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SALUS POPULI SUPREMA LEX ESTO

"The welfare of the people shall be the supreme law."

ROBIN CARNAHAN

SECRETARY OF STATE

MISSOURI REGISTER

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Robin Carnahan

Administrative Rules Division
James C. Kirkpatrick State Information Center
600 W. Main
Jefferson City, MO 65101
(573) 751-4015

Director
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•

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•

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•

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•

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IN THIS ISSUE:

Register Filing Deadlines	Register Publication Date	Code Publication Date	Code Effective Date
April 2, 2012	**May 1, 2012**	May 31, 2012	June 30, 2012
April 16, 2012	**May 15, 2012**	May 31, 2012	June 30, 2012
May 1, 2012	**June 1, 2012**	June 30, 2012	July 30, 2012
May 15, 2012	**June 15, 2012**	June 30, 2012	July 30, 2012
June 1, 2012	**July 2, 2012**	July 31, 2012	August 30, 2012
June 15, 2012	**July 16, 2012**	July 31, 2012	August 30, 2012
July 2, 2012	**August 1, 2012**	August 31, 2012	September 30, 2012
July 16, 2012	**August 15, 2012**	August 31, 2012	September 30, 2012
August 1, 2012	**September 4, 2012**	September 30, 2012	October 30, 2012
August 15, 2012	**September 17, 2012**	September 30, 2012	October 30, 2012
September 4, 2012	**October 1, 2012**	October 31, 2012	November 30, 2012
September 17, 2012	**October 15, 2012**	October 31, 2012	November 30, 2012
October 1, 2012	**November 1, 2012**	November 30, 2012	December 30, 2012
October 15, 2012	**November 15, 2012**	November 30, 2012	December 30, 2012
November 1, 2012	**December 3, 2012**	December 31, 2012	January 30, 2013
November 15, 2012	**December 17, 2012**	December 31, 2012	January 30, 2013
December 3, 2012	**January 2, 2013**	January 29, 2013	February 28, 2013
December 17, 2012	**January 15, 2013**	January 29, 2013	February 28, 2013
January 2, 2013	**February 1, 2013**	February 28, 2013	March 30, 2013
January 15, 2013	**February 15, 2013**	February 28, 2013	March 30, 2013

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. To review the entire year's schedule, please check out the website at http://www.sos.mo.gov/adrules/pubsched.asp

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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 within 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—The most recent version of the statute containing the section number and the date.

Rules appearing under this heading are filed under the authority granted by section 536.025, RSMo 2000. 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 (10) 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 one hundred eighty (180) calendar days or thirty (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—MO HealthNet Division
Chapter 10—Nursing Home Program

EMERGENCY AMENDMENT

13 CSR 70-10.110 Nursing Facility Reimbursement Allowance. The division is adding subsection (2)(O).

PURPOSE: This amendment provides for a change in the Nursing Facility Reimbursement Allowance rate to twelve dollars and eleven cents ($12.11) effective for dates of service July 1, 2012.

EMERGENCY STATEMENT: The Department of Social Services, MO HealthNet Division finds that this emergency amendment is necessary to preserve a compelling governmental interest of collecting state revenue in order to provide nursing facility services to individuals eligible for the MO HealthNet nursing facility program. This emergency amendment changes the Nursing Facility Reimbursement Allowance (NFRA) rate from eleven dollars and seventy cents ($11.70) to twelve dollars and eleven cents ($12.11) effective July 1, 2012. This emergency amendment is necessary to generate additional state matching funds to pay nursing facilities an increased reimbursement rate, also effective July 1, 2012. An early effective date is required because the emergency amendment is necessary to establish the NFRA assessment rate for State Fiscal Year (SFY) 2013. The NFRA needs to be established in order to collect the state revenue to ensure funds are available to pay for nursing facility services for MO HealthNet participants in participating MO HealthNet nursing facilities with the funds appropriated for that purpose.

*This emergency amendment results in an additional NFRA assessment of $6,102,984 for SFY 2013 which yields additional payments of $16,014,127 to nursing facilities. The NFRA will raise approximately $180,261,322 annually. The MO HealthNet Division also finds an immediate danger to public health, safety, and/or welfare which require emergency actions. If this emergency amendment is not enacted, there would be significant cash flow shortages causing a financial strain on Missouri nursing facilities which service approximately twenty-four thousand (24,000) individuals eligible for the MO HealthNet nursing facility program. This financial strain, in turn, will result in an adverse impact on the health and welfare of MO HealthNet participants in need of nursing facility services. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. 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**. The MO HealthNet Division believes this emergency amendment to be fair to all interested parties under the circumstances. This emergency amendment was filed June 20, 2012, becomes effective July 1, 2012, and expires December 28, 2012.*

(2) NFRA Rates. The NFRA rates determined by the division, as set forth in **subsection** (1)(B) above, are as follows:

(M) Effective January 1, 2010, the NFRA will be nine dollars and twenty-seven cents ($9.27) per patient occupancy day. The applicable quarterly survey shall be as defined in subsection (2)(K); *[and]*

(N) Effective October 1, 2011, the NFRA will be eleven dollars and seventy cents ($11.70) per patient occupancy day. The applicable quarterly survey shall be as defined in subsection (2)(K)*[.]*; **and**

(O) Effective July 1, 2012, the NFRA will be twelve dollars and eleven cents ($12.11) per patient occupancy day. The applicable quarterly survey shall be as defined in subsection (2)(K).

*AUTHORITY: sections 198.401, 198.403, 198.406, 198.409, 198.412, 198.416, 198.418, 198.421, 198.424, 198.427, 198.431, 198.433, 198.436, and 208.159, RSMo 2000, and sections 198.439, 208.153, and 208.201, RSMo Supp. [2010] **2011**. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 21, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 15, 1994, effective July 30, 1995. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed June 20, 2012, effective July 1, 2012, expires Dec. 28, 2012. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

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 Plan; Outpatient Hospital Services Reimbursement Methodology. The division is amending section (3).

PURPOSE: This amendment provides for the State Fiscal Year (SFY) 2013 trend factor to be applied in determining FRA funded hospital payments for SFY 2013.

