Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 15—Hospital Program

EMERGENCY AMENDMENT

13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Plan; Outpatient Hospital Services Reimbursement Methodology. The division is amending sections (1), (2), (3), (5), (6), (13), (14), (16), (18), and (21).

PURPOSE: This amendment provides the State Fiscal Year (SFY) 2012 trend factor; clarifies new federal audit and record retention requirements in accordance with federally mandated DSH audit standards; references new regulations relating to Disproportionate Share Hospital (DSH) and Upper Payment Limit (UPL) payments; and revises when Enhanced Graduate Medical Education payments are paid to hospitals.

EMERGENCY STATEMENT: The Department of Social Services, MO HealthNet Division by rule and regulation must define the reasonable costs, manner, extent, quantity, quality, charges, and fees of medical assistance. This emergency amendment will ensure payment to Missouri hospitals providing health care to approximately nine hundred thousand (900,000) Missourians eligible for the MO HealthNet program. This emergency amendment must be implemented on a timely basis because it allows the state to recognize additional costs hospitals are incurring to ensure that quality health care continues to be provided to MO HealthNet participants and the uninsured at hospitals that have relied on MO HealthNet payments to meet those patients' needs. In addition, this emergency amendment must be implemented on an emergency basis because it allows the state to redistribute hospital payments in accordance with federal audit requirements. This emergency amendment helps to offset increasing costs of serving Medicaid patients in hospital settings. This emergency amendment enables the state to recognize increased costs incurred by hospitals beginning July 1, 2011 rather than delaying trend increases approximately six months. Hospitals serve approximately one hundred twenty thousand (120,000) MO HealthNet participants each month. The majority of those served in hospital settings are Missouri's most vulnerable citizens; sixty-two (62) percent of hospital inpatient expenditures are for persons with disabilities and twenty (20) percent are for services provided to children. As a result, the MO HealthNet Division finds an immediate danger to public health, safety, and/or welfare and a compelling governmental interest which requires emergency action. The MO HealthNet program has a compelling government interest in providing continued cash flow for inpatient hospital services. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions****. The MO HealthNet Division believes this emergency amendment is fair to all interested persons and parties under the circumstances. MO HealthNet Division staff worked extensively with the Missouri Hospital Association to ensure that the industry as a whole was adequately represented. Missouri Hospital Association representatives attended numerous meetings. This regulation was reviewed by Missouri Hospital Association staff and is supported by the Missouri Hospital Association Board. A proposed amendment covering this same material will be published in this issue of the Missouri Register. Therefore,*

the Division believes this emergency to be fair to all interested persons and parties under the circumstances. This emergency amendment was filed May 20, 2011, effective June 1, 2011, expires November 28, 2011.

(1) General Reimbursement Principles.

(C) The Title XIX reimbursement for hospitals, excluding those located outside Missouri and in-state federal hospitals, shall include per diem payments, outpatient payments, disproportionate share payments **as described in this regulation through May 31, 2011 and as described in 13 CSR 70-15.220 beginning June 1, 2011**; various MO HealthNet Add-On payments, as described in this rule; or a safety net adjustment, paid in lieu of Direct Medicaid Payments described in section (15) and Uninsured Add-Ons described in *[subsection (18)(B)]* **this regulation through May 31, 2011 and described in 13 CSR 70-15.220 beginning June 1, 2011**. Reimbursement shall be subject to availability of federal financial participation (FFP).

1. Per diem reimbursement—The per diem rate is established in accordance with section (3).

2. Outpatient reimbursement is described in 13 CSR 70-15.160.

3. Disproportionate share reimbursement—The disproportionate share payments described in section (16), and subsection (18)(B), include both the federally mandated reimbursement for hospitals which meet the federal requirements listed in section (6) and the discretionary disproportionate share payments which are allowable but not mandated under federal regulation. These Safety Net and Uninsured Add-Ons shall not exceed one hundred percent (100%) of the unreimbursed cost for MO HealthNet and the cost of the uninsured unless otherwise permitted by federal law. **Beginning June 1, 2011, hospital disproportionate share reimbursements are defined in 13 CSR 70-15.220.**

4. MO HealthNet Add-Ons—MO HealthNet Add-Ons are described in sections (13), (14), (15), (19), and (21) and are in addition to MO HealthNet per diem payments. These payments are subject to the federal Medicare Upper Limit test.

5. Safety Net Adjustment—The payments described in subsection (16)(A) are paid in lieu of Direct Medicaid Payments described in section (15) and Uninsured Add-Ons described in subsection (18)(B).

(2) Definitions.

