



Kentucky  
Hospital  
Association

# Code Blue:

Many Kentucky Hospitals  
Struggling Financially  
Due to Health  
System Changes

April 2015



# Code Blue

## Many Kentucky Hospitals Struggling Financially Due to Health System Changes



### Introduction

Kentucky has emerged as a national leader in expanding health coverage through the implementation of the Affordable Care Act. The creation of Kynect, the online marketplace where consumers can buy health insurance, and the expansion of Medicaid eligibility permitted by the health reform law have resulted in more than 400,000 Kentuckians being enrolled in new health coverage.<sup>1</sup> Under the strong leadership of Governor Steve Beshear, Kentucky became the only state in the southeastern United States to expand Medicaid and create a state-based health exchange. And while the rollout of the federal health exchange was plagued by technical problems and frustrating delays, the smooth operation of Kynect, overseen by Cabinet for Health and Family Services Secretary Audrey Haynes, is viewed as a national model.

An August 2014 Gallup report found the state had reduced the number of uninsured Kentuckians from 20.4% of the population in 2013 to 11.9% by mid-2014. That reduction is larger than any other state except Arkansas.<sup>2</sup> This is good news for those Kentuckians who previously had no health coverage and an important step toward creating a healthier state.

While Kentuckians should be proud of this achievement, it is also important to understand another part of the story: The government's success in expanding health coverage has come at a significant cost to Kentucky hospitals.

Many hospitals in the Commonwealth are now operating under severe financial stress due to major changes in the health system. These financial pressures, which include payment cuts to Kentucky hospitals projected to reach nearly \$7 billion through 2024, have resulted in hospital staff layoffs and threaten to reduce the availability of hospital care, especially in rural areas. As a result, the value of expanded health coverage could be seriously compromised if some hospitals are forced to reduce services due to these financial pressures—jeopardizing the quality of care

and requiring patients to travel outside of their home communities to obtain needed services.

This white paper will highlight the financial challenges that Kentucky's hospitals face and make recommendations to help ensure patients continue to have local access to high quality hospital services in all parts of the Commonwealth.

## Health Reform Reduces Payments to Hospitals

The Affordable Care Act (ACA), the federal health reform law enacted in March 2010, was intended to slow the growth in health care spending and expand health coverage to the uninsured with a variety of reforms. These reforms include:

- Important changes in rules relating to private health insurance, such as eliminating limits on pre-existing conditions and lifetime coverage caps and prohibiting health premiums from being based on a patient's health condition
- Allowing individuals to buy health insurance from online health insurance exchanges (Kentucky's is known as Kynect) and providing financial subsidies to help buy coverage for those whose incomes are below 400% of the poverty level (\$79,160 for a family of three)<sup>3</sup>
- Expanding Medicaid coverage (the federal/state health coverage program for low-income citizens) to people with income up to 138% of the poverty level (\$27,310 for a family of three)<sup>4</sup>

As noted earlier, the implementation of these reforms in Kentucky has resulted in 413,000 additional Kentuckians being signed up for health coverage as of April 21, 2014, with approximately 75% (330,615) enrolled in Medicaid and 25% (82,795) buying private coverage through Kynect.<sup>5</sup>

While the ACA has reduced the number of uninsured Kentuckians by approximately 50%, it also imposes significant cuts in Medicare and Medicaid payments to hospitals to help pay for expanded coverage. The

fifteen year (2010-2024) reduction in payments to Kentucky hospitals due to the ACA is estimated at \$4.6 billion.<sup>6</sup> These payment cuts take many forms.

- **Medicare Rates Below Inflation:** Both Medicaid and Medicare pay hospitals less than the actual cost of delivering care. (Medicare pays 86% and Medicaid pays 82% of the actual cost of treating patients covered under these programs.) Medicare's annual rate updates had not kept up with inflation prior to passage of the ACA, and beginning in 2010, the ACA further reduced annual rate updates.<sup>7</sup>
- **Readmission Penalties:** Beginning in 2012, hospitals that readmit patients within 30 days of discharge at higher-than-expected rates **for any reason** (even if the readmission was not preventable or did not relate to the patient's original hospital stay) have had **all** of their Medicare payments reduced. This penalty increased each year, reaching a 3% level in 2014 where it will remain.<sup>8</sup> Studies have shown that hospitals in states with high rates of poverty and chronic disease—factors that are beyond the control of hospitals—have higher rates of readmissions and are therefore unfairly penalized.<sup>9</sup>
- **Hospital-Acquired Conditions:** Beginning this year, one-fourth of all hospitals in the United States will have all Medicare payments cut if their rates of hospital-acquired conditions increase—even if the rate of occurrence is small.<sup>10</sup>
- **Cuts in Payments for Uncompensated Care:** Both the Medicare and Medicaid programs provide special payments to hospitals to help offset the cost of treating patients who are uninsured or are covered by Medicaid (since Medicaid payments only cover about 82% of a hospital's cost). These payments, known as disproportionate share hospital (DSH) payments, will be significantly reduced under the ACA, despite the fact that the payment shortfall from Medicaid will rise due to the Medicaid expansion, approximately 12% of Kentuckians remain uninsured, and hospitals will continue to incur costs for uncompensated care expenses.

