TITLE 13 – DEPARTMENT OF SOCIAL SERVICES
Division 70 – MO HealthNet Division
Chapter 15 – Hospital Program

EMERGENCY AMENDMENT

13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Methodology. The division is amending sections (1)–(9) and removing sections (10)–(16).

PURPOSE: This emergency amendment adds the All-Patient Refined Diagnosis Related Group (APR-DRG) payment methodology, updates the per diem payment methodology, adds and updates some definitions, and removes supplemental payments.

*EMERGENCY STATEMENT: The Department of Social Services (DSS), MO HealthNet Division (MHD) finds that this emergency amendment is necessary to preserve a compelling governmental interest as it allows the State Medicaid Agency to reimburse Missouri hospitals under the APR-DRG payment methodology beginning July 1, 2025. It is a compelling government interest to reimburse Missouri hospitals under the APR-DRG methodology because it allows DSS to reimburse based on patient characteristics such as: severity of illness, risk of mortality, and resource intensity. The APR-DRG reimbursement methodology incentivizes Missouri hospitals to provide cost-efficient care, which contributes to a financially sustainable Medicaid program. These Medicaid payments allow hospitals to provide sufficient medical care to Medicaid participants. Additionally, components of the payment methodology are calculated on an annual state fiscal year basis. This requires that the new payment system be in effect beginning July 1, 2025. Failure to do so would likely result in significant underpayment or overpayment to Missouri hospitals. As a result, the MHD finds a compelling governmental interest in providing these payments to hospitals beginning July 1, 2025, which requires an early effective date. A proposed amendment, which covers the same material, will be published in an upcoming issue of the **Missouri Register**. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended by the **Missouri** and **United States Constitutions**. The MHD believes this emergency amendment to be fair to all interested parties under the circumstances. The emergency amendment was filed June 23, 2025, effective July 8, 2025, and expires February 26, 2026.*

(1) General Reimbursement Principles.

(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 *[per diem]* reimbursement *[is]* **methodologies are** established in accordance with sections (4)**,** *[and]* (5)**, and (6)**.

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

[3. Acuity adjustment payment (AAP) is established in accordance with section (6).

4. Poison control (PC) payment is established in accordance with section (7).

5. Stop loss payment (SLP) is established in accordance with section (8).] **3. Supplemental payments, graduate medical education (GME) payments, and Psych adjustment payments are established in accordance with 13 CSR 70-15.015.**

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

[7. Graduate medical education (GME) payment is established in accordance with section (9).]

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

[9. Children's outlier (CO) payment is established in accordance with section (10).

10. Psych adjustment (PA) payment is established in accordance with section (11).]

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

(2) Definitions.

[(D) Case mix index (CMI). The hospital CMI for the AAP is determined based on the hospital's MO HealthNet inpatient claims and 3MTM 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 State Fiscal Year (SFY) 2023, each hospital's CMI was calculated as follows:

A. A dataset of complete inpatient stays was established using MO HealthNet fee-for-service claims and managed care encounters combined for calendar years 2019 and 2020. A two-(2-) year dataset was used to account for the potential impact of changes to hospital utilization, costs, and mix of patients due to the COVID-19 public health emergency;

B. Interim claims where multiple claims cover a single inpatient stay were combined into single claims covering the complete inpatient stay;

C. The 3MTM APR-DRG grouping software was applied to the inpatient dataset, using version 38 of the grouper. Each inpatient stay was assigned to a single DRG and severity of illness level. Each APR-DRG is associated with a relative weight reflecting the relative amount of resources required to care for similar stays, compared to an average inpatient stay. APR-DRG weights are provided by 3MTM and are calculated based on a national all-payer population;

D. The national weights were recentered to reflect the average resource requirements within the MO HealthNet population, including both fee-for-service and managed care encounter inpatient stays. Recentered weights are calculated by dividing the APR-DRG national weights by the average case mix for all hospitals. The average case mix is calculated as the sum of the national weights for each inpatient stay divided by the number of stays for all hospitals;

E. A hospital-specific CMI is calculated by summing the MO HealthNet recentered weights for each inpatient stay and dividing the total by the number of inpatient stays for the hospital.

2. For SFY 2024 and forward, the basis of the case mix index will be determined by the division based on combined inpatient stays from the second and third prior calendar years, the current version of the 3MTM APR-DRG grouper, relative weights appropriate for the MO HealthNet population, and the SFY in which an AAP is being calculated.]

*[(E)]***(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.

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

*[(G)]***(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.

*[(H)]***(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 is a numerical value that reflects the relative resource intensity or costliness of treating patients within a specific DRG compared to the average inpatient case.