EMERGENCY STATEMENT: The Department of Social Services, MO HealthNet Division finds that this emergency amendment is necessary

to preserve a compelling governmental interest of collecting state revenue in order to provide health care to individuals eligible for the MO HealthNet program and for the uninsured. An early effective date is required because this emergency amendment establishes the Federal Reimbursement Allowance (FRA) funded hospital payments for dates of service beginning July 1, 2012, 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. As a result, the MO HealthNet Division finds an immediate danger to public health and welfare which requires emergency actions. If this emergency amendment is not enacted, there would be significant cash flow shortages causing a financial strain on Missouri hospitals which serve over eight hundred sixty thousand (860,000) 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. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. 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****. The MO HealthNet Division believes this emergency amendment to be fair to all interested parties under the circumstances. The emergency amendment was filed June 20, 2012, becomes effective July 1, 2012, and expires December 28, 2012.*

(3) Per Diem Reimbursement Rate Computation. Each hospital shall receive a MO HealthNet per diem rate based on the following computation.

(B) Trend Indices (TI). Trend indices are determined based on the four- (4-)*[-]* quarter average DRI Index for DRI-Type Hospital Market Basket as published in *Health Care Costs* by DRI/McGraw-Hill for each State Fiscal Year (SFY) 1995 to 1998. Trend indices starting in SFY 1999 will be determined based on CPI Hospital indexed as published in *Health Care Costs* by DRI/McGraw-Hill for each State Fiscal Year (SFY).

1. The TI are—

A. SFY 1994—4.6%
B. SFY 1995—4.45%
C. SFY 1996—4.575%
D. SFY 1997—4.05%
E. SFY 1998—3.1%
F. SFY 1999—3.8%
G. SFY 2000—4.0%
H. SFY 2001—4.6%
I. SFY 2002—4.8%
J. SFY 2003—5.0%
K. SFY 2004—6.2%
L. SFY 2005—6.7%
M. SFY 2006—5.7%
N. SFY 2007—5.9%
O. SFY 2008—5.5%
P. SFY 2009—5.5%
Q. SFY 2010—3.9%
R. SFY 2011—3.2%—The 3.2% trend shall not be applied in determining the per diem rate, Direct Medicaid payments, or uninsured payments.
S. SFY 2012—4.0%
T. SFY 2013—4.4%

2. The TI for SFY 1996 through SFY 1998 are applied as a full percentage to the OC of the per diem rate and for SFY 1999 the OC of the June 30, 1998, rate shall be trended by 1.2% and for SFY 2000 the OC of the June 30, 1999, rate shall be trended by 2.4%. The OC of the June 30, 2000, rate shall be trended by 1.95% for SFY 2001.

3. The per diem rate shall be reduced as necessary to avoid any negative Direct Medicaid payments computed in accordance with subsection (15)(B).

4. 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 MO HealthNet rate determined in accordance with section (4).

*AUTHORITY: sections 208.152, 208.153, and 208.201, RSMo Supp. [2010] **2011**. 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 June 20, 2012, effective July 1, 2012, expires Dec. 28, 2012. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

EMERGENCY AMENDMENT

13 CSR 70-15.110 Federal Reimbursement Allowance (FRA). The division is amending section (1).

PURPOSE: This amendment provides for the State Fiscal Year (SFY) 2013 trend factor to be applied to the inpatient and outpatient adjusted net revenues determined from the FRA fiscal year cost report.

EMERGENCY STATEMENT: The Department of Social Services, MO HealthNet Division finds that this emergency amendment is necessary to preserve a compelling governmental interest of collecting state revenue in order to provide health care to individuals eligible for the MO HealthNet program and for the uninsured. An early effective date is required because the emergency amendment is necessary to establish the Federal Reimbursement Allowance (FRA) assessment rate effective for dates of service beginning July 1, 2012, in regulation in order to collect the state revenue to ensure access to hospital services for MO HealthNet participants and indigent patients at hospitals that have relied on MO HealthNet payments to meet those patients' needs. The Missouri Partnership Plan between the Centers for Medicare and Medicaid Services (CMS) and the Missouri Department of Social Services (DSS), which establishes a process whereby CMS and DSS determine the permissibility of the funding source used by Missouri to fund its share of the MO HealthNet program, is based on a state fiscal year. The MO HealthNet Division also finds an immediate danger to public health and welfare which requires emergency actions. If this emergency amendment is not enacted, there would be significant cash flow shortages causing a financial strain on Missouri hospitals which serve over eight hundred sixty thousand (860,000) 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. The FRA will raise approximately $1.063 billion for SFY 2013 (July 1, 2012–June 30, 2013), of which $114.3 million is attributable to the trend factor that is the subject of this emergency amendment. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. 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****. The MO HealthNet Division believes this emergency amendment to be fair to all interested parties under the circumstances. The emergency amendment was filed June 20, 2012, becomes effective July 1, 2012, and expires December 28, 2012.*

(1) Federal Reimbursement Allowance (FRA). FRA shall be assessed as described in this section.

(A) Definitions.

1. Bad debts—Amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. Allowable bad debts include the costs of caring for patients who have insurance, but their insurance does not cover the particular service procedures or treatment rendered.

2. Base cost report—Desk-reviewed Medicare/Medicaid cost report. When a hospital has more than one (1) cost report with periods ending in the base year, the cost report covering a full twelve-(12-)*[-]* month period will be used. If none of the cost reports covers a full twelve (12) months, the cost report with the latest period will be used. If a hospital's base cost report is less than or greater than a twelve- (12-)*[-]* month period, the data shall be adjusted, based on the number of months reflected in the base cost report, to a twelve-(12-)*[-]* month period.

3. Charity care—Those charges written off by a hospital based on the hospital's policy to provide health care services free of charge or at a reduced charge because of the indigence or medical indigence of the patient.

4. Contractual allowances—Difference between established rates for covered services and the amount paid by third-party payers under contractual agreements. The Federal Reimbursement Allowance (FRA) is a cost to the hospital, regardless of how the FRA is remitted to the MO HealthNet Division, and shall not be included in contractual allowances for determining revenues. Any redistributions of MO HealthNet payments by private entities acting at the request of participating health care providers shall not be included in contractual allowances or determining revenues or cost of patient care.

