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# 2017 Legislative Guide

*The following legislative priorities for the 2017 session will support a strong hospital community.*

## Reforming Managed Care

The Missouri Hospital Association has developed legislation to address hospitals’ concerns with Medicaid managed care. Staff cataloged those concerns and the MHA Board of Trustees incorporated the product of those discussions into a set of advocacy principles which, in turn, have been incorporated into legislation. Many components of the legislation relate to “regulatory relief.” The legislation to reform managed care addresses the following principles.

### Reduce Administrative Cost

- Managed care utilization review protocols should be standardized across plans, be fairly and transparently adjudicated, and defined in collaboration with network providers.
- To reduce the administrative burden and cost associated with multiple plans supplanting a single fee-for-service agency, administrative obligations should be standardized, including financial and quality data requirements.

### Funding

- Provider taxes should be used to fund payments to providers who pay them and should not be diverted to other uses.
- Alternative payment streams must be developed to offset the loss of federally sanctioned upper payment limit payments associated with traditional Medicaid managed care.

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### In 2015, Missouri hospitals ...

**H** employed **more than 152,000** full- and part-time workers

**H** provided **more than \$9.9 billion** in payroll to rural economies

**H** provided **\$1.77 billion** in capital investment to their local communities

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Reforming Managed Care *continued* ▼

### State Budget Issues

- ▶ HMOs should contribute an equitable share of the cost of funding the state portion of expansion costs.

### Accountability Measures

- ▶ Medicaid managed care plans should have financial incentives to prevent avoidable use of the emergency department by managing their enrollees' behavior without penalizing hospitals.
- ▶ Network adequacy standards should provide access comparable to private coverage for adult, pediatric and behavioral health.
- ▶ MO HealthNet should collect a robust compilation of data on Medicaid plan performance and outcomes.
- ▶ Medical loss ratios should be established to minimize diversion of funds from patient care to HMO profit and administrative expense.

### Provider-Sponsored Delivery Models

- ▶ MO HealthNet should authorize provider-sponsored models of care delivery, including ACOs, primary care health homes and care management for medically complex children.
- ▶ The Medicaid managed care delivery system should allow for shared savings and risk- and gain-sharing arrangements between providers and insurers.
- ▶ Cost savings attributable to better management of treatment costs and utilization should accrue, after payment of reasonable management expenses, to the benefit of state government, providers and alternative payment models.

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## Medicaid Budget and Savings Opportunities

Missouri's state government is struggling with a shortfall in its budget. For the current state fiscal year, Governor Greitens ordered the withholding of \$150 million in spending shortly after taking office. The governor's proposed budget for the state fiscal year beginning July 1 includes proposed spending reductions of more than \$500 million.

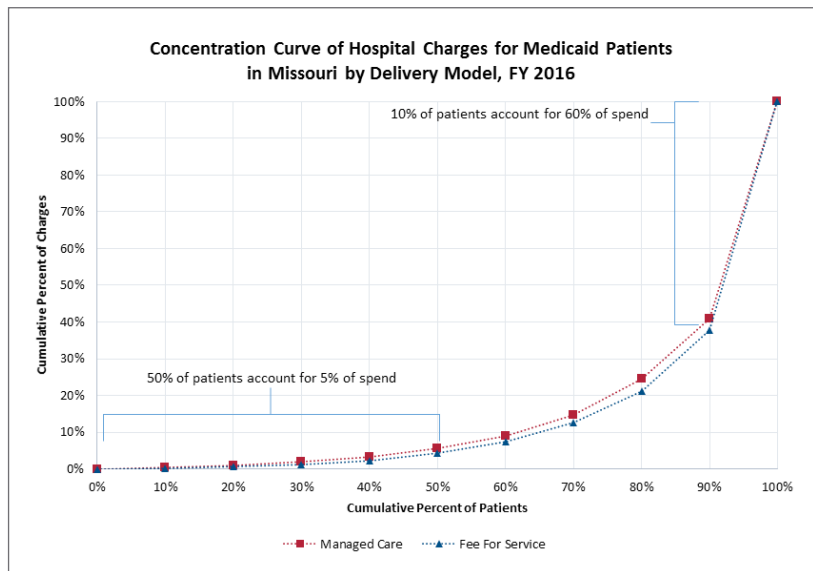
The governor's proposed budget would impose a 3 percent payment reduction for most Medicaid providers, but hospitals were excluded from this direct payment reduction. However, the governor's proposed budget serves as a starting point for legislative debate of state spending, and hospitals are vulnerable to spending reductions as the next state budget is developed and refined in the General Assembly.

