2018 HFMA Spring Institute

KHA Update
Granddaughter’s reaction when she heard I would be presenting at HFMA
Granddaughter’s reaction when she heard I would be presenting at HFMA
After she got her composure back she wanted to say “Hello”
After she got her composure back she wanted to say “Hello”
AGENDA

• Federal Update
• Waiver Update
• MCO Update
• DSH Distribution
• Kentucky Legislative Update
• KY Coop Update
• Questions
Federal Update
Tax Cuts and Jobs Act of 2017

Highlights

• Hospital Tax-exempt Bonds
  ➢ House provision to repeal *not* included

• Advance Refunding of Bonds
  ➢ No advance refundings after Dec. 31, 2017

• ACA Mandate
  ➢ Repealed after Dec. 31, 2018

• Medical Expense Deduction
  ➢ Extended at 7.5% until 2019

• Interest Deduction for Corporate Debt
  ➢ Capped at 30%, but based on House definition of income until 2022

• Executive Compensation Tax
  ➢ 21% employer excise tax for top five over $1 million
**Tax Issues for 2018**

**Making Tweaks**

**Possible Vehicles**
- Technical Corrections
- Infrastructure

**Issues:**
- **Hospital Tax-exempt Bonds**
  - Hearings, work to preserve and expand
  - Increase limit banks can own (S.1925 - Menendez/Cardin)
  - Restore advance refunding bonds (H.R. 5003 - Hultgren/Ruppersberger)

- **Interest Deduction for Corporate Debt**
  - Make permanent definition of income – include interest, tax, depreciation and amortization

- **Executive Compensation Tax**
  - Repeal/Modify 21% employer excise tax for top 5 over $1 million
340(B)

Getting a lot of discussion at the national level.
Focus on 340B

Activity on Multiple Fronts

- OPPS cut
- Energy & Commerce report
- Legislation
- Congressional Hearings
  Senate HELP and House E&C
340B Litigation

- Effective January 1, 2018, OPPS payments slashed for separately payable, non-pass-through outpatient drugs from ASP + 6% to ASP – 22.5%

- The AHA, the AAMC, and AEH filed suit, on November 13, 2017, against HHS in the U.S. District for the District of Columbia to challenge the payment cut. Plaintiffs argue HHS lacks the statutory authority to adopt the payment cut:
  
  — HHS has only two choices in establishing reimbursement for drugs: (1) based on the acquisition costs of these drugs if statistically sound survey data on acquisition cost are available or (2) if that data is not available, ASP + 6%
  
  — HHS improperly utilized MedPac assumptions to impose the reimbursement cut rather than statistically sound survey data on acquisition costs
340B Litigation

- District Court ruled against the plaintiffs but case is on appeal to D.C. Circuit

- Court found it was premature to decide case seeking preliminary injunction prior to rates going into effect. No “presentment” of claims.

- Providers should consider filing appeals of individual drug claims in the event of successful resolution in court.
Lawsuit Continues

- Appeal underway – district court found that the lawsuit was brought prematurely; request to expedite
  - Did not rule on the merits of the claim
  - Hearing Scheduled May 4th

- Litigants:
  - Associations:
    - AHA, AAMC and AEH
  - Members:
    - Eastern Maine Healthcare Systems
    - Henry Ford Health System
    - Adventist Health System’s Park Ridge Health (NC)

- Preserving Rights
  - AHA 340B Alliance Call March 29
    1:00 pm discuss next steps
E&C Report Findings

• HRSA needs more authority
  – The program has grown but HRSA has not

• Congress didn’t clearly define the intent or parameters of 340B
  – Health care has changed over the past 25 years, so should 340B
  – No requirements on how to calculate or report savings
  – No charity care information
  – 340B incentives covered entities to prescribe more expensive drugs
  – Leads to consolidation and decreased quality care
  – DSH may not be the best metric
E&C Report Recommendations

• HRSA should...
  – Finalize rules in areas they have authority
    • Civil monetary penalties
    • Ceiling Price
  – Perform audits at the same rate for manufactures and covered entities

• Congress should...
  – Give HRSA sufficient authority
    • Track use
    • Benefit low income patients
  – Provide HRSA with more resources
  – Identify ways to address duplicative discounts
  – Expand scope of HRSA audits
  – Clarify intent of the program
  – Promote transparency
  – Monitor and define charity care
  – Assess DSH Metric
Legislative Activity

• **340B PAUSE Act / H.R. 4710 – Reps. Bucshon (R-IN) and Gary Peters (D-CA)**
  - moratorium on new 340B DSH hospitals & new child sites for current DSH hospitals
  - new reporting requirements

• **HELP Act / S. 2312 – Sen. Bill Cassidy (R-LA)**
  - moratorium on new 340B DSH hospitals & some child sites
  - new reporting requirements
  - ties the program to charity care

• **Ensuring the Value of the 340B Program Act / S. 2453 – Sen. Charles Grassley (R-IA)**
  - All 340B hospitals required to report aggregate 340B acquisition costs and revenues

Concerns:
- Too burdensome
- Do not address transparency for manufacturers
- Sharing proprietary data may undermine negotiations with payers
Telling the 340B Story

- Blog Postings (addressing various studies)
- Study: 340B Tax-exempt Hospitals Provide $51.7 Billion in Community Benefits
- Grassroots

  - Advocacy Alliance
    - Digital Toolkit
    - www.aha.org/protect340b
- Advertising
340(B)

AHA Protect 340B Drug Pricing Program

- Increased Access to Care
- Clinical Pharmacy Services
- Community Outreach Programs
- Free Vaccinations
- Transportation to Follow-Up Appointments
Major Health Care Issues

- **340(B)** - Getting a lot of discussion at the national level.
  - Need to be sure document how the saving are being used.
  - *Don’t be general, i.e., funding gap in Medicaid (or even charity).* If you do, be sure to consider the impact on arguments for DSH.
Future Focus?
Churning Leadership at HHS

Aug. 9, 2014
Norris Cochran
Acting Secretary

Feb. 10
Jan. 20, 2017
Sylvia Burwell
Obama administration

Sept. 29
Tom Price
Confirmed by Senate
(resigned 9/29)

