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State/Territory Name: MO

State Plan Amendment (SPA) #: 22-0004

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages



Financial Management Group

March 1, 2023

Robert Knodell, Acting Director
Missouri Department of Social Services
P.O. Box 1527
Jefferson City, MO 65102-1527

RE: Missouri Medicaid State Plan Amendment TN: 22-0004

Dear Mr. Knodell:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 22-0004. The purpose of this SPA is to update the inpatient hospital reimbursement methodology, and delete or clarify outdated language.

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 is approved effective July 1, 2022. We are enclosing the CMS-179 and the amended plan pages.

If you have any additional questions or need further assistance, please contact Fred Sebree at fredrick.sebree@cms.hhs.gov.

Sincerely,
Rory Howe
Rory Howe
Director

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER <u>2 2 - 0 0 0 4</u>	2. STATE <u>MO</u>
3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT <input checked="" type="radio"/> XIX <input type="radio"/> XXI	
4. PROPOSED EFFECTIVE DATE <u>July 1, 2022</u>	
6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars) a. FFY <u>2022</u> \$ <u>(2,286,710)</u> b. FFY <u>2023</u> \$ <u>(8,803,272)</u>	
5. FEDERAL STATUTE/REGULATION CITATION <u>42 CFR 447 Subpart C</u>	8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) <u>Attachment 4.19 A - 1-24</u> (Delete Attachment A, Appendix B, Assurance and Findings) (all pages)
7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT <u>Attachment 4.19 A - 1-31</u>	

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

9. SUBJECT OF AMENDMENT
This State Plan Amendment updates the inpatient hospital reimbursement methodology, and deletes or clarifies outdated language.


10. GOVERNOR'S REVIEW (Check One)

GOVERNOR'S OFFICE REPORTED NO COMMENT SLV

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL


12. TYPED NAME
Robert J. Knodell

13. TITLE
Acting Director

14. DATE SUBMITTED 09-12-2022

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

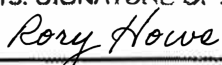
FOR CMS USE ONLY

16. DATE RECEIVED 9/22/2022

17. DATE APPROVED
March 1, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
7/1/2022

19. SIGNATURE OF APPROVING OFFICIAL


20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS

Blocks 7 and 8 updated to reflect appropriate updates 2/9/2022

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 participants, unless otherwise limited by rule, reimbursement will be based solely on the individual participant's days of care (within benefit limitations) multiplied by the individual hospital's Title XIX per diem rate.
- B. The Title XIX reimbursement for hospitals, excluding those located outside Missouri, shall include the payments as outlined below. Reimbursement shall be subject to availability of federal financial participation (FFP).
 - 1. Inpatient per diem reimbursement - The per diem rate is established in accordance with Sections IV and V.
 - 2. Outpatient reimbursement is established in accordance with Attachment 4.19B.
 - 3. Acuity Adjustment Payment (AAP) – The Acuity Adjustment Payment is established in accordance with Section VI.
 - 4. Poison Control (PC) Payment – The Poison Control Payment is established in accordance with Section VII.
 - 5. Stop Loss Payment (SLP) – The Stop Loss Payment is established in accordance with Section VIII.
 - 6. Disproportionate Share Hospital (DSH) Payment - The DSH payment is established in accordance with Section IX.
 - 7. Medicaid Graduate Medical Education (GME) Payment – The GME Payment is established in accordance with Section X.
 - 8. Upper Payment Limit (UPL) Payment – The UPL Payment is established in accordance with Section XI.
 - 9. Children’s Outlier (CO) Payment - The Children’s Outlier Payment is established in accordance with Section XII.

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- C. The Title XIX reimbursement for hospitals located outside Missouri is established in accordance with Section XV.
- D. A hospital 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, will receive the same inpatient per diem and Medicaid payments, as defined in this plan, as the previous owner/operator if the hospital reenters the MO HealthNet Program during the same state fiscal year (SFY). If the hospital does not reenter during the same SFY, the inpatient per diem and Medicaid Payments, as defined in this plan, will be determined based on the base year cost report. If the hospital does not have a base year cost report, the inpatient per diem will be the weighted average statewide per diem rate as determined in Section V.
- E. Effective for dates of services beginning July 1, 2008, reimbursement for inpatient hospital services associated with an admission for the surgical performance of only those human organ and bone marrow transplantations as defined in Attachment 3.1-E is made on the basis of reasonable cost of providing the services as defined and determined by the Division.

The methodology defined in this attachment in Sections I. through XXI. for all other inpatient hospital services reimbursement is not applicable to these specific services. Inpatient hospital costs associated with these services are excluded from the per-diem reimbursement rate computation.

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 this plan or the Missouri Medicaid hospital provider manual and detailed on the audited 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 costs 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.
- B. Bad debt - Bad debts should include the costs of caring for patients who have insurance but are not covered for 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 year cost report - Audited Medicaid cost report from the third prior calendar year. If a facility has more than one (1) cost report with periods ending in the third prior calendar year, the cost report covering a full twelve (12) month period ending in the third prior calendar 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 third prior calendar year will be used. If a hospital's base year cost report is less than or greater than a twelve (12) month period, the data shall be adjusted, based on the number of days reflected in the base year cost report to a twelve (12) month period. Any changes to the base year cost report after the Division issues a final decision on assessment or payments will not be included in the calculations.

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- D. Case Mix Index (CMI). The hospital CMI for the AAP is determined based on the hospital's MO HealthNet's inpatient claims and 3M™ All-Patient Refined Diagnosis Related Groups (APR-DRG) software, a grouping algorithm to categorize inpatient discharges with similar treatment characteristics requiring similar hospital resources.
1. For SFY 2023, each hospital's CMI was calculated as follows:
 - (a) A dataset of complete inpatient stays was established using MO HealthNet fee-for-service claims and managed care encounters combined for calendar years 2019 and 2020. A two-year dataset was used to account for the potential impact of changes to hospital utilization, costs, and mix of patients due to the COVID-19 Public Health Emergency.
 - (b) Interim claims where multiple claims cover a single inpatient stay were combined into single claims covering the complete inpatient stay.
 - (c) The 3M™ APR-DRG grouping software was applied to the inpatient dataset, using version 38 of the grouper. Each inpatient stay was assigned to a single DRG and severity of illness level. Each APR-DRG is associated with a relative weight reflecting the relative amount of resources required to care for similar stays, compared to an average inpatient stay. APR-DRG weights are provided by 3M™ and are calculated based on a national all-payer population.
 - (d) The national weights were recentered to reflect the average resource requirements within the MO HealthNet population, including both fee-for-service and managed care encounter inpatient stays. Recentered weights are calculated by dividing the APR-DRG national weights by the average casemix for all hospitals. The average casemix is calculated as the sum of the national weights for each inpatient stay divided by the number of stays for all hospitals.
 - (e) A hospital-specific CMI is calculated by summing the MO HealthNet recentered weights for each inpatient stay and dividing the total by the number of inpatient stays for the hospital.
 2. For SFY 2024 and forward, the basis of the case mix index will be determined by the Division based on combined inpatient stays from the second and third prior calendar years, the current version of the grouper, relative weights appropriate for the MO HealthNet population, and the SFY in which an AAP is being calculated.
- 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.

