STATE: Missouri

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Inpatient Hospital Services Reimbursement Plan

I. GENERAL REIMBURSEMENT PRINCIPLES

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

C. The Title XIX reimbursement for hospitals, excluding those located outside Missouri and in-state federal hospitals, shall include per-diem payments, and disproportionate share payments; various Medicaid Add-On payments, as described in this plan; or a safety net adjustment, paid in lieu of Direct Medicaid Payments described in section XV and Uninsured Add-Ons described in subsections XVII.B and XVII-1. Reimbursement shall be subject to availability of federal financial participation (FFP).

1. Per-diem reimbursement - The per diem rate is established in accordance with section III.

2. Outpatient reimbursement is described in Attachment 4.19B.

3. Disproportionate share reimbursement - The disproportionate share payments described in sections XVI, XVI-1, XVII.B, and XVII-1 include both the federally mandated reimbursement for hospitals which meet the federal requirements in Subsection VI.A.1 and 2 and the discretionary disproportionate share payments which are allowable but not mandated under federal regulation. These Safety Net and Uninsured Add-Ons shall not exceed one hundred percent (100%) of the unreimbursed cost for Medicaid and the cost of the uninsured unless otherwise permitted by federal law.

4. Medicaid Add-Ons - Medicaid Add-Ons are described in sections XV, XVIII, XX, XXII, and XXIII and are in addition to Medicaid per-diem payments. These payments are subject to the federal Medicare Upper Limit test.

5. Safety Net Adjustment - The payments described in subsection XVI are paid in lieu of Direct Medicaid Payments described in section XV and Uninsured Add-Ons described in subsection XVII.B.

6. For State Fiscal Year (SFY) 2004 and State Fiscal Year (SFY) 2005, each participating hospital will be paid semi-annual payments for unreimbursed cost of providing services to the uninsured, up to the Medicare Upper Payment Limit, as authorized by federal law.

   (a) The Medicare Upper Payment Limit is calculated using the following methodology:

      (1) Medicare acute costs and payments for each hospital are obtained from the hospitals' FY 1999 cost reports. This information is summarized by category (State, Non-State Government and Non-Government).

      (2) The Medicare paid-to-cost ratio is calculated for each hospital using the FY 1999 cost report data.

      (3) Medicaid costs for each hospital are obtained from 4th prior year desk reviewed cost reports trended for inflation through the current state fiscal year.

(d) The State will ensure that no payments made under this methodology will exceed the Federal Upper Payment Limits at 42 CFR 447.272, unless authorized by federal law, as calculated in subparagraph 7.(b) above.

II. Definitions.

A. Allowable costs. Allowable costs are those related to covered Medicaid 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 Missouri Medicaid hospital provider manual and detailed on the desk reviewed 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 should include the costs of caring for patients who have insurance but are not cover the particular services, procedures or treatment rendered. Bad debts should not include the cost of caring for patients whose insurance covers the given procedures but limits coverage. In addition, bad debts should 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 cost report–Desk-reviewed Medicare/Medicaid cost report from the fourth prior year. If a facility has more than one (1) cost report with periods ending in the fourth prior year, the cost report covering a full twelve (12) month period ending in the fourth prior year will be used. If none of the cost reports cover a full twelve (12) months, the cost report with the latest period ending in the fourth prior year will be used.

Any changes to the desk reviewed cost report after the Division issues a final decision on assessment or payments based on the base cost report will not be included in the calculations.

D. Case mix index. The average DRG relative weight as determined from claims information filed with the Missouri Department of Health and Senior Services. This calculation will include both fee-for-service and managed care information. The DRG weight used in the calculation is the same for all years and is the weight that is associated with the latest year of data that is being analyzed (i.e. for SFY 2004, weights for 2003 are applied to all years). The DRG weights will be updated annually using the information published by CMS in the Federal Register.

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.

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

G. Cost report. A cost report details, for purposes of both Medicare and Medicaid 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.

H. 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 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.

I. Disproportionate Share Reimbursement. The disproportionate share payments described in sections XVI, XVI-1, XVII.B, and XVII-1 include both the federally mandated reimbursement for hospitals which meet the federal requirements in Subsection V.A.1 and 2 and the discretionary disproportionate share payments which are allowed but not mandated under federal regulation. These Safety Net and Uninsured Payment Add-Ons shall not exceed one hundred percent (100%) of the unreimbursed cost for Medicaid and the cost of the uninsured unless otherwise permitted by federal law.

J. Effective date.

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

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

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 set forth below:

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.
S. State Fiscal Year 2012 - 4.0%

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 participation in the MO HealthNet Program and which reenters the MO HealthNet Program, shall have its MO HealthNet rate determined in accordance with Section IV.

(5) Non-covered charges combined under a separate heading;

(6) Total charges;

(7) Any partial payment made by third party payors (claims paid equal to or in excess of Medicaid payment rates by third party payors shall not be included in the log);

(8) Medicaid payment received or adjustment taken; and

(9) Date of remittance advice upon which paid claim or adjustment appeared.

