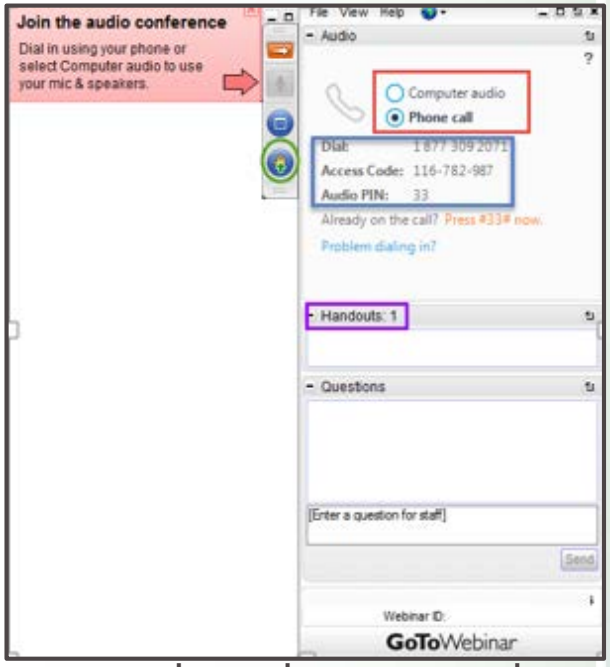
Welcome to the webinar.
The presentation will begin shortly.



- You may listen via phone or via computer audio if your computer has speakers.
- This webinar will be in a “listen only” mode with opportunity to ask questions at the end of the presentation as time allows.
- All lines have been muted. Please enter any questions via the question feature in your control panel.
- If you wish to communicate via phone during the question session please use the “raise your hand” feature in the control panel and your individual line will be unmuted. You must enter the audio PIN for the line to be unmuted.
- Please do not place your line on hold. If you need to step away, please hang-up and redial when you are able to rejoin the call.
- Slides will be placed on the MHA website following the webinar.
- Thank you for your participation!

MISSOURI HOSPITAL ASSOCIATION

2018 Legislative Update: Medicaid Funding/Emergency and Out-of-Network Coverage

October 23, 2018

Medicaid Appropriations for Hospital Services

SFY 19 Medicaid Budget: MHA Advocates to Limit Hospital Cuts

- Governor Greitens' proposed budget for state fiscal year 2019 included recommendations that would have cut Medicaid reimbursements for Missouri hospitals by **$136.3 million**.
- The hospital provider tax — the FRA — helps the state by lessening the amount of General Revenue needed to fully fund the Medicaid program.

  Because of the FRA, the state needs relatively little General Revenue to fund Medicaid hospital payments.
- Based on the amount of state General Revenue actually committed to the Medicaid hospital programs, MHA took the position that a **fair share** budget cut to hospitals would be **$20.8 million**.

SFY 19 Medicaid Budget: MHA Advocates to Limit Hospital Cuts

- Member hospitals and MHA mounted an intense advocacy campaign during the legislative session to reduce budget cuts.
- The **House** recommended cuts of $106.6 million — **$89.9 million** from Missouri hospitals.
  - Restored $38.2 of FRA funded cuts
  - Recommended $16.7 million in cuts from out of state hospitals
- The **Senate** recommended cuts of $37.4 million — **$20.8 million** from Missouri hospitals.
  - Language limited department's authority to cut to $20.8 million
  - Recommended $16.7 million in cuts from out of state hospitals
- The **TAFP Budget** included cuts of $48.9 million — **$32.2 million** from Missouri hospitals.

