Table of Contents

State/Territory Name: MO

State Plan Amendment (SPA) #: 24-0017

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

September 24, 2024

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

RE: TN 24-0017

Dear Mr. Knodell:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Missouri state plan amendment (SPA) to Attachment 4.19-A, MO 24-0017, which was submitted to CMS on July 15, 2024. This plan amendment updates the definition of a safety net hospital and updates the Acuity Adjustment Payment and Stop Loss Payment methodologies.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations. CMS has identified concerns that the state's use of revenues derived from its Federal Reimbursement Allowance (FRA) tax program as a source of Missouri's non-federal share for this state plan amendment may not comply with certain health care-related tax requirements in section 1903(w)(4) of the Social Security Act and implementing regulations in 42 CFR 433.68(f)(3). Approval of this state plan amendment does not constitute an approval of the non-federal share funded by the FRA or NFRA taxes.

Based upon the information provided by the state, we have approved the amendment with an effective date of July 1, 2024. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

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

Sincerely,

[redacted]

Rory Howe
Director
Financial Management Group

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24 — 0017

2. STATE: MO

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

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

4. PROPOSED EFFECTIVE DATE
July 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447 Subpart C

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ 38,002,689
b. FFY 2025 $ 150,262,182

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19 A - pages 11, 12, 13, 22, 25, 26, 27

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19 A - pages 11, 12, 13, 22, 25, 26, 27

9. SUBJECT OF AMENDMENT
This State Plan Amendment updates the definition of a safety net hospital and updates the Acuity Adjustment Payment and Stop Loss Payment methodologies.

10. GOVERNOR'S REVIEW *(Check One)*
(●) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
( ) OTHER, AS SPECIFIED:

SLV

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Robert J. Knodell

13. TITLE
Director

14. DATE SUBMITTED
7-11-24

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

FOR CMS USE ONLY

16. DATE RECEIVED
7/15/2024

17. DATE APPROVED
September 24, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
7/1/2024

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS

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, and SLP.

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 SFY 2023 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 SFY 2023 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 SFY 2023 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 SFY 2023 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, and SLP.

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 SFY 2023 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 SFY 2023 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 SFY 2023 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.

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 SFY 2023 payments are compared to current SFY's estimated claims based payments and when the estimated current year payments are less than the SFY 2023 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 SFY 2023 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.

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. A hospital 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;

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.

   $$MIUR = TMD / TNID$$

   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.

         $$LIUR = ((TMPR + CS) / (TNR + CS)) + ((CC – CS) / THC)$$

3. As determined from the audited base year cost report:

   (a) A public non-state governmental acute care hospital with a LIUR of at least twenty percent (20%) 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

   (b) The hospital is owned or operated by the Board of Curators as defined in Chapter 172, RSMo; or

   (c) 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.