

## **Table of Contents**

**State/Territory Name: MO**

**State Plan Amendment (SPA) #: 14-0024**

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



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**Financial Management Group**

**JUN 08 2015**

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

RE: Missouri State Plan Amendment TN: 14-024

Dear Mr. Kinkade:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 14-024. This amendment provides for a 4.3% increase in inpatient hospital per diem payment rates. This SPA also clarifies the per diem rate calculation for new facilities, clarifies the rate setting methodology for hospitals that terminate from and reenter the Missouri Medicaid program, and clarifies the publication to be used for trend indices.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) 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 14-024 is approved effective July 1, 2014. We are enclosing the CMS-179 and the amended plan pages.

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

Sincerely,

Timothy Hill  
Director

A handwritten signature in black ink, appearing to be 'Timothy Hill', written over the printed name and title.

Enclosures

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

1. TRANSMITTAL NUMBER:

1 4 - 2 4

2. STATE  
Missouri

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

4. PROPOSED EFFECTIVE DATE

July 1, 2014

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

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 2014 \$ 12.892 million

b. FFY 2015 \$ 52.747 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A

Page 6, 6a, 6a-1, 6b, 6b-1, 16g

9. PAGE NUMBER OF THE SUPERSEDES PLAN SECTION  
OR ATTACHMENT (If Applicable):

Attachment 4.19-A

Page 6, 6a, 6b, 16g

10. SUBJECT OF AMENDMENT:

This amendment provides the State Fiscal Year (SFY) 2015 trend factor. This amendment also provides clarification to the hospitals in reference to the per diem rate computation, to the reimbursement for a facility that terminates and reenters the program, and to the publication used for trend indices.

11. GOVERNOR'S REVIEW (Check One)

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ OTHER, AS SPECIFIED:

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPE NAME: Brian Kinkade

14. TITLE: 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 08 2015

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:

JUL 01 2014

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

Kristin FAN

22. TITLE:

Deputy Director

23. REMARKS:

5. The poison control cost shall reimburse the hospital for the prorated Medicaid managed care cost. It will be calculated by multiplying the estimated Medicaid share of the poison control costs by the percentage of MC+ recipients to total Medicaid recipients; and
- C. For new hospitals that do not have a base cost report, Direct Medicaid payments shall be estimated as follows:
1. Hospitals receiving Direct Medicaid payments shall be divided into quartiles based on total beds;
  2. Direct Medicaid payments shall be individually summed by quartile and then divided by the total beds in the quartile to yield an average Direct Medicaid payment per bed;
  3. The number of beds for the new hospital without the base cost report shall be multiplied by the average Direct Medicaid payment per bed to determine the hospital's estimated Direct Medicaid payment for the current state fiscal year; and
  4. For a new hospital licensed after February 1, 2007, estimated total Direct Medicaid payments for the current state fiscal year shall be divided by the estimated Medicaid patient days for the new hospital's quartile to obtain the estimated Direct Medicaid adjustment per patient day. This adjustment per day shall be added to the new hospital's Medicaid rate as determined in section IV, so that the hospital's Direct Medicaid payment per day is included in its per diem rate, rather than as a separate add-on payment. When the hospital's prospective per diem rate is determined in accordance with sections I – III-1., the facility's Direct Medicaid payment will be calculated in accordance with subsection XV-1.B. and reimbursed as an add-on payment rather than as part of the per diem rate. If the hospital is defined as a critical access hospital, its Medicaid per diem rate and Direct Medicaid payment will be determined in accordance with subsection V.F.
  5. A facility previously enrolled for participation in the MO HealthNet Program, which either voluntarily or involuntarily terminates its participation in the MO HealthNet Program and which reenters the MO HealthNet Program, shall have its Direct Medicaid payments determined in accordance with III-1.B.4.

- 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 index for SFY 95 is used to adjust the OC to a common fiscal year end of June 30. The adjusted OC shall be trended through SFY 2001;
- 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

- C. In addition to the Medicaid rate determined by either subsections IV.A. or IV.B., the Medicaid per diem rate for a new hospital licensed after February 1, 2007 shall include an adjustment for the hospital's estimated Direct Medicaid Add-On Payment per patient day, as determined in subsection XV-1.C., until the facility's prospective rate is set in accordance with subsection IV.B. The facility's Direct Medicaid Add-On adjustment will then no longer be included in the per diem rate but shall be calculated as a separate Add-On Payment, as set forth in section XV-1.

