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Summary of Public Comments Regarding the Department of Social Services Access Monitoring Review Plan and Public Hearing for Outpatient Hospital Services Reimbursement Methodology

August 28, 2018

Pursuant to Sections 1902(a) 13(A) of the Social Security Act, 42 Code of Federal Regulations (CFR) 447.205, and Section 11.730 of House Bill No. 2011, 99th General Assembly, Second Regular Session, mandate that proposed changes in statewide Medicaid payment methods and standards affecting hospital services be published and made available for review, comment, and public hearing. The Missouri Department of Social Services (DSS) and the MO HealthNet Division (MHD) received public comments from providers, hospital associations, Managed Care Organizations, and MO HealthNet participants.

Fiscal Impact Comments

COMMENT #1: Brian Kinkade, Vice President of Children's Health and Medicaid Advocacy, with Missouri Hospital Association (MHA), requests the MHD provide clear fiscal estimates referencing the differences in the fiscal estimates shown in the fiscal note accompanying the proposed amendment to 13 CSR 70-15.160, and the MHD public hearing notice. The public notice showed the proposed outpatient cuts as an estimated savings to be $66.5 million annually for the changes in certain outpatient procedures (i.e. bariatric and lumbar/spinal procedures), outpatient radiology procedures and telehealth originating fees, and references the outpatient pharmacy reimbursement is also changing. The rule's fiscal note estimated the aggregate cut to hospitals from the change in pharmacy reimbursement to be $35.7 million. The figure is different from the annualized savings estimated for the proposed amendment to the outpatient reimbursement rule. Based on these inconsistencies, affected providers cannot determine whether the projected savings from this action actually are $102.2 million, or whether the 66.5 million figure includes savings from reduced hospital reimbursements, making it impossible to ascertain the impact on operations.

RESPONSE: The MHD has changed the effective date, which changes the fiscal impact. The fiscal impact was derived from repricing historical utilization data. The MHD estimates a total savings of $66.5 million in expenditures as a result of this change.

The outpatient drug reimbursement will be determined by applying the following hierarchy methodology: National Average Drug Acquisition Cost (NADAC); if there is no NADAC, Missouri Maximum Allowed Cost (MAC) price; if there is no NADAC or MAC, Wholesale Acquisition Cost (WAC), or the Usual and Customary (U&C) charge submitted by the provider if it is lower than the chosen price (NADAC, MAC, or WAC). Outpatient drugs reimbursement for 340B providers will be reimbursed at WAC minus 49%. Based on this methodology, hospitals should be able to evaluate the fiscal impact.

To determine the fiscal impact, the MHD selected one (1) month of outpatient drug claims converting the Healthcare Common Procedure Coding System (HCPCS) J-codes units/quantities to National Drug Code (NDC) units/quantities, then repriced the claims using the reimbursement methodology explained above, and analyzed the savings from that month.

COMMENT #2: Brian Kinkade, Vice President of Children's Health and Medicaid Advocacy, with MHA, expresses that the MHD proposed reductions far exceed the total cost reductions adopted by the House and Senate in the FY 19 budget, and further discusses that to ensure a balanced budget, the General Assembly enacted core reductions to Fee-For-Service (FFS) hospital appropriations for the current fiscal year by $28.7 million in total funds, and in so doing, the legislature rejected the executive branch's proposal to reduce hospital payments by $138 million. Therefore, the MHD proposed reductions far exceed the savings needed to balance the budget, but at between $66.5 million and $102.2 million, they effectively override the legislature's budget decisions, and the FY 19 budget crafted by the General Assembly reflects decisions arrived at through public debate, and should be honored as such. Such drastic changes to the Medicaid budget are properly vetted through the legislative process and by those with responsibility for passing the budget.

RESPONSE: The MHD is operating efficiently, effectively, and ensuring adequate access to the Medicaid program. The MHD is aligning reimbursement with Medicare and other payers. The MHD is in compliance with Section 11.730 of House Bill No. 2011, 99th General Assembly, Second Regular Session, by engaging stakeholders through a public hearing and determining the Federal Reimbursement Allowance (FRA) for the suggested changes in the payment methodology for Medicaid hospital services for fiscal year 2019. The MHD in conjunction with the General Assembly ensures transparency in decision making process. When there are changes effecting hospitals, there will be adequate and ample notification to affected parties, especially hospitals.

