KHA Legislative Priorities for the 2017 Kentucky General Assembly

Protect Funding for Hospital Uncompensated Care

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 cost of delivering the care. There are three types of uncompensated care costs:

- **Charity Care** – Charity care consists of services for which hospitals did not expect to receive payment because the patient was determined as unable to pay.
- **Bad Debt Expense** – Bad debt occurs when patients do pay their bills but do not apply for financial assistance.
- **Medicaid and Medicare Underpayment** – These government programs set fixed reimbursement rates which do not cover the actual cost of caring for patients. Medicaid MCOs generally follow the inadequate fee-for-service rates and continue to impose tremendous administrative burdens that slow timely payment. On average, reimbursement from the Medicare program covers only 86% of actual cost. Medicaid payments are even more inadequate, covering only about 82% of actual cost.

While the ACA has reduced charity care, Kentucky’s Medicaid eligibility has swollen to more than 1.2 million people, or one in three Kentuckians. This has caused hospital losses from the Medicaid program to grow substantially. In addition, because of the growth in deductibles and coinsurance from high deductible insurance plans, bad debts are also increasing.

Hospitals receive disproportionate share payments (DSH) from the Medicare and Medicaid program to help offset uncompensated care costs, but these payments are being substantially reduced under the ACA. In 2014, Kentucky’s hospitals provided an estimated $2.1 Billion in uncompensated care costs, after factoring in the receipt of Medicare and Medicaid DSH payments.

Seventy percent (70%) of Medicaid DSH payments are comprised of federal funds and thirty percent (30%) are state matching funds, which in Kentucky are derived from a small portion of the $183 million in provider taxes paid annually by hospitals. Even though Medicaid expansion has provided coverage to the low income, uninsured, uncompensated care from Medicaid and Medicare short-falls as well as bad debts are continuing to grow, making retention of Medicaid DSH payments essential.

KHA and Kentucky’s hospitals have been diligently working to update the methodology for distributing Medicaid DSH payments to reflect uncompensated care costs from the Medicaid program as well as charity care. **KHA will seek legislation in the 2018 legislative session to implement a comprehensive, well vetted plan**, as more time is needed to obtain, audit and analyze the necessary data from claims subsequent to the expansion of Medicaid. Hospital DSH payments for SFY 2018 will continue to be paid under the current method as provided for in the 2017-2018 biennial budget.

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, “Certificate of Need: Stabilizing Force for Health Care Transformation”, 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. Specifically, the report found:

- CON is a stabilizing force which 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 standards support quality by assuring new facilities operate at volumes sufficient to produce good outcomes and that their 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, expensive technology, or where sufficient volume is needed for good outcomes. Primary care and prevention services, for the most part, are either not covered at all by Kentucky's CON program or they receive an expedited review process.

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.

### Medical Liability Reform

KHA continues to support the need for medical liability reform in Kentucky. Medical liability insurance premium costs are lower for both hospitals and physicians in surrounding states that have enacted liability reforms. The 2012 State Liability Systems Ranking Study conducted for the U.S. Chamber Institute for Legal Reform ranked Kentucky 38th worst among all states on elements related to the litigation environment, such as damages and jury fairness.

Frivolous lawsuits are a major factor driving increased medical liability premiums as well as the practice of defensive medicine. KHA supports passage of peer review protection to provide state level confidentiality to encourage candid discussions involving ways to improve patient safety. We also support lowering the statutory interest rate for appeals of judgments to a more appropriate market rate. The current interest rate of 12 percent is so high that it effectively acts as bar to the filing of appeals.

### Workforce

- KHA supports the Interstate Medical Licensure Compact legislation that would establish a streamlined process for physicians interested in practicing medicine in multiple states. We also support proposed changes to update the existing Nurse Licensure Compact which also supports the ability of nurses to practice in multiple states by expediting the process to receive a Kentucky license. These bills are important to Kentucky's workforce, especially with the increasing use of telemedicine.

- KHA supports the expansion of existing law to protect all hospital workers, both employed and under contract, from assault. The existing law, which applies only to emergency room staff, allows police to make arrests or issue a citation for assault in the fourth degree without witnessing the event if there is probable cause. This law needs to be expanded as staff working throughout the hospital are increasingly being assaulted by violent patients, particularly those receiving treatment for drug use.

- KHA opposes the licensing of lay midwives, which have proposed being called Certified Professional Midwives (CMPs). Lay midwives are not certified nurse midwives, which are advanced practice registered nurses in nurse midwifery. Legislation proposed to license CMPs due to the lack of safeguards to assure quality of existing programs.

- KHA opposes legislation that would allow physician assistants to prescribe controlled substances. Kentucky is experiencing a heroin epidemic due to opioid abuse, and we believe it is prudent to contain the prescription authority of controlled substances to those currently authorized (ie., physicians, dentists, and nurse practitioners).

### Statewide Smoke Free Law

Secondhand smoke is a known cause of lung cancer, heart disease, low birth-weight babies, chronic lung ailments, and other health problems. The World Health Organization...
Statewide Smoke Free Law - continued

has stated “Scientific evidence has firmly established that there is no safe level of exposure to second hand tobacco smoke.” The health problems caused by tobacco use and secondhand smoke exposure come with a huge price tag. Health care costs directly attributed to tobacco use total $1.5 billion a year in Kentucky. Add that to the $2.3 billion in lost productivity due to early deaths from smoking, and the cost is a staggering $3.8 billion every year. Eliminating secondhand smoke in the workplace would save lives, health care costs, cleaning and maintenance costs, and improve worker productivity. It would have a long term positive impact on the Medicaid budget by reducing smoking related illness. 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. KHA supports a smoke free law in Kentucky.

Caregiver Act

KHA opposes the AARP Caregiver Act as it would create unnecessary, costly additional mandates on Kentucky’s hospitals. Kentucky hospitals are already mandated to comply with national standards — through Medicare Conditions of Participation and Joint Commission accreditation standards — which adequately ensure that hospitals educate patients and their caregivers about post discharge care. These standards already require that hospitals undertake an assessment of the patient’s capacity for self care, identify who could be trained to provide post discharge care, actively engage the patient or their representative in the development of the discharge plan, and document in the patient’s record the arrangements for implementation of the discharge plan. Imposing a new state law on top of these national standards is not needed and will only result in an additional cost and burden on hospitals.