SFY 19 Medicaid Budget: MHA Advocates to Limit Hospital Cuts

- MHA and hospitals have continued aggressive advocacy against MO HealthNet Division actions that MHA believes exceed the budget plan passed by the General Assembly.
  - Mounted aggressive campaign in opposition to MO HealthNet's 90 percent Non-Par contract amendment
  - Challenged the legality of MO HealthNet outpatient rule before the Joint Committee on Administrative Rules
  - Issued an extensive significant "Sunshine Request" for documents related to the 90 percent Non-Par contract amendment
  - Organized testimony for Legislative hearings (House Budget Committee, House Committee on Health & Mental Health Policy)
  - Ongoing and regular contact with House and Senate leadership and MO HealthNet Oversight Committee

SFY 2019 MO HealthNet Outpatient Cuts
SFY 2019 Estimated Impact

		SFY 2019 ESTIMATED IMPACT		
		Missouri Hospitals	Out-of-State Hospitals	TOTAL
Outpatient Radiology *Effective 1/1/19*	*Reduced Fee Schedule*	**$3,925,633**	**$130,404**	**$4,056,037**
Outpatient Bariatric & Spinal Surgeries *Effective 1/1/19*	*Change from % of Charge to Fee Schedule*	**$156,755**	**$11,199,756**	**$11,356,511**
Outpatient Pharmacy *Effective 2/1/19*	*Change from % of Charge to Fee Schedule*	**$8,052,656**	**$31,695**	**$8,084,351**
90% Non-Par MCO Reimbursement Cap *Effective 7/1/18*	*Managed Care Contract Amendment*	***Impact to be determined***	***Impact to be determined***	***Impact to be determined***
TOTAL		**$12,135,044**	**$11,361,855**	**$23,496,899**

SFY 2019 MO HealthNet Outpatient Cuts
SFY 2020 Estimated Impact

		SFY 2020 ESTIMATED IMPACT		
		Missouri Hospitals	Out-of-State Hospitals	TOTAL
Outpatient Radiology *Effective 1/1/19*	*Reduced Fee Schedule*	**$7,851,268**	**$260,811**	**$8,112,079**
Outpatient Bariatric & Spinal Surgeries *Effective 1/1/19*	*Change from % of Charge to Fee Schedule*	**$313,506**	**$22,399,513**	**$22,713,019**
Outpatient Pharmacy *Effective 2/1/19*	*Change from % of Charge to Fee Schedule*	**$19,326,381**	**$76,070**	**$19,402,451**
90% Non-Par MCO Reimbursement Cap *Effective 7/1/18*	*Managed Care Contract Amendment*	***Impact to be determined***	***Impact to be determined***	***Impact to be determined***
TOTAL		**$27,491,155**	**$22,736,394**	**$50,227,549**

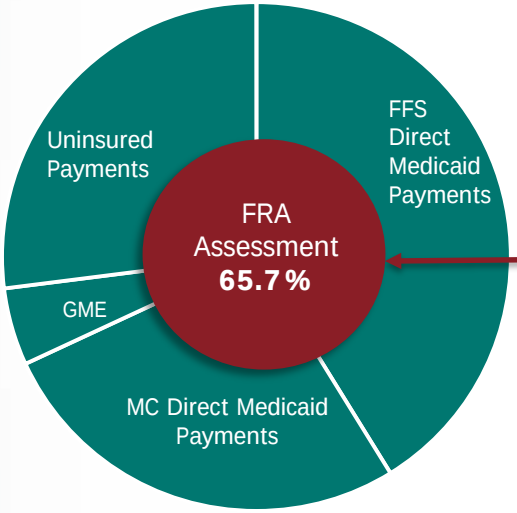
FRA Reauthorization and Payment Safeguards

FRA Payment Safeguard

- Updating a 2001 FRA payment safeguard in law:
  - Former “85 percent test” for FRA tax versus specified hospital payments was obsolete.
  - New standard: Tax cannot exceed 45 percent of all FRA-funded payments.
  - Compels better state tracking of managed care funds and hospital payments. Biggest value is not in protection but process.
  - Advocacy message: State government should be accountable for how it spends public money.