Oct. 10
Eric Hargan
Acting Secretary
and Deputy Secretary

Don J. Wright
Acting Secretary

Jan. 24, 2018
Alex Azar
Confirmed by Senate

Five HHS Secretaries in One Year
New HHS Secretary

- Former president of Lilly USA
- Deputy HHS secretary under George W. Bush
- Confirmed January 24
- Priorities:
  - Drug prices
  - Medicaid “Reform”
    - Block grants; work requirements
  - Make healthcare affordable
    - Transparency & accountability
  - Pay for value
    - Mandatory demos
    - Additional APMs
    - HIT/telehealth

Secretary Alex Azar
Congressional Hearings

U.S. Senate Committee on
Health, Education, Labor & Pensions

Perspectives on the 340B Drug Pricing Program
March 15, 2018

April?
President’s Approval Ratings

Presidents with a sub-50% approval rating lose an average of 40 seats in the midterms

Presidential job approval vs. midterm results since 1966

Trump Job Approval

41.0%
RCP Average: March 12, 2018

Job Approval

- Over 60%
  +3 Seats
- 50%-60%
  -12 Seats
- Under 50%
  -40 Seats

Sources: Gallup, The Cook Political Report, National Journal
## House 2018

If Democrats retain all their seats in 2018, they must pick up all “toss-ups”

### Cook Political Report ratings

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<tr>
<th>Rating</th>
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*Incumbent not seeking reelection

Source: Cook Political Report

March 1, 2018
Is Regulatory Relief in Sight?

This is a focus of AHA
Regulatory Relief

Regulatory Burden Overwhelming Providers, Diverting Clinicians from Patient Care

Regulations are essential to ensure safety and accountability. However, the rapid increase in the scope and volume of mandatory requirements diverts resources from the patient-centered mission of health systems, hospitals and post-acute care providers.

$39 BILLION Spent by health systems, hospitals, and post-acute care providers each year on non-clinical regulatory requirements

629 mandatory regulatory requirements
- Hospitals have to comply with 341 mandatory regulatory requirements.
- Post-acute care providers have an additional 288 requirements.

$7.6 MILLION per community hospital spent annually to comply
- This figure rises to $9 million for those hospitals with post-acute care.
- For the largest hospitals, costs can exceed $19 million annually.
- The average hospital also spends almost $760,000 annually on the information technology investments needed for compliance.

Patients are affected by excessive regulatory burden through:
- Less time with their caregivers
- Unnecessary hurdles to receiving care
- Higher health care costs.

Percent & Number of Regulations, by Domain
- 7 - Billing & Coverage
- 8 - Program Integrity
- 26 - Health IT/ Meaningful Use
- 268 - Post-acute Care
- 96 - Hospital Conditions of Participation
- 78 - Privacy & Security
- 58 - Quality Reporting
- 52 - Fraud & Abuse
- 16 - New Models of Care
Regulatory Relief

Medicare conditions of participation: billing and coverage determinations are the most costly areas:
- The Medicare COPs are important to ensure that care is provided safely and meets standards.
- However, these requirements need to be evaluated carefully to ensure they actually improve safety.
- Existing guidance to simplify billing and coverage determinations should be adopted universally by payers and others to achieve savings.

Regulatory burden costs $1,200 every time a patient is admitted to a hospital.

15 doctors & nurses per hospital for compliance
- 59 full-time equivalent staff are required in each hospital to meet the demands of regulations.
- Over one-quarter of these FTEs are doctors and nurses, who could otherwise be caring for patients.

FTEs Dedicated to Regulatory Burden per Hospital

Reducing regulatory requirements will allow providers to focus on patients, not paperwork.
Major Health Care Provisions Continuing Resolution

• **DSH** - the bill delays $5 billion in Medicaid DSH reductions scheduled for FYs 2018 and 2019.

• **Telehealth** – The bill eliminates a geographic requirement under Medicare for the use of telehealth services for stroke patients, beginning in January 2019.
Major Health Care Provisions
Continuing Resolution

• **Direct Supervision** – The bill extends the enforcement moratorium on “direct supervision” of outpatient therapeutic services for critical access hospitals and small, rural hospitals with 100 or fewer beds for CY 2017. The Centers for Medicare & Medicaid Services (CMS), in the CY 2018 outpatient prospective payment system (PPS) final rule, extended the moratorium for CYs 2018 and 2019 but did not include the remainder of 2017.
  
  – the bill expands the type of personnel permitted to supervise cardiac, intensive cardiac and pulmonary rehabilitation programs to include certain non-physician practitioners.
## Major Health Care Provisions
Continuing Resolution - RURAL

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<td>Medicare Dependent Hospital (MDH) Program</td>
<td>Two year extension of the MDH program, until October 1, 2019</td>
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<tr>
<td>2102</td>
<td>Increased Inpatient Hospital Payment Adjustment for Certain Low-Volume Hospitals</td>
<td>Two year extension of the increased inpatient hospital payment adjustment for certain low-volume hospitals, until October 1, 2019</td>
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<td>2104</td>
<td>Home Health Rural Add-on</td>
<td>Five year extension of the home health rural add-on, until October 1, 2022</td>
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<td>2111</td>
<td>Ground Ambulance Add-on</td>
<td>Five year extension of the 2-percent urban, 3-percent rural, and 22.6-percent super rural ground ambulance add-on, until October 1, 2022</td>
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Waiver Update
1115 Waiver

- **April 1, 2018** – Enrollees can earn Rewards

- **July 1, 2018** – KY HEALTH Begins
  - *Alternative benefit plan* – expansion adults
    - Buy dental/vision; limits on therapy and home health, no non-emergency transportation
  - *Premiums Required* – expansion adults (> 100% FPL)
    - Optional for non-disabled adults below poverty and medically frail
      - If pay premiums then no co-pays

- **Community Engagement** – to be Phased-in on a regional basis
  - Operated and Tracked through Workforce Boards that follows Supplemental Nutrition Assistance Program regions.
    - Pilot in one region, phase-in others after October 1

- **KHA workgroup on implementation** ( +Stakeholder forums)
  - HMA Consultation
Potential Service Regions

http://chfs.ky.gov/dcbs/ServiceRegions.htm
Kentucky Health Program Overview

Kentucky HEALTH is the Commonwealth’s new program for certain low-income adults and their families. The program gets its name from its mission.

