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State/Territory Name: MO

State Plan Amendment (SPA) #: 25-0012

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

October 3, 2025

Robert Knodell, Director
Missouri Department of Social Services
P.O. Box 1527
Jefferson City, MO 65102-1527

RE: TN 25-0012

Dear Mr. Knodell:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Missouri state plan amendment (SPA) to Attachment 4.19-D, MO 25-0012, which was submitted to CMS on July 16, 2025. This plan amendment updates the cost report total Case Mix Index (CMI), provides for replacement facilities to be designated as new or existing consistent with the criteria used for other new or existing nursing facilities, updates the value-based purchasing (VBP) quality measures and the corresponding per diem adjustments, clarifies the base rate for new facilities having their initial prospective rate set, and provides for the multiple component incentive to be recalculated with the semi-annual and annual rate updates.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations. CMS has identified concerns that the state's use of revenues derived from its Nursing Facility Reimbursement Allowance (NFRA) tax program as a source of Missouri's non-federal share for this state plan amendment may not comply with certain health care-related tax requirements in section 1903(w)(4) of the Social Security Act and implementing regulations in 42 CFR 433.68(f)(3). Approval of this state plan amendment does not constitute an approval of the non-federal share funded by the FRA or NFRA taxes.

Based upon the information provided by the state, we have approved the amendment with an effective date of July 1, 2025. 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 Fred Sebree at fredrick.sebree@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director
Financial Management Group

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: 25 — 0012

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, 2025

5. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447 Subpart C

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 549,911
b. FFY 2026 $ 2,170,342

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Att. 4.19D
Pages 76-A, 79, 108-A, 109-A, and 111

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Att. 4.19D
Pages 76-A, 79, 108-A, 109-A, and 111

9. SUBJECT OF AMENDMENT

Effective for dates of service beginning July 1, 2025, this SPA amends the cost report total Case Mix Index (CMI), provides for replacement facilities to be designated as new or existing consistent with the criteria used for other new or existing nursing facilities, updates the value-based purchasing (VBP) quality measures and the corresponding per diem adjustments, clarifies the base rate for new facilities having their initial prospective rate set, and provides for the multiple component incentive to be recalculated with the semi-annual and annual rate updates.

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

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

11. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]

12. TYPED NAME: Jessica Bax

13. TITLE: DSS Director

14. DATE SUBMITTED: 7-7-25

15. RETURN TO

Todd Richardson, Director
MO HealthNet Division
P.O. Box 6500
Jefferson City, MO 65102-6500

FOR CMS USE ONLY

16. DATE RECEIVED: 7/16/2025

17. DATE APPROVED: October 3, 2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/2025

19. SIGNATURE OF APPROVING OFFICIAL: [redacted]

20. TYPED NAME OF APPROVING OFFICIAL: Rory Howe

21. TITLE OF APPROVING OFFICIAL: Director, FMG

22. REMARKS

6. SFY 2025 Rebase. Effective for dates of service beginning July 1, 2024, nursing facility rates shall be rebased using a data bank with cost report ending dates in calendar year 2022, except in instances where 2022 data is not available as explained in (4)(W)2. The 2022 rebase year data shall be used to set rates effective for dates of service beginning July 1, 2024, through such time rates are rebased again or calculated on some other cost report as set forth in regulation. The 2022 base year data shall be adjusted for the following and shall be used to determine the medians, ceilings, and per diem rates for the nursing facilities:

A. The following allowable salaries shall be adjusted by two percent (2%):

(I) Aides and Orderlies (Line 53 of CR (3-95));

(II) Dietary Salaries (Line 60 of CR (3-95));

(III) Laundry Salaries (Line 85 of CR (3-95));

(IV) Housekeeping Salaries (Line 91 of CR (3-95)); and,

(V) Beauty & Barber Salaries (Line 94 of CR (3-95));

B. The total allowable costs, including the salary adjustments detailed above in (4)(W)6.A., shall be trended through June 30, 2024, by the difference in the CMS Market Basket Index (i.e., the "Total – %MOVAVG" index for 2024:2 from the first-quarter 2024 publication) and the midpoint of the facility's rate setting cost report year; and

C. The total patient care costs, including the salary adjustments and trends, shall be adjusted to match the state-wide average total CMI by multiplying the total patient care costs by the quotient of the state-wide average total CMI divided by the facility cost report total CMI.