(A) Allowable costs. Allowable costs are those related to covered MO HealthNet services defined as allowable in 42 CFR chapter IV, part 413, except as specifically excluded or restricted in 13 CSR 70-15.010 or the MO HealthNet hospital provider manual and detailed on the desk-reviewed Medicare/Medicaid cost report. Penalties or incentive payments as a result of Medicare target rate calculations shall not be considered allowable costs. Implicit in any definition of allowable cost is that this cost is allowable only to the extent that it relates to patient care; is reasonable, ordinary, and necessary; and is not in excess of what a prudent and cost-conscious buyer pays for the given service or item. **For purposes of calculating disproportionate share payments and to ensure federal financial participation (FFP), allowable uncompensated costs must meet definitions defined by the federal government.**

(I) Disproportionate share reimbursement. The disproportionate share payments described in section (16), and subsection (18)(B), include both the federally mandated reimbursement for hospitals which meet the federal requirements listed in section (6) and the discretionary disproportionate share payments which are allowed but not mandated under federal regulation. These Safety Net and Uninsured Payment Add-Ons shall not exceed one hundred percent (100%) of the unreimbused cost for MO HealthNet and the cost of the uninsured unless otherwise permitted by federal law. **Beginning June 1, 2011, disproportionate share reimbursement is described in 13 CSR 70-15.220.**

(3) Per Diem Reimbursement Rae Computation. Each hospital shall receive a MO HealthNet per diem rate based on the following computation.

(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 each State Fiscal Year (SFY) 1995 to 1998. Trend indices starting in SFY 1999 will be determined based on CPI Hospital indexed as published in *Health Care Costs* by DRI/McGraw-Hill for each State Fiscal Year (SFY).

1. The TI are—

A. SFY 1994—4.6%
B. SFY 1995—4.45%
C. SFY 1996—4.575%
D. SFY 1997—4.05%
E. SFY 1998—3.1%
F. SFY 1999—3.8%
G. SFY 2000—4.0%
H. SFY 2001—4.6%
I. SFY 2002—4.8%
J. SFY 2003—5.0%
K. SFY 2004—6.2%
L. SFY 2005—6.7%
M. SFY 2006—5.7%
N. SFY 2007—5.9%
O. SFY 2008—5.5%
P. SFY 2009—5.5%
Q. SFY 2010—3.9%
R. SFY 2011—3.2%—The 3.2% trend shall not be applied in determining the per diem rate, Direct Medicaid payments, or uninsured payments.
S. SFY 2012—4.0%

2. The TI for SFY 1996 through SFY 1998 are applied as a full percentage to the OC of the per diem rate and for SFY 1999 the OC of the June 30, 1998, rate shall be trended by 1.2% and for SFY 2000 the OC of the June 30, 1999, rate shall be trended by 2.4%. The OC of the June 30, 2000, rate shall be trended by 1.95% for SFY 2001.

3. The per diem rate shall be reduced as necessary to avoid any negative Direct Medicaid payments computed in accordance with subsection (15)(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, shall have its MO HealthNet rate determined in accordance with section (4).

(5) *[Administrative Actions]* **Reporting Requirements.**

(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 MO HealthNet (excluding cross-over claims) respectively. Separate logs for inpatient and outpatient services should be maintained for MO HealthNet participants covered by managed care. All records must be available upon request to representatives, employees, or contractors of the MO HealthNet 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 MO HealthNet log for each fiscal year must be maintained by either date of service or date of payment by MO HealthNet 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 MO HealthNet log should be used to complete the Medicaid worksheet in the hospital's cost report;

B. Data required to be recorded in logs for each claim include:

(I) Participant name and MO HealthNet number;

(II) Dates of service;

(III) If inpatient claim, number of days paid for by MO HealthNet, classified by adults and peds, each subproviders, newborn, or specific type of intensive care;

(IV) Charges for paid inpatient days and inpatient ancillary charges for paid days classified by cost center as reported in the cost report or allowed outpatient services, classified by cost center as reported on cost report;

(V) Noncovered charges combined under a separate heading;

(VI) Total charges;

(VII) Any partial payment made by third-party payers (claims paid equal to or in excess of MO HealthNet payment rates by third-party payers shall not be included in the log);

(VIII) MO HealthNet payment received or the adjustment taken; and

(IX) Date of remittance advice upon which paid claim or adjustment appeared;

C. A year-to-date total must appear at the bottom of each log page or after each applicable group total, or a summation page of all subtotals for the fiscal year activity must be included with the log; and

D. Not to be included in the outpatient log are claims or line item outpatient charges denied by MO HealthNet or claims or charges paid from an established MO HealthNet fee schedule. This would include payments for hospital-based physicians and certified registered nurse anesthetists billed by the hospital on a professional services claim, payments for certain specified clinical diagnostic laboratory services, or payments for services provided by the hospital through enrollment as a MO HealthNet provider-type other than hospital outpatient.

