PROGRAM DESCRIPTION

Department: Social Services **HB Section(s): 11.765**
Program Name: Hospital Care
Program is found in the following core budget(s): Hospital Care

1a. What strategic priority does this program address?

Provide accessible, quality hospital care and ensure appropriate utilization

1b. What does this program do?

The MO HealthNet Division (MHD) reimburses for inpatient and outpatient hospital services for fee-for-service participants. These services are mandatory Medicaid-covered services and are provided statewide. Inpatient hospital services are medical services provided in a hospital acute or psychiatric care setting for the care and treatment of MO HealthNet participants. Outpatient hospital services include preventive, diagnostic, emergency, therapeutic, rehabilitative, or palliative services provided in an outpatient setting.

A full list of Missouri's 160 licensed hospitals can be found on the Department of Health and Senior Services website at: https://health.mo.gov/safety/healthservregs/directories.php.

Reimbursement Methodology

Inpatient Services

Reimbursement for inpatient hospital stays, also known as a “per diem rate,” is determined by a prospective reimbursement plan. The Missouri state plan provides for an inpatient hospital reimbursement rate based on the 1995 cost report. Total reimbursement is calculated based upon an individual participant’s inpatient length of stay. To determine an inpatient length of stay, MO HealthNet calculates the lesser of:

- The number of days certified as medically necessary by MHD’s authorized utilization review agent
- The number of days billed by the provider for the participant’s length of stay
- The number of days allowed for any diagnosis not subject to review and certification by the utilization review agent. (Such diagnoses can be found on MHD's website at: http://dss.mo.gov/mhd/providers/pdf/exempt-diagnosis-table.pdf)

A hospital is eligible for an inpatient rate reconsideration to increase their per diem rate if it meets prescribed requirements concerning new or expanded inpatient services.

Outpatient Services

Outpatient services, excluding certain diagnostic laboratory procedures, radiology procedures, surgical procedures and drugs are paid on a prospective outpatient reimbursement methodology.

- The prospective outpatient payment percentage is calculated using the MO HealthNet overall outpatient cost-to-charge ratio from the fourth, fifth, and sixth prior year cost reports regressed to the current state fiscal year
- The prospective outpatient payment percentage cannot exceed 100% and cannot be less than 20%
- New MO HealthNet providers that do not have fourth, fifth, and sixth prior year cost reports are set at 75% for the first three fiscal years in which the hospital operates and will have a cost settlement calculated for these three years
- The weighted average prospective outpatient rate for out-of-state hospitals is 27% for FY 2021

Hospitals may also receive reimbursement using funding from the Federal Reimbursement Allowance (FRA) program. The FRA program is a funding source for, but not limited to, inpatient and outpatient services. For a more detailed description of the FRA program, see the FRA program description.

Cost Containment Initiatives

MHD is changing the reimbursement methodology for Outpatient Hospitals services.

- Outpatient Radiology: Effective 01/01/2019, the reimbursement for Outpatient Radiology changed from 125% of Medicare rates to 90% of the 2018 Medicare rate
- Outpatient Surgeries: Effective 01/01/2019, certain Outpatient Surgeries will be paid from a fee schedule. A list of the surgical procedures paid from a fee schedule can be found at: https://dss.mo.gov/mhd/providers/files/outpatient-hospital-surgical-procedure-fee-schedule.pdf
- Outpatient Hospital Drug Reimbursement: MHD is reimbursing hospitals using the National Average Drug Acquisition Cost (NADAC) for drug reimbursement effective 04/01/2019

