Public Notice of Adjustment of Prospective Medicaid Reimbursement Methodology for Inpatient and Outpatient Services

Pursuant to Sections 1902(a)(13)(A) of the Social Security Act and 42 Code of Federal Regulations (CFR) 447.205, which mandates that proposed changes in statewide methods and standards for setting Medicaid payment rates be published and made available for review and comment, this is to advise that:

1.A. The Missouri Department of Social Services, MO HealthNet Division (MHD) provides notice of the following adjustment: Effective for dates of services beginning June 1, 2011, MHD will implement a new statewide methodology for paying Disproportionate Share (DSH) payments in order to comply with the new federally required DSH audit standards. The regulation provides for an interim adjustment to DSH payments and provides for final adjustment to DSH payments based upon the federally mandated DSH audits.

(1) General Reimbursement Principles.

(A) In order to receive federal financial participation (FFP), disproportionate share payments are made in compliance with federal statutes and regulations. Section 1923 of the Social Security Care Act (42 U.S. Code) describes the hospitals that must be paid DSH and those that the state may elect to pay DSH.

(B) Hospitals that must be paid DSH are considered to be federally deemed DSH hospitals. The state must pay DSH to hospitals that meet the following criteria:

1. Obstetrics requirements as described in paragraph (2)(A)1; and

2. Have a Medicaid Inpatient Utilization Rate (MIUR) at least one (1) standard deviation above the statewide mean as defined in paragraph (2)(A)2., or a Low Income Utilization Rate (LIUR) greater than twenty-five (25) percent as defined in paragraph (2)(A)3.

(C) Hospitals that may be paid DSH must meet obstetric requirements as defined in paragraph (2)(A)1.and have a MIUR of at least one (1) percent.

(D) Section 1923(g) of the Social Security Act (Act) limits the amount of DSH payments states can pay to each hospital and earn FFP. To be in compliance with the Act, DSH payments shall not exceed one hundred (100) percent of the uncompensated care costs of providing hospital services to Medicaid and uninsured individuals. Hospital specific DSH limit calculations must comply with federally mandated DSH audit standards and definitions. If the disproportionate share payments exceed the hospital-specific DSH costs, the difference shall be deducted from disproportionate share payments or recouped from future payments.

(E) All DSH payments in the aggregate shall not exceed the federal DSH allotment within a state fiscal period. The DSH allotment is the maximum amount of DSH a state can distribute each year and receive FFP.

(F) The state must submit an annual independent audit of the state's DSH program to the Centers for Medicare and Medicaid Services (CMS). FFP is not available for DSH payments that are found to exceed the hospital-specific eligible uncompensated care cost limit. All hospitals that receive DSH payments are subject to the independent federal DSH audit.

(G) Hospitals qualify for DSH for a period of one (1) state fiscal year and must requalify at the beginning of each state fiscal year to continue to receive disproportionate share payments.

(2) Federally Deemed DSH Hospitals.

(A) The state must pay disproportionate share payments to hospitals that meet specific obstetric requirements and have either a MIUR at least one (1) standard deviation above the state mean or a LIUR greater than twenty-five (25) percent.

1. Obstetric Requirements and Exemptions:

A. Hospitals must have two (2) obstetricians, with staff privileges, who agree to provide non-emergency obstetric services to Medicaid eligibles. Rural hospitals, as defined by the federal Executive Office of Management and Budget, may qualify any physician with staff privileges as an obstetrician.

B. Hospitals are exempt from the obstetric requirements if the facility did not offer nonemergency obstetric services as of December 21, 1987.

C. Hospitals are exempt if inpatients are predominantly under eighteen (18) years of age.

2. MIUR Calculations.

A. As determined from the fourth prior year desk-reviewed cost report, the facility has a Medicaid inpatient utilization rate (MIUR) of at least one (1) standard deviation above the state's mean MIUR for all Missouri hospitals.

B. The MIUR is calculated as follows:

(I) The MIUR will be expressed as the ratio of total Medicaid days (TMD) provided under a state plan divided by the provider's total number of inpatient days (TNID).

(II) 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;

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

3. LIUR Calculations

A. As determined from the fourth prior year desk-reviewed cost report, the LIUR shall be the sum (expressed as a percentage) of the fractions, calculated as follows:

(I) Total MO HealthNet 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

(II) The total amount of the hospital's charges for patient services attributable to charity care (CC) (care provided to individuals who have no source of payment, third-party, or personal resources) 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;

$$\text{LIUR} = \frac{\text{TMPR} + \text{CS}}{\text{TNR} + \text{CS}} + \frac{\text{CC} - \text{CS}}{\text{THC}}$$

(3) State Elected DSH Payments.

