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Summary of Public Comments Regarding Outpatient Hospital Services Reimbursement Methodology

July 22, 2021

The Department of Social Services (DSS) and the MO HealthNet Division (MHD) received public comments from Missouri Hospital Association, Truman Medical Centers, and BJC HealthCare.

Implementation Date Comments

COMMENT #1: Sara Terrace, Vice President of BJC HealthCare, commented that the proposed change to billing protocols, while based on the familiar Medicare APC billing policies, will require significant lead-time for hospitals to implement effectively. For example, BJC just recently completed automating changes to outpatient surgery billing protocols initiated in 2019. We were manually billing these claims until just recently, a delay driven in part by the inconsistent application of the protocols by the Agency's contracted Managed Care Organizations ("MCOs") whose beneficiaries comprise the majority of BJC-member hospitals' MHN-covered patient populations.

Given the highly speculative fiscal impact to all concerned parties, particularly hospitals, and the significant effort required for hospitals to successfully transition to OSFS-based billing, we believe it necessary for the Agency to delay implementation of the OSFS to January 2022 at the earliest. The state should also consider a varied role out of the policy, perhaps on a regional basis, to determine whether/how it will work in practice before implementing statewide. Both approaches would grant all concerned parties the time necessary to understand, plan for, and adapt to OSFS-based billing and payment for outpatient hospital services.

RESPONSE: MHD appreciates Ms. Terrace's comment on the proposed State Plan Amendment (SPA). MHD engaged with its stakeholders regarding this proposed SPA for a minimum of two years. The proposed SPA will align billing protocols with Medicare and commercial insurance billing requirements, which will greatly improve billing practices of the impacted hospitals.

COMMENT #2: Brian Kinkade, Vice President of Children's Health and Medicaid Advocacy, with Missouri Hospital Association (MHA) commented that the July 1 effective date is flawed. The proposed plan amendment is to be effective July 1, 2021. This date is illogical given the 90-day time frame CMS is afforded for the review and approval of proposed state plan amendments. The earliest the state can presume CMS's approval would be early August, and even this date would not allow CMS questions or consideration for the rulemaking DSS is legally obliged to conduct to effectuate the proposed changes.

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The effective date of the state plan amendment must account for DSS's legal obligation to promulgate regulations. A July 1 effective date allows no time for DSS to conduct the rulemaking that would be required to put the change in reimbursement methodology into effect. It is imperative that the state at least try to orchestrate the effective date of the plan amendment with the promulgation of rules necessary to enforce it. Short-circuiting the rulemaking process puts the state at risk for having Medicaid plan requirements that are unenforceable under state law.

Further, the rulemaking process allows time for hospitals to modify automated systems, revise policies, and conduct training needed for them to have a reasonable expectation of compliance. Although the state will rightly claim discussion about the conversion to a Medicare-based outpatient fee schedule has been underway for some time, the fact is specific administrative actions to comply with the new policy cannot be undertaken until the details of the new methodology have been set and approved by MO HealthNet. There is a long-established state process for changing state regulatory policies. DSS should plan on an effective date that is consistent with rulemaking that begins once CMS's approval is received.

RESPONSE: MHD appreciates Mr. Kinkade's comment on the proposed State Plan Amendment (SPA). MHD has been working with the Centers for Medicare & Medicaid Services (CMS) on this State Plan Amendment since February 2020. 42 CFR 447.256 allows SPAs to be approved and effective the first day of the calendar quarter in which an amendment is approved. That process allows MHD to submit an approvable SPA as late as September 30, 2021 to CMS for a July 1, 2021 effective date. Even if MHD waited until the SPA was approved to file the regulation, the regulation process requires 6-8 months until it is promulgated. MHA's comment suggests that every SPA would be approved 6-8 months prior to regulation promulgation, which would create an inefficiency. MHD's current process allows for the SPA and the regulation effective dates to be simultaneous.

Fiscal Impact Comments

COMMENT #1: Sara Terrace, Vice President of BJC HealthCare, commented that the Agency estimates a total savings to MHD (and a cost to hospitals) of somewhere between \$28.1 Million and \$70 Million in State Fiscal Year 2022 ("SFY22"). This savings is generated by:

- Shifting the payment mechanism from individual charges for procedures to the All-Payer Classification ("APC") methodology deployed by Medicare, which "packages" multiple services into a single procedure code for payment at an amount less than would be paid for each component service charged individually;
- Pegging the rates paid for each APC to the Missouri-specific Medicare rate, reduced by ten percent (i.e. "90% of Medicare").

This overall approach makes intuitive sense as a both a cost-control and administrative endeavor, and nearly every hospital should be familiar with APC-based payment given its ubiquity in Medicare. But the wide range of estimated impact suggests that the state does not fully understand the implications of its own preferred policy and, candidly, neither do we. The Agency has graciously provided both data and guidance to help us understand their own work and thereby enable us to more accurately forecast the impact on BJC-member hospitals. But there are simply too many unknowns to accurately predict outcomes with the degree of certainty that both hospitals and state agencies should demand of major shifts in public policy.

While the MCOs may be expected to "follow the state plan," our experience shows they only do so when it directly serves their financial interests. In that regard, it is almost certain that OSFS-realized savings will drive MCO interest in renegotiating relevant aspects of their agreements with BJC and other providers, in order to capture an equivalent savings for themselves. This only adds to the uncertainty the OSFS already carries with it; financial losses for hospitals being the only guaranteed effect.

