Report of the Commission on Financing Health Care for the Medically Indigent

Research Report No. 223
Legislative Research Commission
Frankfort, Kentucky

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Report of the Commission on Financing Health Care for the Medically Indigent

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FOREWORD

The 1984 Senate Concurrent Resolution 6 directed the Legislative Research Commission to conduct a study of the financing of health care for the medically indigent in Kentucky. Over the course of thirteen meetings within a sixteen-month period, the Commission on Financing Health Care for the Medically Indigent studied the existing system in Kentucky, as well as other states, for delivering health care and accepted testimony on suggested improvements to Kentucky's health care delivery system. This report summarizes their findings, including forty-six recommendations for action adopted by the Commission.

This report was prepared through the combined efforts of the members of the Health and Welfare Committee staff. The assistance of the many persons and organizations which provided testimony and data toward the preparation of this report is gratefully acknowleged.

Vic Hellard, Jr.
Director

The Capitol
Frankfort, Kentucky
April, 1987

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SUMMARY

PURPOSE OF COMMISSION

The 1984 Kentucky General Assembly enacted Senate Concurrent Resolution 6 (SCR-6) directing the Legislative Research Commission (LRC) to conduct a study of the financing of health care for the medically indigent. The Commission on Financing Health Care for the Medically Indigent was appointed by the LRC to oversee the study.

SCR-6 indicated the need for study due to the following factors:

- An estimated 15% of Kentuckians are without adequate health insurance.
- Curtailment of Medicaid and Medicare payment policies has resulted in increasing levels of uncompensated care.
- Access to health care has been reduced by Medicaid eligibility restrictions.
- There are a number of uncoordinated state programs to address the problem of indigent care.
- Legislation to purchase health insurance for the unemployed has been proposed in the Congress and should be monitored.
- There is a need for members of the General Assembly to obtain data on the extent and seriousness of the problem and to assess whether current state appropriations are being expended in a cost-effective manner.

The Commission on Financing Health Care for the Medically Indigent was authorized to analyze data on the number of persons uninsured or under-insured for health expenses; eligibility restrictions in the Medicaid program; uncompensated care provided by hospitals, physicians and other health care providers; and to develop a service listing of programs and services currently available to medically indigent persons. The Commission was composed of one Senate member from the Health and Welfare Committee, one House of Representatives member from the Health and Welfare Committee, and one nominee each by the following bodies: the Kentucky Legal Services Corporation, the Cabinet for Human Resources, the Council on Higher Education, the Kentucky Primary Care Association, the Kentucky Medical Association, and the Kentucky Hospital Association. The Commission was directed to report its findings to the Interim Joint Committee on Health and Welfare and the Legislative Research Commission.

OBJECTIVES

The Commission met 13 times during a 16-month period. The final meeting was held on December 17, 1985. Because of the scope of the study and the limited time-frame

for completion, the Commission adopted a formal work plan with specified evaluation objectives, questions and tasks. The study objectives were as follows:

Objective 1: To evaluate the studies of indigent care commissions in other states and indigent care programs currently in existence in other states.

Objective 2: To define "medically indigent" and determine the number and characteristics of the uninsured and under-insured population in Kentucky.

Objective 3: To delineate and assess available services and service gaps to medically indigent persons in Kentucky.

Objective 4: To delineate and assess various private, state and local options for addressing the financing of health care for the medically indigent.

Objective 5: To develop final recommendations for the Interim Joint Committee on Health and Welfare and the Legislative Research Commission on financing health care for medically indigent persons.

PRINCIPLES AND ASSUMPTIONS

The Commission on Financing Health Care for the Medically Indigent adopted the following statements which it believes should serve as a basis for government and private decision-making in addressing the problem of indigent care:

1. Health care services are necessary to sustain human life and health status and should not be explicitly or implicitly denied due to an inability to pay for needed health care. The Commonwealth commits itself to insuring reasonable and fair access to basic health care services for its citizens.

2. Reasonable and fair access to health care services means:

   a. Access to an adequate quality of care, as measured by objective outcome criteria; and

   b. Access to an adequate amount of health care, balancing the potential benefits in relation to the cost; and

   c. Geographic access to services within acceptable travel times, depending on the level of service to be provided; and

   d. Access to health care information to make informed choices; and

   e. Financial access to health care services based on a family's ability to pay.

3. The lack of an effective system and decreased funding for services can be expected to lead to increased medical indigency in the population. However, these changes offer the opportunity for creative intervention and reform.

4. The current system of delivering health care to the medically indigent is disorganized and encourages inefficient forms of care. Targeted funding, uniform screening, case management, risk-sharing, utilization controls and incentives for physicians, hospitals and other providers to provide cost-effective medicine are needed to maximize the available dollars.

5. Preventive and primary care services and increased personal responsibility for one's own health are essential to insure a cost-effective health care delivery system for medically indigent persons.

6. Insuring that health care for the medically indigent is available and providing for adequate funding is ultimately the responsibility of government at the federal, state and local levels. This responsibility can be met through government programs, public/private sector relationships, support of voluntary programs and regulatory or statutory mandates.

7. Assuring reasonable and fair access to health care services for medically indigent persons is an attainable objective, given judicious use of resources and a pluralistic, cooperative effort among policymakers, government officials, payors and providers of health care services.

RECOMMENDATIONS

At the conclusion of its deliberations, consisting of a series of 13 meetings to receive testimony concerning indigent care in Kentucky, the Commission adopted the following recommendations for action:

Legislative Branch:

1. The Kentucky General Assembly should require counties to make available adequate prenatal care services as a condition of state funding for local health services.

2. The Kentucky General Assembly should ratify Executive Order 84-1079 centralizing the administration and management of the Commission on Handicapped Children.

3. The Kentucky General Assembly should enact legislation to require continuous open enrollment by private health insurers for recently unemployed, married or divorced spouses and dependents.

4. The Kentucky General Assembly should enact legislation to require nonprofit health insurance companies, group health insurers, self-insured employee group health plans and health maintenance organizations to offer coverage from the first day of employment and without waiting periods of pre-existing conditions.

5. The Kentucky General Assembly should enact legislation to require employers offering health insurance coverage to employees to also offer dependent coverage to employees at group rates.

6. The Kentucky General Assembly should enact legislation to require nonprofit health insurance companies, individual health insurers, group health insurers, self-insured employee group health plans and health maintenance organizations to offer dependent coverage at group rates up to age 24 (instead of age 21), if the child is chiefly dependent upon the policyholder.

7. The Kentucky General Assembly should enact legislation to require nonprofit health insurance companies, group health insurers, self-insured

employee group health plans and health maintenance organizations to expand the duration of continuation coverage for terminated employees, divorced spouses, widowed spouses and dependents from 9 months to 2 years at the group rate.

8. The Kentucky General Assembly should enact legislation to require non-profit health insurance companies, group health insurers, self-insured employee group health plans and health maintenance organizations to expand minimum benefits in conversion policies by: (1) raising minimum dollar amounts on coverage; (b) expanding minimum services to include physician services if covered in the previous group plan; and (c) requiring coverage of pregnancy, childbirth and miscarriage (which are now specifically excluded).

9. The Kentucky General Assembly should enact legislation to specify responsibilities for notifying former employees of continuation and conversion privileges, and require that separate notice be given to former employees in plain language.

10. The Kentucky General Assembly should enact legislation to permit victims of malpractice to voluntarily submit claims to arbitration panels in lieu of a jury trial. The decision of the panel would be binding on both parties.

11. The Kentucky General Assembly should enact legislation to abolish the contingent fee system as a method of paying attorney's fees in malpractice cases and provide for a sliding fee scale system instead. For example, an attorney might be entitled to 30% of the first $100,000 of an award, 25% of the next $100,000 and 20% of the balance.

12. The Kentucky General Assembly should enact legislation to require a party to a malpractice suit to pay the other party's legal fees if it is found the party acted frivolously in filing suit.

13. The Kentucky General Assembly should enact legislation to establish statutory qualifications for expert medical witnesses in malpractice actions.

14. The Kentucky General Assembly should enact legislation to allow structured settlements in malpractice cases whereby damages are paid in installments throughout the plaintiff's lifetime.

15. The Kentucky General Assembly should enact legislation to require all malpractice claims to be reviewed by a pre-trial screening panel to review the merits of the case and to encourage a settlement before the action may be tried in court.

16. The Kentucky General Assembly should enact legislation to establish a statutory legal standard of medical care to be applied in all malpractice cases.

17. The Kentucky General Assembly should enact legislation to re-establish the Patients' Compensation Fund (KRS Chapter 304) and address the constitutional problems cited in the 1977 Kentucky Supreme Court decision which ruled it unconstitutional.

18. The Kentucky General Assembly should enact legislation to limit the size of malpractice awards.

19. The Kentucky General Assembly should enact legislation to amend the collateral source rule of evidence to allow evidence in a medical malpractice case that the plaintiff has received compensation from other sources (such as health insurance) and require the amount of collateral payment to be deducted from any malpractice award.

Executive Branch:

20. The Department of Insurance should evaluate available coverage under Medicare supplemental insurance policies and insure that rate increases of regulated insurers are justified by claims experience.

21. The Cabinet for Human Resources should consider the implementation of a state-funded program to pay for services not covered by Medicare, such as eyeglasses, dentures, and prescription drugs.

22. The Cabinet for Human Resources should monitor and assure compliance with Hill-Burton requirements as a condition of licensure.

23. State funded indigent care programs (such as Medicaid and programs through the local health department) should assess whether veterans' programs are available to their clients and make referrals if appropriate.

24. A single health care authority should be appointed to administer health care programs for the medically indigent (including Medicaid, maternal and child health, public health departments, primary care centers, state funding of university hospitals and other programs), as well as administering the health insurance contract for state employees, teachers and retirees.

25. The Cabinet for Human Resources should expand eligibility under the Medicaid program to include all low income children in two-parent families under age 18 (or 19 if in school).

26. The Cabinet for Human Resources should implement Medicaid utilization and cost controls including pre-admission screening for admissions to long-term care facilities, homestead liens, and transfer of assets provisions. Both over-utilization and under-utilization should be considered.

27. The Cabinet for Human Resources should implement a program of case management with physician risk-sharing in the Medicaid program to coordinate services and maximize available dollars.

28. The Cabinet for Human Resources should increase state funding for prenatal enough that every pregnant woman in Kentucky has access to the full range of prenatal care services, and add outreach, public advertising and transportation components to the program if possible.

29. The Cabinet for Human Resources should increase the scope of services and reimbursement under the Medicaid program to fully cover obstetrical, prenatal and delivery services, in order to maximize the use of state maternal and child health dollars.

30. The Cabinet for Human Resources should identify areas within the Commission on Handicapped Children, Medicaid and Maternal and Child Health

programs where services are duplicated or are lacking and establish a protocol which will assure that services are provided in the most cost-effective manner possible through a coordinated approach to the allocation of services and payment for those services.

31. The Cabinet for Human Resources should conduct an evaluation of the Commission on Handicapped Children under centralized administration and management, to determine the effects of this action on service delivery, client satisfaction and the cost of providing services.

32. The Cabinet for Human Resources should expand its technical assistance and grantsmanship assistance program to increase the availability of primary care center services in health manpower shortage areas by increasing the number of centers and/or increasing the number of satellite centers, in order to maximize the availability of federal indigent care dollars.

33. The Cabinet for Human Resources should establish a statewide program of subsidized inpatient and outpatient hospital care utilizing community hospitals meeting specific participation criteria, including:

    - A minimum percentage of gross revenue expended on charity care;
    - A minimum percentage of patients who are Medicaid recipients; and
    - An open door policy for charity care patients and/or advertising regarding the willingness of the hospital to admit charity patients.

34. The Cabinet for Human Resources should establish a uniform definition of charity care and develop and require a system of uniform hospital reporting and accounting of charity care expenditures as a condition for licensure.

35. The Cabinet for Human Resources should encourage the development of primary care center services provided in health departments through the provision of financial incentives, technical assistance and coordination of existing state programs.

36. The Cabinet for Human Resources should be encouraged to continue its support of the Kentucky Physicians Care Program by assisting with data collection and analysis and, furthermore, it should periodically inform the Legislative Research Commission as to any research findings.

Private Sector:

37. The Kentucky Hospital Association should encourage provider referrals of the indigent to facilities with an unfulfilled Hill-Burton obligation and publicize the fact of the obligation.

38. The Kentucky Medical Association should be commended for establishing the Kentucky Physicians Care Program and for its decision to continue the program for its second year.

39. The Kentucky Medical Association should be urged to act to encourage increased physician participation in the Kentucky Medical Assistance Program, thereby increasing access to health care by the low income poor.

40. The Kentucky Medical Association should be encouraged to raise the income eligibility limit of the Kentucky Physicians Care Program from 100% to 150% of the federal poverty level.

41. Group-rated insurance pools should be created to make affordable health insurance available to the unemployed and uninsured population.

42. Hospitals which are participating in the Fair Share Program should be encouraged to continue participation and hospitals which are not participating should be encouraged to begin participation.

Other Recommendations:

43. The United States Congress should take steps to insure the solvency of the Medicare Trust Fund.

44. The Veterans Administration should expand outreach efforts to publicize health care benefits to eligible veterans.

45. The Commission adopts the summary and recommendations of the Governor's Special Medicaid Program Review Advisory Committee.

46. The Commission adopts and recommends the following working definition of the term "medically indigent":

    (1) Any person with income not exceeding 100% of the federal poverty level as established by the Commmunity Services Administration ($5,250 per year), and who is not covered by Medicare or Medicaid or other government subsidy and who has no private health insurance coverage; or

    (2) Any person incurring medical expenses within a calendar year that exceed 50% of the person's pre-tax income for that year.

CHAPTER I

INTRODUCTION

A. Purpose and Authority of the Commission

The 1984 Kentucky General Assembly enacted Senate Concurrent Resolution 6 directing the Legislative Research Commission (LRC) to conduct a study of the financing of health care for the medically indigent. The Commission on Financing Health Care for the Medically Indigent was appointed by the LRC to oversee the study.

The problems identified in Senate Concurrent Resolution 6 indicating the need for such a study were as follows:

- An estimated 15% of Kentuckians are without adequate health insurance.
- Curtailment of Medicaid and Medicare payment policies has resulted in increasing levels of uncompensated care.
- Access to health care has been reduced by Medicaid eligibility restrictions.
- There are a number of uncoordinated state programs to address the problem of indigent care.
- Legislation to purchase health insurance for the unemployed has been proposed in the Congress and should be monitored.
- There is a need for members of the General Assembly to obtain data on the extent and seriousness of the problem and to assess whether current state appropriations are being expended in a cost-effective manner.

The Commission on Financing Health Care for the Medically Indigent was requested to collect and analyze data on: (1) the number of persons uninsured or underinsured for health expenses, (2) eligibility restrictions in the Medicaid program, (3) uncompensated care provided by hospitals, physicians and other health care providers, and, (4) to develop a service listing on programs and services currently available to medically indigent persons. At the conclusion of their deliberations, the Commission was instructed to report to the Interim Joint Committee on Health and Welfare and the Legislative Research Commission. This report is a summary of the Commission's findings and recommendations.

B. Study Methodology

The Commission met 13 times during a 16-month period. Because of the scope of the study and the limited time frame for completion, the Commission adopted a formal

work plan with specified evaluation objectives, questions and tasks. The study objectives were as follows:

Objective 1: To evaluate the studies of indigent care commissions in other states and indigent care programs currently in existence in other states.

Objective 2: To define "medically indigent" and determine the number and characteristics of the uninsured and underinsured population in Kentucky.

Objective 3: To delineate and assess available services and service gaps to medically indigent persons in Kentucky.

Objective 4: To delineate and assess various private, state and local options for addressing the financing of health care for the medically indigent.

Objective 5: To develop final recommendations for the Interim Joint Committee on Health and Welfare and the Legislative Research Commission on financing health care for medically indigent persons.

