ONE Powerful Voice

KHA Legislative Priorities for the 2020 Kentucky General Assembly

Kentucky Hospital Association

Medicaid Program

Fully Fund Disproportionate Share Hospital (DSH) Payments

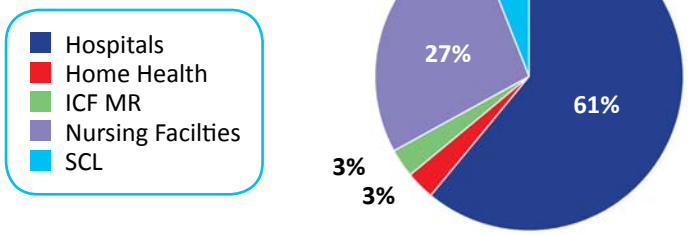
Each year, Kentucky's hospitals provide millions of dollars in uncompensated care – care provided for which no payment is received or the payment received does not cover the hospital's actual cost of delivering the care. Medicaid disproportionate share hospital (DSH) payments help to offset those uncompensated care costs. Even though Medicaid expansion has provided coverage to the low income, uninsured population, uncompensated care from Medicaid and Medicare shortfalls as well as bad debts and charity continue, making retention of Medicaid DSH payments essential. Nearly every Kentucky hospital receives Medicaid DSH payments; therefore, it is imperative that these payments be continued. Medicaid DSH payments are comprised of seventy percent (70%) federal funding and thirty percent (30%) state matching funds, which are derived from the $183 million in provider taxes paid annually by hospitals. **With the required state matching funds being supplied by hospitals and the ongoing importance of these payments, Kentucky hospitals will seek to assure that Medicaid DSH payments are fully funded in the 2021-2022 biennial state budget.**

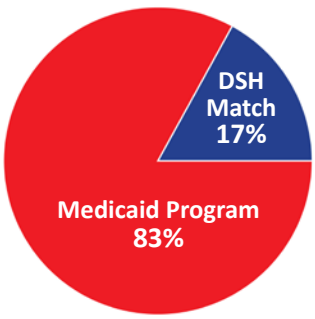
Maintain Medicaid Expansion

The expansion of Medicaid to individuals with income up to 138 percent of poverty has significantly reduced the number of uninsured Kentuckians. Medicaid expansion has improved access to care and helped reduce hospital 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 (DMS) on implementation of the Kentucky HEALTH 1115 waiver.**

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 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.

Kentucky Provider Tax by Class





Use of Hospital Provider Tax

- **The provider tax is used to fund the state share of Medicaid DSH payments to acute and private psychiatric hospitals**
- **Hospital DSH payments will decline sharply when federal ACA DSH cuts begin**

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. The state will be required to provide additional matching funds to cover ten percent of expansion costs in the next biennial budget. If additional Medicaid funding is needed, legislators should look to broaden the provider tax to the remaining taxable categories of providers and insurers/MCOs which do not currently pay a provider tax yet are benefitting from the Medicaid program and the Medicaid expansion.

Retain Certificate of Need

KHA and Kentucky hospitals strongly support retaining the Certificate of Need (CON) program. The CON law is critical to supporting a more level playing field among providers, especially those serving more vulnerable communities. Kentucky is one of 36 states (including the District of Columbia) that maintain a CON program. This year, a national CON expert produced a comprehensive research and impact analysis for KHA which found that Kentucky's CON program provides substantial benefits and is delivering value for Kentuckians. The analysis compared states with varying degrees of CON regulation to states without CON. The report found that CON states outperform no-CON states in access to, and prices of, health care services. **Kentucky outperforms noCON states by any number of measures:**