V. Administrative Actions

A. Cost Reports

1. Each hospital participating in the Missouri Medical Assistance Program shall submit a cost report in the manner prescribed by the state Medicaid agency. The cost report shall be submitted within five (5) calendar months after the close of the reporting period. The period of a cost report is defined in 42 CFR 413.24(f). A single extension, not to exceed thirty (30) days, may be granted upon request of the hospital and the approval of the Missouri Division of Medical Services when the provider's operation is significantly affected due to extraordinary circumstances over which the provider had no control such as fire or flood. The request must be in writing and post marked prior to the first day of the sixth (6th) month following the hospital's fiscal year end.

IV. Per-diem Rate New Hospitals.

- A. Facilities Reimbursed by Medicare on a Per-Diem basis. In the absence of adequate cost data, a new facility's Medicaid rate shall be determined as set forth below in IV.B.
- B. Facilities Reimbursed by Medicare on a DRG Basis. In the absence of adequate cost data, a new facility's initial Medicaid rate may be ninety percent (90%) of the average-weighted, statewide per-diem rate for the year it became certified to participate in the MO HealthNet program until a prospective rate is determined on the facility's rate setting cost report as set forth below in paragraph 1. The facility's rate setting cost report shall be the first full fiscal year cost report. If the facility's first full fiscal year cost report does not include any Medicaid costs, the facility shall continue to receive the initial rate and the prospective rate will be determined from the facility's second full fiscal year cost report. If the facility's second full fiscal year cost report does not include any Medicaid cost, the initial rate shall become the facility's prospective rate and shall be effective the date the facility was enrolled in the MO HealthNet program. The effective date for facilities whose prospective rate was based on the rate setting cost report shall be the first day of the SFY that the rate setting cost report is the base year cost report for determining the Direct Medicaid Add-On Payment.
  - 1. Prospective Per Diem Reimbursement Rate Computation. Each new hospital shall receive a MO HealthNet prospective per diem rate based on the sum of the following components:
    - (a) Total Allowable Cost, less Graduate Medical Education cost, adjusted by the Trend Indices included in III-1.B. from the year subsequent to the rate setting cost report period through the state fiscal year for which the rate is being determined, divided by Medicaid Inpatient Days; plus,
    - (b) Graduate Medical Education cost divided by Medicaid Inpatient Days.
  - 2. The per diem rate shall not exceed the average MO HealthNet inpatient charge per day as determined from the rate setting cost report as adjusted by the applicable Trend Indices;
  - 3. The per diem rate shall be adjusted for rate increases granted in accordance with subsection V.F. for allowable costs not included in the rate setting cost report.
  - 4. The per diem rate shall be reduced as necessary to avoid any negative Direct Medicaid Payments computed in accordance with subsection XV-1.B.

4. A facility previously enrolled for participation in the MO HealthNet Program, which either voluntarily or involuntarily terminates its participation in the MO HealthNet Program and which reenters the MO HealthNet Program, will receive the same inpatient rate and outpatient rate as the previous owner/operator. Such facility will also receive the same Direct Medicaid Add-On Payment and Uninsured Add-On Payment as the previous owner/operator if the facility reenters the MO HealthNet program during the same state fiscal year. If the facility does not reenter during the same state fiscal year, the Direct Medicaid Add-On Payment and Uninsured Add-On Payment will be determined based on the applicable base year data (i.e., fourth prior year cost report for the Direct Medicaid Payment; see section XVII-1 for the applicable data for the Uninsured Add-On Payment). If the facility does not have the applicable base year data, the Direct Medicaid Add-On Payment and the Uninsured Add-On Payment will be based on the most recent audited data available and will include annual trend factor adjustments from the year subsequent to the cost report period through the state fiscal year for which the payments are being determined.

- 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, or equivalent publication regardless of any changes in the name of the publication or publisher, 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%
- V. State Fiscal Year 2015 - 4.3%

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.