EMERGENCY RULE

13 CSR 70-15.015 Direct Medicaid Payments

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

EMERGENCY STATEMENT: The Department of Social Services, MO HealthNet Division (MHD) finds that this emergency rule is necessary to preserve a compelling governmental interest as it allows the State Medicaid Agency to pay hospital providers the per diem rate and Direct Medicaid Payment. These payments provide hospitals the ability to provide sufficient medical care to Medicaid participants and the uninsured. An early effective date is required because this emergency rule establishes the Federal Reimbursement Allowance (FRA) funded hospital payments for dates of service beginning July 1, 2020 in regulation to ensure that quality health care continues to be provided to MO HealthNet participants and indigent patients at hospitals that have relied on MO HealthNet payments to meet those patients’ needs. The division uses the best information available for the trend for the upcoming state fiscal year by using the trend published in the First Quarter Healthcare Cost Review publication, which is generally not available until May. The division must also analyze hospital data, which are not complete until near the end of the state fiscal year, in conjunction with the trend and funding to determine the appropriate level of payments. Without this information, the trends cannot be determined; therefore, due to timing of the receipt of this information and the necessary July 1, 2020 effective date, an emergency regulation is necessary. As a result, the MHD finds it necessary to preserve its compelling governmental interest in providing these payments to hospital providers, which requires an early effective date. If this emergency rule is not enacted, there will be significant cash flow shortages causing a financial strain on Missouri hospitals which serve approximately nine hundred seventy-one thousand (971,000) MO HealthNet participants plus the uninsured. This financial strain, in turn, will result in an adverse impact on the health and welfare of MO HealthNet participants and uninsured individuals in need of medical treatment. This emergency rule limits its scope to the circumstances creating the emergency and complies with the protections extended by the Missouri and United States Constitutions. The MHD believes this emergency rule to be fair to all interested parties under the circumstances. The emergency rule was filed April 30, 2020, becomes effective May 15, 2020, and expires February 24, 2021.

(1) Direct Medicaid Qualifying Criteria.

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

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

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

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

   MIUR = \frac{TMD}{TNID}

   or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Direct Medicaid Payments.

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Effective for payments made on or after July 1, 2018, the estimated MO HealthNet patient days for the SFY shall be determined by adjusting the FFS days from the state’s MMIS for the second prior Calendar Year (CY) (i.e., for SFY 2019, second prior CY would be 2017) by:

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

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

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

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

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

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

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

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

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

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

A. Effective for payments made on or after May 1, 2017, only the Fee-for-Service and Out-of-State components of the MO HealthNet share of both the inpatient and outpatient FRA assessment will be included in the Direct Medicaid add-on payment.
(IV) The difference between the FFS days and the FFS days factored up by the FFS days’ percentage are the managed care days.

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

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

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

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

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

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

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

E. The trended cost per day is calculated by trend the base year costs per day by the trend indices as defined in 13 CSR 70-15.010 (3)(B)1., using the rate calculation in 13 CSR 70-15.010 (3)(A).

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

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

3. The minimum utilization costs for capital and medical education is calculated by determining the difference in the hospital’s cost per day when applying the minimum utilization, as identified in 13 CSR 70-15.010 (5)(C)4., and without applying the minimum utilization. The difference in the cost per day is multiplied by the estimated MO HealthNet patient days for the SFY;

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

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

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

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

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

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

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

3. The number of beds for the new hospital without the base cost report shall be multiplied by the average Direct Medicaid Payment per bed to determine the hospital’s estimated Direct Medicaid Payment for the current state fiscal year; and

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

5. A facility previously enrolled for participation in the MO HealthNet Program, which either voluntarily or involuntarily terminates its participation in the MO HealthNet Program and which reenters the MO HealthNet Program, shall have its Direct Medicaid Payments determined in accordance with 13 CSR 70-15.010 (3)(B)4.

AUTHORITY: sections 208.153, 208.201, and 660.017, RSMo 2016, and section 208.152, RSMo Supp. 2019. This rule was previously filed as part of 13 CSR 70-15.010. Emergency rule filed April 30, 2020, effective May 15, 2020, expires Feb. 24, 2021. An emergency rule and a proposed rule covering this same material will be published in the June 1, 2020, issue of the Missouri Register.

PUBLIC COST: For SFY 2021, this emergency rule may save the state approximately $21.2 million (State Share: $7 million FRA and $345 thousand IGT for DMH) in the time the emergency is effective. For SFY 2021, this proposed rule may cost public entities $4.3 million in the time the emergency is effective.