Helping to Engage & Achieve Long Term Health

This innovative program brings together existing state agencies and programs, and leverages federal funding to improve member access to health, educational, financial, and professional development resources that can help families and communities grow and thrive over the long-term.
### 1115 Waiver

#### How Are We Doing?

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<th>Kentucky Rank</th>
<th>Description</th>
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<td>Frequent Mental Distress</td>
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**America’s Health Rankings 2016**

45th
1115 Waiver

What Determines Health?

Clinical Care (20%)

Healthy Behaviors (30%)

Social & Economic Factors (40%)

Access to healthcare alone will **NOT** dramatically improve the health of Kentuckians.

Note: The remaining 10% is attributed to miscellaneous factors.
1115 Waiver

Kentucky HEALTH Covered Populations

Medicaid Populations *Not Included* in Kentucky HEALTH
- Traditional Medicaid (Aged, Blind & Disabled)
  - Home and Community Based Waiver - 1915(c)
    - No Change
  - Michelle P Waiver - 1915(c)
    - No Change
  - Acquired Brain Injury - 1915(c)
    - No Change
  - Nursing Facility and ICF/MR Residents
    - No Change

Medicaid Populations *Included* in Kentucky HEALTH
- Non-Disabled Adults & Children
  - (Individuals covered before expansion, pregnant women, children, adult expansion population and Former Foster Youth up to age 26)

**Traditional Medicaid Adults Eligible Prior to Expansion**
- Premiums or Copays
- No Change in Benefits (continue to get vision and dental through MCO)
- Community Engagement required, unless primary caretaker of dependent

**Medicaid Expansion Adults**
- Premiums or Copays
- State Employee Benefits
- Vision and Dental available through My Rewards Account
- Community Engagement required, unless primary caretaker of dependent

Notices going out to members on June 1, 2018
1115 Waiver
KHA workgroup on implementation

Community Engagement:

- How will the patients be identified as having to meet the Community Engagement requirements? Who and how will they be notified? How will providers know which of their patients will be impacted by this requirement?
- Who will be administering the tracking for the Community Engagement requirements? What are the logistics behind tracking the community engagement activities? How frequently will the data be updated? If someone other than the MCOs, will there be a real-time eligibility function so that providers are able to check eligibility with each visit to ensure the patient still maintains coverage?
- Are people who fail to have enough community engagement going to be dis-enrolled or suspended? How will this show up on the eligibility report? If in suspense, will hospitals be able to be paid? (same issue as with the bad address – can we bill people who are in “suspense”?)
- How can hospitals be involved in possibly offering volunteer opportunities to qualified recipients?
- Will there be a way for hospital employees who are certified to use the KY Online Gateway system for applications to submit work/community service verification on a hospitalized patient’s behalf?
- Will there be a number to call to report community engagement, or a fax number?
- Hospitals want to understand the community engagement requirement so they understand how gaps in coverage can occur (i.e., is it based on retroactive hours in prior month being met, and if not, do they lose eligibility in the current month? How fast can they take a literacy course? If they take a course, is eligibility back dated to cover the gap or only on a go-forward basis?) Will coverage be retroactively provided once an individual completes the necessary elements?
- If the patient is in the hospital, will their community service be waived for that month? What about if they are ill or injured? Will the patient be considered medically fragile? How will the hospital/patient need to report when a patient becomes medically fragile?
- How does a patient or a provider prove that a patient is medically fragile?
- Will hospitals be able to help reinstate individuals?
Billing Patients

- Hospitals need clear guidance as to when Medicaid patients can be billed.
- Are providers able to collect payments up front for patients during their suspension period and/or “non-eligibility period?” What recourse do providers have in the event a patient arrives for care and is unable to pay for the services to be rendered?
- Can the patient use the money accrued in the patient’s My Rewards Account and/or Deductible account to pay for bills incurred while the patient was in the suspension period?
- Are providers able to turn away patients if they did not pay for the services incurred during their suspension or “non-eligibility period”, outside of ED services?
- If a future prior auth is received and the patient is then suspended due to not meeting the Community Engagement requirement or put into “non-eligibility period” over not paying their premium, will the prior auth be upheld in the event the patient is retroactively reinstated?
- What are the expectations around providers continuing with a course of treatment for a patient who has a change in status due to not paying their premiums? For example, patient is covered by Medicaid when treatment begins; however, they lose coverage 3 weeks into treatment and are unable to pay for ongoing treatment.
NonPayment of Premiums

- How will patients be identified as having to pay premiums? Who will be notifying them?
- How will providers know which of their patients will be impacted by a premium requirement? Will information be current and visibly evident in the patient’s eligibility response in KYMMIS and through the MCOs?
- How will illness/injury be accommodated if it affects the patient’s ability to pay their premium?
- If a member is in the 60 day grace period for non-payment of premiums, will that show up on the eligibility file with a “warning status for non payment of premiums” and be visible to providers? If a patient shows up at the hospital and the hospital determines they are at risk for losing coverage, hospital can notify patient or may even help with premium payment.
- Please clarify that hospitals will be paid for services delivered during the grace period (60 days before eligibility terminated for nonpayment of premium)
- Will there be a fast track process for patients who are delinquent with premium payment to pay up at the point of service? (or for hospitals to pay on their behalf). For example, patients who require emergency or urgent care and show up at the hospital? If so, what is the process? How does the literacy course requirement impact this if they are beyond the grace period?
  - EX: If the patient is beyond the grace period for failure to make premium payments and shows up at the hospital ED, can they or the hospital pay the delinquent premiums (+ the current month, 3 months required) to restore immediate coverage for the hospital’s services, or has the patient lost eligibility such that they could not gain immediate coverage (because they must also take a health or financial literacy course)? In that instance, if the patient is not eligible, would the hospital be able to bill the patient?
NonPayment of Premiums (continued)

- What mechanism will be set up for hospitals to pay premiums on behalf of members? Does this have to be done through a foundation?
- Each time the patient comes out of the “non-eligibility period” and is again eligible for coverage, it is said that they will need to go through the “redetermination process” – What is this process? Does it cause delays in the effective date for the coverage?
- Patients are to report changes in circumstances that impact Medicaid coverage “in a timely manner.” I have seen some say this “timely manner” is 10 days from the occurrence change. Is this correct? Can the provider assist the patient with this notification in order to ensure that the patient meets that deadline?
CoPays

• How will hospitals be able to identify which Medicaid patients are required to pay a co-payment? Some recipients still keep their Medicaid coverage if they don’t pay premiums, but at the end of the grace period, revert back to traditional Medicaid but must pay copays for 6 months.
• Can hospitals waive copay collection and write off to charity?
• Can providers refuse services (other than ED) if the patient will not pay the copay at the time of service?
• Can providers refuse services (other than ED) if the patient has repeatedly refused or failed to pay copays for prior services?

