B. Trend Indices (TI). Trend indices are determined based on the four (4) quarter average DRI Index for DRI-Type Hospital Market Basket as published in Health Care Costs by DRI/McGraw-Hill for SFY 1995 to 1998. Trend indices starting in SFY 1999 will be determined based on the CPI Hospital index as published in Health Care Cost by DRI/McGraw-Hill for each SFY starting with SFY99.

1. The TI are B

   A. State Fiscal Year 1994 - 4.6%.,
   B. State Fiscal Year 1995 - 4.45%;
   C. State Fiscal Year 1996 - 4.575%;
   D. State Fiscal Year 1997 - 4.05%;
   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%
   R. State Fiscal Year 2011 - 3.2% – The 3.2% trend shall not be applied in determining the per diem rate, Direct Medicaid payments or uninsured payments.

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%.

3. The per diem rate shall be reduced as necessary to avoid any negative Direct Medicaid Payments computed in accordance with subsection XV-1.B. If the per diem rate exceeds the trended cost per day as set forth in subsection XV-1.B., the per diem rate shall be reduced to equal the trended cost per day.

4. A facility previously enrolled for participation in the MO HealthNet Program, which either voluntarily or involuntarily terminates its particpation in the MO HealthNet Program and which reenters the MO HealthNet Program, shall have its MO HealthNet rate determined in accordance with Section IV.

IV. Per-diem Rate New Hospitals.

A. Facilities Reimbursed by Medicare on a Per-Diem basis. In the absence of adequate cost data, a new facility's Medicaid rate may be its most current Medicare rate on file for two (2) fiscal years following the facility's initial fiscal year as a new facility. The Medicaid rate for this third fiscal year will be the lower of the most current Medicare rate on file by review date or the facility's Medicaid rate for its second fiscal year indexed forward by the inflation index for the current fiscal year. The Medicaid rate for the facility's fourth fiscal year will be determined in accordance with sections of this plan.

B. Facilities Reimbursed by Medicare on a DRG Basis. In the absence of adequate cost data, a new facility's Medicaid rate may 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 fourth fiscal year cost report in accordance with sections of this plan. If the facility's fourth 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 fifth fiscal year cost report.

C. In addition to the Medicaid rate determined by either subsections IV.A. or IV.B., the Medicaid 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 subsection XV.C., until the facility's fourth fiscal year. The Medicaid rate for the facility's fourth fiscal year will be determined in accordance with sections I. – III. of this plan. 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 section XV. If the facility's fourth fiscal year cost report does not include any Medicaid costs, the facility shall continue to receive the Direct Medicaid Add-On as an adjustment to its initial rate. The prospective rate will be determined on the facility's fifth fiscal year cost report at which time the facility's Direct Medicaid Add-On adjustment will no longer be included in the per diem but be calculated as a separate Add-On payment, as set forth in section XV.

V. Administrative Actions

A. Cost Reports

1. Each hospital participating in the Missouri Medical Assistance Program shall submit a cost report in the manner prescribed by the state Medicaid agency. 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 request of the hospital and the approval of the Missouri Division of Medical Services 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 post marked prior to the first day of the sixth (6th) month following the hospital's fiscal year end.

2. The unreimbursed Medicaid costs are determined by subtracting the hospital's per diem rate from its trended per diem costs. The difference is multiplied by the estimated Medicaid patient days for the current SFY.

(a) The trended cost per day is calculated by trending the base year costs per day by the trend indices listed in paragraph III.B.1., using the rate calculation in subsection III.A. In addition to the trend indices applied to inflate base period costs to the current fiscal year, base year costs will be further adjusted by a Missouri Specific Trend. The Missouri Specific Trend will be used to address the fact that costs for Missouri inpatient care of Medicaid residents have historically exceeded the compounded inflation rates estimated using national hospital indices for a significant number of hospitals. The Missouri Specific Trend will be applied at one and one-half percent (1.5%) per year to the hospitals base year. For example, hospitals with a 1998 base year will receive an additional six percent (6%) trend and hospitals with a 1999 base year will receive an additional four and one-half percent (4.5%) trend.

(I) Effective for dates of service beginning ~~July 1, 2010~~ AUG - 3 2010, the Missouri Specific Trend shall no longer be applied to inflate base period costs.

