Key Issues Affecting Kentucky Hospitals

The Kentucky Hospital Association proudly represents every hospital in the Commonwealth of Kentucky with the goal and mission to improve the overall health of the citizens by ensuring access to high quality hospital care for every Kentuckian. This mission is becoming progressively more challenging for all hospitals, given the economic and health challenges of the state’s citizens as well as the increasing number of reimbursement cuts facing every provider. Today, forty percent of Kentucky hospitals are losing money on operations and there is an onslaught of reimbursement cuts on the horizon. Kentucky hospitals will not be able to continue to provide affordable, quality care under these circumstances and access to care will be compromised for Kentucky’s most vulnerable populations, Medicare and Medicaid beneficiaries.
Since 2011, Massachusetts hospitals have benefitted from more than half a billion dollars in additional payments through a one-sentence amendment in Section 3141 of the Affordable Care Act (ACA). The amendment adjusted payments to all Massachusetts hospitals through an obscure Medicare funding mechanism designed to ensure that hospitals in urban areas are not reimbursed at lower rates than the state’s rural hospitals. In 2008, the Nantucket Cottage Hospital — a small, 19-bed Massachusetts hospital which annually serves about 150 Medicare patients and is located in an area deemed to be rural — converted from a critical access hospital to a prospective payment system (PPS) hospital. As a result of the conversion, the wage data of this one hospital was used to establish a rural floor for the entire state of Massachusetts. Typically, rural hospitals have lower wages, but due to its high cost of living, wages on the island of Nantucket are considerably higher than hospitals on the Massachusetts mainland, so the wage index for all hospitals was substantially increased. Since no urban hospital can receive less than the rural floor, the net effect of this change was to treat all other 81 hospitals in Massachusetts as if they were on an island with the associated higher labor costs. There is clear evidence that the state’s hospitals worked to create this system advantage which even the Centers for Medicare and Medicaid Services (CMS) in its federal regulations called a “manipulation” of the Medicare rural floor payment system. The amendment added to the ACA required that funding to balance increased payments to Massachusetts hospitals be nationally budget neutral, meaning that it would come from reduced payments to all other hospitals in the country which themselves are struggling to care for Medicare patients. The impact is a reduction of $11 million annually in Medicare payments to Kentucky’s hospitals.

Kentucky’s hospitals request all members of the Kentucky delegation to co-sign and support the Hospital Payment Fairness Act — H.R. 2053 (Reps. Brady and Kind)/S. 183 (Sens. McCaskill and Coburn) — to fix the “Bay State Boondoggle,” which is benefitting Massachusetts at the detriment of other states, like Kentucky.

Additionally, there is need for a long-term correction to the Medicare area wage index to bring payment equity to states such as Kentucky which are being harmed by the current wage index system that perpetuates lower Medicare payments to Kentucky’s hospitals. The wage index of Kentucky’s urban and rural hospitals is lower than that of most surrounding states and comparable urban areas. The gap is widening between hospitals located in states receiving the highest wage index compared to those receiving the lowest. Because the wage index affects from 62% to 69% percent of a hospital’s payment and wage index adjustments are budget neutral, these growing disparities are harming the ability of Kentucky hospitals to receive adequate payments necessary to care for patients and maintain services and jobs in their communities. KHA is working to bring forth a specific proposal to correct this inequity in Medicare funding.
Sequestration

The Bipartisan Budget Act of 2013 extended the sequestration of Medicare provider payments through FY 2023 which will continue an across-the-board budget reduction of 2 percent (excluding Medicaid) that began reducing Medicare payments on April 1, 2013. According to analytical reports by Sano Capital Group, the National Rural Health Association and IVantage, Inc., Kentucky is expected to be one of the hardest hit states by Sequestration because of the high number of Medicare beneficiaries. Sequestration is impacting every Kentucky hospital's financial viability and is estimated to cut over 8,000 jobs statewide, with more than 700 of those eliminated jobs to be in hospitals. **Sequestration will reduce Medicare payments by about $68 million in 2014 and 2015** and then increase to more than $70 million in future years. **The cumulative Kentucky hospital loss from 2013-2023 is estimated to be $775 million.**

Kentucky hospitals will experience $4.8 billion in total Medicare payment reductions during the next 10 years from the Affordable Care Act, coding adjustments and sequestration. These cuts are already forcing hospitals to reduce services and staff. Kentucky hospitals continue to have negative Medicare margins, and ongoing reductions will only further reduce hospitals' ability to provide access to needed health care services and invest in technology required for a reformed health care environment.