COMMENT #3: Brian Kinkade, Vice President of Children's Health and Medicaid Advocacy, with MHA, expresses that the MHD's changes in outpatient reimbursement will impact the Federal Reimbursement Allowance (FRA)**.** In June 2018, the MHA staff worked with the MHD staff to establish the correct assessment percentage in the FRA schedule for SFY 2019 based on an annualized savings estimate of $53.7 million in the fiscal note of the proposed amendment to the outpatient reimbursement rule. The MHD public hearing notice reports estimated savings to be at least $66.5 million annually, and suggests there may be a change in the outpatient drug reimbursement methodology as well. Because this amount is different from the annualized savings estimate, the assessment on hospitals likely is overstated. The commenter expressed that there are negative consequences of MHD's rate cutting actions on the FRA, given the FRA is far and away the most successful General Revenue (GR)-saving, federal-revenue maximizing funding strategy the state of Missouri has ever, or will ever implement.

RESPONSE: The MHD did prorate adjustments for the FRA portion of outpatient reimbursement changes for purposes of setting the SFY 19 FRA tax rate. The MHD will take this into consideration for future years as well. The MHD has changed the effective date, which changes the fiscal impact. The fiscal impact was derived from repricing historical utilization data. The MHD estimates a total savings of $66.5 million in expenditures as a result of this change.

Outpatient Drug Comments

COMMENT #4: Brian Kinkade, Vice President of Children's Health and Medicaid Advocacy, with MHA, expresses that the MHD's recommended cuts to 340B pharmacy reimbursement are repugnant to the fundamental philosophy of the 340B program. Congress passed the 340B program to help stretch the scarce resources of health care providers that care for large numbers of low-income and uninsured patients by allowing them to purchase drugs at reduced cost. Those savings are used to enhance existing or fund new services for those individuals who most need financial assistance to access necessary care. Ultimately, cuts to the 340B program will cost the MHD money, as Medicaid beneficiaries either seek replacement services through the Medicaid program or suffer diminished health status and require more care. The very essence of the 340B program is undermined if the state usurps the savings that are intended to shore-up the health care safety net.

RESPONSE: The MHD Medicaid FFS payments comply with the access standards in Section 1902(1) (30) (A) of the Social Security Act and ensures efficiency, economy, quality of care, and access. The MHD continually monitors for access and has an infrastructure established to monitor for access. The participant data is closely monitored to assess the number of participants in each category of assistance. The MHD continually monitors the provider enrollment data to demonstrate the number of providers available in each county.

COMMENT# 5: Tim Wolters, Director of Reimbursement, with Citizens Memorial Hospital (CMH); and Katie Hodges, Payer Analysis, Medicaid Team Lead, with Parallon Business Performance Group, requests clarification how to perform calculations for the applicable drugs and requests the MHD to publish the fee schedule listing the final fee payments and the WAC sources for all the WAC prices and publish the comprehensive list for all of those.

RESPONSE: The outpatient drug reimbursement will be determined by applying the following hierarchy methodology: National Average Drug Acquisition Cost (NADAC); if there is no NADAC, Missouri Maximum Allowed Cost (MAC) price; if there is no NADAC or MAC, Wholesale Acquisition Cost (WAC), or the Usual and Customary (U&C) charge submitted by the provider if it is lower than the chosen price (NADAC, MAC, or WAC). Outpatient drugs reimbursement for 340B providers will be reimbursed at WAC minus 49%. Based on this methodology, hospitals should be able to evaluate the fiscal impact.

The MHD does not publish a retail pharmacy fee schedule. The NADAC is published on the CMS website available at https://data.medicaid.gov/Drug-Pricing-and-Payment/NADAC-National-Average-Drug-Acquisition-Cost-/a4y5-998d. The MAC is published on the MHD website available at https://dss.mo.gov/mhd/cs/pharmacy/pages/mac.htm. The WAC is available from the hospital's wholesaler or distributor.