(b) For hospitals that meet the requirements in paragraphs VI.A.1., VI.A.2. and VI.A.4. of this rule (safety net hospitals), the base year cost report may be from the third prior year, the fourth prior year, or the fifth prior year, based on the determination of the Division of Medical Services exercising its sole discretion as to which report is most representative of costs incurred. For hospitals that meet the requirements in paragraphs VI.A.1., and VI.A.3., of this rule (first tier Disproportionate Share Hospitals), the base year operating costs shall be based on the third prior year cost report. For all other hospitals, the base year operating costs are based on the fourth prior year cost report. For any hospital that has both a twelve-month cost report and a partial year cost report, its base period cost report for that year will be the twelve-month cost report.

(c) The trended cost per day does not include the costs associated with the FRA assessment, the application of minimum utilization, the utilization adjustment and the poison control costs computed in paragraphs XV.B.1., 3., 4., and 5.;

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.

5. A facility previously enrolled for participation in the MO HealthNet Program, which either voluntarily or involuntarily terminates its participation in the MO HealthNet Program and which reenters the MO HealthNet Program, shall have its Direct Medicaid payments determined in accordance with subsection XV.C.

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 up to one hundred percent (100%) of the uninsured costs calculation described in subsection XVII.B. or a payment up to the hospital specific DSH cap amount, whichever is lower. 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-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.

XVII-1. Effective beginning with SFY 2009, in accordance with state and federal laws regarding reimbursement of unreimbursed Medicaid costs and the costs of services provided to uninsured patients, reimbursement for state fiscal year 2001 (July 1 - June 30) shall be determined as follows:

A. Medicaid Add-Ons for Shortfall

The Medicaid Add-On for the period of July, 1998 to December 31, 1998 will be based on fifty percent (50%) of the unreimbursed Medicaid costs as calculated for SFY 1998.

B. Uninsured Add-Ons

The hospital shall receive eighty-nine percent (89%) of the Uninsured costs prorated over the SFY. Hospitals which contribute through a plan approved by the director of health to support the state's poison control center and the Primary Care Resource Initiative for Missouri (PRIMO) shall receive ninety percent (90%) of its uninsured costs prorated over the SFY. DMH hospitals shall receive up to one hundred percent (100%) of their uninsured costs or up to the hospital specific DSH cap amount, whichever is lower. The uninsured Add-On will include:

1. The Add-On payment for the cost of the uninsured will be based on a three-year average of the fourth, fifth and sixth prior base year cost reports. For any hospital that has both a twelve-month cost report and a partial-year cost report, its base period cost report for that year will be the twelve-month cost report. The Add-On payment for the cost of the uninsured is determined by multiplying the charges for charity care and allowable bad debts by the hospital's total cost-to-charge ratio for allowable hospital services from the base year cost report's desk review. The cost of the uninsured is then trended to the current year using the trend indices in subsection III.B.. Allowable bad debts do not include the costs of caring for patients whose insurance covers the particular service, procedure or treatment; and

2. An adjustment to recognize the Uninsured patients share of the FRA assessment not included in the desk review cost. The FRA assessment for Uninsured patients is determined by multiplying the current FRA assessment by the ratio of uninsured days to total inpatient days from the base year cost report;

3. The difference in the projected General Relief per-diem payments and trended costs for General Relief patient days; and

4. The increased costs per day resulting from the utilization adjustment in subsection XV.B. is multiplied by the estimated uninsured days.

5. Notwithstanding any other provision, the Add-on payment for the cost of the uninsured for any public hospital that is not a safety net hospital in state fiscal year 2004 and 2005 shall be up to 175% of the Uninsured costs calculation described in this paragraph subject to the state's disproportionate share allotment and IMD cap. The Add-On payment for public hospitals other than safety net hospitals shall be on a state fiscal year basis in these years.

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

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

2. 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

3. The number of beds for the new hospital without the base cost report shall be multiplied by the average Uninsured payment per bed.

4. A facility previously enrolled for participation in the MO HealthNet Program, which either voluntarily or involuntarily terminates its participation in the MO HealthNet Program and which reenters the MO HealthNet Program, shall have its uninsured payments determined in accordance with subsection XVII.C.

D. Uninsured Add-Ons Effective July 1, 2005 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 Division of Medical Services.

(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.

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-1.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.

REPLACEMENT PAGE AUGUST, 2011

G. Disproportionate Share Hospital Payments.

(1) DSH Audit Payment Adjustments.

