Kentucky Hospital Association

Comments on
Kentucky Health 1115 Waiver Proposal

July 19, 2016

Kentucky Hospital Association (KHA) represents all hospitals in the Commonwealth, and supports the general direction and tenets of the proposed waiver. Kentucky hospitals support the Medicaid expansion and the benefits it has brought to low-income Kentuckians. We understand the concern regarding the financial sustainability of the expansion and we support the efforts of the state to address mounting costs while ensuring that the expansion will continue. We believe the state and the federal government should work within the framework of the proposed waiver and find common ground to allow Kentucky to retain the gains made in reducing the number of uninsured.

Many of the principles articulated in the waiver align with KHA’s principles for Medicaid reform. It uses the private market while still retaining the safety-net for Kentucky’s vulnerable population of pregnant women, children, and the medically frail. Since many of the expansion population are working and may have access to employer based coverage, KHA and Kentucky hospitals support the proposed employer premium assistance program to promote private coverage which will also greatly benefit those Medicaid eligibles by giving them broader provider access and coverage under Kentucky’s patient protection laws that MCOs, although licensed as insurers, have not been required to follow. KHA also supports using the state employee health plan as the benchmark for expansion population benefits, as our membership has long supported greater alignment of Medicaid benefits with commercial plans available to Kentucky’s taxpayers which are financing a portion of Medicaid costs.

KHA and its members also support the cost sharing proposals contained in the 1115 waiver proposal. Our research on the Healthy Indiana waiver indicated that enrollees preferred making one monthly payment as opposed to copayments for every service. Also, the imposition of modest cost sharing is not new to the Kentucky Medicaid program. Medicaid historically has required copayments, and those copayments were only recently waived by the Medicaid Managed Care Organizations (MCOs) after one plan implemented this practice as a marketing tool to increase enrollment and corresponding capitation payments. As the proposed waiver reinstates the program’s existing copayments, as contained in regulations and the State Medicaid Plan, the ability to pay modest premiums in lieu of individual service copayments could be less burdensome to many Medicaid members.
KHA and its members also support the incentives included in the waiver to encourage healthy lifestyles and proper use of services. The My Rewards account concept mirrors private sector actions where employees are being incentivized to undertake similar activities to improve health in return for lower premiums or other benefits. These initiatives are extremely important in lowering the long term cost of the Medicaid program because the high incidence of multiple chronic conditions and use of health services is ultimately related to adoption of healthy behaviors.

KHA and Kentucky hospitals also recommend changes to better strengthen the waiver and lower cost. These revisions relate to managed care and non-emergency use of hospital emergency departments.

**Managed Care**

Ninety percent (90%) of Kentucky’s Medicaid recipients are covered by managed care which is implemented through five separate managed care organizations (MCOs). Kentucky hospitals, like other providers, have been and continue to be extremely burdened by excessive administrative costs, payment denials, erroneous and slow payments as each MCO operates under a different set of policies and imposes different requirements for preauthorization, formularies, payment, and appeals processes. Each MCO also uses different medical necessity review criteria for behavioral health services which not only results in inconsistent decisions but inappropriate denials of care for Medicaid patients. These administrative burdens are especially costly because hospitals are incurring significant resources to collect payment which does not even cover the cost of delivering care to Medicaid patients. While KHA supports the concept of managing care, the existing MCOs have focused on ways to deny or lower payment for services rather than engaging patients to change behavior and take responsibility for their health. These practices have resulted in Kentucky’s MCOs earning the status as the most profitable Medicaid MCOs in the country. According to reports filed by the MCOs with the Kentucky Department of Insurance for 2015, the Kentucky MCOs collectively had a profit margin of 20%, compared to 2.6% nationally. This translates into a profit windfall of more than $600 million in 2015.

There are several places in the proposed waiver which imply that the contracts for the five MCOs would again be extended perhaps for another year, not only continuing the burden on providers, but allowing the continuation of poor performing MCOs since major changes to the MCO contract cannot be made outside of a new procurement. Several other states with comparable Medicaid populations have fewer MCOs. KHA believes that Medicaid should adopt a provider led strategy for managed care and ultimately move away from MCOs. Until that is accomplished, reducing the number of MCOs would save the state money by eliminating redundant payments for MCO activities. It would also help patients and providers by reducing red tape and
achieving more uniformity in MCO practices. Toward that end, KHA and its members strongly urge the waiver to be changed to remove all specific references to using the existing five MCOs, and we encourage that the number of MCOs be reduced to no more than three. We also strongly urge the state to undertake an MCO re-procurement as soon as possible through which the number of MCOs would be reduced and new, strengthened MCO contracts could be issued to address and curtail egregious MCO practices which have been documented through the various provider Technical Advisory Committees and monthly KHA MCO/DMS meetings. We encourage this change to be made prior to the end date of the current MCO contract extension, which would allow for a six month transition of enrollees to the remaining MCOs before the 1115 waiver is implemented.

**Non-Emergency Use of the Emergency Room**

Kentucky hospitals support appropriate use of emergency department (ED) services. Contrary to reports that Medicaid expansion has caused less use of emergency rooms, hospital emergency room visits are increasing. Visits for Medicaid and the uninsured declined briefly in 2012-2013, but following the Medicaid expansion in 2014, ED visits have been steadily and sharply increasing and, in the last quarter of 2015, they were at the highest level in the last five years.

