health insurance or other source of third party coverage for the specific inpatient or outpatient hospital services they received during the year can be considered uninsured. As set forth in CMS' final rule published in the *Federal Register*, December 3, 2014, for 42 CFR 447.295, a service-specific approach must be used to determine whether an individual is uninsured. The service-specific coverage determination can occur only once per individual per service provided and applies to the entire service, including all elements as that service, or similar services, would be defined by MO HealthNet. Determination of an individual's third party coverage status is not dependent on receipt of payment by the hospital from the third party.

2. The costs for inpatient and outpatient hospital services provided to individuals without health insurance or other third party coverage can be considered uninsured and included in calculating the hospital-specific DSH limit.

3. The following individuals shall be considered uninsured:

- A. Individuals whose benefit package



does not cover the hospital service received. If the service is not included in an individual's health benefits coverage through a group health plan or health insurer, and there is no other legally liable third party, the individual is considered uninsured; or

B. Individuals who have reached lifetime insurance limits for certain services or with exhausted insurance benefits at the time of service. When a lifetime or annual coverage limit is imposed by a third party payer, specific services beyond the limit would not be within the individual's health benefit package from that third party payer and would be considered uninsured; or

C. For American Indians/Alaska Natives, Indian Health Services (IHS) and tribal coverage is only considered third party coverage when services are received directly from IHS or tribal health programs or when IHS or a tribal health program has authorized coverage through the contract health service program.

4. The costs associated with the following shall not be included as uninsured costs:

A. Bad debts or unpaid coinsurance/deductibles for individuals with third party coverage. Administrative denials of payment or requirements for satisfaction of deductible, copayment, or coinsurance liability do not affect the determination that a specific service is included in the health benefits coverage; and

B. Prisoners. Individuals who are inmates in a public institution or are otherwise involuntarily in secure custody as a result of criminal charges are considered to have a source of third party coverage. However, an individual can be included as uninsured if a person has been released from secure custody and is referred to the hospital by law enforcement or corrections authorities and is admitted as a patient rather than an inmate to the hospital.

5. These definitions, and the resulting uninsured costs includable in calculating the hospital-specific DSH limit, are subject to change based on any changes that may be incorporated in the final publication of 42 CFR 447.295.

(J) Institution for Mental Diseases (IMD) DSH allotment. The IMD DSH allotment is a portion of the state-wide DSH allotment and is the maximum amount set by the federal government that may be paid to IMD hospitals. Any unused IMD DSH allotment not paid to IMD hospitals for any plan year may be paid to hospitals that are under their projected hospital-specific DSH limit.

(K) Inpatient and outpatient hospital services. For purposes of determining the estimated hospital-specific DSH limit and the

actual hospital-specific DSH limit, the inpatient and outpatient hospital services are limited to inpatient and outpatient hospital services included in the approved Missouri Medicaid State Plan.

(L) Lifetime or annual health insurance coverage limit. An annual or lifetime limit, imposed by a third party payer, that establishes a maximum dollar value, or maximum number of specific services on a lifetime or annual basis, for benefits received by an individual.

(M) Longfall. The longfall is the total amount a hospital has been paid (including all DSH payments) in excess of their hospital-specific DSH limit. The source for this calculation is as follows:

1. Actual longfall. The actual longfall is based on the annual independent DSH audit; and

2. Estimated longfall. The estimated longfall is calculated by the state using data from the state DSH survey, other Medicaid payments, and data provided in the most recent independent DSH audit, if applicable.

(N) Low Income Utilization Rate (LIUR). The LIUR shall be calculated as follows:

1. As determined from the fourth prior year desk-reviewed cost report, the LIUR shall be the sum (expressed as a percentage) of the fractions, calculated as follows:

A. Total MO HealthNet patient revenues (TMPR) paid to the hospital for patient services under a state plan plus the amount of the cash subsidies (CS) directly received from state and local governments, divided by the total net revenues (TNR) (charges, minus contractual allowances, discounts, and the like) for patient services plus the CS; and

B. The total amount of the hospital's charges for patient services attributable to charity care (CC) (care provided to individuals who have no source of payment, third-party, or personal resources) less CS directly received from state and local governments in the same period, divided by the total amount of the hospital's charges (THC) for patient services. The total patient charges attributed to CC shall not include any contractual allowances and discounts other than for indigent patients not eligible for MO HealthNet under a state plan.

$$LIUR = \frac{TMPR + CS}{TNR + CS} + \frac{CC - CS}{THC}$$

(O) Medicaid Inpatient Utilization Rate (MIUR). The MIUR shall be calculated as follows:

1. As determined from the fourth prior year desk-reviewed cost report, the MIUR

will be expressed as the ratio of total Medicaid days (TMD) provided under a state plan divided by the provider's total number of inpatient days (TNID); and

2. The state's mean MIUR will be expressed as the ratio of the sum of the total number of the Medicaid days for all Missouri hospitals divided by the sum of the total patient days for the same Missouri hospitals. Data for hospitals no longer participating in the program will be excluded.

$$MIUR = \frac{TMD}{TNID}$$

(P) Medicaid state plan year. Medicaid state plan year coincides with the twelve- (12-) month period for which a state calculates DSH payments. For Missouri, the Medicaid state plan year coincides with its state fiscal year (SFY) and is July 1 through June 30.

