

**SPECIAL REPORT ON THE
FINANCIAL STRENGTH OF
KENTUCKY'S RURAL HOSPITALS**



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ADAM H. EDELEN
AUDITOR OF PUBLIC ACCOUNTS

March 30, 2015

Audrey Haynes, Secretary
Lisa Lee, Medicaid Commissioner
Cabinet for Health and Family Services
275 East Main Street
Frankfort, KY 40621

RE: Special Report on the Financial Strength of Kentucky's Rural Hospitals

We have completed our Special Report on the Financial Strength of Kentucky's Rural Hospitals. This report provides an overview of the economic challenges facing rural hospitals in the Commonwealth of Kentucky. This analysis is part of an ongoing effort by the Auditor of Public Accounts (APA) to focus attention on health care issues that began with Kentucky's transition to Medicaid managed care, and is intended to address concerns received by this office related to the future economic viability of rural hospitals in the Commonwealth. The results of this analysis are intended to provide policymakers with important information that may be used to effect changes in local, state and federal laws, regulations, and policies that impact the financial well-being of Kentucky's rural hospitals.

Our procedures included:

- identifying the population of Kentucky's rural hospitals;
- obtaining financial information from each of the designated rural hospitals;
- examining and analyzing data relating to critical economic indicators;
- surveying each rural hospital on additional economic and operational factors impacting their fiscal health;
- holding public meetings across rural Kentucky to discuss the financial health and community impact of rural hospitals;
- meeting with representatives from all five Managed Care Organizations (MCOs) currently operating in Kentucky; and
- identifying other economic concerns that could potentially impact future accessibility of health care and delivery of services in rural Kentucky.

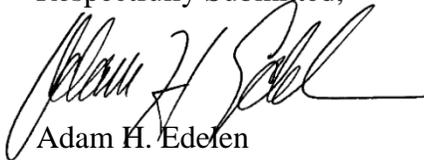


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The results of this study are also meant to assist in understanding the challenges that face small, rural hospitals, which provide health care to 45 percent of Kentuckians and are key economic drivers in their communities. Thus, this study provides information and analysis that identifies risk factors impacting rural health care in the Commonwealth, and thereby highlighting opportunities for improvement evidenced by the recommendations made in this report.

If you wish to discuss this report further, please contact me or Assistant State Auditor Libby Carlin.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "Adam H. Edelen", written in a cursive style.

Adam H. Edelen
Auditor of Public Accounts



SPECIAL REPORT ON THE FINANCIAL STRENGTH OF KENTUCKY'S RURAL HOSPITALS

Report Objectives

The focus of this report is to assess the financial health of rural hospitals in Kentucky, identify factors contributing to the fiscal instability of the hospitals and to offer recommendations to ensure continued access to health care for more than 45 percent of Kentuckians.

Background

The analysis consisted of five main components:

- using a proprietary formula to assess the financial strength of rural hospitals;
- conducting a survey of rural hospitals to improve the understanding of factors impacting their fiscal health;
- conducting 11 public meetings across the Commonwealth to discuss the fiscal health and economic impact of rural hospitals;
- meeting with representatives of the five Managed Care Organizations (MCOs) currently operating in Kentucky;
- analyzing ad hoc demographic reports from the Cabinet for Health and Family Services (CHFS) and an April 11, 2014 report from Deloitte, LLC about managed care in Kentucky.

Observations and Recommendations

Observation 1: 68 percent of Kentucky's rural hospitals scored below the national FSI[®] average and 34 percent of Kentucky's rural hospitals scored sufficiently low as to be considered in poor financial health.

Recommendations:

- CHFS should begin using a financial assessment tool to regularly monitor the financial strength of rural hospitals.
- The Governor should convene a work group to examine, among other objectives, new models

for rural health care delivery to ensure quality of care and continued access in this altered healthcare landscape.

- The work group should evaluate whether Kentucky's current regulatory structure gives hospitals the flexibility to retool their business models for 21st century health care delivery.

Observation 2: Critical Access Hospitals (CAH) scored better overall than acute care hospitals in the FSI[®] assessment, with 34 percent in excellent or good health, compared to 23 percent for acute care hospitals.

Recommendations: CHFS should closely monitor CAHs that are in poor financial health. As discussed in Observation 1, the proposed work group should examine the regulatory structure over acute care hospitals to determine whether those providers have the flexibility to adjust their business models. Additionally, the work group should examine whether other medical services, such as emergency transportation services, may benefit from being transitioned from government or acute care affiliations to CAH affiliations to capitalize on more favorable reimbursement rates.

Observation 3: Hospitals responding to APA's survey indicate on average 72 percent of patients received Medicare or Medicaid benefits, meaning a significant number of low-income and elderly patients are affected if rural hospitals close.

Recommendations: The SIM project and/or proposed work group should evaluate the effects recent changes in the Medicare program are having on rural hospitals and provide recommendations to ease the transition from fee-for-service to the new fee-for-value system. Also, the work group may research transportation needs as a way to expand accessibility options and

provide a safety net for vulnerable citizens in the event of additional hospital closures.

Observation 4: Hospitals with low FSI[®] scores do not have capital reserves sufficient to withstand additional fiscal stress.

Recommendations: The proposed work group should seek to understand the reasons for cash flow problems of rural hospitals to help determine whether the hospital is experiencing a short-term cash flow problem or operational difficulties. The work group should also study the need and feasibility of an emergency capital pool for use in providing short-term loans, transition incentives, financing for equipment and technology advances, and other needs.

Observation 5: Administrative burdens on hospitals have increased since the implementation of Medicaid managed care.

Recommendations:

CHFS should:

- work to improve relations with providers, particularly small, rural hospitals;
- establish a uniform credentialing/re-credentialing process for MCOs;
- report, or require providers to report, any changes in provider certification status to MCOs in a reasonable timeframe; and
- require MCOs to publish preauthorization criteria and formulary schedules within a certain timeframe.

Observation 6: Hospitals indicate MCO policies regarding Emergency Room (ER) visits are causing a significant financial burden.

Recommendations: CHFS should establish contractual restrictions on triage fee caps to avoid overuse of the caps. CHFS should consider contractual provisions specifically permitting the use of triage fees in instances when providers refuse to participate in certain cost savings, utilization management and wellness programs. CHFS should incorporate policies in its MCO contracts that will further enhance its ER SMART initiative.

Observation 7: Weaknesses in the contracts between CHFS and MCOs appear to be hindering improvements from being made to the managed care system in the Commonwealth, and are likely contributing factors to the declining fiscal health of many providers.

Recommendations:

We recommend:

- MCO contractual penalties be strengthened, such as listing specific penalties and establishing criteria for applying penalties;
- CHFS require MCOs to report provider grievances/appeals monthly so it can determine that conflicts are resolved appropriately and timely;
- CHFS update MCO contractual language to strengthen behavioral health integration and wellness program requirements; and
- CHFS consider expanding quality reporting, utilizing QAPI and HEDIS elements.

Observation 8: The number of providers across the Commonwealth - particularly in rural Kentucky - dropped significantly between 2013 and 2014, raising concerns about accessibility at a time when more people are getting insurance.

Recommendations: CHFS should provide the proposed work group periodic updates on the changes in the number of providers across all Medicaid regions. The work group should evaluate regulations to determine if certain advances, such as telemedicine, can be further utilized to boost access to care in remote areas of the Commonwealth that have inadequate primary care or specialty providers. CHFS should continue working to ensure the number of providers in certain areas of the state does not decline further. The work group could assist in studying policies to improve provider adequacy concerns, and should examine other issues related to rural health care access, such as emergency and non-emergency transportation and the role health departments can play in this altered health care landscape.

In nearly every state in America, the sustainability of rural hospitals is a major policy concern. News of hospital closures, underserved populations and the disintegration of rural healthcare networks has become an all-too-common theme across the nation.

Such incidences underscore the importance of rural hospitals to the communities they serve. In Kentucky, rural hospitals provide care to 45 percent of our population. Not only do these hospitals serve as the foundation on which ambulatory service and smaller provider groups operate, they tend to be among the largest employers in their community, paying a significantly higher wage than the local average. Their importance to local communities cannot be overstated.

For the better part of a year, my office has undertaken an effort to assess the financial strength of our rural hospital network in Kentucky to fully understand the challenges these hospitals face in an era of unprecedented transformation. Our efforts have taken us across Kentucky, involving more than 1,500 stakeholders, policymakers and providers.

The hope is to establish a baseline for critical analysis beyond the vagaries of rhetoric to provide policymakers and leaders with a sense of the actual financial condition of each of the 66 rural hospitals in the Commonwealth. Treating rural hospitals as merely a part of the larger health care system - refusing to drill down - robs stakeholders of the information they need to successfully guide the transformation required of these hospitals in such a dynamic environment.

Understanding at a granular level the condition of rural hospitals is vital given the environment. In less than four years, Kentucky's rural hospitals have faced a difficult transition to a managed care system, dealt with costly technological advances and new electronic health records requirements, Medicaid expansion, Medicare payment changes and the introduction of the Affordable Care Act. Not to be forgotten, this period of historic transformation has occurred against the backdrop of significant economic difficulty felt most acutely in rural areas.

At the center of our efforts is the Financial Strength Index[®], a nationally recognized tool that evaluates a hospital's financial health through four key metrics: profit margin, days of cash on hand, debt financing and depreciation expense. The result, which can be found in the following pages, is a ranking of each rural Kentucky hospital. This ranking is based on a three-year average of audited data, ending with fiscal year 2013 numbers, which represent the most recent available year of audited financial statements. Importantly, these financials encompass the first full year of managed care in Kentucky.

While it is clear that there has been a large infusion of new dollars to hospitals as a result of the administration's decision to expand Medicaid,

what is not yet clear is the net effect to the bottom line. Failing to consider the impact of the cost of service to the increased population, as outlined in the administration's own Deloitte study, is tantamount to ignoring one side of the ledger for the benefit of the other. The fact is that a clear picture of the actual net impact won't be known until audited 2014 financials are available later this year. Even then, rural hospitals have additional challenges to face in the coming years when the additional infusion of new dollars will be offset by the loss of Disproportionate Share Hospital payments. It is, however, important to fully understand the point from which we started.

Our work provides just such a baseline.

The index reveals that 68 percent of our rural hospitals ranked below the national average in financial strength, with the bottom one-third scoring low enough to be considered in poor health. The hospitals in the most precarious position serve 250,000 patients, with the overwhelming majority on either Medicare or Medicaid.

Additionally, changes in federal programs can have a critical impact on Kentucky's rural hospitals, with an average of 72 percent of their patients receiving Medicare or Medicaid benefits. These hospitals do not have the capital reserves to weather financial changes of this significance.

Let me be clear, our work is not a rebuke of managed care, Medicaid expansion, or the Affordable Care Act. Certainly, Kentucky cannot afford the former fee-for-service model, which was creating an unsustainable drain on the treasury. The implementation of the ACA and the resulting coverage of 400,000 Kentuckians is historic, laudable and in the long-term best interest of improving conditions in a chronically unhealthy state.

What our work demonstrates is that our rural hospitals have no choice but to change their business models to adapt to this environment. That task — and the implications for our rural populations — is too enormous for local, state and the federal government to expect these rural providers to manage successfully alone.

There are heartening examples of rural hospitals adopting innovation as the best approach for survival. From the efforts of Rockcastle Regional to become a niche provider of ventilator dependent care for those struck by a variety of illnesses to the coalition formed by St. Clair and Highlands Regional to provide administrative efficiencies and adapt to changes under the ACA, innovations are occurring. Many small hospitals have formed relationships with larger networks, consolidating back-of-house operations in an effort to relieve the increased administrative burden associated with managed care.

The Cabinet for Health and Family Services has an opportunity to provide steadier leadership in the coming months and years through increased monitoring, strategic planning, exercising authority over contractors and improving relationships and communication with health providers.

Adopting an analytical tool to monitor the condition of individual rural hospitals is the very foundation of management and accountability. The Cabinet should never be caught unaware of an impending hospital closure. Awareness of difficulty provides opportunities for driving innovation.

To the credit of the Beshear Administration, the state has received a \$2 million federal grant to test innovative payment and service delivery models. As part of this project the Governor's workgroup should examine, among other objectives, new models for health care delivery to ensure quality of care and continued access in this altered healthcare landscape.

The workgroup of stakeholders, policymakers and providers should closely examine the results of enhanced monitoring and evaluate solutions such as mergers, affiliations, management agreements, ACOs and other opportunities for innovation among those hospitals in the most precarious financial position.

The Cabinet has an immediate opportunity to smooth the rougher edges of managed care in the current renegotiation of the contracts with the Managed Care Organizations (MCOs). When the leadership of currently operating MCOs describe the existing contract under which they operate as "soft" and "loose", it is abundantly clear that the Cabinet needs to exercise stronger leadership to ensure a clearer, fairer and simpler system for providers to operate under.

Of particular importance is the need for uniform credentialing to alleviate the administrative burden placed upon rural hospitals dealing with the differing administrative approaches of five different MCOs and enhanced tracking of on-going disputes among the individual MCOs and the provider community. Plainly, there is a demonstrated need for the Cabinet to strengthen its hand in assessing penalties on MCOs that fail to meet both the letter and the spirit of the contracts under which they operate.

As has been said before, the challenge of rural hospital sustainability is a national problem. Through monitoring performance at the granular level and by driving transformation and innovation, we have the opportunity to offer a Kentucky solution to this national problem.

The survival of our rural communities depends upon it.

The focus of this report is to assess the financial health of rural hospitals in Kentucky, identify factors contributing to the fiscal instability of the hospitals and to offer recommendations to ensure continued access to health care for more than 45 percent of Kentuckians. The healthcare industry is comprised of numerous providers across the state, all impacting health care delivery to citizens of the Commonwealth. The focus on rural hospitals is primarily due to their significance related to health care accessibility in areas of the state that may not have readily available alternatives in the event of a hospital closure. Also, many rural hospitals are publicly owned, and financial failure could leave taxpayers in a position of paying for debt accumulated by facilities no longer providing services to the community. Finally, the financial failure of rural hospitals could also have significant impact on the economy of a community in that rural hospitals are primary employers in many of the rural communities they serve.

The analysis consisted of five main components:

- using a proprietary formula to assess the financial strength of rural hospitals;
- conducting a survey of rural hospitals to improve the understanding of factors impacting their fiscal health;
- conducting 11 public meetings across the Commonwealth to discuss the fiscal health and economic impact of rural hospitals;
- meeting with representatives of the five Managed Care Organizations (MCOs) currently operating in Kentucky;
- analyzing ad hoc demographic reports from the Cabinet for Health and Family Services (CHFS) Department of Medicaid Services (DMS) and an April 11, 2014 report from Deloitte, LLC about managed care in Kentucky.

In total, 66 rural hospitals were identified in Kentucky, which are presented in the map in **Exhibit 1** below. Hospitals responding to the APA's request for financial information used to assess financial strength and to the survey are identified in *Appendix I - Responding Hospitals*.

**APA Financial Strength
Index[®] Assessment**

Auditors used data from the 2011, 2012 and 2013 financial statements of 44 of 58 participating rural hospitals or hospital systems for the financial assessment, which are identified in *Appendix I*.

As identified in *Appendix I*, 66 rural hospitals were identified in Kentucky. However, two hospital systems, Appalachian Regional Hospitals (ARH) and Ephraim McDowell, consolidate financial reporting and therefore each system is presented as one entity for the purposes of assessing financial strength. ARH is comprised of eight hospitals and Ephraim McDowell is comprised of two hospitals, and therefore when the consolidation is factored in the total number of individual hospitals or hospital systems subject to financial assessment is 58. As noted above, 44

of these 58 hospitals or hospital systems presented sufficient financial information for the financial strength assessment. The APA used a proprietary method called the Financial Strength Index[®] (FSI[®]) to calculate scores used to measure the financial health of hospitals. A detailed description of this methodology is presented in *Appendix II - The Financial Strength Index[®] Methodology*. This methodology uses four ratios to compare a hospital's financial standing to a national benchmark. The four ratios used in this benchmark include:

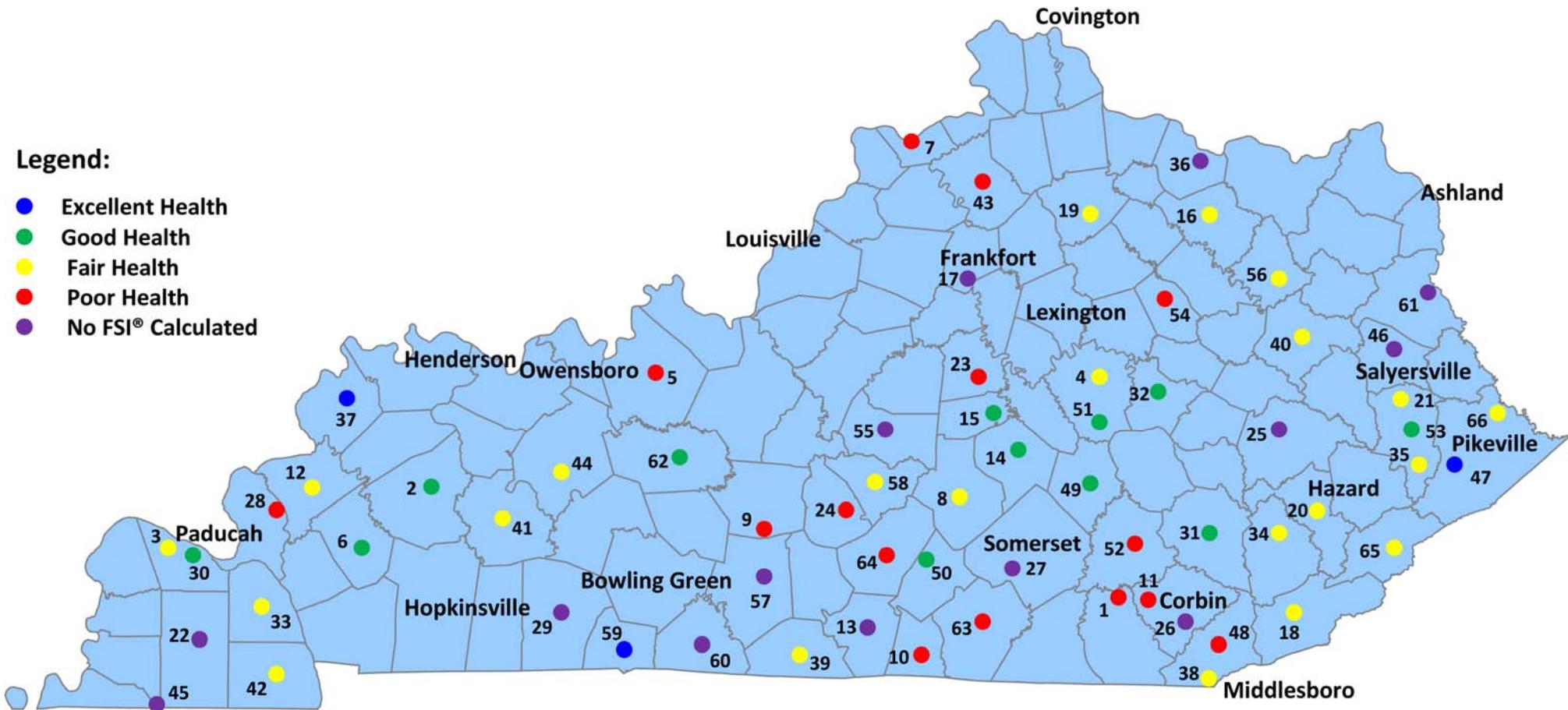
- total margin, which is a ratio to assess the percentage of revenue retained as profit;
- days of cash on hand, which is an indicator of a hospital's ability to pay its short-term debt;
- debt financing, which assesses the amount of assets to debt; and
- depreciation expense, which is a rough assessment of the age of the hospital's facilities.

The FSI[®] assessment did not include FY 2014 because audited financial statements were not yet available at the time of this assessment. Due to the Commonwealth's decision to expand Medicaid in accordance with the provisions of the Affordable Care Act (ACA), it is important to acknowledge that rural hospitals and other providers likely received an increase in Medicaid payments during the fiscal year, which could have impacted the FSI[®] scores, at least temporarily until additional cuts in government-funded payments occur as discussed further below. However, it is also important to note that providers' costs also have increased as the newly-covered Medicaid patients seek first-time or previously-deferred health services. In addition, as a result of Medicaid managed care, administrative costs have increased for many providers.

The time period analyzed provides critical information to policymakers and other stakeholders regarding the fiscal conditions of rural hospitals during a period of significant regulatory and industry change. This information is intended to be used going forward to monitor hospitals' financial health, which is an important indicator of health care access in rural areas, and to help guide decision-makers as they begin rethinking models for delivering care in a healthcare landscape that continues to undergo changes, such as the anticipated loss of Disproportionate Share Hospital (DSH) payments and continuing cuts in Medicare fee-for-service payments.

Kentucky's rural hospitals are identified by numbers in the map in **Exhibit 1** that correspond to identifying numbers in *Appendix I*. In the exhibit, all hospitals have color-coded location markers that identify their FSI[®] assessment, with the exception of the 14 rural hospitals identified by white location markers. Those hospitals either did not provide sufficient information for the FSI[®] calculation or had financial reporting methodologies that did not present all data elements necessary for the calculations.

Exhibit 1 - Location and Financial Strength of Kentucky Rural Hospitals



Source: See Appendix 1 for the list of rural hospitals corresponding to the index numbers above. Refer to Exhibit 2 for FSI® classifications.

APA Surveys of Kentucky Rural Hospitals

The APA surveyed all rural hospital administrators to gather additional data for analysis and to help improve the understanding of factors affecting the fiscal health of these hospitals. The survey questions and a summary of the responses are presented in *Appendix III - Survey Questions and Responses*.

Twenty-three complete survey responses and one partial response were received from hospital administrators, as identified in *Appendix I*. Though responses were received from 24 of the 66 rural hospitals surveyed, respondents were representative of the population of rural hospitals. Responses were received from hospitals from various geographic areas in the state, both CAH and acute care hospitals, public and privately-owned hospitals, and hospitals with varying FSI[®] scores.

Auditor Edelen's Meetings with the Public and MCO Representatives

State Auditor Adam Edelen hosted public meetings in 11 cities, including Prestonsburg, Hazard, Pineville, Morehead, Maysville, Columbia, Campbellsville, Leitchfield, Madisonville, Princeton and Bowling Green. Approximately 1,500 people attended the meetings, including hospital representatives, health professionals, patients, local elected officials, legislators and concerned citizens. In addition, the APA met with representatives from all five MCOs currently operating in Kentucky. Some of the information gathered during these meetings provided the APA additional context related to data analyzed in this report or that was previously widely reported in the community. The opinions and anecdotal examples expressed during the meetings provided valuable insight into the significance of these concerns in the various local communities. Many times, similar examples of problems were repeated at different community meetings held across the state, indicating certain concerns were common and not isolated incidents. In addition to community input, MCOs provided valuable insight regarding specific issues that may be an underlying source of these concerns, obstacles or requirements that affect an MCO's ability to resolve certain issues, and opportunities for improvement.

Analyzing Additional Information Contained in Reports from CHFS and Deloitte, LLC

Concerns continue to be voiced related to Medicaid network adequacy within the Commonwealth. This matter was examined in the APA's first report on Medicaid managed care issued July 31, 2013. This report follows up on this issue to underscore the importance of having an adequate Medicaid network to serve Kentucky's citizens, especially when significant economic stress factors are identified among provider hospitals.

Also, with the passage of the ACA, more individuals are eligible for Medicaid, making it essential to determine whether the Medicaid provider network is adequate to service all Medicaid participants. According to the CHFS' Department for Medicaid Services (DMS), Medicaid expansion under the ACA would increase the number of eligible individuals in Kentucky by 308,000. However, CHFS reported in February 2015 that approximately 375,000 individuals had already enrolled in Medicaid

under the expansion in calendar year 2014.

To assess the adequacy of the state provider network, auditors utilized data from two sources. The APA requested ad hoc reports from DMS that provided a snapshot of the number of providers in each provider type category as of November 1, 2011, February 28, 2013, and June 1, 2014. Managed care implementation began in November 2011, and therefore information from the dates above illustrates changes in the number and location of providers within each provider type category from the beginning of the implementation period to specific dates in subsequent years.

Auditors also obtained and reviewed a detailed report on managed care in Kentucky dated April 11, 2014, performed by Deloitte, LLC for fiscal year 2013. This report was reviewed to gather baseline network adequacy data from the first two years under managed care. The information from the report was then compared to data obtained during APA's analysis to identify potential risks to the network caused by decreases in the number of providers.

Observation 1: 68 percent of Kentucky's rural hospitals scored below the national FSI® average and 34 percent of Kentucky's rural hospitals scored sufficiently low as to be considered in poor financial health.

The FSI® scores for each individual fiscal year, as well as a three-year mean, were calculated for each of the 44 participating rural hospitals or hospital systems. All of the data necessary for calculation of the FSI® were readily available on the hospitals' audited financial statements of net position and balance sheets.

Exhibit 2 below presents the FSI® results for each participating hospital ranked from highest three-year average to lowest. In this assessment, the national average is identified by an index of zero. As can be seen from the exhibit, 30 of the 44 participating hospitals, or 68 percent, scored below the national average on financial strength. **Exhibit 3** below also presents the three-year mean in graphical form.

Exhibit 2 - Kentucky Rural Hospitals FSI®

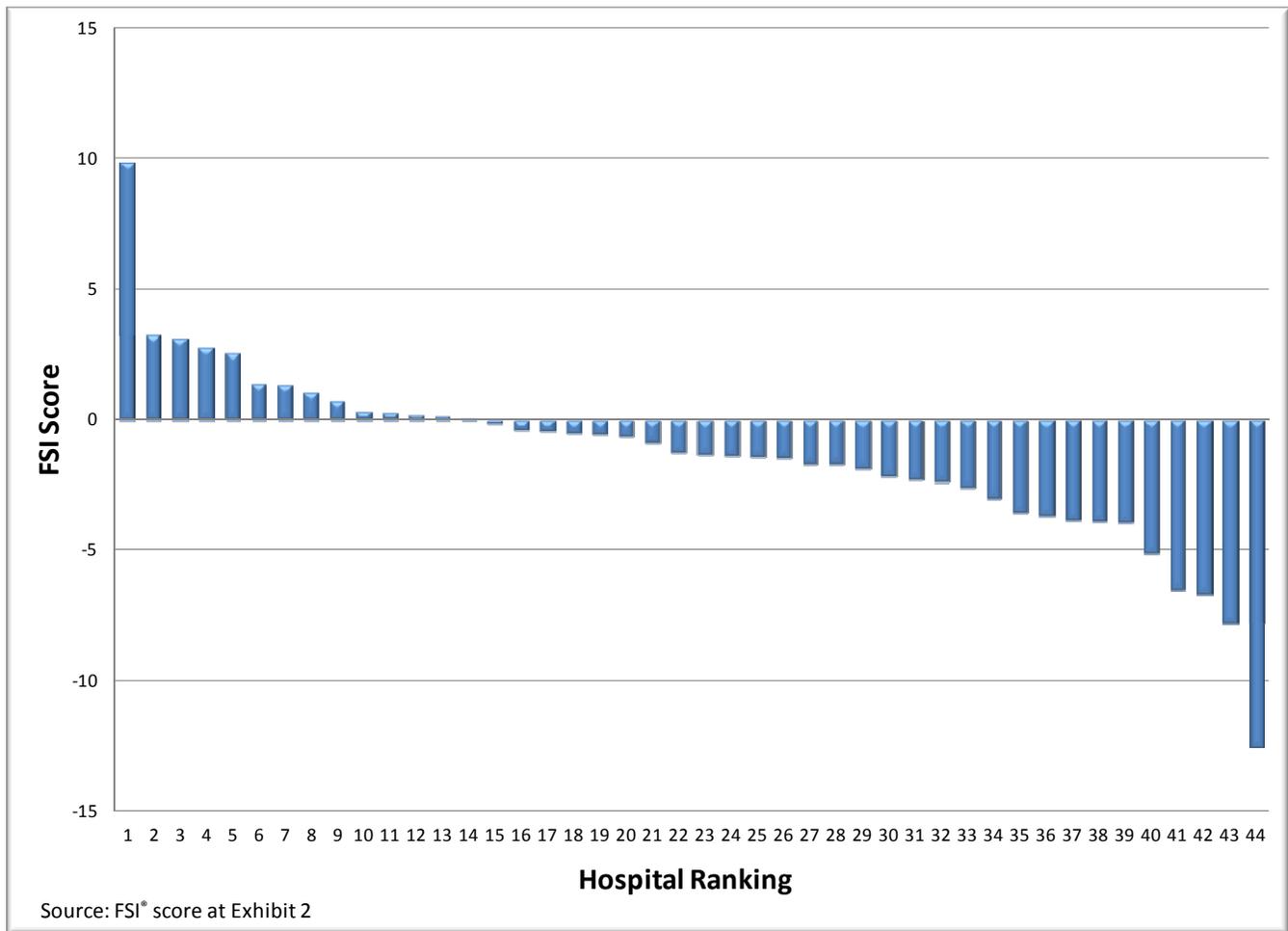
Rank	HOSPITAL	Location - Appendix I	Hospital Type	2011	2012	2013	Mean	Financial Health Classification
1	Methodist Hospital Union County	37	CAH	11.04	7.11	11.38	9.85	Excellent
2	The Medical Center Franklin	59	CAH	3.22	3.52	3.02	3.26	Excellent
3	Pikeville Medical Center	47	Acute	3.91	2.86	2.57	3.11	Excellent
4	Baptist Health Madisonville	2	Acute	-0.59	-1.41	10.35	2.78	Good
5	Ephraim McDowell	14, 15	Acute	2.14	2.96	2.57	2.56	Good
6	Twin Lakes Regional Medical Center	62	Acute	0.58	2.61	0.97	1.39	Good
7	Saint Joseph Martin	53	CAH	*	-0.66	3.32	1.33	Good
8	Manchester Memorial Hospital	31	Acute	1.27	1.25	0.63	1.05	Good
9	Marcum & Wallace Memorial Hospital	32	CAH	*	-0.25	1.73	0.74	Good
10	Lourdes Hospital	30	Acute	*	-0.36	0.94	0.29	Good
11	Saint Joseph Berea	51	CAH	*	1.96	-1.42	0.27	Good
12	Rockcastle Regional Hospital	49	Acute	0.25	0.2	0.11	0.18	Good
13	Russell County Hospital	50	CAH	1.16	-0.18	-0.61	0.12	Good
14	Caldwell Medical Center	6	CAH	-0.02	-0.61	0.8	0.05	Good
N/A	National Average						0	
15	Taylor Regional Hospital	58	Acute	0.16	-0.18	-0.42	-0.15	Fair
16	Murray-Calloway County Hospital	42	Acute	-0.16	-0.6	-0.45	-0.4	Fair
17	Monroe County Medical Center	39	Acute	0.39	0.06	-1.76	-0.43	Fair
18	Marshall County Hospital	33	CAH	-2.85	-1.58	2.81	-0.54	Fair
19	Harrison Memorial Hospital	19	Acute	0.62	0.45	-2.71	-0.55	Fair
20	Baptist Health Paducah	3	Acute	-0.64	-0.14	-1.15	-0.65	Fair
21	Fleming County Hospital	16	Acute	-1.32	0.82	-2.14	-0.88	Fair
22	Muhlenberg Community Hospital	41	Acute	-0.18	-1.3	-2.31	-1.26	Fair
23	Casey County Hospital	8	CAH	-1.14	-1.42	-1.49	-1.35	Fair
24	Crittenden Health System	12	Acute	-1.19	-0.01	-3.01	-1.4	Fair
25	St. Claire Regional Medical Center	56	Acute	-1.25	-2.45	-0.65	-1.45	Fair
26	Highlands Regional Medical Center	21	Acute	-0.73	-1.75	-0.191	-1.46	Fair
27	ARH	Multi	Multiple	-1.76	-1.62	-1.7	-1.69	Fair
28	Ohio County Hospital	44	CAH	-1.9	-1.86	-0.134	-1.7	Fair
29	Baptist Health Richmond	4	Acute	-2.62	-2.58	-0.43	-1.88	Fair
30	Saint Joseph London	52	Acute	*	-1.54	-2.83	-2.18	Poor
31	Breckinridge Memorial Hospital	5	CAH	-1.76	-1.01	-4.06	-2.28	Poor
32	Livingston Hospital	28	CAH	-1.04	-3.03	-3.13	-2.4	Poor
33	Caverna Memorial Hospital	9	CAH	-3.14	-1.87	-2.79	-2.6	Poor
34	Wayne County Hospital	63	CAH	-1.96	-3.57	-3.61	-3.05	Poor
35	Carroll County Memorial Hospital	7	CAH	-4.02	-2.99	-3.73	-3.58	Poor
36	New Horizons	43	CAH	-3.13	-3.02	-4.86	-3.67	Poor
37	Baptist Health Corbin	1	Acute	-4.8	-2.02	-4.78	-3.87	Poor
38	Pineville Community Hospital	48	Acute	-2.48	-2.96	-6.31	-3.91	Poor
39	James B Haggin Memorial Hospital	23	CAH	-2.13	-4.84	-4.93	-3.96	Poor
40	Clinton County Hospital	10	Acute	-4.1	-5.79	-5.4	-5.1	Poor
41	ContinueCARE Hospital	11	LTACH	-5.13	-7.53	-6.9	-6.52	Poor
42	Jane Todd Crawford Hospital	24	CAH	-2.5	-2.75	-14.77	-6.67	Poor
43	Saint Joseph Mount Sterling	54	Acute	*	-9.03	-6.56	-7.8	Poor
44	Westlake Regional Hospital	64	Acute	-10.39	-12.84	-14.38	-12.54	Poor

Legend:

* 2011 Financial Statements not available

Source: FSI® calculated utilizing audited financial information obtained from participating providers. Source of hospital type is KHA.