2. Records of related organizations, as defined by 42 CFR 413.17, must be available upon demand to those individuals or organizations as listed in paragraph (5)(B)1. of this rule.

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

[3] **4.** The MO HealthNet Division shall retain all uniform cost reports submitted for a period of at least three (3) years following the date of submission of the reports and will maintain those reports pursuant to the record keeping requirements of 42 CFR 413.20. If an audit by, or on behalf of, the state or federal government has begun but is not completed at the end of the three (3)-year period, or if audit findings have not been resolved at the end of the three (3)-year period, the reports shall be retained until resolution of the audit findings.

[4] **5.** The MO HealthNet Division shall maintain any responses received on this plan, subsequent changes to this plan, and rates for a period of three (3) years from the date of receipt.

(D) Audits.

1. A comprehensive hospital audit program shall be established in cooperation with the Missouri Medicare fiscal intermediary. Under the terms of the Common Audit Agreement, the Medicare intermediary shall perform the following:

A. Desk review all hospital cost reports;

B. Determine the scope and format for on-site audits;

C. Perform field audits when indicated in accordance with Title XIX principles; and

D. Submit to the state agency the final Title XVIII cost report with respect to each provider.

2. The state agency shall review audited Medicare/Medicaid cost reports for each hospital's fiscal year in accordance with 13 CSR 70-15.040.

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

(6) Disproportionate Share **and Direct Medicaid Qualifying Criteria. Effective June 1, 2011, disproportionate share payment methodology and criteria that must be met to receive DSH payments are described in 13 CSR 70-15.220. The definitions set forth in this section (6) will continue to be used to determine eligibility for Direct Medicaid Payments (15) and the Safety Net adjustment (16).**

(F) Hospital-specific DSH cap. Unless otherwise permitted by federal law, disproportionate share payments shall not exceed one hundred percent (100%) of the unreimbursed cost for MO HealthNet and the cost of the uninsured. The hospital-specific DSH cap shall be computed by combining the estimated unreimbursed MO HealthNet costs for each hospital, as calculated in section (15), with the hospital's corresponding estimated uninsured costs, as determined in section (18). If the sum of disproportionate share payments exceeds the estimated hospital-specific DSH cap, the difference shall be deducted in order as necessary from safety net payments, other disproportionate share lump sum payments, direct Medicaid payments, and if

necessary, as a reduced per diem. All DSH payments in the aggregate shall not exceed the federal DSH allotment within a state fiscal period. **Effective June 1, 2011, hospital specific DSH limits shall be calculated in accordance with federally mandated DSH audit standards as described in 13 CSR 70-15.220.**

(13) Trauma Add-On Payments. Hospitals that meet the following will receive additional Add-On payments.

(E) Effective July 1, 2011, trauma add-on payments will be replaced with Upper Payment Limit payments as described in 13 CSR 70-15.230.

(14) Trauma Outlier Payments.

(F) Effective July 1, 2011, trauma add-on payments will be replaced with Upper Payment Limit payments as described in 13 CSR 70-15.230.

(16) Safety Net Adjustment. A safety net adjustment, in lieu of the Direct Medicaid Payments and Uninsured Add-Ons, shall be provided for each hospital which qualified as disproportionate share under the provision of paragraph (6)(A)4. The safety net adjustment payment shall be made prior to the end of each federal fiscal year.

(E) Effective June 1, 2011, DSH payment calculations and criteria are described in 13 CSR 70-15.220.

(18) In accordance with state and federal laws regarding reimbursement of unreimbursed costs and the costs of services provided to uninsured patients, reimbursement for each State Fiscal Year (SFY) (July 1–June 30) shall be determined as follows:

(G) Effective June 1, 2011, DSH payment calculations and criteria are described in 13 CSR 70-15.220.

(21) Enhanced Graduate Medical Education (GME) Payment—An enhanced GME payment shall be made to any acute care hospital that provides graduate medical education (teaching hospital).

(A) The enhanced GME payment shall be computed in accordance with subsection (21)(B). The payment shall be made *[at] **following*** the end of the state fiscal year. The enhanced GME payment for each state fiscal year shall be computed using the most recent cost data available when the enhanced GME payment is computed. If the cost report is less than or more than a twelve (12)-month period, the cost report data will be adjusted to reflect a twelve (12)-month period. The state share of the enhanced GME payment to a hospital that has cash subsidies shall come from funds certified by the hospital.

*AUTHORITY: sections 208.152, 208.153, **and** 208.201[, and 208.471], RSMo Supp. 2010. This rule was previously filed as 13 CSR 40-81.050. Original rule filed Feb. 13, 1969, effective Feb. 23, 1969. For intervening history please consult the Code of State Regulations. Amended: Filed May 20, 2011. Emergency filed May 20, 2011, effective June 1, 2011, expires Nov. 28, 2011.*