5. Department—Department of Social Services.

6. Director—Director of the Department of Social Services.

7. Division—MO HealthNet Division, Department of Social Services.

8. Engaging in the business of providing inpatient health care—Accepting payment for inpatient services rendered.

9. Federal Reimbursement Allowance (FRA)—The fee assessed to hospitals for the privilege of engaging in the business of providing inpatient health care in Missouri. The FRA is an allowable cost to the hospital.

10. Fiscal period—Twelve- (12-)*[-]* month reporting period determined by each hospital.

11. Gross hospital service charges—Total charges made by the hospital for inpatient and outpatient hospital services that are covered under 13 CSR 70-15.010.

12. Hospital—A place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment, or care for not fewer than twenty-four (24) hours in any week of three (3) or more nonrelated individuals suffering from illness, disease, injury, deformity, or other abnormal physical conditions; or a place devoted primarily to provide, for not fewer than twenty-four (24) hours in any week, medical or nursing care for three (3) or more nonrelated individuals. The term hospital does not include convalescent, nursing, shelter, or boarding homes as defined in Chapter 198, RSMo.

13. Hospital revenues subject to FRA assessment effective July 1, 2008—Each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues subject to the FRA assessment will be determined as follows:

A. Obtain "Gross Total Charges" from Worksheet G-2, Line 25, Column 3, of the third prior year cost report (i.e., FRA fiscal year cost report) for the hospital. Charges shall exclude revenues for physician services. Charges related to activities subject to the Missouri taxes assessed for outpatient retail pharmacies and nursing facility services shall also be excluded. "Gross Total Charges" will be reduced by the following:

(I) "Nursing Facility Charges" from Worksheet C, Part I, Line 35, Column 6.

(II) "Swing Bed Nursing Facility Charges" from Worksheet G-2, Line 5, Column 1.

(III) "Nursing Facility Ancillary Charges" as determined from the Department of Social Services, MO HealthNet Division, nursing home cost report. (Note: To the extent that the gross hospital charges, as specified in subparagraph (1)(A)13.A. above, include long-term care charges, the charges to be excluded through this step shall include all long-term care ancillary charges including skilled nursing facility, nursing facility, and other long-term care providers based at the hospital that are subject to the state's provider tax on nursing facility services.)

(IV) "Distinct Part Ambulatory Surgical Center Charges" from Worksheet G-2, Line 22, Column 2.

(V) "Ambulance Charges" from Worksheet C, Part I, Line 65, Column 7.

(VI) "Home Health Charges" from Worksheet G-2, Line 19, Column 2.

(VII) "Total Rural Health Clinic Charges" from Worksheet C, Part I, Column 7, Lines 63.50–63.59.

(VIII) "Other Non-Hospital Component Charges" from Worksheet G-2, Lines 6, 8, 21, 21.02, 23, and 24.

B. Obtain "Net Revenue" from Worksheet G-3, Line 3, Column 1. The state will ensure this amount is net of bad debts and other uncollectible charges by survey methodology.

C. "Adjusted Gross Total Charges" (the result of the computations in subparagraph (1)(A)13.A.) will then be further adjusted by a hospital-specific collection-to-charge ratio determined as follows:

(I) Divide "Net Revenue" by "Gross Total Charges"; and

(II) "Adjusted Gross Total Charges" will be multiplied by the result of part (1)(A)13.C.(I) to yield "Adjusted Net Revenue."

D. Obtain "Gross Inpatient Charges" from Worksheet G-2, Line 25, Column 1, of the most recent cost report that is available for a hospital.

E. Obtain "Gross Outpatient Charges" from Worksheet G-2, Line 25, Column 2, of the most recent cost report that is available for a hospital.

F. Total "Adjusted Net Revenue" will be allocated between "Net Inpatient Revenue" and "Net Outpatient Revenue" as follows:

(I) "Gross Inpatient Charges" will be divided by "Gross Total Charges";

(II) "Adjusted Net Revenue" will then be multiplied by the result to yield "Net Inpatient Revenue"; and

(III) The remainder will be allocated to "Net Outpatient Revenue."

G. The trend indices listed below will be applied to the apportioned inpatient adjusted net revenue and outpatient adjusted net revenue in order to inflate or trend forward the adjusted net revenues from the FRA fiscal year cost report to the current state fiscal year to determine the inpatient and outpatient adjusted net revenues subject to the FRA assessment.

(I) SFY 2009 = 5.50%

(II) SFY 2009 Missouri Specific Trend = 1.50%

(III) SFY 2010 = 3.90%

(IV) SFY 2010 Missouri Specific Trend = 1.50%

(V) SFY 2011 = 3.20%

(VI) SFY 2012 = 5.33%

(VII) SFY 2013 = 4.4%

14. Net operating revenue—Gross charges less bad debts, less charity care, and less contractual allowances times the trend indices listed in 13 CSR 70-15.010(3)(B).

15. Other operating revenues—The other operating revenue is total other revenue less government appropriations, less donations, and less income from investments times the trend indices listed in 13 CSR 70-15.010(3)(B).

*AUTHORITY: sections 208.201 and 208.453, RSMo Supp. [2010] **2011,** and section 208.455, RSMo 2000. Emergency rule filed Sept. 21, 1992, effective Oct. 1, 1992, expired Jan. 28, 1993. Emergency rule filed Jan. 15, 1993, effective Jan. 25, 1993, expired May 24, 1993. Original rule filed Sept. 21, 1992, effective June 7, 1993. For intervening history, please consult the **Code of State Regulations**.*

*Emergency amendment filed June 20, 2012, effective July 1, 2012, expires Dec. 28, 2012. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

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

EMERGENCY AMENDMENT

13 CSR 70-15.160 Prospective Outpatient Hospital Services Reimbursement Methodology. The division is amending section (1).

PURPOSE: This amendment provides for a change to increase the prospective outpatient rate for federally-designated critical access hospitals and state-designated critical access hospitals for dates of service July 1, 2012, through June 30, 2013.

