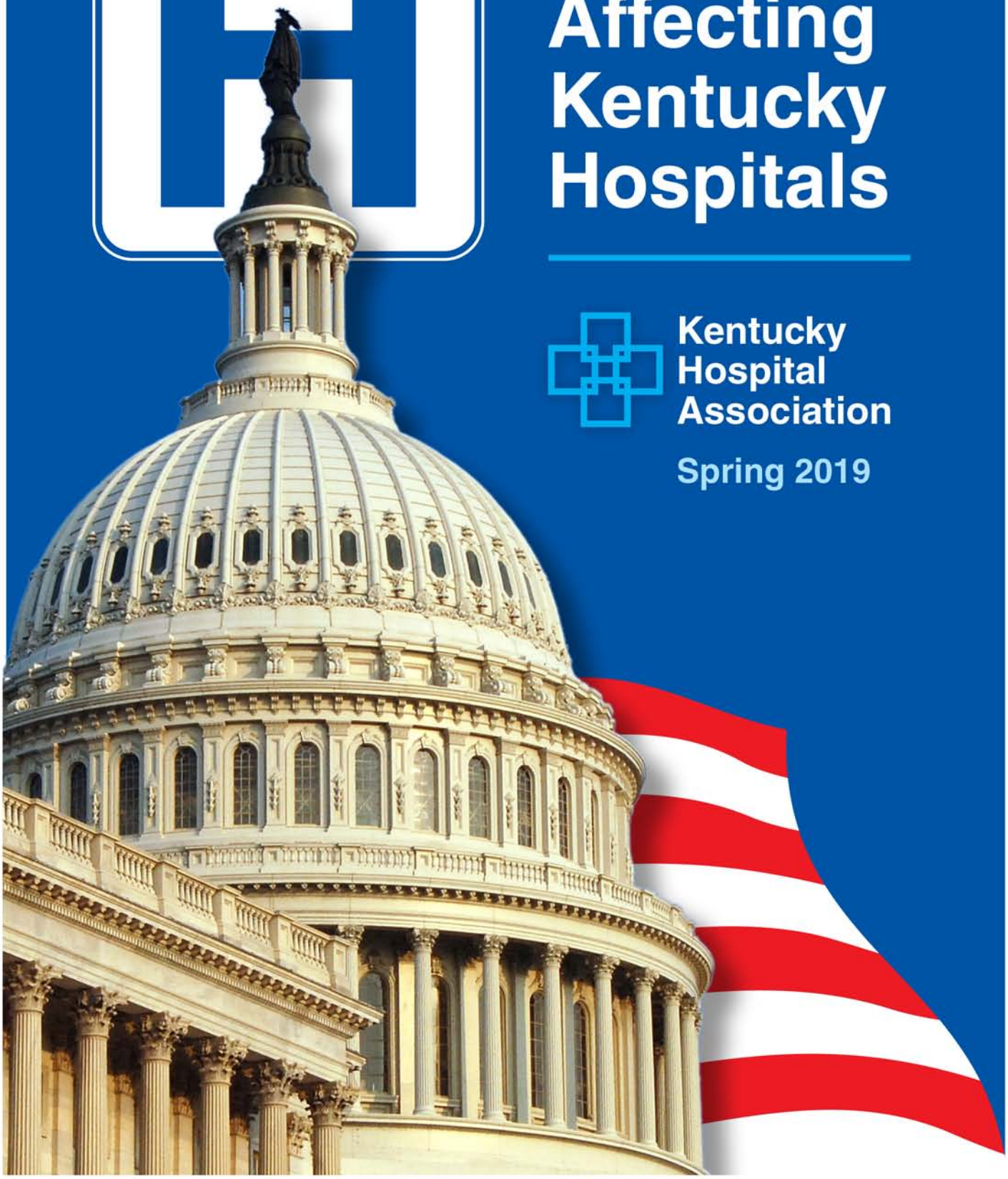
Key Issues Affecting Kentucky Hospitals

Kentucky Hospital Association

Spring 2019



Key Issues Affecting Kentucky Hospitals

The Kentucky Hospital Association (KHA) proudly represents every hospital in the Commonwealth of Kentucky with the goal and mission to improve the overall health of the citizens by ensuring access to high quality hospital care for every Kentuckian. This mission is becoming progressively more challenging for all hospitals, given the economic and health challenges of the state's citizens as well as the increasing number of reimbursement cuts facing every provider. Today, more than fifty percent of Kentucky hospitals are losing money on operations and there is an onslaught of reimbursement cuts on the horizon. Kentucky hospitals will not be able to continue to provide affordable, quality care under these circumstances and access to care will be compromised for Kentucky's most vulnerable populations, Medicare and Medicaid beneficiaries.

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Kentucky Hospital Association

KENTUCKY HOSPITAL ASSOCIATION'S
2019 Key Issues

- **Surprise billing –** support legislation that protects patients, establishes out-of-network provider payment through negotiation and baseball-style arbitration rather than government set rates, holds health plans to the prudent layperson standard for emergency care, and mandates that insurers have accurate directories and provide cost estimates to their insureds instead of imposing notice requirements on health care providers

- **Medicaid DSH –** repeal the DSH cuts or, at least delay and restructure the cuts as recommended by MACPAC, and support legislation to restructure state DSH allotments in relation to a state's poverty population, which would increase the allotment to Kentucky

- **Medicare for All –** oppose all forms of "Medicare for All" legislation that would reduce commercial insurance and move to a single-payer health plan, with payment at Medicare rates which are significantly below cost

- **Medicare Payment –** reject further Medicare cuts in hospital payment, particularly site-neutral payments

- **Drug Pricing and 340B –** reject new limitations on the 340B program and address the high cost of prescription drugs by fast tracking generic medicines and other actions targeted at drug manufacturers

- **Inequitable Medicare Payment Policies –** enact legislation mandating that uncompensated care include Medicaid shortfalls for purposes of distributing Medicare DSH funds; and support legislation to implement a wage index floor and remove the national rural floor budget neutrality calculation, which is benefiting a handful of states to the detriment of Kentucky

- **Protect Medicaid Funding –** maintain support for the enhanced match of 90 percent for the Medicaid expansion population, and support the use of Section 1115 demonstration waivers rather than block grants to reduce Medicaid costs

- **Rural Issues –** preserve Medicare rural hospital designations (CAH, MDH, LVH), support existing payment methods for swing beds, eliminate the 96-hour physician certification requirement for CAHs, apply a permanent moratorium on direct supervision for outpatient therapeutic services in CAHs and small rural hospitals, and support establishment of a new rural emergency hospital designation under Medicare to provide adequate funding for rural hospitals that wish to transition to emergency and outpatient services while ceasing to operate inpatient beds

Kentucky Hospital Association's 2019 Key Issues

Protecting Patients From Surprise Medical Bills

As more insurers tighten provider networks, patients may receive unexpected bills from out-of-network providers. These "surprise" bills most often occur when a patient obtains care at an in-network hospital but receives services from a hospital-based provider (most often an anesthesiologist, pathologist, radiologist, or emergency department physician) that is out-of-network. They can also result when an insurer's provider directory is not accurate. Kentucky's hospitals and health systems are committed to protecting patients from "surprise bills."

The member hospitals and health systems of the Kentucky Hospital Association support legislation that protects patients and addresses out-of-network provider payment through negotiation rather than government established rates. **KHA supports legislation with the following features:**

- **Protect the Patient:** Patients, regardless of the type of health coverage they have, should be held harmless at their in-network cost sharing amounts when receiving care from an out-of-network physician at an in-network hospital or from a provider that was inaccurately indicated as in-network by the patient's insurer. Patients should not be balance billed and should not have to bear the burden of serving as an intermediary between the plan and the out-of-network provider, rather the health plan should be responsible for paying providers directly.
- **Preserve the Role of Private Negotiation:** KHA and its members do not support having the state or federal government establish payment rates for out-of-network providers. A government set rate will never be adequate for all providers and, when set unreasonably low, will simply shift the burden to hospitals in the form of subsidies to the affected providers to maintain access to services for their communities. KHA supports establishment of a process whereby the out-of-network provider and insurer would be given 30 days to negotiate payment. If unsuccessful, payment would be resolved through a state level "baseball style" binding arbitration process where each side would present its best price to be selected by a neutral arbitrator. KHA's members believe such a process would result in payment which better reflects a competitively set price for the geographic market in which the services are rendered.
- **Out-of-Network Notices and Health Plan Transparency:** KHA and its members do not support mandates for hospitals to post on their website every plan in which they participate as this would be burdensome and costly since there are hundreds of different plans, and networks are often changed by the insurer. While hospitals assist patients, upon request, with obtaining cost estimates, Kentucky hospitals support requirements for health plans – not hospitals – to provide their insureds with cost estimates since insurers ultimately control their provider networks and have ready access to cost sharing and deductible information. Health plans should also be the source of truth for determining which providers are in-network as opposed to reliance on provider websites or notices, and should be mandated to maintain accurate, easy to access and up-to-date provider directories.
- **Ensure Patients Have Access to Emergency Care:** KHA and its members support legislation to strengthen health plan adherence to the "prudent layperson standard" and not permit health plans to deny payment for emergency care that, in retrospect, the health plan determined was not an emergency. Recent actions by some health plans to deny coverage of emergency services puts patients' physical, mental and financial health at risk.