### 2012 Medicare Margins - Kentucky Hospitals

<table>
<thead>
<tr>
<th>Margin Type</th>
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</thead>
<tbody>
<tr>
<td>Total Margin</td>
<td>-3.5%</td>
</tr>
<tr>
<td>Inpatient Margin</td>
<td>-2%</td>
</tr>
<tr>
<td>Outpatient Margin</td>
<td>-3.3%</td>
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Includes Inpatient Medicare DSH and IME
Includes PPS and CAHs

**Source:** HCRIS Master File (4Q2013 Release), HANYS Datagen, KHA.
Changes to Hospital Readmission Reduction Program (HRRP)
The Affordable Care Act (ACA) imposes financial penalties on hospitals for “excess” readmissions when compared to “expected” levels of readmissions. The potential penalty increased to two percent of base Medicare payments in fiscal year (FY) 2014 and will increase to three percent in FY 2015 and beyond. The initial payment penalties are based on the 30-day readmission rates for heart attack, heart failure and pneumonia but, beginning in FY 2015, CMS will expand the penalty to include readmissions for chronic obstructive pulmonary disease and patients undergoing total hip or knee replacement.

Kentucky hospitals have been among the states hardest hit by the Hospital Readmissions Reduction Program. In FY 2014, 88% of Kentucky’s 65 PPS hospitals were penalized, compared to about two-thirds of hospitals nationwide. Also, four of the 18 hospitals in the nation that received the maximum two percent payment penalty were located in Kentucky. In FY 2014, Kentucky ranked 46th in readmissions among heart attack patients, 42nd among heart failure patients and 47th among pneumonia patients. In both FY 2013 and 2014, the Readmissions Reduction Program cut Kentucky hospital payments by about $6 million. The disproportionate impact on Kentucky is largely a reflection of the high level of poverty in the state combined with a lack of available alternative services. To illustrate this point, Kentucky hospitals having high readmission penalties are predominately located in Eastern Kentucky, an area with some of the highest levels of poverty in the country, or in other rural areas which are also medically underserved.

KHA has long argued that CMS should adjust its readmission penalties to account for socio-economic conditions and the lack of medical services. Hospitals should not be penalized for factors beyond their control – such as lack of primary care, rehabilitation, mental health services or inadequate transportation – which affect whether a patient is readmitted. Recently, MedPAC, an independent agency that advises Congress on the Medicare program, has found that hospitals servicing large shares of lower income patients tend to have higher readmission rates and are more likely to pay readmission penalties. A study published by the U.S. National Library of Medicine National Institutes of Health had a similar finding. Even CMS’s own data shows that 77% of hospitals serving the most poor patients faced penalties compared to only 36% of hospitals with the fewest poor patients.

To correct this problem, Rep. Jim Renacci introduced H.R. 4188, the Establishing Beneficiary Equity in the Hospital Readmission Program. This legislation adjusts the penalty methodology for hospitals that serve larger amounts of dual eligible beneficiaries, excludes patients with certain extenuating circumstances from the penalty calculation and requires MedPAC to study the appropriateness of using a 30-day readmission threshold as the measure for application of payment penalties.

KHA asks all Kentucky Representatives to co-sign H.R.4188 and Senators to support companion legislation to fix the readmission penalties which are disproportionately affecting Kentucky hospitals for factors beyond their control.

Reject “Site Neutral” Medicare Hospital Outpatient Cuts
KHA strongly opposes legislation that would reduce Medicare payment for services furnished in hospital outpatient departments (HOPDs) to the rate paid to physicians for providing services in their private offices. HOPDs have higher costs due to more stringent licensure, accreditation and regulatory standards as compared to private physician offices. Hospitals also serve more complex patients and more low income, uninsured, Medicare and Medicaid patients where payments do not cover actual costs compared to these other settings. Payment should reflect the cost to hospitals of delivering services, not what a physician gets paid in his or her office.

Congress is asked to oppose legislation reducing hospital outpatient payments to physician office rates.

