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

PROPOSED AMENDMENT

13 CSR 70-15.160 Outpatient Hospital Services Reimbursement Methodology. The division is amending section (1) and adding section (2).

PURPOSE: This proposed amendment updates all documents incorporated by reference that create the outpatient simplified fee schedule. This proposed amendment also adds a rate adjustment methodology for in-state federally deemed critical access hospitals.

(1) *Outpatient Simplified Fee Schedule* (OSFS) Payment Methodology.

(A) Definitions. The following definitions will be used in administering section (1) 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 Outpatient Prospective Payment System (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 Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, *[December 8, 2023]***December 20, 2024**. 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 42 *Code of Federal Regulations* (CFR) 485.606(b), which is incorporated by reference in this rule as published by U.S. Government Publishing Office, U.S. Superintendent of Documents, Washington, DC 20402, October 1, 2023*, and available at https://www.govinfo.gov/content/pkg/CFR-2023-title42-vol5/pdf/CFR-2023-title42-vol5.pdf.* This rule does not incorporate any subsequent amendments or additions.

7. HCPCS. The national uniform coding method maintained by the Centers for Medicare & Medicaid Services (CMS) that incorporates the American Medical Association (AMA) Physicians CPT and the three (3) 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 paragraph (1)(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 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 (1) 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 State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (BIPA); and

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

(B) Effective for dates of service beginning July 20, 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 1 based on the payment method described in subsection (1)(D); and

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, *[December 3, 2024]***July 1, 2025**. 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 (1)(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 subparagraph (1)(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 & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, *[December 22, 2023]***January 9, 2025**. This rule does not incorporate any subsequent amendments or additions.

A. The fee is calculated using the APC relative weight times 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 & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, *[January 4, 2024]***January 9, 2025**. 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 & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, [January 11, 2024*]***January 9, 2025**. 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 & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, *[January 11, 2024]***January 10, 2025**. 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 & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, *[December 22, 2023]***December 17, 2024**. 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 fiftieth percentile fee for Missouri reflected in the *202[3]***5** *National Dental Advisory Service* (NDAS). The 202*[3]***5** NDAS is incorporated by reference and made a part of this rule as published by Wasserman Medical & Dental*, PO Box 510949, Milwaukee, WI 53203, [December 28, 2023]***January 2, 2025**. 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, *[May 13, 2024]***May 5, 2025**. 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, *[May 13, 2024]***May 5, 2025**. 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, *[May 13, 2024]***May 5, 2025**. 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, *[May 13, 2024]***May 5, 2025**. 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 paragraph (1)(B)2. for each billed procedure code; and

6. Nominal charge providers will receive an additional forty percent (40%) of the rate as determined in paragraph (1)(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 (0). 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, *[December 8, 2023]***November 24, 2024**. 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.

(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 (2) 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, *[December 8, 2023]***November 24, 2024**. This rule does not incorporate any subsequent amendments or additions.

(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 one (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, *[January 5, 2024]***January 10, 2025**. This rule does not incorporate any subsequent amendments or additions.

(I) 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.

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

(2) Outpatient Rate Adjustment

(A) Rate adjustment.

1. A rate adjustment may be requested by in-state federally deemed critical access hospitals under this subsection for changes in outpatient allowable costs related to building a new replacement hospital. The effective date for any increase granted under this subsection shall be no earlier than the first day of the month following the division's final determination of the rate adjustment.

A. In-state federally deemed critical access hospitals that build a new replacement hospital and incur costs associated with the new hospital may request an outpatient rate adjustment. A rate adjustment request for projects requiring CON review must include a copy of the CON program approval.

B. An in-state federally deemed critical access hospital will have six (6) months after the new hospital is completed and open to the public to submit a request for outpatient rate adjustment, along with a budget of the project's costs. The rate adjustment request, the project's budget, and any other documentation related to the replacement building's costs shall be provided to MHD. Upon completion of MHD's review, the hospital's outpatient reimbursement rate may be adjusted, if indicated. Failure to submit a request for rate adjustment and project budget within the six- (6-) month period shall disqualify the hospital from receiving a rate increase.

C. Rate adjustments due to building a new hospital will be determined as the increase in capital and operating costs multiplied by the ratio of total Medicaid outpatient costs to total hospital costs as submitted on the most recent audited cost report as of the review date divided by the FFS Medicaid outpatient payments from the audited cost report. This percentage increase will be added to the current outpatient increase to determine the new increase to the fee schedule amounts. The increase will be limited to twenty-five percent (25%) and will be limited to thirty (30) years.

2. The request for a rate adjustment must be submitted in writing to the division and must specifically and clearly identify the project and the total dollar amount involved. The total dollar amount must be supported by generally accepted accounting principles. The hospital will be notified of the division's decision in writing within sixty (60) days of receipt of the hospital's written request or within sixty (60) days of receipt of any additional documentation or clarification which may be required, whichever is later. Failure to submit requested information within the sixty- (60-) day period, shall be grounds for denial of the request.

AUTHORITY: sections 208.201 and 660.017, RSMo 2016, and sections 208.152 and 208.153, RSMo Supp. 2024. Emergency rule filed June 20, 2002, effective July 1, 2002, expired Feb. 27, 2003. Original rule filed June 14, 2002, effective Jan. 30, 2003. Amended: Filed May 3, 2004, effective Oct. 30, 2004. Amended: Filed June 15, 2005, effective Dec. 30, 2005. Emergency amendment filed Sept. 21, 2010, effective Oct. 1, 2010, expired March 29, 2011. Amended: Filed Sept. 30, 2010, effective March 30, 2011. Emergency amendment filed Sept. 20, 2011, effective Oct. 1, 2011, expired March 28, 2012. Amended: Filed July 1, 2011, effective Feb. 29, 2012. Emergency amendment filed June 20, 2012, effective July 1, 2012, expired Dec. 28, 2012. Amended: Filed June 20, 2012, effective Jan. 30, 2013. Amended: Filed July 1, 2013, effective Jan. 30, 2014. Amended: Filed May 1, 2018, effective Jan. 1, 2019. Amended: Filed Jan. 8, 2019, effective July 30, 2019. Amended: Filed April 21, 2021, effective Nov. 30, 2021. Emergency amendment filed June 13, 2022, effective July 1, 2022, expired Feb. 23, 2023. Amended: Filed June 13, 2022, effective Jan. 30, 2023. Emergency amendment filed June 15, 2023, effective June 30, 2023, expired Dec. 26, 2023. Amended: Filed July 13, 2023, effective Jan. 30, 2024. Emergency amendment filed Oct. 16, 2024, effective Oct. 30, 2024, expired April 27, 2025. Amended: Filed Oct. 16, 2024, effective May 30, 2025. Emergency amendment filed June 20, 2025, effective July 8, 2025, expired Feb. 26, 2026. Amended: Filed June 23, 2025.*

**Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1978, 1981, 1986, 1988, 1990, 1992, 1993, 2004, 2005, 2007, 2011, 2013, 2014, 2015, 2016, 2018, 2021, 2023, 2024; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012, 2024; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions approximately $9.5 million for SFY 2026.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, Legal Services Division-Rulemaking, P.O. Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. *To be considered, comments must be received within thirty (30) days after publication of this notice in the* ***Missouri Register****. A public hearing will not be scheduled.*