Medicare DSH payment reductions started in 2013 with a 16% reduction, and these cuts are expected to increase. The start of Medicaid DSH cuts has been delayed until 2017, when total payments will be reduced by 26%, followed by further reductions until payments are cut by 50% in 2019.<sup>11</sup>

It is important to note that DSH payments have never covered the full costs of indigent care. Kentucky hospitals have received Medicaid DSH payments in relation to their costs of treating uninsured people with incomes below the poverty level; however, the DSH payments have only covered 35% of these costs. In fact, when DSH payments are stacked against total uncompensated care costs, the DSH payments received in 2013 only covered 8% of those costs.<sup>12</sup> One reason that DSH payments never covered indigent care costs is because states get a federal DSH allotment that is unrelated to the state’s uninsured rate or percent of population below poverty. Kentucky, although a poor state, gets less in DSH than other states (see chart to the right). Although Kentucky’s DSH allotment is inadequate to cover indigent care costs, it will now be cut by 50%.

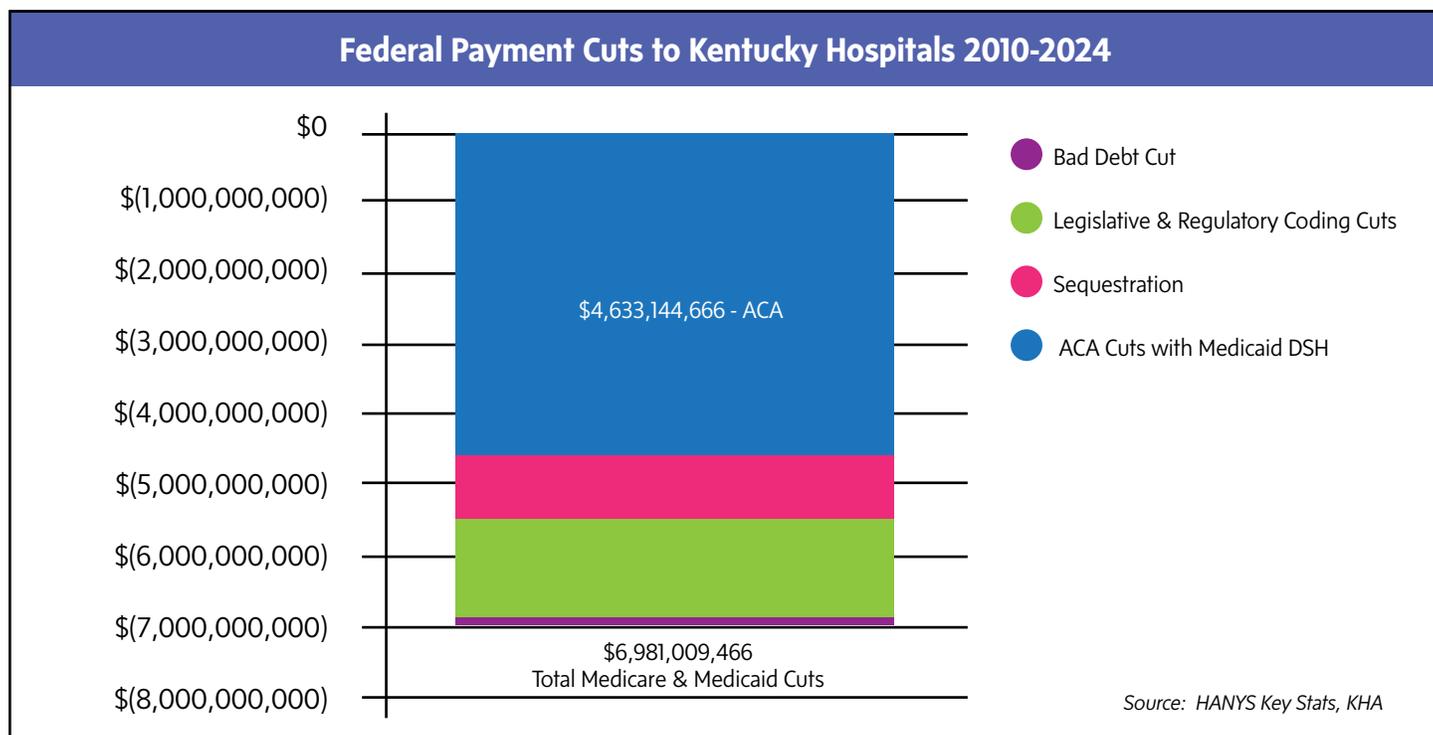
- **Other Payment Reductions:** Hospitals are also experiencing a number of other cuts not directly

STATE	Federal DSH Allotment – FFY 2014
<b>Kentucky</b>	<b>\$154,638,217</b>
Illinois	\$229,291,148
Indiana	\$227,958,061
Missouri	\$505,240,380
Ohio	\$433,253,624
Virginia	\$ 93,430,890
West Virginia	\$ 71,986,756
Tennessee	N/A – (TennCare waiver)

*Source: Preliminary DSH Allotments for FY 2014 and the Preliminary Institutions for Mental Diseases DSH Limits for FY 2014, Federal Register, Vol. 79, No. 40, February 28, 2014*

related to the ACA, including automatic across-the-board federal cuts, known as sequestration, and other cuts in Medicare imposed by federal regulations.<sup>13</sup>

The grand total is nearly \$7 billion in federal cuts to Kentucky hospitals from 2010 through 2024. The table below details the amount and source of these cuts.



## The Impact on Kentucky Hospitals

Although it would appear that increasing the number of people with health coverage would be good news for Kentucky hospitals, the payment cuts outlined on the previous page, along with a number of other factors, reflect a starkly different reality.

The intent of the ACA was that the cuts would be offset, for the most part, by health care payments from people who had previously been uninsured. The original estimates by the Congressional Budget Office projected that half of the newly insured would be covered by private insurance and the other half by expanded Medicaid. That has not been the case in Kentucky, however.

