Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 15—Hospital Program

EMERGENCY AMENDMENT

13 CSR 70-15.160 *[Prospective]* **Outpatient Hospital Services Reimbursement Methodology**. The MO HealthNet Division is adding a new section (5). The division is also amending to remove the Outpatient Surgical Procedures on a Fee Schedule, the last four pages prior to the authority.

PURPOSE: This emergency amendment changes the methodology for reimbursement of outpatient services provided by hospitals enrolled in the MO HealthNet program. Section (5) establishes an outpatient simplified fee schedule in place of the current prospective outpatient payment percentage.

PURPOSE: [This rule establishes a prospective outpatient reimbursement methodology for hospitals in place of the current retrospective reimbursement methodology. This rule establishes the methodology for setting a hospital's prospective outpatient payment percentage for hospital services effective July 1, 2002.] ***This rule establishes the payment methodology for outpatient hospital services.***

EMERGENCY STATEMENT: The Department of Social Services, MO HealthNet Division (MHD) finds that this emergency amendment is necessary to preserve a compelling governmental interest as it allows MHD to pay its hospital providers under a financially sustainable payment methodology that will prevent a budget shortfall for the Medicaid program. On June 30, 2021, Governor Parson signed SS SCS HCS HB 11, which appropriates funding for State Fiscal Year (SFY) 2022 for the MO HealthNet (Medicaid) program. The General Assembly did not appropriate enough funding to ensure that the MO HealthNet program will not have a budget shortfall, which is projected at $52.7 million for SFY 2022. The cost savings from this emergency amendment will save between $14 and $35 million dollars for six months from the effective date of this emergency amendment. Based on the projected savings, this emergency amendment could prevent the MO HealthNet program from experiencing a major budget shortfall for this coming SFY. This emergency amendment is necessary to secure a sustainable Medicaid program in Missouri, and ensure that payments for outpatient services are in line with funds appropriated for that purpose. (See Beverly Enterprises-Missouri Inc. v. Dep't of Soc. Servs., Div. of Med. Servs., 349 S.W.3d 337, 350 (Mo. Ct. App. 2008)) As a result, MHD finds a compelling governmental interest, which requires this emergency action. A proposed amendment, which covers the same material, was published in the June 1, 2021 issue of the ***Missouri Register*** *(46 MoReg 937–943). This emergency amendment limits its scope to the circumstances creating the emergency and complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions****. The MHD believes this emergency amendment to be fair to all interested parties under the circumstances. The emergency amendment was filed July 6, 2021, becomes effective July 20, 2021, and expires February 24, 2022.*

(5) Outpatient Simplified Fee Schedule (OSFS) Payment Methodology

(A) Definitions. The following definitions will be used in administering section (5) 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. The Medicare OPPS Final Rule is incorporated by reference and made a part of this rule as published by the Office of the Federal Register, 800 North Capitol St. NW, Suite 700, Washington, DC 20408, and available at https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action, December 20, 2020. This rule does not incorporate any subsequent amendments or additions.

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

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 Hospital. 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.

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 (5)(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 fourth 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 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%). 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; and

C. A hospital physically located in the State of Missouri

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, and 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.

(B) Effective for dates of service beginning July 1, 2021, 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 on July 1st based on the payment method described in subsection (5)(D).

2. The OSFS is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action, March 24, 2021. This rule does not incorporate any subsequent amendments or additions.

(C) Payment will be the lower of the provider's charge or the payment as calculated in subsection (5)(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 subsection (5)(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. The Medicare OPPS Addendum B is incorporated by reference and made a part of this rule as published by the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action, December 29, 2020. This rule does not incorporate any subsequent amendments or additions.

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.

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. The Medicare OPPS Addendum A is incorporated by reference and made a part of this rule as published by the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action, July 6, 2021. This rule does not incorporate any subsequent amendments or additions.

C. For those APCs with no assigned relative weight, ninety percent (90%) of the 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.

A. The Medicare Clinical Laboratory Fee Schedule is incorporated by reference and made a part of this rule as published by the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action, March 12, 2021. This rule does not incorporate any subsequent amendments or additions.