(Q) Medicare cost reporting methodologies. Medicaid and uninsured costs will be determined utilizing Medicare Cost Report (form CMS 2552) methodologies. The Medicare/Medicaid Cost Report version 2552-96 (CMS 2552-96) shall be used for fiscal years ending on or after September 30, 1996 and prior to May 1, 2010. The Medicare/Medicaid Cost Report version 2552-10 (CMS 2552-10) shall be used for fiscal years beginning on and after May 1, 2010. If the Medicare CMS 2552-10 is superseded by an alternate Medicare developed cost reporting tool during a Medicaid state plan year, that tool must be used for the Medicaid state plan year. The Medicaid Cost Report is completed using the Medicare Cost Report form CMS 2552 using the Medicare cost reporting methodologies. The only difference between the Medicare and Medicaid Cost Report is that the Federal Reimbursement Allowance (FRA) (i.e., the Missouri hospital provider tax) is not reflected in the cost in the Medicaid Cost Report. Based on these methodologies, the costs included in the DSH payment calculation will reflect the Medicaid and uninsured portion of total allowable costs from the Medicare Cost Report or the Medicaid Cost Report, as applicable. Costs such as the Missouri Medicaid hospital provider tax FRA are recognized as allowable costs for Medicaid and DSH program purposes and apportioned to Medicaid, uninsured, Medicare, and other payers following the cost finding principles included in the costs report, applicable instructions, regulations, and governing statutes.

(R) New facility. A new hospital determined in accordance with 13 CSR 70-15.010 without a base year cost report.

(S) Other Medicaid payments. For purposes



of determining estimated hospital-specific DSH limits, the other Medicaid payments include: Direct Medicaid Add-On, Graduate Medical Education (GME), Enhanced GME, Children’s Outliers, and any cost settlements. Upper payment limit (UPL) payments, Trauma Add-On payments and Trauma Outlier payments, if applicable, will be included in addition to the above other Medicaid payments for purposes of determining the hospital-specific DSH limit in the annual independent DSH audit. Any other payments made with state only funds are not required to be offset in determining the hospital-specific DSH limit.

(T) Out-of-state DSH payments. DSH payments received by a Missouri hospital from a state other than Missouri.

(U) Section 1011 payments. Section 1011 payments are made to a hospital for costs incurred for the provision of specific services to specific aliens to the extent that the provider was not otherwise reimbursed for such services. Because a portion of the Section 1011 payments are made for uncompensated care costs that are also eligible under the hospital-specific DSH limit, a defined portion of the Section 1011 payments must be recognized as an amount paid on behalf of those uninsured.

(V) Shortfall. The shortfall is the hospital-specific DSH limit in excess of the total amount a hospital has been paid (including all DSH payments). The source for this calculation is as follows:

1. Actual shortfall. The actual shortfall is based on the annual independent DSH audit; and

2. Estimated shortfall. The estimated shortfall is calculated by the state using data from the state DSH survey, other Medicaid payments, and data provided in the most recent independent DSH audit, if applicable.

(W) State DSH survey. The state DSH survey was designed to reflect the standards of calculating uncompensated care cost established by the federal DSH rules in determining hospital-specific DSH limits. The DSH survey is also similar to, or the same as, the DSH survey that is utilized by the independent auditor during the annual independent DSH audit performed in accordance with the federally-mandated DSH audit rules. The blank state DSH survey is referred to as the state DSH survey template. The following state DSH survey templates and instructions are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109. This rule does not incorporate any subsequent amendments or additions.

1. Version 1 (9/10), also referred to as

the 2011 state DSH survey, was used to calculate the SFY 2011 DSH payment adjustments set forth in section (3) and the SFY 2012 interim DSH payments set forth in section (4).

2. Version 2 (9/11) or Version 3 (2/12). The hospital may elect to complete either Version 2 (9/11) or Version 3 (2/12) on which its SFY 2013 interim DSH payments will be calculated. The survey shall be referred to as the SFY to which payments will relate. For example, the survey used to determine interim DSH payments for SFY 2013 will be referred to as the 2013 state DSH survey.

3. Version 3 (2/12) will be used to calculate interim DSH payments beginning with SFY 2014 as set forth in section (4). The survey shall be referred to as the SFY to which payments will relate.

4. Version 4, designated as Myers and Stauffer LC, DSH Version 7.20, will be used to calculate interim DSH payments beginning with SFY 2017 as set forth in section (4). The state DSH survey shall be the most recent DSH survey collected during the independent DSH audit of the fourth prior SFY (i.e., the most recent survey collected by the independent DSH auditor for the SFY 2013 independent DSH audit will also be used to calculate the interim DSH payment for SFY 2017). The survey shall be referred to as the SFY to which payments will relate.

(X) Taxable revenue. Taxable revenue is the hospital’s total inpatient adjusted net revenues plus outpatient adjusted net revenues determined in accordance with 13 CSR 70-15.110, paragraph (1)(A)13.

(Y) Trends. A trend of one and a half percent (1.5%) will be applied to the hospital’s Estimated Medicaid Net Cost and the Estimated Uninsured Uncompensated Care Cost (UCC) from the year subsequent to the state DSH survey period to the current SFY (i.e., the SFY for which the interim DSH payment is being determined). The first year’s trend shall be adjusted to bring the facility’s cost to a common fiscal year end of June 30 and the full trends shall be applied for the remaining years. The trends shall be compounded each year to determine the total cumulative trend.

