RULES OF

Department of Social Services

Division 70—MO HealthNet Division

Chapter 15—Hospital Program

Title		Page
13 CSR 70-15.010	Inpatient Hospital Services Reimbursement Methodology	3
13 CSR 70-15.011	Reimbursement for Essential Disproportionate Share Hospitals	12
13 CSR 70-15.015	Supplemental Payments	12
13 CSR 70-15.020	Procedures for Admission Certification, Continued Stay Review, and Validation Review of Hospital Admissions	16
13 CSR 70-15.030	Payment and Payment Limitations for Inpatient Hospital Care	20
13 CSR 70-15.040	Hospital Outpatient Settlements	21
13 CSR 70-15.070	Inpatient Psychiatric Services for Individuals Under Age Twenty-One	22
13 CSR 70-15.080	Payment Method for General Relief Recipient Hospital Outpatient Services (Rescinded December 30, 2005)	25
13 CSR 70-15.090	Procedures for Evaluation of Appropriate Inpatient Hospital Admissions and Continued Days of Stay (Rescinded May 30, 2020)	25
13 CSR 70-15.100	Unreimbursed Care Payment Methodology	25
13 CSR 70-15.110	Federal Reimbursement Allowance (FRA)	25
13 CSR 70-15.150	Enhancement Pools (Rescinded September 30, 2018)	28
13 CSR 70-15.160	Outpatient Hospital Services Reimbursement Methodology	28
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	31
13 CSR 70-15.180	Grant to Trauma Hospitals for the Care Provided by Physicians Not Employed by the Hospital	31
13 CSR 70-15.190	Out-of-State Hospital Services Reimbursement Plan	31

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Payment Policy for a Preventable Serious Adverse Event or Hospital or Ambulatory Surgical Center-Acquired Condition (Rescinded June 30, 2012) 31

13 CSR 70-15.220 Disproportionate Share Hospital (DSH) Payments 31

13 CSR 70-15.230 Upper Payment Limit (UPL) Payment Methodology. 37

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

(1) General 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.

(B) The Title XIX reimbursement for hospitals, excluding those located outside Missouri, shall include the payments as outlined below. Reimbursement shall be subject to availability of federal financial participation (FFP).

1. Inpatient reimbursement methodologies are established in accordance with sections (4), (5), and (6).

2. Outpatient reimbursement is established in accordance with 13 CSR 70-15.160.

3. Supplemental payments, graduate medical education (GME) payments, and psych adjustment payments are established in accordance with 13 CSR 70-15.015.

4. Disproportionate share hospital (DSH) payment is established in accordance with 13 CSR 70-15.220.

5. Upper payment limit (UPL) payment is established in accordance with 13 CSR 70-15.230.

(C) The Title XIX reimbursement for hospitals located outside Missouri will be established in accordance with 13 CSR 70-15.190.

(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 audited 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.

(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 year cost report. Audited Medicaid cost report from the third prior calendar year. If a facility has more than one (1) cost report with periods ending in the third 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 year cost report is less than or greater than a twelve- (12-) month period, the data shall be adjusted, based on the number of days reflected in the base year cost report to a twelve- (12-) month period. Any changes to the base year cost report after the division issues a final decision on assessment or payments will not be included in the calculations.

(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) Division. Unless otherwise designated, division refers to the MO HealthNet Division (MHD), a division of the Department of Social Services charged with the administration of the MO HealthNet program.

(H) Diagnosis Related Group (DRG) relative weight. A numerical value that reflects the relative resource intensity or costliness of treating patients within a specific DRG compared to the average inpatient case.

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

(J) 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 rule or the MO HealthNet hospital provider manual.

(K) Reasonable cost. The reasonable cost of inpatient hospital services is an individual hospital's Medicaid cost per day as determined in accordance with section (4) of this regulation using the base year cost report.

(L) 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.

(M) 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.

(N) 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 shall be an allowable cost to the hospital. The FRA is identified in 13 CSR 70-15.110. Effective January 1, 1999, the assessment shall be an allowable cost.

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

1. The *Hospital Manual* as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, July 1, 2025. This rule does not incorporate any subsequent amendments or additions;

2. Chapter 40 of *The Provider Reimbursement Manual* — Part 2, that includes the CMS 2552-10 cost report form and instructions, as published by the Centers for Medicare & Medicaid Services (CMS), 7500 Security Boulevard, Baltimore, MD 21244, February 21, 2024. This rule does not incorporate any subsequent amendments or additions;

3. 42 CFR Chapter IV, Part 413, as published by the Office of the Federal Register, 800 North Capitol St. NW, Suite 700, Washington, DC 20408, October 1, 2024. This rule does not incorporate any subsequent amendments or additions. Only the cost principles from 42 CFR 413 are incorporated by reference;

4. The Missouri Inpatient (IP) APR-DRG Calculator as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, July 1, 2025. This rule does not incorporate any subsequent amendments or additions;

5. The Medicare Inpatient Prospective Payment System (IPPS) FY 2025 Table 2 Case-Mix Index and Wage Index Table by CMS Certification Number (CCN) as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, October 2, 2024. This rule does not incorporate any subsequent amendments or additions; and

6. The Medicare IPPS FY 2025 Table 3 Wage Index Table by CBSA as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, October 2, 2024. This rule does not incorporate any subsequent amendments or additions.

(3) 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 division. 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. All cost reports shall be submitted and certified by an officer or administrator of the hospital.

B. If a cost report is more than ten (10) days past due, the division may withhold fifty thousand dollars ($50,000) in MO HealthNet payments from the hospital until the hospital submits the cost report. If the MO HealthNet payment is less than fifty thousand dollars ($50,000), the entire payment will be withheld. Upon the division's or its authorized contractor's receipt of the cost report prepared in accordance with this regulation, the payment that was withheld will be released to the hospital.

C. A single extension, not to exceed thirty (30) days, may be granted upon the request of the hospital and the approval of the division when the hospital's operation is significantly affected due to extraordinary circumstances over which the hospital had no control, such as fire or flood. The request must be in writing and postmarked prior to the first day of the sixth month following the hospital's fiscal year end.

2. The change of control or ownership of 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 or ownership within five (5) calendar months after the close of the reporting period.

A. Upon learning of a change of control or ownership, the division may withhold fifty thousand dollars ($50,000) of the next available MO HealthNet payment from the hospital identified in the current MO HealthNet participation agreement until the 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 hospital identified in the current MO HealthNet participation agreement.

B. The division may, at its discretion, delay the withholding of funds specified in subparagraph (3)(A)2.A. 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 entities may provide adequate assurances. The buying entity 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. The termination of or by a hospital of participation in the MO HealthNet program requires that the hospital submit a cost report for the period ending with the date of termination within five (5) calendar months from the date of the CMS tie-out notice. No extension in the submitting of cost reports shall be allowed when a termination of participation has occurred.

A. Upon learning of the termination, the division may withhold fifty thousand dollars ($50,000) of the next available MO HealthNet payment from the hospital until the cost report is filed. If the MO HealthNet payment is less than fifty thousand dollars ($50,000), the entire payment will be withheld. Upon the division's or its authorized contractor's receipt of the cost report prepared in accordance with this regulation, the payment that was withheld will be released to the hospital.

4. Amended cost reports or other supplemental. The division or its authorized contractor will notify the hospital by letter when the audit of its cost report is completed. Since this data will be used in the calculation of *per diem* rates, and other Medicaid payments, the hospital shall review the audited cost report data and submit amended or corrected data to the division or its authorized contractor within fifteen (15) days. Data received after the fifteen- (15-) day deadline will not be considered by the division for *per diem* rates, or other Medicaid 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. 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 log for each fiscal year must be maintained by either date of service or date of payment 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 log should be used to complete the Medicaid worksheet in the hospital's cost report;

B. 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

C. Not to be included in the logs are denied claims or line item charges. This would include payments for hospital-based physicians and certified registered nurse anesthetists billed by the hospital on a professional services claim or payments for services provided by the hospital through enrollment as a MO HealthNet provider-type other than hospital.

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 (3)(B)1. of this rule.

(C) Cost report audits.

1. The examination or inspection of a hospital's cost report, files, and any other supporting documentation by the division or its authorized contractor. The division or its authorized contractor may perform the following types of audits:

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

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

C. Level III audits — Requires an in-depth audit, including an on-site review, of hospital cost reports, files, and any other additional information requested and submitted to the division or its authorized contractor. The level III audit will require an in-depth analysis of a hospital's cost report data and an on-site verification of cost report items deemed necessary through a risk assessment or other analyses, etc. Level III audits will require some portion of the hospital's records review be provided on-site.

(4) Inpatient Per Diem Reimbursement Methodology. Effective for admit dates beginning July 1, 2025, the Missouri hospitals listed in subsection (4)(A) will continue to be reimbursed under the inpatient per diem reimbursement methodology and shall receive a Missouri Medicaid per diem rate as calculated in subsection (4)(B).

(A) The following hospitals will continue to be reimbursed under the inpatient per diem reimbursement methodology:

1. In-state specialty pediatric hospitals;

2. In-state pediatric hospitals that are licensed for fewer than fifteen (15) beds and specialized in pediatric orthopedic care;

3. In-state free-standing psychiatric hospitals;

4. In-state free-standing rehabilitation hospitals;

5. In-state free-standing long-term acute care (LTAC) hospitals; and

6. In-state hospitals enrolled in Medicaid on or after January 1, 2025, that have eighty percent (80%) or greater patient mix in mental health and substance abuse.

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

PER DIEM = ((TAC / MPD) * TI) + MIP FRA

1. MIP FRA — Medicaid inpatient share of Federal Reimbursement Allowance (FRA). The Medicaid inpatient share of the FRA assessment will be calculated by dividing the hospital's Medicaid fee-for-service (FFS) and managed care (MC) inpatient days from the base year cost report by total hospital inpatient days from the base year cost report to arrive at the Medicaid utilization percentage. This percentage is then multiplied by the inpatient FRA assessment for the current SFY to arrive at the increased allowable Medicaid cost. This cost is then divided by the estimated Medicaid FFS and MC days for the current SFY to arrive at the increased Medicaid cost per day. The estimated Medicaid FFS and MC days are paid days from the second prior calendar year;

2. MPD — Medicaid FFS inpatient days from the base year cost report;

3. TI — Trend indices. The trend indices are applied to the TAC per day of the per diem rate. The trend index for the base year is used to adjust the TAC per day to a common fiscal year end of June 30. The adjusted TAC per day shall be trended through the current SFY;

4. TAC — Medicaid allowable inpatient routine and special care unit costs, and ancillary costs, from the base year cost report, will be added to determine the hospital's Medicaid total allowable cost (TAC);

5. The per diem for private free-standing psychiatric hospitals shall be the greater of one thousand one hundred ninety-four dollars and twenty-two cents ($1,194.22) or the per diem as calculated in subsection (4)(B);

6. The per diem shall not exceed the average Medicaid inpatient charge per diem as determined from the base year cost report and adjusted, by the TI, except for federally deemed critical access hospitals whose Medicaid FFS charges equal sixty percent (60%) or less of its Medicaid FFS costs;

7. The per diem shall be adjusted for rate increases granted in accordance with subsections (4)(D) and (4)(E); and

8. If the hospital does not have a base year cost report, the inpatient per diem will be the weighted average statewide per diem rate as determined in section (5).