Several bills have been introduced in Congress to address surprise billing but none reflect the position of KHA and its members:

- **"Protecting Patients from Surprise Medical Bills Act" –** This draft legislation was developed by a bipartisan group of U.S. senators led by Bill Cassidy (R-LA). The bill would prohibit balance billing for out-of-network care provided in an emergency or by an out-of-network provider in an in-network facility. Patients would only be responsible for paying an in-network cost sharing amount. **KHA opposes the bill's requirement for government to set the rate to be paid to out-of-network providers by allowing states to set the rate or setting it at the higher of the average in-network negotiated rate or 125%**

of the average allowed amount. If this legislation moves forward, it should be amended to replace government-mandated rates with negotiation and baseball-style arbitration.

- **"No More Surprise Medical Bills" –** This legislation was introduced in the last Congress by Senator Maggie Hassan (D-NH). It establishes extensive notice requirements – upon scheduling, before the date of service and including estimated cost sharing – for any instance where a patient may receive care by an out-of-network provider, except for emergencies. If an out-of-network provider fails to provide these notices, or in emergency situations, the patient only pays in-network cost sharing. Providers may not balance bill and plans and providers are to settle the bill through negotiation, which moves to "baseball-style" arbitration if not resolved in 30 days through negotiation. **While KHA supports the use of baseball-style arbitration for settling out-of-network provider payment, the extensive mandated notice requirements would create new administrative costs on providers and should be deleted from the legislation.**
- **"Reducing Costs for Out-of-network Services Act of 2018" –** This bill was introduced last Congress by four democratic senators, led by Senator Jeanne Shaheen (D-NH). It would direct states to establish maximum charges – either 125% of Medicare or 80% of usual, customary and reasonable – that providers can bill individuals insured through the individual market who are accessing out-of-network care or who are uninsured. **KHA and its members oppose legislation where government would set rates for out-of-network provider payments.**

KHA requests that the Kentucky congressional delegation work to support and/or amend surprise billing legislation to contain only those elements supported by Kentucky hospitals.

Stop Medicaid DSH Cuts and Reform Medicaid DSH

The Medicaid Disproportionate Share Hospital (DSH) program provides critical financial support to Kentucky's hospitals by helping to offset uncompensated care provided to Medicaid recipients and the uninsured. Today, Kentucky receives a federal DSH allotment of approximately $160 Million which, when matched with $68 Million in state funds supplied by hospitals from a provider tax, produces $228 million in total funding. However, these funds cover only a fraction of hospital Medicaid losses and uninsured care.

The Affordable Care Act (ACA) called for significant cuts to the Medicaid DSH program which were slated to begin in 2014. Through a series of congressional actions, these DSH cuts have been delayed but are scheduled to begin later this year, in FFY 2020. Although the ACA originally provided a seven-year phase-in, that has been eliminated such that DSH allotments will be reduced by $4 billion nationally in 2020 and then move immediately to $8 billion in FFY 20121 and thereafter. Based on a CMS proposed rule on how the national cut will be allocated to the states, **in 2021, Kentucky's DSH program will be decimated by a 75% reduction in funding! Kentucky's federal Medicaid DSH allotment will be reduced from $160 million (current) to $40 million which would lower the state's total DSH program funding (when matched) from $228 million to $58 million.**

Impact of Federal DSH Cuts on Kentucky

	Federal Allotment	Total DSH (Federal + State Match)
Current DSH	**$160 Million**	**$228 Million**
FFY 2020	**$100 Million**	**$143 Million**
FFY 2021 and thereafter	**$40 Million**	**$58 Million**

The Medicaid expansion added more than 400,000 people to the Medicaid program such that it now covers one in three Kentuckians. While the uninsured rate has been reduced, 80% of those gaining coverage became Medicaid eligible while only 20% (some 80,000 people) bought a commercial plan. Because Medicaid payments cover only, on average, 80% of the actual cost hospitals incur to treat Medicaid patients, adding more people to the Medicaid program has significantly increased hospital Medicaid losses, and continued Medicaid DSH funding is needed to help offset this shortfall. The need for continued Medicaid DSH funding was underscored by the Medicaid and CHIP Payment and Access Commission (MACPAC) in its 2019 Report to Congress on Medicaid and CHIP. Their analysis of 2014 DSH audit survey data showed a net increase in total uncompensated care costs because of an increase

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Stop Medicaid DSH Cuts and Reform Medicaid DSH - continued

in Medicaid shortfalls, and the increase in Medicaid shortfall was more than twice as large as the decline in unpaid costs of care for uninsured patients.

Moreover, Kentucky's federal Medicaid DSH allotment is **far less** than other states both in total dollars and when compared on the basis of low-income population. **Although Kentucky had the fifth highest poverty rate in 2017, Kentucky's 2017 Medicaid DSH allotment ranked 22nd lowest in total funding and 24th lowest per person in poverty.** (See Appendix for Analysis) Kentucky received about $100 less in DSH allotment per person in poverty compared to the U.S. average and more than $400 less than Connecticut, the state with the fifth highest DSH allotment per population below poverty. Under legislation enacted in 1991, CMS set state-specific DSH allotments based on each state's FY 1992 DSH spending. Accordingly, states that spent the most in FY 1992 still have the largest allotments and states that spent the least still have the smallest allotments. MACPAC's 2019 Report raised concerns that DSH funding should be better targeted to states with higher levels of uncompensated care; however, **due to the limited statutory factors in the ACA that CMS is required to use in reducing state DSH allotments, MACPAC expects that the current inequities in state allotments will be preserved.**

Since Kentucky's DSH allotment is smaller to start with, the state's hospitals will be harmed to a greater extent from continuing the Medicaid DSH cuts, as opposed to other states which receive a much larger allotment, both in total dollars and low-income population. Therefore, **the only way to achieve "fairness" in Medicaid DSH payments is to repeal the DSH cuts for all states, or implement changes to the ACA to lessen the impact of the cuts to Kentucky and structurally reform the Medicaid DSH allotments.**

The 2019 MACPAC Report to Congress on Medicaid and CHIP makes the following recommendations if Congress allows the scheduled disproportionate share hospital allotment cuts to move forward:

- **Phase-in the cuts (as originally intended) and reduce them** to $2 billion instead of the $4 billion in 2020, $4 billion in 2012, $6 billion in 2022 and $8 billion per year from 2023-2029 – because DSH is an important source of revenue for safety-net hospitals, this gives hospitals more time to adjust to reduced funding;
- **Apply DSH reductions first to states with unspent DSH allotments** before applying reductions to other states – unspent DSH allotments occur when DSH allotments exceed hospital uncompensated care; and 50% of unspent allotments in 2016 were attributable to five states (Connecticut, New Hampshire, New Jersey, Pennsylvania, and Washington);
- **Update the DSH allotment methodology** to distribute reductions in a way that improves the relationship between DSH allotments and the number of non-elderly, low-income individuals in a state. The Commission found that this population was correlated to uncompensated care and is less affected by state policy choices, such as Medicaid expansion, which influences DSH reductions under the ACA's current statutory criteria. **Implementation of the MACPAC recommendations would lower the cut to Kentucky's DSH allotment by 12 percent which would provide $23 million more in DSH funding** than if no changes are made to the ACA DSH reduction criteria.

  (See Appendix for MACPAC Recommendations and Kentucky Impact)

Senator Marco Rubio (R-FL) has introduced the ***State Accountability, Flexibility, and Equity for Hospitals Act (SAFE Hospital Act)*** which contains similar recommendations. The SAFE Act would gradually change the DSH allocation formula to be based on the state's share of the total U.S. population earning less than 100 percent of the federal poverty level; prioritize DSH funding to safety-net hospitals while still providing states with flexibility to address unique needs; expand the definition of uncompensated care to include costs incurred by hospitals to provide certain outpatient physician and clinical services; and allow states to reserve some DSH funding allocations for use in future years. According to 2016 Census data, Kentucky is home to 1.8% of the nation's population living under 100% of FPL. **If Kentucky's FY 2017 federal DSH allocation was allocated based on the formula proposed in the SAFE Hospitals Act, it would have received an allocation about 13.5% higher than the allocation it actually received in FY 2017.**

KHA and Kentucky hospitals request the Kentucky Congressional Delegation to take the following action on Medicaid DSH funding:

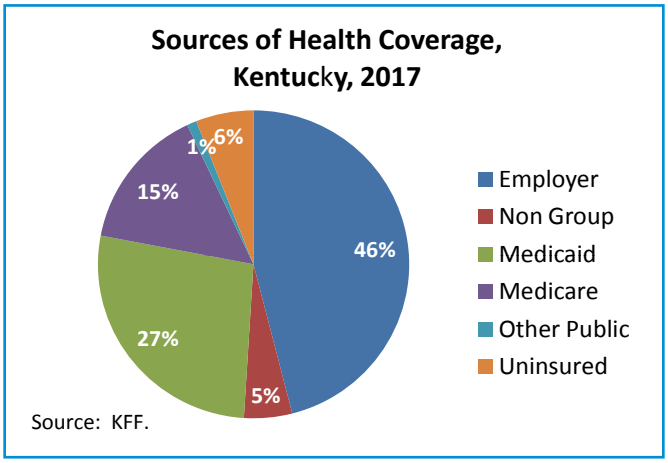
- **Repeal the Medicaid DSH cuts or, at least, continue to delay their implementation;**
- **Support restructuring state Medicaid DSH allotments by co-signing or working to enact the SAFE Hospitals Act to increase Kentucky's**

DSH Allotment, given our extremely high population in poverty; and

- If reductions move forward, Congress should revise Section 1923 of the Social Security Act to require the Secretary of the U.S. Department of Health and Human Services to reduce and phase-in DSH allotment reductions and apply the cuts first to those states with unspent DSH funds, as recommended by MACPAC.

