Summary of Public Comments Regarding the

Department of Social Services (DSS) Access Monitoring Review Plan (AMRP)

The Missouri State DSS the MO HealthNet Division (MHD) received public comments from advocacy groups, providers, constituents, and attorneys.

Nursing Facility Comments

Comment: Several Nursing Facility (NF) provider commenters described that due to the NF rate reduction, they are accepting fewer Medicaid residents. Of these comments, it was described that some facilities are rejecting Medicaid admissions, scrutinizing each admission, or accepting any other payer type other than Medicaid. The commenters discussed a decrease in their Medicaid population.

Response: MHD will monitor the occupancy rate changes. Providers have a choice to accept MO HealthNet. NF providers who are enrolled to accept Medicaid, signed and agreed to the Title XIX Participation Agreement for Nursing Home Services. Within those requirements associated with enrolling as a Medicaid provider, the NF agreed to the following:

> If at any time state or federally appropriated funds available to the MHD for payment to the provider for covered services under this agreement are insufficient to pay the full amount due, the provider agrees to accept payments reduced in proportion to the funding deficiency.

Once a Medicaid participant is admitted to the NF, the resident has protections outlined in state and federal regulations that apply to them as a Medicaid participant. If a resident is admitted on Medicare and is not able to return home and Medicaid qualifying, the NF cannot discharge the participant based on payor source, if a Medicaid bed is available. The MHD has included a table showing the number of facilities and occupancy prior to the rate decrease (April-June 2017 quarter) and a table after the rate decrease (October-December 2017).

Comment: Several NF commenters expressed that due to the NF rate reduction they may consider decertifying Medicaid beds or closing an entire or partial wing. Of those comments, one NF provider commenter stated that they have decertified Medicaid beds at their facility. One NF provider commenter expressed concern with revaluating operating in Missouri due to the NF rate reduction.

Response: MHD has not received any information of providers no longer operating in MO. MHD is unaware that a bed decrease occurred due to a rate change. MHD is aware of only one NF that decreased ten Medicaid/Medicare beds out of a total of 120 beds. DHSS' documentation regarding that NF shows that DHSS recommended a Medicare/Medicaid bed

decrease due to renovations at the NF. However, this did not impact the total number of certified beds in which Medicaid participants has access. There has been an increase in certified beds in which Medicaid participants would have access. There has been an increase of additional 305 Dual Certified Medicare/Medicare beds in 2018. There has been one bed decrease in Medicaid Certified beds in 2018. MHD will continue to monitor access.

Comment: Several NF provider commenters discussed loss in revenue since the rate change, expressing several financial challenges.

Response MHD's Medicaid FFS payments comply with the access standards in Section 1902(a) (30) (A) of the Social Security Act and ensures efficiency, economy, quality of care, and access. MHD will continue to monitor access.

Comment: Several NF provider commenters discussed reducing staff, not providing raises, decreasing staff hours, not creating additional jobs, and not filling open positions. These staff reductions and layoffs include direct care staff, nursing staff, bus drivers, maintenance, food prep, activity aids, and other non-administrative staff working in some capacity for the residents. Several NF provider commenters discussed eliminating nurses and decreasing nursing care and discussed the NF's decline in inpatient care hours. Of those comments, the difficulty in recruiting and maintaining experienced and qualified staff due to the anticipated turn over and financial challenges with the low pay was discussed. Many commenters compared the rates to be lower than that of fast food chains or hospital or other nursing institutions that can pay more for the qualified staff. Some of these commenters expressed that qualified staff were leaving for jobs in fast food and Walmart due to paying higher wages. Several comments expressed how this will potentially impact quality of care.

Response: Under 19 CSR 30-85.042, the NFs shall employ nursing personnel in sufficient numbers and with sufficient qualifications to provide nursing and related services which enable each resident to attain or maintain the highest practicable level of physical, mental and psychological well-being. Additionally, under 19 CSR 30-85.052, NF providers should adhere to the requirements associated with quality of care. MHD encourages NF providers to follow state and federal regulations. MHD has an infrastructure established to monitor for access. MHD will continue to monitor access.

Comment: Several NF provider commenters described their decline inpatient care hours and an increase in the number of Medicaid participants with more complex health issues, and how they are turning away the participants with multiple co-morbidities because the facilities cannot cover the costs.

