

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

PROPOSED AMENDMENT

13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Methodology. The division is amending sections (1), (2), (3), (4), (5), (6), (7), (8), (9), (10), and (11) and adding sections (12), (13), (14), and (15).

PURPOSE: This proposed amendment changes the inpatient reimbursement methodology, deletes or clarifies outdated terms, language, and provisions regarding inpatient hospital services reimbursement methodologies.

(1) General Reimbursement Principles.

(A) For inpatient hospital services provided for an individual entitled to Medicare Part A inpatient hospital benefits and eligible for MO HealthNet, reimbursement from the MO HealthNet Program will be available only when MO HealthNet's applicable payment schedule amount exceeds the amount paid by Medicare. MO HealthNet's payment will be limited to the lower of the deductible and coinsurance amounts or the amount the MO HealthNet applicable payment schedule amount exceeds the Medicare payments. For all other MO HealthNet participants, unless otherwise limited by rule, reimbursement will be based solely on the individual participant's days of care (within benefit limitations) multiplied by the individual hospital's Title XIX *per diem* rate. *[As described in paragraph (5)(D)2. of this rule, as part of each hospital's fiscal year-end cost settlement determination, a comparison of total MO HealthNet-covered aggregate charges and total MO HealthNet payments will be made and any hospital whose aggregate MO HealthNet per diem payments exceed aggregate MO HealthNet charges will be subject to a retroactive adjustment.]*

(B) *[The Title XIX reimbursement for hospitals located outside Missouri and for federally-operated hospitals in Missouri will be determined as stated in 13 CSR 70-15.190.]*

[(C)] The Title XIX reimbursement for hospitals, excluding those located outside Missouri *[and in-state federal hospitals]*, shall include *[per diem payments, outpatient payments, disproportionate share payments, and various MO HealthNet Add-On payments]* **the payments as outlined below.** Reimbursement shall be subject to availability of federal financial participation (FFP).

1. **Inpatient** *[Per]* **per diem** reimbursement is established in accordance with *[section (3)]* **Sections (4) and (5).**

2. Outpatient reimbursement is *[described]* **established in accordance with** 13 CSR 70-15.160.

3. *[Disproportionate share payments are described in 13 CSR 70-15.220.]* **Acuity Adjustment Payment (AAP) is established in accordance with Section (6).**

4. *[MO HealthNet Add-Ons are described in sections (9) and (10) of this rule and 13 CSR 70-15.015 and are in addition to MO HealthNet per diem payments. These payments are subject to the federal Medicare Upper Limit test.]* **Poison Control (PC) Payment is established in accordance with Section (7).**

5. **Stop Loss Payment (SLP) is established in accordance with Section (8).**

6. Disproportionate Share Hospital (DSH) Payment is established in accordance with 13 CSR 70-15.220.

7. Graduate Medical Education (GME) Payment is established in accordance with Section (9).

8. Upper Payment Limit (UPL) Payment is established in accordance with 13 CSR 70-15.230.

9. Children's Outlier (CO) Payment is established in accordance with Section (10).

(C) The Title XIX reimbursement for hospitals located outside Missouri will be established in accordance with 13 CSR 70-15.190.

(2) Definitions.

(A) Allowable costs. Allowable costs are those related to covered MO HealthNet services defined as allowable in 42 CFR chapter IV, part 413, except as specifically excluded or restricted in 13 CSR 70-15.010 or the MO HealthNet hospital provider manual and detailed on the *[desk-reviewed Medicare/]* **audited** Medicaid cost report. Penalties or incentive payments as a result of Medicare target rate calculations shall not be considered allowable costs. Implicit in any definition of allowable cost is that this cost is allowable only to the extent that it relates to patient care; is reasonable, ordinary, and necessary; and is not in excess of what a prudent and cost-conscious buyer pays for the given service or item. *[For purposes of calculating disproportionate share payments and to ensure federal financial participation (FFP), allowable uncompensated costs must meet definitions defined by the federal government.]*

(B) Bad debt. Bad debts include the costs of caring for patients who have insurance but are not covered for the particular services, procedures, or treatment rendered. Bad debts do not include the cost of caring for patients whose insurance covers the given procedures but limits coverage. In addition, bad debts do not include the cost of caring for patients whose insurance covers the procedure although the total payments to the hospital are less than the actual cost of providing care.

(C) Base **year** cost report. *[Desk-reviewed Medi-care/]* **Audited** Medicaid cost report **from the third prior calendar year**. *[When]* **If** a facility has more than one (1) cost report with periods ending in the *[fourth]* **third** prior calendar 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 **year** cost report is less than or greater than a twelve[-] (12[-]) month period, the data shall be adjusted, based on the number of *[months]* **days** reflected in the base **year** cost report to a twelve[-] (12[-]) month period. **Any changes to the base year cost report after the Division issues a final decision on assessment or payments will not be included in the calculations.**

(D) Case Mix Index (CMI). The hospital CMI for the AAP is determined based on the hospital's MO HealthNet inpatient claims and 3M™ All-Patient Refined Diagnosis Related Groups (APR-DRG) software, a grouping algorithm to categorize inpatient discharges with similar treatment characteristics requiring similar hospital resources.

1. For SFY 2023, each hospital's CMI was calculated as follows:

A. A dataset of complete inpatient stays was established using MO HealthNet fee-for-service claims and managed care encounters combined for calendar years 2019 and 2020. A two-year dataset was used to account for the potential impact of changes to hospital utilization, costs, and mix of patients due to the COVID-19 Public Health Emergency.

B. Interim claims where multiple claims cover a single inpatient stay were combined into single claims covering the complete inpatient stay.

C. The 3M™ APR-DRG grouping software was applied to the inpatient dataset, using version 38 of the grouper. Each inpatient stay was assigned to a single DRG and severity of illness level. Each APR-DRG is associated with a relative weight reflecting the relative amount of resources required to care for similar stays, compared to an average inpatient stay. APR-DRG weights are provided by 3M™ and are calculated based on a national all-payer population.

D. The national weights were recentered to reflect the average resource requirements within the MO HealthNet population, including both fee-for-service and managed care encounter inpatient stays. Recentered weights are calculated by dividing the APR-DRG national weights by the average casemix for all hospitals. The average casemix is calculated as the sum of the national weights for each inpatient stay divided by the number of stays for all hospitals.

E. A hospital-specific CMI is calculated by summing the MO HealthNet recentered weights for each inpatient stay and dividing the total by the number of inpatient stays for the hospital.

2. For SFY 2024 and forward, the basis of the case mix index will be determined by the Division based on combined inpatient stays from the second and third prior calendar years, the current version of the 3M™ APR-DRG grouper, relative weights appropriate for the MO HealthNet population, and the SFY in which an AAP is being calculated.

[(D)](E) Charity care. Results from a provider's policy to provide health care services free of charge or a reduction in charges because of the indigence or medical indigence of the patient.

[(E)](F) Contractual allowances. Difference between established rates for covered services and the amount paid by third-party payers under contractual agreements.

[(F)](G) Cost report. A cost report details, for purposes of both Medicare and MO HealthNet reimbursement, the cost of rendering covered services for the fiscal reporting period. The Medicare/Medicaid Uniform Cost Report contains the forms utilized in filing the cost report. The Medicare/Medicaid Cost Report version 2552-10 (CMS 2552-10) shall be used for fiscal years beginning on and after May 1, 2010.

[(G) Critical access. Hospitals which meet the federal definition found in section 1820(c)(2)(B) of the Social Security Act. A Missouri expanded definition of critical access shall also include hospitals which meet the federal definitions of both a rural referral center and sole community provider and is 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.]

(H) Division. Unless otherwise designated, division refers to the MO HealthNet Division (MHD) a division of the Department of Social Services charged with the administration of the MO HealthNet program.

[(H) Disproportionate share reimbursement. The disproportionate share payments are described in 13 CSR 70-15.220.

(I) Effective date.

1. The plan effective date shall be October 1, 1981.

2. The adjustment effective date shall be thirty (30) days after notification to the hospital that its reimbursement rate has been changed unless modified by other sections of the plan.]

[(J)](I) [MO HealthNet]Medicaid inpatient days. *[MO HealthNet]Medicaid* inpatient days are paid *[MO HealthNet]Medicaid* days for inpatient hospital services as reported by the Medicaid Management Information System (MMIS).

[(K) Medicare rate. The Medicare rate is the rate established on the basis of allowable cost as defined by applicable Medicare standards and principles of reimbursement (42 CFR parts 405 and 413) as determined by the servicing fiscal intermediary based on yearly hospital cost reports.]

[(L)](J) Nonreimbursable items. For purposes of reimbursement of reasonable cost, the following are not subject to reimbursement:

1. Allowances for return on equity capital;
2. Amounts representing growth allowances in excess of the intensity allowance, profits, efficiency bonuses, or a combination of these;
3. Cost in excess of the principal of reimbursement specified in 42 CFR chapter IV, part 413; and
4. Costs or services specifically excluded or restricted in this *[plan]rule* or the MO HealthNet hospital provider manual.

[(M) Per diem rates. The per diem rates shall be determined from the individual hospital cost report in accordance with section (3) of this regulation.]

[(N)](K) Reasonable cost. The reasonable cost of inpatient hospital services is an individual hospital's *[MO HealthNet]Medicaid [per diem]* cost per day as determined in accordance with *[the general plan rate calculation from] [section (3)]Section (4)* of this regulation using the base year cost report.

[(O)](L) Specialty [p]Pediatric [h]Hospital. An inpatient pediatric acute care facility which~~—~~:

1. Is licensed as a hospital by the Missouri Department of Health and Senior Services under Chapter 197 of the *Missouri Revised Statutes*;
2. Has been granted substantive waivers by the Missouri Department of Health and Senior Services from compliance with material hospital licensure requirements governing a) the establishment and operation of an emergency department, and b) the provision of pathology, radiology, laboratory, and central services; and
3. Is not licensed to operate more than sixty (60) inpatient beds.