Because Kentucky is a low-income state, ranking 46th in per-capita income, the actual enrollment statistics reveal that 75% of the newly insured in the Commonwealth are covered by Medicaid, and only 25% have bought a private health plan.<sup>14</sup> An estimated 11.9% of Kentuckians (approximately 521,000 people) remain uninsured.<sup>15</sup>

This is important because private health insurance pays health providers at a much higher rate than the Kentucky Medicaid program, which pays hospitals approximately 82% of what it actually costs to care for Medicaid patients. The difference between Medicaid payments and the actual cost is known as the "Medicaid shortfall," which was estimated to be more than \$300 million in Kentucky in 2013.<sup>16</sup> With the addition of more than 300,000 new Medicaid patients under the expansion (bringing the total number of Kentuckians on Medicaid to more than 1.1 million) this shortfall is expected to grow by another \$135 million per year.

**Under health reform, most uninsured Kentuckians are expected to be covered under Medicaid, which only pays hospitals 82% of which it actually costs to care for Medicaid patients.**

## Hospital Revenue Sources are Shifting

While many patients who were previously uninsured and paying their own way are now covered under Medicaid, fewer hospital patients are covered by private health insurance. The reason: KHA member hospitals report as much as 20% of the people now covered by Medicaid previously had private health insurance, which generally paid higher rates to health providers. The result: While more patients have coverage under health reform, a larger portion of reimbursements made to hospitals will not cover costs.

## Study Finds Kentucky Hospitals Will Suffer a Net Loss of \$1 Billion under Health Reform

The national consulting firm of Dobson/DaVanzo recently conducted an independent analysis of the ACA's impact on Kentucky hospitals. The analysis used a model applied in other states that considers the impact on hospital finances of people gaining coverage through both Medicaid and private plans, shifts in the commercial market, and changes in utilization from expanded coverage. **The result of this analysis estimated that Kentucky hospitals will lose more money under the ACA than they gain in new revenue from expanded coverage.** While the amount of charity care will be reduced by expanding Medicaid coverage, the Medicare and Medicaid DSH cuts will be greater than the amount of new revenue. **The bottom line: Kentucky hospitals will have higher losses and lower operating margins due to the ACA, with a projected net loss of \$1 billion from 2014 to 2020.**<sup>17</sup>

**Study shows Kentucky hospitals will have a net loss of \$1 billion from 2014-2020 due to changes in our health care system.**

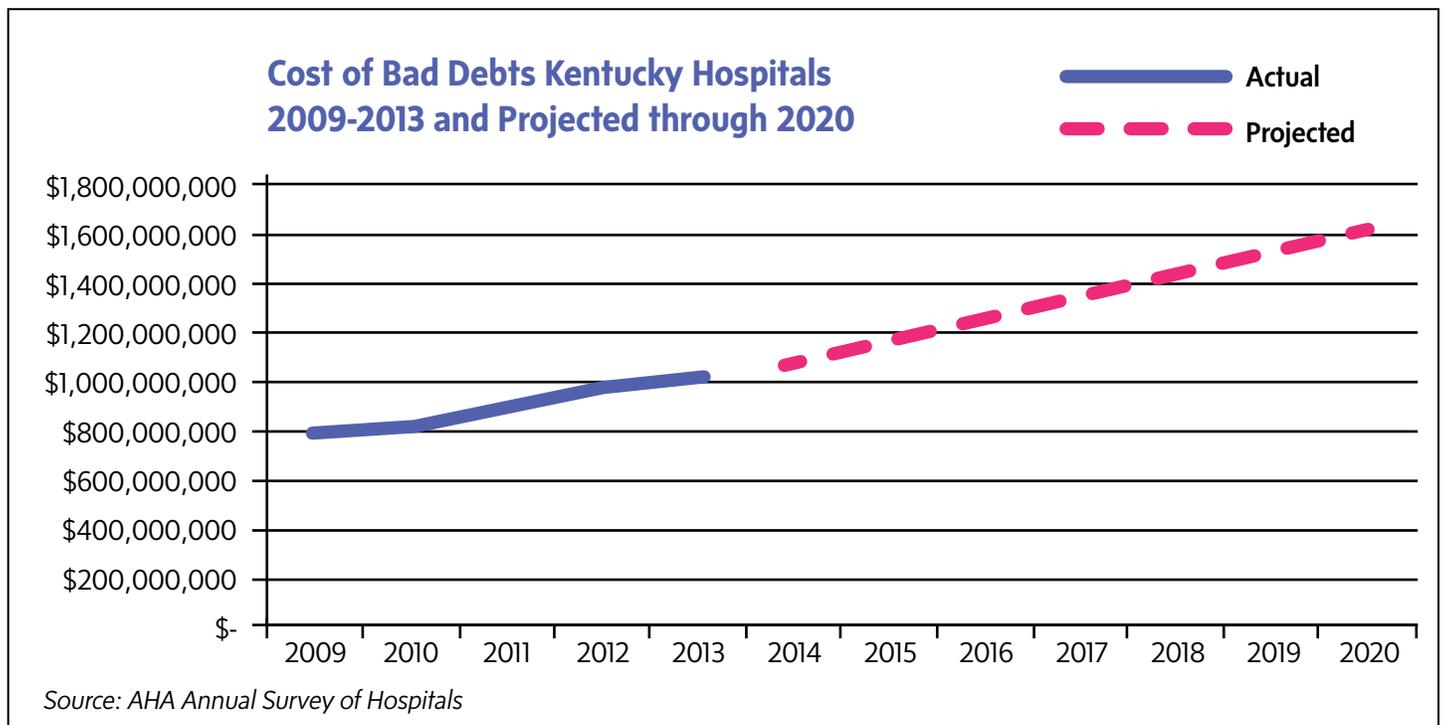
## Hospital Uncompensated Care An Unfortunate Reality

