Trends in Kentucky Hospital Revenue: 2005 through 2013

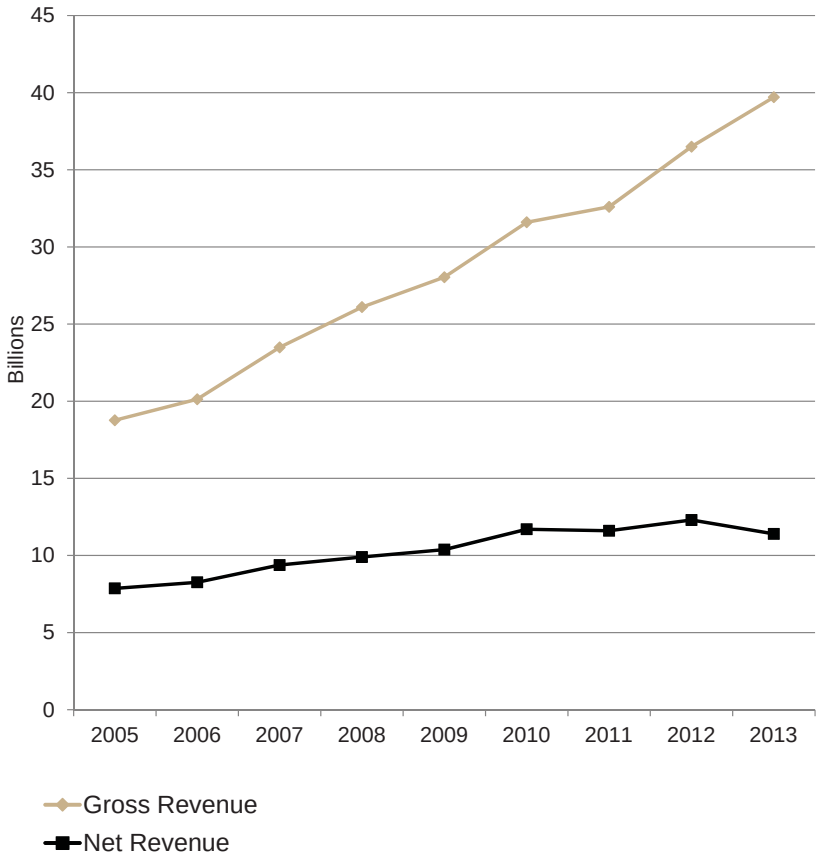
Kentucky hospital gross patient revenue, which represents total charges for patient services, has steadily increased over an eight-year period, rising from $18.8 billion in 2005 to $39.7 billion in 2013. Between 2012 and 2013, total gross patient revenue increased $3.2 billion.

The difference between what hospitals charge (gross revenue) and the amount they receive in payment (net revenue) is considered a contractual adjustment. Contractual adjustments include the difference between charges and fixed payments set by the federal and state governments for Medicare and Medicaid, as well as contractually negotiated discounts with private insurers.

Hospital deductions from revenue include contractual allowances as well as charity care. In 2013, these payment shortfalls topped $28 billion and accounted for 71 percent of Kentucky community hospitals' gross patient revenue.

As a result of contractual adjustments, Kentucky hospital net patient revenue in 2013 was $11.4 billion, which represents a 7.3 percent decline from $12.3 billion received in 2012. Statewide, Kentucky hospitals received only 29 percent of billed charges in 2013, compared with 33.7 percent in 2012. In 2005, hospitals were reimbursed 41.6 percent of billed charges illustrating a widening of the gap between charges and payments.

Deductions from Revenue

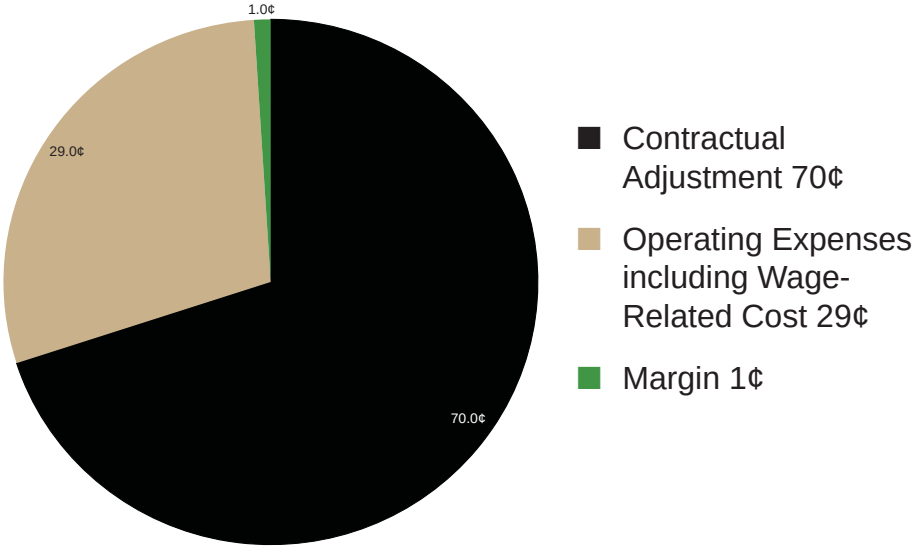


Source: *Medicare Cost Report data provided by Datagen Keystats™*

No Room for Error: Every Penny Counts

This chart illustrates what happens to a typical dollar of hospital patient charges in Kentucky. The contractual adjustments explained above account for an immediate write-off of 70¢. Total operating expenses (other expenses and wage-related costs) consume 29¢. It is important to note that wage-related expenses account for 46 percent of total operating expenses. After all this, hospitals are left with 1¢ per dollar of charges as profit to meet the changing health needs of Kentuckians.

Breakdown of Hospital Dollar



Source: *Medicare Cost Report data provided by Datagen Keystats™*

Underpayment by Medicare and Medicaid

Not only is there a widening gap between payments and charges for hospital services, but there is growing "underpayment" which is occurring because the payment hospitals receive from Medicare and Medicaid is less than the costs hospitals incur to care for Medicare and Medicaid patients.

Medicare Hospital Payments Fail to Keep Up with the Cost of Care

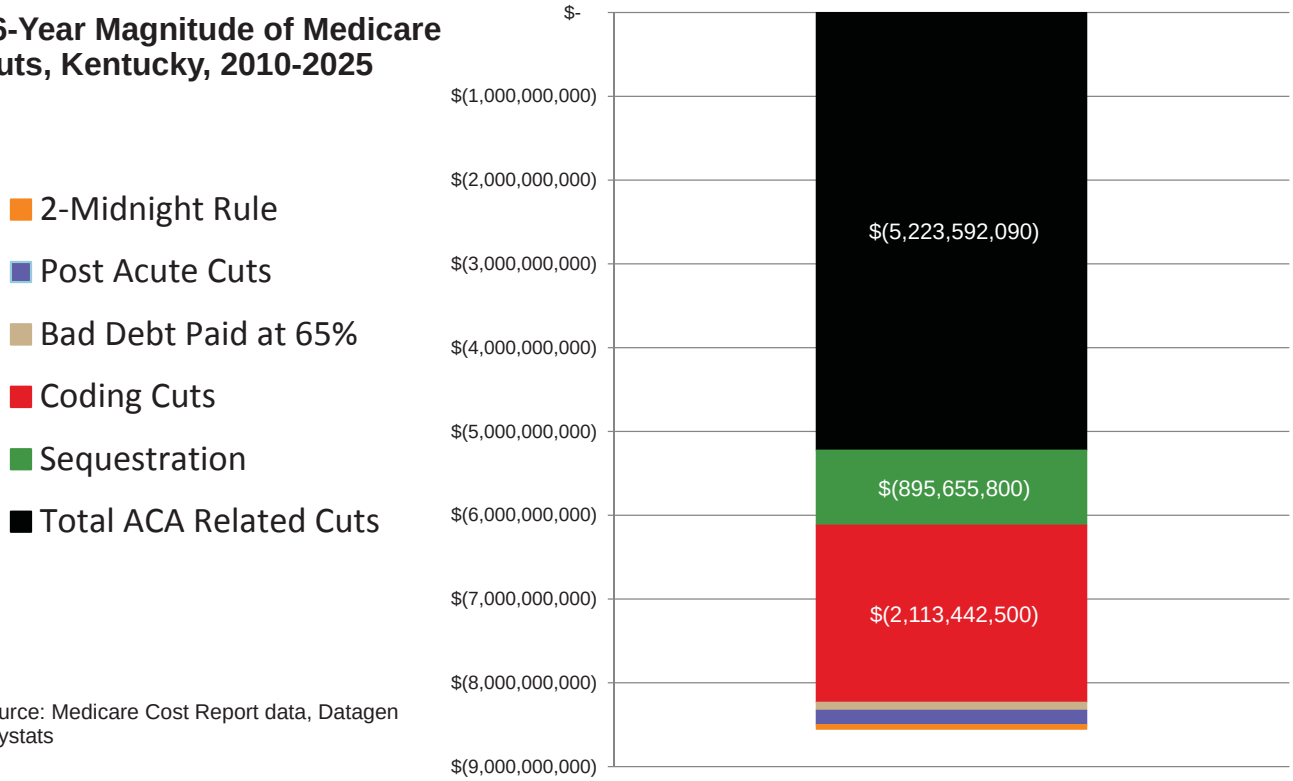
The passage of the Affordable Care Act (ACA) intended to extend health insurance coverage to two-thirds of those Americans who were uninsured by mandating individuals to obtain insurance coverage, subsidizing the purchase of coverage for persons below certain income levels and enrolling more people in state-run Medicaid programs. Because Kentucky has one of the lowest per capita income levels in the nation, 80 percent of those signing up for coverage on the health insurance exchange were enrolled in the Medicaid program, not a private health insurance plan. The state expansion of Medicaid has resulted in adding 375,000 additional people to the Medicaid program, bringing the total to 1.2 million people (1 out of 4 Kentuckians) now covered under Medicaid. As Medicaid is jointly financed by federal and state tax dollars, Kentucky will be required to begin paying for part of the additional Medicaid expenditures generated by the new enrollees in 2017. Unfortunately, Medicaid only reimburses hospitals 82 percent of their actual costs to care for Medicaid patients (including inpatient and outpatient) leaving a growing shortfall of uncompensated care costs by the Medicaid program.

Fifty percent of the cost of the health care reform legislation will be financed through new taxes and 50 percent through Medicare payment cuts. One-third of the total Medicare payment cuts will come from cuts to hospitals. These cuts will outweigh the additional expected revenue from the newly insured, because the majority are covered by Medicaid. In addition to the ACA cuts, the federal government has reduced Medicare payments to Kentucky hospitals through sequestration, and other program changes. When all forms of payment cuts are considered, Kentucky's hospitals are estimated to lose more than $8 billion in Medicare payments from 2010 through 2025.

The following charts and table show the financial loss to Kentucky hospitals from the Medicare program. In 2013, Kentucky hospital revenue from Medicare was projected at $3.1 billion while hospital Medicare patient care costs were $3.3 billion, resulting in a $223 million shortfall. The shortfall grew 28.6 percent in just one year from 2012 to 2013 showing the impact of rising Medicare payment cuts.

On average, about one half of all patients treated by Kentucky hospitals are covered by Medicare; therefore, maintaining adequate Medicare reimbursement is essential to assure that beneficiaries are able to have continued access to quality health care services.

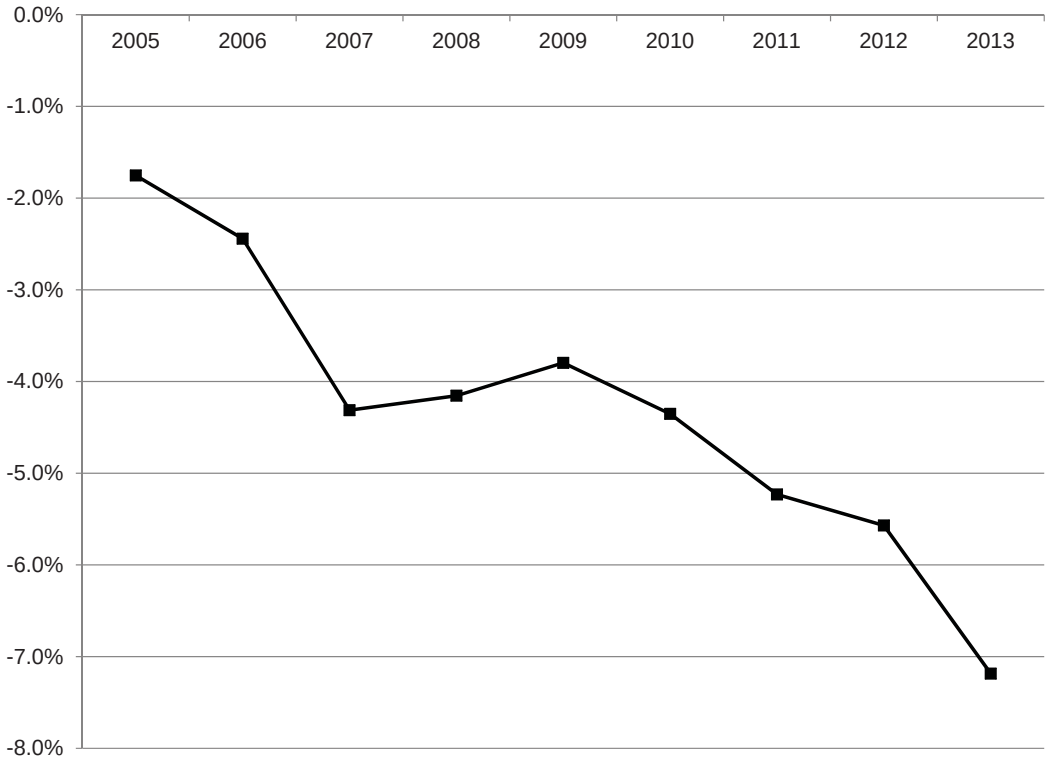
16-Year Magnitude of Medicare Cuts, Kentucky, 2010-2025



Source: Medicare Cost Report data, Datagen Keystats

Kentucky Hospitals' Aggregate Medicare Margins - Margins for PPS and Critical Access Hospitals

Note: This chart shows the trend in Medicare margins for Kentucky hospitals from 2005 through 2013.