B. The Medicare Physician Fee Schedule is incorporated by reference and made a part of this rule as published by the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action, January 4, 2021. This rule does not incorporate any subsequent amendments or additions.

C. The Medicare Durable Medical Equipment Prosthetics/Orthotics and Supplies Fee Schedule is incorporated by reference and made a part of this rule as published by the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action, December 2, 2020. This rule does not incorporate any subsequent amendments or additions.

3. Fees for dental procedure codes in the outpatient hospital setting are calculated based on thirty-eight and one-half percent (38.5%) of the 50th percentile fee for Missouri reflected in the 2021 National Dental Advisory Service (NDAS). The 2021 NDAS is incorporated by reference and made a part of this rule as published by Wasserman Medical & Dental at its website at https://wasserman-medical.com/product-category/dental/ndas/, and available at the MO HealthNet Division, 615 Howerton Court, Jefferson, City MO 65102, April 20, 2021. This rule does not incorporate any subsequent amendments or additions.

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 incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action, April 22, 2021. This rule does not incorporate any subsequent amendments or additions.

B. The MHD Medical Fee Schedule is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action, April 12, 2021. This rule does not incorporate any subsequent amendments or additions.

C. The MHD Other Medical Fee Schedule is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action, April 22, 2021. This rule does not incorporate any subsequent amendments or additions.

D. The MHD Independent Lab—Technical Component Fee Schedule is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action, April 12, 2021. This rule does not incorporate any subsequent amendments or additions.

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

6. Nominal charge providers will receive an additional twenty-five percent (25%) of the rate as determined in (5)(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. Claim lines with packaged procedure codes will be considered paid but with a payment of zero. The Medicare OPPS Addendum D1 is incorporated by reference and made a part of this rule as published by the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at https://dss-ruletracker.mo.gov/dss-proposed-rules/welcome.action, December 29, 2020. This rule does not incorporate any subsequent amendments or additions

(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. The Medicare OPPS Addendum D1 is incorporated by reference and made a part of this rule as published by the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at https://dss-ruletracker.mo.gov/dss-proposed-rules/welcome.action, December 29, 2020. This rule does not incorporate any subsequent amendments or additions.

(G) Drugs. Effective for dates of service beginning April 1, 2019, outpatient drugs are reimbursed in accordance with the methodology described in 13 CSR 70-20.070.

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

AUTHORITY: sections ***208.152,*** *208.153, 208.201, and 660.017, [RSMo 2016, and section 208.152,] RSMo Supp. [2018]* ***2020****. Emergency rule filed June 20, 2002, effective July 1, 2002, expired Feb. 27, 2003. Original rule filed June 14, 2002, effective Jan. 30, 2003. For intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed July 6, 2021, effective July 20, 2021, expires Feb. 24, 2022. A proposed amendment covering this same material was published in the June 1, 2021, issue of the* ***Missouri Register****. An emergency amendment covering this same material will be published in the August 16, 2021, issue of the* ***Missouri Register****.*

PUBLIC COST: This emergency amendment is estimated to initially save the state between fourteen million dollars ($14,000,000) and thirty-five million dollars ($35,000,000) in the time the emergency amendment is effective. This emergency amendment is anticipated to initially cost in state public entities between two hundred forty-five thousand dollars ($245,000) and three million, two hundred thousand dollars ($3,200,000) in the time the emergency amendment is effective.

PRIVATE COST: This emergency amendment is anticipated to initially cost in state private entities between six million, two hundred thousand dollars ($6,200,000) and seventeen million, six hundred thousand dollars ($17,600,000) in the time the emergency amendment is effective. This emergency amendment is anticipated to initially cost out of state entities between eight million, one hundred thousand dollars ($8,100,000) and fourteen million, two hundred thousand dollars ($14,200,000) in the time the emergency amendment is effective.