Deductible Account

• Will hospitals be able to see which recipients have a deductible?
• Who does the hospital bill for the deductible? Do they reduce the amount billed to the MCO by the amount of the deductible?
• Will providers have access to real-time data around the patient’s deductible? If so, may hospitals charge the Deductible Account with the expected cost share prior to rendering services?
Open Enrollment

- If a member does not file their re-determination of eligibility paperwork on time, is their eligibility terminated or are they just suspended for another 90 days in case they turn their paperwork in late?
- Will the eligibility file contain any “warning status” prior to termination of eligibility that is visible to a provider to help inform the member to get their paperwork in? (since members are given 90 days advance notice before their termination date)
- If a member files their paperwork late but within 90 days of their termination date, does eligibility start on the date the paperwork is submitted or the first day of that month, or does it go back to the termination date so there would be no lapse in coverage – and services received during that time could be covered and paid?
- If a member takes a literacy course and files paperwork more than 90 days after their termination date to re-enroll before the next open enrollment, please confirm the effective date of coverage.
Alternative Benefits

• How will hospitals know which members are under the alternative benefit plan? (i.e., there are limits on visits for certain outpatient services, such as therapy and HHA)

My Rewards

• How will the Department determine when to apply a penalty for “non emergency care in an ED?”
• How will the Department know to apply a penalty for a missed appointment? (does this apply to any missed appointment, and will the hospital/MD be required to notify the MCO or the state?) And, do these same expectations apply when a patient is in their suspension or “non-eligibility period”?
Access to Eligibility File Information

- Will hospital staff have the ability to totally view a member’s file to tell them why they may be showing as ineligible? People may show up, be determined as not eligible, and not understand why (i.e., didn’t meet community engagement, didn’t pay premium, didn’t file re-enrollment paperwork on time). Hospitals could help explain reason and also be able to connect the member with resources to get their coverage back. For example, where do they go to take a literacy course, check up on the community engagement, etc (a contact list).
- Hospitals will need to be able to view the entire file. Will this come through from the MCOs when eligibility is checked, or if we don’t file eligibility, will hospitals be able to go to the state file and see all of the information?
- How fast does a member regain eligibility if they take the literacy course? Is there a limit of how many times they can retake the literacy course to regain eligibility?
KHA workgroup on implementation

Presumptive Eligibility
• Are there any changes to presumptive eligibility as it pertains to hospitals? Can hospitals still determine presumptive eligibility (i.e., can hospital make uninsured patient in ED presumptively eligible so that their ED visit is covered?)

Gaps in Coverage
• Is there a way to determine which members subject to the new requirements are at high risk of losing coverage (to make special outreach to, etc)?
• How will the state track who is losing benefits and why (certain types of members) to institute more focused education/resources?
Effective Date of Coverage

• If retro eligibility for NEW Medicaid enrollees goes away under 1115, how do providers/"assisters" establish an effective date for start of coverage that aligns with start of care in the absence of enough information to be able to do full presumptive eligibility application on date of service?
• Such as:
  – Patient comes to ED after hours and is not medically stabilized to discuss financial situation until the following calendar day.
  – NICU baby in a Medicaid household (or whose condition makes it likely that they would be KCHIP-eligible) is admitted to our facility from an outlying hospital, but it could be days before the delivering mother is discharged and can travel to Louisville (or other household-knowledgeable relative is available) to meet with our staff to discuss. In theory this shouldn’t change from current in that the newborn is covered from DOB, if the mother is already a Medicaid-enrollee and completes the form indicating intent to add newborn to Medicaid. Hospitals would just like to make sure that portion is not being sunset and then hospitals need to know what to do in extenuating circumstances where the newborn is going to be the sole Medicaid-eligible recipient in the household, but PE cannot be completed on DOB.
• How can patients gain immediate coverage who would be new enrollees (not currently covered)? Is it accurate that after July 1, coverage would only be prospective once a patient is determined eligible and they have paid their premium – in other words, is there a grace period involved with getting coverage started? Can a hospital use presumptive eligibility to have a person determined eligible and also pay their premium in order to cover an emergency admission?
Non-Emergency Use Penalty

• How will Medicaid patients who present to the ER know if their condition will be considered covered by Medicaid prior to treatment? (so they do not get a My Rewards penalty). Will it be the responsibility of the ER/hospital to inform the patient prior to treatment that the condition is a non-emergency (ie., sore throat)?

• Are their circumstances that will assure no ED penalty is assessed – such as if the Medicaid enrollee first calls the MCO nurse hotline? Other?

Prisoners

• What happens if a Medicaid enrollee in KY Health gets incarcerated? Does that influence their eligibility reinstatement? How will it affect their community service requirement?
MCO Errors

- What type of MCO errors may occur and how are these going to be prevented or resolved? (i.e., concern is with data errors and MCO file not matching state file in real time).

SUD Pilot

- Is this still a pilot or statewide? If a pilot, what are the counties and does it apply to any provider treating a patient from those counties or just providers located in those counties?
- When will this be implemented?
- Will non-hospital IMDs (non-licensed facilities) have to meet any standards?
- Who is heading up the Substance Abuse Disorder program development? Can providers take an active role in this development?
KHA workgroup on implementation

Provider Training
• What is the timeline for training providers? (The Indiana waiver training program was excellent with options for 1 ½ hour in-person training or a webinar).

Additional Requirements
• Are there any other requirements on hospitals that we need to be aware of?
• In the original proposal, an Employer Sponsored Plan Wrap was mentioned as part of an individual’s Year 2 requirement. This element was not mentioned in the approval letter. Is this element still a part of KY HEALTH? If so, can someone elaborate on exactly how that will work?
KHA workgroup on implementation

KHA workgroup will be meeting with the Cabinet a couple of times per month working through the answers to the questions raised.

