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State/Territory Name: MO

State Plan Amendment (SPA) #: 18-0013

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106-2898

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Kansas City Regional Operations Group

September 10, 2019

Jennifer Tidball, Acting Director
Missouri Department of Social Services
Broadway State Office Building
P.O. Box 1527
Jefferson City, MO 65102-1527

Dear Ms Tidball:

On December 31, 2018, the Centers for Medicare & Medicaid Services (CMS) received Missouri's State Plan Amendment (SPA) transmittal #18-0013. This SPA clarifies the calculations for the outpatient cost-to-charge ratio and the outpatient payment percentage, explains how the outpatient payment percentage is calculated for merged facilities, and adds references to the new Medicare/Medicaid Cost Report form (CMS 2552-10) that hospitals are required to complete for fiscal years beginning on and after May 1, 2010. This amendment also describes how outpatient surgical procedures, technical component of outpatient radiology and telehealth originating site fee will be reimbursed, how adjustments will be made in calculating the outpatient percentage rates for hospitals and removes outdated language and date references.

SPA #18-0013 was approved September 9, 2019, with an effective date of January 1, 2019, as requested by the state. Enclosed is a copy of the CMS-179 summary form, as well as the approved pages for incorporation into the Missouri State Plan.

If you have any questions regarding this amendment, please contact Karen Hatcher or Deborah Read at (816) 426-5925.

Sincerely,

Megan K. Buck, Acting Director
Division of Medicaid Field Operations - North

Enclosure

cc:
Todd Richardson, Medicaid Director
Amanda Clutter
Marissa Crump

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

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

1. TRANSMITTAL NUMBER: 18 -- 0013
2. STATE: Missouri
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2019

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 447 Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 2019 $ 0
b. FFY 2020 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B
Page 1bb, 1bbb, 1d, 1e, 2 1f **

9. PAGE NUMBER OF THE SUPERSEDES PLAN SECTION OR ATTACHMENT (If Applicable):
Attachment 4.19-B
Page 1bb, 1bbb, 1bbbb,* 1d, 1e,* and 2

10. SUBJECT OF AMENDMENT:
This amendment clarifies the calculations for the outpatient cost-to-charge ratio and the outpatient payment percentage, explains how the outpatient payment percentage is calculated for merged facilities, and adds references to the new Medicare/Medicaid Cost Report form (CMS 2552-10) that hospitals are required to complete for fiscal years beginning on and after May 1, 2010. This amendment also describes how outpatient surgical procedures, outpatient drugs, the technical component of outpatient radiology procedures and the telehealth originating site fee will be reimbursed. Additionally, this amendment describes how adjustments will be made when calculating the outpatient percentage rates for hospitals. Furthermore, this proposed amendment removes outdated language and date references.

11. 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:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPE NAME: Steve Corsi
14. TITLE: Director
15. DATE SUBMITTED: 12/31/18

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: December 31, 2018
18: DATE APPROVED: September 9, 2019

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2019

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Megan K. Buck

22. TITLE: Acting Director
Division of Medicaid Field Operations - North, Kansas City

23. REMARKS:

* Pen and Ink changes per state response dated 3.4.19
** Pen and Ink change per RAI response dated 6.28.19

FORM HCFA-179 (07-92)

STATE: Missouri

I Prospective Outpatient Hospital Services Reimbursement Methodology for Hospitals Located Within Missouri.

A Outpatient hospital services shall be reimbursed by multiplying a hospital-specific prospective outpatient payment percentage by the hospital's outpatient billed charges associated with adjudicated claims effective for dates of service on and after July 1, 2002 except for services identified in subsection I.C. The prospective outpatient payment percentage for each hospital will be calculated using the hospital's Medicaid overall outpatient cost-to-charge ratio from the hospital's fourth, fifth, and sixth prior base year cost reports regressed to the current State Fiscal Year (SFY). (If the current SFY is 2003, the fourth, fifth and sixth prior year cost reports would be the cost report filed in calendar year 1997, 1998, and 1999.) The Medicaid overall outpatient cost-to-charge ratio is determined by multiplying the total Medicaid outpatient charges for each ancillary cost center, excluding non-hospital services and services paid on a fee schedule, by the appropriate cost-to-charge ratios from Worksheet C (HCFA 2552-10) of the audited Medicare/Medicaid cost report to determine the outpatient cost for each cost center. Total the Medicaid outpatient costs from each cost center then add the Medicaid outpatient share of the GME cost to arrive at total Medicaid outpatient costs. Total the Medicaid outpatient charges from each cost center to arrive at total Medicaid outpatient charges. Then divide the total Medicaid outpatient costs by the total Medicaid outpatient charges to arrive at the overall Medicaid outpatient cost-to-charge ratio. As part of the regression analysis, a hospital's prospective outpatient payment percentage is limited as follows:

1. Under the general methodology (15% option):
A hospital may choose the 15% option which limits the prospective outpatient payment percentage decreases to 15% per year and there is no limit if the prospective outpatient payment percentage increases, except as provided in 4. below.

2. Under the 6% option:
A hospital may choose the 6% option which limits the prospective outpatient payment percentage decrease to 6% per year and the prospective outpatient payment percentage increases to 6% per year, except as provided in 4. below.

STATE: Missouri

3. Once a hospital has chosen an option, it shall be fixed and applied beginning July 1st of year it is selected. If a hospital has not chosen an option, the default is the general methodology. A letter will be sent to the hospital at the beginning of May of the year which the hospital is eligible to select an option. The response is due by the end of May.

4. The prospective outpatient payment percentage shall not exceed one hundred percent (100%) and shall not be less than twenty percent (20%).

B Outpatient cost-to-charge ratios will be as determined in the desk review of the base year cost reports. If adjustments are not made during the desk review, adjustments will be made to remove the cost and charges for services that are not reimbursed at a percentage of billed charges when calculating the cost-to-charge ratios used to determine the outpatient percentage rate.

C Outpatient hospital services reimbursement limited by rule. The services in this section will be excluded from the cost-to-charge ratio used to determine the outpatient percentage rate.

1. Certain clinical diagnostic laboratory procedures

2. The technical component of outpatient radiology procedures

3. Certain outpatient surgical procedures

4. The telehealth originating site fee

5. Outpatient drugs

2. A hospital which has a fourth prior year cost report filed by current owner will have its prospective outpatient payment percentage based on the overall outpatient cost-to-charge ratio from its fourth prior year cost report for the fourth and fifth SFY after the change in ownership or merger which occurred prior to July 1, 2002. For the sixth SFY the hospital's rate will be established in accordance with subsection I.A. of this regulation.

Chart for prospective rates for change in ownership or merger:

1st cost report filed calendar year	Settlement calculated	SFY	SFY Prospective rate granted	Cost reports used for Prospective rate
1998	Yes	1998	No	
1999	Yes	1999	No	
2000	Yes	2000	No	
2001	No	2001	No	
2002	No	2002	No	
2003	No	2003	Yes	1999
N/A	No	2004	Yes	1998, 1999 & 2000
N/A	No	2005	Yes	1999, 2000 & 2001

D Hospital Mergers. Hospitals that merge their operations under one (1) Medicare and MO HealthNet provider number shall have their outpatient percentage rate calculated under the surviving hospital's (the hospital whose Medicare and MO HealthNet provider number remains active) MO HealthNet provider number. The outpatient percentage rate of the surviving entity for the remainder of the state fiscal year in which the merger occurred is determined from combining the cost report data for the applicable cost report periods for the merged facilities. The effective date of the merged rate is the date of the merger. The surviving entity's outpatient percentage rate will be calculated for subsequent state fiscal years using the combined cost report data from the appropriate cost report periods for the merged facilities.

E A hospital that has failed to file one of the cost reports used to determine their prospective outpatient payment percentage for the year, whether it be the fourth (4th), fifth (5th), or sixth (6th) prior year cost report, will have their prospective outpatient payment percentage based on the two cost reports that are on file with the Division plus the average of those two cost reports to be used in place of the missing cost report. For example, if the Division does not have on file a fourth (4th) prior year cost report but has the fifth (5th) and sixth (6th) prior year cost reports, an average of the fifth (5th) and sixth (6th) prior year cost reports would be used in place of the fourth (4th) prior year cost report. This average along with the fifth (5th) and sixth (6th) prior year cost reports would then be used to calculate the prospective outpatient payment percentage.