(A) The state may elect to make hospital disproportionate share payments to hospitals that meet the obstetric requirements defined in paragraph (2)(A)1 and have a MIUR of at least one (1) percent as calculated in subparagraph (2)(A)2(B).

(4) DSH Audit Payment Adjustments.

(A) Beginning in Medicaid state plan year 2011, DSH payments made to hospitals, will be revised based on the results of a state DSH Survey which uses federally-mandated DSH audit standards. 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 2011 DSH audit will be finalized in 2014. The interim adjustments shall be determined as follows:

1. Based upon the state's analysis of the 2011 state's DSH survey using federally-mandated DSH audit standards, DSH payments will be limited to the hospital's projected hospital-specific DSH limit.

2. DSH payments as provided in the state's DSH survey that exceed the projected hospital-specific DSH limits will be recouped from the hospitals to reduce their payments to their projected hospital-specific DSH limit.

(B) Any payments that are recouped from hospitals as a result of the DSH audit will be redistributed to hospitals that are shown to have been paid less than their hospital-specific DSH limits. These redistributions will occur proportionally based on each hospitals uncompensated care shortfall to the total shortfall, not to exceed each hospital's specific projected DSH limit.

1. Redistribution payments to hospitals that have been paid less than their SFY 2011 projected hospital-specific DSH limit must occur after the recoupment of payments made to hospitals that have been paid in excess of their hospital specific DSH limits. The state may establish a hospital-specific recoupment plan. However, total industry redistribution payments may not exceed total industry recoupments collected to date.

2. If the Medicaid program's 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 redistributions will occur proportionally based on each hospitals uncompensated care shortfall to the total shortfall, not to exceed each hospital's specific DSH limit.

(5) Disproportionate Share (DSH) Interim Payments.

(A) SFY 2012 interim DSH payments will be based on the 2011 state DSH survey after applying the trend factor published in *Health Care Costs* by DRI/McGraw-Hill for the current fiscal year.

(B) Federally deemed hospitals will receive the nominal DSH payment of five thousand dollars ($5,000) and the greater of their upper payment limit payment or their hospital specific DSH limit as calculated from the state DSH survey. Except for federally deemed hospitals, hospitals may elect to receive an upper payment limit payment as defined in 13 CSR 70.230 in lieu of DSH payments.

(C) Disproportionate share payments will coincide with the semimonthly claim payment schedule.

(D) New facilities will be paid based on the industry average as determined from the state DSH survey.

(E) Facilities not providing a state DSH survey will have DSH payments calculated using the most recent hospital-specific information provided to the state by the independent auditor.

(6) Department of Mental Health Hospital (DMH) DSH Adjustments and Payments.

(A) Effective June 1, 2011, interim DSH payments made to DMH hospitals will be revised based on the results of a DMH state DSH survey which uses federally-mandated DSH audit standards. These revisions are to serve as interim adjustments until the federally-mandated DSH audits are complete in 2014.

(B) 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. Additional adjustments may be done based on the results of the federally mandated DSH audits as set forth below in subsection (7)(A).

(C) If the Medicaid program's original DSH payments did not fully expend the federal Institute for Mental Disease 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.

(7) Final DSH Adjustments.

(A) Final DSH adjustments will be made after actual cost data is available and the DSH audit is completed. DSH audits are completed three (3) years following the initial independent DSH audit. For example, final adjustments for 2011 will be made following the completion of the annual independent DSH audit in 2014 (SFY 2015).

(8) Record Retention.

(A) Records used to complete the state's DSH survey shall be kept until the final audit is completed. For example, the SFY 2011 state DSH survey will use 2009 cost data which must be maintained until the 2014 DSH audits are completed in SFY 2015.

(B) Records provided by hospitals to the state's independent auditor shall also be maintained until the 2014 federal DSH audit is complete.

MHD plans on making an additional $50 million in payments in State Fiscal Year 2011 to spend the entire federal DSH allotment, provided MHD has state match available through non-general revenue transactions and fund balances. The estimated cost for State Fiscal Year 2012 of this change in methodology is $708 million based upon preliminary calculations using the 2011 State DSH Survey, trended by 4 percent. The method of determining DSH payments for individual hospitals is different under this rule than under the current rule, 13 CSR 70-15.010, but payments under this new rule will equal payments authorized under the current rule, 13 CSR 70-15.010, so there are no new costs. DSH payments are limited by the federal DSH allotment and what can be funded through FRA and IGT transactions so the total amount of payments that MHD can make is the same under both rules.

