

# Emergency Rule

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

### EMERGENCY AMENDMENT

**13 CSR 70-15.230 [Supplemental] Upper Payment Limit (UPL) Payment Methodology.** The division is amending the title and section (2).

*PURPOSE:* This emergency amendment establishes a methodology for determining Upper Payment Limit (UPL) payments provided to State Government owned hospitals beginning July 1, 2022.

*EMERGENCY STATEMENT:* This emergency amendment allows the Department of Social Services, MO HealthNet Division (MHD) to make Upper Payment Limit (UPL) Payments to only State Government owned hospitals. This emergency amendment is necessary to preserve a compelling governmental interest as it allows the State Medicaid Agency to pay State Government owned hospitals a supplemental payment to cover the costs of Medicaid services provided to Missouri participants. As a result, the MHD finds a compelling governmental interest in providing these payments to State Government owned hospitals by July 1, 2022, which requires an early effective date. 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 14, 2022, effective July 01, 2022, and expires February 23, 2023.

(2) [Beginning with State Fiscal Year 2012, each participating hospital may be paid supplemental payments up to the Medicare Upper Payment Limit (UPL).] Beginning with SFY 2023, State Government owned hospitals will be paid a semi-monthly payment up to the inpatient (IP) UPL gap.

(A) [UPL Payment. Supplemental payments may be paid to qualifying hospitals for inpatient services. The total amount of supplemental payments made under this section in each year shall not exceed the Medicare Upper Payment Limit, after accounting for all other supplemental payments. Payments under this section will be determined prior to the determination of payments under subsection (2)(B) below authorizing Medicaid UPL Supplemental Payments for Low Income and Needy Care Collaboration hospitals.] 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 to 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 available IP UPL gap is distributed to each hospital based on the hospital's percent of estimated Medicaid payments for the coming SFY to total estimated payments for the coming SFY for all state government owned hospitals. 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 state shall determine the amount of Medicaid supplemental payments payable under this section on an annual basis. The state shall calculate the Medicare Upper Payment Limit for each of the three (3) categories of hospi-

tals: state hospitals, non-state governmental hospitals, and private hospitals. The state shall apportion the Medicaid supplemental payments payable under this section to each of the three (3) categories of hospitals based on the proportionate Medicare Upper Payment Limits for each category of hospitals.] 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 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

(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 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 PPS hospital market basket index.

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 C.F.R 447.272, payments for each eligible hospital receiving payments under this section will be reduced proportionately to ensure compliance with the IP UPL.

[2. Each participating hospital may be paid its proportional share of the UPL gap based upon its Medicaid inpatient utilization.

(B) Supplemental Payments for Low Income and Needy Care Collaboration Hospitals. Additional Supplemental Payments for Low Income and Needy Collaboration Hospitals may be made if there is room remaining under the UPL to make additional payments without exceeding the UPL, after making the UPL payments in subsection (2)(A) above.

1. Effective for dates of services on or after July 1, 2011, supplemental payments may be issued to qualifying hospitals for inpatient services after July 1, 2011. Maximum aggregate payments to all qualifying hospitals under this section shall not exceed the available Medicare Upper Payment Limit, less all other Medicaid inpatient payments to private hospitals under this State Plan which are subject to the Medicaid Upper Payment Limit.

2. Qualifying criteria. In order to qualify for the supplemental payment under this section, the private hospital must be affiliated with a state or local governmental entity through

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a Low Income and Needy Care Collaboration Agreement. The state or local governmental entity includes governmentally-supported hospitals.

A. A private hospital is defined as a hospital that is owned or operated by a private entity.

B. A Low Income and Needy Care Collaboration Agreement is defined as an agreement between a private hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.

C. Reimbursement methodology. Each qualifying private hospital may be eligible to receive supplemental payments. The total supplemental payments in any fiscal year will not exceed the lesser of—

(I) The difference between each qualifying hospital's inpatient Medicaid billed charges and Medicaid payment the hospital receives for covered inpatient services for Medicaid participants during the fiscal year; or

(II) For hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) program, the difference between the hospital's specific DSH cap and the hospital's DSH payments during the fiscal year.

D. Payments under this section will be determined after the determination of payments under subsection (2)(A) above authorizing Medicaid UPL supplemental payments.]

**AUTHORITY:** sections [208.152,] 208.153, and 208.201, and 660.017, RSMo 2016, and section 208.152, RSMo Supp. [2010] 2021. 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, expires Feb. 23, 2023. An emergency amendment and a proposed amendment covering this same material will be published in the July 15, 2022, issue of the *Missouri Register*.

**PUBLIC COST:** This emergency amendment is estimated to cost the state approximately \$12.5 million (State Share: \$3.7 million FRA and \$566 thousand IGT for DMH) in the time the emergency is effective. This emergency amendment is estimated to increase payments to state entities by approximately \$12.5 million in the time the emergency is effective.

**PRIVATE COST:** This emergency amendment will not cost private entities more than five hundred dollars (\$500) in the time the emergency is effective.

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## FISCAL NOTE PUBLIC COST

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

<b>Rule Number and Name:</b>	13 CSR 70-15.230 Upper Payment Limit (UPL) Payment Methodology
<b>Type of Rulemaking:</b>	Emergency Amendment

### II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
State Hospitals enrolled in MO HealthNet - 6	Estimated impact for 6 months of SFY 2023: \$12.5 million
Department of Social Services, MO HealthNet Division	Estimated cost for 6 months of SFY 2023: Total \$12.5 million; State Share \$3.7 million (FRA) State Share \$566 thousand (IGT)

### III. WORKSHEET

<b>Other Government (Public) &amp; State Hospitals Impact:</b>			
<b>Estimated Cost for 6 Months of SFY 2023:</b>			
	FRA Fund	IGT Fund	Total
Estimated Impact to State Hospitals	\$10,788,980	\$1,661,580	\$12,450,560
Estimated Impact to Other Government (Public) Hospitals	\$0	\$0	\$0
<b>Total Estimated Impact</b>	<b>\$10,788,980</b>	<b>\$1,661,580</b>	<b>\$12,450,560</b>
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share	\$3,673,917	\$565,810	\$4,239,727
<b>Department of Social Services, MO HealthNet Division Cost:</b>			
<b>Estimated Cost for 6 Months of SFY 2023:</b>			
	FRA Fund	IGT Fund	Total
Estimated Cost	\$10,788,980	\$1,661,580	\$12,450,560
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share Cost	\$3,673,917	\$565,810	\$4,239,727

Updated 01/31/2021

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## 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 \$3.8 million for 6 months of SFY 2023.

13 CSR 70-15.010

13 CSR 70-15.015

13 CSR 70-15.220

13 CSR 70-15.230

The fiscal impact is estimated based on historical utilization and enrollment. Other variables such as the length of the Federal Public Health Emergency and Medicaid Expansion enrollment may indirectly affect the hospital utilization both positively and negatively. Due to the uncertainty of these variables, the state will continue to monitor the impacts to the Managed Care Organizations and hospitals.

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## FISCAL NOTE PRIVATE COST

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## II. SUMMARY OF FISCAL IMPACT

<b>Estimate of the number of entities by class which would likely be affected by the adoption of the rule:</b>	<b>Classification by types of the business entities which would likely be affected:</b>	<b>Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:</b>
<b>In-State Hospitals – 0</b>	<b>Private Hospitals enrolled in MO HealthNet</b>	<b>Estimated impact for 6 months of SFY 2023: \$0 million</b>

## III. WORKSHEET

N/A

## IV. ASSUMPTIONS

There is no estimated impact to in-state private hospitals since this regulation is only for payments made to state owned or operated hospitals.