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State/Territory Name: MO

State Plan Amendment (SPA) #: 23-0015

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



Financial Management Group

December 18, 2023

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

RE: Missouri Medicaid State Plan Amendment TN: 23-0015

Dear Mr. Knodell:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 23-0015. This Medicaid State Plan Amendment (SPA) provides for a per diem increase of \$10.00 for all nursing facilities, an increase of \$0.87 to the Value Based Purchasing (VBP) adjustments for qualifying nursing facilities, and a revision to the reimbursement for hospital based nursing facilities with less than 1,000 Medicaid patient days that do not submit a cost report to remove the working capital allowance and change the patient care incentive to 4.75%.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. 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) based on its similarities between the NFRA tax program and the state's Federal Reimbursement Allowance (FRA) tax program. Approval of this state plan amendment does not constitute an approval of the non-federal share funded by the FRA or NFRA taxes. This is to inform you that Medicaid State plan amendment is approved effective July 1, 2023. We are enclosing the CMS-179 and the amended plan pages.

If you have any additional questions or need further assistance, please contact Fred Sebree at fredrick.sebree@cms.hhs.gov.

Sincerely,

A black rectangular box redacting the signature of the sender.

Rory Howe
Director

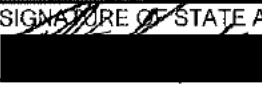
TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER 2 3 — 0 0 1 5	2. STATE MO
	3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT <input checked="" type="radio"/> XIX <input type="radio"/> XXI	
TO: CENTER DIRECTOR CENTERS FOR MEDICAID & CHIP SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2023	
5. FEDERAL STATUTE/REGULATION CITATION 42 CFR 447 Subpart C	6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars) a. FFY 2023 \$ 15,316,740 b. FFY 2024 \$ 61,509,011	
7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Att. 4-19D Pages 108, 109, 113, and 117	8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Att. 4-19D Pages 108, 109, 113, and 117	

9. SUBJECT OF AMENDMENT

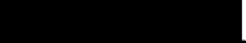
This State Plan Amendment provides for a per diem increase of \$10.00 for all nursing facilities, an increase of \$0.87 to the Value Based Purchasing (VBP) adjustments for qualifying nursing facilities, and a revision to the reimbursement for hospital based nursing facilities with less than 1,000 Medicaid patient days that do not submit a cost report to remove the working capital allowance and change the patient care incentive to 4.75%.

10. 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

11. SIGNATURE OF STATE AGENCY OFFICIAL 	15. RETURN TO MO HealthNet Division P.O. Box 6500 Jefferson City, MO 65102
12. TYPED NAME Robert J. Knodell	
13. TITLE Director	
14. DATE SUBMITTED 9-27-23	

FOR CMS USE ONLY

16. DATE RECEIVED 9/28/2023	17. DATE APPROVED December 18, 2023
PLAN APPROVED - ONE COPY ATTACHED	
18. EFFECTIVE DATE OF APPROVED MATERIAL 7/1/2023	19. SIGNATURE OF APPROVING OFFICIAL 
20. TYPED NAME OF APPROVING OFFICIAL Rory Howe	21. TITLE OF APPROVING OFFICIAL Director, FMG

22. REMARKS

12/13/2023 - State authorized update in block 15 to include "return to" information

3. Value Based Purchasing (VBP) Incentive. 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. The facility shall receive a per diem adjustment for each Quality Measure (QM) Performance threshold that it meets. The threshold for each QM is based on national cut-points used by CMS in its Five Star Rating System. Each threshold is the maximum QM value a facility can have in order to receive the per diem adjustment. These thresholds are listed in Table A3 of the Five-Star Quality Rating System: Technical Users' Guide dated January 2017. The thresholds listed in Table A3 have been rounded to the nearest tenth for purposes of determining the VBP Incentive. Table A3 of the Five-Star Quality Rating System: Technical Users' Guide dated January 2017 is incorporated by reference and made a part of this plan as published by CMS and available at <https://dss.mo.gov/mhd/providers/nursing-home-reimbursement-resources.htm>.

(I) SFY 2023 QM Performance Measure table. The facility's most current twelve- (12-) month rolling average QM value as of January 21, 2022 is used to determine the per diem adjustment(s) the facility qualified to receive for the rates effective July 1, 2022. The QM Performance Measure threshold, rounded to the nearest tenth, and per diem adjustments are as follows:

QM Performance	Threshold	Per Diem Adjustment
Decline in Late-Loss ADLs	<= 10.0%	\$1.00
Decline in Mobility on Unit	<= 8.0%	\$1.00
High-Risk Residents w/ Pressure Ulcers	<= 2.7%	\$1.00
Anti-psychotic Medications	<= 6.8%	\$1.00
Falls w/ Major Injury	<= 1.3%	\$1.00
In-dwelling Catheter	<= 1.1%	\$1.00
Urinary Tract Infection	<= 1.9%	\$1.00

(II) SFY 2024 QM Performance Measure table. Effective for dates of service beginning July 1, 2023, the QM Performance Measure per diem adjustments are as follows:

QM Performance	Threshold	Per Diem Adjustment
Decline in Late-Loss ADLs	<= 10.0%	\$1.87
Decline in Mobility on Unit	<= 8.0%	\$1.87
High-Risk Residents w/ Pressure Ulcers	<= 2.7%	\$1.87
Anti-psychotic Medications	<= 6.8%	\$1.87
Falls w/ Major Injury	<= 1.3%	\$1.87
In-dwelling Catheter	<= 1.1%	\$1.87
Urinary Tract Infection	<= 1.9%	\$1.87

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B. A VBP percentage will also be applied to the per diem adjustment for each facility that qualifies for a VBP Incentive. The VBP percentage will be determined by the total QM score calculated from the Five-Star Rating System scores for each of the eight (8) long-term QMs, as follows:

(I) The facility's most current twelve- (12-) month rolling average QM value as of January 21, 2022 is used to determine the facility's QM Score and VPB Percentage for the rates effective July 1, 2022;

(II) For each QM value, the corresponding number of QM points will be determined from Table A3 of the Five-Star Quality Rating System: Technical Users' Guide dated January 2017;

(III) The QM points for all of the QMs will be summed to determine the facility's total QM Score.

