

Summary of Public Comments Regarding the Department Of Social Services (DSS)

MO HealthNet Managed Care Reimbursement Methodology

January 14, 2019

In response to a public notice issued on June 9, 2018 and a public hearing held June 19, 2018, the Missouri Department of Social Services(DSS) MO HealthNet Division (MHD) received public comments from providers, representatives from hospitals, advocacy groups, health commissions, a legislator, a graduate student, an insurance company, and associations.

Contract and Reimbursement Comments

Comment: Several commenters inquired if there will be a change in the Managed Care Organizations' (MCO) rates pursuant to the contract change being proposed (capping out of network payments at 90 percent (90%) of the MO HealthNet Medicaid fee schedule). Commenters asked if the rates are automatically adjusted periodically based on Mercer's calculations regarding what is or is not actuarially sound, and if this change would automatically trigger a rate reduction.

Response: There was no adjustment applied to the actuarial rates for the rating period beginning July 1, 2018, pursuant to this proposed contract change. The rates assume more providers will contract with the health plans and reimbursement levels for participating providers will be largely consistent with current managed care contracting. The rates are adjusted annually based on actuarial principles and are certified as actuarially sound.

Comment: Several commenters expressed they oppose this contract change for the following reason: the proposed amendment change would force hospitals and other providers that do not contract with Managed Care plans to accept reimbursements at 90% of the Medicaid Fee-for-Service (FFS) rates, and this action undermines hospitals' ability to negotiate a fair price for their services. The commenters expressed the contract amendment affects all hospitals and benefits the managed care plans solely, giving the plans an unfair advantage when negotiating reimbursements with participating and non-participating hospitals, which gives the plans leverage when contracting with hospitals. Commenters expressed concern about reimbursement rates being potentially below cost, if hospitals are not able to negotiate sufficient rates. Commenters stated MHD should not influence negotiations between hospitals and health plans, and the amendment should be written to ensure mutual terms for both parties exist. Commenters expressed any additional cuts to the Missouri Medicaid program will have an adverse impact on Missouri hospitals.

Response: The intent of this provision is to create greater network adequacy for MHD covered participants by increasing provider participation with the managed care health plans. The rates assume more providers will contract with the health plans, and reimbursement levels for participating providers will be largely consistent with current managed care contracting. The majority of services are currently provided through participating providers.

Other states currently have policies in place regarding non-participating hospital providers. Please see the document titled Attachment A: Examples of States Managed Care Non-Participating Hospital Reimbursement, on page 8 of this notice.

Any policy or reimbursement change in managed care is reviewed by the state's actuary to assess the fiscal impact of the change on the rates paid to contracted health plans and to the state's budget. The rates must be certified by the state's actuary as being actuarially sound.

Comment: A commenter suggested the state examine the health plans' practices to determine factors that contribute to any concerns about excess costs.

Response: MHD appreciates the comment and actively reviews both managed care plans and Fee-for-Service providers for any quality or access concerns regarding the Medicaid program.

Comment: Several commenters expressed concern that MHD does not intend to adjust payments to the managed care plans. Commenters stated the amendment will reduce the health plans' expenses, therefore providing financial reward to the plans while providing no reward to the taxpayers or to general revenue. One commenter expressed this amendment serves neither the noble mission of serving our neediest citizens nor the reputation of MHD as a public servant. Commenters expressed this amendment will reduce the health plans' expenses and maintain their revenues, causing them to be financially rewarded without improving health care outcomes or access to services for Medicaid participants. Commenters urged MHD to reconsider this amendment in light of participants in need of care.

Response: Any policy or reimbursement change in managed care is reviewed by the state's actuary to assess the fiscal impact of the change on the rates paid to the contracted health plans and to the state's budget. The rates are adjusted annually based on actuarial principles and are certified as actuarially sound.

Comment: Several commenters expressed MHD's expectation that reimbursement levels for participating providers will be largely consistent with managed care contracting is inaccurate, particularly for rural hospitals, because rural hospitals have little contracting leverage when dealing with managed care plans, and generally are forced to accept whatever rate is offered. Commenters expressed rural hospitals in particular are suffering from Medicare and Medicaid cuts, to include four rural Missouri hospitals which have closed in the past four years, and a number of hospitals that are incurring significant operating losses and are in danger of closing.