[(P)](M) Trend factor. The trend factor is a measure of the change in costs of goods and services purchased by a hospital during the course of one (1) year.

[(Q) Children's hospital. An acute care hospital operated primarily for the care and treatment of children under the age of eighteen (18) years old and which has designated in its licensure application at least sixty-five percent (65%) of its total licensed beds as a pediatric unit.]

[(R)](N) [FRA] 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 shall be an allowable cost to the hospital.** The *[Federal Reimbursement Allowance (FRA)]* is identified in 13 CSR 70-15.110. Effective January 1, 1999, the assessment shall be an allowable cost.

[(S)](O) [Incorporates]Incorporation by Reference. This rule incorporates by reference the following:

1. The Hospital Provider Manual 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 [\[https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action\]](https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action), **March 6, 2020** <http://manuals.momed.com/manuals/>, **June 8, 2022**. This rule does not incorporate any subsequent amendments or additions; and

2. Medicare/Medicaid Cost Report CMS 2552-10, which is incorporated by reference and made a part of this rule as published by the Centers for Medicare [and] & Medicaid Services at its website <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html>, [February 18, 2020] **June 8, 2022**. This rule does not incorporate any subsequent amendments or additions.

3. 42 CFR 405, which is incorporated by reference and made a part of this rule as published by CMS at its website <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-405?toc=1>, June 8, 2022. This rule does not incorporate any subsequent amendments or additions.

4. 42 CFR 413, which is incorporated by reference and made a part of this rule as published by CMS at its website <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413?toc=1>, June 8, 2022. This rule does not incorporate any subsequent amendments or additions.

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

(A) The per diem rate shall be determined from the 1995 base year cost report in accordance with the following formula:

$$\text{Per Diem} = \frac{(OC * TI)}{MPD} + \frac{CMC}{MPDC}$$

1. OC—The operating component is the hospital’s total allowable cost (TAC) less CMC;

2. CMC—The capital and medical education component of the hospital’s TAC;

3. MPD—Medicaid inpatient days;

4. MPDC-MPD—Medicaid patient days for capital costs as defined in paragraph (3)(A)3. with a minimum utilization of sixty percent (60%) as described in paragraph (5)(C)8.;

5. TI—Trend indices. The trend indices are applied to the OC of the per diem rate. The trend index for SFY 1995 is used to adjust the OC to a common fiscal year end of June 30. The adjusted OC shall be trended through SFY 2001;

6. TAC—Allowable inpatient routine and special care unit expenses, ancillary expenses, and graduate medical education costs will be added to determine the hospital’s total allowable cost (TAC);

7. The per diem shall not exceed the average MO HealthNet inpatient charge per diem as determined from the base year cost report and adjusted by the TI;

8. The per diem shall be adjusted for rate increases granted in accordance with subsection (5)(F) for allowable costs not included in the base year cost report; and

(B) Trend Indices (TI). Trend indices starting in SFY 2016 will be determined based on the Hospital Market Basket index as published in Healthcare Cost Review by Institute of Health Systems (IHS), or equivalent publication, regardless of any changes in the name of the publication or publisher, for each State Fiscal Year (SFY).

1. The per diem rate shall be reduced as necessary to avoid any negative Direct Medicaid payments computed in accordance with 13 CSR 70-15.015.

2. 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, will receive the same inpatient rate and outpatient rate as the previous owner/operator. Such facility will also receive the same Direct Medicaid Add-On

Payment and Uninsured Add-On Payment as the previous owner/operator if the facility reenters the MO HealthNet Program during the same state fiscal year. If the facility does not reenter during the same state fiscal year, the Direct Medicaid Add-On Payment and Uninsured Add-On Payment will be determined based on the applicable base year data (i.e., fourth prior year cost report for the Direct Medicaid Payment; see 13 CSR 70-15.220 for the applicable data for the Uninsured Add-On Payment). If the facility does not have the applicable base year data, the Direct Medicaid Add-On Payment and the Uninsured Add-On Payment will be based on the most recent audited data available and will include annual trend factor adjustments from the year subsequent to the cost report period through the state fiscal year for which the payments are being determined.

(4) Per Diem Rate—New Hospitals.

(A) In the absence of adequate cost data, a new facility's initial MO HealthNet rate shall be ninety percent (90%) of the average-weighted, statewide per diem rate for the year it became certified to participate in the MO HealthNet program until a prospective rate is determined on the facility's rate setting cost report as set forth below in paragraph (4)(A)1. The facility's rate setting cost report shall be the first full fiscal year cost report. If the facility's first full fiscal year cost report does not include any Medicaid costs, the facility shall continue to receive the initial rate, and the prospective rate will be determined from the facility's second full fiscal year cost report. If the facility's second full fiscal year cost report does not include any Medicaid cost, the initial rate shall become the facility's prospective rate and shall be effective the date the facility was enrolled in the MO HealthNet program. The effective date for facilities whose prospective rate was based on the rate setting cost report shall be the first day of the SFY that the rate setting cost report is the base year cost report for determining the Direct Medicaid Add-On Payment as described in 13 CSR 70-15.015.

1. Prospective Per Diem Reimbursement Rate Computation. Each new hospital shall receive a MO HealthNet prospective per diem rate based on the sum of the following components:

A. Total Allowable Cost, less Graduate Medical Education cost, adjusted by the Trend Indices in subsection (3)(B) from the year subsequent to the rate setting cost report period through the state fiscal year for which the rate is being determined, divided by Medicaid Inpatient Days; plus

B. Graduate Medical Education cost divided by Medicaid Inpatient Days.

2. The per diem rate shall not exceed the average MO HealthNet inpatient charge per day as determined from the rate setting cost report as adjusted by the applicable Trend Indices.

3. The per diem rate shall be adjusted for rate increases granted in accordance with subsection (5)(F) for allowable costs not included in the rate setting cost report.

4. The per diem rate shall be reduced as necessary to avoid any negative Direct Medicaid Payments computed in accordance with 13 CSR 70-15.015.

(B) In addition to the MO HealthNet rate determined by subsection (4)(A), the MO HealthNet per diem rate for a new hospital licensed after February 1, 2007, shall include an adjustment for the hospital's estimated Direct Medicaid Add-On Payment per patient day, as determined in 13 CSR 70-15.015, until the facility's prospective rate is set in accordance with subsection (4)(A). The facility's Direct Medicaid Add-On adjustment will then no longer be included in the per diem rate but shall be calculated as a separate Add-On Payment, as set forth in 13 CSR 70-15.015.]

[(5)](3) Reporting Requirements.

(A) Cost Reports.

1. Each hospital participating in the MO HealthNet [p]Program shall submit a cost report in the manner prescribed by the [state MO HealthNet agency]Division. The cost report shall be submitted

within five (5) calendar months after the close of the reporting period. The period of a cost report is defined in 42 CFR 413.24(f). *[A single extension, not to exceed thirty (30) days, may be granted upon the request of the hospital and the approval of the MO HealthNet Division when the provider's operation is significantly affected due to extraordinary circumstances over which the provider had no control such as fire or flood. The request must be in writing and postmarked prior to the first day of the sixth month following the hospital's fiscal year end.]*

A. All cost reports shall be submitted and certified by an officer or administrator of the hospital.

B. If a cost report is more than ten (10) days past due, the Division may withhold fifty thousand dollars (\$50,000) in MO HealthNet payments from the hospital until the hospital submits the cost report. If the MO HealthNet payment is less than fifty thousand dollars (\$50,000), the entire payment will be withheld. Upon the Division's or its authorized contractor's receipt of the cost report prepared in accordance with this regulation, the payment that was withheld will be released to the hospital.

C. A single extension, not to exceed thirty (30) days, may be granted upon the request of the hospital and the approval of the Division when the hospital's operation is significantly affected due to extraordinary circumstances over which the hospital had no control, such as fire or flood. The request must be in writing and postmarked prior to the first day of the sixth month following the hospital's fiscal year end.

2. The change of control[, or ownership[, or termination]] of [or by] a hospital of participation in the program requires that the hospital submit a cost report for the period ending with the date of change of control[, or ownership[, or termination]] within five (5) calendar months after the close of the reporting period. *[No extensions in the submitting of cost reports shall be allowed when a termination of participation has occurred.]*

A. *[If a provider notifies, in writing, the director of the Institutional Reimbursement Unit of the division prior to the change of control, ownership, or termination of participation in the MO HealthNet program, the division will withhold all remaining payments from the selling provider until the cost report is filed. Upon receipt of a cost report prepared in accordance with this regulation, any payment that was withheld will be released to the selling provider.]* **Upon learning of a change of control or ownership, the Division may withhold fifty thousand dollars (\$50,000) of the next available MO HealthNet payment from the hospital identified in the current MO HealthNet participation agreement until the cost report is filed. If the MO HealthNet payment is less than fifty thousand dollars (\$50,000), the entire payment will be withheld. Once the cost report prepared in accordance with this regulation is received, the payment will be released to the hospital identified in the current MO HealthNet participation agreement.**

B. *[If the director of the Institutional Reimbursement Unit does not receive, in writing, notification of a change of control or ownership upon learning of a change of control or ownership, fifty thousand dollars (\$50,000) of the next available MO HealthNet payment, after learning of the change of control or ownership, will be withheld from the provider identified in the current MO HealthNet participation agreement until a cost report is filed. If the MO HealthNet payment is less than fifty thousand dollars (\$50,000), the entire payment will be withheld. Once the cost report prepared in accordance with this regulation is received, the payment will be released to the provider identified in the current MO HealthNet participation agreement.]*

C.] The [MO HealthNet] Division may, at its discretion, delay the withholding of funds specified in [s]Subparagraph[s] [(5)(A)2.A. and B.](3)(A)2.A. until the cost report is due based on

assurances satisfactory to the [d]Division that the cost report will be timely filed. A request jointly submitted by the buying and selling [provider]entities may provide adequate assurances. The buying [provider]entity must accept responsibility for ensuring timely filing of the cost report and authorize the [d]Division to immediately withhold fifty thousand dollars (\$50,000) if the cost report is not timely filed.