PRIVATE COST: For SFY 2021, this emergency rule may cost private entities $38.1 million in the time the emergency is effective.
## Emergency Rules

### FISCAL NOTE
PUBLIC COST

<table>
<thead>
<tr>
<th>Rule Number and Title:</th>
<th>13 CSR 70-15.015 Direct Medicaid Payments</th>
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</thead>
<tbody>
<tr>
<td>Type of Rulemaking:</td>
<td>Emergency Rule</td>
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### SUMMARY OF FISCAL IMPACT

<table>
<thead>
<tr>
<th>Affected Agency or Political Subdivision</th>
<th>Estimated Cost of Compliance in the Aggregate</th>
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</thead>
<tbody>
<tr>
<td>Department of Social Services, MO HealthNet Division</td>
<td>SFY 2021 Impact (6 months): Total Cost – ($21.2) million</td>
</tr>
<tr>
<td></td>
<td>State Share (FRA Fund) – ($7) million</td>
</tr>
<tr>
<td></td>
<td>State Share (IGT Fund for DMH) = ($345) thousand</td>
</tr>
<tr>
<td>Other Government (Public) &amp; State Hospitals enrolled in MO HealthNet (40)</td>
<td>The estimated cost for SFY 2021 - $2.2 million</td>
</tr>
</tbody>
</table>

### WORKSHEET

#### Department of Social Services, MO HealthNet Division Savings:

**Estimated Savings for 6 Months of SFY 2021:**

<table>
<thead>
<tr>
<th>Estimated Savings</th>
<th>FRA Fund</th>
<th>IGT Fund for DMH</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments with days change</td>
<td>$431,705,452</td>
<td>$5,646,366</td>
<td>$437,351,817</td>
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<tr>
<td>Payments without days change</td>
<td>$451,929,321</td>
<td>$6,637,622</td>
<td>$458,566,942</td>
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<tr>
<td>Impact of days change</td>
<td>($20,223,869)</td>
<td>($991,256)</td>
<td>($21,215,125)</td>
</tr>
<tr>
<td>State Share Percentage</td>
<td>34.868%</td>
<td>34.868%</td>
<td>34.868%</td>
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<tr>
<td>State Share</td>
<td>($7,051,558)</td>
<td>($345,626)</td>
<td>($7,397,184)</td>
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</table>

#### Other Government (Public) & State Hospitals:

**Estimated Costs for 6 Months of SFY 2021:**

<table>
<thead>
<tr>
<th>Estimated Costs</th>
<th>FRA Fund</th>
<th>IGT Fund for DMH</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments with days change</td>
<td>$65,439,707</td>
<td>$5,646,366</td>
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<tr>
<td>Payments without days change</td>
<td>$66,626,421</td>
<td>$6,637,622</td>
<td>$73,264,043</td>
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<td>Impact of days change</td>
<td>($1,186,715)</td>
<td>($991,256)</td>
<td>($2,177,971)</td>
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<tr>
<td>State Share Percentage</td>
<td>34.868%</td>
<td>34.868%</td>
<td>34.868%</td>
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<tr>
<td>State Share</td>
<td>($413,778)</td>
<td>($345,626)</td>
<td>($759,404)</td>
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IV. ASSUMPTIONS

The estimated cost is based upon the data in FRA 20-3 with adjustments to the base days. The base year for the SFY 2021 fee for service (FFS) days used for the SFY 2021 Direct Medicaid payments are calendar year 2019 days from the MMIS system. The percentage of managed care (MC) days to the total of FFS days plus MC days is from either the 2017 or 2018 cost report based on whether the hospital was in a MC extension region or a psychiatric hospital. However, these assumptions will change for SFY 2021 due to revenue and cost factors that are unknown at the time this regulation was filed.
Emergency Rules

FISCAL NOTE
PRIVATE COST

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

<table>
<thead>
<tr>
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</table>

II. SUMMARY OF FISCAL IMPACT

<table>
<thead>
<tr>
<th>Estimate of the number of entities by class which would likely be affected by the adoption of the rule:</th>
<th>Classification by types of the business entities which would likely be affected:</th>
<th>Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:</th>
</tr>
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<tbody>
<tr>
<td>In-state hospitals - 100</td>
<td>Private Hospitals enrolled in MO HealthNet</td>
<td>The estimated cost for SFY 2021 - $19 million</td>
</tr>
</tbody>
</table>

III. WORKSHEET

Private In-State Hospitals:
Estimated Costs for 6 Months of SFY 2021:

<table>
<thead>
<tr>
<th>Estimated Payments with days change</th>
<th>FRA Fund</th>
<th>IGT Fund for DMH</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Payments without days change</td>
<td>$366,265,745</td>
<td>$0</td>
<td>$366,265,745</td>
</tr>
<tr>
<td>Estimated Impact of days change</td>
<td>($19,037,155)</td>
<td>$0</td>
<td>($19,037,155)</td>
</tr>
</tbody>
</table>

State Share Percentage: 34.868%
State Share: ($6,637,780) $0 ($6,637,780)

IV. ASSUMPTIONS

The estimated cost is based upon the data in FRA 20-3 with adjustments to the base days. The base year for the SFY 2021 fee for service (FFS) days used for the SFY 2021 Direct Medicaid payments are calendar year 2019 days from the MMIS system. The percentage of managed care (MC) days to the total of FFS days plus MC days is from either the 2017 or 2018 cost report based on whether the hospital was in a MC extension region or a psychiatric hospital. However, these assumptions will change for SFY 2021 due to revenue and cost factors that are unknown at the time this regulation was filed.