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- 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 2552-10 (CMS 2552-10) shall be used for fiscal years beginning on and after May 1, 2010. If the Medicare CMS 2552-10 is superseded by an alternate Medicare developed cost reporting tool during a Medicaid state plan year, that tool must be used for the Medicaid state plan year.
- H. Division. Unless otherwise designated, division refers to the MO HealthNet Division (MHD) a division of the Department of Social Services charged with the administration of the MO HealthNet program.
- I. Medicaid inpatient days. Medicaid inpatient days are paid Medicaid days for inpatient hospital services as reported by the Medicaid Management Information System (MMIS).
- J. Non-reimbursable items. For purposes of reimbursement of reasonable cost, the following are not subject to reimbursement:
1. Allowances for return on equity capital;
 2. Amounts representing growth allowances in excess of the intensity allowance, profits, efficiency bonuses, or a combination of these;
 3. Cost in excess of the principal of reimbursement specified in 42 CFR chapter IV, part 413; and
 4. Costs or services or costs and services specifically excluded or restricted in this plan or the Medicaid hospital provider manual.
- K. Reasonable cost. The reasonable cost of inpatient hospital services is an individual hospital's Medicaid cost per day as determined in accordance with Section III of this plan using the base year cost report.
- L. Specialty Pediatric Hospital. An inpatient pediatric acute care facility which:
1. Is licensed as a hospital by the Missouri Department of Health and Senior Services under Chapter 197 of the Missouri Revised Statutes;
 2. Has been granted substantive waivers by the Missouri Department of Health and Senior Services from compliance with material hospital licensure requirements governing (a) the establishment and operation of an emergency department, and (b) the provision of pathology, radiology, laboratory and central services; and
 3. Is not licensed to operate more than 60 inpatient beds.
- M. Trend factor. The trend factor is a measure of the change in costs of goods and services purchased by a hospital during the course of one (1) year.

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Supersedes TN# 04-01

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N. Federal Reimbursement Allowance (FRA). The health care-related tax assessed to hospitals for the privilege of engaging in the business of providing inpatient health care in Missouri. The FRA shall be an allowable cost to the hospital.

III. Administrative Actions

A. Cost Reports

1. Each hospital participating in the Missouri Medicaid Program shall submit a cost report in the manner prescribed by the Division. 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) All cost reports shall be submitted and certified by an officer or administrator of the hospital.
 - (b) If a cost report is more than ten (10) days past due, fifty thousand dollars (\$50,000) in payments may be withheld from the hospital until the cost report is submitted. If the Medicaid payment is less than fifty thousand dollars (\$50,000), the entire payment will be withheld. Upon receipt of a cost report prepared in accordance with this plan, the payments that were withheld will be released to the hospital.
 - (c) A single extension, not to exceed thirty (30) days, may be granted upon request of the hospital and the approval of the Division when the hospital's operation is significantly affected due to extraordinary circumstances over which the hospital 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 change of control or ownership of a hospital requires that the hospital submit a cost report for the period ending with the date of change of control or ownership within five (5) calendar months
 - (a) Upon learning of a change of control or ownership, the Division may withhold fifty thousand dollars (\$50,000) of the next available Medicaid payment from the hospital identified in the current Medicaid participation agreement until a cost report is filed. If the Medicaid payment is less than fifty thousand dollars (\$50,000), the entire payment will be withheld. Once the cost report prepared in accordance with this plan is received, the payment will be released to the hospital identified in the current Medicaid participation agreement.
 - (b) The Division may, at its discretion, delay the withholding of funds specified in III.A.2.(a) until the cost report is due based on assurances satisfactory to the Division that the cost report will be timely filed. A request jointly submitted by the buying and selling entities may provide adequate assurances. The buying entity must accept responsibility for ensuring timely filing of the cost report and authorize the Division to immediately withhold fifty thousand dollars (\$50,000) if the cost report is not timely filed.

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3. The termination of or by a hospital of participation in the Medicaid program requires that the hospital submit a cost report for the period ending with the date of termination within five (5) calendar months from the date of the CMS Tie Out Notice. No extension in the submitting of cost reports shall be allowed when a termination of participation has occurred.
 - (a) Upon learning of the termination, the Division may withhold fifty thousand dollars (\$50,000) of the next available Medicaid payment from the hospital until a cost report is filed. If the Medicaid payment is less than fifty thousand dollars (\$50,000), the entire payment will be withheld. Once the cost report prepared in accordance with this plan is received, the payment will be released to the hospital.
4. Amended cost reports or other supplemental. The Division or its authorized contractor will notify the hospital by letter when the audit of its cost report is completed. Since, this data will be used in the calculation of per diem rates and other Medicaid payments, the hospital shall review the audited cost report data and submit amended or corrected data to the Division or its authorized contractor within fifteen (15) days. Data received after the fifteen (15) day deadline will not be considered by the Division for per diem rates and other Medicaid payments, unless the hospital requests in writing and receives an extension to file additional information prior to the end of the fifteen (15) day deadline.

B. Records

1. All hospitals are required to maintain financial and statistical records in accordance with 42 CFR 413.20. For purposes of this plan statistical and financial records shall include beneficiaries' medical records and patient claim logs separated for inpatient and outpatient services billed to and paid for by Missouri Medicaid (excluding cross-over claims), respectively. All records must be available upon request to representatives, employees, or contractors of the Missouri Medicaid Program, Missouri Department of Social Services, General Accounting Office (GAO), or the United States Department of Health and Human Services (HHS). The content and organization of the inpatient and outpatient logs shall include the following:
 - (a) A separate Medicaid log for each fiscal year must be maintained by either date of service or date of payment by Medicaid for claims and all adjustments of those claims for services provided in the fiscal period. Lengths of stay covering two (2) fiscal periods should be recorded by date of admission. The information from the Medicaid log should be used to complete the Medicaid worksheets in the hospital's cost report;
 - (b) 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
 - (c) Not to be included in the inpatient or outpatient logs are claims or line item charges denied by Medicaid. This would include payments for hospital-based physicians and certified registered nurse anesthetists billed by the hospital on a professional services claim, or payments for services provided by the hospital through enrollment as a Medicaid provider type other than hospital.

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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 III.B.1 of this plan.

C. Cost Report Audits

1. The examination or inspection of a hospital's cost report, files, and any other supporting documentation by the Division or its authorized contractor. The Division or its authorized contractor may perform the following types of audits:
 - (a) Level I Audit – Requires a limited review of hospital cost reports, files, and any other additional information requested and submitted to the Division or its authorized contractor. The limited review may include, but is not limited to, items such as a comparative analysis of a hospital's cost report data to industry data, a review of a hospital's prior year data to determine any outliers that may warrant further review, requesting additional details of the reported information, all of which could lead to potential adjustment(s) after such further review, as well as, making and standard adjustments. Level I Audits may be provided off-site;
 - (b) Level II Audit – Requires a desk review of hospital cost reports, files, and any other additional information requested and submitted to the Division or its authorized contractor. The desk review may include, but is not limited to, review procedures in a Level I Audit plus a more detailed analysis of a hospital's cost report data to identify items that would require further review including requesting additional details of the reported information or documentation to support amounts reflected in the cost report, all of which could lead to potential adjustment(s) after such further review, as well as making any standard adjustments. Level II Audits may be provided off-site; or
 - (c) Level III Audits – Requires an in depth audit, including, but not limited to, an on-site review of hospital cost reports, files, and any other additional information requested and submitted to the Division or its authorized contractor. The Level III Audit will require an in depth analysis of a hospital's cost report data and an on-site verification of cost report items deemed necessary through a risk assessment or other analyses, all of which could lead to potential adjustment(s) after such further review, as well as making any standard adjustments. Level III Audits will require some portion of the hospital's records review be provided on-site.