(Z) Uncompensated care costs (UCC). The uncompensated care costs eligible for consideration in determining the hospital-specific DSH limit are calculated by reducing costs incurred in furnishing inpatient and outpatient hospital services to the Medicaid and uninsured populations by revenues received from Medicaid (not including DSH payments), Medicare, private pay, managed care, self-pay, other third parties, and Section 1011 payments. The costs are to be calculated using

Medicare cost report costing methodologies described in this rule and should not include costs for services that were denied for any reason. For purposes of this calculation, the Medicaid and uninsured populations include:

1. The Medicaid population includes all Medicaid eligible individuals including dual eligible and managed care participants; and

2. The uninsured population includes individuals without health insurance or other third-party coverage as defined in this rule, consistent with 42 CFR 447.

(AA) Uninsured revenues. Payments received on a cash basis that are required to be offset against the uninsured cost to determine the uninsured net cost include any amounts received by the hospital, by or on behalf of, either self-pay or uninsured individuals during the SFY under audit.

(3) DSH Payment Adjustments.

(A) Beginning in Medicaid state plan year 2011, DSH payments made to hospitals will be revised based on the results of a 2011 state DSH survey. The revisions based on the 2011 state DSH survey will ensure state fiscal year (SFY) 2011 DSH payments are eligible for FFP through compliance with the federal DSH rules. These revisions are to serve as interim adjustments until the federally-mandated annual independent DSH audits are complete. Annual independent DSH audits are finalized three (3) years following the SFY year-end reflected in the audit. For example, the SFY 2011 DSH audit will be finalized in 2014. The interim adjustments shall be determined as follows:

1. 2011 estimated hospital-specific DSH limits were determined based upon the state’s calculations using data provided in the 2011 state DSH survey, SFY 2011 other Medicaid payments maintained by MHD, and data provided in the final 2007 independent DSH audit, if applicable. DSH payments will be limited to the hospital’s estimated hospital-specific DSH limit. The state’s calculations will be based on 2011 state DSH surveys received by MO HealthNet as of May 31, 2011. However, a corrected survey may be accepted if it is supported by documentation and the state determines the correction is appropriate and has a material impact on the survey results. The state’s calculations are set forth below—

A. The 2011 estimated hospital-specific DSH limit is calculated as follows:

(I) 2011 estimated Medicaid net cost from the 2011 state DSH survey;

(II) Less actual SFY 2011 other Medicaid payments;

(III) Equals 2011 estimated Medicaid uncompensated care cost;



(IV) Plus 2011 estimated uninsured uncompensated care cost from the 2011 state DSH survey;

(V) Equals 2011 estimated hospital-specific DSH limit;

B. The total 2011 estimated longfall/shortfall for each hospital is calculated as follows:

(I) 2011 estimated hospital-specific DSH limit;

(II) Less DSH payments paid by MHD during SFY 2011;

(III) Less out-of-state DSH payments received by the hospital during SFY 2011;

(IV) Equals total 2011 estimated longfall/shortfall;

C. The total 2011 estimated hospital DSH liability is an overpayment subject to recoupment which will be the SFY 2011 interim DSH payment adjustment for hospitals with an estimated longfall. The total 2011 estimated hospital DSH liability is the lesser of the—

(I) The 2011 estimated longfall; or

(II) DSH payments paid during SFY 2011;

D. Hospitals that merge their operations under one (1) Medicare and MO HealthNet provider number shall have their SFY 2011 DSH payments adjusted based on combining the results of the 2011 state DSH surveys prorated monthly for the time period the merger was effective. If a 2011 estimated DSH liability is identified, the surviving hospital assumes the responsibility for the overpayment. The calculation for combining and prorating the 2011 state DSH surveys is set forth below—

(I) The estimated hospital DSH liability prior to the merger shall be calculated as follows:

(a) The calculations set forth in subparagraphs (3)(A)1.A., (3)(A)1.B., and (3)(A)1.C. will be calculated based on each separate hospital's 2011 state DSH survey, prorated monthly for the time period prior to the merger;

(II) The estimated hospital DSH liability beginning with the month the merger is effective shall be calculated as follows:

(a) The 2011 state DSH surveys for each hospital shall be added together to yield a combined 2011 state DSH survey and prorated monthly for the time period the merger was effective. The calculations set forth in subparagraphs (3)(A)1.A., (3)(A)1.B., and (3)(A)1.C. will be calculated for the combined 2011 state DSH survey;

(III) The total estimated hospital DSH liability for the merged entity will be the sum of the amounts determined in part

(3)(A)1.D.(I) for each hospital plus the combined amount determined in part (3)(A)1.D.(II); and

E. Facilities not providing a 2011 state DSH survey shall have their SFY 2011 DSH payments revised using the most recent hospital-specific information provided to the state by the independent DSH auditor trended to the applicable SFY using the trend factor published in *Health Care Costs* by DRI/McGraw-Hill and listed in 13 CSR 70-15.010. A facility that was not included in the most recent hospital-specific information provided to the state by the independent DSH auditor shall have their entire SFY 2011 DSH payment recouped.

2. DSH payments paid during SFY 2011 that exceed the 2011 estimated hospital-specific DSH limits will be recouped from the hospitals to reduce their payments to their 2011 estimated hospital-specific DSH limit.