Response: MHD's Medicaid FFS payments comply with the access standards in Section 1902(a) (30) (A) of the Social Security Act and ensures efficiency, economy, quality of care, and access. Under 19 CSR 30-85.042, the NFs shall employ nursing personnel in sufficient numbers and with sufficient qualifications to provide nursing and related services which enable each resident

to attain or maintain the highest practicable level of physical, mental and psychological well-being. MHD encourages NF providers to follow state and federal regulations. MHD will continue to monitor access.

Comment: Several NF provider commenters discussed the inability to enhance services/products offered, such as monitoring programs, expanding quality oversight, repair improvements, electronic management tools, clinical reference tools, and maintenance projects. Some NF provider commenters discussed not providing the necessary repairs to the facilities, facility equipment, and structural repairs. Some NF provider comments mention they will only repair items related to safety or potential hazards. Some of the NF provider commenters expressed safety concerns that they would not make necessary structural and equipment repairs, such as to the failing roofs, failing broilers, backup generators, parking lot potholes and cracks, transportation vehicles, and etc.

Response: Under 19 CSR 30-85.012, 85.022, and 85.032, NFs must adhere to the construction standards, fire safety and emergency preparedness, and physical plan requirements. MHD encourages NF providers to follow the state and federal regulations. MHD will continue to monitor access.

Comment: Some NF provider commenters discussed reducing food choices and dietary needs, housekeeping, laundry, activities, transportation, off-site outings and activities, and plant operations.

Response: Under 19 CSR 30-85.052, NF must follow the dietary requirements, activities and plan operations. NF providers have options in what choices are offered as long as they adhere to state and federal regulations. MHD encourages NFs to be more interactive and collaborative with community organizations and to access community based services to assist with on-site and off-site activities that would not result in additional costs to the NF providers. MHD will continue to monitor access.

Comment: Several NF provider commenters discussed the hardship from the increased CMS regulation.

Response: At this time, please direct any concerns regarding CMS' requirements to CMS.

Comment: Some NF provider commenters and non-provider commenters discussed the difficulty persons will have finding NF providers within a reasonable distance of their homes who are accepting Medicaid patients, especially in rural parts of the state if NFs were to close as a result of the rate reduction. Some commenters expressed concern on the hardships families will experience to travel to further NFs, since NFs are turning away Medicaid residents.

Response: MHD is unaware of a significant decrease in the number of Medicaid beds available. However, MHD will continue to monitor access. As shown in the draft AMRP on page 53, the distance standards remain adequate.

Comment: Several NF provider commenters and non-provider commenters discussed that the rates are not covering the cost of care for Medicaid residents. Of those comments, it was discussed that for State Fiscal Year (SFY) 2016 the Medicaid shortfall for SFY is $15.86 per patient and projecting that the 2018 projected difference is $24.55. Of those comments, a commenter expressed concern that the Missouri Medicaid Rates have not kept up with inflation or the CMS Market Basket Index for skilled nursing facilities and that the rate has only increased by 0.06% for the four year period of 2016-2019, excluding the July 1, 2015, $1.29 NFRA add-on as an actual net rate increase.

Response: MHD is charged with the administration of the RSMO 208.159 Title XIX Medicaid program including the development of reasonable rates. MHD has determined the reasonable reimbursement rates in accordance with the NF regulation 13 CSR 70-10.015/016. The reasonableness standard includes facility's cost of providing services as a factor. The Medicaid program is also a voluntary program and agrees to accept the Medicaid reimbursement as payment in full for Medicaid participants. Providers do not have to participate in the Medicaid program if they do not believe they can sustain operations financially.

The MHD updated the NF section in the AMRP to demonstrate a comparison of the average NF private pay and commercial insurance reimbursement rates to the MHD NF rates. The MHD's Medicaid FFS payments comply with the access standards in Section 1902(a) (30) (A) of the Social Security Act and ensures efficiency, economy, quality of care, and access. MHD continually monitors for access and have infrastructure established to monitor for access.