(C) Trend indices (TI). For trend indices for SFY 2018 and forward, refer to the Hospital Market Basket index as published in Healthcare Cost Review by Institute of Health Systems, or

equivalent publication, regardless of any changes in the name of the publication or publisher, for each SFY.

(D) Adjustments to rates. A hospital's inpatient per diem rate may be adjusted only under the following circumstances:

1. When information contained in the cost report is found to be intentionally misrepresented, such adjustment shall be made retroactive to the date of the original rate. Such adjustment shall not preclude the division from imposing any sanctions authorized by any statute or regulation; and

2. When a rate reconsideration is granted in accordance with subsection (4)(E).

(E) Rate reconsideration.

1. Rate reconsideration may be requested under this subsection for changes in allowable costs which occur subsequent to the base year cost report described in subsection (4)(B). The effective date for any increase granted under this subsection shall be no earlier than the first day of the month following the division's final determination of the rate reconsideration.

2. The following may be subject to review under procedures established by the division:

A. New or expanded inpatient services. A hospital, at times, may offer to the public new or expanded inpatient services which may require certificate of need (CON) approval.

(I) 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.

(II) Non-state 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 CON. Rate reconsideration requests for projects requiring CON review must include a copy of the CON program approval. Non-state 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.

(III) A hospital (state or non-state) 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 review. Upon completion of the review, the hospital's inpatient reimbursement rate 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.

(IV) Rate reconsiderations 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 SNF and swing bed cost) to total hospital cost as submitted on the most recent cost report filed with the division or its authorized contractor as of the review date divided by total acute care patient days including all special care units and nursery, but excluding swing bed days. The most recent cost report filed must be audited prior to the finalization of the rate reconsideration.

(V) 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 total acute care patient days (excluding nursery and swing bed days) are less than sixty percent (60%) of total possible bed days, the sixty percent (60%) number plus nursery days will be used to determine the rate increase. If the total acute care patient days (excluding nursery and swing bed days) are at least sixty percent (60%) of total possible bed days, the total acute care patient days plus nursery days will be used to determine the rate increase. This computation will apply to capital costs only.

(VI) 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; and

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

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 Medicaid program.

4. The request for a rate reconsideration must be submitted in writing to the division and must specifically and clearly identify the project and the total dollar amount involved. The total dollar amount must be supported by generally accepted accounting principles. The hospital shall demonstrate the rate reconsideration is necessary, proper, and consistent with efficient and economical delivery of covered patient care services. The hospital will be notified of the division's decision in writing 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.

(5) Inpatient Per Diem Reimbursement Rate Computation for New Hospitals. Effective for admit dates beginning July 1, 2025, for new Missouri hospitals that continue to be reimbursed under the per diem reimbursement methodology, each new Missouri hospital's rate setting cost report shall be the first full fiscal year cost report, which includes inpatient Medicaid costs, otherwise the hospital shall continue to receive the weighted average statewide per diem rate as determined below.

(A) Free-standing psychiatric hospitals. In the absence of adequate cost data, a new hospital's Medicaid rate shall be one hundred percent (100%) of the maximum per diem rate for a free-standing psychiatric hospital, excluding the state psychiatric hospitals, until a prospective rate is determined

on the hospital's rate setting cost report, in accordance with section (4).

(B) Long-term acute care hospitals. In the absence of adequate cost data, a new hospital's Medicaid rate shall be one hundred percent (100%) of the weighted average statewide per diem rate for long-term acute care hospitals until a prospective rate is determined on the hospital's rate setting cost report, in accordance with section (4).

(C) Rehabilitation hospitals. In the absence of adequate cost data, a new hospital's Medicaid rate shall be one hundred percent (100%) of the weighted average statewide per diem rate for rehabilitation hospitals until a prospective rate is determined on the hospital's rate setting cost report, in accordance with section (4).

(6) Inpatient Diagnosis Related Group (DRG) Reimbursement Methodology. Effective for discharge dates beginning July 1, 2025, Missouri hospitals shall be reimbursed under the DRG reimbursement methodology using components from the base year cost report and claims data period. Those components are from the following data sources:

(A) Historical claims data: FFS claims and MC encounter data from MMIS for SFY 2024.

1. Future updates will utilize FFS claims and MC encounter data from MMIS for the second full prior calendar year (i.e., for SFY 2027, calendar year 2024 paid claims will be utilized);

(B) Cost report data: The fourth prior year cost reports.

1. Future updates will utilize the third prior year audited cost reports available as of January 31 prior to the beginning of the SFY;

(C) Labor portion and wage index: Federal fiscal year (FFY) 2025 inpatient prospective payment system (IPPS) wage data.

1. Future updates will be obtained from the final rule or any subsequent correction notice that is available as of January 31 prior to the beginning of the SFY;

(D) Hospitals reimbursed under DRG —

1. All hospitals except for those listed in subsection (4)(A);

(E) DRG grouper type.

1. The DRG grouper utilized to classify cases into DRG categories will be the Solventum All-Patient Refined (APR) DRG.

2. The version utilized is 42, released on October 1, 2024;

(F) Statewide base rates development.

1. Statewide base rates.

A. The base year claims data (FFS claims and MC encounters) is repriced under the current reimbursement methodology. This base year repricing establishes the intended budget for the DRG system. The in-state hospital data and out-of-state hospital data is separated and, utilizing the DRG formula, a base rate is iterated for each set of claims data;

(G) Hospital base rate components.

1. Statewide base rate.

A. Two (2) base rates are established for reimbursement in the DRG system. One (1) for in-state hospitals and one (1) for out-of-state hospitals.

2. Wage index.

A. For Medicare IPPS hospitals, the wage index is based on the Medicare IPPS post-reclass effective as of the October prior to the beginning of the SFY.

B. For non-Medicare IPPS hospitals, the wage index is based on the Medicare IPPS for the hospital's Medicare Core-based Statistical Area (CBSA) effective as of the October prior to the beginning of the SFY.

C. In-state federally deemed critical access hospitals (CAH) will have their wage index set to 1.000, regardless of their assigned CBSA.

3. Hospital DRG rate add-ons.

A. Free-standing in-state children's hospitals will receive a two thousand five hundred dollar ($2,500) rate add-on to their base rate.

B. In-state federally deemed CAHs will receive a one thousand five hundred dollar ($1,500) rate add-on to their base rate.

C. Indirect Medical Education (IME) Factor.

(I) In-state hospitals with approved medical education programs identified in the Medicare cost report will have an IME add-on to their base rate. The IME formula is calculated from the base year cost report as follows:

(a) Full-time employee (FTE) counts: Worksheet S-3, Lines 14, 16, and 17, Column 9.

I. Updated FTEs can be submitted to the division if a hospital meets the criteria in 13 CSR 70-15.015(9)(D);

(b) Sum of hospital beds: Worksheet S-3, Lines 14, 16, and 17, Column 2; and

(c) Formula: Round (1.35 * ((1 + (FTE counts / hospital beds))$^{.405}$ – 1),4) * 50%.

4. Hospital specific base rates.

A. Each hospital will have a specific base rate calculated based on the following formula:

(I) Adjust the statewide base rate by the wage index.

(a) Wage adjusted rate = (statewide base rate * labor portion * wage index) + (statewide base rate * (1 – labor portion));

(II) Add IME (if applicable) to the wage adjusted rate.

(a) IME and wage adjusted rate = wage adjusted rate * IME factor; and

(III) Add children's or CAH add-on (if applicable).

(a) Hospital specific rate = IME and wage adjusted rate + children's or CAH add-on;

(H) Hospital cost-to-charge ratios (CCR).

1. Utilizing the base year cost reports, hospital specific CCRs are established.

A. Costs: Worksheet D-1, Line 49, Title XIX (if there is not Title XIX, then Title XVIII is utilized).

B. Charges: Worksheet D-3, Lines 30–35, and 202, Column 2, Title XIX (if there is no Title XIX, then Title XVIII is utilized);

(I) Transfer payments.

1. Transfers shall be identified as claims with a discharge status of 02, 05, and 66 and not having an assigned DRG of 580 or 581.

2. The reimbursement to hospitals for inpatient services provided to claims identified as transfers shall be the lesser of A. or B. below:

A. The DRG amount.

(I) Formula: Hospital Specific Base Rate * DRG relative weight; and

B. The amount in subparagraph (6)(I)2.A. divided by the assigned DRGs average length of stay (ALOS) multiplied by the claims length of stay (LOS) plus one (1).

(I) Formula: (DRG payment / DRG ALOS) * (LOS + 1);

(J) Outlier payments.

1. Cost outlier payments are an additional payment made at the time a claim is processed for exceptionally costly services.

A. A cost outlier threshold shall be established for each DRG at the time the DRG relative weights are calculated, using the same information used to establish the relative weights. The cost threshold is the greater of thirty thousand dollars ($30,000) or mean cost for the DRG plus 1.96 standard deviation.

B. Charges for non-covered services and services not reimbursed under the inpatient DRG methodology shall be deducted from the total billed charges. The remaining billed

charges are converted to cost using the hospital specific CCR.

C. If the net cost for the claim exceeds the cost outlier threshold, a cost outlier payment is made at eighty percent (80%) of the costs above the threshold.

D. DRGs excluded from cost outliers.

(I) Mental Health and Substance Abuse DRGs.

(a) DRGs 750-1 through 776-4.

2. Day outlier payments are an additional payment made at the time a claim is processed for exceptionally long lengths of stay in the Mental Health and Substance Abuse DRGs (DRGs 750-1 through 776-4).

