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State/Territory Name: MO

State Plan Amendment (SPA) #: 18-0008

This file contains the following documents in the order listed:

- 1) Approval Letter – Revised
- 2) Approval Letter - Original
- 3) Summary Form (with 179-like data)
- 4) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Financial Management Group

February 12, 2019

Dr. Steve Corsi, Director
Missouri Department of Social Services
Broadway State Office Building
P.O. Box 1527
Jefferson City, MO 65102

RE: Missouri Medicaid State Plan Amendment TN: 18-0008

Dear Dr. Corsi:

It has come to our attention that the original approval package sent for state plan amendment 18-008 contained errors. The original approval package contained earlier versions of the plan pages that had subsequently been revised by the State. In an effort to correct this error, we have attached a revised approval package containing the correct version of the plan pages. Thank you for your patience and cooperation.

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

Sincerely,

Kristin Fan
Director

Enclosures



Financial Management Group

January 15, 2019

Dr. Steve Corsi, Director
Missouri Department of Social Services
Broadway State Office Building
P.O. Box 1527
Jefferson City, MO 65102

RE: Missouri Medicaid State Plan Amendment TN: 18-0008

Dear Dr. Corsi:

We have reviewed the proposed amendment to Attachments 4.19-A and 4.19-B of your Medicaid State plan submitted under transmittal number (TN) 18-0008. This amendment modifies provisions pertaining to the identification of and non-payment for Health Care Acquired Conditions and Provider-Preventable Conditions, as required by Section 2702 of the Affordable Care Act of 2010.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 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 18-0008 is approved effective April 28, 2018. 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,

Kristin Fan
Director

Enclosures

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

1. TRANSMITTAL NUMBER:

1 8 - 0008

2. STATE
Missouri

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

4. PROPOSED EFFECTIVE DATE

April 1, 2018

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 434, 438, 447 and 1902(a)(4), 1902(a)(6), and 1903 of the Social Security Act

7. FEDERAL BUDGET IMPACT:

a. FFY FFY 18 \$ 0

b. FFY FFY 19 \$ 30,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A ab updated

Attachment 4.19-A 14-ac removed

Attachment 4.19-B Page 2-1 updated

Attachment 4.19-B Page 2-2 removed

Attachment 4.19-A aa updated

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

Attachment 4.19-A ab updated

Attachment 4.19-A 14-ac removed

Attachment 4.19-B Page 2-1 updated

Attachment 4.19-B Page 2-2 removed

10. SUBJECT OF AMENDMENT:

This State Plan Amendment (SPA) proposes to amend the provisions governing Health Care Acquired Conditions (HCAC) covered under the Medicaid State Plan to allow for adjustment of provider payments due to HCACs.

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:

16. RETURN TO:

MO HealthNet Division

P.O. Box 6500

Jefferson City, MO 65102

13. TYPE NAME: Steve Corsi

14. TITLE: Director

15. DATE SUBMITTED: August 2, 2018

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

JAN 16 2019

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: APR 28 2018

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMG

23. REMARKS:

XI-1. Payment Adjustment for Provider-Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 434, 438, 447, and 1902(a)(4), 1902(a)(6), and 1903 of the Social Security Act, with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The state identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19-A of this State Plan.

- X Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19-B of this state plan.

- X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

The State will identify the occurrence of Health Care-Acquired Conditions (HCAC) and adjust provider payments as follows:

- The MMIS will deny payment for claims in which the Present on Admission (POA) indicator is not filled with a valid POA indicator. Valid POA indicators are:

Y = Yes - present at the time of inpatient admission

N = No - not present at the time of inpatient admission

U = Unknown - documentation is insufficient to determine if condition is present on admission.

W = Clinically undetermined - provider is unable to clinically determine whether condition was present on admission or not.

- All inpatient hospital claims priced and paid in the MMIS according to existing payment methodologies for the provider will be collected on a quarterly basis.
- The quarterly extract of inpatient claims will go through the HCAC logic of the 3M™ All-Patient Refined Diagnosis Related Groups (APR-DRGs) software in order to determine whether the HCAC condition affects payment.
- The grouper will assign a DRG to the claims, identify the presence of a HCAC condition and if the condition occurred during the stay.
- The applicable APR-DRG grouper version and list of Medicaid HCAC conditions will be used based on the date of service on the claim. The present-on-admission (POA) indicator values of "N" (not present on admission) and "U" (insufficient documentation) will be used to flag the claim for the HCAC payment adjustment.
- The DRG assignment process will be used for the purpose of identifying the effect of a HCAC on the resources needed to care for a patient. If removing the HCAC condition results in a DRG with a lower relative weight, only then will the payment be affected and adjusted by a percentage based on the difference in the DRG weights. The percentage represents the portion of the payment related to the HCAC.

Other Provider-Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 434, 438, 447, and 1902(a)(4), 1902(a)(6), and 1903 of the Social Security Act, with respect to non-payment for provider-preventable conditions (PPC).

In addition, the Medicaid agency meets the following requirements under 42 CFR 447.26(c)(2)-(5), as follows:

(c)(2) - No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by the provider.

(c)(3)- Reductions in provider payment may be limited to the extent that the following apply:

- i. The identified provider-preventable conditions would otherwise result in an increase in payment.
- ii. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

(c)(5)- Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19-B of this state plan.

 X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

The State will identify the occurrence of OPPCs and deny provider payments as follows:

- Claims in the MMIS will be identified for the presence of any one of the OPPCs based on the type of bill, diagnoses and procedures submitted on the claim. Payment for the claims will be denied, if appropriate.
- Such payment limitations shall only apply to the provider where the OPPC occurred and shall not apply to care provided by other providers should the patient subsequently be transferred or admitted to another hospital for needed care.