Improving Health Insurance Coverage

Today, approximately 90% of U.S. residents and 94% of Kentucky residents have health insurance coverage through commercial insurance or governmental programs. Enrollment in coverage supports the health and wellbeing of individuals and communities by improving access to care and positive health outcomes while also reducing the financial strain on individuals and families.



A variety of public policy proposals to expand health coverage and contain costs have been suggested that are often characterized as "single-payer" approaches. The most popular is often referred to as "Medicare for All." This approach could include everything from a government-administered single-payer health plan to an option for individuals to buy-in to Medicare coverage.

One approach would replace commercial and employer-sponsored coverage – which provides about one-half of all coverage in Kentucky – and transition all Americans to a new governmental run plan. Several independent analyses estimate such a plan would cost approximately $32 trillion over 10 years and require a combination of new taxes and employer contributions in lieu of their current investment in employee premiums. Another form of "Medicare for All' would be the creation of a public program in health insurance exchanges that would provide a new coverage option in the individual market. This would use the Medicare infrastructure to administer the program and use Medicare networks and rates. Senators Tim Kaine (D-VA) and Michael Bennet (D-CO) have introduced legislation based on this model.

KNG Health Consulting prepared an analysis of The Impact of Medicare-X Choice on Coverage, Healthcare Use, and Hospitals for the American Hospital Association. The report modeled the effects of the Medicare-X Choice Act (S. 1970 and H.R. 4094) on coverage and health care spending. Medicare-X Choice would allow any individual to voluntarily enroll in a public plan offered on the health insurance exchange, and the plan would reimburse providers using Medicare rates.

The report's key findings include:

Insurance Coverage:

- While the number of uninsured nationally would fall by 5.5 million, 36.5 million people would leave private insurance for the new government-run public plan (12.6 million would leave commercial individual market coverage and 22.6 million would leave employer-sponsored coverage).
- Ninety percent (90%) of the enrollment in the public plan would come from individuals previously covered through employer-sponsored or commercial individual coverage.

Health Care Spending

- Reductions in total health care spending would occur due to reduced payments to providers, given the large differences in Medicare rates and commercial insurance payments.
- The increase in revenue from newly insured individuals would not be sufficient to offset the lost revenue from shifts between private and public insurance coverage.

Hospital Payment

- While hospital-based services represent 47% of baseline health care spending, these services would account for roughly 67% of the reduction in total spending from Medicare-X Choice implementation.
- Hospital services would be disproportionately

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affected and would experience a 10% reduction in payments – a loss of $774 billion between 2024 - 2033, without a commensurate reduction in costs.

- Medicare-X Choice would produce larger negative impacts to hospitals in non-metropolitan areas and would be expected to increase the number of hospitals with negative margins.

Kentucky Impact:

- Kentucky would experience a reduction of approximately $10 billion in spending from 2024-2033 of which 67%, or $6.4 billion, would represent payment cuts to Kentucky hospitals.

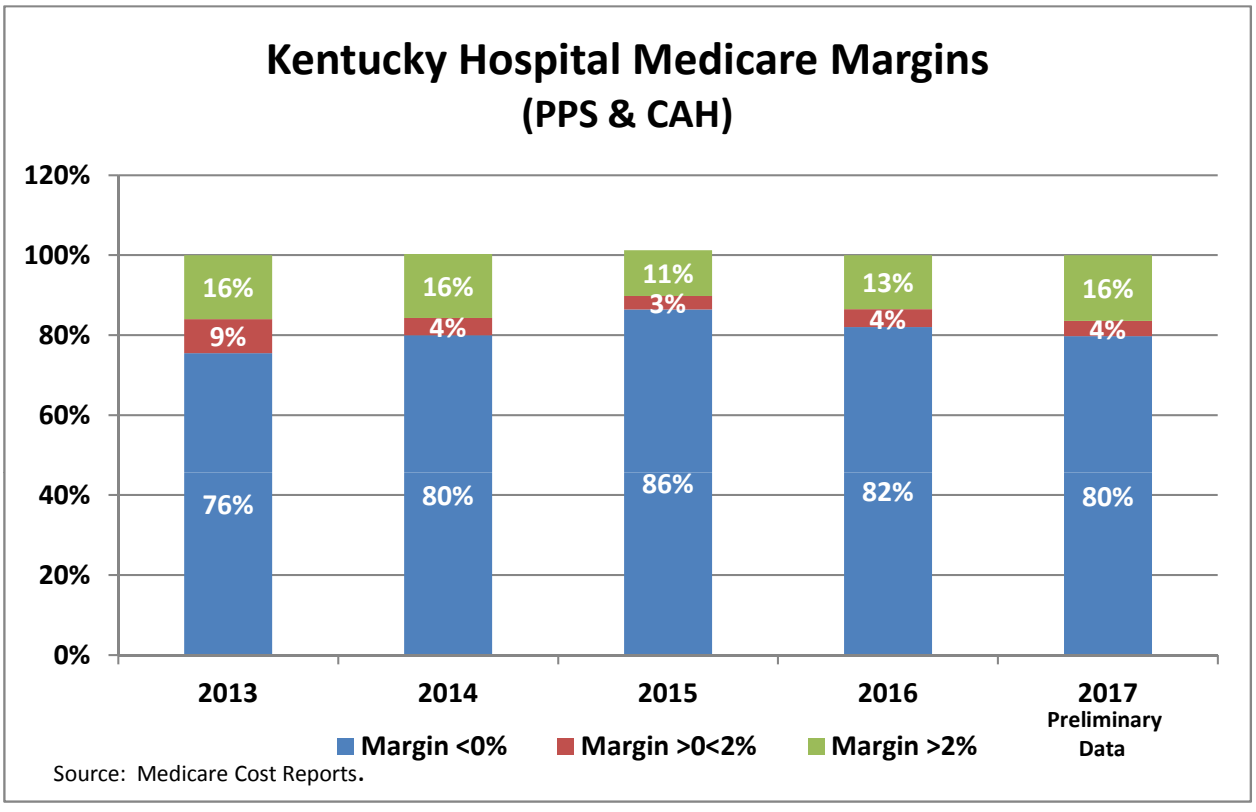
Since the Kentucky impacts are based on 17% of individuals in Kentucky moving from employer-sponsored or commercial coverage to a government-run plan, **these losses would be magnified many times over under a single-payer plan that eliminates commercial insurance.**

The losses in payment would not be offset from reduced costs. Medicare for All could still rely on the use of insurers to administer the program – through Medicare Advantage plans – which would continue to subject providers to significant administrative costs while also reducing payment.

Medicare margins for about 80% of Kentucky hospitals have been consistently negative; therefore, the implementation of policies to move more people to insurance that pays Medicare rates which, in Kentucky cover only 90% of costs, would be disastrous. Patients throughout the state would suffer reduced access to services and, in some communities, hospitals would close.

Rather than abolish the private health insurance system, KHA and its members support other efforts to address the remaining uninsured. According to the Kaiser Family Foundation, more than half (55%) of the remaining uninsured are already eligible for coverage through tax credits or under Medicaid. **More robust enrollment efforts to better educate the public about available insurance options could yield gains in coverage.** However, 45% of uninsured nonelderly adults are uninsured because the cost is too high. Congress can help lower costs by addressing the high cost of drugs, which represent the largest component of health insurance premiums (nearly 25%, according to America's Health Insurance Plans).

KHA and Kentucky hospitals request that the Kentucky congressional delegation oppose all forms of "Medicare for All" legislation that would reduce commercial insurance and move toward a single-payer health plan.

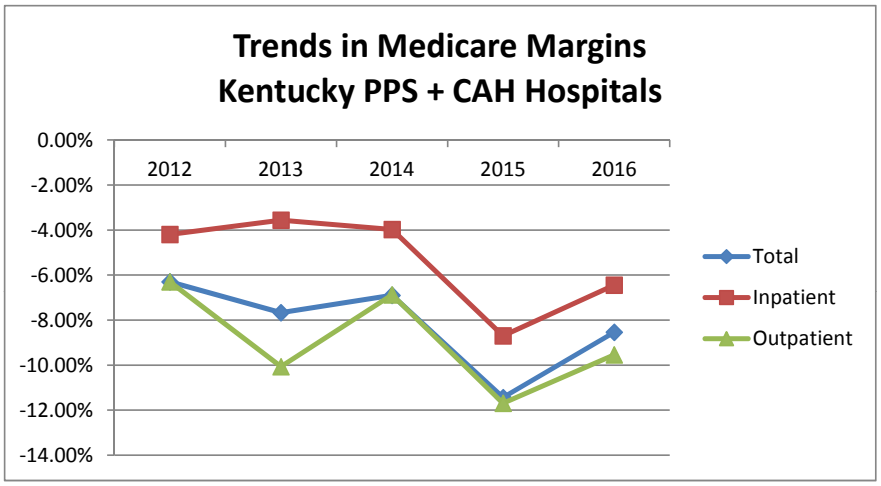


Source: Medicare Cost Reports.