In 2013, the cost of uncompensated care provided by Kentucky hospitals totaled about \$2.3 billion.<sup>18</sup> This included losses from Medicaid and Medicare payments that were below actual costs, charity care costs provided to uninsured patients and the cost of bad debts. Bad debts accounted for 43% of all uncompensated care costs in 2013 and have grown by nearly \$200 million over the past three years as more privately insured patients have moved to plans with higher deductibles and copayments they cannot afford.<sup>19</sup> This problem is expected to worsen under health reform as some of the insurance plans sold through the state health insurance exchange contain significant cost-sharing requirements. The average annual deductible in the lowest-cost “bronze” plans ranges from \$5,000 to \$6,000 for an individual and \$10,000 to \$12,000 for a family. While this encourages patients to be better health care consumers, as a practical matter it translates into more bad debt for health care providers when patients cannot pay the required high deductibles and copayments.

The chart below shows that the cost of bad debts was \$789 million in 2009 and grew to more than \$1 billion in 2013—a 28% increase. If this trend continues, bad debts will be more than \$1.6 billion in 2020.

The bottom line is that hospital uncompensated care is not going away as a result of the ACA. While there will be some reduction in charity care as more people are covered under Medicaid, the “Medicaid shortfall” and losses from bad debts are predicted to grow, and many people will remain uninsured.

A February 2015 report issued by Deloitte and prepared for the Cabinet for Health and Family Services included a statement that Kentucky hospitals had received \$506 million more in Medicaid reimbursement since January of 2014 due to the Medicaid expansion. The implication was that Kentucky hospitals are reaping significant financial benefits from DSH and expansion payments.<sup>20</sup> While charity care has declined due to people gaining Medicaid coverage, uncompensated care is far more than just charity care.

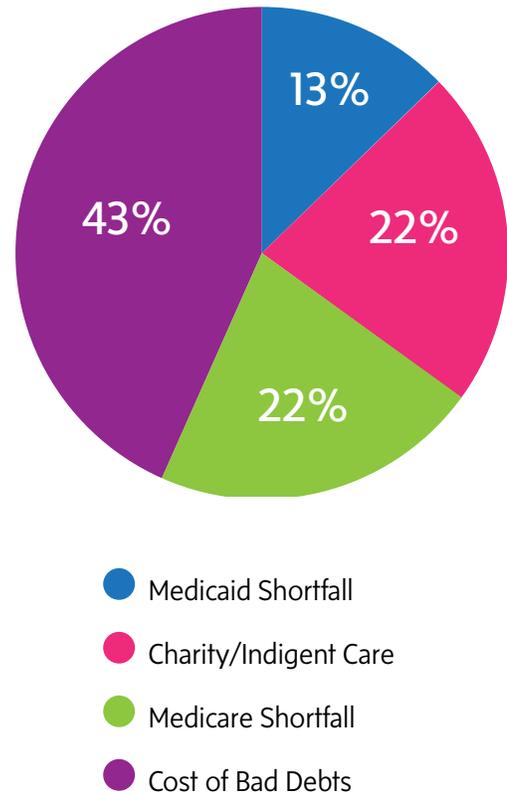


## Total Uncompensated Kentucky Hospital Costs, 2013

Medicaid Shortfall	\$ 300 Million
Acute and Private Psychiatric Hospital Indigent Costs to Uninsured Persons Below Poverty	\$ 281.3 Million
Teaching Hospital and Other Hospital Charity Costs	\$ 234.4 Million
Medicare Shortfall	\$ 509 Million
Cost of Bad Debt	\$ 1 Billion
<b>Grand Total Uncompensated Costs</b>	<b>\$ 2.324 Billion</b>
2013 DSH Payment	\$ 186.5 Million*
<b>Difference</b>	<b>\$2.137 Billion</b>

*\*Excludes DSH payments made to state owned and operated mental hospitals*

## Breakdown of Total Uncompensated Care Costs, Kentucky Hospitals, 2013



The report failed to note that:

- The payments hospitals received for providing services to Medicaid expansion patients did not cover the actual cost to deliver those services (paying 82% as previously noted). If hospitals received \$506 million in payment for treating patients covered by Medicaid expansion, it cost hospitals \$617 million to actually deliver the care, leaving a \$111 million gap in unpaid costs.
- Medicare payments to hospitals will be cut by \$4.6 billion from 2010 to 2024 to help finance health reform.
- Hospital bad debts have doubled in the past five years.
- Kentucky hospitals had \$2.3 billion in total uncompensated costs in 2013, which far outstrips DSH payments and the increase in Medicaid payments due to the expansion.

## State Audit Finds Rural Hospitals Hit Hardest

A recently released state audit highlights the financial struggles under which many rural hospitals are operating. Using data from 2011 to 2013, the audit assessed the financial health of Kentucky's rural hospitals using the Financial Strength Index® (FSI) that measures four key benchmarks: a hospital's total profit margin, days of cash on hand, debt financing and depreciation expense. The auditor's findings are sobering and include:

- 68% of Kentucky's rural hospitals scored below the national average on the FSI assessment, and 34% scored low enough to be considered in poor financial health.
- Hospitals with low FSI scores do not have capital reserves sufficient to withstand additional fiscal stress.

- Rural hospitals indicated that an average of 72% of all patients received Medicaid or Medicare benefits. Since these government programs pay less than what it costs a hospital to provide care, the financial situation faced by these hospitals could become worse as the percentage of private pay patients declines, DSH payments are reduced and cuts are made to Medicare.
- The audit also notes employee layoffs and closures of rural hospitals (discussed in the next section of this report).