3. *[All cost reports shall be submitted and certified by an officer or administrator of the provider. Failure to file a cost report, within the period prescribed in this subsection, may result in the impositions of sanctions as described in 13 CSR 70-3.030.]* **The termination of or by a hospital of participation in the MO HealthNet program requires that the hospital submit a cost report for the period ending with the date of termination within five (5) calendar months from the date of the CMS Tie-Out Notice. No extension in the submitting of cost reports shall be allowed when a termination of participation has occurred.**

A. Upon learning of the termination, the Division may withhold fifty thousand dollars (\$50,000) of the next available MO HealthNet payment from the hospital until the cost report is filed. If the MO HealthNet payment is less than fifty thousand dollars (\$50,000), the entire payment will be withheld. Upon the Division's or its authorized contractor's receipt of the cost report prepared in accordance with this regulation, the payment that was withheld will be released to the hospital.

4. Amended cost reports or other supplemental. The [d]Division **or its authorized contractor** will notify the hospital by letter when the [desk review]audit of its cost report is completed. Since this data [may]will be used in the calculation of *per diem* rates, [direct payments, trended costs, or uninsured add-on]and other Medicaid payments, the hospital shall review the [desk review]audited cost report data [and the schedule of key data elements] and submit amended or corrected data to the [d]Division **or its authorized contractor** within fifteen (15) days. Data received after the fifteen[-] (15[-]) day deadline will not be considered by the [d]Division for *per diem* rates, [direct payments, trended costs, or uninsured]or other Medicaid payments unless the hospital requests in writing and receives an extension to file additional information prior to the end of the fifteen[-] (15[-]) day deadline.

(B) Records.

1. All hospitals are required to maintain financial and statistical records in accordance with 42 CFR 413.20. For purposes of this plan, statistical and financial records shall include beneficiaries' medical records and patient claim logs separated for inpatient and outpatient services billed to and paid for by MO HealthNet (excluding cross-over claims) respectively. *[Separate logs for inpatient and outpatient services should be maintained for MO HealthNet participants covered by managed care.]* All records must be available upon request to representatives, employees, or contractors of the MO HealthNet program, Missouri Department of Social Services, General Accounting Office (GAO), or the United States Department of Health and Human Services (HHS). The content and organization of the inpatient and outpatient logs shall include the following:

A. A separate [MO HealthNet] log for each fiscal year must be maintained by either date of service or date of payment [by MO HealthNet] for claims and all adjustments of those claims for services provided in the fiscal period. Lengths of stay covering two (2) fiscal periods should be recorded by date of admission. The information from the [MO HealthNet] log should be used to complete the Medicaid worksheet in the hospital's cost report;

[B. Data required to be recorded in logs for each claim include:

(I) Participant name and MO HealthNet number;

(II) Dates of service;

(III) *If inpatient claim, number of days paid for by MO HealthNet, classified by adults and peds, each subprovider, newborn, or specific type of intensive care;*

(IV) *Charges for paid inpatient days and inpatient ancillary charges for paid days classified by cost center as reported in the cost report or allowed outpatient services, classified by cost center as reported on cost report;*

(V) *Noncovered charges combined under a separate heading;*

(VI) *Total charges;*

(VII) *Any partial payment made by third-party payers (claims paid equal to or in excess of MO HealthNet payment rates by third-party payers shall not be included in the log);*

(VIII) *MO HealthNet payment received or the adjustment taken; and*

(IX) *Date of remittance advice upon which paid claim or adjustment appeared;]*

[C.] **B.** A year-to-date total must appear at the bottom of each log page or after each applicable group total, or a summation page of all subtotals for the fiscal year activity must be included with the log; and

[D.] **C.** Not to be included in the [outpatient] logs are **denied** claims or line item [outpatient] charges [denied by MO HealthNet or claims or charges paid from an established MO HealthNet fee schedule]. This would include payments for hospital-based physicians and certified registered nurse anesthetists billed by the hospital on a professional services claim, [payments for certain specified clinical diagnostic laboratory services,] or payments for services provided by the hospital through enrollment as a MO HealthNet provider-type other than hospital[outpatient].

2. Records of related organizations, as defined by 42 CFR 413.17, must be available upon demand to those individuals or organizations as listed in paragraph [(5)(B)1.] **(3)(B)1.** of this rule.

[3. *The MO HealthNet Division shall retain all uniform cost reports submitted for a period of at least three (3) years following the date of submission of the reports and will maintain those reports pursuant to the record-keeping requirements of 42 CFR 413.20. If an audit by, or on behalf of, the state or federal government has begun but is not completed at the end of the three- (3-) year period, or if audit findings have not been resolved at the end of the three- (3-) year period, the reports shall be retained until resolution of the audit findings.*

4. *The MO HealthNet Division shall maintain any responses received on this plan, subsequent changes to this plan, and rates for a period of three (3) years from the date of receipt.*

(C) *New, Expanded, or Terminated Services. A hospital, at times, may offer to the public new or expanded inpatient services which may require Certificate of Need (CON) approval, or may permanently terminate a service.*

1. *A state hospital, i.e., one owned or operated by the board of curators as provided for in Chapter 172, RSMo, or one owned or operated by the Department of Mental Health, may offer new or expanded inpatient services to the public provided it receives legislative appropriations for the project. A state hospital may submit a request for inpatient rate reconsideration if the project meets or exceeds a cost threshold of one (1) million dollars for capital expenditures or one (1) million dollars for major medical equipment expenditures as described in 19 CSR 60-50.300.*

2. *Nonstate hospitals may also offer new or expanded inpatient services to the public, and incur costs associated with the additions or expansions which may qualify for inpatient rate reconsideration requests. Such projects may require a Certificate of Need (CON). Rate reconsideration requests for projects requiring CON review must include a copy of the CON program approval. Nonstate hospitals may request inpatient rate reconsiderations for projects not requiring review by the CON program, provided each project meets or exceeds a cost threshold of one (1) million dollars for capital expenditures as described in 19 CSR 60-50.300.*

3. A hospital (state or nonstate) will have six (6) months after the new or expanded service project is completed and the service is offered to the public to submit a request for inpatient rate reconsideration, along with a budget of the project's costs. The rate reconsideration request and budget will be subject to desk review and audit. Upon completion of the desk review and audit, the hospital's inpatient reimbursement rates may be adjusted, if indicated. Failure to submit a request for rate reconsideration and project budget within the six- (6-) month period shall disqualify the hospital from receiving a rate increase prior to recognizing the increase through the trended cost calculation (direct Medicaid payments). Failure to submit a request shall not prohibit the division from reducing the rate in the case of a terminated service.

4. Failure to submit a budget concerning terminated services may result in the imposition of sanctions as described in 13 CSR 70-3.030.

5. The effective date for any increase granted under this subsection shall be no earlier than the first day of the month following the MO HealthNet Division's final determination on rate reconsideration.

6. Any inpatient rate reconsideration request for new, expanded, or terminated services must be submitted in writing to the MO HealthNet Division and must specifically and clearly identify the issue and total dollar amount involved. The total dollar amount must be supported by generally accepted accounting principles. The hospital shall demonstrate the adjustment is necessary, proper, and consistent with efficient and economical delivery of covered patient care services. The hospital will be notified in writing of the agency's decision within sixty (60) days of receipt of the hospital's written request or within sixty (60) days of receipt of any additional documentation or clarification which may be required, whichever is later. Failure to submit requested information within the sixty- (60-) day period shall be grounds for denial of the request. If the state does not respond within the sixty- (60-) day period, the request shall be deemed denied.

7. Rate adjustments due to new or expanded services will be determined as total allowable project cost (i.e., the sum of annual depreciation, annualized interest expense, and annual additional operating costs) multiplied by the ratio of total inpatient costs (less skilled nursing facility (SNF) and swing bed cost) to total hospital cost as submitted on the most recent cost report filed with the agency as of the review date divided by total acute care patient days including all special care units and nursery, but excluding swing bed days.

8. Total acute care patient days (excluding nursery and swing bed days) must be at least sixty percent (60%) of total possible bed days. Total possible bed days will be determined using the number of licensed beds times three hundred sixty-five (365) days. If the days, including neonatal units, are less than sixty percent (60%), the sixty percent (60%) number plus newborn days will be used to determine the rate increase. This computation will apply to capital costs only.

9. Major medical equipment costs included in rate reconsideration requests shall not include costs to replace current major medical equipment if the replacement does not result in new or expanded inpatient services. The replacement of inoperative or obsolete major medical equipment, by itself, does not qualify for rate reconsideration, even if the new equipment costs at least one (1) million dollars.]

[(D)](C) Cost Report Audits.

1. [A comprehensive hospital audit program shall be established in cooperation with the Missouri Medicare fiscal intermediary. Under the terms of the Common Audit Agreement, the Medicare intermediary shall perform the following:] **The examination or inspection of a hospital's cost report, files, and any other supporting documentation by the Division or its**

authorized contractor. The Division or its authorized contractor may perform the following types of audits:

A. *[Desk review all hospital cost reports;]* **Level I Audit** – Requires a more narrow scope of review of hospital cost reports, files, and any other additional information requested and submitted to the Division or its authorized contractor. The limited review may include items such as comparative analysis of a hospital’s cost report data to industry data, a review of a hospital’s prior year data to determine any outliers that may warrant further review, requesting additional details of the reported information, all of which could lead to potential adjustment(s) after such further review, as well as, making and standard adjustments, etc. **Level I Audits may be provided off-site;**

B. *[Determine the scope and format for on-site audits;]* **Level II Audit** – Requires a desk review of hospital cost reports, files, and any other additional information requested and submitted to the Division or its authorized contractor. The desk review may include review procedures in a Level I Audit plus a more detailed analysis of a hospital’s cost report data to identify items that would require further review including requesting additional details of the reported information, documentation to support amounts reflected in the cost report, etc. **Level II Audits may be provided off-site; or**

C. *[Perform field audits when indicated in accordance with Title XIX principles; and]* **Level III Audits** – Requires an in depth audit, including an on-site review, of hospital cost reports, files, and any other additional information requested and submitted to the Division or its authorized contractor. The Level III Audit will require an in depth analysis of a hospital’s cost report data and an on-site verification of cost report items deemed necessary through a risk assessment or other analyses, etc. **Level III Audits will require some portion of the hospital’s records review be provided on-site**

[D. Submit to the state agency the final Title XVIII cost report with respect to each provider.