Delay Implementation of Medicare “Two-Midnight” Patient Status Rule
Whether a patient is admitted to a hospital as an inpatient or treated under outpatient observation status has implications for Medicare payment and Medicare beneficiary coverage, such as qualification for skilled nursing care and coverage of rehabilitation services. Traditionally, the decision to admit a patient as an inpatient has been left to the judgment of the treating physician. However, CMS recovery audit contractors (RACs) and Medicare administrative contractors (MACs) have repeatedly second guessed physician judgment, declaring that some patients who were treated as inpatients should have not have been admitted. In an effort to clarify this issue, CMS issued a “two-midnight” policy in the FY 2014 inpatient PPS final rule, which applied to both PPS and critical access hospitals. Under this rule, hospital admissions spanning two midnights are seen as appropriate for inpatient payment and those that do not are considered outpatient cases, regardless of clinical...
Most providers (56%) in the region report receiving Because of costs involved, hospitals are appealing only Of the remaining 36%, 2/3 involved a one-day stay 97% of all audits, while the remaining 3% involve primarily outpatient billing or coding errors. Consider the following performance of the Regional RAC contractor for Kentucky and six other states:\(^1\):

- Complex inpatient claims account for 97% of all audits, while the remaining 3% involve primarily outpatient billing or coding errors
- Most audited inpatient claims (65% - 75%) are focused on short stays
- Thirty-four percent of claims audited have no payment error or an underpayment, compared to 56% nationally, indicating a higher audit burden being placed on hospitals in the region
- Of the remaining 36%, 2/3 involved a one-day stay where the RAC agreed care was medically necessary but should have been billed as an outpatient visit
  - Most patients had heart conditions, GI disorders or fainting and collapse
- Because of costs involved, hospitals are appealing only 46% of denials, but when they do, nearly one-half of the denials are overturned\(^1\) in favor of the provider
- Most providers (56%) in the region report receiving no education from CMS or the RAC on how to avoid payment errors

Kentucky’s hospitals are incurring significant increases in administrative burden and costs by having to hire additional staff just to manage the growing burden of audits. These costs are adding to hospital expenses at a time when hospital reimbursements are shrinking from all sources and they are taking limited resources away from direct patient care. While hospitals understand the need for auditors to identify billing mistakes, CMS and Congress need to make the audit process more fair and transparent.

The Medicare Audit Improvement Act, H.R. 1250/S. 1012 — legislation supported by KHA and the American Hospital Association — would make much needed changes to the RAC program. It would establish annual limits on medical record requests, require that audits be focused on widespread payment errors, improve auditor transparency, establish financial penalties linked to RAC performance and require that physicians – not non-physician auditors – review and issue any denials related to medical necessity. Also, this legislation fixes a regulatory problem which exists between RAC and hospital payment rules. On March 13, 2013, CMS issued a proposed rule to allow hospitals to receive full outpatient payments for inpatient claims denied during a RAC audit when care is appropriate at the outpatient level, but only if the claim is one year old or less. This time limitation is a problem because RACs can go back three years to audit claims. This legislation corrects this problem by allowing denied inpatient claims to be billed as outpatient claims without regard for existing filing limitations.

KHA asks Kentucky Representatives and Senators to co-sign H.R. 1250/S. 1012 and work for the passage of this legislation to make needed changes to the RAC program.

Changes to Medicare Recovery Audit Contractor (RAC) Program

Kentucky hospitals are drowning in audit programs, having to copy mountains of charts and are experiencing a significant number of inaccurate RAC denials where hundreds of thousands of dollars are being unjustly recouped. This is extremely burdensome and costly for Kentucky hospitals when the vast majority of claims audited by the RAC are found to have no payment errors. Consider the following performance of the Regional RAC contractor for Kentucky and six other states:\(^1\):

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- Most audited inpatient claims (65% - 75%) are focused on short stays
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\(^1\) Source: American Hospital Association, Data through Fourth Quarter 2013, RACTrac Survey, March 2014.