Source: *CMS Impact Files; Medicare Cost Report data provided by Datagen Keystats™*

Medicare Margins: 2005 - 2013

	2005	2006	2007	2008	2009
Revenues	$2,705,351,139	$2,806,946,825	$2,908,552,754	$2,959,731,130	$3,125,959,129
Costs	$2,752,777,766	$2,875,523,060	$3,034,003,105	$3,082,713,378	$3,244,642,319
Gain/(Loss)	($47,426,626)	($68,576,236)	($125,450,351)	($122,982,248)	($118,683,191)
Margin	-1.8%	-2.4%	-4.3%	-4.2%	-3.8%

	2010	2011	2012	2013
Revenues	$3,212,463,613	$3,261,167,162	$3,270,664,835	$3,100,320,300
Costs	$3,352,303,956	$3,431,797,817	$3,452,830,943	$3,323,069,066
Gain/(Loss)	($139,840,343)	($170,630,655)	($182,166,108)	($222,748,766)
Margin	-4.4%	-5.2%	-5.6%	-7.2%

Note: Includes PPS and CAH facilities.

Source: *Healthcare Cost Report Information System (HCRIS) Database provided by the Centers for Medicare and Medicaid Services (CMS) and Datagen Keystats™*

Medicare Wage Index

Kentucky hospitals, despite being efficient providers with a lower average cost than most other states, receive lower payments than most other states due to the Medicare Wage Index.

Medicare pays acute care hospitals (excluding critical access hospitals) a flat fee based on a patient's diagnosis, or DRG (Diagnosis Related Group). A hospital's DRG payment is the product of two components: (1) a standardized amount, or base rate, which is adjusted by the hospital's area average wage level and (2) the DRG's relative weight.

The base rate is intended to represent the cost of an average Medicare inpatient discharge. One standardized amount is applied to all hospitals paid under the DRG system within the 48 contiguous states. This payment system is known as the Inpatient Prospective Payment System (IPPS).

The hospital wage index is used to adjust the standardized amount for area differences in hospital wage levels to account for the local wage variation or cost of labor in the hospital's area. It is intended to measure the average wage level for hospital workers in each Metropolitan Statistical Area (MSA) or rural area (comprised of counties that have not been assigned to an MSA), relative to the national average wage level.

Because Kentucky has a lower average wage level, hospitals in Kentucky historically have been paid less under the Medicare program than hospitals in adjacent states. Although Kentucky's hospitals must compete regionally for skilled employees, Kentucky's Medicare wage index for both urban and rural hospitals is lower than its regional counterparts. This situation is perpetuated because continued low payment negatively impacts hospitals' ability to increase wages.

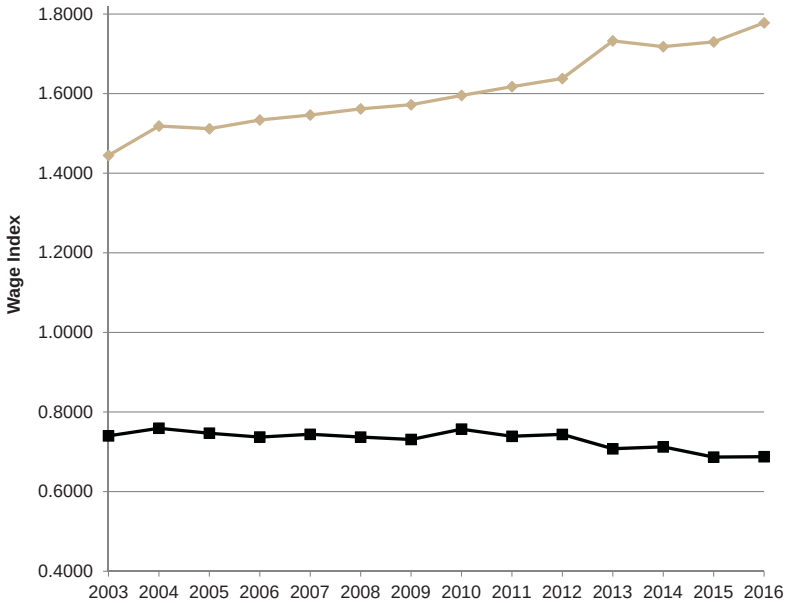
Kentucky's rural hospitals are paid less than rural hospitals in five surrounding states, and hospitals in Kentucky's major metropolitan areas of Louisville and Lexington continue to be paid less than hospitals in Cincinnati, Indianapolis and Nashville.

Rural Wage Index				Urban Area Wage Index			
State	FFY 2014 Wage Index	FFY 2015 Wage Index	FFY 2016 Wage Index	City/MSA	FFY 2014 Wage Index	FFY 2015 Wage Index	FFY 2016 Wage Index
Ohio	0.8411	0.8360	0.8235	Huntington/Ashland	0.8780	0.8685	0.8676
Indiana	0.8371	0.8264	0.8189	Clarksville/Hopkinsville	0.7790	0.7722	0.7714
Illinois	0.8384	0.8309	0.8400	Evansville/Henderson	0.8413	0.8581	0.8905
Virginia	0.7819	0.7697	0.7822	Owensboro	0.7865	0.7722	0.7855
Missouri	0.8020	0.7996	0.7950	Bowling Green	0.8574	0.8402	0.8248
West Virginia	0.7453	0.7267	0.7328	Elizabethtown	0.7790	0.7722	0.7714
Tennessee	0.7456	0.7327	0.7308	Lexington	0.8805	0.8862	0.8791
				Louisville	0.8762	0.8531	0.8737
KENTUCKY	0.7790	0.7722	0.7714				
				Cincinnati	0.9264	0.9260	0.9265
				Indianapolis	0.9981	1.0009	0.9893
				Nashville	0.9039	0.8907	0.8743

Source: *CMS Federal Register*

To complicate matters, there is an ever-increasing gap between hospitals located in areas with the highest wage index compared to those located in areas with the lowest wage index. Since the system is budget neutral, this inequality is perpetuated as hospitals with a low index cannot catch up. Kentucky has the 40th lowest rural wage index, and none of its urban areas have a wage index of 1.0, which would equal the national average. This results in Kentucky's hospitals receiving about $2,000 less per case for providing the same level of care as hospitals located in high wage index urban and rural areas.

Wage Index - High vs. Low, 2003-2016



Source: *Federal Register*

Medicaid

The number of Kentuckians covered by the Kentucky Medicaid program increased by 32 percent from 2014 to 2015 as a result of Medicaid expansion. At the end of state fiscal year (SFY) 2014, Medicaid covered approximately 1.2 million people, or about 25 percent of the state's total population. While expansion eligibles grew from 108,379 to 375,498 between SFY 2014 and 2015, there was also a seven percent increase in traditional Medicaid enrolles as more people signed up due to outreach efforts and because of the individual mandate to be insured under the ACA. While the costs of expansion enrollees are 100 percent federally funded until 2017, when the state will begin paying a portion which will grow to 10 percent, the growth in traditional enrollees – known as "woodworkers" – is much more costly because the state must fund 30 percent of their cost.

Average cost per eligible has fluctuated since 2011, both for traditional Medicaid eligibles as well as KCHIP. From 2011-2013, state government spending per eligible declined by 4.7 percent. This reflects the per member per month savings obtained by the state in signing fixed-price contracts with three managed care organizations to cover the majority of the traditional Medicaid population.

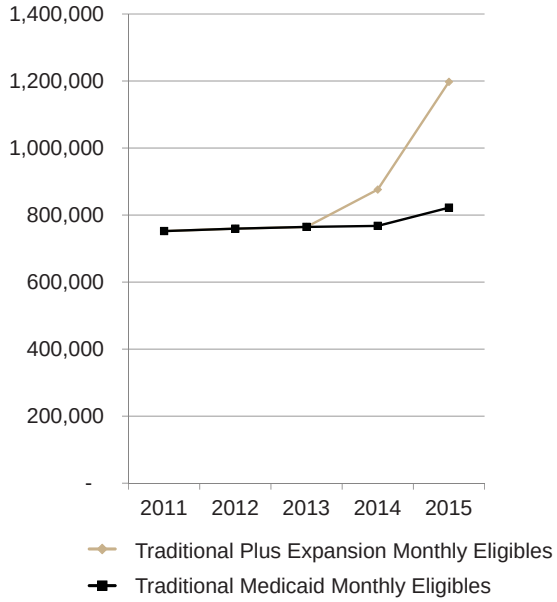
However, the average cost per eligible has increased in both 2014 and 2015, and the SFY 2015 cost of $646.10 per eligible per month was 11 percent higher than in 2013. This was driven by a 26 percent growth in costs for expansion enrollees and, to a lesser extent, a 13.5 percent increase in KCHIP costs, as spending for non-expansion enrollees declined slightly. This may reflect pent-up demand for services by persons previously uninsured.

The Medicaid expansion also significantly changed the mix of people covered by the program when eligibility became tied to modified adjusted gross income rather than based on categories of women, children, aged, blind or diabled. As a result, the expansion changed Medicaid from a program that largely focused on women and children to include men and childless adults.

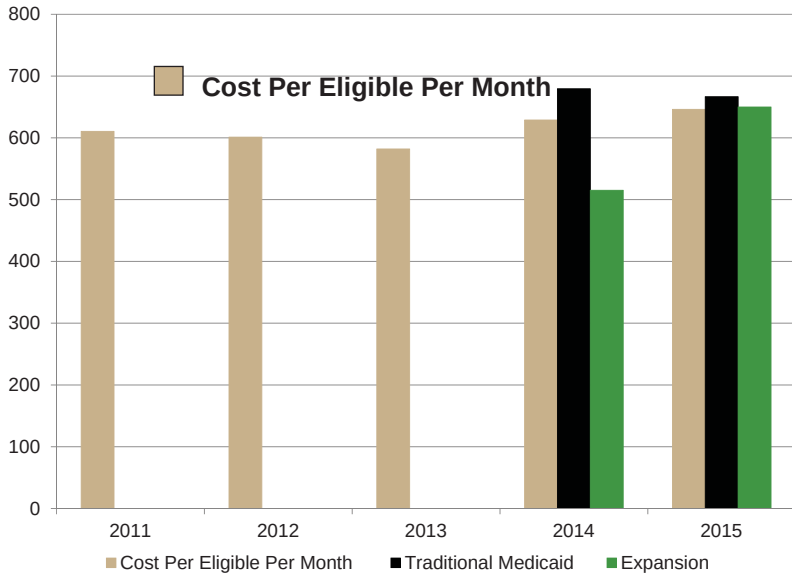
Growth in Medicaid Eligibles and Monthly Cost: SFY 2011 - 2015

	State Fiscal Year					% Change	
	2011	2012	2013	2014	2015	2014-2015	2011-2015
Average Monthly Eligibles	815,460	825,648	829,826	941,182	1,243,432	32.1%	52.5%
Average Monthly Traditional Medicaid	752,234	759,481	764,712	767,798	822,187	7.1%	9.3%
Average Monthly Expansion				108,379	375,498	246.5%	
Average Monthly KCHIP	63,227	66,167	65,114	65,004	45,746	-29.6%	-27.6%
Cost Per Eligible Per Month	610.39	601.13	581.88	628.79	646.10	2.8%	5.9%
Cost Per Eligible Per Month By Type:							
Traditional Medicaid				679.43	666.46	-1.9%	
Expansion				515.02	649.81	26.2%	
KCHIP				220.24	249.88	13.5%	

Number of Monthly Medicaid Eligibles without KCHIP



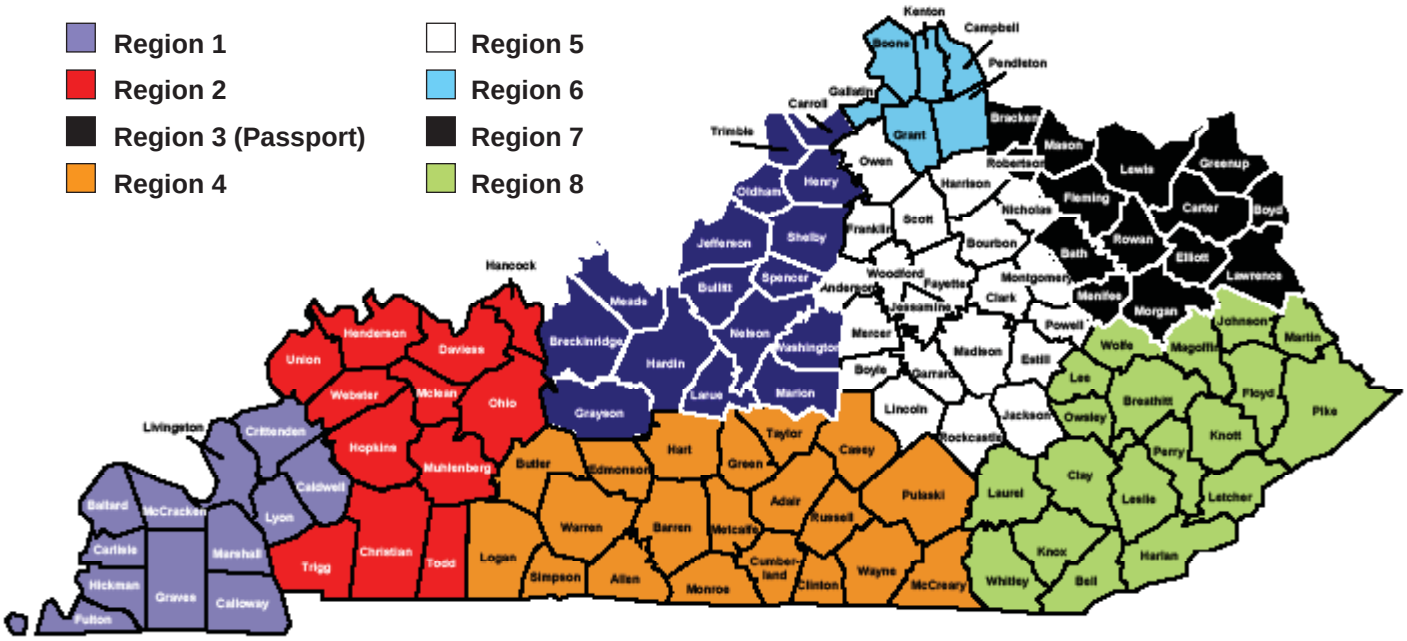
Cost Per Eligible Per Month



Source: *Kentucky Legislative Research Commission Report EOYCM*

Medicaid Managed Care

The state is divided into eight regions for purposes of Medicaid managed care contracting.



Source: *Department for Medicaid Services*

Some 170,000 Medicaid enrollees residing in Jefferson County and 15 nearby counties (Region 3) have had their physical health services covered and managed by Passport Health Plan, a Medicaid HMO, since the late 1990s. On November 1, 2011, Kentucky implemented Medicaid managed care for some 560,000 Medicaid recipients in the remaining geographic areas outside of the region served by Passport Health Plan by contracting with Medicaid managed care organizations (MCOs). MCOs are paid a fixed monthly capitated rate per Medicaid enrollee and are at financial risk for recipient utilization and service expenditures. They are responsible for managing both physicial and behavioral health services for their members.