(I) A cost report total CMI is determined for each facility based on a resident-weighted average of the four (4) quarterly total CMIs covering the facility's cost report period.

(II) The state-wide total CMI is a simple average of the cost report CMIs for all nursing facilities included in the databank.

(PP) Nursing facility (NF). Effective October 1, 1990, skilled nursing facilities, skilled nursing facilities/intermediate care facilities, and intermediate care facilities as defined in Chapter 198, RSMo, participating in the Medicaid Program will all be subject to the minimum federal requirements found in section 1919 of the Social Security Act.

1. HIV nursing facility. A nursing facility that operates exclusively for persons with the human immunodeficiency virus (HIV) that causes acquired immunodeficiency syndrome (AIDS) and that was granted an exemption from Certificate of Need under section 197.316, RSMo.

2. New MO HealthNet nursing facility. A qualified facility not previously certified for participation in the Medicaid Program within the last twenty-four (24) months. A new MO HealthNet nursing facility shall be given an interim reimbursement rate until a prospective rate is established on its rate setting cost report. A facility previously Medicaid certified within the last twenty-four (24) months (i.e., a facility that terminated participation in the MO HealthNet program and subsequently re-enrolled in the MO HealthNet program) is not considered to be a new MO HealthNet nursing facility regardless of any changes, including, but not limited to, a change of ownership, change of operator, tax identification change, merger, bankruptcy, name change, address change, payment address change, Medicare number change, National Provider Identifier (NPI) change, or facilities/offices that have been closed and reopened at the same or different locations. This includes replacementfacilities, which are newly constructed facilities with beds never certified for Medicaid or previously licensed by the Department of Health and Senior Services and put in service in place of existing Medicaid beds.

(QQ) Occupancy rate. The occupancy rate is the percentage of a facility's capacity that is occupied by patients. This may also be referred to as occupancy, utilization, or utilization rate.

1. Total occupancy rate. A facility's total actual patient days divided by the total bed days for the same period as determined from the cost report. For a distinct part facility that only has part of its total licensed beds certified for participation in the MO HealthNet program and that completes a worksheet one (1) of the cost report, the occupancy rate is determined by dividing the total actual patient days from the certified portion of the facility by the total bed days from the certified portion for the same period from the cost report.

2. Medicaid occupancy rate. A facility's Medicaid patient days divided by the total patient days for the same period as determined from the cost report.

(RR) Patient care. This cost component includes costs reported in the cost report on lines 46-70.

(III) SFY 2025 QM Performance Measure Table. Effective for dates of service beginning July 1, 2024, the QM Performance Measure per diem adjustments are as follows:

QM Performance	Threshold	Per Diem Adjustment
Decline in Late-Loss ADLs	< or = 10.0%	$3.04
Decline in Mobility on Unit	< or = 8.0%	$3.04
High-Risk Residents w/ Pressure Ulcers	< or = 2.7%	$3.04
Anti-Psychotic Medications	< or = 6.8%	$3.04
Falls w/ Major Injury	< or = 1.3%	$3.04
In-Dwelling Catheter	< or = 1.1%	$3.04
Urinary Tract Infection	< or = 1.9%	$3.04

(IV) SFY 2026 QM Performance Measure Table. Effective for dates of service beginning July 1, 2025, the QM Performance Measured and related per diem adjustments are as follows:

QM Performance	Threshold	Per Diem Adjustment
Decline in Late-Loss ADLs (Percentage of long-stay residents whose need for help with daily activities has increased)	< or = 10.0%	$3.42
Decline in Mobility on Unit (Percentage of long-stay residents whose ability to walk independently worsened)	< or = 8.0%	$3.42
High-Risk Residents w/ Pressure Ulcers (Percentage of high risk long-stay residents with pressure ulcers)	< or = 2.7%	$3.42
Anti-Psychotic Medications (Percentage of long-stay residents who received an antipsychotic medication)	< or = 6.8%	$3.42
Falls w/ Major Injury (Percentage of long-stay residents experiencing one or more falls with major injury)	< or = 1.3%	$3.42
In-Dwelling Catheter (Percentage of long-stay residents with a catheter inserted and left in their bladder)	< or = 1.1%	$3.42
Urinary Tract Infection (Percentage of long-stay residents with a urinary tract infection)	< or = 1.9%	$3.42