*EMERGENCY STATEMENT: The Department of Social Services, MO HealthNet Division, finds that this emergency amendment is necessary to lessen the impact of the decreased reimbursement resulting from radiology services being paid on a Medicaid fee schedule for federally-designated critical access hospitals (CAHs) and state-designated CAHs to ensure radiology services are available to MO HealthNet participants and uninsured individuals in the rural areas served by the federally-designated and state-designated CAHs. The MO HealthNet Division also finds an immediate danger to public health, safety, and/or welfare which require emergency actions. The MO HealthNet Division determined the impact of reimbursing radiology services on a Medicaid fee schedule disproportionately affects federally-designated and state-designated CAHs and could result in radiology services no longer being available to MO HealthNet participants and uninsured individuals in the rural areas served by the federally-designated and state-designated CAHs. Federally-designated CAHs are defined in section 1820(c)(2)(B) of the Social Security Act which includes criteria such as: rural hospitals with no more than twenty-five (25) acute care inpatient beds that have federal limits on their lengths of stay, are located more than thirty-five (35) miles away from another hospital, and make available twenty-four- (24-) hour emergency care services. State-designated CAHs are defined in 13 CSR 70-15.010 (2)(H) and include hospitals which meet the federal definitions of both a rural referral center and a sole community provider and are adjacent to at least one (1) county that has a Medicaid-eligible population of at least twenty-five percent (25%) of the total population of the county or hospitals which are the sole community hospital located in a county that has a Medicaid population of at least twenty-five percent (25%) of the total population of the county. In order to ensure access to radiology services provided by federally-designated and state-designated CAHs, the MO HealthNet Division determined an increase to the prospective outpatient percentage rate for non-radiology services is necessary to lessen the impact of the decreased reimbursement resulting from the radiology fee schedule. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. 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**. The MO HealthNet Division believes this emergency amendment to be fair to all interested parties under the circumstances and has discussed the proposed change with the hospital industry association and industry leaders. This emergency amendment was filed June 20, 2012, becomes effective July 1, 2012, and expires December 28, 2012.*

(1) Prospective Outpatient Hospital Services Reimbursement Percentage for Hospitals Located Within Missouri.

(C) Outpatient Hospital Services Reimbursement Limited by Rule.

1. Effective for dates of service September 1, 1985, and annually updated, certain clinical diagnostic laboratory procedures will be reimbursed from a Medicaid fee schedule which shall not exceed a national fee limitation.

2. Effective for service dates beginning October 1, 2011, and annually updated, the technical component of outpatient radiology procedures will be reimbursed from a Medicaid fee schedule. Medicaid fee schedule amounts will be based on one hundred twenty-five percent (125%) of the Medicare Physician fee schedule rate using Missouri Locality 01. The list of affected procedure codes and the Medicaid fee schedule rate for the technical component of outpatient radiology procedures will be published on the MO HealthNet website at www.dss.mo.gov/mhd beginning October 1, 2011.

3. Effective for service dates October 1, 2011**,** through June 30, 2012, hospitals which meet the federal definition of Critical Access Hospital (CAH) found in section 1820(c)(2)(B) of the Social Security Act will receive a five percent (5%) increase to their prospective outpatient payment percentage rate determined in accordance with subsection (1)(A).

4. Effective for service dates July 1, 2012, through June 30, 2013, hospitals which meet the federal definition of Critical Access Hospital (CAH) found in section 1820(c)(2)(B) of the Social Security Act will receive a five percent (5%) increase to their prospective outpatient payment percentage rate determined in accordance with subsection (1)(A).

5. Effective for service dates July 1, 2012, through June 30, 2013, hospitals which meet the state definition of Critical Access Hospital (CAH) defined in 13 CSR 70-15.010 will receive a three percent (3%) increase to their prospective outpatient payment percentage rate determined in accordance with subsection (1)(A).

*[4.]***6.** Services of hospital-based physicians and certified registered nurse anesthetists shall be billed on a CMS-1500 professional claim form and reimbursed from a Medicaid fee schedule or the billed charge, if less. The CMS-1500 professional claim form 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 www.dss.mo.gov/mhd, November 1, 2010. This rule does not incorporate any subsequent amendments or additions.

*[5.]***7.** Outpatient hospital services provided for those recipients having available Medicare benefits shall be reimbursed by Medicaid to the extent of the deductible and coinsurance as imposed under Title XVIII.

*[6.]***8.** Effective for payment dates beginning October 1, 2010, reimbursement of Medicare/Medicaid crossover claims (crossover claims) for Medicare Part B and Medicare Advantage/Part C outpatient hospital services with dates of service on or after January 1, 2010, except for public hospitals operated by the Department of Mental Health (DMH), shall be determined as follows:

A. Crossover claims for Medicare Part B outpatient hospital services in which Medicare was the primary payer and the MO HealthNet Division (MHD) is the payer of last resort for cost-sharing (i.e., coinsurance, copay, and/or deductibles) must meet the following criteria to be eligible for MHD reimbursement:

(I) The crossover claim must be related to Medicare Part B outpatient hospital services that were provided to MO HealthNet participants also having Medicare Part B coverage; and

(II) The crossover claim must contain approved outpatient hospital services which MHD is billed for cost-sharing; and

(III) The Other Payer paid amount field on the claim must contain the actual amount paid by Medicare. The MO HealthNet provider is responsible for accurate and valid reporting of crossover claims submitted to MHD for payment regardless of how the claim is submitted. Providers submitting crossover claims for Medicare Part B outpatient hospital services to MHD must be able to provide documentation that supports the information on the claim upon request. The documentation must match the information on the

Medicare Part B plan's remittance advice. Any amounts paid by MHD that are determined to be based on inaccurate data will be subject to recoupment;

B. Crossover claims for Medicare Advantage/Part C (Medicare Advantage) outpatient hospital services in which a Medicare Advantage plan was the primary payer and MHD is the payer of last resort for cost-sharing (i.e., coinsurance, copay, and/or deductibles) must meet the following criteria to be eligible for MHD reimbursement:

