Key Issues Affecting Kentucky Hospitals

Kentucky Hospital Association

Spring 2017

Key Issues Affecting Kentucky Hospitals

The Kentucky Hospital Association 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.

Table of Contents - Spring 2017

Key Issues

Small and Rural Issues

Kentucky Hospital Association

Key Issues

ACA Repeal and Replace

The Affordable Care Act (ACA) has substantially reduced the number of uninsured Kentuckians which has been helpful to hospitals. When the ACA was enacted, the Congressional Budget Office estimated that 60 percent of the uninsured population would access subsidized private insurance coverage while 40% would gain coverage through Medicaid. In Kentucky, however, 80 percent of those gaining coverage qualified for expanded Medicaid, meaning that Kentucky's hospitals and health care providers did not receive the anticipated increase in commercial reimbursement necessary to offset the Medicare payment cuts included in the ACA being used to finance expanded coverage. In fact, commercial payment for hospital care has declined since 2014, as some individuals have moved from private insurance to Medicaid. While the Medicaid expansion has reduced charity care, Medicaid losses are growing as one in three Kentuckians is now covered under that program.

As Congress acts to repeal and replace the Affordable Care Act (ACA), Kentucky hospitals request consideration of the following items:

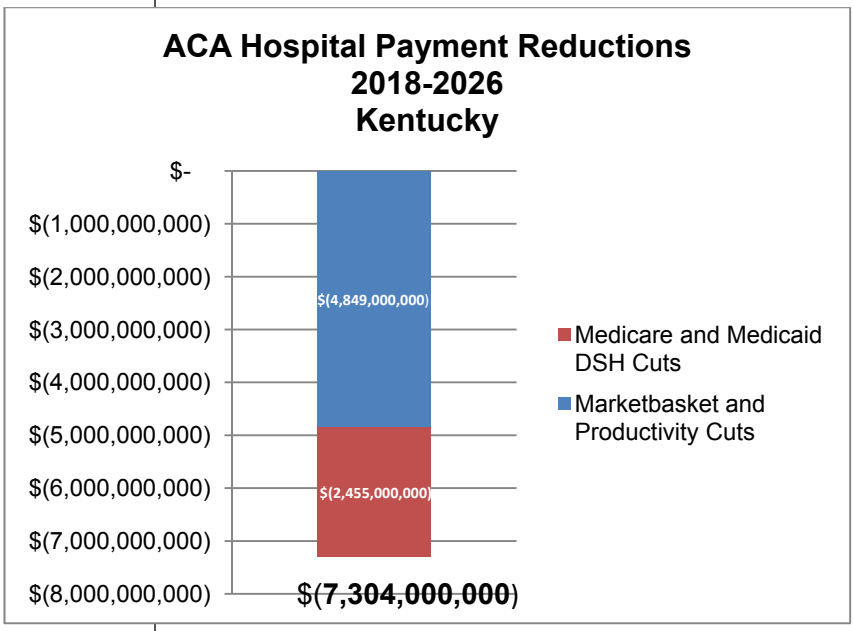
Prospectively Repeal Hospital Payment Cuts

The ACA financed the cost of expanded coverage through a combination of increased taxes and reductions in federal spending. Of the $500 billion in spending reductions, approximately $155 billion was taken from hospitals. Since 2010, hospital Medicare reimbursement has been reduced under the ACA to free up federal funds to pay federal subsidies for insurance sold on exchanges and the federal cost of Medicaid expansion.

The ACA imposed hospital payment cuts in several ways:

- **Reducing the annual market basket payment rate increase -** The annual market basket adjustment is intended to adjust payments for inflation. Under the ACA, the market basket is first cut by a specific percentage as required in the Act, and then cut again for "productivity". These adjustments are required from 2010 through 2019, and are cumulative in nature.
- **Reducing Medicare Disproportionate Share Hospital (DSH) Payments –** The ACA specifies a change in the formula for Medicare DSH payments under which 25% of a hospital's payment is based on the amount they previously would have received prior to the ACA cuts and the remaining 75% comes from a national uncompensated care pool which is reduced annually based on changes in the percentage of individuals that are uninsured. These reductions began in 2014.
- **Reducing Medicaid Disproportionate Share Hospital (DSH) Payments –** The ACA contains a specific schedule of reductions in federal Medicaid DSH allotments to states based on anticipated reductions in uncompensated care due to coverage expansion. These reductions have been delayed but are scheduled to begin in 2018 and extend through 2025. When fully implemented, these cuts are anticipated to reduce Kentucky's Medicaid DSH payments by 60%, which represents a loss of more than $100 million annually.

Through these measures, **the ACA will impose $7.3 billion in payment reductions to Kentucky's hospitals from 2018 through 2026.**



Source: "State Level Estimates of the Impact of Repealing the Affordable Care Act on Hospitals," Dobson/DaVanzo, December, 2016.

The elimination of coverage, without a replacement, would result in hospitals returning to pre-ACA levels of uncompensated care while still being subjected to massive cuts in Medicare and Medicaid funding. Kentucky hospital Medicare margins have been declining since the ACA was enacted and, **in 2015, the average aggregate Medicare margin was negative 7.59%, and 82 percent of Kentucky hospitals had a negative Medicare margin. Clearly, Kentucky hospitals cannot continue to absorb the magnitude of losses which would occur from**

- continued next page -

these ongoing Medicare payment cuts along with the loss of coverage, if only the coverage provisions of the ACA are repealed. If Congress repeals the taxes used to pay for coverage, then the hospital Medicare cuts should also be prospectively repealed.

Establish Fair Baseline for Kentucky Medicaid Spending Limits

Future federal funding for Medicaid could be capped, either through a per capita cap limit or a block grant. The per capita cap is preferable because it would grow with increased enrollment, which is important to Kentucky where such a large percent of the population is low income and could become eligible for Medicaid. Under the proposed American Health Care Act, per capita caps would be set using 2016 spending as the baseline. This would put Kentucky hospitals at an extreme disadvantage relative to other states with supplemental payment programs in place to enhance hospital Medicaid payments. Those states would have that enhanced funding grandfathered and included in their spending cap. Kentucky has not put supplemental payments in place for non-university hospitals, even though acute care hospitals have repeatedly successfully won several rate appeals and received settlements for ongoing inadequate Medicaid payment rates. Unfortunately, while hearing officers and courts have found hospital Medicaid rates to be inadequate, the state has never improved the underlying payment rates to reasonable levels. **Unless Kentucky's baseline for a future spending limit is set at an amount to allow those rates to be increased in accordance with the findings of hearing officers and the courts, Kentucky hospitals will be foreclosed from receiving federal matching funds even if state matching funds are obtained. Therefore, the amount required to raise hospital payments to adequate levels should be added to Kentucky's baseline under any capped funding legislation in order to treat Kentucky equitably with other states.**

Increase Insurance Competition

Kentucky could benefit from increased competition in the commercial health insurance market. The commercial market is dominated by two insurers, Anthem and Humana, which have a combined 85 percent market share. Also, the size of the Kentucky individual market is small with few plans offered. In one-half of Kentucky's counties (59 counties), there is only one exchange plan offered, and in 74 counties, the only choice is a narrow network plan offered by a single insurer. Deductibles are so high that individuals are essentially "self-insured" for the health care services they are likely to use. Insurer dominance creates inappropriate leverage over providers in setting rates and imposing payment policies that do not benefit providers or patients. **Kentucky hospitals support efforts to increase insurance competition and improve the adequacy of coverage.**

Oppose Medicare DSH Changes in IPPS Proposed FFY 2018 Rule

On April 14, 2017, the Centers for Medicare & Medicaid Services (CMS) published its hospital inpatient prospective payment system (IPPS) proposed changes for fiscal year 2018 rates. This rule contains a proposal to change the Medicare disproportionate share hospital (DSH) program that will be **extremely harmful to Kentucky hospitals. If this proposal is not altered, Kentucky's hospitals stand to lose $26 million in Medicare DSH funding in FY 2018, $51 million in FY 2019, and $77 million in 2020 and each year thereafter! In fact, Kentucky is projected to have the fifth largest loss in aggregate Medicare DSH funding among all states, and one of the highest percentage reductions in Medicare DSH payments of sixty percent! The CMS proposal would result in a massive redistribution of Medicare DSH payments from Medicaid expansion states to non-expansion states, because CMS's new proposed definition of "uncompensated care" would exclude Medicaid program losses.** This penalizes Kentucky because, although uninsured costs have declined as people have gained Medicaid coverage, hospitals continue to lose money on every Medicaid patient because Medicaid payments do not cover the actual cost of care.