The audit recommends that the state regularly monitor the fiscal strength of rural hospitals and create a task force to examine new models of rural health delivery to ensure quality of care and continued access.

## Hospital Layoffs Affect Kentucky Communities

The pressures under which Kentucky hospitals are operating affect the lives and health of Kentuckians. Hospitals are being forced to reduce costs to make up for the payment reductions outlined in this report. Since employee wages and benefits typically make up 60% of a hospital's expenses, some Kentucky hospitals have had no choice but to reduce staff to keep their doors open.

A September 2014 survey of Kentucky hospitals conducted by the Kentucky Hospital Association examined actions taken to reduce costs in 2013 and 2014. The survey results are disturbing:

- More than 65% of 109 Kentucky hospitals responding to the survey have taken action to reduce hospital staff, eliminating slightly more than 7,700 positions through layoffs, attrition or abolishing positions.<sup>21</sup>

**“Rural hospitals are teetering on the edge of survival in many Kentucky communities.”  
Kentucky State Auditor Adam Edelen.**

## This represents more than a 10% reduction of Kentucky's statewide hospital workforce reported in 2013.<sup>22</sup>

- Eighty percent of jobs reduced through attrition occurred in urban facilities, while about two-thirds of the layoffs and job eliminations also occurred in urban hospitals. However, jobs were eliminated in more rural hospitals than in urban facilities. Nearly two-thirds of facilities eliminating positions and not filling vacancies were rural hospitals, and one-half of the hospitals experiencing layoffs were also located in rural areas. Because rural hospitals employ fewer staff than urban facilities, even small reductions in their workforce can have a substantial impact on the hospital and the local community.
- About 44% of the Kentucky hospital workforce has experienced either a freeze or reduction in wages. Almost 9% of all hospital employees had their wages cut, while 56% experienced some type of reduction in benefits (such as a reduction in health and retirement benefits).<sup>23</sup>
- More than 40% of hospitals reported reducing programs and services to lower operating costs (such as the closure of psychiatric units and outpatient clinics).<sup>24</sup>
- Approximately one-third of hospitals implemented reductions in employee benefits in 2013-2014 and roughly the same percentage froze wages. About 80% of rural hospitals implemented reductions in wages and benefits compared to about 20% of urban hospitals.

Following are a few specific examples of recent actions announced by Kentucky hospitals.

- Nicholas County Hospital, a 25-bed critical access hospital in Carlisle, announced it was closing in May 2014.<sup>25</sup>
- Parkway Regional Hospital in Fulton, a 70-bed hospital in Fulton with 192 employees, announced it would close in 2015. Taxes paid by the hospital make up 18% of the City of Fulton's revenue.<sup>26</sup>

## Hospital Workforce Reductions Occurring in 2013-2014

	# Employees	# (%) of Hospitals*
Layoffs	1,268	36 (33%)
Attrition	4,922	51 (47%)
Eliminated Positions	1,516	61 (56%)
<b>Total Workforce Reduction</b>	<b>7,707</b>	

\*Includes all hospitals within a system reporting aggregated data; percent of total respondents taking specified action to reduce workforce

Source: Kentucky Hospital Actions to Reduce Costs, Kentucky Hospital Association, January 2015

## Kentucky Hospitals Making Reductions in Wages, Benefits, and Services 2013-2014

	# (%) of Hospitals	Location
Wage Freeze	35 (32%)	29 (83%) Rural 6 (17%) Urban
Wage Reduction	12 (11%)	10 (83%) Rural 2 (17%) Urban
Benefit Reduction	38 (35%)	30 (79%) Rural 8 (21%) Urban
Health Care Services Reduction	46 (42%)	33 (72%) Rural 13 (28%) Urban

Source: Kentucky Hospital Actions to Reduce Costs, Kentucky Hospital Association, January 2015

- KentuckyOne Health (the largest health system in Kentucky with ten hospitals) laid off 500 employees in February 2014 and will not fill 200 job openings to address an estimated \$218 million deficit.<sup>27</sup>
- Jennie Stuart Medical Center in Hopkinsville announced a layoff of 70 employees in July 2014, citing "regulatory and reimbursement challenges."<sup>28</sup>
- TJ Samson Community Hospital in Glasgow cut between 39 and 49 jobs and implemented pay cuts, including a 10% pay reduction for management and salaried positions.<sup>29</sup>

These closures and layoffs, while devastating to the affected employees and their families, also have a significant economic impact. Through the jobs provided, taxes paid, and the purchase of services and supplies, hospitals represent a significant economic driver for the state and the communities they serve. These dollars have a ripple effect as they move through the larger economy, supporting other businesses and jobs in the community. As a result, reductions in the hospital workforce hurt not only local communities but the state as a whole in terms of

## Geographic Location of Hospital Workforce Reductions

	% Employees Affected	# (%) of Hospitals*
Layoffs	62% Urban 38% Rural	18 (50%) Urban 18 (50%) Rural
Attrition	83% Urban 17% Rural	19 (36%) Urban 32 (64%) Rural
Eliminated Jobs	68% Urban 32% Rural	23 (38%) Urban 38 (62%) Rural

\*Includes all hospitals within a system reporting aggregated data; percent of total respondents taking specified action to reduce workforce

Source: Kentucky Hospital Actions to Reduce Costs, Kentucky Hospital Association, January 2015

## Kentucky Hospitals: An Important Part of Our Economy

- Kentucky hospitals paid \$4.1 billion in employee wages and benefits in 2012.
- Kentucky hospitals rank 6th highest among private employers in wages paid to employees.
- The average 2012 wage for a hospital employee in Kentucky was 20% higher than the average wage of all other private employers.
- Kentucky hospitals are responsible for generating approximately \$4.9 billion in local economic activity from goods and services bought by hospitals and their employees.
- Kentucky hospitals are responsible for approximately \$604 million in state and local tax revenue through the taxes they pay directly and tax revenue generated from their employees.
- Kentucky hospitals pay \$183 million in provider taxes, which generates \$610 million for the Medicaid program.
- Kentucky receives \$343.7 million in income and sales taxes linked to wages and salaries of Kentucky hospital employees.
- The total value of community benefits provided by Kentucky hospitals (including charity care, community health programs, financial contributions and losses on Medicaid and Medicare) exceeded \$2 billion in costs in 2012.