C. Data Collection and Testimony

What became evident in conducting the study was that critical research and data were lacking. As a result, the following data collection efforts were instituted:

(1) Approximately 20 states with recent indigent care commissions and studies were contacted to obtain their reports and final recommendations;

(2) Compilations of indigent care studies and programs in other states were obtained from the National Conference of State Legislatures, Intergovernmental Health Policy Project, National Governors' Association and other organizations;

(3) A search of the literature on indigent care was conducted through the University of Kentucky NASA-TAP program, the Council of State Governments, the Rand Corporation and several other health data bases;

(4) Two national conferences on indigent care provided descriptive and statistical information on indigent care programs and expenditures nationwide;

(5) The Department for Social Insurance, Cabinet for Human Resources, provided information on Medicaid eligibility and expenditures;

(6) The Department for Health Services, Cabinet for Human Resources, provided program descriptions, eligibility criteria and expenditures for state indigent care programs under their direction. A special data collection effort was conducted by the Division of Maternal and Child Health;

(7) The Kentucky Commission on Handicapped Children provided a program description, eligibility criteria and expenditure report;

(8) The Kentucky Department of Insurance provided data on the number of persons in Kentucky enrolled in commercial health insurance plans;

(9) The Kentucky Hospital Association conducted a survey of hospitals to determine current levels of uncompensated care;

(10) County expenditures for indigent care were obtained through the Department for Health Services, Cabinet for Human Resources; and

(11) The Kentucky Medical Association provided a study on the Kentucky Physicians Care Program conducted by the Urban Studies Center at the University of Louisville.

Written and oral testimony was received from a variety of interested individuals and organizations on the following topics:

(1) Other state programs serving the medically indigent;

(2) Other state studies of health care for the medically indigent;

(3) Alternative methodologies for defining and estimating the number of persons who are medically indigent;

(4) The Kentucky Medical Assistance Program (Medicaid) including eligibility requirements, services, reimbursement and financing mechanisms;

(5) The role of public health departments and primary care centers in serving medically indigent persons;

(6) The availability and funding of maternal and child health services in the Commonwealth;

(7) Voluntary private sector indigent care programs including the Kentucky Physicians Care program, the Hospital Fair Share program and philanthropic contributions;

(8) Uncompensated care in Kentucky hospitals;

(9) Changes in the health care environment, which may lead to increased levels of medical indigency, such as health maintenance organization development, reduced hospital occupancy and competition in the health insurance industry;

(10) Relative county, state and federal responsibilities for health care for the medically indigent.

(11) The provision of subsidized indigent care in university and university-affiliated pediatric hospitals; and

(12) Prefiled legislation relating to the provision and financing of health care for the medically indigent.

In August 1985, the Governor created a 36-member committee charged with the responsibility of developing long range recommendations on the future of the Kentucky Medical Assistance Program. In September, the Commission on Financing Health Care for the Medically Indigent requested an extension of the time for its activities from the Legislative Research Commission, in order to review the final report of the Governor's Special Medicaid Program Review Team, due to Secretary Austin by December 2, 1985. The extension was granted by the Legislative Research Commission.

D. Fundamental Principles and Assumptions

Any public policy relating to health care for the medically indigent must be based on broad agreement on fundamental principles and assumptions. Thus, the Commission on Financing Health Care for the Medically Indigent adopts the following statements to serve as a basis for government and private decision-making in addressing the problem of indigent care:

1. Health care services are necessary to sustain human life and a positive health status, and should not be explicitly or implicitly denied due to an inability to pay for needed health care. The Commonwealth commits itself to insuring reasonable and fair access to basic health care services for its citizens.

2. Reasonable and fair access to health care services means:

    a. Access to an adequate quality of care, as measured by objective outcome criteria; and

    b. Access to an adequate amount of health care, balancing the potential benefits in relation to the cost; and

    c. Geographic access to services within acceptable travel times, depending on the level of service to be provided; and

    d. Access to health care information on which to base informed choices; and

    e. Financial access to health care services based on a family's ability to pay.

3. The lack of an effective health care delivery system and decreased funding for health related services can be expected to lead to increased medical indigency in the population. However, these changes offer the opportunity for creative intervention and reform.

4. The current system of delivering health care to the medically indigent is disorganized, and encourages inefficient forms of care. Targeted funding, uniform screening, case management, risk-sharing, utilization controls and incentives for physicians, hospitals and other providers to provide cost-effective medicine are needed to maximize the available dollars.

5. Preventive and primary care services, and increased personal responsibility for one's own health are essential to insure a cost-effective health care delivery system for medically indigent persons.

6. Insuring that health care for the medically indigent is available and providing for adequate funding is ultimately the responsibility of government at the federal, state and local levels. This responsibility can be met through government programs, public/private sector cooperative efforts, support of voluntary programs and regulatory or statutory mandates.

7. Assuring reasonable and fair access to health care services for medically indigent persons is an attainable objective, given judicious use of resources and a pluralistic, cooperative effort among policymakers, government officials, payors and providers of health care services.

CHAPTER II

THE PROBLEM OF MEDICAL INDIGENCY

A. Why is Medical Indigency a Problem?

Scenarios. There are flaws in our system of financing and delivering health care to the medically indigent which have serious ramifications for people seeking care, government agencies, taxpayers and providers of health care services. The Scenarios in Appendix B illustrate existing problems:

- Families without access to health insurance at group rates, or who cannot afford the cost of continuation coverage if the head of household becomes unemployed;
- Individuals who forego preventive health care (such as prenatal services) because of the immediate out-of-pocket expense, resulting in high cost catastrophic care (such as neonatal services);
- Persons with chronic conditions who cannot obtain health insurance or whose insurance is limited by pre-existing conditions provisions;
- Older people who cannot become eligible for Medicaid unless they are institutionalized, even though in-home services would be a less costly and more humane alternative to institutional long term care;
- Persons who qualify for Medicaid despite the existence of substantial real and personal assets;
- Young adults working at low paying, service-oriented jobs whose employers do not provide health insurance as a benefit;
- Persons with terminal illnesses who are unable to continue working and whose health group insurance benefits run out after one year;
- Indigent care programs which cover the cost of hospital inpatient care but do not cover the cost of less costly outpatient alternatives;
- Physicians who become overwhelmed by the volume of indigent care they are providing and who are unable to compete in the competitive health care environment;
- Hospitals which provide a disproportionate amount of indigent care and begin to face the possibility of closure unless they limit their indigent care commitment;
- Alternative delivery systems (such as health maintenance organizations) which negotiate hospital discounts for their patients, thereby restraining the ability of the hospital to cost-shift to private pay patients; and

- Commercial and non-profit health insurance companies which negotiate discounts for their subscribers to remain competitive with the alternative delivery systems, and then are accused of insensitivity to the problem of indigent care.

Problem Statement. The central issue related to health care for the medically indigent is that people exist who are in need but cannot afford health care. Needless suffering, pain and disability, as well as premature death, have measurable social and economic consequences. Unmet health care needs directly result in a reduction of a person's range of opportunity and constitute an unacceptable waste of human resources and potential.

Although medical indigency is a problem across the nation, concern in any particular state depends on the history of the development of the health care delivery system, political forces, geographic factors and economic conditions therein.

Geographic Accessibility. Geographic location is a major barrier to receiving health care services in Kentucky and significantly affects access for the medically indigent. Some areas of the state have no health services for medically indigent persons; this lack particularly affects older people and others without transportation. There are hidden private costs associated with traveling long distances to obtain health care, including personal transportation costs, living expenses while away from home, time away from employment and loss of family contact and support. In addition, distantly located health care often encourages delays in obtaining treatment. By the time an indigent person seeks health services, he or she may be seriously ill and require expensive acute care.

Financial Accessibility. Financial access is closely related to eligibility for public health insurance programs, such as Medicaid and Medicare, and coverage by private health insurance policies. Even in those instances where people are apparently insured, there may be serious gaps in coverage that could result in a lack of financial accessibility to health care. For example, although the Kentucky Medical Assistance Program now covers about 50% of persons under the poverty level, some providers are reluctant to accept Medicaid patients. A 1981 LRC study found that 85% of physicians were participating in Medicaid, but that over 50% of participating physicians saw fewer than 49 Medicaid patients annually.[1] Similarly, an analysis by the Department for Health Services of 1984 of primary care physician participation in the Kentucky Medicaid program showed that 51.3% of primary care physicians in Kentucky do not participate, and only 20.5% of Kentucky physicians participate to the extent they receive in excess of $5,000 annually in Medicaid reimbursement (representing an average of 100 Medicaid clients).

Moreover, nearly every person over age 65 receives Medicare benefits but approximately 28% of Medicare recipients do not carry supplemental insurance to cover the substantial copayments and coinsurance required under Medicare.[2] For the non-aged population, private insurance coverage is now considered to be much less comprehensive than previously believed: 26% of persons receiving health insurance through their employers can be considered to be "underinsured."[3]

Another dimension of medical indigency is the obvious financial consequences for families with inadequate health insurance coverage who incur catastrophic medical expenses. Banks and other lending institutions have anecdotally observed that health expenses are a major contributor to bankruptcy for individuals and families. A 1978 study in New York showed the cost of health care as a major cause of bankruptcy in approximately 5% of the cases studied and as the fifth greatest area of debt.[4] Financial stress is also associated with family disruption and violence.

Practical Accessibility. Another aspect of health care access can be described as "practical accessibility." The current system of delivering and financing health care to the medically indigent can be viewed as an unstructured complex of services which only the most resourceful can negotiate. The sickest and neediest people may lack the strength and resources to locate service providers, to contend with the eligibility determinations process, make appointments and advocate for their health needs. Thus, the maze of eligibility requirements, service providers and programs, and variable fee schedules may pose a significant barrier for even those individuals who qualify for subsidized care.[5] Other practical accessibility factors particularly affecting the medically indigent include excessive waiting times, complicated appointment protocols and referral mechanisms, inconvenient hours of operation and intimidating facilities.

Uncompensated Care. For many health care providers, the problem of medical indigency is one of uncompensated care, including charity care, bad debt and contractual allowances. To the extent that the financial burden for providing health care to the medically indigent is overwhelming or unevenly distributed, the result can be "provider burn out", cynicism and allegations of discriminatory treatment based on ability to pay for services.

Although uncompensated hospital care is not new, there is some evidence that the proportion of uncompensated care is increasing.[6] Uncompensated care is paid for in three ways: (1) lower provider incomes and profit margins, (2) tax revenues, or (3) cost shifting to less aggressive purchasers (employers and insurers).[7] The recession in the early 1980's, the implementation of Diagnosis Related Groups in the Medicare program, cost containment by Medicaid, discounting by large insurers, utilization controls and pressure by employers to reduce health insurance premium costs may be contributing to higher levels of uncompensated care. Although bad debt and charity accounts for only 6% of hospital revenues nationwide,[8] and 6.3% in Kentucky,[9] the uneven distribution of indigent care places some hospitals at a distinct competitive disadvantage. Teaching hospitals have traditionally carried a large proportion of the indigent care costs and are now running deficits or having to limit their charity admissions. In addition, as the health care environment becomes more competitive and cost-conscious there are increased incentives to deny treatment or transfer indigent patients to those hospitals which will still admit them, thereby exacerbating the already inequitable distribution of indigent care. A reasonable assumption is that hospitals facing financial pressures will cut back on charity care to protect themselves from losses.

Inefficiency in the Provision of Care. Finally, many current health care financing mechanisms for the medically indigent encourage inefficient forms of care. Public programs are targeted at specific recipients for specific services. Often, the only care available to the medically indigent is hospital care partially because those limited government funding programs for the medically indigent have focused primarily on treating the most acutely ill patients. Utilization of hospital emergency rooms for basic health care services has been well documented.[10] Many pregnant women do not receive prenatal care services, even though prenatal care is widely acknowledged to result in later cost savings for delivery services and neonatal intensive care.[11] In a fragmented service system where only the most urgent health needs are met, the cost-saving advantages of a comprehensive health delivery system are completely unavailable to the indigent patient. In addition, the utilization controls such as preadmission hospital review and mandatory second opinions for surgery found in most health insurance programs are generally unavailable in programs serving the medically indigent. Thus, the argument can be made that current allocations for indigent care are not expended in a cost-effective manner and contribute to the sentiment that program expansion or new program development should not occur until existing programs are operating at maximum efficiency. Meanwhile, the costs of medical indigency have continued to escalate.

B. Who are the Medically Indigent?

1. Alternative Definitions of Medically Indigent

Medical indigency is a complex function of level of poverty, health insurance coverage and need for medical services. A widely accepted definition of the "medically indigent" is they are persons who are uninsured by public or private health insurance, lack adequate health insurance coverage or both. However, in their attempts to assess the need for indigent care programs and to serve some segment of this population, state commissions, research organizations and policy makers have narrowed this definition. Consequently, people believed to constitute the medically indigent have come to represent all persons who are below the poverty level and are ineligible for Medicare or Medicaid to everyone, regardless of income, with a special focus on the unemployed and persons with catastrophic medical expenses. Some of the definitions now in use include:

(1) Persons below a certain percentage of the federal poverty guidelines as set by the Community Services Administration. In Texas, this is 100% of the poverty guidelines, in Florida 125% and in Indiana 200%.

(2) Persons below a fixed annual income (most frequently this is the State's Medicaid income eligibility standard).

(3) Persons without health insurance.

(4) Persons not eligible for governmental assistance programs such as Medicaid, Medicare or general assistance.

(5) Persons who are recently unemployed.

(6) Persons with inadequate health insurance coverage.

(7) Persons suffering a catastrophic illness.

(8) Persons lacking a regular source of medical care.

(9) Persons falling into targeted population groups (Texas—low income women and minority group members; South Carolina—migrant or seasonal farmworkers.)

The Commonwealth of Kentucky, through the Cabinet for Human Resources, is responsible for providing medical care to "public assistance recipients" and "other persons eligible for medical assistance" in accordance with applicable state and federal laws and regulations (KRS Chapter 205), the agency budget request and actual funds appropriated. Although the phrases "indigent persons" or "medically indigent" appear frequently throughout the Kentucky Revised Statutes (See Appendix C), no statutory definition for these terms is provided. Further, there is not general statutory obligation for the state to pay for all indigent care. Thus, we are left with an administrative determination of the medically indigent through eligibility guidelines for medically needy persons for participation in Medicaid or other assistance programs administered by the Cabinet for Human Resources.

There are several Kentucky statutes that relate to the responsibility of local government to provide indigent health care. KRS 212.370 requires the Louisville and Jefferson County Board of Health to provide "medical care of the indigent" of the city and county. KRS 212.628 authorizes the Lexington and Fayette County Board of Health to provide "medical care to the indigent" of the city and county. Further, KRS 67.083 authorizes all county fiscal courts to "appropriate funds" for "hospitals, ambulance service, programs for the health and welfare of the aging and juveniles, and other public health facilities and services." These statutes leave the defining of the medically indigent to the local board of health or fiscal court, since no statutory direction is provided. Kentucky counties are now spending a total of approximately $6 million per year for hospital indigent care.

The main purpose of a statutory definition of the medically indigent is to identify those persons for whom compensation for medical care will be provided and to determine the level of government responsible for paying for that care. Because a statutory definition of medical indigency implies a legal obligation to provide care for those so defined, most states do not have a definition written into statute. In fact, courts in Nevada and California have held that a state's provision of Medicaid does not satisfy a general statutory obligation to provide health care to indigent persons.[12] As a practical matter, such definitions appear in eligibility guidelines for assistance programs to allow for easy changes to adapt to fluctuations in funding and size of the eligible population without having to ask the legislature

to amend state law. Table 4 shows minimum income limitations for the Medicaid, AFDC and SSI programs in Kentucky. (The percentage figures show the percent of the federal poverty guidelines represented by each eligibility level.)

TABLE 1

Monthly Income Eligibility Limits

Program	Number of Persons			
	1	2	3	4
AFDC*	$259.00 59%	$314.50 53%	$364.45 49%	$455.10 51%
SSI*	$325.00	$488.00	NA	NA
Medically Needy*	$192.00 44%	$225.00 38%	$267.00 36%	$325.00 37%
Federal Poverty Guidelines**	$438.00	$588.00	$738.00	$888.00

SOURCE: *Kentucky Administrative Regulations (1985)
**Social Security Bulletin, July 1985

As Table 1 shows, Kentucky currently defines a medically needy person (through Medicaid eligibility standards) as a person earning $192/month ($2304/year) or less. Persons receiving aid to families with dependent children and supplemental security income (for aged, blind and disabled persons) are also automatically eligible for Medicaid. This currently translates into approximately 335,000 total Medicaid recipients.