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

1. The *Hospital 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://mydss.mo.gov/media/pdf/hospital-manual, June 27, 2024]***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, which is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services (CMS) *[at its website https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935]***, 7500 Security Boulevard, Baltimore, MD, 21244**, February 21, 2024. This rule does not incorporate any subsequent amendments or additions; *[and]*

3. 42 CFR **Chapter IV, Part** 413, which is incorporated by reference and made a part of this rule as published by the *[U.S. Government Publishing Office and available at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413?toc=1, June 8, 2022]* **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 IP APR-DRG Calculator 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, July 1, 2025. This rule does not incorporate any subsequent amendments or additions;

5. Medicare IPPS FY 2025 Table 2 Case-Mix Index and Wage Index Table by CMS Certification Number (CCN) as published by the CMS for Medicare IPPS. The Medicare IPPS FY 2025 Table 2 Case-Mix Index and Wage Index Table by CMS Certification Number (CCN) 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, October 2, 2024. This rule does not incorporate any subsequent amendments or additions; and

6. Medicare IPPS FY 2025 Table 3 Wage Index Table by CBSA as published by the CMS for Medicare IPPS. The Medicare IPPS FY 2025 Table 3 Wage Index Table by CBSA 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, October 2, 2024. This rule does not incorporate any subsequent amendments or additions.

(4) Inpatient *Per Diem* Reimbursement *[Rate Computation]* **Methodology**. Effective for **admit** dates *[of service]* beginning July 1, *[2022]* **2025**, *[each]* **the** Missouri hospital**s 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 *[based on the following computation:]* **as calculated in subsection (4)(B).**

(A) **Hospitals that 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 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 hundred percent (100%) of the SFY 2022 weighted average statewide per diem rate for private free-standing psychiatric hospitals]* **one thousand one hundred ninety-four dollars and twenty-two cents ($1,194.22)** or the *per diem* as calculated in subsection (4)*[(A)]* **(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 hospital's 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)(C) and](4)(D)]* **and (4)(E)**;

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);

*[(B)]***(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;

*[(C)]***(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)(D);

*[(D)]***(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)(A). 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 *[of service]* beginning July 1, *[2022]* **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) 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 acute care hospitals until a prospective rate is determined on the hospital's rate setting cost report, in accordance with section (4).]

*[(B)]***(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 *[weighted average statewide]* **maximum** *per diem* rate for **a** free-standing psychiatric hospital*[s]*, excluding the state psychiatric hospitals, until a prospective rate is determined on the hospital's rate setting cost report, in accordance with section (4).

*[(C)]***(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).

*[(D)]***(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) Acuity Adjustment Payment (AAP).

(A) Beginning with SFY 2023, hospitals that 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. Ownership type of the hospital is determined based on the type of control reported on Schedule S-2, Part I, Line 21, Column 1 of the hospital's base year cost report. 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) Private ownership. 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. If the hospital's estimated Medicaid FFS claims payments for the coming SFY plus the preliminary AAP exceeds the hospital's SFY 2023 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 SFY 2023 Medicaid FFS payments received. If no reduction is necessary, the preliminary AAP shall be considered final.

(C) Non-state government owned or operated (NSGO) ownership. 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. If the hospital's estimated Medicaid FFS claims payments for the coming SFY plus the preliminary AAP exceeds the hospital's SFY 2023 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 SFY 2023 Medicaid FFS payments received. If no reduction is necessary, the preliminary AAP shall be considered final.

(D) 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.]

(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).

(I) 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.

(I) Will receive a two thousand five-hundred-dollar ($2,500) rate add-on to their base rate.

B. In-state federally deemed CAHs.

(I) 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.

(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) 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 and MC days for the SFY for which the PC payment is being calculated. The estimated Medicaid FFS and MC days are paid days from the second prior calendar year; 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.

(8) Stop Loss Payment (SLP).

(A) Beginning with SFY 2023 hospitals that meet the requirements set forth below shall receive an SLP. Ownership type of the hospital is determined based on the type of control reported on Schedule S-2, Part I, Line 21, Column 1 of the hospital's base year cost report. 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) Private ownership. 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 SFY 2023 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 (8)(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. Privately owned 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 SFY 2023 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 (8)(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 (8)(B)2., the hospital will not receive any additional payments.

(C) NSGO ownership. 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 SFY 2023 Medicaid FFS payments received then summed to calculate a total increase or decrease in payments for the entire NSGO 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 NSGO 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 (8)(C). 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 NSGO ownership group.

(D) 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.

(9) Medicaid Graduate Medical Education (GME) Payments. Effective 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 paragraph 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 facility PRA's with the following criteria:

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

(D) 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) Children's Outlier (CO) Payment.

(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 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;

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; and

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%).

(11) Psych Adjustment (PA) Payment.

(A) Beginning with SFY 2024, 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 11.770, RSMo, 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 (11)(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.

(12) Safety Net Hospitals.