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

1. Based upon the state's analysis of the 2011 state's DSH survey using federally-mandated DSH audit standards, DSH payments will be limited to the hospital's projected hospital-specific DSH limit. The state's analysis of the 2011 state DSH survey is based on surveys received by MO HealthNet as of May 31, 2011. However, a corrected survey may be accepted if it is supported by documentation and the state determines the correction is appropriate and has a material impact on the survey results.
2. DSH payments as provided in the state's DSH survey that exceed the projected hospital-specific DSH limits will be recouped from the hospitals to reduce their payments to their projected hospital-specific DSH limit.
   (a) The amount of DSH payments to be recouped from a hospital by the MO HealthNet Division determined in accordance with section XVII-1.G.(1)(A)2. shall be limited in each state fiscal year to two percent of the hospital's total inpatient adjusted net revenues plus outpatient adjusted net revenues as set forth in section XVII-1.G.(5) until the final DSH audit is complete.
   (b) The limitation on recoupment of DSH payments shall only apply to recoupments determined in accordance with section XVII-1.G.(1).A.2. No limitation on the recoupment of DSH payments shall apply if the recoupment is determined as a result of the final DSH audit set forth in section XVII-1.G.(4). DSH overpayments identified through the final DSH audit that are recouped and not redistributed will be returned by the State to CMS.

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

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

(b) Hospitals which qualify as safety net hospitals under Section VI.A.4.(b) and (c) shall receive payment up to 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 up to 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 up to one hundred percent (100%), or a payment up to the hospital specific DSH cap amount, whichever is lower;

3. 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.

(d) A facility previously enrolled for participation in the MO HealthNet Program, which either voluntarily or involuntarily terminates its participation in the MO HealthNet Program and which reenters the MO HealthNet Program, shall have its uninsured payments determined in accordance with subsection XVII-1.E.3.

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.

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

(2) Disproportionate Share (DSH) Interim Payments.

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

(B) Federally deemed hospitals will receive the nominal DSH payment of five thousand dollars ($5,000) and the greater of their upper payment limit payment or their hospital specific DSH limit as calculated from the state DSH survey. Except for federally deemed hospitals, hospitals may elect to receive an upper payment limit payment in lieu of DSH payments.

1. Hospitals that elect to receive an upper payment limit payment rather than a DSH payment must submit a request to the MO HealthNet Division on an annual basis.
2. The upper payment limit calculation and upper payment limit payment calculation is set forth in section I.C.7-1.

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

1. An annual Disproportionate share payment will be calculated for each hospital at the beginning of each State Fiscal Year (SFY). The annual amount will be processed over the number of financial cycles during the SFY.

(D) New facilities will be paid based on the industry average as determined from the state DSH survey as set forth below. A new facility's eligibility to receive DSH payments will be determined from the most recent cost report or supplemental data available from the hospital if they do not have a base year cost report on which the state DSH survey was based.

1. Hospitals receiving DSH payments based on the state DSH survey shall be divided into quartiles based on total beds;
2. DSH payments shall be individually summed by quartile and then divided by the total beds in the quartile to yield an average DSH payment per bed;
3. The number of beds for the new hospitals shall be multiplied by the average DSH payment per bed to determine the DSH payment.

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

(3) Department of Mental Health Hospital (DMH) DSH Adjustments and Payments.
(A) Effective June 1, 2011, interim DSH payments made to DMH hospitals will be revised based on the results of a DMH state DSH survey which uses federally-mandated DSH audit standards. These revisions are to serve as interim adjustments until the federally-mandated DSH audits are complete in 2014.
(B) Beginning in SFY 2012 due to structural changes occurring at the DMH facilities, interim DSH payments will be based on the third prior base year cost report trended to the current SFY adjusted for the FRA assessment paid by DMH hospitals. Additional adjustments may be done based on the results of the federally mandated DSH audits.
(C) If the original DSH payments did not fully expend the federal Institute for Mental Disease DSH allotment for any plan year, the remaining IMD DSH allotment may be paid to hospitals that are under their projected hospital-specific DSH limit. These redistributions will occur proportionally based on each hospitals uncompensated care shortfall to the total shortfall, not to exceed each hospital's specific DSH limit.

(4) Final DSH Adjustments.
(A)Final DSH adjustments will be made after actual cost data is available and the DSH audit is completed.