If you have additional questions email Nancy Galvagni

NGalvagni@kyha.com
# Medicaid Membership

<table>
<thead>
<tr>
<th>MCO</th>
<th>Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna</td>
<td>246,423</td>
</tr>
<tr>
<td>Anthem</td>
<td>116,146</td>
</tr>
<tr>
<td>Humana Care Source</td>
<td>137,915</td>
</tr>
<tr>
<td>Passport</td>
<td>300,601</td>
</tr>
<tr>
<td>Wellcare</td>
<td>437,238</td>
</tr>
<tr>
<td>FFS</td>
<td>150,392</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>05/01/17</th>
<th>Jul. '17</th>
<th>Oct. '17</th>
<th>Nov. '17</th>
<th>Dec. '17</th>
<th>Jan. '18</th>
<th>Feb. '18</th>
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<td>119,049</td>
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<td>303,810</td>
<td>306,314</td>
<td>308,267</td>
<td>307,726</td>
<td>308,740</td>
<td>310,977</td>
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<td>Wellcare</td>
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<td>438,293</td>
<td>439,116</td>
<td>440,153</td>
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<td>446,226</td>
<td>447,972</td>
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<td>FFS</td>
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<td>154,278</td>
<td>143,254</td>
<td>152,648</td>
<td>155,564</td>
<td>145,913</td>
<td>145,718</td>
</tr>
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</table>

|                | 1,388,715 | 1,400,608 | 1,394,756 | 1,409,256 | 1,411,465 | 1,399,633 | 1,405,818 |
MCO Update

• All five MCOs received **6 month contract extension** (Jan 1, 2018 – June 30, 2018).
  – **IMD Waiver** in new contract
• Working on another 6 months extension now
• Unclear if/when RFP will be issued but several companies in KY forming networks
• KHA Tracking **MCO Issues Resolution**
  – KHA Monthly Member MCO Calls
• **MCO Performance Report for 2017** updated by April 1 (2016 report currently available on KHA website)
MCO Issues Lists

Cumulative Days of Issues Outstanding
(Lower is Better)
(As of 2/16/18)

Number of Issues Outstanding
(Lower is Better)
(As of 2/16/18)
MCO Issues Lists

Rate of Issue Days per 10,000 Members (Lower is Better) (As of 2/16/18)

- Aetna
- Anthem
- Humana Care Source
- Passport
- Wellcare

Trend in Rate of Issue Days per 10,000 Members (Lower is Better) (As of 2/15/18)

- Aetna
- Anthem
- Humana Care Source
- Passport
- Wellcare
2016 MCO scorecard

# 2016 MCO Scorecard

MLR: 85% SFY 2016, 90% SFY 2017

## Table 1: MCO Medical Loss Ratio

DMS Contract Requires 90%

Kentucky Medicaid MCO Medical Loss Ratios and Profits - as of December 31, 2016

<table>
<thead>
<tr>
<th>Annual 2016 DOI STATEMENT</th>
<th>Aetna Better Health</th>
<th>Anthem MCO</th>
<th>Humana</th>
<th>Passport</th>
<th>Wellcare</th>
<th>Total All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid - Kentucky</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Revenue, Medicaid</td>
<td>$1,062,881,977</td>
<td>$583,157,263</td>
<td>$294,289,038</td>
<td>$1,730,097,322</td>
<td>$2,590,509,181</td>
<td>$6,260,934,781</td>
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<td>Total Hospital and Medical Expenses Medicaid</td>
<td>$803,276,717</td>
<td>$493,174,663</td>
<td>$280,167,162</td>
<td>$1,644,681,907</td>
<td>$2,253,369,566</td>
<td>$5,474,670,015</td>
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<tr>
<td>Increase in Reserves for Accident and Health Contracts</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(1,280,459)</td>
<td>-</td>
<td>(1,280,459)</td>
</tr>
<tr>
<td>Medical Loss Ratio</td>
<td>76%</td>
<td>85%</td>
<td>95%</td>
<td>95%</td>
<td>87%</td>
<td>87%</td>
</tr>
</tbody>
</table>

| Claim Adjustment Expenses                 | $25,774,574         | $27,336,548| $20,522,283 | $1,237,383 | $30,192,146 | $105,062,934 |
| General Administrative Expenses           | $70,380,388         | $31,935,162| $22,734,406 | $164,749,524 | $236,046,288 | $525,845,768 |
| Administrative Loss Ratio                 | 9.0%                | 10.2%      | 14.7%   | 9.6%      | 10.3%     | 10.1%      |

| Net Underwriting Gain or (Loss): Medicaid | $163,450,298         | $30,710,890| -$29,134,813| -$79,291,033| $70,901,181 | $156,636,523 |
| Underwriting Ratio (Profit)               | 15%                 | 5%         | -10%    | -5%       | 3%        | 3%         |

| Excess Profit (Actual -Profit at 2.6%)    | $135,815,367         | $15,548,801|          |          | $3,547,942  | $154,912,110 |

Source: 2015 Annual Statement, pg. 7., Milliman definitions of MLR, Administrative Loss Ratio and Underwriting Ratio

# 2016 MCO Scorecard

## 2017 Guide to Choosing a Medicaid Health Plan

### PREVENTIVE CARE

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Childhood Immunizations</th>
<th>Well-Child Visits in the First 15 Months of Life</th>
<th>Well-Child Visits Ages 3 to 6</th>
<th>Diabetes Testing HbA1c</th>
<th>Tobacco Use Cessation</th>
<th>Cervical Screening</th>
<th>Prenatal Care</th>
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<tbody>
<tr>
<td>Aetna Better Health of Kentucky</td>
<td>★★</td>
<td>★★</td>
<td>★★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★★</td>
</tr>
<tr>
<td>Anthem BCBS Medicaid</td>
<td>★</td>
<td>★★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★★</td>
</tr>
<tr>
<td>Humana - CareSource</td>
<td>★</td>
<td>★</td>
<td>★★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★★</td>
</tr>
<tr>
<td>Passport Health Plan</td>
<td>★★★★</td>
<td>★★★</td>
<td>★★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★★</td>
</tr>
<tr>
<td>WellCare of Kentucky</td>
<td>★★</td>
<td>★★★</td>
<td>★★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★★</td>
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### GETTING HELP WHEN NEEDED