Former FRA Safeguard

FRA assessment cannot exceed
85% of FRA-funded
hospital **Direct Medicaid** payments

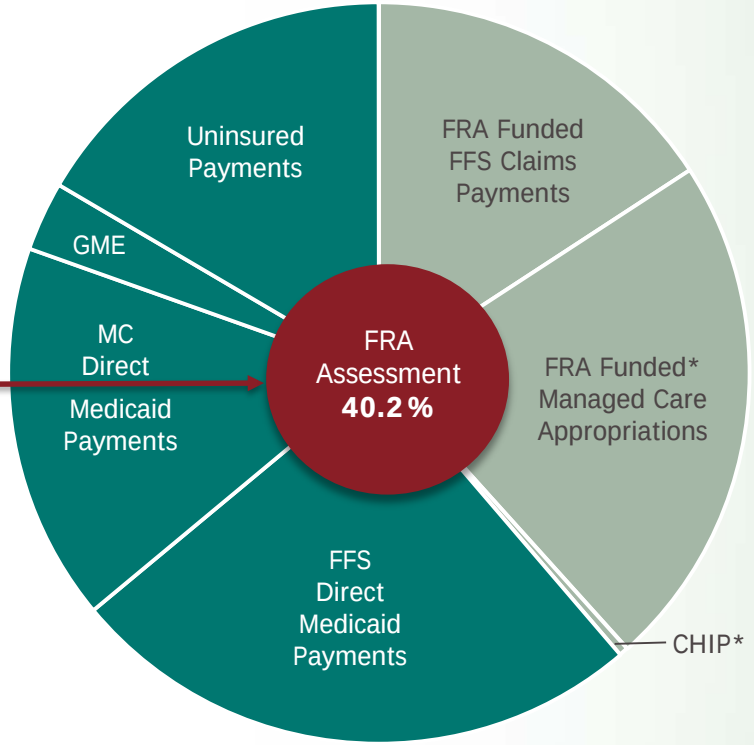


SFY 18 Hospital Direct Medicaid Payments
$1.664 Billion

SFY 18 FRA Assessment
$1.093 Billion

New FRA Safeguard

FRA assessment cannot exceed
45% of **ALL**
FRA-funded hospital payments



SFY 18 Total Estimated Hospital Payments
$2.716 Billion

*Assumes hospitals receive 50 percent of managed care and CHIP

Data Source: MO HealthNet Division

New Health Insurance Coverage Standards

Insurance Coverage of Emergency Treatment

- S.B. 982 clarifies that the "prudent layperson" law requiring coverage of hospital emergency services based on the patient's symptoms will be applied without regard to the final diagnosis.
- An insurer's payment denial based on the absence of an emergency medical condition must involve a medical record review by a board-certified physician.
- Medical records are to be furnished to the insurer within 45 processing days.

Insurance Coverage of Emergency Treatment

- The treating emergency physician will determine what services are necessary to screen and stabilize the patient, which insurers must cover.
- Requires insurers to pay providers, rather than patients, for out-of-network services to screen and stabilize an emergency medical condition and for follow-up care authorized by the insurer.

Insurance Coverage of Mammography

- Requires insurance coverage of annual mammograms for women age 40 and older. Under current law, coverage of annual examinations begins at age 50. (H.B. 1252)
- Adds digital mammography and breast tomosynthesis to the definition of low-dose screening mammography in a state law requiring insurance coverage of mammography.
- As of 1/1/19, payment will “reflect the resource costs of each modality, including the increased resource cost of breast tomosynthesis.”