(IV) The VBP percentage for each scoring range is listed in the following table.

QM Scoring Tier	Minimum Score	VBP Percentage
1	600	100%
2	520	75%
3	440	50%
4	360	25%
5	0	0%

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.

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.

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A. Ceilings. The patient care, ancillary, and administration cost component ceilings shall be updated for any global per diem adjustments as set forth in (12)(A). The effective date of the updated ceilings shall be the effective date of the global per diem adjustment. The ceiling used to determine the prospective rate shall be the ceiling in effect at the beginning of the rate setting period.

B. Asset Value. The asset value shall be updated annually as set forth in (4)(E). The asset value for the year coinciding with the rate setting cost report year (i.e., the end of the cost report period) shall be used.

C. Age of Beds and Bed Equivalencies. The age of beds shall be calculated by subtracting the year the beds were originally licensed from the year coinciding with the rate setting cost report year (i.e., the end of the cost report period). The age of bed equivalencies shall be calculated by subtracting the year the capital expenditures were made from the year coinciding with the rate setting cost report (i.e., the end of the rate setting cost report period).

3. A facility with a valid Medicaid participation agreement in effect after June 30, 2022, which either voluntarily or involuntarily terminates its participation in the Medicaid Program and which reenters the Medicaid Program within two (2) years, shall have its prospective rate established as the rate in effect on the day prior to the date of termination from participation in the program plus rate adjustments which may have been granted with effective dates subsequent to the termination date but prior to reentry into the program as described in subsection (12)(A). This prospective rate shall be effective for service dates on and after the effective date of the reentry following a voluntary or involuntary termination.

(12) Adjustments to the Reimbursement. Subject to the limitations prescribed elsewhere in this plan, a facility's reimbursement rate may be adjusted as described in this section.

(A) Global Per Diem Rate Adjustments. A facility with either an interim rate or a prospective rate may qualify for the global per diem rate adjustments as set forth in this sub-section. Global per diem rate adjustments shall be allocated, and added to, the patient care, ancillary, and administration cost component ceilings based on the ceiling in effect at the time the global per diem adjustment is granted, unless the adjustment is directly attributable to a specific cost component(s). If the adjustment is directly attributable to a specific cost component(s), it shall be added to the specified cost component ceiling.

1. FY-2024 per diem adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2023, shall be granted an increase to their per diem rate effective for dates of service beginning July 1, 2023 of ten dollars and zero cents (\$10.00);

B. The rate to which the FY-2024 adjustment of ten dollars and zero cents (\$10.00) shall be added is the facility's rate as of June 30, 2023. The FY-2024 adjustment shall be effective for dates of service beginning July 1, 2023.

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(II) The rate paid to the out-of-state nursing facility for comparable services by the state in which the provider is located. The out-of-state provider must notify the division of any reimbursement changes made by its state Medicaid agency. The provider must also include a copy of the rate letter issued by their state Medicaid agency detailing the rate and effective date. The effective date of the rate change is as follows:

(a) Rate increases—If the provider notifies the division within thirty (30) days of receipt of notification from their state of the per diem rate increase, the effective date of the rate increase for purposes of reimbursement from Missouri shall be the same date as indicated in the issuing state’s rate letter. If the division does not receive written notification from the provider within thirty (30) days of the date the provider received notification from their state of the rate increase, the effective date of the rate increase for purposes of reimbursement from Missouri shall be the first day of the month following the date the division receives notification; or

(b) Rate decreases—The effective date of the rate decrease for purposes of reimbursement from Missouri shall be the same date as indicated in the issuing state’s rate letter.

(B) Hospital based nursing facilities.

1. The Title XIX reimbursement rate for hospital based providers that provide services of less than one thousand (1,000) patient days for Missouri Title XIX participants, relative to their fiscal year, and that are exempt from filing a cost report as prescribed in section (10) shall be determined as follows:

A. For hospital based nursing facilities that have less than one thousand (1,000) Medicaid patient days, the rate base cost report will not be required.

B. The prospective rate will be the sum of the ceilings for the patient care, ancillary, and administration cost components, plus the median per diem for capital. In addition, the patient care incentive of four and seventy-five hundredths percent (4.75%) of the patient care median will be granted; and

2. For hospital based nursing facilities that provide one thousand (1,000) or more patient days for Missouri Title XIX participants, relative to their fiscal year, a prospective rate shall be set by one (1) of the following:

A. The hospital based nursing facility requests, in writing, that their prospective rate be determined from their rate setting cost report as set forth in this plan; or

B. The sum of the ceilings for patient care, ancillary, and administration and the median per diem for capital. In addition, the patient care incentive of four and seventy-five hundredths percent (4.75%) of the patient care median will be granted.

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