Response: MHD appreciates the comment and will continue to monitor rates through the state's actuary to assess the fiscal impact of the change on the rates paid to contracted health plans and fiscal impact to the state's budget.

Comment: A commenter requested explanation regarding what problem MHD is trying to solve. The commenter is unaware of any supporting evidence that suggests health plans are having difficulty

contracting with Missouri providers. The commenter inquired whether there is network adequacy or other issues of concern.

Response: The intent of this provision is to create greater network adequacy for MHD covered participants by increasing provider participation with the managed care health plans. The rates assume more providers will contract with the health plans, and reimbursement levels for participating providers will be largely consistent with current managed care contracting. The majority of services are currently provided through participating providers.

Comment: A commenter expressed this contract change is not consistent with federal regulations governing Medicaid managed care contracting, and that this will result in legal and financial risks to the program.

Response: The MHD complies with federal and state regulations per state actuarial certification.

Comment: Several commenters expressed the reduction of reimbursement for non-participating providers will result in a reduction to hospitals. One commenter stated this reduction will result in a decrease in reimbursement of slightly over \$1 million, and they will not be able to sustain operations, since there are other reductions proposed by MO HealthNet and by Medicare. Commenters expressed that the change will reduce reimbursements from plans below the rates MO HealthNet pays for comparable services, when hospitals incur additional costs treating managed care patients. These costs relate to additional requirements for preauthorization or other efforts to ensure the services will be covered, while the billing and collection process is also more difficult than for traditional MO HealthNet services. The commenters expressed that current Fee-for-Service rates do not adequately compensate the cost of providing patient care, so adding this reduction is a cause for concern with no improvement to efficiency, quality of care, access, or State savings.

Response: Managed Care rates are adjusted at least annually based on actuarial principles and are certified as actuarially sound to the Centers for Medicare and Medicaid Services. MHD is working with stakeholder groups to determine opportunities to reduce administrative burden concerns in the managed care process.

Comment: A commenter inquired if the physicians providing emergency services at Missouri hospitals are covered under this policy.

Response: The contract amendment did not impact emergency services. Emergency services are covered under 2.6.12a of the contract.

Comment: Several provider commenters requested that MHD allow for mandatory administrative review by a neutral third party before the health plans are allowed to reduce payments.

Response: MHD appreciates the comment. MHD contracts with a third party actuary. All policy or reimbursement changes in managed care are reviewed to assess the fiscal impact of the change on the rates paid to contracted health plans and to the state's budget. The rates must be certified by the state's actuary as being actuarially sound. Managed Care plans notify MHD of changes to their policies

prior to implementing to ensure they are in compliance with their contract with MHD. This notification allows MHD time to share with the actuary.

Comment: Several commenters expressed concern that MHD did not consider extra costs of contracting with the health plans, and that hospitals incur additional costs to serve Medicaid Managed Care enrollees. Additional costs may be attributed to the Prior Authorization (PA) processes, and denied claims for care already delivered. The commenters expressed that compelling hospitals to accept a 90% of the Fee-For-Service rate prevents the market from working to determine a fair price for care delivered through the managed care plans.

Response: All policy or reimbursement changes in managed care are reviewed by the state's actuary to assess the fiscal impact of the change on the rates paid to contracted health plans and to the state's budget. The rates must be certified by the state's actuary as being actuarially sound. MHD is working with stakeholder groups to determine opportunities to reduce administrative burden concerns in the managed care process.

Comment: Several commenters expressed concern that if the health plans do not like current contracted rates, they will arbitrarily demand a rate reduction, and if the provider does not agree, the plan will terminate the agreement and thus force the artificial payment floor to be triggered. Another concern expressed is that the health plans might implement payment policy changes and/or administrative process changes that have the effect of lowering reimbursement or increasing administrative burden. A commenter expressed that one health plan threatened a provider to either accept the lower rates or face termination and payment of 90% of the fee schedule. The commenters requested that the rate methodology be updated and that reductions from 100% are insulting to the hospital provider community.

Response: MHD appreciates the comment. MHD will continue to work with the actuary to update rates based on actuarially sound principles.