Insurance Coverage of Other Services

- Includes chemical dependency in a definition of mental health conditions for which insurance coverage is required. (S.B. 718, S.B. 951)
- Requires health insurers to reimburse for services delivered by an assistant physician on the same basis as for comparable mid-level practitioners. (S.B. 951, S.B. 718)

Senate Bill 982 – "Surprise Billing" of Out-of-Network Care

S.B. 982 Surprise Billing of Out-of-Network Care

- Effective January 1, 2019
- Applies to:
  - Health care professional — "a physician or other health care practitioner licensed, accredited or certified by the state of Missouri to perform specified health services consistent with state law"
  - Unanticipated out-of-network care — "health care services received by a patient in an in-network facility from an out-of-network health care professional from the time the patient presents with an emergency medical condition until the time the patient is discharged"

Adjudication Process

- Professional submits claim for unanticipated out-of-network care within 180 days of date of service.
- Heath carrier offers to pay a reasonable reimbursement rate within 45 days. If the professional participates in any of the carrier plans, the carrier is to pay the professional the highest in-network contracted commercial rate between the professional and carrier.
- If the health care professional declines, the professional and carrier have 60 days from the date of the initial offer to negotiate.
- Arbitration process begins after day 60 if agreement cannot be reached.

Arbitration Process

- Initiated by either the carrier or professional.
- Professional and carrier execute a nondisclosure agreement.
- Must provide written notification to the director and the other party within 120 days of the end of the negotiation period.
- Arbitration process can consist of more than one claim. Must represent similar circumstances and services provided by the same professional.
- Director randomly selects an arbitrator for each case.
  - Director to specify criteria for an approved arbitrator by rule.
- Cost of the arbitrator will be shared equally.
  - Cost includes time to review materials, travel expenses and reasonable time for drafting decision.

Arbitration Process

- Establish fair reimbursement rates.
  - Arbitrator determines a fair payment rate between 120 percent of Medicare allowed and the 70th percentile of the usual and customary rate.
  - Rate may take into account the provider's training, education, experience, circumstances and complexity of the case, and average contracted rate for comparable services.
- Arbitrator's final decision is binding on all parties.

Effect on Patient

- If a professional bills a carrier for unanticipated out-of-network care, the professional cannot bill the patient more than what the patient would have paid if the service was provided by an in-network health care professional.
  - Cost-sharing requirements based on either an agreed upon rate or the rate established through the arbitration process.
  - Carrier is required to inform the professional of its enrollee's cost-sharing requirements within 45 days of receiving a claim.
  - In-network deductible and out-of-pocket maximum applies to unanticipated out-of-network claims.
- Patient should not be required to participate in the arbitration process.

Federal Proposal – Surprise Billing Discussion Draft

- Protecting Patients from Surprise Medical Bills Act
- Senators Cassidy (R-LA), Bennet (D-CO), Young (R-IN), Grassley (R-IA), Carper (D-DE) and McCaskill (D-MO)
- **Proposed**
- **If enacted, effective January 1, 2020**

Federal Proposal – Emergency Services

- Emergency services – medical screening examination
- Plan shall pay an out-of-network provider
  - Defers to state law if state law prescribes how surprise billing and payment should be adjudicated – S.B. 982
  - Greater of:
    - Average amount – median in-network amount
    - Usual, customary and reasonable rate — 125 percent of the average allowed amount for all private health plans for services provided by a provider in the same or similar specialty within same geographic area. Determined by statistically significant benchmarking database maintained by a nonprofit organization.
- Limiting out-of-pocket liability to be the same if services were performed by in-network provider

Federal Proposal – Subsequent Non-Emergency Services

- Subsequent non-emergency services – services provided after emergency services within the same visit
- Requires hospitals to notify the patient in writing before additional services are provided by an out-of-network provider or out-of-network facility
  - Information about higher cost-sharing
  - Option to transfer to an in-network facility
  - Written acknowledgement of such notice – patient required to sign in advance

Federal Proposal – Non-Emergency Services

- Non-emergency services provided by an out-of-network provider at an in-network facility
- Plan shall pay an out-of-network provider
  - Defers to state law if state law prescribes how surprise billing and payment should be adjudicated
  - Average amount – median in-network amount
  - Usual, customary and reasonable rate – 125 percent of the average allowed amount for all private health plans for services provided by a provider in the same or similar specialty within same geographic area. Determined by statistically significant benchmarking database maintained by a nonprofit organization.
- Limiting out-of-pocket liability to be the same if services were performed by in-network provider