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2016 Legislative Agenda & Guiding Principles

DECEMBER 2016

Overview

1. 2016 Top Priorities
   - Hospital Provider Fee Enterprise
   - Mitigating Against Provider Cuts
   - Behavioral Health: 72-Hour Holds
2. Additional Key Themes
   - "Return of 2015"
   - Workforce
3. Other Issues

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Top Issue: Hospital Provider Fee Enterprise

Key Concept

- Removing the HPF from TABOR will ensure a more certain future for HPF by protecting it from budget scrutiny and will support the legislature's ability to allocate General Fund resources to key priorities.

Approved Guiding Principles (July 2015)

- Current financing, functions, and governance of HPF will not change, except as necessary to comply with state TABOR law and federal Medicaid law
- CHA Board-approved principles and key compromises reached with the health community in 2009 (and embodied in HB 09-1293) will not be jeopardized

Additional Considerations

- To be successful, the tenor of the conversation must be positive and focused on "win-win" scenarios for both Republicans and Democrats.
- This is not a health care issue, this is a state budget issue best lead by the general business community. The health care community – including hospitals – should not be viewed as the face of this effort.

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Top Issue: Mitigating Against Provider Cuts

Key Concept

- Governor Hickenlooper's proposed budget includes $376 million in Medicaid provider rate cuts (totaling $65 million in General Fund cuts):
  - $100 million reduction in Hospital Provider Fee = $200 million state/federal funds
  - 1 percent across-the-board rate cut = $45 million state/federal funds
  - Discontinuation of primary care rate "bump" = $131 million state federal funds

Political Considerations

- The 2016-17 budget has a $373 million General Fund shortfall, and cuts were spread across many funding areas.
- The fiscal reality is that rate cuts are likely to occur. Some funding may be restored.
- Transitioning the HPF into an Enterprise will help forestall these cuts from happening in the future, and we need to maintain a broad and diverse coalition to be successful with Enterprise.

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Top Issue:
Behavioral Health: 72-Hour Holds

Key Concept

- State law should recognize and defer to federal obligations of "non-designated" facilities when treating patients placed on a 72-hour mental health hold.

Approved Guiding Principles (July 2015)

- Limit scope of legislation to address targeted issues within civil commitment statute
- Consistent with CHA Workforce guiding principles, consider amending statutes regarding professionals that can place and remove a 72-hour hold

Conceptual Agreement

- Facilities that do not provide inpatient psychiatric care should not be designated or subject to the oversight of OBH; they are best regulated by CDPHE.
- Basic data on the volume of 72-hour holds should be collected from all receiving facilities, whether designated or not.

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Additional Key Themes

- **"Return of 2015"**
  - Hospital Liens
  - Out-of-Network Providers in In-Network Facilities
  - Pricing Transparency
  - Relocating the Office of Behavioral Health
- **Workforce**
  - Community Paramedicine/ Community Integrated Healthcare
  - Interstate Licensure Compact

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Hospital Liens

Key Concept

- 2015 legislation requiring hospitals to bill payers prior to filing a lien has resulted in increased legal actions against hospitals.
- The statute needs to be amended to provide a "good faith" exemption for facilities that made a good faith attempt to comply.

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"Out-of-Network"

Key Concept

- Consumers should be protected from unforeseeable "surprise" bills due to in/out of network status of their provider
  - Law requires payers to hold consumers harmless, but doesn't apply to all plans

Adopted Guiding Principles (July 2015)

- Consumers should be protected from "surprise" bills when they have done due diligence to seek care from in-network providers.
  - Consumers should also have the right to seek care from an out-of-network provider and understand financial implications of doing so
  - An individual's insurer is the best source for real-time network information
  - Hospitals should play an active role in protecting patients in these types of situations
- Networks are a mechanism that enable payers/providers to provide higher value to consumers. CHA negotiations on this issue should:
  - Ensure an even playing field for network negotiations
  - Enable facilities to have a meaningful choice about being in- or out-of-network

Potential Agreement (Details Still TBD)

- CHA is supportive of the NAIC state model law on this issue and network adequacy.
- Consumers should receive a basic notice prior to receiving out-of-network care and be directed to their insurer to verify the financial consequences of pursuing out-of-network care.