Source: Kentucky Hospitals' Economic Importance to Their Communities, KHA

lower tax revenue and loss of business to other firms in the community. **The Kentucky Hospital Association estimates that the loss of 7,706 hospital jobs translates into a \$31 million reduction in income and sales taxes and an estimated \$208 million loss in local spending for goods and services.**<sup>30</sup>

## Continuing Problems with Medicaid Managed Care

The statewide implementation of Medicaid managed care, in which private managed care organizations (MCOs) provide coverage to Medicaid patients, continues to be a cause of concern among Kentucky hospitals. The program has increased administrative costs of hospitals while slowing the payment of claims, reducing payment rates and increasing denials of services.

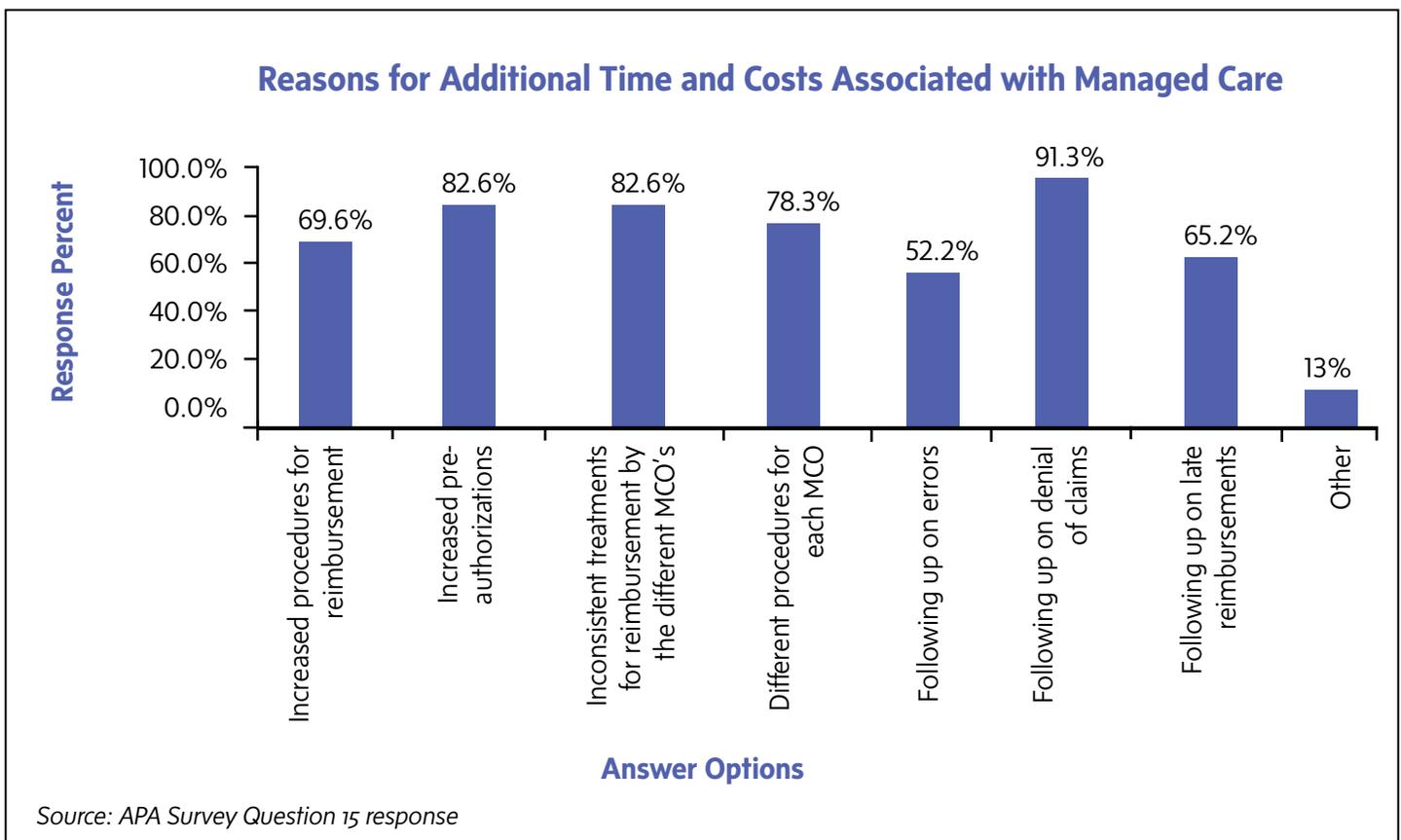
Some Medicaid managed care plans are paying hospitals only \$50 for care provided in the emergency room, although the actual costs are much higher for ERs to screen patients to rule out life-threatening conditions. This is a significant issue for Kentucky hospitals, particularly in view of a recent study that found the expansion of Medicaid is likely to lead to more emergency room use due to patients' lack of access to primary care.<sup>32</sup>

