V Definitions

A Base cost report. Desk-reviewed Medicare/Medicaid cost report. When a facility has more than one (1) cost report with periods ending in the fourth prior calendar year, the cost report covering a full twelve (12)-month period will be used. If none of the cost reports cover a full twelve (12) months, the cost report with the latest period will be used. If a hospital's base cost report is less than or greater than a twelve (12)-month period, the data shall be adjusted, based on the number of months reflected in the base cost report to a twelve (12)-month period.

B Cost report. A cost report details, for purposes of both Medicare and Medicaid reimbursement, the cost of rendering covered services for the fiscal reporting period. The Medicare/Medicaid Uniform Cost Report contains the forms utilized in filing the cost report. The Medicare/ Medicaid Cost Report version 2552-96 (CMS 2552-96) shall be used for fiscal years ending on or after September 30, 1996. The Medicare/Medicaid Cost Report version 2552-10 (CMS 2552-10) shall be used for fiscal years beginning on and after May 1, 2010.

C Effective date.
1. The plan effective date shall be July 1, 2002.
2. New prospective outpatient payment percentages will be effective July 1 of each SFY.

D Nominal charge provider. A nominal charge provider is determined from the fourth (4^{th}) prior year desk reviewed cost report. The hospital must meet the following criteria:
1. An acute care hospital with an unsponsored care ratio of at least sixty-five percent (65%) and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of more than forty percent (40%). The unsponsored care ratio is determined as the sum of bad debts and charity care divided by total net revenue. The hospital must meet one of the federally mandated Disproportionate Share qualifications; or
2. The hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental disorders.

VI Outpatient Simplified Fee Schedule (OSFS) Payment Methodology. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient hospital services.

A Definitions. The following definitions will be used in administering section (VI) 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.

3. APC relative weight. The national relative weights calculated by Medicare and listed in the January Addendum B of each year.

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 Hospitals. 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 MO HealthNet 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 section (VI)(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 (4th) 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.

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, 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, MO HealthNet Division (MHD) policies and fee schedules are used. The fee schedule will be updated as follows:

1. MHD will review and adjust the OSFS annually, effective July 1st based on the payment method described in section (VI)(D).

2. The MHD OSFS is published under "Fee Schedules & Rate Lists" on the MO HealthNet website at https://dss.mo.gov/mhd/providers/fee-for-service-providers.htm.

C Payment will be the lower of the provider's charge or the payment as calculated under the OSFS Payment Methodology.

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. 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.

   (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.

      I The APC relative weight, as defined in section (VI)(A)(3).

      II The Missouri conversion factor, as defined in section (VI)(A)(9).

      III The payment level adjustment, as defined in section (VI)(A)(12).

   (b) 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.

3. Fees for dental procedure codes in the outpatient hospital setting are calculated based on 38.5% of the 50th percentile fee for Missouri reflected in the 2021 National Dental Advisory Service (NDAS).

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 published on the MO HealthNet website at https://dss.mo.gov/mhd/providers/pages/cptagree.htm. To navigate the site, users must agree to the licensure terms and conditions, select “Download” or “Full Search”, and select “Dental Services”.

   (b) The MHD Medical fee schedule is published on the MO HealthNet website at https://dss.mo.gov/mhd/providers/pages/cptagree.htm. To navigate the site, users must agree to the licensure terms and conditions, select “Download” or “Full Search”, and select “Medical Services”.

   (c) The MHD Other Medical fee schedule is published on the MO HealthNet website at https://dss.mo.gov/mhd/providers/pages/cptagree.htm. To navigate the site, users must agree to the licensure terms and conditions, select “Download” or “Full Search”, and select “Other Medical”.

   (d) The MHD Independent Lab – Technical Component fee schedule is published on the MO HealthNet website at https://dss.mo.gov/mhd/providers/pages/cptagree.htm. To navigate the site, users must agree to the licensure terms and conditions, select “Download” or “Full Search”, and select “Independent Lab – Technical Component”.

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

6. Nominal charge hospitals will receive an additional twenty-five percent (25%) of the rate as determined in section (VI)(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. Individual claim lines with packaged procedure codes will be considered paid but with a payment of zero.

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

OUTPATIENT HOSPITAL SERVICES - OUT-OF-STATE HOSPITALS AND FEDERALLY-OPERATED HOSPITALS LOCATED WITHIN THE STATE OF MISSOURI

1. 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. Outpatient hospital services must be submitted on the UB-92 claim form.

2. Outpatient Reimbursement. The outpatient reimbursement is the same as the reimbursement for Missouri hospitals as described in sections I through VI.