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Financial Transparency

Key Concept

- With expansion of coverage giving consumers more "skin in the game," consumers should have access to quality and cost information that allows them to make an informed decision about their health care

Approved Guiding Principles (July 2015)

- Efforts to expand transparency of price and/or care quality should:
  - Be accurate and meaningful to consumer decision-making
  - Support Colorado's commitment to a "culture of coverage"
  - Reflect mutual buy-in and accountability for payers, providers, and consumers

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Relocating Office of Behavioral Health

Key Concept

- Remove the Office of Behavioral Health (OBH) from the Colorado Department of Human Services (CDHS) and align it with another health agency, likely the Department of Health Care Policy and Financing (HCPF)
  - OBH has oversight of: federal SAMHSA block grants, which fund Community Mental Health Centers and behavioral health prevention efforts; State Mental Health Institutes; regulatory authority over professionals and facilities providing behavioral health services.

Proposed Position

- Colorado's health care regulatory system is misaligned, making compliance difficult and inefficient for private industry.
- Although significantly more changes are needed to better align state regulatory systems and funding streams, moving OBH is a good first step.
  - Realignment will assist ongoing and upcoming initiatives related to behavioral health, including SIM and the re-bid of the Accountable Care Collaborative.
  - Given tight fiscal constraints, the state has the responsibility to use limited funds as effectively and efficiently as possible, and there are efficiencies to be gained.
- CHA should advise policymakers on prudent realignment options and considerations for dividing current OBH responsibilities

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Workforce Regulation

Key Concept

- Consumers should have access to health care professionals enabled to deliver care to the full extent of their training and ability

Approved Guiding Principles (July 2015)

- Laws that, without sound evidence, inhibit professionals' ability to exercise the full scope of their training and ability or that inhibit informed consumer choice should be eliminated or mitigated
- The health care industry needs to be nimble to adapt to quickly-changing markets, including expanding health care delivery through non-traditional means, including telehealth and/or new provider types that may or may not necessitate state regulation
- Facilities and health systems have significant regulatory and legal obligations that help to ensure the delivery of high-quality health care

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Workforce Regulation

Community Paramedics/Community Integrated Health Care Services

- 2014 legislation created CDPHE-facilitated workgroup to study this issue. CHA was well-represented and has been instrumental in negotiations between EMS community and home health providers.
- Task Force Recommendations build upon existing licensing infrastructure with minimal impact to those currently operating under a health facility license.
  - Definition Overview – Community Integrated Health Care Services: Health and social services provided to medically underserved to fill patient care gaps and prevent duplication of services. Services are to be provided by a health care business entity under supervision of a physician or NP.
  - Hospitals and health systems would have the authority to hire health care professionals to provide community integrated health care services, and would be liable for their actions as with any other employee.

Proposed Recommendation: Conceptual Support

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Workforce Regulation

Interstate Licensure Compact

- Legislation may be forthcoming to break down barriers to interstate delivery of health care services.
  - The Interstate Medical Licensure Compact (sponsored by the Federation of State Medical Boards) allows for portability of a physician license across state lines and increases access to telehealth services.
  - It was adopted by 11 states in 2015 (AL, IA, ID, IL, MN, MT, UT, WV, WY; considered not passed in 9: MD, MI, NE, OK, PA, RI, TX, VT, WI)

Proposed Recommendation: Conceptual Support

- CHA would be supportive of this for non-physician professionals as well, and will consider this issue for CHA legislative agenda in 2017.
- Limitation: CHA should not compromise on "mode specific" interstate licensure agreements, or anything that would restrict a professional's ability to practice to the full extent of their training.

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Other Issues

- **Clinical Performance & Health Care Delivery**
  - Sunset/Sunrise Reviews:
    - Surgical Technologists & Assistants
    - Health Facility Acquired Infection Advisory Committee
    - Medical Assistants
  - Changes to Air Ambulance Regulations
  - Mental Health for EMS Workers
  - STEMI Task Force Recommendations
  - Adequacy of Peer Review
  - Free-Standing Emergency Departments
- **Consumer & Insurance Issues**
  - Connect for Health: enrollment period change, privatizing, voter approval of taxes
  - End-of-Life Care
  - Cancer Caucus Recommendations
  - Advance Directive Registry
  - Insurance benefits (optometric), network, and formulary initiatives
  - Protecting dependents from inadvertent disclosures of health information
  - Workers Compensation Changes
  - Pinnacol out-of-state products

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