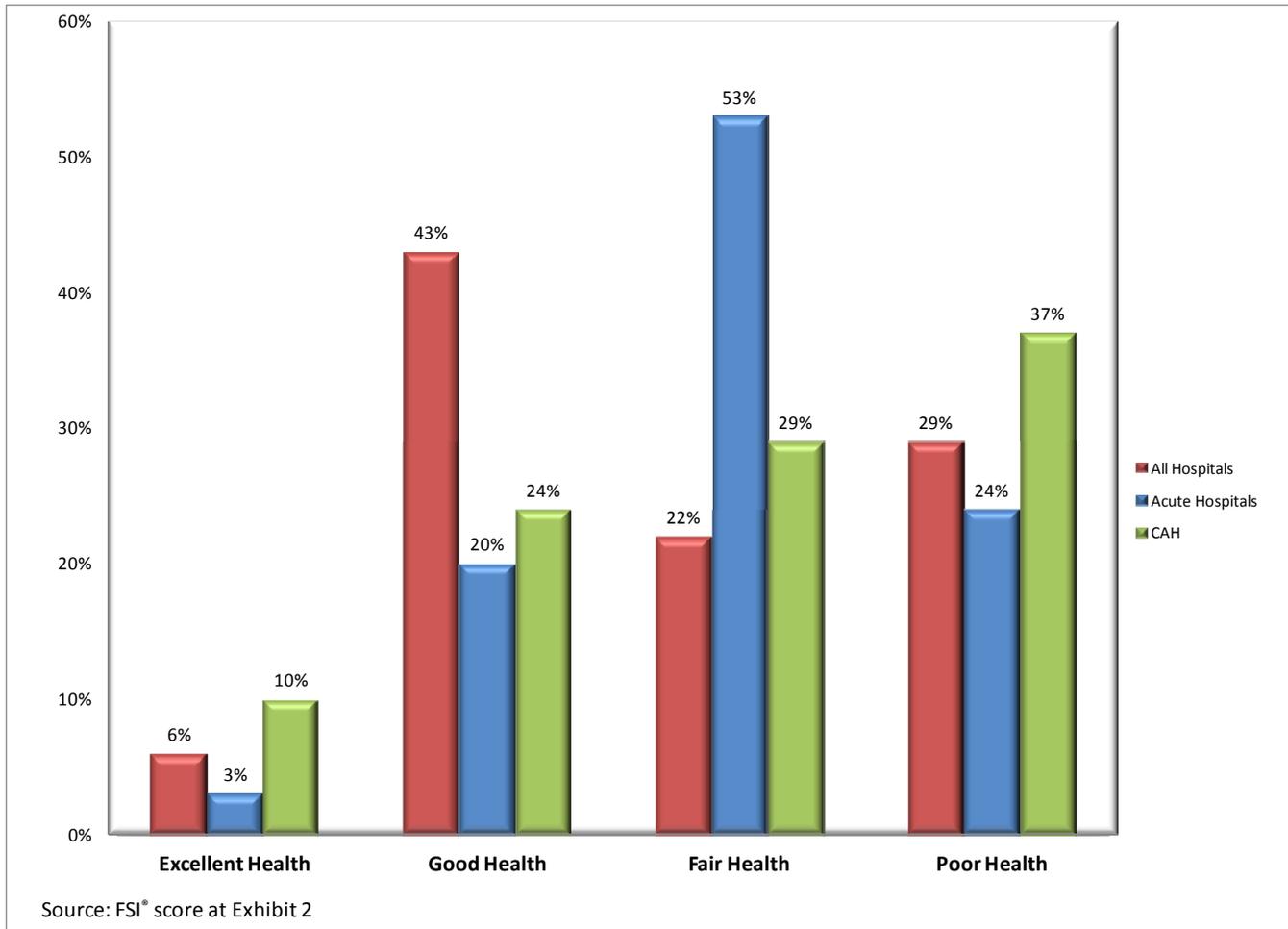
Exhibit 3 - FSI® Ratio Calculations 3-Year Mean



The hospitals that scored below the national average had a total combined 837,806 inpatient, outpatient, and emergency department patients during FY 2013. Approximately 58 percent of these hospitals’ patients were on Medicaid or Medicare, or both. These figures demonstrate the importance of understanding the financial stability of these hospitals, which serve a disproportionate share of Kentucky’s low-income and elderly population.

Another component of the FSI® is the categorization of index scores into four assessment classifications - excellent health, good health, fair health, and poor health. The description of these categorizations is included in *Appendix II*. Of the rural Kentucky hospitals assessed, only seven percent had a sufficient score on the FSI® to be ranked in the excellent health classification, which is defined as having an FSI® greater than three. In contrast, 34 percent of the hospitals had FSI® scores resulting in a classification of poor financial health, which is defined as having an FSI® score at or below -2. **Exhibit 2** above indicates the assessment classification for each hospital and **Exhibit 4** below depicts the classification for all hospitals assessed.

Exhibit 4 - FSI® Assessment Classifications



The hospitals in poor health had a total combined 267,316 inpatient, outpatient, and emergency department patients during FY 2013. Approximately 60 percent of their patients are on Medicaid and Medicare. Again, these hospitals serve a significant number of low-income and elderly individuals.

The healthcare industry nationally and in Kentucky has undergone a transformation in recent years caused by many factors, including a poor economic climate, fast-changing, expensive technological advances, new electronic health records requirements, implementation of Medicaid managed care, the ACA, Medicaid expansion and more. Additional changes are on the horizon, including scheduled reductions in Medicaid DSH payments and continued cuts in Medicare fee-for-service payments. These industry changes create significant challenges to rural hospitals, and those hospitals assessed as being in poor health using the FSI® criteria likely have little flexibility to withstand such challenges.

Additionally, rural hospitals are important economic drivers in their communities. Information obtained from the Kentucky Hospital Association (KHA) indicated Kentucky hospitals in total paid employees \$4.1 billion in wages and benefits in 2012. Due to their geographic locations, rural hospitals are more likely to have significant impact on the economy of the communities they serve. For example, Fulton's city manager stated in a media report that taxes paid by Parkway Regional Hospital makes up approximately 18% of the city's revenue.

In analyzing the rural hospitals assessment, it is noteworthy that 12 of the 14 hospitals that scored above the national average are owned or affiliated by a multi-hospital provider organization or are managed by a professional management organization that is affiliated with multiple hospitals. These arrangements can allow small community hospitals to remain financially viable and provide basic care, as well as strengthening their operations by giving them access to additional financial and other resources. Hospitals in Richmond and Muhlenberg made decisions in recent years to merge or affiliate with providers that operate large facilities in the nearby communities of Lexington and Owensboro, respectively. These hospitals scored fair in the FSI[®] assessment during the timeframe covered by this report, but are examples of hospitals that can be monitored to determine whether their recent affiliations have a long-term positive effect on their fiscal stability.

Rural hospitals that are geographically well-positioned, such as Pikeville Medical Center, which has remained unaffiliated and is independently managed, score high on the index. Alternately, some of the hospitals in poor fiscal health are located in small, geographically-isolated communities, such as Clinton County Hospital and Wayne County Hospital in southern Kentucky. Those hospitals, which are unaffiliated, are vital to their communities due to the long distances individuals would have to travel to access larger, regional hospitals.

Hospitals having agreements with professional management organizations generally fared well in the FSI[®]. Management agreements with professional management companies can provide small hospitals with high-quality managers to run the hospitals efficiently and effectively. Twin Lakes Regional Medical Center, Russell County Hospital and Caldwell Medical Center, all of which are considered in good fiscal health, have agreements with a professional management company.

Other innovative solutions appear to play a role in hospitals that are not in poor fiscal shape. Rockcastle Regional Hospital, for example, serves a small community but has developed a specialty by providing ventilator-dependent care to patients with spinal cord injuries, genetic birth defects, chronic obstructive pulmonary disease (COPD) and neurological diseases like amyotrophic lateral sclerosis (ALS) and muscular dystrophy. This hospital is the only one of its kind in Kentucky and serves patients from across the country.

At least two rural hospitals, St. Claire Regional Medical Center and Highlands Regional Medical Center, have joined a coalition to provide efficiencies, improve patient access and adapt to changes under the ACA. The hospitals will remain independent but will coordinate with University of Kentucky HealthCare, St. Mary's Medical Center in West Virginia and Our Lady of Bellefonte Hospital in Russell in certain areas, such as negotiating vendor contracts. The coalition will allow the hospitals to form an Accountable Care Organization (ACO) as outlined in the ACA. An ACO is a network of coordinated health providers that provides care for a group of patients and that utilizes a payment and care delivery model that ties provider reimbursements to both the quality of care and reductions in the total cost of that care. Although St. Claire and Highlands scored fair in the FSI[®] assessment, they are important examples of hospitals to monitor to determine whether the affiliation they formed is a successful model for other hospitals to consider.

While the APA believes the FSI[®] paints a fairly accurate picture of the financial strength of rural hospitals, some qualifications should be noted. St. Joseph Mt. Sterling, for example, is ranked second to last. Two of the four FSI[®] measures - depreciation and debt financing - are likely to be negatively affected in the FSI[®] calculation because the hospital opened a new, state-of-the-art facility in 2011. Because the hospital is owned by KentuckyOne Health, the largest hospital system in Kentucky, it is unlikely to be at risk of closing.

In addition, ContinueCARE Hospital, which is ranked fourth to last, is a Long Term Acute Care Hospital (LTACH), which is a special designation under Medicare. LTACH facilities specialize in treating patients who stay more than 25 days who may have more than one serious condition. Due to the way the hospital is structured, it is unlikely to ever score well on the FSI[®].

Recommendations

CHFS should begin using a financial assessment tool to regularly monitor the financial strength of rural hospitals. Access to health care is critical at a time when hundreds of thousands of Kentuckians have been added to the insured rolls. Hospital administrations have a responsibility to project the fiscal impact of policy, regulatory and industry changes, and to adjust operations to manage through those changes. However, in order to protect Kentuckians, hospitals must also have solid partnerships with regulators and policymakers. Monitoring the financial viability of Kentucky rural hospitals is important to ensure that the Commonwealth has sufficient information on hand to plan for and attempt to prevent potential gaps in health care accessibility. In the absence of sufficient information, CHFS, local communities, and the public may be caught off guard by the closing of a hospital. CHFS should closely monitor the hospitals that are considered in poor financial health, and those that are considered vital to a community due to their geographic location.

Kentucky was selected for a \$2 million State Innovation Model (SIM) Design Award from the Centers for Medicare and Medicaid Services (CMS) Innovation Center, which is interested in testing innovative payment and service delivery models that have the potential to lower costs for government insurance programs while maintaining or improving quality of care for program beneficiaries. We understand payment and delivery reforms are priorities of CHFS and anticipate that many of the recommendations throughout this report will be the focus of this SIM project. As part of the SIM project, the Governor should convene a work group to examine, among other objectives, new models for rural health care delivery to ensure quality of care and continued access in this altered healthcare landscape.

To survive and flourish in this vastly different landscape, we recommend rural hospitals continue to find ways to innovate and adapt, and for some of them to contract for outside expertise to have the help and benefit available to guide them during this time of transition. The work group should consist of a broad range of individuals with varying expertise, such as policymakers, managed care representatives, health care and insurance experts. It should begin by closely examining hospitals in poor and fair financial health and finding pathways for assisting those providers in identifying risks and taking action to adapt to the changing business climate, such as possible affiliations, mergers, management agreements, networks, ACOs and other opportunities to innovate. The Governor held a leadership summit in January 2015 to engage providers in a discussion about the transformation of the delivery of health care services. The work group should ensure that providers continue to facilitate communications and be engaged in planning for a smooth transition.

The work group should evaluate whether Kentucky's current regulatory structure gives hospitals the flexibility to retool their business models for 21st century health care delivery. Parkway Regional Hospital in Fulton, for example, announced in late 2014 that it was closing its inpatient and emergency departments in March 2015, citing a 50 percent drop in inpatient admissions over the last four years. The work group should consider, for example, whether the regulatory structure permits hospitals that have underutilized, costly inpatient beds to cease or scale back inpatient care and focus primarily on emergency services, outpatient and other specialty care instead. CHFS indicated it is taking steps in this direction, and has already sought feedback from stakeholders regarding modernizing the certificate of need (CON) program, and planning additional opportunities for feedback in spring 2015.

Observation 2: 34 percent of Critical Access Hospitals (CAH) achieved an FSI[®] assessment of excellent or good health, compared to 23 percent for acute care hospitals.

Acute care hospitals are defined as hospitals that provide 24-hour short-term inpatient medical, surgical, obstetrical and pharmaceutical services. Acute care hospitals may or may not provide similar services on an outpatient basis. **Exhibit 2** identifies the classification of hospitals as acute or CAH.

Federal legislation enacted as part of the Balanced Budget Act (BBA) of 1997 authorized states to establish a State Flex Program under which certain facilities participating in Medicare could become CAHs. CAH hospitals are considered a separate hospital provider type, and have a different federal reimbursement methodology from general acute hospitals. KRS 216.380 establishes the specific requirements for hospitals to obtain CAH designation in the Commonwealth. At a minimum, federal law requires that a hospital that participates in Medicare and seeks CAH status must meet specific criteria, including but not limited to:

- furnish 24-hour emergency care services seven days a week;
- maintain no more than 25 inpatient beds, although it may also operate a distinct part rehabilitation and/or psychiatric unit, each with up to 10 beds;
- have an annual average length of stay of 96 hours or less per patient for acute care; and
- be located more than a 35-mile drive from any hospital or other CAH, or located more than a 15-mile drive from any hospital or other CAH in an area with mountainous terrain or only secondary roads, or was certified as a CAH prior to January 1, 2006 based on the state's designation as a "necessary provider" of health care services to residents in the areas.

The higher percentage of CAHs achieving top FSI[®] scores can be attributed, at least in part, to the differences in their federal reimbursement methodologies when compared to acute care hospitals. CAHs are paid for most inpatient and outpatient services to Medicare patients at 101 percent of reasonable costs. Additionally, KRS 216.380(13) establishes the requirement that Kentucky CAHs receive reimbursements for Medicaid patients at least equal to the rates established for Medicare patients. Therefore, for federally reimbursable costs, CAHs receive above reasonable costs of services provided to Medicaid and Medicare recipients, whereas acute care hospitals are reimbursed at established standard fixed rates. This is an even more significant factor when considering the patient payer mix in rural hospitals in Kentucky. Hospitals responding to the APA's survey responded on average that 71 percent of patients in rural hospitals are either Medicare or Medicaid recipients. This statistic is further discussed in Observation 3 below.

Another reason more CAHs achieve higher FSI[®] scores relates to their business model. The U.S. Department of Health and Human Services (HHS) indicates that CAH's limited size and short length of stay helps these hospitals focus on providing care for common conditions, while referring other conditions to larger hospitals. Therefore, patients requiring longer term or costlier treatment, or both, may not be treated at CAHs.

Also, CAHs are exempt from recently implemented mandatory Medicare pay-for-performance initiatives, which result in reduced payments and penalties for many hospitals. These initiatives include the Value-Based Purchasing (VBP) Program, the Hospital-Acquired Conditions (HAC) Program, and the Hospital Readmissions Reduction Program. Of these programs, the most significant initiative is the VBP Program, which began in October 2012. Under this program, CMS states that hospitals are no longer paid for the quantity of services provided, but instead are paid based on the quality of care, how closely best clinical practices are followed, and how well hospitals enhance patients' experiences of care during hospital stays. Hospitals with high quality scores are given incentive payments, which are paid for by redistributing funds withheld from all hospitals' Medicare Diagnosis-Related Group (DRG) payments. The amount withheld from hospitals began at one percent in FY 2013, and is scheduled to increase to two percent in FY 2017. Although high-scoring hospitals will receive incentive payments, initial across-the-board payment reductions may create further fiscal stress for hospitals already experiencing fiscal instability.

Another initiative impacting acute care hospitals noted above is the HAC program. The HAC program measures how often a particular preventable condition occurs at a given hospital, rating hospitals from one to 10. In 2014, CMS released the final scores, and indicated those hospitals with a total HAC score above the 75th percentile, or seven or higher on the 10-point scale, may be subject to a payment reduction of one percent of its Medicare payments from October 1, 2014 through September 30, 2015. Kentucky had three rural acute care hospitals with a Total HAC score over seven - Jackson Purchase Medical Center, Muhlenberg Community Hospital, and Lourdes Hospital.

The third Medicare pay-for-performance initiative, the Hospital Readmissions Reduction Program, requires CMS to reduce payments to acute care hospitals with excess readmissions. The program was in effect for discharges beginning October 1, 2012. Federal fiscal year (FFY) beginning October 1, 2014 marked the beginning of the third year in which penalties were applied to hospitals. In Kentucky, a total of 63 rural and urban hospitals, or 66 percent of all hospitals in the Commonwealth, are being penalized for discharges between October 1, 2014 and September 30, 2015. The average hospital penalty for hospitals in Kentucky was 1.21 percent, which is the highest average penalty of all states. **Exhibit 5** below presents a list of all states penalized, and the

average penalty for each. In analyzing rural hospitals for the purposes of this report, 40 of the 63 Kentucky hospitals penalized, or more than 63 percent, were rural hospitals. Additionally, eight out of nine Kentucky hospitals that received the FFY 2015 maximum penalty of three percent were rural hospitals. A list of all Kentucky hospitals penalized over the past three years, as well as the annual penalty rate, is presented in *Appendix IV - Medicare Readmission Penalties for Kentucky Hospitals FFY 2013-2015*, with rural hospitals denoted.

Although a higher percentage of CAHs than acute care hospitals achieved excellent or good health assessments overall, it should be noted that eight hospitals assessed to be in poor health are CAHs. A review of the map at **Exhibit 1** identifies the poor performing CAHs are in various portions of the state, although south central and south eastern Kentucky have a concentration of acute hospitals and CAHs assessed as poor.

**Exhibit 5 - Average Medicare Readmission Penalties by State - Year 3
Effective for Hospital Admissions from October 1, 2014 to September 30, 2015**

State	% of All Hospitals Penalized	No. of Hospitals Penalized	Avg Hospital Penalty
Alabama	76%	71	0.63%
Alaska	24%	5	0.83%
Arizona	62%	48	0.58%
Arkansas	47%	37	1.02%
California	64%	223	0.41%
Colorado	34%	27	0.33%
Connecticut	88%	28	0.65%
Delaware	86%	6	0.22%
District of Columbia	78%	7	1.00%
Florida	79%	148	0.58%
Georgia	65%	89	0.51%
Hawaii	56%	10	0.20%
Idaho	12%	5	0.62%
Illinois	65%	118	0.78%
Indiana	53%	68	0.62%
Iowa	19%	23	0.68%
Kansas	26%	34	0.44%
Kentucky	66%	63	1.21%
Louisiana	59%	72	0.71%
Maine	41%	15	0.31%
Maryland*			
Massachusetts	80%	55	0.78%
Michigan	52%	71	0.64%
Minnesota	27%	36	0.40%
Mississippi	56%	55	0.70%
Missouri	61%	66	0.67%
Montana	9%	5	0.44%
Nebraska	14%	13	0.33%
Nevada	56%	20	0.76%
New Hampshire	35%	9	0.41%
New Jersey	98%	63	0.82%
New Mexico	45%	19	0.35%
New York	80%	148	0.73%
North Carolina	65%	74	0.47%
North Dakota	4%	2	0.18%
Ohio	63%	107	0.73%
Oklahoma	52%	66	0.57%
Oregon	30%	18	0.14%
Pennsylvania	72%	126	0.63%
Rhode Island	67%	8	0.67%
South Carolina	71%	44	0.61%
South Dakota	15%	8	0.27%
Tennessee	72%	83	0.75%
Texas	56%	213	0.52%
Utah	30%	14	0.66%
Vermont	27%	4	0.10%
Virginia	76%	66	0.97%
Washington	37%	34	0.50%
West Virginia	56%	30	0.96%
Wisconsin	37%	47	0.43%
Wyoming	31%	9	0.38%

* Penalties do not apply to Maryland hospitals.

Source: Kaiser Health News analysis of data from CMS.

www.kaiserhealthnews.org

(KHN) is a nonprofit national health policy news service.

Recommendations

CHFS should closely monitor CAHs that are in poor financial health, particularly those that meet the geographic requirements to be CAHs, such as Wayne County Hospital in southern Kentucky. Access to care would be hindered for residents of that community because the closest hospitals are more than 30 minutes away.

For those that are exempt from the geographic requirements, stakeholders should evaluate potential new models for operations and affiliations, and evaluate the regulatory changes necessary to facilitate these modifications. Jane Todd Crawford Hospital, for example, is ranked third worst on the FSI[®]. It is a CAH, but it is located 14 miles, or 22 minutes, from Taylor Regional Hospital in Campbellsville. James B. Haggin Memorial Hospital, also considered a CAH, is ranked sixth worst on the FSI[®] and is 9.4 miles, or 14 minutes, from Ephraim McDowell Regional Medical Center in Danville. CHFS and stakeholders of small CAHs that are geographically close to large facilities should evaluate whether there is a continued need in this changing healthcare landscape to provide traditional inpatient services that may be jeopardizing the continued existence of needed emergency departments.

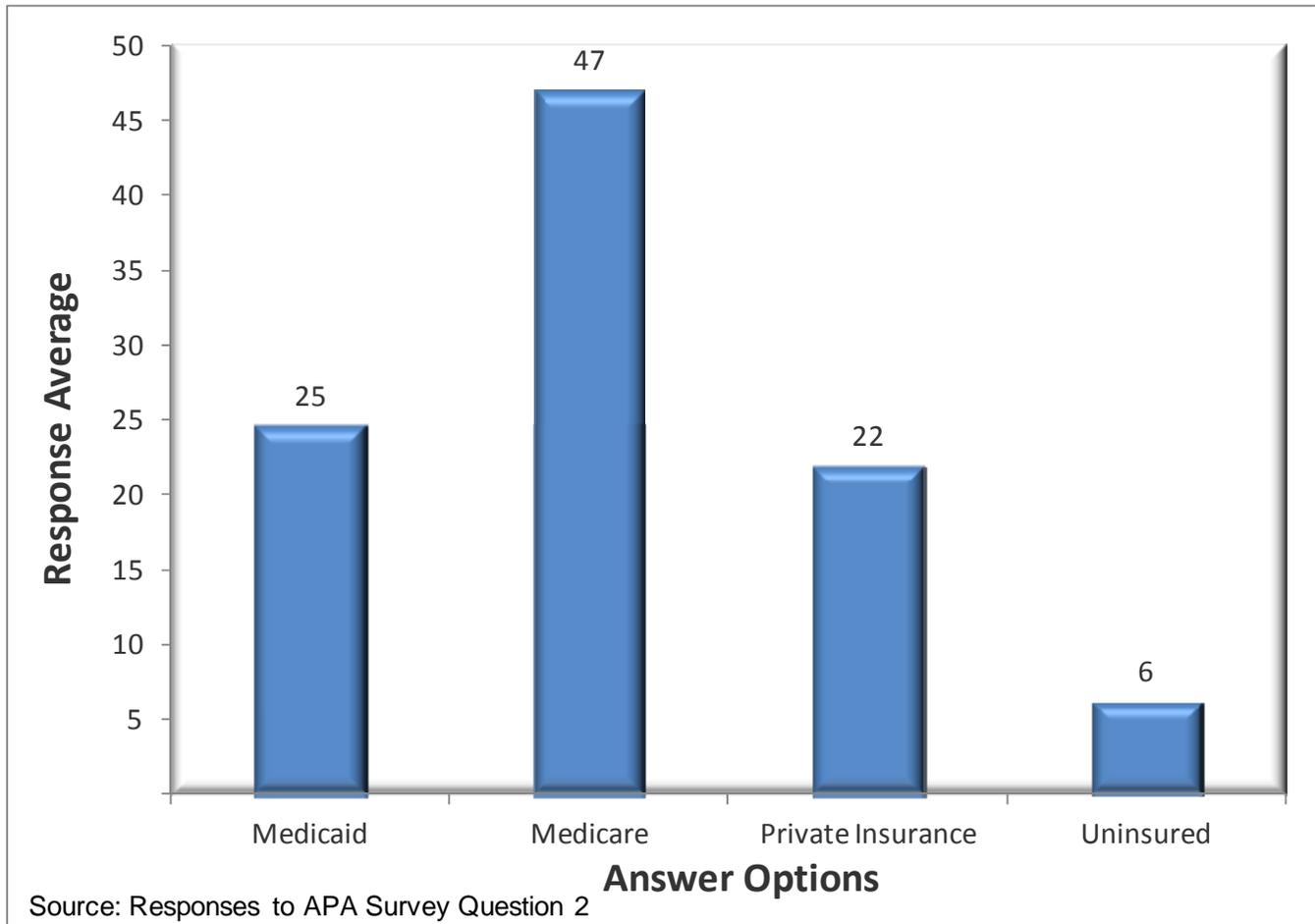
As discussed in detail in the first observation, a work group convened by the Governor should examine the regulatory structure over acute care hospitals to determine whether those providers have the flexibility to adjust their business models, such as by decreasing or eliminating inpatient beds and shifting patients from high-cost inpatient beds to outpatient care models. The work group also could help acute care hospitals identify ways to control costs.

Additionally, because a higher percentage of CAHs overall exhibit more favorable fiscal stability ratings, the proposed work group recommended in the first analysis should examine whether other medical services, such as emergency transportation services, may benefit from being transitioned from government or acute care affiliations to CAH affiliations to capitalize on more favorable reimbursement rates.

Observation 3: Hospitals responding to APA's survey indicate on average 72 percent of patients received Medicare or Medicaid benefits, meaning a significant number of low-income and elderly patients are affected if rural hospitals close.

The second question on the APA survey of rural hospitals requested information on the mix of payment methods used by patients. Hospitals reported a range of 52 to 91 percent of patients participating in Medicaid and Medicare, with responding hospitals reporting an average of 72 percent of patients receiving such benefits. Data obtained from CHFS indicates that during FY 2013, more than 58 percent of patients in all Kentucky rural hospitals were Medicaid or Medicare recipients. **Exhibit 6** presents the mix of payment methods used by patients for those hospitals that responded to the survey.

Exhibit 6 - Survey Response - Payer Mix Percentages



Based on information reported by The Advisory Board Company, a contractor of CHFS, the information obtained from CHFS regarding the mix of payment types for all rural hospitals depicts Kentucky's government insurance mix is higher than national average. The Advisory Board Company reported in a January 29, 2015 meeting of hospital providers that the current nationwide payer mix is approximately 50 percent government insurance and 50 percent commercial insurance. However, the contractor reported that the trend is for this mix to change to 75 percent government insurance and 25 percent commercial insurance. This is especially troubling given that the American Hospital Association reported that the Medicare hospital payment-to-cost ratio in 2012 was only 86 percent, whereas private payer sources, including commercial insurance, had a payment-to-cost ratio of 149 percent. Hospitals that are financially struggling under the current payer mix, and those who already serve a disproportionate share of Medicaid and Medicare patients, will face even greater challenges as the percentage of private-pay patients declines.

With an average of 58 percent of all rural hospital patients receiving Medicare and Medicaid benefits, it is apparent that the financial strength of rural hospitals is significantly affected by the administration of these federal programs, which serve some of the Commonwealth's most vulnerable citizens. Hospital operations, including services provided, can be highly sensitive to changes in these programs as was evident during the transition from Kentucky's Medicaid fee-for-service program to a managed care program.

Other significant changes on the horizon are the scheduled reductions in Medicaid DSH payments and continued cuts in Medicare fee-for-service payments. DSH provides additional payments to hospitals for the extra costs incurred in treating uninsured or low-income patients. One element of recent healthcare reforms is to phase out this payment to hospitals because they should have little uncompensated care as a result of the Medicaid expansion. The loss of DSH payments will be significant to hospitals, even though prior to the phase out the hospitals will be receiving both DSH payments and Medicaid reimbursement for formerly uninsured/underinsured patients. Still, hospital administrators confirm that costs have increased due to the increased utilization of services, particularly by new Medicaid patients that had deferred preventative care and treatment. The phase-out was initially set to begin in 2014, but recently has been deferred until 2017.

Also, as can be seen in **Exhibit 6**, although an average of one-fourth of patients in participating rural hospitals receive Medicaid benefits, an average of 47 percent receive Medicare benefits, which is the federally administered program for senior citizens. Much attention has been given to the effects the Medicaid expansion and managed care transition have had on providers, but a closer examination is needed to assess the effects of Medicare changes.

For example, when the Nicholas County Hospital closed, the hospital board chair told the press that one cause for its closing was that it received 44 cents on the dollar in Medicare reimbursement. As discussed in the second analysis, acute care hospitals, which are on average performing below the CAHs, are under a different, less generous Medicare reimbursement structure than CAHs.

As noted above, Medicare also has begun several pay-for-performance initiatives that will reduce total Medicare payments to providers by 5.4 percent by FY 2017. In its January 2015 presentation, The Advisory Board Company indicated that Medicare payments cuts are becoming the norm and reported that Medicare fee-for-service payment cuts to hospitals are anticipated to be approximately \$260 billion nationally between 2013 and 2022.

Poor and elderly citizens have the greatest obstacles to health care accessibility, and therefore these statistics raise questions about any potential options that will be available to serve these citizens if rural hospitals find that their operations are no longer financially viable. Funding cuts may lead to a lack of innovation that impairs problem resolution and creates more fiscal penalties, thereby making resources scarcer.

Recommendations

As discussed in the recommendations for Observation 1, the SIM Design Award project has the potential to assist rural hospitals in improving care and decreasing costs for beneficiaries of Medicare and Medicaid. The SIM project or proposed work group, or both, should evaluate the effects recent changes to the Medicare program are having on rural hospitals and provide recommendations to ease the transition from fee-for-service to the new fee-for-value system. The work group could explore strategies for hospitals experiencing costly Medicare readmission penalties and HAC penalties to try to reduce those rates. Also, as detailed in previous recommendations, it should examine the regulatory structure to ensure there is flexibility to innovate.

In addition, the work group may research transportation needs as a way to expand accessibility options and provide a safety net for vulnerable citizens in the event of additional hospital closures. For example, the work group should determine whether the expansion of non-emergency transportation services could not only improve accessibility concerns overall, but also assist Medicare and Medicaid recipients in receiving routine well care services, non-emergency physician services, and other services that could reduce the occurrence of costly medical treatments caused by delayed care. Currently, non-emergency transportation services are covered by Medicare in certain situations, such as when transportation by ambulance is needed to obtain treatment or diagnose a health condition and utilizing another form of transportation could endanger the patient's health or when the patient has a written note from his or her doctor indicating ambulance transportation is necessary due to the individual's medical condition. Further evaluation is needed to determine whether further coordination of these types of services and/or an expansion of these types of services would assist in improving access to non-emergency services.

Observation 4: Hospitals with low FSI[®] scores do not have capital reserves sufficient to withstand additional fiscal stress.

APA survey questions three and four relate to cash reserves on hand. The responses to these questions provide additional information when assessing fiscal health, such as information regarding the fiscal flexibility of the hospital. Low cash reserve balances may indicate weaknesses in a hospital's ability to maintain its facilities and equipment, and its ability to withstand fiscal stress, such as late or disrupted payments from federal programs. It may also pose financial problems for vendors who receive delayed payments from hospitals for services provided and can jeopardize a hospital's ability to make payroll.

Survey respondents reported a range of \$0 to \$112,004,075 of capital reserves on hand, which was reported as being sufficient to cover operations for a range of 0 to 245 days on average. This analysis is important for identifying the hospital's ability to manage operations during periods in which cash flow is inconsistent or delayed, which can occur when federal program payments are delayed or the hospital experiences downturns in the demand for certain types of services. The higher the level of capital reserves, the better the hospital can withstand changes in revenue that impact cash flow. This is of particular concern for small, unaffiliated hospitals that lack the support of a parent corporation or partner when cash flow is delayed. A representative of one MCO reported that a small provider sought a cash advance from the MCO because it was experiencing cash flow difficulties.

Presented below in **Exhibit 7** are the top five and bottom five FSI[®] ranked hospitals, as well as the average number of days their capital reserves as reported in their financial statements could cover expenses between 2011 and 2013. The hospitals with the bottom five FSI[®] scores reported dangerously low capital reserves.