Background

Under the ACA, beginning in FY 2014, 25 percent of federal Medicare DSH funds are paid to eligible hospitals on a hospital-specific basis, while the remaining 75 percent are put into a national pool and distributed based on each hospital's proportion of uncompensated care costs to the total for all eligible hospitals. To date, CMS has used Medicaid volume as a proxy measure of uncompensated care costs. Under the proposed rule, CMS intends to phase-in over three years a move to use unaudited data from Medicare cost reports and to define "uncompensated care" to include only charity and non-Medicare bad debts and exclude losses from Medicaid underpayment.

Exclusion of Medicaid Shortfall from Uncompensated Costs

Harm to Kentucky

Kentucky's Medicaid payments for inpatient care, on average, cover only 75% of allowable costs leaving hundreds of millions of dollars in uncompensated care. With 1.4 million people covered by Medicaid – one in every three Kentuckians – hospitals have millions of dollars in Medicaid losses, yet they are ignored in the CMS proposal. Kentucky's PPS hospitals already have a negative 8 percent Medicare margin based on the current level of Medicare DSH

payments, so **a sixty percent reduction in DSH funding will cause hospital Medicare margins to plummet even further to an estimated negative ten percent.**

On average 75% of all patients in Kentucky hospitals are covered by Medicare or Medicaid where payment does not cover the cost of care, and in many rural hospitals, the proportion of governmental patients runs 80% to 90%. Within the last two years, five Kentucky hospitals have either closed or ceased providing inpatient care. Kentucky hospitals cannot absorb the magnitude of the $77 million in losses which will be created when CMS's new methodology is fully phased-in.

Redistribution of Payments to Non-Expansion States

Of the 49 states and the District of Columbia which are impacted by the CMS proposed change, 30 states will lose DSH funds while 20 will see an increase. Of the states experiencing a cut, 83 percent (25 states) also are a Medicaid expansion state, while 70 percent (14 states) of those experiencing a gain did not expand Medicaid. The transfer of DSH funding just among the top five states losing and gaining funds will total approximately $1 Billion in Medicare DSH funds:

Top 5 States Losing DSH Funds

State	Estimated Loss in 2020	Expanded Medicaid
California	($450 M)	Yes
New York	($ 345M)	Yes
Pennsylvania	($ 102M)	Yes
Michigan	($ 94M)	Yes
Kentucky	**($ 77M)**	**Yes**
Subtotal	**($1.1Billion)**	

Top 5 States Gaining DSH Funds

State	Estimated Gain in 2020	Expanded Medicaid
Texas	$ 603M	No
Florida	$ 153M	No
Georgia	$ 137M	No
North Carolina	$ 119M	No
New Jersey	$ 74M	Yes
Subtotal	**$1.1Billion**	

Source: Analysis of Medicare cost reports, HANYS, KHA.

Why Medicaid Losses Should be Included

- ✓ The purpose of Medicare DSH is to help cover losses associated with providing care to the low income population. Since Medicaid is, by definition, a program for low income people, capturing Medicaid losses in the definition of uncompensated care meets the purpose of the Medicare DSH program in identifying those hospitals with a large low income population.
- ✓ Medicaid shortfalls should be counted as uncompensated costs because Medicaid DSH payments do not offset these losses. Despite hospitals becoming more cost-efficient, in SFY 2015, Kentucky hospitals experienced over $100 million in Medicaid losses just for inpatient care that were not covered by Medicaid DSH payments. Moreover, CMS has available data to calculate a hospital's Medicaid shortfall net of any Medicaid DSH payments.
- ✓ Including Medicaid shortfalls in the definition of uncompensated care will not increase the aggregate amount of Medicare DSH funding in the 75% DSH pool; rather it will change the distribution of the available DSH payments to be more equitable among states. If Medicaid shortfalls are excluded (as proposed), hospitals in states where uncompensated care costs have shifted from the classification of "charity" to "Medicaid shortfall" will be shortchanged in the ability to receive DSH funding and a windfall will be created for other states that have not expanded Medicaid and continue to have more losses classified as charity. In order to treat all states and hospitals equitably and prevent a major redistribution of Medicare DSH funding which is critical to the hospitals of Kentucky, it is imperative that CMS alter their proposed definition of uncompensated care to include Medicaid shortfalls along with charity and non-Medicare bad debt.

Use of Unaudited Cost Report Data

CMS proposes to use data from Medicare cost reports before it has been audited. This is also extremely problematic because the use of erroneous unaudited data, which may overstate a hospital's uncompensated care, would result in a windfall for that hospital and a reduction for all other hospitals in the 75 percent DSH pool. An analysis of 2014 unaudited cost report data by the American Hospital Association found a number of hospitals reporting uncompensated care costs that totaled more than 50 percent of the total expenses for the facility as a whole as well as individual hospitals with extremely overstated bad debt expenses. Although the 75% pool is a fixed amount, inaccurate and overstated data by even a small number of hospitals will affect the DSH payment of all other hospitals.

- continued next page -

[1]Maryland operates under a Medicare waiver

Oppose Medicare DSH Changes in IPPS Proposed FFY 2018 Rule - contined

KHA requests the Kentucky delegation to submit a delegation letter in opposition to CMS's proposed changes to the Medicare DSH program contained in the FY 2018 IPPS proposed rule by urging CMS to do the following:

- Include hospitals' Medicaid shortfall in the definition of uncompensated care costs for calculating Medicare DSH,
- Use only audited uncompensated care data from cost reports (Worksheet S-10), and
- Provide a stop loss to minimize financial hardship to hospitals that will experience a significant reduction in DSH funding.

S-10 Uncompensated Care Distribution Analysis
Estimated Change in Medicare Payments for DSH Eligible Hospitals