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IV. Inpatient Per Diem Reimbursement Rate Computation. Effective for dates of service beginning July 1, 2022, each Missouri hospital shall receive a Missouri Medicaid per diem rate based on the following computation:

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

$$\text{PER DIEM} = ((\text{TAC} / \text{MPD}) * \text{TI}) + \text{MIP FRA}$$

1. MIP FRA – Medicaid Inpatient Share of FRA. The Medicaid inpatient share of the FRA Assessment will be calculated by dividing the hospital’s Medicaid patient days from the base year cost report by total hospital patient days from the base year cost report to arrive at the Medicaid utilization percentage. This percentage is then multiplied by the inpatient FRA assessment for the current SFY to arrive at the increased allowable Medicaid cost. This cost is then divided by the estimated Medicaid days for the current SFY to arrive at the increased Medicaid cost per day;
 2. MPD – Medicaid fee-for-service (FFS) inpatient days from the base year cost report;
 3. TI – Trend indices. The trend indices are applied to the TAC per day of the per diem rate. The trend index for the base year is used to adjust the TAC per day to a common fiscal year end of June 30. The adjusted TAC per day shall be trended through the current SFY;
 4. TAC – Medicaid allowable inpatient routine and special care unit costs, and ancillary costs, from the base year cost report, will be added to determine the hospital’s Medicaid total allowable cost (TAC);
 5. The per diem for private free-standing psychiatric hospitals shall be the greater of one-hundred percent (100%) of the SFY 2022 weighted average statewide per diem rate for private free-standing psychiatric hospitals or the per diem as calculated in IV.A.;
 6. 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, except for federally deemed critical access hospitals whose Medicaid FFS charges equal sixty percent (60%) or less of its Medicaid FFS costs;
 7. The per diem shall be adjusted for rate increases granted in accordance with Subsections IV.C. and IV.D.
 8. If the hospital does not have a base year cost report, the inpatient per diem will be the weighted average statewide per diem rate as determined in Section V.
- B. Trend Indices (TI). For trend indices for State Fiscal Year 2018 and forward, refer to the Hospital Market Basket index as published in Healthcare Cost Review by Institute of Health Systems (IHS), or equivalent publication, regardless of any changes in the name of the publication or publisher, for each State Fiscal Year (SFY).

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C. Adjustments to Rates. A hospital's inpatient per diem 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 Division from imposing any sanctions authorized by any statute or regulation.
2. When a rate reconsideration is granted in accordance with Subsection IV.D.

D. Rate Reconsideration

1. Rate reconsideration may be requested under this subsection for changes in allowable cost which occur subsequent to the base year cost report described in Subsection IV.A. The effective date for any increase granted under this subsection shall be no earlier than the first day of the month following the Division's final determination of the rate reconsideration.
2. The following may be subject to review under procedures established by the Division:
 - (a) New or expanded inpatient services. A hospital, at times, may offer to the public new or expanded inpatient services which may require Certificate of Need (CON) approval.
 - (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.
 - (2) Non-state hospitals, 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 CON. Rate reconsideration requests for projects requiring CON review must include a copy of the CON program approval. Non-state 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.
 - (3) A hospital (state or non-state) 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 review. Upon completion of the review, the hospital's inpatient reimbursement rate 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.

- (4) Rate reconsiderations due to new or expanded services will be determined as total allowable project cost (i.e., the sum of annual depreciation, annualized interest expense and annual additional operating costs) multiplied by the ratio of total inpatient costs (less SNF and swing bed cost) to total hospital cost as submitted on the most recent cost report filed with the Division or its authorized contractor as of the review date divided by total acute care patient days including all special care units and nursery, but excluding swing bed days. The most recent cost report filed must be audited prior to the finalization of the rate reconsideration.
- (5) Total acute care patient days (excluding nursery and swing bed days) must be at least sixty percent (60%) of total possible bed days. Total possible bed days will be determined using the number of licensed beds times three hundred sixty-five (365) days. If the total acute care patient days (excluding nursery and swing bed days) are less than sixty percent (60%) of total possible bed days, the sixty percent (60%) number plus nursery days will be used to determine the rate increase. If the total acute care patient days (excluding nursery and swing bed days) are at least sixty percent (60%) of total possible bed days, the total acute care patient days plus nursery days will be used to determine the rate increase. This computation will apply to capital costs only.
- (6) Major medical equipment costs included in rate reconsideration requests shall not include costs to replace current major medical equipment if the replacement does not result in new or expanded inpatient services. The replacement of inoperative or obsolete major medical equipment, by itself, does not qualify for rate reconsideration, even if the new equipment costs at least one (1) million dollars.
- (b) When the hospital experiences extraordinary circumstances, which may include, but are not limited to, an act of God, war or civil disturbance.
3. The following will not be subject to review under these procedures:
- (a) The use of Medicare standards and reimbursement principles;
- (b) The method for determining the trend factor;
- (c) The use of all-inclusive prospective reimbursement rates; and
- (d) Increased costs for the successor owner, management or leaseholder that result from changes in ownership, management, control, operation or leasehold interests by whatever form for any hospital previously certified at any time for participation in the Medicaid program.

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4. The request for a rate reconsideration must be submitted in writing to the Division, and must specifically and clearly identify the project and the total dollar amount involved. The total dollar amount must be supported by generally accepted accounting principles. The hospital shall demonstrate the rate reconsideration is necessary, proper, and consistent with efficient and economical delivery of covered patient care services. The hospital will be notified of the Division's decision in writing within sixty (60) days of receipt of the hospital's written request or within sixty (60) days of receipt of any additional documentation or clarification which may be required, whichever is later. Failure to submit requested information within the sixty (60) day period shall be grounds for denial of the request.
- V. Inpatient Per Diem Reimbursement Rate Computation for New Hospitals. Effective for dates of service beginning July 1, 2022, each new Missouri hospital's rate setting cost report shall be the first full fiscal year cost report, which includes inpatient Medicaid costs, otherwise the hospital shall continue to receive the weighted average statewide per diem rate as determined below.
- A. Acute care hospitals. In the absence of adequate cost data, a new hospital's Medicaid rate shall be one-hundred percent (100%) of the weighted average statewide per diem rate for acute care hospitals until a prospective rate is determined on the hospital's rate setting cost report, in accordance with Section IV.
 - B. Free-standing psychiatric hospitals. In the absence of adequate cost data, a new hospital's Medicaid rate shall be one-hundred percent (100%) of the weighted average statewide per diem rate for free-standing psychiatric hospitals, excluding the state psychiatric hospitals, until a prospective rate is determined on the hospital's rate setting cost report, in accordance with Section IV.
 - C. Long Term Acute Care hospitals. In the absence of adequate cost data, a new hospital's Medicaid rate shall be one-hundred percent (100%) of the weighted average statewide per diem rate for long term acute care hospitals until a prospective rate is determined on the hospital's rate setting cost report, in accordance with Section IV.
 - D. Rehabilitation hospitals. In the absence of adequate cost data, a new hospital's Medicaid rate shall be one-hundred percent (100%) of the weighted average statewide per diem rate for rehabilitation hospitals until a prospective rate is determined on the hospital's rate setting cost report, in accordance with Section IV.
- VI. Acuity Adjustment Payment (AAP)
- A. Beginning with SFY 2023, hospitals that meet the requirements set forth below shall receive an AAP. A hospital that is designated as a Long Term Acute Care hospital, free-standing Psychiatric hospital, or a free-standing Rehabilitation hospital does not qualify to receive an AAP. Ownership type of the hospital is determined based on the Type of Control reported on Schedule S-2, Part I, Line 21, Column 1 of the hospital's base year cost report. For purposes of this section, Medicaid payments received shall include the following payments.
 1. For SFY 2022, the Medicaid per diem payments, Direct Medicaid payments, GME payments, and CO payments.
 2. For SFY 2023 and forward, the Medicaid per diem payments, AAP, PC payment, SLP, GME payments, and CO payments.

