

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

PROPOSED AMENDMENT

13 CSR 70-15.190 Out-of-State Hospital Services Reimbursement Plan. The division is amending sections (1), (2), (3), (4), (5), and (6), and deletes sections (7), (8), (9), (10), (11), (12), (13), and (14).

PURPOSE: This amendment establishes the method of reimbursing out-of-state hospitals for inpatient or outpatient care provided to any participants of Missouri Medicaid, whether they are under age twenty-one (21) or age twenty-one (21) and over. The division is amending the methodology for both inpatient and outpatient reimbursement for out-of-state hospitals, and updating outdated language and terms.

- (1) Covered inpatient hospital services include those items and services allowed by the Medicaid State Plan including medically necessary care in a semi-private room. If prior authorized Missouri Medicaid may reimburse for a private room if it is certified medically necessary by a physician to avoid jeopardizing the health of the patient or to protect the health and safety of other patients. No payment will be made for any portion of the room charge when the *[recipient]***participant** requests and is provided a private room when the private room is not medically necessary.
- (2) Payment for authorized inpatient hospital services shall be made on a prospective per diem basis for services provided outside Missouri if the services are covered by the Missouri *[Medical Assistance (]Medicaid[)]* Program. To be reimbursed for furnishing services to Missouri Medicaid *[recipients]***participants**, out-of-state *[providers]***hospitals** must complete a Missouri *[Medical Assistance]***Medicaid** Program Provider Participation Application and have the application approved by the Missouri Department of Social Services, *[Division of Medical Services]***Missouri Medicaid Audit and Compliance (MMAC)**.
- (3) Determination of Payment. The payment for inpatient hospital services provided by an out-of-state *[provider]***hospital** shall be the lowest of:

- (A) *[At the out-of-state hospital's election, the prospective inpatient payment may be based on information from the hospital's Medicare base year cost report and all financial documentation required by Missouri regulations for hospitals operating in Missouri with inflationary increases as granted by the Missouri General Assembly or the out-of-state hospital may be exempt from the cost report filing requirements if the hospital accepts the projected statewide average per diem rate for Missouri hospitals as calculated by the Department of Social Services, Division of Medical Services for the state fiscal year in which the service was provided. The effective date for any increase above the statewide average per diem rate for Missouri hospitals shall be the first day of the month following the Division of Medical Services determination of per diem rate based on information from the hospital's Medicare base year cost report and all financial documentation required by Missouri regulation for hospitals operating in Missouri;]* **For the out-of-state hospitals whose per diem was set on the hospital's audited Medicaid cost report prior to July 1, 2022, the hospital's per diem will be the rate in effect as of June 30, 2022. For all other out-of-state hospitals, the hospital's per diem will be fifty percent (50%) of the weighted statewide average per diem rate for Missouri hospitals as calculated by the MO HealthNet Division for the SFY in which the service was provided;**
or
- (B) The amount of total charges billed by the hospital. The *[provider's]* hospital's billed charges must be their usual and customary charges for services; or
- (C) The Medicare deductible or coinsurance, if applicable, up to the amount allowed by the Missouri Medicaid program.
- (4) *[Per Diem Reimbursement Rate Computation. The per diem reimbursement rate computation is the same as calculated for Missouri hospitals at 13 CSR 70-15.010(3).*
- (5) *If a provider fails to submit all financial documentation required by Missouri regulations (Medicare cost report, working trial balance, audited financial statements, Medicaid supplemental schedules, and Worksheet C2552-83 for ancillary costs and charges) for hospitals operating in Missouri within thirty (30) days of making the election to receive payment based on information from cost reports, the payment shall be based on the projected statewide average per diem rate in Missouri as developed by the Department of Social Services, Division of Medical Services for the state fiscal year.*
- (6) *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. Inpatient and outpatient hospital services must be submitted on the UB-92 claim form.*
- (7) *Out-of-state hospitals are subject to the Department Concurrent Hospital Review process (utilization review) for all non-emergency services.*
- (8) *The payment for authorized outpatient hospital services provided by an out-of-state hospital shall be the [lowest]lower of:*

(A) *[At the out-of-state hospital's election, a prospective outpatient payment percentage calculated using the Medicaid over-all outpatient cost-to-charge ratio from the fourth, fifth, and sixth prior base year cost reports and all documentation required by Missouri regulation for hospitals operating in Missouri regressed to the current state fiscal year or the out-of-state hospital may be exempt from the cost report filing requirement if the hospital accepts the projected statewide average outpatient payment percentage as developed by the Department of Social Services, Division of Medical Services for the state fiscal year in which the service was provided. The effective date for any increase above the statewide average outpatient payment percentage shall be the first day of the month following the Division of Medical Services determination of the outpatient payment percentage based on information from the hospital's Medicare base year cost report and all financial documentation required by Missouri regulation for hospitals operating in Missouri;]***The outpatient reimbursement as described in 13 CSR 70-15.160;** or

(B) The amount of total charges billed by the hospital.

[(9) Outpatient Reimbursement Rate Computation. The outpatient reimbursement rate computation is the same as calculated for Missouri hospitals at 13 CSR 70-15.160.]

*[(10)]***(5) Disproportionate Share [Providers]Hospital (DSH) Payments.** Out-of-state hospitals do not qualify for *[disproportionate share (JDSH)]* payments. *[unless they have a low income utilization rate exceeding twenty-five percent (25%) for Missouri residents and the out-of-state hospital can demonstrate that the provision of services to Missouri residents has not been considered in establishing their DSH status in any other state.*

(11) All Medicaid services are subject to program compliance reviews. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made.

(12) Regardless of changes of ownership, management, control, operation, leasehold interests by whatever form for any hospital previously certified for participation in the Medicaid program, the department will continue to make all the Title XIX payments directly to the entity with the hospital's current provider number and hold the entity with the current provider number responsible for all Medicaid liabilities.

(13) Participation in the Missouri Medicaid program shall be limited to hospitals who accept as payment in full for covered services rendered to Medicaid recipients the amount paid in accordance with Missouri statute and regulations.

*(14)]***(6) Definitions.**

(A) The definitions from regulation 13 CSR 70-15.010 are incorporated as 13 CSR 70-15.190.

(B) *[Base year cost report—shall be either a 1995 Medicare cost report and Missouri's supplemental cost report schedules for those hospitals enrolled in the Missouri Medicaid program as of the effective date of this regulation or the most recent submitted cost report to Medicare and Missouri's supplemental cost report schedules for those hospitals that elect to enroll in Missouri Medicaid after the effective date of this regulation.*

(C) *[Out-of-state—not within the physical boundaries of Missouri.*

(D) Usual and customary charge—the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.

AUTHORITY: section 208.201 and 660.017, RSMo.* Original rule filed April 15, 2004, effective Oct. 30, 2004. Emergency amendment filed June 16, 2022, effective July 1, 2022, expired Feb. 23, 2023. Amended filed June 16, 2022, effective Dec. 15, 2022.

**Original authority: 208.201, RSMo 1987.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

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**. No public hearing is scheduled.*