KHA Legislative Priorities for the 2019 Kentucky General Assembly

Kentucky Hospital Association

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Medicaid Expansion and Program Funding

The expansion of Medicaid to individuals with income up to 138 percent of poverty has added approximately 450,000 adults to the program. As a result, the number of uninsured Kentuckians has significantly dropped. Medicaid expansion has not only improved access to care but has helped hospitals by reducing charity care. This has been essential as Kentucky's hospitals continue to face cuts in Medicare and Medicaid payments which, in part, are tied to expanded coverage. **Kentucky hospitals strongly support maintaining the Medicaid expansion and have worked proactively with the Department for Medicaid Services on implementation of the Kentucky HEALTH 1115 waiver.**

Medicaid expansion will require the state to provide matching funds to cover ten percent of expansion costs beginning in 2020. Kentucky's hospitals have paid a Medicaid provider tax every year since 1994, and pay $183 million in taxes annually, which generates about $830 million for the Medicaid program. Only 17 percent ($32 million) of the hospital tax is used to directly benefit hospitals as matching funds for Medicaid Disproportionate Share Hospital (DSH) payments, with the balance going into the general Medicaid program that benefits all providers, including those that pay no tax. The federal provider tax rules specifically allow eighteen categories of providers to be taxed, yet Kentucky imposes a provider tax on only five provider categories, and hospitals pay the majority – 61 percent – of all provider taxes collected.

The hospitals sought and the General Assembly capped their tax level in 2006 as hospitals could no longer carry the burden for every other health care category. This cap is vital to protecting hospitals, many of which are operating on razor-thin margins and **cannot afford to have their existing provider tax raised. Therefore, if additional Medicaid funding is needed, legislators should look to broaden the tax to the remaining thirteen categories of providers and insurers/MCOs which do not currently pay a provider tax yet are benefiting from the Medicaid program and the Medicaid expansion.**

Need for Hospital Medicaid Rate Improvement

Medicaid payments to hospitals are inadequate and for most hospitals only cover about 75% of the actual cost of treating Medicaid patients. As a result of expansion, 25 percent, on average, of a hospital's patients are now covered by Medicaid and in some rural hospitals, the percent is even higher. The losses from inadequate Medicaid rates that do not cover cost are not sustainable, particularly in light of massive cuts in other payment programs which have been used to subsidize Medicaid losses. Medicaid losses are no longer considered in the distribution of Medicare disproportionate share funding, which is estimated to reduce payments to Kentucky hospitals by $77 million by next year. Also, congressionally mandated cuts to federal Medicaid disproportionate share hospital (Medicaid DSH) payments are to begin in 2020 and by 2021, Kentucky's Medicaid DSH funding will be reduced from $226 million to $60 million, amounting to a 75 percent reduction.

Most other states use hospital provider taxes to fund supplemental payments to bring hospital Medicaid payments up to cost. In Kentucky, supplemental payments exist only for university hospitals, children's hospitals and one state psychiatric hospital.

KHA is working to design a mechanism to improve Medicaid payments for all hospitals to help offset the impact of these federal payment cuts. The program will be modeled after successful programs that currently operate in other states, and will be compliant with all federal requirements for provider-directed payments as 93 percent of hospital payments flow through the Medicaid managed care organizations (MCOs). **KHA will seek enabling legislation for this program.**

Interstate Medical Licensure Compact

KHA and Kentucky's hospitals support passage of physician compact legislation to establish an expedited process for physicians located in other states that are part of the compact to obtain a Kentucky license from the Kentucky Board of Medical Licensure. An expedited license would be granted to physicians who are board certified, hold an unrestricted license and have an otherwise clean application. The compact creates another pathway for licensure and does not change Kentucky's Medical Practice Act. It is needed to increase access to health care for people in rural and underserved areas by allowing patients to more easily consult medical experts through the use of telemedicine technology. It also strengthens public protection by facilitating state medical board sharing of investigative and disciplinary information. Twenty-two states have enacted the compact legislation.