(c) 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) Not to be included in the outpatient log are claims or line item outpatient charges denied by Medicaid or claims or charges paid from an established Medicaid 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 Medicaid 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 Section V B.1 of this plan.

3. Records to support and document DSH payments must be maintained and available for future federal audits. Records used to complete DSH audit surveys shall be kept seven (7) years following the final DSH audit. For example, the SFY 2011 state DSH survey will use 2009 cost data which must be maintained seven (7) years following the completion of the 2014 DSH audit (2022). Records provided by hospitals to the state's independent auditor shall also be maintained for seven (7) years following the completion of the final federal 2014 DSH audit.

4. 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 such 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.

5. 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, i.e., not owned or operated by the Board of Curators as provided for in Chapter 172, RSMo, or not owned or operated by the Department of Mental Health, 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.

D. 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:

   (a) Desk review all hospital cost reports;

   (b) Determine the scope and format for on-site audits;

   (c) Perform field audits when indicated in accordance with Title XIX principles; and

   (d) Submit to the state agency the final Title XVIII cost report with respect to each such provider.

2. The state agency shall review audited Medicaid-Medicare cost reports for each hospitals fiscal year in accordance with Appendix B.

3. Annual DSH audits are completed by an independent auditor in accordance with federal DSH audit standards. Hospitals receiving DSH payments are subject to the annual DSH audit.

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. Such adjustment shall be made retroactive to the date of the original rate. Such adjustment shall not preclude the Medicaid agency from imposing any sanctions authorized by any statute or regulation;

2. When rate reconsideration is granted in accordance with subsection V.F.;

3. When the Medicare per-diem rate is changed by the servicing fiscal intermediary based on a new audit finding for the base year. This adjustment may be applied and effective no earlier than the first day of the month following notification by the MO HealthNet Division; and

4. When a hospital documents to the MO HealthNet Division, a change in its status from nonprofit to proprietary, or from proprietary to nonprofit, its direct Medicaid payments for the State Fiscal Year will be adjusted to take into account

D. Specialty Pediatric hospitals shall not qualify for disproportionate share payments by meeting the state defined requirements. However, they will qualify for disproportionate share payments if they meet the federal requirements as defined in (VI) (A) 1. and (VI) (A) 2.

E. Hospitals shall not send amended cost reports or other data necessary for qualification for disproportionate share classification for purposes of rate reconsideration unless the reports or other necessary data are received within sixty (60) days of the date of the division's notification of the final determination of the rate.

F. Hospital-specific DSH cap. Unless otherwise permitted by federal law, disproportionate share payments shall not exceed one hundred percent (100%) of the unreimbursed cost for Medicaid and the cost of the uninsured. The hospital-specific DSH cap shall be computed by combining the estimated unreimbursed Medicaid costs for each hospital, as calculated in Section XV, with the hospital's corresponding estimated uninsured costs, as determined in Sections XVII and XVII-1. If the sum of disproportionate share payments exceeds the estimated hospital-specific DSH cap, the difference shall be deducted in order as necessary from safety net payments, other disproportionate share lump sum payments, direct Medicaid payments, and if necessary, as a reduced per diem. All DSH payments in the aggregate shall not exceed the federal DSH allotment within a state fiscal period.

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. 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 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 XVII~~I~~.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.

XX-1. Enhanced Graduate Medical Education (GME) Payment– Effective beginning with SFY 2009, an Enhanced GME payment shall be made to any acute care hospital that provides graduated medical education (teaching hospital).

A. The enhanced GME payment shall be computed in accordance with subsection (XX)(B). The payment shall be made at the end of the state fiscal year. The enhanced GME payment for each 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 the eighty-five and sixty-two-one-hundredth percent (85.62%) for SFY 2000. The percentage difference is then multiplied by the Medicaid share of the aggregate approved amount reported on worksheet E-3 part IV of the Medicare cost report (HCFA 2552-96) for the fourth prior fiscal year and trended to the current state fiscal year. The resulting product is the enhanced GME payment.

C. Beginning with SFY 2012, enhanced GME payments will be made following the end of the state fiscal year.

OS Notification

State/Title/Plan Number: Missouri 11-012

Type of Action: SPA Approval

Required Date for State Notification: 05/15/2012

Fiscal Impact: FFY 11 $12,521,000 FFY 12 $50,214,000

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: Yes **or Decrease:** No

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: 0

Reduces Benefits: No

Detail:
Effective for services on or after July 1, 2011, this amendment provides for a trend increase of 4% in inpatient hospital per diem rates. This SPA also clarifies audit and record keeping requirements associated with the independent DSH audits, updates the plan language to correct erroneous references to other State plan sections, and changes the timing of enhanced graduate medical education payments (from periodically during the State fiscal year to being made once at the end of the SFY). Inpatient hospital payments in Missouri are funded by state appropriations, a previously approved provider tax, and previously approved IGTs.

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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