(I) The crossover claim must be related to Medicare Advantage outpatient hospital services that were provided to MO HealthNet participants who also are either a Qualified Medicare Beneficiary (QMB Only) or Qualified Medicare Beneficiary Plus (QMB Plus); and

(II) The crossover claim must be submitted as a Medicare UB-04 Part C Professional Crossover claim through the MHD online *[Internet]* billing system; and

(III) The crossover claim must contain approved outpatient hospital services which MHD is billed for cost-sharing; and

(IV) The Other Payer paid amount field on the claim must contain the actual amount paid by the Medicare Advantage plan. The MO HealthNet provider is responsible for accurate and valid reporting of crossover claims submitted to MHD for payment. Providers submitting crossover claims for Medicare Advantage outpatient hospital services to MHD must be able to provide documentation that supports the information on the claim upon request. The documentation must match the information on the Medicare Advantage plan's remittance advice. Any amounts paid by MHD that are determined to be based on inaccurate data will be subject to recoupment;

C. MHD reimbursement for approved outpatient hospital services. MHD will reimburse seventy-five percent (75%) of the allowable cost-sharing amount; and

D. MHD will continue to reimburse one hundred percent (100%) of the allowable cost-sharing amounts for outpatient services provided by public hospitals operated by DMH as set forth above in paragraph (1)(C)4.

AUTHORITY: sections 208.152, 208.153, and 208.201, RSMo Supp. 2011. Emergency rule filed June 20, 2002, effective July 1, 2002, expired Feb. 27, 2003. Original rule filed June 14, 2002, effective Jan. 30, 2003. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed June 20, 2012, effective July 1, 2012, expires Dec. 28, 2012. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

EMERGENCY AMENDMENT

13 CSR 70-15.220 Disproportionate Share Hospital Payments. The division is amending sections (2), (5), (6), (9), and (10).

PURPOSE: This amendment provides for the following changes: sections (2) and (5) were changed to ensure interim Disproportionate Share Hospital (DSH) payments are not made to federally-deemed DSH hospitals and new facilities in excess of their estimated hospital-specific DSH limit, and section (5) also was changed to clarify how a hospital is to notify MO HealthNet if they elect to receive a upper payment limit payment in lieu of a DSH payment; section (6) was changed to allow Department of Mental Health (DMH) hospitals to adjust interim DSH payments based on the results of a DMH state DSH survey; section (9) was changed to reflect how new facilities' interim DSH payments would be determined to ensure interim DSH payments are not made in excess of their estimated hospital-specific DSH limit; and section (10) was changed to clarify the definition of IMD DSH allotment and to change the definition of the uninsured costs that can be included in determining the hospital-specific DSH limit by allowing uninsured costs to include the cost of each service furnished to an individual who had no health insurance or other source of third party coverage for that service. The change in the uninsured definition is being made to be consistent with the proposed change in the federal definitions impacting the hospital-specific DSH limit proposed under 42 CFR 447.295.

EMERGENCY STATEMENT: The Department of Social Services, MO HealthNet Division by rule and regulation must define the reasonable costs, manner, extent, quantity, quality, charges, and fees of medical assistance. This emergency amendment will ensure payment to Missouri hospitals providing health care to approximately eight hundred sixty thousand (860,000) Missourians eligible for the MO HealthNet program plus the uninsured. This emergency amendment must be implemented on an emergency basis because it allows the state to make Disproportionate Share Hospital (DSH) payments for state fiscal year (SFY) 2013 considering the expanded federal definition of the cost of the uninsured in the proposed rule 42 CFR 447.295 published in the ***Federal Register*** *on January 18, 2012, and for the payments to be made on a timely basis, beginning July 1, 2012. This regulation ensures that quality health care continues to be provided to MO HealthNet participants and the uninsured at hospitals that have relied on MO HealthNet payments to meet those patients' needs. As a result, the MO HealthNet Division finds an immediate danger to public health and welfare which requires emergency actions. The MO HealthNet program has a compelling governmental interest in providing continued cash flow for inpatient hospital services. A proposed amendment, which covers the same material, was published in the* ***Missouri Register*** *May 1, 2012 (37 MoReg 681–684), and no comments were received. 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****. The MO HealthNet Division believes this emergency amendment to be fair to all interested parties under the circumstances. The emergency amendment was filed June 20, 2012, becomes effective July 1, 2012, and expires December 28, 2012.*

(2) Federally-Deemed DSH Hospitals.

(A) The state must pay disproportionate share payments to hospitals that meet specific obstetric requirements and have either a MIUR at least one (1) standard deviation above the state mean or a LIUR greater than twenty-five percent (25%). **The state shall not make DSH payments in excess of each hospital's estimated hospital-specific DSH limit.**

1. Obstetric requirements and exemptions.

A. Hospitals must have two (2) obstetricians, with staff privileges, who agree to provide non-emergency obstetric services to Medicaid eligibles. Rural hospitals, as defined by the federal Executive Office of Management and Budget, may qualify any physician with staff privileges as an obstetrician.

B. Hospitals are exempt from the obstetric requirements if the facility did not offer non-emergency obstetric services as of December 21, 1987.

C. Hospitals are exempt if inpatients are predominantly under eighteen (18) years of age.

2. MIUR calculations.

A. As determined from the fourth prior year desk-reviewed cost report, the facility has a MIUR of at least one (1) standard deviation above the state's mean MIUR for all Missouri hospitals.

B. The MIUR is calculated as follows:

(I) The MIUR will be expressed as the ratio of total Medicaid days (TMD) provided under a state plan divided by the provider's total number of inpatient days (TNID).

(II) 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.

$$\text{MIUR} = \frac{\text{TMD}}{\text{TNID}}$$

3. LIUR calculations.

A. As determined from the fourth prior year desk-reviewed cost report, 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.

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

(5) Disproportionate Share Hospital (DSH) Interim Payments.