Some of the definitions of medical indigency in other states can be applied to Kentucky to estimate the cost of including more of the state's medically indigent under Medicaid. For purposes of this report, the average Medicaid recipient is assumed to use $1,032 per year in health services. This figure is derived by factoring out expenditures for long-term institutional care, mental health clinics, non-emergency transportation, social services and payments for Part B Medicare coverage. The state's cost of adding a person to the Medicaid program, based on the current matching formula of 70% federal and 30% state funds would be $309 per year. The following illustrates the cost of expanding Medicaid based on poverty levels and insurance.

Income Status. Under current federal poverty guidelines, a person earning less than $5,250 per year ($437 per month) is considered impoverished in Kentucky (See Table 2).

TABLE 2

Poverty Levels in Kentucky
and Cost of Medicaid Coverage

Level of Poverty	Number of Persons	Percent of Total Population	Annual Cost of Adding to Medicaid*
Below 100%	671,491	17.6%	$103,376,259*
Below 125%	896,593	23.5%	$172,932,777
Below 150%	1,114,064	29.2%	$240,131,316
Below 200%	1,556,638	40.8%	$376,886,682

*These figures assume the current 336,940 Medicaid recipients that are already included in each poverty level; thus, the cost listed is in addition to current expenditures.

TABLE 3
Number of Kentuckians
by Type of Health Insurance

Blue Cross/Blue Shield*	1,127,212
Commercial Insurers*	1,164,862
Medicare**	490,000
Medicaid	336,940
Health Maintenance Organizations	135,000
Uninsured Kentuckians***	553,217
Total Population	3,815,291

*Includes self-insured population.

**72% of Medicare recipients also carry Medicare Supplement Insurance

***1984 Data based on percentage estimates contained in the 1985 Urban Institute study and applied to Kentucky's population.

Insurance Status. The cost to the Commonwealth of adding 553,217 Kentuckians without health insurance to the Medicaid program would be approximately $165 million per year (based on the state's share of the matching formula). Table 3 shows the health insurance coverage in Kentucky. Also to be considered are persons who are "recently unemployed." Definitions of the recently unemployed vary by state, but in Kentucky, statistics are available for persons unemployed for more than 13 weeks (this is the cut-off point for payment of unemployment insurance benefits). At present 8.9% (153,294) of Kentuckians are unemployed, as compared to a national unemployment rate of 6.9%. How many of these persons have insurance through a family member or are covered under a public or private insurance program is unknown. Assuming that these persons' health insurance benefits were lost when their jobs were terminated, the cost of adding the unemployed, regardless of resources, to Medicaid would be an additional $47.4 million per year in state funds.

Finally, it should be noted that if the eligibility guidelines for Medicaid are raised, federal law requires that eligibility guidelines for AFDC must also be raised. The AFDC income standard is currently set at 133% of the medically needy income guidelines under Medicaid. Thus, to raise eligibility levels under Medicaid, the AFDC income standard would have to be adjusted accordingly. (The Cabinet for Human Resources has estimated that each 10% raise in the AFDC standard would cost the Commonwealth $4.3 million in state funds.) Of course, these restrictions would not apply to a separate pool of state general fund dollars to fund indigent health care.

2. Commission's Definition of "Medically Indigent"

In addition to identifying persons eligible for compensated care, there are other purposes for defining the term "medically indigent." They include: (1) to delineate the target population for this report; (2) to establish a uniform definition for use by policymakers, including legislators, executive agency officials, administrators of local government programs and health care providers; and (3) to pose the question of whether a uniform definition should be used by agencies of state and local government administering programs serving persons with limited access to health care services.

The Commission considered but did not adopt a recommended statutory definition of the term "medically indigent." Instead, the Commission adopts and recommends a working definition of the term "medically indigent".

The current estimate is that 193,626 Kentuckians are below 100% of the poverty level and are not covered by public or private health insurance. This estimate is based on extrapolations from the 1985 Urban Institute study set forth in Table 11. The number of persons in Kentucky with medical expenses exceeding 50% of pre-tax income is estimated to be less than 1% of the total population, or no more than 38,000 persons.

RECOMMENDATIONS:

1. Any person with income not exceeding 100% of the federal poverty level as established by the Community Services Administration ($5,250 per year), and who is not covered by Medicare or Medicaid or other government subsidy and who has no private health insurance coverage; or

2. Any person incurring medical expenses within a calendar year that exceed 50% of the person's pre-tax income for that year.

3. Review of National Studies Estimating the Extent of Medical Indigency

As the concern about the rising numbers of the medically indigent has grown, discussion of the problem has been hampered by a lack of reliable state-specific data estimating the number of people affected. Several states have conducted household surveys, asking questions on the number of individuals covered by private health insurance, Medicare and Medicaid and on the extent of insurance coverage. In the absence of such a survey in Kentucky, we must rely heavily on national estimates.

The three nationally recognized studies discussed in this study are limited by definitional problems and certain aspects are now becoming outdated. These studies do, however, provide rough estimates of the numbers of uninsured and underinsured persons, and some descriptive information regarding the characteristics of the medically indigent population.

Virtually every national study and analysis has concluded that the number of uninsured persons has increased in the 1980's as a result of the 1981-82 recession, increasing employer consciousness about rising health care costs, the shift from a manufacturing to a service-based economy and the increase in female-headed households.[13] In 1963, 30% of the population lacked any type of health insurance coverage. This proportion steadily decreased during the 1960's and 70's so that by the mid 1970's the proportion of the population without health insurance was about 12%. For a number of reasons described in the various studies, this trend then reversed itself and the numbers of uninsured and underinsured people began again to rise.[14] The following is a brief summary of the major national studies and analyses conducted since 1977 estimating the number of uninsured and underinsured people in the United States and their demographic characteristics.

a. National Center for Health Services Research (NCHSR): 1977[15]

This study is based on data from the 1977 National Medical Care Expenditure Survey, a comprehensive 18-month household survey. Six household interviews of a nationwide sample of over 40,000 individuals were conducted over an 18-month period during 1977-78. NCHSR found that, nationwide, 26.2 million persons, or 12.6% of the civilian noninstitutionalized population, were uninsured. The percentage was 16.2% in the South. Children under age 18 represented 30.4% of the total uninsured population; 12.5% of all children under age 18 were uninsured. 43.4% of these children lived in households where at least one member had health insurance; 28.2% lived in households where at least one member was privately insured. Table 4 contains the summary of other study findings.

TABLE 4

Percent of Persons Nationwide Without Insurance by Selected Characteristics

AGE	Under 18	18-24	Over 65
	12.5%	21.9%	4.3%
RACE	White	All Others	
	11.7%	18.1%	
PLACE OF RESIDENCE	Rural	Urban	
	18.0%	12.0%	

SOURCE: National Medical Care Expenditure Survey, 1977

There was very little variation in health insurance coverage between the sexes or in a self assessment of perceived health status. Educational status was a significant predictor of health insurance coverage; fewer years of education correlates with a lesser likelihood of having health insurance. In a further analysis of the National Medical Care Expenditure Survey, Karen Davis and Diane Rowland concluded that 8.6% of the population was always uninsured during a given year, while another 7.5% were uninsured during part of the year.[16] For the population under age 65, 9.5% were always uninsured and 8.3% were uninsured part of the year. Nearly one-third of all persons aged 19-24 were uninsured during the course of a year. Davis and Rowland also concluded that in the South, 20.5% were uninsured part of the year and 11.6% were always uninsured, due to the nature of the employment and less extensive unionization. Low income people and blacks are far more likely to be uninsured part of the year than other segments of the population. The authors cautioned that any study taking a snapshot view of the uninsured at a given point in time understates the number of people who spend some portion of the year without health insurance. Similarly, relying on a percent of the total population who are uninsured will always overestimate the extent of the problem since nearly every person over age 65 is covered by Medicare.

b. Robert Wood Johnson Foundation Study: 1982[17]

This study was drafted using data from the 1982 National Access Survey conducted by Louis Harris and Associates and additional analyses by the University of Chicago, Center for Administration Studies. The data was collected from telephone interviews with 6000 randomly selected adults and children.

The study showed that 8.2% of the total population was uninsured, but that 12% of Americans have "particularly serious trouble coping with the medical care system" because of a lack of health insurance coverage, other financial problems, or a lack of knowledge about where to seek care. The relatively low percent of uninsured can be attributed to the fact that the insurance status of the adult interviewee was automatically assigned to his or her dependents. A summary of the other study findings can be found in Table 5.

TABLE 5

Percent of Persons Nationwide Without Insurance by Selected Characteristics

Under Age 17			10.2%
Adults	Place of Residence	Rural	9.2%
		Urban	7.8%
	Race	White	7.1%
		Black	11.9%
		Hispanic	14.5%
	Employment Status	Employed	7.1%
		Unemployed	28.6%
		Not in Labor Force	7.9%
	Below 158% of Poverty		20.1%
Families with Seriously Ill Member		Total	9.2%
		Resulting in Major Financial Problems	2.6%**

*Represents 22.7% of families with a seriously ill member.

SOURCE: Robert Wood Johnson Foundation Study, 1982

c. Urban Institute Study: 1982[18]

This study was conducted using 1982 population survey data. The study showed that in 1982, 14.4% of all persons were uninsured; one-third of whom were children. 27.4% of uninsured children were living with an insured adult. In the East South Central Region 19.6% of the population was uninsured. Other study findings are summarized in Table 6.

TABLE 6

Percent of Persons Nationwide Without Insurance by Selected Characteristics

AGE	Under Age 19		17.7%
	Under Age 65		16.5%
	Between 19-64	Employed	52.3%
		Unemployed	15.6%
		Disabled	1.3%
		Housekeepers	16.2%
		Retired	8.4%
		Students	6.1%
Percent of Poverty Level	Below 100%		35.4%
	Between 100-199%		29.3%
	Between 200-299%		15.9%
	Between 300-399%		8.6%
	Over 400%		10.8%

SOURCE: Urban Institute Study, 1982

d. Committee on Ways and Means: 1982[19]

A 1982 background report on poverty by the Committee on Ways and Means of the U.S. House of Representatives concluded that 17.4% of the total population was uninsured and that 30% of the uninsured population had incomes below the poverty level.

e. National Center for Health Services Research: Analysis of the Underinsured[20]

This study was based on the 1977 National Medical Care Expenditure Survey and focused on persons who had health insurance at least part of the year. The substantial gaps in insurance coverage illustrated that simply using a fixed percentage of uninsured persons will severely underestimate the extent of the problem. The authors concluded that 13% of the insured population had inadequate health insurance coverage, using as a measure of inadequacy potential out-of-pocket expenses exceeding 10% of a family's income.

f. Urban Institute Update: 1985[21]

This study used current population surveys from 1980, 1982 and 1983 to estimate the increase in the number of uninsured persons from 1980-1984. The author estimated that the proportion of uninsured under age 65 had increased from 14% of the population in 1980 to 16% in 1983-84. Preliminary estimates for 1984 were that the proportion of the population under age 65 who were uninsured had remained stable in 1984 at a little over 16%. Table 7 contains summaries of other study findings.

TABLE 7

National Population Uninsured by Employment Status

	Year	
	1980	1983
Persons employed	33%	25%
Persons unemployed	27%	31%
Uninsured children living with an insured adult	—	33%

SOURCE: Urban Institute Update, 1985

Katherine Swartz emphasizes the importance of family income as a predictor of insurance status: almost two-thirds of all the uninsured have incomes below 200% of poverty level. She also sets forth the proposition that the 1981-82 recession caused many families to lose their health insurance when primary wage earners lost their jobs—in contrast to previous periods of unemployment when secondary earners were more likely to be unemployed. The depth of the recession in the manufacturing sector in 1981-82 also increased the number of persons without health insurance, since health insurance is a widely held benefit in manufacturing.

According to Swartz, the proportion of young adults ages 19-24 without health insurance increased between 1980-1983 from one-fifth to one-fourth of that population. Adults between ages 50-59 have improved their health insurance status somewhat during the same period; 11% of all adults ages 50-59 had no health insurance in 1983, compared to 13% in 1980. Nearly 25% of all people living in a female-headed household were uninsured in 1983. Table 8 summarizes data for the period between 1980-83.

In summary, Swartz said income and employment status are by far the highest predictors of health insurance status. Age, race, sex of family head, education of family head, the presence of dependent children, occupation and industry were of little importance relative to income and employment status. According to her estimates, the proportion of the population without health insurance decreased steadily through 1980, then increased in the period between 1980-83 and leveled off in 1983-84. Four events may have triggered the reversal of the post war trend toward reducing the number of uninsured: the recession of 1981-82, the recession's impact on employers' consciousness of rapidly rising costs for providing health insurance, cutbacks in Medicaid eligibility coupled with an increase in the

number of female-headed households, and the increasing numbers of persons with chronic illness who are unable to obtain insurance due to adverse medical histories.

TABLE 8

National Population Uninsured by Age and Income Level

		1980	1982	1983
Number of Uninsured		28.7 millon	30.7 million	32.7 million
Percent of Population		14.4%	15.2%	16.05%
Percent Children Uninsured		16.7%	17.3%	17.7%
Percent of Poverty Level	Below 100%	28%	33.5%	35%
	100-200%	29%	30%	29%
	200-300%	19%	17%	16%
	300-400%	10%	8.5%	9%
	400% +	14%	11%	11%

SOURCE: Urban Institute Update, 1985

4. Analysis of the National Studies

The findings of the major national studies and analyses are difficult to juxtapose due to the differing methodologies, variations in definitions, and the various sampling strategies. For example, the Urban Institute focused on only people under age 65; whereas the National Center for Health Services Research study surveyed the entire population. Each study used a different method of determining whether an individual had health insurance; the Robert Wood Johnson study assumed similar coverage for the entire family if the head of household identified himself as having health insurance. Studies also vary as to whether the individual surveyed was covered only at one point in time or had insurance coverage for the entire year. Even among those identified as having health insurance coverage, it is uncertain whether the self-reporting of complex insurance coverage was accurate, or whether their health insurance policies might be subject to substantial limitations of which the individual surveyed was not aware, such as limitations on pre-existing conditions or specific illnesses. Nonetheless, some striking similarities do exist, which are summarized in Table 9.

TABLE 9

Percent of Persons Without Insurance by Selected Characteristics
(Based on findings of Urban Institute, National Center for Health Services Research and Robert Wood Johnson Foundation Studies, 1977-1985)

Geographical Region	Total U.S. Population Without Insurance: Total Southern Population Without Insurance:	8-16% 12-19%
Age	Under Age 18 Ages 19-24 Under Age 65	10-17% 20-25% 12-16%*
Other Employed	Children Adults Black Over Age 65 + And Not Covered by Medicare	30-34% 52-66% 12-18% 1-4%
Percent Always Uninsured by Income Level	Poor Near Poor Middle Income High Income	14% 12% 7.6% 4.9%
Percent of Poverty Level	Below 100% Between 100-199% Between 200-299% Between 300-399% Over 400% of Poverty	28-35% 29-30% 16-19% 8-10% 11-14%

*Uses higher range Robert Wood Johnson Foundation figure showing serious difficulty in obtaining medical care.

5. Review of Kentucky Study Estimating the Extent of Medical Indigency

Most estimates of the extent of medical indigency in Kentucky are reached by deducting the number of Medicaid recipients from the total number of persons with incomes under 100% of the poverty level. Some problems in this approach include the existence of as many as 100,000 Medicare recipients under the poverty level (some of which also qualify for Medicaid), several thousand Medicaid recipients above the poverty level but who have qualified under Medicaid spend-down provisions, and an unknown number of persons with incomes below the poverty level who nevertheless have private health insurance. **For these reasons, it was decided to calculate the number of uninsured Kentuckians using national surveys as a basis for estimating the number and describing the characteristics of medically indigent persons.** At least one study of Kentuckians, a 1983 University of Kentucky Martin Center survey, has been published which validates the results of the national studies.