MHA is engaging with state officials to promote ways for hospitals and state government to collaborate to improve care and streamline government operations and costs.

In this environment, MHA is working to focus attention on the opportunities and cost savings associated with "superutilizers" in the Medicaid program. As shown in the following graphic, 10 percent of Medicaid enrollees generate 60 percent of Medicaid spending. Identifying those high utilizers and better managing their care is essential to ensuring the fiscal stability of the Medicaid program.

Inappropriate use of hospital emergency departments by Medicaid enrollees is often cited as a concern by state legislators. An initiative called "LANE" (Low Acuity Non-Emergency) would reduce hospital

emergency department Medicaid payments based on a state methodology that designates a percentage of those visits as “nonemergent.” MHA is collaborating with emergency physicians and others to craft a more sophisticated and effective approach, using technology to identify and better manage the care of patients with frequent or inappropriate emergency department care.



## Containing Health Care Costs — Medical Liability

### *Jefferson v. Missouri Baptist*

Missouri hospitals’ most significant medical liability concern is the 2014 *Jefferson v. Missouri Baptist* court ruling of the Eastern District Missouri Court of Appeals. Taking advantage of an omitted word in the 2005 medical liability reform legislation, the court applied a significantly broader standard for determining when physicians act as an agent of a hospital or other organization. In doing so, the court expanded hospital liability for the acts and omissions of physicians who are not hospital employees. Although the decision does not set a statewide precedent, it is being applied as such and is the impetus for significant premium increases for medical malpractice liability coverage. Higher premiums boost the cost of delivering health care services. MHA will be promoting legislation to restore the original intent of the 2005 medical malpractice reform law.

### Merchandising Practices Act

MHA supports legislation to block use of the state’s Merchandising Practices Act to pursue or augment medical liability or other personal injury lawsuits. Defense counsel note a growing incidence of Missouri’s Merchandising Practices Act being used as a basis for lawsuits to recover damages for personal injury or death, augmenting the remedies available through the medical malpractice liability and wrongful death statutes. The addition of a new layer of potential litigation expense and potential liability exacerbates the pressure on defendants to settle the lawsuits to the benefit of plaintiffs’ attorneys.

### Prompt Service of Process

MHA supports legislation to establish a deadline for notifying all parties that a medical malpractice lawsuit has been filed. Plaintiffs’ attorneys often file a medical malpractice lawsuit within the statute of limitations, but then cause significant delays in service of process to notify all parties that the lawsuit has been filed. The legislation will establish a reasonable standard for ensuring that all parties are made aware of the litigation in a timely fashion.

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# Streamlining Government and Regulatory Reform

MHA's Streamlining Government Initiative solicits member suggestions to help determine existing regulatory requirements that are unnecessary, overly burdensome, duplicative or inconsistent with other federal or state requirements.

Last legislative session, MHA worked with the state legislature to approve a number of regulatory reform proposals, including proposals to eliminate duplicative regulations and unnecessary data collection. These efforts continue, including legislation to allow the regulatory standards of the Centers for Medicare & Medicaid Services — the federal agency that administers the Medicare and Medicaid programs — to supplant duplicative and sometimes inconsistent state licensure standards.

By contractual agreement with the federal government, Missouri's state hospital licensure officials serve as the regulatory compliance inspectors of CMS. All hospitals must comply with CMS regulatory standards to treat Medicare and Medicaid enrollees. State licensure standards are largely duplicative, but sometimes inconsistent, because of regulator interpretations and restrictions on Missouri's ability to keep current with evolving standards of quality and safety.

Having a single regulatory standard will reduce the cost and complexity of administering parallel and sometimes inconsistent regulatory systems without affecting the regulatory standards for Missouri hospitals.

The Missouri Department of Health and Senior Services recently allowed the University of Kansas Medical Center to rely solely on CMS standards as a basis for regulating its Missouri clinics. Missouri hospitals should be afforded the same opportunity.