Comment: Some commenters expressed concern that the Medicaid rates were set in 1995 for nursing facilities and have not been rebased since state fiscal year 2005, using 2001, trended data and requesting clarification concerning page 47 of the Draft AMRP, regarding the partial rebase of 2005. A commenter did not agree with the manner in which the rate was calculated questioning the validity of the reimbursement system described in the Draft AMRP, and further expressed that the rate is based on taking money from the nursing facilities and is not based on any cost analysis or utilization criteria.

Response: MHD is charged with the administration of the RSMO 280.159 Title XIX Medicaid program including the development of reasonable rates. MHD has determined the reasonable reimbursement rates in accordance with the NF regulation 13 CSR 70-10.015/016. The reasonableness standard does not require that the reimbursement rates cover a facility's cost of providing service. The Medicaid program is a voluntary program and providers agree to accept the Medicaid reimbursement as payment in full for Medicaid participants. Providers do not have

to participate in the Medicaid program if they do not believe they can sustain operations financially.

Comment: A commenter expressed concern about the table on page 48 stating that the real reason for the rate reduction is to meet the administration's general revenue reduction in the fiscal year 2018 budget.

Response: MHD administers the program within the appropriation granted for the program in a manner that is consistent with efficiency, economy, quality of care, and access.

Comment: A commenter expressed that the division has failed to uniformly apply the plan to existing rates before and after the $5.37 reduction, expressing that the state discriminately includes the Nursing Facility Reimbursement Allowance (NFRA) when setting rates for new facilities but not for older facilities. This violates the State Plan.

Response: MHD sets reimbursement rates in accordance with 13 CSR 70-10.015 and 10.016. The current NFRA is an allowable cost. If the NFRA per patient day changes NF rates are revised to include the revised NFRA in its reimbursement rate.

Comment: A commenter expressed concern that the access calculation for NFs is incorrect because MHD determined access solely on the access of non-occupied beds using the Certificate of Need (CON) data for one calendar end quarter and indicated that MHD should have used Medicare Advisory Payment Commission (MedPAC) criteria. Furthermore, they go on to express that the CON data is unaudited and unverified.

Response: The CON data provides information on the capacity and supply of NF providers in Missouri and is readily available to the MHD from the DHSS. CON data is reviewed for reasonableness by DHSS upon receipt of the data. MHD performs additional reviews and comparisons of the CON data to ensure accuracy. MHD does not use one factor in determining access. The Draft AMRP also includes network access report on page 53.

Comment: A commenter stated that MHD does not reimburse NF for Medicare Part A coinsurance for participants' eligible for Medicare and Medicaid programs, if the resident resides in a Medicare/Medicaid certified bed, and if the stay is eligible for Medicare reimbursement.

Response: As permitted by Federal law, states can limit Medicare cost-sharing payments, under certain circumstances. MHD reprices NF services for Medicare/Medicaid dual eligible participants and the reimbursement is limited to what MHD reimburses. As stated in MHD Provider Bulletin MO HealthNet Reimbursement of Medicare Crossover Claims For Skilled Nursing Facility Benefits accessed from the MHD Provider Bulletin webpage https://dss.mo.gov/mhd/providers/pages/bulletins.htm, or directly from: https://dss.mo.gov/mhd/providers/pdf/bulletin32-36_2010mar17.pdf. If Medicare reimbursed the NF less than what MHD would reimburse, MHD will reimburse the difference up to MHD's

maximum allowable reimbursement. If Medicare reimbursed the NF more than what MHD would reimburse, MHD does not make any additional reimbursements. Therefore, MHD may not reimburse the full coinsurance amount but the NFs can claim that amount as a bad debt on their Medicare cost report.

Utilization Rate Comments for All Programs

Comment: A commenter expressed concern about the utilization rate comparison for all programs in the Draft AMRP discussing that there is no analysis about what this utilization rate change may mean for access and does not indicate beneficiary need to compare to the utilization rate.

Response: Please refer to page 109 of the Draft AMRP showing that a utilization review of FFS participants accessing provider services by county type was demonstrated for Calendar Year (CY) 2015 and CY 2016. This utilization data was based on claims data demonstrating reliable data to determine access to services. This data is based on the claims submitted for reimbursement. This data demonstrates the participants by adult or child in urban, basic, and rural counties for covered services. This data would not reflect services accessed for non-covered services or when providers have not submitted claims to MHD for reimbursement. Please refer to page 50 for utilization of NF. However, MHD is expanding this utilization data to reflect the utilization per category of assistance within the county level for NF. This will demonstrate access based on category of assistance to better understand the utilization rates of the participants. MHD continues to monitor access including analyzing utilization.