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- B. **Private Ownership.** A hospital shall receive an AAP if the hospital's MO HealthNet CMI is greater than a threshold set annually by the Division. The preliminary AAP is calculated by multiplying the hospital's MO HealthNet CMI times the estimated Medicaid FFS claims payments for the coming SFY. If the hospital's estimated Medicaid FFS claims payments for the coming SFY plus the preliminary AAP exceeds the hospital's prior SFY Medicaid FFS payments received increased by a stop-gain percent, the preliminary AAP will be reduced so the estimated Medicaid FFS claims payments for the coming SFY plus the final AAP is equal to the stop-gain percent of the hospital's prior SFY Medicaid FFS payments received. If no reduction is necessary, the preliminary AAP shall be considered final.
- C. **Non-State Government Owned or Operated (NSGO) Ownership.** A hospital shall receive an AAP if the hospital's MO HealthNet CMI is greater than a threshold set annually by the Division. The preliminary AAP is calculated by multiplying the hospital's MO HealthNet CMI times the estimated Medicaid FFS claims payments for the coming SFY. If the hospital's estimated Medicaid FFS claims payments for the coming SFY plus the preliminary AAP exceeds the hospital's prior SFY Medicaid FFS payments received increased by a stop-gain percent, the preliminary AAP will be reduced so the estimated Medicaid FFS claims payments for the coming SFY plus the final AAP is equal to the stop-gain percent of the hospital's prior SFY Medicaid FFS payments received. If no reduction is necessary the preliminary AAP shall be considered final.
- D. The annual final AAP will be calculated for each hospital at the beginning of each SFY. The annual amount will be processed over the number of financial cycles during the SFY.

VII. Poison Control (PC) Payment

- A. The PC Payment shall be determined for hospitals which operated a Poison Control Center during the base year and which continues to operate a Poison Control Center. The PC Payment shall reimburse the hospital for the Medicaid share of the total Poison Control cost and shall be determined as follows:
1. The total Poison Control cost from the base year cost report will be divided by the total hospital days from the base year cost report to determine a cost per day. This cost per day will then be multiplied by the estimated Medicaid days for the SFY for which the PC Payment is being calculated. The estimated Medicaid days are paid days from the second prior calendar year.
 2. The annual final PC Payment will be calculated for each eligible hospital at the beginning of each SFY. The annual amount will be processed over the number of financial cycles during the SFY.

VIII. Stop Loss Payment (SLP)

- A. Beginning with SFY 2023 hospitals that meet the requirements set forth below shall receive a SLP. Ownership type of the hospital is determined based on the Type of Control reported on Schedule S-2, Part I, Line 21, Column 1 of the hospital's base year cost report. For purposes of this section, Medicaid payments received shall include the following payments.
1. For SFY 2022, the Medicaid per diem payments, Direct Medicaid payments, GME payments, and CO payments.
 2. For SFY 2023 and forward, the Medicaid per diem payments, AAP, PC payment, SLP, GME payments, and CO payments.

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- B. Private Ownership. Total estimated Medicaid FFS payments for the coming SFY for each hospital shall include estimated Medicaid FFS claims payments, and any final AAP and PC Payment. The total estimated Medicaid FFS payments for each hospital shall be subtracted from the hospital's prior SFY Medicaid FFS payments received then summed to calculate a total increase or decrease in payments for the entire private ownership group. A positive result represents a decrease in payments and a negative amount represents an increase in payments. If the result is a decrease in total payments to the private ownership group, this amount shall represent the total Stop Loss Amount.
1. SLP will be made if a total Stop Loss Amount was calculated in VIII.B. Each hospital that shows a decrease in Medicaid payments shall receive a SLP in the amount of the decrease in payments unless the sum of each hospital's SLP is greater than the total Stop Loss Amount. If the sum is greater than the total Stop Loss Amount, each hospital's SLP shall be calculated by multiplying the total Stop Loss Amount times the ratio of the hospital's decrease in Medicaid payments to the total decrease in payments for the entire private ownership group.
 2. Privately Owned Free-Standing Psychiatric Hospitals. Total estimated Medicaid FFS payments for the coming SFY for each hospital shall include estimated Medicaid FFS claims payments, and any final AAP and PC payment. The total estimated Medicaid FFS payments for each hospital shall be subtracted from the hospital's prior SFY Medicaid FFS payments received then summed to calculate a total increase or decrease in payments for the entire privately owned free-standing psychiatric hospital ownership group. A positive result represents a decrease in payments and a negative amount represents an increase in payments.
 - (a) If a hospital has a decrease in payments as calculated in VIII.B.2, the hospital will receive a payment equal to the amount of payment decrease. If the hospital has an increase in payments as calculated in VIII.B.2, the hospital will not receive any additional payments.
- C. NSGO Ownership. Total estimated Medicaid FFS payments for the coming SFY for each hospital shall include estimated Medicaid FFS claims payments, and any final AAP and PC Payment. The total estimated Medicaid FFS payments for each hospital shall be subtracted from the hospital's prior SFY Medicaid FFS payments received then summed to calculate a total increase or decrease in payments for the entire NSGO ownership group. A positive result represents a decrease in payments and a negative amount represents an increase in payments. If the result is a decrease in total payments to the NSGO ownership group, this amount shall represent the total Stop Loss Amount.
1. SLP will be made if a total Stop Loss Amount was calculated in VIII.C. Each hospital that shows a decrease in Medicaid payments shall receive a SLP in the amount of the decrease in payments unless the sum of each hospital's SLP is greater than the total Stop Loss Amount. If the sum is greater than the total Stop Loss Amount, each hospital's SLP shall be calculated by multiplying the total Stop Loss Amount times the ratio of the hospital's decrease in Medicaid payments to the total decrease in payments for the entire NSGO ownership group.
- D. The annual SLP will be calculated for each hospital at the beginning of each SFY. The annual amount will be processed over the number of financial cycles during the SFY.

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IX. Disproportionate Share Hospital (DSH) Payments

A. Interim DSH Payments.

1. Beginning with SFY 2017, the interim DSH payments will be based on the most recent version of the state DSH survey and must be submitted to the independent DSH auditor as the MO HealthNet Division's authorized agent. The state DSH survey shall be the most recent DSH survey collected during the independent DSH audit of the fourth prior SFY (i.e., the most recent survey collected by the independent DSH auditor for the SFY 2019 independent DSH audit will also be used to calculate the interim DSH payment for SFY 2023). The survey shall be referred to as the SFY to which payments will relate.
 - (a) Each hospital must complete and submit the state DSH survey to the independent DSH auditor, the MO HealthNet Division's authorized agent, in order to be considered for an interim DSH payment. The state DSH survey is due to the independent DSH auditor by the March 1 preceding the beginning of each SFY (i.e., the state DSH survey used for SFY 2023 interim DSH payments will be due to the independent DSH auditor by March 1, 2022). The Division may grant an industry-wide extension on the March 1 deadline due to unanticipated circumstances that affect the industry as a whole. The independent DSH auditor may perform an initial review of the required state DSH survey submitted by the hospital and make preliminary adjustments for use in calculating the interim DSH payment. The independent DSH auditor shall provide the hospital with any preliminary adjustments that are made for review and comment prior to the data being provided to the Division for use in calculating the interim DSH payment for the SFY. Additional or revised audit adjustments may be made to the DSH survey for purposes of the independent DSH audit.
 - (b) Trends. A trend of 1.5% will be applied to the hospital's Estimated Medicaid Net Cost and the Estimated Uninsured Uncompensated Care Cost (UCC) from the year subsequent to the state DSH survey period to the current SFY (i.e., the SFY for which the interim DSH payment is being determined). The first year's trend shall be adjusted to bring the facility's cost to a common fiscal year end of June 30 and the full trends shall be applied for the remaining years. The trends shall be compounded each year to determine the total cumulative trend.
 - (c) The interim DSH payments will be calculated as follows:
 - (1) The estimated hospital-specific DSH limit is calculated as follows:
 - a. Estimated Medicaid net cost from the state DSH survey trended in Section IX.A.1.(b);
 - b. Less estimated other Medicaid payments calculated by the Division;
 - c. Equals estimated Medicaid uncompensated care cost;
 - d. Plus trended estimated uninsured uncompensated care cost from the state DSH survey trended in Section IX.A.1.(b);
 - e. Equals estimated hospital-specific DSH limit;