A prime example of this practice was reported by the administrator of Marshall County Hospital in March of 2015. A Medicaid patient came to the hospital in advanced stages of labor and the baby was delivered in the emergency room as the hospital does not have an obstetrics department. Although the charges for the delivery totaled \$2,500, the hospital was only paid \$50 (\$42 from the MCO and \$8 from the patient).<sup>33</sup> The March 30, 2015, state audit of rural hospitals cited a similar example of a hospital that was paid \$50 for the treatment of a car accident victim that cost the hospital \$7,000 and found that another hospital had only ten days of cash on hand due to below-cost emergency room payments. The auditor recommended that CHFS impose contractual restrictions on the use of these \$50 "triage fees."<sup>34</sup>

The recent state audit also found that Medicaid managed care was imposing an additional administrative burden on approximately 80% of rural hospitals. Administrative costs increased an average of \$157,000 (between \$20,000 and \$630,000 per year) for rural hospitals surveyed, and half reported they have had to hire new administrative personnel and increase overtime to deal with this burden. The most common reasons for additional time and costs associated with managed care were “following up on denial of claims, increased pre-authorizations, and different procedures/treatments” for each of the five MCOs that provide coverage to Kentucky Medicaid patients (see chart below). Credentialing, the process by which providers are approved by the MCOs, was also cited as a significant problem as each of the five MCOs had different credentialing requirements. The process took approximately six to eight weeks prior to managed care and now takes up to eight or nine months in some cases.<sup>35</sup>

At the state administrative level, the state auditor further found that weakness in the contracts between the state 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.”<sup>36</sup> To improve contracts with MCOs, the auditor recommended “strengthening penalties for contractual noncompliance, improving CHFS’ ability to monitor quality and programmatic requirements, and improving transparency.”

A September 2014 report by the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services also found problems with state standards for access to care in states with Medicaid managed care. The report found that the standards varied widely, from one primary care provider for every 100 enrollees to one provider for every 2,500 enrollees (Kentucky requires one primary care provider for every 1,500 enrollees). The OIG also found access standards were not adequately enforced by



the states and that the federal Centers for Medicare and Medicaid (CMS) provide limited oversight of state access standards. The OIG recommended that CMS strengthen its oversight and methods to assess compliance and that states improve efforts to identify and address violations of access standards.<sup>37</sup>

## Improving the Situation

Like any business, hospitals must take in enough revenue to cover all their operating costs. However, the almost \$7 billion in cuts that Kentucky hospitals will experience through 2024, combined with the fact that the vast majority of those newly insured are covered by Medicaid, which does not cover the actual cost of care, will severely limit the ability of hospitals to make up the difference.

While state government cannot reverse cuts in federal payments to hospitals, it can improve the state Medicaid program, on which rural hospitals heavily rely. Kentucky's hospital community urges Governor Beshear to continue his strong leadership in health care by directing the following changes to the state Medicaid program. These actions can work to the benefit of patients, hospitals and the communities they serve:

- Standardize the use of review criteria by Medicaid Managed Care Organizations (MCOs) to ensure the same criteria are used by all MCOs in determining medical necessity of covered physical and behavioral health services provided to a Medicaid patient.

**John Hackbarth, chief financial officer for Owensboro Health, was recently quoted about the financial challenges facing Kentucky hospitals: “Three years ago we had one payor for Kentucky Medicaid patients and now, after movement to a managed care model, we have five insurance plans, plus some patients remaining on Kentucky Medicaid indemnity. This has increased costs in many areas such as contracting, compliance, billing, IT and case management because we are dealing with five times the amount of rules and hoops to jump through for a slower payment and ultimately less reimbursement.”<sup>31</sup>**

- Allow providers to have the right to an external appeal of medical necessity service denials that result in reduced or no payments, including when services have already been rendered to patients.
- Reduce the administrative burden on providers by standardizing policies and processes across all MCOs.
- Require the MCOs to abide by the Medicaid State Plan under which hospital staff, not MCOs, determine which patients presenting to an emergency room have a non-emergency condition and prohibit the \$50 triage fee for medical screening and treatment that is not authorized under provider contracts with the MCOs.
- Strengthen oversight of provider networks to ensure care is accessible to Medicaid patients in their local communities.

- The recommendations of the March 2015 state audit on rural hospitals should be fully implemented, with special attention to resolving weaknesses in contracts with MCOs and establishing uniform criteria among all five MCOs.

If Kentucky hospitals, especially those in rural areas, are to continue as vital community and economic contributors, it is critical that state policymakers recognize the financial pressures they are experiencing and act to ensure their continued operations.

Otherwise, Kentucky's success in expanding health coverage will be diminished as the newly insured in many areas of the Commonwealth will not have access to a local hospital for the care they need and deserve.

## Footnotes

1 Based on total Medicaid inpatient and outpatient payments compared to total Medicaid inpatient and outpatient allowable costs

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2 Arkansas, Kentucky Report Sharpest Drops in Uninsured Rate, GALLUP Well-Being, August 5, 2014

3 HHS Poverty Guidelines, January 22, 2014

4 Ibid

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6 Hospital Association of New York State, "15 Year Medicare Cut Analysis, Estimated Value of Enacted Cuts and Cuts Under Consideration Since the ACA, Kentucky February 2015, KHA