Three-year statewide contracts (excluding Region 3) were initially awarded to WellCare, Coventry Cares of Kentucky and Kentucky Spirit Health Plan, a subsidy of Centene Corporation.

Although contracts were signed with the MCOs in July 2011, managed care implementation began in November of 2011, which was an extremely short time frame for MCOs to obtain provider contracts and put operational systems in place to properly pay claims. This resulted in significant problems for patients and providers as noted in a report by the Urban Institute evaluating the first year of Medicaid managed care implementation. The report found that providers had increased administrative difficulties including administrative burden, delays in prior authorization of services, claims denials and payment delays. Patients had difficulties maintaining continuity of prescription medication, and gaps in behavioral health services were exacerbated.[1] In 2012, the MCOs claimed to be losing more money than predicted and in October 2012 Kentucky Spirit gave notice to the state that it would terminate its contract one year early on July 5, 2013. In February of 2013, the state provided a supplementary seven percent rate increase to WellCare and Coventry in addition to the scheduled annual rate increases required under the original contract with these MCOs.

To provide more competition and plan choice, the state also awarded contracts to Humana Care Source, WellCare and Coventry to provide coverage in Region 3 in addition to Passport Health Plan. An open enrollment was conducted and coverage under the new plans began January 1, 2013. Management of behavioral health services for Region 3 recipients was also moved to the MCOs at that time. Despite the state's initial re-assignment of a substantial number of enrollees to Humana, WellCare and Coventry, the majority switched back to Passport Health Plan. Anthem became the fifth MCO doing business in Kentucky when Medicaid Expansion began on January 1, 2014.

1 "Evaluation of Statewide Risk-Based Managed Care in Kentucky" Urban Institute, November 2, 2012

Persons Eligible for Enrollment	Persons Ineligible for Enrollment
Temporary Assistance to Needy Families (TANF)	Individuals who shall spend down to meet eligibility criteria
Children and Family Related	Individuals currently Medicaid eligible and have been in a nursing facility for more than 30 days
Aged, blind and disabled Medicaid only	Individuals determined eligible for Medicaid due to a nursing facility admission including those individuals eligible for institutionalized hospice
Pass through	Individuals served under the Supports for Community Living, Michele P. home and community based, or other 1915(c) Medicaid waivers
Poverty level pregnant women and children	Qualified Medicare Beneficiaries (QMBs), specified low income Medicare beneficiaries (SLMBs) or qualified Disabled Working Individuals (QDWIs)
Aged, blind and disabled receiving state supplementation	Timed, limited covereage for illegal aliens for emergency medical conditions
Aged, blind and disabled receiving Supplemental Security Income (SSI)	Working disabled program
Under the age of 21 years and in an inpatient psychiatric facility	Individuals in an intermediate care facility for the mentally retarded (ICF-MR)
Children under the age of 18 who are receiving adoption assistance and have special needs	Individuals who are eligible for the Breast or Cervical Cancer Treatment Program

Source: *Department for Medicaid Services*

The following tables show SFY 2014 and 2015 monthly eligibles by MCO. About 1.1 million or 90 percent of the 1.2 million total Medicaid eligibles are under managed care with only 134,000, or 10 percent, still covered under the traditional fee-for-service Medicaid program operated by the state.

As of June 2015, WellCare was the largest MCO with 37 percent of managed care enrollees, followed by Coventry and Passport with 25 percent and 22 percent respectively. Anthem and Humana are small plans with only 16 percent combined.

WellCare's average membership increased the most – by 167 percent – from 2014 to 2015, followed by the two smallest plans, with Humana growing by 153 percent and Anthem by 97 percent. Coventry had the smallest increase of 5 percent.

Even though overall membership grew due to the addition of enrollees from Medicaid expansion, both WellCare and Coventry lost market share from 2014 to 2015. Comparing enrollment by plan in June 2015 to June 2014, WellCare's share declined from 39 percent to 37 percent, and Coventry's share of enrollment dropped the most from 31 percent in 2014 to 25 percent in 2015. In contrast, Passport Health Plan's share of enrollment grew from 20 percent to 22 percent. Anthem and Humana also gained share, but still remain the smallest plans.

- continued next page -

Medicaid Managed Care - continued

Change in Share of Enrollment by MCO

	Anthem	Coventry	Humana	Passport	WellCare
June 2014	4%	31%	7%	20%	39%
June 2015	6%	25%	10%	22%	37%

Monthly Eligibles by MCO

Month	Anthem	Coventry	Humana	Passport	WellCare	Total MCO Enrollees
July 2014	39,781	304,310	73,239	194,836	388,758	1,000,924
August 2014	44,955	309,827	80,398	206,464	399,808	1,041,452
September 2014	48,279	310,395	85,473	211,802	404,363	1,060,312
October 2014	51,814	312,198	90,170	217,547	409,143	1,080,872
November 2014	54,269	312,548	93,277	221,494	412,649	1,094,237
December 2014	58,049	314,214	37,624	227,017	416,932	1,053,836
January 2015	62,947	303,301	104,394	241,585	429,702	1,141,929
February 2015	66,610	306,085	109,648	248,516	436,205	1,167,064
March 2015	67,808	301,439	111,349	249,374	434,282	1,164,252
April 2015	69,751	301,797	114,797	252,914	436,482	1,175,741
May 2015	71,360	298,518	115,518	254,042	432,908	1,172,346
June 2015	71,467	292,823	115,688	253,074	427,099	1,160,151
SFY 2015 Average Monthly Eligibles	58,924	305,621	188,596	231,555	419,028	1,109,426
July 2013		273,849	16,909	128,800	285,126	836,049
August 2013		269,892	16,740	128,290	286,512	703,414
September 2013		274,318	16,886	130,574	295,078	712,992
October 2013		269,560	16,312	128,209	292,095	707,699
November 2013		260,900	16,410	128,477	297,698	703,383
December 2013		266,380	16,711	131,518	302,058	716,569
January 2014	11,141	272,361	27,844	145,533	318,045	774,836
February 2014	23,697	296,253	48,708	170,811	358,701	898,020
March 2014	27,723	315,254	54,786	184,055	379,105	960,823
April 2014	41,080	348,601	73,577	209,397	422,239	1,094,845
May 2014	36,330	320,127	68,333	194,665	391,643	1,011,123
June 2014	39,887	319,314	73,467	202,222	400,038	1,034,979
SFY 2014 Average Monthly Eligibles	29,976	290,567	37,224	156,879	335,695	846,228

Source: *Department for Medicaid Services*

Payments for Services

The Kentucky Medicaid program pays hospitals less than the actual cost to treat Medicaid patients. Inpatient rates cover, on average, only 75 percent of the actual costs hospitals incur to treat Medicaid patients. In terms of total payments for both in-patient and outpatient care, Medicaid payments cover only about 82 percent of actual costs. Until November 1, 2011, care for all other Medicaid patients was paid on a fee-for-service basis at rates set by the state Department for Medicaid Services. The MCOs have generally tied hospital reimbursement rates to those rates established by the Department for Medicaid Services.

The following tables compare spending for Medicaid services before and after statewide managed care.

Medicaid Spending on Mandated and Optional Services: 2011 vs. 2015

	SFY 2011 FFS Expenditures Medicaid (Non-KCHIP) FFS & Passport	SFY 2013 Total Medicaid (Non-KCHIP) FFS & MCO	FFS & MCOs (non-KCHIP)	SFY 2015 FFS & MCOs (Non-KCHIP)	% Change Total Spending 2014-2015
Mandatory					
Inpatient Hospital					26%
Psych Distinct Part Unit	$ 1,068,125,257.00	$ 825,891,064.18	$ 983,304,959.15	$ 1,239,032,860.57	32%
Rehab Distinct Part Unit	$ 27,303,599.00	$ 13,611,352.27	$ 17,808,293.72	$ 23,555,741.65	37%
Supplemental Payments (Intensive Operating Allowance)			$ 8,343,852.56	$ 11,418,693.99	-24%
Physicians	$ 559,596,514.00	$ 515,306,243.47	$ 21,048,700.00	$ 16,091,200.00	39%
Nursing Facilities	$ 500,008,294.00	$ 429,337,325.70	$ 500,399,850.76	$ 697,499,681.29	8%
Outpatient Hospital	$ 8,270,478.00	$ 7,070,546.89	$ 874,092,100.00	$ 944,936,199.10	76%
Home Health	$ 843,389,330.00	$ 809,972,902.71	$ 670,382,521.57	$ 1,179,421,280.20	0%
Durable Medical Equipment (DME)	$ 41,331,986.00	$ 40,840,633.47	$ 35,511,936.57	$ 35,594,926.16	33%
Family Planning	$ 93,993,431.00	$ 73,938,286.54	$ 74,356,212.18	$ 98,774,144.27	-4%
EPSDT - Screens	$ 5,526,549.00	$ 4,337,218.00	$ 4,782,326.00	$ 4,569,110.37	1154%
EPSDT - Related	$ 23,336,232.00	$ 10,863,963.47	$ 1,134,200.00	$ 14,217,993.39	14%
Laboratories	$ 85,863,804.00	$ 52,128,602.08	$ 51,535,277.58	$ 58,802,767.42	26%
Dental	$ 60,113,797.00	$ 35,870,037.73	$ 55,558,762.36	$ 69,769,220.15	5%
Non-Emergency Transportation	$ 110,821,665.00	$ 93,227,416.07	$ 141,252,934.26	$ 147,710,575.99	98%
Ambulance	$ 4,089,123.00	$ 2,449,743.15	$ 2,746,292.29	$ 5,425,091.26	39%
Vision	$ 19,793,927.00	$ 16,995,316.01	$ 17,693,196.07	$ 24,536,739.15	14%
Hearing	$ 27,339,370.00	$ 15,548,802.63	$ 37,087,809.24	$ 42,326,697.37	490%
Primary Care (FQHC)	$ 675,584.00	$ 1,447,722.36	$ 1,431,017.04	$ 8,444,226.29	-5%
Rural Health	$ 129,248,074.00	$ 99,505,012.52	$ 94,123,798.78	$ 89,631,906.57	-32%
Qualified Medicare Beneficiaries (QMBs)	$ 64,539,223.00	$ 49,847,483.38	$ 61,375,554.26	$ 41,521,864.74	135%
Nurse Practioner/Midwife	$ 791,526.00	$ 1,294,602.03	$ 1,245,100.00	$ 2,928,862.93	194%
Subtotal Mandatory	$ 3,674,157,763.00	$ 3,099,484,274.66	$ 3,655,214,694.39	$ 4,756,209,782.86	32%
Optional					
ICF-MR			$ -	$ -	-21%
Pharmacy	$ 137,976,852.00	$ 133,822,719.30	$ 192,828,700.00	$ 152,202,500.00	66%
Community Mental Health Centers	$ 713,874,750.00	$ 508,068,206.89	$ 728,976,604.46	$ 1,209,830,411.13	34%
Mental Hospital	$ 96,711,248.00	$ 98,706,661.91	$ 105,752,471.93	$ 141,828,611.51	-5%
Psychiatric Residential Treatment Facilities (PRTF)	$ 33,107,965.00	$ 25,525,099.31	$ 25,670,464.02	$ 24,308,587.01	-10%
Renal Dialysis	$ 18,161,717.00	$ 11,211,630.63	$ 7,350,815.48	$ 6,590,469.17	16%
Podiatry	$ 19,495,927.00	$ 16,368,797.92	$ 17,693,426.05	$ 20,440,925.75	86%
Supports for Community Living (formerly AIS MR)	$ 3,278,833.00	$ 3,807,123.99	$ 4,474,282.81	$ 8,333,631.73	4%
Ambulatory Surgical	$ 266,487,874.00	$ 263,837,160.64	$ 296,334,400.00	$ 308,602,108.00	48%
Home & Community Based Services	$ 14,362,019.00	$ 11,222,253.87	$ 10,487,290.28	$ 15,545,099.53	-27%
Adult Day Care	$ 28,262,192.00	$ 23,872,026.14	$ 23,510,300.00	$ 17,091,636.00	9%
Model Waivers	$ 56,983,289.00	$ 61,530,720.96	$ 67,714,900.00	$ 73,717,400.00	1%
Hospice	$ 5,745,034.00	$ 5,097,146.84	$ 4,474,100.00	$ 4,513,700.00	-14%
Preventive	$ 36,640,165.00	$ 31,705,609.47	$ 32,808,676.63	$ 28,212,997.92	17%
Commission for Children with Special Health Care Needs	$ 39,652,405.00	$ 30,434,769.88	$ 21,425,167.33	$ 25,121,884.86	-11%
Targeted Case Mgmt. - Emotionally Disturbed Children	$ 7,522,945.00	$ 1,104,915.47	$ 6,633,828.69	$ 5,895,492.20	-40%
Targeted Case Mgmt. - Mentally Ill Adults	$ 17,073,616.00	$ 10,962,870.22	$ 5,611,212.00	$ 3,350,302.93	-47%
Title V/DCBS	$ 7,205,343.00	$ 7,884,267.44	$ 3,639,026.00	$ 1,938,127.04	2%
School-Based Services	$ 130,386,277.00	$ 113,947,744.91	$ 156,262,100.00	$ 159,821,700.00	38%
Early Intervention - First Steps	$ 5,493,977.00	$ 8,852,546.40	$ 9,333,400.00	$ 12,836,700.00	32%
Impact Plus	$ 392,012.00	$ 218,129.95	$ 12,268,700.00	$ 16,149,000.00	-64%
Other Lab/X-Ray (included in Lab through FY 96)	$ 12,666,269.00	$ 20,110,608.38	$ 37,040,344.48	$ 13,266,182.45	-19%
Nurse Anesthetist	$ 1,921,324.00	$ 6,081,616.69	$ 3,631,758.32	$ 2,931,949.46	61%
Brain Injury	$ 16,983,382.00	$ 24,675,291.55	$ 8,028,039.48	$ 12,949,214.70	15%
Brain Injury Long Term Care	$ 17,433,123.00	$ 19,749,022.36	$ 22,713,200.00	$ 26,010,502.00	3%
HANDS	$ 12,080,706.00	$ 14,508,772.18	$ 15,852,100.00	$ 16,307,800.00	-15%
Home Care Waiver	$ 21,316,871.00	$ 24,195,437.29	$ 20,773,500.00	$ 17,589,184.00	
Personal Care Assistance	$ 8,488,183.00	$ 7,697,229.98	$ -	$ -	
Chiropractic		$ -	$ -	$ -	85%
Clinical Social Workers	*$ 17,721,990.00*	*$ 33,217,251.60*	$ 10,066,536.06	$ 18,580,625.86	1802%
Physical Therapist		$ 228,991.49	$ 264,882.26	$ 5,039,363.40	127%
Occupational Therapist		$ 1,219,613.73	$ 1,753,009.30	$ 3,985,085.69	118%
Psychologist		$ 143,622.43	$ 176,946.36	$ 386,318.59	526%
Physician Assistant		$ 2,871.50	$ 121,861.52	$ 763,038.36	74%
Comprehensive Outpatient Rehab Facility		$ 71,241.72	$ 2,857,415.00	$ 4,980,959.00	13%
Specialized Childrens's Service Clinics	$ 9,487,500.00	$ 11,256,468.17	$ -	$ -	61%
Money Follows the Person-Post Transition		$ -	$ 96,392.40	$ 155,479.71	-36%
Money Follows the Person-Benefits	$ 1,724,226.00	$ 4,304,638.14	$ 4,636,900.00	$ 2,984,600.00	-114%
Money Follows the Person-Enhanced Benefits	$ 290,760.00	$ 234,520.46	$ (877,500.00)	$ 120,200.00	-100%
Michelle P Waiver		$ -	$ 7,071,200.00	$ -	16%
Unknown	$ 34,022,424.00	$ 30,186,779.50	$ 247,221,000.00	$ 285,892,700.00	253%
Private Duty Nursing			$ 29,976,610.22	$ 105,932,449.53	
Subtotal Optional	$ 1,792,951,198.00	$ 1,566,064,379.31	$ 2,144,654,061.08	$ 2,754,206,937.53	28%
Total Mandatory and Optional Spending	$ 5,467,108,961.00	$ 4,665,548,653.97	$ 5,799,868,755.47	$ 7,510,416,720.39	31%

