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State/Territory Name: Missouri

State Plan Amendment (SPA) #: 24-0006

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

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

Medicaid and CHIP Operations Group

November 12, 2024

Todd Richardson, Director
MO HealthNet Division
Missouri Department of Social Services
P O Box 6500
Jefferson City, MO 65102-6500

Re: Missouri State Plan Amendment MO-24-0006

Dear Director Richardson:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number MO-24-0006. This amendment updates the Medicare fee schedules, MO HealthNet fee schedules, and the National Dental Advisory Service (NDAS) used to determine outpatient reimbursement rates.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulation 42 CFR 447 Subpart F.

This letter is to inform you that Missouri Medicaid SPA MO-24-0006 was approved on November 12, 2024, with an effective date of July 1, 2024.

If you have any questions, please contact Rhonda Gray at 410-786-6140 or via email at Rhonda.Gray@cms.hhs.gov .

Sincerely,

Ruth A. Hughes, Acting Director
Division of Program Operations

Enclosures

cc: Marissa Crump, Missouri Medicaid
Glenda Kremer, Missouri Medicaid

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: 24 — 0006

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, 2024

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447 Subpart F

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ 2,780,793
b. FFY 2025 $ 10,995,221

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19 B - pages 1c, 1d, 1e, 1f, 1g, 1h and New page 57

Attachment 3.1A- New page 14b

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19 B - pages 1c, 1d, 1e, 1f, 1g, 1h

Delete pages 1bb, 1bbb, 1i, 1j, 1k, 1l, 1m

9. SUBJECT OF AMENDMENT
This State Plan updates the Medicare fee schedules, MO HealthNet fee schedules, and the National Dental Advisory Service (NDAS) used to determine outpatient reimbursement rates. This also adds language for the new multiple procedure discounting, bilateral procedure (Modifier 50) pricing to align with Medicare pricing, and the 15% additional increase for nominal charge providers.

10. 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:

SLV

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME
Robert J. Knodell

13. TITLE
Director

14. DATE SUBMITTED
7-11-24

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

FOR CMS USE ONLY

16. DATE RECEIVED
July 12, 2024

17. DATE APPROVED
November 12, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2024

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL
Ruth A. Hughes

21. TITLE OF APPROVING OFFICIAL
Acting Director, Division of Program Operations

22. REMARKS

Box 7: State authorized pen and ink change on 10/21/24

Rural Emergency Hospital (REH) Clinics: REH Services as certified by Medicare, including emergency department and observation services.

OUTPATIENT HOSPITAL SERVICES

I. 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 I. 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 42 Code of Federal Regulation (CFR) 485.606(b).

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 I.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 twenty percent (20%) 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, 2024, 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. 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 I.D.

2. The MHD Outpatient Hospital Fee Schedule is published on the MO HealthNet website at https://mydss.mo.gov/mhd/cpt effective July 1, 2024. To navigate the site users must agree to the licensure terms and conditions, select “Download” or “Full Search”, and select “Outpatient Hospital”.

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

OUTPATIENT 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 2024 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://mydss.mo.gov/mhd/cpt, effective July 1, 2024. 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 HealthNet website at https://mydss.mo.gov/mhd/cpt, effective July 1, 2024. 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://mydss.mo.gov/mhd/cpt, effective July 1, 2024. 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://mydss.mo.gov/mhd/cpt, effective July 1, 2024. 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. In-state federally-deemed critical access hospitals will receive an additional forty percent (40%) of the rate as determined in section I.B.2. for each billed procedure code.

6. Nominal charge hospitals will receive an additional forty percent (40%) of the rate as determined in section I.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. Multiple procedure discounting. Effective for dates of service beginning July 1, 2024, MHD applies multiple procedure discounting for those procedure codes identified as "Procedure or Service, Multiple Procedure Reduction Applies" under Medicare OPPS Addendum D1. These procedures are paid separately but are discounted when two or more services are billed on the same date of service. Procedure codes considered for the multiple procedure reduction under the OSFS exclude dental procedures. The multiple procedure claim line with the highest allowed amount is priced at one hundred percent (100%) of the maximum allowed amount. The second and subsequent covered procedures are priced at fifty percent (50%) of the maximum allowed amount. The Medicare OPPS Addendum D1 is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at https://www.cms.gov/license/ama?file=/files/zip/2024-nfrm-opps-addenda.zip, December 8, 2023. This rule does not incorporate any subsequent amendments or additions.

OUTPATIENT HOSPITAL SERVICES (continued)

H. Modifier 50 Bilateral procedure pricing. Effective for dates of service beginning July 1, 2024, MHD applies bilateral procedure pricing for those procedure codes identified on the Medicare *National Physician Fee Schedule Relative Value File* with an indicator of '1' under the BILAT SURG column. These procedures may be subject to a payment adjustment when billed with modifier 50 and performed bilaterally on both sides of the body at the same operative session. Claim lines appropriately billed with these bilateral procedures and modifier 50 are priced at one hundred and fifty percent (150%) of the maximum allowed amount for a single code. The Medicare *National Physician Fee Schedule Relative Value File* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at https://www.cms.gov/medicare/payment/fee-schedules/physician/pfs-relative-value-files/rvu24a, January 5, 2024. This rule does not incorporate any subsequent amendments or additions.

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

OUTPATIENT HOSPITAL SERVICES - OUT-OF-STATE HOSPITALS AND FEDERALLY-OPERATED HOSPITALS LOCATED WITHIN THE STATE OF MISSOURI

I. Out-of-state hospitals shall present claims to Missouri Medicaid within three hundred sixty-five (365) days from the date of service. In no case shall Missouri be liable for payment of a claim received beyond one (1) year from the date services were rendered. Outpatient hospital services must be submitted on the UB-04 claim form.

II. Outpatient Reimbursement. The outpatient reimbursement is the same as the reimbursement for Missouri hospitals as described in section I.

RURAL EMERGENCY HOSPITAL (REH) REIMBURSEMENT

I. Rural Emergency Hospitals (REH) will be reimbursed under the outpatient hospital services reimbursement methodology described on pages 1c through 1h of this attachment.

II. Rural emergency hospitals will receive an additional forty percent (40%) of the rate as determined on page 1e in paragraph I.B.2. of this attachment for each billed procedure code.