III Closed facilities. Hospitals which closed after January 1, 1999 but before July 2, 2002 will have final settlements for cost reports ending during this time period calculated in accordance with Attachment 4.19B Appendix A.

IV Outpatient Hospital Fee Schedule Methodology. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient hospital services.

1. Certain clinical diagnostic laboratory procedures will be reimbursed from a Medicaid fee. The Medicaid fee schedule rates are based on eighty percent (80%) of the Medicare Clinical Lab Fee Schedule rate, effective January 1 of each year, using Missouri Locality 01. The Medicaid outpatient hospital lab fee schedule is published on the MO HealthNet website at https://dss.mo.gov/mhd/providers/files/fee-schedule-outpatient-hospital-lab3.pdf.

2. The technical component of outpatient radiology procedures will be reimbursed from a Medicaid fee schedule. The list of procedure codes and the Medicaid fee schedule rate for the technical component of outpatient radiology procedures will be published on the MO HealthNet website indicated below.

(a) Effective for dates of service beginning October 1, 2011 through December 31, 2018, the technical component of outpatient radiology procedures will be reimbursed according to the outpatient Medicaid fee schedule. These rates are based on one hundred twenty-five percent (125%) of the Medicare Physician fee schedule rate using Missouri Locality 01. The Medicaid outpatient radiology fee schedule for the calendar years of 2016, 2017, and 2018 is published on the MO HealthNet website at https://dss.mo.gov/mhd/providers/files/outpatient-hospital-radiology-fee-schedule18.pdf.

(b) Effective for dates of service beginning January 1, 2019, the technical component of the outpatient radiology procedures will be reimbursed according to the outpatient Medicaid fee schedule. These rates are based on ninety percent (90%) of the Medicare Physician fee schedule rate, effective January 1, 2018, using Missouri Locality 01. The Medicaid outpatient radiology fee schedule for the calendar years of 2017, 2018, and 2019 is published on the MO HealthNet website at https://dss.mo.gov/mhd/providers/files/outpatient-hospital-radiology-fee-schedule.pdf.

3. Effective for dates of service beginning January 1, 2019, certain outpatient surgical procedures are reimbursed according to the outpatient Medicaid fee schedule. These rates are based on the 2018 Medicare Hospital Prospective Payment System Addendum B. The list of outpatient surgical procedure codes are reimbursed according to the Medicaid fee schedule. The Medicaid outpatient surgical procedure fee schedule is published on the MO HealthNet website at https://dss.mo.gov/mhd/providers/files/outpatient-hospital-surgical-procedure-fee-schedule.pdf.

4. Effective for dates of service beginning January 1, 2019, the telehealth originating site fee is paid at the lesser of the billed amount or the outpatient fee schedule amount of $15.60.

V Definitions

A Base cost report. Desk-reviewed Medicare/Medicaid cost report. When a facility has more than one (1) cost report with periods ending in the fourth prior calendar year, the cost report covering a full twelve (12)-month period will be used. If none of the cost reports cover a full twelve (12) months, the cost report with the latest period will be used. If a hospital's base cost report is less than or greater than a twelve (12)-month period, the data shall be adjusted, based on the number of months reflected in the base cost report to a twelve (12)-month period.

B Cost report. A cost report details, for purposes of both Medicare and Medicaid reimbursement, the cost of rendering covered services for the fiscal reporting period. The Medicare/Medicaid Uniform Cost Report contains the forms utilized in filing the cost report. The Medicare/ Medicaid Cost Report version 2552-96 (CMS 2552-96) shall be used for fiscal years ending on or after September 30, 1996. The Medicare/Medicaid Cost Report version 2552-10 (CMS 2552-10) shall be used for fiscal years beginning on and after May 1, 2010.

C Effective date.
1. The plan effective date shall be July 1, 2002.
2. New prospective outpatient payment percentages will be effective July 1 of each SFY.

D Nominal charge provider. A nominal charge provider is determined from the fourth (4^{th}) prior year desk reviewed cost report. The hospital must meet the following criteria:
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 of the federally mandated Disproportionate Share qualifications; or
2. The hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental disorders.