Source: *Department for Medicaid Services*

Change in FFS and MCO Spending by Service, SFY 2014-2015

	SFY 2014 FFS	SFY 2015 FFS	% Change FFS	SFY 2014 MCO	SFY 2015 MCO	% Change MCO Payments
Mandatory						
Inpatient Hospital	170,749,700	140,186,000	-18%	$812,555,259	$1,098,846,861	35%
Psych Distinct Part Unit	4,924,800	4,541,900	-8%	$12,883,494	$19,013,842	48%
Rehab Distinct Part Unit	3,228,500	1,183,100	-63%	$5,115,353	$10,235,594	100%
Supplemental Payments (Intensive Operating Allowance)	21,048,700	16,091,200	-24%			
Physicians	43,898,900	31,316,100	-29%	$456,500,951	$666,183,581	46%
Nursing Facilities	874,092,100	944,876,700	8%		$59,499	
Outpatient Hospital	99,527,900	66,424,500	-33%	$570,854,622	$1,112,996,780	95%
Home Health	18,189,100	16,579,600	-9%	$17,322,837	$19,015,326	10%
Durable Medical Equipment (DME)	19,584,100	20,490,300	5%	$54,772,112	$78,283,844	43%
Family Planning				$4,782,326	$4,569,110	-4%
EPSDT - Screens	1,134,200	4,314,900	280%		$9,903,093	
EPSDT - Related	17,218,900	21,093,300	23%	$34,316,378	$37,709,467	10%
Laboratories	1,668,800	1,439,000	-14%	$53,889,962	$68,330,220	27%
Dental	2,442,700	2,742,500	12%	$138,810,234	$144,968,076	4%
Non-Emergency Transportation	2,562,300	2,466,000	-4%	$183,992	$2,959,091	1508%
Ambulance	2,152,300	1,766,300	-18%	$15,540,896	$22,770,439	47%
Vision	827,700	853,800	3%	$36,260,109	$41,472,897	14%
Hearing	31,400	20,600	-34%	$1,399,617	$8,423,626	502%
Primary Care (FQHC)	54,806,500	37,157,600	-32%	$39,317,299	$52,474,307	33%
Rural Health	59,585,100	36,873,900	-38%	$1,790,454	$4,647,965	160%
Qualified Medicare Beneficiaries (QMBs)	345,200	461,000	34%	$899,900	$2,467,863	174%
Nurse Practioner/Midwife	2,167,800	2,149,500	-1%	$44,905,432	$136,301,363	204%
Subtotal Mandatory	1,400,186,700	1,353,027,800	-3%	$2,302,101,226	$3,541,632,846	54%

Change in FFS and MCO Spending by Service, SFY 2014-2015

	SFY 2014 FFS	SFY 2015 FFS	% Change FFS	SFY 2014 MCO	SFY 2015 MCO	% Change MCO Payments
Optional						
ICF-MR	192,828,700	152,202,500	-21%			
Pharmacy	71,354,100	79,529,000	11%	$657,622,504	$1,130,301,411	72%
Community Mental Health Centers	5,846,800	11,548,500	98%	$99,905,672	$130,280,112	30%
Mental Hospital	1,653,800	848,900	-49%	$24,016,664	$23,459,687	-2%
Psychiatric Residential Treatment Facilities (PRTF)	577,800	332,600	-42%	$6,773,015	$6,257,869	-8%
Renal Dialysis	6,033,000	6,385,900	6%	$11,660,426	$14,055,026	21%
Podiatry	451,200	483,100	7%	$4,023,083	$7,850,532	95%
Supports for Community Living (formerly AIS MR)	296,281,400	308,099,500	4%	$53,000	$502,608	848%
Ambulatory Surgical	1,209,700	1,116,500	-8%	$9,277,590	$14,428,600	56%
Home & Community Based Services	23,510,300	17,028,000	-28%		$63,636	
Adult Day Care	67,714,900	73,717,400	9%			
Model Waivers	4,474,100	4,513,700	1%			
Hospice	23,284,100	20,546,300	-12%	$9,524,577	$7,666,698	-20%
Preventive	354,000	349,400	-1%	$21,071,167	$24,772,485	18%
Commission for Children with Special Health Care Needs	5,465,500	5,475,500	0%	$1,168,329	$419,992	-64%
Targeted Case Mgmt. - Emotionally Disturbed Children	771,800	476,300	-38%	$4,839,412	$2,874,003	-41%
Targeted Case Mgmt. - Mentally Ill Adults	1,135,200	789,000	-30%	$2,503,826	$1,149,127	-54%
Title V/DCBS	156,262,100	159,821,700	2%			
School-Based Services	9,333,400	12,836,700	38%			
Early Intervention - First Steps	12,268,700	16,149,000	32%			
Impact Plus	2,067,800	746,800	-64%	$34,972,544	$12,519,382	-64%
Other Lab/X-Ray (included in Lab through FY 96)	853,900	913,600	7%	$2,777,858	$2,018,349	-27%
Nurse Anesthetist	562,700	359,300	-36%	$7,465,339	$12,589,915	69%
Brain Injury	22,609,700	25,407,100	12%	$103,500	$603,402	483%
Brain Injury Long Term Care	15,852,100	16,307,800	3%			
HANDS	20,703,100	17,588,500	-15%	$70,400	$684	-99%
Home Care Waiver						
Personal Care Assistance						
Chiropractic	194,000	156,100	-20%	$9,872,536	$18,424,526	87%
Clinical Social Workers				$264,882	$5,039,363	1802%
Physical Therapist				$1,753,009	$3,985,086	127%
Occupational Therapist				$176,946	$386,319	118%
Psychologist		500		$121,862	$762,538	526%
Physician Assistant				$2,857,415	$4,980,959	74%
Comprehensive Outpatient Rehab Facility				$286,835	$324,073	13%
Clinical Social Workers						
Physical Therapist						
Occupational Therapist						
Psychologist						
Comprehensive Outpatient Rehab Facility						
Specialized Childrens's Service Clinics		(24,200)		$96,392	$179,680	86%
Money Follows the Person-Post Transition	4,636,900	2,984,600	-36%			
Money Follows the Person-Benefits	(877,500)	120,200	-114%			
Money Follows the Person-Enhanced Benefits	7,071,200		-100%			
Michelle P Waiver	247,221,000	285,892,700	16%			
Unknown				$29,976,610	$105,932,450	253%
Private Duty Nursing		58,200				
Subtotal Optional	1,201,705,500	1,222,760,700	2%	$ 943,235,396	$ 1,531,828,510	62%
Total Mandatory and Optional Spending	2,601,892,200	2,575,788,500	-1.0%	3,245,336,622	5,073,461,356	56%

Source: *Department for Medicaid Services*

Payments for Medicaid Services

Spending for hospital inpatient services declined by about $100 million, or 10 percent, after the introduction of statewide managed care through MCOs, comparing 2011 with 2013 payments. Outpatient hospital payments also declined by about 8 percent, or $45 million. Spending on psychiatric inpatient care plummeted as well after MCOs were introduced, falling by 24 percent from 2011 to 2013.

Inpatient payments to hospitals increased in SFY 2014 by $189 million as a result of Medicaid expansion, which occurred in January of 2014. Outpatient hospital spending also increased by $155 million in SFY 2014 compared to the prior year. However, spending for mental hospital services remained at the same level in 2014 despite an increase in eligibles. Pharmacy expenditures, which had been reduced from 2011-2013, rose to slightly above the same level as in 2011.

SFY 2015 data reflects 12 months of experience under Medicaid expansion. Average monthly eligibles grew by 13.4 percent from 2013-2014, reflecting 6 months of the expansion, but the full impact was felt in SFY 2015 where eligibles increased 50 percent over 2013 levels and by 32 percent from 2014. This growth in eligibles accounted for increased spending for most services; however, payments for some services did not increase at the same rate as enrollees.

Expenditures in SFY 2015 for inpatient hospital services increased by 26 percent (less than the growth in eligibles), but a 76 percent increase occurred in outpatient hospital expenditures, indicating that most services provided to the expansion population were delivered on an outpatient basis. This data illustrates the movement away from inpatient to outpatient services for the Medicaid population, which, in part, is caused by tighter criteria to qualify for inpatient admission and patients being denied inpatient admission and instead being authorized only for observation. In 2011, two-thirds of payments to hospitals were for inpatient services and 37 percent were for outpatient care; whereas, in 2015, total payments for inpatient and outpatient services were about equal. Pharmacy spending also rose in 2015 to equal spending on inpatient hospital services.

However, the decline in spending on mental hospital services continued in SFY 2015 as mental hospital payments dropped by five percent from SFY 2014 levels despite the growth in eligibles and the expansion of Medicaid coverage for substance abuse treatment. This trend points to the continued high denial rates by the MCOs for Medicaid patients, particularly children, to gain admission to a psychiatric hospital and then to remain in the hospital for treatment.

Among mandatory services, the largest growth has occurred for screening services, followed by hearing, payments to nurse practitioners and non-emergency transportation.

Each MCO has different systems for processing and paying claims and for reviewing medical necessity of services. A significant factor not apparent in the data is slow payment, non-payment and erroneous payment by the MCOs which plays a large part in the reduction in payments to all providers. Also, in SFY 2015, two of the five MCOs continued to pay hospitals only $50 to evaluate and treat Medicaid patients presenting to the emergency department (ED) that the MCO later denied as not having an emergency condition. Hospitals still incurred a much greater cost to screen and treat patients, and patients continued to present to the ED despite these policies which lowered payment. According to a KHA survey in 2014, hospitals lost $38 million from being paid only $50 for ED care compared to what they were owed by these MCOs. Similarly, hospitals continued to admit and treat patients with behavioral health conditions based on the determination of the patient's physician that care was necessary even though admission or care may have later been denied by the MCO. Because patients are still continuing to receive services from providers who are not being paid, data which shows payments have not kept pace with the increase in enrollees should not be used to conclude that utilization or actual treatment costs have been reduced by managed care.

Mandated, Optional and KCHIP Spending

The Kentucky Medicaid program spent $9.6 billion in SFY 2015. Eighty percent, or $7.6 billion, was expenditures for benefits for enrollees other than KCHIP, which comprised only $137 million, or 1.5 percent, of total spending. Nearly $5 billion (64 percent) was for mandatory services, while $2.8 billion (36 percent) was for optional services.

In 2015, total spending on hospital acute inpatient services (excluding psychiatric and rehabilitation) and outpatient services has comprised less than one third (31 percent) of total benefit spending. Top Spending categories included 16 percent for pharmacy services, 12 percent for nursing facilities and 9 percent on physician services.

Of the $9.6 billion program, $3 billion was spent for ACA expansion enrollees, and of that amount, $2.8 billion (97 percent) was paid to the five MCOs.

Mandated and Optional Medicaid Benefit Spending by Type of Service: SFY 2015 MCO and Fee for Service