A. A day outlier threshold shall be established for each DRG at the time the DRG relative weights are calculated, using the same information used to establish the relative weights. The day threshold is the ALOS of the DRG.

B. A day outlier per diem payment may be made for covered days in excess of the day outlier threshold at the rate of five hundred dollars ($500) per day;

(K) Policy adjustors. Claims for inpatient stays that meet certain criteria will qualify for further adjustments to the payments.

1. Pediatric.

A. Adjustment factor: 1.70.

B. Qualifying criteria: The DRG's assigned service category is Pediatric.

2. General Medicine.

A. Adjustment factor: 1.31.

B. Qualifying criteria: The DRG's assigned service category is General Medicine.

3. Mental Health and Substance Abuse.

A. Adjustment factor: 1.92.

B. Qualifying criteria: The DRG's assigned service category is Mental Health and Substance Abuse.

4. Obstetrics.

A. Adjustment factor: 1.27.

B. Qualifying criteria: The DRG's assigned service category is Obstetrics;

(L) Example DRG claim calculation.

B	C	D	E	F	G
2	Missouri Medicaid DRG Pricing Calculator - Rates Effective: 7/1/2025				
3	This DRG Pricing calculator will provide an estimated DRG payment for inpatient hospital services for Missouri Medicaid recipients.				
4	Indicates data to be input by the user				Indicates payment policy parameters set by Medicaid
5	Information		Data		Comments or Formula
6	INFORMATION FROM THE HOSPITAL				
7	Covered Charges		$250,000.00		UB-04 Field Locator 47 minus FL 48
8	Length of Stay		10		Total Length of Stay (Discharge minus Admit Date)
9	Covered Days		10		Covered Days from Claim
10	Discharge Status		01		
11	APR-DRG Code		723-3		From separate APR-DRG grouping software
12	HOSPITAL INFORMATION				
13	Hospital Specific Facility Rate		$7,684.89		Provider Specific Rate
14	Hospital Specific cost-to-charge ratio		0.2650		Provider Specific CCR
15	APR-DRG INFORMATION				
16	APR-DRG Description		VIRAL ILLNESS		
17	APR-DRG Service Line Description		Internal Medicine		
18	DRG Relative Weight		1.1472		
19	Cost Outlier Threshold		$43,548.52		
20	Average LOS		3.44		
21	Day Outlier Threshold		0.00		Only populated for Mental Health and Substance Abuse DRGs
22	Policy Adjuster		1.31		
23	DRG BASE PAYMENT				
24	DRG Base Payment		$8,816.11		E13 * E18
25	TRANSFER PAYMENT				
26	Transfer Indicator		No		If E10 in ('02', '05', '66') AND E11 is NOT 580 or 581 Then Yes Else No
27	Transfer Adjusted Payment		$0.00		If E26 = Yes then (E24 / E20) * (E8 + 1) else 0
28	Transfer Payment or DRG Payment		$0.00		If E26 = Yes then Minimum of E27 or E24 else 0
29	POLICY ADJUSTER PAYMENT				
30	Policy Adjuster Payment		$2,732.99		If E26 = Yes then E31 - E28 else E31 - E24
31	DRG Payment with Policy Adjuster		$11,549.10		If E26 = Yes then E28 * E22 else E24 * E22
32	OUTLIER PAYMENT				
33	Cost or Day Outlier?		Cost Outlier		If E17 = "Mental Health and Substance Abuse" then Day Outlier else Cost Outlier
34	DAY OUTLIER CALCULATIONS				
35	Day Outlier Indicator		No		If E33 = "Day Outlier" AND (E9 - E21) > 0 then Yes else No
36	Day Outlier - Per Diem Amount		N/A		$500.00 per day
37	Day Outlier Payment		$0.00		If E35 = "Yes" AND E33 = "Day Outlier" then (E9 - E21) * E36 else 0
38	COST OUTLIER CALCULATIONS				
39	Estimated Cost of the Stay		$66,250.00		E7 * E14
40	Marginal Cost Percentage		80%		Marginal Cost set to 80%
41	Cost Outlier Indicator		Yes		If E39 > E19 then Yes else No
42	Cost Above Threshold		$22,701.48		If E41 = "Yes" then E39 - E19 else 0
43	Cost Outlier Payment		$18,161.18		E42 * E40
44	Outlier Payment		$18,161.18		If E33 = "Day Outlier" AND E35 = "Yes" then E37, if E33 = "Cost Outlier" AND E41 = "Yes" then E43 else 0
45	CALCULATION OF ALLOWED AMOUNT				
46	Allowed Amount		$29,710.28		E31 + E44
47					

(M) New hospitals shall be assigned the following DRG payment components:

1. Statewide base rate based upon their in-state or out-of-state status;

2. Wage index based upon the CBSA in which the hospital resides;

3. Hospital specific CCR based upon their most recently filed cost report.

A. In the absence of a cost report, the following CCR will be utilized:

(I) In-state: The average CCR of all in-state hospitals reimbursed by DRG until a cost report has been filed with the division; and

(II) Out-of-state: The average urban CCR in the state the hospital resides, as found in the Medicare prospective payment system (PPS) annual release documents;

4. Base rate add-ons.

A. For new in-state hospitals only, base rate add-ons will be considered based upon the designation of the hospital.

(I) New free-standing in-state children's hospitals will be eligible for the children's base rate add-on.

(II) New in-state federally deemed CAHs will be eligible for the CAH base rate add-on.

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

(A) The per diem rate for merged hospitals shall be calculated –

1. For the remainder of the SFY in which the merger occurred, the merged rate is calculated by multiplying each hospital's estimated Medicaid paid days by its per diem rate, summing the estimated per diem payments and estimated Medicaid 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; or

2. For subsequent SFYs, the per diem rate will be based on the combined data from the base year cost report for each facility.

(8) 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.

(9) Inappropriate Placements.

(A) The hospital inpatient reimbursement as determined under this plan shall not apply to any participant who is receiving inpatient hospital care when the participant 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.

AUTHORITY: sections 208.201 and 660.017, RSMo 2016, and sections 208.152 and 208.153, RSMo Supp. 2025. 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 readopted: 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. 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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 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 19, 1993. Emergency amendment filed Nov. 16, 1992, effective Dec. 2, 1992, expired March 31, 1993. Emergency amendment filed Jan. 15, 1993, effective Jan. 25, 1993, expired May 24, 1993. 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Amended: Filed Dec. 15, 1999, effective June 30, 2000. Emergency amendment filed May 1, 2000, effective May 11, 2000, terminated Sept. 4, 2000. Emergency amendment filed Aug. 25, 2000, effective Sept. 4, 2000, expired March 2, 2001. Amended: Filed May 1, 2000, effective Dec. 30, 2000. Emergency amendment filed April 9, 2001, effective April 19, 2001, expired Oct. 15, 2001. Amended: Filed April 9, 2001, effective Sept. 30, 2001. Amended: Filed Aug. 24, 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. Amended: Feb. 18, 2003, effective Aug. 30, 2003. Amended: Filed Jan. 29, 2004, effective Aug. 30, 2004. Amended: Filed June 15, 2005, effective Dec. 30, 2005. Amended: Filed Feb. 1, 2006, effective

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**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, 2023, 2024, 2025; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012, 2024; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

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 Supplemental Payments

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

(1) Definitions.

(A) Base year cost report. Audited Medicaid cost report from the third prior calendar year. If a facility has more than one (1) cost report with periods ending in the third 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 year cost report is less than or greater than a twelve- (12-) month period, the data shall be adjusted, based on the number of days reflected in the base year cost report to a twelve- (12-) month period. Any changes to the base year cost report after the division issues a final decision on assessment or payments will not be included in the calculations.

(B) Case mix index (CMI). The hospital CMI is determined based on the hospital's MO HealthNet inpatient claims and Solventum All-Patient Refined Diagnosis Related Groups (APR-DRG) software, a grouping algorithm to categorize inpatient discharges with similar treatment characteristics requiring similar hospital resources.

1. For SFY 2026 and forward, the basis of the case mix index will be determined by the division based on the inpatient dataset utilized in the annual update of the Missouri APR-DRG reimbursement methodology.

(C) 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.

(D) Division. Unless otherwise designated, division refers to the MO HealthNet Division (MHD), a division of the Department of Social Services charged with the administration of the MO HealthNet program.

(E) Medicaid fee-for-service (FFS) inpatient days. Medicaid FFS inpatient days are paid Medicaid FFS days for inpatient hospital services as reported by the Medicaid Management Information System (MMIS) from the second prior calendar year.

(F) Medicaid managed care (MC) inpatient days. Medicaid MC inpatient days are paid Medicaid MC days for inpatient hospital services as reported by the Managed Care Health Plans on the Hospital Services Reporting Form from the second prior calendar year.

(G) 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 shall be an allowable cost to the hospital. The FRA is identified in 13 CSR 70-15.110. Effective January 1, 1999, the assessment shall be an allowable cost.

(H) State-deemed critical access hospital (CAH). A public hospital located in a county in the Missouri Bootheel with no more than one hundred five (105) acute care inpatient beds.

(2) Inpatient Direct Medicaid Payments.

(A) Inpatient direct Medicaid payments will be made to hospitals that are reimbursed under an APR-DRG reimbursement methodology for the following allowable MO HealthNet cost:

1. The increased MO HealthNet cost resulting from the FRA assessment becoming an allowable cost on January 1, 1999.

(B) The division will calculate the inpatient direct Medicaid payment as follows:

1. The Medicaid share of the inpatient FRA assessment will be calculated by dividing the hospital's inpatient Medicaid days, FFS and MC, by the total inpatient hospital days from the base year cost report to arrive at the Medicaid utilization percentage. This percentage is then multiplied by the inpatient FRA assessment for the current state fiscal year (SFY) to arrive at the increase allowable Medicaid cost for the inpatient FRA assessment. This amount will then be divided by the total of Medicaid FFS inpatient days and Medicaid MC inpatient days to arrive at a per day amount; and

2. The per day amount calculated in (2)(B)1. will be multiplied by the Medicaid FFS inpatient days to arrive at the FFS inpatient direct Medicaid payment.