Protect Access by Maintaining Adequate Medicare Payments

The adequacy of Medicare payments is extremely important to Kentucky hospitals because, on average, 49% of all hospitalized Kentucky patients are covered by Medicare. Unfortunately, Kentucky hospitals continue to lose money on caring for Medicare patients because Medicare payments cover only 90% of actual costs. The percent of costs covered by Medicare payments has declined substantially since passage of the Affordable Care Act (ACA) in 2010. The following charts show that Kentucky hospitals have already experienced nearly $2.7 billion in payment reductions from 2010 to 2018 and another $8.4 billion in cuts is expected from 2019-2028 for a grand total **$11 billion reduction in Medicare payments to Kentucky hospitals over the period 2010 to 2028.** Three actions are responsible for ninety percent of these reductions: the ACA's requirement that Medicare rates be set below actual inflation, ACA-mandated reductions in Medicare DSH payments and cuts from sequestration. The net result of the legislative and regulatory enacted Medicare cuts is an estimated 19% reduction in Medicare revenue to Kentucky hospitals in 2019, which will grow to negative 22.4% by 2028.

These payment reductions have caused a growing number of Kentucky hospitals to have Medicare losses. Since 2013, roughly 80% of Kentucky's hospitals have consistently had negative Medicare margins. Also concerning is that Kentucky hospitals lose more money on Medicare outpatient services at a time when more services are shifting to the outpatient setting. The Medicare inpatient margin for Kentucky PPS hospitals was **negative 6.5%** in 2016 but their outpatient margin was **negative 9.5%!** Reductions in outpatient payment, such as through the expansion of site-neutral payment policies that would lower hospital-based outpatient payment to physician office rates, would be particularly damaging to Kentucky's hospitals.



Source: Medicare Cost Reports

With double digit negative Medicare margins, Kentucky's hospitals cannot absorb further Medicare payment reductions. The chart on the next page illustrates how existing Medicare hospital payments could be affected by additional cuts that Congress may consider.

In particular, please note the following proposals, along with their ten-year impacts, which would be the most devastating to Kentucky:

- **Elimination of the Sole Community Hospital program .....-$2.5 Billion**
- **Site-neutral Payments (for ASC and excluded HOPDs).....-$563 Million**
- **Reducing Medicare Bad Debt Reimbursement .....-$350 Million**
- **Elimination of Critical Access Hospital Status .....-$317 Million**

Adoption of any proposals that would further reduce Medicare payment will seriously jeopardize the ability of Kentucky hospitals to maintain access to services for their communities.

Kentucky's hospitals and health systems urge the Kentucky congressional delegation to reject further Medicare cuts to payments for hospital care.

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Potential Medicare Cuts Analysis

Accumulated Impact of Possible Medicare Changes

Kentucky

This report shows annual impact estimates for all cuts in the analysis over the period of 2019-2028. The values shown reflect annual impact estimates of proposals that have been put before Congress as well as other potential changes.

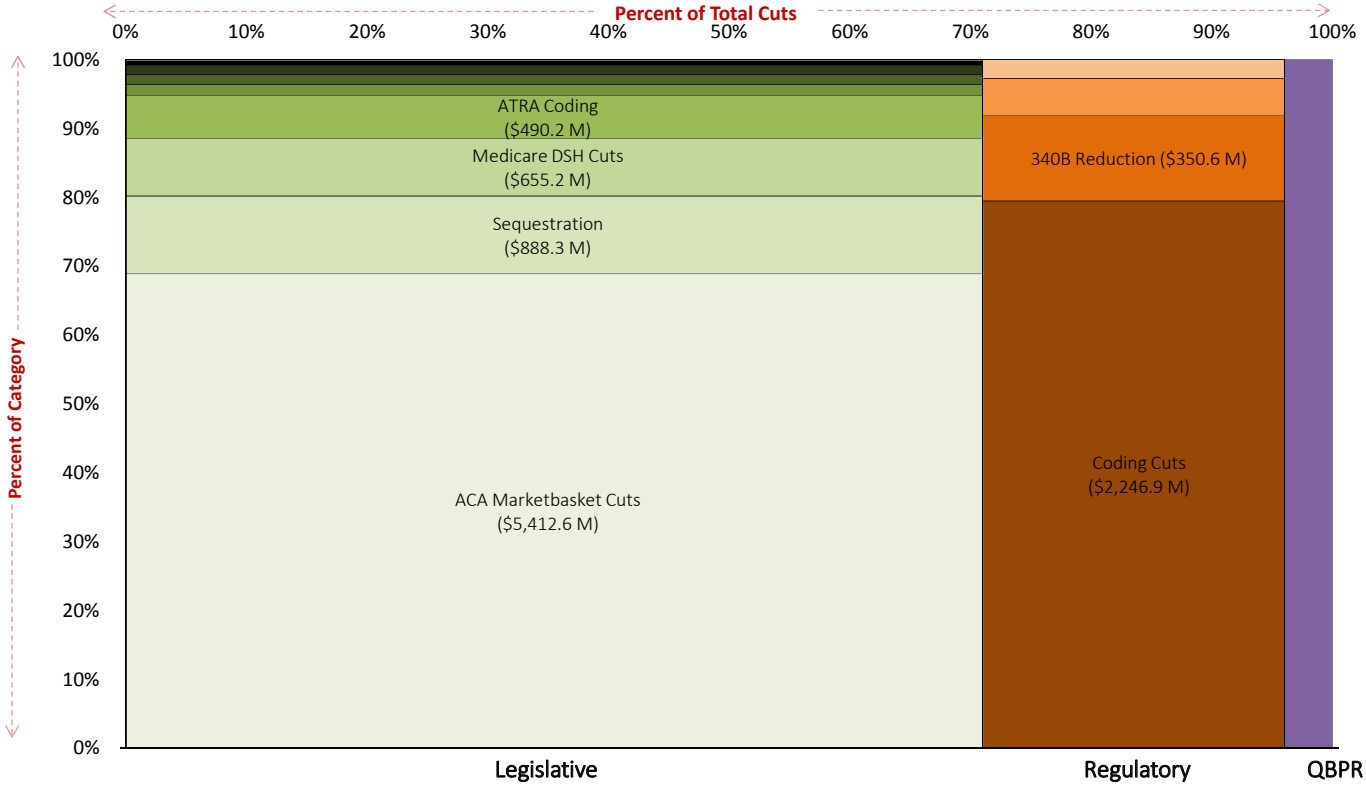
	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	10 Year Estimate of Proposals 2019-2028
Graduate Medical Education Funding:											
IME Payments based on a National Pool	$7,933,000	$8,156,400	$8,385,700	$8,621,300	$8,863,500	$9,067,600	$9,276,100	$9,480,300	$9,679,300	$9,882,400	**$89,345,600**
IME and DGME Payments based on a National Pool	$51,688,540	$50,028,267	$48,307,414	$46,524,252	$44,677,006	$43,188,889	$41,654,714	$40,160,350	$38,710,508	$37,219,124	**$442,159,064**
Rural Hospital Programs:											
SCH Program Elimination	($223,732,200)	($228,878,000)	($234,142,100)	($239,527,500)	($245,036,700)	($250,672,400)	($256,438,000)	($262,079,400)	($267,583,200)	($273,202,500)	**($2,481,292,000)**
CAH Inpatient Payment Cut to 100% of Cost	($418,700)	($431,700)	($445,000)	($459,100)	($473,300)	($488,100)	($503,100)	($518,000)	($533,100)	($548,400)	**($4,818,500)**
CAH Outpatient Payment Cut to 100% of Cost	($614,900)	($634,100)	($653,300)	($673,800)	($694,900)	($716,300)	($738,600)	($760,700)	($782,700)	($805,900)	**($7,075,200)**
CAH Swing Bed Payment Cut to 100% of Cost	($313,100)	($322,800)	($332,800)	($342,900)	($353,700)	($364,500)	($376,100)	($387,300)	($398,500)	($410,200)	**($3,601,900)**
Elimination of CAH Status	($24,920,400)	($26,190,800)	($27,512,000)	($28,886,300)	($30,315,200)	($32,013,200)	($33,819,900)	($35,690,200)	($37,638,500)	($39,675,200)	**($316,661,700)**
Expiration of MDH Add-on	$0	$0	$0	$0	($2,928,400)	($2,995,600)	($3,064,700)	($3,132,000)	($3,197,800)	($3,265,000)	**($18,583,500)**
Expiration of Expanded LVH Add-on	$0	$0	$0	$0	($14,217,100)	($14,544,100)	($14,878,700)	($15,206,000)	($15,525,400)	($15,851,500)	**($90,222,800)**
Post-Acute Payment Proposals:											
Reduce FFY 2020 IRF Rate by 5.0%	$0	($10,023,500)	($10,244,100)	($10,469,500)	($10,700,000)	($10,946,000)	($11,187,000)	($11,432,700)	($11,673,000)	($11,918,200)	**($98,594,000)**
Reduce CY 2020 HH Rate by 5.0%	$0	($2,357,900)	($2,410,400)	($2,463,200)	($2,517,600)	($2,572,500)	($2,629,300)	($2,684,600)	($2,741,000)	($2,795,900)	**($23,172,400)**
FFY 2020 LTCH Rate Update of 2.0%	$0	($211,900)	($216,700)	($221,500)	($226,200)	($231,700)	($236,700)	($241,900)	($246,800)	($252,000)	**($2,085,400)**
FFY 2020 SNF MB Update of 0%	$0	($599,300)	($611,600)	($623,400)	($635,900)	($648,700)	($661,900)	($674,300)	($687,800)	($699,400)	**($5,842,300)**
Wage Index Floor Adjustments:											
Repeal of National Rural Floor BN	$9,009,500	$9,238,700	$9,474,000	$9,716,200	$9,964,500	$10,188,900	$10,418,600	$10,643,900	$10,864,200	$11,089,300	**$100,607,800**
Repeal of Frontier Rural Floor	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
Federal DSH Payments:											
Repeal of Medicare DSH UCC Pool	$109,869,300	$148,514,100	$152,287,100	$155,947,100	$159,480,000	$161,623,500	$162,889,700	$164,423,800	$167,412,000	$170,927,500	**$1,553,374,100**
Medicare DSH Based on 100% UCC Pool	$36,623,000	$49,504,700	$50,762,600	$51,982,500	$53,160,100	$53,874,600	$54,296,600	$54,807,900	$55,804,100	$56,975,700	**$517,791,800**
DSH UCC Removed from IPPS	$0	($15,634,000)	($5,795,600)	($7,499,200)	($9,495,200)	($11,800,100)	($15,093,000)	($17,976,000)	($19,249,800)	($20,091,300)	**($122,634,200)**
Other Proposals:											
Bad Debt Reimbursement at 25%	($11,462,300)	($23,568,700)	($36,256,600)	($37,182,800)	($38,132,500)	($39,007,800)	($39,902,900)	($40,778,800)	($41,635,700)	($42,509,000)	**($350,437,100)**
Extension of Sequestration (2.0% reduction to payments)	$0	$0	$0	$0	$0	$0	$0	$0	$0	($69,221,600)	**($69,221,600)**
OPD/ASC Payment Equalization-Targeted Services	($18,677,800)	($19,107,800)	($19,547,300)	($19,996,800)	($20,456,700)	($20,927,100)	($21,408,500)	($21,879,500)	($22,338,900)	($22,808,200)	**($207,148,600)**
OPPS SN (PO, Excluding Clinic)	($32,061,000)	($32,798,100)	($33,553,000)	($34,324,800)	($35,114,300)	($35,921,700)	($36,748,100)	($37,556,700)	($38,345,100)	($39,150,000)	**($355,572,800)**
340B Uncompensated Care-Based Redistribution	$0	($13,952,100)	($14,273,100)	($14,601,600)	($14,937,000)	($15,280,700)	($15,632,300)	($15,975,900)	($16,311,300)	($16,654,200)	**($137,618,200)**
340B User Fee (Trump)	$0	($207,000)	($207,000)	($207,000)	($207,000)	($207,000)	($207,000)	($207,000)	($207,000)	($207,000)	**($1,863,000)**
340B User Fee (Collins)	$0	($143,800)	($143,800)	($143,800)	($143,800)	($143,800)	($143,800)	($143,800)	($143,800)	($143,800)	**($1,294,200)**