(5) Each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues will be determined as follows:
(A). Obtain "Gross Total Charges" from Worksheet G-2, Line 25, Column 3, of the third prior year cost report for the hospital. Charges shall exclude revenues for physician services. Charges related to activities subject to the Missouri taxes assessed for outpatient retail pharmacies and nursing facility services shall also be excluded. "Gross Total Charges" will be reduced by the following:
1. "Nursing Facility Charges" from Worksheet C, Part I, Line 35, Column 6.
2. "Swing Bed Nursing Facility Charges" from Worksheet G-2, Line 5, Column 1.
3. "Nursing Facility Ancillary Charges" as determined from the Department of Social Services, MO HealthNet Division, nursing home cost report. (Note: To the extent that the gross hospital charges, as specified in section XVII-1.G.(5)(A)., include long-term care charges, the charges to be excluded through this step shall include all long-term care ancillary charges including skilled nursing facility, nursing facility, and other long-term care providers based at the hospital that are subject to the state's provider tax on nursing facility services.
4. "Distinct Part Ambulatory Surgical Center Charges" from Worksheet G-2, Line 22, Column 2.
5. "Ambulance Charges" from Worksheet C, Part I, Line 65, Column 7.
6. "Home Health Charges" from Worksheet G-2, Line 19, Column 2.

7. "Total Rural Health Clinic Charges" from Worksheet C, Part I, Column 7, Lines 63.50–63.59.
8. "Other Non-Hospital Component Charges" from Worksheet G-2, Lines 6, 8, 21, 21.02, 23, and 24.

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

(C). "Adjusted Gross Total Charges" (the result of the computations in section XVII-1.G.(5)(A).) will then be further adjusted by a hospital-specific collection-to-charge ratio determined as follows:

1. Divide "Net Revenue" by "Gross Total Charges."
2. "Adjusted Gross Total Charges" will be multiplied by the result of section XVII-1.G.(5)(C).1 to yield "Adjusted Net Revenue."

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

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

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

1. "Gross Inpatient Charges" will be divided by "Gross Total Charges."
2. "Adjusted Net Revenue" will then be multiplied by the result to yield "Net Inpatient Revenue."
3. The remainder will be allocated to "Net Outpatient Revenue."

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

1. SFY 2009 = 5.50%
2. SFY 2009 Missouri Specific Trend = 1.50%
3. SFY 2010 = 3.90%
4. SFY 2010 Missouri Specific Trend = 1.50%
5. SFY 2011 = 3.20%
6. SFY 2012 = 5.33%

(2) The Medicaid payments for each hospital are subtracted from the hospital's Medicare UPL to yield a UPL gap for each hospital. The aggregate UPL gap for each category is the sum of each hospital's UPL gap prior to any adjustments for out-of-state hospital costs and payments. For out of state hospital costs and payments, the utilization adjustments are based on State budget expenditure reports.

A. An adjustment is calculated to account for out-of-state recipients who come to Missouri hospitals. The out-of-state cost is determined by multiplying each hospital's trended cost per day by the out-of-state days, trended for cost inflation and utilization. The trended cost per day and out-of-state days are from the 2nd prior year FRA schedule. The out-of-state costs are summed to arrive at the aggregate cost for each category.

B The UPL is calculated by multiplying the aggregate out-of-state costs for each category by the Medicare paid to cost ratio for each category.

C. Medicaid per diem payments for out-of-state recipients are calculated by multiplying each hospital's per diem by the out-of-state days, trended for cost inflation and utilization. The per diems and out-of-state days are from the 2nd prior year FRA schedule. The trended per diem payments are totaled for each category and subtracted from each category's out-of-state UPL to yield an out-of-state UPL gap.

(3) The out-of-state UPL gap for each category is added to the UPL gap calculated prior to the out-of-state adjustment to arrive at the total UPL gap for each category.

(c) UPL Payment.

(1) The actual payment amount to each participating hospital will be the difference between the hospital's costs of uninsured services for the current state fiscal year, as determined in section XVII, and its uninsured add-on payments for the current state fiscal year plus the hospital's calculated trauma payments as determined in sections XXII and XXIII.

(2) Beginning with State Fiscal Year 2012, the UPL payment calculation set forth in section I.7-1.(C)(1) shall no longer apply. Each participating hospital shall be paid supplemental payments up to the Medicare Upper Payment Limit (UPL) as set forth below.