(C) The division will calculate the inpatient direct Medicaid payment for new hospitals as follows:

1. In the absence of adequate cost report data, a new hospital's Medicaid share of the inpatient FRA assessment

shall be one hundred percent (100%) of the weighted average statewide Medicaid per day amount, as calculated in paragraph (2)(B)1., for the hospital type (i.e., acute care hospital, psychiatric hospital, long-term care hospital, rehabilitation hospital); and

2. In the absence of Medicaid FFS inpatient days, a new hospital's paid days shall be one hundred percent (100%) of the average statewide Medicaid FFS inpatient days for the hospital type (i.e., acute care hospital, psychiatric hospital, long term care hospital, rehabilitation hospital). These days are then multiplied by the per day amount calculated in (2)(C)1. to arrive at the FFS inpatient direct Medicaid payment.

(D) Effective for payments made on or after July 1, 2025, only the FFS component of the Medicaid share of the inpatient assessment will be included in the inpatient direct Medicaid payment.

(3) Outpatient Direct Medicaid Payments.

(A) Outpatient direct Medicaid payments will be made to hospitals for the following allowable MO HealthNet cost:

1. The increased MO HealthNet cost resulting from the FRA assessment becoming an allowable cost on January 1, 1999.

(B) The division will calculate the outpatient direct Medicaid payment as follows:

1. The Medicaid share of the outpatient FRA assessment will be calculated by dividing the hospital's outpatient Medicaid charges, FFS and MC, by the total outpatient hospital charges from the base year cost report to arrive at the Medicaid utilization percentage. This percentage is then multiplied by the outpatient FRA assessment for the current SFY to arrive at the increased allowable Medicaid cost for the outpatient FRA assessment; and

2. The FFS outpatient ratio will be calculated by dividing the hospital's outpatient FFS Medicaid charges by the hospital's outpatient Medicaid charges, FFS and MC. This ratio is then multiplied by the increased allowable Medicaid cost for the outpatient FRA assessment to arrive at the FFS outpatient direct Medicaid payment.

(C) The division will calculate the outpatient direct Medicaid payment for new hospitals as follows:

1. In the absence of a base year cost report, a new hospital's Medicaid share of the outpatient FRA assessment shall be one hundred percent (100%) of the weighted average statewide Medicaid utilization percentage, as calculated in paragraph (3)(B)1., for the hospital type (i.e., acute care hospital, psychiatric hospital, long term care hospital, rehabilitation hospital). This percentage is then multiplied by the outpatient FRA assessment for the current SFY to arrive at the increased allowable Medicaid cost for the outpatient FRA assessment; and

2. In the absence of a base year cost report, a new hospital's FFS outpatient ratio shall be one hundred percent (100%) of the weighted average statewide FFS outpatient ratio, as calculated in paragraph (3)(B)2., for the hospital type (i.e., acute care hospital, psychiatric hospital, long term care hospital, rehabilitation hospital). This ratio is then multiplied by the increased allowable Medicaid cost for the outpatient FRA assessment to arrive at the FFS direct Medicaid payment.

(D) Effective for payments made on or after July 1, 2022, only the FFS component of the Medicaid share of the outpatient FRA assessment will be included in the outpatient direct Medicaid payment.

(4) Acuity Adjustment Payment (AAP).

(A) Beginning with SFY 2026, hospitals that are paid on a per diem and meet the requirements set forth below shall receive an AAP. A hospital that is designated as a long-term acute care hospital, free-standing psychiatric hospital, or a free-standing rehabilitation hospital does not qualify to receive an AAP. For purposes of this section, Medicaid payments received shall include the following payments:

1. The Medicaid per diem payments, AAP, PC payment, and stop-loss payment (SLP).

(B) A hospital shall receive an AAP if the hospital's MO HealthNet case mix index is greater than a threshold set annually by the division. The preliminary AAP is calculated by multiplying the hospital's MO HealthNet case mix index times the estimated Medicaid FFS claims payments for the coming SFY. The estimated Medicaid FFS claims payments are calculated by multiplying the Medicaid FFS inpatient days times the per diem for the coming SFY. If the hospital's estimated Medicaid FFS claims payments for the coming SFY plus the preliminary AAP exceeds the hospital's prior SFY Medicaid FFS payments received increased by a stop-gain percentage, the preliminary AAP will be reduced so the estimated Medicaid FFS claims payments for the coming SFY plus the final AAP is equal to the stop-gain percent of the hospital's prior SFY Medicaid FFS payments received. If no reduction is necessary, the preliminary AAP shall be considered final.

(C) The annual final AAP will be calculated for each hospital at the beginning of each SFY. The annual amount will be paid out over the number of financial cycles during the SFY.

(5) Poison Control (PC) Payment.

(A) The PC payment shall be determined for hospitals which operated a poison control center during the base year and which continues to operate a poison control center. The PC payment shall reimburse the hospital for the Medicaid share of the total poison control cost and shall be determined as follows:

1. The total poison control cost from the base year cost report will be divided by the total hospital days from the base year cost report to determine a cost per day. This cost per day will then be multiplied by the estimated Medicaid FFS inpatient days and Medicaid MC inpatient days; and

2. The annual final PC payment will be calculated for each eligible hospital at the beginning of each SFY. The annual amount will be paid out over the number of financial cycles during the SFY.

(6) Stop-Loss Payment (SLP) for Hospitals That Are Reimbursed Under the Per Diem Reimbursement Methodology.

(A) Beginning with SFY 2026 hospitals that are paid on a per diem and meet the requirements set forth below shall receive an SLP. For purposes of this section, Medicaid payments received shall include the following payments:

1. The Medicaid per diem payments, AAP, PC payment, and SLP.

(B) Total estimated Medicaid FFS payments for the coming SFY for each hospital shall include estimated Medicaid FFS claims payments, and any final AAP and PC payment. The total estimated Medicaid FFS payments for each hospital shall be subtracted from the hospital's prior SFY Medicaid FFS payments received then summed to calculate a total increase or decrease in payments for the entire private ownership group. A positive result represents a decrease in payments and a negative amount represents an increase in payments. If the result is a decrease in total payments to the private ownership group, this amount shall represent the total stop-loss amount.

1. SLP will be made if a total stop-loss amount was calculated in subsection (6)(B). Each hospital that shows a

decrease in Medicaid payments shall receive a SLP in the amount of the decrease in payments unless the sum of each hospital's SLP is greater than the total stop-loss amount. If the sum is greater than the total stop-loss amount, each hospital's SLP shall be calculated by multiplying the total stop-loss amount times the ratio of the hospital's decrease in Medicaid payments to the total decrease in payments for the entire private ownership group.

2. Free-standing psychiatric hospitals. Total estimated Medicaid FFS payments for the coming SFY for each hospital shall include estimated Medicaid FFS claims payments, and any final AAP and PC payment. The total estimated Medicaid FFS payments for each hospital shall be subtracted from the hospital's prior SFY Medicaid FFS payments received then summed to calculate a total increase or decrease in payments for the entire privately owned free-standing psychiatric hospital ownership group. A positive result represents a decrease in payments and a negative amount represents an increase in payments.

A. If a hospital has a decrease in payments as calculated in paragraph (6)(B)2., the hospital will receive a payment equal to the amount of payment decrease. If the hospital has an increase in payments as calculated in paragraph (6)(B)2., the hospital will not receive any additional payments.

(C) The annual SLP will be calculated for each hospital at the beginning of each SFY. The annual amount will be paid out over the number of financial cycles during the SFY.

(7) Stop-Loss Payment (SLP) for Hospitals That Are Reimbursed Under the APR-DRG Reimbursement Methodology.

(A) Beginning with SFY 2026 hospitals that are paid under the APR-DRG and meet the requirements set forth below shall receive a SLP.

1. Total estimated Medicaid claims-based payments from the DRG base year are calculated. The DRG claims based system is calculated based on 13 CSR 70-15.010(6). The FFS supplemental payments for the most recent SFY are added to each hospital's estimated reimbursement.

2. The estimated DRG payments are then subtracted from the per diem repriced claims plus the FFS supplemental payments to get an estimated difference in reimbursement.

3. If the estimated DRG payment is greater than the per diem repriced claims plus the FFS supplemental payments, then no SLP will be calculated.

4. If the estimated DRG payment is less than the per diem repriced claims plus the FFS supplemental payments, then a SLP will be calculated to hold a hospital to a maximum of a one and seven thousand five hundred forty-five ten thousandths percent (1.7545%) estimated loss.

5. SLP special considerations.

A. If the following hospital types are eligible for a SLP, then their stop loss is held to zero percent (0%):

(I) Federally deemed CAHs;

(II) Safety net hospitals as defined in subparagraph (13)(A)1.A.; and

(III) State-deemed CAHs.

6. The annual SLP will be calculated for each hospital at the beginning of each SFY. The annual amount will be processed over the number of financial cycles during the SFY.

7. The SLP calculations are based on a prospective estimate using historical claims data and will not be trued up with actual claims data at the end of the SFY.

(8) Psych Adjustment (PA) Payment.

(A) Beginning with SFY 2026, hospitals that have FFS psychiatric hospital days as identified in the MMIS shall receive a PA payment.

1. The PA payment is a set dollar amount appropriated by the General Assembly pursuant to section 11.780 of CCS SS SCS HCS HB 11 (2025), and distributed to eligible hospitals proportionately as follows:

A. The FFS psychiatric hospital days for each hospital will be divided by the total FFS psychiatric hospital days for all hospitals to determine a percentage for each hospital. This percentage will then be multiplied by the set dollar amount in paragraph (8)(A)1. to determine the PA payment. The FFS psychiatric hospital days are paid days from the second prior calendar year.

2. The annual final PA payment will be calculated for each eligible hospital at the beginning of each SFY. The annual amount will be paid out over the number of financial cycles during the SFY.

(9) Medicaid Direct Graduate Medical Education (GME) Payments. Beginning with SFY 2023, a GME payment calculated as the sum of the intern and resident based GME payment and the GME stop-loss payment shall be made to any acute care hospital that provides graduate medical education.

(A) Intern and resident (I&R) based GME payment. The I&R based GME payment will be based on the per I&R Medicaid allocated GME costs not to exceed a maximum amount per I&R. The division will determine the number of full-time equivalent (FTE) I&Rs. Total GME costs will be determined using Worksheet A of the base year cost report adjusted by the trend index. Total GME costs is multiplied by the ratio of Medicaid FFS and MC days to total days to determine the Medicaid allocated GME costs which is then divided by the number of FTE I&Rs to calculate the Medicaid allocated cost per I&R. The I&R based GME payment is calculated as the number of FTE I&Rs multiplied by the minimum established by the division or the Medicaid allocated cost per I&R.