- **Access is Strong: Kentucky provides better access to most health care services than no-CON states.**
- **Costs are Low: Kentucky has lower prices and costs than no-CON states – in fact, Kentucky has the sixth lowest price (net payment) per inpatient discharge in the U.S. and the cost per unit of outpatient service is 40 percent lower than states with no-CON laws.**
- **Value is High: Kentucky hospitals provide better value than no-CON states, considering Kentucky serves a more vulnerable population that uses more services.** Kentucky's total per capita health care costs are less than the national average, on par with the average of states that have no CON laws, but lower than other nearby no-CON states (IN, OH, PA).
- **Impact of CON Repeal: Repeal would likely cause hospitals to close, costs to rise and access to worsen, particularly in rural communities. KHA's study identified at least thirteen hospitals vulnerable to closure, and all are the sole provider in their communities.** Closure would eliminate jobs, which provide an economic benefit, and require thousands of patients, who are typically older, poorer and more dependent on public assistance, to travel further for hospital and emergency care. Moreover, if Kentucky were to mirror the no-CON state statistics, it would **lose 12 hospitals and Kentuckians (and their payors) would pay $600 million more per year for inpatient services.**

There are inherent features of the U.S. health care system that limit competition:

- Health care is not a free market – seventy percent of Kentucky hospital patients, on average, are covered by Medicare and Medicaid, where government sets payment rates that are below actual cost, requiring cross subsidization for hospitals to maintain essential services.
- Federal EMTALA laws require hospitals to treat all patients, regardless of ability to pay, and society sees health care as a right.
- Insurance continues to insulate consumers from the true cost of care.

Kentucky's CON program has been modernized over the last several years such that primary care and most outpatient services are now exempt from CON.[1] **KHA supports retaining CON for new beds, ambulatory surgery centers, expensive technology or where sufficient volume is needed for good outcomes. KHA will oppose legislation fully or partially repealing CON.**

Medical Liability Reform

KHA and Kentucky hospitals continue to support the need for medical liability reform in Kentucky. The 2019 State Liability Systems Ranking Study conducted for the U.S. Chamber Institute for Legal Reform ranked Kentucky 40th among all states on elements related to the litigation environment, such as damages and jury fairness.

The lack of tort reform creates additional costs for the business community and the health care system in terms of frivolous lawsuits, inflated damages and defensive medicine. Medical liability insurance premium costs are lower for both hospitals and physicians in surrounding states that have enacted liability reforms. Kentucky is also 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 reforms. KHA and Kentucky hospitals support the following reforms along with a constitutional amendment to permit the General Assembly to evaluate the reforms that have been successful in other states and enact those or similar reforms in Kentucky.

Eliminate Phantom Damages

Today, the "billed" charges for medical services – not the "paid" charges– are being used to determine economic damages for medical expenses in personal injury litigation. Government and commercial payers reimburse only a fraction of billed charges. Kentucky hospitals believe that injured patients should be compensated for amounts they or their insurer has actually paid for medical care; but when recoveries are calculated using billed charges, "phantom damages" are created which neither the patient nor their insurer ever paid. Since pain and suffering and punitive damages are typically calculated as a multiple of economic damages, the use of billed charges inappropriately and dramatically inflates total damages in litigation. Phantom damages are adversely impacting businesses and medical provider liability insurance premiums and are a contributing factor in the rising cost of health care. **KHA and Kentucky hospitals support legislation to bring fairness to the calculation**

[1] CON no longer covers ambulatory care clinics, most mobile health services, most diagnostic imaging equipment, community mental health centers, primary care centers, rehabilitation agencies, retail based health clinics, residential crisis stabilization units, residential freestanding substance use disorder facilities with 16 or less beds, residential hospice facilities, rural health clinics, special health clinics, relocation of acute care beds among hospitals under common ownership in the area development district, redistribution of existing licensed beds among service lines in an acute care hospital.

of damages in general liability and medical malpractice litigation by limiting a plaintiff's recovery for medical expense damages to the amounts actually paid to health care providers. This will help reduce the cost of litigation and liability insurance without depriving plaintiffs from recovering legitimate reimbursement for their care.

Attorney Fees

According to the American Medical Association, 28 states have limitations on attorney fees, with 12 states having sliding fee schedules. Contingency fees are typically forty percent of a total award although some may reach as high as fifty percent if a case goes through an appeal. **KHA and Kentucky hospitals support legislation to enact reasonable limits on contingency fees on a sliding scale basis.** A sliding scale removes some incentive for lawyers to seek excessive jury awards and also helps to direct a greater portion of the award to the plaintiff.