Requested Exemptions

Comment: Several commenters requested that that Safety Net Hospitals be granted the same hold harmless as the Local Public Health Agency and Specialty Pediatric Hospital Services groups. Many providers requested that MHD exempt services provided by nominal charge safety net hospitals in addition to the exemption allowed for specialty pediatrics and Local Public Health Agencies, as this will be necessary to be able to continue to provide services. The commenters expressed that reducing rates to safety-net health care institutions' patients will cause additional barriers and limitations to accessing care.

Response: MHD appreciates the comment but is not considering any additional individual exemptions. MHD and Managed Care plans continually monitor for adequate access and have an infrastructure established. The plans are certified yearly by the Department of Insurance, Financial Institutions and Professional Registration.

Comment: Several commenters requested that rural hospitals be exempt from these provisions, as they have little contracting leverage, feel they suffer significant cuts, and some facilities are closing, negatively impacting access to care.

Response: MHD appreciates the comment but is not considering any additional exemptions for individual providers. MHD and Managed Care plans continually monitor for adequate access and have an infrastructure established. The plans are certified yearly by the Department of Insurance, Financial Institutions and Professional Registration.

Comment: Some commenters requested exemptions for provider agreements after June 19, 2018, as a result of the 90% reimbursement and for provider agreements that were terminated or not renewed after June 19, 2018, as a result of the 90%.

Response: MHD appreciates the comment but is not considering any exemptions for individual providers. MHD and Managed Care plans continually monitor for adequate access and have an infrastructure established. The plans are certified yearly by the Department of Insurance, Financial Institutions and Professional Registration.

Federal Reimbursement Allowance (FRA) Comments

Comment: Several commenters requested that MHD conduct a required analysis on the FRA, expressing that the rate reduction does have an impact on the FRA and a substantial impact on hospital reimbursement under the Medicaid Managed Care program, and requested that the MHD present its analysis on the FRA to the General Assembly and the hospitals before the amendment is executed.

Response: MHD did prorate adjustments for the Federal Reimbursement Allowance (FRA) portion of outpatient reimbursement changes for purposes of setting the SFY 19 FRA tax rate. The MHD will continue to take this into consideration for future years as well.

Network Adequacy and Access to Care Comments

Comments: Several commenters expressed concern that by reducing Medicaid rates, the safety-net health care institutions will receive the low-income patients, and will face additional barriers and limitations to accessing the medical care they need to maintain healthy and productive lives in their communities. The commenters expressed making such reimbursement cuts is a reduction in their ability to continue to provide service to those most in need in our communities.

Response: The Managed Care plans continually monitor for access and have infrastructure(s) established to monitor for access. The rates assume more providers will contract with the health plans and reimbursement levels for participating providers will be largely consistent with current managed care contracting. The rates are adjusted annually based on actuarial principles and are certified as actuarially sound. MHD works with an independent actuary to assist with review of financial data and cost reviews. MHD reviews programs across the national landscape and locally with all payers and determines policies and rate setting based on all factors.

Comment: A commenter inquired about how this change ensures efficiency, economy, quality of care, and access.

Response: This provision's intent is to increase provider participation in managed care and allow for greater network access for Medicaid participants. The health plans and providers may still negotiate reimbursement arrangements under managed care. The rates assume more providers will contract with the health plans and reimbursement levels for participating providers will be largely consistent with current managed care contracting. The majority of services are provided through participating providers. Other states currently have policies in place regarding non-participating providers; please see the attachment, "Examples of States Managed Care Non-Participating Hospital Reimbursement," on page 8 of this notice.

Comment: A commenter expressed concern for patient safety, suggesting the proposed reimbursement methodology results in a decrease in revenue for hospitals, especially small rural hospitals, and the likely outcome will be a reduction in money to fund ongoing or planned patient safety initiatives. The commenter further expressed that as financial resources are stretched thinner, fewer resources become available for patient safety initiatives and staff expenditures, which include training and updating staff regarding patient safety recommendations. The cuts in these areas directly affect the quality of health care available to the residents of this state. The commenter requested that the state reconsider the proposed amendment to the managed care contracts, as they can adversely impact quality and availability of health care for Missouri residents.