(B) GME stop-loss payment. The total I&R based GME payment for each hospital shall be subtracted from the hospital's prior SFY GME payments received then summed to calculate a total increase or decrease in payments for the entire group of hospitals that provide graduate medical education. A positive result represents a decrease in payments and a negative amount represents an increase in payments. If the result is a decrease in total payments to the hospitals, this amount shall represent the total GME stop-loss amount. GME stop-loss payments will be made if a total GME stop-loss payment amount was calculated in the subsection above. Each hospital that shows a decrease in GME Medicaid payments shall receive a GME stop-loss payment in the amount of the decrease in payments unless the sum of each hospital's GME stop-loss payment is greater than the total GME stop-loss amount. If the sum is greater than the total GME stop-loss amount, each hospital's GME stop-loss payment shall be calculated by multiplying the total GME stop-loss amount times the ratio of the hospital's decrease in GME Medicaid payments to the total decrease in GME Medicaid payments.

(C) Hospitals who implement a GME program prior to July 1 of the SFY and do not have a base year cost report to determine GME costs shall receive an I&R based GME payment based on the statewide average per resident amount (PRA) determined as follows:

1. The number of FTE I&Rs shall be reported to the division by June 1 prior to the beginning of the SFY in order to have a GME payment calculated; and

2. The I&R based GME payment shall be calculated as the number of FTE I&Rs multiplied by the Medicaid capped

statewide average PRA. The Medicaid capped statewide average PRA is calculated as follows:

A. By applying a straight average to the list of hospital PRA's with the following criteria:

(I) A hospital's PRA used in the straight average shall be the minimum as established by the division or the hospital's actual PRA.

(D) Hospitals who expand a currently federally approved GME program as of July 1 of the SFY shall have the ability to submit updated I&R numbers to the division.

1. The number of expanded FTE I&Rs shall be reported to the division by June 1 prior to the beginning of the SFY in order to have a GME payment calculated; and

2. The I&R based GME payment shall be calculated as the expanded number of FTE I&Rs multiplied by the minimum of the hospital-specific PRA or Medicaid capped statewide average PRA as described in subsection (9)(A).

(E) The hospital's I&R based GME payment plus GME stop-loss payment, if applicable, will be calculated for each hospital at the beginning of each SFY. The annual amount will be paid on a quarterly basis during the SFY.

(10) Medicaid Indirect Medical Education (IME) Payment. Beginning with SFY 2026, an IME payment will be paid to public acute care safety-net hospitals who serve as the primary teaching hospitals for the state's two (2) public medical schools, University of Missouri – Columbia School of Medicine and University of Missouri – Kansas City School of Medicine. The payment will be for the difference between IME payments paid under the DRG methodology and one hundred percent (100%) of allowable funds. The payment will be calculated as follows:

(A) IME add-on amount = wage adjusted rate x IME factor;

1. Wage adjusted rate is defined in 13 CSR 70-15.010(6)(G)4.A.(I)(a); and

2. IME factor is defined in 13 CSR 70-15.010(6)(G)3.C.

(B) Case-mix index as defined in subsection (1)(B).

(C) Claim count: FFS and MC paid claims from the second prior SFY.

1. Example: SFY 2026 IME payment will utilize SFY 2024 claim counts.

2. Future updates will utilize FFS and MC paid claims from the second full prior calendar year (i.e., for SFY 2027 beginning July 1, 2026, calendar year 2024 paid claims will be utilized).

(D) Formula: IME add-on amount x case-mix index x claim count.

(E) The hospital's IME payment will be calculated for each eligible hospital at the beginning of each SFY. The annual amount will be processed on a quarterly basis during the SFY.

(11) Children's Outlier (CO) Payment. Effective for discharges on or after July 1, 2025, children's outlier payments will no longer be made.

(A) The outlier year is based on a discharge date between July 1 and June 30.

(B) Beginning July 1, 2022, for fee-for-service claims only, outlier payments 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 federal disproportionate share hospital (DSH) requirements in paragraph (10)(B)1. and for MO HealthNet-eligible infants under the age of one (1) will be made to any other Missouri Medicaid hospital.

1. The following criteria must be met to be eligible for outlier payments 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; and

B. As determined from the base year audited Medicaid cost report, the hospital 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) (including such patients who receive benefits through a managed care entity) 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;

$$MIUR = TMD / TNID$$

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) 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.

$$LIUR = ((TMPR + CS) / (TNR + CS)) + ((CC - CS) / THC)$$

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 federal DSH requirements, a MO HealthNet-eligible child under the age of six (6) years, as of the date of discharge; and

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

(I) The total reimbursable charges for dates of service must be at least one hundred fifty percent (150%) of the sum of claim payments for each claim; or

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

3. Claims eligible for outlier review must –

A. Have been submitted in their entirety for claims processing;

B. The claim must have been paid; and

C. An annual outlier file, for paid claims only, must be submitted to the division no later than December 31 of the second calendar year following the end of the outlier year (i.e., claims for outlier year 2022 are due no later than December 31, 2024).

4. After the review, reimbursable costs for each claim will be determined using the following data from the audited Medicaid hospital cost report for the year ending in the same calendar year as the outlier year (i.e., Medicaid hospital cost reports ending in 2022 will be used for the 2022 outlier 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; and

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

5. The outlier payments will be determined for each hospital as follows:

A. Sum all reimbursable costs for all eligible outlier claims to equal total reimbursable costs;

B. Subtract total claim payments, which includes MO HealthNet claims payments, third-party payments, and co-pays, from total reimbursable costs to equal excess cost; and

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

(12) Safety Net Hospitals.

(A) Inpatient hospital providers may qualify as a safety-net hospital based on the following criteria. Hospitals shall qualify for a period of only one (1) SFY and must requalify at the beginning of each SFY to continue their safety-net hospital designation:

1. As determined from the most recent DSH survey for the MIUR and LIUR and from the base year cost report for the licensed beds and the occupancy rate —

A. A public non-state governmental acute care hospital with a LIUR of at least twenty percent (20%), a MIUR greater than one (1) standard deviation from the mean, 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 DSH qualifications;

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

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

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

(A) The other Medicaid payments, if applicable, shall be —

1. Combined under the surviving hospital's Medicaid provider number for the remainder of the SFY in which the merger occurred; and

2. Calculated for subsequent SFYs based on the combined data from the base year cost report for each facility.

(14) 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.

(15) Directed Payments. Effective July 1, 2022, the Missouri Medicaid managed care organizations shall make inpatient and outpatient directed payments to in-state in-network hospitals pursuant to 42 CFR 438.6(c) as approved by the Centers for Medicare & Medicaid Services.

AUTHORITY: sections 208.201 and 660.017, RSMo 2016, and sections 208.152 and 208.153, RSMo Supp. 2025. 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. Emergency amendment filed Aug. 26, 2021, effective Sept. 10, 2021, expired March 8, 2022. Amended: Filed Aug. 26, 2021, effective March 30, 2022. Emergency amendment filed June 14, 2022, effective July 1, 2022, expired Feb. 23, 2023. Amended: Filed June 14, 2022, effective Jan. 30, 2023. Emergency amendment filed June 20, 2025, effective July 7, 2025, expired Feb. 26, 2026. Amended: Filed June 23, 2025, effective Jan. 30, 2026.*

**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, 2021, 2023, 2024, 2025; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012, 2024; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

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;

(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; and

(Y) Written Request. A notice to the address of the provider as listed in the MO HealthNet Division's system, in writing, transmitted via the U.S. mail or other private or common carrier, facsimile, e-mail, or any other method/mode of transmittal that is deemed by MO HealthNet to be an efficient, cost-effective, verifiable, and a reliable method or mode of communication with the provider, applying provider, or provider's representative.

(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: sections 208.201 and 660.017, RSMo 2016. 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. Amended: Filed Jan. 7, 2022, effective July 30, 2022.*

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

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

(1) 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 is included in the MO HealthNet exempt diagnosis table, which 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/pdf/Exempt-Diagnosis-Table.pdf, November 9, 2021. All other admissions require certification per 13 CSR 70-15.020. This rule does not incorporate any subsequent amendments or additions.

(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, and at its website at https://dss.mo.gov/mhd/, November 9, 2021. 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. 2021, and sections 208.153 and 208.201, RSMo 2016. 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 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. Amended: Filed Jan. 10, 2022, effective July 30, 2022.*

**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, 2021; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012; and 208.201, RSMo 1987, amended 2007.*

13 CSR 70-15.040 Hospital Outpatient Settlements

PURPOSE: This regulation defines the specific procedures used to calculate the final outpatient settlements for hospital providers.

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. This regulation defines the specific procedures used to calculate outpatient settlements for Missouri in-state hospitals participating in the Missouri Medicaid program. Outpatient settlements are only determined for new hospitals and nominal charge providers.

(A) The hospital's settlement will be determined after the division receives a Medicare cost report 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 Centers for Medicare and Medicaid Services (CMS) 2552-10, 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 charges used to determine the cost, and the payments used to determine the final settlement, will be from the division's paid claims data for reimbursable services paid on a percentage basis under 13 CSR 70-15.160(1)-(2). This data includes only claims on which Medicaid made payment.

(C) Pursuant to 13 CSR 70-15.160(5), effective for dates of service beginning July 20, 2021, payment for outpatient hospital services will be final, with no cost settlement.

(2) Definitions.

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

(B) 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.

(C) 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.

(D) New hospitals. A hospital which does not have a fourth prior year cost report necessary for establishment of a prospective rate will have final settlement calculated for their initial three (3) cost report periods.

(E) Nominal charge provider. A nominal charge provider must meet one (1) of 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. 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%); or

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

(F) Division. Unless otherwise designated, division refers to the MO HealthNet Division (MHD) a division of the Department of Social Services charged with the administration of the MO HealthNet program.

(G) Incorporation 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 https://manuals.momed.com/manuals, September 10, 2021. This rule does not incorporate any subsequent amendments or additions; and

2. 42 CFR part 413, which is incorporated by reference and made a part of this rule as published by the Office of the Federal Register, 800 North Capitol St. NW, Suite 700, Washington, DC 20408, and available at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413?toc=1, November 1, 2021. This rule does not incorporate any subsequent amendments or additions.

(3) Hospital Outpatient Settlements will be calculated as follows:

(A) The hospital's Medicaid outpatient cost will be determined by multiplying the overall outpatient cost-to-charge ratio, determined in accordance with paragraph (3)(A)1. of this rule, by the Medicaid charges from subsection (1)(B) of this rule. To this product will be added the Medicaid outpatient share of Direct Graduate Medical Education (GME) to arrive at the total outpatient Medicaid cost. The GME will be determined during the Medicaid cost report audit. The Medicaid payments from subsection (1)(B) will be substracted from the total outpatient Medicaid cost to determine the final overpayment or underpayment.