Enacted Medicare Cuts Analysis

Relative Magnitude of Enacted Medicare Cuts

Kentucky

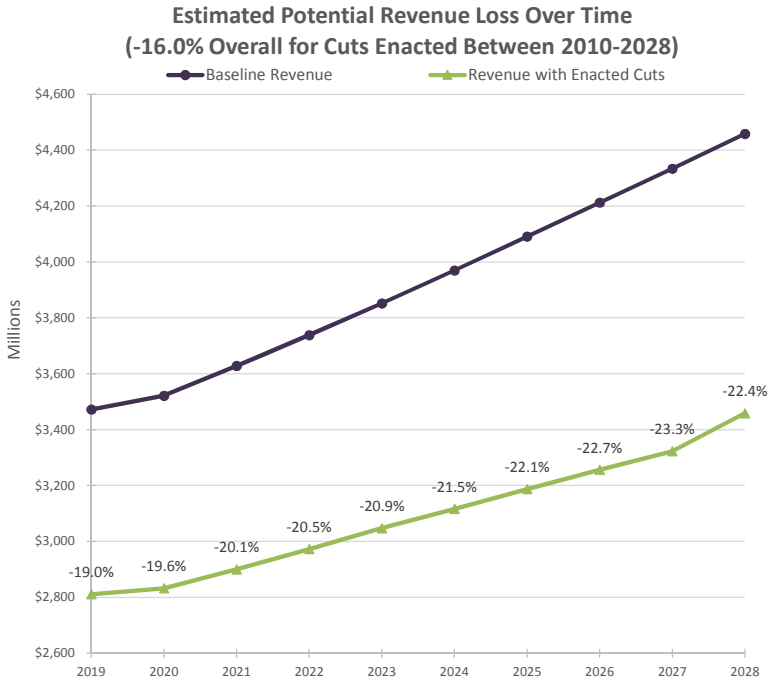
The graph below reflects the relative magnitude of each cut included in this analysis. Cuts are grouped together by category - with additional details in subsequent reports. The horizontal axis indicates the relative size of each category as a percent of the whole; the vertical axis indicates each individual cut's share of its category.



Cuts Enacted (2010-2028): Legislative	
ACA Marketbasket Cuts	($5,412,612,900)
Sequestration	($888,306,900)
Medicare DSH Cuts	($655,216,600)
ATRA Coding	($490,193,400)
Bad Debt at 65%	($126,226,100)
PAMA CLFS Adjustment	($112,056,900)
OPPS SN (PN)	($104,766,600)
Hospice Transfer Adjustment	($53,490,800)
Post Acute MB Caps	($16,354,200)
Total Legislative Cuts	**($7,859,224,400)**

Cuts Enacted (2010-2028): Regulatory	
Coding Cuts	($2,246,922,500)
340B Reduction	($350,613,600)
LTCH SN Adjustment	($152,719,900)
OPPS Clinic SN (PO)	($76,343,300)
WAC Payments at 103%	($1,148,100)
Total Regulatory Cuts	**($2,827,747,400)**

Quality Based Payment Reform (2010-2028)	
Quality	($335,476,500)
Total Cuts Enacted	**($11,022,448,300)**



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Impact of Enacted Medicare Cuts on Kentucky

			Impact of Enacted Cuts (2010-2018)	Impact of Enacted Cuts (2019-2028)	Total Impact (2010-2028)
Legislative (1)	ACA Marketbasket Cuts	IPPS Marketbasket Reduction	($559,716,400)	($2,784,018,600)	($3,343,735,000)
		OPPS Marketbasket Reduction	($242,523,100)	($1,244,323,200)	($1,486,846,300)
		IPF Marketbasket Reduction	($12,121,300)	($84,263,300)	($96,384,600)
		Post-Acute Marketbasket Reductions	($83,632,100)	($402,014,900)	($485,647,000)
	Other Cuts	Sequestration (2.0% reduction to payments)	($328,157,500)	($560,149,400)	($888,306,900)
		Medicare DSH Cuts	($309,289,200)	($345,927,400)	($655,216,600)
		Medicaid DSH Cuts	$0	$0	$0
		ATRA IPPS Retrospective Coding Adjustment	($207,773,000)	($282,420,400)	($490,193,400)
		Post-Acute Marketbasket Caps	($1,238,000)	($15,116,200)	($16,354,200)
		PAMA CLFS Adjustment	($3,190,200)	($108,866,700)	($112,056,900)
		OPPS SN (PN)	($14,458,100)	($90,308,500)	($104,766,600)
		Hospice Transfer Adjustment	$0	($53,490,800)	($53,490,800)
		Reimbursable Bad Debt reduced to 65%	($40,043,800)	($86,182,300)	($126,226,100)
New		New Legislative Cut 1	$0	$0	$0
		New Legislative Cut 2	$0	$0	$0
		New Legislative Cut 3	$0	$0	$0
		New Legislative Cut 4	$0	$0	$0
		New Legislative Cut 5	$0	$0	$0
Regulatory (2)	Coding	IPPS Coding Adjustments	($574,854,800)	($1,069,917,300)	($1,644,772,100)
		OPPS Packaging Inflation Adjustment	($52,112,800)	($211,012,200)	($263,125,000)
		LTCH Prospective Budget Neutrality Adjustment	($43,624,500)	($116,504,200)	($160,128,700)
		HH Prospective Coding Reduction	($52,229,500)	($126,667,200)	($178,896,700)
	Other	LTCH Site-Neutral Adjustment	($19,831,300)	($132,888,600)	($152,719,900)
		340B Reduction	($27,167,500)	($323,446,100)	($350,613,600)
		WAC Drug Payments Reduced to 103%	$0	($1,148,100)	($1,148,100)
		OPPS Clinic SN (PO)	$0	($76,343,300)	($76,343,300)
QBPR (3)		Readmissions Reduction Program	($57,660,500)	($147,313,200)	($204,973,700)
		Hospital Acquired Condition Reduction Program	($15,255,100)	($77,795,900)	($93,051,000)
		Value-based Purchasing	($7,926,500)	($29,525,300)	($37,451,800)
Total Enacted Cuts			**($2,652,805,200)**	**($8,369,643,100)**	**($11,022,448,300)**