RESPONSE: The reason for the range in estimated impact is because MHD has been working on the OSFS since 2018. The first modeling was performed in 2019, which used 2018 claims data and utilization, which reflected the \$70 million impact. The more recent modeling was performed using Fiscal Year (FY) 2020 claims data and utilization which estimated a reduction in payment of \$28 million.

COMMENT #2: Brian Kinkade, Vice President of Children’s Health and Medicaid Advocacy, with Missouri Hospital Association (MHA) commented that the state’s fiscal impact estimates do not inspire confidence. The department’s estimates of the net reduction in hospital outpatient payments resulting from the proposed fee schedule range from \$28 million to \$70 million. The variance between the department’s low estimate and its high estimate is more than 150%. This remarkably broad range strongly suggests the department has no clear idea how much proposed policy will impact hospitals. Further, more recent (and lower) estimates have been based on dates of service during the height of the government’s initial response to COVID-19 when services were being rationed and patients were hesitant to seek hospital care. Any projection using data from this period should be viewed with suspicion. Last year was so aberrant that it is unclear why the department would even consider using it for forward-looking spending projections.

Finally, MHA questions the veracity of the department’s impact estimates because it steadfastly refuses to consider the downward pressure its fee for service policy change will put on the rates managed care plans will be willing to pay for hospital outpatient services. The department must ensure its managed care rates are sufficient for the plans to provide fair reimbursement for and adequate access to the care their enrollees need. The department, for its convenience, cannot simply ignore the spill-over impact its fee for service policy changes will have on the rates the plans are able or willing to pay, and the impact this will have on the Medicaid safety net in general.

RESPONSE: The reason for the range in estimated impact is because MHD has been working on the OSFS since 2018. The first modeling was performed in 2019, which used 2018 claims data and utilization, which reflected the \$70 million impact. The more recent modeling was performed using Fiscal Year (FY) 2020 claims data and utilization which estimated a reduction in payment of \$28 million. MHD agrees with Mr. Kinkade’s observation that the COVID-19 pandemic affected data and utilization during that timeframe, which is why it is necessary to provide the range.

In reference to Mr. Kinkade’s concern regarding managed care rate sufficiency, MHD’s rates paid to the managed care organizations (MCO) are actuarially sound as approved by CMS. Actuarially sound as defined by CMS means rates are projected to provide for all reasonable, appropriate and attainable costs that are required under the terms of the contract and for the operation of the MCO for the time period and population under the terms of the contract.

Reimbursement Methodology Comments

COMMENT #1: Brian Kinkade, Vice President of Children’s Health and Medicaid Advocacy, with Missouri Hospital Association (MHA) commented that the proposed reimbursement structure is ill-suited for some hospitals. Medicaid is essential to children’s health care. Children’s hospitals are critical to rendering the treatments many Medicaid children need to thrive. The state’s proposed methodology is based on Medicare fee schedules with no accommodation for the safeguards and special payment provisions Medicare employs for children’s hospitals to ensure their payments are fair and adequate. For example, Medicare outpatient reimbursement for children’s hospitals is augmented by “traditional corridor payments” to prevent them from being under-reimbursed. Because MO HealthNet excludes this safeguard of the proposed fee schedule on children’s hospitals, MHA and its children’s hospitals favor an adjustment to their payments similar to that provided to critical access hospitals and nominal charge providers.

The demands of the ongoing COVID-19 pandemic must be considered in the adequacy of the state's reimbursement rates, especially in consideration of the extraordinary actions the federal government has taken to shore up states and their health care providers. MHD's proposed plan amendment would result in tens of millions of dollars being cut from hospital reimbursement. MHA does not oppose the imposition of a fee schedule per se, but respectfully suggests it could be implemented with the less jarring budgetary effect on the hospital industry.

RESPONSE: MHD uses Medicare's Outpatient Prospective Payment System as the basis for the OSFS; it is not adopting Medicare's payment policies. The OSFS will not utilize Medicare's grouping software logic or other calculations to discount or bundle payments, such as conditional packaging, comprehensive APCs or composite APCs. MHD is actively working with the Children's Hospitals to identify and address concerns about costs for the care of children in these hospitals. MHD will also review the claims data for Children's hospitals during the first year of the OSFS and will consider any changes that may need to be made.

COMMENT #2: Charlie Shields, President and Chief Executive Officer, with Truman Medical Centers explained what Truman is, the population Truman serves, and the services Truman provides.

He also expressed that Truman appreciates the department's recognition that a nominal charge provider like TMC/UH requires an additional adjuster to the Outpatient Simplified Fee Schedule (OSFS). However, TMC/UH strongly feels that a safety net provider like TMC/UH should be treated the same as rural critical access hospitals receiving the forty percent (40%) adjuster to OSFS rates instead of the proposed twenty-five percent (25%). As outlined above this is because a) our **Essential** role in Western Missouri's health care delivery, b) the multitude of services we provide in partnership and/or coordination with the state of Missouri, and c) our inability to cross-subsidize commercial/Medicare revenues to supplement inadequate Medicaid payment rates. In essence, TMC/UH is an urban critical access hospital that incurs far more costs, often unreimbursed, than a typical community hospital and must be compensated at a level that allows TMC/UH to continue to care for Western Missouri's most vulnerable patients.

RESPONSE: MHD appreciates Mr. Shield's' comment on the proposed State Plan Amendment (SPA). MHD does not amend the proposed SPA to allow for a 40% adjustment to OSFS rates for nominal charge providers. For some nominal charge providers, a 40% adjustment would result in paying those hospitals more than 100% of cost.