3. The amount of SFY 2011 DSH payments to be recouped from a hospital by the MO HealthNet Division will be limited in each state fiscal year to two percent (2%) of the hospital's taxable revenue set forth as follows. For recoupments made during SFY 2012 the recoupment amount will be limited to two percent (2%) of the hospital's SFY 2011 taxable revenue. Any balance remaining to be recouped during SFY 2013 will be limited to two percent (2%) of the hospital's SFY 2012 taxable revenue. Any balance remaining to be recouped will be incorporated in the final DSH adjustment, if applicable. The limitation on recoupment of DSH payments shall only apply to recoupments determined in accordance with section (3). No limitation on the recoupment of DSH payments shall apply if the hospital DSH liability is determined as a result of the final annual independent DSH audit set forth in section (6).

(B) Any payments that are recouped from hospitals as a result of the state's calculation in subsection (3)(A) will be redistributed to hospitals that are shown to have been paid less than their 2011 estimated hospital-specific DSH limits (i.e., estimated shortfall). These redistributions will occur proportionally based on each hospital's 2011 estimated shortfall to the total 2011 estimated shortfall, not to exceed each hospital's 2011 estimated hospital-specific DSH limit.

1. Redistribution payments to hospitals that have been paid less than their 2011 estimated hospital-specific DSH limit must occur after the recoupment of payments made to hospitals that have been paid in excess of their 2011 estimated hospital-specific DSH limits. The state may establish a hospital-specific recoupment plan. However, total indus-

try redistribution payments may not exceed total industry recoupments collected to date.

2. If the Medicaid program's original DSH payments did not fully expend the federal DSH allotment for any plan year, the remaining DSH allotment may be paid to hospitals that are under their estimated hospital-specific DSH limit. These payments will occur proportionally based on each hospital's estimated shortfall to the total estimated shortfall, not to exceed each hospital's estimated hospital-specific DSH limit.

(4) Interim DSH Payments.

(A) Beginning with SFY 2012, interim DSH payments shall be calculated on an annual basis as set forth below.

1. SFY 2012 interim DSH payments will be based on the state's calculations using data provided in the 2011 state DSH survey after applying the trend factor published in *Health Care Costs* by DRI/McGraw-Hill for the current fiscal year, estimated SFY 2012 other Medicaid payments calculated by MHD in accordance with 13 CSR 70-15.010, and data provided in the final 2007 independent DSH audit, if applicable.

2. Beginning with SFY 2013, interim DSH payments will be based on the state's calculations using data provided in the state DSH survey for the applicable SFY, estimated other Medicaid payments calculated by MHD in accordance with 13 CSR 70-15.010 for the applicable SFY, and data provided in the most recent final independent DSH audit, if applicable.

(B) The interim DSH payments will be calculated as follows:

1. The estimated hospital-specific DSH limit is calculated as follows:

A. Estimated Medicaid net cost from the state DSH survey calculated in accordance with subsection (2)(C);

B. Less estimated other Medicaid payments calculated by MHD in accordance with 13 CSR 70-15.010;

C. Equals estimated Medicaid uncompensated care cost;

D. Plus estimated uninsured uncompensated care cost from the state DSH survey calculated in accordance with subsection (2)(E);

E. Equals estimated hospital-specific DSH limit;

2. The estimated uncompensated care costs potentially eligible for MHD interim DSH payments excludes out-of-state DSH payments and is calculated as follows:

A. Estimated hospital-specific DSH limit;

B. Less estimated out-of-state (OOS) DSH payments;



C. Equals estimated uncompensated care cost (UCC) net of OOS DSH payments;

3. Hospitals determined to have a negative estimated UCC net of OOS DSH payments (payments exceed costs) will not receive interim DSH payments because their estimated payments for the SFY are expected to exceed their estimated hospital-specific DSH limit; and

4. Qualified DSH hospitals determined to have a positive estimated UCC net of OOS DSH payments (costs exceed payments) will receive interim DSH payments. The interim DSH payments are subject to the federal DSH allotment, the availability of state funds, and the estimated hospital-specific DSH limits less estimated OOS DSH payments. The interim DSH payments will be calculated as follows:

A. Interim DSH payments to qualified DSH hospitals determined to have a positive estimated UCC net of OOS DSH payments will be calculated as follows:

(I) Up to one-hundred percent (100%) of the available federal DSH allotment will be allocated to each hospital with a positive estimated UCC net of OOS DSH payments, and the allocation shall result in each hospital receiving the same percentage of their estimated UCC net of OOS DSH payments. The allocation percentage will be calculated at the beginning of the SFY by dividing the available federal DSH allotment to be distributed by the total hospital industry's positive estimated UCC net of OOS DSH payments; and

(II) The allocated amount will then be reduced by one percent (1%) for hospitals that do not contribute through a plan that is approved by the director of the Department of Health and Senior Services to support the state's poison control center and the Primary Care Resource Initiative for Missouri (PRIMO) and Patient Safety Initiative.

(C) Hospitals may elect not to receive an interim DSH payment for a SFY by completing a DSH Waiver form. Hospitals that elect not to receive an interim DSH payment for a SFY must notify the division, or its authorized agent, that it elects not to receive an interim DSH payment for the upcoming SFY. If a hospital does not receive an interim DSH payment for a SFY, it will not be included in the independent DSH audit related to that SFY and will not be eligible for final DSH audit payment adjustments related to that SFY unless it submits a request to the division to be included in the independent DSH audit.