(E) Adjustments to Rates. The prospectively determined individual hospital’s reimbursement rate may be adjusted only under the following circumstances:

1. *When information contained in the cost report is found to be intentionally misrepresented. The adjustment shall be made retroactive to the date of the original rate. This adjustment shall not preclude the MO HealthNet Division from imposing any sanctions authorized by any statute or rule; or*

2. *When rate reconsideration is granted in accordance with subsection (5)(F).*

(F) Rate Reconsideration.

1. *Rate reconsideration may be requested under this subsection for changes in allowable cost which occur subsequent to the base period described in subsection (3)(A). The effective date for any increase granted under this subsection shall be no earlier than the first day of the month following the MO HealthNet Division’s final determination on rate reconsideration.*

2. *The following may be subject to review under procedures established by the MO HealthNet Division:*

A. *New, expanded, or terminated services as detailed in subsection (5)(C);*

B. *When the hospital experiences extraordinary circumstances which may include, but are not limited to, an act of God, war, or civil disturbance; and*

C. *Per diem rate adjustments for critical access hospitals.*

(I) Critical access hospitals meeting either the federal definition or the Missouri expanded definition may request per diem rate adjustments in accordance with this subsection. The per diem rate increase will result in a corresponding reduction in the direct Medicaid payment.

(a) Hospitals which meet the federal definition as a critical access hospital will have a per diem rate equal to one hundred percent (100%) of their estimated MO HealthNet cost per day as determined in 13 CSR 70-15.015.

(b) Hospitals which meet the Missouri expanded definition as a critical access hospital will have a per diem rate equal to seventy-five percent (75%) of their estimated MO HealthNet cost per day as determined in 13 CSR 70-15.015. This includes new hospitals meeting the Missouri expanded definition as a critical access hospital whose interim MO HealthNet rate was calculated in accordance with subsection 13 CSR 70-15.015.

3. The following will not be subject to review under these procedures:

A. The use of Medicare standards and reimbursement principles;

B. The method for determining the trend factor;

C. The use of all-inclusive prospective reimbursement rates; and

D. Increased costs for the successor owner, management, or leaseholder that result from changes in ownership, management, control, operation, or leasehold interests by whatever form for any hospital previously certified at any time for participation in the MO HealthNet program, except a review may be conducted when a hospital changes from nonprofit to proprietary or vice versa to recognize the change in its property taxes, see paragraph (5)(E)4.

4. As a condition of review, the MO HealthNet Division may require the hospital to submit to a comprehensive operational review. The review will be made at the discretion of the MO HealthNet Division and may be performed by it or its designee. The findings from any such review may be used to recalculate allowable costs for the hospital.

5. The request for an adjustment must be submitted in writing to the MO HealthNet Division and must specifically and clearly identify the issue and the total dollar amount involved. The total dollar amount must be supported by generally acceptable accounting principles. The hospital shall demonstrate the adjustment is necessary, proper, and consistent with efficient and economical delivery of covered patient care services. The hospital will be notified in writing of the agency's decision within sixty (60) days of receipt of the hospital's written request or within sixty (60) days of receipt of any additional documentation or clarification which may be required, whichever is later. Failure to submit requested information within the sixty- (60-) day period shall be grounds for denial of the request. If the state does not respond within the sixty- (60-) day period, the request shall be deemed denied.

(G) Sanctions. Sanctions may be imposed against a provider in accordance with 13 CSR 70-3.030 and other applicable state and federal regulations.]

(4) Inpatient Per Diem Reimbursement Rate Computation. Effective for dates of service beginning July 1, 2022, each Missouri hospital shall receive a Missouri Medicaid *per diem* rate based on the following computation:

(A) The *per diem* shall be determined from the base year cost report in accordance with the following formula:

$$\text{PER DIEM} = ((\text{TAC} / \text{MPD}) * \text{TI}) + \text{MIP FRA}$$

1. **MIP FRA - Medicaid Inpatient Share of FRA.** The Medicaid inpatient share of the FRA Assessment will be calculated by dividing the hospital's Medicaid patient days from the base year cost report by total hospital patient days from the base year cost report to arrive at the Medicaid utilization percentage. This percentage is then multiplied by the inpatient FRA assessment for the current SFY to arrive at the increased allowable Medicaid cost. This cost is then divided by the estimated Medicaid days for the current SFY to arrive at the increased Medicaid cost per day;

2. **MPD – Medicaid inpatient days from the base year cost report;**

3. **TI – Trend indices.** The trend indices are applied to the TAC per day of the *per diem* rate. The trend index for the base year is used to adjust the TAC per day to a common fiscal year end of June 30. The adjusted TAC per day shall be trended through the current SFY;

4. **TAC – Medicaid allowable inpatient routine and special care unit costs, and ancillary costs, from the base year cost report, will be added to determine the hospital's Medicaid total allowable cost (TAC);**

5. **The *per diem* for private free-standing psychiatric hospitals shall be the greater of one-hundred percent (100%) of the SFY 2022 weighted average statewide *per diem* rate for private free-standing psychiatric hospitals or the *per diem* as calculated in (4)(A).;**

6. **The *per diem* shall not exceed the average Medicaid inpatient charge *per diem* as determined from the base year cost report and adjusted by the TI;**

7. **The *per diem* shall be adjusted for rate increases granted in accordance with Subsections IV.C. and IV.D.**

8. **If the hospital does not have a base year cost report, the inpatient *per diem* will be the weighted average statewide *per diem* rate as determined in Section (5).**

(B) Trend Indices (TI). For trend indices for State Fiscal Year 2018 and forward, refer to the Hospital Market Basket index as published in Healthcare Cost Review by Institute of Health Systems (IHS), or equivalent publication, regardless of any changes in the name of the publication or publisher, for each State Fiscal Year (SFY).

(C) Adjustments to Rates. A hospital's inpatient *per diem* rate may be adjusted only under the following circumstances:

1. **When information contained in the cost report is found to be intentionally misrepresented. Such adjustment shall be made retroactive to the date of the original rate. Such adjustment shall not preclude the Division from imposing any sanctions authorized by any statute or regulation.**

2. **When a rate reconsideration is granted in accordance with Subsection (4)(D).**

(D) Rate Reconsideration

1. **Rate reconsideration may be requested under this subsection for changes in allowable costs which occur subsequent to the base year cost report described in Subsection (4)(A). The effective date for any increase granted under this subsection shall be no earlier than the first day of the month following the Division's final determination of the rate reconsideration.**

2. **The following may be subject to review under procedures established by the Division:**

A. New or expanded inpatient services. A hospital, at times, may offer to the public new or expanded inpatient services which may require Certificate of Need (CON) approval.

(I) A state hospital, i.e., one owned or operated by the Board of Curators as provided for in Chapter 172, RSMo, or one owned or operated by the Department of Mental Health, may offer new or expanded inpatient services to the public provided it receives legislative

appropriations for the project. A state hospital may submit a request for inpatient rate reconsideration if the project meets or exceeds a cost threshold of one (1) million dollars for capital expenditures or one (1) million dollars for major medical equipment expenditures as described in 19 CSR 60-50.300.

(II) Non-state hospitals, may also offer new or expanded inpatient services to the public, and incur costs associated with the additions or expansions which may qualify for inpatient rate reconsideration requests. Such projects may require a CON. Rate reconsideration requests for projects requiring CON review must include a copy of the CON program approval. Non-state hospitals may request inpatient rate reconsiderations for projects not requiring review by the CON program, provided each project meets or exceeds a cost threshold of one (1) million dollars for capital expenditures as described in 19 CSR 60-50.300.

(III) A hospital (state or non-state) will have six (6) months after the new or expanded service project is completed and the service is offered to the public to submit a request for inpatient rate reconsideration, along with a budget of the project's costs. The rate reconsideration request and budget will be subject to review. Upon completion of the review, the hospital's inpatient reimbursement rate may be adjusted, if indicated. Failure to submit a request for rate reconsideration and project budget within the six (6) month period shall disqualify the hospital from receiving a rate increase prior to recognizing the increase through the trended cost calculation.

(IV) Rate reconsiderations due to new or expanded services will be determined as total allowable project cost (i.e., the sum of annual depreciation, annualized interest expense and annual additional operating costs) multiplied by the ratio of total inpatient costs (less SNF and swing bed cost) to total hospital cost as submitted on the most recent cost report filed with the Division or its authorized contractor as of the review date divided by total acute care patient days including all special care units and nursery, but excluding swing bed days. The most recent cost report filed must be audited prior to the finalization of the rate reconsideration.

(V) Total acute care patient days (excluding nursery and swing bed days) must be at least sixty percent (60%) of total possible bed days. Total possible bed days will be determined using the number of licensed beds times three hundred sixty-five (365) days. If the total acute care patient days (excluding nursery and swing bed days) are less than sixty percent (60%) of total possible bed days, the sixty percent (60%) number plus nursery days will be used to determine the rate increase. If the total acute care patient days (excluding nursery and swing bed days) are at least sixty percent (60%) of total possible bed days, the total acute care patient days plus nursery days will be used to determine the rate increase. This computation will apply to capital costs only.

(VI) Major medical equipment costs included in rate reconsideration requests shall not include costs to replace current major medical equipment if the replacement does not result in new or expanded inpatient services. The replacement of inoperative or obsolete major medical equipment, by itself, does not qualify for rate reconsideration, even if the new equipment costs at least one (1) million dollars.

B. When the hospital experiences extraordinary circumstances which may include, but are not limited to, an act of God, war or civil disturbance.