University of Kentucky Survey: Access to Health Care in Kentucky[22]

In a statewide telephone poll of 969 Kentuckians conducted in fall of 1983, the University of Kentucky James W. Martin Graduate Center for Public Administration

found that 18% of Kentuckians indicated that they were "not covered by health insurance." Seventy percent of those persons with health insurance coverage stated they had obtained it through their employers. Only 82% of the population with health insurance were confident that their health insurance "would meet the cost of a major illness" in their family. Because of the problems inherent in a telephone survey of low income people, and the relatively low number of respondents, the 18% figure cannot be considered conclusive, but can be used as a general indicator of the proportion of medically indigent persons in the Commonwealth.

6. Estimates of the Number and Characteristics of Medically Indigent Kentuckians

The Kentucky population 1979, 1980 and 1985 are as follows:

TABLE 10

Kentucky Population by Year

1979 (Census)	3,559,034
1980 (Estimate)	3,660,777
1985 (Estimate)	3,815,291

SOURCE: How many Kentuckians: Population Forecasts 1980-2020, 1983

The Urban Institute estimate of the proportion of persons without health insurance in 1984 was 14%, and slightly higher for the South. A key predictor of health insurance status is employment. Kentucky's unemployment rate has declined from 11.7% in 1983 to 9.3% in 1985, but still lags 1.8% behind the rest of the nation. Despite reduced unemployment rates in Kentucky, the number of persons in the civilian labor force has not increased significantly in the last three years, indicating that the number of people with access to employer-sponsored health insurance has not increased significantly in Kentucky. Thus, there is no reason to believe that the proportion of persons without health insurance has declined in Kentucky since the 1984 national estimate. Using the 14.5% figure applied to Kentucky's 1985 population, and the midpoint on other national estimates characterizing the medically indigent population, the estimates are given in Table 11.

TABLE 11

Estimates of Uninsured Kentuckians by Selected Characteristics*

		Number	Percent of All Kentuckians
Total Uninsured Kentuckians		553,217	14.5%
Age	Under 65	539,429	16.0%
	Between 0-19	166,254	13.5%
	Between 20-24	76,237	22.5%
Percent of Poverty	Below 100%	193,626	35%
	Between 100-200%	160,432	29%
	Over 200%	199,159	36%
Total Employed Uninsured Kentuckians		287,672	52%

*Based on percentage estimates contained in the 1985 Urban Institute study and applied to Kentucky's population.

CHAPTER III

ROLE OF FEDERAL, STATE AND LOCAL GOVERNMENT

A. History and Legal Authority

In Kentucky, by legislative action and court decisions, the primary responsibility for caring for the medically indigent historically has resided in the counties. This responsibility was limited, however, by a 1947 court decision (*City of Paducah vs. McCracken County,* 305 Ky 539) which at that time construed the state statutes as limiting the duty of the county to care for its medically indigent citizens to their ability to pay, and said that cities should share in that duty. Thus, in reality, responsibility for providing health services to the medically indigent was shared by city, county and state government, as well as health providers and private philanthropic organizations.

This pluralistic effort is best illustrated by a description of the programs serving the medically indigent during the last 50 years. For example, the Commission on the Study of Indigent Medical Care, appointed in 1957 by Governor Albert B. "Happy" Chandler, listed the following programs serving the medically indigent:

- The state mental heath program, providing care in mental hospitals;
- The state tuberculosis program, providing care in TB hospitals;
- The crippled children's program;
- Various service programs operated by the State Department of Health and local health departments;
- The vocational rehabilitation program operated by the State Department of Education;
- The medical program of the Veterans Administration;
- The Medicare program for servicemen's dependents;
- County programs for reimbursing hospitals for indigent care expenses;
- County owned and operated hospitals, including Louisville General Hospital, Louisville Marine Hospital, Waverly Hills Sanatorium; and
- Other ad hoc services in various counties, including the Visiting Nurse Association, university dentistry clinics, county physicians employed to care for medically indigent persons, drugs purchased by county fiscal courts or provided gratuitously by pharmacies, and indigent medical care beds in nursing homes.

A survey of county judges and hospitals conducted by the 1957 Commission showed the total county/city expenditures for indigent care to be $2.1 million; charity care expenditures by community hospitals were estimated to be $1.37 million.

The final report of the Commission, entitled *A Long Range Plan: Medical Care for Indigent Persons in Kentucky,* estimated that 12.5% of all Kentuckians (or 400,000 persons) were medically indigent, defined as unable to pay the cost of necessary medical care, and called for an equitable health care plan that would spread the cost of health care to the indigent among all taxpayers.[23]

These recommendations and promises of federal assistance in the form of the Kerr-Mills Act, passed by Congress in 1960, led to the passage of the Kentucky Medical Assistance Act (KRS 205.570) in 1960 and establishment of the Kentucky Medical Care Program on January 1, 1961. The program initially covered only public assistance recipients for minimal essential services including physician care, hospital services, dental care and drugs; and physician and hospital services to an additional group of medically indigent aged persons. Nursing home coverage was added in 1963. The program was substantially expanded in 1966 with the implementation of the Kentucky Medical Assistance Program (Medicaid), made possible by the passage of Title XIX of the Social Security Act in 1965. The goal of Medicaid was to offer comprehensive medical care to all persons who could not otherwise afford it.

Under Medicaid, services such as lab and x-ray, home health, community mental health and transportation were added to the previous program. By 1980, the array of services had been further expanded to include intermediate care, skilled nursing care, primary care, screening, family planning, hearing and vision services, and renal dialysis.

Meanwhile, several other programs serving the medically indigent had grown in size and sophistication. By far the most extensive was Medicare (Title XVIII of the Social Security Act), a federally funded and administered program providing a hospital insurance plan (Part A) and a supplemental medical insurance plan (Part B) for persons 65 years of age and older; and for disabled persons under the age of 65 who receive cash benefits from Social Security or railroad retirement programs. The Crippled Children's Commission, which began in 1927, by 1980 had become a $5.7 million program with nearly 14,500 handicapped children under its care. About ten community health centers had been established during the 1960's and early 1970's, under the auspices of the Office of Economic Opportunity "War on Poverty," and later under the Public Health Service. During the 1970's public health departments gradually shifted their focus from tuberculosis and other traditional public health concerns and became service sites for prenatal care, family planning and well child care; some offered primary care and home health care as well. The Maternal and Child Health Program, which had been funded by state and federal government since the 1930's, was gradually expanded and offered a broad range of services funded by federal block grant funds, Medicaid, and state general fund dollars. University teaching hospitals became tertiary care centers, offering sophisticated diagnostic and treatment services to medically indigent persons.

State government's role in developing health services for medically indigent persons was related primarily to the availability of federal and state funds for that purpose, rather than any specific statutory responsibility to provide health care for the medically indigent. KRS 205.520 states, in part, that the Kentucky General Assembly "recognizes and declares that it is an essential function, duty and responsibility of the state government to provide medical care to its indigent citizenry." This section suggests that the Commonwealth's responsibility to provide indigent medical care is generally satisfied through the Kentucky Medical Assistance Program (Medicaid). The extent of that responsibility is primarily defined by the Cabinet's eligibility criteria for Medicaid and budgetary limitations. General authority for health and welfare was delegated to the Cabinet for Human Resources under KRS Chapter 194.

Until 1978, the counties had specific permissive authority to provide needed health care services to the medically indigent. KRS 67.080 provided that a fiscal court "...may make provision for the maintenance of the poor, provide a poorhouse and poor farm, appropriate county funds for the benefit of infirmaries for the sick located in the county, provide for the care, treatment and maintenance of the sick and poor and provide a hospital for that purpose, or contract with any hospital in the county to do so." In addition, KRS 204.050 provided that the county court or the county judge "...may cause medical aid to be employed at the public expense for such of the poor of the county as he deems proper." KRS 67.080 was substantially amended by the 1978 General Assembly and KRS 204.050 was repealed. The provisions of KRS 67.080 relating to indigent care were replaced by an amendment to KRS 67.083 which permitted the fiscal court to appropriate funds and employ personnel to provide for "the provision of hospitals, ambulance service, programs for the health and welfare of the aging and juveniles, and other public health facilities and services."

The Louisville-Jefferson County Board of Health currently appears to have specific statutory responsibility for indigent care in their jurisdiction. KRS 212.370 provides that the Louisville and Jefferson County Board of Health shall have "exclusive control and operation", subject to the acts of the general assembly and regulations of the cabinet for human resources, of "all matters relating to institutions safeguarding the public health, including city or county hospitals, tuberculosis hospitals, eruptive hospitals, chronic hospitals, medical care of the indigent and all other matters affecting public health..." Fayette County has much more permissive language in KRS 212.628 which says the Lexington-Fayette County Board of Health may control, operate or monitor all matters within the county affecting public health including institutions established to safeguard the public health which may encompass city or county medical facilities, nursing homes, and medical care of the indigent.

In conclusion, the only direct statutory responsibility for caring for the medically indigent in Kentucky appears to rest with the Louisville-Jefferson County Board of Health, under KRS 212.370, and the Cabinet for Human Resources under KRS Chapter 205

(through the Medicaid program). However, a number of other governmental entities, including the Cabinet for Human Resources, units of county and city government and public health departments, have general authority to provide indigent care services if they so desire and if funds are available.

B. Federal Programs

1. Medicare

Description. The Medicare program authorized under provision of Title XVIII of the Social Security Act was enacted in 1965 to provide insurance protection for older people against the costs of health care. Amendments to the Social Security Act subsequent to 1965 broadened coverage to include some disabled persons and certain individuals suffering from end-stage renal disease. Medicare is the largest personal health care financing program in the United States and, except for Social Security, the largest entitlement program in the federal budget.

Medicare is provided in two components: Part A, Hospital Insurance (HI), and Part B, Supplemental Medical Insurance (SMI). HI is received without charge by the aged or disabled Social Security recipient. People aged 65 or older or disabled people not covered by Social Security (e.g., federal pension recipients and some self-employed persons) may purchase Medicare Part A coverage for $174 per month (1985 rate). HI provides coverage for the cost of inpatient hospital stays and certain post-hospital services.

Coverage under Part B is optional and may be purchased by the recipient for a monthly fee of $15.50 (1985 rate). SMI provides coverage for physician services and certain physician-ordered services and supplies, outpatient services, and home health agency services.

Recipients are subject to copayment and deductibles, depending on the service provided, including a $75 per year deductible under both HI and SMI. Generally, after fulfilling the deductible, 100% of covered hospital costs are paid under HI, and 80% of approved physician and laboratory services are paid under SMI. However, some services are subject to different copayments or deductibles.

Eligibility/Number Served. Eligibility for Medicare is open to the following persons:

A. Persons 65 or over entitled to monthly Social Security or Railroad Retirement payments; or

B. Disabled persons after 30 months entitlement to monthly Social Security or Railroad Retirement payments; or

C. Persons with end-stage renal disease requiring renal dialysis or a kidney transplant, if they are currently insured, are entitled to monthly Social Security benefits, or if they are spouses or dependent children of such persons. Eligibility begins the third month after renal dialysis begins.

As of 1982, approximately 467,000 Kentuckians were covered by Medicare Part A—403,000 due to age and 64,000 due to disability.[24]

Analysis. Medicare provides health insurance benefits to many Kentuckians who would otherwise have no coverage. However, there are recurring complaints about Medicare, because of the considerable copayments and deductibles that beneficiaries must pay under the program, and because of some gaps in coverage. For example, Medicare provides little or no coverage for eyeglasses, hearing aids, or prescription and over-the-counter drugs. Because of these out-of-pocket expenses and coverage gaps, many Medicare supplement policies are offered by commercial insurers.

The Health Care Financing Administration (HCFA) estimates that nationwide 67% of aged Medicare recipients have some form of private insurance in addition to Medicare, 13% are covered also by Medicaid, and 21% have no other source of coverage. Although beneficiaries may be covered by other third party coverage, their level of coverage may still be inadequate to their needs. HCFA also estimates that persons with both Medicare and private insurance still pay out-of-pocket expenses representing 20% of their total medical expenditures. Persons with Medicare only and with both Medicare and Medicaid paid 29% and 4% respectively. Because the researchers did not tabulate insurance premiums on supplemental coverage as an out-of-pocket expense, the gap between persons covered by both Medicare and Medicaid and other persons appears larger than expected.

If recipients have other health insurance coverage, whether coverage under a private supplemental policy or under another public program, Medicare is the payer of last resort. An individual may also be covered by both Medicare and Medicaid. If the patient is covered by both, Medicaid is always the payer of last resort. Medicare pays all covered services before Medicaid pays any of the services it covers. In Kentucky, Medicaid provides the following to Medicare-covered individuals:

A. Payment for Medicare Part B premium charges if SSI or State Supplementation is received.

B. Some recipients in long-term care facilities are allowed an income deduction to cover Part B charges. Other Medicare covered clients are allowed the deduction as a spend-down Medicaid item.

C. Payment for Medicare Part B deductibles and co-insurance amounts for covered outpatient services.

D. Inpatient hospital deductible.

E. Payment for any applicable Medicare Part A co-insurance amount up to the 14th day of readmission during the same Medicare spell of illness.

According to the 1980 federal census for Kentucky, there are 309,662 persons over the age of 65. The average annual income for a household containing at least one member aged 65 or older is $6,788. The median annual income for these households is $10,127.

RECOMMENDATIONS:

1. The United States Congress should insure the solvency of the Medicare Trust Fund.

2. The Department of Insurance should evaluate available coverage under Medicare supplemental insurance policies and insure that rate increases of regulated insurers are justified by claims experience.

3. The Cabinet for Human Resources should consider the implementation of a state-funded program to pay for services not covered by Medicare, such as eyeglasses, dentures, and prescription drugs.

2. Veteran's Programs

Description. The Veterans Administration (VA) was authorized to provide medical services to entitled veterans of the United States Armed Services under Title 38 of the Veterans Act of 1958. The VA provides hospital, nursing home, domiciliary care, and outpatient medical and dental care to eligible veterans primarily through a system of VA medical centers funded by the Federal Government. It operates 172 hospitals, 220 clinics, and 89 nursing home units in the United States, Puerto Rico, and the Phillipines.

In Kentucky, medical services are provided primarily through VA medical centers in Louisville and Lexington. Although there is a VA facility in Fort Thomas, this facility is under the jurisdiction of the Cincinnati Medical Center. The Lexington center offers more comprehensive inpatient services than the Louisville center, such as psychiatric care, intermediate and nursing home care, and cardiac care. If a veteran needs non-emergent services not available in Louisville, the patient is transferred to either the Lexington or Indianapolis VA hospital for treatment. If emergent care is needed, the VA medical center in Louisville has agreements with local hospitals to provide care until the patient can be transferred to a VA facility.

Both centers offer extensive outpatient services through their outpatient clinics. Although inpatient services are generally available
to any entitled veteran, services through the outpatient clinics are available only to veterans meeting certain further requirements explained below.

Eligibility/Numbers Served. Entitlement to medical care is determined on the basis of length of service and type of discharge. Veterans enlisting before September, 1980 did not have to meet a durational requirement; they were entitled to services even if they served only one day. For example, the VA cites the case of a Kentucky veteran of World War II who reported for duty the day the war ended, served less than one day before being discharged, and was deemed entitled to care. However, under provisions of P.L. 96-461, any veteran enlisting after September, 1980 must have served at least two years of active duty to be entitled to coverage. Reservists and national guard members are not eligible. In addition to length of service, the veteran must have been discharged with an other than dishonorable discharge.

In order to establish entitlement, the veteran must make application through the local VA office. Establishing eligibility is a one-time determination which can usually be made by viewing the veteran's discharge papers. Only the veteran, not the spouse or family, is entitled to services.

Inpatient services are open to qualified veterans, although, in the absence of sufficient bed availability, priority is given to veterans with service-connected conditions.