Exhibit 7 - Days of Operation Covered by Capital Reserves

FSI Rank	Name	<u>Days Calculated per Fiscal Year</u>			Average Days
		2011	2012	2013	
1	Methodist Hospital Union County	257.23	186.61	293.12	245.65
2	The Medical Center Franklin	134.48	55.72	37.35	75.85
3	Pikeville Medical Center	162.08	144.41	141.62	149.37
4	Baptist Health Madisonville	69.76	91.00	49.19	69.98
5	Ephraim McDowell	161.19	166.90	154.66	160.92
40	Clinton County Hospital	49.79	6.27	3.85	19.97
41	ContinueCARE Hospital	12.49	12.23	4.84	9.85
42	Jane Todd Crawford Hospital	5.54	7.22	2.99	5.25
43	Saint Joseph Mount Sterling	N/A	0.00	0.00	0.00
44	Westlake Regional Hospital	4.96	8.57	5.10	6.21

N/A Saint Joseph Mount Sterling did not submit financial statements for 2011.

Source: APA calculation of the number of days cash reserves cover operations utilized data reported in financial statements of participating rural hospitals.

Recommendations

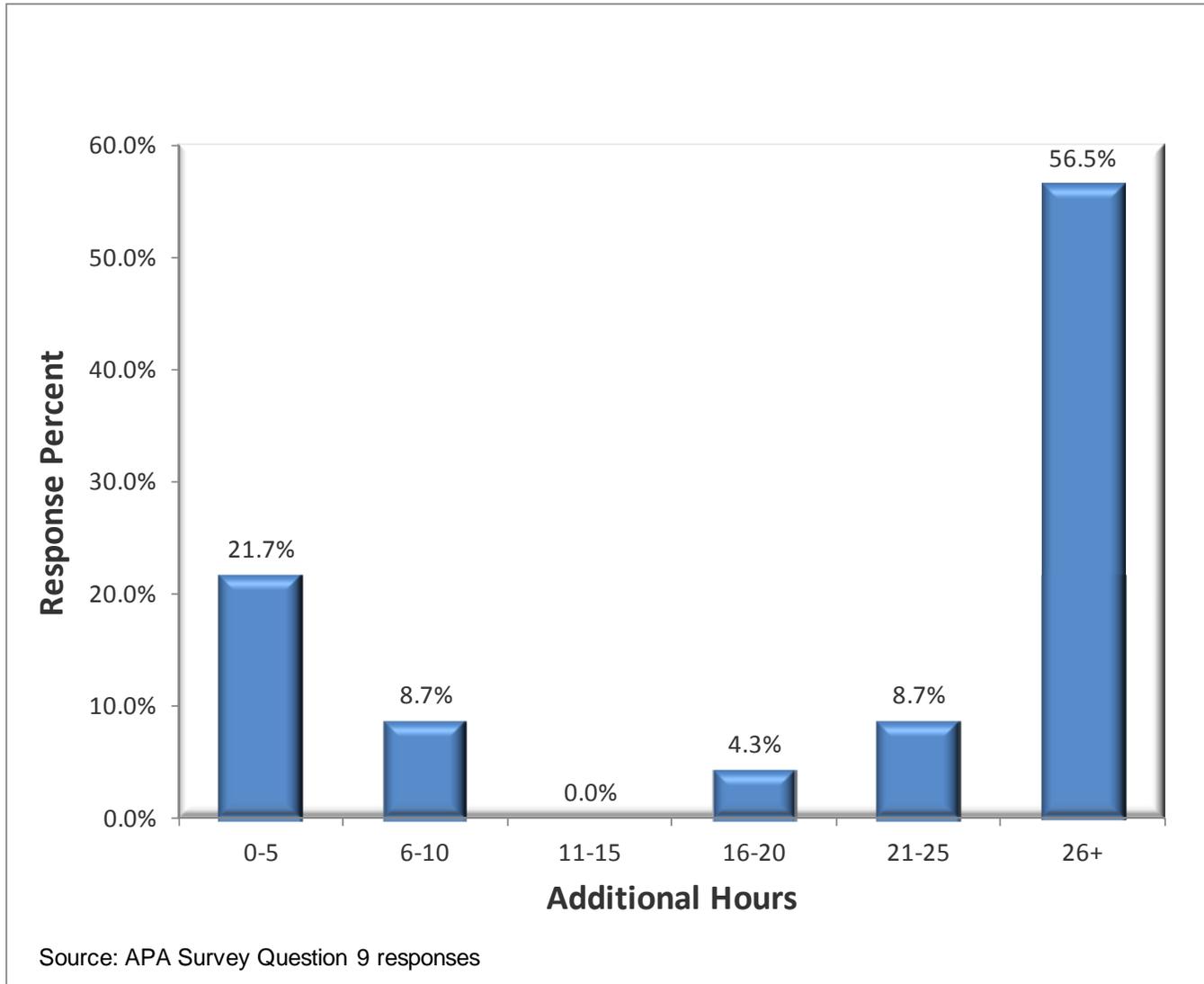
Observation 1 included a recommendation that CHFS and the proposed work group closely monitor rural hospitals using the FSI[®] assessment. The work group should seek to understand the reasons for cash flow problems of these hospitals to help determine whether the hospital is experiencing a short-term cash flow problem or whether the hospital is having serious operational difficulties.

The work group should also study the need and feasibility of an emergency capital pool for use in providing short-term loans, transition incentives, financing for equipment and technology advances, and other needs to aid health care facilities willing to put forth efforts to improve their long-term viability. MCOs may be incentivized to assist in establishing such pools in order to maintain a healthy provider network, and other funding mechanisms may also be available, such as healthcare information technology (IT) related grants, etc.

Observation 5:
Administrative burdens on hospitals have increased since the implementation of Medicaid managed care.

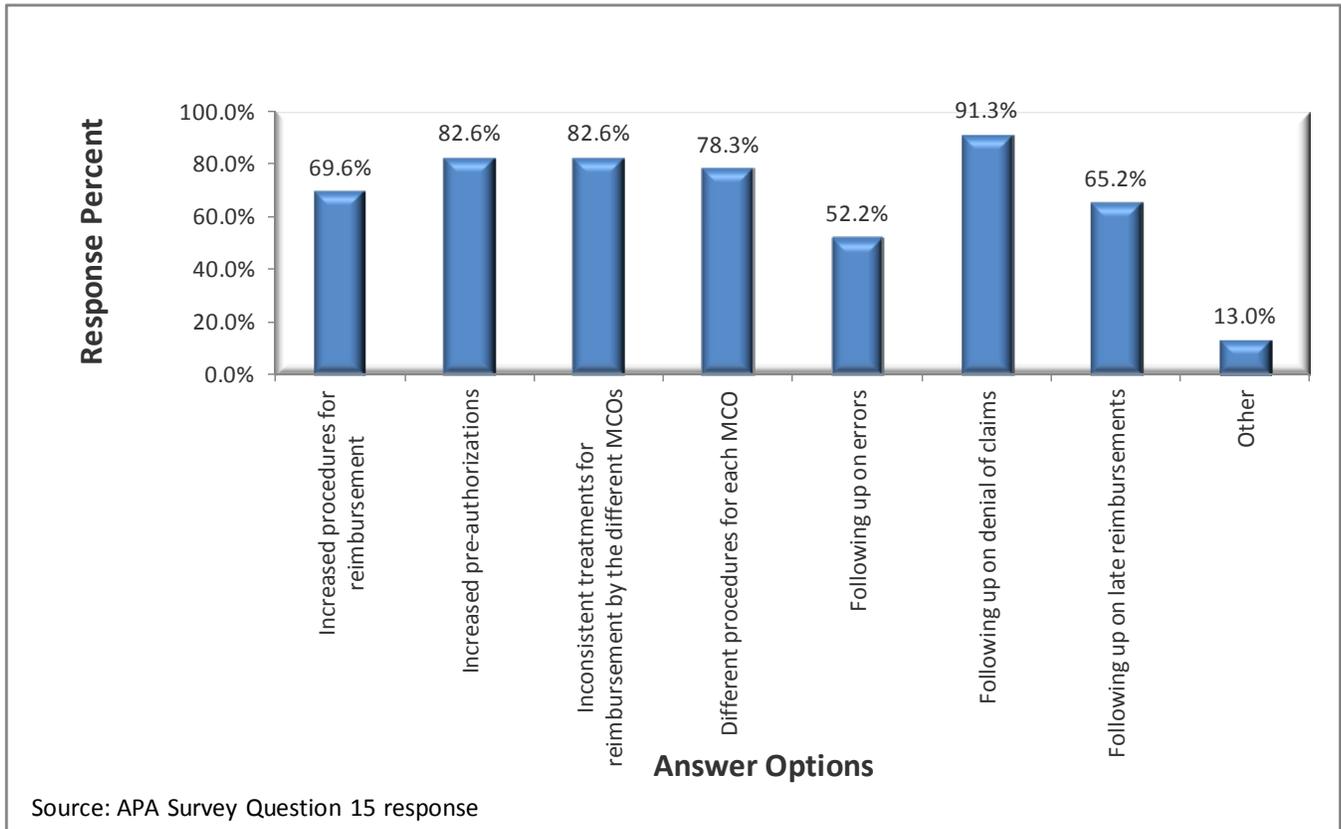
More than 79 percent of survey respondents reported that administrative costs have increased since the implementation of managed care. These respondents reported that hospital administration costs have increased between \$20,000 and \$630,000 per year, which is an average of \$156,796 in total for all respondents combined. The survey further inquired about the approximate number of hours per week necessary to cover administrative duties, and responses are depicted in **Exhibit 8**. As identified in **Exhibit 8**, 56.5 percent of respondents reported that administrative hours had increased by 26 or more hours per week. Additionally, more than half the respondents reported that it has been necessary to hire additional administrative staff and increase overtime to cover the additional administrative duties.

**Exhibit 8 - Survey Response - Number of Additional Hours Per Week
Related to Managed Care Administrative Duties**



When asked about the most significant reasons for additional time and costs associated with managed care, the most common responses were following up on denial of claims, increased pre-authorizations, and different procedures/treatments for each MCO. **Exhibit 9** identifies the summary of responses from all respondents. Respondents that identified additional time and costs classified as “Other” were asked to state those reasons. The responses reported as “Other” included lost physician productivity, additional involvement at the corporate level, and Emergency Room (ER) triage fees. Significant increases in the administrative burden are particularly difficult for small providers that have fewer staff dedicated to functions not directly related to patient care. Also, in rural Kentucky where there are shortages of medical staff, it becomes more important for hospitals to find alternatives for handling administrative functions that do not further impact the provision of care.

**Exhibit 9 - Survey Response - Reasons for
Additional Time and Costs Associated with Managed Care**



During public meetings, hospital administrators voiced concerns that administrative problems were repeatedly expressed in meetings with MCOs and CHFS, but that problems were not being resolved or communicated effectively. Additionally, MCO representatives acknowledged that some delays in resolving problems may be due to instances of poor communications with rural hospitals. For example, MCOs indicated there may be good solutions that would ease some administrative concerns over time, but that some providers may resist those options.

When the APA inquired about the nature of regular meetings with CHFS, responses indicated the agency tended to be hands off in its handling of problems between providers and MCOs. MCO representatives referred to regular meetings hosted by the KHA, and CHFS leadership also indicated it did have regular meetings with many types of providers. The APA was unable to document any specific meetings hosted by CHFS directed toward the hospital community, especially rural hospitals, and was informed that CHFS representatives attending the regularly held KHA meetings may not have the appropriate levels of authority to facilitate problem resolution. Such meetings are important to address unique concerns occurring in high-risk areas. Meetings hosted by KHA, although

admirable for improving dialogue, may not be appropriate venues or provide the appropriate opportunities for CHFS to assert itself as the oversight body for both hospitals and MCOs.

In addition to responses provided in the survey, providers also indicated during public meetings that credentialing, or the process by which healthcare providers are approved by the MCOs, has become administratively burdensome. Credentialing involves verification of the provider's medical license, educational degrees and certificates, proof of malpractice coverage, etc. Instead of having a centralized credentialing process, each MCO has its own process for credentialing providers and, therefore, providers may have to submit records up to five different times with no guarantee that the same documentation submitted to each will satisfy the individual MCO's requirements. Under the former fee-for-service program, credentialing providers through CHFS took approximately six to eight weeks. However, this process is now reportedly taking up to eight or nine months in some instances. One hospital stated that it had to create a "credentialing department" that cost around \$150,000 each year.

To further ascertain the fiscal stress of the hospitals, APA survey questions five and six gathered data regarding employees over the last 24 months and found that layoffs occurred in 20 percent of the hospitals responding to the survey. The five hospitals responding that layoffs had occurred reported that a range of three to 106 employees were laid off during this period. Although hospitals did not identify the specific reasons for these layoffs, information obtained during public meetings indicated that increasing administrative costs was a factor in those decisions. Survey results obtained by the KHA indicated that statewide, approximately 10 percent of the hospital workforce was reduced from 2013-2014 due to attrition, job elimination and layoffs, or a total of 7,706 jobs. Of these reductions, approximately 1,804 were attributed to rural hospitals, which include the loss of 80 jobs due to the closing of Nicholas County Hospital. Also, Parkway Regional Hospital in Fulton County announced it would close in March 2015, resulting in the loss of another nearly 200 positions. Additionally, the KHA survey identified approximately a third of all Kentucky hospitals implemented reductions in wages and benefits during the same time frame, with 80 percent of those being rural hospitals.

Nine hospitals reported making cuts to other budget areas to afford the cost of the additional administrative duties. Personnel were reduced from such areas as:

- Patient Accounts
- Medical Records
- Administration
- Utilization Review
- Nursing

- Patient Care Services
- Physician Practices

Cutting front-line workers responsible for providing patient care to add staff to handle new administrative burdens is troubling at a time when providers are faced with an influx of newly-insured patients and are being asked to improve the quality of care. In addition, the impact of layoffs at rural hospitals in those communities is important to consider. With some exceptions, health care practitioners and technical occupations in Kentucky make more than the median annual wage for all occupations, according to the Bureau of Labor Statistics. Job losses in the health care field in a rural community deplete already drained public coffers and affect the service industry in those areas.

Recommendations

CHFS should work to improve relations with providers, particularly small, rural hospitals. CHFS should consider appointing a liaison to establish relationships with rural providers and encourage participation by individual provider representatives in the provider relation meetings. Additionally, CHFS should host regularly scheduled provider relation meetings specifically to address administrative concerns and assist in improving CHFS/MCO/provider relationships by encouraging problem resolution. CHFS should require that all MCOs have representatives at each meeting. The APA acknowledges that CHFS and KHA recently hosted a well-attended leadership summit geared toward the hospital community. Such jointly-sponsored meetings are important for building positive provider relations, and should continue to be incorporated into CHFS' overall communications strategy.

CHFS should establish a uniform credentialing/re-credentialing process for MCOs. Creating a uniform process for credentialing providers could benefit not only providers, but also MCOs, while having the added benefit of improving DMS' oversight capabilities. Many individuals indicated the reason for delays was due to different credentialing methodologies among the MCOs. Because of these concerns, we recommend CHFS:

- Require uniform procedures be developed and consistently applied through a statewide contractor. The utilization of a statewide contractor will ensure that not only are uniform elements required from providers, but that the process will be implemented consistently. Furthermore, uniform credentialing through one source will avoid duplicate documentation submissions from providers and should enhance response timeframes since the provider can be credentialed with all applicable MCOs simultaneously through one source.
- Require that the credentialing/re-credentialing process follow the National Committee for Quality Assurance (NCQA) Standards and Guidelines. This also will assist providers given that the information

required will be similar to information submitted for Medicare credentialing, which follows NCQA standards.

- Establish timeframe limitations in MCO contracts for credentialing/re-credentialing providers once all relevant information has been obtained. A review of other states identified that one border state, Tennessee, requires that provider credentialing be completed within 30 days of receipt of all relevant information.
- Require the credentialing/re-credentialing contractor to notify providers at least 60 days before credentials expire.
- Require MCOs to report to CHFS any program integrity concerns related to providers that keep them from being credentialed. These providers should be monitored, and integrity concerns reported to the statewide credentialing contractor. Providers with validated program integrity concerns should not be credentialed under any MCO.

CHFS should report, or require providers to report, any changes in provider certification status to MCOs in a reasonable timeframe. One MCO reported that providers are already required to give CHFS this information, but there is a delay in CHFS informing MCOs and this delay could lead to MCOs inadvertently applying incorrect billing rates.

CHFS should require MCOs to publish preauthorization criteria and formulary schedules within a certain timeframe. CHFS should require MCOs to submit changes in preauthorization criteria or formulary changes for approval prior to making changes.

Observation 6: Hospitals indicate MCO policies regarding ER visits are causing a significant financial burden.

After increased administrative burden, the next most frequently discussed topic at the public meetings held by Auditor Edelen was ER visits. Specifically, hospitals indicate serious concerns regarding a “triage fee” policy implemented by some MCOs, which allows only a \$50 reimbursement for ER visits if the MCO does not consider the visit to have been an emergency situation. With the implementation of Medicaid managed care in Kentucky, one method for controlling costs is to reduce the number of high-cost, non-emergency ER visits and encourage members to utilize family doctors. MCOs establishing a \$50 reimbursement policy do so in order to incentivize hospitals to refer non-emergency ER patients to a doctor’s office instead of utilizing ER services. However, hospitals argue that the triage fee is not sufficient to permit hospitals to meet federal requirements. Federal law requires hospitals to assess all patients coming to the ER to determine whether a true emergency exists. In certain situations, the costs of these initial assessments are high, especially when lab and radiological procedures are required. One hospital reported, as an example, that it was reimbursed \$50 for treating a car accident victim that cost the hospital \$7,000. Another hospital stated that it only had ten days of cash on hand, and therefore was

experiencing a cash flow problem resulting from below-cost reimbursements for ER services. As a result, the hospital administrator indicated it now required patients to pay up front for emergency services.

Currently, the Commonwealth's contract with MCOs does not address triage fees. Providers have said that CHFS has indicated it cannot limit the triage fee because it is an issue to be negotiated between the provider and MCO. However, a review of MCO contracts in other states identified alternatives. For example, Tennessee's TennCare program indicates that MCOs must "base coverage decisions for emergency services on the severity of the symptoms at the time of presentation and shall cover emergency services where the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson." Further, the contract requires that the MCO "pay for emergency screening services conducted to determine whether an emergency medical condition exists and for all emergency services that are medically necessary until the member is stabilized."

Recommendations

CHFS should establish contractual restrictions on triage fee caps to avoid overuse of the caps. Tennessee's MCO contract contains provisions for the coverage of emergency care that requires emergency coverage decisions be made based on the severity of the symptoms at the time of presentation, and requires that ER services be covered when the symptoms are of sufficient severity to constitute an emergency in the judgment of a prudent layperson. While not specifically banning the use of triage fees, these types of guidelines for emergency care places more judgment in the hands of the attending medical worker, and requires emergency assessment to be covered if symptoms warrant such an assessment, even if the ultimate diagnosis may fall under a different level of care.

Also, CHFS should consider contractual provisions specifically permitting the use of triage fees in instances when providers refuse to participate in certain cost savings, utilization management and wellness programs, such as case management programs. Enhanced ER decision-making may become an incentive for providers to actively participate in MCO programs that address overutilization or readmission concerns, or both.

CHFS provided information to the APA regarding its ER SMART initiative. This initiative appears to be addressing utilization problems, and CHFS indicates it is already seeing success among "super-utilizers." We recommend to the extent possible, CHFS incorporate policies in its MCO contracts that will further enhance this initiative.

**Observation 7:
Weaknesses in the
contracts between CHFS
and MCOs appear to be
hindering improvements
from being made to the
managed care system in
the Commonwealth, and
are likely contributing
factors to the declining
fiscal health of many
providers.**

Auditors reviewed contracts between CHFS and MCOs, and compared them to Tennessee's contract with MCOs, which is considered a model in managed care. Persistent issues with managed care are unlikely to be resolved without contractual changes, and it is important that changes are implemented to help all providers continue to adapt in the managed care environment. CHFS officials are currently in the process of making revisions to the contracts, so although this is not primarily a rural hospital matter, auditors determined the timeliness of the situation warranted follow-up and additional examination.

Auditors found several areas for improvement in areas such as strengthening penalties for contractual noncompliance, improving CHFS' ability to monitor quality and programmatic requirements, and improving transparency.

While strengthened penalties are part of the equation, so too are incentives for innovations that will lead toward improved health of Kentuckians. In our review of the contracts, we identified room for improvement in regard to wellness, accountability and other areas that are at the heart of a managed care program that succeeds over the long term in improving the health of Kentuckians. Now that MCOs have weathered the managed care rollout challenges that assisted the Commonwealth in achieving short-term savings, it is time to look for ways to strengthen contracts to make sure managed care is focused on saving taxpayer dollars in the long-run by improving wellness and diminishing the need for costly health care services. One MCO in the Commonwealth, for example, has established health councils to build relationships with social service agencies in member communities. The MCO places case managers in provider networks to identify members who are frequent users of health care and to help determine if other resources, such as food or housing assistance, are needed to get a member on a path toward improvement. The MCO monitors social service agencies that may be struggling and can assist in getting them resources. Many other opportunities for innovation abound, and CHFS could incentivize MCOs to move in that direction.

CHFS must ensure a high level of transparency and accountability over insurance companies that are ultimately accountable to shareholders, not taxpayers. The Commonwealth's relationships with certain private contractors in the past, such as with private prison operators, has demonstrated that problems arise when there is a lack of proper oversight. MCO contracts require MCOs to submit nearly 150 reports to CHFS throughout the year, yet improvements can be made in analyzing the data to monitor performance and compiling it in such a way to allow Medicaid members and the public to compare MCOs.

MCO contracts, for example, require MCOs to have a Quality Assessment/Performance Improvement (QAPI) program to assess, monitor, evaluate and improve the quality of care provided to Medicaid

members. This assessment is to utilize information from multiple quality evaluations, such as member surveys and Health Care Effectiveness Data and Information Set (HEDIS) measures. The MCOs are then required to report to CHFS annually an assessment of its QAPI program. The information gathered should provide CHFS a large volume of quality measures to assess MCO performance for both contract monitoring purposes and also to provide members and the public performance information. CHFS compiles a brochure for Medicaid members with some of the data but should review a report issued by the state of Tennessee and look for ways to improve its reporting and presentation of quality of care data it provides to Medicaid members, the public and media.

Also, MCO contracts contain language that may provide opportunities for oversight and assessment of the MCOs in certain areas, but it is unclear how the information is being monitored and reported by CHFS. For example, MCO contracts state that administrative costs shall not exceed 10 percent of the total Medicaid managed care contract costs. However, the contract does not contain penalties for failing to meet this requirement, and the APA was unable to determine how this requirement was monitored.

The contract contains additional requirements that do not stipulate penalties or other parameters for strengthening compliance, which impairs the effectiveness of the contract elements. As noted above, there are examples of case management programs within MCOs operating in Kentucky that may provide CHFS examples of specific program requirements that are working, or could work more effectively when applied on a statewide basis. Although the contract does contain sanctions for breach of contract, many elements of the contract may be more effective and easier to administer through the provision of penalties.

The current MCO contract also contains language that, if expanded, could provide CHFS opportunities for additional advances in health care delivery. For example, the integration of medical and behavioral health services is a growing trend for improving the long-term health of the individual while also decreasing long-term costs. A 2006 report by the National Association of State Mental Health Program Directors reported that persons with serious mental illness are dying 25 years earlier than the general population, and that the underlying risk factors are treatable – such as increased incidences of smoking, obesity, substance abuse, and inadequate access to medical care. Kentucky's MCO contract makes references to this type of integration, among other elements requiring MCOs to have provider provisions for Primary Care Physicians (PCPs) to have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems. The Kentucky contract also requires that QAPI reporting discussed above contain behavioral health measures. However, the contract does not specifically require that the MCO have a behavioral health integration

program, and does not stipulate penalties for a MCO's failure to require such integration.

Another section of the contract that could provide additional advances in reaching long-term objectives is related to wellness programs. The contract currently includes a section related to Member Education and Outreach. However, the section primarily addresses educating members about their benefits and services of the MCO's program. In reviewing contracts of other states, examples are noted in which member outreach programs also include provisions to enhance the general health and well-being of the members, such as efforts to improve health literacy and coordination of resources with social service organizations. These wellness programs are key to improving the health of Kentuckians, especially those served by the MCOs since those receiving federal aid often have the greatest barriers in obtaining this information elsewhere.

The current MCO contract also does not require specific reporting of provider grievances/appeals to CHFS. MCOs are responsible for the provider grievance/appeals process, and for resolution of those matters. Although the MCOs are required to maintain the documentation of its appeals, it is not required to report those matters and their disposition to CHFS regularly. The lack of this reporting creates a gap in information that should be an important element in CHFS' programmatic monitoring.

Recommendations

We recommend MCO contractual penalties be strengthened to include listing specific penalties and establishing criteria for applying penalties. For example, the state of Tennessee withholds a certain percentage of monthly capitation payments. The capitation withhold starts at ten percent and decreases over time when there are no contractual deficiencies identified. If no deficiencies are reported, or if the deficiencies are corrected, the withheld funds are returned with the following month's capitation payment. If there are unresolved deficiencies, the funds are retained by the program.

We recommend CHFS require MCOs to report provider grievances/appeals monthly so it can determine that conflicts are resolved appropriately and timely, and also make determinations as to whether penalties should be applied. This information also may assist CHFS in identifying trends in conflicts and determining whether solutions exist to satisfy MCOs and providers.

We recommend CHFS update MCO contractual language to strengthen behavioral health integration and wellness program requirements. For example, contracts should specifically require MCOs develop behavioral health integration program and wellness programs. Also, we recommend the contract identifies a penalty for an MCO's failure to establish a behavioral health integration and wellness program within a certain time frame. CHFS also may establish incentives for MCOs to implement

expanded wellness programs, such as embedding case managers at hospitals and other methods for coordination with local social service agencies.

CHFS should consider expanding quality reporting, utilizing QAPI and HEDIS elements, including the member and provider satisfaction assessments. Although summary information provided to members can be a useful tool, a more in-depth comparative analysis of the data available could not only assist the agency in its contract monitoring, but also add transparency to CHFS' quality ranking process.

Observation 8: The number of providers across the Commonwealth - particularly in rural Kentucky - dropped significantly between 2013 and 2014, raising concerns about health care accessibility at a time when more people are getting insurance.

The report from Deloitte, LLC addresses the provider network in detail. The results of that study indicated the number and type of providers are within the limits specified in the MCO contracts as to the number of patients per provider and the distance from patients to providers. The results of the ad hoc reports obtained from DMS, however, indicate a decrease in providers in 36 of the 65 provider types from 2013 to 2014. As depicted in **Exhibit 10**, 22 provider types decreased by more than 10 percent from 2011 to 2014, with the following critical provider types within the top 10 with the highest percentage decrease:

- General Hospitals - 59 percent decrease;
- Physician - Group - 28 percent decrease; and
- Physician Individual - 23 percent decrease.

These results also indicate that the most significant changes are between FY 2013 and 2014, which are in stark contrast to the changes between 2011 and 2013, where only five of the 18 provider types decreased by more than 10 percent. The entire list of provider types and variances between 2011-2013, 2013-2014, and total changes between 2011-2014 is presented in *Appendix V - Changes in Providers Between November 2011 and June 2014*.

Exhibit 10 - Decreases Greater Than 10% in Medicaid Provider Types Between 2011 and 2014

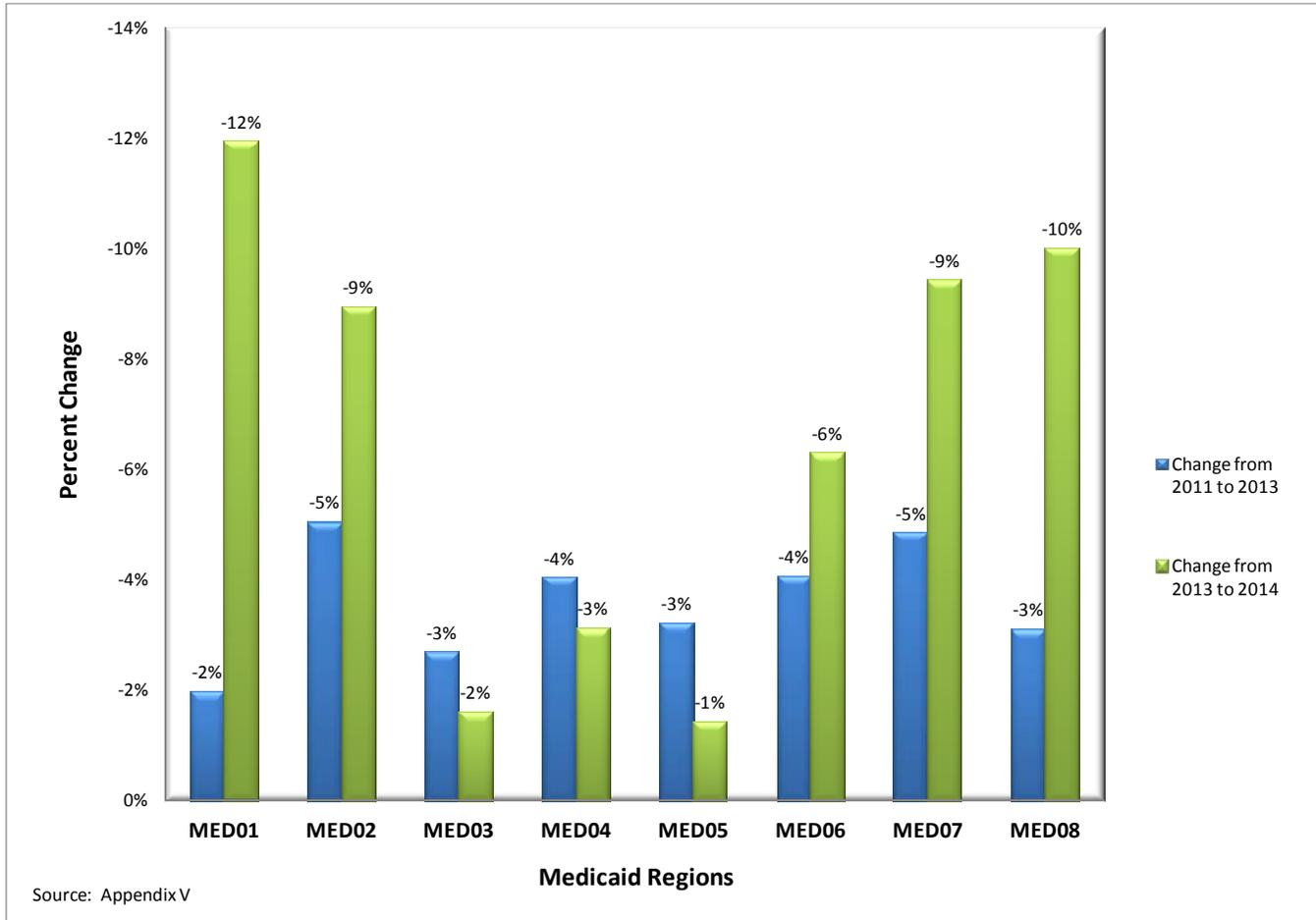
Provider Type	2011-2013 % Change	2013-2014 % Change	Total 2011-2014 % Change
01 - General hospital	-57%	-5%	-59%
90 - DME Supplier	-34%	-20%	-47%
86 - X-Ray / Misc. Supplier	-29%	-20%	-43%
50 - Hearing Aid Dealer	-28%	-15%	-39%
20 - Preventive & Remedial Public Health	1%	-29%	-29%
65 - Physician - Group	-7%	-23%	-28%
85 - Chiropractor	-12%	-15%	-25%
52 - Optician (528 - Optical clinic)	-9%	-17%	-25%
64 - Physician Individual	-11%	-13%	-23%
56 - Non-Emergency Transportation	3%	-24%	-22%
36 - Ambulatory Surgical Centers	-5%	-16%	-20%
13 - Specialized Children Service Clinics	0%	-19%	-19%
31 - Primary Care	5%	-23%	-18%
37 - Independent Laboratory	-6%	-12%	-17%
91 - CORF (Comprehensive Out-patient Rehab)	-17%	0%	-17%
93 - Rehabilitation Distinct Part Unit	0%	-17%	-17%
29 - Impact Plus	-5%	-11%	-16%
45 - EPSDT Special Services	-3%	-12%	-15%
17 - Acquired Brain Injury	0%	-13%	-13%
30 - Community Mental Health	0%	-13%	-13%
55 - Emergency Transportation	-10%	-2%	-12%
77 - Optometrist - Individual	-6%	-6%	-12%

Source: Kentucky Cabinet for Health and Family Services

Next, changes in total Medicaid providers by managed care region were analyzed. Those results are presented in **Exhibit 11**. This data indicates a troubling trend, indicating that rural Kentucky has been affected significantly more than other regions by a loss of providers. Medicaid regions 01 through 08 represent geographic areas in the state, and are depicted in *Appendix VI - Changes in Providers by Medicaid MCO Region*. Region 09 represents out-of-state providers. For the period from November 1, 2011 to February 28, 2013, the number of in-state providers in Regions 01 through 08 decreased by two to five percent, and out-of-state providers in Region 09 declined by 18 percent. There is a significant difference, however, when the changes in providers are compared across all regions from 2013 to 2014. Regions 01 and 02 located in western Kentucky saw declines in the total number of providers of 12 percent and nine percent, respectively. Regions 07 and 08, located in eastern Kentucky reflected decreases in total providers of nine percent and 10 percent, respectively, followed by Region 06 in northern Kentucky, which reflected a six percent decrease. By comparison, total providers in the central part of the Commonwealth decreased between one and three percent. As *Appendix V* presents, with all years taken into consideration,

total providers in all regions declined between five and 29 percent between November 1, 2011 and June 30, 2014, with five out of eight in-state regions declining more than 10 percent.