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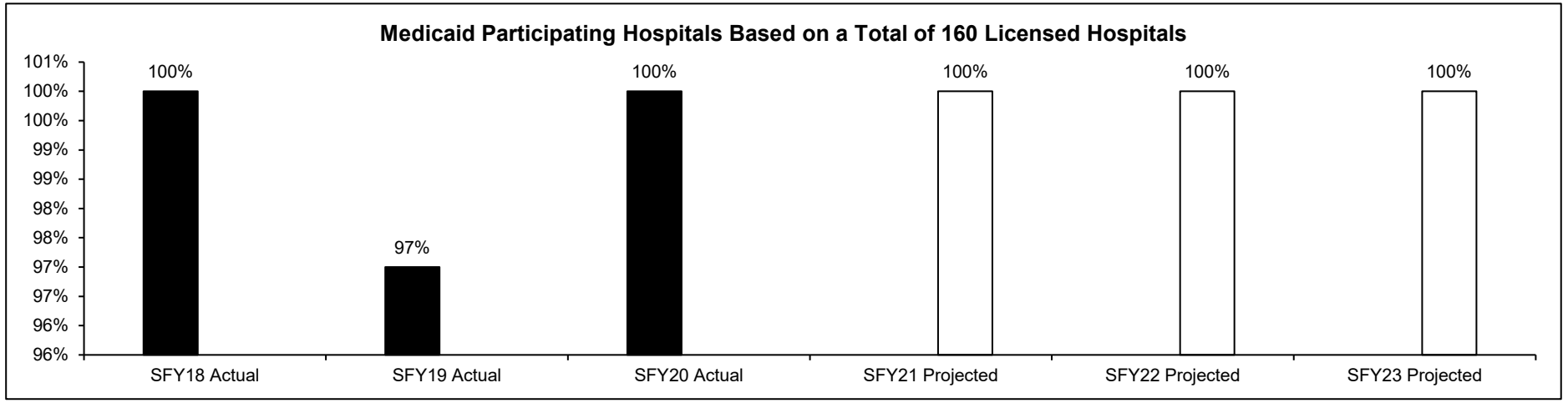
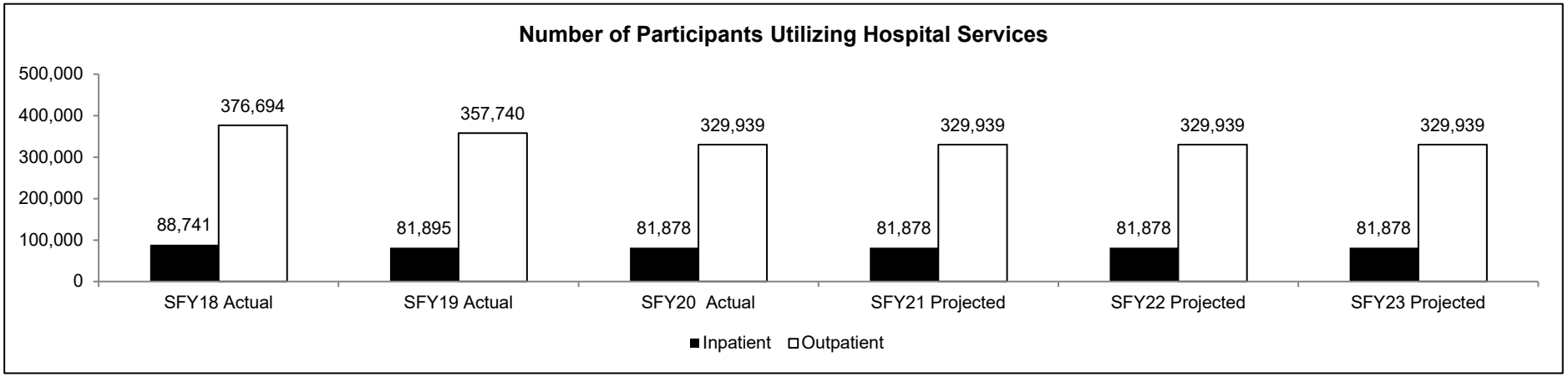
2a. Provide an activity measure(s) for the program.



Note: The number of licensed hospitals includes separate licensing for hospitals with multiple sites.



Future projections are based on eligibility requirements as of 7/1/20.

