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MHA
MISSOURI HOSPITAL ASSOCIATION

Medicaid Managed Care Advocacy: An Overview

By Daniel Landon, MHA's Senior Vice President of Governmental Relations

Medicaid managed care is a financing and delivery model. Rather than have the Medicaid agency pay providers directly for treating Medicaid enrollees, it introduces an intermediary. The state agency contracts with health maintenance organizations, generally called health plans, to pay them a fixed monthly premium for each Medicaid enrollee. The plans are responsible for assembling networks of health care providers and paying them to deliver treatment in accordance with plan protocols and standards. Federal standards dictate that at least 85 percent of managed care premiums must be spent on patient care, so plans are authorized to expend as much as 15 percent for administrative expenses and profit.

In theory, paying a fixed fee for each enrollee creates incentives to deliver care efficiently, improve outcomes and reward investments in preventing illness. In practice, Medicaid managed care in Missouri is far less rosy. Many hospitals and other providers consider the focus of Medicaid managed care to be managing cash rather than managing care. Most hospital executives and practitioners believe that Medicaid managed care plans bring far more complexity and hassle to the delivery system than they generate in value or efficiency. In particular, their Byzantine utilization review standards seem designed to delay and deny payment and increase providers' administrative costs. They are made even more maddening by the refusal of the state Medicaid agency and the three Medicaid managed care plans to implement common standards among the plans.

Accordingly, the Missouri Hospital Association is working to legislatively change Medicaid managed care standards to promote accountability and fairness. Working with its members, MHA compiled a list of things hospitals don't like about Medicaid managed care. The list was incorporated into a set of MHA board-endorsed advocacy principles and a state legislative proposal to address those concerns.

In May 2017, the geographic scope of Medicaid managed care in Missouri expanded. Previously, Medicaid managed care was limited to the region of the state broadly described as the "I-70 corridor," encompassing a broad swath of 54 counties in the mid-section of the state, running from Kansas City to St. Louis. Through a late night budget amendment enacted with no hearings and little debate in 2015, the Missouri General Assembly authorized the expansion of Medicaid managed care to all counties. However, not all Medicaid enrollees are covered by Medicaid managed care. Almost all children and low-income parents are included. Medicaid enrollees who are elderly, blind or disabled are not.

In June 2018, the state Medicaid agency unveiled a proposed change to its contracts with its Medicaid managed care vendors, to take effect July 1. The change says that if a hospital or other Medicaid provider does not contract with a Medicaid

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managed care plan, its Medicaid payment rate will drop to 90 percent of the fee-for-service payment amount. The contract amendment does more than regulate non-contracting hospitals, of whom there are only a few. It affects all hospitals by tilting the market in favor of the three Medicaid managed care plans by giving them all the leverage in negotiating contracts. If hospitals do not agree to accept whatever payment rate the Medicaid managed care plan offers, the plan can simply refuse to sign a contract. The Medicaid agency's action puts a "thumb on the scale" in what is supposed to be a free-market negotiation.

MHA pulled out the stops in orchestrating an advocacy campaign opposing the contract change. One hundred hospital CEOs signed letters to the governor, including every member of the MHA Board of Trustees. More than 60 hospitals submitted statements of opposition at a legislatively mandated public hearing on the proposal. More than a dozen hospital executives and governing board members presented direct testimony. There were scores of contacts with and by state legislators.

Unfortunately, the administration of new Gov. Mike Parson, who had just taken office, declined to stop or delay the proposed contract amendment, which was initiated by the administration of his predecessor, Eric Greitens. As expected, the Medicaid managed care plans now are using the new contracting amendment as a weapon — terminating or threatening to terminate hospitals' current contracts to force payment concessions from hospitals. What is most galling is that the Medicaid agency is not reducing its payments to the Medicaid health plans, so that the program savings do not accrue to state government. The plans themselves are enriched by stable revenues and lowered costs.

In the wake of the state's contract amendment, MHA launched a Medicaid Managed Care Accountability Initiative. It will formalize and expand MHA's focus on tracking and reporting on Medicaid managed care accountability and value, or lack thereof. Work is underway to assess the effects of the contracting changes on Missouri hospitals and their communities.

For more information on Medicaid managed care, read the August 2018 edition of HIDI HealthStats, "How Effective Are Medicaid MCOs At Managing Care In Missouri?"

BRYANT SCHOLARS PROGRAM ADDRESSES RURAL HEALTH ACCCESS

The Lester R. Bryant Scholars Pre-Admissions Program at the University of Missouri - School of Medicine encourages young people from rural backgrounds to pursue an education in medicine. Program participants are more likely to choose a primary care specialty and twice as likely to choose family medicine as their specialty when compared to nonparticipants. Outcomes also find that 68 percent of Bryant Scholars practice in a rural location, and 76 percent practice in Missouri.

Addressing the current Bryant Scholars participants, Jon Doolittle, Regional President of Northwest Medical Center, stated, "There's nothing more energizing than time spent visiting with brilliant young people who are committed to servant leadership of rural Missouri communities. It is a great pleasure to help them understand the dignity and importance of the vocation they are preparing to carry out, and to laugh with them as we contemplate the joys and the difficulty of the mission ahead."

