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

**PROPOSED AMENDMENT**

**13 CSR 70-15.230 Upper Payment Limit (UPL) Payment Methodology** The division is amending section (2) and the purpose statement.

*PURPOSE: This proposed amendment is updating the UPL payment methodology.*

*PURPOSE: This rule establishes a methodology for determining Upper Payment Limit (UPL) payments provided to* ***state government-owned*** *hospitals beginning July 1, [2011]****2022****. [The regulation also establishes an additional UPL supplemental payment for hospitals with a Low Income and Needy Care Collaboration Agreement.]*

(2) Beginning with SFY 2023, state government-owned hospitals will be paid a semi-monthly payment up to the inpatient (IP) UPL gap.

(A) Prior to each SFY, the division shall calculate the estimated Medicaid payments for the coming SFY for each hospital. The total estimated Medicaid payments for each hospital shall be subtracted from the hospital's IP UPL calculated in accordance to the methodology set forth below then summed to calculate the IP UPL gap. The IP UPL gap is reduced by the estimated inpatient fee-for-service Graduate Medical Education (GME) payments for the coming SFY for each hospital to calculate the total amount of funding available. *[previous]* SFY*['s]* **2023** payments are compared to current SFY's estimated claims based payments and when the estimated current year payments is less than *[prior year]***SFY 2023** payments, that hospital is eligible for a UPL payment. The available IP UPL gap is distributed to each eligible hospital based on the percent to total of the available room in the *[prior year]***SFY 2023** and current year comparison. The available gap under the IP UPL for each eligible hospital will be aggregated to create the supplemental payment amount. The total calculated supplemental payment amount will be paid to eligible hospitals.

1. The IP UPL will be determined based on the hospital's Medicaid inpatient costs using Medicare cost reporting principles. All Medicare cost report worksheet, column, or line references are based upon the Medicare Cost Report (MCR) CMS 2552-10 and should be adjusted for any CMS-approved successor MCR. The amount that Medicare would pay shall be calculated as follows:

A. Using Medicare cost report data within the previous two (2) years of the IP UPL demonstration dates in accordance with IP UPL guidelines set by CMS, Total Medicare Costs shall be derived from the reported Inpatient Hospital Cost on the following cost report variable locations:

(I) Worksheet D-1, Hospital/IPF/IRF Components, Column 1, Line 49;

(II) Plus Organ Acquisitions Cost from all applicable Worksheets D-4, Column 1, Line 69;

(III) Plus GME Aggregated Approved Amount from Worksheet E-4, Column 1, Line 49;

B. Total Medicare Patient Days shall be derived from Worksheet S-3, Part I, Column 6, Lines 14, 16, and 17 of the same cost report as the Total Medicare Costs;

C. A calculated Medicare Cost *Per Diem* shall be calculated by dividing the Total Medicare Costs by the hospital's Total Medicare Patient Days;

D. The calculated Medicare Cost *Per Diem* shall be multiplied by the total Medicaid Patient Days from a twelve- (12-) month data set from the prior two (2) years of the IP UPL demonstration dates in accordance with the IP UPL guidelines set by CMS to derive the hospital's IP UPL.

(I) The data source for the Medicaid Patient Days and Total Medicaid Payments shall be from the state's Medicaid Management Information System (MMIS) claims data;

E. The calculated IP UPL shall be inflated from the midpoint of the hospital's cost report period to the midpoint of the IP UPL demonstration period using the CMS Prospective Payment System (PPS) hospital market basket index; and

F. If payments in this section would result in payments to any category of hospitals in excess of the IP UPL calculation required by 42 CFR 447.272, payments for each eligible hospital receiving payments under this section will be reduced proportionately to ensure compliance with the IP UPL.

*AUTHORITY: sections 208.153, 208.201, and 660.017, RSMo 2016, and section 208.152, RSMo Supp. 2022.* Emergency rule filed May 20, 2011, effective July 1, 2011, expired Dec. 28, 2011. Original rule filed May 20, 2011, effective Jan. 30, 2012. Emergency amendment filed June 14, 2022, effective July 1, 2022, expired Feb. 23, 2023. Amended: Filed June 14, 2022, effective Jan. 30, 2023. Emergency amendment was filed July 26, 2024, effective August 9, 2024, and expires February 27, 2025. Amendment filed July 26, 2024.*

**Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1981, 1986, 1988, 1990, 1992, 1993, 2004, 2005, 2007, 2011, 2013, 2014, 2015, 2016, 2018, 2021; 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: This proposed amendment will not cost the state agencies more than five hundred dollars ($500) in the aggregate for SFY 2025. This proposed amendment is estimated to cost state government-owned hospitals four million ($4 million) in the aggregate for SFY 2025.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate for SFY 2025.*

*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.*