Response: The intent of this provision is to increase provider participation in managed care and allow for greater network access for Medicaid participants. The health plans and providers may still negotiate reimbursement arrangements under managed care. The rates assume more providers will contract with the health plans and reimbursement levels for participating providers will be largely consistent with current managed care contracting. The majority of services are provided through participating providers. Other states currently have policies in place regarding non-participating providers; please see the attachment, "Examples of States Managed Care Non-Participating Hospital Reimbursement," on page 8 of this notice.

Comment: A commenter expressed mental health services in rural areas are underserved and it is difficult to get providers due to location and poor reimbursement for services. The commenter expressed difficulty in the credentialing process because insurance companies state there are enough providers in an area and then denies access to provider boards. The commenter expressed that a new provider was credentialed with Medicare in less than 30 days and credentialed with Medicaid, too. Then, the provider applied to two health plans in May, 2018 and has yet to be credentialed as of the date of the public hearing. The commenter's concern is that if the reimbursement methodology is changed then the health plans will have even less motivation to credential providers in a timely manner.

Response: MHD appreciates the comment. While this comment is not relevant to this amendment, specific concerns regarding enrollment with the Managed Care plans can be directed to the MHD Managed Care at the email address MHD.MCCommunications@dss.mo.gov.

Comments: Several commenters requested that MHD evaluate the impact of access to hospital care on rural residents before imposing this floor on managed care payments.

Response: The Managed Care plans continually monitor for adequate access and have an infrastructure(s) established. The plans are certified yearly by the Department of Insurance, Financial Institutions and Professional Registration. The rates assume more providers will contract with the health plans and reimbursement levels for participating providers will be largely consistent with current managed care contracting. The rates are adjusted annually based on actuarial principles and are certified as actuarially sound.

Comment: Several commenters expressed that by making the non-contracted rate lower than the Fee-For-Service payment, this proposal unintentionally incentivizes the managed care plans to contract with the smallest number of providers required for network adequacy tests. A commenter expressed that in order for the Medicaid program to be strong; it has to provide access to the citizens of our state who rely on these important Medicaid benefits. The same commenter stated regardless of what formal network adequacy tests show, there is not sufficient access for Medicaid beneficiaries unless all providers are able to participate.

Response: The Managed Care plans continually monitor for adequate access and have an infrastructure established. The plans are certified yearly by the Department of Insurance, Financial Institutions and Professional Registration.

Attachment A: Examples of States Managed Care Non-Participating Hospital Reimbursement

Arizona:	Reimburse non-participating providers for emergency services at the fee-for-service rate
Florida:	State law restricts Medicaid managed care plans from paying providers more than 120% of Medicaid rates
Georgia:	After three attempts to negotiate with providers, the health plan could reimburse non-participating providers at 90% of the Medicaid fee schedule
Indiana:	Non-participating hospitals receive 2% less than the fee schedule rate
Iowa:	Non-participating providers are paid at 80% of the fee schedule
Kansas:	Non-participating hospitals can be paid as little as 90% of the fee-for-service rate
Kentucky:	Payment to non-participating providers is capped at 100% of the Medicaid fee schedule
Louisiana:	Reimburse emergency and post-stabilization services provided by non-participating providers at 100% of the fee schedule
Michigan:	Out of network hospital claims must be paid at the established Medicaid rate in effect on the date of service
New Jersey:	Pay non-participating hospitals at 90% of the Medicaid fee-for-service rate
New Mexico:	Payments to non-participating providers limited to 95% of the fee schedule, except I/T/Us, Federal Qualified Health Centers/Rural Health Clinics, family planning providers and emergency providers
Oregon:	Multiple provisions dependent upon what type of hospital it is, varies from 100% to 64% of the Medicare rate
Pennsylvania:	Provide funding within MCO rates and allow MCO to negotiate with providers
Tennessee:	Payments to non-participating providers cannot be less than 80% of the reimbursement rate for a contracted provider
Texas:	Varies from 95% to 100%, dependent upon regulation
Virginia:	Payment must follow the Medicaid fee schedule
West Virginia:	Non-participating hospitals are paid at 80% of the rate