Exhibit 11 - Percentage Decrease in Medicaid Providers by MCO Region



At the time of Deloitte’s study of fiscal year 2013, the provider network was within MCO contractual specifications; however, the ad hoc reports analyzed indicate that certain provider types and certain regions have decreased significantly more than others between November of 2011 and June of 2014. A decrease in providers, particularly in rural Kentucky, coupled with increase in members creates additional health care accessibility concerns, especially given the potential loss of additional providers associated with rural hospitals that have fiscal stability concerns. CHFS is not monitoring this decline, creating additional concerns that accessibility issues are not being addressed.

Recommendations

CHFS should provide the proposed work group periodic updates on the changes in the number of providers across all Medicaid regions, particularly in rural Kentucky. Improving access, particularly in rural areas of the Commonwealth, needs to be a priority over the coming years.

The proposed work group should evaluate regulations to determine if certain advances, such as telemedicine, can be further utilized to boost access to care in remote areas of the Commonwealth that may have inadequate primary care or specialty providers. This may be especially necessary to further promote behavioral health and medical integration requirements recommended above.

The APA acknowledges that CHFS recognizes the need to identify current and future health care workforce shortage areas and develop legislative and policy changes that may be needed to increase the supply of providers and to create a pipeline to improve the recruitment and retention of quality healthcare professionals. We urge CHFS to continue working to ensure the number of providers in certain areas of the state does not decline to a level such that it would present serious access issues, particularly to the state's elderly and low-income population. The proposed work group could assist in studying policies to improve provider adequacy concerns, including expanding scholarship programs, establishing programs to identify potential in-state medical students earlier, enhancing recruitment and retention efforts in the medical field in rural areas, ensuring regulations are sufficient for identifying the actual numbers of licensed professionals practicing at any given time, and other innovative solutions for enhanced recruitment and retention of health care workers.

While the focus of this study was on rural hospitals, the work group also should examine other issues related to rural health care access, including emergency and non-emergency transportation. The APA heard from several ambulance providers during public meetings who expressed concern about the low reimbursement rates they receive. Attention needs to be given to ensuring an adequate ambulance network remains in rural areas of Kentucky. In addition, one MCO representative reported that non-emergency transportation is a growing concern. If the goal is toward preventative care and wellness, Medicaid members must have adequate transportation to make appointments and receive care. The work group should examine regulations regarding non-emergency transportation and study whether MCOs could appropriately establish ways to ensure their members have adequate transportation.

In addition, we recommend the work group closely examine the role public health departments should play in these new models of health care delivery. Public health departments have established connections with segments of the population that MCOs have reported are difficult for them to identify and reach. In addition, they have experience in education and outreach with these populations that could be useful to CHFS and MCOs in understanding how to effectively improve health literacy and wellness.

APPENDICES

Responses to Request for Audited Financial Statements and Survey

	Hospital	Ownership	Hospital Type	Financial Statements			Survey
				2011	2012	2013	
1	Baptist Health Corbin	Voluntary non-profit - Private	Acute	✓	✓	✓	✓
2	Baptist Health Madisonville	Voluntary non-profit - Private	Acute	✓	✓	✓	✓
3	Baptist Health Paducah	Voluntary non-profit - Private	Acute	✓	✓	✓	✓
4	Baptist Health Richmond	Voluntary non-profit - Private	Acute	✓	✓	✓	×
5	Breckinridge Memorial Hospital	Government - Local	CAH	✓	✓	✓	×
6	Caldwell Medical Center	Government - Hospital District or Authority	CAH	✓	✓	✓	✓
7	Carroll County Memorial Hospital	Voluntary non-profit - Private	CAH	✓	✓	✓	×
8	Casey County Hospital	Government - Hospital District or Authority	CAH	✓	✓	✓	✓
9	Caverna Memorial Hospital	Voluntary non-profit - Private	CAH	✓	✓	✓	✓
10	Clinton County Hospital	Voluntary non-profit - Private	Acute	✓	✓	✓	✓
11	ContinueCARE Hospital	Voluntary non-profit - Private	LTACH	✓	✓	✓	×
12	Crittenden Health System	Proprietary	Acute	✓	✓	✓	×
13	Cumberland County Hospital ¹	Voluntary non-profit - Other	CAH	✓	✓	✓	×
14	Ephraim McDowell Fort Logan ² Hospital	Voluntary non-profit - Private	CAH	✓	✓	✓	×
15	Ephraim McDowell Regional Medical ² Center	Voluntary non-profit - Other	Acute	✓	✓	✓	✓
16	Fleming County Hospital	Voluntary non-profit - Other	Acute	✓	✓	✓	×
17	Frankfort Regional Medical Center	Proprietary	Acute	×	×	×	×
18	Harlan ARH Hospital ²	Voluntary non-profit - Other	Acute	✓	✓	✓	×
19	Harrison Memorial Hospital	Voluntary non-profit - Other	Acute	✓	✓	✓	✓
20	Hazard ARH Regional Medical Center ²	Voluntary non-profit - Private	Acute	✓	✓	✓	×
21	Highlands Regional Medical Center	Proprietary	Acute	✓	✓	✓	✓
22	Jackson Purchase Medical Center	Government - Hospital District or Authority	Acute	×	×	×	×
23	James B Haggin Memorial Hospital		CAH	✓	✓	✓	×
24	Jane Todd Crawford Hospital	Voluntary non-profit - Private	CAH	✓	✓	✓	✓
25	Kentucky River Medical Center	Voluntary non-profit - Other	Acute	×	×	×	×
26	Knox County Hospital ¹	Government - Local	CAH	✓	✓	✓	✓
27	Lake Cumberland Regional Hospital	Proprietary	Acute	×	×	×	×
28	Livingston Hospital and Healthcare Services	Voluntary non-profit - Private	CAH	✓	✓	✓	✓
29	Logan Memorial Hospital	Proprietary	Acute	×	×	×	×
30	Lourdes Hospital	Voluntary non-profit - Private	Acute	×	✓	✓	×
31	Manchester Memorial Hospital	Voluntary non-profit - Private	Acute	✓	✓	✓	✓
32	Marcum and Wallace Memorial Hospital	Voluntary non-profit - Private	CAH	×	✓	✓	✓
33	Marshall County Hospital	Government - Hospital District or Authority	CAH	✓	✓	✓	✓
34	Mary Breckinridge ARH Hospital ²	Voluntary non-profit - Private	CAH	✓	✓	✓	×
35	McDowell ARH Hospital ²	Voluntary non-profit - Private	CAH	✓	✓	✓	×
36	Meadowview Regional Medical Center	Proprietary	Acute	×	×	×	×
37	Methodist Hospital Union County	Voluntary non-profit - Private	CAH	✓	✓	✓	✓
38	Middlesboro ARH Hospital ²	Voluntary non-profit - Private	Acute	✓	✓	✓	×
39	Monroe County Medical Center	Voluntary non-profit - Private	Acute	✓	✓	✓	×
40	Morgan County ARH Hospital ²	Voluntary non-profit - Private	CAH	✓	✓	✓	×
41	Muhlenberg Community Hospital	Voluntary non-profit - Private	Acute	✓	✓	✓	✓
42	Murray-Calloway County Hospital	Voluntary non-profit - Other	Acute	✓	✓	✓	×
43	New Horizons Health Systems Inc	Proprietary	CAH	✓	✓	✓	✓
44	Ohio County Hospital	Proprietary	CAH	✓	✓	✓	×
45	Parkway Regional Hospital ³	Proprietary	Acute	×	×	×	×
46	Paul B Hall Regional Medical Center	Proprietary	Acute	×	×	×	×
47	Pikeville Medical Center	Voluntary non-profit - Private	Acute	✓	✓	✓	×
48	Pineville Community Hospital	Voluntary non-profit - Other	Acute	✓	✓	✓	×
49	Rockcastle Regional Hospital & Respiratory Center	Voluntary non-profit - Private	Acute	✓	✓	✓	×

Continued on next page

Responses to Request for Audited Financial Statements and Survey (Continued)

	Hospital	Ownership	Hospital Type	Financial Statements			Survey
				2011	2012	2013	
50	Russell County Hospital	Government - Local	CAH	✓	✓	✓	✓
51	Saint Joseph Berea	Voluntary non-profit - Private	CAH	×	✓	✓	×
52	Saint Joseph London	Voluntary non-profit - Private	Acute	×	✓	✓	×
53	Saint Joseph Martin	Voluntary non-profit - Private	CAH	×	✓	✓	×
54	Saint Joseph Mount Sterling	Voluntary non-profit - Private	Acute	×	✓	✓	×
55	Spring View Hospital	Proprietary	Acute	×	×	×	✓
56	St. Claire Regional Medical Center	Voluntary non-profit - Private	Acute	✓	✓	✓	✓
57	T. J. Samson Community Hospital	Voluntary non-profit - Other	Acute	×	×	×	×
58	Taylor Regional Hospital	Government - Hospital District or Authority	Acute	✓	✓	✓	✓
59	The Medical Center Franklin	Voluntary non-profit - Other	CAH	✓	✓	✓	×
60	The Medical Center Scottsville ¹	Voluntary non-profit - Private	CAH	✓	✓	✓	×
61	Three Rivers Medical Center	Voluntary non-profit - Private	Acute	×	×	×	×
62	Twin Lakes Regional Medical Center	Proprietary	Acute	✓	✓	✓	✓
63	Wayne County Hospital Inc	Voluntary non-profit - Other	CAH	✓	✓	✓	×
64	Westlake Regional Hospital	Voluntary non-profit - Other	Acute	✓	✓	✓	×
65	Whitesburg ARH Hospital ²	Government - Hospital District or Authority	Acute	✓	✓	✓	×
66	Williamson ARH Hospital ²	Voluntary non-profit - Other	Acute	✓	✓	✓	×

Footnotes and Legend

- ✓ Financial statements received/Participated in survey
- ×
- 1 Financial statements not received/Did not participate in survey
- 1 Financial data did not contain required data elements for FSI analysis
- 2 Part of a consolidated group for financial reporting
- 3 Announced closing March 2015

Source: APA - hospitals participating in APA Survey and request for audited financial statements. CMS is the source of ownership information.

Determining the rural hospital population to evaluate

According to KHA, a hospital is considered urban if it is in an urbanized area of 50,000 or more people. KHA provided information on 127 Kentucky hospitals, designating them as either urban or rural based on 2010 Census data. This criterion identified 61 urban and 66 rural hospitals in Kentucky.

Audited financial statements were requested from each of the 66 rural hospitals. Auditors learned that eight of the 66 rural hospitals are reported and audited as a consolidated entity. Therefore, for the purposes of financial analysis these eight entities are treated as a single financial entity, bringing the total population of hospitals or hospital systems to 58.

Financial information was received from 48 of the 58 hospitals or hospital systems contacted. Eleven rural hospitals elected not to participate in the assessment, and an additional 4 hospitals submitted data that was not conducive for the assessment due to reporting methodologies that did not include specific data elements required. A review of the responses indicates that for-profit hospitals comprised the majority of non-responding hospitals, likely due to proprietary concerns in sharing detailed financial information.

Time period assessed

Financial data utilized for this assessment was obtained from financial statements available for participating rural hospitals for the three most recent fiscal years (2011, 2012, and 2013). This time period also presents information important to the assessment because it begins with fiscal year 2011, which is the last fiscal year in which the Commonwealth of Kentucky operated its Medicaid program as a fee-for-service program. Medicaid managed care was implemented in fiscal year 2012 on November 1, 2011; therefore, fiscal year 2013 is the first full fiscal year under the managed care program. At the time of this assessment, audited financial data was not available for fiscal year 2014, which is the first fiscal year of operations impacted by Medicaid expansion in the Commonwealth.

Calculating the Financial Strength Index[®]

The Financial Strength Index[®] (FSI[®]) was developed by Cleverly + Associates, financial consultants to the hospital industry, as a single measurement to allow someone to determine a hospital's financial standing in regards to a national benchmark. The APA received permission to utilize this methodology by its developers, Cleverly + Associates, financial consultants in the hospital industry. The FSI[®] is calculated by normalizing four financial ratios: total margin, days cash on hand, debt financing, and depreciation expense.

- **Total Margin:** this ratio is calculated by dividing net income by total revenues. It measures the percentage of revenue kept as profit.
- **Days Cash on Hand:** this ratio measures the hospital's ability to pay off short term debt. It indicates the number of days that a hospital could operate without acquiring any additional cash and is calculated by adding cash and unrestricted investments less bad debt expense and depreciation and dividing that number by 365.

- **Debt Financing:** This ratio measures the amount of assets financed by debt. It is calculated by subtracting net assets from total assets and then dividing the resulting number by total assets.
- **Depreciation Expense:** This is a rough measure of the age of a hospital's facilities. Depreciation expense is calculated by dividing accumulated depreciation by total property, plant, and equipment.

Each of the four ratios is normalized using median values taken from all U.S. hospitals. By normalizing the values around national medians, the resulting FSI[®] for each hospital can be used as a method to determine the financial health of a particular hospital against not only other hospitals in the study, but also against all hospitals nationally. Since FSI[®] is set up to compare hospitals to the national median; a hospital performing exactly at median levels for the nation would have an FSI[®] of 0. There are no minimums or maximums in deterring FSI[®], so specific values are set as indicators of financial health. An FSI[®] of greater than 3 indicates that a hospital is in excellent health, a score from 0 to 3 indicates good financial health, a score from -2 to 0 indicates fair financial health, and a score of less than -2 indicates poor financial health. The lower the score on the FSI[®], the poorer the financial condition of the hospital.

1. What is the name of your hospital?			
<u>Answer Options</u>	<u>Response Count</u>		
Refer to respondees listed in Appendix I.	24		
2. What is the percentage makeup of patients at your hospital? Please round to the nearest %.			
<u>Answer Options</u>	<u>Response Average</u>	<u>Response Total</u>	<u>Response Count</u>
Medicaid	25%	589	24
Medicare	47%	1,104	24
Private Insurance	22%	526	24
Uninsured	6%	148	24
3. What was the amount of your cash reserves on hand on June 30, 2014? Please round to the nearest dollar.			
<u>Answer Options</u>	<u>Response Average</u>	<u>Response Total</u>	<u>Response Count</u>
\$	\$13,928,100	\$334,274,399	24
4. How many operating days would the above amount of cash reserves cover? Please round to the nearest whole day.			
<u>Answer Options</u>	<u>Response Average</u>	<u>Response Total</u>	<u>Response Count</u>
Number of Days	97.96	2,351	24
5. Have you laid off employees due to fiscal difficulties in the last 24 months?			
<u>Answer Options</u>	<u>Response Percent</u>	<u>Response Count</u>	
Yes	20.8%	5	
No	79.2%	19	
6. How many employees have you laid off in the last 24 months?			
<u>Answer Options</u>	<u>Response Average</u>	<u>Response Total</u>	<u>Response Count</u>
Employees	40.00	200	5

7. Have administrative costs increased since the implementation of Managed Care?			
<u>Answer Options</u>	<u>Response Percent</u>	<u>Response Count</u>	
Yes	79.2%	19	
No	20.8%	5	
8. What, approximately, has been the increase in administrative costs per year since Managed Care implementation? Please round to the nearest dollar.			
<u>Answer Options</u>	<u>Response Average</u>	<u>Response Total</u>	<u>Response Count</u>
\$	\$156,796	\$2,822,322	18
9. How many additional hours per week have been necessary to cover the administrative duties related to Managed Care?			
<u>Answer Options</u>	<u>Response Percent</u>	<u>Response Count</u>	
0-5	21.7%	5	
6-10	8.7%	2	
11-15	0.0%	0	
16-20	4.3%	1	
21-25	8.7%	2	
26+	56.5%	13	
10. Has it been necessary to hire additional staff to cover the additional administrative duties related to Managed Care?			
<u>Answer Options</u>	<u>Response Percent</u>	<u>Response Count</u>	
Yes	52.2%	12	
No	47.8%	11	
11. Has overtime increased to cover the additional administrative duties related to Managed Care?			
<u>Answer Options</u>	<u>Response Percent</u>	<u>Response Count</u>	
Yes	52.2%	12	
No	47.8%	11	

12. Have budgets to other departments or areas been cut to cover the additional administrative duties related to Managed Care?		
<u>Answer Options</u>	<u>Response Percent</u>	<u>Response Count</u>
Yes	39.1%	9
No	60.9%	14
14. Which areas or departments?		
<u>Answer Options</u>	<u>Response Count</u>	
Open ended response, responses included (duplicates merged): Several, Supplies, Marketing, Administration, Patient Accounts, Medical Records, Nursing, Physical Practices, Patient Care Services, Environmental Services, Accounting, Utilization Review, Credentialing, Nursing, Facilities, Multiple, Most All Areas	9	
15. What are the reasons for the additional time and costs associated with Managed Care?		
<u>Answer Options</u>	<u>Response Percent</u>	<u>Response Count</u>
Increased procedures for reimbursement	69.6%	16
Increased pre-authorizations	82.6%	19
Inconsistent treatments for reimbursement by the different MCOs	82.6%	19
Different procedures for each MCO	78.3%	18
Following up on errors	52.2%	12
Following up on denial of claims	91.3%	21
Following up on late reimbursements	65.2%	15
Other	13.0%	3

16. In your opinion, what are the strengths of Managed Care compared to Pay Per Service?

Answer Options

Response Count

Open ended response, responses included (duplicates merged):

23

"In our opinion, there are no strengths. No positives for patients or providers. Cut reimbursements and increased administrative costs."

"Managed Care has helped to lower our self pay population & thus our bad debt expense. Exchange has given more people access to health care."

"Timeliness of coverage."

"Being a CAH, we have not seen any strengths." "[Hospital] is a CAH,

"None."

"None that can be seen, except balancing the state's budget."

"Managed Care can drive down utilization; Managed Care can improve the health of patients through the implementation of wellness programs."

"It does add some competitiveness in that environment and gives the patient's choices."

"In theory, the care should be better coordinated and an individual should be responsible for their own health, This is theory only, reality does not work this way."

"Cost containment (which is working but at the expense of caregivers)."

"Consistency of reimbursement."

"None. We have not experienced any "managed care" for our patient population, just additional administrative costs and significant denials and underpayments for claims submitted."

"Provider reps are more accessible."

"Allows for greater competition among providers."

17. In your opinion, what are the weaknesses of Managed Care compared to Pay Per Service?

Answer Options

Response Count

Open ended response, responses included (duplicates merged):

23

"Promised wellness and education for patient and has yet to deliver."

"Inconsistent rules among the different MCOs has led to increased administrative costs. Denials for medically necessary procedures lowers the quality of care."

"It is hard to know when a patient changes plans."

"They have not done what they were suppose to do, MANAGE PATIENTS. They only manage the money. The \$50 triage fee is going to close lots of hospital because the patient has NO liability."

"Not managing, the patients care; everything; requires a preauthorization; claim denials."

"Incentivizing out-of-state corporations to deny care and devastate Kentucky hospitals; Systemic denials and underpayments; Illusion of better care because MCOs know how to "game" indicators."

"Although all MCOs are supposed to be following Medicaid's rules, they are not. There seems to be more management of paying providers than there is of managing patients behavior."

"Delays in payment, denials."

"The weaknesses of Managed Care in KY primarily relates to pre-authorizations for the most part that simply do not add to the quality of care for the patient and only serves as an administrative burden and an opportunity for payment denials."

"Not managing the patients care; everything requires a preauthorization; claims denials."

"Having so many different Managed Care Organizations and no consistency among them. We have had to hire one FTE for this purpose as well as employee an outside Revenue Cycle Group."

"You cannot herd patients to follow the rules because they have no financial interest in their medical care. It is just "free" and they take no responsibilities. The hospital and other providers are punished." because no one can get the Medicaid population to follow rules."

"Unfair reimbursement especially in the ER. Denials are a game - if the admission was approved, how could they pay the ER at \$50????? Also, do they understand EMTALA? It's easy to say tests aren't necessary when you have the results but doctors do not have x-ray vision and cannot tell if there is a problem without diagnostic testing."

"Variable rules for each MCO."

"Too much fight for reimbursement."

"Inconsistency, inappropriate triage payments, administrative burden, etc."

"Has created unnecessary delays to providing care."

"Same as 14. We have not experienced any "managed care" for our patient population, just additional administrative costs and significant denials and underpayments for claims submitted."

18. Is there anything you would like to add regarding the financial health of your hospital and Managed Care that has not been covered

Answer Options

Response Count

Open ended response, responses included (duplicates merged):

23

"We do appreciate the Medicaid expansion of Medicaid. More people with more coverage."

"Many self pay patients who picked up insurance through the exchange have complained that they were misled regarding deductibles & co-pays."

"The Medicaid program has been underfunded for years. Now it has been passed on to the providers as a result of Obama Care and expanded Medicaid. We have had increasing numbers in our ER of which the MCO's are only paying a \$50 triage fee. Also factor in the sequestration and continue to struggle financially unless we get additional relief."

"MCOs are hurting hospitals more than people realize."

"I included in the number of lay-offs, hours cut to all remaining employees. We have let @ 10 employees go, the hourly limits placed on remaining employees add up to the equivalent of 13 employees."

"Managed Care is Kentucky as we have experienced in Kentucky is merely a managed payment system; I have seen no instances of what I would describe as managed care whose objectives would/should be to manage a patient/member to effect improved health."

"The Medicaid program has been underfunded for years. Now it has been passed on to the providers as a result of Obama Care and expanded Medicaid, we have had increasing numbers in our ER of which the MCO's are only paying a \$50 triage fee. Also factor in the sequestration and continue to struggle financially unless we get additional relief."

"There are certain things with each Managed Care Organization that has hurt the hospital's financial health. It does now take the hospital more resources to get our revenue. The hospital has to deploy a lot of hours to staying on top of each of the Managed Care Organizations. One in particular has really hurt the ED department."

"They need to have people on their end who will answer the phone when we have claim issues - especially [MCO name redacted]."

"Cash balance strong due to strong mgmt, however MCO practices this year are negatively effecting hospital at an alarming rate."

"Historically, Kentucky Medicaid has been underfunded, and has not paid for the cost of care provided to the eligible enrollment. Managed care has increased the cost to provide the care, and has significantly reduced the amount of reimbursements available to providers. Significant dollars have been removed from the program to provide care - those dollars are going to out of state insurance companies. This course cannot continue if Kentucky truly desires to provide for care to the vulnerable populations."

"The initial paid claim on many of the managed care contracts for ED visits has been only at the \$50 triage fee; numerous issues exist regarding no payment on ED patients under 6, etc."

Name	City	State	County	FFY 2013	FFY 2014	FFY 2015	Rural Hospital?
				Readmission Penalty	Readmission Penalty	Readmission Penalty	
Baptist Health Louisville	Louisville	KY	Jefferson	0.26%	0.07%	0.00%	
Owensboro Health Regional Hospital	Owensboro	KY	Daviess	0.00%	0.00%	0.00%	
Baptist Health Richmond	Richmond	KY	Madison	0.16%	0.01%	0.02%	YES
Georgetown Community Hospital	Georgetown	KY	Scott	0.11%	0.04%	0.05%	
Clark Regional Medical Center	Winchester	KY	Clark	0.00%	0.00%	0.06%	
University Of Louisville Hospital	Louisville	KY	Jefferson	0.08%	0.07%	0.06%	
Jewish Hospital - Shelbyville	Shelbyville	KY	Shelby	0.14%	0.00%	0.08%	
Baptist Health Lexington	Lexington	KY	Fayette	0.15%	0.21%	0.14%	
Baptist Health Corbin	Corbin	KY	Knox	0.00%	0.03%	0.16%	YES
Lourdes Hospital	Paducah	KY	Mccracken	0.18%	0.00%	0.17%	YES
Saint Joseph Mount Sterling	Mount Sterling	KY	Montgomery	0.00%	0.00%	0.17%	YES
Norton Hospitals, Inc	Louisville	KY	Jefferson	0.15%	0.12%	0.18%	
Saint Joseph London	London	KY	Laurel	1.00%	0.23%	0.19%	YES
Hardin Memorial Hospital	Elizabethtown	KY	Hardin	0.00%	0.10%	0.28%	
Ephraim McDowell Regional Medical Center	Danville	KY	Boyle	0.19%	0.27%	0.30%	YES
Baptist Health Paducah	Paducah	KY	Mccracken	0.11%	0.35%	0.31%	YES
Frankfort Regional Medical Center	Frankfort	KY	Franklin	0.00%	0.15%	0.33%	YES
Saint Joseph Hospital	Lexington	KY	Fayette	0.38%	0.24%	0.34%	
University Of Kentucky Hospital	Lexington	KY	Fayette	0.37%	0.29%	0.42%	
St Elizabeth Ft Thomas	Fort Thomas	KY	Campbell	0.63%	0.40%	0.43%	
Meadowview Regional Medical Center	Maysville	KY	Mason	0.79%	0.95%	0.45%	YES
T J Samsom Community Hospital	Glasgow	KY	Barren	0.16%	0.11%	0.47%	YES
Baptist Health Madisonville	Madisonville	KY	Hopkins	0.00%	0.08%	0.48%	YES
Spring View Hospital	Lebanon	KY	Marion	1.00%	0.41%	0.51%	YES
Bourbon Community Hospital	Paris	KY	Bourbon	0.15%	0.10%	0.53%	
Murray-Calloway County Hospital	Murray	KY	Calloway	0.21%	0.49%	0.53%	YES
Paul B Hall Regional Medical Center	Paintsville	KY	Johnson	0.91%	0.72%	0.55%	YES
Lake Cumberland Regional Hospital	Somerseset	KY	Pulaski	0.30%	0.09%	0.58%	YES
Baptist Health Lagrange	La Grange	KY	Oldham	0.00%	0.00%	0.60%	
Muhlenberg Community Hospital	Greenville	KY	Muhlenberg	0.00%	0.00%	0.63%	YES
Pikeville Medical Center	Pikeville	KY	Pike	0.60%	0.19%	0.63%	YES
St Elizabeth Medical Center	Lakeside Park	KY	Kenton	0.18%	0.13%	0.76%	
Jewish Hospital & St Mary'S Healthcare	Louisville	KY	Jefferson	0.99%	0.53%	0.80%	
Taylor Regional Hospital	Campbellsville	KY	Taylor	0.40%	0.42%	0.84%	YES
Parkway Regional Hospital	Fulton	KY	Fulton	0.54%	1.28%	0.90%	YES
Logan Memorial Hospital	Russellville	KY	Logan	0.10%	0.42%	0.92%	YES
St Claire Regional Medical Center	Morehead	KY	Rowan	0.72%	0.53%	1.02%	YES
Highlands Regional Medical Center	Prestonsburg	KY	Floyd	1.00%	0.98%	1.14%	YES
Greenview Regional Hospital	Bowling Green	KY	Warren	0.12%	0.16%	1.15%	
Our Lady Of Bellefonte Hospital	Ashland	KY	Boyd	0.70%	0.40%	1.20%	
The Medical Center At Bowling Green	Bowling Green	KY	Warren	0.25%	0.38%	1.27%	
Harrison Memorial Hospital	Cynthiana	KY	Harrison	0.67%	0.78%	1.37%	YES
Rockcastle County Hospital, Inc	Mount Vernon	KY	Rockcastle	1.00%	0.93%	1.37%	YES
St Elizabeth Florence	Florence	KY	Boone	0.86%	0.70%	1.40%	
King's Daughters' Medical Center	Ashland	KY	Boyd	1.00%	1.07%	1.48%	
Crittenden Health System	Marion	KY	Crittenden	1.00%	1.31%	1.52%	YES
Jackson Purchase Medical Center	Mayfield	KY	Graves	0.20%	1.08%	1.67%	YES
Twin Lakes Regional Medical Center	Leitchfield	KY	Grayson	0.12%	0.77%	1.69%	YES
Middlesboro Appalachian Regional Healthcare Hosp	Middlesboro	KY	Bell	0.33%	0.87%	2.11%	YES
Flaget Memorial Hospital (Member Of Saint Joseph)	Bardstown	KY	Nelson	0.00%	0.05%	2.22%	
Methodist Hospital	Henderson	KY	Henderson	1.00%	0.68%	2.25%	
Saint Joseph East	Lexington	KY	Fayette	0.08%	0.00%	2.26%	
Clinton County Hospital, Inc	Albany	KY	Clinton	1.00%	1.15%	2.31%	YES
Kentucky River Medical Center	Jackson	KY	Breathitt	0.42%	0.57%	2.42%	YES
Fleming County Hospital	Flemingsburg	KY	Fleming	1.00%	1.17%	2.76%	YES
Jennie Stuart Medical Center	Hopkinsville	KY	Christian	0.73%	0.90%	2.94%	
Harlan Appalachian Regional Healthcare Hospital	Harlan	KY	Harlan	1.00%	2.00%	3.00%	YES
Hazard ARH Regional Medical Center	Hazard	KY	Perry	1.00%	1.22%	3.00%	YES
Memorial Hospital	Manchester	KY	Clay	1.00%	1.69%	3.00%	
Monroe County Medical Center	Tompkinsville	KY	Monroe	1.00%	2.00%	3.00%	YES
Pineville Community Hospital	Pineville	KY	Bell	1.00%	2.00%	3.00%	YES
Three Rivers Medical Center	Louisa	KY	Lawrence	1.00%	1.01%	3.00%	YES
Westlake Regional Hospital	Columbia	KY	Adair	1.00%	2.00%	3.00%	YES
Whitesburg ARH Hospital	Whitesburg	KY	Letcher	0.96%	1.27%	3.00%	YES
Williamson ARH Hospital	South Williamson	KY	Pike	1.00%	1.37%	3.00%	YES

Source: Centers for Medicare and Medicaid Services

Appendix V

Changes in Medicaid Provider Types Between 2011 and 2014

Provider Type	2011-2013 % Change	2013-2014 % Change	Total 2011-2014 % Change
01 - General hospital	-57%	-5%	-59%
90 - DME Supplier	-34%	-20%	-47%
86 - X-Ray / Misc. Supplier	-29%	-20%	-43%
50 - Hearing Aid Dealer	-28%	-15%	-39%
20 - Preventive & Remedial Public Health	1%	-29%	-29%
65 - Physician - Group	-7%	-23%	-28%
85 - Chiropractor	-12%	-15%	-25%
52 - Optician (528 - Optical clinic)	-9%	-17%	-25%
64 - Physician Individual	-11%	-13%	-23%
56 - Non-Emergency Transportation	3%	-24%	-22%
36 - Ambulatory Surgical Centers	-5%	-16%	-20%
13 - Specialized Children Service Clinics	0%	-19%	-19%
31 - Primary Care	5%	-23%	-18%
37 - Independent Laboratory	-6%	-12%	-17%
91 - CORF (Comprehensive Out-patient Rehab Facility)	-17%	0%	-17%
93 - Rehabilitation Distinct Part Unit	0%	-17%	-17%
29 - Impact Plus	-5%	-11%	-16%
45 - EPSDT Special Services	-3%	-12%	-15%
17 - Acquired Brain Injury	0%	-13%	-13%
30 - Community Mental Health	0%	-13%	-13%
55 - Emergency Transportation	-10%	-2%	-12%
77 - Optometrist - Individual	-6%	-6%	-12%
42 - Home and Community Based Waiver	-5%	-4%	-9%
60 - Dentist - Individual	-2%	-6%	-8%
39 - Dialysis Clinic	0%	-8%	-8%
02 - Mental Hospital	0%	-8%	-8%
28 - Children Targeted Case Management	0%	-7%	-7%
15 - Health Access Nurturing Development Svcs	-1%	-6%	-7%
34 - Home Health	-3%	-4%	-7%
92 - Psychiatric Distinct Part Unit	-7%	0%	-7%
41 - Model Waiver	0%	-5%	-5%
44 - Hospice	0%	-4%	-4%