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## Workforce

### **Modifying APRN Practice Standards**

State legislative battles between physician and nursing advocates regarding practice standards for advanced practice registered nurses have become more politically toxic in recent years as more aggressive legislation has been proposed that would sever all, or most, of the physician-APRN collaboration standards of current law and regulation. As directed by its board, MHA has not supported those nursing proposals, continuing its practice of favoring more incremental reforms to loosen, but not sever, collaborative practice standards. Specifically, the standards for mileage between the APRN and physician seem obsolete with the ready availability of modern technology, and limitations on the types of drugs that may be prescribed appear to be inconsistent with evidence from other states.

The MHA board convened an ad hoc work group of hospital executives and others with clinical backgrounds to assess the topic. Broadly, the participants favored less reliance on somewhat arbitrary statutory requirements and more emphasis on clinical judgment and ensuring that practice standards focus on patient outcomes. A query of MHA-member hospitals indicated strong support for retaining collaborative practice arrangement between physicians and APRNs.

### **Violence Against Health Care Workers**

MHA supports legislation that would impose enhanced criminal penalties on those who commit assault or other acts of violence against hospital emergency department and trauma center personnel. Current law already provides for some criminal penalties in these circumstances of which the legislation would strengthen and broaden.

## Providing Behavioral Health Services

The challenges of providing behavioral health services is exacerbated by a shortage of psychiatrists and psychologists in large swaths of Missouri. Without access to behavioral health providers, patients with psychiatric ailments who seek treatment at hospital emergency departments too often must be kept there awaiting placement at a behavioral health treatment facility.

Using funds from the hospital provider assessment, the Federal Reimbursement Allowance, the Missouri Hospital Association will ask the General Assembly to consider an appropriation item to authorize a payment stream to offset some of the costs of managing behavioral health patients as they await transfer to a behavioral health treatment facility.

The FRA funds to support this initiative would be made available by the implementation of federal reductions in funding for Medicaid Disproportionate Share Hospitals payments beginning in October 2017. The federal funding reductions are authorized by the federal Patient Protection and Affordable Care Act of 2010. In Missouri, all of the state share of Medicaid DSH payments is funded by the FRA. If federal reductions restrict Medicaid DSH payments beginning in October 2017, the FRA funds that would have been used to support those DSH payments will become available for other hospital uses. With many hospitals voicing concern about challenges in delivering care to behavioral health patients, MHA proposes to redirect those hospital funds to help address those challenges.

## Opposing the Diversion of the FRA

Missouri's budget shortfall in the current state fiscal year led Governor Greitens to withhold \$150 million in spending. The governor's proposed budget for the state fiscal year beginning July 1 includes proposed spending reductions of more than \$500 million. This fiscal environment exacerbates the pressure on state officials to consider redirecting the FRA to be used for purposes other than hospital payments. MHA continues to strongly oppose efforts to divert the FRA for any other use.

### What is the FRA?

The FRA is Missouri's hospital provider tax. It began in 1992 and is the third largest source of revenue in the state budget. The hospital FRA is used to fund nearly the entire state share of hospital-related Medicaid expenditures. In SFY 2015, it generated \$1 billion in tax revenue and \$2 billion in federal Medicaid matching funds for a total of \$3 billion in Medicaid hospital-related payments. The hospital FRA is a major source of revenue for the state.

In FY 1990, 39.5 percent of the Medicaid budget was funded by general revenue. By FY 2016, the percentage had fallen to 15.4 percent.

### How is the FRA used?

- ▶ The FRA greatly benefits state government. State government uses it to eliminate the need for general revenue to fund Medicaid hospital care.
- ▶ The hospital FRA frees up hundreds of millions of dollars of traditional general revenue to fund other state priorities, such as schools and veterans' services.

FRA Assessment Compared to State Sources of General Revenue	
Revenue Producer	Estimated Revenue (After Refunds) FY 2016
Individual Income Tax	\$6.023 billion
Sales and Use Tax	\$2.032 billion
<b>Hospital FRA</b>	<b>\$1.087 billion</b>
Corporate Income Tax	\$339.7 million
County Foreign Insurance Tax	\$219.0 million