Determining eligibility for treatment at the VA's outpatient clinics is more complicated, since it is limited according to the degree of service-connected disability and other factors, as follows:

A. 100% disability—entitled to all services;

B. Greater than 50% but less than 100% disability—entitled to all services except dental care;

C. Less than 50% disability—entitled to treatment of service-connected disability only;

D. Veterans of World War I and the Spanish-American War—entitled to all services except dental care;

E. Veterans who are in need of aid and attendance or who are housebound—entitled to all services except dental care;

F. Former prisoners of war—entitled to all services.

The VA estimates that 401,609 veterans currently reside in Kentucky.[25] Table 12 gives utilization statistics for federal fiscal year 1985 (October, 1984—September, 1985) for the Lexington and Louisville medical centers.

TABLE 12

VA Hospital Utilization Statistics

	Lexington	Louisville
Total Outpatient Visits	107,424	96,601
Average Daily Inpatient Census (Hospital)	732	283
Average Daily Inpatient Census (Nursing Home)	98	-0-*
Total Beds—Inpatient	904	363
Total Beds—Nursing Home	100	-0-*
*Louisville has no VA nursing home beds.		

Budget/Expenditures. The Lexington medical center's budget for federal fiscal year 1985 was $75,868,438.[26] The Louisville medical center's budget for the same period was $35,000,000.[27]

Analysis. Although most veterans are entitled to service through the VA system, many may not take advantage of this service because they have other health insurance coverage which allows them to more readily access health care coverage from other providers, or because they live in a community geographically distant from a VA medical center. While the former may apply more to residents of the Lexington and Louisville areas, the latter may apply more to residents of the eastern and western regions of Kentucky.

RECOMMENDATIONS:

1. The U. S. Veterans Administration should expand outreach efforts to publicize health care benefits to eligible veterans.

2. State funded indigent care programs (such as Medicaid and programs through the local health departments) should assess whether veteran's programs are available to their clients and make referrals if appropriate.

3. Hill-Burton Programs

Description. The Hill-Burton Act of 1946 (P.L. 79-725) provided a mechanism for channeling federal aid to states for the construction of health facilities, including hospitals. The Hill-Harris Amendments of 1954 revised and expanded the Hill-Burton Act to include funding for modernization or replacement of public and non-profit hospitals. However, a facility receiving federal construction grants under provisions of the Act had to comply with certain requirements.

To be granted funds, a state had to establish a Hospital Planning Council to survey existing facilities to assess the need for new construction. The New York Hospital Planning Council evolved into the first Certificate of Need (CON) program, being established in the early 1960's. By 1980, every state had enacted CON legislation. (Five states have since repealed their CON statutes.) Further, a facility accepting grants or loans under Hill-Burton agreed to two separate obligations:

A. To provide a specified percentage (usually 5%) of uncompensated care for a 20 year period; and

B. To not discriminate in the provision of service based on ability to pay for emergency services.

No funds have been provided under the Hill-Burton Act since 1974. The bulk of funds were provided in the early and mid-1960's.

Eligibility/Number Served. As of January 1, 1985, 123 Kentucky health facilities were under a Hill-Burton obligation to provide uncompensated care. Table 13 lists the number of these facilities classified by type.

TABLE 13

Number of Kentucky Facilities with a Hill-Burton Requirement by Type

Private non-profit hospitals	35
Public non-profit hospitals	28
Public health centers (especially local health departments)	46
Nursing homes	5
Rehabilitation centers	6
Out-patient clinics	3
Total of all facilities	123

When these facilities' obligations will be fulfilled depends upon several factors. Although the obligation is scheduled to be fulfilled 20 years from the date the construction at the facility was completed, this date can only be used as a guideline. To fulfill its obligation, the facility must provide a yearly dollar amount of uncompensated care equal to the lesser of 10% of the amount of Hill-Burton funds received or 3% of the facility's operating costs minus any Medicaid or Medicare payments received by the facility. If a facility provides more uncompensated care in a year than the yearly target amount, its obligation can be fulfilled in less than 20 years. Conversely, if it provides less, its obligation will be extended beyond the 20 years. As of January 1, 1985, the last Kentucky facility's Hill-Burton obligation is scheduled to be fulfilled in the year 2000.

Table 14 lists the amount of funds received by Kentucky facilities to which an obligation for providing uncompensated care is attached.

The current yearly obligation for uncompensated care held by Kentucky health facilities under the Hill-Burton Act provisions is approximately $8.83 million.

Analysis. As previously stated, funds under Hill-Burton have not been allocated since 1974. Many Kentucky facilities will be under an obligation to provide uncompensated care for at least 15 more years. Although hospitals are the primary health facility with an obligation, other types of facilities are also under obligation. A list of these facilities and their obligations is included in Appendix D.

TABLE 14

Amount of Funds Received by Kentucky Facilities
Under the Hill-Burton Act (in Millions)

Funds directly under Hill-Burton Act	$72.6
Supplemental funds under the Appalachian Regional Development Act and the Public Works and Economic Development Act	$11.9
Interest subsidy on loans	$ 3.8
Total Funds Under Hill-Burton Obligation	$88.3

RECOMMENDATIONS:

1. The Cabinet for Human Resources should monitor and assure compliance with Hill-Burton requirements as a condition of licensure.

2. The Kentucky Hospital Association should encourage provider referrals to facilities with a Hill-Burton obligation and publicize the fact of the obligation.

C. Joint Federal/State Programs

Since the early 1960's, Kentucky has made substantial efforts to provide health care services for its medically indigent citizenry. Bolstered by a similar commitment from the federal government, there are now a number of joint federal/state programs seeking to serve medically indigent persons through reimbursement to providers, targeting services for specific underserved populations and through the direct provision of health care services. This section of the report provides information on each of the various programs, including a program description, eligibility requirements, budget and expenditures, an analysis and recommendations.

One observation made by program analysts and the Commission members was the apparent lack of coordination among the various programs designed to serve the medically indigent. It has been suggested that serious efforts should be made to fully coordinate the activities of the various programs, including eligibility, reimbursement for services, and services integration and coordination.

RECOMMENDATIONS:

1. A single health care authority should be appointed to administer health care programs for the medically indigent (including Medicaid, maternal and child

health, public health departments, primary care centers, state funding of university hospitals and other programs) as well as administering the health insurance contract for state employees, teachers and retirees.

2. The Commission adopts the summary and recommendations of the Governor's Special Medicaid Program Review Advisory Committee.

1. Kentucky Medical Assistance Program (Medicaid)

Description. The Kentucky Medical Assistance Program (Medicaid) is the largest, most comprehensive program financing health care services for medically indigent persons in the state. Medicaid covers a broad array of services and, with some limitations, can be described as a comprehensive health insurance package for those persons who qualify. Because of its size and scope of coverage, Medicaid has a definite impact on the financing and delivery of health services to the medically indigent in the Commonwealth.

Medicaid covers the following mandatory services: hospital (inpatient and outpatient), physician, skilled nursing, home health, family planning, screening, lab and x-rays, dental, transportation, vision care and hearing care. In addition, Kentucky has elected to provide the following optional services: pharmacy, intermediate care, Medicare premiums, community mental health center services, mental hospital, renal dialysis, primary care/rural health clinic, podiatry, Alternative Intermediate Services for the Mentally Retarded (AIS/MR), ambulatory surgery, home/community based waiver, adult day care, nurse midwife and nurse anesthetist services. See Appendix G for Medicaid services by date of implementation. A brief history of the Medicaid program is found in Chapter III under "History and Legal Authority."

Eligibility/No. Served. Medicaid recipients are comprised of two major groups: the categorically needy and the medically needy, both receiving the same benefits under the program. The "categorically needy" are recipients of cash assistance through Supplemental Security Income (SSI), Aid to Families with Dependent Children (AFDC) or State Supplementation to SSI. Coverage of the categorically needy is mandated by federal law.

The "medically needy" are persons who meet the technical eligibility criteria for AFDC or SSI but whose income or resources exceed the limitations qualifying them for cash assistance. The medically needy group is an optional component of the program, i.e. the states decide whether to participate. In Kentucky, both the categorically needy and medically needy groups are covered; in addition, Kentucky has chosen to cover children and parents in unemployed families, despite the fact that these families do not receive AFDC cash payments in Kentucky (although federal funds are available to match state funds for this purpose). Unemployment is generally defined as follows: employment of less than 100 hours per month by a person with prior labor market experience, with certain employment registration and employment search requirements; not on strike or temporarily unemployed due to weather conditions, and available for full time employment.

Federal law provides the state the opportunity to cover several other groups not currently funded in Kentucky. These groups, the estimated number of persons and cost of coverage include:

(1) Children between the ages of 5 and 21 who live in low income, two-parent families. Coverage of these children, sometimes referred to as "Ribicoff children," is allowable under DEFRA provisions. The Kentucky Medical Assistance Program currently covers only those children born on or after October 1, 1983 and between birth and age 5. Due to the effective date of the federal legislation, only children between birth and age 2 are currently covered by the Kentucky Medical Assistance Program. To be eligible, the income of the child's family must fall below income limits for the program, but no technical eligibility factor (such as incapacity, desertion, or death of one or both parents) must be established to qualify for the program. CHR has estimated that more than 15,000 children could potentially qualify if this option were exercised, at an estimated cost of $13.5 million.

(2) Children between the ages of 18 (if not in school), or 19 (if in school) to age 21, who live in low-income, one-parent families. KMAP provided coverage to these children until October, 1981, when eligibility was scaled back as a cost-cutting measure, in response to the OBRA changes. To be eligible , the income of the child's family must fall below income limits for the program and a technical eligibility factor (such as incapacity, desertion, or death of one or both parents) must be established. CHR has estimated that more than 3,000 children could potentially qualify if this option were exercised, at an estimated cost of $2.0 million.

(3) All families below the poverty level meeting AFDC technical eligibility requirements. Federal law requires that the medically needy income level be set at no more than 133 1/3% of the AFDC payment level although the income level can be set anywhere between 100% and 133 1/3% of the maximum payment level. Thus, in order to cover all families under the federal poverty guidelines, the General Assembly would have to approve an increase in the maximum AFDC payment amount so that the combined amount received from the AFDC payment and food stamps can be raised from the current 56% of the federal poverty guidelines to 100%. (See Chapter 1 for poverty guidelines). Estimates provided to the Eligibility Subcommittee of the Special Medicaid Program Review Advisory Committee projected such an increase would cost $135.4 million ($39.6 million in state funds) for increased AFDC payments to currently eligible persons and an undetermined amount in additional Medicaid funds. A 33% increase in the AFDC payment would add an estimated 13,500 new AFDC recipients and 3,200 new medically needy recipients at a cost of $61.4 million in AFDC costs and $3.6 million in Medicaid costs.

Appendix F includes a detailed description of Medicaid eligibility groups.

The Medicaid program currently covers about 343,000 persons in Kentucky. The vast majority of these persons live in families with incomes significantly below the poverty level. Table 15 gives the average number of recipients participating in Medicaid as of July 1985, by eligibility group.

TABLE 15

Kentucky Medicaid Participation by Eligibility Group*

Eligibility	Group	No. of Participants
Categorically Needy	Aged, Blind and Disabled-SSI	97,458
	AFDC recipients & relatives	160,186
	Children in federally subsidized adoptions	191
	Children in foster care	1,535
	Children under age 5 in intact families	844
	Total Categorically Needy	260,967
Medically Needy	Aged, Blind, Disabled-SSI	2,107
	Other Aged, Blind, Disabled	13,701
	Children deprived of support & specified relatives	26,954
	Unemployed parents & children	33,120
	Children in psychiatric hosp.	91
	Children in foster care & state subsidized adoptions	2,399
	Total Medically Needy	78,372

*As of July, 1985

Budget/Expenditures. Medicaid has increased from 2.5% of total general fund expenditures in 1969-70 to a projected 7.0% in FY 1985-86, or a 1,140% increase in general fund expenditures during this period. Appendix G shows historical and projected Medicaid expenditures and services.

The Medicaid program had a FY 1985 budget of $547.2 million. Because of a potential $49.5 million budget deficit in FY 1986, program reductions were made in August, 1985 in the following service areas: hospital, skilled nursing, intermediate care, physician, community mental health, home health, mental hospital and primary care services. High growth areas of the Medicaid budget include hospital services, skilled nursing services, intermediate care services, transportation services, pharmacy services and mental hospital services.

In total, institutional services comprise 66% of the Medicaid budget. This is despite significant increases in programs designed to keep people out of institutions, such as home health care services, community mental health services and community based services

for mentally retarded persons. In addition, the Kentucky Health Facilities and Health Services Certificate of Need and Licensure Board has added significantly to the number of long-term care beds in the Commonwealth, which are supported by nearly 80% Medicaid dollars. It is estimated that each addition of 100 long term care beds adds approximately $1 million in annual Medicaid expenditures.

Analysis. A Special Medicaid Program Review Advisory Committee was appointed on August 1, 1985 by Governor Collins to propose long term solutions in the areas of program eligibility, services and financing.

The major Committee recommendations which have been approved include extending eligibility to low income children under age 18 (19 if in school); an increase in the AFDC benefit level by 33% during the 1986-88 biennium and thereafter, to reflect inflation plus 5% until the federal poverty level is reached; increased recipient financial responsibility (homestead liens, transfers of assets, family responsibility); reforms in the delivery and payment for health care services to the medically indigent (case management, health maintenance organizations, risk-sharing by providers); implementation of preventive services and consumer education; expansion of community based services, such as the Home and Community Based Waiver and hospice care; utilization controls (pre-admission screening for long term care); a study of the reimbursement of long term care; changes in home health services and reimbursement amounts; limits on payment for organ transplants and other "high tech" services; updating fee schedules for dental, obstetrical, primary care and other selected providers; appropriate use of transportation services; elimination of fraud and abuse; employment of an independent consulting firm to conduct a management audit; a review of licensure standards; development of a quality assurance mechanism; continuance of the long term care bed moratorium with continuing study into other payment mechanisms, the needs of the population, tax credits, etc.; and the enactment of living will legislation. Appendix E presents a detailed description of the recommendations.

Medicaid can be viewed as a health insurance program with comprehensive benefits for those who qualify. The budget has grown an average of 16% in the last ten years. Expenditures are distributed between 45% optional and and 55% mandatory services; both mandatory and optional services are growing at the same rate. Institutional services continue to consume two-thirds of the Medicaid budget, and have been among the fastest growing budget items despite the recent implementation of community-based services. For example, long term care facility care consumes about 40% of the Medicaid budget (for fewer than 4% of the recipients) and in the aggregate is the fastest growing Medicaid budget item. The care of eighty percent (80%) of Kentucky nursing home residents in intermediate care and 50% of patients in skilled care is funded entirely by Medicaid.

From an appropriations standpoint, Medicaid has been a continuing problem. Medicaid has exceeded its budget every year since 1976. Despite a $30 million windfall created by the lifting of a federal cap on Medicaid expenditures, Medicaid officials were

recently forced to cut $43 million from the FY 1985 projected $577 million in expenditures to stay within budget. These cost increases were not due to increased numbers of recipients—in fact there has been only a 3.7% increase. The budget request from the Cabinet for Human Resources is $634.4 million for FY 1986 and $692.1 million for FY 1987, or approximately a 9.5% annual increase. The projected increase between FY 1985 and FY 1986 is primarily due to increases in the reimbursement to nursing homes, physicians, home health agencies, pharmacists and hospitals.

Medicaid has been described as significantly lacking in the reimbursement controls, cost controls, utilization controls and management controls that one would expect in any health insurance program. However, the days of increased spending in the Medicaid program may be coming to an end. Despite the favorable 70% federal matching rate, it is uncertain whether the Kentucky General Assembly will continue to appropriate the 30% state matching funds at previous rates of growth. In addition, Congress will likely be turning to Medicaid to solve its own budget crisis.

One controversial major cost control effort by the Kentucky Medicaid program was the implementation of the Citicare program in Louisville for 40,000 AFDC recipients. Citicare was a pre-paid primary care network whereby recipients were locked in to a particular primary care physician who was paid a flat monthly fee to cover the recipient's health care needs. Therefore, the physician would be at risk for higher expenditures; the financial incentives were to keep patients healthy and out of the hospital. Medicaid recipients under Citicare were also deterred from using costly hospital emergency rooms for routine care.