	Comparison	FFY 2018			Estimated FFY 2019			Estimated FFY 2020		
	Proxy Distribution Amount	Transitional S-10 Distribution Amount	Impact of Switch to S-10	Percent Change	Transitional S-10 Distribution Amount	Impact of Switch to S-10	Percent Change	Transitional S-10 Distribution Amount	Impact of Switch to S-10	Percent Change
U.S.	**$6,962,310,900**	**$6,962,310,900**	**$0**	**0.0%**	**$6,962,310,900**	**$0**	**0.0%**	**$6,962,310,900**	**$0**	**0.0%**
Alabama	$108,692,600	$116,956,500	$8,263,900	7.6%	$124,076,700	$15,384,100	14.2%	$131,513,400	$22,820,800	21.0%
Alaska	$9,702,200	$11,681,900	$1,979,700	20.4%	$12,824,800	$3,122,600	32.2%	$9,256,300	($445,900)	-4.6%
Arizona	$122,734,200	$119,263,900	($3,470,300)	-2.8%	$103,368,300	($19,365,900)	-15.8%	$83,941,200	($38,793,000)	-31.6%
Arkansas	$53,719,100	$55,329,800	$1,610,700	3.0%	$50,828,500	($2,890,600)	-5.4%	$44,738,600	($8,980,500)	-16.7%
California	$867,065,600	$721,208,900	($145,856,700)	-16.8%	$580,075,900	($286,989,700)	-33.1%	$417,281,700	($449,783,900)	-51.9%
Colorado	$65,590,100	$61,504,400	($4,085,700)	-6.2%	$56,254,700	($9,335,400)	-14.2%	$49,143,500	($16,446,600)	-25.1%
Connecticut	$71,573,100	$63,297,900	($8,275,200)	-11.6%	$53,138,600	($18,434,500)	-25.8%	$49,512,800	($22,060,300)	-30.8%
Delaware	$19,770,500	$20,595,200	$824,700	4.2%	$19,353,300	($417,200)	-2.1%	$18,218,200	($1,552,300)	-7.9%
D.C.	$35,504,700	$29,563,400	($5,941,300)	-16.7%	$22,305,200	($13,199,500)	-37.2%	$15,650,100	($19,854,600)	-55.9%
Florida	$560,703,000	$602,368,600	$41,665,600	7.4%	$658,396,500	$97,693,500	17.4%	$713,358,500	$152,655,500	27.2%
Georgia	$210,178,400	$252,583,900	$42,405,500	20.2%	$299,990,600	$89,812,200	42.7%	$347,295,400	$137,117,000	65.2%
Hawaii	$15,530,100	$12,618,700	($2,911,400)	-18.7%	$9,994,500	($5,535,600)	-35.6%	$5,410,900	($10,119,200)	-65.2%
Idaho	$17,951,700	$18,518,300	$566,600	3.2%	$20,059,300	$2,107,600	11.7%	$21,012,300	$3,060,600	17.0%
Illinois	$292,288,500	$276,634,900	($15,653,600)	-5.4%	$271,055,600	($21,232,900)	-7.3%	$268,831,100	($23,457,400)	-8.0%
Indiana	$141,654,900	$170,401,600	$28,746,700	20.3%	$188,236,700	$46,581,800	32.9%	$210,661,800	$69,006,900	48.7%
Iowa	$51,151,000	$42,833,000	($8,318,000)	-16.3%	$36,421,100	($14,729,900)	-28.8%	$30,014,300	($21,136,700)	-41.3%
Kansas	$36,096,700	$37,490,500	$1,393,800	3.9%	$39,048,400	$2,951,700	8.2%	$40,976,800	$4,880,100	13.5%
Kentucky	$128,804,200	$103,012,400	($25,791,800)	-20.0%	$78,163,300	($50,640,900)	-39.3%	$51,739,100	($77,065,100)	-59.8%
Louisiana	$145,802,300	$157,529,800	$11,727,500	8.0%	$173,998,700	$28,196,400	19.3%	$192,357,400	$46,555,100	31.9%
Maine	$23,151,300	$24,710,000	$1,558,700	6.7%	$28,077,900	$4,926,600	21.3%	$31,935,800	$8,784,500	37.9%
Maryland	$0	$0	$0		$0	$0		$0	$0	
Massachusetts	$146,572,900	$138,893,900	($7,679,000)	-5.2%	$133,869,100	($12,703,800)	-8.7%	$129,716,200	($16,856,700)	-11.5%
Michigan	$218,600,600	$195,386,900	($23,213,700)	-10.6%	$157,982,900	($60,617,700)	-27.7%	$124,417,400	($94,183,200)	-43.1%
Minnesota	$76,471,400	$64,284,300	($12,187,100)	-15.9%	$48,619,600	($27,851,800)	-36.4%	$32,871,500	($43,599,900)	-57.0%
Mississippi	$98,051,200	$95,051,600	($2,999,600)	-3.1%	$93,776,500	($4,274,700)	-4.4%	$93,701,800	($4,349,400)	-4.4%
Missouri	$123,192,800	$139,376,700	$16,183,900	13.1%	$157,415,600	$34,222,800	27.8%	$177,330,400	$54,137,600	43.9%
Montana	$8,464,600	$10,428,800	$1,964,200	23.2%	$12,269,200	$3,804,600	44.9%	$14,042,500	$5,577,900	65.9%
Nebraska	$23,649,600	$25,205,600	$1,556,000	6.6%	$30,762,500	$7,112,900	30.1%	$36,321,200	$12,671,600	53.6%
Nevada	$52,443,000	$47,550,100	($4,892,900)	-9.3%	$42,514,000	($9,929,000)	-18.9%	$36,493,600	($15,949,400)	-30.4%
New Hampshire	$12,092,100	$15,759,900	$3,667,800	30.3%	$17,893,800	$5,801,700	48.0%	$20,035,700	$7,943,600	65.7%
New Jersey	$172,229,200	$202,387,900	$30,158,700	17.5%	$223,005,600	$50,776,400	29.5%	$246,478,900	$74,249,700	43.1%
New Mexico	$39,287,800	$37,454,700	($1,833,100)	-4.7%	$33,031,900	($6,255,900)	-15.9%	$26,272,100	($13,015,700)	-33.1%
New York	$759,711,000	$616,518,000	($143,193,000)	-18.8%	$511,100,200	($248,610,800)	-32.7%	$414,828,000	($344,883,000)	-45.4%
North Carolina	$214,058,400	$249,504,900	$35,446,500	16.6%	$290,324,400	$76,266,000	35.6%	$333,375,100	$119,316,700	55.7%
North Dakota	$9,068,700	$10,417,500	$1,348,800	14.9%	$10,936,600	$1,867,900	20.6%	$11,126,400	$2,057,700	22.7%
Ohio	$226,001,400	$221,895,700	($4,105,700)	-1.8%	$204,403,000	($21,598,400)	-9.6%	$188,018,300	($37,983,100)	-16.8%
Oklahoma	$106,279,500	$103,045,400	($3,234,100)	-3.0%	$103,405,100	($2,874,400)	-2.7%	$105,937,100	($342,400)	-0.3%
Oregon	$55,773,500	$54,080,600	($1,692,900)	-3.0%	$48,723,400	($7,050,100)	-12.6%	$40,367,800	($15,405,700)	-27.6%
Pennsylvania	$254,306,300	$219,735,200	($34,571,100)	-13.6%	$186,365,300	($67,941,000)	-26.7%	$152,192,300	($102,114,000)	-40.2%
Puerto Rico	$91,651,400	$91,725,800	$74,400	0.1%	$88,727,300	($2,924,100)	-3.2%	$87,026,700	($4,624,700)	-5.0%
Rhode Island	$25,344,700	$26,249,900	$905,200	3.6%	$24,087,900	($1,256,800)	-5.0%	$22,137,000	($3,207,700)	-12.7%
South Carolina	$103,771,600	$120,279,700	$16,508,100	15.9%	$141,300,100	$37,528,500	36.2%	$162,123,800	$58,352,200	56.2%
South Dakota	$12,401,400	$12,963,400	$562,000	4.5%	$12,833,400	$432,000	3.5%	$12,168,100	($233,300)	-1.9%
Tennessee	$168,676,200	$166,888,800	($1,787,400)	-1.1%	$165,609,000	($3,067,200)	-1.8%	$165,002,300	($3,673,900)	-2.2%
Texas	$585,819,200	$801,921,900	$216,102,700	36.9%	$995,270,300	$409,451,100	69.9%	$1,189,173,300	$603,354,100	103.0%
Utah	$31,512,800	$41,439,300	$9,926,500	31.5%	$51,166,300	$19,653,500	62.4%	$61,395,800	$29,883,000	94.8%
Vermont	$6,164,300	$5,360,900	($803,400)	-13.0%	$4,436,200	($1,728,100)	-28.0%	$3,610,500	($2,553,800)	-41.4%
Virginia	$118,006,900	$131,946,600	$13,939,700	11.8%	$159,295,600	$41,288,700	35.0%	$186,697,800	$68,690,900	58.2%
Washington	$109,898,600	$95,181,600	($14,717,000)	-13.4%	$78,424,100	($31,474,500)	-28.6%	$58,647,800	($51,250,800)	-46.6%
West Virginia	$51,843,800	$45,560,000	($6,283,800)	-12.1%	$36,101,500	($15,742,300)	-30.4%	$27,401,400	($24,442,400)	-47.1%
Wisconsin	$79,945,700	$73,166,100	($6,779,600)	-8.5%	$67,256,500	($12,689,200)	-15.9%	$63,482,300	($16,463,400)	-20.6%
Wyoming	$1,113,500	$2,238,300	$1,124,800	101.0%	$3,493,000	$2,379,500	213.7%	$4,756,300	$3,642,800	327.1%

Note:
- Totals given are for eligible hospitals only. Individual totals may not foot due to rounding

Wage Index

Fix Bay State Boondoggle

Since 2011, Massachusetts hospitals have reaped an estimated $ 1.3 Billion in redirected Medicare inpatient and outpatient payments in fiscal years 2012 to 2016 through a one-sentence amendment in Section 3141 of the Affordable Care Act (ACA). The amendment adjusted payments 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.** From 2012 to 2016, Kentucky hospitals have lost more than $60 million in Medicare payment due to this provision of the ACA.

The following table illustrates the differences in the rural wage index between Kentucky and the four states benefitting most from the Bay State Boondoggle. **The wage index for rural hospitals in Massachusetts and California exceeds the rural wage index for Kentucky hospitals by 50 to 60 percent and New Jersey and Connecticut's rural wage index is about 50% higher.** Despite strong bipartisan support of legislation to end the manipulation, repeal efforts have been stymied by those seeking to perpetuate it.

