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

EMERGENCY RULE

13 CSR 70-15.220 Disproportionate Share Hospital Payments.

PURPOSE: This rule implements a new state methodology for paying Disproportionate Share (DSH) payments in order to comply with the new federally required DSH audit standards. The regulation provides for an interim adjustment to DSH payments and provides for final adjustment to DSH payments based upon the federally mandated DSH audits.

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 rule will ensure payment to Missouri hospitals providing health care to approximately nine hundred thousand (900,000) Missourians eligible for the MO HealthNet program plus the uninsured. This emergency rule must be implemented on an emergency basis because it allows the state to redistribute disproportionate share hospital (DSH) payments to hospitals in accordance with federal audit requirements. Section 1923(j) of the Social Security Act (SSA) requires States to submit an annual independent certified audit of its DSH payments and reimburse the Federal government for any overpayments detected. Beginning with DSH payments relating to Medicaid State plan rate year 2011, "FFP is not available in expenditures for DSH payments that are found in the independent certified audit to exceed the hospital-specific eligible uncompensated care cost limit." 42 C.F.R. § 455.304(a)(2). In addition, CMS requires that audits "must be taken into consideration for Medicaid State plan rate year 2011 uncompensated care cost estimates and associated DSH payments." Medicaid Program; Disproportionate Share Hospital Payments, 73 Fed. Reg. 77904, 77948 (Dec. 19, 2008) ("Final Rule"). The independent audit reports for Medicaid State plan rate years 2005 – 2007 were completed in December 2010 and reflected that Missouri's current methodology resulted in excess DSH payments to the hospitals. Based upon the results of these audits, the Department determined that its current methodology was providing excess DSH payment and as a result, SFY 2011 payments likely would need to be adjusted and the methodology for determining future DSH payments needed to be changed that more closely followed the new DSH rules. Due to the age of the data in the 2005 – 2007 audits and the significant changes in hospital payments and costs, the Department did not believe that the amounts reported in the 2005–2007 audits to be reflective of current industry payments and costs. Since 2007, the Department has made drastic cuts in Medicaid payments to hospitals resulting in larger Medicaid shortfalls and larger DSH limits. The State determined that it needed to use more recent data to make adjustments to the SFY 2011 DSH payments. Therefore, the Department decided to follow the DSH audit methodology and collect 2009 data from hospitals trended to 2011 to determine if adjustments to the SFY 2011 DSH payments are necessary. The Department developed a State DSH Survey to collect the 2009 data which follows the same

format as the requirements laid out by the DSH audit rule (using the Medicare cost report and following the definitions of uninsured). This emergency rule allows SFY 2011 DSH payments to be adjusted in accordance with the federally mandated DSH standards beginning in SFY 2011. DSH payments to hospitals that are estimated to be in excess of their hospital-specific eligible uncompensated care cost limit will be recouped and redistributed to hospitals whose DSH payments are less than their hospital-specific eligible uncompensated care cost limit. Without this emergency regulation, hospitals would forego $94.4 million in payments that are subject to recoupment in accordance with DSH federal audit regulations. This emergency rule also allows for SFY 2012 DSH payments to be determined in accordance with the federally mandated DSH standards and for the payments to be made on a timely basis, beginning July 1, 2011. 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, safety, and/or welfare and a compelling governmental interest which requires emergency action. The MO HealthNet program has a compelling government interest in providing continued cash flow for inpatient hospital services. The scope of this emergency rule is limited 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 rule is fair to all interested persons and parties under the circumstances. MO HealthNet Division staff worked extensively with the Missouri Hospital Association to ensure that the industry as a whole was adequately represented. Missouri Hospital Association representatives attended numerous meetings. This regulation was reviewed by Missouri Hospital Association staff and is supported by the Missouri Hospital Association Board. A proposed rule covering this same material will be published in this issue of the Missouri Register. Therefore, the Division believes this emergency to be fair to all interested persons and parties under the circumstances. This emergency rule was filed May 20, 2011, effective June 1, 2011, expires November 28, 2011.*

(1) General Reimbursement Principles.

(A) In order to receive federal financial participation (FFP), disproportionate share payments are made in compliance with federal statutes and regulations. Section 1923 of the Social Security Care Act (42 U.S. Code) describes the hospitals that must be paid DSH and those that the state may elect to pay DSH.

(B) Hospitals that must be paid DSH are considered to be federally deemed DSH hospitals. The state must pay DSH to hospitals that meet the following criteria:

1. Obstestrics requirements as described in paragraph (2)(A)1; and

2. Have a Medicaid Inpatient Utilization Rate (MIUR) at least one (1) standard deviation above the statewide mean as defined in paragraph (2)(A)2., or a Low Income Utilization Rate (LIUR) greater than twenty-five (25) percent as defined in paragraph (2)(A)3.

(C) Hospitals that may be paid DSH must meet obstetric requirements as defined in paragraph (2)(A)1.and have a MIUR of at least one (1) percent.

(D) Section 1923(g) of the Social Security Act (Act) limits the amount of DSH payments states can pay to each hospital and earn FFP. To be in compliance with the Act, DSH payments shall not exceed one hundred (100) percent of the uncompensated care costs of providing hospital services to Medicaid and uninsured individuals. Hospital specific DSH limit calculations must

comply with federally mandated DSH audit standards and definitions. If the disproportionate share payments exceed the hospital-specific DSH costs, the difference shall be deducted from disproportionate share payments or recouped from future payments.