Price Transparency

Since 2005, KHA has provided comparative inpatient hospital price information for consumers on its public website. KHA's pricing website allows consumers to obtain comparable information by diagnosis-related grouping (DRG) on the number of annual discharges and each hospital's average price. This information is based on all-payor billing data which KHA col-

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lects from all Kentucky hospitals. The Association is expanding its consumer pricing website to provide outpatient pricing information for ambulatory surgery procedures as well as selected radiology, laboratory and other services.

Hospitals are also federally mandated to make pricing information available. Section 2718 of the Affordable Care Act (ACA) requires all U.S. hospitals to make public a list of the hospital's standard charges, which can be the chargemaster or another form of the hospital's choice. As of January 1, 2019, every U.S. hospital is also required to post its chargemaster on the facility's website in a downloadable format.

In view of the existing federal mandates and pricing data already available through KHA, consumers have access to comparable pricing information; therefore, state legislation requiring hospital posting or reporting data to another entity would be duplicative, costly and unnecessary.

Personal Injury Protection (PIP)

Kentucky's hospitals provide valuable services to their communities and stand ready 24 hours, 7 days a week to respond when patients are injured and to save lives. The Kentucky Department of Insurance recently performed a study to estimate the financial impact on hospitals if payment under Personal Injury Protection (PIP) were limited to the Kentucky workers' compensation fee schedule. The study used limited data from three carriers and found this change would reduce payment by $34 million; however, when those reductions are applied to all hospital claims where auto insurance is primary, payment at workers' compensation rates would reduce payment by $216 million annually!

A KHA analysis of claims billed to auto insurance found that 92% of all inpatient cases came through the emergency department (ED) and another 4% were transferred from another hospital. Similarly, 83% of outpatient claims billed to an auto carrier had ED services. The workers' compensation fee schedule for hospitals pays only slightly above cost and was not designed for automobile accident victims who access care through the ED and more often involve trauma care, which is costly to treat. **Since hospitals are the only medical providers with a federal EMTALA obligation to screen and treat all persons who present to an ED without regard to ability to pay, it is the position of the KHA and Kentucky hospitals that legislation reducing payment to the workers' compensation fee schedule exempt all inpatient cases as well as any hospital outpatient service that has ED services as part of the claim.**

Surprise Billing

As more insurers tighten networks to reduce premiums, patients can receive unexpected bills from out-of-network providers. These "surprise" bills occur when a patient obtains care at an in-network hospital but receives services from a hospital-based provider (most often an anesthesiologist, pathologist, radiologist or emergency department physician) that is out-of-network.

- Mandating hospital-based providers participate in the same network as hospitals: Hospital-based physicians often do not participate in the same networks as hospitals because the health plan rates are unreasonably low or because the health plan will not accept the physician as a participating provider. **Kentucky hospitals will oppose this mandate because it would result in insurers being able to force acceptance of potentially unreasonably low payment rates with hospitals having to subsidize the losses in order to maintain these hospital-based services.**
- Establishment of benchmark for setting an out-of-network rate: **KHA supports legislation that would establish a reasonable benchmark for determining out-of-network payment such as the use of "usual and customary rates" (UCR) received by like providers in the same geographic area, using an impartial database, but only if such data is transparent to providers.** If linked to Medicare, rates must reflect amounts paid in the commercial market so that hospitals are not forced to subsidize inadequate rates.
- Network adequacy: Part of the problem causing "surprise bills" is inadequate or narrow insurance networks. **Any "surprise billing" legislation must address the issue of network adequacy.**
- Out-of-Network Notices: Hospitals can provide patients with a standard notice that some facility-based providers may be out-of-network. However, hospitals cannot provide specific charge information for every out-of-network provider due to the sheer number of providers in large facilities and because those providers do not notify hospitals of their charges for every procedure they may perform. Insurers – not hospitals – have information on their subscriber's cost sharing requirements and should be responsible for informing them of out-of-pocket costs.

Reduce the Number of Medicaid Managed Care Organizations (MCOs)

Kentucky hospitals continue to experience problems from Medicaid managed care organizations (MCOs). Having five MCOs has increased provider administrative burden five-fold, just to follow five different sets of rules for preauthorization, appeals, credentialing and payment. KHA strongly supports legislation to limit Kentucky to no more than three Medicaid MCOs.