Appendix V

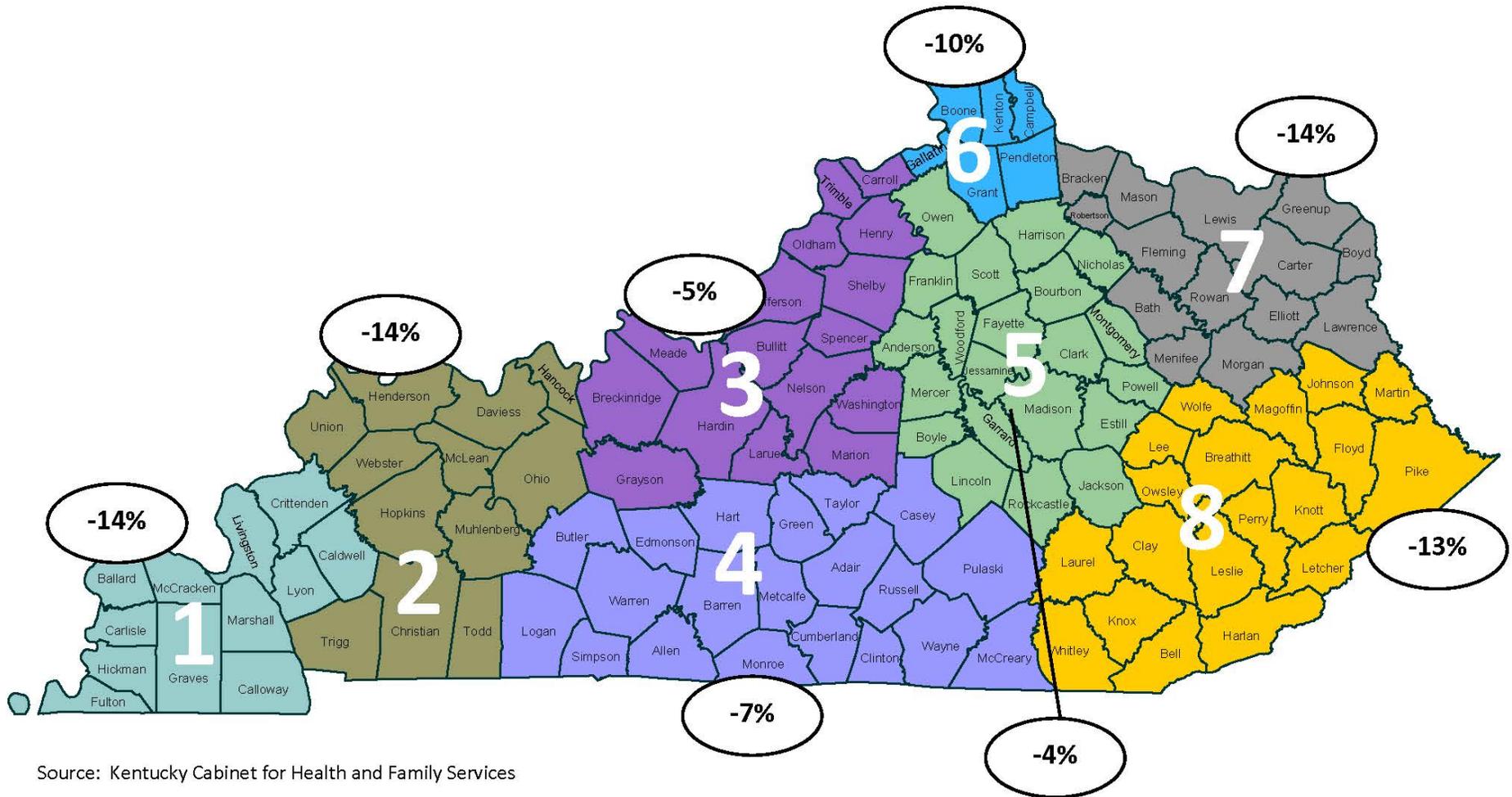
Changes in Medicaid Provider Types Between 2011 and 2014, Continued

Provider Type	2011-2013 % Change	2013-2014 % Change	Total 2011-2014 % Change
74 - Nurse Anesthetist	-2%	-2%	-4%
54 - Pharmacy	0%	-3%	-3%
43 - Adult Day Care	-1%	-2%	-3%
12 - Nursing Facility	0%	-3%	-3%
80 - Podiatrist	-7%	7%	0%
11 - ICF/MR	0%	0%	0%
14 - MFP Pre-Transition Services	0%	0%	0%
22 - Commission for Handicapped Children	0%	0%	0%
23 - Title V/DSS	0%	0%	0%
24 - First Steps/Early Int.	0%	0%	0%
27 - Adult Targeted Case Management	0%	0%	0%
58 - Net Clinic (Capitation)	0%	0%	0%
81 - Licensed Professional Clinical Counselor	0%	0%	0%
83 - Licensed Marriage and Family Therapist	0%	0%	0%
84 - Licensed Psychological Practitioner	0%	0%	0%
99 - Not on File	0%	0%	0%
61 - Dental - Group	1%	1%	1%
70 - Audiologist	2%	-1%	1%
95 - Physician Assistant	5%	-2%	3%
04 - Psychiatric Residential Treatment Facility	4%	0%	4%
33 - Support for Community Living (SCL)	4%	1%	5%
21 - School Based Health Services	4%	2%	6%
89 - Psychologist	-29%	50%	6%
35 - Rural Health Clinic	3%	6%	9%
87 - Physical Therapist	-2%	21%	19%
57 - Net (Capitation)	0%	20%	20%
78 - Certified Nurse practitioner	12%	9%	22%
98 - MCO (Managed Care Organization)	67%	20%	100%
88 - Occupational Therapist	-15%	162%	123%
82 - Clinical Social Worker	-12%	391%	332%
10 - ICF/MR Clinic	*	*	*
66 - Behavioral Health Multi-Specialty Group	*	*	*
79 - Speech-Language Pathologist	*	*	*
Total Average Change	-8%	-7%	-15%

* Provider Type had 0 providers before 2014

MCO Region	Changes Between Nov 1, 2011 - Feb 28, 2013				Changes Between Feb 28, 2013 - June 30, 2014			TOTAL Changes Between Nov 1, 2011 - June 30, 2014	
	Provider Count Nov 1, 2011	Provider Count Feb 28, 2013	Difference	% Difference	Provider Count June 30, 2014	Difference	% Difference	Difference	% Difference
MED01	1,521	1,491	(30)	-2%	1,313	(178)	-12%	(208)	-14%
MED02	2,238	2,125	(113)	-5%	1,935	(190)	-9%	(303)	-14%
MED03	7,397	7,199	(198)	-3%	7,084	(115)	-2%	(313)	-4%
MED04	2,802	2,689	(113)	-4%	2,605	(84)	-3%	(197)	-7%
MED05	5,942	5,751	(191)	-3%	5,669	(82)	-1%	(273)	-5%
MED06	1,624	1,558	(66)	-4%	1,460	(98)	-6%	(164)	-10%
MED07	1,796	1,709	(87)	-5%	1,548	(161)	-9%	(248)	-14%
MED08	3,485	3,377	(108)	-3%	3,039	(338)	-10%	(446)	-13%
MED09	12,674	10,350	(2,324)	-18%	8,974	(1,376)	-13%	(3,700)	-29%
Grand Total	39,479	36,249	(3,230)	-8%	33,627	(2,622)	-7%	(5,852)	-15%

Source: Kentucky Cabinet for Health and Family Services



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**CABINET FOR HEALTH AND FAMILY SERVICES'
MANAGEMENT RESPONSE**



**CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF THE SECRETARY**

Steven L. Beshear
Governor

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Audrey Tayse Haynes
Secretary

March 18, 2015

Honorable Adam H. Edelen
Auditor of Public Accounts
209 St. Clair Street
Frankfort, KY 40621

Dear Auditor Edelen:

On behalf of the Cabinet for Health and Family Services ("Cabinet"), I appreciate the opportunity to supplement the Auditor's *Special Report on the Financial Strength of Kentucky's Rural Hospitals* (hereinafter "*Special Report*") with observations from the Cabinet. The Cabinet, as both a regulator and a funding source, has had a hands-on relationship with Kentucky's rural hospitals for many years. That relationship enables the Cabinet to provide some perspective to the survey and forum responses that the Auditor of Public Accounts ("APA") has gathered for its report. The *Special Report* focuses on the financial challenges facing rural hospitals, the changing health care environment and how those changes will affect the financial health of the rural hospitals. The Cabinet's focus is on the efficient and economical provision of quality health care services that will lead to improved health outcomes for Kentucky's citizens and enforcement of the regulatory process to ensure the health and safety of the public. Despite the differing roles and statutory charges of the APA and the Cabinet, there are many areas of mutual agreement between the recommendations contained in the report and the activities of the Cabinet. I look forward to your continued interest and support as the Cabinet works to ensure that quality health care is accessible to all Kentuckians.

BACKGROUND

It is important to note that much of the data relied upon by the APA appears to represent 2011-2013, which preceded implementation of segments of the Affordable Care Act that have had positive impacts for rural hospitals. A full and current analysis should take into account the impacts of the three significant policy decisions by Governor Steve Beshear which have unalterably changed the face of health care delivery in the Commonwealth:

- The first was the transition for most Medicaid enrollees into a managed care system. Three years post-transition, the positive results of this decision can be found in improvements in HEDIS measures for this population. HEDIS (Healthcare Effectiveness Data and Information Set) is a tool used by more than 90 percent of America's health plans to measure performance on health care and service.
- The second significant policy decision was the expansion of Medicaid coverage for those whose income is less than 138% of the federal poverty level; the Medicaid Expansion Report, 2014 outlines the positive impacts of this policy decision ([http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky Medicaid Expansion One-Year Study FINAL.pdf](http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf)); and,
- Third, the creation of kynect, the state's health benefit exchange under the Affordable Care Act, along with the Medicaid expansion has resulted in a dramatic decrease in the uninsured population of the Commonwealth.

Without repeating detailed analyses that are publicly available on either the Cabinet's or Governor Beshear's websites, the following are important to highlight.

Managed Care: The provision of health care preventive services under Managed Care improved from 2013 to 2014 as evidenced by the following: annual dental visits increased by 15.8%, adult preventive services increased by 36.7%, breast cancer screening increased by 20.6%, cervical cancer screening increased by 3.0%, and colorectal cancer screening increased by 16.1%. While there are many areas that still have room to improve, the quality measures used to evaluate the managed care organizations demonstrate that managing Medicaid members' care makes a significant difference in members obtaining care and ultimately achieving improved health. Another example of better outcomes was recently reported in the Courier Journal. Since the 2011 transition from fee-for-service reimbursement to managed care, the number of foster children who suffer from significant behavioral health illnesses who are in out-of-state placements has decreased from 123 to 5. The ability to bring these children back into the state for treatment was partly due to in part to a cooperative program between the Department for Community Based Services (DCBS) and the MCOs, who have the ability to individualize care in a way the Cabinet was not able to do.

Medicaid Expansion: A total of 310,887 new members enrolled in Kentucky's Medicaid program by the end of State Fiscal Year 2014. The expansion of Medicaid is estimated to have a significant positive cumulative fiscal of impact on Kentucky's economy of \$30.1 billion through 2021. This economic impact is a result of direct spending on health care and its indirect impact on other spending. Based on Kentucky Medicaid claims data, the state's health care system and overall economy realized an infusion of \$1.16 billion in the form of new federal payments to health care providers in the first calendar year of implementation. Hospitals alone received over one-half billion dollars from January 2014 to September 2014 and hospitals experienced a reduction in uncompensated care costs of \$1.2 billion when comparing the first three quarters of CY 2013 to the same period in CY 2014.

Table 2. Medicaid Payments for Expansion Members Only [2014]

Provider Type	Payments
Hospital	559,878,000
Pharmacy	263,648,000
Physicians, Primary Care, FQHC, etc.	228,593,000
Other Providers	106,256,000
Total	1,158,375,000

Please note that due to the billing and payment cycle these totals most likely only represent completed claims for January through September 2014.

See Appendix 1 or go to link immediately below

http://governor.ky.gov/healthierky/Documents/medicaid/Medicaid_Hospital_Report.pdf

Medicaid expansion also offers opportunities for improvements in substance use treatment, a long-standing health care issue for Kentucky. The epidemic of substance use in Kentucky has been well documented. Based on an analysis of provider enrollment and claims data, more than 300 new behavioral health providers have enrolled to serve Kentucky Medicaid members and about 13,000 individuals with a substance use disorder have received related treatment services since January 2014.

kynect: Over 100,000 Kentuckians enrolled or re-enrolled in insurance health plans offered through the state's health insurance exchange (kynect) for 2015. A Gallup-Healthways Well-Being Index report found Kentucky's uninsured rate fell from 20.4 percent in 2013 to 9.8 percent midway through 2014 — the second-highest reduction of uninsured people in the country. Increased numbers of Kentuckians with insurance coverage provides an opportunity for additional economic and societal gains through improved health outcomes. Previously uninsured individuals will now have access to primary care and preventive services, which can lead to better health. Poor health has a cost. As such, the opportunity for improved health may contribute to additional positive fiscal impacts for the Commonwealth.

Financial Health of Rural Hospitals

The Special Report notes that Medicare is the major funding source for most rural hospitals in Kentucky. This echoes many of the findings of the American Hospital Association (AHA) regarding the sustainability of small and rural hospitals under the changing face of health care nationwide. In a fact sheet issued in September 2014,¹ the AHA voiced its national legislative agenda aimed at protecting rural and small hospitals:

¹ <http://www.aha.org/content/15/2015-2-11-fs-rural-small.pdf>

The AHA is focused on ensuring all hospitals have the resources they need to provide high-quality care and meet the needs of their communities. That means:

- *Advocating for appropriate Medicare payments;*
- *Working to extend expiring Medicare provisions that help them maintain financial viability;*
- *Improving federal programs to account for special circumstances in rural communities; and,*
- *Seeking adequate funding for annually appropriated rural health programs.*

In addition, existing special rural payment programs – the CAH, sole community hospital (SCH), Medicare-dependent hospital (MDH), and rural referral center (RRC) programs – need to be reauthorized, updated and/or protected.

In an examination of the impact of health care reform measures on rural and small hospitals,² the AHA summarized many of the pressures that have affected all rural and small hospitals nationwide, which are likewise reflected in Kentucky’s rural hospitals. Rural hospitals’ low-patient volumes make it difficult for them to manage the high fixed costs of operating a hospital. Users of rural hospitals tend to be older, have lower incomes and are more likely to suffer from chronic illnesses. Rural and small hospitals have a limited supply of health professionals and are challenged to recruit new providers, particularly specialists. Nonprofit and government-owned rural hospitals find it difficult to secure the financial resources necessary to invest in cutting edge technology and, therefore, are at a competitive disadvantage in attracting commercially insured patients. The annual hospital utilization data reported to the Office of Health Policy noted the following increases and decreases in commercially insured patients for the Kentucky hospitals listed in the *Special Report Exhibit 2 “Kentucky Rural Hospitals FSI®”*. This would suggest that Kentucky hospitals are impacted similarly to other hospitals in the nation:

Commercially Insured Patients as a Share of Billed Charges Mix			
Financial Health Classification	2010	2014	Change
Excellent Hospitals (3)	31.9%	36.5%	14%
Good Hospitals (11)	22.3%	22.7%	2%
Fair Hospitals (15)	25.7%	24.8%	-4%
Poor Hospitals (15)	25.2%	22.3%	-11%

The AHA acknowledges a transformative trend for hospitals, including rural and small hospitals, is moving more care from inpatient to outpatient settings. Inpatient stays are dropping while outpatient visits are rising, as a result of new technologies, reimbursement rules and payment models, a trend that has been occurring for a number of years. According to state health facts data compiled by the Kaiser Family Foundation, the number of inpatient days per thousand in the U.S. declined from 704 days/1000 in 1999, to 591 days/1000 in 2012. That same data source shows inpatient days/1000 in Kentucky declined from 832 to 664 for the same period. This trend is not confined to the general population, but also impacts the Medicare population. An article that appeared on the Health Affairs website indicated a 6% decline in cumulative inpatient discharges per fee-for-service Medicare beneficiary from 2004 to 2010. Health system leaders are responding to these

² <http://www.aha.org/research/reports/tw/11apr-tw-rural.pdf>

changes through mergers and acquisitions, reorganizations and other measures that streamline care delivery. This shift from inpatient to outpatient care isn't the end game, but simply a start toward a more integrated model that reaches patients in the home.

While the *Special Report* recommends that the Cabinet regularly monitor the fiscal strength of individual rural hospitals, such intervention by the Cabinet is not within the Cabinet's statutory authority. Nonprofit and government-owned rural hospitals have governing bodies that have a fiduciary duty to ensure their viability. Organizations such as the American Hospital Association's Center for Healthcare Governance provide resources to enable hospital board members to increase their knowledge and understanding of the challenges of governance in a changing health delivery environment.³ Public oversight and transparency can be accomplished by encouraging these governing bodies to post their most recent financial statements, audits and/or tax filings (such as their IRS Form 990) online so their community can monitor their fiscal strength.⁴ Additionally, the general public can review IRS 990 tax filings by logging onto Guidestar, a free website that provides information about each nonprofit's mission, legitimacy, impact, reputation, finances, programs, transparency, and governance. (<http://www2.guidestar.org/SearchResults.aspx>).

New Business Models

The Cabinet agrees with the APA in emphasizing the need for rural hospitals to modernize business models to respond to the challenges listed above.⁵ Medicare's Hospital Readmissions Reduction Program (specifically referenced in the *Special Report*) enacted by Congress, is driving the focus on making care more accessible and coordinated with ambulatory providers to avoid unnecessary inpatient stays. There are penalties for high rates of readmission within 30 days post-discharge. This requires hospitals to place greater focus on what happens to their patients once they leave the hospital. While Kentucky hospitals comprise approximately two percent (2%) of all U.S. hospitals, nine of the 39 U.S. hospitals that were assessed the maximum penalty were Kentucky hospitals, representing 23% of the total number of U.S. hospitals that were assessed the maximum penalty by Medicare in federal fiscal year 2015. The penalties are based on readmissions for the period June 2010 through June 2013.⁶ Alternative payment models are creating incentives for providers to deliver high-quality care across the care continuum and reduce the number and length of inpatient stays and emergency department visits. One of the major challenges rural hospitals face in adapting to the new paradigm, as noted above, is fixed hospital costs. The hospital stay has always been intended as the last resort, but there has been no mechanism or financial incentive to effectively coordinate care until now. With emerging alternative payment models and "value-based" programs, hospital executives are now examining multiple ways to reduce fixed costs. Most importantly, this shift from inpatient to outpatient services is pushing innovation in care delivery.

Because health systems across the country are undergoing significant changes in response to a myriad of factors, including but not limited to the Affordable Care Act, Kentucky has recognized the need to update

³ <http://www.americangovernance.com/resources/index.shtml>

<http://www.americangovernance.com/resources/reports/transformational-governance/index.shtml>

⁴ Observation # 1 and Observation # 2 recommendations.

⁵ Observation # 1 and Observation # 2 recommendations.

⁶ <http://www.kyforward.com/our-health/2014/10/21/nine-hospitals-in-kentucky-are-charged-the-maximum-medicare-penalty-for-readmissions/>

the Certificate of Need (CON) program to better enable health care providers to work toward improved health for all Kentuckians. In considering changes to the CON program and the State Health Plan, the Cabinet needs to adopt a holistic approach to revisions. The changes occurring today are causing all organizations to refocus on the original mission of health care that is reflected in the National Quality Strategy (Triple Aim): better health for our citizens, better care for all individuals, and better financial stewardship of public dollars. The emerging understanding of true impacts on health care is that the health status of a "population" is *not solely dependent on the number of hospitals and doctors in the community*, but on a more complete continuum of care and support services within a community.

On October 8, 2014, the Cabinet requested feedback from all interested stakeholders on the ways to update the CON process that would further the implementation of the following core principles:

- Supporting the Evolution of Care Delivery
- Incentivizing Development of a Full Continuum of Care
- Incentivizing Quality
- Improving Access to Care
- Improving Value of Care
- Promoting Adoption of Efficient Technology
- Exempting Services for which CON is no longer necessary

Comments have been received from 43 entities, including the Kentucky Hospital Association and 19 Kentucky hospitals/ health care systems. Some have expressed concern that deregulation of CON would allow competition that would be damaging to existing providers, while others point out that competition creates accountability and such market pressures force health providers to provide quality services at lower costs. Support is fairly strong for Kentucky to provide new health care delivery models that would allow flexibility for a hospital to meet the needs of its service area.

State Innovation Model (SIM) Design Award

As was discussed in the *Special Report*, Kentucky is in a unique and important position to benefit from the Centers for Medicare & Medicaid Services (CMS) State Innovation Model Design Award (SIM) it received. In recognition of the changing trends in health care delivery, the Cabinet proactively pursued this grant to enhance Kentucky's ability to holistically tackle its unique population's health care delivery and payment system challenges.⁷ A summary of the effort can be seen in the power point located in Appendix 2. The SIM work group includes a robust stakeholder engagement process. There will be five distinct work groups, including hospitals as well as other health care providers that will address the challenges of today's health care delivery environment. Through the work group convened by the Cabinet for the SIM⁸, the guiding theme, not just for rural hospitals but for all provider groups, will be robust payment and delivery reforms that catalyze improved health outcomes, aligning economic incentives with improvements in Core Population Health Metrics. It would be duplicative and short sighted to create a separate review entity to focus on a more limited scope of issues.

As discussed above, under the Governor's leadership, Kentucky enrolled 413,410 individuals in new health coverage, including Medicaid and private Qualified Health Plans (QHPs) through kynect's initial open

⁷ Observation # 3 and Observation # 4 recommendations.

⁸ Observation # 1 recommendation.

enrollment which closed on April 15, 2014. An estimated 75% of those enrolled indicated they were previously uninsured. While a tremendous start, this enrollment success is only the first step toward transformation. Improved population health and cost containment must follow, built on the principles of efficiency, sustainability and prevention.

Kentucky has historically been plagued by poor health, regularly ranked among the worst states across traditional indicators (45th overall; 50th in tobacco use; 42nd in obesity). With a Model Design award from CMS, Kentucky will develop structural payment and delivery reforms that target these chronic diseases, as well as the state's unique health disparities and rural access challenges, with the goal of incentivizing desired outcomes and discouraging high-cost, low-yield efforts. The Cabinet joins the APA in envisioning a system that incorporates value-based purchasing in health plans to drive population health improvements with an ultimate goal to utilize evidence-based, cost-effective payment and technology reforms to drive better individual and population health. Undergirding the work of the diverse members of the SIM group will be the robust, well-coordinated participation of stakeholders across the health care system.

Healthcare Workforce

As the APA observes, the Cabinet recognizes the need to closely monitor the health workforce capacity in the Commonwealth. Moreover, a number of the recommendations identified by the APA, such as consideration of scholarship programs, enhanced recruitment efforts in rural areas, and similar initiatives, align with the recommendations of the Deloitte Health Care Workforce Capacity Report (2013) that was commissioned by the Cabinet. The Cabinet is leading the state's participation in the National Governors' Association Health Workforce Policy Academy, which, in partnership with stakeholders, has identified four core areas of focus: improved data collection and analysis; policy coordination; evolution of health workforce planning; and health workforce pipeline efforts. To date, the state's health workforce planning efforts have been hindered by the lack of a centralized data collection effort, making routine analysis of health workforce capacity data cumbersome and expensive. Thus, per the recommendation of the Deloitte Health Workforce Report, the Cabinet is first addressing the data infrastructure required for rigorous and robust monitoring and analysis by actively partnering with stakeholders to establish processes (already in place in a number of states) by which health profession licensure data is regularly collected, analyzed and reported on, for the benefit of stakeholders across the Commonwealth. See Appendix 3.

The *Special Report* raised concerns regarding a decrease of providers by type in the Medicaid program from 2011 to 2014. However, the Cabinet's tracking of participating providers who actually received payments for providing services to the Medicaid population projects a different picture (see Appendix 4). This appendix displays the percentage increase of providers who actually received payments from the Medicaid program between 2011 and 2014. The number of providers receiving payments from Medicaid increased in excess of 40 percent between 2011 and 2014.⁹

Clarifications and Changes

The Cabinet is pleased with the opportunity to offer clarification on some specific provider concerns captured in the *Special Report*. For example, non-emergency transportation, which the hospitals champion as necessary to bring their patients to their door, has long been a part of the Medicaid program. The expenditure for non-emergency health transportation in the Medicaid program is expected to exceed ninety million dollars

⁹ Observation # 8 recommendation.

(\$90,000,000) in the current year, and is much more user friendly than the non-emergency service offered in the Medicare program.¹⁰

Reaching out to providers, particularly hospitals, continues to be a Cabinet priority as evidenced by regional MCO forums hosted by the cabinet for the past two years, as well as more than 250 hours of meetings conducted by senior management of the Department for Medicaid Services with hospital representatives. Personally, senior cabinet officials and I have spent many hours in meetings with hospital executives and board members and have attended many meetings or conferences in which they have extended an invitation. In late January, the Cabinet, along with the Kentucky Hospital Association, cosponsored a summit for hospital CEOs and board members on healthcare transformation, specifically for hospitals. The Advisory Board Company, a nationally recognized research and consulting firm that assists hospitals, led the discussion. The Cabinet will, of course, continue such efforts and encourage hospital executives to take advantage of the opportunity to participate in such meetings.¹¹

The Cabinet also continues to monitor the performance of the managed care organizations. In addition to at least eighty (80) monthly, quarterly, or yearly reports filed by the managed care organizations and assessed by the Cabinet, the Cabinet also makes available on its Medicaid website all Managed Care Oversight Quality Branch Reports.¹² These reports include the external quality review organization (EQRO) reports, which grade the quality and effectiveness of care provided to members enrolled in the managed care program and HEDIS and QAPI reports. Perhaps more importantly, the Cabinet summarized the HEDIS 2013 quality performance data in a consumer-friendly brochure entitled "A Member's Guide to Choosing a Medicaid Health Plan." A copy of this brochure is found at Appendix 5.¹³

The managed care program continues to evolve as both the Department for Medicaid Services and the MCO contractors begin to normalize the systems and strategies that must be in place for meaningful oversight of quality and improvements in the delivery of health care services. The upcoming rebid of managed care contracts provides the Cabinet with an opportunity to address concerns raised by providers and highlighted in the *Special Report*, such as strengthening penalties for non-compliance with contract requirements, revisiting processes that the MCOs have for provider appeals, uniform credentialing criteria, improved communications between the MCOs and the providers, and diverting nonemergency visits from hospital emergency rooms.¹⁴

Be assured that the Cabinet for Health and Family Services will continue its efforts to secure access to and availability of quality health care for all Kentuckians. Thank you for the opportunity to comment on the *Special Report* of the APA.

Sincerely,



Audrey Tayse Haynes

¹⁰ Observation # 3 recommendation.

¹¹ Observation # 5 recommendation.

¹² <http://www.chfs.ky.gov/dms/pqomcoqbreports.htm>

¹³ Observation # 7 recommendation.

¹⁴ Observation # 5, Observation # 6, and Observation # 7 recommendations.

Appendix 1

**Medicaid Expansion, Enrollment, and Payment in
Kentucky**

Cabinet for Health and Family Services

2/11/2015

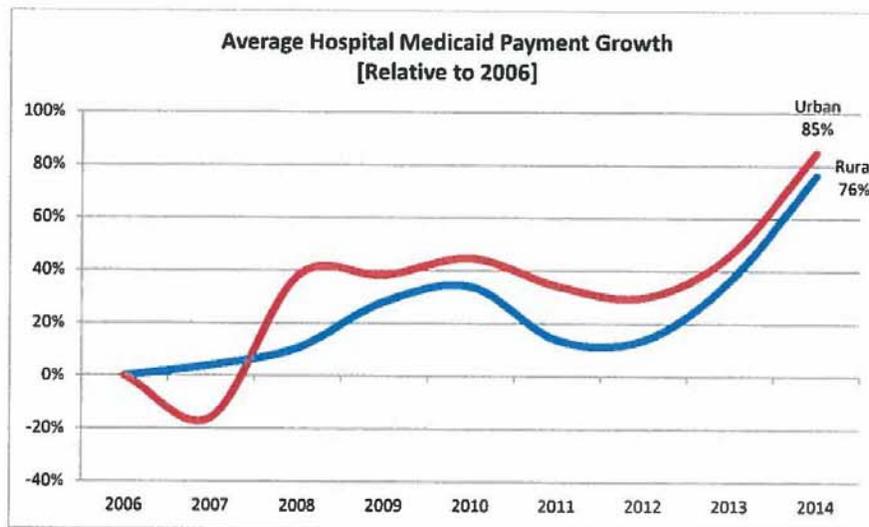
The following report aims to examine four primary issues:

1. The changing nature of Medicaid payments under Medicaid managed care;
2. The impact of Medicaid expansion upon payments;
3. The importance of Medicaid payments throughout the Commonwealth; and
4. The changing payments for urban and rural hospitals

The Impact of Recession and Managed Care

As a result of the 2007 recession, Medicaid experienced unprecedented growth in enrollment. At the same point in time, hospitals received an increase in their rate structure. These two factors combined to dramatically increase payments to hospitals. In 2006, inpatient and outpatient Medicaid payments to hospitals were \$992 million and by 2009 they were \$1.34 billion. That growth occurred more quickly in Urban Hospitals, which experienced 38% payment growth over that time period. Rural hospitals experienced 28% growth over the same period.

Rapid acceleration in Medicaid payments, unit cost growth, utilization and a variety of other factors eventually led the Governor and General Assembly to agree the Commonwealth must transition the majority of Medicaid enrollees to Managed Care in November 2011. Nursing home residents and members of a waiver program were excluded from the transition. Under managed care, hospitals initially experienced declines in payment, especially in the first year. This was primarily due to new accountability measures and billing processes. However, those payments have started to increase again. By the end of state fiscal year 2013, both urban and rural hospitals, on average, exceeded their pre-managed care payment levels.



This increase in payment is not limited to hospitals. Table 1 displays payment totals for the major categories of expenditures in Medicaid. Between 2011 and 2012 there was a shift toward outpatient hospital treatment and away from extended inpatient stays. In 2013, both categories increased. Payments increased again in 2014 due

in large part to Medicaid expansion¹. All payments throughout this report are rounded to the nearest thousand dollars.

Table 1. Medicaid Payments by Major Categories²

Service Type	2010	2011	2012	2013	2014
Inpatient Hospital	855,326,000	760,232,000	629,820,000	807,890,000	931,740,000
Outpatient Hospital	522,147,000	485,894,000	569,096,000	589,277,000	833,712,000
Pharmacy	707,486,000	674,711,000	678,438,000	576,529,000	935,140,000
Primary Care ³	693,935,000	626,182,000	461,559,000	441,408,000	698,678,000
Nursing Facilities	842,911,000	849,236,000	863,013,000	878,270,000	930,702,000
Waiver	421,318,000	478,595,000	567,828,000	628,922,000	719,223,000
Other	1,206,866,000	1,102,301,000	957,412,000	893,931,000	1,123,611,000
Total	5,249,989,000	4,977,151,000	4,727,166,000	4,816,227,000	6,172,806,000

Note: Date listed is the date the payment entered the DMS database as a clean claim.

Medicaid Expansion

As a result of Medicaid expansion, more Kentuckians are insured now than ever before, and providers are beginning to receive substantial payments for individuals who would have previously gone untreated or been unable to pay for their care. Table 2 demonstrates the key provider types that received the largest share of payments for Medicaid expansion members in 2014. Table 2 includes claims payments for both in-state and out-of-state providers. The amounts listed here exceed those in the DeLoitte report due to the inclusion of supplemental and non-claims payments.

Table 2. Medicaid Payments for Expansion Members Only [2014]

Provider Type	Payments
Hospital	559,878,000
Pharmacy	263,648,000
Physicians, Primary Care, FQHC, etc.	228,593,000
Other Providers	106,256,000
Total	1,158,375,000

Please note that due to the billing and payment cycle these totals most likely only represent completed claims for January through September 2014.

¹ 2014 payments only include 9-10 months of Medicaid expansion reimbursements since there is a lag between dates of service and payment

² Payments listed here include only verified claims payments. The table does not include encounter, non-claims, intensive operating allowance, intergovernmental transfers, Disproportionate Share Hospital payments, or any other payment made on behalf of a member to a third party.

³ Primary care includes physician, physician group, primary care clinic, rural health clinic, FQHC, nurse practitioner, physician assistant, and payments for primary care performed at a local health department.

Aside from members, hospitals have been the primary beneficiaries of Medicaid expansion. Hospitals are beginning to see their share of uncompensated visits significantly drop as Medicaid begins to reimburse for the previously uninsured. Data submitted to the Cabinet for Health and Family Services by the Kentucky Hospital Association (KHA) has shown that hospitals experienced a 60% reduction in the types of claims that result in uncompensated care⁴ when comparing the first three quarters of 2013 to the same time period in 2014. Table 3 lists the hospitals that have received the largest payment amounts for treating Medicaid Expansion enrollees. Only those hospitals receiving more than \$10 million in payments have been listed individually.