Source: Kentucky Hospital Association, All Payor Claims Data.

Kentucky hospitals are required by federal law (EMTALA), to perform a medical screening examination (MSE) on every patient who presents to a hospital emergency room to determine if an emergency medical condition is present and to provide necessary stabilizing treatment. CMS’s federal EMTALA rules define a medical
screening exam as not only an examination of the patient but also any reasonable testing needed to make a diagnosis, which could be extensive based on the patient’s presenting symptoms, in order to rule out an emergency condition. In 2014, the Kentucky Medicaid program revised its recipient cost sharing regulation to require an $8 copayment for non-emergency care received in a hospital emergency room. In order to implement this cost sharing requirement, the Medicaid program was required to comply with certain federal laws and regulations. These federal requirements call for hospital personnel performing the MSE to determine if the patient has a non-emergency condition and when this occurs, the hospital is also required to inform the patient of the required copayment for obtaining treatment at the ED along with alternative settings where the patient could go for treatment with a lower or no copayment1.

On December 31, 2013, CMS approved a Kentucky Medicaid State Plan Amendment (SPA) which states, “Hospitals will operationalize this process by performing the required EMTALA screening on the patient and if they determine the condition non-emergent (determined by medical professional at the hospital), the ER staff (either a nurse, doctor or intake staff) will advise the recipient that it is not a condition that requires emergency treatment, and that they (the hospital) will assist them in locating another facility (late night clinic, etc.), call their primary care physician when they are open, or go to urgent care clinic that may be available.” This SPA has not and cannot be implemented due to the actions of two MCOs (Wellcare and Coventry/Aetna) which are not following the directives of the SPA. Specifically, after contracts were signed with hospitals specifying payment rates, these two MCOs unilaterally implemented a “triage” fee under which they pay a flat rate of $50 (less an $8 copay) for claims that, upon the MCO’s review using a proprietary and undisclosed algorithm, they determine are a non-emergency visit to an emergency department. This rate does not cover the cost of screening the patient. According to a KHA survey, these MCOs are collectively classifying 37% of all emergency department visits as non-emergent (one MCO classifies 50% as non-emergent), and the non-emergent visits are then paid $50, less the $8 copayment. The difference between the ER triage payment and the amount hospitals are owed under their contracted rate (which mirrors the Medicaid fee-for-service rate) totals approximately $38 million annually in losses for services provided to

1 A state may amend its State Medicaid Plan to impose cost sharing for non-emergency services furnished in the hospital emergency department if the individual has actually available and accessible alternative nonemergency services and the hospital informs the beneficiary after receiving an appropriate medical screening examination and after a determination has been made that the individual does not have an emergency medical condition but before providing the non-emergency services that a copayment is required and the name and location of an alternative non-emergency service providers actually available and accessible to provide the services without cost sharing [42 U.S.C. 1396o-1(e)]. CMS rules also require states to submit a Medicaid State Plan Amendment and specifically state that, in order to impose cost sharing for non-emergency use of the emergency department, “…the hospital providing the care” must conduct an appropriate MSE to rule out an emergency condition and provide information about cost sharing and accessible alternative providers [42 CFR 447.52, 447.54].
enrollees of these MCOs. This practice is serving to enhance the MCO’s profits, not change enrollee behavior as data shows that ED visits are rising.

It is clear by the SPA and under federal rules that the hospital treating the patient, not an MCO software program or a reviewer in another state, must determine the emergency or non-emergency condition of the patient. The proposed 1115 waiver calls for requiring hospitals to follow federal rules and the SPA in relation to enrollees seeking non-emergent care in an ED, yet this cannot be done when MCOs continue to ignore the SPA and make their own determination of non-emergency care. Similarly, the proposed waiver will also impact enrollees by reducing their My Rewards account for non-emergency use of an ED. If these MCO practices are not stopped and MCOs instead of hospital ED personnel who perform the MSE decide whether a patient’s condition is a non-emergency, patients will be harmed.

Therefore, since the waiver specifically intends that federal rules and the SPA be followed for non-emergency use of an ED, KHA and its members specifically request that the waiver further clarify that the Kentucky SPA will be fully enforced against all MCOs such that hospitals actually performing the EMTALA medical screening exam will be responsible for determining if the patient has a non-emergent condition, and MCOs will be prohibited from apply their own determination and imposing a non-contracted triage fee based on the MCO’s determination. KHA stands ready to work with the Department for Medicaid Services on a process to implement the SPA in conformity with federal law.

**Premium Assistance Clarification**

The waiver indicates that the State will permit third parties to pay required premium payments on behalf of a member. It specifically mentions “non-profit organizations, provider groups, and other third parties” as entities which will be permitted to assist members with monthly premiums. We would appreciate receiving clarification as to whether individual hospitals (both nonprofit and proprietary) would be permitted to provide premium assistance and if so, whether this may be done directly or if contributions would be required to be provided through a foundation. We encourage the State to allow all hospitals the opportunity to assist members directly to maintain coverage through the payment of premiums on their behalf.

In summary, KHA and Kentucky hospitals support the 1115 waiver proposal and encourage the state and federal government to find common ground and reach approval. We hope that our clarifications can be added to the proposal, and we stand ready to work with the Cabinet on implementation of the waiver.