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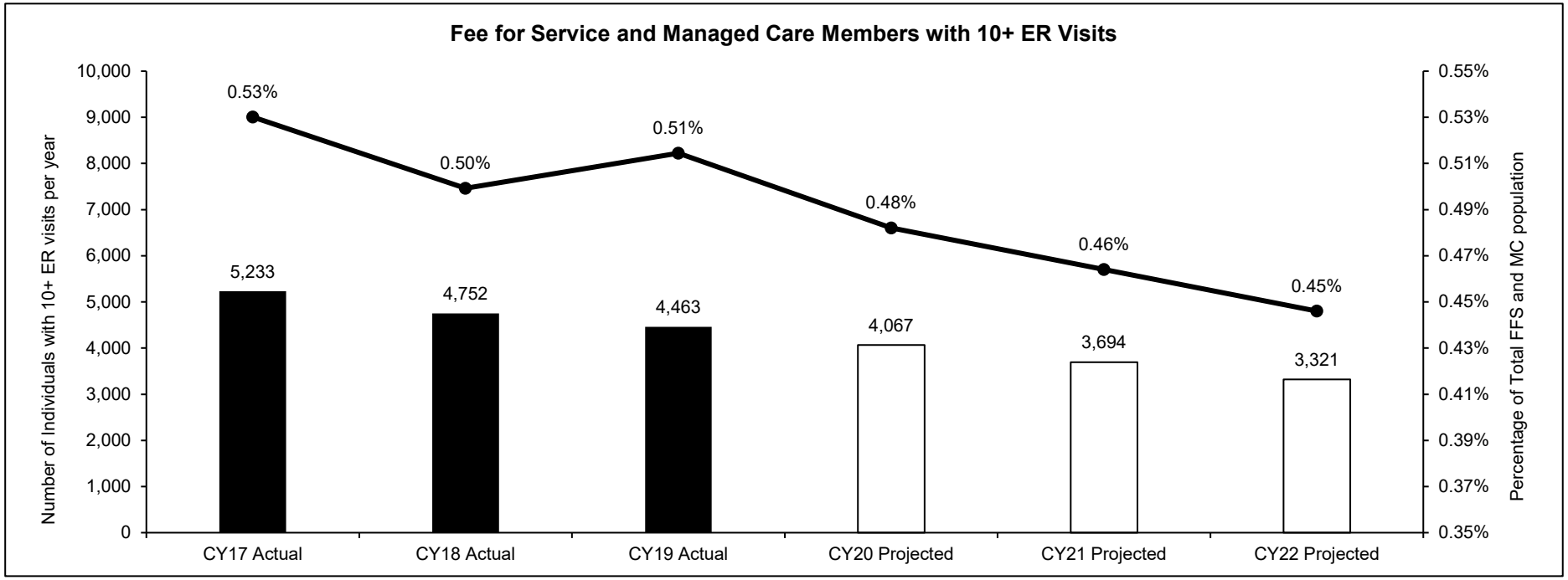
2b. Provide a measure(s) of the program's quality.



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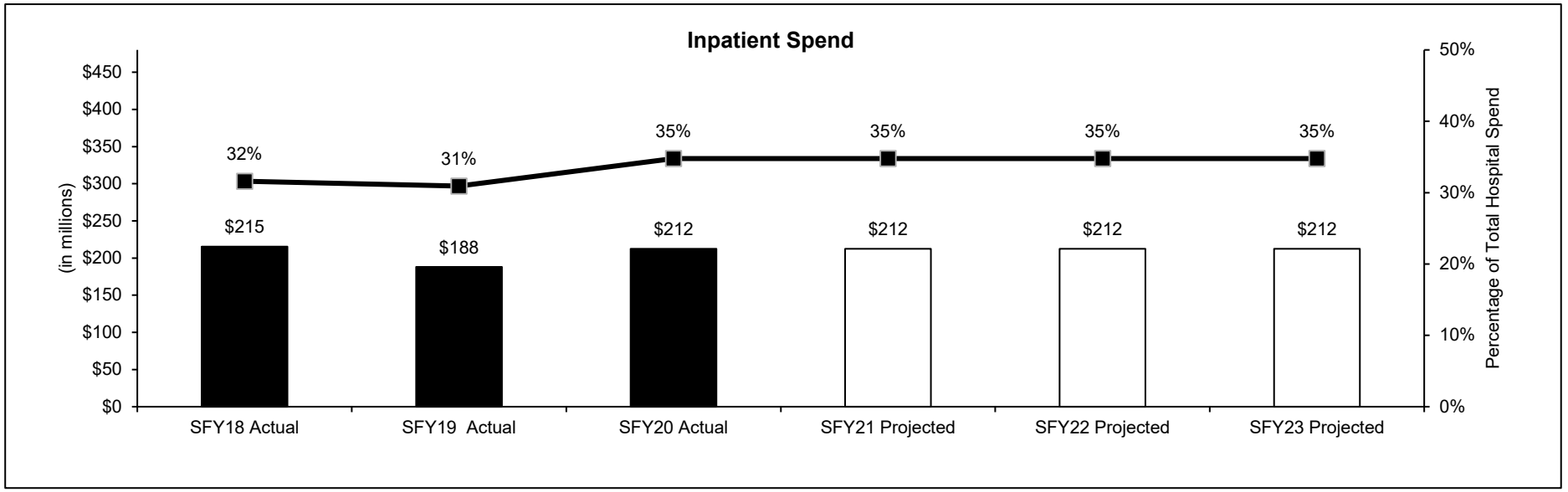
2c. Provide a measure(s) of the program's impact.

In SFY 2019, the hospital program comprises 12.56% of the total Medicaid program dollars. Approximately 315% of hospital expenditures were for inpatient services and 65% were for outpatient services.