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- (2) The estimated uncompensated care costs potentially eligible for interim DSH payments excludes out-of-state (OOS) DSH payments and is calculated as follows:
 - a. Estimated hospital-specific DSH limit;
 - b. Less estimated OOS DSH payments;
 - c. Equals estimated uncompensated care cost (UCC) net of OOS DSH payments;
 - (3) Hospitals determined to have a negative estimated UCC net of OOS DSH payments (payments exceed costs) will not receive interim DSH payments because their estimated payments for the SFY are expected to exceed their estimated hospital-specific DSH limit; and
 - (4) Qualified DSH hospitals determined to have a positive estimated UCC net of OOS DSH payments (costs exceed payments) may receive interim DSH payments. The interim DSH payments are subject to the federal DSH allotment and the estimated hospital-specific DSH limits less estimated OOS DSH payments. The interim DSH payments will be calculated as follows:
 - a. Up to one-hundred percent (100%) of the available federal DSH allotment will be allocated to each hospital with a positive estimated UCC net of OOS DSH payments, and the allocation shall result in each hospital receiving the same percentage of their estimated UCC net of OOS DSH payments. The allocation percentage will be calculated at the beginning of the SFY by dividing the available federal DSH allotment to be distributed by the total hospital industry's positive estimated UCC net of OOS DSH payments; and
 - b. The allocated amount will then be reduced by one percent (1%) for hospitals that do not contribute 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.
2. Federally deemed DSH hospitals shall receive an interim DSH payment to the extent that it has room under its projected hospital-specific DSH limit based on the state DSH survey and shall be limited to the hospital's projected hospital-specific DSH limit. A federally deemed DSH hospital may refuse a DSH payment by submitting a request to the Division on an annual basis.
 3. An annual DSH payment will be calculated for each hospital at the beginning of each SFY. The annual amount will be processed over the number of financial cycles during the SFY.

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4. New Facilities

(a) Beginning with SFY 2017, new facilities that do not have a Medicaid cost report on which to base the state DSH survey shall complete the state DSH survey and receive an interim DSH payment as follows:

- (1) A new facility that does not have cost report data for the fourth prior year may complete the state DSH survey using actual, untrended cost and payment data from the most recent 12 month cost report filed with the Division.
- (2) A new facility that has not yet filed a twelve (12) month Medicaid cost report with the Division may complete the state DSH survey using facility projections to reflect anticipated operations for the interim DSH payment period. Trends shall not be applied to the data used to complete the state DSH survey.

5. Facilities not providing a state DSH survey

(a) Beginning with SFY 2017, hospitals that do not submit the state DSH survey by March 1 will not be eligible to receive an interim DSH payment for that SFY.

6. Facilities electing not to receive interim DSH payments

- (a) Hospitals may elect not to receive an interim DSH payment for a SFY by completing a DSH Waiver form. This includes federally deemed hospitals that do not have UCC to justify the receipt of an interim DSH payment. Hospitals that elect not to receive an interim DSH payment for a SFY must notify the Division, or its authorized agent, that it elects not to receive an interim DSH payment for the upcoming SFY. If a hospital does not receive an interim DSH payment for a SFY, it will not be included in the independent DSH audit related to that SFY, and will not be eligible for final DSH audit payment adjustments related to that SFY unless it submits a request to the Division to be included in the independent DSH audit. The request must be approved by the Division and all necessary data elements must be submitted to the independent DSH auditor in order to be included in the audit and eligible for final DSH payment adjustments.
- (b) If a hospital received an interim DSH payment and later determined that it did not have UCC for Medicaid and the uninsured to support part or all the interim DSH payment that it received or is receiving, the hospital may request that the interim DSH payments be stopped or it may return the entire interim DSH payment it received. Such requests must be sent to the Division in writing and may be submitted anytime during the SFY if a hospital believes it is being overpaid.

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7. Exceptions Process to Use Alternate Data for Interim DSH Payment.

- (a) A hospital may submit a request to the Division to have its interim DSH payment based on alternate data as set forth below rather than the state DSH survey required to be submitted for the year (i.e., required state DSH survey) if it meets the criteria for any of the circumstances detailed below in IX.A.7.(d). The request must include an explanation of the circumstance, the impact it has on the required state DSH survey period, and how it causes the data to be materially misstated or unrepresentative. The Division shall review the facility's request and may, at its discretion and for good cause shown, use the alternate data in determining the interim DSH payment for the SFY. The Division shall notify the facility of its decision regarding the request.
- (1) Alternate state DSH survey. A state DSH survey completed using the actual, untrended cost and payment data from the most recent twelve (12) month cost report filed with the Division. Any hospital requesting an exception must complete an alternate state DSH survey. If the most recent full year cost report filed with the Division does not reflect the impact of any material changes, a supplemental schedule, as defined below, may be completed and submitted in addition to the alternate state DSH survey. If the impact of any changes is reflected in the most recent full year cost report filed with the Division, the facility may only use the alternate state DSH survey;
- (2) Alternate state DSH survey supplemental schedule. A supplemental schedule developed by the Division to recognize material changes that have occurred at a hospital that are not yet reflected in the hospital's alternate state DSH survey. The supplemental schedule uses the data from the alternate state DSH survey as the basis and includes additional fields to reflect changes that occurred subsequent to the alternate state DSH survey period through the SFY for which the interim DSH payment is being calculated. The blank alternate state DSH survey supplemental schedule is referred to as the alternate state DSH survey supplemental template.
- (b) The provider must submit both the required state DSH survey and the alternate data for review to determine if the facility meets the criteria set forth below in IX.A.7.(d).
- (c) The interim DSH payment based on the applicable alternate data shall be calculated in the same manner as the interim DSH payment based on the required state DSH survey, except for the trends applied to the alternate data as noted below. The allocation percentage calculated at the beginning of the SFY as set forth in Section IX.A.1.(c)(4) shall be applied to the estimated UCC net of OOS DSH payments based on the alternate data to determine the preliminary interim DSH payment.
- (1) Alternate state DSH survey. The trends applied to the alternate state DSH survey shall be from the year subsequent to the alternate state DSH survey period to the current SFY for which the interim DSH payment is being determined;
- (2) Alternate state DSH survey supplemental schedule. Trends shall not be applied to an alternate state DSH survey supplemental schedule since it incorporates changes from the full year cost report period through the SFY for which the interim DSH payment is being calculated.

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(d) Following are the circumstances for which a provider may request that its interim DSH payment be based on alternate data rather than the required state DSH survey, including the criteria and other requirements:

- (1) The 20.00% DSH Outlier. A provider may request that the alternate state DSH survey be used prior to the interim DSH payment being determined for the SFY if the Untrended Total Estimated Net Cost from the alternate state DSH survey is at least 20.00% higher than the Trended Total Estimated Net Cost from the required state DSH survey (i.e., the increase is at least 20.00% rounded to two decimal places).
 - a. Both the required state DSH survey and the alternate state DSH survey must be submitted to the Independent DSH auditor and the Division, respectively, no later than March 1 preceding the beginning of each SFY for which interim DSH payments are being made.