A. UPL Payment. Supplemental payments shall be paid to qualifying hospitals for inpatient services. The total amount of supplemental payments made under this section in each year shall not exceed the Medicare Upper Payment Limit, after accounting for all other supplemental payments.

1. The state shall determine the amount of Medicaid supplemental payments payable under this section on an annual basis. The state shall calculate the Medicare Upper Payment Limit for each of the three categories of hospitals: state hospitals, non-state governmental hospitals, and private hospitals. The state shall apportion the Medicaid supplemental payments payable under this section to each of the three categories of hospitals based on the proportionate Medicare Upper Payment Limits for each category of hospitals.
2. Each participating hospital shall be paid its proportional share of the UPL gap based upon its Medicaid inpatient utilization. The Medicaid inpatient utilization will be determined from the second prior year cost report.

XXII-2. SFY Trauma Add-On Payments will no longer be paid beginning with SFY 2012.

XXIII. Trauma Outlier Payments.

A. Effective through the end of SFY 2008, outlier adjustments for trauma inpatient services involving exceptionally high cost for Missouri Medicaid eligible recipients will be made to hospitals meeting the criteria established below:

1. Hospital must be a Level I, II, or III trauma center as designated by the Missouri Department of Health and Senior Services.

B. Claims for all dates of service eligible for trauma outlier review must --

1. Have been submitted to the Division of Medical Services fiscal agent 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

2. Be submitted for outlier review with all documentation as required by the Division of Medical Services by the end of the third (3rd) quarter of the current state fiscal year. The prior years information will be used to determine the trauma outlier payment for the current state fiscal year (for example, SFY 2004 trauma outlier payments will be based on 2003 data). Out of state trauma claims may be included.

3. The claims for trauma inpatient services may include services provided to Medicaid eligible individuals from states outside Missouri when provided in a Missouri hospital.

4. The claim must be an inpatient that originated in the hospital emergency room or a direct admit from another hospital's emergency room and must have a diagnosis code that is included in the table of valid trauma diagnosis codes listed below:

800.00 - 959.99
980.00 - 981.99
983.00 - 983.99
986.00 - 987.99
989.00 - 989.99
991.00 - 994.99
E800.00 - E999.99

5. The payment for the claim as determined by the product of days of service times the appropriate year cost per day (including the assessment per day and the utilization adjustment per day) must be less than the cost of the claim as determined by product of charges times the hospital specific cost-to-charge ratio.

C. Trauma outlier payments for qualifying hospitals will be determined as follows:

1. Multiply charges on claim by hospital specific second (2nd) prior year cost to charge ratio to determine patient-specific trauma costs;

2. Multiply days of care by the appropriate year's cost per day including the assessment per day and utilization adjustment per day (estimated for SFY 2004 using the 2000 cost report with some exceptions) to determine patient-specific payments; and

3. Determine difference between trauma costs and payments.

D. The Division of Medical Services will require a signed affidavit attesting to the validity of the data.

XXIII-2. SFY Trauma Outlier payments will no longer be paid beginning with SFY 2012.

OS Notification

State/Title/Plan Number: Missouri 10-012

Type of Action: SPA Approval

Required Date for State Notification: 09/27/2011

Fiscal Impact: FFY 10 $-0- FFY 11 $-0-

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:
Effective August 3, 2010, this amendment modifies the inpatient hospital rate setting methodology and the Disproportionate Share Hospital (DSH) payment methodology to comply with the DSH Auditing and Reporting final rule that became effective on January 19, 2009. The State will be expanding uncompensated care levels by not applying trend factors to base period costs used in setting current IH payment rates. Provisions are also being added to allow for an interim reconciliation, recoupment and redistribution process for DSH payments based on a provider submitted survey, to provide for a recoupment and redistribution process for any DSH overpayments identified during the DSH audit, and to provide for interim DSH payments for the next state plan rate year based on the provider survey. The State is also clarifying how payment rates for new facilities and facilities reentering the Medicaid program will be calculated.

Other Considerations:
This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor. This OSN has been reviewed in the context of the ARRA and approval of the OSN is not in violation of ARRA provisions. Tribal consultation was not required for this amendment.

CMS Contact:
Tim Weidler (816) 426-6429, National Institutional Reimbursement Team