(B) The interim DSH payments will be calculated as follows:

1. The estimated hospital-specific DSH limit is calculated as follows:

A. Estimated Medicaid net cost from the state DSH survey.

B. Less estimated Medicaid supplemental payments calculated by MHD in accordance with 13 CSR 70-15.010.

C. Equals estimated Medicaid uncompensated care cost.

D. Plus estimated uninsured uncompensated care cost from the state DSH survey.

E. Equals estimated hospital-specific DSH limit*[.]***;**

2. The estimated uncompensated care costs potentially eligible for MHD interim DSH payments excludes out-of-state DSH payments and is calculated as follows:

A. Estimated hospital-specific DSH limit*[.]***;**

B. Less estimated out-of-state (OOS) DSH payments*[.]***;**

C. Equals estimated uncompensated care cost (UCC) net of OOS DSH payments*[.]***;**

3. Hospitals determined to have a negative estimated UCC net of OOS DSH payments (payments exceed costs) will not receive interim DSH payments because they are expected to exceed their estimated hospital-specific DSH limit *[unless they meet the requirement in subsection (5)(C).]***; and**

4. Qualified DSH hospitals determined to have a positive estimated UCC net of OOS DSH payments (costs exceed payments) *[and hospitals that meet the requirements of subsection (5)(C)]* will receive interim DSH payments. The interim DSH payments are subject to the federal DSH allotment and the estimated hospital-specific DSH limits. The interim DSH payments will be calculated as follows:

A. Interim DSH payments to qualified DSH hospitals determined to have a positive estimated UCC net of OOS DSH payments will be calculated as follows:

(I) Up to one-hundred percent (100%) of the available federal DSH allotment will be allocated based on each hospital's positive estimated UCC net of OOS DSH payments to the total positive estimated UCC net of OOS DSH payments; and

(II) The allocated amount will then be reduced by one percent (1%) for hospitals that do not contribute through a plan that is approved by the director of the Department of Health and Senior Services to support the state's poison control center and the Primary Care Resource Initiative for Missouri (PRIMO) and Patient Safety Initiative*[; and]***.**

[B. Interim DSH payments to federally-deemed hospitals are set forth in subsection (5)(C).]

(C) *[Federally-deemed hospitals will receive the nominal DSH payment of five thousand dollars ($5,000) and the greater of their upper payment limit payment or their estimated interim DSH payment as calculated above in subsection (5)(B). Except for federally-deemed hospitals, hospitals]* **Hospitals** may elect to receive an upper payment limit payment as defined in 13 CSR 70-15.230 in lieu of DSH payments. **Hospitals that elect to receive an upper payment limit payment rather than a DSH payment must submit a request to the MO HealthNet Division on an annual basis.**

(D) Disproportionate share payments will coincide with the semi-monthly claim payment schedule *[with the exception of the federally-deemed hospitals who will be paid the nominal DSH payment of five thousand dollars ($5,000) at the end of the SFY]*.

(E) New facilities **that do not have a Medicare cost report on which to base the state DSH survey** will be paid *[based on]* the **lesser of the estimated hospital-specific DSH limit based on the estimated state DSH survey or the industry average estimated interim DSH payment. The** industry average estimated interim DSH payment as determined from subsection (5)(B) **is** calculated as follows:

1. Hospitals receiving interim DSH payments shall be divided into quartiles based on total beds;

2. DSH payments shall be individually summed by quartile and then divided by the total beds in the quartile to yield an average interim DSH payment per bed; and

3. The number of beds for the new facility shall be multiplied by the average DSH payment per bed.

(6) Department of Mental Health Hospital (DMH) DSH Adjustments and Payments.

(B) Beginning in SFY 2012, due to structural changes occurring at the DMH facilities, interim DSH payments will be based on the third prior base year cost report trended to the current SFY adjusted for the federal reimbursement allowance (FRA) assessment paid by DMH hospitals. **The interim DSH payments calculated using the third prior base year cost report may be revised based on the results of a DMH state DSH survey.** Additional adjustments may be done based on the results of the federally-mandated DSH audits as set forth below in subsection (7)(A).

(9) State DSH Survey Reporting Requirements.

(A) Each hospital participating in the MO HealthNet program shall submit a state DSH survey prescribed by the state MO HealthNet agency and must be submitted by December 31 of each year. However, a corrected survey may be accepted if it is supported by documentation and the state determines the correction is appropriate and has a material impact on the survey results. The state DSH survey for each interim DSH payment period shall be completed based on the third prior year Medicare cost report *[and]* adjusted *[for inflationary trends and volume adjustments to]* **to reflect anticipated operations for** the interim DSH payment period. **The historical Medicare cost report data may be adjusted for inflationary trends, volume adjustments, changes in reimbursement methodology, and/or other business decisions (i.e., expanded or terminated services, etc.)** For example, the state DSH survey that will be used to determine SFY 2013 interim DSH payments will be based on the state DSH survey completed using the 2010 Medicare

cost report data adjusted by the hospital to 2013.

1. If a new facility does not have a third prior year Medicare cost report, the state DSH survey shall be completed using the second prior year Medicare cost report, if available, adjusted to reflect anticipated operations for the interim DSH payment period.

2. If a new facility does not have a second prior year Medicare cost report, the state DSH survey shall be completed using the prior year Medicare cost report, if available, adjusted to reflect anticipated operations for the interim DSH payment period.

3. If a new facility does not have a prior year Medicare cost report, the state DSH survey shall be completed using facility projections to reflect anticipated operations for the interim DSH payment period. Interim DSH payments determined from this state DSH survey are limited to the industry average estimated interim DSH payment as set forth in subsection (5)(E).

(10) Definitions.

(C) Estimated uninsured net cost. Estimated uninsured net cost is the cost of providing inpatient and outpatient hospital services to individuals with**out** *[no]* **health insurance or other** *[source of]* third party *[reimbursement]* **coverage** for the *[inpatient and outpatient]* hospital services they receive **during the year less uninsured payments received on a cash basis for the applicable Medicaid state plan year**. *[If the individual had health insurance, even if the third-party insurer did not pay, those services are insured and cannot be included as uninsured costs.]* The costs are to be calculated using Medicare cost report costing methodologies described in this rule and should not include costs for services that were denied for any reason. The estimated uninsured net cost is calculated as the sum of the following estimated data reported on the state DSH survey.

1. Uninsured inpatient net cost.

2. Uninsured outpatient net cost.

(H) Individuals without health insurance or other third party coverage.

