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Rebecca McDowell Cook

Secretary of State

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Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule.

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The rules are codified in the *Code of State Regulations* in this system—

Title	*Code of State Regulations*	Division	Chapter	Rule
1	CSR	10-	1.	010
Department		Agency, Division	General area regulated	Specific area regulated

They are properly cited by using the full citation , i.e., 1 CSR 10-1.010.

Each department of state government is assigned a title. Each agency or division in the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraph 1., subparagraph A., part (I), subpart (a), item I. and subitem a.

RSMo—Cite material in the RSMo by date of legislative action. The note in parentheses gives the original and amended legislative history. The Office of the Revisor of Statutes recognizes that this practice gives users a concise legislative history.

Rules appearing under this heading are filed under the authority granted by section 536.025, RSMo Supp. 1999. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons and findings which support its conclusion that there is an immediate danger to the public health, safety or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

Rules filed as emergency rules may be effective not less than ten days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the *Missouri Register* as soon as practicable.

All emergency rules must state the period during which they are in effect, and in no case can they be in effect more than 180 calendar days or 30 legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 15—Hospital Program

ORDER TERMINATING EMERGENCY AMENDMENT

By the authority vested in the Division of Medical Services under sections 208.152, 208.153, 208.201 and 208.471, RSMo 1994, the division hereby terminates an emergency amendment effective May 4, 2000, as follows:

13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Plan; Outpatient Hospital Services Reimbursement Methodology **is terminated**.

A notice of emergency rulemaking containing the text of the emergency amendment was published in the *Missouri Register* on December 15, 1999 (24 MoReg 2938–2939). This emergency amendment was superseded by Final Order of Rulemaking 13 CSR 70-15.010(3) and (18) which became effective April 30, 2000.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 15—Hospital Program

EMERGENCY AMENDMENT

13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Plan; Outpatient Hospital Services Reimbursement Methodology. The division is amending sections (15), (18), and (21).

PURPOSE: The amendment to section (15) provides for using a base year cost report that is the most representative of costs for safety net hospitals, the amendment to section (18) adjusts the percent of uninsured costs paid for SFY 2000 and the amendment to section (21) provides for an add-on payment to all teaching hospitals for graduate medical education.

EMERGENCY STATEMENT: The Balanced Budget Act of 1997 and the Terms and Conditions of the Medicaid Section 1115 Health Care Reform Demonstration Project placed a limit on Federal Financial Participation made to Missouri for disproportionate share payments by establishing allotments for federal fiscal years (FFY) 1998 through 2002 and FFY 2003 and thereafter. In addition, for state fiscal year 2000 there are costs for Graduate Medical Education in Missouri's hospitals that are uncompensated. The Division of Medical Services finds that this emergency amendment is necessary, to preserve a compelling governmental interest requiring an early effective date in that the emergency amendment makes adjustments to the uninsured add-on payments for state fiscal year 2000 to ensure access to hospital services for indigent and Medicaid recipients at hospitals which have relied on disproportionate share payments in meeting those needs and to ensure adequate facilities for training doctors so there is access to hospital services for indigent and Medicaid recipients. The Division of Medical Services also finds an immediate danger to public health and welfare which requires emergency action. If this emergency amendment is not enacted it will cause significant cash flow shortages and financial strain on all hospitals who serve the more than 600,000 Medicaid recipients and uninsured and those hospitals that are involved in the training of doctors. This will, in turn, result in an adverse impact on the health and welfare of those in need of medical care and treatment. This emergency amendment limits its scope to the circumstances creating the emergency and complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions****. Therefore, the division believes this emergency amendment to be fair to all interested persons and parties under the circumstances. Emergency amendment filed May 1, 2000 effective May 11, 2000, expires November 6, 2000.*

(15) Direct Medicaid Payments.

(B) Direct Medicaid payment will be computed as follows:

1. The Medicaid share of the FRA assessment will be calculated by dividing the hospital's Medicaid patient days by total hospital's patient days to arrive at the Medicaid utilization percentage. This percentage is then multiplied by the FRA assessment for the current SFY to arrive at the increased allowable Medicaid costs;

2. The unreimbursed Medicaid costs are determined by subtracting the hospital's per-diem rate from its trended per-diem costs. The difference is multiplied by the estimated Medicaid patient days for the current SFY.

A. The trended cost per day is calculated by trending the base year operating costs per day by the trend indices listed in paragraph (3)(B)1., using the rate calculation in subsection (3)(A).

B. For hospitals that meet the requirements in paragraphs (6)(A)1., (6)(A)2. and (6)(A)4. of this rule (safety net hospitals), the base year cost report may be from the second prior year, the third prior year, or the fourth prior year, based on the determination of the Division of Medical Services exercising its sole discretion as to which report is most representative of costs incurred. For hospitals that meet the requirements in paragraphs (6)(A)1. and (6)(A)3. of this rule (first tier

Disproportionate Share Hospitals), the base year operating costs shall be based on the third prior year cost report. For all other hospitals, the base year operating costs are based on the fourth prior year cost report.

[B] **C**. 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 (15)(B)1., 3., 4., and 5.;

3. The minimum utilization costs for capital and medical education is calculated by determining the difference in the hospital's cost per day when applying the minimum utilization as identified in paragraph (5)(C)4., and without applying the minimum utilization. The difference in the cost per day is multiplied by the estimated Medicaid patient days for the SFY;

4. The utilization adjustment cost is determined by estimating the number of Medicaid inpatient days the hospital will not provide as a result of the MC+ 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 Medicaid days for the current SFY to arrive at the Medicaid utilization adjustment; and

5. The poison control cost shall reimburse the hospital for the prorated Medicaid managed care cost. It will be calculated by multiplying the estimated Medicaid share of the poison control costs by the percentage of MC+ recipients to total Medicaid recipients.