Delay Reductions in Medicaid and Medicare DSH

The Medicare and Medicaid Disproportionate Share Hospital (DSH) programs have provided valuable financial support to Kentucky’s hospitals by helping to offset uncompensated care provided to Medicaid recipients, low-income Medicare beneficiaries and the uninsured. Because the Affordable Care Act was estimated to expand coverage to most uninsured Americans by 2019, Congress deemed it appropriate to cut both Medicaid and Medicare DSH payments to hospitals. The Medicare DSH reductions began in FY 2014 while the Medicaid DSH cuts have now been postponed. The budget deal signed by the President in December of 2013 delayed the cuts until October 1, 2015 (FFY 2016), but doubled the amount of the reductions. However, the Protecting Access to Medicare Act of 2014 (PAMA) included a further delay of the Medicaid DSH cuts until October 1, 2016 (FY 2017), while also adding another year of cuts by extending them until 2024. Kentucky’s Governor has implemented an expansion of the Medicaid program up to 138% of the poverty level. As of
April 10, 80%, or 322,827 people, of those who obtained coverage through the state health insurance exchange (kynect) qualified for Medicaid coverage. Since Medicaid payments cover only 75%, on average, of actual costs to treat Medicaid patients, hospital uncompensated care costs due to Medicaid underpayment will significantly increase. Hospitals also continue to experience ongoing indigent care from individuals who either choose or cannot afford insurance as well as illegal aliens. Bad debt costs also continue to rise as individuals with private coverage cannot afford to pay their required copayments and deductibles. The manner in which CMS will redistribute Medicaid DSH funds among states has not been finalized. The combination of these factors could result in Kentucky hospitals providing much more uncompensated care with fewer funds to offset those costs.

Congress is asked to take action to delay Medicare and Medicaid DSH cuts until coverage expansions are more fully realized and to provide more time for analysis of CMS’s proposed method to redistribute remaining DSH funds.

KHA supports H.R. 1920/S.1555, the DSH Reduction Act, which would eliminate the first two years of the ACA's cuts to the Medicare and Medicaid DSH program.

President’s Budget and Cuts to Hospitals

President Obama’s proposed FY 2015 budget contained more than $400 billion in Medicare reductions with $372 billion coming from Medicare provider payments. KHA is very concerned with the following proposed reductions:

- Reduce bad debt payments by $30.8 billion
- Reduce Medicare graduate medical education payments by nearly $15 billion
- Reduce critical access hospital (CAH) payments to 100 percent of reasonable costs and eliminate the designation for hospitals located less than 10 miles from another hospital (which would impact two Kentucky CAHs) [$2.4 billion]
- Adjust payment updates for certain post-acute care providers (inpatient rehab, long-term care hospitals, home health agencies and skilled nursing facilities (SNFs)) [$98 billion]
- Reduce payment to inpatient rehabilitation facilities (IRFs) by reinstituting the 75% standard to restrict the types of patients that can be treated [$2.4 billion]; equalize payments for certain conditions between IRF and SNF [$1.6 billion]
- Strengthen the independent payment advisory board (IPAB) by lowering targeted spending growth [$12.9 billion]

KHA is opposed to these cuts which reduce funding to struggling rural hospitals and cut needed resources to teaching hospitals which are training Kentucky’s future physicians. Also, the combination of payment cuts and increased limitations on patients who may be treated in IRFs could reduce beneficiary access to needed rehabilitation services. Reductions to bad debt payments come at a time when total hospital bad debt is rising, thereby creating more uncompensated care.

Continued reductions in provider payments will only further weaken Kentucky hospitals whose Medicare payments are already below actual costs. KHA has previously provided recommendations for achieving savings in other ways which include:

- Raise the age for Medicare eligibility for future generations
- Expand use of physician extenders and other appropriately trained providers
- Amend laws and regulations to eliminate current barriers to clinical integration
- Control pharmaceutical expenditures
- Permit states to restructure Medicaid program benefits and recipient cost sharing to curtail inappropriate utilization
- Encourage healthy lifestyles, such as through meaningful employer tax credits for wellness programs, rewarding individuals who obtain required screenings for their age and for managing chronic conditions, taxing sugar-sweetened beverages, etc.
- Enact meaningful liability reform to lower costs
- Ban physician self referral to certain in-office ancillary services which has been documented as driving unnecessary utilization and costs