- (2) Extraordinary Circumstances. A provider may request that alternate data be used if the facility experienced an extraordinary circumstance during or after the required state DSH survey report period up to the SFY for which the interim DSH payment is being calculated that caused the required DSH survey report period to be materially misstated and unrepresentative. If circumstances a.i., a.ii., a.iii., or a.iv. below are applicable, the facility may complete and submit the applicable alternate data.
 - a. Extraordinary circumstances include unavoidable circumstances that are beyond the control of the facility and include the following:
 - i. Act of God (i.e., tornado, hurricane, flooding, earthquake, lightening, natural wildfire, etc.);
 - ii. War;
 - iii. Civil disturbance; or
 - iv. If the data to complete the required state DSH survey set forth in paragraph IX.A.1. is not available due to a change in ownership because the prior owner is out of business and is uncooperative and unwilling to provide the necessary data.
 - b. A change in hospital operations or services (i.e., terminating or adding a service or a hospital wing; or a change of owner, except as noted in IX.A.7.(d)(2)a.iv., manager, control, operation, leaseholder or leasehold interest, or Medicare provider number by whatever form for any hospital previously certified at any time for participation in the MO HealthNet program, etc.) does not constitute an extraordinary circumstance.
 - c. Both the required state DSH survey and the alternate data must be submitted to the independent DSH auditor and the Division no later than March 1 if the alternate data is to be used to determine the interim DSH payment at the beginning of the SFY.

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- d. A hospital may submit a request to use alternate data due to extraordinary circumstances after March 1, but the alternate data and the resulting interim DSH payment will be subject to the same requirements as the Interim DSH Payment Adjustments noted below in IX.A.7.(d)(3)b.-d. The requests relating to extraordinary circumstances received after the March 1 deadline will be included with the Interim DSH Payment Adjustments requests in IX.A.7.(d)(3) in distributing the unobligated DSH allotment, and subject to appropriation authority, remaining for the SFY.

(3) Interim DSH Payment Adjustment.

- a. After the interim DSH payment has been calculated for the current SFY based on the required state DSH survey, a provider may request that alternate data be used if the Untrended Total Estimated Net Cost from the alternate data is at least twenty percent (20.00%) higher than the Trended Total Estimated Net Cost from the required state DSH survey (i.e., the increase is at least twenty percent (20.00%) rounded to two decimal places).
- b. The Division will process interim DSH payment adjustments once a year. After all requests are received, the Division will determine whether revisions to the interim DSH payments are appropriate. Any revisions to the interim DSH payments are subject to the unobligated DSH allotment and appropriation authority remaining for the SFY;
- c. The request, including the alternate data, must be submitted to the Division by December 31 of the current SFY for which interim DSH payments are being made; and
- d. To the extent that state funds are available, the DSH allotment for the SFY that has not otherwise been obligated will be distributed proportionally to the hospitals determined to meet the above criteria, based on the difference between the preliminary interim DSH payment based on the alternate data and the original interim DSH payment.

- (4) If a provider received an exception that allows it to use alternate data for interim DSH payment purposes under IX.A.7. in the prior SFY, it may continue to use alternate data for its interim DSH payment until the required state DSH survey reflects the annual impact of the change. The alternate state DSH survey supplemental schedule should be used until the most recent cost report on file with the division reflects the annual impact of the change. Both the required state DSH survey and the applicable alternate data must be submitted to the independent DSH auditor and the division no later than March 1 preceeding the beginning of each SFY for which the interim DSH payment is being made.

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B. Department of Mental Health (DMH) Interim DSH Payments.

1. 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. The interim DSH payments calculated using the third prior base year cost report may be revised based on the results of a DMH state DSH survey. Additional adjustments, may be done based on the results of the federally mandated DSH audits.

C. Interim DSH Payment Adjustments.

1. To minimize hospital longfalls, Interim DSH payments made to hospitals will be revised if changes to federally mandated DSH audit standards are enacted during a SFY, updated for Medicaid expansion until it is captured in the required state DSH survey, or any changes in Medicaid reimbursement until it is captured in the required state DSH survey. 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 2019 DSH audit will be finalized in Calendar Year (CY) 2022.

D. Final DSH Adjustments.

1. Final DSH adjustments will be made after actual cost data is available and the DSH audit is completed.
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 payments will occur proportionally based on each hospital's uncompensated care shortfall to the total shortfall, not to exceed each hospital's specific DSH limit.
3. If the original DSH payments did not fully expend the federal Institute for Mental Disease (IMD) 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 payments will occur proportionally based on each hospital's uncompensated care shortfall to the total shortfall, not to exceed each hospital's specific DSH limit.

E. Hospital-Specific DSH Cap.

1. Unless otherwise permitted by federal law, disproportionate share hospital payments shall not exceed one hundred percent (100%) of the unreimbursed cost for Medicaid and the unreimbursed cost of the uninsured. The hospital-specific DSH cap shall be computed by combining the estimated unreimbursed Medicaid costs for each hospital with the hospital's corresponding estimated unreimbursed uninsured costs. All DSH payments in the aggregate shall not exceed the federal DSH allotment within a state fiscal period.

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- X. Medicaid GME Payments. Effective beginning with SFY 2023, a GME payment calculated as the sum of the Intern and Resident Based GME payment and the GME Stop Loss payment, shall be made to any acute care hospital that provides graduate medical education.
- A. Intern and Resident (I&R) Based GME payment. The I&R GME payment will be based on the per I&R Medicaid allocated GME costs not to exceed a maximum amount per I&R. The Division will determine the number of full time equivalent (FTE) I&Rs. Total GME costs will be determined using Worksheet A of the base year cost report adjusted by the trend index. Total GME costs is multiplied by the ratio of Medicaid FFS and MC days to total days to determine the Medicaid allocated GME costs which is then divided by the number of FTE I&Rs to calculate the Medicaid allocated cost per I&R. The I&R Based GME payment is calculated as the number of FTE I&Rs multiplied by the minimum established by the Division or the Medicaid allocated cost per I&R.
- B. GME Stop Loss payment. The total I&R Based GME payment for each hospital shall be subtracted from the hospital's prior SFY GME payments received then summed to calculate a total increase or decrease in payments for the entire group of hospitals that provide graduate medical education. A positive result represents a decrease in payments and a negative amount represents an increase in payments. If the result is a decrease in total payments to the hospitals this amount shall represent the total GME Stop Loss Amount.
- GME Stop Loss Payments will be made if a total GME Stop Loss Payment Amount was calculated in the paragraph above. Each hospital that shows a decrease in Medicaid GME payments shall receive a GME Stop Loss Payment in the amount of the decrease in payments unless the sum of each hospital's GME Stop Loss Payment is greater than the total GME Stop Loss Amount. If the sum is greater than the total GME Stop Loss Amount, each hospital's GME Stop Loss Payment shall be calculated by multiplying the total GME Stop Loss Amount times the ratio of the hospital's decrease in Medicaid GME payments to the total decrease in Medicaid GME payments.
- C. Hospitals who implement a GME program prior to July 1st of the SFY and do not have a base year cost report to determine GME costs shall receive an I&R Based GME payment based on the statewide average Per Resident Amount (PRA) determined as follows:
1. The number of FTE I&Rs shall be reported to the Division by June 1st prior to the beginning of the SFY in order to have a GME payment calculated.
 2. The I&R Based GME payment shall be calculated as the number of FTE I&Rs multiplied by the Medicaid Capped Statewide Average PRA. The Medicaid Capped Statewide Average PRA is calculated as follows:
 - (a) By applying a straight average to the list of facility PRA's with the following criteria:
 - (1) A facility's PRA used in the straight average shall be the minimum as established by the Division or the facility's actual PRA.
- D. The hospital's I&R Based GME Payment plus GME Stop Loss Payment, if applicable, will be calculated for each hospital at the beginning of each SFY. The annual amount will be processed on a quarterly basis during the SFY.