Source: Federal Register.

	FFY 2017 Rural Wage Index
KENTUCKY	**0.7894**
California	1.2781
Massachusetts	1.1836
Connecticut	1.1714
New Jersey	1.1358

Kentucky's hospitals request all members of the Kentucky delegation to co-sign and support legislation to fix the "Bay State Boondoggle," which is primarily benefitting Massachusetts at the detriment of other states, like Kentucky. KHA thanks Senator McConnell and Representatives Guthrie and Barr for their past leadership in co-sponsoring prior bills to address this issue. This legislation has no budgetary impact, but is critical to stop these unfair cuts to Kentucky hospitals. Since this wage index manipulation passed as part of the ACA, it should be part of ACA repeal.

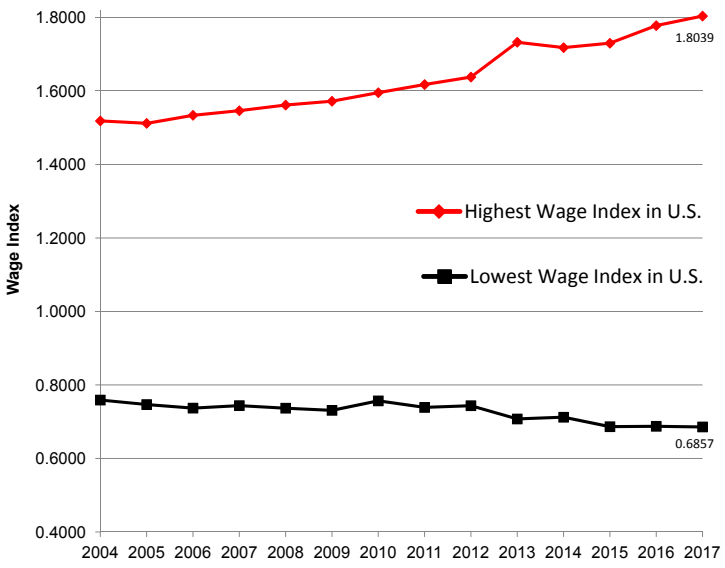
Implement Wage Index Floor

Additionally, there is need for a long-term correction to the Medicare area wage index to bring payment equity to states, such as Kentucky, which are being harmed by the current wage index system that perpetuates lower Medicare payments to Kentucky's hospitals. The wage index of Kentucky's urban and rural hospitals is lower than that of most surrounding states and comparable urban areas. This is a national issue, affecting many states, as the gap between the highest and lowest wage index is ever-increasing. There is a 163% difference between hospitals located in areas with the highest wage index compared to those in areas with the lowest wage index. With depressed payments due to this gap, hospitals in low wage index areas cannot catch up.

The current Medicare payment structure favors a handful of states. In theory, the wage index is used to modify Medicare hospital inpatient and outpatient payments

- continued next page

Wage Index Gap (High vs Low 2004-2017)



based on geographic differences in wages but, in reality, the distortions within the system promote inefficiency and unpredictability, and perpetuate inequity among states. The wage index is calculated by collecting salary and hourly wage data from every hospital. An "average" wage is computed for each of the 400+ MSAs for urban wage index labor markets, and all non-MSA hospitals within a state are grouped into one statewide rural labor market. The operating base payment rate is divided into two components: the labor share (which is adjusted by the wage index) and the non-labor share. The labor share is set at 62% of the operating rate for areas where the wage index is less than or equal to 1.0 (the national average), and it is set at 69.6% if the wage index is more than the national average. **Kentucky has the 38th lowest rural wage index and no area in Kentucky has a wage index at or above 1.0.** In fact, none of the following states have a single urban area with a wage index at 1.0 or greater: Alabama, Tennessee, Georgia, Florida, Ohio, Texas, South Carolina, North Carolina, Louisiana, Kentucky, Mississippi, Arkansas, Iowa, Idaho, Kansas, Missouri, New Mexico, Oklahoma and Utah.

The wage index is a significant issue for Kentucky's hospitals because Medicare covers about one half of all patients treated in hospitals.

KHA supports addressing the wage index inequity by instituting a wage index floor, to reduce the gap between the lowest and highest wage index. Our goal is for the floor to be set at .91 with the understanding that this may need to be a phased in process starting with a floor of .874, which would stop the immediate bleeding but not achieve the full correction necessary to achieve payment equity. A .874 floor would provide an estimated $18 million in payments to Kentucky hospitals. However, it would not provide the necessary relief to Kentucky's urban hospitals which is why a .91 floor should be adopted. A .91 floor would raise Kentucky's Medicare payments by an estimated $48 million annually.

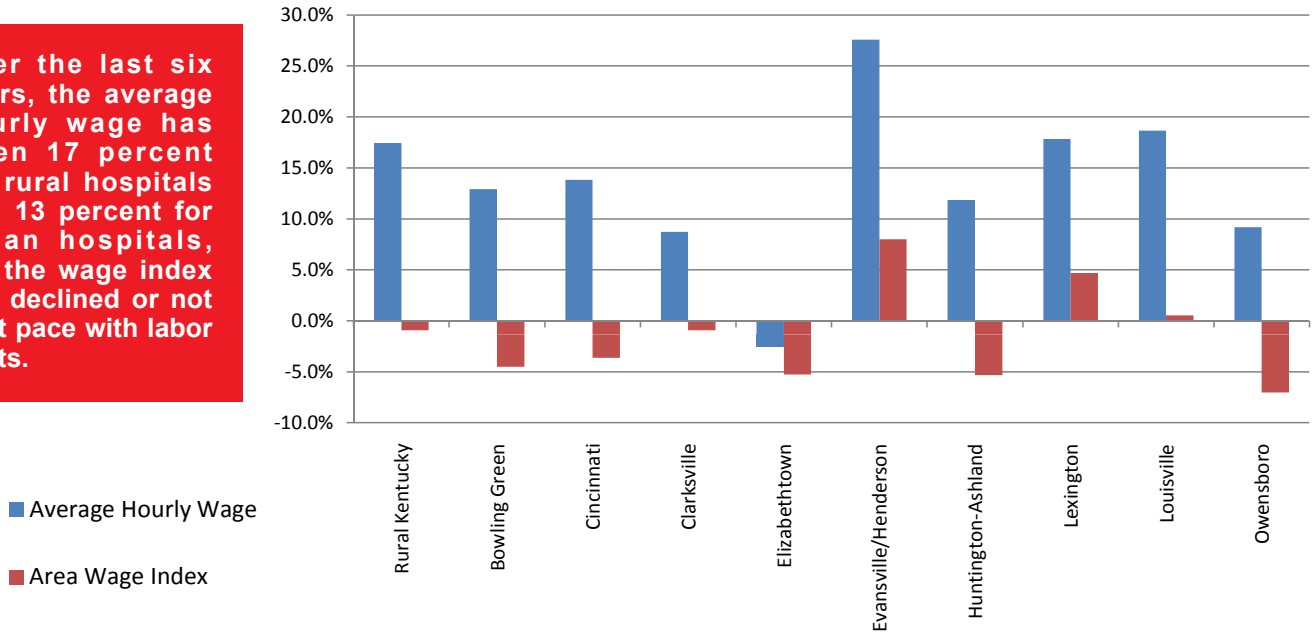
S.397, the Fair Medicare Hospital Payments Act of 2017, which sets a .874 national wage index floor, has been introduced by Senator Johnny Isakson (R-GA). **KHA requests the Kentucky delegation to co-sponsor S. 397 and House companion legislation H.R. 1130 introduced by Rep. Diane Black (R-TN) as the first step to phasing in a wage index floor of 0.91, which is needed to bring about equity among states in Medicare payments.**

MSA – Kentucky	FFY 2017 Wage Index
Huntington/Ashland	.8405
Clarksville/Hopkinsville	.7894*
Cincinnati/Northern Kentucky	.9240
Evansville/Henderson	.9021
Owensboro	.7894*
Bowling Green	.8289
Elizabethtown	.7894*
Lexington	.9140
Louisville	.8864
Rural Kentucky	.7894