3. The following will not be subject to review under these procedures:

A. The use of Medicare standards and reimbursement principles;

B. The method for determining the trend factor;

C. The use of all-inclusive prospective reimbursement rates; and

D. Increased costs for the successor owner, management or leaseholder that result from changes in ownership, management, control, operation or leasehold interests by whatever form for any hospital previously certified at any time for participation in the Medicaid program.

4. The request for a rate reconsideration must be submitted in writing to the Division and must specifically and clearly identify the project and the total dollar amount involved. The total dollar amount must be supported by generally accepted accounting principles. The hospital shall demonstrate the rate reconsideration is necessary, proper, and consistent with efficient and economical delivery of covered patient care services. The hospital will be notified of the Division's decision in writing within sixty (60) days of receipt of the hospital's written request or within sixty (60) days of receipt of any additional documentation or clarification which may be required, whichever is later. Failure to submit requested information within the sixty (60) day period, shall be grounds for denial of the request.

(5) *Per Diem* Reimbursement Rate Computation for New Hospitals. Effective for dates of service beginning July 1, 2022, each new Missouri hospital's rate setting cost report shall be the first full fiscal year cost report, which includes inpatient Medicaid costs, otherwise the hospital shall continue to receive the weighted average statewide *per diem* rate as determined below.

(A) Acute care hospitals. In the absence of adequate cost data, a new hospital's Medicaid rate shall be one-hundred percent (100%) of the weighted average statewide *per diem* rate for acute care hospitals until a prospective rate is determined on the hospital's rate setting cost report, in accordance with Section (4).

(B) Free-standing psychiatric hospitals. In the absence of adequate cost data, a new hospital's Medicaid rate shall be one-hundred percent (100%) of the weighted average statewide *per diem* rate for free-standing psychiatric hospitals, excluding the state psychiatric hospitals, until a prospective rate is determined on the hospital's rate setting cost report, in accordance with Section (4).

(C) Long Term Acute Care hospitals. In the absence of adequate cost data, a new hospital's Medicaid rate shall be one-hundred percent (100%) of the weighted average statewide *per diem* rate for long term acute care hospitals until a prospective rate is determined on the hospital's rate setting cost report, in accordance with Section (4).

(D) Rehabilitation hospitals. In the absence of adequate cost data, a new hospital's Medicaid rate shall be one-hundred percent (100%) of the weighted average statewide *per diem* rate for rehabilitation hospitals until a prospective rate is determined on the hospital's rate setting cost report, in accordance with Section (4).

(6) Acuity Adjustment Payment (AAP)

(A) Beginning with SFY 2023, hospitals that meet the requirements set forth below shall receive an AAP. Ownership type of the hospital is determined based on the Type of Control reported on Schedule S-2, Part I, Line 21, Column 1 of the hospital's base year cost report.

For purposes of this section, Medicaid payments received shall include the following payments.

1. For SFY 2022, the Medicaid *per diem* payments, Direct Medicaid payments, GME payments, and CO payments.

2. For SFY 2023 and forward, the Medicaid *per diem* payments, AAP, PC payment, SLP, GME payments, and CO payments.

(B) Private Ownership. A hospital shall receive an AAP if the hospital's MO HealthNet case mix index is greater than a threshold set annually by the Division. The preliminary AAP is calculated by multiplying the hospital's MO HealthNet case mix index times the estimated Medicaid payments for the coming SFY. If the hospital's estimated Medicaid payments for the coming SFY plus the preliminary AAP exceeds the hospital's prior SFY Medicaid payments received by a stop-gain percentage, the preliminary AAP will be reduced so the estimated Medicaid payments for the coming SFY plus the final AAP is equal to the stop-gain percent of the hospital's prior SFY Medicaid payments received. If no reduction is necessary, the preliminary AAP shall be considered final.

(C) Non-State Government Owned or Operated (NSGO) Ownership. A hospital shall receive an AAP if the hospital's MO HealthNet case mix index is greater than a threshold set annually by the Division. The preliminary AAP is calculated by multiplying the hospital's MO HealthNet case mix index times the estimated Medicaid payments for the coming SFY. If the hospital's estimated Medicaid payments for the coming SFY plus the preliminary AAP exceeds the hospital's prior SFY Medicaid payments received by a stop-gain percentage, the preliminary AAP will be reduced so the estimated Medicaid payments for the coming SFY plus the final AAP is equal to the stop-gain percent of the hospital's prior SFY Medicaid payments received. If no reduction is necessary the preliminary AAP shall be considered final.

(D) The annual final AAP will be calculated for each hospital at the beginning of each SFY. The annual amount will be paid out over the number of financial cycles during the SFY.

(7) Poison Control (PC) Payment

(A) The PC payment shall be determined for hospitals which operated a Poison Control Center during the base year and which continues to operate a Poison Control Center. The PC payment shall reimburse the hospital for the Medicaid share of the total Poison Control cost and shall be determined as follows:

1. The total Poison Control cost from the base year cost report will be divided by the total hospital days from the base year cost report to determine a cost per day. This cost per day will then be multiplied by the estimated days for the SFY for which the PC payment is being calculated.

2. The annual final PC payment will be calculated for each eligible hospital at the beginning of each SFY. The annual amount will be paid out over the number of financial cycles during the SFY.

(8) Stop Loss Payment (SLP)

(A) Beginning with SFY 2023 hospitals that meet the requirements set forth below shall receive a SLP. Ownership type of the hospital is determined based on the Type of Control reported on Schedule S-2, Part I, Line 21, Column 1 of the hospital's base year cost report. For purposes of this section, Medicaid payments received shall include the following payments.

1. For SFY 2022, the Medicaid *per diem* payments, Direct Medicaid payments, GME payments, and CO payments.

2. For SFY 2023 and forward, the Medicaid *per diem* payments, AAP, PC payment, SLP, GME payments, and CO payments.

(B) Private Ownership. Total estimated Medicaid payments for the coming SFY for each hospital shall include any final AAP and PC payment. The total estimated Medicaid payments for each hospital shall be subtracted from the hospital's prior SFY Medicaid payments received then summed to calculate a total increase or decrease in payments for the entire private ownership group. A positive result represents a decrease in payments and a negative amount represents an increase in payments. If the result is a decrease in total payments to the private ownership group, this amount shall represent the total Stop Loss Amount.

1. SLP will be made if a total Stop Loss Amount was calculated in (8)(B). Each hospital that shows a decrease in Medicaid payments shall receive a SLP in the amount of the decrease in payments unless the sum of each hospital's SLP is greater than the total Stop Loss Amount. If the sum is greater than the total Stop Loss Amount, each hospital's SLP shall be calculated by multiplying the total Stop Loss Amount times the ratio of the hospital's decrease in Medicaid payments to the total Stop Loss Amount.

(C) NSGO Ownership. Total estimated Medicaid payments for the coming SFY for each hospital shall include any final AAP and PC payment. The total estimated Medicaid payments for each hospital shall be subtracted from the hospital's prior SFY Medicaid payments received then summed to calculate a total increase or decrease in payments for the entire NSGO ownership group. A positive result represents a decrease in payments and a negative amount represents an increase in payments. If the result is a decrease in total payments to the NSGO ownership group, this amount shall represent the total Stop Loss Amount.

1. SLP will be made if a total Stop Loss Amount was calculated in (8)(C). Each hospital that shows a decrease in Medicaid payments shall receive a SLP in the amount of the decrease in payments unless the sum of each hospital's SLP is greater than the total Stop Loss Amount. If the sum is greater than the total Stop Loss Amount, each hospital's SLP shall be calculated by multiplying the total Stop Loss Amount times the ratio of the hospital's decrease in Medicaid payments to the total Stop Loss Amount.

(D) The annual SLP will be calculated for each hospital at the beginning of each SFY. The annual amount will be paid out over the number of financial cycles during the SFY.

(9) Medicaid Graduate Medical Education (GME) Payments. Effective beginning with SFY 2023, a GME payment calculated as the sum of the Intern and Resident Based GME payment and the GME Stop Loss payment, shall be made to any acute care hospital that provides graduate medical education.

(A) Intern and Resident (I&R) Based GME payment. The I&R Based GME payment will be based on the per I&R Medicaid allocated GME costs not to exceed a maximum amount per I&R. The Division will determine the number of full time equivalent (FTE) I&Rs. Total GME costs will be determined using Worksheet A of the base year cost report adjusted by the trend index. Total GME costs is multiplied by the ratio of Medicaid days to total days to determine the Medicaid allocated GME costs which is then divided by the number of FTE I&Rs to calculate the Medicaid allocated cost per I&R. The I&R Based GME payment is

calculated as the number of FTE I&Rs multiplied by the minimum established by the Division or the Medicaid allocated cost per I&R.

(B) GME Stop Loss payment. The total I&R Based GME payment for each hospital shall be subtracted from the hospital's prior SFY GME payments received then summed to calculate a total increase or decrease in payments for the entire group of hospitals that provide graduate medical education. A positive result represents a decrease in payments and a negative amount represents an increase in payments. If the result is a decrease in total payments to the hospitals this amount shall represent the total GME Stop Loss Amount.

GME Stop Loss Payments will be made if a total GME Stop Loss Payment Amount was calculated in the paragraph above. Each hospital that shows a decrease in GME Medicaid payments shall receive a GME Stop Loss Payment in the amount of the decrease in payments unless the sum of each hospital's GME Stop Loss Payment is greater than the total GME Stop Loss Amount. If the sum is greater than the total GME Stop Loss Amount, each hospital's GME Stop Loss Payment shall be calculated by multiplying the total GME Stop Loss Amount times the ratio of the hospital's decrease in GME Medicaid payments to the total GME Stop Loss Amount.

(C) Hospitals who implement a GME program prior to July 1st of the SFY and do not have a base year cost report to determine GME costs shall receive an I&R Based GME payment based on the statewide average Per Resident Amount (PRA) determined as follows:

1. The number of FTE I&Rs shall be reported to the Division by June 1st prior to the beginning of the SFY in order to have a GME payment calculated.