Drug Pricing and 340B

The U.S. health care system is facing a prescription drug spending crisis fueled by staggering increases in recent years in the price of drugs. The burden of these rising prices is falling on patients and their families, and to providers of care, including Kentucky's hospitals and health systems. Between 2015-2017, total U.S. hospital and health system spending on drugs increased, on average, by 18.5 percent per admission, including a 28.7 percent increase per outpatient adjusted admission. This follows a 38.7 percent increase in prescription drug spending in the inpatient setting from 2013-2015.[1]

For 25 years, the 340B Drug Pricing program has provided safety-net hospitals with financial help to manage rising prescription drug costs and stretch limited resources to better serve their patients and communities. **KHA and Kentucky's hospitals strongly oppose any efforts to scale back or significantly reduce the benefits of the 340B program.** To participate in the program, a hospital must be public or not-for-profit, and qualify as a critical access hospital, a Medicare sole community hospital, a Medicare rural referral center or a Medicare disproportionate share hospital by providing a certain percentage of services to low-income Medicare and Medicaid patients or a certain amount of indigent care. **In Kentucky, 85 hospitals (out of 100 short-term acute care hospitals) qualify to receive 340B discounted outpatient drugs.**

The 340B Program requires drug companies to offer safety net hospitals and clinics the "best price" for outpatient drugs, which is nothing more than the lowest price the drug company is willing to sell to any purchaser. This law does not mandate drug manufacturers to sell drugs at a loss, just at their lowest price. The law seeks to prevent drug companies from arbitrarily marking up the price of drugs they sell to not-for-profit health care providers. According to the Health Resources and Services Administration (HRSA), the federal agency responsible for administering the 340B program, enrolled hospitals and other covered entities can achieve average savings of 25 to 50 percent in pharmaceutical purchases.

The 340B program is a small program with big benefits. It accounts for only 3 percent of the pharmaceutical industry's $457 billion in U.S. annual sales. **Because it is funded by drug company discounts, not federal dollars, 340B does not cost the government one penny.** The savings that safety net hospitals receive on outpatient pharmaceutical purchases are used to assist low-income patients and support services important to local communities.

Ways Kentucky hospitals use 340B savings:

- **Provide expensive infusion, chemotherapy and specialty pharmacy medications to patients that cannot afford them**
- **Provide naloxone to first responders**
- **Cover uninsured and underinsured outpatient prescriptions at hospital discharge**
- **Provide community benefits such as free transportation, meals and clothing for indigent patients**
- **Provide medications for mission trips**
- **Help fund community health center services**
- **Help cover copays for low-income patients**
- **Help with charity care and Medicaid losses**

Drug manufacturers are lobbying to reduce the 340B discounts by advocating new restrictions which would be damaging to Kentucky hospitals. **KHA and Kentucky hospitals do not support new limitations on the 340B program, and particularly, oppose the following proposals:**

- Limiting use of the discounted drugs to "uninsured" patients, instead of all patients of 340B-covered entities, as intended under the law – Placing new restrictions on patients that can receive discounted drugs would be particularly problematic in Kentucky because more than 80% of hospital patients are covered either by Medicare or Medicaid, which pay less than the actual cost of care, creating millions of dollars in losses annually. ***Restricting use of the 340B program to only "uninsured patients" would greatly harm the ability of Kentucky hospitals to serve Medicare and Medicaid patients.***
- Placing a moratorium on expansion of the program to DSH hospitals, including prohibiting existing 340B hospitals from using discounted drugs in new hospital-operated outpatient facilities – As more services are being developed on an outpatient basis, this limitation would be damaging to hospitals and their patients.

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[1] AHA/FAH Drug Survey, 2019 and 2016.

Drug Pricing and 340B - continued

- Imposing new reporting requirements on covered entities which would be very burdensome and involve major changes in hospital inventory practices – 340B hospitals are already required to meet numerous program integrity requirements, including participating in audits conducted by HRSA and drug manufacturers and maintaining auditable records and inventories of all 340B and non-340B prescription drugs.
- Imposing "user" fees only on covered entities to audit both covered entities and manufacturers

Rather than put restrictions on the 340B program, we urge the Kentucky congressional delegation to address the underlying problem of skyrocketing drug prices. These policies should focus on the entities that set the list prices of drugs – drug companies – and not those on the front lines of providing patient care each day. Possible actions include:

- Fast-track generic medicines to market;
- Prevent drug manufacturers from making small adjustments to older drugs in order to reap the financial benefits and protections reserved for new drugs;
- Prohibit payments to generic manufacturers to delay the release of a cheaper version of a prescription drug;
- Increase disclosure requirements related to drug pricing, research and development at the time of application for drug approval to improve transparency around drug pricing;
- Develop pay-for-value drug purchasing models, such as a Medicare-negotiated VBP arrangement through which reimbursement is based in part on health outcomes;
- Align Medicare and Medicaid payment with the most commonly used dosage to prevent waste and added cost;
- Require mandatory, inflation-based rebates for Medicare drugs when the average sales price for a drug increases faster than a specified inflation benchmark, thereby protecting beneficiaries and the program from dramatic increases in drug costs;
- Allow providers and patients to reimport drugs that were either manufactured in the U.S. or manufactured in another country that meets or exceeds U.S. safety standards for drug manufacturing; and
- Implement stricter requirements on direct-to-consumer advertising disclosures and remove tax incentives for drug promotion activities

Fix Inequitable Medicare Payment Policies

In addition to preventing further cuts in Medicare payments, Kentucky hospitals are suffering due to federal payment policies that have redistributional effects. Two such policies that lower funding to Kentucky's hospitals relative to other states are the Medicare Wage Index and the recent changes to the allocation of Medicare disproportionate share hospital (DSH) payments.

Medicare Disproportionate Share Hospital (DSH) Payments

Section 3133 of the ACA amends the Medicare DSH adjustment provision under section 1886(d)(5)(F) of the Act. Whereas a qualifying DSH hospital was previously paid a per-discharge adjustment based on their DSH Patient percentage (a formula based on services provided to low-income Medicare and Medicaid patients), under the ACA's changes, only 25% of a hospital's Medicare DSH payment is based on this method while 75% of the payment now comes from a national uncompensated care pool divided among DSH-eligible hospitals on the basis of hospital uncompensated care. Hospitals have three categories of uncompensated care:

- **Charity Care –** defined as care provided to uninsured individuals that meet certain financial eligibility criteria for which the hospital does not expect to receive payment
- **Bad Debt –** defined as unreimbursed care for persons from whom the hospital expected but did not receive payment
- **Medicaid Shortfall –** defined as losses suffered when Medicaid reimbursement is less than the cost of care provided

Two years ago, CMS, in regulations, changed the methodology for determining uncompensated care costs that is used to distribute funds from the national DSH pool. Under these rules, **CMS limited uncompensated care to charity and non-Medicare bad debt and excluded Medicaid shortfalls entirely.** The modification of the definition of uncompensated care does not increase the aggregate amount

of Medicare DSH payments – it changes how that funding is distributed to DSH hospitals throughout the country.

This change is having a devastating impact on Kentucky hospitals and other states that expanded Medicaid.

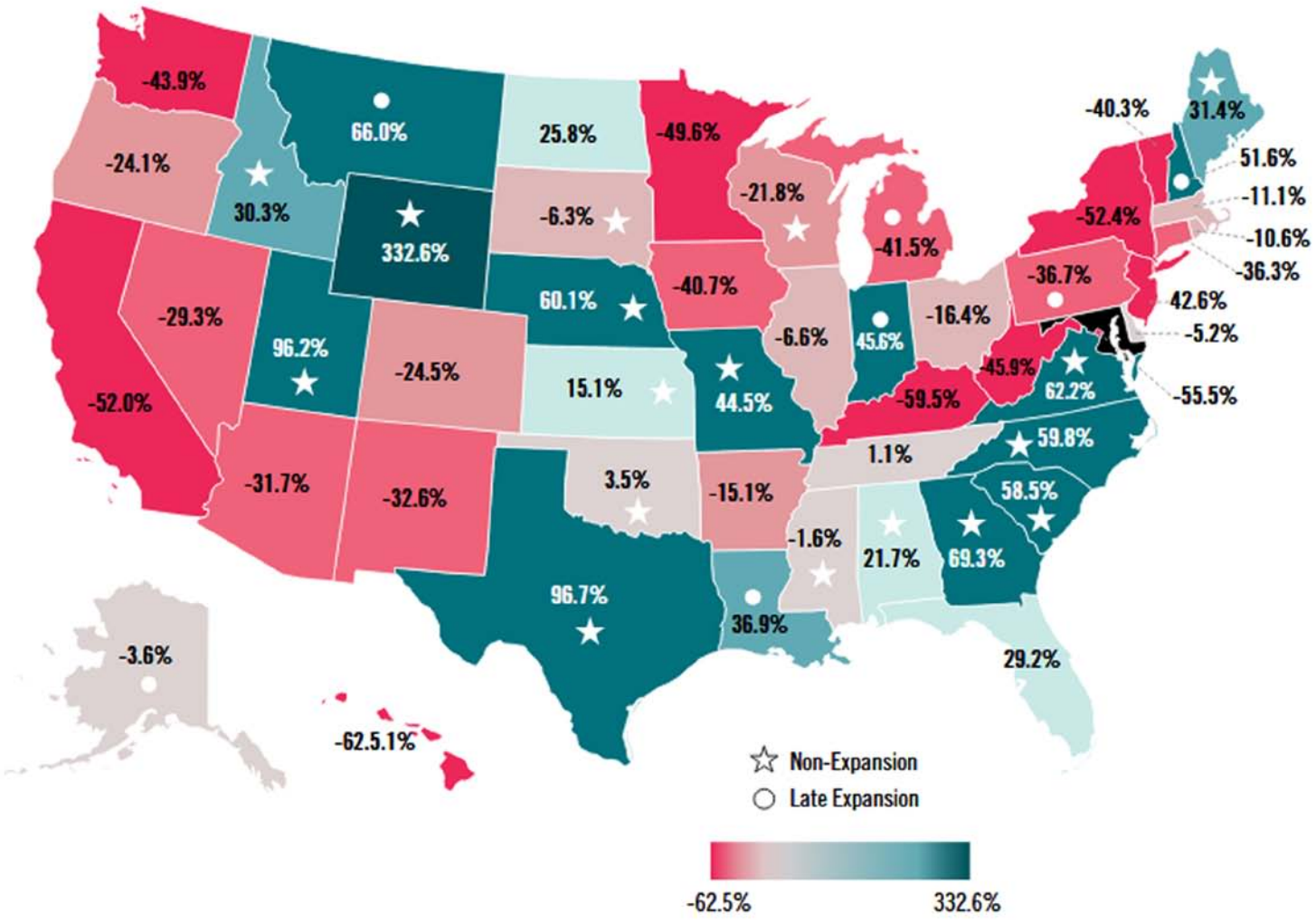
Because Kentucky is one of the poorest states in the nation, 80% of the uninsured population gaining insurance coverage under the ACA qualified for Medicaid. Medicaid expansion increased the number of Kentuckians covered by this program from about 830,000 in 2013 to 1.4 million currently, where one in three Kentuckians are now covered by Medicaid.