Citicare became operational in September of 1983 and was cancelled effective June 30, 1984 by the Governor. Reasons given for the cancellation were the need for a uniform statewide program and concerns about administrative costs. Citicare administrators had estimated annual savings to the state of $4.5 million, or a 17% savings. Savings were due primarily to reduced hospitalization and emergency room use. CHR officials contested these estimates.

It is likely that the case management and perhaps the capitation features of Citicare will be resurrected in the next several years, perhaps through the implementation of the "KenPAC" program and through the contracting of Medicaid services to licensed HMO's desiring to care for a fixed number of recipients. These reforms would begin to bring the program into the mainstream of the changes occurring in the health care industry, and would have the added advantage of instituting certain utilization and management controls and providing for more predictable expenditures in the program.

RECOMMENDATIONS:

1. The Cabinet for Human Resources should expand eligibility under the Medicaid program to include all low income children in two-parent families under age 18 (or 19 if in school).

2. The Cabinet for Human Resources should implement Medicaid utilization and cost controls including pre-admission screening for admissions to long term care facilities, homestead liens, and transfer of assets provisions. Both overutilization and underutilization should be considered.

3. The Cabinet for Human Resources should implement a program of case management with physician risk-sharing in the Medicaid program to coordinate services and maximize available dollars.

2. Maternal and Child Health Program

Description. The Maternal and Child Health program refers to fifteen separate programs designed to reduce infant and maternal mortality and morbidity and to improve health care for young children. Regional Pediatric Program: Regional Pediatric Clinics in 14 counties provide general pediatric, diagnostic and management services to medically indigent children with chronic health conditions requiring continuous supervision. Eligibility is extended to low income (under 100% of the poverty level) children under age 21 with a confirmed or suspected chronic condition. In FY 1984, 1,100 persons were served.

Regional Developmental Disabilities Clinics: This program provides medical and developmental evaluations for preschool children suspected of having developmental disabilities. Services are provided at four clinic sites. In FY 1984, 230 persons were served.

Birth Defects and Dysmorphology Clinics: This program provides comprehensive genetic studies, evaluation and counseling to persons with potential genetic disorders. Services are provided at the Child Evaluation Center in Louisville, with payment on a sliding fee schedule. In FY 1984, 188 persons were served.

Diagnostic and Evaluation Clinics: This program provides comprehensive interdisciplinary evaluations to multihandicapped children. Services are provided at the Child Evaluation Center in Louisville to children under age 21. In FY 1984, 750 persons were served, using a sliding fee schedule.

Childhood Lead Screening Program: This program provides community education, child screening, pediatric management and environmental epidemiology services to children ages 1-6 residing in high risk census tracts in Louisville. Eligibility is extended to all Jefferson County children receiving WIC, EPSDT, Well Child and affiliated services; there are no fees for services. In FY 1984, 7,426 persons were served.

Nutrition Services Branch: This program provides funding to local health departments to employ nutritionists for maternal and child health programs. In FY 1984, 23,729 persons were served in 20 local health departments serving 88 counties.

Regionalization of Perinatal Care: The regionalization program is a system of maternal and neonatal care geared towards treating complications and abnormalities at the appropriate specialty level. The system includes Level I, II and III hospitals; specially-trained professionals, including neonatologists and pediatric intensive infant care nurses and support services, and transportation. Twenty-four contracted Level II and Level III hospitals are reimbursed for neonatal intensive care and transportation services to critically ill neonates. The target population is all newborn babies and mothers in need of specialized

care. Medicaid-eligible newborns are automatically eligible on day 15 of hospitalization; other infants become eligible depending on the particular hospital's criteria for charity care. In FY 1984, 1,052 babies were covered through the reimbursement of up to 75% of uncollectable inpatient costs to their respective hospitals. On average, the participating hospitals receive less than 50% of their costs. It is assumed that 100% of the target population was served.

Neonatal Intensive Care Program: The neonatal intensive care program is a companion program to the regionalized perinatal care program, providing appropriate training and education to Level I and Level II hospitals, consultation, follow-up of NICU graduates, transport services and research. The services are provided by a team of professionals at the University of Kentucky Albert B. Chandler Medical Center's Intensive Care Nursery. In FY 1984, 383 medically indigent infants were served, with an average length of stay of 17 days.

Children and Youth Project: This program provides the same services described under the Neonatal Intensive Care Program to Western Kentucky, as well as comprehensive health services for program eligible infants and children. Eligibility is available to premature and other high-risk infants born at Humana Hospital-University, children under age 13 residing in certain census tracts, other high-risk premature infants born at Humana Hospital-University and others born outside Jefferson County but who cannot obtain comprehensive care in their counties. In FY 1984, 4,215 infants and children were served.

Metabolic Diagnosis and Treatment Services: Screening services for phenylketonuria (PKU), galactosemia and congenital hypothyroidism are provided through the Department for Health Services Laboratory, hospitals and private laboratories. Definitive diagnosis and follow-up services are provided by the University of Louisville and University of Kentucky Departments of Pediatrics through contracts with the Division of Maternal and Child Health. In FY 1984, 156 infants and children with PKU, galactosemia and congenital hypothyroidism were served. Diagnosis and follow-up services are provided at no charge, regardless of income; special formulas are provided using a fee schedule based on 185% of poverty guidelines.

Maternal and Child Health Well Child Program: The Well Child Program provides preventive health assessments, diagnosis and treatment for acute illnesses, and referral for handicapping conditions identified through the assessment. Eligibility is extended to low income (under 100% of the poverty level) children under age 7 who are not eligible for medical assistance. The program is available in 117 county health departments, and served 14,500 medically indigent children in FY 1984.

Regional Pediatric Program: Regional Pediatric Clinics in 14 counties provide general pediatric, diagnostic and management services to medically indigent children with chronic health conditions requiring continuous supervision. Eligibility is extended to low income (under 100% of the poverty level) children under age 21 with a confirmed or suspected chronic condition. In FY 1984, 1,100 persons were served.

Regional Developmental Disabilities Clinics: This program provides medical and developmental evaluations for preschool children suspected of having developmental disabilities. Services are provided at four clinic sites. In FY 1984, 230 persons were served.

Birth Defects and Dysmorphology Clinics: This program provides comprehensive genetic studies, evaluation and counseling to persons with potential genetic disorders. Services are provided at the Child Evaluation Center in Louisville, with payment on a sliding fee schedule. In FY 1984, 188 persons were served.

Diagnostic and Evaluation Clinics: This program provides comprehensive interdisciplinary evaluations to multihandicapped children. Services are provided at the Child Evaluation Center in Louisville to children under age 21. In FY 1984, 750 persons were served, using a sliding fee schedule.

Childhood Lead Screening Program: This program provides community education, child screening, pediatric management and environmental epidemiology services to children ages 1-6 residing in high risk census tracts in Louisville. Eligibility is extended to all Jefferson County children receiving WIC, EPSDT, Well Child and affiliated services; there are no fees for services. In FY 1984, 7,426 persons were served.

Nutrition Services Branch: This program provides funding to local health departments to employ nutritionists for maternal and child health programs. In FY 1984, 23,729 persons were served in 20 local health departments serving 88 counties.

Special Supplemental Food Program for Women, Infants and Children (WIC): This program provides specific nutritious foods to pregnant, breastfeeding and postpartum women, infants and children up to age 5. Eligibility is extended to all those persons under 185% of poverty certified to be at nutritional risk. Services are provided at local health departments and independent health agencies in all 120 counties. In FY 1984, 96,529 persons were served.

Budget/Expenditures. FY 1985 federal, state and local budgeted expenditures for the various components of the perinatal care system are shown in Table 16.

TABLE 16

Perinatal Care System Budget and Number Served

Program	Total Budget	State Share	Indigent Patients Served
Prenatal Clinic	$ 2,684,129	$1,271,178	5,409
Regionalization—Perinatal Care	5,976,700	5,976,700	1,052
Neonatal Intensive Care	164,000	123,000	383
Children & Youth Project	274,800	226,080	1,265
Family Planning	6,618,451	196,410	82,560
Metabolic Screening*	172,486	50,000	156
Genetic Disease	97,522	5,022	190
Nutrition Services Branch	535,475	236,100	23,729
WIC**	33,070,314	-0-	96,529
Total Perinatal System	$49,593,877	$8,084,490	211,273

* All children are provided free diagnosis; medically indigent children are provided free formula.
** The perinatal portion of WIC is 40% of the total ($13,228,125 and 38,611 served).

FY 1985 budgeted figures for other related maternal and child health programs are shown in Table 17.

TABLE 17

Maternal and Child Health Budget and Number Served

Program	Total Budgeted	State Budgeted	Indigent Patients Served
Well Child	$1,042,302	$ 760,100	14,500
Regional Pediatric	121,090	104,025	818
Developmental Disabilities	61,390	15,140	85
Birth Defects/ Dysmorphology	18,500	18,500	70
Diagnostic & Evaluation	144,300	70,300	219
Lead Screening	167,979	105,000	5,327
Total Other MCH	$1,555,561	1,073,065	21,019

Analysis. In recent years, infant mortality in Kentucky and the rest of the nation have remained relatively stable, but the United States still lags behind at least 12 other developed nations. The Southern Governors' Association recently reported that Kentucky had the fifteenth-highest infant mortality rate among the 50 states and the District of Columbia. In 1982, there were 10.6 deaths per 1000 live births nationwide and 12.0 deaths per 1000 live births in Kentucky. This is a drop in Kentucky from 16.7 per 1000 in 1974 and 12.2 per 1000 in 1981. Kentucky had an infant mortality rate of 11.6 per 1000 in 1983 and 1984. Rates are much higher for blacks, lower income counties and very young mothers.[28]

Despite the availability of prenatal care services to women in 112 counties in the Commonwealth, the Division for Maternal and Child Health estimates that only 50% of the need for prenatal care is being met. Currently, at least 8,000 women are receiving no prenatal care during their pregnancies, or an insufficient number of visits. A well-funded prenatal care system would include non-emergency transportation services,home health visits, and outreach or marketing efforts to insure that all pregnant women were aware of the availability of subsidized prenatal care services.

Extensive research on prenatal care services has documented its cost-effectiveness. The Institute of Medicine in its report entitled *Preventing Low Birthweight*[29] estimated the cost savings in reductions in the number of low birthweight infants at $3.38 for every dollar expended on prenatal care. The report did note the need to maintain financing for necessary neonatal intensive care services during the transition period.

Currently, 65% of all state funding for maternal and child health is concentrated in the area of regionalization of perinatal care, compared to 14% for prenatal care. Since only 50% of the need for prenatal care services is being met, it would appear reasonable to move toward a shift in funding priorities from perinatal care to neonatal care services. Any theoretical shift in funding from neonatal intensive care services to prenatal care services must of necessity be incremental and gradual in nature, and include an increased appropriation to maintain both perinatal and prenatal care services during the transition period.

The maternal and child health program can be described as a program targeting a specific population (low income pregnant women, low income women in childbearing years, new mothers and low income young children), during a specific time period (during pregnancy and immediately after birth), for services which would presumably not be otherwise available. Since maternal and child health services are funded in part through state funds, efforts have been made to insure that maternal and child health clients are non-Medicaid eligible. Thus, the vast majority of maternal and child health clients are medically indigent. However, a certain proportion of maternal and child health dollars are expended on clients who have exhausted their Medicaid benefits (such as by exceeding the 14 day limitation on hospital days) or who cannot locate Medicaid providers willing to serve them (such as physicians to perform deliveries for the low Medicaid fee). In addition, some medically indigent children served under the maternal and child health program are not currently eligible for Medicaid because of Kentucky's decision not to cover all low income

children under age 18. At a minimum, an indepth analysis of hospital days reimbursed under the Regionalization of Perinatal Care program is needed to determine whether there are potential savings in state dollars in this area.

Another problem area in the maternal and child health program is the varying eligibility requirements between programs and service available throughout the state. The relationship between the maternal and child health program and such services as the Commission on Handicapped Children, Community Health Centers, university indigent care programs and public health department services is confusing to clients and difficult to negotiate. Since none of these programs provide comprehensive health services, specific health conditions can easily go untreated. Efforts should be made to determine areas of duplication and gaps in services, and whether integrated service delivery is possible, given the varying eligibility requirements, service locations and target populations of the different programs.

RECOMMENDATIONS:

1. The Cabinet for Human Resources should increase state funding for prenatal care so that every pregnant woman in Kentucky has access to the full range of prenatal care services, and add outreach, public advertising and transportation components to the program, if possible.

2. The Cabinet for Human Resources should increase the scope of services and reimbursement under the Medicaid program to fully cover obstetrical, prenatal and delivery services, in order to maximize the use of state maternal and child health dollars.

3. The Kentucky General Assembly should require counties to make available adequate prenatal care services as a condition of state funding for local health services.

3. Kentucky Commission for Handicapped Children

Description. The Commission for Handicapped Children (originally Crippled Children's Commission) was established in 1924 by the Kentucky General Assembly to care for physically handicapped children whose parents could not afford treatment. Since its implementation, the commission's program has remained close to its founding purpose.

The Commission is currently managed through a central office located in Louisville, with services delivered through regional offices located in twelve district health departments. These offices, which contract with the Commission to provide services, are located in Paducah, Hopkinsville, Owensboro, Bowling Green, Elizabethtown, Covington, Lexington, Somerset, Barbourville, Hazard, Morehead and Ashland. Through these clinics, children are examined and diagnosed and may be referred for further evaluation and treatment. Services available to clients include:

- medical services
- hospitalization

- surgical services
- anesthesia
- convalescent care
- medications
- prosthetics and such appliances as hearing aids and wheelchairs
- support services, such as speech pathology, audiology, physical and occupational therapy, psychological and social services.

Eligibility/Numbers Served. Eligibility for service is based on three factors: age, medical condition, and financial situation. In order to be eligible, the child must be under age 21 and have a covered condition. The family's financial eligibility is based on income, insurance coverage and family size. The Commission uses an elaborate sliding fee scale for families who can pay for at least a portion of the expenses.

Table 18 summarizes the income eligibility limits for services through the Commission on Handicapped Children.

TABLE 18

Commission on Handicapped Children Income Eligibility Limits

	Minor Conditions		Major Conditions	
Family Size	With Insurance	Without Insurance	With Insurance	Without Insurance
1	$11,520	$12,520	$13,520	$14,520
2	12,900	13,900	14,900	15,900
3	14,280	15,280	16,280	17,280
4	15,660	16,660	17,660	18,660
5	17,040	18,040	19,040	20,040

Generally, children whose family income exceeds these limits are not eligible for services; however, if the service is not available from another provider near the patient's home, service may be provided with the family paying 100% of any charges for the service.

A second eligibility factor is that the child's condition must be both amenable to treatment and listed as one of the conditions covered by the program. Diagnostic categories include:

- cerebral palsy
- cystic fibrosis
- cranio-facial anomalies, including cleft lip and palate
- neurological disorders
- orthopedic conditions, including amputation, clubfoot and scoliosis
- hemophilia
- plastic surgery, including burns, heart defects, eye injuries and disease
- hearing problems.

During fiscal year 1983-84, the program served 15,882 unduplicated patients. Table 19 is a statistical summary of the clients serviced during this period.

TABLE 19

Number of Clients Served by the
Commission on Handicapped Chidlren

Type of Service	Number Served
Clinic Visits	28,382
New Patients	4,897
Physicians' Services	14,116
Hospital Services	1,520
Hospital Days	9,265

Budget/Expenditures. Table 20 indicates the revenue and Table 21 indicates the expenditures anticipated during fiscal year 1985-86 by the Commission for Handicapped Children.

TABLE 20

Anticipated Revenue for the
Commission on Handicapped Chidlren

Source	Budget
State General Fund	$5,121,100
Federal Block Grant	3,076,428
Trust and Agency Funds	292,300
Total	$8,488,828

TABLE 21

Anticipated Expenditures by the
Commission on Handicapped Children

Program	Budget
Capital Outlay	$ 35,000
Operating Expenses	195,000
Personnel	1,350,000
Care and Support	5,208,828
District Contracts	1,700,000
Total	$8,488,828

The commission reports that its average expenditure for care per child is $660 per year.