- **Data produced by the Medicaid Department and an external review organization shows significant differences between the five MCOs in denial rates, grievances and appeals, contract compliance and quality.** Insurance filings also show that two MCOs did not meet a 90% Medical Loss Ratio in 2017, meaning they did not spend at least 90% of their capitation payments on health care services, rather than administrative costs and profits.

- **All of the MCOs receive the same capitation rates;** therefore, the state would pay the same amount in total capitation payments if the number of MCOs is reduced. **The commonwealth should reduce the number of MCOs by contracting only with those with the best historical performance.**
- Limiting the number of MCOs would reduce "red tape" and administrative burden on providers as well as costs to the state by eliminating redundant payments to five MCOs for the same core functions.
- MCO past performance and contract compliance should be a requirement in the consideration of future contracts.

Retain the Certificate of Need (CON) Program

KHA supports retaining the CON program and requiring all providers to follow the same rules in order to assure a level playing field and to protect the public. Kentucky is one of 37 states, including the District of Columbia, with a certificate of need program. Because Kentucky oversees the proliferation of health care services through statewide health planning and CON, Kentucky hospitals have one of the lowest costs per day and costs per stay in the nation.

In 2014, a national CON expert produced a white paper for KHA that examined the value of CON as the health care environment increasingly moves away from fee-for-service to outcomes-based payment. The report concluded that eliminating or significantly de-regulating CON would run counter to transformation efforts. The report found:

- CON is a stabilizing force that allows existing providers to embrace new payment models, like accountable care organizations and payment bundling, which require a level of financial risk to be taken by providers. CON deregulation would result in greater fragmentation rather than enhancing integration of care.
- CON does not hamper incentives for developing a full continuum of care. There is sufficient capacity for the expensive services covered under the State Health Plan, and most primary care services are not regulated by CON.
- CON supports quality by assuring new facilities operate at volumes sufficient to produce good outcomes and that volume does not come at the expense of existing providers, which would reduce quality of existing programs.
- Eliminating or deregulating CON could reduce access to care by destabilizing local health care systems. Smaller, rural hospitals and safety-net hospitals are especially vulnerable to the loss of profitable patients to entities targeting patients with commercial insurance, who pay no provider tax, and have no EMTALA obligation.
- CON deregulation does not improve value, as states without CON have significantly greater duplication of resources and operate on average at lower volumes per provider.

Kentucky's CON program is not onerous, as full review and conformity with the State Health Plan is only required for new beds, ambulatory surgery centers and expensive technology or where sufficient volume is needed for good outcomes. Primary care and most outpatient services are now exempt from CON.

KHA will oppose legislation repealing CON or containing special exemptions for certain facilities or providers, and will seek to require that any such providers treat indigent and Medicaid patients, participate in the provider tax, comply with comparable quality and safety standards and prohibit the self-referral of patients to facilities with which the provider has an ownership interest in order to prevent unnecessary utilization.

Smoke-Free Initiatives

Kentucky has both the highest cancer rate and the highest smoking rate in the nation. According to the Coalition for a Smoke-Free Tomorrow, tobacco-related illnesses and secondhand smoke cost Kentucky nearly 9,000 lives and $1.92 billion in health care expenditures each year. Nearly one-third of those costs are covered by Medicaid. Secondhand smoke is a known cause of lung cancer, heart disease, low birth-weight babies, chronic lung ailments and other health problems. Numerous studies show that smoke-free laws have a positive or neutral impact to businesses, and recent polls show a majority of Kentuckians support a law that would prohibit smoking in most public places.

E-cigarettes, which contain nicotine, flavoring and other chemicals, are popular among teens and, according to the National Institute on Drug Abuse, are the most commonly used form of tobacco among youth in the United States. They are readily available and believed to be safer than cigarettes, yet early evidence suggests these devices may increase the likelihood of teens moving to cigarettes. Accordingly, e-cigarettes should be regulated and taxed in the same manner as other tobacco products.