1. The overall outpatient cost-to-charge ratio will be determined by multiplying the outpatient charges for each ancillary cost center, excluding Provider Based Rural Health Clinic (PBRHC) or Provider Based Federally Qualified Health Centers (PBFQHC), on worksheet C part I column 7 by the appropriate cost-to-charge ratio from worksheet C part I column 9 to determine the outpatient cost for each cost center. 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.

(4) Under no circumstances will the division accept amended cost reports for final settlement determination or adjustment after the date of the division's notification of the final settlement amount.

AUTHORITY: sections 208.153, 208.201, and 660.017, RSMo 2016, and sections 208.152 and 208.471, RSMo Supp. 2021. 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. Amended: Filed Sept. 22, 2021, effective April 30, 2022.*

**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, 2021; 208.153, RSMo 1967, amended 1973, 1989, 1990, 1991, 2007, 2012; 208.201, RSMo 1987, amended 2007; 208.471, RSMo 1992, amended 2001, 2014, 2018; and 660.017, RSMo 1993, amended 1995.*

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

PURPOSE: This rule provides the legal basis where inpatient 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 publication of the entire text of the material that is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

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

(A) Under the direction of a physician; and

(B) In a psychiatric hospital facility or an inpatient psychiatric program in a hospital, either of which is accredited by a national organization whose psychiatric hospital accrediting program has been approved by Centers for Medicare & Medicaid Services (CMS) or is licensed by the hospital licensing authority of Missouri; or

(C) In a psychiatric residential treatment facility (PRTF) that is operated as a public institution by the Missouri Department of Mental Health (DMH) and is exempt from the hospital licensing law, that is accredited by the Joint Commission, the Council on Accreditation, The Commission on Accreditation of Rehabilitation Facilities, Det Norske Veritas (DNV) or equivalent organization, and is certified as complying with the requirements at 42 CFR 441 subpart D and the condition of participation at 42 CFR 483 subpart G by the designated state

agency for which such authority has been authorized; or

(D) In a privately operated PRTF that is accredited by the Joint Commission, the Council on Accreditation, the Commission on Accreditation of Rehabilitation Facilities, Det Norske Veritas (DNV), or equivalent organization, and is certified as complying with the requirements at 42 CFR 441 subpart D and the condition of participation at 42 CFR 483 subpart G by the designated state agency for which such authority has been authorized; and

(E) 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) Reimbursement for inpatient psychiatric services, as provided for in this rule, shall be made as follows:

(A) For psychiatric hospitals and inpatient psychiatric programs within general hospitals, reimbursement will be calculated in accordance with the provisions for inpatient hospital care reimbursement at 13 CSR 70-15.010;

(B) For state-operated PRTF services for individuals under the age of twenty-one (21), reimbursement will be calculated as follows:

1. The MO HealthNet Division shall reimburse state-operated PRTFs for services based on the individual participant's days of care multiplied by the facility's Title XIX per diem rate less any payments made by participants;

2. The per diem for a state-operated PRTF is calculated as follows:

A. Determine the total costs from the second prior year hospital cost report (i.e., FY 2021 per diem rate is based off the hospital's 2019 cost report) for PRTF services;

B. Trend the total cost of the state operated PRTF by the Hospital Market Basket 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;

C. Determine the total PRTF patient days from the DMH Customer Information Management, Outcomes and Reporting (CIMOR) system for the second prior year to correspond with the hospital cost report; and

D. Divide the trended cost as determined in subparagraphs (2)(B)2.A. and (2)(B)2.B. of this rule by the total patient days as determined in subparagraph (2)(B)2.C. of this rule to arrive at the state-operated PRTF per diem; and

3. The per diem is updated each state fiscal year using the second prior year cost report;

(C) For private PRTF services for individuals under the age of twenty-one (21), reimbursement will be calculated as follows:

1. Effective for dates of service on or after September 29, 2021, the division will reimburse private PRTFs on a prospective per diem rate. The prospective Missouri private PRTF per diem rate was created using a wage rate model which utilized data derived from cost surveys prepared and submitted by potential PRTF providers. These cost surveys were collected February 2021 or prior. The model specifically examines potential facility, occupancy, staff to patient ratios, necessary nursing hours per patient day, direct care and behavioral health professional wage and overhead expense, and risk factors. For a detailed breakdown of these calculations, see https://dss.mo.gov/mhd/cs/psych/pdf/mo-prtf-wage-rate-build-model.pdf. The Missouri Prospective PRTF Rate Methodology document 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, on its website at https://dss.mo.gov/mhd/cs/psych/pdf/mo-prtf-wage-rate-build-model.pdf, October 1, 2021. This rule does not incorporate any subsequent amendments or additions. The per diem rate is included in the MO HealthNet Division (MHD) fee schedule, which 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, August 13, 2021. This rule does not incorporate any subsequent amendments or additions; and

(D) For state-operated and private PRTFs, medical leave days and therapeutic leave days will be paid to the PRTF at fifty percent (50%) of the per diem rate. Medical leave days include inpatient hospital medical/surgical stays and inpatient hospital psychiatric stays. Five (5) days of leave are allowed for medical/surgical stays per treatment episode, and five (5) days of leave are allowed for inpatient psychiatric stays per treatment episode. Therapeutic leave is for purposes of transition from the PRTF to the designated placement and must be included in the participant's plan of care. Ten (10) days of leave are allowed for therapeutic leave per treatment episode.

(3) 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.

(4) 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 that –

1. Includes a physician;

2. Has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and

3. Has knowledge of the individual's situation;

(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 (5). 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 (5) within fourteen (14) days after admission.

(5) 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 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 behavioral health disorders, and a psychologist who has a master's degree or doctorate in clinical psychology and is licensed.

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

1. A psychiatric social worker who is licensed;

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

3. An occupational therapist who is licensed and who has specialized training or one (1) year of experience in treating individuals with behavioral health disorders; or

4. A psychologist who has a master's degree or doctorate in clinical psychology and is licensed.

(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.

(6) Inpatient psychiatric services shall include active treatment which means implementation of a professionally developed and supervised individual plan of care, as described in section (7), that meets the following requirements:

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

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

(7) An individual plan of care is a written plan developed for each participant 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 participant's situation and reflects the need for inpatient psychiatric care;

(B) Be developed by a team of professionals specified under section (5) in consultation with the participant, 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 participant's family, school, and community upon discharge; and

(F) Be reviewed every thirty (30) days by the treatment facility interdisciplinary team specified in section (5) 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 participant's overall adjustment as an inpatient.

(8) Before admission or before authorization for payment, the team described in section (4) of this rule must make medical, psychiatric, and social evaluations of each applicant's or participant's need for care in the hospital or PRTF. 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 or continued care in the hospital or PRTF for individuals who apply for Medicaid after admission.

(9) Audits to monitor facility or program compliance shall be performed by a medical review agent as authorized by the MO HealthNet Division. Inpatient admissions of July 1, 1991, and after 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 facility 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 is reviewed for quality of care;

(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 a nationally recognized, evidence-based clinical tool;

(E) If the medical record documentation regarding the patient's condition and planned services meet the criteria in subsection (9)(D) of this rule, the services are approved by either the nurse or social worker reviewer;

(F) If the criteria in subsection (9)(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 facility shall be notified. The facility may request of the medical review agent a reconsideration review. The facility 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) Facilities are notified by the MO HealthNet Division 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 or PRTF setting in accordance with 13 CSR 70-15.010;

2. No Medicaid payment shall be made on behalf of any participant 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: sections 208.201 and 660.017, RSMo 2016. 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. Emergency amendment filed Aug. 13, 2021, effective Sept. 29, 2021, expired March 27, 2022. Amended: Filed Aug. 13, 2021, effective March 30, 2022. Amended: Filed May 17, 2023, effective Dec. 30, 2023. Emergency amendment filed Dec. 16, 2025, effective Dec. 31, 2025, expired June 28, 2026. Amended: Filed Dec. 16, 2025, effective July 30, 2026.*

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

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.

(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 year cost report – Audited Medicaid cost report from the third prior calendar year. If a hospital has more than one (1) cost report with periods ending in the third 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 year cost report is less than or greater than a twelve- (12-) month period, the data shall be adjusted, based on the number of days reflected in the base year cost report, to a twelve- (12-) month period. Any changes to the base year cost report after the division issues a final decision on assessment will not be included in the calculations.

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 zero percent (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 2023 =
(a) Inpatient Adjusted Net Revenues – 3.8%
(b) Outpatient Adjusted Net Revenues – 0%
(II) SFY 2024 =
(a) Inpatient Adjusted Net Revenues – 0%
(b) Outpatient Adjusted Net Revenues – 0%
(III) SFY 2025 =
(a) Inpatient Adjusted Net Revenues – 0%
(b) Outpatient Adjusted Net Revenues – 0%
(IV) SFY 2026 =
(a) Inpatient Adjusted Net Revenues – 4.5%
(b) Outpatient Adjusted Net Revenues – 0%

(B) Each hospital engaging in the business of providing 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 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 60-50.470. 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. 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.

3. 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.

4. 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 and 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 additional payments from 13 CSR 70-15.010, 13 CSR 70-15.015, 13 CSR 70-15.220, and 13 CSR 70-15.230 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.

(2) The FRA assessment shall not exceed six percent (6%) of the inpatient adjusted net revenues and outpatient adjusted net revenues.

(A) Beginning July 1, 2022, the FRA assessment shall be determined at a rate of five and four-tenths percent (5.40%) 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.

(B) Beginning July 1, 2023, the FRA assessment shall be determined at a rate of four and eight-tenths percent (4.80%) 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.

(C) Beginning July 1, 2024, the FRA assessment shall be determined at a rate of four and two-tenths percent (4.20%) 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.