Medicaid has helped to reduce hospital charity care but it has also increased hospitals' losses from the Medicaid program because Medicaid payments cover only 80% of actual costs to treat Medicaid patients. CMS's change to the Medicare DSH methodology, which excludes Medicaid losses from uncompensated care costs, is extremely damaging and is essentially penalizing Kentucky hospitals for the expanded Medicaid program.

The new CMS DSH methodology has the effect of redistributing Medicaid DSH funding out of Medicaid expansion states into non-expansion states. State-by-state impact analyses show that Kentucky will have the fifth largest dollar loss in Medicare DSH funding, following California, New York, Pennsylvania and Michigan, and also one of the highest percentage reductions in DSH payments nationally!

This is illustrated by the map below with funding moving from red states to green states, which are also states that have not expanded Medicaid.

DSH UCC ESTIMATE:
Estimated Days Proxy vs. A full Transition to S-10 Data



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Fix Inequitable Medicare Payment Policies - continued

As a result of this regulatory change, Kentucky's Medicaid DSH payments have been cut for the last two years and the losses to Kentucky's DSH hospitals are projected to be $77 million this year when the methodology change is fully implemented.

Excluding Medicaid shortfalls runs counter to the core purpose of Medicare DSH payments which is to assist those hospitals serving a disproportionate percentage of low-income patients with unreimbursed costs. Medicaid shortfalls should be included in the CMS definition of uncompensated care for the Medicare DSH program since it is unpaid care and is directly linked to the low-income population. Prior to changing the methodology, CMS used Medicaid inpatient utilization (and dual eligible days) as a proxy measure for uncompensated costs in distributing Medicare DSH funds. The new methodology, which now eliminates Medicaid shortfalls, is not only ill-advised but will significantly redistribute DSH funding among hospitals and penalize the very facilities with the largest shares of governmental patients that need DSH funding to remain financially viable.

KHA and Kentucky hospitals request the Kentucky congressional delegation to amend the Medicare DSH statute [42 U.S.C. 1395ww (r)(2)(C)] to mandate that uncompensated care be defined to include Medicaid shortfalls for the distribution of Medicare DSH payments from the national uncompensated care pool. This is needed to treat all states equally by having all categories of uncompensated costs counted in the DSH distribution methodology.

Suggested Amendment to 42 U.S.C. 1395ww (r)(2)(C):

(C) Factor three. A factor equal to the percent, for each subsection (d) hospital, that represents the quotient of—

(i) the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data (including, in the case where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such alternative data)); and

(ii) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (as so estimated, based on such data); **and**

(iii) for purposes of this subsection, uncompensated care shall include Medicaid shortfalls defined as the difference between the cost of providing care to Medicaid eligible patients and the payments a hospital received for those services.

Medicare Wage Index

Implement a Wage Index Floor

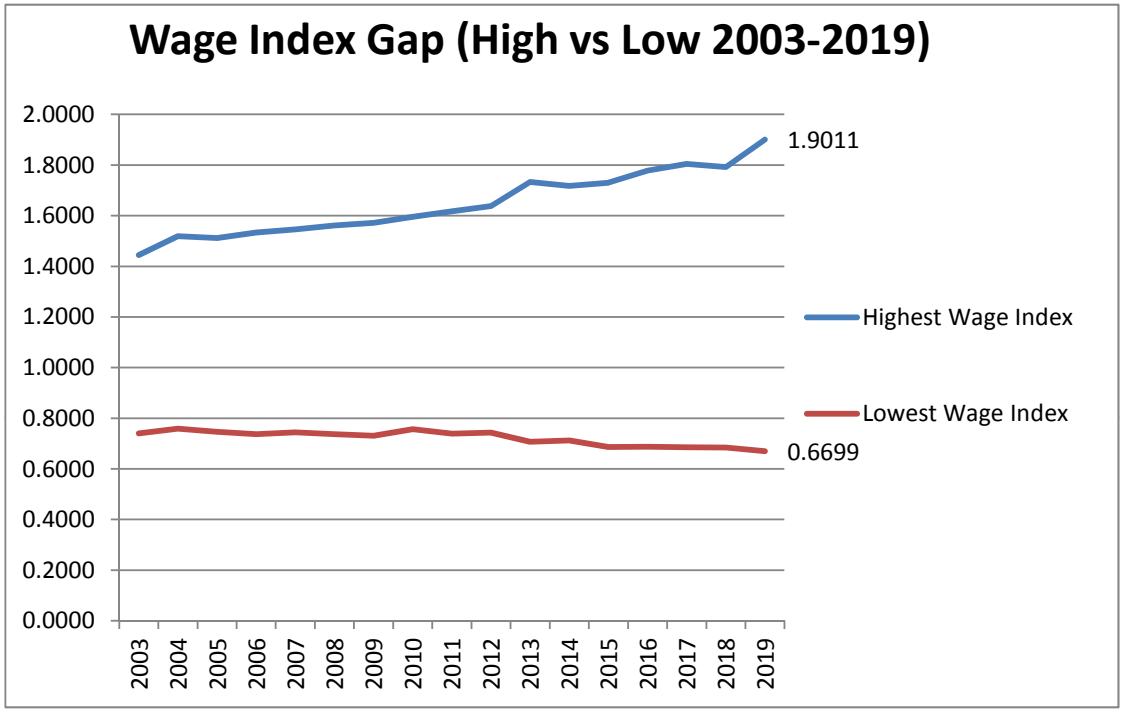
The current Medicare payment structure favors a handful of states to the detriment of Kentucky and other states. The wage index is intended to adjust payments to reflect geographic differences in wages but, in reality, the distortions within the system promote inefficiency and unpredictability and perpetuate inequity among states.

The national base DRG rate is divided into a labor and a non-labor component, with the labor component adjusted by the wage index. The labor component is set at 62% of the national rate for Kentucky and other states whose average wage costs are below the national average, but it is set at 69.6% for those states with wage costs above the national average. The wage index is computed from data reported by hospitals in 400+MSAs for urban wage index labor markets, but all non-MSA hospitals within a state are grouped into one statewide rural labor market and have payments adjusted by the state's rural wage index. **Kentucky has the 33rd lowest rural wage index and no area in Kentucky has a wage index at or above 1.0. Because Kentucky's wage index for both urban and rural hospitals is below the national average as well as most surrounding states, Kentucky hospitals receive lower payments for the care they are providing to Medicare patients. The average per case loss in payment relative to payment at the full federal operating rate (national average) for each of Kentucky's geographic areas due to the wage index is displayed on the following page. This is a significant problem because Medicare covers about one-half of all patients treated in Kentucky hospitals.**

Inequity in the wage index is a national issue, affecting many states, as the gap between the highest and lowest wage index is ever-increasing. There is a 184% difference between hospitals located in areas with the highest wage index compared to those in areas with the lowest wage index. With continuous depressed payments due to this gap, hospitals in low wage index areas – including Kentucky – cannot catch up.

MSA-Kentucky	FFY 2019 Wage Index	Average per Case Loss From U.S. Operating Rate
Bowling Green	0.8094	-$ 668
Clarksville/Hopkinsville	0.7959	- $ 715
Cincinnati/Northern Kentucky	0.9196	- $ 282
Elizabethtown	0.8004	- $ 699
Evansville/Henderson	0.9082	- $ 322
Huntington/Ashland	0.8362	- $ 574
Lexington	0.9015	- $ 345
Louisville	0.8763	- $ 433
Owensboro	0.8691	- $ 459
Rural Kentucky	0.7959	- $ 715

Source: Federal Register, KHA.