2. The I&R Based GME payment shall be calculated as the number of FTE I&Rs multiplied by the Medicaid Capped Statewide Average PRA. The Medicaid Capped Statewide Average PRA is calculated as follows:

A. By applying a straight average to the list of facility PRA's with the following criteria:

(I) A facility's PRA used in the straight average shall be the minimum as established by the Division or the facility's actual PRA.

(D) The hospital's I&R Based GME Payment plus GME Stop Loss Payment, if applicable, will be calculated for each hospital at the beginning of each SFY. The annual amount will be paid on a quarterly basis during the SFY.

[(6)](10) [Outlier Adjustment for Children Under the Age of Six (6).]Children's Outlier (CO) Payment

(A) The outlier year is based on a discharge date between July 1 and June 30.

[(A)](B) [Effective for admissions beginning on or after July 1, 1991, outlier adjustments for medically necessary inpatient services involving exceptionally high cost or exceptionally long lengths of stay for MO HealthNet-eligible children under the age of six (6) will be made to hospitals meeting the criteria under this plan and, for MO HealthNet-eligible infants under the age of one (1), will be made to any other MO HealthNet hospital except for specialty pediatric hospitals.] Beginning July 1, 2022, for fee-for-service claims only, outlier payments for medically necessary inpatient services involving exceptionally high cost or exceptionally long lengths of stay for MO HealthNet-eligible children under the age of six (6) will be made to hospitals, meeting the Federal DSH requirements in Paragraph (10)(B)1., and for MO HealthNet-eligible infants under the age of one (1) will be made to any other Missouri Medicaid hospital.

1. The following criteria must be met to be eligible for outlier *[adjustments]* payments for children one (1) year of age to children under six (6) years of age:

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

B. As determined from the *[fourth prior year desk-reviewed]* **base year audited Medicaid** cost report, the *[facility]* **hospital** must have either~~[-]~~:

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

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

$$MIUR = TMD / TNID$$

or

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

(a) 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

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

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

$$LIUR = ((TMPR + CS) / (TNR + CS)) + ((CC - CS) / THC)$$

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

(I) Has an unsponsored care ratio of at least ten percent (10%). The unsponsored care ratio is determined as the sum of bad debts and CC divided by TNR and also meets either of the criteria in subparagraph (6)(A)1.B.; or

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

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

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

(I) The acute care hospital has an unsponsored care ratio of at least sixty-five percent (65%) and is licensed for less than fifty (50) inpatient beds; or

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

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

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

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

2. The following criteria must be met for the services to be eligible for outlier review:

A. The patient must be a MO HealthNet-eligible infant under the age of one (1) year, or for hospitals that meet the [criteria under paragraph (6)(A)1.] **federal DSH requirements**, a MO HealthNet-eligible child under the age of six (6) years, [for all dates of service presented for review] **as of the date of discharge; and**

B. [Hospitals requesting outlier review for children one (1) year of age to children under six (6) years of age must have qualified under paragraph (6)(A)1. for the state fiscal year corresponding with the fiscal year end of the cost report referred to in paragraph (6)(A)6.; and

C.] One (1) of the following conditions must be satisfied:

(I) The total reimbursable charges for dates of service [as described in paragraph (6)(A)4.] must be at least one hundred fifty percent (150%) of the sum of [total third-party liabilities and MO HealthNet inpatient] claim payments for [that] **each** claim; or

(II) The dates of service must exceed sixty (60) days and less than seventy-five percent (75%) of the total service days [was] **were** reimbursed by MO HealthNet.

3. Claims [for all dates of service] eligible for outlier review must[—]:

A. Have been submitted [to the MO HealthNet Division fiscal agent or the managed care health plan] in their entirety for [routine] claims processing[, and claim payment must have been made before the claims are submitted to the division for outlier review]; and

B. The claim must have been paid; and

[B.](C) [Be submitted for outlier review with all documentation as required by the MO HealthNet Division no later than ninety (90) days from the last payment made by the fiscal agent or the managed care health plan through the normal claims processing system for those dates of service.] **An annual outlier file, for paid claims only, must be submitted to the Division no later than December 31 of the second calendar year following the end of the outlier year (i.e. claims for outlier year 2022 are due no later than December 31, 2024).**

[4. Information for outlier reimbursement processing will be determined from claim charges and MO HealthNet payment data, submitted to the MO HealthNet Division fiscal agent or managed care health plan, by the hospital through normal claim submission. If the claim information is determined to be incomplete as submitted, the hospital may be asked to provide claim data directly to the MO HealthNet Division for outlier review.

5. The claims may be reviewed for—

A. Medical necessity at an inpatient hospital level-of-care;

B. Appropriateness of services provided in connection with the diagnosis;

C. Charges that are not permissible per the MO HealthNet Division; policies established in the hospital provider manual and hospital bulletins; and

D. If the hospital is asked to provide claim information, the hospital will need to provide an affidavit vouching to the accuracy of final payments by the MO HealthNet Division, managed care health plans, and other third-party payors. The calculation of outlier payments will be based on the standard hospital payment defined in subparagraph (6)(A)7.B.]

6. After the review, reimbursable costs for each claim will be determined using the following data from the *[most recent Medicaid hospital cost report filed by June 1 of each year]* **audited Medicaid hospital cost report for the year ending in the same calendar year as the outlier year (i.e. Medicaid hospital cost reports ending in 2022 will be used for the 2022 outlier year):**

A. Average routine (room and board) costs for the general and special care units for all days of the stay eligible per the outlier review; **and**

B. Ancillary cost-to-charge ratios applied to claim ancillary charges determined eligible for reimbursement per the outlier review[; *and*

C. No cost will be calculated for items such as malpractice insurance premiums, interns and residents, professional services, or return on equity].

7. *[Each state fiscal year, outlier adjustment payments for each hospital will be made for all claims submitted before March 1 of the preceding state fiscal year which satisfy all conditions in paragraphs (6)(A)1.-5.]* The **outlier** payments will be determined for each hospital as follows:

A. Sum all reimbursable costs *[per paragraph (6)(A)6.]* for all *[applicable]* **eligible** outlier claims to equal total reimbursable costs;

B. *[For those claims, subtract third-party payments and MO HealthNet payments, which includes both per diem payments and Direct Medicaid Add-On payments, from total reimburseable costs to equal excess cost]* **Subtract total claim payments, which includes MO HealthNet claims payments, third party payments, and co-pays, from total reimbursable costs to equal excess cost;** and

C. Multiply excess costs by fifty percent (50%).

[(B) Effective for admissions beginning on or after July 1, 1997, outlier adjustments shall also be made for MO HealthNet participants enrolled in managed care. All criteria listed under subsection (6)(A) applies to managed care outlier submissions.

(C) Effective for admissions beginning on or after May 1, 2017, outlier adjustments will only be made for the fee for service claims. All criteria listed under subsection (6)(A) will continue to be applied to the fee for service outlier submissions.]

(11) Safety Net Hospitals

(A) Inpatient hospital providers may qualify as a Safety Net Hospital based on the following criteria. Hospitals shall qualify for a period of only one (1) SFY and must re-qualify at the beginning of each SFY to continue their Safety Net Hospital designation.

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

2. As determined from the audited base year cost report, the facility must have either:

A. A Medicaid inpatient utilization rate (MIUR) at least one (1) standard deviation above the state's mean MIUR for all Missouri hospitals: The MIUR will be expressed as the ratio of total Medicaid days (TMD) (including such patients who receive benefits through a managed care entity) provided under a state plan divided by the provider's total number of inpatient days (TNID). The state's mean MIUR will be expressed as the ratio of the sum of the total number of 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. (Alternative language using CMS definition of mean MIUR.): The state's mean MIUR will be expressed as the ratio of the sum of all Medicaid participating hospitals' MIURs divided by the total number of Medicaid participating hospitals for a state plan year.

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

or;

B. A low income utilization rate in excess of twenty-five percent (25%).

(I) The low-income utilization rate (LIUR) shall be the sum (expressed as a percentage) of the fractions, calculated as follows:

(a) Total Medicaid patient revenues (TMPR) paid to the hospital for patient services under a state plan (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) 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 etc.) For patient services plus the cash subsidies, and;

(b) The total amount of the hospital's charges for patient services attributable to charity care (CC) less cash subsidies 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 charity care shall not include any contractual allowances and discounts other than for indigent patients not eligible for medical assistance under a State Plan.

$$\text{LIUR} = ((\text{TMPR} + \text{CS}) / (\text{TNR} + \text{CS})) + ((\text{CC} - \text{CS}) / \text{THC})$$

3. As determined from the audited base year cost report,

A. The acute care hospital has an unsponsored care ratio of at least sixty- five percent

(65%) and is licensed for less than fifty (50) inpatient beds; or

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

C. A public non-state governmental acute care hospital with a LIUR of at least forty percent (40%) and a MIUR greater than one standard deviation from the mean, and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of at least forty percent (40%); or

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

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

(12) Hospital Mergers. Hospitals that merge their operations under one Medicare and Medicaid provider number shall have their Medicaid reimbursement combined under the surviving hospital's (the hospital's whose Medicare and Medicaid provider number remained active) Medicaid provider number.

(A) The *per diem* rate for merged hospitals shall be calculated:

1. For the remainder of the SFY in which the merger occurred, the merged rate is calculated by multiplying each hospital's estimated Medicaid paid days by its *per diem* rate, summing the estimated *per diem* payments and estimated Medicaid paid days, and then dividing the total estimated *per diem* payments by the total estimated paid days to determine the weighted *per diem* rate. The effective date of the weighted *per diem* rate will be the date of the merger.

2. For subsequent SFYs, the *per diem* rate will be based on the combined data from the base year cost report for each facility.

(B) The Other Medicaid Payments, if applicable, shall be:

1. Combined under the surviving hospital's Medicaid provider number for the remainder of the SFY in which the merger occurred; and

2. Calculated for subsequent SFYs based on the combined data from the base year cost report for each facility.

[(7)](13) Payment Assurance. The state will pay each hospital, which furnishes the services in accordance with the requirements of the state plan, the amount determined for services furnished by the hospital according to the standards and methods set forth in the rules implementing the Hospital Reimbursement Program.