Table 3. Hospital Payments for Medicaid Expansion [2014]

Hospital	Payments
UK Chandler Medical Center	82,370,000
Norton Healthcare	43,447,000
University of Louisville Hospital	57,662,000
Jewish Hospital	23,612,000
St Elizabeth	18,963,000
Owensboro Health Regional Hospital	14,444,000
Baptist Health Lexington	13,636,000
The Medical Center at Bowling Green	13,128,000
ARH Hazard	12,867,000
Kings Daughters Medical Center	11,285,000
Other Kentucky Hospitals	251,498,000
Total (In-state only)	542,912,000

Geographic Impact of Medicaid and Medicaid Expansion

Table 4 provides a county-by-county accounting of the flow of payments for Medicaid Expansion enrollees. While Fayette and Jefferson counties have received large amounts of funding because of their concentration of hospitals that serve as regional providers, these funds have benefited the entire Commonwealth. Table 5 is a similar chart, but it allocates the payments to the county of the member who is receiving the service.

For example, if a Madison County resident has a procedure performed at the University of Kentucky, the payment associated with that procedure will be included in the Fayette County total on Table 4 and the Madison County total on Table 5.

⁴ In the Kentucky Hospital Association database these are classified as pending insurance, self-pay, and charity care claims

Table 4. Distribution of Medicaid Expansion Claims Payments by County of Provider [2014]

County	Payments	County	Payments	County	Payments
Adair	3,321,000	Grant	2,595,000	Mason	5,970,000
Allen	1,528,000	Graves	6,693,000	Meade	1,378,000
Anderson	928,000	Grayson	5,359,000	Meniffee	573,000
Ballard	171,000	Green	1,320,000	Mercer	1,814,000
Barren	11,148,000	Greenup	2,277,000	Metcalfe	526,000
Bath	714,000	Hancock	107,000	Monroe	1,442,000
Bell	8,360,000	Hardin	22,026,000	Montgomery	6,634,000
Boone	11,011,000	Harlan	9,851,000	Morgan	1,646,000
Bourbon	4,238,000	Harrison	3,036,000	Muhlenberg	3,685,000
Boyd	27,189,000	Hart	1,919,000	Nelson	5,860,000
Boyle	11,780,000	Henderson	7,896,000	Nicholas	326,000
Bracken	219,000	Henry	837,000	Ohio	3,130,000
Breathitt	6,693,000	Hickman	135,000	Oldham	4,674,000
Breckinridge	1,776,000	Hopkins	11,432,000	Owen	570,000
Bullitt	3,103,000	Jackson	2,403,000	Owsley	759,000
Butler	778,000	Jefferson	197,696,000	Pendleton	377,000
Caldwell	1,385,000	Jessamine	3,576,000	Perry	25,043,000
Calloway	6,308,000	Johnson	5,919,000	Pike	19,894,000
Campbell	11,336,000	Kenton	34,439,000	Powell	1,370,000
Carlisle	201,000	Knott	1,118,000	Pulaski	18,692,000
Carroll	2,147,000	Knox	5,000,000	Robertson	3,000
Carter	2,286,000	Larue	751,000	Rockcastle	2,706,000
Casey	1,879,000	Laurel	15,852,000	Rowan	9,456,000
Christian	8,742,000	Lawrence	4,139,000	Russell	3,802,000
Clark	8,082,000	Lee	1,022,000	Scott	6,555,000
Clay	5,261,000	Leslie	2,827,000	Shelby	3,083,000
Clinton	1,572,000	Letcher	9,776,000	Simpson	1,958,000
Crittenden	999,000	Lewis	2,286,000	Spencer	481,000
Cumberland	2,365,000	Lincoln	2,672,000	Taylor	5,138,000
Daviess	23,239,000	Livingston	1,199,000	Todd	654,000
Edmonson	691,000	Logan	2,823,000	Trigg	1,203,000
Elliott	393,000	Lyon	261,000	Trimble	335,000
Estill	2,856,000	McCracken	22,177,000	Union	1,039,000
Fayette	152,003,000	McCreary	2,136,000	Warren	32,001,000
Fleming	2,167,000	McLean	379,000	Washington	532,000
Floyd	14,955,000	Madison	14,564,000	Wayne	2,355,000
Franklin	7,330,000	Magoffin	1,574,000	Webster	779,000
Fulton	1,309,000	Marion	5,298,000	Whitley	16,519,000
Gallatin	305,000	Marshall	5,237,000	Wolfe	911,000
Garrard	558,000	Martin	1,308,000	Woodford	2,018,000
				Unknown / Out of State	84,935,000
				TOTAL	1,054,061,000

Note: Date listed is the date the payment entered the DMS database as a clean claim.

Table 5. Distribution of Medicaid Expansion Claims Payments by County of Member [2014]

County	Payments	County	Payments	County	Payments
Adair	5,400,000	Grant	5,466,000	Mason	5,445,000
Allen	4,918,000	Graves	9,140,000	Meade	6,591,000
Anderson	3,851,000	Grayson	8,149,000	Menifee	1,751,000
Ballard	1,717,000	Green	3,170,000	Mercer	4,627,000
Barren	10,174,000	Greenup	9,969,000	Metcalfe	3,220,000
Bath	3,755,000	Hancock	1,544,000	Monroe	2,952,000
Bell	11,635,000	Hardin	20,508,000	Montgomery	8,602,000
Boone	14,023,000	Harlan	15,719,000	Morgan	4,136,000
Bourbon	5,434,000	Harrison	4,349,000	Muhlenberg	7,042,000
Boyd	15,055,000	Hart	5,591,000	Nelson	9,756,000
Boyle	7,851,000	Henderson	9,270,000	Nicholas	2,954,000
Bracken	2,674,000	Henry	4,413,000	Ohio	6,066,000
Breathitt	7,162,000	Hickman	1,106,000	Oldham	4,690,000
Breckinridge	5,235,000	Hopkins	9,537,000	Owen	2,465,000
Bullitt	15,303,000	Jackson	5,683,000	Owsley	2,454,000
Butler	3,337,000	Jefferson	162,786,000	Pendleton	2,918,000
Caldwell	2,427,000	Jessamine	11,570,000	Perry	20,284,000
Calloway	6,770,000	Johnson	8,918,000	Pike	18,151,000
Campbell	15,109,000	Kenton	31,342,000	Powell	5,514,000
Carlisle	895,000	Knott	7,560,000	Pulaski	17,158,000
Carroll	3,035,000	Knox	12,218,000	Robertson	678,000
Carter	9,349,000	Larue	3,855,000	Rockcastle	6,384,000
Casey	5,080,000	Laurel	18,000,000	Rowan	6,059,000
Christian	10,959,000	Lawrence	6,497,000	Russell	5,857,000
Clark	10,131,000	Lee	3,787,000	Scott	9,042,000
Clay	9,532,000	Leslie	6,042,000	Shelby	5,930,000
Clinton	2,968,000	Letcher	13,202,000	Simpson	3,722,000
Crittenden	1,988,000	Lewis	4,760,000	Spencer	2,826,000
Cumberland	2,397,000	Lincoln	6,523,000	Taylor	4,870,000
Daviess	19,690,000	Livingston	2,185,000	Todd	2,375,000
Edmonson	3,170,000	Logan	5,417,000	Trigg	2,718,000
Elliott	2,019,000	Lyon	1,405,000	Trimble	2,281,000
Estill	5,947,000	McCracken	13,265,000	Union	2,648,000
Fayette	56,521,000	McCreary	6,540,000	Warren	22,574,000
Fleming	5,516,000	McLean	1,790,000	Washington	3,397,000
Floyd	14,223,000	Madison	21,752,000	Wayne	5,697,000
Franklin	8,245,000	Magoffin	5,124,000	Webster	3,145,000
Fulton	1,741,000	Marion	5,556,000	Whitley	13,340,000
Gallatin	2,026,000	Marshall	5,370,000	Wolfe	2,943,000
Garrard	4,182,000	Martin	4,260,000	Woodford	4,673,000
				Unknown / Out of State	1,348,000
				TOTAL	1,054,061,000

Note: Date listed is the date the payment entered the DMS database as a clean claim.

Urban and Rural Hospital Spending

The following tables provide a detailed look at the payments made to rural and urban hospitals. Urban and rural classifications were derived from the Census Bureau listings. What is first apparent from an examination is that all hospitals, both urban and rural, face unique challenges and opportunities. Some hospitals are experiencing declining Medicaid payments while others are flourishing. The other noticeable trend is the overall growth of payments. After the decline of SFY 2012, total payments increased in 2013 and have increased again in 2014. This analysis does not address hospitals' private pay payments or Medicare payments; however, Medicaid payments have unequivocally increased for hospitals, on average.

Table 6. Medicaid Claims Payments to Rural Hospitals by Calendar Year

County	Hospital	2010	2011	2012	2013	2014
Multiple	Appalachian Regional Healthcare	63,195,000	53,969,000	51,203,000	65,709,000	93,923,000
Adair	Westlake Regional Hospital	2,639,000	1,912,000	1,385,000	2,316,000	2,178,000
Barren	T.J. Samson Community Hospital	14,116,000	12,548,000	15,812,000	16,385,000	19,676,000
Bell	Pineville Community Hospital	4,399,000	3,556,000	2,461,000	3,252,000	3,978,000
Boyle	Ephraim McDowell Reg Medical Center	12,146,000	10,441,000	9,791,000	13,259,000	22,738,000
Breathitt	Kentucky River Medical Center	9,009,000	7,295,000	13,247,000	9,880,000	11,144,000
Breckinridge	Breckinridge Memorial Hospital	1,680,000	1,259,000	2,036,000	1,673,000	1,640,000
Caldwell	Caldwell Medical Center	1,544,000	1,528,000	1,428,000	1,553,000	1,748,000
Calloway	Murray-Calloway County Hospital	7,302,000	6,670,000	5,435,000	8,143,000	9,169,000
Carroll	Carroll County Memorial Hospital	2,724,000	2,807,000	1,625,000	1,759,000	2,102,000
Casey	Casey County Hospital	1,748,000	1,329,000	1,322,000	1,513,000	1,741,000
Clay	Manchester Memorial Hospital	9,320,000	7,487,000	8,076,000	8,736,000	10,093,000
Clinton	Clinton County Hospital	2,880,000	2,105,000	1,582,000	1,679,000	2,215,000
Crittenden	Crittenden Health Systems	1,102,000	820,000	912,000	1,110,000	1,472,000
Cumberland	Cumberland County Hospital	1,616,000	1,261,000	852,000	1,084,000	1,995,000
Estill	Marcum & Wallace Memorial Hospital	3,429,000	3,318,000	3,242,000	3,168,000	3,696,000
Fleming	Fleming County Hospital	2,144,000	1,894,000	1,687,000	2,701,000	2,752,000
Floyd	Highlands Regional Medical Center	16,119,000	12,636,000	11,334,000	12,876,000	14,965,000
Floyd	Saint Joseph Martin	3,887,000	3,476,000	3,667,000	4,068,000	5,573,000
Franklin	Frankfort Regional Medical Center	7,977,000	8,477,000	7,938,000	8,371,000	11,801,000
Fulton	Parkway Regional Hospital	1,606,000	1,220,000	1,373,000	1,689,000	1,817,000
Graves	Jackson Purchase Medical Center	7,452,000	6,121,000	8,464,000	8,225,000	10,616,000
Grayson	Twin Lakes Regional Medical Center	6,009,000	5,279,000	5,921,000	5,496,000	6,861,000
Green	Jane Todd Crawford Hospital	2,150,000	1,661,000	1,821,000	1,639,000	1,710,000
Harrison	Harrison Memorial Hospital	5,065,000	4,358,000	3,299,000	4,432,000	5,694,000
Hart	Caverna Memorial Hospital Inc	1,624,000	1,537,000	1,384,000	1,308,000	1,650,000
Hopkins	Baptist Health Madisonville	15,104,000	10,804,000	10,349,000	13,839,000	20,191,000
Johnson	Paul B Hall Regional Medical Center	9,706,000	8,270,000	9,766,000	9,140,000	8,723,000
Knox	Knox County Hospital	6,428,000	4,723,000	3,797,000	3,282,000	4,017,000
Laurel	Saint Josephs London	17,861,000	14,975,000	18,128,000	21,038,000	26,275,000
Lawrence	Three Rivers Medical Center	6,314,000	4,626,000	5,877,000	6,144,000	7,428,000
Leslie	Mary Breckinridge ARH Hospital	4,067,000	2,571,000	1,325,000	1,705,000	4,342,000
Lincoln	Ephraim McDowell Fort Logan Hospital	3,510,000	2,893,000	2,990,000	3,645,000	4,246,000
Livingston	Livingston Hospital & Healthcare Services	2,018,000	1,669,000	1,140,000	1,727,000	2,215,000
Logan	Logan Memorial Hospital	2,267,000	1,905,000	2,398,000	2,011,000	3,573,000

County	Hospital	2010	2011	2012	2013	2014
McCracken	Baptist Health Paducah	15,945,000	13,169,000	13,462,000	18,227,000	25,463,000
McCracken	Lourdes	7,503,000	7,474,000	8,112,000	10,732,000	15,668,000
Madison	Baptist Health Richmond	8,983,000	7,310,000	7,023,000	8,869,000	16,901,000
Madison	Saint Joseph Berea	5,295,000	4,931,000	4,162,000	4,528,000	7,242,000
Marion	Spring View Hospital	5,642,000	4,670,000	6,780,000	4,860,000	7,532,000
Marshall	Marshall County Hospital	1,450,000	1,209,000	1,103,000	1,086,000	1,426,000
Mason	Meadowview Regional Medical Center	5,613,000	4,395,000	5,529,000	6,717,000	8,886,000
Mercer	The James B Haggin Memorial Hospital	1,625,000	1,484,000	1,197,000	1,297,000	2,121,000
Monroe	Monroe County Medical Center	2,619,000	1,964,000	1,774,000	1,812,000	1,930,000
Montgomery	Saint Joseph Mount Sterling	5,378,000	4,566,000	4,721,000	8,241,000	9,762,000
Montgomery	Muhlenberg Community Hospital	4,027,000	3,304,000	2,542,000	3,343,000	4,306,000
Nelson	Flaget Memorial Hospital	6,910,000	7,239,000	7,321,000	4,719,000	7,091,000
Nicholas	Nicholas County Hospital	797,000	1,087,000	914,000	939,000	479,000
Ohio	Ohio County Hospital	4,206,000	3,696,000	3,080,000	4,473,000	5,253,000
Owen	New Horizons Health Systems Inc	1,026,000	1,035,000	717,000	738,000	985,000
Pike	Pikeville Medical Center	27,787,000	26,096,000	25,815,000	33,909,000	36,696,000
Pulaski	Lake Cumberland Regional Hospital	24,378,000	19,808,000	16,043,000	24,139,000	26,819,000
Rockcastle	Rockcastle Regional Hospital	2,739,000	2,417,000	1,792,000	2,666,000	3,027,000
Rowan	St Claire Regional Medical Center	12,133,000	10,807,000	10,653,000	13,843,000	18,575,000
Russell	Russell County Hospital	3,256,000	2,874,000	2,761,000	2,921,000	4,611,000
Simpson	The Medical Center at Franklin	1,834,000	1,579,000	1,712,000	1,726,000	2,078,000
Taylor	Trigg Regional Hospital	8,909,000	7,319,000	6,646,000	7,622,000	9,452,000
Trigg	Trigg County Hospital Inc	812,000	861,000	619,000	1,528,000	1,607,000
Union	Methodist Hospital Union County	1,337,000	1,223,000	824,000	1,431,000	1,693,000
Wayne	Wayne County Hospital Inc	2,459,000	2,203,000	2,030,000	1,944,000	2,405,000
Whitley	Baptist Health Corbin	25,562,000	21,002,000	20,813,000	29,716,000	35,655,000
	Rural Hospital Total	448,382,000	381,122,000	381,212,000	456,581,000	590,144,000

Note: Urban and Rural classification was derived using Census Bureau designation. Date listed is the date the payment entered the DMS database as a clean claim.

Table 7. Medicaid Claims Payments to Urban Hospitals by Calendar Year

County	Hospital	2010	2011	2012	2013	2014
Allen	The Medical Center at Scottsville	1,730,000	1,539,000	1,696,000	2,608,000	2,374,000
Boone	Gateway Rehab Hospital at Florence	670,000	368,000	317,000	533,000	872,000
Boone	St Elizabeth Florence	15,528,000	12,288,000	10,486,000	9,153,000	14,074,000
Bourbon	Bourbon Community Hospital	4,162,000	3,520,000	2,897,000	2,797,000	5,400,000
Boyd	Kings Daughters Medical Center	43,121,000	35,097,000	32,742,000	35,987,000	37,857,000
Boyd	Our Lady of Bellefonte Hospital	9,450,000	7,721,000	9,160,000	11,462,000	13,389,000
Campbell	St Elizabeth Fort Thomas	8,051,000	6,987,000	7,749,000	8,248,000	12,735,000
Christian	Jennie Stuart Medical Center	15,211,000	11,565,000	13,920,000	15,288,000	14,988,000
Clark	Clark Regional Medical Center	3,801,000	12,951,000	9,278,000	12,042,000	14,818,000
Daviess	Owensboro Health Regional Hospital	30,770,000	27,421,000	25,186,000	37,743,000	48,742,000
Fayette	Baptist Health Lexington	33,314,000	27,849,000	25,468,000	36,229,000	46,592,000
Fayette	Cardinal Hill Rehabilitation Hospital	6,280,000	5,403,000	6,521,000	7,128,000	8,961,000
Fayette	Continuing Care Hospital	1,998,000	1,071,000	706,000	1,439,000	2,705,000
Fayette	Saint Joseph East	15,920,000	14,787,000	11,529,000	18,046,000	20,410,000
Fayette	Saint Joseph Hospital	16,036,000	13,657,000	11,236,000	17,538,000	25,228,000
Fayette	Select Specialty Hospital	2,295,000	2,080,000	309,000	713,000	755,000
Fayette	Shriners Hospital for Children - Lexington	142,587,000	125,456,000	1,707,000	1,932,000	2,263,000
Fayette	UK Chandler Medical Center	-	2,100,000	3,696,000	184,373,000	241,332,000
Grant	St Elizabeth Grant	-	-	17,529,000	17,513,000	22,808,000
Hardin	Hardin Memorial Health	15,186,000	20,165,000	17,529,000	17,513,000	22,808,000
Hardin	Lakeview Rehabilitation Group Partners	280,000	165,000	210,000	219,000	568,000
Henderson	Methodist Hospital	17,117,000	13,789,000	10,420,000	16,396,000	18,945,000
Jefferson	Baptist Health Louisville	11,089,000	12,624,000	11,877,000	12,082,000	20,813,000
Jefferson	Jewish Hospital	68,242,000	71,068,000	76,485,000	42,480,000	62,352,000
Jefferson	Kindred Hospital	14,098,000	11,203,000	11,530,000	9,788,000	9,253,000
Jefferson	Norton Healthcare	171,530,000	166,448,000	155,565,000	162,877,000	186,097,000
Jefferson	University of Louisville Hospital	68,774,000	69,397,000	65,520,000	58,381,000	71,767,000
Kenton	Healthsouth Northern Ky Rehab Hospital	204,000	277,000	320,000	362,000	712,000
Kenton	St Elizabeth	43,814,000	38,359,000	38,943,000	50,107,000	63,054,000
Oldham	Baptist Health La Grange	3,251,000	3,291,000	3,915,000	3,730,000	7,037,000
Scott	Georgetown Community Hospital	5,347,000	4,109,000	4,539,000	5,703,000	8,944,000
Shelby	Jewish Hospital Shelbyville	4,552,000	3,397,000	3,591,000	2,365,000	2,515,000

County	Hospital	2010	2011	2012	2013	2014
Warren	Commonwealth Regional Specialty Hospital	1,289,000	739,000	115,000	574,000	685,000
Warren	Southern Ky Rehabilitation Hospital	793,000	868,000	690,000	911,000	1,367,000
Warren	The Medical Center at Bowling Green	30,007,000	25,813,000	21,293,000	33,406,000	44,127,000
Warren	Tri-Star Greenview Regional Hospital	4,930,000	4,131,000	5,029,000	5,245,000	9,405,000
Woodford	Bluegrass Community Hospital	1,406,000	1,134,000	1,119,000	1,013,000	1,829,000
	Urban Hospital Total	812,833,000	759,880,000	738,346,000	829,848,000	1,050,296,000

Note: Urban and Rural classification was derived using Census Bureau designation. Date listed is the date the payment entered the DMS database as a clean claim

Disproportionate Share Hospital (DSH) Payments

Acknowledging that hospitals typically bear significant costs associated with treating the uninsured and under-insured, the Federal government created the disproportionate share (DSH) payment program. These DSH payments allow hospitals that treat a significant number of indigent individuals to receive payments from a pool in proportion to the number of indigent patients treated.

As a result of Medicaid expansion, the number of uninsured in Kentucky is dramatically decreasing. This trend was anticipated in the Affordable Care Act and language was included to begin reducing those payments immediately. However, as a result of recent budget negotiations at the federal level, those reductions were postponed until 2017. Therefore this year Kentucky hospitals will receive a full DSH payment based on their share of indigent care in preceding years in addition to the increased payments they are receiving as a result of Medicaid expansion.⁵

Tables 8 and 9 display 2014 Medicaid expansion payments by hospital alongside the DSH payments received in the same year. It should be noted that due to the lag between service and payment, the Medicaid expansion payments represent only 9-10 months of actual service. The DSH payments include the final payment for FFY 2014 as well as the initial payment for FFY 2015. This is equivalent to one full year of DSH allocation. Despite this representing only a partial year’s worth of service for Medicaid expansion, there are only four hospitals in the state whose Medicaid expansion payments did not exceed their 2014 DSH payments.

Overall, rural hospitals received 297% more payment from Medicaid expansion than from DSH, while urban hospitals received 257% more payment from Medicaid expansion than from DSH.

Table 8. Comparison of Medicaid Expansion Payments at Rural Hospitals to DSH Payments in 2014

COUNTY	HOSPITAL	EXPANSION REVENUE	DSH PAYMENTS	Expansion as % of DSH
Multiple	Appalachian Regional Healthcare	26,806,000	9,690,000	277%
Adair	Westlake Regional Hospital	643,000	779,000	83%
Barren	T J Samson Community Hospital	5,641,000	1,443,000	391%
Bell	Pineville Community Hospital	1,104,000	607,000	182%
Boyle	Ephraim McDowell Reg Medical Center	6,980,000	2,242,000	311%
Breathitt	Kentucky River Medical Center	3,255,000	950,000	343%
Breckinridge	Breckinridge Memorial Hospital	474,000	312,000	152%
Caldwell	Caldwell Medical Center	585,000	219,000	267%
Calloway	Murray-Calloway County Hospital	3,059,000	863,000	354%
Carroll	Carroll County Memorial Hospital	822,000	467,000	176%
Casey	Casey County Hospital	374,000	469,000	80%
Clay	Manchester Memorial Hospital	2,216,000	901,000	246%
Clinton	Clinton County Hospital	575,000	141,000	408%

⁵ It should be noted that even though hospitals will receive an allotment equal to that received in previous years, if they fail to document a commensurate level of service provision or other financial shortfalls associated with Medicare or Medicaid they federal government will claw back those funds as a part of the DSH audit process.

COUNTY	HOSPITAL	EXPANSION REVENUE	DSH PAYMENTS	Expansion as % of DSH
Crittenden	Crittenden Health Systems	478,000	219,000	218%
Cumberland	Cumberland County Hospital	419,000	211,000	198%
Estill	Marcum & Wallace Memorial Hospital	959,000	583,000	164%
Fleming	Fleming County Hospital	892,000	567,000	157%
Floyd	Highlands Regional Medical Center	3,429,000	2,534,000	135%
Floyd	Saint Joseph Martin	1,785,000	1,458,000	122%
Franklin	Frankfort Regional Medical Center	3,332,000	561,000	594%
Fulton	Parkway Regional Hospital	624,000	60,000	1040%
Graves	Jackson Purchase Medical Center	3,442,000	522,000	659%
Grayson	Twin Lakes Regional Medical Center	2,151,000	309,000	696%
Green	Jane Todd Crawford Hospital	406,000	431,000	94%
Harrison	Harrison Memorial Hospital	1,654,000	1,062,000	156%
Hart	Caverna Memorial Hospital Inc	466,000	120,000	388%
Hopkins	Baptist Health Madisonville	6,863,000	1,179,000	582%
Johnson	Paul B Hall Regional Medical Center	2,456,000	1,512,000	162%
Knox	Knox County Hospital	666,000	391,000	170%
Laurel	Saint Joseph London	7,089,000	2,574,000	275%
Lawrence	Three Rivers Medical Center	2,027,000	458,000	443%
Leslie	Mary Breckinridge ARH Hospital	919,000	836,000	110%
Lincoln	Ephraim McDowell Fort Logan Hospital	891,000	567,000	157%
Livingston	Livingston Hospital & Healthcare Services	701,000	188,000	373%
Logan	Logan Memorial Hospital	1,532,000	310,000	494%
Madison	Baptist Health Richmond	5,356,000	1,011,000	530%
Madison	Saint Joseph Berea	2,315,000	690,000	336%
Marion	Spring View Hospital	2,909,000	373,000	780%
Marshall	Marshall County Hospital	368,000	189,000	195%
Mason	Meadowview Regional Medical Center	3,476,000	406,000	856%
McCracken	Baptist Health Paducah	9,082,000	1,392,000	652%
McCracken	Lourdes	4,957,000	1,049,000	473%
Mercer	The James B Haggin Memorial Hospital	762,000	233,000	327%
Monroe	Monroe County Medical Center	480,000	328,000	146%
Montgomery	Saint Joseph Mount Sterling	3,086,000	1,011,000	305%
Muhlenberg	Muhlenberg Community Hospital	1,416,000	904,000	157%
Nelson	Flaget Memorial Hospital	3,323,000	1,487,000	223%
Nicholas	Nicholas County Hospital	65,000	230,000	28%
Ohio	Ohio County Hospital	1,338,000	509,000	263%
Owen	New Horizons Health Systems Inc	254,000	30,000	847%
Pike	Pikeville Medical Center	9,568,000	2,462,000	389%
Pulaski	Lake Cumberland Regional Hospital	7,976,000	3,319,000	240%
Rockcastle	Rockcastle Regional Hospital	1,025,000	483,000	212%
Rowan	St Claire Regional Medical Center	4,877,000	2,081,000	234%

COUNTY	HOSPITAL	EXPANSION REVENUE	DSH PAYMENTS	Expansion as % of DSH
Russell	Russell County Hospital	1,470,000	662,000	222%
Simpson	The Medical Center at Franklin	665,000	464,000	143%
Taylor	Taylor Regional Hospital	2,745,000	458,000	599%
Trigg	Trigg County Hospital Inc	619,000	254,000	244%
Union	Methodist Hospital Union County	385,000	40,000	963%
Wayne	Wayne County Hospital Inc	609,000	301,000	202%
Whitley	Baptist Health Corbin	9,219,000	2,568,000	359%
Whitley	Oak Tree Hospital	273,000	-	
Rural Hospital Subtotal		174,335,000	58,664,000	297%

Note: Urban and Rural classification was derived using Census Bureau designation. Date listed is the date the payment entered the DMS database as a clean claim.

Table 9. Comparison of Medicaid Expansion Payments at Urban Hospitals to DSH Payments in 2014

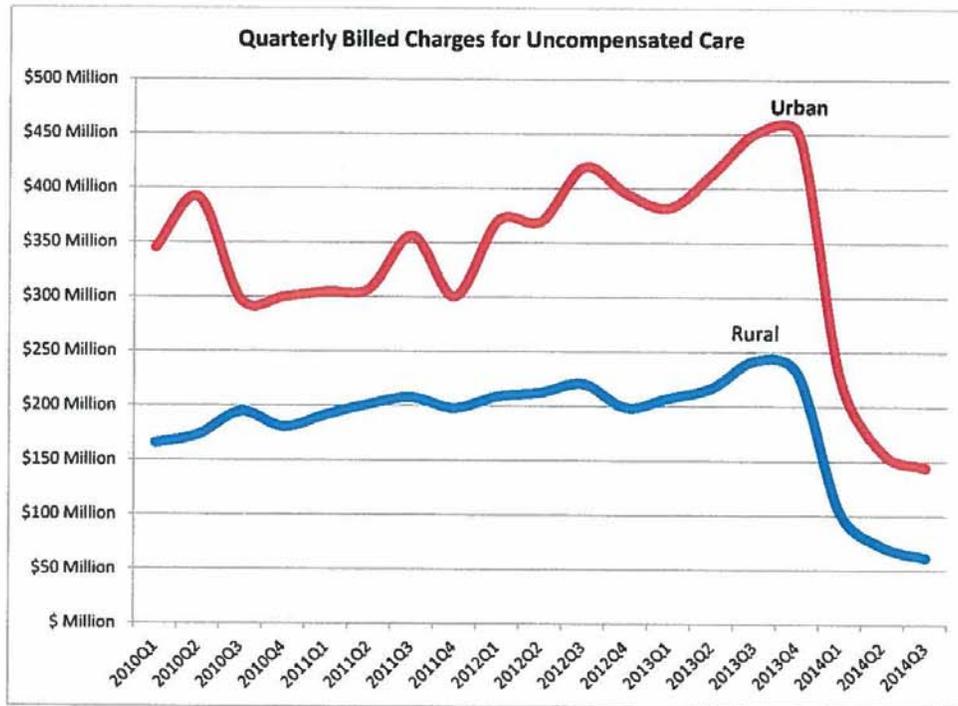
COUNTY	HOSPITAL	EXPANSION REVENUE	DSH PAYMENTS	Expansion as % of DSH
Allen	The Medical Center at Scottsville	626,000	481,000	130%
Boone	Gateway Rehab Hospital at Florence	454,000	-	
Boone	St Elizabeth Florence	5,880,000	3,004,000	196%
Bourbon	Bourbon Community Hospital	1,977,000	342,000	578%
Boyd	Kings Daughters Medical Center	11,285,000	3,077,000	367%
Boyd	Our Lady Of Bellefonte Hospital	4,621,000	513,000	901%
Campbell	Select Specialty Hospital	374,000	-	
Campbell	St Elizabeth Fort Thomas	5,200,000	2,713,000	192%
Christian	Jennie Stuart Medical Center	4,517,000	1,026,000	440%
Clark	Clark Regional Medical Center	4,701,000	1,554,000	303%
Daviess	Owensboro Health Regional Hospital	14,444,000	2,082,000	694%
Fayette	Baptist Health Lexington	13,636,000	2,168,000	629%
Fayette	Cardinal Hill Rehabilitation Hospital	2,555,000	163,000	1567%
Fayette	Continuing Care Hospital	454,000	-	
Fayette	Select Specialty Hospital	104,000	-	
Fayette	Shriners Hospitals For Children	48,000	-	
Fayette	Saint Joseph Hospital	9,675,000	2,346,000	412%
Fayette	Saint Joseph East	4,426,000	1,294,000	342%
Fayette	UK Chandler Medical Center	82,370,000	29,397,000	280%
Grant	St Elizabeth Grant	1,351,000	683,000	198%
Hardin	Hardin Memorial Health	8,872,000	2,432,000	365%
Hardin	Lakeview Rehabilitation Group Partners	284,000	-	
Henderson	Methodist Hospital	4,783,000	623,000	768%
Jefferson	Baptist Health Louisville	8,577,000	873,000	982%
Jefferson	Jewish Hospital	23,612,000	1,940,000	1217%
Jefferson	Kindred Hospital	1,096,000	-	

COUNTY	HOSPITAL	EXPANSION REVENUE	DSH PAYMENTS	Expansion as % of DSH
Jefferson	Norton Healthcare	43,447,000	4,624,000	940%
Jefferson	University of Louisville Hospital	57,662,000	66,054,000	87%
Kenton	Healthsouth Northern Ky Rehab Hospital	238,000	-	
Kenton	St Elizabeth	18,963,000	7,333,000	259%
Oldham	Baptist Health La Grange	2,411,000	358,000	673%
Scott	Georgetown Community Hospital	3,468,000	659,000	526%
Shelby	Jewish Hospital Shelbyville	1,249,000	275,000	454%
Warren	Commonwealth Regional Specialty Hospital	68,000	-	
Warren	Tri-Star Greenview Regional Hospital	3,728,000	609,000	612%
Warren	Southern Ky Rehabilitation Hospital	493,000	-	
Warren	The Medical Center at Bowling Green	13,128,000	3,967,000	331%
Woodford	Bluegrass Community Hospital	844,000	336,000	251%
Urban Hospital Subtotal		361,501,000	140,926,000	257%

Note: Urban and Rural classification was derived using Census Bureau designation. Date listed is the date the payment entered the DMS database as a clean claim.

The figure on the following page shows the change in billed charges for uncompensated care. Costs, on average, are typically ~30% of billed charges. Given the large reductions in uncompensated care that hospitals have reported in 2014 through their KHA data submissions, it is highly likely that many of the hospitals listed on the following tables eight and nine will have to pay back some of the DSH payments they receive to the Federal government once they are audited.

In the event of such an occurrence, those funds revert first to other hospitals within their given pool, and if those hospitals lack excess capacity to receive extra DSH payments according to CMS, then they could flow from the University pool to the Acute Care pool or vice-versa. More generally speaking, hospitals that experience tremendous reductions in uncompensated care as a result of Medicaid expansion or Qualified Health Plans may lose much larger shares of their DSH payment simply because they have not provided enough uncompensated care to qualify for them; however, in that event, those funds could flow to other Kentucky hospitals still experiencing larger amounts of uncompensated care.