(D) Hospitals may elect to receive an upper payment limit payment as defined in 13 CSR 70-15.230 in lieu of DSH payments. Hospitals that elect to receive an upper payment limit payment rather than a DSH payment must sub-

mit a request to the MO HealthNet Division on an annual basis. If a hospital does not receive an interim DSH payment for a SFY, it will not be included in the independent DSH audit related to that SFY, and will not be eligible for final DSH audit payment adjustments related to that SFY unless it submits a request to the division to be included in the independent DSH audit.

(E) Disproportionate share payments will coincide with the semimonthly claim payment schedule.

(F) New facilities that do not have a Medicare/Medicaid cost report on which to base the state DSH survey will be paid the lesser of the estimated hospital-specific DSH limit less OOS DSH payments based on the estimated state DSH survey or the industry average estimated interim DSH payment. The industry average estimated interim DSH payment is calculated as follows:

1. Hospitals receiving interim DSH payments, as determined from subsection (4)(B), shall be divided into quartiles based on total beds;

2. DSH payments shall be individually summed by quartile and then divided by the total beds in the quartile to yield an average interim DSH payment per bed; and

3. The number of beds for the new facility shall be multiplied by the average interim DSH payment per bed.

(G) Interim DSH Payments for Hospital Mergers.

1. Hospitals that merge prior to the beginning of the SFY. Hospitals that merge their operations under one (1) Medicare and MO HealthNet provider number shall have their interim DSH payment determined based on adding each hospital's state DSH survey to yield a combined state DSH survey and applying the same calculations in subsection (4)(B).

2. Hospitals that merge after the beginning of the SFY. The interim DSH payments that have been determined separately for the hospitals will be added together and paid to the surviving hospital effective with the approval date of the merger.

(H) If the Medicaid program's original interim DSH payments did not fully expend the federal DSH allotment for any plan year, the remaining DSH allotment may be paid to hospitals that are under their estimated hospital-specific DSH limit. These payments will occur proportionally based on each hospital's estimated shortfall to the total estimated shortfall, not to exceed each hospital's estimated hospital-specific DSH limit less OOS DSH payments.

(5) Department of Mental Health Hospital

(DMH) DSH Adjustments and Payments.

(A) Effective June 1, 2011, interim DSH payments made to DMH hospitals will be revised based on the results of a DMH state DSH survey which uses federally-mandated DSH audit standards. These revisions are to serve as interim adjustments until the federally-mandated DSH audits are complete in 2014.

(B) Beginning in SFY 2012, due to structural changes occurring at the DMH facilities, interim DSH payments will be based on the third prior base year cost report trended to the current SFY adjusted for the federal reimbursement allowance (FRA) assessment paid by DMH hospitals. The interim DSH payments calculated using the third prior base year cost report may be revised based on the results of a DMH state DSH survey. Additional adjustments may be done based on the results of the federally-mandated DSH audits as set forth below in subsection (6)(A).

(C) If the Medicaid program's original DSH payments did not fully expend the federal Institute for Mental Disease (IMD) DSH allotment for any plan year, the remaining IMD DSH allotment may be paid to hospitals that are under their projected hospital-specific DSH limit.

(6) Final DSH Adjustments.

(A) Final DSH adjustments will be made after actual cost data is available and the annual independent DSH audit is completed. Annual independent DSH audits are completed three (3) years following the state fiscal year-end reflected in the audit. For example, final DSH adjustments for SFY 2011 DSH payments will be made following the completion of the annual independent DSH audit in 2014 (SFY 2015).

(B) Final DSH adjustments may result in a recoupment for some hospitals and additional DSH payments for other hospitals based on the results of the annual independent DSH audit as set forth below—

1. Hospital DSH liabilities are overpayments which will be recouped. If the annual independent DSH audit reflects that a facility has a hospital DSH liability, it is an overpayment to the hospital and is subject to recoupment. The hospital's DSH liability shown on the final independent DSH audit report, that is required to be submitted to CMS by December 31, will be due to the division by March 31 of the following year;

2. Any overpayments that are recouped from hospitals as the result of the final DSH adjustment will be redistributed to hospitals that are shown to have a total shortfall. These redistributions will occur proportionally based on each hospital's total shortfall to the



total shortfall, not to exceed each hospital-specific DSH limit less OOS DSH payments;

3. Redistribution payments to hospitals that have a total shortfall must occur after the recoupment of hospital DSH liabilities. However, total industry redistribution payments may not exceed total industry recoupments collected to date;

4. If the amount of DSH payments to be recouped as a result of the final DSH adjustment is more than can be redistributed, the entire amount will be recouped and the federal share will be returned to the federal government. The state share of the final DSH recoupments that has not been redistributed to hospitals with DSH shortfalls may be used to make a hospital upper payment limit payment and/or a state-only Quality Improvement payment to all non-DMH hospitals. The state-only Quality Improvement payment will be paid proportionally to non-DMH hospitals based on the number of hospital staffed beds to total staffed beds for the same state fiscal year the final DSH adjustment relates to. Staffed beds are reported on the Missouri Annual Licensing Survey which is mandated by the Department of Health and Senior Services in accordance with 19 CSR 10-33.030; and

5. If the Medicaid program's original interim DSH payments did not fully expend the federal DSH allotment for any plan year, the remaining DSH allotment may be paid to hospitals that are under their hospital-specific DSH limit as determined from the annual independent DSH audit. These payments will occur proportionally based on each hospital's shortfall to the total shortfall, not to exceed each hospital's hospital-specific DSH limit less OOS DSH payments.