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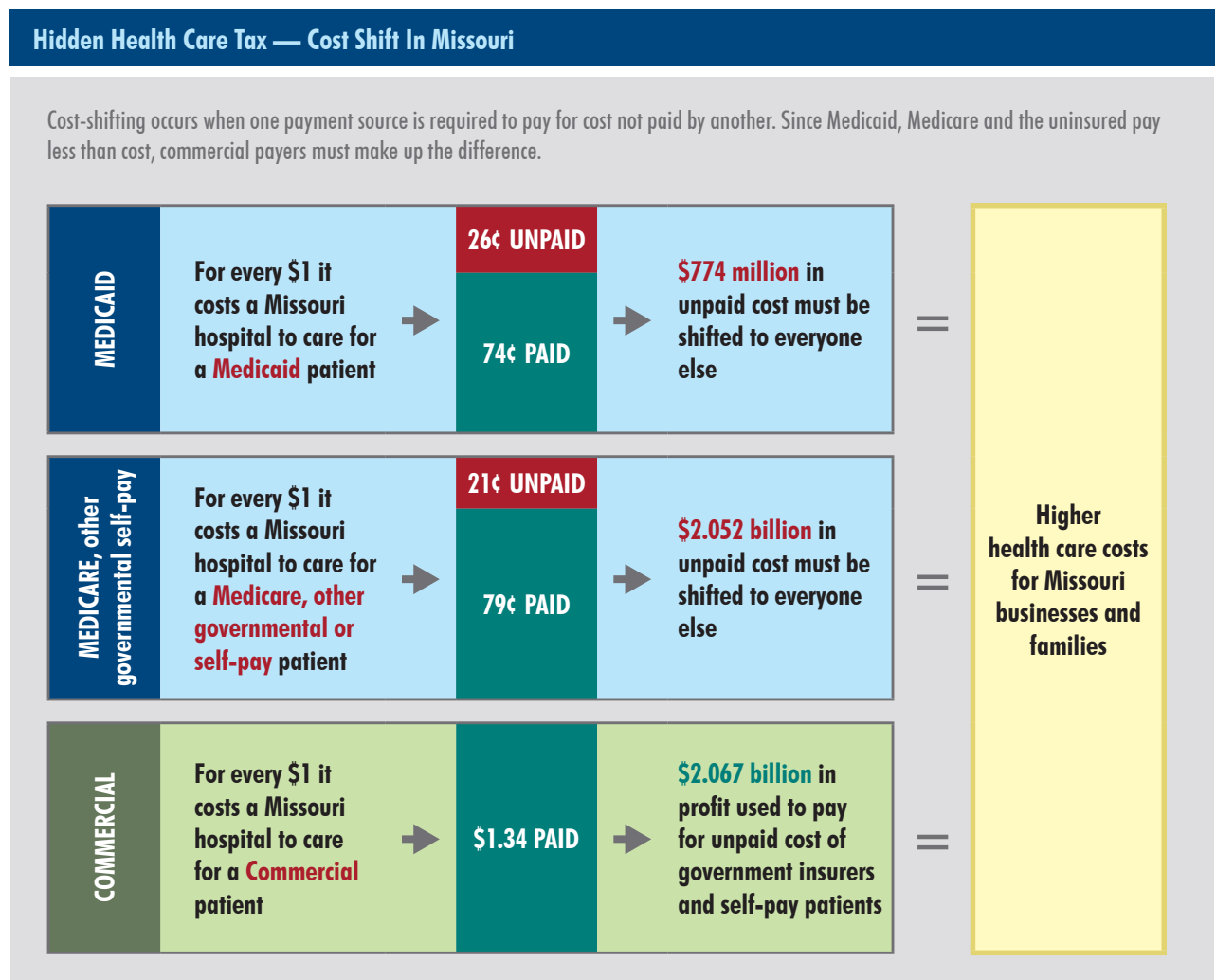
Opposing the Diversion of the FRA *continued* ▼

**How much cost-shifting is generated by below-cost payments?**

Although the FRA has saved the state billions in general revenue, the net losses incurred by the payment system have been shifted to private payers.

**What is FRA diversion?**

If state officials use their budgetary authority to redirect FRA to uses other than hospital payments, hospitals will incur even greater losses. This will exacerbate pressures to cost-shift to employers, insurers and patients — increasing Missouri’s “Hidden Health Care Tax.”



## Other Issues

### Covenants Not To Compete

Covenants not to compete are used by hospitals to recruit a new physician to a practice or community to ensure that hospitals have a reasonable period of time to recover the significant investment required to recruit and place the physician, and develop the practice.