Preserving and Expanding the 340B Drug Discount Program

In 1990, Congress established the Medicaid drug rebate program which requires drug manufacturers to have a rebate agreement with the federal government under which they supply their products to state Medicaid programs at the lowest price offered to other purchasers. Section 340B of the Public Health Service Act requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at discounted prices to taxpayer-supported health care facilities, including public and nonprofit disproportionate share hospitals that serve low-income and indigent populations. The Affordable Care Act further expanded eligibility to critical access hospitals and certain sole community hospitals and rural referral centers. In Kentucky, 85 hospitals (out of 100 short-term acute care hospitals)
quality to receive 340B discounted outpatient drugs, which allows them to receive an average savings of 25% to 50% on pharmaceutical purchases. These savings are passed on to the Medicaid program in lower hospital costs, thus saving millions of dollars for taxpayers. Expanding the program would allow eligible safety-net hospitals to stretch limited resources, eliminate the burden of maintaining two separate inventories and pricing structures for inpatient and outpatient drugs, generate more savings for the state Medicaid program and save the federal government $1.2 billion by reducing critical access hospital drug costs, since these facilities are cost reimbursed by Medicare.

KHA requests the Kentucky congressional delegation to support extending the 340B discounts to the purchase of drugs used during inpatient hospital stays, and oppose any efforts to scale back this important program.

Permanent Solution to “Doctor Fix”
The recently passed Protecting Access to Medicare Act of 2014 stopped a projected 23.7% cut in Medicare physician payments by providing a 0.5 percent update through December 31, 2014, and a zero update from January 1, 2015, through March 31, 2015, when the temporary “fix” will expire. While congressional leaders agreed on policies to permanently fix the sustainable growth rate (SGR) formula, outlined in the SGR Repeal and Medicare Provider Payment Modernization Act of 2014 (H.R. 4015/S. 2000), no agreement has been reached on how to pay for the legislation’s significant cost.

Kentucky hospitals support a permanent solution for physician payments, but hospitals cannot sustain additional cuts to fund the solution for a flawed Medicare physician payment system.

Medicaid Managed Care
In November 2011, Kentucky implemented Medicaid managed care under a 1915b federal waiver. Three managed care organizations (MCOs) – Kentucky Spirit (Centene), WellCare and Coventry – were awarded three-year contracts to manage care for approximately 560,000 Medicaid recipients residing in areas of the state outside of the greater Louisville area; however, Kentucky Spirit terminated their contract early in July of 2013. The state brought on three additional MCOs (Anthem, Humana Care Source and Passport Health Plan) who were eligible to enroll the Medicaid expansion population and these plans will be available to all Medicaid recipients who are under managed care during the open enrollment period that will begin in May. In January 2013, Humana Care Source, WellCare and Coventry were added as choices to Passport Health Plan in the greater Louisville region. The move to managed care was intended to save the commonwealth $1.3 billion over the course of the initial three-year MCO contract, and based on a comparison of spending pre and post MCOs (2011 versus 2013), the largest reductions have occurred in reimbursement for inpatient hospital services and, particularly, for inpatient psychiatric care.

While timeliness of claims payment has somewhat improved, Kentucky hospitals and other providers continue to experience significant issues with the administrative burden of having to comply with five different sets of utilization review and claims payment policies as well as inappropriate medical necessity denials. Two MCOs have adopted “triage” policies to deny, on average, 50% of all emergency room care as “non-emergency” using proprietary criteria after care has already been provided. One MCO is using proprietary criteria to deny not only inpatient but often outpatient behavioral health and substance abuse services. Thus, while Medicaid spending for services has been reduced, provider costs have increased to comply with MCO administrative requirements and because hospitals continue to treat patients who are inappropriately denied coverage by the MCO – such as for behavioral health services when there are not safe alternative placements available to meet patient needs.

KHA and its members have raised these concerns repeatedly with the Cabinet and the Kentucky Department of Medicaid services; however, the Department continues to dismiss problems and has not made a significant effort to compel the MCOs to comply with federal rules, state laws or their contracts. CMS approved the Kentucky 1915b waiver based on documentation of compliance with the requirements for assuring beneficiary access to quality services. KHA and member hospital representatives met with CMS officials on November 20, 2012, and provided documentation of the problems taking place, yet, CMS officials have never responded. Recently, a federal judge issued findings in the case of ARH vs. Coventry Health and Life Insurance Company and the Cabinet for Health and Family Services which support the concerns KHA raised.