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Getting Child Care Quickly</th>
<th>Child Customer Service</th>
<th>Parent Overall Satisfaction with Child’s Health Plan</th>
<th>21 and Under Dental Visits</th>
<th>Getting Adult Care Quickly</th>
<th>Adult Customer Service</th>
<th>Adult Overall Satisfaction with Health Plan</th>
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</thead>
<tbody>
<tr>
<td>Aetna Better Health of Kentucky</td>
<td>★★★★</td>
<td>★</td>
<td>★★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
</tr>
<tr>
<td>Anthem BCBS Medicaid</td>
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<tr>
<td>Humana - CareSource</td>
<td>★★★★</td>
<td>★</td>
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<tr>
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<td>★★★★</td>
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<td>★</td>
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<td>★</td>
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<td>★</td>
</tr>
</tbody>
</table>

*Source: DMS*

2016 MCO Scorecard

Table 2: Medicaid Prior Authorization Denials by Medicaid MCO
(excludes pharmacy)

<table>
<thead>
<tr>
<th>MCO</th>
<th>SFY 2014</th>
<th>SFY 2015</th>
<th>SFY 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coventry/Aetna</td>
<td>13.30%</td>
<td>13.74%</td>
<td>15.22%</td>
</tr>
<tr>
<td>WellCare</td>
<td>11.92%</td>
<td>14.89%</td>
<td>16.28%</td>
</tr>
<tr>
<td>Humana</td>
<td>14.90%</td>
<td>16.72%</td>
<td>14.95%</td>
</tr>
<tr>
<td>Anthem</td>
<td>9.22%</td>
<td>10.17%</td>
<td>10.72%</td>
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<tr>
<td>Passport</td>
<td>8.72%</td>
<td>8.26%</td>
<td>10.13%</td>
</tr>
<tr>
<td>AVG ALL</td>
<td>11.86%</td>
<td>12.88%</td>
<td>13.94%</td>
</tr>
</tbody>
</table>

Source: MCO Dashboard Reports, DMS

2016 MCO scorecard

### Payment of Hospital Claims by MCOs
#### Clean Claims Paid Promptly in 30 Days (Paid and not denied)

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Coventry/Aetna</td>
<td>84.36%</td>
<td>88.36%</td>
<td>88.39%</td>
<td>87.87%</td>
<td>87.96%</td>
<td>86.34%</td>
<td>68.58%</td>
<td>79.67%</td>
<td>83.60%</td>
</tr>
<tr>
<td>Anthem</td>
<td>85.48%</td>
<td>81.42%</td>
<td>81.76%</td>
<td>79.33%</td>
<td>77.68%</td>
<td>78.58%</td>
<td>80.36%</td>
<td>75.06%</td>
<td>74.25%</td>
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<tr>
<td>Humana Care Source</td>
<td>67.70%</td>
<td>64.18%</td>
<td>83.63%</td>
<td>81.73%</td>
<td>77.64%</td>
<td>84.74%</td>
<td>76.60%</td>
<td>87.67%</td>
<td>94.90%</td>
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<tr>
<td>Passport</td>
<td>92.74%</td>
<td>84.01%</td>
<td>89.31%</td>
<td>76.61%</td>
<td>94.02%</td>
<td>94.10%</td>
<td>93.55%</td>
<td>93.12%</td>
<td>93.12%</td>
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<tr>
<td>Wellcare</td>
<td>87.30%</td>
<td>No Report</td>
<td>87.51%</td>
<td>89.26%</td>
<td>89.78%</td>
<td>89.14%</td>
<td>90.49%</td>
<td>91.05%</td>
<td>90.98%</td>
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</table>

### Percent of Dollars Owed to Hospitals Paid Promptly in 30 Days (90% Required)

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<th></th>
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</thead>
<tbody>
<tr>
<td>Coventry/Aetna</td>
<td>96.88%</td>
<td>96.53%</td>
<td>97.46%</td>
<td>94.33%</td>
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<td>96.59%</td>
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<td>96.21%</td>
<td>99.31%</td>
<td>99.42%</td>
<td>97.26%</td>
<td>99.66%</td>
<td>98.64%</td>
<td>98.80%</td>
</tr>
<tr>
<td>Humana Care Source</td>
<td>70.23%</td>
<td>69.55%</td>
<td>82.78%</td>
<td>86.51%</td>
<td>85.08%</td>
<td>82.66%</td>
<td>78.54%</td>
<td>90.70%</td>
<td>98.94%</td>
</tr>
<tr>
<td>Passport</td>
<td>99.08%</td>
<td>89.24%</td>
<td>90.70%</td>
<td>77.38%</td>
<td>97.14%</td>
<td>91.19%</td>
<td>98.92%</td>
<td>99.92%</td>
<td>99.92%</td>
</tr>
<tr>
<td>Wellcare</td>
<td>93.05%</td>
<td>No Report</td>
<td>94.53%</td>
<td>96.11%</td>
<td>97.49%</td>
<td>88.83%</td>
<td>94.63%</td>
<td>97.12%</td>
<td>95.95%</td>
</tr>
</tbody>
</table>

DSH Distribution
Five Key Differences

• Source of Data
• Allocation from University Pool
• Essential Hospitals
• Potential Penalties
• Payments and Final Settlements
Source of Data

- Prior to 2013 it was based upon Uninsured Shortfall based upon KHCP applications
- Since 2013, percentages frozen at 2012 levels
- Future payments based on Total Uncompensated Costs:
  - Uninsured/Charity costs
  - Medicaid Shortfall
- Using current CMS rules - pending lawsuit
PROPOSED MODEL

Pools

• **Retain Three Pools:**
  – **University Pool** - set at 37% of allotment (Current), except that initial and final DSH payment is determined based on uncompensated costs reported on teaching hospital DSH Audit Surveys with an allotment of 100% of uncompensated costs (resulting in a net of 70% coverage due to the IGT match)
  
  – **Psychiatric Pool** – 19% of allotment (Current)
  
  – **Acute Pool:**
    
    State allotment
    - Psych Pool %
    - **University Pool Payment**
    Acute Care Pool
PROPOSED MODEL

Distributions

• Prior Distribution:
  ➢ Pools distributed per allocation percentages, i.e., Universities received full pool allocation

• Proposed Distribution:
  ➢ Pools distributed based upon most recent DSH surveys (including transfers from University Pool if so indicated)
Status of “Cross-over” Lawsuit

- March 8, 2018: The U.S. District Court for the District of Columbia voided the CMS rule in its entirety regarding how third-party payments, such as private insurance or Medicare, are treated for purposes of calculating the hospital-specific limitation on Medicaid disproportionate share hospital payments.
- Don’t know if it will be appealed.
Status of “Cross-over” Lawsuit

Impact:

• Hospitals with current indications of payback vs. original DSH distribution will likely see a reduction in required repayments.