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XI. Upper Payment Limit (UPL) Payment

- A. Beginning with SFY 2023, State Government owned hospitals will be paid a semi-monthly payment up to the Inpatient (IP) UPL gap.
1. Prior to each SFY, the Division shall calculate the estimated Medicaid payments for the coming SFY for each hospital. The total estimated Medicaid payments for each hospital shall be subtracted from the hospital's IP UPL calculated in accordance to the methodology set forth below then summed to calculate the IP UPL gap. The IP UPL gap is reduced by the estimated inpatient FFS GME payments for the coming SFY for each hospital to calculate the total amount of funding available. The previous SFY's payments are compared to current SFY's estimated claims based payments and when the estimated current year payments are less than prior year payments, that hospital is eligible for a UPL payment. The available IP UPL gap is distributed to each eligible hospital based on the percent to total of the available room in the prior year and current year comparison. The available gap under the IP UPL for each eligible hospital will be aggregated to create the supplemental payment amount. The total calculated supplemental payment amount will be paid to eligible hospitals.
 - (a) The IP UPL will be determined based on the hospital's Medicaid inpatient costs using Medicare cost reporting principles. All Medicare cost report worksheet, column, or line references are based upon the Medicare Cost Report (MCR) CMS 2552-10 and should be adjusted for any CMS approved successor MCR. The amount that Medicare would pay shall be calculated as follows:
 - (1) Using Medicare cost report data within the previous two years of the IP UPL demonstration dates in accordance with IP UPL guidelines set by CMS, Total Medicare Costs shall be derived from the reported Inpatient Hospital Cost on the following cost report variable locations:
 - a. Worksheet D-1, Hospital/IPF/IRF Components, Column 1, Line 49
 - b. Plus Organ Acquisitions Cost from all applicable Worksheets D-4, Column 1, Line 69
 - c. Plus GME Aggregated Approved Amount from Worksheet E-4, Column 1, Line 49
 - (2) Total Medicare Patient Days shall be derived from Worksheet S-3, Part I, Column 6, Lines 14, 16, and 17 of the same cost report as the Total Medicare Costs.
 - (3) A calculated Medicare Cost Per Diem shall be calculated by dividing the Total Medicare Costs by the hospital's Total Medicare Patient Days.

- (4) The calculated Medicare Cost Per Diem shall be multiplied by the total Medicaid Patient Days from a twelve (12) month data set from the prior two (2) years of the IP UPL demonstration dates in accordance with the IP UPL guidelines set by CMS to derive the hospital's IP UPL.
 - a. The data source for the Medicaid Patient Days and Total Medicaid Payments shall be from the state's MMIS claims data.
- (5) The calculated IP UPL shall be inflated from the midpoint of the hospital's cost report period to the midpoint of the IP UPL demonstration period using the CMS PPS hospital market basket index.
- (6) If payments in this section would result in payments to any category of hospitals in excess of the IP UPL calculation required by 42 C.F.R 447.272, payments for each eligible hospital receiving payments under this section will be reduced proportionately to ensure compliance with the IP UPL.

XII. Children's Outlier (CO) Payment

- A. The outlier year is based on a discharge date between July 1 and June 30.
- B. Beginning July 1, 2022, for FFS claims only, outlier payments for medically necessary inpatient services involving exceptionally high cost or exceptionally long lengths of stay for Missouri Medicaid-eligible children under the age of six (6) will be made to hospitals, meeting the federal DSH requirements in Subsection XII.B.1., and for Missouri Medicaid-eligible infants under the age of one (1) will be made to any other Missouri Medicaid hospital.
 1. The following criteria must be met to be eligible for outlier payments for children one (1) year of age to children under six (6) years of age:
 - (a) If the facility offered nonemergency obstetric services as of December 21, 1987, there must be at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to these services under the Missouri Medicaid plan. In the case of a hospital located in a rural area (area outside of a metropolitan statistical area, as defined by the federal Executive Office of Management and Budget), the term obstetrician includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. This section does not apply to hospitals either with inpatients predominantly under eighteen (18) years of age or which did not offer nonemergency obstetric services as of December 21, 1987;

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- (b) As determined from the base year audited Medicaid cost report, the hospital must have either:
- (1) A Medicaid inpatient utilization rate (MIUR) at least one (1) standard deviation above the state's mean MIUR for all Missouri hospitals. The MIUR will be expressed as the ratio of total Medicaid days (TMD) (including such patients who receive benefits through a managed care entity) provided under a state plan divided by the provider's total number of inpatient days (TNID). The state's mean MIUR will be expressed as the ratio of the sum of the total number of the Medicaid days for all Missouri hospitals divided by the sum of the total patient days for the same Missouri hospitals. Data for hospitals no longer participating in the program will be excluded;

$$\text{MIUR} = \text{TMD} / \text{TNID}$$

or

- (2) A low-income utilization rate (LIUR) in excess of twenty-five percent (25%). The LIUR shall be the sum (expressed as a percentage) of the fractions, calculated as follows:
- a. Total Medicaid patient revenues (TMPR) paid to the hospital for patient services under a state plan plus the amount of the cash subsidies (CS) directly received from state and local governments, divided by the total net revenues (TNR) (charges, minus contractual allowances, discounts, and the like) for patient services plus the CS; and
- b. The total amount of the hospital's charges for patient services attributable to charity care (CC) less CS directly received from state and local governments in the same period, divided by the total amount of the hospital's charges (THC) for patient services. The total patient charges attributed to CC shall not include any contractual allowances and discounts other than for indigent patients not eligible for MO HealthNet under a state plan;

$$\text{LIUR} = ((\text{TMPR} + \text{CS}) / (\text{TNR} + \text{CS})) + ((\text{CC} - \text{CS}) / \text{THC})$$

2. The following criteria must be met for the services to be eligible for outlier review;
- (a) the patient must be a Missouri Medicaid eligible infant under the age of one (1) year or, for hospitals that meet the federal DSH requirements, a Missouri Medicaid eligible child under the age of six (6) years as of the date of discharge; and
- (b) one (1) of the following conditions must be satisfied:
- (1) the total reimbursable charges for dates of service must be at least one hundred fifty percent (150%) of the sum of all claim payments for each claim; or
- (2) the dates of service must exceed sixty (60) days and less than seventy-five percent (75%) of the total service days were reimbursed by Medicaid.

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3. Claims eligible for outlier review must:
 - (a) have been submitted in their entirety for claim processing; and
 - (b) the claim must have been paid; and
 - (c) an annual outlier file, for paid claims only, must be submitted to the Division no later than December 31 of the second calendar year following the end of the outlier year (i.e. claims for outlier year 2022 are due no later than December 31, 2024).
4. After the review, reimbursable costs for each claim will be determined using the following data from the audited Medicaid hospital cost report for the year ending in the same calendar year as the outlier year (i.e. cost report year ends ending in 2022 will be used for the 2022 outlier year):
 - (a) average routine (room and board) costs for the general and special care units for all days of the stay eligible per the outlier review; and
 - (b) ancillary cost to charge ratios applied to claim ancillary charges determined eligible for reimbursement per the outlier review.
5. The outlier payments will be determined for each hospital as follows:
 - (a) sum all reimbursable costs for all eligible outlier claims to equal total reimbursable costs;
 - (b) subtract total claim payments, which includes Medicaid claims payments, third party payments, and co-pays, from total reimbursable costs to equal excess cost; and
 - (c) multiply excess costs by fifty percent (50%).