U.S. District Judge Karl Forrester wrote,"...CMS approved the waiver without having actuarially sound capitated rates and adequate networks from the MCOs, as required by statute." Forrester also stated,“...both the Cabinet and the MCOs have demonstrated that they have not complied with the requirements and do not intend to do so. The statutory safeguards were ignored. Kentucky MCOs have been ‘gaming’ the system ever since to improve their financial position, with the result that they have run roughshod over the rights of Medicaid beneficiaries and providers. If the waiver had not been arbitrarily and capriciously approved, none of the gamesmanship could have taken place."
KHA and its members are very concerned that expansion of the Medicaid program to an additional 330,000 people who will be covered under MCOs will only exacerbate the ongoing problems.

**KHA requests that Kentucky delegation members contact CMS officials regarding the status of their investigation into the potential federal regulatory violations related to the management and administration of the MCO program in Kentucky. The Association also asks that you accompany KHA on any follow-up meetings with CMS.**

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**Improving Quality and Patient Safety**

KHA is leading improvement efforts that are changing the way hospitals provide care for patients. Since 2012, KHA has worked in partnership with the Hospital Research and Education Trust (HRET) of the American Hospital Association under a contract through the CMS Partnership for Patients to operate a Hospital Engagement Network (HEN) in Kentucky. The goal of the program is to reduce hospital acquired conditions by 40 percent and hospital readmissions by 20 percent. During the last two years, 91 Kentucky hospitals participated in KHA's HEN. The gains in quality were so impressive that CMS has extended the program, which was originally slated to end in 2013, for another year through December 2014. Eighty (80) Kentucky hospitals have remained in KHA's program this year. As the program's leader in Kentucky, KHA provides face-to-face meetings featuring focus area experts, monthly coaching calls for hospitals to network and learn from each other, collection of monthly data for hospitals to measure their progress to attainment of goals, technical assistance, and tools and resources on improving patient safety culture. Thus far, among other improvements, participating hospitals reduced:

- Central-line associated blood stream infections (CLAB-SIs) in all settings by 79%
- Injury from falls by 65%
- Pressure ulcers by 60%
- Early Elective deliveries (which can increase complications and NICU days) by 58%
- VTE (deep vein blood clot that results in a pulmonary embolism) by 34%
- Surgical site infections (across multiple types of surgery) by 20%
- Readmissions by heart failure patients by 14%
- Ventilator-associated pneumonia to a level where there are **zero cases**

KHA, through a separate non-profit subsidiary – The Kentucky Institute for Patient Safety and Quality (KIPSQ) - operates a federally certified Patient Safety Organization (PSO). Currently, 76 Kentucky hospitals have joined KHA's PSO and another twenty-two hospitals belong to other PSOs. KIPSQ collects and analyzes adverse event data from its members to identify how systems of care can be changed to reduce error. Hospital members receive patient safety alerts, monthly webinars on relevant patient safety topics and participate in focused studies to investigate how errors can occur and strategies for prevention. The federal act which created PSOs provides a federal privilege and confidentiality to providers for reporting adverse events. This is extremely important to encourage reporting to PSOs and for PSOs and providers to undertake the critical evaluation necessary to reduce preventable harm.

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**Emergency Preparedness**

**Sustained Funding for Hospital Preparedness**

The Hospital Preparedness Program (HPP), the primary federal funding program for hospital emergency preparedness, has provided critical resources since 2002 to improve health care surge capacity and hospital preparedness for a wide range of emergencies. For the past 12 years, KHA has administered this program, working closely with the Kentucky Department for Public Health and helping regional coalitions across the state develop localized plans and resources. Unfortunately, authorized funding levels and annual appropriations for the HPP have significantly declined at a time when the need for disaster preparedness is growing. While the Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 (PAHPRA) reduced HPP appropriations to $374.7 million for FY 2014-2018, Congress reduced HPP appropriations even further by 50% – to $244 million for FY 2014 – and the President’s FY 2015 budget would continue this reduced funding level. This is resulting in HPP staff in Kentucky being reduced to minimal levels, which will greatly limit the ability to develop, update and sustain emergency preparedness and response capabilities.