KHA supports legislation that would decrease smoking rates, particularly among Kentucky's youth, and reduce exposure to secondhand smoke. Kentucky hospitals support making tobacco products, including e-cigarettes, more expensive through increased excise taxes, raising the legal age to purchase tobacco products and making all school grounds tobacco-free.

Medical Marijuana

The Drug Enforcement Administration has classified marijuana as a Schedule 1 drug – meaning it has high potential for abuse and no current legitimate therapeutic uses. While some reports have indicated a therapeutic benefit of cannabinoid

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drugs for pain relief, they have also pointed out issues with smoked marijuana as well as potential harmful psychological effects that could diminish its therapeutic value. There is also evidence to suggest that its use is linked to the development of substance use disorder for alcohol, tobacco and other illicit drugs.

KHA and Kentucky's hospitals do not endorse legislation to legalize medical marijuana. Kentucky hospital physician leaders have expressed there is no scientific evidence to support the benefits of medical marijuana as a standard of care and, in the absence of such evidence, it could exacerbate the commonwealth's existing substance abuse problems. KHA supports the conduct of rigorous, sound scientific research through the FDA regulatory process to learn and develop medicinal properties found in marijuana and other plants that may help patients.

Medical Liability Reform

KHA and Kentucky hospitals continue to support the need for medical liability reform in Kentucky. The 2017 State Liability Systems Ranking Study conducted for the U.S. Chamber Institute for Legal Reform ranked Kentucky 42nd worst among all states on elements related to the litigation environment, such as damages and jury fairness.

Kentucky is at a distinct disadvantage in recruiting and retaining physicians due to the negative medical liability environment, particularly when the majority of other states have enacted medical liability reforms. An estimated $50 to $100 billion is spent annually in the United States on defensive medicine. This, coupled with the lack of tort reform, hinders access to affordable health care in the commonwealth.

A major factor which drives increased medical liability premiums as well as the practice of defensive medicine is frivolous lawsuits. In 2017, Kentucky enacted medical review panels to sift out meritless cases and encourage early settlement of valid cases without going to court. Unfortunately, the Kentucky Supreme Court recently ruled this measure to be unconstitutional.

Without a change to the constitution, it is clear that Kentucky will be unable to adopt the same common sense reforms that have been widely adopted throughout the country. According to the American Medical Association, most states have enacted the following medical liability reforms:

- Damage Award Limits/Cap – 35 jurisdictions have a limit or a cap, ranging from $250,000 to $2.25 million, and 2 states allow a court to review a damage awarded.
- Joint and Several Liability – 26 jurisdictions allow for joint and several liability.
- Limits on Attorney Fees – 28 states have limitations, with 12 states having sliding fee schedules.
- Periodic Payments – 30 jurisdictions either allow or require periodic payments for damages
- Pretrial Alternative Dispute Resolution and Screening Panels – 27 states have specific provisions for alternative dispute resolution (arbitration, mediation) in medical liability cases. 17 states have medical screening panels.
- Affidavit or Certificate of Merit – 28 states have these requirements for a medical liability claim to move forward
- Expert Witness Standards – 32 states have minimum qualifications for expert witnesses who testify in medical malpractice cases

KHA and Kentucky hospitals support the above listed reforms as well as legislation that will allow voters to consider changing Kentucky's constitution to permit the General Assembly to evaluate the reforms that have been successful in other states and enact those or similar reforms in Kentucky.

Collection of Data from Ambulatory Facilities

In the 2018 legislative session, HB 444 eliminated certain ambulatory facilities from certificate of need and licensure. These include primary care centers, rural health clinics, special health clinics, retail-based and urgent care clinics, diagnostic clinics and rehabilitation agencies. An unintended consequence of removing these facilities from state licensure was their removal under other laws requiring licensed facilities to report data to the Cabinet for Health and Family Services.

Continued data reporting is needed for policymakers to evaluate changes in service utilization as well as for consumers to have comparative price data in all outpatient settings. **KHA and Kentucky hospitals support the passage of legislation to correct this oversight and maintain the Cabinet's authority to require the reporting of data from these ambulatory facilities.**

For further information about this legislation and KHA's Government Relations, please contact:

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