KHA supports addressing the wage index inequity by instituting a wage index floor, to reduce the gap between the lowest and highest wage index. The goal is for the floor to be set at 0.91 with the understanding that this may need to be a phased-in process starting with a floor of 0.874, which would stop the immediate bleeding but not achieve the full correction necessary to create payment equity. A 0.874 floor would provide an estimated $18 million in payments to Kentucky hospitals but it would not provide the necessary relief to Kentucky's urban hospitals, which is why a 0.91 floor should be adopted. A .91 floor would raise Kentucky's Medicare payments by an estimated $48 million annually.

KHA requests the Kentucky delegation to pursue legislation to phase-in a wage index floor of 0.91, which is needed to bring about equity among states in Medicare payments.

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Eliminate National Budget Neutrality for the Rural Wage Index Floor

A one-sentence amendment in Section 3141 of the Affordable Care Act (ACA) resulted in reducing Medicare payments from across the country to pay for increased reimbursement to all Massachusetts hospitals through an obscure Medicare funding mechanism, known as the "rural floor," designed to ensure that hospitals in urban areas are not reimbursed at lower rates than the state's rural hospitals. Through an orchestrated effort, the Nantucket Cottage Hospital – a small, 19-bed Massachusetts hospital which annually serves about 150 Medicare patients and is located in an area deemed to be rural – converted from a critical access hospital to a prospective payment system (PPS) hospital. This action resulted in applying the higher labor costs of the isolated island hospital (which became the rural floor) to all Massachusetts hospitals. There is clear evidence that the state's hospitals worked to create this system advantage, which even the Centers for Medicare and Medicaid Services (CMS) in its federal regulations called a "manipulation" of the Medicare rural floor payment system. The amendment added to the ACA required that funding to balance increased payments to Massachusetts hospitals be nationally budget neutral, meaning that it would come from reduced payments to all other hospitals in the country which themselves are struggling to care for Medicare patients. **The impact is an annual reduction of about $12 million in Medicare payments to Kentucky's hospitals.** Medicare payments to Kentucky hospitals would increase by an estimated $100 million over the next ten years if the national rural floor budget neutrality calculation were repealed and returned to being calculated at the state level.

Kentucky's hospitals request all members of the Kentucky delegation to fix this ongoing inequity which is primarily benefitting Massachusetts and a handful of other states at the detriment of other states, including Kentucky.

Protect Medicaid Funding

As of February 2019, 37 states (including the District of Columbia) have adopted the Medicaid expansion. **Kentucky hospitals support the Medicaid expansion and urge that Congress maintain the enhanced federal match for states that expanded their Medicaid programs.** Kentucky's Medicaid program now covers 1.4 million Kentuckians of which some 450,000 were added from Medicaid expansion.

According to the University of Louisville's Commonwealth Institute of Kentucky, Kentucky's uninsured rate fell from 20.4 percent in 2013 to 7.8 percent in 2016 – the largest decline in the country – due to the Medicaid expansion. Research on the impact of Medicaid expansion nationally has shown positive effects on access to care, utilization of services, affordability and financial security among the low-income population, although provider shortages remain a challenge in some areas such as Kentucky where emergency department utilization among Medicaid recipients remains high. Studies also show improved self-reported health following expansion as well as increases in early stage cancer screenings and diagnoses, increases in treatment for opioid use disorder and reduced probability of rural hospital closure.

For states that expanded, the federal government paid 100% of Medicaid costs of those newly eligible for coverage from 2014 to 2016. The federal share is gradually phasing down to 90% in 2020 (where it will remain in later years), still well above Kentucky's 70 percent traditional federal Medicaid match rate.

Prior congressional proposals to change the Medicaid program would have reduced the enhanced federal match for expansion eligibles. KHA and Kentucky hospitals are concerned that any proposed reduction in matching funds would eliminate Kentucky's ability to sustain the expansion. In order to better manage the ongoing cost of the Medicaid expansion, Kentucky has sought a Section 1115 demonstration waiver (Kentucky HEALTH) to add modest premiums for the expansion population as well as a community engagement requirement for certain adults. Kentucky's hospitals have been working collaboratively with state officials to implement the 1115 waiver and establishing programs to assist enrollees maintain coverage by meeting their obligations under the waiver. While the waiver is estimated to save Kentucky $2 billion over a five-year period, those savings are predicated on Kentucky continuing to receive the enhanced federal match rate for the expansion population. Therefore, any legislation which reduces the enhanced match below 90 percent will raise Kentucky's state share beyond the ability of the state to fund it, short of raising taxes, substantially reducing benefits or cutting provider payments which are already inadequate.

The federal government's maintenance of the 90 percent enhanced federal match for expansion enrollees is paramount to Kentucky's ability to sustain coverage for the 450,000 Kentuckians who rely on the Medicaid expansion for their health care.

KHA also urges Congress to allow states to experiment under existing Section 1115 demonstration waiver authority to make structural changes to their Medicaid programs rather than imposing block grants that will simply cap future Medicaid funding. Because Kentucky has such a large percent of low-income population which can move in and out of Medicaid eligibility, a Medicaid block grant would be very harmful since federal funding would not change to reflect increases in actual Medicaid enrollment and corresponding costs. A block grant would shift the risk of higher Medicaid enrollment and spending onto the state which would necessitate higher state taxes or cuts in services for low-income residents, including children, seniors and people with disabilities. As of February 2019, nine expansion states have approved or pending Section 1115 waivers that add community engagement/work requirements as a condition of eligibility for expansion adults. (Arizona, Arkansas, Indiana, Michigan, New Hampshire, Kentucky, Ohio, Virginia and Utah). In addition, a number of expansion states have approved or pending waivers that add eligibility and enrollment restrictions, copays, and/or healthy behavior provisions affecting expansion populations. Allowing states to design changes to their Medicaid programs under Section 1115 waivers is a better approach to encourage innovative solutions that can save money while continuing to protect coverage for vulnerable patients. **KHA and Kentucky's hospitals urge Congress to reject Medicaid block grants and support continued state use of Section 1115 demonstration programs.**

Rural Issues

In recent years, rural providers have endured major challenges through expansion of Medicaid, sequestration, Medicaid cuts and the threat of cuts by other government payers. Rural hospitals in Kentucky are a critical infrastructure and a health care safety net for rural Kentuckians. Since 2014, two Kentucky rural hospitals have closed and two more have discontinued inpatient services.

- **Nearly 45 percent of the population resides in rural areas.**
- **Sixty-four of the 97 acute hospitals in the commonwealth are located in rural areas.**
- **Kentucky now has 27 certified critical access hospitals (CAHs) representing nearly one-third of the acute care hospitals in the state.**
- **There are rural hospitals and CAHs in every congressional district in Kentucky, save one. In that district (Third Congressional District), all the hospitals have direct ties to other rural hospitals throughout the state due to transfers and referrals for specialty services.**
- **Over one third of Kentucky acute care hospitals have a special Medicare designation, such as "Rural Referral Center," "Medicare Dependent Hospital" or "Sole Community Hospital," indicating the extent to which they serve the rural population.**

The issues below are particularly critical to Kentucky's small rural hospitals:

Access

- Protect rural communities' access to care by **preserving Medicare rural hospital designations including the critical access hospital, Medicare dependent hospital and low-volume hospital designations.**

Post-Acute Care:

- Preserve the swing bed designation and payment structure by **rejecting any new policies that would reduce payments or increase administrative burden for post-acute care services provided in swing beds.** Swing bed services provide access to post-acute and rehabilitative services for rural Americans in high quality settings, close to their homes.

Critical Access Hospital (CAH) Relief of 96-Hour Physician Certification Rule

- CMS interprets current law to require physicians admitting patients to a CAH to certify the patient will stay 96 hours or less in the hospital as a condition of payment. There are many contributing factors that may result in a patient staying longer than anticipated in a hospital including approval for post-acute services and ability to appropriately place a patient following discharge. **Please support legislation to eliminate the 96-hour**

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Rural Issues - continued

physician certification requirement as a condition of payment for critical access hospitals.

Physician Supervision

- In the Calendar Year (CY) 2009-2013 outpatient PPS rules, CMS mandated new requirements for "direct supervision" of outpatient therapeutic services, requiring that a physician or a non-physician practitioner be immediately available to furnish assistance and direction throughout certain outpatient procedures. Small, rural PPS hospitals and critical access hospitals have expressed concern that shortages of physicians and nurse practitioners in their communities make it difficult to comply with this requirement in cases where patient safety is not a factor requiring direct supervision. This policy reduces access to outpatient therapeutic services for Medicare patients at local rural hospitals, since hospitals unable to comply may limit their hours of operation or close certain programs. **KHA urges the Kentucky congressional delegation to pass a permanent enforcement moratorium on the CMS direct supervision policy for outpatient therapeutic services provided in critical access hospitals and small, rural hospitals.**

Support New Models of Care

- Establishment of a Rural Emergency Hospital (REH) designation under the Medicare program would allow existing rural hospitals to meet a community's need for emergency and outpatient services without having to provide inpatient care. Emergency services would be provided 24 hours a day, 365 days a year, and communities would have the flexibility to align additional outpatient and post-acute services with community needs and receive enhanced payment. **KHA supports legislation to establish a new designation under the Medicare program to allow rural hospitals to continue providing necessary emergency, observation, and outpatient services at enhanced reimbursement rates but cease inpatient services.**

For further information about these key issues and KHA's Government Relations, please contact:

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