Related MHA Resources

2018 Primary Care Physicians: Missouri Workforce Update
http://bit.ly/PCPReport2018

2018 Annual Workforce Report
http://bit.ly/WorkforceReport2018

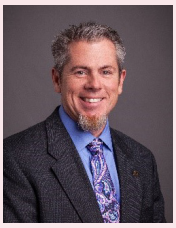
Workforce Web Page
https://web.mhanet.com/workforce.aspx

A MESSAGE FROM

Chris Lang, FACHE
CEO, Cass Regional Medical Center

The contract changes to Medicaid managed care are not good policy. Given recent health care-related actions by the Department of Health and Senior Services (i.e. the opioid letter to physicians) and other Missouri governmental entities, there seems to be a relatively adversarial relationship toward hospitals, threatening the financial stability faced by the industry. And, this significantly contributes to the financial health of Missouri. This action will take any bargaining power hospitals had with the Medicaid managed care plans and throw it out the window. Not only could it result in immediate revenue losses, but it also likely sets the ceiling for future rate negotiations with the Medicaid managed care plans who now would have less incentive to negotiate in good faith. All of this is being done under the auspices of improving access for patients who are participants in the Medicaid managed care plans. Where is the data to support a lack of access requiring this kind of action? Furthermore, one needs to question the financial side of this transaction. As proposed, no financial returns are coming back to the state, so where does a 10 percent drop in rates end up?

This action should serve as another rallying cry for boards and board members to become involved in the advocacy process on behalf of the facilities they serve. This can be done by contacting legislators or visiting them in person to discuss concerns – and rally others within the community who have keen interest in health care. It also further demonstrates the need for the PAC campaign and why contributions are so important. Without taking a local stand, hospitals will continue to be challenged with policies that are formed by those who, at times, have minor understanding of their short- and long-term impacts to a system that is under pressure from all fronts.



Regulatory Compliance for Pharmacies: What to Ask About USP 797/USP 800

By Rich McKown, Healthcare Director, Burns & McDonnell Engineering Company, Inc.
rmckown@burnsmcd.com | 816/822-3929

Draft versions of the new USP standards for drug compounding are out for public comment. Once the standards are final, compounding pharmacies must comply. Hospitals will need to show a plan for any discrepancies found — and it could throw their accreditation with Medicare and Medicaid into question.

Every hospital pharmacy has different procedures that will require a tailored solution. The processes for receiving, storing, unpacking, transferring, compounding and administering can be done in many ways. The design of these rooms and the type of equipment used are all dependent on procedures — and facility design should be customized around them.

To streamline the renovation process and get pharmacies online faster, we recommend a design-build approach, which can compress that timeframe by more than 50 percent. From day one, bring everyone to the table to guide the design, including the design and construction teams, USP certification personnel, and equipment procurement professionals. This allows a clear path forward for the renovation without losing time, especially if the final constructed product doesn't meet certification requirements.

A room under renovation cannot be used for drug compounding, but with careful coordination and planning, the space will still be available to conduct critical work during construction.

There is no "one size fits all" solution. The key is to select an experienced team that can quickly price alternate solutions for capital planning, and then design and construct to that budget.

Target Zero *By Alison Williams, MHA's Vice President of Clinical Quality Improvement*

Significant efforts by the health care industry throughout the past decade have culminated in improved, high quality, safe care for patients. Recent updates to hospital-acquired conditions data show a reduction of 8 percent from 2014 to 2016 — a change that translates into 350,000 fewer such conditions, 8,000 fewer inpatient deaths and a national savings of almost $3 billion. The preliminary new baseline rate for HACs now is 90 per 1,000 discharges – down from 98 per 1,000 discharges at the end of 2014.[i] This is exciting news and demonstrates the value of the work hospitals have engaged in through initiatives such as the Hospital Engagement Networks and the Hospital Improvement Innovation Network.

Despite these successful reductions, hospital-acquired harm is still the third leading cause of death in the U.S., and with 90 patients out of every 1,000 being harmed, this statistic is both staggering and intolerable. It is time to enter into the next phase of truly providing exceptional care — designing for control, avoiding drift and driving to zero. Despite opinions on whether achieving a zero harm rate is realizable, many health care organizations of all shapes, sizes and demographic profiles are doing and sustaining it.

MHA, in collaboration with hospital members, began producing three healthcare-associated infection* harm dashboards in March 2018. The harm dashboards track catheter-associated urinary tract infections (CAUTI), central line-associated bloodstream infections (CLABSI) and *Clostridium difficile* (*C. diff*). Each of these infections are largely preventable with well-established evidence-based practices, regardless of care location. By taking a zero tolerance approach, Missouri hospitals can improve patient safety and the financial position of the organization.

The intent of the Missouri Harm Dashboards is two-fold.

1. Use modified data transparency to inspire a statewide drive toward zero harm.
2. Provide hospital leaders with a tool to engage front-line staff to improve care and reduce infections.

Hospital leaders are encouraged to expand data transparency and share these dashboards with health care team members. While a zero rate of infections may seem out of reach, I am reminded of a quote by Norman Vincent Peale, "Shoot for the moon. Even if you miss, you'll land among the stars." Focusing our eyes on the audacious goal of zero will surely enable health care organizations to achieve even greater strides in patient health.

*Recent medical literature notes the use of the term healthcare-associated infection to refer to the spectrum across which infections related to medical care may occur.

[i] Agency for Healthcare Research and Quality. (2018, June). AHRQ National Scorecard on Hospital-Acquired Conditions Updated Baseline Rates and Preliminary Results 2014–2016. Retrieved from https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/pfp/natlhacratereport-rebaselining2014-2016_0.pdf

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