XIII. Safety Net Hospitals

- A. Inpatient hospital providers may qualify as a Safety Net Hospital based on the following criteria. Hospitals shall qualify for a period of only one (1) SFY and must re-qualify at the beginning of each SFY to continue their Safety Net Hospital designation.
 1. If the facility offered non-emergency obstetric services as of December 21, 1987, there must be at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to those services under the Missouri Medicaid plan. In the case of a hospital located in a rural area (area outside of a Metropolitan Statistical Area, as defined by the federal executive Office of Management and Budget), the term obstetrician includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. This section does not apply to hospitals either with inpatients predominantly under eighteen (18) years of age or which did not offer non-emergency obstetric services as of December 21, 1987;

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2. As determined from the audited base year cost report, the facility must have either:
- (a) A Medicaid inpatient utilization rate (MIUR) at least one (1) standard deviation above the state's mean MIUR for all Missouri hospitals: The MIUR will be expressed as the ratio of total Medicaid days (TMD) (including such patients who receive benefits through a managed care entity) provided under a state plan divided by the provider's total number of inpatient days (TNID). The state's mean MIUR will be expressed as the ratio of the sum of the total number of Medicaid days for all Missouri hospitals divided by the sum of the total patient days for the same Missouri hospitals. Data for hospitals no longer participating in the program will be excluded.

$$\text{MIUR} = \text{TMD} / \text{TNID}$$

or

- (b) A low income utilization rate in excess of twenty-five percent (25%).
 - (1) The low-income utilization rate (LIUR) shall be the sum (expressed as a percentage) of the fractions, calculated as follows:
 - a. Total Medicaid patient revenues (TMPR) paid to the hospital for patient services under a state plan (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) plus the amount of the cash subsidies (CS) directly received from state and local governments, divided by the total net revenues (TNR) (charges, minus contractual allowances, discounts etc.) For patient services plus the cash subsidies, and;
 - b. The total amount of the hospital's charges for patient services attributable to charity care (CC) less cash subsidies directly received from state and local governments in the same period, divided by the total amount of the hospital's charges (THC) for patient services. The total patient charges attributed to charity care shall not include any contractual allowances and discounts other than for indigent patients not eligible for medical assistance under a State Plan.

$$\text{LIUR} = ((\text{TMPR} + \text{CS}) / (\text{TNR} + \text{CS})) + ((\text{CC} - \text{CS}) / \text{THC})$$

3. As determined from the audited base year cost report,
- (a) The acute care hospital has an unsponsored care ratio of at least sixty- five percent (65%) and is licensed for less than fifty (50) inpatient beds; or
 - (b) The acute care hospital has an unsponsored care ratio of at least sixty- five (65%) and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of more than forty percent (40%); or

- (c) A public non-state governmental acute care hospital with a LIUR of at least forty percent (40%) and a MIUR greater than one standard deviation from the mean, and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of at least forty percent (40%); or
- (d) The hospital is owned or operated by the Board of Curators as defined in Chapter 172, RSMo; or
- (e) The hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental disorders.

XIV. 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 per diem rate for merged hospitals shall be calculated:
 - 1. For the remainder of the SFY in which the merger occurred, the merged rate is calculated 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.
 - 2. For subsequent SFYs, the per diem rate will be based on the combined data from the base year cost report for each facility.
- B. The Other Medicaid Payments, if applicable, shall be:
 - 1. Combined under the surviving hospital's Medicaid provider number for the remainder of the SFY in which the merger occurred; and
 - 2. Calculated for subsequent SFYs based on the combined data from the base year cost report for each facility.

XV. Out-of-State (OOS) Hospital Services Reimbursement

- A. Covered inpatient hospital services include those items and services allowed by the Medicaid State Plan including medically necessary care in a semi-private room. If prior authorized Missouri Medicaid may reimburse for a private room if it is certified medically necessary by a physician to avoid jeopardizing the health of the patient or to protect the health and safety of other patients. No payment will be made for any portion of the room charge when the participant requests and is provided a private room when the private room is not medically necessary.

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- B. Payment for authorized inpatient hospital services shall be made on a prospective per diem basis for services provided outside Missouri if the services are covered by the Missouri Medicaid Program. To be reimbursed for furnishing services to Missouri Medicaid participants, OOS hospitals must complete a Missouri Medicaid Program Provider Participation Application and have the application approved by the Missouri Department of Social Services, Missouri Medicaid Audit and Compliance (MMAC).
- C. Determination of Payment. The payment for inpatient hospital services provided by an OOS hospital shall be the lowest of:
1. For the OOS hospitals whose per diem was set on the hospital's audited Medicaid cost report prior to July 1, 2022, the hospital's per diem will be the rate in effect as of June 30, 2022. For all other OOS hospitals, the hospital's per diem will be fifty percent (50%) of the weighted statewide average per diem rate for Missouri hospitals as calculated by the Division for the SFY in which the service was provided; or
 2. The amount of total charges billed by the hospital. The hospital's billed charges must be their usual and customary charges for services; or
 3. The Medicare deductible or coinsurance, if applicable, up to the amount allowed by the Missouri Medicaid program;
- D. DSH Payments. OOS hospitals do not qualify for DSH payments.
- E. Definitions.
1. The definitions as described in Section II.
 2. Out-of-state - not within the physical boundaries of Missouri.
 3. Usual and customary charge - the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.

XVI. Inappropriate Placements

- A. The hospital per diem rates as determined under this plan and in effect on October 1, 1981, shall not apply to any participant who is receiving inpatient hospital care when s/he is only in need of nursing home care.
1. If a hospital has an established ICF/SNF or SNF only Medicaid rate for providing nursing home services in a distinct part setting, reimbursement for nursing home services provided in the inpatient hospital setting shall be made at the hospital's ICF/SNF or SNF only rate.

No Medicaid payments will be made on behalf of any participant who is receiving inpatient hospital care and is not in need of either inpatient or nursing home care.

XVII. Payment Adjustment for Provider-Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 434, 438, 447, and 1902(a)(4), 1902(a)(6), and 1903 of the Social Security Act, with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The state identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19-A of this State Plan.

Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19-B of this state plan.

Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

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The State will identify the occurrence of Health Care-Acquired Conditions (HCAC) and adjust provider payments as follows:

- The MMIS will deny payment for claims in which the Present on Admission (POA) indicator is not filled with a valid POA indicator. Valid POA indicators are:
 - Y = Yes - present at the time of inpatient admission
 - N = No - not present at the time of inpatient admission
 - U = Unknown - documentation is insufficient to determine if condition is present on admission.
 - W = Clinically undetermined - provider is unable to clinically determine whether condition was present on admission or not.
- All inpatient hospital claims priced and paid in the MMIS according to existing payment methodologies for the provider will be collected on a quarterly basis.
- The quarterly extract of inpatient claims will go through the HCAC logic of the 3M™ All-Patient Refined Diagnosis Related Groups (APR-DRGs) software in order to determine whether the HCAC condition affects payment.
- The grouper will assign a DRG to the claims, identify the presence of a HCAC condition and if the condition occurred during the stay.
- The applicable APR-DRG grouper version and list of Medicaid HCAC conditions will be used based on the date of service on the claim. The present-on-admission (POA) indicator values of "N" (not present on admission) and "U" (insufficient documentation) will be used to flag the claim for the HCAC payment adjustment.
- The DRG assignment process will be used for the purpose of identifying the effect of a HCAC on the resources needed to care for a patient. If removing the HCAC condition results in a DRG with a lower relative weight, only then will the payment be affected and adjusted by a percentage based on the difference in the DRG weights. The percentage represents the portion of the payment related to the HCAC.

The State will identify the occurrence of OPPCs and deny provider payments as follows:

- Claims in the MMIS will be identified for the presence of any one of the OPPCs based on the type of bill, diagnoses and procedures submitted on the claim, Payment for the claims will be denied, if appropriate.
- Such payment limitations shall only apply to the provider where the OPPC occurred and shall not apply to care provided by other providers should the patient subsequently be transferred or admitted to another hospital for needed care.

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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