Additionally, contingency fees should be clear, fair and transparent to enhance public and client understanding of contingency fee arrangements. **KHA supports legislation to require advertisements by attorneys to include contingency fees charged along with the public reporting of data on awards, medical and legal expenses and net amount paid to the client.**

KHA Position on Other Legislative Issues

Kentucky Hospital Association

APRN Collaborative Agreement

Current law requires that an advanced practice registered nurse (APRN) have a collaborative agreement with a physician in order to prescribe controlled substances (CAPA-CS). **KHA and Kentucky hospitals believe it is important for the collaborative agreement to be meaningful to assure that an APRN prescribes appropriately.** As current law does not contain specific prescribing or oversight requirements, **KHA recommends outlining specific standards to be met under the CAPA-CS before an APRN could be released from the agreement.** Establishing standards would also improve consistency in APRN evaluation among collaborating physicians. As hospitals are experiencing an increase in nurses obtaining an APRN license with less critical care experience, these changes will benefit patients by assuring a level of competency is met before an APRN would independently prescribe controlled substances and, particularly, opioids. KHA and Kentucky hospitals will continue to assure that any release of an APRN from the CAPA-CS for licensure purposes does not preclude a hospital from continuing to require a collaborative agreement as a condition of hospital employment.

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. Proponents of legalization often cite its benefits in reducing pain based on a 2014 study which found that between 1999 and 2010, states with medical cannabis laws had a nearly 25 percent lower average rate of opioid overdose deaths than states without such laws. That study was recently replicated by researchers at Stanford University; and, when seven more years of data was included from more states with legalized medical marijuana, the association between medical marijuana laws and opioid overdose deaths reversed – states with medical marijuana laws had average rates of opioid overdose deaths that were nearly 23 percent higher than those without these laws. The researchers concluded that there is no connection between marijuana availability and fatal opioid overdoses. This finding is significant since the majority of people obtaining medical marijuana are doing so for chronic pain. The Stanford researchers recommended large-scale clinical trials to determine how individuals respond to medical marijuana.

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, legalization could exacerbate the state'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.

Taxation of Vaping Devices

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.

E-cigarettes, which contain nicotine and flavoring, are the most commonly used form of tobacco among youth in the United States; and, according to the Kentucky Substance Abuse Prevention Program, the use of e-cigarettes nearly doubled among Kentucky youths from 2016 to 2018. The use of e-cigarettes is particularly unsafe for children, teens and young adults, as nicotine is highly addictive and can harm adolescent brain development which continues into the early to mid-20s. E-cigarettes can also contain other harmful substances including heavy metals, volatile organic compounds and may also be used to deliver illicit substances. They are readily available and evidence suggests these devices may increase the likelihood of teens moving to cigarettes.

Kentucky raised its excise tax on cigarettes in 2018 from 60 cents to $1.10 per pack, but it did not extend to e-cigarettes. **KHA and Kentucky hospitals support legislation to extend the state's existing tobacco tax to e-cigarettes. Raising the tax on all tobacco products is a core strategy to reduce smoking and the adverse health risks associated with e-cigarettes particularly among Kentucky's youth.**

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Ambulatory Facility Data Reporting

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.**

Medical Payments under 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. To address concerns with perceived overutilization of certain services, auto insurers have sought legislation to reduce payment to all medical providers under Personal Injury Protection (PIP) to match the worker's compensation fee schedule. This broad brush approach is ill-advised for hospitals because nearly all hospital services billed under PIP are related to emergency care. A KHA analysis of claims billed to auto insurance found that 92 percent of all inpatient cases came through the emergency department (ED) and another 4 percent were transferred from another hospital. Similarly, 83 percent of outpatient claims billed to an auto carrier had ED services.

The Kentucky Department of Insurance performed a study to estimate the financial impact on hospitals if payment under 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!

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. Any legislation proposing to reduce hospital payment under PIP will simply result in a transfer of money from struggling Kentucky hospitals to wealthy insurance companies, most of which already have negotiated rates with hospitals. **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 any legislation reducing payment under PIP should exempt hospitals entirely, or at a minimum, it must exempt all inpatient cases as well as any hospital outpatient service that has ED services as part of the claim.**

For more information about KHA Legislative Priorities, contact:

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