(D) Beginning July 1, 2025, the FRA assessment shall be determined at a rate of five percent (5.0%) 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. Emergency amendment filed Aug. 26, 2021, effective Sept. 10, 2021, expired March 8, 2022. Amended: Filed Aug. 26, 2021, effective April 30, 2022. Emergency amendment filed June 15, 2022, effective July 1, 2022, expired Feb. 23, 2023. Amended: Filed June 15, 2022, effective Jan. 30, 2023. Emergency amendment filed June 15, 2023, effective June 30, 2023, expired Dec. 26, 2023. Amended: Filed June 28, 2023, effective Feb. 29, 2024. Emergency amendment filed July 26, 2024, effective Aug. 9, 2024, expired Feb. 27, 2025. Amended: Filed July 26, 2024, effective Feb. 28, 2025. Emergency amendment filed June 20, 2025, effective July 7, 2025, expired Feb. 26, 2026. Amended: Filed June 23, 2025, effective Jan. 30, 2026.

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

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

(A) Definitions. The following definitions will be used in administering section (1) 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 Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, December 20, 2024. 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 42 *Code of Federal Regulations* (CFR) 485.606(b), which is incorporated by reference in this rule as published by U.S. Government Publishing Office, U.S. Superintendent of Documents, Washington, DC 20402, October 1, 2023. This rule does not incorporate any subsequent amendments or additions;

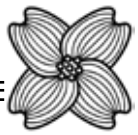
7. HCPCS. The national uniform coding method maintained by the Centers for Medicare & Medicaid Services (CMS) that incorporates the American Medical Association (AMA) Physicians CPT and the three (3) HCPCS unique coding levels I, II, and III;

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 (1)(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 third 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 twenty



percent (20%) 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 of 2000 (BIPA); 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 (1)(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, August 5, 2025. 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 (1)(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 (1)(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 Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, January 9, 2025. 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 OPPS *Addendum A* effective as of January 1 of each year as published by the CMS for Medicare OPPS), 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 OPPS *Addendum A* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, January 9, 2025. 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 OPPS *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 & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, January 9, 2025. 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 & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, January 10, 2025. 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 & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, December 17, 2024. 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 2025 *National Dental Advisory Service* (NDAS). The 2025 NDAS is incorporated by reference and made a part of this rule as published by Wasserman Medical & Dental, PO Box 510949, Milwaukee, WI 53203, January 2, 2025. 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, May 5, 2025. 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, May 5, 2025. 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, May 5, 2025. 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, May 5, 2025. 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 (1)(B)2. for each billed procedure code; and

6. Nominal charge providers will receive an additional forty percent (40%) of the rate as determined in paragraph (1)(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 OPPS *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 OPPS *Addendum D1* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, November 24, 2024. 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 OPPS *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) Multiple procedure discounting. Effective for dates of service beginning July 1, 2024, MHD applies multiple procedure discounting for those procedure codes identified as "Procedure or Service, Multiple Procedure Reduction Applies" under Medicare OPPS *Addendum D1*. These procedures are paid separately but are discounted when two (2) or more services are billed on the same date of service. Procedure codes considered for the multiple procedure reduction under the OSFS exclude dental procedures. The multiple procedure claim line with the highest allowed amount is priced at one hundred percent (100%) of the maximum allowed amount. The second and subsequent covered procedures are priced at fifty percent (50%) of the maximum allowed amount. The Medicare OPPS *Addendum D1* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, November 24, 2024. This rule does not incorporate any subsequent amendments or additions.

(H) Modifier 50 bilateral procedure pricing. Effective for dates of service beginning July 1, 2024, MHD applies bilateral procedure pricing for those procedure codes identified on the Medicare *National Physician Fee Schedule Relative Value File* with an indicator of one (1) under the BILAT SURG column. These procedures may be subject to a payment adjustment when billed with modifier 50 and performed bilaterally on both sides of the body at the same operative session. Claim lines appropriately billed with these bilateral procedures and modifier 50 are priced at one hundred fifty percent (150%) of the maximum allowed amount for a single code. The Medicare *National Physician Fee Schedule Relative Value File* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, January 10, 2025. This rule does not incorporate any subsequent amendments or additions.

(I) 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.

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

(2) Outpatient Rate Adjustment.

(A) Rate Adjustment.

1. A rate adjustment may be requested by in-state federally deemed critical access hospitals under this subsection for changes in outpatient allowable costs related to building a new replacement hospital. The effective date for any increase granted under this subsection shall be no earlier than the first day of the month following the division's final determination of the rate adjustment.

A. In-state federally deemed critical access hospitals that build a new replacement hospital and incur costs associated with the new hospital may request an outpatient rate adjustment. A rate adjustment request for projects requiring certificate of need (CON) review must include a copy of the CON program approval.

B. An in-state federally deemed critical access hospital will have six (6) months after the new hospital is completed and open to the public to submit a request for outpatient rate adjustment, along with a budget of the project's costs. The rate adjustment request, the project's budget, and any other documentation related to the replacement building's costs shall be provided to MHD. Upon completion of MHD's review, the hospital's outpatient reimbursement rate may be adjusted, if indicated. Failure to submit a request for rate adjustment and project budget within the six- (6-) month period shall disqualify the hospital from receiving a rate increase.

C. Rate adjustments due to building a new hospital will be determined as the increase in capital and operating costs multiplied by the ratio of total Medicaid outpatient costs to total hospital costs as submitted on the most recent audited cost report as of the review date divided by the FFS Medicaid outpatient payments from the audited cost report. This percentage increase will be multiplied by the current critical access hospital outpatient increase and the result added to the current outpatient increase to determine the new increase to the fee schedule amounts. The increase will be limited to twenty-five percent (25%) of the critical access hospital outpatient increase and will be limited to thirty (30) years.

2. The request for a rate adjustment must be submitted in writing to the division and must specifically and clearly identify the project and the total dollar amount involved. The total dollar amount must be supported by generally accepted accounting principles. The hospital will be notified of the division's decision in writing 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.

AUTHORITY: sections 208.201 and 660.017, RSMo 2016, and sections 208.152 and 208.153, RSMo Supp. 2025. 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. Emergency amendment filed June 13, 2022, effective July 1, 2022, expired Feb. 23, 2023. Amended: Filed June 13, 2022, effective Jan. 30, 2023. Emergency amendment filed June 15, 2023, effective June 30, 2023, expired Dec. 26, 2023. Amended: Filed July 13, 2023, effective Jan. 30, 2024. Emergency amendment filed Oct. 16, 2024, effective Oct. 30, 2024, expired April 27, 2025. Amended: Filed Oct. 16, 2024, effective May 30, 2025. Emergency amendment filed June 20, 2025, effective July 7, 2025, expired Feb. 26, 2026. Amended: Filed June 23, 2025, effective Jan. 30, 2026.

**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, 2021, 2023, 2024, 2025; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012, 2024; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

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 participant 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 according to subsections (2)(A) or (2)(B) for services provided outside Missouri if the services are covered by the Missouri Medicaid Program. To be reimbursed for furnishing services to Missouri Medicaid participants, out-of-state hospitals must complete a Missouri Medicaid Program Provider Participation Application and have the application approved by the Missouri Department of Social Services, Missouri Medicaid Audit and Compliance (MMAC).

(A) The payment for authorized inpatient hospital services provided by an out-of-state free-standing psychiatric hospital shall be the lowest of —

1. The hospital's per diem rate, which will be the weighted statewide average per diem rate for Missouri free-standing psychiatric hospitals as calculated by the MO HealthNet Division for the State Fiscal Year (SFY) in which the service was provided; or

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

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

(B) The payment for authorized inpatient hospital services provided by an out-of-state hospital, except for free-standing psychiatric hospitals, shall be calculated using an All Patient Refined Diagnosis Related Groups (APR DRG) reimbursement methodology as described in 13 CSR 70-15.010(6).

(3) The payment for authorized outpatient hospital services provided by an out-of-state hospital shall be the lower of —

(A) The outpatient reimbursement as described in 13 CSR 70-15.160; or

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

(4) Disproportionate Share Hospital (DSH) Payments. Out-of-state hospitals do not qualify for DSH payments.

(5) Definitions.

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

(B) Out-of-state is defined as not within the physical boundaries of Missouri.

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

AUTHORITY: sections 208.201 and 660.017, RSMo 2016. Original rule filed April 15, 2004, effective Oct. 30, 2004. Emergency amendment filed June 16, 2022, effective July 1, 2022, expired Feb. 23, 2023. Amended: Filed June 16, 2022, effective Jan. 30, 2023. Emergency amendment filed June 20, 2025, effective July 7, 2025, expired Feb. 26, 2026. Amended: Filed June 23, 2025, effective Jan. 30, 2026.*

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

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 (DSH) 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 publication of the entire text of the material that is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) General Reimbursement Principles.

(A) In order to receive federal financial participation (FFP), disproportionate share hospital (DSH) 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 DSH 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 & 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 defined per 42 CFR 447.299(c)(6), (7), and (10) and 42 CFR 447.295. 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.

1. The estimated Medicaid net cost shall be trended as set forth in subsection (2)(Y).

(D) Estimated uninsured uncompensated care cost. Estimated uninsured uncompensated care cost is defined per 42 CFR 447.295 and 42 CFR 447.299(c)(12)–(15).

1. The estimated uninsured uncompensated care cost shall be trended as set forth in subsection (2)(Y).

(E) 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.

(F) Hospital DSH liability. The hospital DSH liability is the amount of DSH overpayments subject to recoupment as determined from the final annual independent DSH audit. It is the lesser of the total longfall or the DSH payments paid for the SFY.

(G) 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.

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

1. 42 CFR Chapter IV, Part 447, as published by the Office of the Federal Register, 800 North Capitol St. NW, Suite 700, Washington, DC 20408, October 1, 2024. This rule does not incorporate any subsequent amendments or additions;

2. 42 CFR Chapter IV, Part 455, as published by the Office of the Federal Register, 800 North Capitol St. NW, Suite 700, Washington, DC 20408, October 1, 2024. This rule does not incorporate any subsequent amendments or additions;

3. The state DSH survey template and instructions as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, April 22, 2025. This rule does not incorporate any subsequent amendments or additions; and

4. The alternate state DSH survey supplemental template and instructions as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, May 21, 2025. This rule does not incorporate any subsequent amendments or additions.

(I) Individuals without health insurance or other third-party coverage for the services received.

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 are 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 for the inpatient or outpatient hospital services they received during the year are considered uninsured and included in calculating the hospital-specific DSH limit.

3. The following costs shall be considered uninsured and included in calculating the hospital-specific DSH limit:

A. Costs for services provided to 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 hospital services are considered uninsured costs; and

B. Costs for services provided to 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 costs, as long as the benefits were exhausted when the patient was admitted; and

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. Unpaid balances due for claims denied by the third-party payer for billing discrepancies, which include but are not limited to denials due to lack of pre-authorization, denials due to timely filing, denials due to lack of medical necessity, etc.; and

C. 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 federal DSH audit regulation changes. The division reserves the right to determine whether changes in federal DSH audit regulation will be applied to the interim DSH payment calculations.