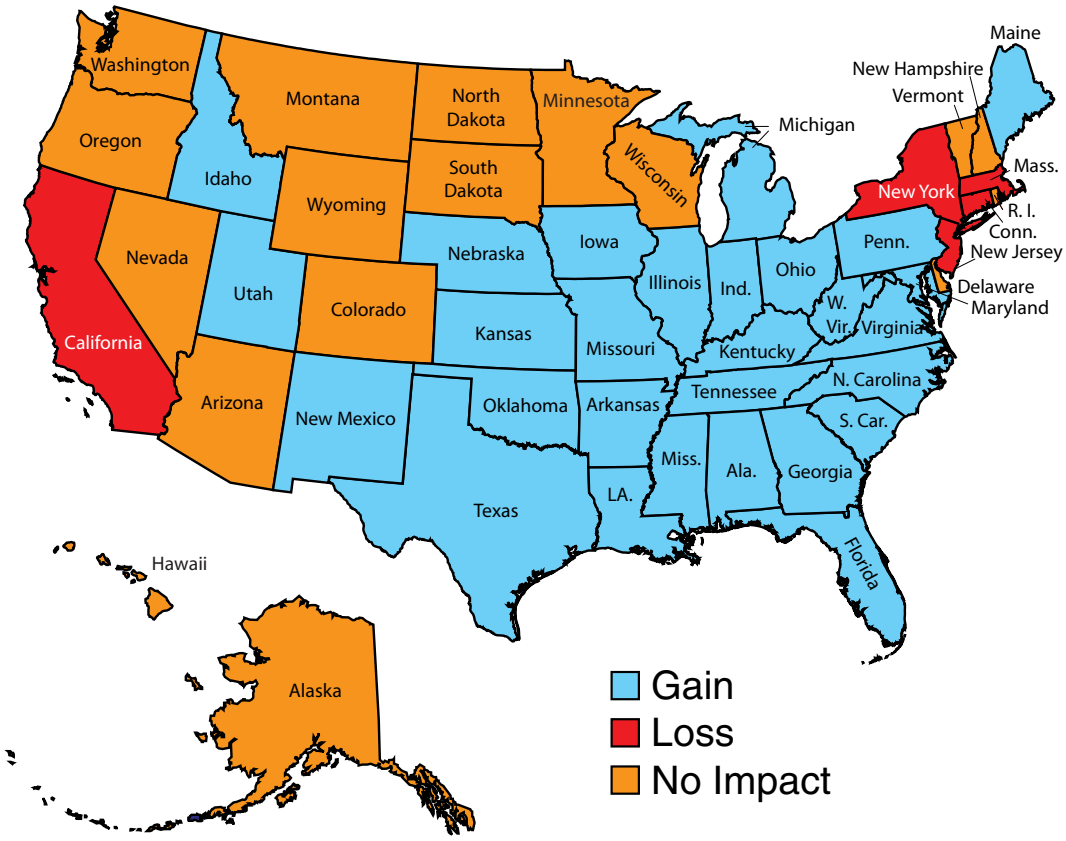
*No urban area can have a wage index lower than the state's rural wage index.

FFY 2011-2017 Percent Change in Average Hourly Wage Compared to Medicare Wage Index, Kentucky IPPS Hospitals

Over the last six years, the average hourly wage has risen 17 percent for rural hospitals and 13 percent for urban hospitals, yet the wage index has declined or not kept pace with labor costs.



Impact of Medicare and .91 Wage Index Floor

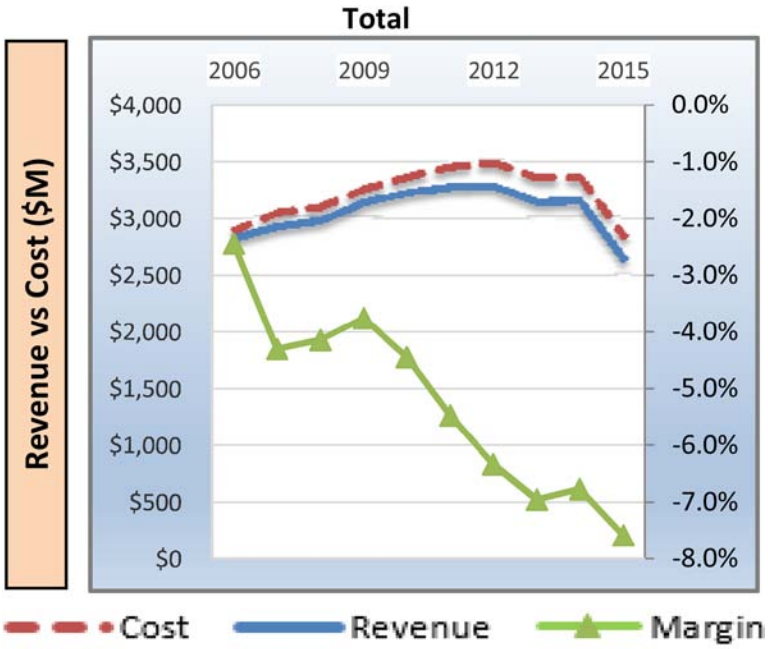


Reject Cuts to Hospital Payment

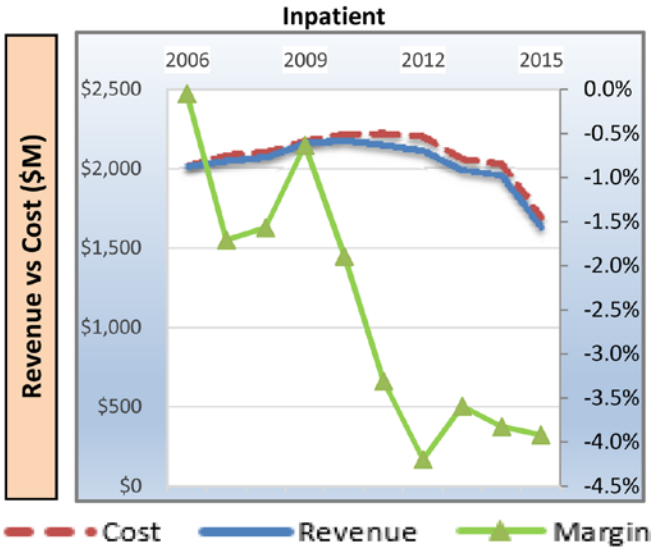
Every time Congress grapples with a fiscal crisis, payments for hospital care are at risk. Kentucky's hospitals continue to lose money on caring for Medicare patients and, as a whole, have negative Medicare margins which continue to decline. In 2010 when the ACA was enacted, the aggregate Medicare margin for Kentucky's PPS and critical access hospitals was already a negative 4.45% and **Kentucky's Medicare margins have since declined further to reach negative 7.59% in 2015.** This continues the negative margin trend that has been ongoing for nearly ten years and has been worsening each year. Hospitals lose more money on Medicare outpatient services which is concerning as more services are being shifted to the outpatient setting.