**KHA urges Congress to increase the FY 2015 appropriation for the HPP to $374 million, consistent with the amount authorized in PAHPRA.**

- **continued next page** -
CMS Proposed Emergency Preparedness Rule

CMS issued a rule in December 2013 that would establish emergency preparedness conditions of participation that hospitals would have to meet to participate in the Medicare and Medicaid programs. Inpatient providers, including hospitals, long-term care facilities and critical access hospitals, would be required to comply with emergency and standby power system requirements.

While Kentucky hospitals support the concept of assuring that providers have emergency preparedness plans, it is important that CMS rules align with existing standards that hospitals are already meeting including from The Joint Commission, National Fire Protection Association and the HPP, as well as state and local governments. KHA is also very concerned that CMS has underestimated the cost and time hospitals will need to implement its proposed changes and feel that the agency’s proposed one-year timeframe will be too short for most hospitals to comply once the final rule is issued. KHA provided detailed comments to CMS on revisions to the proposed rule and timetable which it hopes are reflected in the final rule.

Small and Rural Issues

Medicare Extenders

The Medicare Dependent Hospital (MDH) and Low Volume Hospital (LVH) programs impacting 20 Kentucky small and rural hospitals were extended by the Protecting Access to Medicare Act of 2014 (PAMA) through March 31, 2015. These are extremely important programs and they are critical to preserving access to hospital services in many rural Kentucky communities.

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

Kentucky hospitals strongly encourage Congress to permanently extend these rural provisions.

Physician Supervision

In the Calendar Year (CY) 2009-2013 outpatient PPS rules, CMS mandated new requirements for “direct supervision” of outpatient therapeutic services, requiring that a physician or a non-physician practitioner be immediately available to furnish assistance and direction throughout the procedure. Small, rural PPS hospitals and critical access hospitals have expressed concern that shortages of physicians and nurse practitioners in their communities make it difficult to comply with this requirement. This policy has the effect of reducing access to outpatient therapeutic services for Medicare patients at local rural hospitals, since hospitals unable to comply may limit their hours of operation or close certain programs.

KHA supports the Protecting Access to Rural Therapy Services Act, H.R. 2801/S. 1143, which would adopt a default standard of “general supervision” for outpatient therapeutic services, develop a reasonable exceptions process with provider input for services that require direct supervision, ensure that standards match critical access hospital rules which allow a physician or nurse practitioner to be present within 30 minutes of being called, and prohibit CMS retroactive application of its flawed policy.

KHA requests the Kentucky delegation to co-sponsor H.R. 2801/S. 1143 and work for their passage.

96-Hour Rule

On September 5, 2013, CMS released a clarification of the federal critical access hospital (CAH) statute, which requires a 96-hour “average” annual length of stay. Under CMS’s clarification, the agency indicated it would begin enforcing a condition of payment that requires a physician to certify that a Medicare patient may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission. If enforced, CAHs will be forced to eliminate any services which go beyond 96 hours, even though the hospital’s “average” length of stay for all admissions would remain at or below 96 hours. This would severely affect the ability of CAHs to operate and care for Medicare patients.

KHA and Kentucky hospitals support the Critical Access Hospital Relief Act of 2014, H.R. 3991/S. 2037,
which would remove the 96-hour physician certification requirement as a condition of payment. CAHs would still be required to meet the 96-hour “average” annual length of stay.

Preserve Critical Access Hospitals (CAHs)

While CAHs receive cost-based reimbursement in order to promote financial viability, this special payment is in no way the “silver bullet” to ensure these safety net hospitals continue to keep their doors open. CAHs have been hard-hit in recent years and many of Kentucky’s 29 CAHs are unsure about their future. **Kentucky hospitals ask Congress to support the following provisions to ensure CAH viability and flexibility:**

- **Maintain the CAH program as it is and reject any proposals to limit the designation or decertify safety net CAHs based on mileage from other hospitals.** Many Kentucky CAHs were designated as “Necessary Providers of Care” because Kentucky’s Governor identified these facilities as essential to providing access to basic health care needs for rural Kentuckians.

- **Shield Kentucky CAHs from future Medicare cuts.** Kentucky CAHs receive 101 percent of cost reimbursement and run on a very thin margin. In fact, 45 percent of Kentucky CAHs lose money on operations with an overall profit margin for CAHs of 1.91 percent. Cuts in Medicare payment have a devastating impact on Kentucky’s CAHs as they also receive the Medicare rate for Medicaid patients.

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

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