Analysis. Although the Commission for Handicapped Children receives the majority of its funds from the state, a substantial portion is received from various federal grants which place limits on how this money can be expended. By its statutory authority, the Commission's services are limited to the treatment of children up to age 21. Under current statutes, provision of services to indigent persons over age 21 is not possible; however, the range of conditions covered under the program could be expanded. Precedents exist over the sixty year history of the program for such expansion. The Commission estimates that 69% of children (30,000) needing services provided by the Commission are, in fact, receiving them. Financing of an expanded program would have to be found in state or private funds, since no federal funds are available. Historically, the Commission has pro-

vided services to persons with chronic physically handicapping conditions. The Director of the Commission has stated that without a major restructuring of the program and a vast infusion of money, the Commission is not capable of providing the range of services (including preventive and acute care) needed by the children of the Commonwealth.

Effective January 1, 1985, the Commission for Handicapped Children was re-established, by Executive Order 84-1079, in response to complaints of weak management and slow provision of services under a decentralized program housed within the Cabinet for Human Resources. It was alleged that decentralization of services and management had considerably weakened the effectiveness of the program. Under its reorganization plan, the Cabinet for Human Resources anticipated the establishment of an independent Commission which would reduce administrative and indirect costs, thereby freeing more money for provision of services, enable the Commission to develop grant proposals and secure private funding, improve the service delivery system, improve the morale of employees and service providers, and allow greater latitude for advocacy for the needs of handicapped children.

Under the provisions of KRS 12.028, the Executive Order re-establishing the Commission expires 90 days after *sine die* adjournment of the General Assembly. Unless action is taken in the 1986 General Assembly, the Commission will revert to its former decentralized organizational structure within the Department for Health Services.

In October, 1983, the Legislative Research Commission published an evaluation of the decentralized program entitled *The Crippled Children's Services Program (Research Report No. 201).* In that report, the researchers were unable to establish either a positive or negative correlation between the decentralization of the program and the efficient and effective delivery of services.

RECOMMENDATIONS:

1. The Kentucky General Assembly should ratify Executive Order 84-1079 centralizing the administration and management of the Commission on Handicapped Children.

2. The Cabinet for Human Resources should identify areas within the Commission on Handicapped Children, Medicaid and Maternal and Child Health programs where services are duplicated or are lacking, and establish a protocol which will assure that services are provided in the most cost-effective manner possible, through a coordinated approach to the allocation of services and payment for those services.

3. The Cabinet for Human Resources should conduct an evaluation of the Commission on Handicapped Children under centralized administration and management, to determine the effects of this action on service delivery, client satisfaction and the cost of providing services.

4. Primary Care Centers

Description. Federally subsidized Community Health Centers licensed as primary care centers or rural health clinics deliver services in 15 health manpower shortage areas in

Kentucky. The 15 centers are administered by nine organizations and are located in Louisville, Lexington, Northern Kentucky and Eastern Kentucky. (See Appendix H.) They employ 410 persons, including 33 full time equivalent (FTE) physicians and 20 FTE nurse practitioners and physician assistants.

Community Health Centers are required to provide basic ambulatory medical care services, dental services, nursing services, laboratory, x-ray, health education, pharmacy and other ancillary services. (Services are provided either directly by the centers or on contract.) In addition, some centers offer such services as optometry, podiatry and social work services. The philosophical orientation of the centers is ensuring continuity of care, primary prevention, and access to other levels of care (such as hospitals) when necessary and appropriate.

In addition to the Community Health Center program, the Kentucky Physician Placement Service acts as a state-funded clearinghouse to match physicians and health manpower shortage areas needing their services. The Placement Service also contracts with the Public Health Service to place National Health Service Corps (NHSC) personnel. Currently there are 42 NHSC primary care physicians, three dentists, two podiatrists and one nurse practitioner practicing in Kentucky, many in community health centers. Despite this infusion of personnel, there are still 65 health manpower shortage areas in Kentucky, located primarily in rural western Kentucky, eastern Kentucky and in inner city areas of Louisville and Lexington.

Eligibility/No. Served. Eligibility for Community Health Center services is based on family income, with services provided on a sliding fee schedule. In 1984, 73,333 patients generated 231,375 visits in the 15 centers. Of these patients, 54% had incomes below the federal poverty level, 22% were covered by Medicaid, 30% were eligible for maximum discount of charges, and 15% were eligible for a partial discount of charges because their incomes were between 100% and 200% of the poverty level.

Budget/Expenditures. In FY 1985, nine organizations administering the 15 community health centers had combined budgets of $16,243,431, of which $7,061,758 (or 43.5%) is funded through Section 330 of the U.S. Public Health Service Act. The remainder is funded through local government contributions, patient fees, Medicaid and Medicare reimbursement and other third party payment. State government contributed $156,550 through the Fayette County Health department, which operates its own Community Health Center. The Kentucky Physician Placement Service is funded by the Public Health Service through its National Health Service Corps program ($70,522), the Appalachian Regional Commission ($22,804) and $322,900 in state funding.

Analysis. Primary care centers and rural health clinics provide comprehensive health services to low income persons in places where services would otherwise not likely be available. The fact that a full array of primary care services is available at a single site minimizes fragmentation and enhances continuity of care. It can be assumed that community health centers prevent a number of persons from delaying seeking care until their il-

lness is serious, and also prevent some people from "spending down" for medical care expenses until they become eligible for Medicaid.

Despite the existence of the 15 centers there are still 65 health manpower shortage areas in Kentucky. Thus the centers can be assumed to be providing only a small proportion of the primary care services needed by the medically indigent population.

A continuing problem is the unavailability of funds for acute care services for medically indigent persons receiving services through the community health centers. This problem, which is also experienced by independent physician practitioners providing charity care, forces the primary care centers to rely on local hospital charity care admission policies. There is currently no statewide program subsidizing local community hospitals for charity care.

RECOMMENDATIONS:

1. The Cabinet for Human Resources should expand its technical assistance and grantsmanship assistance program to increase the availability of primary care center services in health manpower shortage areas by increasing the number of centers and/or increasing the number of satellite centers, in order to maximize the availability of federal indigent care dollars.

D. Joint State/Local Programs

1. State and Local Funding of University Hospitals

Description. University medical centers have traditionally been major providers of indigent care because of their educational and research mission. Kentucky university medical centers provide both inpatient and outpatient care for medically indigent persons through university-affiliated hospitals, outpatient departments and ambulatory clinics. In the last five years, increasing financial pressures have resulted in changes in administrative policies regarding indigent care in university medical centers in Kentucky.

The University of Kentucky has reported over $29 million in uncompensated care for FY 1983-84. This includes $3.6 million in charity care, $4.4 million in bad debts and $21 million in contractual allowances. The University of Kentucky regards the $7.1 million state appropriation in support of UK's educational program as teaching funds rather than indigent care funding. On July 1, 1981, the University of Kentucky Hospital adopted a policy restricting the admission (including patients referred by or seeking transfer from other hospitals or institutions, patients seen in the emergency room or outpatient clinics, or others seeking admission to the hospital) of indigent patients to those requiring immediate care and those for which payment was assured. In addition, on January 29, 1982, the Council of Supervisors, University Hospital adopted a policy reducing the acceptance and admission of both indigent and Medicaid patients, requiring the neonatal intensive care unit to become self-supporting and refusing to admit all long-term indigent and Medicaid psychiatry patients. Restrictions were implemented through a Financial Allowance and Pa-

tient Payment Policy including a requirement that both inpatient and ambulatory patients be held responsible for payment for services rendered, with some financial allowance for inpatients based on family income.

In 1983, the University of Louisville concluded a series of agreements with a subsidiary of Humana, Inc. to lease its new $73 million, 404 bed university hospital to the private, investor-owned corporation. Humana agreed to lease the multi-building complex for $6.5 million annually for four years, with the option to renew the lease for nine additional four-year periods at $6.0 million annually. Humana agreed to provide medically necessary treatment to indigent residents of Jefferson County, and for persons outside of Jefferson County, up to 10% of the total amount of government funding. First year government funding included $19.8 million in contributions to a Quality and Charity Care Trust: $14.8 million from the Commonwealth of Kentucky, $2.9 million from Jefferson County and $2.1 million from the City of Louisville. The contributions of the various levels of government are to increase annually by the lesser of the Consumer Price Index or the rate of increase in state tax revenue. The subsidized care is limited to inpatient hospital care at Humana Hospital University. Ninety percent of the trust is to be used to provide medically necessary care for medically indigent persons who are residents of Jefferson County; 10% of the fund is to be used for indigents residing outside of Jefferson County. If the respective governments fail to provide funding, the hospital may stop providing care for the indigent. Humana bills the trust at the rate of 95% of charges. There are a number of other related agreements regarding additional obligations and contributions by Humana, Inc. and responsibilities of the university, including provisions on membership on the Hospital Board; residents' salaries; maintenance, insurance and upkeep; payment of certain university faculty; educational support; and distribution of pre-tax profits.

Since May of 1983, Humana Hospital-University has reported $4.0 million to $6.0 million in losses in caring for the medically indigent, and approximately $1.5 million in profits annually. Losses are defined as the total indigent care provided less the amount reimbursed by the Quality and Charity Trust Fund. The main area of loss has been in caring for non-Jefferson County residents. In 1985, Humana Hospital-University reported providing $6.5 million in hospital care for indigent patients outside Jefferson County. Under the Charity and Trust Agreement, Humana was paid for $2.0 million of this care. Thus, Humana reported that it absorbed $4.5 million in unpaid charges for out-of-county indigent patients. Humana provided a total of $6.4 million in unreimbursed care for both Jefferson County and out-of-county patients.

In addition to the two university-related hospitals, Kosair Children's Hospital functions as the primary teaching facility for the Department of Pediatrics at the University of Louisville. All pediatric services except newborn services were discontinued in 1974 at the University Hospital in Louisville. Kosair Children's Hospital has city and county appropriations in the amount of $182,333 to provide indigent care to children.

Eligibility/No. Served. In FY 1983-84, the University of Kentucky Hospital admitted 511 indigent patients, or 3.3% of its total patients, and 5,323 Medicaid recipients, or

34.6% of its patients. Eligibility is based on family income, health insurance status and ability to pay.

In FY 1984 Humana Hospital-University had an average of 94 indigent patients per day, or 35% of its total occupancy; an average of 61 Medicaid patients per day, or 23% of its beds were occupied by Medicaid recipients. An additional 49,000 indigent patients were treated in the emergency room during the first 16 months of operation. Eligibility for charity care under the Trust Agreement is based on Hill-Burton Guidelines.

In 1984 Kosair-Children's Hospital admitted 369 indigent patients, or 5.6% of their total patients, and 1896 Medicaid patients, representing 29% of total admissions. Financial assistance determinations are based on an income determination policy; no child is turned away because of an inability to pay.

Budget/Expenditures. The state appropriation for indigent care through the university hospitals consists of $16.0 million to Humana Hospital-University. In addition, the University of Kentucky arguably receives a state appropriation of $7.1 million for educational expenses; there is no comparable appropriation to the University of Louisville. Both university hospitals and a number of other hospitals across the state incur expenses for charity care, bad debt and contractual allowances for state and federal government programs. Table 22 shows the amounts spent in these categories in 1984 as estimated by the Kentucky Hospital Association.

TABLE 22*

Hospital Indigent Care in Kentucky

Category	Amount	% of Revenue
Medicare Contractual Allowances	$155.1 million	9.3%
Medicaid Contractual Allowances	58.0 million	3.5%
Other Contractual Allowances	14.7 million	0.9%
Bad Debts	39.3 million	2.4%
Indigent Care/Charity Care	64.3 million	3.9%**

*1984 data
**Includes the University of Kentucky, but not Humana Hospital-University or the remaining six Humana Hospitals in Kentucky.

Since hospital-specific data is not available, it is not possible to evaluate the concentration of charity care provided in particular hospitals.

Analysis. The current state appropriations for the two university hospitals are intrinsically related to the educational and research missions and previous administrative arrangements made by the universities, and should be viewed in that light. Nonetheless, current arrangements do not adequately meet the needs of the medically indigent in Kentucky in terms of the scope of coverage, or access or availability of service. The universities are not geographically close to medically indigent persons residing in rural areas of the Commonwealth. In addition, only inpatient hospital services are covered; thus the benefits of comprehensive health care and cost efficiency in providing outpatient hospital services are being lost. The University of Kentucky has been forced to restrict the care available to the medically indigent, further limiting access to eastern Kentuckians.

A number of Kentucky community hospitals provide unsubsidized care to the medically indigent. It is reasonable to assume that a community-based system for providing both inpatient and outpatient hospital care to the medically indigent would greatly improve access to health care throughout the state. It would, of course, be necessary to finance that care through one of several sources, including: (l) state general fund dollars, (2) county general fund dollars with a state matching program, (3) a tax on gross or net hospital revenues, and (4) a tax on health insurance premiums.

RECOMMENDATIONS:

1. The Cabinet for Human Resources should establish a statewide program of subsidized inpatient and outpatient hospital care, utilizing community hospitals meeting specific participation criteria, including:

   - A minimum percentage of gross revenue expended on charity care;
   - A minimum percentage of patients who are Medicaid recipients; and
   - An open door policy for charity care patients and/or advertising regarding the willingness of the hospital to admit charity patients.

2. The Cabinet for Human Resources should establish a uniform definition of charity care and develop and require a system of uniform hospital reporting and accounting of charity care expenditures as a condition for licensure.

2. Local Health Departments

Description. Local and district health departments exist in all 120 counties in Kentucky, and provide a wide range of preventive health services to the medically indigent, Medicaid recipients and other persons. In general, services provided by health departments include screening, diagnosis and health education and promotion. Health departments are administered by the Local Health Services Program in the Cabinet for Human Resources, which exists for the purpose of strengthening the administrative and programmatic functions of local health departments serving residents of Kentucky counties. Special programs funded or administered by the Local Health Services Program include risk reduction, chronic disease, communicable diseases, hypertension, cervical cancer services, diabetes

control, immunizations, tuberculosis, sexually transmitted diseases control and dental services.

County and district health boards are established through the Kentucky Revised Statutes (Chapter 212). In addition, county health department powers, duties and functions are enumerated by statute. Duties related to tuberculosis control, vital statistics and other health department functions and services are also mandated by statute. (See Chapter III, A, for a more comprehensive description of the history and legal authority of local health departments.)

Eligibility/No. Served. The majority of services delivered in health departments are delivered on a sliding fee scale. Sliding fee scales vary by program, due primarily to state and federal guidelines for the particular program. Appendix I provides detailed information on the total number served by program area, and the percentage in each program under federal poverty guidelines. In total, 304,556 persons received health services from the health departments; 183,584 had incomes below the federal poverty level.

Budget/Expenditures. Approximately $17.0 million in federal and state funds was expended by local and district health departments in FY 1985, with additional contributions of $16.0 million by local government. Table 23 gives a partial listing of indigent care programs through the local health departments, their funding and the number of persons served.

TABLE 23

Local Health Department Programs

	Funding Source			
Program	Federal	State	Local	Number Served
Hypertension	$300,000	$ 621,078	$ 109,266	22,000
Cancer	-0-	555,527	88,524	16,000
Diabetes Control	81,089	1,380,921	100,000	9,200
Tuberculosis	98,000	1,967,454	766,000	88,000
Immunization	144,396	953,425	1,157,892	133,000
Sex/Trans/Disease	280,800	479,219	719,662	48,000

Analysis. Health departments are a major provider of health care for the medically indigent, but are in fact the provider of last resort for a number of low income and medically indigent persons in Kentucky. Although several health departments have obtained licensure as primary care centers, providing far more comprehensive services than the remainder of the health departments, there are still 65 health manpower shortage areas in the state, where additional primary care services for the medically indigent are needed. Primary care center licensure has the advantages of allowing Medicaid reimbursement at the higher primary care center rate, thus reducing much higher Medicaid expenses for acute care treatment when primary care is unavailable or delayed.