(7) Record Retention.

(A) Records used to complete the state's DSH survey shall be kept until the final audit is completed. For example, the SFY 2011 state DSH survey will use 2009 cost data which must be maintained until the 2014 DSH audits are completed in SFY 2015.

(B) Records provided by hospitals to the state's independent auditor shall also be maintained until the federal independent DSH audit is complete.

(8) State DSH Survey Reporting Requirements.

(A) Prior to SFY 2017, each hospital participating in the MO HealthNet program shall submit a state DSH survey prescribed by the state MO HealthNet agency and must be submitted by December 31 of each year. However, a corrected survey may be accepted if it is supported by documentation and the state determines the correction is appropriate and has a

material impact on the survey results. The state DSH survey for each interim DSH payment period shall be completed based on the third prior year Medicare cost report adjusted to reflect anticipated operations for the interim DSH payment period. The historical Medicare cost report data may be adjusted for inflationary trends, volume adjustments, changes in reimbursement methodology, and/or other business decisions (i.e., expanded or terminated services, etc.) For example, the state DSH survey that will be used to determine SFY 2013 interim DSH payments will be based on the state DSH survey completed using the 2010 Medicare cost report data adjusted by the hospital to 2013.

1. If a new facility does not have a third prior year Medicare cost report, the state DSH survey shall be completed using the second prior year Medicare cost report, if available, adjusted to reflect anticipated operations for the interim DSH payment period.

2. If a new facility does not have a second prior year Medicare cost report, the state DSH survey shall be completed using the prior year Medicare cost report, if available, adjusted to reflect anticipated operations for the interim DSH payment period.

3. If a new facility does not have a prior year Medicare cost report, the state DSH survey shall be completed using facility projections to reflect anticipated operations for the interim DSH payment period. Interim DSH payments determined from this state DSH survey are limited to the industry average estimated interim DSH payment as set forth in subsection (4)(F).

(B) Beginning in SFY 2016, each hospital must complete and submit the state DSH survey set forth in paragraph (2)(W)4. (i.e., required state DSH survey) to the independent DSH auditor, the MO HealthNet Division's authorized agent, in order to be considered for an interim DSH payment for the subsequent SFY (i.e., DSH surveys collected during SFY 2016 will be used to calculate SFY 2017 interim DSH payments). The independent DSH auditor will distribute the state DSH survey template to the hospitals to complete and will notify them of the due date, which shall be a minimum of thirty (30) days from the date it is distributed. However, the state DSH survey is due to the independent DSH auditor no later than March 1 preceding the beginning of each state fiscal year for which the interim DSH payment is being calculated (i.e., the state DSH survey used for SFY 2017 interim DSH payments will be due to the independent DSH auditor no later than March 1, 2016). Hospitals that do not submit the state DSH survey by March 1 will not be eligible to

receive an interim DSH payment for that SFY. The division may grant an industry-wide extension on the March 1 deadline due to unanticipated circumstances that affect the industry as a whole. The independent DSH auditor may perform an initial review of the required state DSH survey submitted by the hospital and make preliminary adjustments for use in calculating the interim DSH payment. The independent DSH auditor shall provide the hospital with any preliminary adjustments that are made for review and comment prior to the data being provided to MHD for use in calculating the interim DSH payment for the SFY. Additional or revised audit adjustments may be made to the DSH survey for purposes of the independent DSH audit.

1. A new facility that does not have cost report data for the fourth prior year may complete the state DSH survey using actual, untrended cost and payment data from the most recent twelve- (12-) month cost report filed with the division.

2. A new facility that has not yet filed a twelve- (12-) month Medicaid cost report with the division may complete the state DSH survey using facility projections to reflect anticipated operations for the interim DSH payment period. Trends shall not be applied to the data used to complete the state DSH survey. Interim DSH payments determined from this state DSH survey are limited to the industry average estimated interim DSH payment as set forth in subsection (4)(F).

3. Hospitals may elect not to receive an interim DSH payment for a SFY by completing a DSH Waiver form. Hospitals that elect not to receive an interim DSH payment for a SFY must notify the division, or its authorized agent, that it elects not to receive an interim DSH payment for the upcoming SFY. If a hospital does not receive an interim DSH payment for a SFY, it will not be included in the independent DSH audit related to that SFY, and will not be eligible for final DSH audit payment adjustments related to that SFY unless it submits a request to the division to be included in the independent DSH audit.

4. If a hospital received an interim DSH payment and later determined that it did not have uncompensated care costs for Medicaid and the uninsured to support part or all the interim DSH payment that it received or is receiving, the hospital may request that the interim DSH payments be stopped or it may return the entire interim DSH payment it received.

5. Exceptions Process to Use Alternate Data for Interim DSH Payment.

A. A hospital may submit a request to the division to have its interim DSH payment



based on alternate data as set forth below rather than the state DSH survey required to be submitted for the year (i.e., required state DSH survey) if it meets the criteria for any of the circumstances detailed below in subparagraph (8)(B)5.D. The request must include an explanation of the circumstance, the impact it has on the required state DSH survey period, and how it causes the data to be materially misstated or unrepresentative. The division shall review the facility's request and may, at its discretion and for good cause shown, use the alternate data in determining the interim DSH payment for the SFY. The division shall notify the facility of its decision regarding the request.