Type of Service	SFY 2015 FFS & MCOs (Non-KCHIP)	SFY 2015 Spending as % of Total Benefits Spending	SFY 2014 Spending As % of Total Benefits Spending
Mandatory			
Inpatient Hospital	$ 1,239,032,861	16.2%	17.0%
Psych Distinct Part Unit	$ 23,555,742	0.3%	0.3%
Rehab Distinct Part Unit	$ 11,418,694	0.1%	0.1%
Supplemental Payments (Intensive Operating Allowance)	$ 16,091,200	0.2%	17.4%
Physicians	$ 697,499,681	9.1%	8.6%
Nursing Facilities	$ 944,936,199	12.4%	14.9%
Outpatient Hospital	$ 1,179,421,280	15.4%	11.4%
Home Health	$ 35,594,926	0.5%	0.6%
Durable Medical Equipment (DME)	$ 98,774,144	1.3%	1.3%
Family Planning	$ 4,569,110	0.1%	0.1%
EPSDT - Screens	$ 14,217,993	0.2%	0.0%
EPSDT - Related	$ 58,802,767	0.8%	0.9%
Laboratories	$ 69,769,220	0.9%	1.0%
Dental	$ 147,710,576	1.9%	2.4%
Non-Emergency Transportation	$ 5,425,091	0.1%	0.3%
Ambulance	$ 24,536,739	0.3%	0.0%
Vision	$ 42,326,697	0.6%	0.6%
Hearing	$ 8,444,226	0.1%	0.0%
Primary Care (FQHC)	$ 89,631,907	1.2%	1.6%
Rural Health	$ 41,521,865	0.5%	1.0%
Qualified Medicare Beneficiaries (QMBs)	$ 2,928,863	0.0%	0.0%
Nurse Practioner/Midwife	$ 138,450,863	1.8%	0.8%
Subtotal Mandatory	$ 4,894,660,646	64.0%	63.5%
Optional			
ICF-MR	$ 152,202,500	2.0%	3.3%
Pharmacy	$ 1,209,830,411	15.8%	12.4%
Community Mental Health Centers	$ 141,828,612	1.9%	1.8%
Mental Hospital	$ 24,308,587	0.3%	0.4%
Psychiatric Residential Treatment Facilities (PRTF)	$ 6,590,469	0.1%	0.1%
Renal Dialysis	$ 20,440,926	0.3%	0.3%
Podiatry	$ 8,333,632	0.1%	0.1%
Supports for Community Living (formerly AIS MR)	$ 308,602,108	4.0%	5.1%
Ambulatory Surgical	$ 15,545,100	0.2%	0.2%
Home & Community Based Services	$ 17,091,636	0.2%	0.4%
Adult Day Care	$ 73,717,400	1.0%	1.2%
Model Waivers	$ 4,513,700	0.1%	0.1%
Hospice	$ 28,212,998	0.4%	0.6%
Preventive	$ 25,121,885	0.3%	0.4%
Commission for Children with Special Health Care Needs	$ 5,895,492	0.1%	0.1%
Targeted Case Mgmt. - Emotionally Disturbed Children	$ 3,350,303	0.0%	0.1%
Targeted Case Mgmt. - Mentally Ill Adults	$ 1,938,127	0.0%	0.1%
Title V/DCBS	$ 159,821,700	2.1%	2.7%
School-Based Services	$ 12,836,700	0.2%	0.2%
Early Intervention - First Steps	$ 16,149,000	0.2%	0.2%
Impact Plus	$ 13,266,182	0.2%	0.6%
Other Lab/X-Ray (included in Lab through FY 96)	$ 2,931,949	0.0%	0.1%
Nurse Anesthetist	$ 12,949,215	0.2%	0.1%
Brain Injury	$ 26,010,502	0.3%	0.4%
Brain Injury Long Term Care	$ 16,307,800	0.2%	0.3%
HANDS	$ 17,589,184	0.2%	0.4%
Home Care Waiver	$ -	0.0%	0.0%
Personal Care Assistance	$ -	0.0%	0.0%
Chiropractic	$ 18,580,626	0.2%	0.2%
Clinical Social Workers	$ 5,039,363	0.1%	0.2%
Physical Therapist	$ 3,985,086	0.1%	0.2%
Occupational Therapist	$ 386,319	0.0%	0.2%
Psychologist	$ 763,038	0.0%	0.2%
Physician Assistant	$ 4,980,959	0.1%	0.2%
Comprehensive Outpatient Rehab Facility	$ 324,073	0.0%	0.2%
Clinical Social Workers	$ -	0.0%	0.2%
Physical Therapist	$ -	0.0%	0.2%
Occupational Therapist	$ -	0.0%	0.2%
Psychologist	$ -	0.0%	0.2%
Comprehensive Outpatient Rehab Facility	$ -	0.0%	0.2%
Specialized Childrens's Service Clinics	$ 155,480	0.0%	0.0%
Money Follows the Person-Post Transition	$ 2,984,600	0.0%	0.1%
Money Follows the Person-Benefits	$ 120,200	0.0%	0.0%
Money Follows the Person-Enhanced Benefits	$ -	0.0%	0.1%
Michelle P Waiver	$ 285,892,700	3.7%	4.2%
Unknown	$ 105,932,450	1.4%	0.5%
Private Duty Nursing	$ 58,200	0.0%	
Subtotal Optional	$ 2,754,589,210	36.0%	36.5%
Total Mandatory & Optional	$ 7,649,249,856		
KCHIP Expenditures	$ 137,170,369		
Other Expenditures*	$ 1,854,219,104		
Grand Total Medicaid and KCHIP Benefit Spending	$ 9,640,639,329		

Source: *Kentucky LRC DMS EEY Report, SFY 2015*

**Includes transportation, disproportionate share hospital (DSH) payments, intergovernmental transfers (IGTs), supplementary insurance, Part D Medicare clawback, consumer directed payments, health information technology (HIT) and other adjustments.*

Medicaid Underpayment

Medicaid payments do not cover the actual costs to hospitals to deliver care to Medicaid patients – inpatient and outpatient payments cover only about 82 percent of costs which leaves a substantial uncompensated cost. In SFY 2015, hospitals were paid approximately $2.4 billion for inpatient and outpatient services; however, these services provided to Medicaid patients actually cost about $2.9 billion to deliver, leaving hospitals with an unpaid Medicaid shortfall for the year of approximately $453 million. This shortfall is based on reported payments and is likely even higher since it does not consider services rendered by hospitals where cost was incurred but payment was substantially reduced (such as MCOs paying only $50 for emergency room patients the MCO considered not to have an emergency condition) or even denied altogether by the MCOs.

MCO Capitation and Service Payments

In SFY 2015, the Department for Medicaid Services reported making capitation payments of approximately $6.6 billion, an increase of $2.2 billion over 2014 payments. MCO capitation payments comprised nearly 70 percent of total Medicaid program spending. The five MCOs received $3.8 billion in capitation payments for non-expansion enrollees and $2.8 billion for ACA expansion enrollees. (*Source: LRC End of Year Report SFY 2015*) MCO dashboard reports reported $6.4 billion in SFY 2015 capitation payments.

Capitation Payments to MCOs: SFY 2012-2015

		Anthem	Coventry	Humana	Passport	WellCare	Total
SFY 2013	July 2012		$ 85,566,584.34		$ 68,652,126.19	$ 57,420,871.93	$ 256,407,155.19
	August 2012		$ 84,143,269.09		$ 67,283,225.66	$ 57,262,085.18	$ 252,967,501.69
	September 2012		$ 83,052,391.74		$ 69,682,520.72	$ 59,217,920.30	$ 261,095,774.57
	October 2012		$ 87,693,333.09		$ 68,436,170.43	$ 61,892,428.35	$ 262,310,102.96
	November 2012		$ 73,804,603.67		$ 68,493,118.44	$ 79,991,355.76	$ 263,829,923.16
	December 2013		$ 72,793,660.51		$ 70,080,851.14	$ 80,181,141.52	$ 264,917,734.88
	January 2013		$ 80,445,276.71	$ 11,670,114.93	$ 31,283,968.81	$ 91,992,996.96	$ 256,267,513.33
	February 2013		$ 75,736,774.40	$ 9,650,709.06	$ 49,625,318.17	$ 95,248,279.28	$ 271,407,135.79
	March 2013		$ 79,829,894.21	$ 8,182,253.44	$ 54,524,397.59	$ 100,659,809.98	$ 284,452,300.63
	April 2013		$ 85,717,772.55	$ 6,945,606.49	$ 58,790,991.27	$ 102,340,850.88	$ 294,287,487.35
	May 2013		$ 83,296,601.32	$ 6,647,476.13	$ 58,628,419.01	$ 99,167,986.13	$ 286,855,337.62
	June 2013		$ 79,185,181.18	$ 6,763,182.76	$ 59,169,661.34	$ 95,371,940.53	$ 280,027,120.78
	SFY 2013 Sum		$ 971,265,342.81	$ 49,859,342.81	$ 724,650,768.77	$ 980,747,666.80	$ 3,234,825,087.95
SFY 2014	July 2013		$ 102,286,913.83	$ 6,790,378.09	$ 58,317,883.35	$ 117,375,379.54	$ 292,295,944.69
	August 2013		$ 104,784,612.29	$ 6,739,780.03	$ 57,933,626.50	$ 121,897,335.50	$ 291,922,111.15
	September 2013		$ 106,705,780.96	$ 6,837,952.83	$ 58,701,465.31	$ 125,305,810.18	$ 296,411,154.43
	October 2013		$ 101,856,313.98	$ 5,886,190.49	$ 60,220,200.84	$ 121,801,418.62	$ 290,941,203.24
	November 2013		$ 97,867,615.71	$ 5,914,687.62	$ 60,327,098.66	$ 124,377,807.94	$ 288,442,047.02
	December 2013		$ 99,854,111.68	$ 6,055,863.22	$ 61,418,317.43	$ 125,926,633.35	$ 293,412,896.44
	Before Expansion Subtotal		$ 613,355,348.45	$ 38,224,852.28	$ 356,918,592.09	$ 736,684,385.13	$ 1,753,425,356.97
	January 2014	$ 7,221,454.51	$ 105,101,081.97	$ 13,280,706.30	$ 70,302,386.07	$ 139,044,149.52	$ 334,929,563.52
	February 2014	$ 15,005,010.24	$ 117,804,929.94	$ 26,109,028.65	$ 84,852,842.97	$ 160,629,142.97	$ 404,353,075.20
	March 2014	$ 17,508,087.55	$ 126,783,499.09	$ 29,455,603.98	$ 92,412,776.05	$ 170,705,750.61	$ 436,734,001.07
	April 2014	$ 25,577,969.19	$ 143,310,824.78	$ 40,356,006.07	$ 107,465,023.42	$ 195,627,274.58	$ 512,351,382.57
	May 2014	$ 22,715,291.06	$ 132,545,681.20	$ 37,769,493.27	$ 102,026,775.68	$ 184,800,592.97	$ 479,826,016.95
	June 2014	$ 24,739,973.69	$ 133,178,352.22	$ 40,576,584.60	$ 106,147,402.58	$ 189,834,652.61	$ 494,421,690.47
	After Expansion Subtotal	$ 112,767,786.24	$ 758,724,369.20	$ 187,547,422.87	$ 563,207,206.77	$ 1,040,641,563.26	$ 2,662,615,729.78
	SFY 2014 Sum	$ 112,767,786.24	$ 1,372,079,717.65	$ 225,772,275.15	$ 920,125,798.86	$ 1,777,325,948.39	$ 4,416,041,086.75
SFY 2015	July 2014	$23,967,790.00	$129,579,135.00	$40,541,359.00	$103,199,695.00	$185,071,590.00	$482,359,569.00
	August 2014	$26,304,090.00	$131,733,224.00	$44,077,720.00	$108,297,889.00	$189,697,267.00	$500,110,190.00
	September 2014	$27,842,363.00	$132,195,702.00	$46,555,781.00	$111,031,051.00	$192,053,005.00	$509,677,902.00
	October 2014	$29,527,831.00	$132,990,820.00	$48,461,367.00	$113,608,984.00	$195,328,443.00	$519,917,445.00
	November 2014	$30,829,163.00	$133,566,703.00	$60,072,306.00	$115,729,465.00	$197,123,191.00	$537,320,828.00
	December 2014	$32,482,295.00	$134,368,363.00	$52,124,586.00	$118,360,483.00	$199,091,486.00	$536,427,213.00
	January 2015	$34,151,281.00	$128,292,892.00	$55,799,022.00	$125,871,394.00	$205,693,653.00	$549,808,242.00
	February 2015	$36,804,466.00	$129,306,680.00	$58,622,135.00	$129,331,771.00	$208,620,103.00	$562,685,155.00
	March 2015	$37,770,491.00	$124,142,372.00	$60,334,590.00	$130,059,843.00	$208,528,660.00	$560,835,956.00
	April 2015	$38,599,521.00	$124,171,118.00	$61,640,643.00	$131,531,119.00	$209,367,354.00	$565,309,755.00
	May 2015	$39,094,295.00	$123,008,357.00	$62,032,403.00	$131,980,698.00	$207,864,400.00	$563,980,153.00
	June 2015	$39,072,129.00	$120,576,505.00	$61,905,836.00	$131,259,931.00	$205,134,336.00	$557,948,737.00
	SFY 2015 Sum	$396,445,715.00	$1,543,931,871.00	$652,167,748.00	$1,450,262,323.00	$2,403,573,488.00	$6,446,381,145.00
SFY 2015	Average Capitation/Member	$6,728.07	$5,051.78	$6,916.04	$6,263.13	$5,736.07	$5,810.55
SFY 2015	Average Per Member Per Month	$560.67	$420.98	$576.34	$521.93	$478.01	$484.21

Source: *MCO Dashboard Reports, Department for Medicaid Services*

All MCOs reported a combined total of $5.1 billion in payments to service providers, leaving a $1.5 billion difference between capitation and provider service payments. This 22 percent aggregate margin is higher than the 8 to 10 percent expected for administrative costs and profits when Medicaid managed care was initiated.

Passport continued to have the lowest administrative and profit margin again in 2015 at 11 percent for SFY 2015, as they had a 10 percent margin in SFY 2014. Coventry led with a 32 percent margin, followed by Humana (27 percent), Anthem (21 percent) and WellCare (16 percent). While some margins were lower than in SFY 2014, they exceed CMS Medical Loss Ratio minimum standards of 15 percent, and what is considered reasonable for Medicaid plans.

Medicaid Managed Care Capitation Payments and Margin: SFY 2014-2015

SFY 2015	Anthem	Coventry	Humana	Passport	WellCare	Total* (from MCO Dashboard)	Total (from LRC EEY Report)
Total Capitation Payments*	$ 396,445,715	$ 1,543,931,871	$ 652,167,748	$ 1,450,262,323	$ 2,403,573,488	$ 6,446,381,145	$ 6,624,860,287
Service Payments to Providers**	$ 312,240,948	$ 1,048,279,285	$ 475,935,248	$ 1,292,037,067	$ 2,007,614,517	$ 5,136,107,065	$ 5,136,107,065
Difference	$ 84,204,767	$ 495,652,586	$ 176,232,500	$ 158,225,256	$ 395,958,971	$ 1,310,274,080	$ 1,488,753,222
% Difference of Capitation	21%	32%	27%	11%	16%	20%	22%

SFY 2014	Anthem	Coventry	Humana	Passport	WellCare	Total* (from MCO Dashboard)	Total (from LRC EEY Report)
Total Capitation Payments*	$ 105,978,620	$ 1,335,900,304	$ 221,967,596	$ 901,718,453	$ 1,742,837,379	$4,308,402,352	$ 3,979,404,971
Service Payments to Providers**	$ 51,704,272	$ 908,508,642	$ 120,476,084	$ 808,073,300	$ 1,447,663,547	$ 3,336,425,845	$ 3,336,425,845
Difference	$ 54,274,348	$ 427,391,662	$ 101,491,512	$ 93,645,153	$ 295,173,832	$ 971,976,507	$ 642,979,126
% Difference of Capitation	51%	32%	46%	10%	17%	23%	16%