Comment #6: Pat Dillon, VP Advocacy and Government Relations, with Mosaic Life Care, express that the MHD's reimbursement proposed change will force Mosaic Life Care to "carve out" their physician administered drug claims for Missouri Medicaid. Mosaic Life Care participates in the 340B Drug Discount Program as a Sole Community Hospital and Northwest Medical Center participates as a Critical Access Hospital. Both entities are subject to the Orphan Drug Exclusion outlined in the Affordable Care Act. The majority of high dollar specialty drugs is designated as Orphan Drugs and is exempt from the 340B pricing. This results in Mosaic Life Care purchasing the drugs at WAC, because the drug manufacturers do not offer discounts on these drugs. The commenter express that the reimbursement as a percentage of charges to offset any loss of discount on these drugs currently received will go away with the proposed reduction to WAC – 49%, and will no longer be able to capture

savings under the proposal from their other non-Orphan 340B drugs. The result is our most vulnerable patients will suffer and costs for the MHD will increase through replacement services. Studies have shown that 340B drug prices are lower than manufacturer rebates, so we propose that a shared savings arrangement between the MHD and 340B entities would be a better solution than an across the board percentage off of WAC.

RESPONSE: The MHD Medicaid FFS payments comply with the access standards in Section 1902(1) (30) (A) of the Social Security Act and ensures efficiency, economy, quality of care, and access. The MHD continually monitors for access and has an infrastructure established to monitor for access. The participant data is closely monitored to assess the number of participants in each category of assistance. The MHD continually monitors the provider enrollment data to demonstrate the number of providers available in each county. The 340B entities have the option of carving in or carving out for Medicaid.

COMMENT #7: Paula Littleton, Director Budget and Reimbursement, with University of Missouri Health Care, requests that the MHD reconsider the outpatient drug reimbursement proposal of WAC minus 49% and that this is a drastic cut that does not benefit Missouri facilities and patients. Please consider pending this for further review and analysis to ensure patients and hospitals are not put at risk. More options need to be vetted; WAC minus 49% is too drastic.

RESPONSE: The MHD Medicaid FFS payments comply with the access standards in Section 1902(1) (30) (A) of the Social Security Act and ensures efficiency, economy, quality of care, and access. The MHD continually monitors for access and has an infrastructure established to monitor for access. The participant data is closely monitored to assess the number of participants in each category of assistance. The MHD continually monitors the provider enrollment data to demonstrate the number of providers available in each county. The 340B entities have the option of carving in or carving out for Medicaid.

Radiology Comments

COMMENT #8: Brian Kinkade, Vice President of Children's Health and Medicaid Advocacy, with MHA, expresses that the MHD's proposed reduction in radiology reimbursement disregards hospitals' costs to provide the service. The MHD's radiology rate is based on the Medicare physician fee schedule, and this fee schedule reflects the cost of service delivered in a clinic or office setting, and not in a hospital setting. If the Medicare fee schedule sets a fair reimbursement for radiology services delivered in physicians' offices, the same rate paid to a hospital will fall short of the hospital's cost to deliver the service, and setting the reimbursement rate at 90 percent of the Medicare rate exacerbates the disparity.

RESPONSE: Effective January 1, 2019, the MHD will reduce reimbursement rates for the technical component of the hospitals providing radiology procedures from 125% of the Medicare rate to 90% of the most current Medicare allowable radiology rate. The rate change only affects hospitals billing the technical component for radiology services and does not affect the physician or professional component reimbursement. The hospitals radiology reimbursement will be updated annually to reflect the most current 90% of the Medicare allowable radiology rates.

COMMENT #9: Paula Littleton, Director Budget and Reimbursement, with University of Missouri Health Care, The payment reduction to hospitals from 125% of the Medicare allowed amount to 90% of the

Medicare allowed amount is a concern for University of Missouri Health Care in regards to the Outpatient Radiology services. The reduction jeopardizes hospitals across the State with their ability to serve patients cost effectively; risking patients access to adequate care. Medicare rates are calculated to cover costs, reducing rates to 90% does not cover costs.

RESPONSE: Effective January 1, 2019, the MHD will reduce reimbursement rates for the technical component of the hospitals providing radiology procedures from 125% of the Medicare rate to 90% of the most current Medicare allowable radiology rate. The rate change only affects hospitals billing the technical component for radiology services and does not affect the physician or professional component reimbursement. The hospitals radiology reimbursement will be updated annually to reflect the most current 90% of the Medicare allowable radiology rates.

Managed Care Comments

COMMENT #10: Brian Kinkade, Vice President of Children's Health and Medicaid Advocacy, with MHA, requests that the MHD account for the changes in the managed care program that proceed from its change in FFS reimbursement. As a rule, Medicaid managed care plans base their FFS outpatient reimbursement on the MHD's fee schedules or reimbursement policies. When the MHD cuts outpatient radiology reimbursement, most hospitals will receive a commensurate reduction under their managed care provider agreements as well. By failing to account for this fact, the MHD's savings estimates significantly are under reported.