- continued next page -

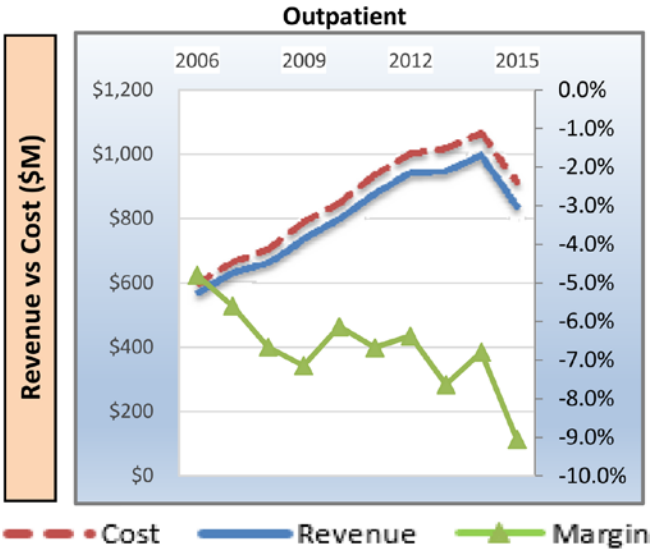
Declining Medicare Margins



Declining Medicare Margins



Declining Medicare Margins



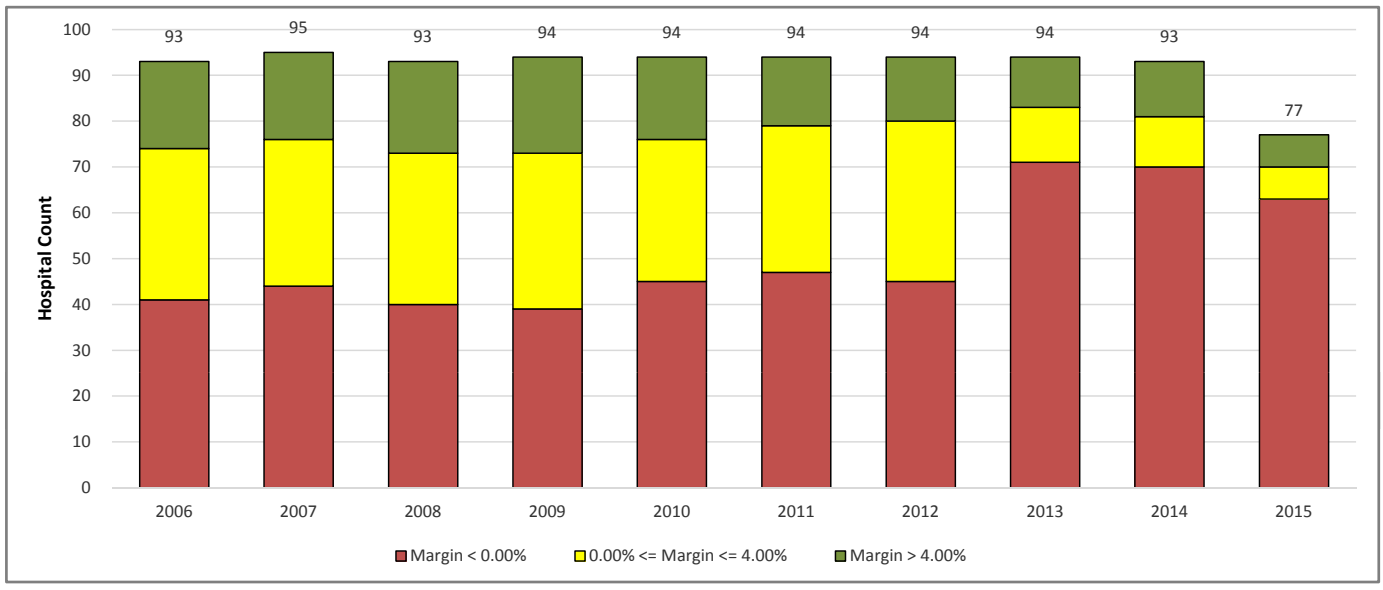
Source: Medicare Cost Reports.

Health economists consider a positive 4% margin the minimum necessary to ensure hospitals have sufficient funds to improve patient care and to reinvest in modernization. Not only do Kentucky hospitals have an aggregate **negative** Medicare margin, but the number and percentage of hospitals with inadequate margins is increasing. In 2010, 81 percent of Kentucky hospitals had inadequate Medicare margins, and by 2015, the percent has risen to 91 percent!

Medicare Margins Analysis

Kentucky Hospital Distribution Trend

PPS & CAH



FFY	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Hospital Count										
PPS & CAH										
Margin < 0.00%	41	44	40	39	45	47	45	71	70	63
0.00% <= Margin <= 4.00%	33	32	33	34	31	32	35	12	11	7
Margin > 4.00%	19	19	20	21	18	15	14	11	12	7
Total	93	95	93	94	94	94	94	94	93	77

Source: Medicare Cost Reports.

Reject Cuts to Hospital Payment - continued

When existing losses are coupled with growing cuts mandated by the Affordable Care Act (ACA) and losses from the Medicaid program, Kentucky's hospitals cannot absorb further payment reductions. Several Kentucky hospitals have already reduced their hospital workforce and taken other actions, including reducing or closing services, to aggressively cut expenses. In the last two years, four rural hospitals have closed. Additional reductions in Medicare payments will only further reduce hospitals' ability to provide access to needed health care services and invest in the technology and infrastructure necessary to operate in a reformed health care environment. There could be a loss of more jobs, services and even additional hospital closures, leaving patients in rural areas at risk of having to travel much further for hospital care.

The chart below illustrates how existing Medicare hospital payments would be affected by additional cuts that Congress may consider. The impacts in this analysis include several of the major cuts proposed in recent years. Site-neutral outpatient payment could reduce Kentucky hospital payments by $161 million to $345 million over ten years, depending on what services are targeted.

Kentucky's hospitals urge the Kentucky congressional delegation to reject further cuts to funding for hospital care.

We specifically urge the delegation to reject "site-neutral" Medicare Hospital Outpatient Department cuts, reductions to indirect medical education payments, cuts in reimbursable Medicare bad debts, elimination of CAH and sole community hospital status, and changes to the Medicare DSH payments that exclude Medicaid losses from the definition of uncompensated care costs used to distribute payments.

KHA has previously provided recommendations for achieving savings in other ways which include:

- Raise the age for Medicare eligibility for future generations
- Expand use of physician extenders and other appropriately trained providers
- Amend laws and regulations to eliminate current barriers to clinical integration
- Control rising pharmaceutical expenditures
- Enact meaningful liability reform
- Encourage healthy lifestyles, such as through meaningful tax credits for wellness programs, rewarding individuals who obtain required screenings for their age and for managing chronic conditions.

Proposed Medicare Cuts Analysis

Accumulated Impact of Medicare Proposals

Kentucky

This report shows annual impact estimates for all cuts in the analysis over the period of 2017-2026. The values shown reflect annual impact estimates of proposals that have been put before Congress.

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	10 Year Estimate of Proposals 2017-2026
Graduate Medical Education Funding:											**($53,389,900)**
IME Reduced by 10%	($4,670,200)	($4,797,000)	($4,919,700)	($5,082,800)	($5,246,300)	($5,414,700)	($5,588,700)	($5,739,600)	($5,888,900)	($6,042,000)	
IME Payments based on a National Pool	$0	$0	$4,533,600	$4,683,800	$4,834,500	$4,990,000	$5,149,900	$5,289,200	$5,426,600	$5,567,800	**$40,475,400**
DGME Capped at 120% of U.S. Average Resident Salary	($3,309,200)	($3,377,600)	($3,448,000)	($3,519,300)	($3,592,100)	($3,666,600)	($3,742,400)	($3,820,300)	($3,899,100)	($3,980,100)	**($36,354,700)**
Outpatient Payment Equalization:											**($161,979,500)**
OPD/Physician Payment Equalization-E/M Services	($14,491,700)	($14,774,300)	($15,077,000)	($15,498,900)	($15,918,000)	($16,347,300)	($16,789,000)	($17,242,000)	($17,690,600)	($18,150,700)	
OPD/Physician Payment Equalization-Targeted Services	($30,844,800)	($31,446,700)	($32,091,500)	($32,989,500)	($33,880,500)	($34,795,000)	($35,735,000)	($36,699,800)	($37,654,100)	($38,632,700)	**($344,769,600)**
OPD/ASC Payment Equalization-Targeted Services	($16,746,400)	($17,073,000)	($17,423,400)	($17,911,400)	($18,394,900)	($18,891,200)	($19,401,800)	($19,925,200)	($20,443,100)	($20,975,300)	**($187,185,700)**
Rural Hospital Programs:											**($410,555,100)**
SCH Program Elimination	($39,724,200)	($39,610,300)	($39,699,500)	($40,064,300)	($40,375,200)	($40,669,700)	($40,946,700)	($42,052,200)	($43,145,600)	($44,267,400)	**($16,866,400)**
CAH Payment Cut to 100% of Cost	($1,469,500)	($1,513,900)	($1,560,500)	($1,608,900)	($1,657,000)	($1,706,900)	($1,758,100)	($1,810,700)	($1,863,200)	($1,917,700)	**($416,745,500)**
Elimination of CAH Status	($34,088,700)	($36,418,000)	($38,400,200)	($39,688,000)	($40,967,300)	($42,287,300)	($43,648,400)	($45,351,400)	($47,058,500)	($48,837,700)	
Post-Acute Payment Proposals:											**($171,766,300)**
Post-Acute Marketbasket Reduction	($3,556,000)	($4,019,300)	($7,573,800)	($10,984,100)	($14,536,200)	($18,235,000)	($22,085,800)	($26,083,300)	($29,956,300)	($34,736,500)	**($60,185,400)**
IRF Site-Neutral Adjustment	($5,433,400)	($5,487,500)	($5,600,100)	($5,751,300)	($5,906,700)	($6,065,900)	($6,229,900)	($6,398,100)	($6,570,800)	($6,741,700)	
Medicare DSH Payments:											**($633,021,100)**
Paul Ryan Medicare DSH Proposal	$0	$64,733,400	$28,817,500	($25,777,200)	($108,200,500)	($111,625,100)	($115,142,100)	($118,732,700)	($121,990,300)	($125,104,100)	**($223,790,600)**
Tom Price Medicare DSH Proposal	$0	($7,865,800)	($16,539,100)	($25,777,200)	($26,581,800)	($27,361,500)	($28,138,600)	($29,594,400)	($30,610,200)	($31,322,000)	
Other Proposals:											**($360,134,500)**
Reimbursable Bad Debt reduced to 25%	($11,685,400)	($23,828,100)	($36,600,000)	($37,716,100)	($38,837,600)	($39,993,400)	($41,183,100)	($42,307,300)	($43,420,400)	($44,563,100)	

