E. State Fiscal Year 1998 - 3.1%;
F. State Fiscal Year 1999 - 3.8%
G. State Fiscal Year 2000 - 4.0%
H. State Fiscal Year 2001 - 4.6%
I. State Fiscal Year 2002 - 4.8%
J. State Fiscal Year 2003 - 5.0%
K. State Fiscal Year 2004 - 6.2%
L. State Fiscal Year 2005 - 6.7%
M. State Fiscal Year 2006 - 5.7%
N. State Fiscal Year 2007 - 5.9%
O. State Fiscal Year 2008 – 5.5%
P. State Fiscal Year 2009 – 5.5%
Q. State Fiscal Year 2010 – 3.9%

2. The TI for SFY 96 through SFY 98 are applied as a full percentage to the OC of the per-diem rate and for SFY 99 the OC of June 30, 1998 rate shall be trended by 1.2% and for SFY 2000 the OC of June 30, 1999 rate shall be trended by 2.4%. The OC of the June 30, 2000 rate shall be trended by 1.95%.

III-1. Per-Diem Reimbursement Rate Computation. Effective for dates of service beginning July 1, 2008, the per diem rate shall be reduced as necessary to avoid any negative Direct Medicaid Payments computed in accordance with subsection XV.B. Each general plan (GP) hospital shall receive a Medicaid per-diem rate based on the following computation.

A. The per diem rate shall be determined from the 1995 cost report in accordance with the following formula:

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

1. OC - The operating component is the hospital's TAC less CMC;

2. CMC - The capital and medical education component of the hospital's TAC;

3. MPD - Medicaid inpatient days;

4. MPDC - MPD as defined in III.A.3. with a minimum utilization of sixty percent (60%) as described in paragraph V.C.4.;

5. TI -Trend Indices. The trend indices are applied to the OC of the per-diem rate. The trend indices for SFY 95 is used to adjust the OC to a common fiscal year end of June 30;

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 Medicaid 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 V.F., for allowable costs not included in the base year cost report

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

4. The utilization adjustment cost is determined by estimating the number of Medicaid inpatient days the hospital will not provide as a result of the MC+ Health Plans limiting inpatient hospital services. These days are multiplied by the hospital's cost per day to determine the total cost associated with these days. This cost is divided by the remaining total patient days from its base period cost report to arrive at the increased cost per day. This increased cost per day is multiplied by the estimated Medicaid days for the current SFY to arrive at the Medicaid utilization adjustment;

   A. Effective January 1, 2010, hospitals other than safety net hospitals as defined in subsection VI.B. will receive sixty-seven percent (67%) of the utilization adjustment calculated in accordance with paragraph XV-1.B.4. Safety net hospitals will continue to receive one hundred percent (100%) of the adjustment calculated in accordance with paragraph XV-1.B.4.

   B. Effective July 1, 2010, hospitals other than safety net hospitals as defined in subsection VI.B., children's hospitals as defined in subsection II.S. and specialty pediatric hospitals as defined in subsection II.P. will receive thirty-four percent (34%) of the utilization adjustment calculated in accordance with paragraph XV-1.B.4. Children's hospitals and specialty pediatric hospitals will receive fifty percent (50%) of the adjustment calculated in accordance with paragraph XV-1.B.4. Safety net hospitals will continue to receive one hundred percent (100%) of the adjustment calculated in accordance with paragraph XV-1.B.4.

   C. Effective July 1, 2011, the utilization adjustment will no longer apply to any hospital other than safety net hospitals as defined in subsection VI.B., children's hospitals as defined in subsection II.S. and specialty pediatric hospitals as defined in subsection II.P. Children's hospitals and specialty pediatric hospitals will continue to receive fifty percent (50%) of the adjustment calculated in accordance with paragraph XV-1.B.4. Safety net hospitals will continue to receive one hundred percent (100%) of the adjustment calculated in accordance with paragraph XV-1.B.4.

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

C. For new hospitals that do not have a base cost report, Direct Medicaid payments shall be estimated as follows:

1. Hospitals receiving Direct Medicaid payments shall be divided into quartiles based on total beds;

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

3. The number of beds for the new hospital without the base cost report shall be multiplied by the average Direct Medicaid payment per bed to determine the hospital's estimated Direct Medicaid payment for the current state fiscal year; and

4. For a new hospital licensed after February 1, 2007, estimated total Direct Medicaid payments for the current state fiscal year shall be divided by the estimated Medicaid patient days for the new hospital's quartile to obtain the estimated Direct Medicaid adjustment per patient day. This adjustment per day shall be added to the new hospital's Medicaid rate as determined in section IV, so that the hospital's Direct Medicaid payment per day is included in its per diem rate, rather than as a separate add-on payment. When the hospital's per diem rate is determined from its fourth (4th) prior year cost report in accordance with sections I – III, the facility's Direct Medicaid payment will be calculated in accordance with subsection XV.B. and reimbursed as an add-on payment rather than as part of the per diem rate. If the hospital is defined as a critical access hospital, its Medicaid per diem rate and Direct Medicaid payment will be determined in accordance with subsection V.F.

XVI-1. Safety Net Adjustment. Effective beginning with SFY 2009, a Safety Net Adjustment, in lieu of the Direct Medicaid Payments and Uninsured Add-Ons, shall be provided for each hospital which qualified as disproportionate share under the provision of paragraph VI.A.4. The safety net adjustment payment shall be made prior to the end of each federal fiscal year.