1. Individuals who have no health insurance or other source of third party coverage for the specific inpatient or outpatient hospital services they received during the year can be considered uninsured. As set forth in CMS' proposed rule published in the *Federal Register*, January 18, 2012, for 42 CFR part 447.295, a service-specific approach must be used to determine whether an individual is uninsured. The service-specific coverage determination can occur only once per individual per service provided and applies to the entire service, including all elements, as that service, or similar services, would be defined by MO HealthNet. Determination of an individual's third party coverage status is not dependent on receipt of payment by the hospital from the third party.

2. The costs for inpatient and outpatient hospital services provided to individuals without health insurance or other third party coverage can be considered uninsured and included in calculating the hospital-specific DSH limit.

3. The following individuals shall be considered uninsured:

A. Individuals whose benefit package does not cover the hospital service received. If the service is not included in an individual's health benefits coverage through a group health plan or health insurer, and there is no other legally liable third party, the individual is considered uninsured; or

B. Individuals who have reached lifetime insurance limits for certain services or with exhausted insurance benefits at the time of service. When a lifetime or annual coverage limit is imposed by a third party payer, specific services beyond the limit would not be within the individual's health benefit package from that third party payer and would be considered uninsured; or

C. For American Indians/Alaska Natives, Indian Health Services (IHS) and tribal coverage is only considered third party coverage when services are received directly from IHS or tribal health programs or when IHS or a tribal health program has authorized coverage through the contract health service program.

4. The costs associated with the following shall not be included as uninsured costs:

A. Bad debts or unpaid co-insurance/deductibles for individuals with third party coverage. Administrative denials of payment or requirements for satisfaction of deductible, copayment, or coinsurance liability do not affect the determination that a specific service is included in the health benefits coverage; and

B. Prisoners. Individuals who are inmates in a public institution or are otherwise involuntarily in secure custody as a result of criminal charges are considered to have a source of third party coverage. However, an individual can be included as uninsured if a person has been released from secure custody and is referred to the hospital by law enforcement or corrections authorities and is admitted as a patient rather than an inmate to the hospital.

5. These definitions, and the resulting uninsured costs includable in calculating the hospital-specific DSH limit, are subject to change based on any changes that may be incorporated in the final publication of 42 CFR 447.295.

*[(H)]***(I)** Institution for Mental Diseases (IMD) DSH allotment. The IMD DSH allotment is a portion of the state-wide DSH allotment and is *[payable only]* **the maximum amount set by the federal government that may be paid** to IMD hospitals. **Any unused IMD DSH allotment not paid to IMD hospitals for any plan year may be paid to hospitals that are under their projected hospital-specific DSH limit.**

*[(I)]***(J)** Inpatient and outpatient hospital services. For purposes of determining the estimated hospital-specific DSH limit and the actual hospital-specific DSH limit, the inpatient and outpatient hospital services are limited to inpatient and outpatient hospital services included in the approved Missouri Medicaid State Plan.

(K) Lifetime or annual health insurance coverage limit. An annual or lifetime limit, imposed by a third party payer, that establishes a maximum dollar value, or maximum number of specific services, on a lifetime or annual basis, for benefits received by an individual.

*[(J)]***(L)** Longfall. The longfall is the total amount a hospital has been paid (including all DSH payments) in excess of their hospital-specific DSH limit and is considered an overpayment subject to recoupment. The source for this calculation is as follows:

1. Actual longfall. The actual longfall is based on the annual independent DSH audit; and

2. Estimated longfall. The estimated longfall is calculated by the state using data from the state DSH survey, Medicaid supplemental payments, and data provided in the most recent independent DSH audit, if applicable.

*[(K)]***(M)** Medicaid state plan year. Medicaid state plan year coincides with the twelve**-** (12-)*[-]* month period for which a state calculates DSH payments. For Missouri, the Medicaid State Plan Year coincides with its state fiscal year (SFY) and is July 1 through June 30.

*[(L)]***(N)** Medicaid supplemental payments. For purposes of determining estimated hospital-specific DSH limits, the Medicaid supplemental payments include: Direct Medicaid Add-On, Graduate Medical Education (GME), Enhanced GME, Children's Outliers, Trauma Outliers, and any cost settlements. Upper payment limit (UPL) supplemental payments will be included in addition to the above Medicaid supplemental payments for purposes of determining the hospital-specific DSH limit in the annual independent DSH audit. Any supplemental payments made with state only funds are not required to be offset in determining the hospital-specific DSH limit.

*[(M)]***(O)** Medicare cost reporting methodologies. Medicaid and uninsured costs will be determined utilizing Medicare cost report (form 2552-96) methodologies. If the Medicare 2552-96 is superseded by an alternate Medicare developed cost reporting tool during

a Medicaid state plan year, that tool must be used for the Medicaid state plan year. Based on these methodologies, the costs included in the DSH payment calculation will reflect the Medicaid and uninsured portion of total allowable costs from the Medicare cost report. Costs such as the Missouri Medicaid hospital provider tax (federal reimbursement allowance or FRA) are recognized as allowable costs for Medicaid and DSH program purposes and apportioned to Medicaid, uninsured, Medicare, and other payers following the cost finding principles included in the costs report, applicable instructions, regulations, and governing statutes.

*[(N)]***(P)** New facility. A new hospital determined in accordance with 13 CSR 70-15.010 without a base year cost.

*[(O)]***(Q)** Out-of-state DSH payments. DSH payments received by a Missouri hospital from a state other than Missouri.

*[(P)]***(R)** Section 1011 payments. Section 1011 payments are made to a hospital for costs incurred for the provision of specific services to specific aliens to the extent that the provider was not otherwise reimbursed for such services. Because a portion of the Section 1011 payments are made for uncompensated care costs that are also eligible under the hospital-specific DSH limit, a defined portion of the Section 1011 payments must be recognized as an amount paid on behalf of those uninsured.

