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State/Territory Name: Missouri

State Plan Amendment (SPA) MO: 22-0029

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

December 1, 2022

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

RE: TN 22-0029

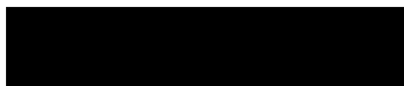
Dear Mr. Knodell:

We have reviewed the proposed Missouri State Plan Amendment (SPA) to Attachment 4.19-B, MO-22-0029, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on September 6, 2022. This SPA updates the definition and criteria for Nominal Charge Providers and updates MO Health Net fee schedules for outpatient reimbursement when a Medicare rate is not available.

Based upon the information provided by the State, we have approved the amendment with an effective date of July 1, 2022. We are enclosing the approved CMS-179 and a copy of the new state plan page.

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**	1. TRANSMITTAL NUMBER 2 2 — 0 0 2 9	2. STATE MO
	3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT (●) XIX ( ) XXI	
TO: CENTER DIRECTOR CENTERS FOR MEDICAID & CHIP SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2022 and August 1, 2022	
5. FEDERAL STATUTE/REGULATION CITATION 42 CFR 447 Subpart F	6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars) a. FFY 2022 $ 120,759 b. FFY 2023 $ 538,913	
7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.19 B - pages 1bb, 1bbb, 1c, 1d, 1e, 1f,1g, 1h, 1i, 1j, 1k, 1l	8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)* Attachment 4.19 B - pages 1c, 1d, 1e, 1f, 1g	

9. SUBJECT OF AMENDMENT

This State Plan revises the definition and criteria for nominal charge providers as well as updates the MO HealthNet fee schedules and the National Dental Advisory Service (NDAS) used to determine the outpatient reimbursement rate when a Medicare rate is not available.

10. GOVERNOR'S REVIEW *(Check One)*

- (●) GOVERNOR'S OFFICE REPORTED NO COMMENT SLV
- ( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
- ( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
- ( ) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL [redacted]	15. RETURN TO
12. TYPED NAME Robert J. Knodell	
13. TITLE Acting Director	
14. DATE SUBMITTED 08-25-2022	

FOR CMS USE ONLY

16. DATE RECEIVED 9/6/2022	17. DATE APPROVED December 1, 2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL July 1, 2022	19. SIGNATURE OF APPROVING OFFICIAL [redacted]
20. TYPED NAME OF APPROVING OFFICIAL Todd McMillion	21. TITLE OF APPROVING OFFICIAL Director, Division of Reimbursement Review

22. REMARKS

Pen and ink change to block 4 authorized on 11/14/2022 to remove August 1, 2022.

OUTPATIENT HOSPITAL SERVICES

VI Outpatient Simplified Fee Schedule (OSFS) Payment 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.

A Definitions. The following definitions will be used in administering section (VI) of this rule:

1. Ambulatory Payment Classification (APC). Medicare's ambulatory payment classification assignment groups of Current Procedural Terminology (CPT) or Healthcare Common Procedures Coding System (HCPCS) codes. APCs classify and group clinically similar outpatient hospital services that can be expected to consume similar amounts of hospital resources. All services within an APC group have the same relative weight used to calculate the payment rates.

2. APC conversion factor. The unadjusted national conversion factor calculated by Medicare effective January 1 of each year, as published with the Medicare OPPS Final Rule, and used to convert the APC relative weights into a dollar payment.

3. APC relative weight. The national relative weights calculated by Medicare for the Outpatient Prospective Payment System (OPPS).

4. Current Procedural Terminology (CPT). A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations.

5. Dental procedure codes. The procedure codes found in the Code on Dental Procedures and Nomenclature (CDT), a national uniform coding method for dental procedures maintained by the American Dental Association.

6. Federally-Deemed Critical Access Hospitals. Hospitals that meet the federal definition found in section 1820(c)(2)(B) of the Social Security Act.

7. HCPCS. The national uniform coding method maintained by the Centers for Medicare and Medicaid Services (CMS) that incorporates the American Medical Association (AMA) Physicians CPT and the three HCPCS unique coding levels, I, II, and III.

OUTPATIENT HOSPITAL SERVICES (continued)

8. Medicare Inpatient Prospective Payment System (IPPS) wage index. The wage area index values are calculated annually by Medicare, published as part of the Medicare IPPS Final Rule.

9. Missouri conversion factor. The single, statewide conversion factor used by the MO HealthNet Division (MHD) to determine the APC-based fees, uses a formula based on Medicare OPPS. The formula consists of: sixty percent (60%) of the APC conversion factor, as defined in section (VI)(A)2. multiplied by the St. Louis, MO Medicare IPPS wage index value, plus the remaining forty percent (40%) of the APC conversion factor, with no wage index adjustment.

10. Nominal charge provider. A nominal charge provider is determined from the third (3rd) prior year audited Medicaid cost report. The hospital must meet the following criteria:

    a. A public non-state governmental acute care hospital with a low income utilization rate (LIUR) of at least forty percent (40%) 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%). The hospital must meet one (1) of the federally mandated Disproportionate Share qualifications.; or

    b. The hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental disorders.

11. Outpatient Prospective Payment System (OPPS). Medicare's hospital outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 (BBRA) and the Medicare, Medicaid, SCHIP Benefits Improvement and Protection Act (BIPA) of 2000.