7 Impact of Affordable Care Act on Hospital Finances in Kentucky, Dobson/DaVanzo, January 30, 2014

8 Ibid

9 Rice, Sabriva, "Safety net hospitals face socio-economic disadvantages", Modern Healthcare, June 7, 2014

10 Ibid

11 Ibid

12 Kentucky Hospital Statistics, January 2014, KHA

13 Ibid

14 Kynect statistics, April 21, 2014

15 Arkansas, Kentucky Report Sharpest Drops in Uninsured Rate, GALLUP Well-Being, August 5, 2014

16 Kentucky Hospital Statistics, January 2014, KHA

17 Impact of Affordable Care Act on Hospital Finances in Kentucky, Dobson/DaVanzo, January 30, 2014

18 2012 Community Benefits Report, KHA

19 Ibid

20 Medicaid Expansion, Enrollment, and Payment in Kentucky, Cabinet for Health and Family Services, February 11, 2015

21 Kentucky Hospital Actions to Reduce Costs, Kentucky Hospital Association, 2014

22 Kentucky Hospitals Economic Importance to Their Communities, 2013

23 Kentucky Hospital Actions to Reduce Costs, Kentucky Hospital Association, 2014

24 Ibid

25 Ibid

26 Fulton hospital says it will close by March 31 due to shrinking population and patient counts, WKMS, December 14, 2014

27 KentuckyOne's CEO cites health care reform as reason for layoffs, Lexington Herald-Leader, January 29, 2014 and KentuckyOne Health confirms 500 layoffs; 200 jobs not filled, Lexington Herald-Leader, February 28, 2014

28 JSMC announces cuts, layoffs, Kentucky New Era, July 16, 2014

29 91 Hospital and Health System Layoffs in 2014, Becker's Hospital Review, June 14, 2014

30 Kentucky Hospital Actions to Reduce Costs, Kentucky Hospital Association, 2014

31 Performing surgery on hospital budgets, The Lane Report, March 11, 2014

32 Taubman, S., Allen H., Wright, B., Baicker, K., Finkelstein, A., "Medicaid Increases Emergency Department Use: Evidence from Oregon's Health Insurance Experiment", Science, 17 January 2014, Vol. 343 No. 6168

33 Email to KHA from David Fuqua, CEO of Marshall County Hospital March 23, 2015

34 Special Report on the Financial Strength of  
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Accounts, March 30, 2015

35 Ibid

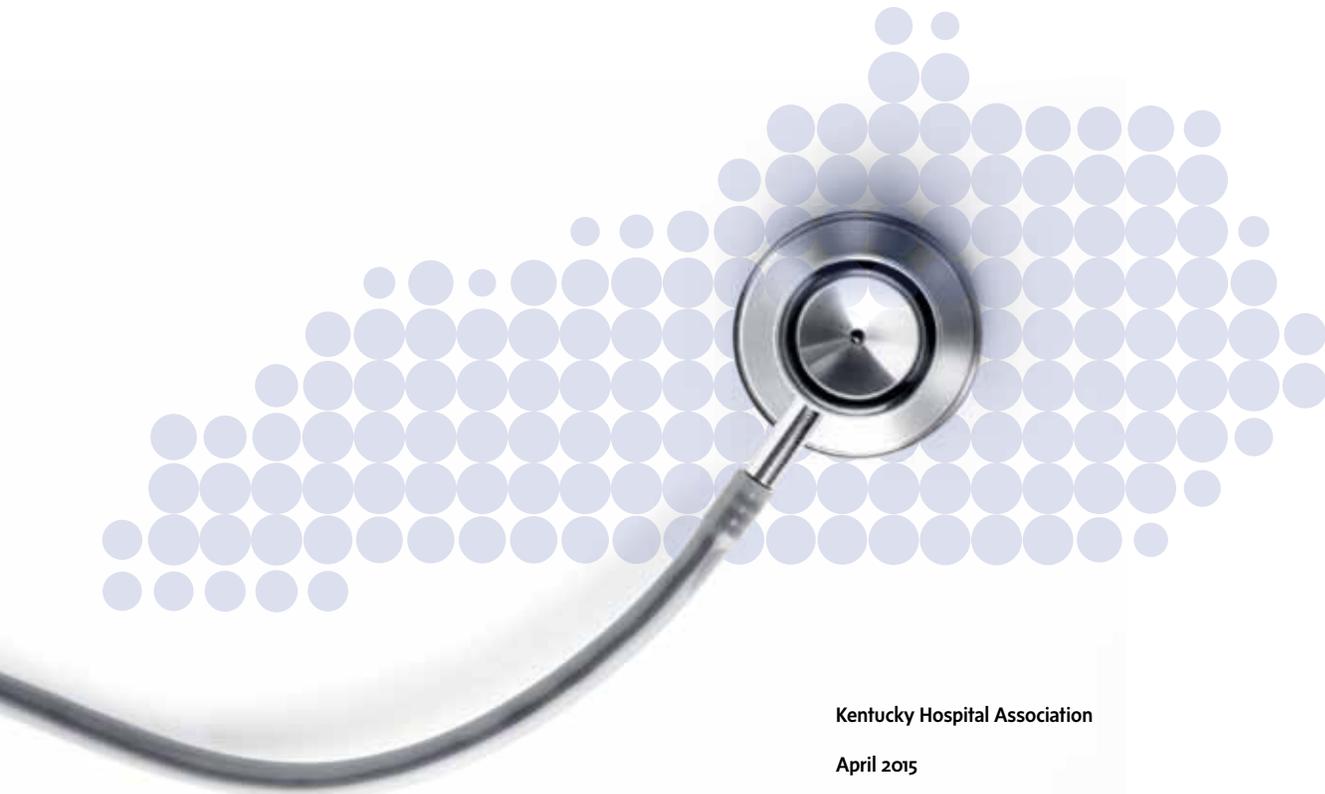
36 Ibid

37 State Standards for Access to Care in Medicaid  
Managed Care, Office of Inspector General,  
Department of Health and Human Services, September  
2014



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