4. Mental Illness Diagnosis Add-On. Each facility with a prospective rate on or after July 1, 2022, and which meets the following criteria shall receive a per diem adjustment:

A. If at least forty percent (40%) of a facility's Medicaid participants have the following mental illness diagnosis, the facility shall receive a per diem adjustment of five dollars ($5.00):

(I) Schizophrenia

(II) Bi-polar

(G) Prospective Rate Calculation.

1. A preliminary per diem shall be calculated and is the sum of:

A. The cost component per diems as set forth in (11)(A)-(11)(E), plus

B. The patient care incentive and multiple component incentive set forth in (11)(F)1. and (11)(F)2., respectively.

2. A base rate shall be determined and is the greater of:

A. The preliminary per diem, and

B. The facility's prospective rate as of June 30, 2022, excluding NFRA.

C. The base rate for new nursing facilities operating under an interim rate whose initial prospective rate is effective on or after July 1, 2022 is the greater of:

(I) The preliminary per diem, and

(II) The facility's interim rate on the day before the effective date of the initial prospective rate, excluding NFRA.

3. The facility's rebased rate shall be the sum of:

A. The facility's base rate, plus

B. The NFRA in effect for the applicable date of service.

(H) Semi-Annual and Annual Rate Updates. Each facility with a prospective rate on or after July 1, 2022 shall have its rate updated for the following items as described below:

1. Semi-Annual Acuity Adjustment for Patient Care Per Diem Rate. Each facility's patient care per diem rate will be adjusted semi-annually using a current Medicaid CMI. The patient care per diem rate will be adjusted effective for dates of service beginning January 1 and July 1 of each year. The Medicaid CMI will be updated based on the facility's average Medicaid CMI from the two (2) preceding quarterly calculations. The allowable patient care cost per day determined in (11)(A)1. shall be adjusted by the applicable Medicaid CMI and shall be the facility's patient care per diem to be included in the facility's total prospective per diem rate, effective each January 1 and July. The applicable Medicaid CMI are as follows:

A. Effective for dates of service beginning January 1 of each year, each facility's Medicaid CMI will be updated using the average of the preceding July 1 and October 1 quarterly Medicaid CMI calculations.

B. Effective for dates of service beginning July 1 of each year, each facility's Medicaid CMI will be updated using the average of the preceding January 1 and April 1 quarterly Medicaid CMI calculations.

2. Semi-Annual Adjustment for VBP Incentive. Each facility's QM Performance data shall be re-evaluated semi-annually and the per diem add-on rate shall be adjusted accordingly. The VBP will be recalculated effective for dates of service beginning January 1 and July 1 of each year. The QM Performance data will be updated based on the most current data available as of November 15 for the January 1 rate adjustment and as of May 15 for the July 1 rate adjustment. For facilities that do not have updated data as of the review date, prior period data will be carried forward. This provision will be applied to data frozen by CMS. A facility must meet the criteria set forth in (11)(F)3. each period and will lose any per diem adjustments for which it does not continue to qualify.

3. Semi-Annual Adjustment for Mental Illness Diagnosis Add-On. Each facility's Mental Illness Diagnosis data shall be re-evaluated semi-annually and the per diem add-on rate shall be adjusted accordingly. The Mental Illness Diagnosis will be recalculated effective for dates of service beginning January 1 and July 1 of each year. The Mental Illness Diagnosis data will be updated based on the final resident listing for October for the January 1 rate adjustment and the final resident listing for April for the July 1 rate adjustment. For facilities that do not have updated data as of the review date, prior period data will be carried forward. A facility must meet the criteria set forth in (11)(F)4. each period and will lose any per diem adjustments for which it does not continue to qualify.