(I) Alternate state DSH survey. A state DSH survey completed using the actual, untrended cost and payment data from the most recent twelve- (12-) month cost report filed with the division. Any hospital requesting an exception must complete an alternate state DSH survey. If the most recent full year cost report filed with the division does not reflect the impact of any material changes, a supplemental schedule, as defined below, may be completed and submitted in addition to the alternate state DSH survey. If the impact of any changes is reflected in the most recent full year cost report filed with the division, the facility may only use the alternate state DSH survey.

(II) Alternate state DSH survey supplemental schedule. A supplemental schedule developed by the division to recognize material changes that have occurred at a hospital that are not yet reflected in the hospital's alternate state DSH survey. The supplemental schedule uses the data from the alternate state DSH survey as the basis and includes additional fields to reflect changes that occurred subsequent to the alternate state DSH survey period through the SFY for which the interim DSH payment is being calculated. The blank alternate state DSH survey supplemental schedule is referred to as the alternate state DSH survey supplemental template. This template and instructions are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website dss.mo.gov/mhd, February 1, 2017. This rule does not incorporate any subsequent amendments or additions.

B. The provider must submit both the required state DSH survey and the alternate data for review to determine if the facility meets the criteria set forth below in subparagraph (8)(B)5.D.

C. The interim DSH payment based on the applicable alternate data shall be cal-

culated in the same manner as the interim DSH payment based on the required state DSH survey, except for the trends applied to the alternate data as noted below in parts (8)(B)5.C.(I) and (II). The allocation percentage calculated at the beginning of the SFY year as set forth in part (4)(B)4.A.(I) shall be applied to the estimated UCC net of OOS DSH payments based on the alternate data to determine the preliminary interim DSH payment.

(I) Alternate state DSH survey. The trends applied to the alternate state DSH survey shall be from the year subsequent to the alternate state DSH survey period to the current SFY for which the interim DSH payment is being determined.

(II) Alternate state DSH survey supplemental schedule. Trends shall not be applied to an alternate state DSH survey supplemental schedule since it incorporates changes from the full year cost report period through the SFY for which the interim DSH payment is being calculated.

D. Following are the circumstances for which a provider may request that its interim DSH payment be based on alternate data rather than the required state DSH survey, including the criteria and other requirements:

(I) Twenty Percent (20.00%) DSH Outlier. A provider may request that the alternate state DSH survey be used prior to the interim DSH payment being determined for the SFY if the Untrended Total Estimated Net Cost on the "Report Summary" tab, Column J, from the alternate state DSH survey is at least twenty percent (20.00%) higher than the Trended Total Estimated Net Cost on the "Report Summary" tab, Column L, from the required state DSH survey (i.e., the increase is at least twenty percent (20.00%) rounded to two (2) decimal places).

(a) Both the required state DSH survey and the alternate state DSH survey must be submitted to the independent DSH auditor and the division, respectively, no later than March 1 preceding the beginning of each SFY for which interim DSH payments are being made;

(II) Extraordinary Circumstances. A provider may request that alternate data be used if the facility experienced an extraordinary circumstance during or after the required state DSH survey report period up to the SFY for which the interim DSH payment is being calculated that caused the required DSH survey report period to be materially misstated and unrepresentative. If circumstances found in items (8)(B)5.D.(II)(a)I.–III. below are applicable, the facility may complete and submit the applicable alternate

data.

(a) Extraordinary circumstances include unavoidable circumstances that are beyond the control of the facility and include the following:

I. Act of nature (i.e., tornado, hurricane, flooding, earthquake, lightning, natural wildfire, etc.);

II. War;

III. Civil disturbance; or

IV. If the data to complete the required state DSH survey set forth in paragraph (2)(W)4. is not available due to a change in ownership because the prior owner is out of business and is uncooperative and unwilling to provide the necessary data.

(b) A change in hospital operations or services (i.e., terminating or adding a service or a hospital wing; or, a change of owner, except as noted in item (8)(B)5.D.(II)(a)IV., manager, control, operation, leaseholder or leasehold interest, or Medicare provider number by whatever form for any hospital previously certified at any time for participation in the MO HealthNet program, etc.) does not constitute an extraordinary circumstance.

(c) Both the required state DSH survey and the alternate data must be submitted to the independent DSH auditor and the division, respectively, no later than March 1 if the alternate data is to be used to determine the interim DSH payment at the beginning of the SFY.

(d) A hospital may submit a request to use alternate data due to extraordinary circumstances after March 1, but the alternate data and the resulting interim DSH payment will be subject to the same requirements as the Interim DSH Payment Adjustments noted below in subparts (8)(B)5.D.(III)(b)–(d). The requests relating to extraordinary circumstances received after the March 1 deadline will be included with the Interim DSH Payment Adjustments requests in part (8)(B)5.D.(III) in distributing the unobligated DSH allotment and available state funds remaining for the SFY; or

(III) Interim DSH Payment Adjustment.

(a) After the interim DSH payment has been calculated for the current SFY based on the required state DSH survey, a provider may request that alternate data be used if the Untrended Total Estimated Net Cost on the "Report Summary" tab, Column J, from the alternate data is at least twenty percent (20.00%) higher than the Trended Total Estimated Net Cost on the "Report Summary" tab, Column L, from the required state DSH survey (i.e., the increase is at least twenty percent (20.00%) rounded to two (2)



decimal places).