12. Payment level adjustment. The percentage applied to the Medicare fee to derive the OSFS fee.

OUTPATIENT HOSPITAL SERVICES (continued)

B Effective for dates of service beginning July 1, 2022, outpatient hospital services shall be reimbursed on a predetermined fee-for-service basis using an OSFS based on the APC groups and fees under the Medicare Hospital OPPS. Effective for dates of service beginning August 1, 2022, when service coverage and payment policy differences exist between Medicare OPPS and Medicaid, MHD policies and fee schedules are used. The fee schedule will be updated as follows:

1. MHD will review and adjust the OSFS annually, effective July 1st, based on the payment method described in section VI.D.

2. The MHD OSFS is published under "Fee Schedules & Rate Lists" on the MO HealthNet website at https://dss.mo.gov/mhd/providers/fee-for-service-providers.htm.

C Payment will be the lower of the provider's charge or the payment as calculated in section VI.D.

D Fee schedule methodology. Fees for outpatient hospital services covered by the MO HealthNet program are determined by the HCPCS procedure code at the line level and the following hierarchy:

1. The APC relative weight or payment rate assigned to the procedure in the Medicare OPPS Addendum B is used to calculate the fee for the service, with the exception of the hospital observation per hour fee which is calculated based on the method described in section VI.D.1.(b). Fees derived from APC weights and payment rates are established using the Medicare OPPS Addendum B effective as of January 1 of each year as published by the CMS for Medicare OPPS.

   (a) The fee is calculated using the APC relative weight multiplied by the Missouri conversion factor. The resulting amount is then multiplied by the payment level adjustment of ninety percent (90%) to derive the OSFS fee.

OUTPUTPATIENT HOSPITAL SERVICES (continued)

(b) The hourly fee for observation is calculated based on the relative weight for the Medicare APC (using the Medicare OPPS Addendum A effective as of January 1 of each year as published by the CMS for Medicare OPPS) which corresponds with comprehensive observation services multiplied by the Missouri conversion factor divided by forty (40), the maximum payable hours by Medicare. The resulting amount is then multiplied by the payment level adjustment of ninety percent (90%) to derive the OSFS fee.

(c) For those APCs with no assigned relative weight, ninety percent (90%) of the current Medicare APC payment rate is used as the fee.

2. If there is no APC relative weight or APC payment rate established for a particular service in the Medicare OPPS Addendum B, then the MHD approved fee will be ninety percent (90%) of the rate listed on other Medicare fee schedules, effective as of January 1 of each year: Clinical Laboratory Fee Schedule; Physician Fee Schedule; and Durable Medical Equipment Prosthetics/Orthotics and Supplies Fee Schedule, applicable to the outpatient hospital service.

3. Fees for dental procedure codes in the outpatient hospital setting are calculated based on 38.5% of the 50th percentile fee for Missouri reflected in the 2022 National Dental Advisory Service (NDAS).

4. If there is no APC relative weight, APC payment rate, other Medicare fee schedule rate or NDAS rate established for a covered outpatient hospital service, then a MO HealthNet fee will be determined using the MHD Dental, Medical, Other Medical or Independent Lab – Technical Component fee schedules.

   (a) The MHD Dental fee schedule is published on the MO HealthNet website at https://dss.mo.gov/mhd/providers/pages/cptagree.htm, effective June 7, 2022. To navigate the site, users must agree to the licensure terms and conditions, select “Download” or “Full Search”, and select “Dental Services”.

   (b) The MHD Medical fee schedule is published on the MO HealthNetwebsite at https://dss.mo.gov/mhd/providers/pages/cptagree.htm, effective June 7, 2022. To navigate the site, users must agree to the licensure terms and conditions, select “Download” or “Full Search”, and select “Medical Services”.

OUTPATIENT HOSPITAL SERVICES (continued)

(c) The MHD Other Medical fee schedule is published on the MOHealthNet website at https://dss.mo.gov/mhd/providers/pages/cptagree.htm, effective June 7, 2022. To navigate the site, users must agree to the licensure terms and conditions, select "Download" or "Full Search", and select "Other Medical".

(d) The MHD Independent Lab – Technical Component fee schedule is published on the MO HealthNet website at https://dss.mo.gov/mhd/providers/pages/cptagree.htm, effective June 7, 2022. To navigate the site, users must agree to the licensure terms and conditions, select "Download" or "Full Search", and select "Independent Lab – Technical Component".

5. Federally-deemed critical access hospitals will receive an additional forty percent (40%) of the rate as determined in section VI.B.2. for each billed procedure code.

6. Nominal charge hospitals will receive an additional twenty-five percent (25%) of the rate as determined in section VI.B.2. for each billed procedure code.

E. Packaged services. MHD adopts Medicare guidelines for procedure codes identified as "Items and Services Packaged into APC Rates" under Medicare OPPS Addendum D1. These procedures are designated as always packaged. Individual claim lines with packaged procedure codes will be considered paid but with a payment of zero.

F. Inpatient only services. MHD adopts Medicare guidelines for procedure codes identified as "Inpatient Procedures" under Medicare OPPS Addendum D1. These procedures are designated as inpatient only (referred to as the inpatient only (IPO) list). Claim lines with inpatient only procedures will not be paid under the OSFS.

G. Payment for outpatient hospital services under this rule will be final, with no cost settlement.