Sources: **MCO Dashboard Reports, Department for Medicaid Services, SFY 2015*

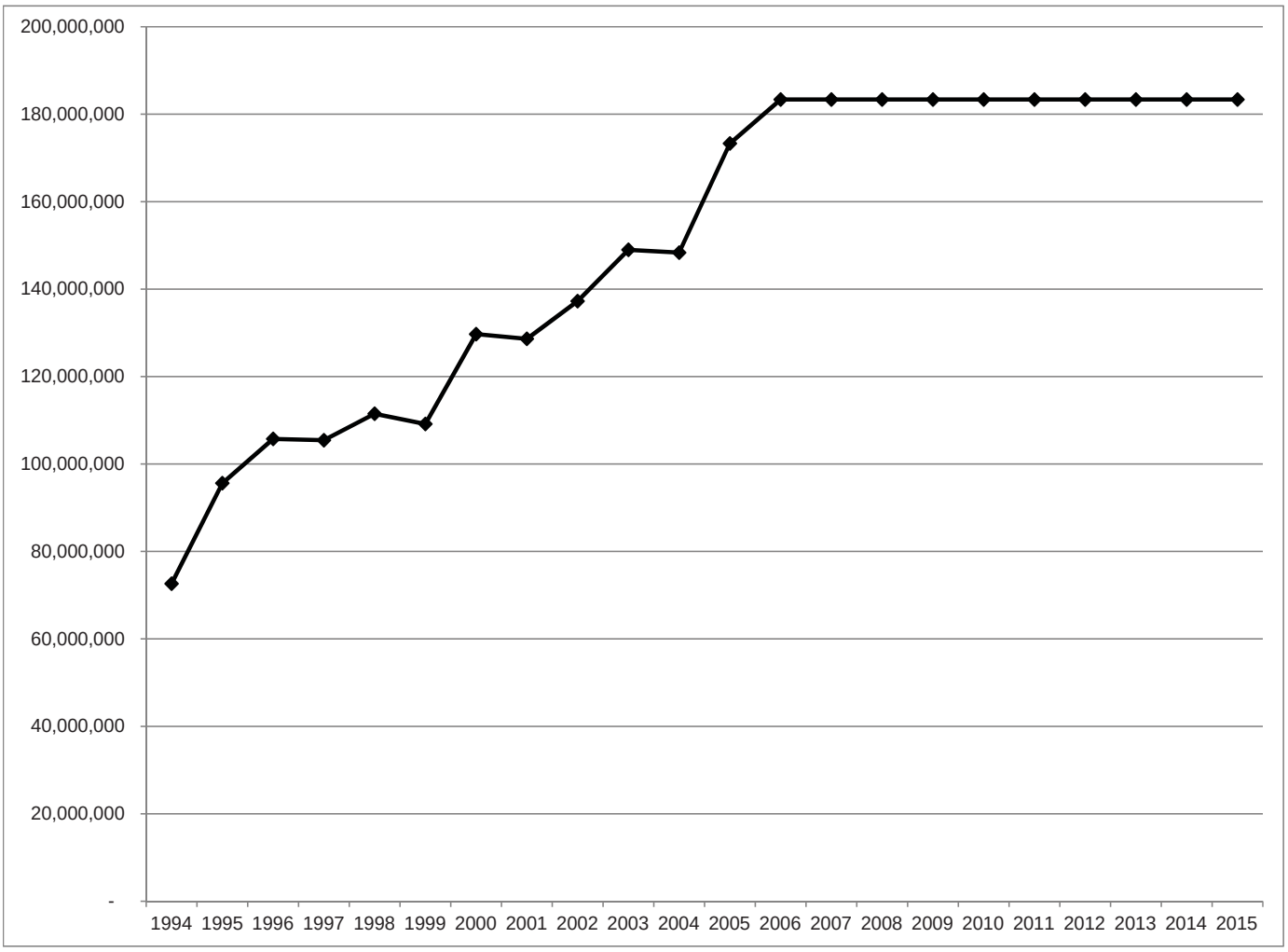
***MCO Quarterly Report 78, includes mandatory, optional and KCHIP reported expenditures*

Hospital Provider Tax

Since state fiscal year 1994, all Kentucky hospitals have paid a provider tax to the state equal to 2.5 percent of gross receipts received by the hospital for patient care services. By being based on receipts, regardless of expenses, hospitals were subject to being taxed even if they lost money. The tax grew from $72.6 million at its inception to $183 million in state fiscal year 2005 - 2006. At that time, the Kentucky General Assembly recognized that continued escalation was not sustainable for hospitals and the tax was frozen at that level for future years. Because the Medicaid program is jointly funded by the federal and state government with the federal government supplying roughly $2.00 in matching funds for every $1.00 in state funds, the $183 million annual hospital provider tax, when federally matched, generates approximately $610 million in state Medicaid spending each year. Approximately $175 million of those funds are directly earmarked for hospital payments leaving the remaining $435 million to pay for other expenses within the Medicaid program.

At the time that the provider tax was initiated, physicians, nursing homes, prescription drugs, home health, ICF-MR and HMOs were also taxed in addition to hospitals. The tax was removed from physicians in 1999 and from prescription drugs in 2000.

Growth in Kentucky Hospital Provider Tax: 1994 - 2015



Source: *Kentucky Revenue Cabinet*

Operating Margins

Hospitals need a positive total income (total margin) to stay in business. Hospitals that have a negative total margin (deficit) are not receiving sufficient revenue to pay all their expenses and must use other sources of funds, such as cash reserves, investment income or the sale of assets to pay for their expenses. Unless these hospitals can alleviate the deficit by increasing revenues and/or cutting expenses, they may be forced to shut down operations. Shortfalls and the deterioration of margins limit a hospital's ability to provide charity care, invest in new equipment, update facilities and pay principal on current and long-term debt. Excess revenues are necessary to hire well-trained staff, replace worn-out or obsolete buildings and equipment, conduct medical research, keep pace with advances in medical technology and information systems and help cover the cost of care for patients who cannot pay.

Short-term acute care hospitals in Kentucky experienced a continuing decrease in operating margins from 2012 to 2013 when margins not only dropped by more than 200 percent but were negative 2.6 percent, indicating hospitals lost money from operations. As a result of aggressive cost cutting and a significant reduction in employees, total margins rebounded in 2014, but only to 1.7 percent (the same level as in 2012). This remains inadequate to meet costs of inflation, maintain facilities, upgrade equipment and meet the continuing costs of electronic records and new technology. In 2013, 69 percent of hospitals lost money from their core business – caring for patients. Preliminary data from 80 percent of hospitals reporting in 2014 shows improvement, yet more than half of all hospitals lost money on patient services.

The Lewin Group, a national consulting firm based in Washington, DC, noted in a 2004 report that "hospitals need to maintain margins between four and six percent to acquire technology and meet changing community health care needs." Even though Kentucky's hospitals are efficient and the cost per discharge in Kentucky is lower than most other states, hospitals cannot meet the minimum margin on operations to maintain or improve services.

Kentucky Short-Term Acute Care Hospital Margins

Year	Percent of Hospitals Experiencing a Loss from Patient Services	Operating Margin
2014*	52%	1.70%
2013	69%	-2.60%
2012	58%	1.70%
2011	57%	3.06%
2010	45%	2.19%
2009	40%	2.44%
2008	46%	0.00%

Source: *Medicare Cost Report data provided by Datagen Keystats™*
**Preliminary Data - 82% of hospitals reporting*

Some hospitals have endowments that enable them to continue to provide services beyond the level of operating income they receive. For those hospitals, a negative operating margin may not be critical as long as their total margin is positive. However, income from sources other than hospitals' primary business is not always readily available and is insufficient to ensure survival indefinitely. During periods when the economy has slowed and investments perform poorly, hospitals depending on endowments and other investment income sources to supplement their budgets are challenged financially to keep their doors open and continue to provide care to their community. Other hospitals may not have large endowments or sources of other income. As a result, their operating margin and total margin will be similar. In these situations, a low or negative operating margin and low total margin may reveal the hospital is under financial stress.

The calculation of total margin includes both operating income and income from other sources. Examples of non-operating income include investments, trust income, contributions and county tax appropriations. Total margin reveals the composite financial health of a facility over the course of a given period, for example, one year. If total margin is negative, the hospital is losing money after all sources of revenue and income have been considered.

The following chart shows that Kentucky hospitals have increasingly had to rely on other sources of revenue to attain a more adequate margin. Critical access hospitals have lower margins than acute-care hospitals and, in 2013, barely broke even after considering all sources of revenue. Acute hospitals also had negative operating margins and had to rely on other sources of income to obtain a 4 percent total margin in 2013. Margins for both groups improved in 2014, based on preliminary data, due to aggressive actions by hospital management to lower expenses.

Trends and Operating Margin - Kentucky Acute and Critical Access Hospitals: 2010 - 2014

	Year	Number of Hospitals Reporting	Number of Hospitals Experiencing Loss from Patient Service	Number of Hospitals Experiencing Loss from Total Operations	Operating Margin	Total Margin
Acute Hospitals	2014	52	26	9	1.80%	8.40%
	2013	65	42	27	-2.40%	4.00%
	2012	65	34	16	1.90%	5.60%
	2011	63	34	18	3.14%	6.36%
	2010	65	29	16	2.29%	5.74%
Critical Access Hospitals	2014	25	14	10	-1.10%	3.50%
	2013	29	23	13	-6.60%	0.30%
	2012	29	21	13	-2.50%	0.00%
	2011	26	17	13	0.98%	2.90%
	2010	30	14	10	1.91%	3.22%

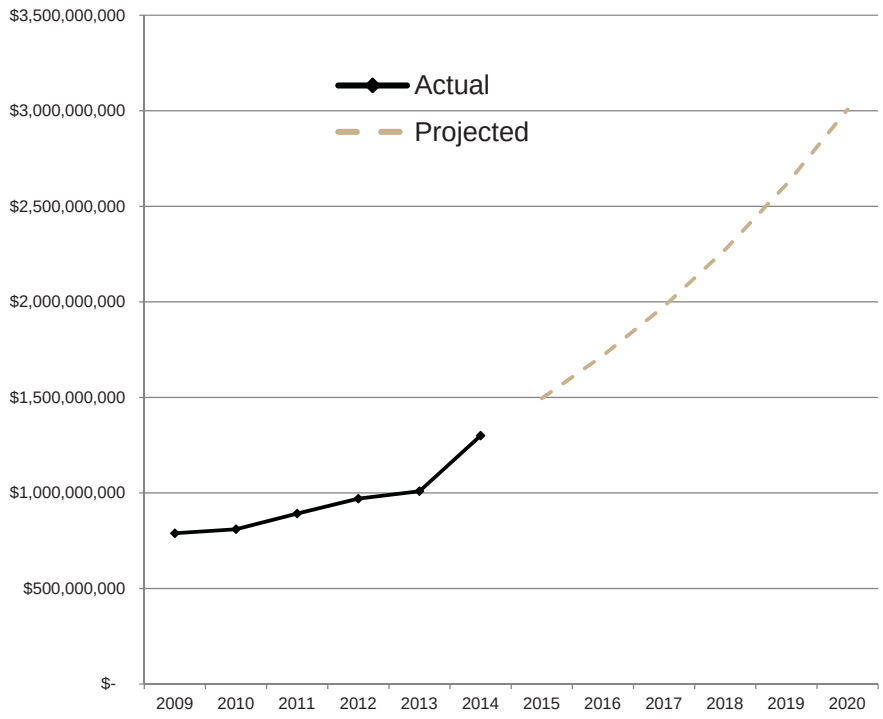
Source: *Medicare Cost Report data provided by Datagen Keystats™*

Uncompensated Care

Kentucky's hospitals are the safety net for their communities. All patients presenting at a hospital are treated, regardless of whether they have insurance or they can afford to pay. The state expanded the Medicaid program in 2014 under the Affordable Care Act (ACA) which reduced the number of individuals who were uninsured. Despite that action, Kentucky hospitals are continuing to experience increasing uncompensated care costs at a time when hospital margins are declining. Uncompensated care represents the difference between the actual cost of caring for patients and the payment hospitals receive for providing that care. It includes losses from the Medicaid and Medicare programs due to payments that are below the actual cost of caring for those patients. Losses from the Medicare program have grown due to cuts in hospital payments nationally and in Kentucky to help pay for expanded coverage under the ACA, as well as from federal sequestration and other regulatory actions. Losses from the state Medicaid program have also grown, as about 400,000 additional people are now covered under this program where payments do not cover actual costs. Uncompensated care also includes charity care costs for services provided to patients who are uninsured, as well as bad debt expense.

Rising Bad Debts

Bad debts occur when individuals with insurance coverage fail to pay their required deductibles, copayments or coinsurance. The chart to the right shows that bad debt expense was $789 million in 2009 and grew to $1.3 billion in 2014, a 65% increase. Bad debts are also comprising a larger share of total uncompensated costs – accounting for 57% of all uncompensated care costs in 2014 compared to 49% in 2013. Bad debts for Kentucky community hospitals have grown by $400 million (46%) in just the past three years as more privately insured patients move to plans with higher deductibles and copayments that they cannot afford. This represents an average annual increase of 15% in bad debt expense from 2011-2014. If this growth rate continues, Kentucky hospital bad debt losses will top $3 billion by 2020.



Source: AHA Annual Survey of Hospitals

Disproportionate Share Hospital Payments

Hospitals receive some limited financial assistance for uncompensated care costs through the Medicare and Medicaid Disproportionate Share Hospital (DSH) programs.

Medicare DSH

Hospitals paid under the Medicare Inpatient Prospective Payment System (IPPS) with a high percentage of Medicaid and low-income Medicare patients can receive special funding. These payments, known as a Medicare DSH payments, are essential to ensure patients continue to have access to necessary services. In Kentucky, 64 hospitals receive Medicare DSH payments. The impact of these payments is extremely important. In 2013, Kentucky IPPS hospitals had a negative 8% Medicare margin; however, in the absence of Medicare DSH payments, this margin would have been negative 17.13%. Since 2010, these vital payments have declined, and they will be lowered even more because the ACA reduces Medicare DSH payments nationally by $22.1 billion from fiscal year 2014 through 2019 to help fund the expansion of Medicaid and subsidized insurance under the ACA. Beginning in 2014, hospitals receive 25% of their Medicare DSH funding in the traditional way, based on their own percentage of low income patients, with the remaining 75% coming from a national pool that will be reduced as the rate of the uninsured nationally declines. DSH funding in this pool was cut by $546 million in FY 2014, another $1.25 billion in FY 2015 and an additional $1.2 billion in FY 2016. Even after accounting for the receipt of Medicare DSH payments, Kentucky hospitals experienced an overall Medicare payment shortfall of nearly $263 million in 2014.