• Funds won’t be transferred from University Pool to Acute Pool
ESSENTIAL HOSPITALS

• KHA’s Model defines “Essential Hospitals”:
  – **Subset of Acute Care Pool**
  – **MIUR** – hospitals with a Medicaid utilization rate greater than 1 standard deviation above the mean for acute care hospitals
    • Excludes pediatric teaching hospital days due to IOA
    • Will vary each year, based on DSH Audit Survey
  – **LIUR** – hospitals whose percentages of inpatient charity charges + Medicaid net patient revenue to total net patient revenue are 120% of the statewide average for all hospitals
    • Will vary each year, based on DSH Audit Survey
  – **Critical Access Hospitals**
  – Based on the 2015 DSH audit data
    • **Model contains 44 Essential Hospitals**
  – Pro-rata share of 200% of Uncompensated Care
POTENTIAL PENALTIES

• Having current data is critical in the new process.  
  – Extensions shall be limited to rare circumstances  
  – Extension requests shall be received at least ten (10) days prior to the deadline  
  – Extensions shall be granted for no more than thirty (30) calendar days from the original due date 
• If DSH surveys are late:  
  – No initial payment  
  – Final payment reduced by 20%
PAYMENTS

• Currently get 90% in November and 10% in September

• Proposal: There will be an initial payment (based on submitted DSH Audit Surveys) which is later reconciled to a final payment (4+ years after initial payment) using audited survey data
Status of Legislation

• HB 289 passed by the House
  – Floor amendment defeated
• Senate passed it on 3/21/18
• Pending Governor’s signature
• 2015 DSH surveys used for 2018 payment
• Myers and Stauffer working on:
  – DSH payment tool
  – Provider training
ACA Cuts Delayed
Future Impact of ACA Cuts
(Represents a 75% cut)

DSH funding of $225.6 million is **not** adequate to cover the total Uncompensated Care and will get worse as the federally mandated ACA cuts come into play.

<table>
<thead>
<tr>
<th>FFY</th>
<th>Federal Match</th>
<th>KY Match</th>
<th>Total Spend</th>
<th>% of FFY '17</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>$159,159,603</td>
<td>$66,503,209</td>
<td>$225,662,812</td>
<td>82%</td>
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<tr>
<td>2018</td>
<td>$129,153,294</td>
<td>$55,351,412</td>
<td>$184,504,706</td>
<td>73%</td>
</tr>
<tr>
<td>2019</td>
<td>$114,599,423</td>
<td>$49,114,039</td>
<td>$163,713,462</td>
<td>63%</td>
</tr>
<tr>
<td>2020</td>
<td>$100,046,986</td>
<td>$42,877,280</td>
<td>$142,924,266</td>
<td>54%</td>
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<tr>
<td>2021</td>
<td>$ 85,495,986</td>
<td>$36,641,137</td>
<td>$122,137,122</td>
<td>54%</td>
</tr>
<tr>
<td>2022</td>
<td>$ 70,946,427</td>
<td>$30,405,612</td>
<td>$101,352,038</td>
<td>45%</td>
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<tr>
<td>2023</td>
<td>$ 56,398,314</td>
<td>$24,170,706</td>
<td>$ 80,569,020</td>
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<tr>
<td>2024</td>
<td>$ 41,851,651</td>
<td>$17,936,422</td>
<td>$ 59,788,073</td>
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<td>2025</td>
<td>$ 42,337,963</td>
<td>$18,144,841</td>
<td>$ 60,482,804</td>
<td>27%</td>
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</table>

Uncompensated Care was $333 million in ‘15

- Medicaid Shortfall: $265,389,279
- Charity Care: $67,713,091
- Total Uncompensated: $333,102,360

Some states are compensating for the cuts.
## Future Impact of ACA Cuts

<table>
<thead>
<tr>
<th>SFY</th>
<th>CYE</th>
<th>Original Proposal - National Cut</th>
<th>CHIP Bill - National Cut</th>
<th>% Cut vs 2017</th>
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<tr>
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<td>2017</td>
<td>2,000,000,000</td>
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<tr>
<td>2019</td>
<td>2018</td>
<td>3,000,000,000</td>
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<tr>
<td>2020</td>
<td>2019</td>
<td>4,000,000,000</td>
<td>8,000,000,000</td>
<td>74%</td>
</tr>
<tr>
<td>2021</td>
<td>2020</td>
<td>5,000,000,000</td>
<td>8,000,000,000</td>
<td>74%</td>
</tr>
<tr>
<td>2022</td>
<td>2021</td>
<td>6,000,000,000</td>
<td>8,000,000,000</td>
<td>74%</td>
</tr>
<tr>
<td>2023</td>
<td>2022</td>
<td>7,000,000,000</td>
<td>8,000,000,000</td>
<td>74%</td>
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<tr>
<td>2024</td>
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<tr>
<td>2025</td>
<td>2024</td>
<td>8,000,000,000</td>
<td>8,000,000,000</td>
<td>73%</td>
</tr>
</tbody>
</table>

Cabinet will include additional funds in September distribution.
Kentucky Legislative Update
The Kentucky General Assembly has completed 55 of its 60 legislative days and are returning on Tuesday and Wednesday, March 27 and 28 to continue to pass legislation. When they recess on Thursday to allow the Governor to act on legislation that has passed the General Assembly, they are scheduled to be in recess until they return on April 12-13 to override vetoes by the Governor. While this Tuesday and Wednesday were originally scheduled to be days to only concur on amendments that were added by the other house, they continue to pass legislation.

