

I. General Principles

- A. This rule defines the specific procedures used to calculate outpatient settlements for Missouri in-state hospitals participating in the Missouri Medicaid program. Outpatient settlements are only determined for new hospitals and nominal charge providers.
- B. The hospital's settlement will be determined after the division receives a Medicare cost report with a Notice of Provider Reimbursement (NPR). The cost report used for the settlement shall be the one with the latest NPR at the time the settlement is calculated. The data used, except for Medicaid data, shall be as reported in the cost report unless adjusted by this rule. The current version of the cost report is CMS 2552-10, and references in this rule are from this cost report. However, the division will use the version of the report received from the fiscal intermediary, which may change the references.
- C. The Medicaid charges used to determine the cost, and the payments used to determine the final settlement will be from the division's paid claims data for reimbursable services paid on a percentage basis under Attachment 4.19B. This data includes only claims on which Medicaid made payment.

II. Definitions

- A. Medicaid payments. Medicaid payments included in the settlement include actual Medicaid claims payments, partial insurance payments on claims, patient liability amounts for coinsurance and deductibles. If the insurance payments exceed the Medicaid liability, the claim will not be considered a Medicaid claim.
- B. Outpatient services/cost. Reimbursable outpatient services or costs are services or costs that are provided prior to the patient being admitted to the hospital. Only outpatient services or cost which are reimbursed on a percentage of charge as defined in Attachment 4.19B will be included in the final settlement, unless they are excluded elsewhere in this rule.
- C. Ancillary charges. Ancillary charges are the charges billed by the hospital for services that are not routinely provided in the routine care center and are not provided to all patients.
- D. New hospitals. A hospital which does not have a fourth prior year cost report necessary for establishment of a prospective rate will have final settlement calculated for their initial three (3) cost report periods.

E. Nominal charge provider. A nominal charge provider must meet one of the following criterias:

1. An acute care hospital with an unsponsored care ratio of at least sixty-five percent (65%) and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of more than forty percent (40%). The unsponsored care ratio is determined as the sum of bad debts and charity care divided by total net revenue. The hospital must meet one (1) of the federally mandated Disproportionate Share qualifications.; or
2. A public non-state governmental acute care hospital with a low income utilization rate (LIUR) of at least fifty percent (50%) and a Medicaid inpatient utilization rate (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
3. The hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental disorders.

F. 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.

III. Hospital Outpatient Settlements will be calculated as follows:

A. The hospital's Medicaid outpatient cost will be determined by multiplying the overall outpatient cost-to-charge ratio, determined in accordance with section III.A.1., by the Medicaid charges from section I.C. To this product will be added the Medicaid outpatient share of Graduate Medical Education (GME) to arrive at the total outpatient Medicaid cost. The GME will be determined during the Medicaid cost report audit. The Medicaid payments from section I.C. will be subtracted from the total outpatient Medicaid cost to determine the final overpayment or underpayment.

1. The overall outpatient cost-to-charge ratio will be determined by multiplying the outpatient charges for each ancillary cost center excluding PBRHC or PBFQHC on worksheet C part 1 column 7 or by the appropriate cost-to-charge ratio from worksheet C part 1 column 9 for each cost center. Total the outpatient costs from each cost center and total the outpatient charges from each cost center. Divide the total outpatient costs by the total outpatient charges to arrive at the overall outpatient cost-to-charge ratio.

IV. Under no circumstances will the Division accept amended cost reports for final settlement determination or adjustment after the date of the Division's notification of the final settlement amount.