Contracts between physicians and hospitals are “arms-length transactions” made by sophisticated and capable professionals on both sides. Physicians are not forced to sign a contract that includes a non-compete provision and can always negotiate or refuse to sign the offer if a compromise cannot be reached with the hospital.

Covenants not to compete do not bind a physician forever. The contracts rarely last more than two years and often include the opportunity for the physician to “buy out” the covenant not to compete.

Legislation to prohibit covenants not to compete will disadvantage Missouri hospitals near state borders where the adjacent state allows them. This would allow out-of-state organizations to “poach” Missouri physicians and then use their contracts to discourage a return to Missouri.

Physician recruiting is very difficult for not-for-profit hospitals because they are limited in what they can pay doctors because of IRS rules that require all compensation agreements to be within “fair market value” parameters. Often such hospitals have to engage costly compensation consultants to provide an opinion. And, typically, such hospitals pay beyond the 75th percentile in a given specialty.

### Medical Specialty Board Certification

MHA opposes legislation that would restrict the authority of hospitals and their medical staff to make their physician employment and medical staff privileging decisions.

The legislation builds upon a law enacted in 2016 which prevents the state physician licensure agency from using a more rigorous system of medical specialty board certification advanced by the Federation of State Medical Boards. The legislative sponsor now is concerned that physicians may be free from state licensure obligations tied to this specialty board certification system, but won’t be able to practice if hospitals, their medical staff and insurers make compliance with this specialty board certification system a condition of employment or staff privileges.

MHA is working to block the legislation. This would preserve the authority of hospitals and their medical staff to set the criteria used in making physician employee and medical staff privileging decisions.

### Reducing Bad Debt

In the 2013 legislative session, a compromise gave health maintenance organizations the ability to market high deductible insurance products but only when combined with fully funded health savings accounts so that health care providers would be able to seek reimbursement for medical expenses.

Last legislative session, a number of insurance companies supported bills to delete the requirement to have health savings accounts and allow HMOs to sell policies that have co-payments higher than 50 percent.

The bills would have allowed HMOs to sell policies for \$6,850 on self-only coverage and \$13,700 on the other policies.

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Other Issues *continued* ▼

Uncollected deductibles and copayments already have a negative impact on hospital bottom lines. Missouri hospitals reported \$577 million in bad debt in 2015. This legislation would substantially increase those costs.

Last year, these bills were soundly defeated, but could again be before the legislature.

### Sepsis Protocols

MHA supports sepsis protocols in hospitals. Many Missouri hospitals already have sepsis protocols incorporating the Centers for Disease Control and Prevention's seven best practices. But, we oppose a requirement that those protocols be approved by the Missouri Department of Health and Senior Services. The rulemaking process at DHSS historically has been extremely slow and cumbersome for Missouri hospitals. Fixing protocols in statute would freeze medical practice at one point in time and is contrary to good medical practice and good public policy. Hospitals don't need a state regulation to provide detailed guidance on how to identify and treat sepsis since it already exists in practice.

### Certificate of Need

Historically, MHA has opposed repeal of certificate of need review and approval for new hospitals. Thus far in 2017, the likely focus of debate about certificate of need will be on the process by which the decisions are made, not the standards themselves. Legislation is pending that would change the process by which CON decisions are made, by replacing the legislator members of the Missouri Health Facilities Review Committee with gubernatorial appointees and prohibiting ex parte communications concerning CON applications. The MHA Board of Trustees will consider the association's stance regarding these changes in the CON process.



### Improving the Health of Missourians

Missouri's hospitals are committed to improving health. The foundation of this effort is embracing the Triple Aim — better health and better care at lower cost.

Hospitals provide benefit to their communities through various services and programs — often outside of the hospital campus — that support healthier communities and improve individual health. By providing better care, hospitals create value for patients and the health care system. And, by focusing on health improvement and high-quality care, hospitals are helping reduce the cost of chronic, often preventable conditions, which improves value for patients.

For those without insurance, or the underinsured, hospitals provide a safety net for care. With hundreds of thousands of uninsured Missourians, this investment is essential to the individuals who receive the care and communities throughout the state.

With the Triple Aim as a guiding principle, hospitals are making Missouri a healthier place to live. And, that's good for all Missourians.