Impact of Medicare DSH Payments on Medicare Margins of Kentucky IPPS Hospitals

	2005	2006	2007	2008	2009	2010	2011	2012	2013
Margin with Medicare DSH	-1.88%	-2.62%	-4.61%	-4.48%	-4.08%	-4.69%	-5.90%	-6.72%	-7.79%
Margin without Medicare DSH	-10.54%	-11.80%	-13.95%	-13.79%	-12.98%	-13.98%	-14.73%	-15.50%	-17.13%

Source: *Medicare Cost Reports, Keystats, Medicare Margin Analysis*

Medicaid DSH

Kentucky hospitals also receive some limited funding through the Medicaid DSH program, which is intended to help offset losses from the Medicaid program as well as care provided to the uninsured. Kentucky, like each other state, receives a federal Medicaid DSH allotment which must be matched with state funds, for distribution to hospitals. Kentucky funds the state DSH match by using provider taxes. The match needed equates to about $28 million, or roughly 15% of the $183 million in provider taxes Kentucky hospitals pay each year. In 2014, Kentucky distributed $221 million in Medicaid DSH funding, of which $159.3 million was federal funding. State law divides the funds into three pools for distribution to hospitals on a prorata basis:

Pool	Percent of State DSH Allotment	2014 Amount	Distribution
Acute Care	43.92%	$97,072,916	Acute care, critical access, rehabilitation, long-term acute hospitals
Psychiatric	19.08%		
	92.30%	$34,559,957	State mental hospitals
	7.70%	$2,883,117	Private psychiatric hospitals
Teaching	37%	$ 81,778,185 (gross) $ 57,244,730 (Net) – Teaching hospitals supply the state match (30%); therefore they net only 70% of the DSH funds allocated to this pool	University hospitals
Total All	100%	$221,022,121	

Source: *Department for Medicaid Services*

Total Uncompensated Costs

In 2014, total uncompensated care costs of Kentucky community hospitals totaled nearly $2.3 billion, an 11% increase over 2013. After accounting for Medicaid DSH payments, the cost of uncompensated care was $2.1 billion. Bad debts represented the largest component of uncompensated care costs, comprising 57% of these costs, followed by the Medicaid shortfall which comprises 20% of these costs and has risen 51% from 2013 to 2014. The Medicare shortfall has also increased by 18% from 2013 to make up 12% of uncompensated costs. Charity care has declined by the same percentage that the Medicaid shortfall rose as about 80% of the people gaining insurance coverage in Kentucky in 2014 qualified for Medicaid. Medicaid DSH funds distributed to acute care hospitals, private psychiatric hospitals and the net funds paid to teaching hospitals totaled $157.2 million in 2014, which covered only 7 percent of total uncompensated costs, leaving $2.1 billion in uncovered costs.

Total Uncompensated Kentucky Hospital Costs, 2014

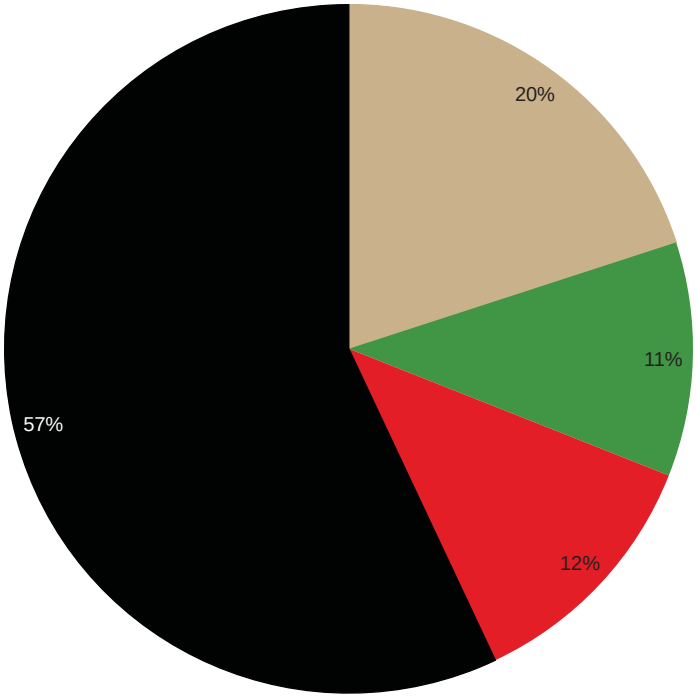
Medicaid Shortfall	$	453,000,000
Medicare Shortfall	$	262,714,447
Cost of Bad Debt	$	1,300,000,000
Charity Care Cost	$	255,000,000
Total Uncompensated Costs	$	2,270,714,447
2014 Medicaid DSH Payment*	$	157,200,763
Uncompensated Costs After DSH	$	2,113,513,684

**Medicare shortfall after accounting for Medicare DSH payments*

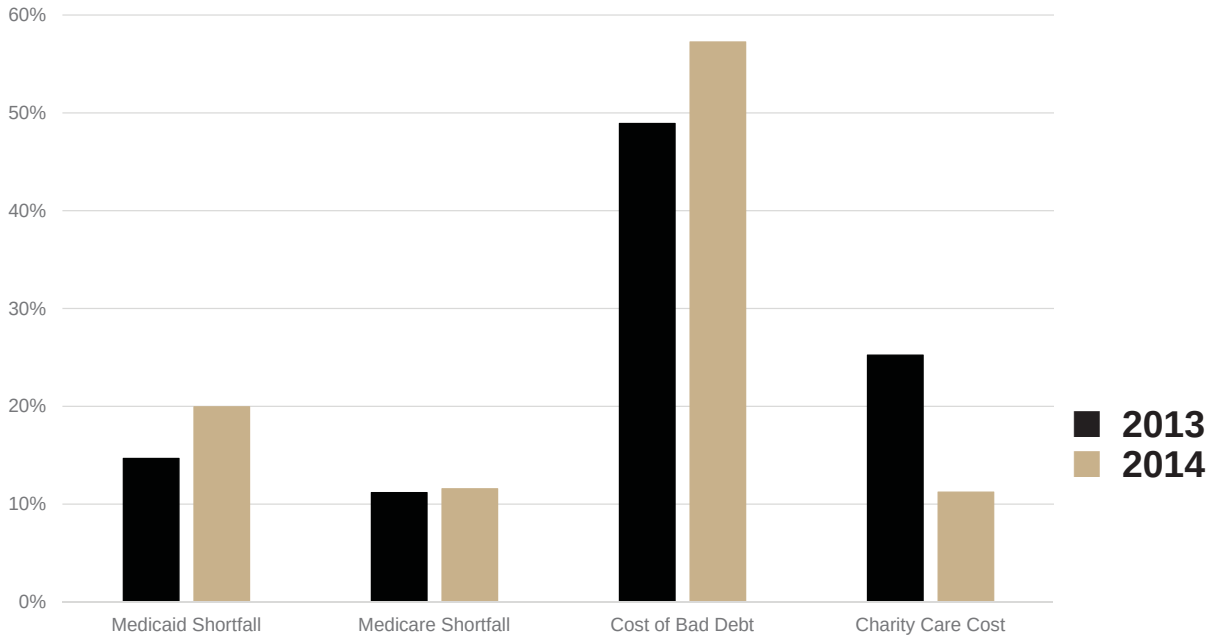
***DSH payments exclude state owned and operated mental hospitals and includes net amount received by teaching hospitals.*

Source: *Medicare Cost Reports, AHA 2015 Annual Survey of Hospitals, Medicaid SFY 2015 inpatient and outpatient payments adjusted by state average cost coverage*

Breakdown of Uncompensated Care Costs, 2014



Change in Composition of Uncompensated Care by Category, 2013-2014



	2013 Amount	2014 Amount	Percent Change
Medicaid Shortfall	$ 300,000,000	$ 453,000,000	51%
Medicare Shortfall	$ 222,748,766	$ 262,714,447	18%
Cost of Bad Debt	$ 1,000,000,000	$ 1,300,000,000	30%
Charity Care Cost	$ 515,700,000	$ 255,000,000	-51%
Total Uncompensated Costs	$ 2,038,448,766	$ 2,270,714,447	11%

Kentucky HMO Market

As of December 31, 2014, there were 13 health maintenance organizations (HMOs) licensed to do business in the state of Kentucky. Two plans, CHA and CMD, are licensed but not doing business in the state. Five of the plans provide Medicaid managed care. Four plans (Anthem, Anthem Managed Care Plan, United HealthCare of Kentucky and University Health Passport) do business exclusively in Kentucky. Total enrollment for all Kentucky HMOs for the year ended December 31, 2014, was 2,191,094 or about 50 percent of the state's population. However, growth in enrollment was due to a 71 percent increase in Medicaid MCO enrollment from 2013 due to Mediciad eligibility expansion under the ACA. Enrollment in commercial HMOs was largely unchanged, despite the individual health insurance mandate that took effect in 2014.

Anthem remains the dominant commercial HMO, with 80 percent market share, followed distantly by Humana, with 14 percent share from its two plans. Together, these two HMOs comprise 94 percent of the Kentucky HMO enrollment market, while Bluegrass Family Health and United Healthcare make up the remaining 6 percent, with each having a 3 percent market share. Anthem had a slight enrollment gain, while Humana and United both saw membership declines in 2014.

When type of plan is considered, Anthem (62 percent) and Humana (24 percent) dominate the group HMO market with a combined market share of 86 percent. The same is true in the individual HMO market where these two plans have a combined market share of 85 percent (Anthem 64 percent, Humana 21 percent). Group health plan members represent 38 percent of all commercial HMO enrollees, followed by dental- or vision-only plans (32 percent) and then individual coverage (11 percent).

Kentucky HMO Enrollment: 2013 - 2014

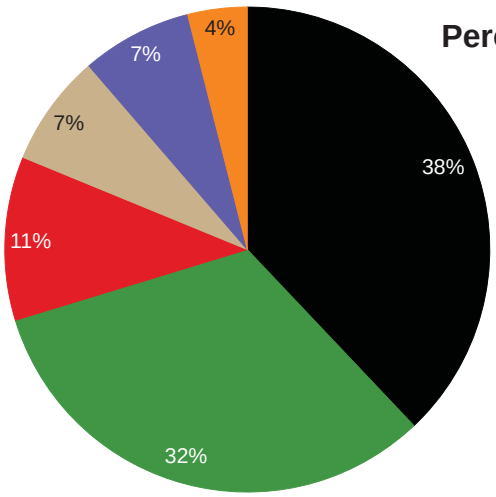
	2013 Enrollment	Market %	2014 Enrollment	Market %
Medicaid MCO				
Coventry	256,251	39.5%	306,658	28%
WellCare	260,354	40.2%	412,832	37%
Humana	-	0.0%	96,811	9%
Anthem Kentucky Managed Care Plan	-	0.0%	57,951	5%
University Health Passport	131,518	20.3%	236,330	21%
Total Medicaid MCO	648,123	100.0%	1,110,582	100%
Commercial HMO				
Coventry			9,261	1%
WellCare	2,751	0.3%	12,544	1%
Anthem Kentucky Managed Care Plan			709	0%
Anthem	838,564	78.6%	849,936	79%
Aetna	823	0.1%	603	0%
Bluegrass	34,725	3.3%	34,283	3%
Humana Health Plan Kentucky	154,810	14.5%	142,508	13%
Humana Health Plan Ohio	5,463	0.5%	7,635	1%
United Healthcare Kentucky	22,333	2.1%	17,341	2%
United Healthcare Ohio	6,944	0.7%	5,692	1%
Total Commercial HMO	1,066,413	100.0%	1,080,512	100%
GRAND TOTAL	1,714,536		2,191,094	

Source: *Kentucky HMO Book*

The eleven plans actually doing business in Kentucky experienced a $902 million profit before taxes in 2014 on their entire HMO operations, which was a 66 percent increase over 2013, largely due to increased revenue from Medicaid expansion. The five plans providing Medicaid managed care had a profit of $514 million and all of the plans except Humana operated at a profit. Humana Health Plan reported a 1 percent loss; however, Medicaid is a very small portion of its overall business, and Kentucky represents only 20 percent of the plan's total premium revenue. Kentucky represents 35 percent of Coventry's premium revenue and 97 percent for WellCare. The six remaining commercial plans doing business in Kentucky generated a profit of $389 million. The two commercial (non-MCO) plans doing business exclusively in Kentucky, Anthem and United Healthcare of Kentucky, had incomes of $202.2 million and $3.1 million respectively in 2014. This represents a slight 2 percent loss for Anthem compared to 2013 but a 58 percent loss for United Healthcare of Kentucky.

Commercial HMO Plan Types, 2014

Commercial HMO	Total Kentucky Members	% Market	Individual	% Market	Group	% Market	Medicare Advantage	% Market	Medicare Supplemental	Federal Employees	Dental / Vision Only
Coventry	9,261	1%	9,261	8%	0		0		0	0	0
WellCare	12,544	1%	7,335	6%	0		5,209	12%	0	0	0
Anthem Kentucky Managed Care Plan	709	0%	709	1%	0		0		0	0	0
Anthem	849,936	79%	75,978	64%	254,419	62%	12,474	29%	79,589	79,101	348,375
Aetna	603	0%	0		593	0%	10	0%	0	0	0
Bluegrass	34,283	3%	6	0%	34,277	8%	0		0	0	0
CHA	-										
CMD	-										
Humana Health Plan	142,508	13%	24,645	21%	100,345	24%	14,759	34%	0	1,603	1,156
Humana Health Plan Ohio	7,635	1%	0		0		7,635	18%	0	0	0
United Healthcare Kentucky	17,341	2%	4	0%	17,337	4%	0		0	0	0
United Healthcare Ohio	5,692	1%	0		2,962	1%	**2,730**	**6%**	0	0	0
Total Commercial HMO	1,080,512	100%	117,938		409,933		42,817		79,589	80,704	349,531



Percent of Kentucky HMO Enrollees by Plan Type, 2014

- Group
- Dental/Vision Only
- Individual
- Federal Employees
- Medicare Supplemental
- Medicare Advantage

Medicare Advantage

There were 862,887 Medicare beneficiaries in Kentucky in 2015, according to the Kaiser Family Foundation. As of April 2016, 236,679 (27 percent) of Medicare beneficiaries in Kentucky were enrolled in a Medicare Advantage Plan. Nearly 59 percent of all enrollees were in a plan operated by Humana. About 15 percent of Humana Medicare Advantage members in Kentucky were in an HMO plan through Humana Health Plan or Humana Health Plan of Ohio.

Anthem has the second largest share of Kentucky Medicare Advantage enrolleees with 15.5 percent, with nearly one third covered through Anthem Health Plans of Kentucky.