Provider Rate Reductions Comments for Other Programs

Comment: One commenter discussed that the reduction to Medicaid Fee-For-Service (FFS) provider rates mandated by the General Assembly in 2017, and the long-term failure of Medicaid provider rates to keep up with rising medical costs mean these problems are likely to worsen.

Response: MHD has an infrastructure established to monitor for access. Please check back for the updated plan with the analysis for services mentioned.

Comment: Commenters discussed that MHD cannot implement the proposed rate reductions announced in July 2017, and that the state must submit a State Plan Amendment (SPA) to CMS prior to implementing any rate reduction. A commenter discussed that the state is required to submit an AMRP with the SPA and receive CMS approval prior to implementation of the provider rate reduction. One commenter discussed that the AMRP is a required component of any SPA that proposes to reduce provider rates. This commenter referenced 42 CFR 447.203(b)(6) stating that it requires any SPA proposing to reduce provider payment rates that could result in diminished access be accompanied by an AMRP completed within the last 12 months for each serviced for which rates are to be reduced. Of those comments, it was discussed that the AMRP failed to address the impact of the recent rate reductions. The plan did

not include 3% rate reductions for the following services and 6% rate reduction for Private Duty Nursing. The reductions to the following services were referenced:

Home Health
Rehabilitation Center
Dental
Audiology
Optical
Physician – I believe I have this information in the plan.
Behavioral Health
Ambulance
IEP Direct Services
Home and Community Based Services
Private Duty Nursing

Response: When required, MHD submitted SPA or amended state regulations to effectuate proposed rate changes. MHD follows state and federal laws. The State also relied on guidance given by CMS on November 16, 2017, issued to State Medicaid Directors.

Comment: One commenter discussed that the rate data in the AMRP is only provided through fiscal year 2017, not mentioning fiscal year 2018 cuts.

Response: MHD provided the applicable rate information as it was available and per CMS guidelines. MHD will monitor for access.

Comment: A provider expressed concern that the recent rate reduction for in home services has severely affected families, children, and hospitals. Of this comment it was discussed that the home care suffered an across the board 3% reduction with private duty nursing suffering with a 6% cut. For children covered under Medicaid this created a significant lack of in home services. As a result, families are being placed on a waiting list and children are remaining in hospitals because adequate in home services are unavailable. This violates the mandate of EPSDT, which requires that medical assistance be furnished with reasonable promptness to all eligible individuals. The commenter is concerned that Missouri citizens are being under served and that the state is violating federal law and exposing itself to litigation.

Response: MHD is in process of updating the Home Health portion of the AMRP, which included in-home services.

Data Comments

Comment: One commenter discussed that the data requirements shown in 42 CFR 447.203 (b) (1) is not met in the AMRP. There is no methodology for the rate-setting process or provider reimbursement process.

Response: Please refer to the Draft AMRP which includes data requirements in accordance with 42 CFR 447.203.

Comment: A commenter discussed that there is not an analysis to private insurance in all the programs of the AMRP and suggested utilizing State of Missouri employee insurance plan as a comparison.

Response: MHD appreciates the suggestion is researching ways in which to compare rates to private health plans. The MHD does not collect reimbursement rates from private health insurance companies. While the Missouri Department of Insurance is responsible for regulating private insurance companies doing business in Missouri, there is not a law that requires private health plans to report or publish their provider reimbursement rates. The MHD does not currently have a resource for private-payer rate data. The MHD will explore options for obtaining commercial payer data. However, the MHD has compared Medicaid rates to specific Medicare rates. The MHD updated the NF section in the AMRP to demonstrate a comparison of the average NF private pay and commercial insurance reimbursement rates to the MHD NF rates.

Physician and Hospital Comments

Comment: One commenter expressed concern that the physician discussion on page 15 may be counting physicians who are only accepting Managed Care patients. Of that comment, it was discussed that Medicaid enrollees may not be able to find private physicians who accept Medicaid, based on the physician participation discussion on page 15.