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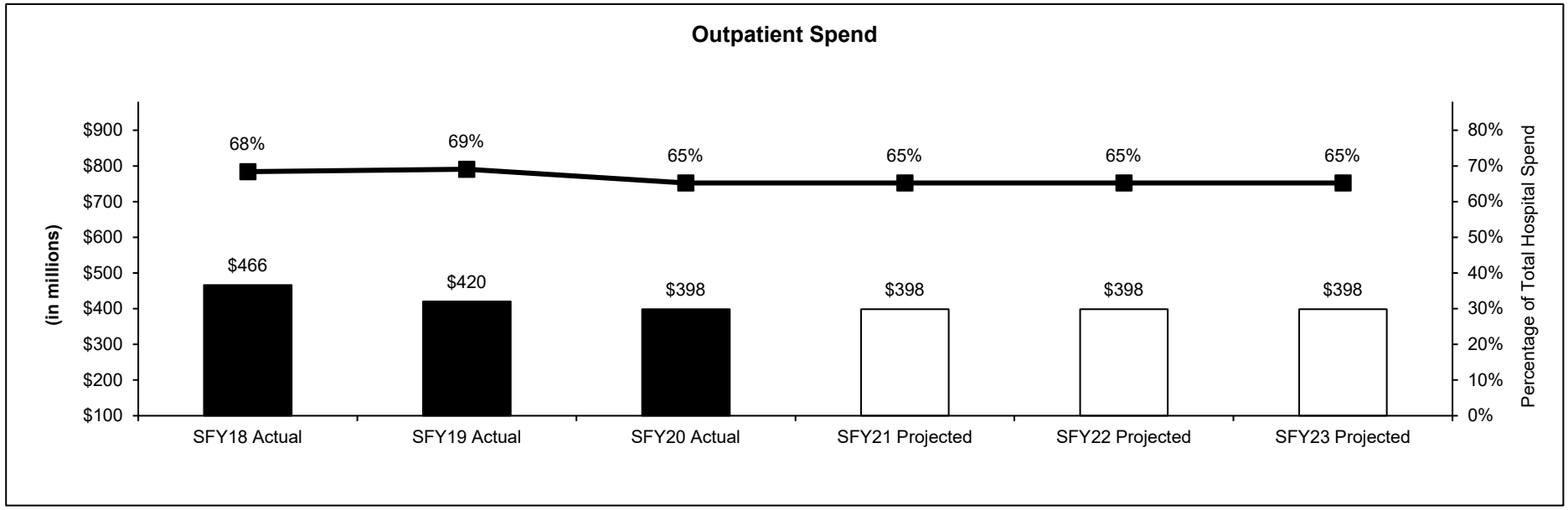

MHD is currently reviewing hospital reimbursement methodologies therefore projections are static.

Target: Improve outpatient reimbursement payment policies and priorities by aligning outpatient reimbursement methodology with other payers by adopting a simplified fee schedule. Eighteen state Medicaid programs currently pay based on a simplified fee schedule. Twenty one state Medicaid programs have adopted or plan to adopt the Medicare Ambulatory Payment Classification (APC) or Enhanced Ambulatory Patient Grouping System (EAPG) outpatient reimbursement methodologies. Only twelve states rely primarily on cost reimbursement (interim rate or percent of charges).

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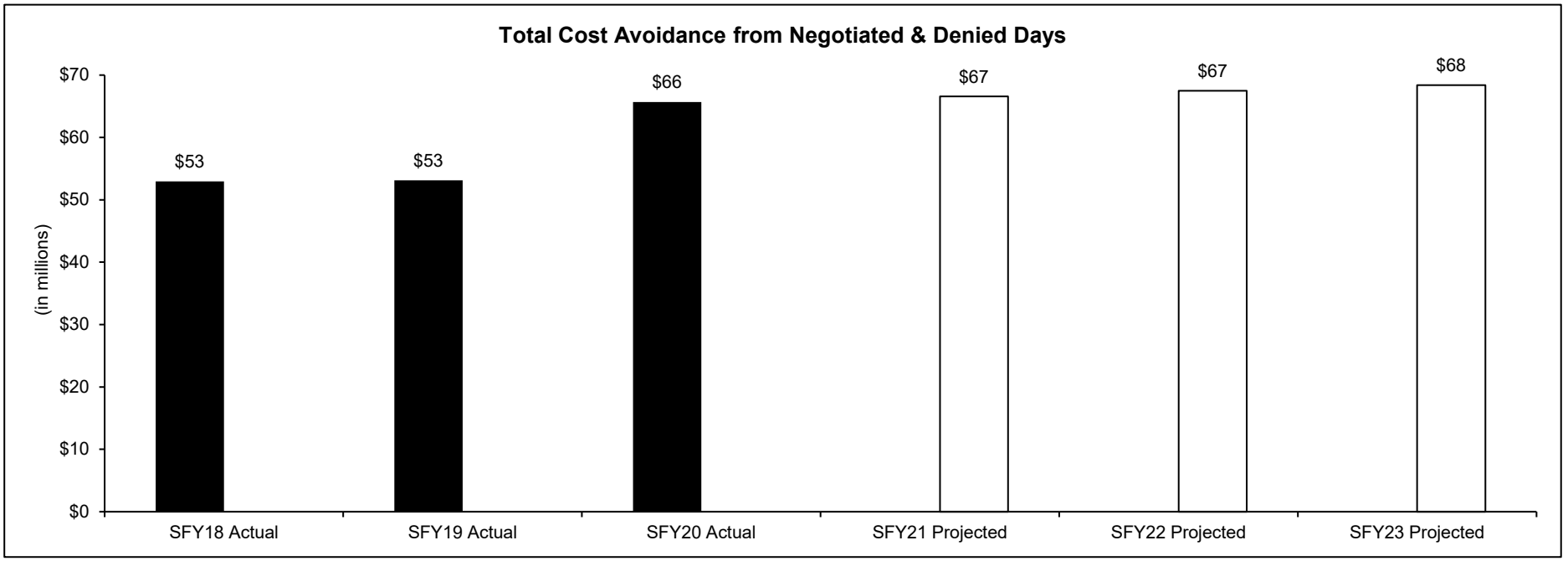
2d. Provide a measure(s) of the program's efficiency.