(18) In accordance with state and federal laws regarding reimbursement of unreimbursed costs and the costs of services provided to uninsured patients, reimbursement for each State Fiscal Year (SFY) (July 1–June 30) shall be determined as follows:

(B) Uninsured Add-Ons. The hospital shall receive *[eighty-one percent (81%)]* **eighty-four percent (84%)** of the Uninsured costs prorated over the SFY. Hospitals which contribute through a plan approved by the director of health to support the state's poison control center and the Primary Care Resource Initiative for Missouri (PRIMO) shall receive *[eighty-two percent (82%)]* **eighty-five percent (85%)** of its uninsured costs prorated over the SFY. The uninsured Add-On will include:

1. The Add-On payment for the cost of the Uninsured. This is determined by multiplying the charges for charity care and allowable bad debts by the hospital's total cost-to-charge ratio for allowable hospital services from the base year cost report's desk review. The cost of the Uninsured is then trended to the current year using the trend indices reported in subsection (3)(B). Allowable bad debts do not include the costs of caring for patients whose insurance covers the particular service, procedure or treatment;

2. An adjustment to recognize the Uninsured patients share of the FRA assessment not included in the desk-reviewed cost. The FRA assessment for Uninsured patients is determined by multiplying the current FRA assessment by the ratio of uninsured days to total inpatient days from the base year cost report;

3. The difference in the projected General Relief per-diem payments and trended costs for General Relief patient days;

4. The increased costs per day resulting from the utilization adjustment in subsection (15)(B) is multiplied by the estimated uninsured days; and

5. In order to maintain compliance with the Balanced Budget Act of 1997 (BBA) DSH cap and the budget neutrality provisions contained in Missouri's Medicaid Section 1115 Health Care Reform Demonstration Proposal, the Uninsured Add-On for SFY 2000 has been established at *[eighty-two percent (82%)]* **eighty-five percent (85%)** of the cost of the uninsured as computed in accordance with this subsection. *[One factor in determination of the payment percentage is an estimate that fifty-four ($54) million dollars shall be paid from July 1, 1999 thru April 30, 2000 related to previously uninsured parents covered under the Medicaid Section 1115 Health Care Reform Demonstration Proposal. The SFY 2000 payment percentage shall be increased by an additional one percent (1%) for every three point five ($3.5) million dollars increment not paid for parents covered under the Medicaid Section 1115 Health Care Reform Demonstration Proposal as of April 30, 2000. For example, if total spending on the Medicaid Section 1115 Health Care Reform Demonstration Proposal parent population is forty-seven ($47) million dollars, as of April 30, 2000, the Uninsured Add-On percentage from SFY 2000 shall be increased by two percent (2%).]*

(21) Enhanced Graduate Medical Education (GME) Payment—An enhanced GME payment shall be made to *[an]* **any** acute care hospital that provides graduate medical education (teaching hospital) *[if the hospital is a children's hospital or is a safety net hospital. A safety net hospital for purposes of this section is a hospital that has an unsponsored care ratio of at least sixty-five percent (65%) or the hospital is owned or operated by the Board of Curators as defined in Chapter 172, RSMo and the Missouri Rehabilitation Center created by Chapter 199, RSMo or their successors]*.

(A) The enhanced GME payment shall be *[fifty percent (50%) of the teaching hospital's remaining unreimbursed aggregate approved amount for direct GME.]* **computed in accordance with subsection (21)(B).** The payment shall be made at the end of the state fiscal year. The enhanced GME payment for each state fiscal year shall be computed using the most recent cost data *[available from the Medicare cost report]* available when the enhanced GME payment is computed. If the cost report is less than or more than a twelve (12)-month period, the cost report data will be adjusted to reflect a twelve (12)-month period. **The state share of the enhanced GME payment to a hospital that has cash subsidies shall come from funds certified by the hospital.**

(B) *[The remaining unreimbursed aggregated approved amount for direct GME shall be calculated by subtracting the current state fiscal year Medicare and Medicaid GME payments based on the Medicare methodology on worksheet E-3 Part IV from the Medicare cost report (HCFA 2552-96), the provisions of which are incorporated by reference and made part of this rule, from the total unreimbursed approved amount from direct GME. The Medicaid GME payments will include both non-managed care and managed care payments from the hospital's base year cost report trended forward.]* **The enhanced GME payment will be computed by first determining the percentage difference between the McGraw-Hill CPI index for hospital services and Medicare update factors applied to the per resident amounts from 1986 to the most recent SFY. For example, the percentage difference has been computed to be eighty-five and sixty-two-one-hundredth percent (85.62%) for SFY 2000. The percentage difference is than multipled by the Medicaid share of the aggregate approved amount reported on worksheet E-3 part IV of the Medicare cost report (HCFA 2552-96) for the fourth prior fiscal year and trended to the current state fiscal year. The resulting product is the enhanced GME payment.**

AUTHORITY: sections 208.152, 208.153, 208.201 and 208.471, RSMo 1994. 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 consult the ***Code of State Regulations****. Emergency amendment filed May 1, 2000, effective May 11, 2000, expires Nov. 6, 2000. A proposed rule covering some of this material is published in this issue of the* ***Missouri Register****.*