[(8)](14) Inappropriate Placements.

(A) The hospital *per diem* rate as determined under this plan and in effect on October 1, 1981, shall not apply to any participant who is receiving inpatient hospital care when s/he is only in need of nursing home care.

1. If a hospital has an established intermediate care facility/skilled nursing facility (ICF/SNF) or SNF-only MO HealthNet rate for providing nursing home services in a distinct part setting, reimbursement for nursing home services provided in the inpatient hospital setting shall be made at the hospital's ICF/SNF or SNF-only rate.

2. No MO HealthNet payments will be made on behalf of any participant who is receiving inpatient hospital care and is not in need of either inpatient or nursing home care.

(15) Directed Payments. Effective July 1, 2022, the Missouri Medicaid managed care organizations shall make inpatient and outpatient directed payments to in-network hospitals pursuant to 42 CFR 438.6(c) as approved by the Centers for Medicare & Medicaid Services.

[(9) MO HealthNet GME Add-On—A MO HealthNet Add-On determined for Graduate Medical Education (GME) costs shall be allocated based on the estimated effect of implementation of a MO HealthNet managed care system in accordance with this section.

(A) The MO HealthNet GME Add-On for MO HealthNet participants covered under a Managed Care Plan shall be determined using the base year cost report and paid in quarterly installments. The base year cost report shall be the fourth prior fiscal year (i.e., the base year for SFY 1999 is the FY 1995 cost report). The hospital per diem shall continue to include a component for GME related to MO HealthNet participants not included in a managed care system.

1. Total GME cost shall be multiplied by a managed care allocation factor which incorporates the estimated percentage of the hospital's MO HealthNet population included in a managed care system and the estimated implementation date for a managed care system. For example: If a hospital has 1) an annual GME cost of one hundred thousand dollars (\$100,000), 2) forty percent (40%) of their MO HealthNet days are related to MO HealthNet participants eligible for MO HealthNet managed care, and 3) the projected implementation date for managed care is October 1, 1995; the prorated GME Add-On is thirty thousand dollars (\$30,000).

2. The annual GME Add-On shall be paid in quarterly installments.

(10) Enhanced Graduate Medical Education (GME) Payment. An enhanced GME payment shall be made to any acute care hospital that provides graduate medical education (teaching hospital).

(A) The enhanced GME payment shall be computed in accordance with subsection (10)(B). The payment shall be made following 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 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 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 then multiplied by the MO HealthNet share of the aggregate approved amount reported on worksheet E-4 of the Medicare cost report (CMS 2552-10) for the fourth prior fiscal year and trended to the current state fiscal year. The resulting product is the enhanced GME payment.

(11) Hospital Mergers. Hospitals that merge their operations under one (1) Medicare and MO HealthNet provider number shall have their MO HealthNet reimbursement combined under the surviving hospital's (the hospital whose Medicare and MO HealthNet provider number remains active) MO HealthNet provider number.

(A) The disproportionate share status of the merged hospital provider shall be—

1. The same as the surviving hospital's status was prior to the merger for the remainder of the state fiscal year in which the merger occurred; and

2. Determined based on the combined desk-reviewed data from the appropriate cost reports for the merged hospitals in subsequent fiscal years.

(B) The per diem rate for merged hospitals shall be calculated—

1. For the remainder of the state fiscal year in which the merger occurred by multiplying each hospital's estimated MO HealthNet paid days by its per diem rate, summing the estimated per diem payments and estimated MO HealthNet paid days, and then dividing the total estimated per diem payments by the total estimated paid days to determine the weighted per diem rate. The effective date of the weighted per diem rate will be the date of the merger. This merged rate will also be used in fiscal years following the effective date.

(C) The Direct Medicaid Payments, Uninsured Add-On Payments, and GME payments, if the surviving facility continues the GME program, shall be—

1. Combined under the surviving hospital's MO HealthNet provider number for the remainder of the state fiscal year in which the merger occurred; and

2. Calculated for subsequent state fiscal years based on the combined data from the appropriate cost report for each facility.]

AUTHORITY: sections 208.152, 208.153, 208.201, 660.017, and RSMo. This rule was previously filed as 13 CSR 40-81.050. Original rule filed Feb. 13, 1969, effective Feb. 23, 1969. Emergency rescission and rule filed Sept. 21, 1981, effective Oct. 1, 1981, expired Jan. 13, 1982. Rescinded and readopted: Filed Sept. 21, 1981, effective Jan. 14, 1982. Emergency amendment filed June 21, 1982, effective July 1, 1982, expired Oct. 10, 1982. Amended: Filed June 21, 1982, effective Oct. 11, 1982. Emergency amendment filed July 21, 1982, effective July 30, 1982, expired Nov. 27, 1982. Emergency amendment filed June 21, 1983, effective July 1, 1983, expired Oct. 12, 1983. Amended: Filed June 21, 1983, effective Oct. 13, 1983. Amended: Filed Sept. 13, 1983, effective Dec. 11, 1983. Emergency amendment filed Dec. 21, 1983, effective Jan. 1, 1984, expired April 11, 1984. Emergency amendment filed March 14, 1984, effective March 28, 1984, expired June 10, 1984. Amended: Filed March 14, 1984, effective June 11, 1984. Emergency amendment filed June 21, 1984, effective July 1, 1984, expired Oct. 10, 1984. Amended: Filed July 12, 1984, effective Oct. 11, 1984. Amended: Filed Sept. 12, 1984, effective Jan. 12, 1985. Amended: Filed Jan. 15, 1985, effective May 27, 1985. Amended: Filed May 16, 1985, effective Sept. 1, 1985. Emergency amendment filed June 20, 1985, effective July 1, 1985, expired Oct. 28, 1985. Amended: Filed June 20, 1985, effective Oct. 1, 1985. Amended: Filed Sept. 4, 1985, effective Dec. 1, 1985. Emergency amendment filed Oct. 17, 1985, effective Oct. 27, 1985, expired Jan. 11, 1986. Amended: Filed Oct. 17, 1985, effective Feb. 13, 1986. Amended: Filed Dec. 16, 1985, effective April 1, 1986. Amended: Filed Feb. 14, 1986, effective May 11, 1986. Amended: Filed March 17, 1986, effective June 28, 1986. Amended: Filed April 2, 1986, effective July 1, 1986. Amended: Filed Aug. 1, 1986, effective Oct. 11, 1986. Emergency amendment filed Sept. 19, 1986, effective Oct. 1, 1986, expired Jan. 15, 1987. Emergency amendment filed Sept. 24, 1986, effective Oct. 4, 1986, expired Jan. 29, 1987. Emergency amendment filed Oct. 22, 1986, effective Nov. 1, 1986, expired Feb. 1, 1987. Amended: Filed Nov. 4, 1986, effective Jan. 30, 1987. Amended: Filed Nov. 12, 1986, effective Feb. 2, 1987. Amended: Filed Nov. 14, 1986, effective Jan. 30, 1987. Emergency amendment filed June 19, 1987, effective July 1, 1987, expired Oct. 29, 1987. Amended: Filed Aug. 18, 1987, effective Oct. 25, 1987. Amended: Filed Jan. 5, 1988, effective March 25, 1988. Amended: Filed March 2, 1988, effective May 12, 1988. Emergency amendment filed April 15, 1988, effective April 25, 1988, expired Aug. 22, 1988. Emergency amendment filed May 17, 1988, effective May 27, 1988, expired Sept. 23, 1988. Amended: Filed May 17, 1988, effective Aug. 11, 1988. Amended: Filed June 2, 1988, effective Aug. 25, 1988. Emergency amendment filed June 21, 1988, effective July 1, 1988, expired Oct. 28, 1988. Amended: Filed June 28, 1988, effective Sept. 29, 1988. Emergency amendment filed July 15, 1988, effective July 25, 1988, expired Nov. 21, 1988. Amended: Filed July*