Proposed Medicare Cuts Analysis - Notes:

This analysis is intended for advocacy purposes only, not intended for budgeting purposes, and indicates how existing Medicare provider payments would be affected by additional cuts that Congress may consider to achieve Medicare payment policy and/or long-term deficit reduction goals. The impacts shown in this analysis include several of the major cuts proposed in recent years. Due to the lack of data, some proposals are not included in this analysis, and each proposal shown in this analysis is described below.

IME/DGME:

- IME Cuts (source: FFY 2017 Presidential Budget): This impact reflects the recommendation to reduce IME reimbursement by 10% for IPPS hospitals.
- IME Payments based on a National Pool (source: Proposal for the "Medicare IME Pool Act of 2015" introduced by Representative Kevin Brady of Texas): This impact reflects the proposal, beginning FFY 2019, to convert 100% of IME payments into a national pool that would be allocated to hospitals annually based on the national distribution of full-time resident positions.
- DGME Cuts (source: Simpson-Bowles Commission): This impact reflects the recommendation to limit teaching hospitals' Direct Graduate Medical Education (DGME) reimbursement to 120% of the national average salary paid to residents in 2010, updated annually thereafter.

Outpatient Payment Equalization:

- OPD/Physician Payment Equalization for E/M Services (source: H.R. 3630): This impact reflects the U.S. House-approved policy from 2011 to cap payment to hospitals for outpatient evaluation and management (E/M) services at the payment level provided to physicians under the Medicare physician fee schedule.
- OPD/Physician Payment Equalization for Targeted Services (source: MedPAC policy option): This impact reflects a MedPAC policy option from 2013 to cap payments to hospitals for certain outpatient services (66 APCs) at the payment level provided to physicians under the Medicare physician fee schedule.
- OPD/ASC Payment Equalization for Targeted Outpatient Services (source: MedPAC policy option): This impact reflects a MedPAC policy option from 2013 to cap payment to hospitals for certain outpatient services (12 APCs) at the payment level provided to Ambulatory Surgical Centers (ASCs) under the ASC payment system.

Rural Programs:

- SCH Program Elimination (source: Congressional Budget Office): This impact reflects the recommendation to eliminate special inpatient payment status for sole community hospitals (SCHs).
- CAH Payment Cuts (source: FFY 2014 Presidential Budget): This impact reflects a reduction in Medicare reasonable cost-based payments to Critical Access Hospitals (CAHs) from 101% to 100% for Inpatient, Outpatient and swing bed services.
- Elimination of CAH Status: This is the impact of including CAHs in the PPS programs for Inpatient, Outpatient and swing bed services, instead of paying at 101% of Medicare reasonable costs.

Post Acute Care Programs:

- Post-Acute Marketbasket Reduction (source: FFY 2017 Presidential Budget): These impacts reflect reductions of 1.1 percent to the marketbasket updates for inpatient rehabilitation facilities, long-term care hospitals, and home health agencies. Skilled nursing facilities would receive a 2.5 percent reduction in 2017, 2.0 percent in 2019, 1.0 percent in each of 2020-2023, and 0.97 beginning in 2024.
- IRF Site-Neutral Adjustment (source: MedPAC policy option): This impact reflects a MedPAC policy option from 2014 to cap inpatient rehabilitation payments for certain conditions to the amount that would have been paid in a skilled nursing facility.

Medicare DSH Payments:

- Paul Ryan Medicare DSH Proposal (source: "A Better Way"): Impacts reflect the estimated change in DSH payments made to hospitals were House Speaker Paul Ryan's proposal for distribution of the national uncompensated care payment (UCP) pool implemented, without a repeal of the ACA. This proposal would drop reductions to the pool for FFYs 2018 and 2019 and distribute based solely on charity care amounts found on Worksheet S-10 of the Medicare cost report. In addition, beginning with FFY 2021, Medicare DSH payments would change to be paid based entirely upon the UCC pool. Amounts incorporate projected changes to the national uninsured rate provided by the Congressional Budget Office (CBO).
- Tom Price Medicare DSH Proposal (source: Proposal for the "Empowering Patients First Act"): Impacts reflect the estimated change in DSH payments made to hospitals were Representative Tom Price's proposal for distribution of the national uncompensated care payment (UCP) pool implemented, without a repeal of the ACA. This proposal would distribute based solely on charity care amounts found on Worksheet S-10 of the Medicare cost report. Amounts incorporate projected changes to the national uninsured rate provided by the Congressional Budget Office (CBO).

Other Cuts Under Consideration:

- Bad Debt Payment Cuts (source: FFY 2017 Presidential Budget): These impacts reflect the recommendation to reduce payments for reimbursable bad debts for all provider settings from 65% to 25%, over 3 years.

The date sources for Medicare payment data are the respective CMS payment rule Impact Files, Medicare Cost Reports (2012, 2013, 2014, and 2015), and/or Medicare Claims data (2013, 2014).

All of the impacts in this analysis reflect Medicare FFS payments. Dollar impacts may differ from those provided by other organizations due to differences in source data and analytic methods. Dollar impacts have been rounded to the nearest hundred dollars; totals may not foot due to rounding; dollar amounts less than $50 will appear as zeros.

Preserve and Expand the 340B Drug Discount Program

The 340B Drug Pricing Program is a small program with big benefits. It accounts for only 2 percent of the $374 billion in annual drug purchases made in the U.S. Given the increasing high cost of pharmaceuticals, the 340B program is essential to creating healthier communities.

The 340B Program comes from a federal law (Section 340B of the Public Health Services Act) that 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. The 340B program regulates the sale of drugs between drug manufacturers and not-for-profit health care providers and, in doing so, saves the state and federal government money because the drug discount is passed on to the State's Medicaid program.

To participate in the 340B 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 patients 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,** which allows them to receive an average savings of 25% to 50% on outpatient pharmaceutical purchases. These savings are not only passed on to the Medicaid program in lower hospital costs, thus saving millions of dollars for taxpayers, but the savings allow hospitals to stretch their resources as far as possible to serve low-income and Medicaid patients. The 340B program requires participating hospitals to meet numerous program integrity requirements. These include annually recertifying their eligibility, participating in audits conducted by HRSA and drug manufacturers and maintaining auditable records and inventories of all 340B and non-340B prescription drugs.

HRSA's proposed omnibus guidance for the 340B program was withdrawn by the Trump Administration on January 30, 2017. This is a positive step as the guidance would have redefined who was considered a patient under the program in a way that jeopardized hospitals' ability to serve vulnerable populations.

However, drug manufacturers want to roll back the 340B program through new restrictions, such as by inappropriately 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 hospital qualifications for the program or on patients that can receive discounted drugs would be particularly problematic in Kentucky. The vast majority 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. Medicaid expansion has resulted in 30% to 40% of hospital patients now being covered by Medicaid on top of another 50% who are covered by Medicare. Restricting use of the 340B program would greatly harm the ability of Kentucky hospitals to serve Medicare and Medicaid patients. In fact, Kentucky hospitals support expanding the 340B program to require discounts for expensive inpatient drugs. This would eliminate the burden of maintaining two separate inventories and pricing structures for inpatient and outpatient drugs, and generate more savings for the state Medicaid program. It would also save taxpayers money, as the Congressional Budget Office has indicated that expanding the program to cover inpatient services would save the federal government upwards of $1.2 billion.