The final tables provide historical perspective on DSH payments. Acute Care and Critical Access hospitals annually report their costs associated with treating indigent persons. Those costs are used to approximate the percentage of statewide indigent care provided by each individual hospital. That percentage is applied to the federal funds available in determination of DSH awards. This causes fluctuations in the annual DSH payments.

Recognizing that the statutory definitions of indigence (KRS 205.641) would prevent the majority of hospitals from reporting significant indigent costs, the Kentucky Hospital Association and the Cabinet for Health and Family Services agreed to use historical percentages for one biennium in order to determine DSH allocations. This language was included in the budget bill. After this period, a new method of allocating DSH funding must be determined.

Disproportionate Share Hospital Payments to Rural Acute and Critical Access Hospitals

County	Hospital	2010	2011	2012	2013	2014
Adair	Westlake Regional Hospital	781,000	713,000	770,000	696,000	779,000
Barren	T J Samson Community Hospital	944,000	862,000	875,000	1,263,000	1,443,000
Bell	Pineville Community Hospital	534,000	445,000	565,000	541,000	607,000
Boyle	Ephraim McDowell Reg Medical Center	2,058,000	1,556,000	1,967,000	1,991,000	2,242,000
Breathitt	Kentucky River Medical Center	372,000	244,000	638,000	836,000	950,000
Breckinridge	Breckinridge Memorial Hospital	197,000	283,000	409,000	284,000	312,000
Caldwell	Caldwell Medical Center	118,000	157,000	188,000	203,000	219,000
Calloway	Murray-Calloway County Hospital	613,000	596,000	543,000	756,000	863,000
Carroll	Carroll County Memorial Hospital	218,000	282,000	410,000	415,000	467,000
Casey	Casey County Hospital	440,000	406,000	473,000	419,000	469,000
Clay	Manchester Memorial Hospital	739,000	968,000	1,055,000	812,000	901,000
Clinton	Clinton County Hospital	211,000	185,000	201,000	129,000	141,000
Crittenden	Crittenden Health Systems	199,000	219,000	262,000	194,000	219,000
Cumberland	Cumberland County Hospital	272,000	177,000	178,000	194,000	211,000
Estill	Marcum & Wallace Memorial Hospital	592,000	564,000	888,000	536,000	583,000
Fleming	Fleming County Hospital	428,000	398,000	493,000	503,000	567,000
Floyd	Highlands Regional Medical Center	1,507,000	841,000	908,000	735,000	2,534,000
Floyd	Saint Joseph Martin	1,313,000	895,000	2,278,000	1,949,000	1,458,000
Franklin	Frankfort Regional Medical Center	550,000	588,000	569,000	502,000	561,000
Fulton	Parkway Regional Hospital	111,000	67,000	69,000	54,000	60,000
Graves	Jackson Purchase Medical Center	637,000	518,000	698,000	475,000	522,000
Grayson	Twin Lakes Regional Medical Center	351,000	159,000	406,000	281,000	309,000
Green	Jane Todd Crawford Hospital	442,000	444,000	430,000	385,000	431,000
Harrison	Harrison Memorial Hospital	569,000	583,000	1,264,000	950,000	1,062,000
Hart	Caverna Memorial Hospital Inc	117,000	133,000	142,000	108,000	120,000
Hopkins	Baptist Health Madisonville	828,000	872,000	754,000	1,033,000	1,179,000
Johnson	Paul B Hall Regional Medical Center	1,206,000	1,240,000	1,853,000	1,368,000	1,512,000
Knox	Knox County Hospital	669,000	504,000	1,002,000	356,000	391,000
Laurel	Saint Joseph London	2,158,000	1,404,000	3,066,000	2,326,000	2,574,000
Lawrence	Three Rivers Medical Center	725,000	369,000	435,000	408,000	458,000
Leslie	Mary Breckinridge ARH Hospital	587,000	398,000	624,000	737,000	836,000
Lincoln	Ephraim McDowell Fort Logan Hospital	596,000	380,000	543,000	506,000	567,000
Livingston	Livingston Hospital & Healthcare Services	210,000	187,000	256,000	172,000	188,000
Logan	Logan Memorial Hospital	234,000	196,000	346,000	279,000	310,000
Madison	Baptist Health Richmond	1,254,000	784,000	1,180,000	913,000	1,011,000
Madison	Saint Joseph Berea	991,000	893,000	1,032,000	633,000	690,000

Marion	Spring View Hospital	293,000	286,000	329,000	331,000	373,000
Marshall	Marshall County Hospital	279,000	146,000	219,000	171,000	189,000
Mason	Meadowview Regional Medical Center	381,000	369,000	315,000	359,000	406,000
McCracken	Baptist Health Paducah	908,000	784,000	967,000	1,224,000	1,392,000
McCracken	Lourdes	1,057,000	767,000	1,256,000	949,000	1,049,000
Mercer	The James B Haggin Memorial Hospital	227,000	208,000	258,000	209,000	233,000
Monroe	Monroe County Medical Center	326,000	236,000	320,000	293,000	328,000
Montgomery	Saint Joseph Mount Sterling	701,000	2,111,000	1,335,000	920,000	1,011,000
Muhlenberg	Muhlenberg Community Hospital	276,000	149,000	572,000	794,000	904,000
Multiple	Appalachian Regional Healthcare	8,553,000	7,709,000	9,404,000	8,650,000	9,690,000
Nelson	Flaget Memorial Hospital	1,170,000	1,209,000	1,718,000	1,341,000	1,487,000
Nicholas	Nicholas County Hospital	107,000	105,000	271,000	208,000	230,000
Ohio	Ohio County Hospital	376,000	334,000	511,000	455,000	509,000
Owen	New Horizons Health Systems Inc	92,000	88,000	46,000	27,000	30,000
Pike	Pikeville Medical Center	2,860,000	2,197,000	2,775,000	2,216,000	2,462,000
Pulaski	Lake Cumberland Regional Hospital	2,198,000	2,246,000	4,463,000	2,954,000	3,319,000
Rockcastle	Rockcastle Regional Hospital	438,000	363,000	474,000	431,000	483,000
Rowan	St Claire Regional Medical Center	1,234,000	1,597,000	2,425,000	1,878,000	2,081,000
Russell	Russell County Hospital	469,000	448,000	569,000	587,000	662,000
Simpson	The Medical Center at Franklin	421,000	261,000	378,000	411,000	464,000
Taylor	Taylor Regional Hospital	378,000	322,000	431,000	408,000	458,000
Trigg	Trigg County Hospital Inc	250,000	133,000	177,000	223,000	254,000
Union	Methodist Hospital Union County	224,000	108,000	72,000	37,000	40,000
Wayne	Wayne County Hospital Inc	293,000	288,000	346,000	271,000	301,000
Whitley	Baptist Health Corbin	3,905,000	3,256,000	2,977,000	2,313,000	2,568,000
Rural Total		51,187,000	45,230,000	60,378,000	51,602,000	58,669,000

Note: Urban and Rural classification was derived using Census Bureau designation. Data based on request made by Auditor of Public Accounts and fulfilled by HP.

Disproportionate Share Hospital Payments to Urban Acute and Critical Access Hospitals

County	Hospital	2010	2011	2012	2013	2014
Allen	The Medical Center at Scottsville	547,000	397,000	505,000	431,000	481,000
Boone	St Elizabeth Florence	2,697,000	2,332,000	2,819,000	2,676,000	3,004,000
Bourbon	Bourbon Community Hospital	319,000	241,000	350,000	306,000	342,000
Boyd	Kings Daughters Medical Center	2,268,000	2,439,000	3,504,000	2,773,000	3,077,000
Campbell	Our Lady Of Bellefonte Hospital	742,000	468,000	558,000	460,000	513,000
Christian	St Elizabeth Fort Thomas	2,382,000	2,158,000	2,292,000	2,405,000	2,713,000
Clark	Jennie Stuart Medical Center	638,000	497,000	776,000	906,000	1,026,000
Daviess	Clark Regional Medical Center	1,251,000	671,000	1,352,000	1,381,000	1,554,000
Fayette	Owensboro Health Regional Hospital	1,793,000	1,537,000	1,954,000	1,855,000	2,082,000
Fayette	Baptist Health Lexington	1,236,000	1,207,000	1,559,000	1,910,000	2,168,000
Fayette	Cardinal Hill Rehabilitation Hospital	161,000	145,000	406,000	158,000	163,000
Fayette	Saint Joseph East	351,000	832,000	1,258,000	1,156,000	1,294,000
Fayette	Saint Joseph Hospital	998,000	2,409,000	2,393,000	2,098,000	2,346,000
Fayette	Select Specialty Hospital	800,000	748,000	833,000	618,000	683,000
Grant	St Elizabeth Grant	2,554,000	1,957,000	2,771,000	2,192,000	2,432,000
Hardin	Hardin Memorial Health	1,233,000	585,000	663,000	559,000	623,000
Henderson	Methodist Hospital	466,000	587,000	676,000	771,000	873,000
Jefferson	Baptist Health Louisville	2,825,000	2,226,000	2,563,000	1,744,000	1,940,000
Jefferson	Jewish Hospital	4,049,000	3,700,000	4,110,000	4,109,000	4,624,000
Jefferson	Kindred Hospital	6,638,000	7,426,000	6,954,000	6,532,000	7,333,000
Jefferson	Norton Healthcare	120,000	247,000	394,000	322,000	358,000
Kenton	St Elizabeth	288,000	352,000	519,000	583,000	659,000
Oldham	Baptist Health La Grange	422,000	422,000	476,000	255,000	275,000
Scott	Georgetown Community Hospital	2,788,000	2,515,000	3,717,000	3,536,000	3,967,000
Shelby	Jewish Hospital Shelbyville	846,000	756,000	335,000	895,000	609,000
Warren	The Medical Center at Bowling Green	151,000	169,000	200,000	294,000	336,000
Warren	Tri-Star Greenview Regional Hospital	38,563,000	37,043,000	43,937,000	40,925,000	45,475,000
Woodford	Bluegrass Community Hospital	547,000	397,000	505,000	431,000	481,000
	Urban Total	2,697,000	2,332,000	2,819,000	2,676,000	3,004,000

Note: Urban and Rural classification was derived using Census Bureau designation. Data based on request made by Auditor of Public Accounts and fulfilled by HP.

Disproportionate Share Hospital Payments to Private Psychiatric Hospitals

Hospital	2010	2011	2012	2013	2014
The Brook KMI Hospital	1,028,000	868,000	533,000	164,000	148,000
Lincoln Trail Hospital	184,000	144,000	-	-	-
North Key Community Care-Inpatient Services	-	-	56,000	3,000	-
Our Lady Of Peace	537,000	702,000	1,277,000	1,960,000	2,103,000
Ridge Behavioral Health	112,000	67,000	56,000	31,000	31,000
River Valley Behavioral Health Hospital	251,000	105,000	79,000	147,000	158,000
The Brook Dupont Hospital	772,000	854,000	637,000	434,000	443,000
Private Psychiatric Total	2,883,000	2,739,000	2,638,000	2,739,000	2,883,000

Note: Data based on request made by Auditor of Public Accounts and fulfilled by HP.

Disproportionate Share Hospital Payments to State Mental Hospitals

Hospital	2010	2011	2012	2013	2014
Central State Hospital	12,224,000	9,988,000	9,917,000	9,846,000	9,891,000
Eastern State Hospital	10,236,000	11,295,000	11,520,000	11,746,000	13,009,000
Western State Hospital	12,099,000	13,277,000	12,259,000	11,240,000	11,660,000
State Mental Total	34,560,000	34,560,000	33,696,000	32,832,000	34,560,000

Note: Data based on request made by Auditor of Public Accounts and fulfilled by HP.

Disproportionate Share Hospital Payments to University Hospitals

Hospital	2010	2011	2012	2013	2014
UK Chandler Medical Center	25,411,000	23,826,000	28,407,000	26,163,000	29,397,000
University of Louisville Hospital	50,308,000	47,987,000	55,421,000	51,796,000	66,054,000
University Total	75,719,000	71,813,000	83,828,000	77,959,000	95,452,000

Note: Data based on request made by Auditor of Public Accounts and fulfilled by HP.

Appendix 2

Commonwealth of Kentucky
Cabinet for Health and Family Services (CHFS)
Office of Health Policy (OHP)



**State Innovation Model (SIM) Model Design
Overview**



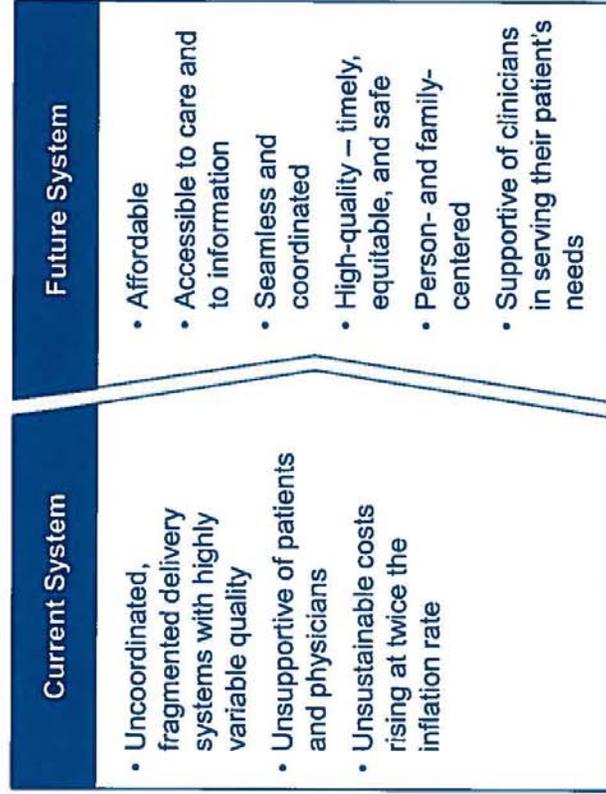
**State Innovation Model (SIM)
Overview**



CMS Goals for the SIM Program

The Centers for Medicare & Medicaid Services (CMS) State Innovation Model (SIM) initiative is focused on testing the ability of state governments to use regulatory and policy levers to accelerate health transformation.

- CMS is providing financial and technical support to states for developing and testing state-led, multi-payer health care payment and service delivery models that will impact all residents of the participating states
- The overall goals of the SIM initiative are to:
 - *Establish public and private collaboration with multi-payer and multi-stakeholder engagement*
 - *Improve population health*
 - *Transform health care payment and delivery systems*
 - *Decrease total per capita health care spending*



Source: CMS SIM Round Two Funding Opportunity Announcement Webinar

CMS' Triple Aim Strategy

Improve health system performance

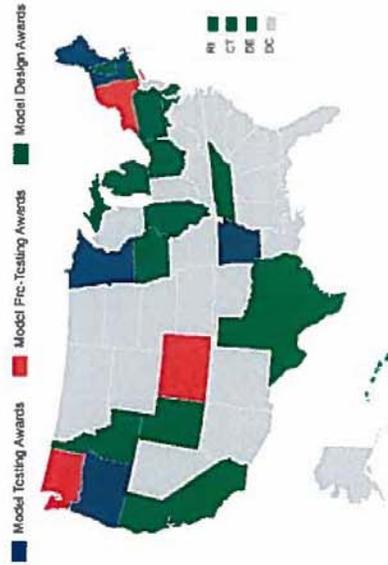
Increase quality of care

Decrease costs



Current Landscape of the SIM Program

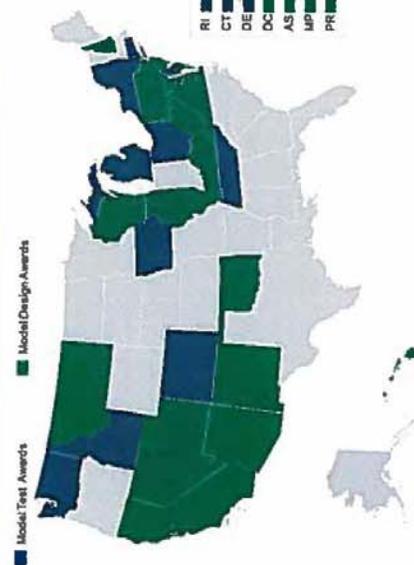
The Center for Medicare & Medicaid Innovation (CMMI) within CMS awarded states cooperative agreements in two rounds to design and implement strategies for service delivery and payment reform.



Source: Centers for Medicare & Medicaid Services

Round 1 SIM Grant Recipients

- Nearly \$300 million was awarded to 25 states in December 2012 to design or test innovative health care payment and service delivery models during Round 1 of the SIM initiative.
- Awardee Breakdown:
 - **Model Testing Awards: 6**
 - **Model Pre-Testing Awards: 3**
 - **Model Design Awards: 16**



Source: Centers for Medicare & Medicaid Services

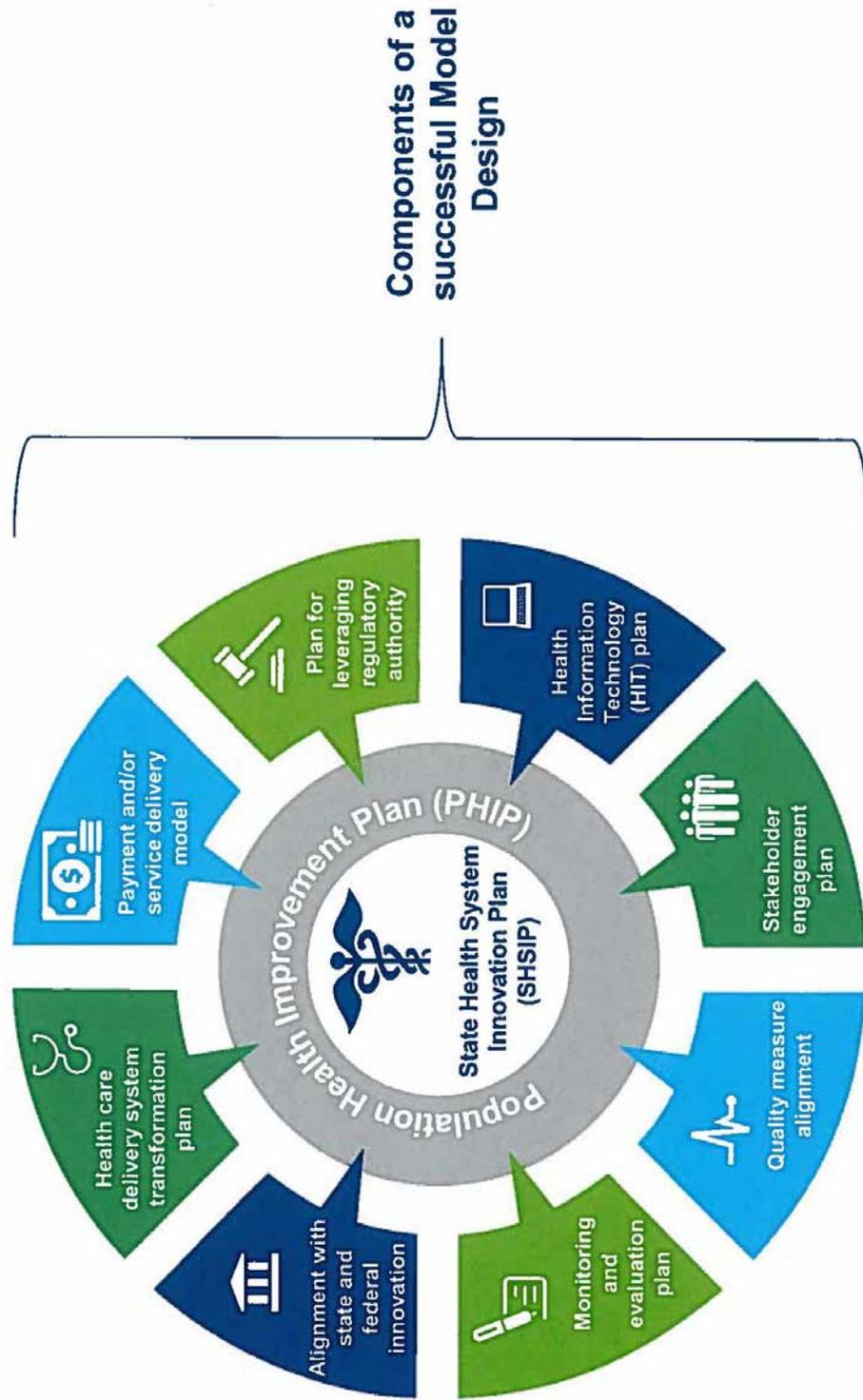
Round 2 SIM Grant Recipients

- CMMI added more parameters in Round 2 that better correlate with successful statewide health transformation. It also selected Model Test/Model Design applications based on their potential to impact the health of the entire state population.
- In December 2014, more than \$660 million was provided to 32 awardees (28 states, three territories, and the District of Columbia) for Round 2.
- Awardee Breakdown:
 - **Model Testing Awards: 11**
 - **Model Design Awards: 21**



Components of a SIM Model Design

CMS requires a State Health System Innovation Plan – also referred to as the “Model Design” – as the final deliverable for a SIM Model Design grant.



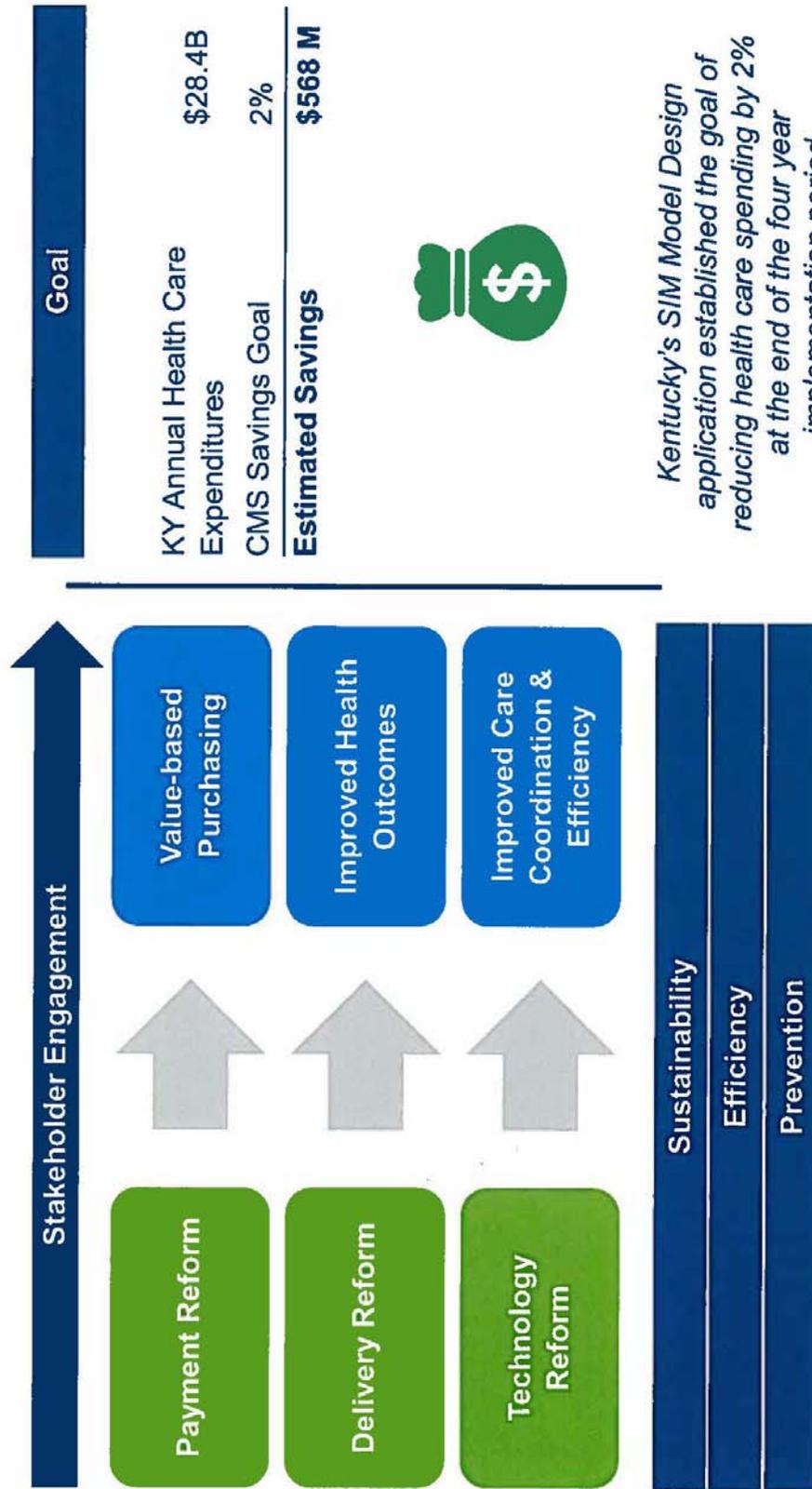


KY SIM Proposal Overview



Kentucky's Vision for its SIM Model Design

Kentucky's Model Design will incorporate multiple payers, including Medicaid managed care organizations (MCOs), the Kentucky Employee Health Plan, insurers offering Qualified Health Plans (QHPs) through Kynect, and Medicare in an effort to achieve health system transformation.

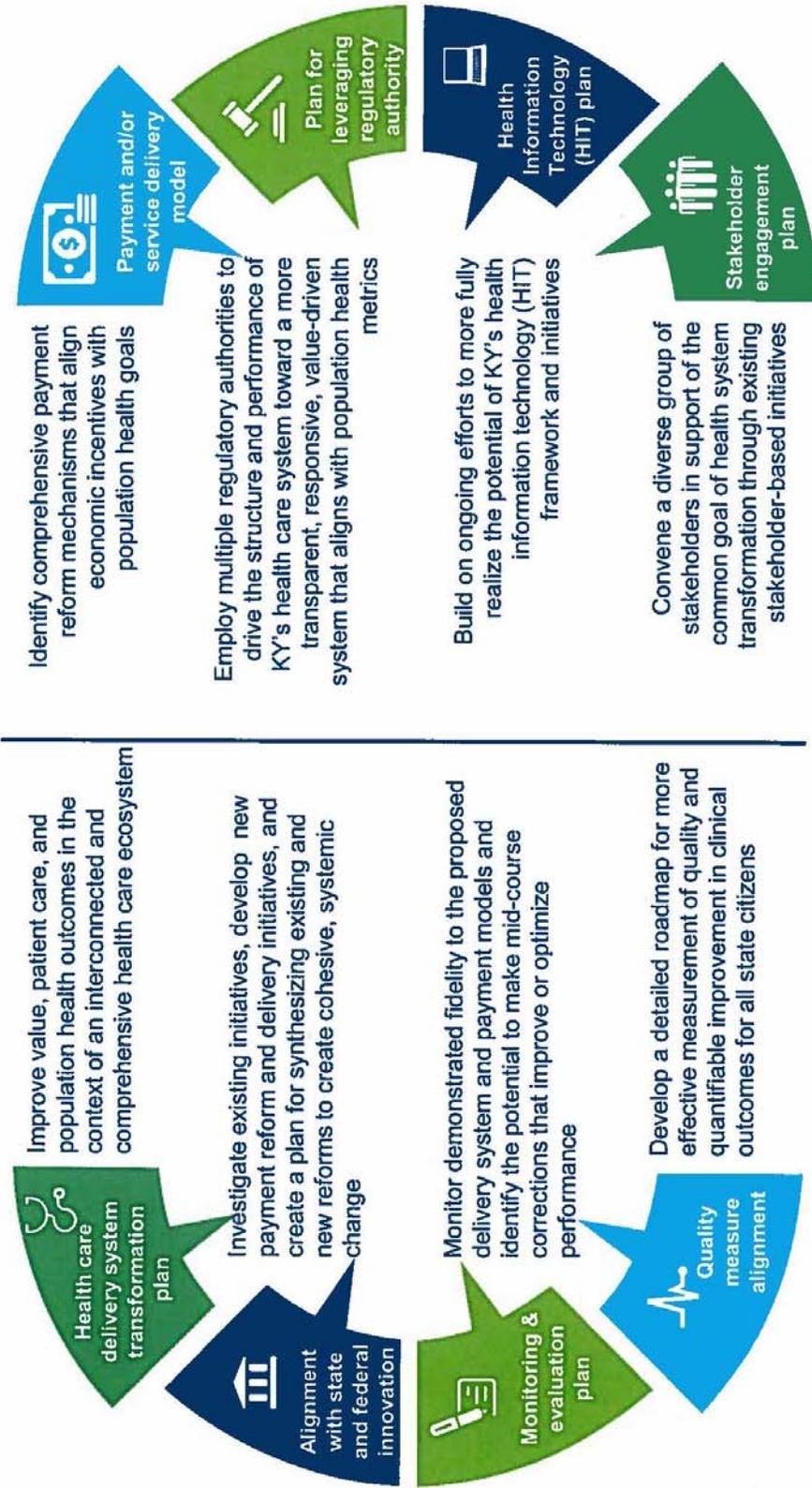


Kentucky's SIM Model Design application established the goal of reducing health care spending by 2% at the end of the four year implementation period.



Kentucky's Vision for the State Health System Innovation Plan

CMS requires a number of work products to comprise a State Health System Innovation Plan as the final deliverable for a SIM Model Design grant. Kentucky will leverage existing state infrastructure and established programs to meet its goals for each plan component.

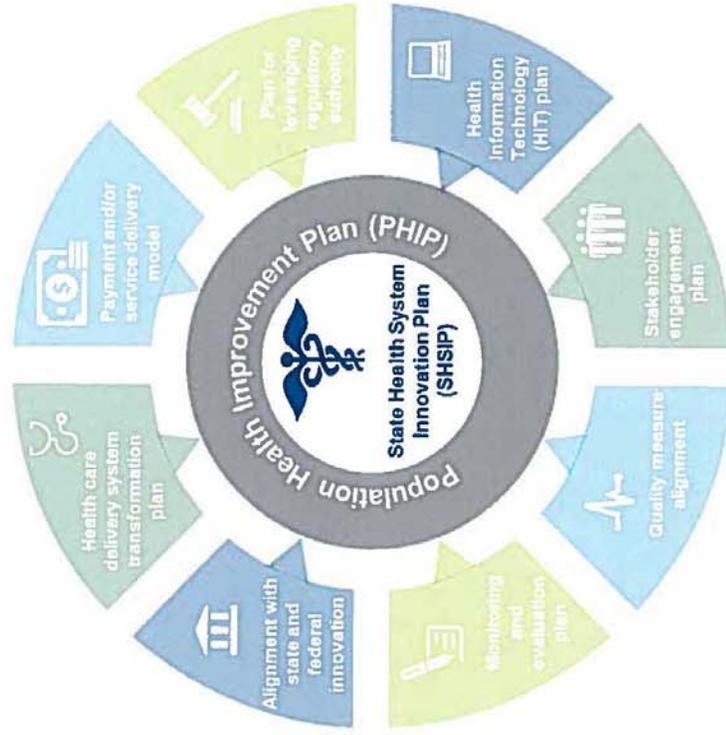


Kentucky's Vision for the Population Health Improvement Plan

During the SIM Model Design phase, Kentucky will build upon existing health initiatives both within the Commonwealth and at a national level in order to develop an integrated, comprehensive Population Health Improvement Plan (PHIP).

PHIP Overview

- The PHIP will help to facilitate the integration of population health strategies and metrics with public health officials and health care delivery systems, with a focus on the following:
 - Narrowing health disparities
 - Expanding access to care at the local level
 - Improving chronic disease prevention and management
- Additionally, the PHIP will be focused on the following core population health metrics:
 - Tobacco use
 - Obesity
 - Diabetes
- The PHIP is central to the overall vision of the SIM project. Themes of the PHIP will be woven throughout other components of the Model Design





High-Level Model Design Considerations

Kentucky will propose and discuss with stakeholders multiple key questions that its Model Design components will address and subsequently weave into the final State Health System Innovation Plan.

Key Questions	
How do we infuse a population health focus into payment reform initiatives?	How can we increase the linkages between delivery system reforms and public health initiatives?
How do we build on existing delivery system reform initiatives underway in KY?	How should we align with Medicare's payment reform initiatives?
How do we improve the coordination of services across delivery systems (physical health, behavioral health, long-term care)?	How do we increase access to services and care coordination in rural areas of the state?
How can we build consensus and support for initiatives for reforms that require regulatory or statutory changes?	How do we develop robust, multi-payer support for the SIM initiatives?
How do we address the role of consumers in directing and managing the cost of their care?	How will we manage the economic disruption that delivery system and payment reforms will create?



A Closer Look at the Population Health Improvement Plan

All SIM Model Design and Model Test states must develop a plan to improve the health and well-being of the state population, or a PHIP, within the context of the health system delivery and payment transformation plan that accomplishes five key objectives.