*[(Q)]***(S)** Shortfall. The shortfall is the hospital-specific DSH limit in excess of the total amount a hospital has been paid (including all DSH payments). The source for this calculation is as follows:

1. Actual shortfall. The actual shortfall is based on the annual independent DSH audit; and

2. Estimated shortfall. The estimated shortfall is calculated by the state using data from the state DSH survey, Medicaid supplemental payments, and data provided in the most recent independent DSH audit, if applicable.

*[(R)]***(T)** State DSH survey. The state DSH survey was designed to reflect the standards of calculating uncompensated care cost established by the federal DSH rules in determining hospital-specific DSH limits. The DSH survey is also similar to the DSH survey that is utilized by the independent auditor during the annual independent DSH audit performed in accordance with the federally-mandated DSH audit rules. The blank state DSH survey is referred to as the state DSH survey template. The following state DSH survey templates and instructions are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109. This rule does not incorporate any subsequent amendments or additions.

1. Version 1 (9/10), also referred to as the 2011 state DSH survey, was used to calculate the SFY 2011 DSH payment adjustments set forth in section (4) and the SFY 2012 interim DSH payments set forth in section (5).

2. Version 2 (9/11) **or Version 3 (2/12). The hospital may elect to complete either Version 2 (9/11) or Version 3 (2/12) on which its SFY 2013 interim DSH payments** will be *[used to calculate interim DSH payments beginning with SFY 2013 as set forth in section (5)]* **calculated**. The survey shall be referred to as the SFY to which payments will relate. For example, the survey used to determine interim DSH payments for SFY 2013 will be referred to as the 2013 state DSH survey.

3. Version 3 (2/12) will be used to calculate interim DSH payments beginning with SFY 2014 as set forth in section (5). The survey shall be referred to as the SFY to which payments will relate.

*[(S)]***(U)** Taxable revenue. Taxable revenue is the hospital's total inpatient adjusted net revenues plus outpatient adjusted net revenues determined in accordance with 13 CSR 70-15.110, paragraph (1)(A)13.

*[(T)]***(V)** Uncompensated care costs (UCC). The uncompensated care costs eligible for consideration in determining the hospital-specific DSH limit are calculated by reducing costs incurred in furnishing inpatient and outpatient hospital services to the Medicaid and uninsured populations, reduced by revenues received under Medicaid (not including DSH payments) and Section 1011 payments. The costs are to be calculated using Medicare cost report costing methodologies described in this rule and should not include costs for services that were denied for any reason. For purposes of this calculation the Medicaid and uninsured populations include:

1. The Medicaid population includes all Medicaid eligible individuals including dual eligible and managed care participants; and

2. The uninsured population includes individuals with**out** *[no]* **health insurance or other** source of third-party *[reimbursement for the inpatient and outpatient services they receive]* **coverage as defined in this rule, consistent with 42 CFR part 447**. *[If the individual had health insurance, even if the third-party insurer did not pay, those services are insured and cannot be included as uninsured costs.]*

*[(U)]***(W)** Uninsured revenues. Payments received on a cash basis that are required to be offset against the uninsured cost to determine the uninsured net cost include any amounts received by the hospital, by or on behalf of, either self-pay or uninsured individuals during the SFY under audit.

AUTHORITY: sections 208.152, 208.153, and 208.201, RSMo Supp. [2010] ***2011, and section 208.158, RSMo 2000****. Emergency rule filed May 20, 2011, effective June 1, 2011, expired Nov. 28, 2011. Original rule filed May 20, 2011, effective Jan. 30, 2012. Amended: Filed April 2, 2012. Emergency amendment filed June 20, 2012, effective July 1, 2012, expires Dec. 28, 2012.*

The Secretary of State shall publish all executive orders beginning January 1, 2003, pursuant to section 536.035.2, RSMo Supp. 2011.

EXECUTIVE ORDER
12-06

WHEREAS, the State of Missouri has experienced a prolonged period of record heat and low precipitation and this weather pattern is expected to continue into the future; and

WHEREAS, these weather conditions have created a significant risk of fire in many parts of the state; and

WHEREAS, fires involving vegetation, grass and timber have occurred in recent days; and

WHEREAS, the state will continue to be proactive where the health and safety of the citizens of Missouri are concerned; and

WHEREAS, the resources of the State of Missouri may be needed to assist affected jurisdictions and to help relieve the condition of distress and hazard to the safety and welfare of our fellow Missourians.

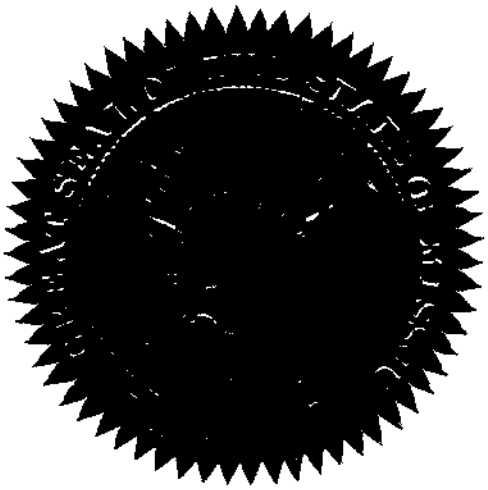
NOW, THEREFORE, I, JEREMIAH W. (JAY) NIXON, GOVERNOR OF THE STATE OF MISSOURI, by virtue of the authority vested in me by the Constitution and laws of the State of Missouri, do hereby direct that the Missouri State Emergency Operations Center be activated.

I further direct the State Emergency Management Agency, State Fire Marshal, and such other state agencies as determined appropriate to address the fire danger affecting this state by maintaining and coordinating communications with local authorities affected by fire danger, continuing planning and preparation efforts including the identification and readying of firefighting and public safety assets and personnel, and providing such assistance needed by local authorities.

I further order the State Fire Marshal to coordinate the deployment of fire resources through the mutual aid system.

I further order the Adjutant General to prepare plans to respond to fire related situations and to identify units, personnel and assets appropriate for those circumstances and to place such units on notice for possible activation should the need arise.

This order shall terminate on July 29, 2012 unless extended in whole or in part.



IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 29th day of June, 2012.

Jeremiah W. (Jay) Nixon
Governor

ATTEST:

Robin Carnahan
Secretary of State