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State/Territory Name: Missouri

State Plan Amendment (SPA) MO: 22-0003

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601



Financial Management Group

September 15, 2022

Robert Knodell
Acting Director
Missouri Department of Social Services
Broadway State Office Building
PO Box 1527
Jefferson City, MO 65102

RE: TN 22-0003

Dear Mr. Knodell:

We have reviewed the proposed Missouri State Plan Amendment (SPA) to Attachment 4.19-B, MO-22-0003, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on April, 4th, 2022. This SPA removes Provider Based Rural Health Clinics and Provider Based Federally Qualified Health Clinics from outpatient settlements. Based upon the information provided by the State, we have approved the amendment with an effective date of May 1, 2022. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Robert Bromwell at (410) 786-5914 or robert.bromwell@cms.hhs.gov.

Sincerely,



Todd McMillion
Director
Division of Reimbursement Review

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER <u>2</u> <u>2</u> — <u>0</u> <u>0</u> <u>0</u> <u>3</u>	2. STATE Missouri
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	

TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE May 1, 2022
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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 447 Subpart C F	7. FEDERAL BUDGET IMPACT a. FFY 2022 \$0 million b. FFY 2023 \$0 million
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8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.19 B Appendix A Pages 1, and 2, 3	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Attachment 4.19 B Appendix A Page 1, and 2, 3
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10. SUBJECT OF AMENDMENT

This State Plan Amendment for Attachment 4.19 B Appendix A adds general principles and definitions, removes all language related to PBRHC and PBFQHC settlements, and removes outdated terms, language, and provisions regarding the calculation of hospital outpatient settlements.

11. GOVERNOR'S REVIEW (Check One)

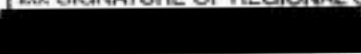
GOVERNOR'S OFFICE REPORTED NO COMMENT **slv** OTHER, AS SPECIFIED
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL 	16. RETURN TO MO HealthNet Division P.O. Box 6500 Jefferson City, MO 65102
13. TYPED NAME Robert J. Knodel	
14. TITLE Acting Director	
15. DATE SUBMITTED 04-04-2022	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED April 4, 2022	18. DATE APPROVED September 15, 2022
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL May 1, 2022	20. SIGNATURE OF REGIONAL OFFICIAL 
21. TYPED NAME Todd McMillion	22. TITLE Director, Division of Reimbursement Review

23. REMARKS

Pen and ink changed authorized via email on 9/13/2022. Changes made to block 6 from 42 CFR Subpart C to 42 CFR Subpart F and blocks 8 and 9 to add 4.19-B, Appendix A page 3.

Outpatient Settlements for New Hospitals and Nominal Charge Providers

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 interim 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. For the interim payment methodology, see page 1c of Attachment 4.19B.

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 that does not have a fourth prior year cost report necessary for establishment of a prospective rate will have a 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 Provider-Based Rural Health Clinic (PBRHC) or Provider-Based Federally Qualified Health Clinic (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.

V. Reconciliation

A. The Division shall send written notice to the hospital of the following:

1. Underpayments. If the total reimbursement due to the hospital exceeds the interim payments made for the reporting period, the Division will make a lump-sum payment to the hospital to bring total interim payments into agreement with the total reimbursement due to the hospital; or
2. Overpayments. If the total interim payments made to the hospital for the reporting period exceeds the total reimbursement due from the hospital for the period, the Division arranges with the hospital for repayment through a lump-sum refund, or if that poses a hardship for the hospital, through offset against subsequent interim payments or a combination of offset and refund.