Response: Please refer to page 7 of the Draft plan, the MHD focuses on the 33% of the FFS population. Additionally, all the FFS Network Adequacy data demonstrates the FFS enrolled providers only. The managed care enrollment data is not indicated on the FFS AMRP. On page 15, "enrolled in MO HealthNet," means enrolled as FFS provider accepting FFS Medicaid participants. The data shown on page 15 represents the providers accepting FFS Medicaid participants. FFS Medicaid participants are able to utilize the MHD Provider Search page on the DSS MHD page accessed from: https://dss.mo.gov/mhd/participants/, found at: https://apps.dss.mo.gov/fmsMedicaidProviderSearch/, to access the contact information for the FFS Medicaid enrolled providers. They may also contact Participant Services at 1-800-392-2161 to assist them with finding a provider for the services in which they need.

Comment: A hospital provider commenter expressed concern that hospitals are struggling to stay open because their rates continually decline every year. Of the comment, it was discussed that hospitals are losing money every week due to the insurance companies only paying a percentage of the bill, patients not paying, and Medicaid refusing to pay or a lower amount, and Medicare paying only 50% of the bill.

Response: MHD continues to monitor for access. MHD sets rates in accordance with efficiency, economy, quality of care, and access.

Ongoing Public Input Comments

Comment: Some commenters expressed concern that there is no system for ongoing public input as required by CFR 447.203(b) (2).

Response: MHD appreciates the comment and as a result has established a webpage for easier access for ongoing public comment. Please refer to the MHD webpage found at: https://dss.mo.gov/mhd/amrp.htm, established for ongoing public comment.

Distance Standards Comments

Comment: Some commenters expressed concern that the distance standards, for all programs within the AMRP, do not provide an actual measure of access, of which a commenter expressed concern for those living in rural areas. Of the comments, it was expressed that the distance standards used does not provide an actual measure of access and that the distance standards do not mean that a provider is available or accepting new patients. Of those comments, it was discussed that there is not an adequate number or Home Health agencies reflected in the Draft AMRP.

Response: There is not a specific distance standard requirement for FFS. For consistency and accuracy, MHD predominately uses the distance standards required by Health Maintenance Organizations (HMOs). Furthermore, 88% of Home Health providers are enrolled with MO HealthNet. The FFS Network Adequacy data starting on page 57 of the Draft AMRP for all programs, and NF which starts on page 54, shows the distance to providers by county. This demonstrates the travel distance for rural, basic, and urban counties. However, Home Health agencies travel to the participants' home to provide services in the home.

Comment: A commenter expressed concern that there is not a comparison to the general population for any specialty or provider type except NFs. The distance standard and 90% baseline might only comply with the system for Missouri managed care plans, but there is no indication that this metric its results are consistent with access available to the general population. The plan does not address if the general population has the same travel distance requirements or deals with the same holes in access. This information could be found by accessing how many providers enrolled in private insurance plans within various specialties and geographic areas. Even in the one area where the plan briefly discusses Medicaid participant access versus general population access (nursing home access), it compares vacant availability of beds in nursing facilities in terms of percentages. This metric does not indicate whether there is actual access but instead indicates there are beds available for a participant somewhere. The percentage does not demonstrate access based on geography or participant locations. In any event, the failure to even attempt such an analysis in areas besides "nursing home" access is highly problematic and a major deficiency in the plan.

Response: As shown on page 5 of the Draft AMRP**,** MHD is pursuing ways in which to compare rates to private health plans. The MHD continually monitors for access and is developing additional infrastructures for comparisons to the general population.

Adequacy and Monitoring Comments

Comment: A commenter expressed that there was no discussion in the AMRP or analysis of adequacy of Medicaid services and only used some comparisons to Medicare and utilization rates but should include discussion of access to specific provider types and beneficiary changes and characteristics and that the decrease in FFS participants and increase in physician-related providers seems to imply that the access must be adequate but does not address actual participation of providers.

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

Comment: A commenter discussed that there are no effort to develop any monitoring procedures for analyzing impact on these cuts in the future, in the AMRP.

Response: MHD continually monitors for access and has infrastructure established to monitor for access.