(E) All DSH payments in the aggregate shall not exceed the federal DSH allotment within a state fiscal period. The DSH allotment is the maximum amount of DSH a state can distribute each year and receive FFP.

(F) The state must submit an annual independent audit of the state's DSH program to the Centers for Medicare and Medicaid Services (CMS). FFP is not available for DSH payments that are found to exceed the hospital-specific eligible uncompensated care cost limit. All hospitals that receive DSH payments are subject to the independent federal DSH audit.

(G) Hospitals qualify for DSH for a period of one (1) state fiscal year and must requalify at the beginning of each state fiscal year to continue to receive disproportionate share payments.

(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 (25) percent.

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 nonemergency 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 Medicaid inpatient utilization rate (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;

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

(3) State Elected DSH Payments.

(A) The state may elect to make hospital disproportionate share payments to hospitals that meet the obstetric requirements defined in paragraph (2)(A)1 and have a MIUR of at least one (1) percent as calculated in subparagraph (2)(A)2(B).

(4) DSH Audit Payment Adjustments.

(A) Beginning in Medicaid state plan year 2011, DSH payments made to hospitals, will be revised based on the results of a state DSH Survey which uses federally-mandated DSH audit standards. These revisions are to serve as interim adjustments until the federally-mandated DSH audits are complete. DSH audits are finalized three (3) years following the SFY year-end reflected in the audit. For example, the SFY 2011 DSH audit will be finalized in 2014. The interim adjustments shall be determined as follows:

1. Based upon the state's analysis of the 2011 state's DSH survey using federally-mandated DSH audit standards, DSH payments will be limited to the hospital's projected hospital-specific DSH limit.

2. DSH payments as provided in the state's DSH survey that exceed the projected hospital-specific DSH limits will be recouped from the hospitals to reduce their payments to their projected hospital-specific DSH limit.

(B) Any payments that are recouped from hospitals as a result of the DSH audit will be redistributed to hospitals that are shown to have been paid less than their hospital-specific DSH limits. These redistributions will occur proportionally based on each hospitals uncompensated care shortfall to the total shortfall, not to exceed each hospital's specific projected DSH limit.

1. Redistribution payments to hospitals that have been paid less than their SFY 2011 projected hospital-specific DSH limit must occur after the recoupment of payments made to hospitals that have been paid in excess of their hospital specific DSH limits. The state may establish a hospital-specific recoupment plan. However, total industry redistribution payments may not exceed total industry recoupments collected to date.

2. If the Medicaid program's original DSH payments did not fully expend the federal DSH allotment for any plan year, the remaining DSH allotment may be paid to hospitals that are under their hospital-specific DSH limit. These redistributions will occur proportionally based on each hospitals uncompensated care shortfall to the total shortfall, not to exceed each hospital's specific DSH limit.

(5) Disproportionate Share (DSH) Interim Payments.

(A) SFY 2012 interim DSH payments will be based on the 2011 state DSH survey after applying the trend factor published in *Health Care Costs* by DRI/McGraw-Hill for the current fiscal year.

(B) 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 hospital specific DSH limit as calculated from the state DSH survey. Except for federally deemed hospitals, hospitals may elect to receive an upper payment limit payment as defined in 13 CSR 70.230 in lieu of DSH payments.

(C) Disproportionate share payments will coincide with the semimonthly claim payment schedule.

(D) New facilities will be paid based on the industry average as determined from the state DSH survey.

(E) Facilities not providing a state DSH survey will have DSH payments calculated using the most recent hospital-specific information provided to the state by the independent auditor.

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

(A) Effective June 1, 2011, interim DSH payments made to DMH hospitals will be revised based on the results of a DMH state DSH survey which uses federally-mandated DSH audit standards. These revisions are to serve as interim adjustments until the federally-mandated DSH audits are complete in 2014.

(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 FRA assessment paid by DMH hospitals. Additional adjustments may be done based on the results of the federally mandated DSH audits as set forth below in subsection (7)(A).

(C) If the Medicaid program's original DSH payments did not fully expend the federal Institute for Mental Disease DSH allotment for any plan year, the remaining IMD DSH allotment may be paid to hospitals that are under their projected hospital-specific DSH limit.

(7) Final DSH Adjustments.

(A) Final DSH adjustments will be made after actual cost data is available and the DSH audit is completed. DSH audits are completed three (3) years following the initial independent DSH audit. For example, final adjustments for 2011 will be made following the completion of the annual independent DSH audit in 2014 (SFY 2015).

(8) Record Retention.

(A) Records used to complete the state's DSH survey shall be kept until the final audit is completed. For example, the SFY 2011 state DSH survey will use 2009 cost data which must be maintained until the 2014 DSH audits are completed in SFY 2015.

(B) Records provided by hospitals to the state's independent auditor shall also be maintained until the 2014 federal DSH audit is complete.

AUTHORITY: Sections 208.152, 208.153, and 208.201, RSMo Supp. 2010. Original rule filed May 20, 2011. Emergency rule May 20, 2011, effective June 1, 2011, expires Nov. 28,. 2011.