Source: *Centers for Medicare and Medicaid Services*

Plan	Enrollees
Aetna Better Health, Inc. (OH)	14
Aetna Health, Inc, (PA)	35
Aetna Life Insurance Company	5,633
Anthem Health Plans of Kentucky, Inc.	10,954
Anthem Insurance Companies, Inc.	25,762
Baptist Health Plan, Inc.	828
BCBS Of Michigan Mutual Insurance Company	1,694
C and O Employees' Hospital Association	776
Caresource Kentucky Co.	83
Gateway Health Plan Of Ohio, Inc.	1,570
Highmark Senior Health Company	1,960
Humana Benefit Plan Of Illinois, Inc.	18,359
Humana Health Plan Of Ohio, Inc.	8,667
Humana Health Plan, Inc.	12,784
Humana Insurance Company	94,708
Humana Medical Plan, Inc.	4,267
Molina Healthcare Of Ohio, Inc.	12
Riverlink Health	1,102
Sierra Health And Life Insurance Company, Inc.	31,700
Signature Advantage, LLC	87
Stableview Health	188
United Mine Workers Of America Health & Retirement	2,425
UnitedHealthcare Insurance Company	1,751
UnitedHealthcare Of Wisconsin, Inc.	2,430
University Health Care, Inc.	1,056
WellCare Health Insurance Company of Kentucky, Inc	7,834
TOTAL	236,679

Economic Importance of Kentucky Hospitals

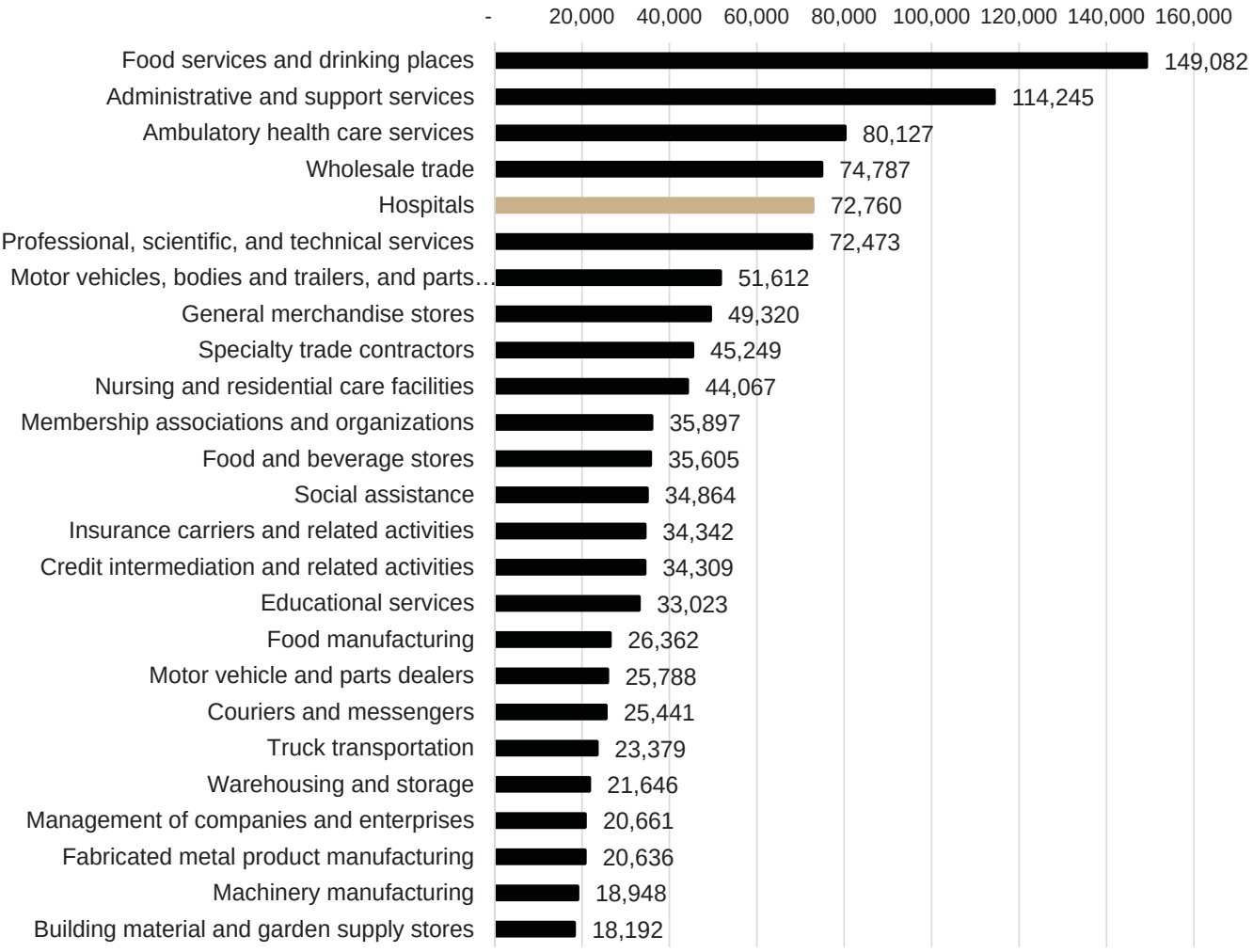
Kentucky's hospitals are the cornerstones of their communities – always there when you need them – 24 hours a day, seven days a week, 365 days a year. Accessible hospital care is just as necessary for quality of life as are public schools, transportation, public utilities and police protection. In addition to contributing to the quality of life and health, Kentucky's hospitals make a tremendous contribution to the state's economy and the financial well-being of the communities they serve. Hospitals provide well-paying jobs that supply state and local tax revenue. Hospitals and their employees also support other Kentucky businesses through their purchases of goods and services.

Kentucky's hospitals spend over $7 billion each year on staff salaries and the purchase of supplies and services. These dollars have a "ripple effect" as they move through the larger economy, supporting other businesses and jobs in the community and generating tax revenue used to fund state programs.

Based on Medicare cost reports, Kentucky hospitals provided 71,372 full-time equivalent (FTE) jobs in 2014, about 1,000 fewer than in 2013. These jobs generated nearly $4.1 billion dollars in annual local payroll.

Employment by Detailed Industry in Kentucky: 2014

According to the U.S. Bureau of Economic Analysis (BEA) report of average employment and wages for 2014, hospitals ranked fifth highest among other industries in Kentucky in terms of FTE jobs, and fourth highest in wages and salaries. In many communities, the local hospital is the largest private employer. The BEA uses employment and salary surveys to make estimations based on the North American Industry Classification System (NAICS). Compared to 2013, the number of FTEs in Kentucky hospitals remained essentially flat in 2014.

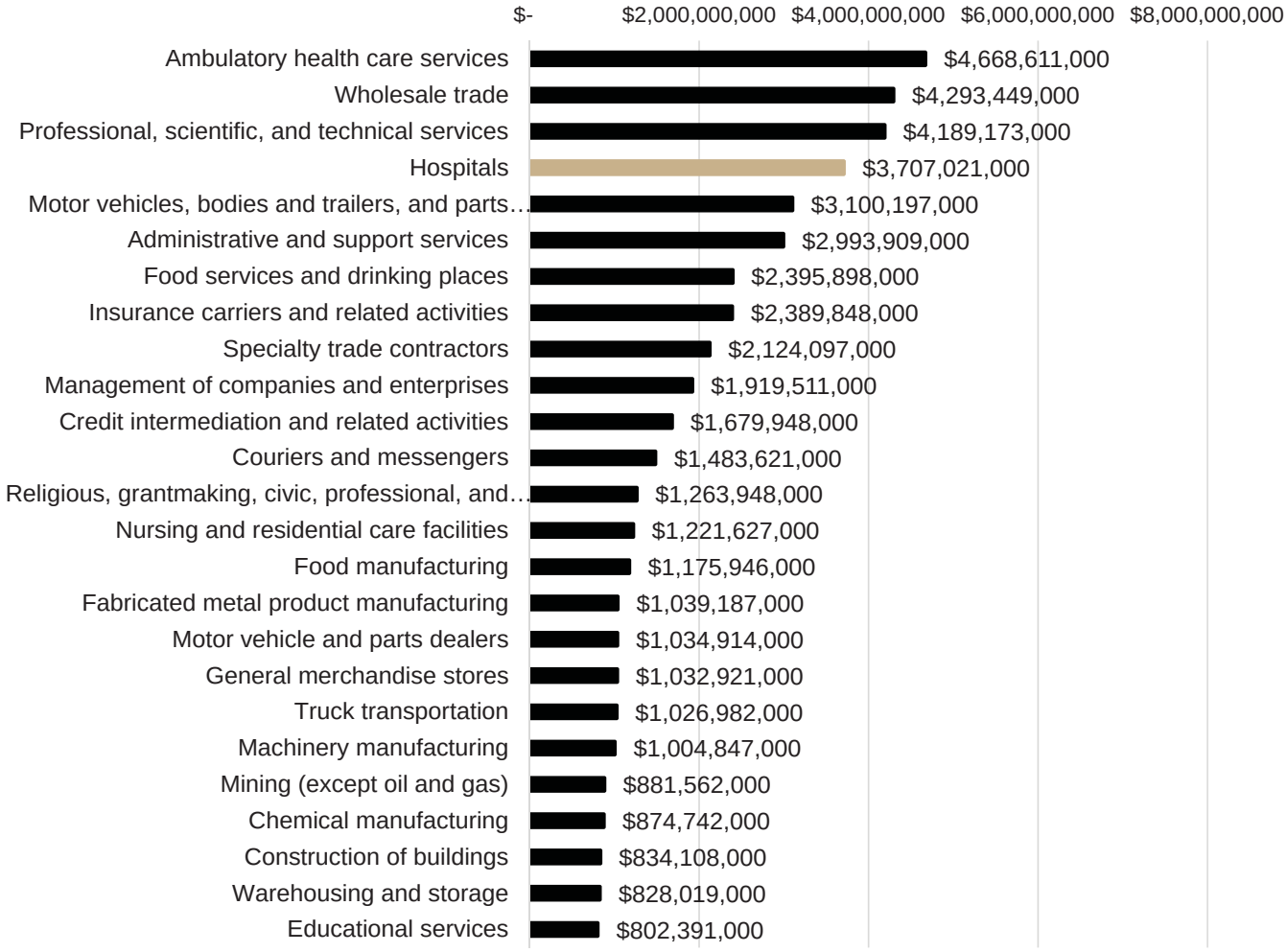


Source: *U.S. Bureau of Economic Analysis*

Employee Compensation by Detailed Industry in Kentucky: 2014

Because hospital workers are highly trained, the average Kentucky hospital employee wage in 2014 ($50,948) was 22 percent higher than the average wage of all other private employers in the state ($41,647) according to the U.S. Bureau of Economic Analysis (2014).

Because of the sheer number of jobs, as well as their relatively high pay, hospitals remain one of the largest paychecks in Kentucky. Among industries defined at the comparable level of detail, only ambulatory health care services and professional, scientific and technical services have greater employee compensation.



Source: *U.S. Bureau of Economic Analysis; Includes wages, salaries and supplements*

Tax Revenue

Kentucky's hospitals are responsible for approximately $595.2 million in state and local tax revenue through the taxes they pay directly and tax revenue generated from their employees.

- Kentucky hospitals pay more than $76.8 million in city and county occupational taxes and public school occupational taxes.
- Hospitals pay another $183 million in provider taxes to the state to help support the Kentucky Medicaid program. When matched with federal funds, their provider tax supports approximately $610 million annually in state Medicaid spending.
- Kentucky receives $335.4 million in income and sales taxes linked to the wages and salaries of Kentucky hospital employees.

Hospital Spending

Funds spent by hospitals and their employees to buy goods and services flow to local businesses and then ripple throughout the economy. Kentucky's hospitals are responsible for generating over $5 billion in local economic activity from the purchases they make and those made by their employees.

- Kentucky hospitals purchase many goods and services and generate over $3.1 billion annually in purchases from local companies. The table to the right estimates the top hospital purchases made from local companies.

Source: *KHA Economic Importance Study. Prepared for Kentucky Hospital Association by Paul Coomes, Ph.D., Professor of Economics and Barry Kornstein, Senior Research Analyst, University of Louisville using data from Medicare Cost Reports and IMPLAN.*

Estimated Local Spending by Kentucky Hospitals

Total Hospital Local Purchases	$3,142,990,183.85
Real estate	$819,005,722.50
Sum of commodities not shown	$528,256,611.27
Medical and diagnostic labs and outpatient care	$278,550,456.75
Employment services	$219,080,250.98
Management of companies and enterprises	$173,188,467.23
Electricity, and distribution services	$124,949,770.17
Wholesale trade distribution services	$100,394,053.67
Insurance	$91,347,593.09
Securities, commodity contracts, investments	$86,679,641.56
Telecommunications	$78,751,626.29
Restaurant, bar, and drinking place services	$61,279,300.28
Services to buildings and dwellings	$59,285,142.53
Management, scientific and technical consulting	$53,704,389.38
Accounting, tax preparation, bookkeeping, payroll	$52,554,760.57
Commercial, industrial machinery and maintenance	$51,117,033.13
US Postal delivery services	$45,316,572.99
Advertising and related services	$41,316,708.42
Truck transportation services	$39,384,699.07
Office administrative services	$37,973,092.05
Legal services	$34,758,567.41
Maintained and repaired nonresidential structures	$33,725,435.60

Hospital Employee Spending

Hospital employees spend an estimated $1.978 billion in local purchases. The top estimated local purchases made by hospital employees are listed to the right.

Source: *KHA Economic Importance Study. Prepared for Kentucky Hospital Association by Paul Coomes, Ph.D., Professor of Economics and Barry Kornstein, Senior Research Analyst, University of Louisville using data from Medicare Cost Reports and IMPLAN.*

Estimated Local Spending by Kentucky Hospital Employees

Total Employee Local Purchases	$1,978,966,665.47
Sum of commodities not shown	$445,642,269.48
Imputed rental services of owner-occupied dwellings	$296,032,421.60
Private hospital services	$214,397,783.56
Physicians, dentists and other health practices	$131,234,285.06
Restaurant, bar, and drinking place services	$121,462,637.79
Wholesale trade distribution services	$108,323,327.76
Real estate buying, selling, leasing, managing	$70,768,447.94
Depository credit institutions and monetary auth.	$57,627,656.38
Nursing and residential care services	$47,044,007.65
Retail Services - General merchandise	$37,473,606.08
Telecommunications	$36,252,249.85
Retail Services - Motor vehicle and parts	$34,957,665.68
Electricity, and distribution services	$33,903,799.21
Medical and diagnostic labs, outpatient and other	$31,778,912.42
Retail Services - Food and beverage	$30,579,486.51
Insurance	$30,035,064.48
Education - Colleges, universities and junior colleges	$27,368,542.45
Securities, commodity contracts, investments	$23,424,914.59
Refined petroleum products	$19,195,634.02
Retail Services - Nonstore, direct and electronic sales	$16,509,569.56
Retail Services - Health and personal care	$16,303,064.55

Economic Impact of Hospital Payment Reductions

Kentucky hospitals are also an important part of the state and local economic development strategies. Therefore, it is important that they be financially strong and stable. The financial strength of hospitals is intimately tied to payments from Medicare and Medicaid because approximately 70 percent of patient days are covered by one of these programs. Reductions in reimbursement from these governmental programs not only adversely impact hospitals and their employees, but state and local government and the broader economy as well.

A ten percent change in Kentucky hospital net patient revenue (the amount hospitals actually collect) resulting from payment cuts in Medicare, Medicaid or other programs, would:

- Reduce hospital employee wages and salaries by about $400 million, and result in some combination of lost jobs and reduced pay per job in the broader community.
- Reduce state and local government tax revenue by approximately $77.5 million.
- Cause a ripple effect to other businesses resulting in a loss of $1.96 billion in regional sales.