Note: The number of inpatient days are negotiated or denied based on clinical review.

Target: Increase cost avoidance by continuing to avoid unnecessary inpatient admissions or lengths of stay.

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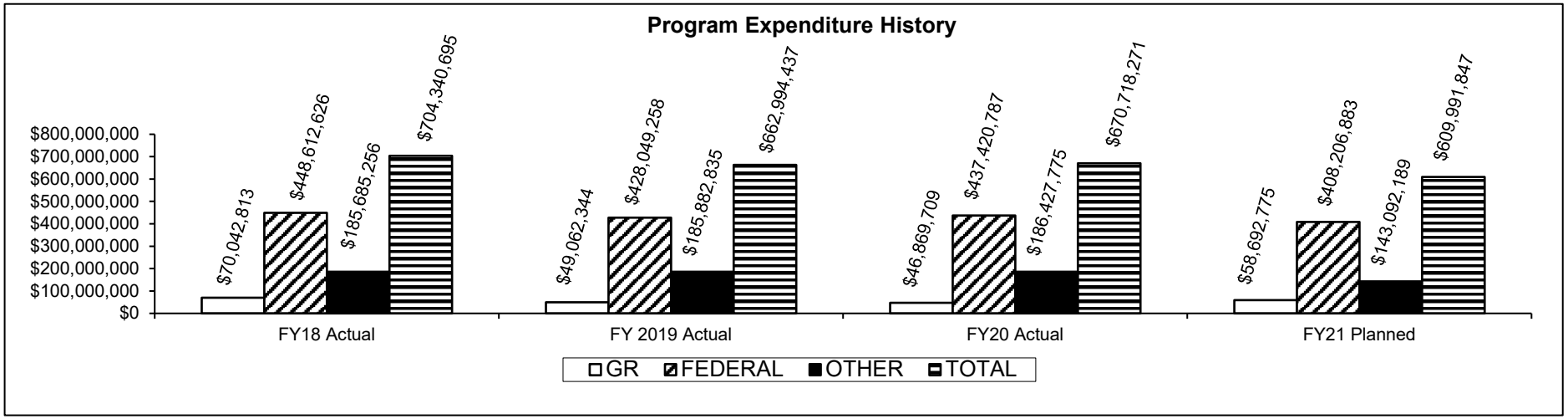
3. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year. (*Note: Amounts do not include fringe benefit costs.)*



Planned FY2021 expenditures are net of reverted and reserves.

4. What are the sources of the "Other " funds?

Federal Reimbursement Allowance Fund (0142), Healthy Families Trust Fund (0625), and Pharmacy Reimbursement Allowance Fund (0144)

5. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: Sections 208.152 and 208.153, RSMo;
Federal law: Social Security Act Sections 1905(a)(1) and (2), 1923(a)-(f);
Federal regulations: 42 CFR 440.10 and 440.20

6. Are there federal matching requirements? If yes, please explain.

The FMAP (Federal Medical Assistance Percentage) fluctuates annually based on state and national economic and population data, but generally the state matching requirement is around 35% and the federal match is around 65%.

7. Is this a federally mandated program? If yes, please explain.

Yes, if the state elects to have a Medicaid program.