A. The safety net adjustment for facilities which meet the requirements in subparagraph VI.A.4.(b) or VI.A.4(c) shall be computed in accordance with the Direct Medicaid Payment calculation described in section XV and the uninsured costs calculation described in subsection XVII.D. The safety net adjustment will include the last three quarters of the SFY ending June 30 and the first quarter of the next SFY beginning July 1 to correspond with the FFY of October 1 to September 30.

B. The safety net adjustment for facilities which qualify under subparagraph VI.A.4.(d) shall be computed in accordance with the Direct Medicaid payment calculation described in section XV and the uninsured costs calculation described in subsection XVII.B. The safety net adjustment will include the last three (3) quarters of the SFY ending June 30 and the first quarter of the next SFY beginning July 1 to correspond with the FFY of October 1 to September 30.

C. Notwithstanding subparagraph B, the safety net adjustment for governmental facilities in state fiscal year 2004 and 2005 shall be up to 175% of unreimbursed Medicaid costs plus 175% of the Uninsured costs calculation described in subsection XVIII.B. subject to the state's disproportionate share allotment and IMD cap. The safety net adjustment shall be on a state fiscal year basis in these years.

E. Uninsured Add-Ons effective July 1, 2009 for all facilities except DMH safety net facilities as defined in VI.A.4.(d). DMH safety net facilities will continue to be calculated in accordance with subparagraph XVII.B. The Uninsured Add-on for all facilities except DMH safety net facilities will be based on the following:

1. Determination of the Cost of the Uninsured:

   (a) Allocate the uninsured population as determined from the Current Population Survey (CPS), Annual Social and Economic Supplement (Table HI05) as published by the U.S. Census Bureau, to the same categories of age (COA) and age groups as the managed care rate cells as determined by the Managed Care Unit of the MO HealthNet Division;

   (b) Determine the total annual projected cost of the uninsured population by multiplying the number of uninsured for each rate cell by the average contract per member per month (PMPM) for that individual managed care rate cell multiplied by twelve (12); and

   (c) Determine the amount of the total annual projected cost of the uninsured population that is related to hospital services by multiplying the total annual projected cost of the uninsured population as calculated in XVII-1.E.1.(b) above by the percentage of the contract PMPM for each individual rate cell that is related to hospital services. This would be the maximum amount of uninsured add-on payments that could be made to hospitals. This amount is also subject to the DSH cap;

2. Proration to individual hospitals of the cost of the uninsured calculated in paragraph XVII-1.E.1.

   (a) Determine each individual hospital's uninsured add-on payment by dividing the individual hospital's uninsured cost as determined from the three (3) year average of the fourth, fifth, and sixth prior base year cost reports by the total uninsured cost for all hospitals as determined from the three (3) year average of the fourth, fifth, and sixth prior base year cost reports, multiplied by either the total annual projected cost of the uninsured population that is related to hospital services or the DSH cap for hospitals whichever is lower. The DSH cap for hospitals is the federal DSH allotment less the IMD allotment less any redirections of DSH for Medicaid coverage of uninsured individuals as authorized by appropriation and as approved by CMS.

(a) Hospitals which qualify as safety net hospitals under Section VI.A.4.(b) and (c) shall receive payment of one hundred percent (100%) of their proration, or a payment up to the hospital specific DSH cap amount, whichever is lower. The percentage of proration payment to non-safety net hospitals shall be ninety-nine percent (99%), or a payment up to the hospital specific DSH cap amount, whichever is lower, unless the hospital contributes through a plan that is approved by the director of the Department of Health and Senior Services to support the state's poison control center and the Primary Care Resource Initiative for Missouri (PRIMO) and Patient Safety Initiative, in which case they shall receive one hundred percent (100%), or a payment up to the hospital specific DSH cap amount, whichever is lower;

1. For new hospitals that do not have a base cost report, uninsured payments shall be estimated as follows:

   (a) Hospitals receiving uninsured payments shall be divided into quartiles based on total beds;

   (b) Uninsured payments shall be individually summed by quartile and then divided by the total beds in the quartile to yield an average uninsured payment per bed; and

   (c) The numbers of beds for the new hospital without the base cost report shall be multiplied by the average uninsured payment per bed.

F. Uninsured add-on payments will coincide with the semi-monthly claim payment schedule established by the Medicaid fiscal agent. Each hospital's semi-monthly add-on payment shall be the hospital's total cost of the uninsured as determined in section XVII.D., divided by the number of semi-monthly pay dates available to the hospital in the state fiscal year.

OS Notification

State/Title/Plan Number: **Missouri 09-07**

Type of Action: **SPA Approval**

Required Date for State Notification: 06/24/2010

Fiscal Impact: **FFY 09 $12,500,000** **FFY 10 $41,795,000**

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0
or
Eligibility Simplification: No

Provider Payment Increase: No or Decrease: No

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: 0

Reduces Benefits: No

Detail: This State plan amendment (SPA) (1) provides for the annual update for inflation, (2) begins to phase out utilization adjustment supplement for all hospitals except for safety net hospitals and children's hospitals, and increases disproportionate share hospital (DSH) calculation to allow for payment of 100% of the available DSH allotment. Missouri relies on State appropriations (in part derived from provider taxes) and IGTs derived from local government appropriations to fund inpatient hospital payments. The State demonstrated that Non-DSH payments fit within the UPL.

This OSN has been reviewed in the context of the ARRA and approval of the OSN is not in violation of ARRA provisions.

Other Considerations:
This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor.

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