- 1 Identifies gaps in access and disparities in the health status of state residents
- 2 Leverages and builds upon interventions and strategies including in an existing public health State Health Improvement Plan (SHIP)
- 3 Creates an inventory of current efforts to advance the health of the entire state population, including efforts to integrate public health and health care delivery
- 4 Leverages existing health care transformation efforts to advance population health
- 5 Includes a data-driven implementation plan that identifies measurable goals, objectives, and interventions that will enable the state to improve the health of the entire state population



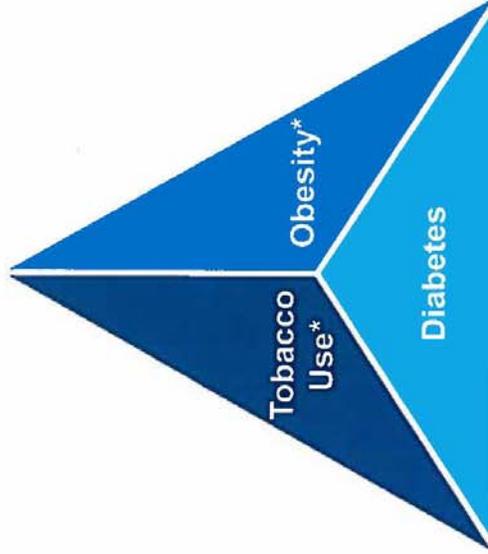
Population Health Improvement Plan + kyhealthnow

CMS and the Centers for Disease Control and Prevention (CDC) require all PHIPs to establish statewide goals and metrics focused on reducing the rate of tobacco use, the incidence of obesity, and the incidence of chronic diseases such as diabetes.

PHIP Alignment with kyhealthnow

- CMS/CDC encourages SIM states to leverage existing health care transformation efforts to advance population health underway in the state
- In Kentucky, this poses the opportunity to align with and further advance the seven major health goals of kyhealthnow:
 1. **Health insurance** - Reduce Kentucky's rate of uninsured individuals to less than five percent
 2. **Smoking*** - Reduce Kentucky's smoking rate by 10 percent
 3. **Obesity*** - Reduce the rate of obesity among Kentuckians by 10 percent
 4. **Cancer** - Reduce Kentucky cancer deaths by 10 percent
 5. **Cardiovascular Disease** - Reduce cardiovascular deaths by 10 percent
 6. **Dental Decay** - Reduce the percentage of children with untreated dental decay by 25 percent, and increase adult dental visits by 10 percent
 7. **Drug Addiction** – Reduce deaths from drug overdose by 25 percent, and reduce the average number of poor mental health days of Kentuckians by 25 percent

CMS/CDC Core Population Health Metrics



*CMS/CDC Core Population Health Metrics

Source: kyhealthnow Home (www.governor.ky.gov)

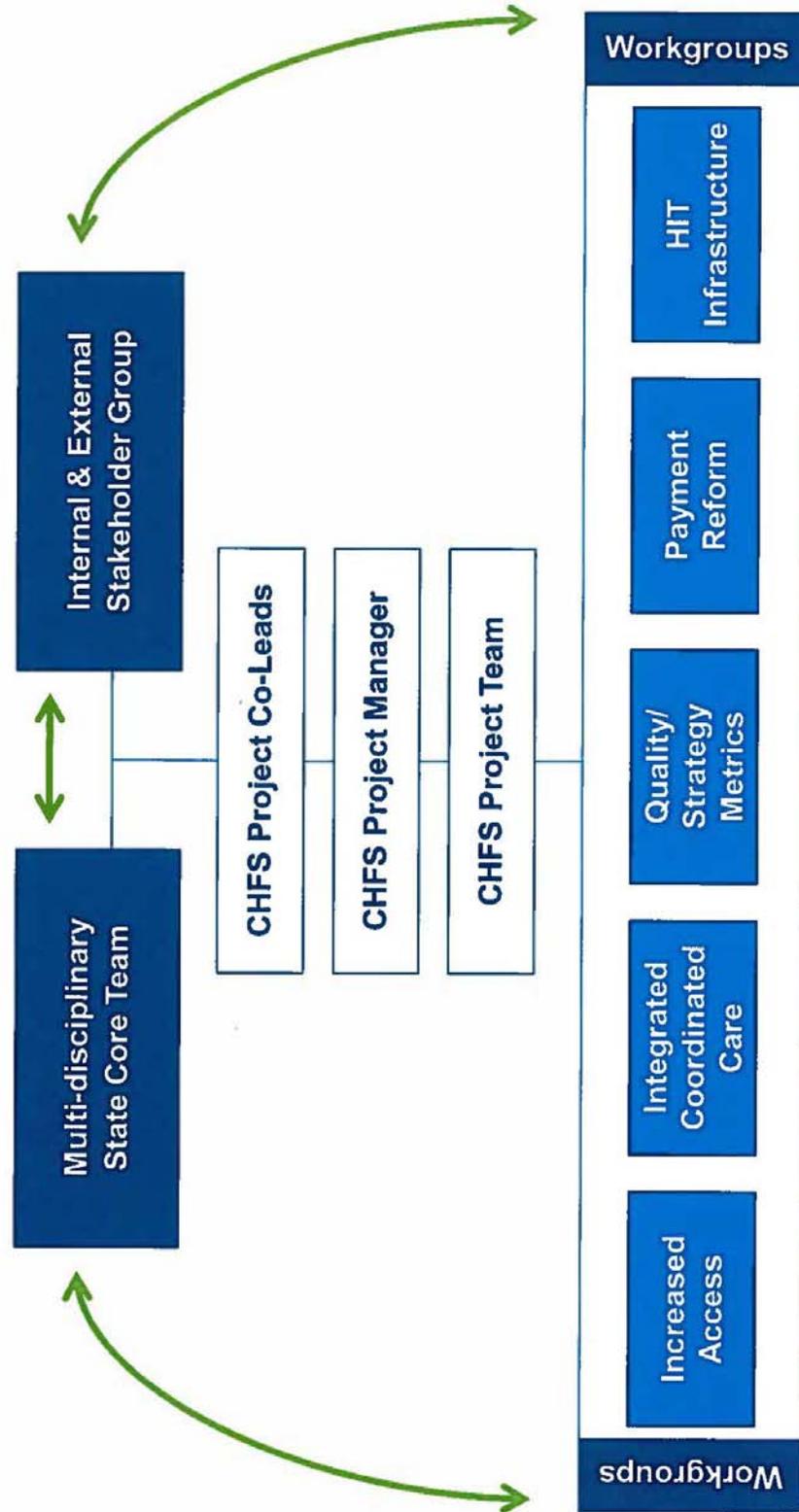


KY SIM Project Overview



Kentucky's SIM Project Structure

While the CHFS is the lead applicant agency for Kentucky's SIM Model Design, the process will rely on consistent input from and two-way communication among a multi-disciplinary state Core Team and internal and external stakeholders to develop, implement, and sustain the SIM initiatives.





Kentucky's SIM Project Timeline

Strong stakeholder engagement as well as adherence to a thorough project methodology will be critical in the development of a successful SIM Model Design.

Task	2015												2016		
	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.	Jan.			
	Stakeholder Engagement														
Phase 1: Define <ul style="list-style-type: none"> Finalize roles and responsibilities Identify goals and objectives Generate innovation ideas for payment and delivery reform 															
Phase 2: Develop Model Design <ul style="list-style-type: none"> Identify components of redesigned system Leverage existing initiatives in support of Model Design Reach consensus on Model Design 															
Phase 3: Develop Financial Model <ul style="list-style-type: none"> Develop financial savings estimate Identify regulatory requirements for supporting new model design Reach consensus on cost savings 															
Phase 4: Finalize State Innovation Model <ul style="list-style-type: none"> Develop implementation strategy Finalize budget for testing Submit Model Design 															



Proposed Stakeholder Meeting Schedule

A monthly meeting of key stakeholders and agreed-upon workgroups will be essential for obtaining buy-in and driving the development of a successful model.

March 2015

M	T	W	T	F
2	3	4	5	6
9	10	11	12	13
16	17	18	19	20
23	24	25	26	27
30	31			

April 2015

M	T	W	T	F
6	7	8	9	10
13	14	15	16	17
20	21	22	23	24
27	28	29	30	

May 2015

M	T	W	T	F
4	5	6	7	8
11	12	13	14	15
18	19	20	21	22
25	26	27	28	29

Calendar Legend

Workgroup Meeting

Stakeholder Meeting

Note: All meeting dates are still proposed at this time. While this schedule represents three months, stakeholder and workgroup meetings will occur throughout the duration of the SIM initiative.

Appendix 3



Policy Academy
*Building A Transformed Health Workforce:
Moving From Planning to Implementation*

DRAFT ACTION PLAN
January 30, 2015

DRAFT

KENTUCKY'S HEALTH WORKFORCE ACTION PLAN

Building a Transformed Health Care Workforce:
Moving from Planning to Implementation

Team Members

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Office of Health Policy

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Education & Workforce Development
Cabinet

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Office of the Commissioner
Department for Public Health
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Cabinet for Health & Family Services

Mike Bartlett
Deputy Policy Advisor
Office of Governor Beshear

Gordon Slone
Executive Director
Office of Occupations & Professions
Public Protection Cabinet

Vestena Robbins, Ph.D.
Policy Advisor
Department for Behavioral Health and
Developmental and Intellectual
Disabilities
Cabinet for Health & Family Services

JP Hamm, JD
Executive Director
Office of Human Resources,
Cabinet for Health & Family Services

Core Area #1: Data

Overview of Issue

Kentucky must base its health workforce strategies on accurate data. Although various health profession licensure boards currently collect some data, there is no standardization among them, either technology or core fields, nor is there any required or voluntary routine reporting of this data by the licensure boards to a central entity that can analyze trends and make projections. Per the recommendation of the recently commissioned Health Workforce Study (Deloitte Consulting, 2013), Kentucky will seek to harmonize the fields collected by health profession licensure boards and to obtain consistently updated data from those entities. Finally, Kentucky must synthesize licensure data with other sources, including health systems, educational systems, and employers.

Five-Year Vision

Kentucky has a regular reporting structure (at least annually) for core data fields of certified and/ or licensed health professionals. This data is analyzed in concert with data from health and educational systems and health-related employers to support effective workforce planning and transformation of health care systems.

Goal #1

Each licensure board and/or certification agency collects core data fields identified by the state as being necessary for meaningful data analysis.

Outcome Measure/Indicator of Success #1

Where necessary, licensure boards amend their regulations to require reporting of core fields by health professionals when renewing licenses.

Outcome Measure/Indicator of Success #2

Where necessary, licensure boards ensure the necessary technological infrastructure to capture the minimum core data fields.

Strategy #1: Convene all relevant data reporters and discuss the objectives for collecting common fields among them and the value to developing an adequate health care talent pipeline in Kentucky and the opportunities to benefit their respective board's mission.

Strategy #2: Identify and operationalize a funding mechanism to support any technological changes that need to be undertaken to support system changes among the relevant data reporters and a designated central reporting entity.

Strategy #3: Share data results with licensure boards and the education and workforce development systems to support health care sector work and industry partnerships.

Goal #2

Licensure boards regularly report data to a central entity harmonizes, analyzes, and regularly reports on the data.

Outcome Measure/Indicator of Success #1

Where necessary, agreements or memoranda of understanding will be entered into between relevant data reporters and the state and/or the relevant reporting entity.

Outcome Measure/Indicator of Success #2

The central reporting entity will have the technological infrastructure to harmonize and analyze the data as reported by licensure boards.

Strategy #1: Identify the appropriate reporting agency and outline their technological infrastructure to support the work, e.g., the Kentucky Center for Education and Workforce Statistics, the State Data Center, infrastructure within Cabinets (Office of Occupations and Professions, Cabinet for Health & Family Services, others?).

Strategy #2: Craft a template for a Memorandum of Agreement (MOA) that can be used by each of the licensure boards and present MOA to all licensure boards for review and approval.

Strategy #3: Modify data collection processes among relevant data reporters, create a transmission process between the boards and reporting agency and a method of communicating results to boards, workforce systems and the public.

Core Area #2: Redesign of Health Workforce Planning

Overview of Issue

Health workforce planning must adapt to the changing landscape of care delivery. Projections must be based on analytical models of care as it will be delivered in the future, rather than how it has been delivered in the past. Thus, Kentucky must work toward creating a health workforce plan that accurately captures and responds to ongoing changes in care models.

Five-Year Vision

Kentucky's health workforce plan relies on stakeholder approved metrics that are responsive to Kentucky's health workforce needs in view of changing models of coverage and care delivery.

Goal #1

Kentucky's health workforce plan uses metrics that are widely accepted as best practices for projecting needs in the post-Affordable Care Act era.

Outcome Measure/Indicator of Success #1

Kentucky has researched, discussed, and selected appropriate metrics, in consultation with experts and in view of models used in other states.

Outcome Measure/Indicator of Success #2

Kentucky's health system stakeholders are in agreement on the metrics selected, which will mirror or closely align with those they use for their internal forecasting.

<p>Strategy #1: Review health care workforce metrics in states and regions across the country, including but not limited to government regulatory agencies, and advocacy groups.</p>
<p>Strategy #2: Present potential metrics to all stakeholder groups including health care providers, associations, workforce system partners, trade associations and community-based partners and finalize metrics after input.</p>
<p>Strategy #3: Present the metrics to the central reporting entity identified in Core Area #4 and/or the Kentucky Workforce Investment Board for adoption and development of a data dashboard on approved metrics.</p>

Goal #2

Kentucky's health workforce plan includes projections for new and emerging types of health professionals, not just those that have been relied on in the past.

Outcome Measure/Indicator of Success #1

Kentucky's health workforce plan includes professionals such as Community Health Workers and other new and emerging types of health professionals, along with para-professionals.

Outcome Measure/Indicator of Success #2

Kentucky's health workforce plan includes new and emerging technologies such as telehealth and telemonitoring.

<p>Strategy #1: Research emerging types of professionals in other states across all health delivery sectors and engage stakeholders to determine which are most likely to help meet Kentucky's needs.</p>
<p>Strategy #2: Explore evolving practices for projecting need with national experts; including representatives of professionals (e.g., the benchmarking sources identified in the Deloitte Health Workforce Report (2013)), health system representatives, local health departments, and community organizations.</p>
<p>Strategy #3: Identify and use real time labor market tools like Labor Insights to support Health Care Sector and Industry Partnership work.</p>
<p>Strategy #4: Support Health Care Industry Partnership development in identifying viable career pathways in emerging health professions and emerging technologies.</p>
<p>Strategy #5: Work with the K-Career system in Kentucky to develop seamless career pathways and/or modify existing pathways in the Commonwealth and its economic regions as needed.</p>

Core Area #3: Pipeline

Overview of Issue

Kentucky must understand and project its health workforce needs in view of the pipeline of professionals, both existing and those in training. To do so will require close partnership with the educational system from K-12 and post-secondary education, along with partnership with the Commonwealth's Workforce Investment team, to develop strategies to ensure that the right professionals are being trained in view of projected needs and opportunities for employment. In essence, Kentucky needs to train, re-train, recruit and retain appropriate numbers of health professionals across all sectors.

Five-Year Vision

Kentucky's health workforce plan is directly aligned with the needs of the population and translates to projections of the education, workforce investment, and financial sectors, leading to a seamless health delivery system.

Goal #1

Kentucky's health education system has the capacity to deliver the necessary professionals, either by training new students or re-training existing professionals.

Outcome Measure/Indicator of Success #1

All schools report existing capacity and pipeline across all degree programs.

Outcome Measure/Indicator of Success #2

The K-career system makes projections and reports/tracks the students entering health-related degree or training programs, as well as the retention rates for such students.

Strategy #1: All higher education institutions in Kentucky report, and the Council on Postsecondary Education tracks, all enrollments and degree attainment, as well as retention for such students, in every health professions field.
Strategy #2: Develop employer-led Health Care Industry Partnerships including education, economic development and workforce development partners across the Commonwealth to articulate and address emerging and incumbent workforce training needs.
Strategy #3: Identify the emerging and incumbent workforce skill needs within the Industry Partnership's economic region and assess the K-Career education and training partners' current program offerings.
Strategy #4: Align the education and training partners' program offerings to create career pathways to address emerging workforce and incumbent worker training needs.
Strategy #5: Align state and local workforce system resources to support Industry Partnerships and individual customer health care training needs.

Goal #2

Kentucky's educational system and/or other coordinating entities/agencies are able to ensure and coordinate clinical placements for all students enrolled in degree programs.

Outcome Measure/Indicator of Success #1

Kentucky schools report and track success in clinical placements across all relevant health degree programs.

Outcome Measure/Indicator of Success #2

Kentucky schools adopt a state-wide centralized placement system for non-physician health professionals.

Strategy #1: Convene stakeholders to achieve consensus on areas that need improvement regarding clinical placements, including coordinated efforts on placements.
Strategy #2: Identify a mechanism, including an entity with appropriate technical capacity, to coordinate annual or more frequent reporting of clinical placement and tracking.
Strategy #3: Research mechanisms to increase the willingness of practitioners to accept (or increase their numbers) of students for clinical placements.

Goal #3

All health profession degree program graduates who wish to pursue primary care/family medicine in Kentucky are able to do so.

Outcome Measure/Indicator of Success #1

Kentucky develops new mechanisms to increase incentives for primary care practitioners to stay in the Commonwealth and practice in underserved areas.

Outcome Measure/Indicator of Success #2

Kentucky increases its residency slots for primary care/family medicine.

Strategy #1: Convene stakeholders to determine whether there is agreement that an incentive program would achieve the desired result of increasing access to care and meeting the needs of Kentuckians in underserved areas.
Strategy #2: Achieve consensus among stakeholders as to which health professionals should be included in an incentive program and under what terms incentives are appropriate.
Strategy #3: Seek out champions of the proposed program and identify possible funding streams.
Strategy #4: Convene stakeholders to discuss strengths and barriers to in-state residency training for primary care physicians.
Strategy #5: Research creative financing mechanisms to fund primary care residency slots.
Strategy #6: Research creative financing mechanisms to incentivize health professionals to practice primary care in underserved areas.

Core Area #4: Policy Coordination

Overview of Issue

Kentucky currently lacks a coordinated state-level health workforce plan. As a threshold question, Kentucky must determine where the state health workforce data gathering and analysis identified in Core Area # 1 will take place, as well as from where policy recommendations based on that data should be issued. The ultimate goal will be for Kentucky to develop a sustainable means to create and regularly update a state health workforce plan that is based on high-quality data and includes evidence-based policy analysis and recommendations.

Five-Year Vision

Kentucky has a coordinated state health workforce plan that includes timely, comprehensive data analysis and evidence-based policy recommendations to ensure that Kentucky's health workforce plan meets the needs of Kentuckians.

Goal #1

Kentucky has a single entity responsible for issuing an annual state health workforce plan containing policy recommendations, performance metrics, an analysis of the health workforce pipeline, along with maintaining a real-time ongoing data dashboard assessing the state of the health workforce.

Outcome Measure/Indicator of Success #1

A central entity for workforce planning and policy is selected and funded.

Outcome Measure/Indicator of Success #2

Kentucky issues its first updated health workforce plan by June 2016.

<p>Strategy #1: Investigate models for health workforce analysis and planning in other states and determine a model that best fits Kentucky's needs and existing infrastructure.</p>
<p>Strategy #2: Create a state-level health care sector panel that includes representatives from the Cabinet for Health & Family Services, health care providers (including licensure boards), educational systems, consumer advocates, and appropriate stakeholders affiliated with the Kentucky Workforce Investment Board and the Department of Workforce Investment.</p>
<p>Strategy #3: The state-level panel will be charged with developing a state-level health care workforce plan which will review licensure data, real time labor market data, projected need for health care services across the state, and Industry Partnership insights that includes performance metrics.</p>
<p>Strategy #4: Incorporating evidence on best practices in other states, the state-level panel will identify a single entity or office to take primary responsibility for the health workforce plan development, including to conduct research and policy studies that will continue to inform and fine tune the Commonwealth's health care workforce plan.</p>
<p>Strategy #5: Kentucky issues its first updated health workforce plan by June 2016, reflecting updated data and timely policy analysis and recommendations.</p>

Appendix 4

**PERCENT INCREASE OR DECREASE IN
NUMBER OF PARTICIPATING MEDICAID PROVIDERS
FROM 2011 to 2014 AS REFLECTED IN CLAIMS PAID**

Provider Type	Percent Change
01 - General hospital	-40%
02 - Mental Hospital	0%
04 - Psychiatric Residential Treatment Facility	26%
11 - ICF/MR	0%
12 - Nursing Facility	8%
13 - Specialized Children Service Clinics	-27%
14 - MFP Pre-Transition Services	0%
15 - Health Access Nurturing Development Svcs	-3%
17 - Acquired Brain Injury	-2%
20 - Preventive & Remedial Public Health	-10%
21 - School Based Health Services	10%
22 - Commission for Handicapped Children	450%
23 - Title V/DSS	0%
24 - First Steps/Early Int.	0%
27 - Adult Targeted Case Management	0%
28 - Children Targeted Case Management	0%
29 - Impact Plus	-15%
30 - Community Mental Health	0%
31 - Primary Care	15%
33 - Support for Community Living (SCL)	11%
34 - Home Health	-1%
35 - Rural Health Clinic	18%
36 - Ambulatory Surgical Centers	-22%
37 - Independent Laboratory	9%
39 - Dialysis Clinic	12%
41 - Model Waiver	15%
42 - Home and Community Based Waiver	-4%
43 - Adult Day Care	-2%
44 - Hospice	-4%
45 - EPSDT Special Services	-6%
50 - Hearing Aid Dealer	-27%
52 - Optician	-13%
54 - Pharmacy	1%
55 - Emergency Transportation	-1%
56 - Non-Emergency Transportation	-6%
57 - Net (Capitation)	45%
60 - Dentist - Individual	16%
61 - Dental - Group	15%
64 - Physician Individual	98%
65 - Physician - Group	-4%
66 - Behavioral Health Multi-Specialty Group	∞
70 - Audiologist	49%
74 - Nurse Anesthetist	111%
77 - Optometrist - Individual	39%
78 - Certified Nurse practitioner	161%

Provider Type	Percent Change
79 - Speech-Language Pathologist	∞
80 - Podiatrist	28%
81 - Licensed Professional Clinical Counselor	∞
82 - Clinical Social Worker	136%
83 - Licensed Marriage and Family Therapist	∞
84 - Licensed Psychological Practitioner	∞
85 - Chiropractor	7%
86 - X-Ray / Misc. Supplier	-20%
87 - Physical Therapist	86%
88 - Occupational Therapist	87%
89 - Psychologist	182%
90 - DME Supplier	-29%
91 - CORF (Comprehensive Out-patient Rehab Facility)	-33%
92 - Psychiatric Distinct Part Unit	-12%
93 - Rehabilitation Distinct Part Unit	-8%
95 - Physician Assistant	98%
99 - Not on File	-100%
Total	44%

Notes:

- * Date listed is calendar year of payment
- ** Providers had to receive at least \$0.01 in payment during calendar year
- *** Provider count is based on unduplicated billing provider Medicaid ID numbers
- **** Provider count is based on aggregate national

∞ Denotes new provider type not eligible for the Medicaid Program in 2011

Source: Medicaid claims paid to providers in 2011 and 2014, as extracted from Medicaid Claims Database on 3/9/2014.

Appendix 5

Kentucky Medicaid has expanded managed care across the state. Members now have five health plans to choose from: **Anthem, CoventryCares of Kentucky, Humana CareSource, Passport Health Plan, and WellCare of Kentucky.**

This guide is intended to help Members choose a health plan that best meets the needs of you and your family. Here you will find information about the care offered by the health plans and Members' satisfaction with the quality of care and services provided. You will also find information about how to reach each health plan in case you need help or have questions.

Some questions to consider in deciding upon a health plan might be:

- "Is my current doctor in the plan?"
- "Do you have any special services that I or someone in my family might need?"
- "Do you have someone at your plan who can speak my language?"

In managed care:

- You have a choice of doctors, dentists, hospitals, pharmacists and labs available to you.
- You have a choice of health plans to select.
- Your benefits are the same as regular Medicaid.
- You may be entitled to additional services if you need them.
- Your copayments cannot be more than regular Medicaid and may be less.

Please check our website at

<http://chfs.ky.gov/dms/mcolinks.htm>

for resources you can use to help you learn more about managed care, including:

- Links to the health plans websites (links and phone numbers can also be found in this guide.)
- Information on eligibility.
- Enrollment information.

If you have any questions or problems with your health plan, call:

1-855-446-1245



A Member's Guide to Choosing a Medicaid Health Plan

..... **2014**



A Member's Guide to Choosing a Medical Health Plan



KEY: More Stars Mean Better Health Plan Performance. ★★ Above Average ★★ Average ★ Below Average

PREVENTIVE CARE					
Health Plan	Childhood Immunizations NEW PLAN NO RATING AVAILABLE	Adolescent Immunizations	Cervical Cancer Screening	Prenatal Care	
Anthem	★★				
CoventryCares of Kentucky	★★	★	★★	★	
Humana CareSource	★	★★	★	★	
Passport Health Plan	★★★	★★★	★★★	★★★	
WellCare of Kentucky	★★	★★	★	★★	

ACCESS TO CARE					
Health Plan	Dental Visits NEW PLAN NO RATING AVAILABLE	Adult Primary Care Visits	Child Primary Care Visits	Adult Doctor Availability	Child Doctor Availability
Anthem	★	★	★★	★★	★★
CoventryCares of Kentucky	★	★	★	★	★★
Humana CareSource	★★★	★★★	★	★★	★★
Passport Health Plan	★★★	★★★	★★★	★★★	★★
WellCare of Kentucky	★★★	★★★	★★★	★★★	★★

GETTING HELP WHEN NEEDED					
Health Plan	Getting Adult Care Quickly NEW PLAN NO RATING AVAILABLE	Getting Child Care Quickly	Adult Customer Service	Child Customer Service	Parent Overall Satisfaction with Child's Care
Anthem	★★	★★	★	★★	★★
CoventryCares of Kentucky	★	★★	★★	★★	★★
Humana CareSource	★★	★★	★★★	★★	★★
Passport Health Plan	★★	★★	★★	★★	★★
WellCare of Kentucky	★★	★★	★★	★★	★★

CONTACT HEALTH PLAN FOR MORE INFORMATION		
Health Plan	Phone Number	Website
Anthem (Not Available in Jefferson County and Surrounding counties, Region 3)	1-800-901-0020	https://mss.anthem.com/ky/pages/aboutus.aspx
CoventryCares of Kentucky	1-855-300-5528	http://chcmidicaid-kentucky.coventryhealthcare.com/
Humana CareSource	1-855-852-7005	https://www.caresource.com/members/
Passport Health Plan	1-800-578-0603	http://www.passporthealthplan.com/
WellCare of Kentucky	1-877-389-9457	https://kentucky.wellcare.com/

Ratings are compared to state averages and from information submitted by the health plans.

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AUDITOR'S REPLY

We have reviewed and considered the information provided by CHFS in its response to this report. Although we acknowledge CHFS identified some areas of common ground, it is disconcerting to the APA that CHFS declined to offer a response to the observations related to the FSI[®] index of rural hospitals and the poor financial health scores for one-third of the hospitals assessed. The focus of the CHFS response largely centered on repeating analyses related to improved health outcomes, increases in the number of insured Kentuckians and the economic impact of Medicaid expansion on the Commonwealth's economy – none of which the APA disputed in the *Special Report*. It is important to clarify certain elements of this report and the recommendations contained in it.

CHFS stated in the background section of its response that the APA's special report was based on data from 2011-2013, and indicated a full and current analysis should take into consideration three policy decisions that changed healthcare in Kentucky, including transition to managed care, the expansion of Medicaid coverage, and the creation of kynect. Two of these three policy decisions were implemented during periods that were not within the period covered by this report; however, the APA's report did take into consideration the Commonwealth's transition to managed care, which began in November 2011. In fact, the APA first reported on this transition in the *Special Report of Certain Policies, Procedures, Controls and Financial Activity Regarding Medicaid Managed Care* issued in July 2013. Although this special report on rural hospitals acknowledges the timeframe covered was 2011 through 2013, it is important to point out that FY 2013 financial information is the most recent audited data available for many rural hospitals at the time of this report. Therefore, neither the APA nor CHFS can assess the full fiscal impact of activities occurring during FY 2014.

The APA did request FY 2014 audited financial statements from several rural hospitals to determine the availability of the data. Only two hospitals contacted, Clinton County and Ohio County, were able to provide financial statements at the time of the request. In reviewing the financial statements of those two hospitals, the cash influx related to Medicaid expansion alone was not sufficient in creating a significant impact on the financial strength of the hospitals. In the case of the Clinton County Hospital, although its 2014 FSI[®] score improved from a -5.4 in FY 2013 to a -4.66, its score remained in the poor health assessment classification. Ohio County Hospital's FY 2013 FSI[®] score was -1.34, which was sufficient for it to be classified as fair. However, its FY 2014 FSI[®] score dropped to -2.48, which is classified as poor.

Also, in its response CHFS indicated that hospitals received more than \$500 million from January through September 2014, and that hospitals are seeing a reduction in uncompensated care due to Medicaid expansion. However, the focus on these payments alone is not sufficient in understanding the fiscal impact of the overall healthcare transformation taking place. Focusing on only the revenue does not take into consideration the increased administrative burden of implementing managed care, the effects of Medicare pay-for-performance policies and penalties or the impending loss of DSH payments. Sufficient data for 2014 is not available to the APA or CHFS at this time to assess the net result of this healthcare transformation process.

To further illustrate this point, in its 2014 Medicaid Expansion Report for the Commonwealth of Kentucky issued in March 2015, Deloitte Consulting LLP states, "Based on provider utilization, it can be inferred that the Medicaid expansion population is more actively seeking care for previously unaddressed health needs. For the top three provider types (based on utilization), the Medicaid expansion population is using primary care more than the comparative group at a rate of approximately 55%." With the individuals enrolled in Medicaid expansion utilizing services at a rate of 55% higher

Auditor's Reply

than traditional Medicaid patients, it is evident that the increased utilization and volume of new members enrolled also carries a cost of providing the services that must be considered in the overall fiscal impact for providers. In fact, Deloitte's March 2014 report states, "The average health care costs of Medicaid expansion recipients are about 1.6% greater than the costs of members in the comparative group, implying that the costs between the populations are level, or perhaps slightly higher, among Medicaid expansion recipients."

It is also important to reiterate that the intent of this report is to provide a baseline analysis to CHFS to monitor the stability of rural hospitals and ensure continued access to health care for rural Kentuckians. It is troubling that CHFS indicated it is not within its statutory mandate to "intervene" by monitoring the financial strength of rural hospitals. Ensuring appropriate healthcare accessibility for some of the Commonwealth's most vulnerable is within its mandate, however. The closing of two rural hospitals signal a significant risk to the sustainability of the Medicaid provider network. The performance of routine financial assessments is an important planning and monitoring function to ensure that CHFS has tools to help predict and address provider shortages. Therefore, we strongly reiterate the recommendation for CHFS to implement procedures to assess the financial strength of rural hospitals to sufficiently monitor the Commonwealth's largest federal program.

Finally, CHFS also addressed changes in Medicaid providers in its response. Its response presents a different set of data than it provided the APA in September 2014, depicting only those eligible Medicaid providers that received a payment during calendar years 2011 through 2014. CHFS indicates the data identifies more than a 40 percent increase in the number of Medicaid providers receiving payments. However, the data is not responsive to APA's observation regarding the total number of providers eligible to serve Medicaid patients, which speaks to accessibility and network adequacy concerns. Although the APA doesn't question the accuracy of the data CHFS used in its response, the information may be misleading in light of concerns about adequate health workforce capacity. CHFS in its response stated that it recognizes the need to closely monitor health workforce capacity, and provided detailed information regarding its workforce project.

The APA reviewed the raw data utilized by CHFS to determine how it arrived at the large percentage increase in paid providers reported. Below is a table that depicts the total population of all providers in the data CHFS provided the APA in September 2014, and the data it utilized in its response.

	2011	2014	Difference	Percentage Change
APA Utilized Data (All Providers)	39,479	33,627	(5,852)	-15%
CHFS Response Data (Providers Paid)	19,310	27,828	8,518	44%

In analyzing the data further, 79 percent of the 8,518 additional providers depicted in the Cabinet's response between 2011 and 2014 are in three provider categories, as presented below:

Provider Type	2011	2014	Difference	Percentage Change
60 - Dentist - Individual	870	1,010	140	16%
64 - Physician Individual	6,189	12,285	6,096	98%
74 - Nurse Anesthetist	405	856	451	111%
Total	7,464	14,151	6,687	

The chart above reflects an increase of 6,096 eligible individual physicians receiving payment, while the data provided by CHFS to the APA reflects a decrease of 4,244 total eligible providers in that category. Although it is plausible that Medicaid expansion has led to more of the eligible providers receiving payment, using payment received numbers to project a different picture of the workforce situation is misleading given the known workforce shortage.

Sufficient data exists to support the APA's concerns regarding network adequacy and accessibility, and therefore the APA stands by its observation and recommendations regarding the need to improve monitoring, recruitment, and retention of providers in the Commonwealth. The APA's observation identifies red flags that indicate the need to closely monitor the declines in the number of eligible providers, as well as the reasons providers are foregoing their eligibility to treat Medicaid patients.