(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 for inpatient and outpatient hospital services (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 state DSH survey, 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 inpatient services attributable to charity care (CC) less inpatient cash subsidies (ICS) directly received from state and local governments in the same period, divided by the total amount of the hospital's inpatient 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.

$$LIUR = ((TMPR + CS) / (TNR + CS)) + ((CC - ICS) / (THC))$$

(O) Medicaid inpatient utilization rate (MIUR). The MIUR shall be calculated as follows:

1. As determined from the state DSH survey, the MIUR will be expressed as the ratio of total Medicaid eligible inpatient hospital days (TMID) provided under a state plan divided by the provider's total number of inpatient hospital 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 = TMID / 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 Medicaid Cost Report is completed using the Medicare Cost Report form CMS 2552, using the Medicare cost reporting methodologies. Based on these methodologies, the costs included in the DSH payment calculation will reflect the Medicaid and uninsured portion of total allowable hospital 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 cost 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 any non-claim specific Medicaid payment made to a hospital for inpatient or outpatient hospital services including but not limited to Direct Medicaid, acuity adjustment payment, poison control payment, stop loss payment, graduate medical education (GME), children's outliers, cost settlements, and upper payment limit (UPL) payments, if applicable, will be included 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 for inpatient and outpatient hospital services (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, and other Medicaid payments.

(W) State DSH survey. Beginning with SFY 2017, 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 2019 independent DSH audit will also be used to calculate the interim DSH payment for SFY 2023). 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) Uninsured revenues. Payments received on a cash basis that are required per 42 CFR 455.301 through 42 CFR 455.304 and 42 CFR 447.299 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) Interim DSH Payments.

(A) Beginning with SFY 2013, interim DSH payments shall be calculated on an annual basis and will be based on the state's calculations using data provided in the state DSH survey for the applicable SFY, and estimated other Medicaid payments calculated by the division in accordance with 13 CSR 70-15.010, 13 CSR 70-15.015, and 13 CSR 70-15.230 for the applicable SFY.

(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 the division in accordance with 13 CSR 70-15.010, 13 CSR 70-15.015, and 13 CSR 70-15.230;

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. This includes federally deemed hospitals that do not have uncompensated care costs to justify the receipt of an interim DSH payment. 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. If the request is approved by the division, the hospital must submit all necessary data elements to the independent DSH auditor in order to be included in the audit and eligible for final DSH payment adjustments.

(D) Disproportionate share payments will coincide with the semimonthly claim payment schedule.

(E) New facilities that do not have a Medicare/Medicaid cost report on which to base the state DSH survey will be paid the estimated hospital-specific DSH limit less OOS DSH payments based on the estimated state DSH survey.

(F) 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 (3)(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.

(G) Interim DSH payment adjustments.

1. To minimize hospital longfalls, interim DSH payments made to hospitals will be revised if changes to federally mandated DSH audit standards are enacted during a SFY, updated for Medicaid expansion until it is captured in the required state DSH survey, or any changes in Medicaid reimbursement until it is captured in the required state DSH survey. These revisions are to serve as interim adjustments until the federally mandated DSH audits are complete. DSH audits are finalized three (3) years following the SFY year-end reflected in the audit. For example, the SFY 2019 DSH audit will be finalized in calendar year (CY) 2022.

(4) Department of Mental Health (DMH) Hospitals DSH Adjustments and Payments.

(A) Beginning in SFY 2026, the DMH hospitals interim DSH payments will be calculated in accordance with subsection (3)(B). Additional adjustments may be done based on the results of the federally mandated DSH audits as set forth below in subsection (5)(A).

(5) 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 2022 DSH payments will be made following the completion of the annual independent DSH audit in 2025 (SFY 2026).

(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 September 30 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 in excess of the amount able to be redistributed 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;

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;

6. 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 IMD hospitals that are under their projected 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; and

7. Bankrupt-liquidation or closed hospitals are not eligible for final DSH redistributions or unspent allotment payments.

(6) State DSH Survey Reporting Requirements.

(A) Beginning in SFY 2016, each hospital must complete and submit the state DSH survey set forth in subsection (2)(W) (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 (3)(E).

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. If the request is approved by the division, the hospital must submit all necessary data elements to the independent DSH auditor in order to be included in the audit and eligible for final DSH payment adjustments.

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 (6)(A)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.

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 (6)(A)5.D.

C. The interim DSH payment based on the applicable alternate data shall be calculated 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 (6)(A)5.C.(I) and (II). The allocation percentage calculated at the beginning of the SFY year as set forth in part (3)(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) 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 (6)(A)5.D.(I)(a)I.-IV. 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 God (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 subsection (2)(W) 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 (6)(A)5.D.(I)(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 (6)(A)5.D.(II)(a)-(c). The requests relating to extraordinary circumstances received after the March 1 deadline will be included with the interim DSH payment adjustments requests in part (6)(A)5.D.(II) in distributing the unobligated DSH allotment and available state funds remaining for the SFY;

(II) Interim DSH payment adjustment.

(a) 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.

(b) 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.

(c) 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; and

(III) If a provider received an exception that allows it to use alternate data for interim DSH payment purposes under paragraph (6)(A)5. in the prior SFY, it may continue to use alternate data for its interim DSH payment until the required state DSH survey reflects the annual impact of the change. The alternate state DSH survey supplemental schedule should be used until the most recent cost report on file with the division reflects the annual impact of the change. Both the required state DSH survey and the applicable alternate data must be submitted to the independent DSH auditor and the division no later than March 1 preceeding the beginning of each SFY for which the interim DSH payment is being made.

AUTHORITY: sections 208.158, 208.201, and 660.017, RSMo 2016, and sections 208.152 and 208.153, RSMo Supp. 2025. 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. Emergency amendment filed June 16, 2022, effective July 1, 2022, expired Feb. 23, 2023. Amended: Filed June 16, 2022, effective Jan. 30, 2023. Amended: Filed Jan. 18, 2024, effective Aug. 30, 2024. Emergency amendment filed June 20, 2025, effective July 8, 2025, expired Feb. 26, 2026. Amended: Filed June 23, 2025, effective Jan. 30, 2026.*

**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, 2021, 2023, 2024, 2025; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012, 2024; 208.158, RSMo 1967; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

13 CSR 70-15.230 Upper Payment Limit (UPL) Payment Methodology

PURPOSE: This rule establishes a methodology for determining Upper Payment Limit (UPL) payments provided to state government-owned hospitals beginning July 1, 2022.

(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 SFY 2023, state government-owned hospitals will be paid an interim payment semi-monthly up to the estimated inpatient (IP) UPL gap.

(A) Prior to each SFY, the division shall calculate the estimated Medicaid payments for the coming SFY for each hospital. The total estimated Medicaid payments for each hospital shall be subtracted from the hospital's IP UPL calculated in accordance with the methodology set forth below, then summed to calculate the IP UPL gap. The IP UPL gap is reduced by the estimated inpatient fee-for-service Graduate Medical Education (GME) payments for the coming SFY for each hospital to calculate the total amount of funding available. The previous SFY's payments are compared to current SFY's estimated claims-based payments and when the estimated current year payments are less than prior year payments, that hospital is eligible for a UPL payment. The available IP UPL gap is distributed to each eligible hospital based on the percent to total of the available room in the prior year and current year comparison. The available gap under the IP UPL for each eligible hospital will be aggregated to create the supplemental payment amount. The total calculated supplemental payment amount will be paid to eligible hospitals.

1. The IP UPL will be determined based on the hospital's Medicaid inpatient costs using Medicare cost reporting

principles. All Medicare cost report worksheet, column, or line references are based upon the Medicare Cost Report (MCR) CMS 2552-10 and should be adjusted for any CMS-approved successor MCR. The amount that Medicare would pay shall be calculated as follows:

A. Using Medicare cost report data within the previous two (2) years of the IP UPL demonstration dates in accordance with IP UPL guidelines set by CMS, Total Medicare Costs shall be derived from the reported Inpatient Hospital Cost on the following cost report variable locations:

(I) Worksheet D-1, Hospital/IPF/IRF Components, Column 1, Line 49;

(II) Plus Organ Acquisitions Cost from all applicable Worksheets D-4, Column 1, Line 69; and

(III) Plus GME Aggregated Approved Amount from Worksheet E-4, Column 1, Line 49;

B. Total Medicare Patient Days shall be derived from Worksheet S-3, Part I, Column 6, Lines 14, 16, and 17 of the same cost report as the Total Medicare Costs;

C. A calculated Medicare Cost *Per Diem* shall be calculated by dividing the Total Medicare Costs by the hospital's Total Medicare Patient Days;

D. The calculated Medicare Cost *Per Diem* shall be multiplied by the total Medicaid Patient Days from a twelve-(12-) month data set from the prior two (2) years of the IP UPL demonstration dates in accordance with the IP UPL guidelines set by CMS to derive the hospital's IP UPL.

(I) The data source for the Medicaid Patient Days and Total Medicaid Payments shall be from the state's Medicaid Management Information System (MMIS) claims data;

E. The calculated IP UPL shall be inflated from the midpoint of the hospital's cost report period to the midpoint of the IP UPL demonstration period using the CMS Prospective Payment System (PPS) hospital market basket index; and

F. If payments in this section would result in payments to any category of hospitals in excess of the IP UPL calculation required by 42 CFR 447.272, payments for each eligible hospital receiving payments under this section will be reduced proportionately to ensure compliance with the IP UPL.

(3) Beginning with SFY 2026, state government-owned hospitals will be paid a final payment up to the final IP UPL gap.

AUTHORITY: sections 208.201 and 660.017, RSMo 2016, and sections 208.152 and 208.153, RSMo Supp. 2025. Emergency rule filed May 20, 2011, effective July 1, 2011, expired Dec. 28, 2011. Original rule filed May 20, 2011, effective Jan. 30, 2012. Emergency amendment filed June 14, 2022, effective July 1, 2022, expired Feb. 23, 2023. Amended: Filed June 14, 2022, effective Jan. 30, 2023. Emergency amendment filed July 26, 2024, effective Aug. 9, 2024, expired Feb. 27, 2025. Amended: Filed July 26, 2024, effective Feb. 28, 2025. Amended: Filed Aug. 18, 2025, effective March 30, 2026.*

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