15, 1988, effective Oct. 29, 1988. Emergency amendment filed Aug. 5, 1988, effective Aug. 15, 1988, expired Dec. 13, 1988. Amended: Filed Oct. 18, 1988, effective Jan. 13, 1989. Emergency amendment filed Dec. 16, 1988, effective Jan. 1, 1989, expired May 1, 1989. Amended: Filed Aug. 16, 1989, effective Nov. 11, 1989. Amended: Filed Sept. 26, 1989, effective Dec. 28, 1989. Emergency amendment filed Dec. 1, 1989, effective Jan. 1, 1990, expired April 29, 1990. Amended: Filed Dec. 1, 1989, effective Feb. 25, 1990. Amended: Filed Dec. 1, 1989, effective May 11, 1990. Amended: Filed Jan. 10, 1989, effective April 12, 1990. Amended: Filed Feb. 5, 1990, effective May 11, 1990. Amended: Filed Feb. 16, 1990, effective April 26, 1990. Emergency amendment filed May 30, 1990, effective July 1, 1990, expired Oct. 28, 1990. Amended: Filed May 30, 1990, effective Sept. 28, 1990. Emergency amendment filed May 30, 1990, effective July 1, 1990, expired Oct. 28, 1990. Amended: Filed May 30, 1990, effective Sept. 28, 1990. Amended: Filed Oct. 2, 1990, effective Feb. 14, 1991. Emergency amendment filed Oct. 15, 1990, effective Nov. 1, 1990, expired Feb. 28, 1991. Amended: Filed Oct. 15, 1990, effective Feb. 14, 1991. Amended: Filed Oct. 15, 1990, effective Feb. 14, 1991. Emergency amendment filed Dec. 21, 1990, effective Jan. 1, 1991, expired March 31, 1991. Emergency amendment filed Jan. 3, 1991, effective Jan. 15, 1991, expired May 13, 1991. Amended: Filed Feb. 14, 1991, effective July 8, 1991. Emergency amendment filed March 4, 1991, effective March 14, 1991, expired May 13, 1991. Emergency amendment filed March 7, 1991, effective March 17, 1991, expired July 14, 1991. Amended: Filed March 7, 1991, effective Aug. 30, 1991. Emergency amendment filed June 20, 1991, effective July 1, 1991, expired Oct. 28, 1991. Emergency amendment filed June 20, 1991, effective July 1, 1991, expired Oct. 28, 1991. Amended: Filed June 18, 1991, effective Oct. 31, 1991. Emergency amendment filed July 5, 1991, effective July 15, 1991, expired Aug. 15, 1991. Amended: Filed July 2, 1991, effective Dec. 9, 1991. Amended: Filed July 2, 1991, effective Dec. 9, 1991. Emergency amendment filed Aug. 8, 1991, effective Aug. 18, 1991, expired Dec. 15, 1991. Amended: Filed Aug. 5, 1991, effective Jan. 13, 1992. Emergency amendment filed Oct. 11, 1991, effective Oct. 21, 1991, expired Feb. 17, 1992. Emergency amendment filed Oct. 18, 1991, effective Oct. 28, 1991, expired Feb. 24, 1992. Emergency amendment filed Oct. 18, 1991, effective Oct. 28, 1991, expired Feb. 24, 1992. Amended: Filed Oct. 18, 1991, effective April 9, 1992. Emergency amendment filed Nov. 15, 1991, effective Dec. 3, 1991, expired April 1, 1992. Emergency amendment filed March 13, 1992, effective April 2, 1992, expired July 30, 1992. Amended: Filed Nov. 15, 1991, effective April 9, 1992. Emergency amendment filed Feb. 3, 1992, effective Feb. 18, 1992, expired June 16, 1992. Emergency amendment filed Feb. 7, 1992, effective Feb. 19, 1992, expired June 17, 1992. Emergency amendment filed March 13, 1992, effective April 2, 1992, expired July 30, 1992. Emergency amendment filed April 2, 1992, effective April 18, 1992, expired Aug. 15, 1992. Emergency amendment filed Aug. 6, 1992, effective Aug. 16, 1992, expired Dec. 13, 1992. Amended: Filed April 2, 1992, effective Feb. 26, 1993. Emergency amendment filed Sept. 21, 1992, effective Oct. 1, 1992, expired Jan. 28, 1993. Emergency amendment filed Sept. 21, 1992, effective Oct. 1, 1992, expired Jan. 28, 1993. Emergency amendment filed Sept. 21, 1992, effective Oct. 1, 1992, expired Jan. 28, 1993. Emergency amendment filed Nov. 3, 1992, effective Nov. 20, 1992, expired March 19, 1993. Emergency amendment filed Nov. 3, 1992, effective Nov. 20, 1992, expired March 19, 1993. Emergency amendment filed Nov. 16, 1992, effective Dec. 2, 1992, expired March 31, 1993. Emergency amendment filed Jan. 15, 1993, effective Jan. 25, 1993, expired May 24, 1993. Emergency amendment filed Jan. 15, 1993, effective Jan. 25, 1993, expired May 24, 1993. Emergency amendment filed Jan. 15, 1993, effective Jan. 25, 1993, expired May 24, 1993. Emergency amendment filed March 2, 1993, effective March 22, 1993, expired July 19, 1993. Amended: Filed Sept. 21, 1992, effective June 7, 1993. Amended: Filed Sept. 21, 1992, effective

June 7, 1993. Amended: Filed Nov. 3, 1992, effective June 7, 1993. Amended: Filed Nov. 3, 1992, effective June 7, 1993. Amended: Filed Nov. 16, 1992, effective June 7, 1993. Emergency amendment filed May 14, 1993, effective May 25, 1993, expired Sept. 21, 1993. Emergency amendment filed May 14, 1993, effective May 25, 1993, expired Sept. 21, 1993. Emergency amendment filed May 14, 1993, effective May 25, 1993, expired Sept. 21, 1993. Emergency amendment filed June 17, 1993, effective June 27, 1993, expired Oct. 24, 1993. Emergency amendment filed June 18, 1993, effective July 1, 1993, expired Oct. 28, 1993. Amended: Filed March 16, 1993, effective Oct. 10, 1993. Amended: Filed April 6, 1993, effective Oct. 10, 1993. Emergency amendment filed Sept 2, 1993, effective Sept. 18, 1993, expired Jan. 15, 1994. Emergency amendment filed Sept. 2, 1993, effective Sept. 18, 1993, expired Jan. 15, 1994. Amended: Filed Sept. 2, 1993, effective Jan. 31, 1994. Emergency amendment filed Oct. 15, 1993, effective Oct. 25, 1993, expired Feb. 21, 1994. Amended: Filed Oct. 15, 1993, effective June 6, 1994. Amended: Filed Oct. 15, 1993, effective June 6, 1994. Emergency amendment filed Dec. 2, 1993, effective Dec. 18, 1993, expired April 16, 1994. Amended: Filed Dec. 2, 1993, effective July 30, 1994. Emergency amendment filed Dec. 13, 1993, effective Jan. 5, 1994, expired May 4, 1994. Amended: Filed Dec. 13, 1993, effective July 30, 1994. Emergency amendment filed Dec. 20, 1993, effective Jan. 1, 1994, expired April 30, 1994. Amended: Filed Dec. 20, 1993, effective July 30, 1994. Emergency amendment filed Jan. 14, 1994, effective Feb. 2, 1994, expired June 1, 1994. Amended: Filed Jan. 14, 1994, effective July 30, 1994. Emergency amendment filed Jan. 14, 1994, effective Feb. 2, 1994, expired June 1, 1994. Emergency amendment filed Jan. 26, 1994, effective Feb. 5, 1994, expired June 4, 1994. Amended: Filed Jan. 14, 1994, effective July 30, 1994. Emergency amendment filed Feb. 16, 1994, effective Feb. 26, 1994, expired June 25, 1994. Emergency amendment filed March 14, 1994, effective April 2, 1994, expired July 30, 1994. Emergency amendment filed April 4, 1994, effective April 16, 1994, expired July 29, 1994. Emergency amendment filed April 6, 1994, effective April 17, 1994, expired Aug. 14, 1994. Emergency amendment filed April 25, 1994, effective May 5, 1994, expired Sept. 1, 1994. Emergency amendment filed May 20, 1994, effective June 2, 1994, expired Sept. 29, 1994. Emergency amendment filed May 20, 1994, effective June 2, 1994, expired Sept. 29, 1994. Emergency amendment filed May 20, 1994, effective June 5, 1994, expired Oct. 2, 1994. Emergency amendment filed June 2, 1994, effective June 12, 1994, expired Oct. 9, 1994. Emergency amendment filed June 2, 1994, effective June 12, 1994, expired Oct. 9, 1994. Amended: Filed Feb. 28, 1994, effective Sept. 30, 1994. Emergency amendment filed June 15, 1994, effective June 25, 1994, expired Oct. 22, 1994. Emergency amendment filed June 16, 1994, effective June 26, 1994, expired Oct. 23, 1994. Emergency amendment filed June 20, 1994, effective July 1, 1994, expired Oct. 28, 1994. Emergency amendment filed June 23, 1994, effective July 12, 1994, expired Nov. 8, 1994. Amended: Filed April 4, 1994, effective Oct. 30, 1994. Amended: Filed April 4, 1994, effective Oct. 30, 1994. Amended: Filed June 15, 1994, effective Jan. 29, 1995. Emergency amendment filed Aug. 30, 1994, effective Sept. 9, 1994, expired Jan. 6, 1995. Emergency amendment filed Sept. 23, 1994, effective Oct. 3, 1994, expired Jan. 30, 1995. Emergency amendment filed Oct. 7, 1994, effective Oct. 23, 1994, expired Feb. 19, 1995. Emergency amendment filed Oct. 12, 1994, effective Oct. 22, 1994, expired Feb. 18, 1995. Emergency amendment filed Dec. 15, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency amendment filed Jan. 20, 1995, effective Jan. 31, 1995, expired May 30, 1995. Emergency amendment filed Feb. 9, 1995, effective Feb. 20, 1995, expired June 19, 1995. Emergency amendment filed June 20, 1995, effective June 30, 1995, expired Oct. 27, 1995. Emergency amendment filed June 20, 1995, effective July 1, 1995, expired Oct. 28, 1995. Amended: Filed Dec.

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amendment filed June 20, 2016, effective July 1, 2016, expired Dec. 27, 2016. Amended: Filed June 23, 2016, effective Jan. 30, 2017. Emergency amendment filed June 20, 2017, effective July 1, 2017, expired Feb. 22, 2018. Amended: Filed June 20, 2017, effective Jan. 30, 2018. Emergency amendment filed June 21, 2018, effective July 1, 2018, expired Feb. 28, 2019. Amended: Filed June 21, 2018, effective Jan. 30, 2019. Amended: Filed April 30, 2020, effective Nov. 30, 2020. Emergency amendment filed June 14, 2022, effective July 1, 2022, expired Feb. 23, 2023. Amended filed June 14, 2022, effective Dec. 14, 2022.

**Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1978, 1981, 1986, 1988, 1990, 1992, 1993, 2004, 2005, 2007, 2011, 2013, 2014, 2015, 2016, 2018; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

PUBLIC COST: Fee For Service: This proposed amendment is estimated to cost the state approximately \$897.4 million (State Share: \$302.9 million FRA and \$2.6 million IGT for DMH) for SFY 2023. This proposed amendment is estimated to increase payments to public entities by approximately \$130.6 million for SFY 2023.

Directed Payments: This proposed amendment is estimated to save the state approximately \$19 million (State Share: \$6.5 million FRA and \$0 million IGT for DMH) for SFY 2023. This proposed amendment is estimated to cost public entities by approximately \$17.5 million for SFY 2023.

PRIVATE COST: Fee For Service: This proposed amendment is estimated to increase payments to in-state private entities by approximately \$766.8 million for SFY 2023.

Directed Payments: This proposed amendment is estimated to cost in-state private entities approximately \$1.6 million for SFY 2023.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, Legal Services Division-Rulemaking, P.O. Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing will not be scheduled.*