(A) A hospital 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. The hospital must meet the specific obstetric requirements set forth in 13 CSR 70-15.220(1)(B)1.;

2. As determined from the audited base year cost report, the facility must have either—

A. A Medicaid inpatient utilization rate (MIUR) at least one (1) standard deviation above the state's mean MIUR for all Missouri hospitals. The MIUR will be expressed as the ratio of total Medicaid days (TMD) (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 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

B. A low-income utilization rate in excess of twenty-five percent (25%).

(I) The low-income utilization rate (LIUR) shall be the sum (expressed as a percentage) of the fractions, calculated as follows:

(a) Total Medicaid patient revenues (TMPR) paid to the hospital for patient services under a state plan (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) 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, etc.) for patient services plus the cash subsidies; and

(b) The total amount of the hospital's charges for patient services attributable to charity care (CC) less cash subsidies 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 charity care shall not include any contractual allowances and discounts other than for indigent patients not eligible for medical assistance under a state plan.

LIUR = ((TMPR + CS) / (TNR + CS)) + ((CC – CS) / THC); and

3. As determined from the audited base year cost report—

A. A public non-state governmental acute care hospital with an LIUR of at least twenty percent (20%) and an 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

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

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

*[(13)]***(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.

[(B) 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)]***(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.

*[(15)]***(9)** Inappropriate Placements.

(A) The hospital *[per diem rate]* **inpatient reimbursement** as determined under this plan *[and in effect on October 1, 1981]*, shall not apply to any participant who is receiving inpatient hospital care when 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.

[(16) 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. 2024. This rule was previously filed as 13 CSR 40-81.050. Original rule filed Feb. 13, 1969, effective Feb. 23, 1969. For intervening history, please consul the ***Code of State Regulations****. Emergency amendment filed June 23, 2025, effective July 8, 2025, expired Feb. 26, 2026. An emergency amendment covering the same material will be published in the Aug. 1, 2025, issue of the* ***Missouri Register****.*

PUBLIC COST: This emergency amendment will cost state agencies or political subdivisions approximately $27.8 million in the time the emergency amendment is effective.

PRIVATE COST: This emergency amendment will cost private entities approximately $225.4 million in the time the emergency amendment is effective.

FISCAL NOTE
PUBLIC COST

I. **Department Title:** 13 Social Services
Division Title: 70 MO HealthNet Division
Chapter Title: 15 Hospital Program

Rule Number and Title:	13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Methodology
Type of Rulemaking:	Emergency Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Other Government (Public) Hospitals enrolled in MO HealthNet - 39	**Net Estimated Cost for 6 months of SFY 2026: $27.8 million**
Department of Social Services, MO HealthNet Division	**Net Estimated Cost for 6 months of SFY 2026: $0**

III. WORKSHEET

Other Government (Public) Hospitals Impact			
Estimated Cost for 6 months of SFY 2026			
Estimated Cost to Public Hospitals	$27,645,809	$0	$27,645,809
Estimated Cost to State Hospitals	$1,298,107	$1,113,318	$184,789
Total Estimated Cost Impact	$28,943,915	$1,113,318	$27,830,597
State Share Percentage	35.3425%	35.3425%	35.3425%
State Share	$10,229,503	$393,474	$9,836,029

Department of Social Services, MO HealthNet Division Impact			
Estimated Savings for 6 months of SFY 2026			
	FRA Fund	IGT Fund	Total
Estimated Savings to MHD	$254,331,039	$1,113,318	$253,217,721
State Share Percentage	35.3425%	35.3425%	35.3425%
State Share	$89,886,947	$393,474	$89,493,473

IV. ASSUMPTIONS

The following regulations are impacted by the change to the hospital reimbursement methodology and the impact of all the regulations should be netted to arrive at the total impact. The net impact is a cost to the state of $25.6 million for 6 months of SFY 2026.

13 CSR 70-15.010
13 CSR 70-15.015

The net fiscal impact is estimated based on the DRG modeling and updates to the data used to calculate the inpatient per diems. There was an increase in the FRA tax rate which increased the inpatient per diems. There was also an increase to the minimum per diem for free-standing psychiatric hospitals.

FISCAL NOTE
PRIVATE COST

I. Department Title: 13 Social Services
Division Title: 70 MO HealthNet Division
Chapter Title: 15 Hospital Program

Rule Number and Title:	13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Methodology
Type of Rulemaking:	Emergency Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
In-state Hospitals – 94	**In-state Private Hospitals enrolled in MO HealthNet**	**Net Estimated Cost for 6 months of SFY 2026: $225.4 million**

III. WORKSHEET

Private Hospitals Impact	
Estimated Cost for 6 months of SFY 2026	
	Total
Estimated Cost to Private Hospitals	$225,387,123
SFY 2026 Blended FMAP	35.3425%
State Share	$79,657,444

IV. ASSUMPTIONS

The following regulations are impacted by the change to the hospital reimbursement methodology and the impact of all the regulations should be netted to arrive at the total impact. The net impact is a cost to the state of $25.6 million for 6 months of SFY 2026.

13 CSR 70-15.010
13 CSR 70-15.015

The net fiscal impact is estimated based on the DRG modeling and updates to the data used to calculate the inpatient per diems. There was an increase in the FRA tax rate which increased the inpatient per diems. There was also an increase to the minimum per diem for free-standing psychiatric hospitals.