KHA requests the Kentucky congressional delegation to oppose changes to the 340B program, which would limit hospital participation or limit use of discounted drugs for all patients. We also request the delegation to support extending the 340B discounts to the purchase of drugs used during inpatient hospital stays, which would assist hospitals in lowering the cost of care and reducing losses from the Medicare and Medicaid programs.

Support IMD Legislation

The Medicaid Institutions for Mental Disease (IMD) exclusion has been in place since 1965 when the Medicaid statute was enacted. This provision – contained in Section 1905(a) of the Act – states that federal financial participation (FFP) is not available for any medical assistance services provided to an individual between the ages of 21 to 64 who is a patient in an IMD. The law defines an IMD as a hospital with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental disease. Because of this antiquated law, private psychiatric hospitals that have more than 16 inpatient beds are precluded from treating adult Medicaid patients because (1) the federal government will not provide Medicaid matching funds for those services, and (2) an individual patient's eligibility for Medicaid is extinguished while they are inpatients in an IMD. Medicaid will only pay for psychiatric inpatient care for adult Medicaid patients in psychiatric units of acute care hospitals, yet care in a private IMD costs less than in a unit of an acute care hospital due to differences in overhead and other expenses between the two types of hospitals

The IMD is creating a significant barrier to access to behavioral health services in Kentucky, particularly under the Medicaid expansion which has added 400,000 Kentuckians – mainly childless and older adults – to the

- continued next page -

program. These newly eligible people, however, cannot be treated in our state's free-standing psychiatric hospitals because the state cannot receive matching funds due to the IMD exclusion..

In May of 2016, CMS issued a final rule setting forth updated requirements for Medicaid managed care which, beginning in July of 2016, permitted states to pay capitation to MCOs for enrollees age 21-64 who receive inpatient treatment in an IMD for psychiatric or substance use disorder inpatient care and the patient's length of stay in the IMD does not exceed fifteen (15) days in the month. Despite this new regulatory flexibility, the Cabinet for Health and Family Services has not yet implemented this change which is desperately needed to increase access to behavioral health and drug treatment.

Last year, **H.R. 2646**, which codified the new CMS rules permitting IMDs to be paid by Medicaid (through MCOs) to treat adults for up to 15 days per month and provide grant funding for mental health education, passed the U.S. House of Representatives on July 6, 2016, with a vote of 422-2, and with support from **Congressmen Yarmuth, Rogers, Guthrie and Barr. KHA urges the passage of legislation to end the outdated IMD exclusion, which is needed to expand access to addiction treatment and behavioral health care in Kentucky.**

Small and Rural Issues

Permanently Extend the Medicare-Dependent Hospital (MDH) and Low-Volume Adjustment (LVH) Programs

The Medicare-Dependent Hospital (MDH) and Low-Volume Hospital (LVH) programs impacting 28 Kentucky small and rural hospitals were extended by the Medicare Access and CHIP Reauthorization Act of 2015 until September 30, 2017. These are extremely important programs and they are critical to preserving access to hospital services in many rural Kentucky communities.

- Medicare inpatient hospital payment adjustment for LVHs - Qualifying LVHs receive add-on payments based on the number of Medicare discharges. Twenty-eight (28) Kentucky hospitals qualify for this adjustment and receive $9.3 million annually in LVH funding.
- MDH program - The MDH program provides enhanced reimbursement to support rural health infrastructure and small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. This greater dependence on Medicare may make these hospitals more financially vulnerable to prospective payment, and the MDH designation is designed to reduce this risk. Nine Kentucky hospitals have MDH status and receive $5 million annually in MDH funding.

H.R. 1955 and S.872, the Rural Hospital Access Act, seeks to make these programs permanent. KHA strongly supports this legislation and we urge each member of the Kentucky Congressional delegation to co-sign these bills and work for their passage. KHA thanks Congressmen Rogers and Barr who have already co-sponsored H.R. 1955.

Physician Supervision

Direct Supervision of Outpatient Therapeutic Services

In the calendar year (CY) 2009-2013 outpatient Prospective Payment System (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 the procedure. 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. This policy has the effect of reducing 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 supports the Rural Hospital Regulatory Relief Act of 2017, H.R. 741, sponsored by Representative Lynne Jenkins (R-KS) and S. 243, sponsored by Senator John Thune (R-SD). The legislation would adopt a default standard of "general supervision" for outpatient therapeutic services, develop a reasonable exceptions process with provider input for risky and complex outpatient services that require a higher, direct level of supervision, create a special rule for critical access hospitals to recognize their unique size and Medicare conditions of participation and prohibit CMS retroactive application of its flawed policy.

KHA requests the Kentucky delegation to co-sponsor H.R. 741 and S. 243 and work for the passage of these bills.

Small and Rural Issues

Physician Supervision of Cardiac and Pulmonary Rehabilitation Programs

Cardiac rehabilitation (CR) and pulmonary rehabilitation (PR) are medically directed and supervised programs designed to improve a patient's physical, psychological and social functioning. Both programs utilize supervised exercise, risk factor modification, education, counseling, behavioral modification, psychosocial assessment and outcomes assessment. In 2008, the Medicare Improvements for Patients and Providers Act (MIPPA) established Medicare coverage for both cardiac and pulmonary rehabilitation as long as a physician ensures that the programs are safe, comprehensive, cost effective and medically appropriate for individual patients. Since 2008, CMS has required that a physician be immediately available for each rehabilitation session.

The current law imposes a more stringent requirement for direct physician supervision for cardiac and pulmonary rehabilitation services than should be required, making it very difficult for these programs to operate in areas where physicians are scarce. The policy imposes unnecessary costs and resource burdens in both rural and urban areas.

KHA supports legislation which would amend the Social Security act to allow physician assistants, nurse practitioners and clinical nurse specialists to supervise cardiac and pulmonary rehabilitation programs.

Preserve Critical Access Hospitals (CAHs)

While CAHs receive cost-based reimbursement in order to promote financial viability, this special payment is in no way the "silver bullet" to ensure these safety net hospitals continue to keep their doors open. CAHs have been hard hit in recent years and many of Kentucky's 29 CAHs are unsure about their future.

Kentucky hospitals ask Congress to support the following provisions to ensure CAH viability and flexibility:

- Maintain the CAH program as it is and reject any proposals to limit the designation or decertify safety net CAHs based on mileage from other hospitals. Many Kentucky CAHs were designated as "Necessary Providers of Care" because Kentucky's Governor identified these facilities as essential to providing access to basic health care needs for rural Kentuckians.
- Shield Kentucky CAHs from future Medicare cuts. Kentucky CAHs receive 101 percent of cost reim- bursement and run on a very thin margin. In fact, 45 percent of Kentucky CAHs lose money on operations with an overall profit margin for CAHs of 1.91 percent. Cuts in Medicare payment have a devastating impact on Kentucky's CAHs as they also receive the Medicare rate for Medicaid patients.

Post Acute Issues

Flexibility Needed Under Bundled Payments

CMS has implemented bundled payment for hip and knee replacement and has planned but delayed additional bundles for cardiac care until October of 2017. Under bundled payment, hospitals share risk for the cost of all services a patient receives for ninety (90) days post discharge. Under CMS rules, all health care services provided during this ninety day period are paid according to Medicare fee-for-service rates. This methodology puts certain post acute providers at a competitive disadvantage. Specifically, rehabilitation hospitals and long term acute hospitals are paid an all-inclusive DRG rate while skilled nursing facilities, which also offer certain rehab services, are paid on a per diem rate. This arrangement causes the cost for rehabilitation hospitals and long term acute hospitals to be higher because those post acute providers are unable to negotiate a different payment mechanism, such as a per diem, to better compete with other post acute providers.

The Kentucky delegation is urged to work with CMS to provide more flexibility in the bundled payment program to allow post acute providers the opportunity to be paid on an alternative basis so there can be more competition for post acute services.

For more information about Key Issues Affecting Kentucky Hospitals, contact:

Kentucky Hospital Association

2501 Nelson Miller Parkway
Louisville, Kentucky 40223
502-426-6220 • Fax 502-426-6226 • www.kyha.com