MISSOURI HOSPITAL ASSOCIATION

Herb B. Kuhn
President and CEO
P.O. Box 60
Jefferson City, MO 65102

May 5, 2021

Jamie Purnell
Social Services Manager
MO HealthNet Division
615 Howerton Ct., 2nd Floor
Jefferson City, MO 65109

Dear Ms. Purnell:

On behalf of its 141 members, the Missouri Hospital Association submits the following comments concerning the proposed Medicaid state plan amendment on outpatient reimbursement posted for public review by the Missouri Department of Social Services (DSS) on April 5, 2021.

The proposed reimbursement structure is ill-suited to 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 "transitional corridor payments" to prevent them from being under-reimbursed. Because MO HealthNet excludes this safeguard from its proposed methodology and in light of the disproportionate adverse effect 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 a less jarring budgetary effect on the hospital industry.

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 pressures 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 services 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.

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 for CMS questions or consideration for the rulemaking DSS is legally obliged to conduct to effectuate the proposed changes.

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 dates 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-establish 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.

Thank you for the opportunity to comment on the proposed state plan amendment.

Sincerely,

Brian Kinkade
Vice President of Children's Health and Medicaid Advocacy

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