**Action Requested: We NEED YOUR IMMEDIATE ACTION ON SB 112 – Telehealth**

There are several bills that impact hospitals that we still before the legislature and we ask that you contact your Senator and House of Representative member at home today and in Frankfort at **502 564-8100** with the following requests. Legislators need to get as many calls as possible! Please ask your staff to make calls as well.
KHA Alert

Telehealth Legislation

**SB 112** (Alvarado) requires the CHFS to regulate telehealth; set requirements for delivery of services to Medicaid recipients; require payment parity in reimbursement, the same as in a face to face encounter; require health benefit plan coverage to same extent as through provided in person; and require any fully insured health benefit plans or self-insured plans issued or renewed after July 1, 2019, to public employees to comply with the requirements. SB 112 is scheduled to be voted on the House floor on Tuesday. *Position – Support SB 112 with NO amendments.*

Please contact your House member and ask that they Support SB 112 with no amendments. KHA Opposes **HFA2** (Gooch) that removes payment parity language for commercial insurers. This would allow insurers to pay a lesser amount than the same payment as for a face to face encounter. HFA 2 is being pushed by the health insurers.

Hospitals incur the same costs as the costs to provide care for Telehealth services as face to face encounters – the same bricks and mortar, costs of equipment, the same staff and the same or increased liability costs.
Health Care Transparency

**SB 154** (Alvarado) – Health Care Transparency — Would require all health insurers to develop an incentive program that is designed to steer patients to the cheapest provider for every service, except for emergency care. Insurers would be required to pay an enrollee 50% of the difference between the insurer’s allowed amount and the provider’s charge, which is likely to direct patients away from hospitals. KHA is unaware of any state that has passed legislation as comprehensive as this. *Position* – Oppose

**SB 154 is awaiting a vote on the Senate floor. Please contact your Senator and House member and ask to oppose SB 154.**
KHA Alert

**PIP Legislation**

**SB 121** (Girdler) – Moves auto insurance medical expenses charges for health facilities and licensed practitioners to the worker’s comp fee schedule. SB 121 passed the Senate with an amendment to pay hospitals 80% of UCR.

We understand that there will be an attempt to amend SB 121 onto a House bill that is awaiting action in the Senate. There was a proposed amendment in the House that was never presented to exempt hospitals from the provisions of SB 121. Since we do not know what version of the bill will be offered, we do not know what impact there would be for hospitals. **Please ask your Senator and House member to oppose SB 121 unless it exempts hospitals from the provisions of the bill.**
How to contact legislators

http://www.lrc.ky.gov/home.htm
How to contact legislators

http://www.lrc.ky.gov/Find%20Your%20Legislator/Find%20Your%20Legislator.html
Email Your Legislators

http://www.lrc.ky.gov/whoswho/email.htm

Kentucky Legislature

Legislator E-mail Addresses

- Your legislators appreciate your input. To better serve you, they ask that you include your name, home address, and e-mail address in your message.
- You can send e-mail to the Legislative In-box, where it is sorted by staff and directed to any legislators indicated in the message.
- If you are requesting information, please include a voice phone number and postage mailing address.

<table>
<thead>
<tr>
<th>SENATE</th>
<th>HOUSE</th>
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</thead>
<tbody>
<tr>
<td>INDEX of NAMES</td>
<td>INDEX of NAMES</td>
</tr>
<tr>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>click here</td>
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<tr>
<td>B</td>
<td></td>
</tr>
<tr>
<td>Sen. Joe Bowen (8)</td>
<td>Rep. Linda Belcher (49)</td>
</tr>
<tr>
<td>click here</td>
<td>Linda <a href="mailto:Belcher@lrc.ky.gov">Belcher@lrc.ky.gov</a></td>
</tr>
</tbody>
</table>
We (Nancy, Sarah, Claire) read through a lot draft legislation
• I’m just glad my granddaughter also finds them to be interesting.
Key Bills Influenced by KHA

- HB 69 – Credentialing, Medical Necessity Criteria
- SB 121 – Auto Insurance (amending to exempt hospitals)
- SB 154 – Transparency (charge posting, financial incentive to direct insured to lowest priced provider – interim study anticipated)
- SB 112 – Telehealth (in House, issue is payment parity)
- SB 236 – Surprise Billing (interim study)
- SB 5 – Pharmacy Carve Out ($36M state cost; 340B exemption) – now a pharmaceutical transparency bill (MCO data reporting) and allows DMS to set rates
- HB 200 – State Budget (DSH fully funded; bundled denials)
- HB 4 – Peer Review (signed by Governor)
- HB 444 – Streamline CON (contains KHA amendments)
Kentucky Health Cooperative
Kentucky Health Cooperative
(Original)

- Estimated Liabilities $105 million
- Estimated Assets $ 41 million
- Billing for patient balances on EOB’s
- Order on Claims < $1,000 – write-off
  - List of claims were to be distributed March 2017
    - Filed before October 14, 2016
    - For which the claim amount was $1,000 or <
    - Had not been adjudicated prior to 12/28/16
- Litigation
  - Federal Government liable for funding Risk Corridor Payments
  - ACA’s reinsurance program
  - Suit filed vs former top management and contractors
• **Federal Litigation:** Settlement has been reached in the separate action filed by the KYHC Liquidator against the Federal Government which sought payments under the ACA’s reinsurance program. On March 7, 2018, Judgment was entered in favor of KYHC and the Liquidator in the amount of $16,200,000. The timing and amount of payment, if any, on the settlement is currently unknown and dependent upon an appropriation from Congress or the outcome of other pending litigation making its way to the U.S. Supreme Court.

• **Third Party Litigation:** The Liquidator’s action against KYHC’s former top management is proceeding in Franklin Circuit Court. The separate actions in US District Court against KYHC former contractors are pending as the parties litigate procedural issues regarding the proper form and venue for the disputes. As previously reported, the Liquidator is hopeful for a substantial recovery of damages based on information learned surrounding the co-op’s failure.
Questions?

Thank You and may God bless America!

Carl Herde – cherde@kyha.com