FISCAL NOTE
PUBLIC COST

I. Department Title: Title 13–Department of Social Services
Division Title: Division 70–MO HealthNet Division
Chapter Title: Chapter 15–Hospital Program

Rule Number and Title:	13 CSR 70-15.160 Outpatient Hospital Services Reimbursement Methodology
Type of Rulemaking:	Emergency Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Other Government (Public) & State Hospitals enrolled in MO HealthNet - 33	The estimated cost for 6 months of SFY 2022 is between ($245) thousand and $3.2 million
Department of Social Services, MO HealthNet Division	SFY 2022 Impact (6 Months): Total Savings is between $14 million and $35 million; State Share is between $4.8 million and $11.9 million

III. WORKSHEET

Other Government (Public) & State Hospitals Cost:	
Estimated Cost for 6 Months of SFY 2022:	
Estimated Cost to State Hospitals	Between ($3,713,778) and ($401,909)
Estimated Cost to Other Government (Public) Hospitals	Between ($3,468,548) and ($3,619,579)
Total Estimated Cost	Between ($245,230) and ($3,217,670)
Department of Social Services, MO HealthNet Division Savings:	
Estimated Savings for 6 Months of SFY 2022:	
Estimated Savings	Between $14,065,681 and $35,029,302
Times FFY 2020 State Share Percentage	33.99%
Estimated State Share Savings	Between $4,780,925 and $11,906,460

IV. ASSUMPTIONS

This fiscal note reflects the annual estimated impact based on a hospital-by-hospital analysis of the change in reimbursement for hospital outpatient services. The impact represents an estimate of payment using an APC-based fee schedule as the basis compared to the current reimbursement methodology. This fiscal impact includes the impact to both in-state and out-of-state hospitals.

The initial simulation/savings analysis represents an estimate of payment using an APC-based fee schedule. This should not be construed as a forecast or projection of savings. A number of factors need to be considered when looking at the simulated payment results and making decisions in regard to payment levels for the first year of implementation. For example,

- Crosswalks: MO HealthNet crosswalks emergency room/clinic visits to state-specific procedure codes. This practice does not provide the detail needed to determine the level of complexity for a given encounter. The level of complexity drives the fee to a lower or higher payment level.
- Reporting only surgical procedures: MHD requires hospitals to report surgery procedure codes on their outpatient claims with a zero billed amount. These surgery procedure code lines are considered informational only and not for payment. Hospitals submit revenue codes for their facility and supply charges related to the surgery procedure code reported on the claim. Hospitals are paid for these facility and supply charges. The facility and supply revenue codes submitted on the claim are cross-walked to state-specific procedure codes. Therefore, in simulating payment, we were not able to identify the line-level charges for the surgery and tie them to the simulated payment. In addition, there is no way to validate how many surgeries were not billed as reporting-only lines.
- 90% of Medicare and packaging: The simulation was set at 90% of the Medicare fees but does not include Medicare's bundling logic.
- Coding contingency factor: We expect that the transition from payment based on a percent of charges to a fee schedule will result in more detailed procedure and line-level claims data. The new payment method and billing requirements will be driven now based on the Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) detail. MHD will have a better idea of what outpatient hospital services are purchased.

FISCAL NOTE
PRIVATE COST

I. Department Title: Title 13–Department of Social Services
Division Title: Division 70–MO HealthNet Division
Chapter Title: Chapter 15–Hospital Program

Rule Number and Title:	13 CSR 70-15.160 Outpatient Hospital Services Reimbursement Methodology
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II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
In-state hospitals – 79 Out-of-state hospitals – 160	Private and Out-of-State Hospitals enrolled in MO HealthNet	The estimated cost for 6 months of SFY 2022 is between $14.3 and $31.8 million

III. WORKSHEET

Private Hospitals: **Estimated Costs for 6 Months of SFY 2022:**	
Estimated Cost to In-State Private Hospitals	Between $6,210,519 and $17,591,385
Estimated Cost to Out-of-State Hospitals	Between $8,100,392 and $14,220,247
Total Estimated Cost	Between $14,310,911 and $31,811,632

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This fiscal note reflects the annual estimated impact based on a hospital-by-hospital analysis of the change in reimbursement for hospital outpatient services. The impact represents an estimate of payment using an APC-based fee schedule as the basis compared to the current reimbursement methodology. This fiscal impact includes the impact to both in-state and out-of-state hospitals.

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