(b) The division will process interim DSH payment adjustments once a year. After all requests are received, the division will determine whether revisions to the interim DSH payments are appropriate. Any revisions to the interim DSH payments are subject to the unobligated DSH allotment remaining for the SFY and availability of state funds.

(c) The request, including the alternate data, must be submitted to the division by December 31 of the current SFY for which interim DSH payments are being made.

(d) To the extent that state funds are available, the DSH allotment for the SFY that has not otherwise been obligated will be distributed proportionally to the hospitals determined to meet the above criteria, based on the difference between the preliminary interim DSH payment based on the alternate data and the original interim DSH payment;

(IV) If a provider met the criteria to use alternate data for an Interim DSH Payment Adjustment ((8)(B)5.D.(III)) in the prior SFY, it may continue to use alternate data for its interim DSH payment until the required state DSH survey reflects the impact of the change. The hospital must submit the request and the alternate data to the division for review and approval no later than March 1.

AUTHORITY: sections 208.152, 208.153, 208.158, and 208.201, RSMo 2016. Emergency rule filed May 20, 2011, effective June 1, 2011, expired Nov. 28, 2011. Original rule filed May 20, 2011, effective Jan. 30, 2012. Emergency amendment filed June 20, 2012, effective July 1, 2012, expired Dec. 28, 2012. Amended: Filed April 2, 2012, effective Oct. 30, 2012. Amended: Filed Jan. 13, 2015, effective Sept. 30, 2015. Amended: Filed Feb. 1, 2016, effective July 30, 2016. Amended: Filed Dec. 30, 2016, effective Aug. 30, 2017.*

**Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1981, 1986, 1988, 1990, 1992, 1993, 2004, 2005, 2007, 2011, 2013, 2014, 2015, 2016; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012; 208.158, RSMo 1967; and 208.201, RSMo 1987, amended 2007.*

13 CSR 70-15.230 Supplemental Upper Payment Limit Methodology

PURPOSE: This rule establishes a methodology for determining Upper Payment Limit (UPL) payments provided to hospitals beginning July 1, 2011. The regulation also establishes an additional UPL supplemental payment for hospitals with a Low Income and

Needy Care Collaboration Agreement.

(1) General Principles.

(A) Hospital Upper Payment Limit (UPL) payments cannot exceed the Medicare Upper Payment Limit as authorized by federal law and included in Missouri's State Plan.

(2) Beginning with State Fiscal Year 2012, each participating hospital may be paid supplemental payments up to the Medicare Upper Payment Limit (UPL).

(A) UPL Payment. Supplemental payments may be paid to qualifying hospitals for inpatient services. The total amount of supplemental payments made under this section in each year shall not exceed the Medicare Upper Payment Limit, after accounting for all other supplemental payments. Payments under this section will be determined prior to the determination of payments under subsection (2)(B) below authorizing Medicaid UPL Supplemental Payments for Low Income and Needy Care Collaboration hospitals.

1. The state shall determine the amount of Medicaid supplemental payments payable under this section on an annual basis. The state shall calculate the Medicare Upper Payment Limit for each of the three (3) categories of hospitals: state hospitals, non-state governmental hospitals, and private hospitals. The state shall apportion the Medicaid supplemental payments payable under this section to each of the three (3) categories of hospitals based on the proportionate Medicare Upper Payment Limits for each category of hospitals.

2. Each participating hospital may be paid its proportional share of the UPL gap based upon its Medicaid inpatient utilization.

(B) Supplemental Payments for Low Income and Needy Care Collaboration Hospitals. Additional Supplemental Payments for Low Income and Needy Collaboration Hospitals may be made if there is room remaining under the UPL to make additional payments without exceeding the UPL, after making the UPL payments in subsection (2)(A) above.

1. Effective for dates of services on or after July 1, 2011, supplemental payments may be issued to qualifying hospitals for inpatient services after July 1, 2011. Maximum aggregate payments to all qualifying hospitals under this section shall not exceed the available Medicare Upper Payment Limit, less all other Medicaid inpatient payments to private hospitals under this State Plan which are subject to the Medicaid Upper Payment Limit.

2. Qualifying criteria. In order to qualify for the supplemental payment under this

section, the private hospital must be affiliated with a state or local governmental entity through a Low Income and Needy Care Collaboration Agreement. The state or local governmental entity includes governmentally-supported hospitals.

A. A private hospital is defined as a hospital that is owned or operated by a private entity.

B. A Low Income and Needy Care Collaboration Agreement is defined as an agreement between a private hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.

C. Reimbursement methodology. Each qualifying private hospital may be eligible to receive supplemental payments. The total supplemental payments in any fiscal year will not exceed the lesser of—

(I) The difference between each qualifying hospital's inpatient Medicaid billed charges and Medicaid payment the hospital receives for covered inpatient services for Medicaid participants during the fiscal year; or

(II) For hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) program, the difference between the hospital's specific DSH cap and the hospital's DSH payments during the fiscal year.

D. Payments under this section will be determined after the determination of payments under subsection (2)(A) above authorizing Medicaid UPL supplemental payments.

AUTHORITY: sections 208.152, 208.153, and 208.201, RSMo Supp. 2010. Emergency rule filed May 20, 2011, effective July 1, 2011, expired Dec. 28, 2011. Original rule filed May 20, 2011, effective Jan. 30, 2012.*

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