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State/Territory Name: MO

State Plan Amendment (SPA) #: 13-14

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

JUN 11 2014

Brian Kinkade, Director
Missouri Department of Social Services
Broadway State Office Building
P.O. Box 1527
Jefferson City, MO 65102

RE: Missouri State Plan Amendment TN: 13-14

Dear Ms. Miller:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 13-14. This amendment provides for a trend factor of 3.7 percent in calculating inpatient hospital per diem rates. This amendment also updates the State plan to make references to the current version of the Medicare/Medicaid cost report (CMS 2552-10) and to clarify the payment methodology for merged hospitals.

As part of our review of TN 13-14, we analyzed the State's submittal of the State fiscal year 2014 inpatient hospital upper payment limit (UPL) demonstration. This UPL demonstration indicated that SFY 2014 inpatient hospital Medicaid payments would remain under the UPL. However, the SFY 2014 UPL was based on the SFY 2013 UPL demonstration trended to SFY 2014. This is not consistent with CMS' policy that the UPL be based on the most recent data available to the State, generally not to exceed two years in age. We are approving this SPA based on the commitment in Missouri's March 13, 2014 letter that the final inpatient hospital UPL demonstration would be submitted to CMS upon completion. The final, update SFY 2014 should be submitted to CMS by June 30, 2014 in accordance with our annual UPL requirements as outlined in State Medicaid Director Letter #13-003.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. This is to inform you that Medicaid State plan amendment 13-14 is approved effective July 1, 2013. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Tim Weidler at (816) 426-6429.

Sincerely,

Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 13 - 14

2. STATE: Missouri

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2013

5. TYPE OF PLAN MATERIAL *(Check One):*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447 Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 2013 $ 10.891 million
b. FFY 2014 $ 44.032 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A
Page 3, 6, 6a, 20, 21a

9. PAGE NUMBER OF THE SUPERSEDES PLAN SECTION OR ATTACHMENT (If Applicable):
Attachment 4.19-A
Page 3, 6, 6a, 20, 21a

10. SUBJECT OF AMENDMENT:
This amendment provides the State Fiscal Year (SFY) 2014 trend factor. This amendment also adds references to the new Medicare/Medicaid Cost Report form (CMS 2552-10) that hospitals are required to complete for fiscal years beginning on and after May 1, 2010, corrects a State Plan page reference, and provides clarification on the per diem rates and payments of hospitals that merged their operations under one Medicare and MO HealthNet provider number.

11. GOVERNOR'S REVIEW (Check One)

☑ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY

14. TITLE: Acting Director

15. DATE SUBMITTED:

16: RETURN TO:
MO HealthNet Division
P.O. Box 6500
Jefferson City, MO 65102

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18: DATE APPROVED: JUN 11 2014

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2013

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director, Policy & Financial Mgt. CMCS

23. REMARKS:

FORM HCFA-179 (07-92)

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~~ 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 2552-96 (CMS 2552-96) shall be used for fiscal years ending on or after September 30, 1996. The Medicare/Medicaid Cost Report version 2552-10 (CMS 2552-10) shall be used for fiscal years beginning on and after May 1, 2010.

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.

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-1.A.3. with a minimum utilization of sixty percent (60%) as described in paragraph V.C.8.;

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

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%
   T. State Fiscal Year 2013 – 4.4%
   U. State Fiscal Year 2014 – 3.7%

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.

XIX. 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 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 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. 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 Medicaid 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 date from the appropriate cost report for each facility.

D. Merger of Children's Acute Care Hospital. When an acute care children's hospital merges with another acute care hospital, all the provisions in subsection XIX.A., shall apply, except the Medicaid provider number for the children's hospital will remain active for per diem and outpatient payments. The direct Medicaid payments and Uninsured Add-On payments will be made under the Medicaid number requested by the surviving hospital.

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 and E-3 part VI of the Medicare cost report (HCFA 2552-96) and 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.

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