B. Effective for dates of services beginning July 1. 2011, MHD establishes a methodology for determining Upper Payment Limit (UPL) payments provided to hospitals. MHD also established an additional UPL supplemental payment for hospitals with a Low Incomes and Needy Care Collaboration Agreement.

(1) General Principles.

(A) Hospital UPL payments cannot exceed the Medicare Upper Payment Limit as authorized by federal law and included in Missouri's State Plan.

(2) Beginning with State Fiscal Year 2012, each participating hospital may be paid supplemental payments up to the Medicare Upper Payment Limit (UPL).

(A) UPL Payment. Supplemental payments may be paid to qualifying hospitals for inpatient services. The total amount of supplemental payments made under this section in each year shall not exceed the Medicare Upper Payment Limit, after accounting for all other supplemental payments. Payments under this section will be determined prior to the determination of payments under section (B) below authorizing Medicaid UPL supplemental payments for low income and needy care collaboration hospitals.

1. The state shall determine the amount of Medicaid supplemental payments payable under this section on an annual basis. The state shall calculate the Medicare Upper Payment Limit for each of the three categories of hospitals: state hospitals, non-state governmental hospitals, and private hospitals. The state shall apportion the Medicaid supplemental payments payable under this section to each of the three categories of hospitals based on the proportionate Medicare Upper Payment Limits for each category of hospitals.

2. Each participating hospital may be paid its proportional share of the UPL gap based upon its Medicaid inpatient utilization.

(B) Supplemental Payments for Low Income and Needy Care Collaboration Hospitals. Additional Supplemental Payments for Low Income and Needy Collaboration Hospitals may be made if there is room remaining under the UPL to make additional payments without exceeding the UPL, after making the UPL payments in (2)(A) above.

1. Effective for dates of services on or after July 1, 2011, supplemental payments may be issued to qualifying hospitals for inpatient services after July 1, 2011. Maximum aggregate payments to all qualifying hospitals under this section shall not exceed the available Medicare Upper Payment Limit, less all other Medicaid inpatient payments to private hospitals under this State Plan which are subject to the Medicare Upper Payment Limit.

2. Qualifying Criteria. In order to qualify for the supplemental payment under this section, the private hospital must be affiliated with a state or local governmental entity through a Low Income and Needy Care Collaboration Agreement. The state or local governmental entity includes governmentally supported hospitals.

A. A private hospital is defined as a hospital that is owned or operated by a private entity.

B. A Low Income and Needy Care Collaboration Agreement is defined as an agreement between a private hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.

C. Reimbursement Methodology. Each qualifying private hospital may be eligible to receive supplemental payments. The total supplemental payments in any fiscal year will not exceed the lesser of:

(I) The difference between each qualifying hospital's inpatient Medicaid billed charges and Medicaid payment the hospital receives for covered inpatient services for Medicaid participants during the fiscal year; or

(II) For hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) program, the difference between the hospital's specific DSH cap and the hospital's DSH payments during the fiscal year.

D. Payments under this section will be determined after the determination of payments under subsection 2(A) above authorizing Medicaid UPL supplemental payments.

The estimated cost of $120.5 million is based upon data included in the estimated UPL for SFY 2011, trended by four (4) percent for State Fiscal Year 2012.

C. The Missouri Department of Social Services, MO HealthNet Division (MHD) provides notice of the following adjustments to 13 Code of State Regulations 70-15.010: Effective for dates of services beginning July 1, 2011, this change in methodology provides for a four percent State Fiscal Year 2012 trend factor to allow MHD to recognize additional costs hospitals are incurring to ensure quality health continues to be provided to MO HealthNet participants. The change in methodology also clarifies new federal audit and record retention requirements in accordance with federally mandated DSH audit standards. The new methodology references regulations relating to Disproportionate Share Hospital (DSH) and Upper Payment Limit (UPL) payments. The regulation also revises when Enhanced Graduate Medical Education payments are paid to hospitals. The payments will be made following the end of the state fiscal year.

The estimated cost of this change in methodology for State Fiscal Year 2012 is $79.1 million.

2. A copy of the proposed reimbursement adjustments is available for public review by going to any Department of Social Services Family Support Division Office or by contacting the Department of Social Services, MO HealthNet Division at PO Box 6500, Jefferson City, MO 65102-6500, Attn: Ian McCaslin, M.D., M.P.H., Director or at www.dss.mo.gov/mhd

3. Written comments must be delivered by regular mail, express or overnight mail, in person or by courier within thirty days after publication of this notice and must be sent or delivered to the following address:
Department of Social Services
MO HealthNet Division
P.O. Box 6500
Jefferson City, MO 65102-6500
Attention: Ian McCaslin, M.D., M.P.H., Director

4. No public hearing will be held.