RESPONSE: The Managed Care Organizations are not required to follow the FFS reimbursement structure or levels for these services and have flexibility in contracting. The MHD works with an independent actuary to assist with review of financial data and cost reviews. The MHD reviews programs across the national landscape and locally with all payers and determines policies and rate setting based on all factors.

Outpatient Hospital Comments

COMMENT #11: Jennifer Keith, Manager Financial Analysis, with SLUCare Physician Group, requests clarification regarding if the outpatient hospital services reimbursement applies to all provider types or specifically just hospitals, describing their agency as a large physician practice which does bill at the outpatient hospital setting, and are trying to determine if this applies them.

RESPONSE: These changes only apply to outpatient hospitals services.

COMMENT #12: David Waldman, Doctor, with Patient First in Leawood Kansas; and Phillip Harness, CEO of Doctors Hospitals, LLC, requests clarification as to whether the proposed amendment affects the current reimbursement methodology for out-of-state hospitals set forth in 13 CSR 70-15.190.

RESPONSE: The outpatient hospital services reimbursement methodology does apply to out-of-state hospitals. 13 CSR 70-1.190 defines out-of-state hospitals and accordingly it also subjects out-of-state hospitals to the outpatient reimbursement rate computation as calculated for Missouri hospitals at 13 CSR 70-15.160.

COMMENT #13: Russ Oppenborn, Sr. Director State Regulatory Affairs, with Missouri Care, requests confirmation that the 50 outpatient procedures are claim level payments and not line level.

RESPONSE: The outpatient claims reimburse at the line level for each code; therefore, the 50 procedures will be reimbursed on the line level of the claim, and the rate for each procedure code includes facility and supply charges.

COMMENT # 14: Paula Littleton, Director Budget and Reimbursement, with University of Missouri Health Care, expresses that moving outpatient surgical procedure codes to a fee schedule amount to reduce the out of state reimbursement is reasonable. However, the surgical procedure transition needs to be timely vetted for impact to Missouri hospitals. The codes on the list should not be a moving target, subject to change within a moment's notice with an approach of impending change(s) at any given time throughout the year.

RESPONSE: Effective January 1, 2019, the MHD will update certain outpatient surgical procedures to be reimbursed on a fee schedule instead of a percentage of the agency's billed charges. The MHD in conjunction with the General Assembly ensures transparency in the decision making process. When there are changes effecting hospitals, there will be adequate notification to affected parties, including hospitals.

Access Comments

COMMENT #15: Tim Walters, Director of Reimbursement, with CMH, requests that the MHD reconsider the level of cuts because rural areas cannot survive with these kinds of cuts, with the Medicare cuts and lack of Medicaid expansion and the level of cuts are just too extreme right now; the rural hospitals cannot make up for the magnitude of cuts, and that the hospitals do not have enough commercial volume to make up for the magnitude of cuts like this.

RESPONSE: The MHD is operating efficiently, effectively, and ensuring adequate access to the Medicaid program. The MHD is aligning reimbursement with Medicare and other payers. The MHD continually monitors for access and has an infrastructure established to monitor for access. The participant data is closely monitored to assess the number of participants in each category of assistance. The MHD continually monitors the provider enrollment data to demonstrate the number of providers available in each county.

COMMENT #16: Many participant commenters request that the MHD do not pass the proposed reductions in reimbursement. The commenters are concerned about the payment reductions and how that will affect their health care and expresses that it has been difficult or impossible to find providers, including hospitals that accept MO HealthNet. The commenters express that they were told that the costs associated with health care supplies, salaries, and general overhead are rising and are concerned that the facilities where they receive care will no longer be able to care for them.

RESPONSE: MO HealthNet participants should contact the Participant Services Unit at 1-800-392-2161 for assistance. The Participant Services Unit will help the participant in locating a provider in their area to provide care of covered services. The participant may also go to the Participant Services website at https://dss.mo.gov/mhd/participants/fee-for-service/, to Find Provider who accepts MO HealthNet.

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has an infrastructure established to monitor for access. The participant data is closely monitored to assess the number of participants in each category of assistance. The MHD continually monitors the provider enrollment data to demonstrate the number of providers available in each county.