There are several problems associated with the provision of comprehensive care through health departments, including the unavailability of personnel, changes in thinking and philosophical orientation of health primary departments toward comprehensive health services delivery, and the potential loss of patients from the private sector. Incentives for health departments to develop and provide the full range of primary care services would include providing financial incentives at the state level for those health departments desiring participation in such a program, exemption of health departments from certificate of need requirements and amendment of existing statutes relating to health departments to increase their authority and responsibility for indigent care, and perhaps repeal of the county home rule statute to permit higher taxation in those counties. Local community hospitals might also benefit by these incentives, if they wish to provide primary care center services in outpatient hospital clinics.

In health departments not desiring primary care center licensure, efforts should be made to fully coordinate state and local programs, to insure that federal funding is maximized wherever possible, and that medically indigent persons are provided with broad access to health department services. Efforts such as increased outreach and transportation, marketing of health departments services and coordination of existing programs would ameliorate accessibility problems which medically indigent persons now experience in attempting to obtain needed services.

RECOMMENDATIONS:

1. The Cabinet for Human Resources should encourage the development of primary care center services provided in health departments through the provision of financial incentives, technical assistance and coordination of existing state programs.

CHAPTER IV

Role of the Private Sector

> "Sometimes give your services for nothing . . . and if there be an opportunity of serving one who is a stranger in financial straits, give full assistance to all such. For where there is love of man, there is also love of the art."[30]

This quotation from Hippocrates suggests that physicians have always been encouraged to provide care to all persons irrespective of their ability to pay. In fact, the view has been that for physicians to fail to give to charity by providing free care is to fail in a moral obligation which would make the provider less of a professional. Likewise, hospitals have been encouraged to provide free care to the poor. However, criticisms have been leveled at both physicians and hospitals as to whether these groups of providers have consistently provided their "fair share" of free care for the medically indigent. Under the current voluntary indigent care programs, the net effect has been medical care for the indigent which has been uneven and crisis-oriented services.

In Kentucky, the private sector has taken two important structured approaches in 1984 and 1985 regarding the provision of free health care for the medically indigent. The Kentucky Medical Association created and established the "Kentucky Physicians Care Program" and the Kentucky Hospital Association sponsored the "Fair Share Program." In addition, the attempt was made by the sponsoring entities to document and measure the contributions of participating physicians and hospitals.

A. The Kentucky Physicians Care Program

Description. The Kentucky Medical Association initially proposed a "Kentucky Physicians Care Program" for a twelve-month trial and the program was established in January, 1985, in cooperation with the Kentucky Cabinet for Human Resources.

Under this program, which is unique in the United States, people certified as needing non-emergency medical care are referred to a physician who has agreed to see the person without charging a professional fee for the patient's initial visit. Emergency calls are referred to the nearest emergency room. Indigent families (defined as those below the federal poverty guidelines) are certified as eligible by case workers of the Kentucky Cabinet for Human Resources, Department for Social Insurance. Once certified, a person needing medical care calls a toll-free line during normal working hours and talks to an operator, who is either a registered nurse or someone under the supervision of a registered nurse. The operator refers the person to a participating physician of the appropriate speciality. Referrals are made on a rotating basis to participating physicians residing in the same county as the patient. If the patient has already been examined by one of these physicians or if no par-

ticipating physicians of the appropriate specialty practice in the patient's home county, the patient is referred to the nearest physician in the appropriate specialty area. Actual arrangements for the care and any follow-up are left to the patient and the physician. If the patient needs follow-up care and the physician is unable or unwilling to provide it, or if the patient prefers to see a different physician, that patient is referred to another physician.

Eligibility/Number Served

Program Participants. From January, 1985 through June, 1985, approximately 18,000 people in 7,500 families applied and were certified for the program. Program demographics show these people have the following general characteristics:

- Participants are under age 65;
- Participants are more likely than all Kentuckians to live alone;
- Two-thirds of participants have not completed high school;
- The average family income is $280 per month;
- The average family resources are $39 cash on hand or in the bank;
- Half have been denied eligibility by the Medicaid program during the previous two years; and
- One-fourth have been refused medical care due to inability to pay; and
- Three-fourths have gone to a physician.

Persons enrolled in the program represented about 2 1/2 percent of Kentuckians living in poverty. The program met a greater portion of health care needs in Western Kentucky than in other parts of the Commonwealth. About half of enrolled families called the KMA for referrals, with an average of 33 referrals for every 100 people in the program.

Participating Physicians. Half of the actively practicing licensed physicians in the Commonwealth volunteered for the program, with participation highest in northeastern Kentucky and lowest in midwestern Kentucky. Although an average of 2.8 referrals have been logged per participating physician, persons in southeastern and midwestern Kentucky had three times the average number of referrals, due either to a greater need for health care or to lower physician participation, and half of the participating physicians had no direct referrals. Referrals were most frequently made to primary care physicians, especially family practitioners, who averaged 7.3 referrals.

Program Utilization. Program participants averaged 3 ambulatory visits per participant during the first 5 1/2 months of operation. This figure is higher than the average utilization rate for the general population of the Southern region of the United States and higher than the utilization rate of AFDC-related Medicaid recipients in Jefferson County. However, only about one visit in seven reportedly was due to a KPC referral. Although 43

percent of visits not due to referrals were free to the patient, a total of 6,000 referrals were made during this period, resulting in about 7,000 actual visits.

Analysis. Although participants expressed the need for coverage of related services such as medicine, tests and other costs, four of five families were satisfied with the program. Most participants indicated information about the program came from the social worker who consulted with each applicant; however, some people enrolling had no previous knowledge of the Kentucky Physicians Care program.

An estimated 1,000 families received health care through the program they would not have received otherwise. Almost the same number would have struggled to pay for needed health care out of their meager resources.

Twice as many calls were made to the hot line in January as in February or March, with even fewer calls made during the period from April through June, 1985. Because of the volume of calls, some people reported having to dial the hot line 3 or more times to get through to the hot line operator in January, a problem which was ameliorated in subsequent months.[31]

The findings of the first half-year of the Kentucky Physicians Care program were presented to the Kentucky Medical Association House of Delegates
in September, 1985. Subsequently, the House of Delegates resolved to continue the Program for calendar year 1986 (see Appendix J) with several contingencies, as follow:

1. Program funding being continued, as appropriate, by the Kentucky Health Care Access Foundation, with KMA contributing in-kind services as done in 1985;

2. A continuing commitment from the Cabinet for Human Resources to evaluate program applicants for eligibility, as is currently being done;

3. Some modifications being made to the program by the Kentucky Physicians Care Operating Committee which will address problems inherent in some types of delivery, such as pre- and post-natal care;

4. The Kentucky Hospital Association continuing its Fair Share Program as currently operated;

5. The Kentucky Health Care Access Foundation vigorously encouraging the active participation of free-standing emergency centers, health maintenance organizations, and all other health care delivery and/or financing organizations in Kentucky Physicians Care or the Fair Share Program, as may be appropriate; and

6. The Kentucky Health Care Access Foundation making Kentucky legislators aware of the plight of those ineligible for Medicaid assistance solely because they do not meet the confusing and arbitrary requirements of the Medicaid Program, while working to broaden the societal financial obligation necessary to provide care to those in need of such assistance.

RECOMMENDATIONS:

1. The Kentucky Medical Association should be commended for establishing the Kentucky Physicians Care Program and for its decision to continue the program for its second year.

2. The Kentucky Medical Association should be urged to act to encourage increased physician participation in the Kentucky Medical Assistance Program, thereby increasing access to health care by the low income poor.

3. The Cabinet for Human Resources should be encouraged to continue its support of the Kentucky Physicians Care Program by assisting with data collection and analysis and, furthermore, that the Legislative Research Commission be periodically informed as to any research findings.

4. The Kentucky Medical Association should be encouraged to raise the income eligibility limit of the Kentucky Physicians Care Program from 100% to 150% of the federal poverty level.

B. Hospital Uncompensated Care

Description. During the 1980 General Assembly, the Kentucky Legislature passed Senate Concurrent Resolution 23, supporting the Kentucky voluntary efforts at health care cost containment. In June, 1981, the University of Kentucky hospital announced a new admissions policy designed to address hospital budget problems by limiting the number of Medicaid and indigent persons. In the months subsequent to this announcement, there was much public and private discussion of who had responsibility for the care of the indigent. In response to the hospital's new admissions policy and public concern about who would care for the medically indigent, the University Hospital announced the formation of the Health Care Access Committee in May, 1983. The Health Care Access Committee was given the charge "to identify issues and focus on solutions to the developing medically-indigent patient care crisis in Central and Eastern Kentucky."[32] During the 1984 General Assembly, a bill (84 BR 859) was introduced which would have required all hospitals to provide a fair share of medically necessary hospital care to the medically indigent; however, this bill did not pass out of the House.

In September, 1984, the Health Care Access Committee issued its tentative recommendations. In addition to recommending the establishment of what became the Kentucky Physicians Care program, the Committee recommended the establishment of a hospital "fair share" program. The Committee recommended the formation of the Health Care Access Foundation "to serve as a clearinghouse for information on problems of access to health care, to speak in support of needed improvements to the system, and to evaluate the effectiveness and responsiveness of health care providers and related agencies with reference to voluntary efforts and related proposals contained in these recommendations and report regularly on participation, non-participation, and compliance."[33] The Foundation, which was incorporated in December, 1984, facilitated the establishment of both the

Physicians Care program, discussed earlier, and the Fair Share program and currently monitors both programs.

The Fair Share program is based on the desirability of providing as much hospital charity care as possible, while at the same time attempting to assure that no individual hospital will suffer as a result of providing care to indigents and Medicaid recipients. However, this program is designed to be a stop-gap solution, the necessary first step toward a long-term solution to Kentucky's indigent health care problems.

Eligibility/Number Served. Hospitals participating in the Fair Share program agree to provide a percentage of their total revenues, including net patient revenue and other operating revenue, as indigent care. Indigent care under the program is the sum of charity care and 40 % of the hospital's bad debt. Each hospital is asked to voluntarily provide at least as much charity and Medicaid care as was provided on the average by all hospitals in 1982 in their area development district (ADD). In addition, the University of Kentucky is asked to give 5% of its patient revenues to charity care and to see a minimum of 15% Medicaid patients, and Humana-University is asked to fulfill its contractual obligation. Table 24 shows the targeted percent of hospital care to be provided within each ADD.

No statistics are available to show the number of individuals who have benefited from the Fair Share program. Although the amount of indigent care is compiled by the hospitals, the number of individuals served is not uniformly gathered.

There are currently 97 hospitals participating in the Fair Share program.

Analysis. Hospitals use a wide variety of definitions when identifying uncompensated care. Simply stated, uncompensated care is health care that has been provided for which no payment is received. Although there are no uniform definitions or accounting practices currently in use, it is clear that uncompensated care is not synonymous with indigent or charity care. Many of the people who generate uncompensated care are not poor; they either lack adequate health insurance or simply do not pay their bills, despite the apparent ability to do so. The total amount of uncompensated care is a function of several distinct factors.

Definition of Uncompensated Care. Uncompensated care has three main components: bad debts; indigent or charity care; and Medicaid, Medicare, and other contractual allowances. Bad debts are defined by hospitals as doubtful accounts that are not expected to be paid in the future and represent the difference between rates billed and the amount expected to be recovered. Accounts classified as bad debts involve patients with adequate financial resources whom the hospital originally expected to pay but have failed to do so, despite efforts to collect the bill.

Indigent or charity care, in contrast, represents unpaid charges for patients who are determined medically indigent at the time of admission and who are recognized not to have the financial resources or means (such as health insurance) to be financially responsible. The hospital never expected to be paid for these patients.

TABLE 24

Targeted Fair Share Percent of Hospital Care by ADD

Area Development District (ADD)	% Charity Care*	% Medicaid**
Purchase	1.8	5.7
Pennyrile	2.6	7.2
Green River	2.1	6.0
Barren River	2.6	7.1
Lincoln Trail	2.2	10.8
Kentuckiana[1]	2.6	6.4
Northern Kentucky	2.5	6.9
Buffalo Trace	1.9	11.5
Gateway	2.6	12.0
FIVCO	2.3	12.0
Big Sandy	2.3	11.4
Kentucky River	2.6	16.9
Cumberland Valley	2.6	18.2
Lake Cumberland	1.5	11.7
Bluegrass[2]	2.6	6.9

*Based on total patient revenue
**Based on total patient days
[1] Excluding Humana Hospital-University
[2] Excluding University of Kentucky

Medicaid, Medicare and other contractual allowances represent costs incurred by patients covered by Medicaid, Medicare or other third party payers (such as health insurance or health maintenance organizations) that were not fully reimbursed, due to limits on reimbursement rates, length of stay, procedures covered and similar factors.

Amount of Uncompensated Care. The American Hospital Association estimates that $6.2 billion in uncompensated care was provided nationally in 1982, representing approximately 6% of hospital revenues. Although this percentage seems small, public and

teaching hospitals have historically provided a larger proportion of uncompensated care. Table 25 shows the distribution of uncompensated care and hospital charges by type of hospital in 1982.

TABLE 25

Kentucky Uncompensated Care and Hospital Charges by Hospital Type

Hospital Type	Uncompensated Care	Hospital Charges
Voluntary Non-Teaching	41.7%	43.1%
Voluntary Teaching	18.6%	20.7%
Government Teaching	17.7%	6.4%
Investor-Owned	5.1%	7.8%
Government Non-Teaching	16.9%	12.0%
Total	100%	100%

There is a substantial discrepancy when comparing the distribution of uncompensated care with the distribution of total hospital charges, which suggests that public and teaching hospitals are bearing a greater share proportionally of uncompensated care.

The Kentucky Hospital Association reports that hospitals in Kentucky had $331,429,279 in uncompensated care in 1984. Table 26 breaks down this figure by category.

TABLE 26

Kentucky Hospital Uncompensated Care by Category

Source	Uncompensated Care Amount	% of Total Revenues	% of Uncompensated Care
Medicare Contractuals	$155,137,672	9.3%	46.8%
Medicaid Contractuals	57,970,099	3.5%	17.5%
Other Contractuals	14,716,610	0.9%	4.4%
Bad Debts	39,288,069	2.4%	11.8%
Indigent Care	64,316,829	3.9%	19.4%
Total	$331,429,279	20.0%	99.9%

The total amount of uncompensated care provided by Kentucky hospitals grew by 12.4% from 1983 to 1984, with the largest growth occurring in Medicaid contractuals and allowances, due to limits placed on Medicaid reimbursement.

Paying for Uncompensated Care. Hospitals generally fund uncompensated care in three ways: using operating profits, shifting uncompensated costs to private payers ("cost shifting") and with government funds. Because Kentucky does not have a general program for indigent health care outside of the Medicaid program, hospitals in Kentucky have funded uncompensated care primarily by shifting costs among private third-party payers. This method will grow less practical as private business and government seek to reduce health care expenditures. Third-party payers will increasingly insist on paying only for costs incurred by their beneficiaries, making cost shifting more difficult. For example, Blue Cross/Blue Shield of Kentucky now stipulates to hospitals that they will not participate in any bad debt accounts other than those covered by Blue Cross with such accounts being limited to 6% of hospital revenue.

University Hospitals. Aside from the uncompensated care provided by the community hospitals in Kentucky, the Commonwealth's two university teaching hospitals, the University of Kentucky Medical Center and the Humana Hospital-University of the University of Louisville, have traditionally provided a high proportion of uncompensated care. For fiscal year 1983-84, the University of Kentucky Medical Center provided $29,148,000 in uncompensated care—representing approximately 30% of total patient revenues. Actions were taken in 1981 and 1982 to restrict the admission of indigent patients to those requiring immediate care and those for which payment was assured. Restrictions were also implemented through a Financial Allowance and Patient Payment Policy including a requirement that both inpatient and ambulatory patients be held responsible for payment for services rendered, with financial allowances for inpatients based on family income.

In 1983, the University of Louisville concluded a series of agreements with a subsidiary of Humana, Inc. to lease the new university hospital to the private, investor-owned corporation. Humana agreed to lease the multi-building complex for $6.5 million annually for four years, with the option to renew the lease for nine additional four-year periods at $6.0 million per year. Humana agreed to provide medically necessary treatment to indigent residents of Jefferson County, and for persons outside of Jefferson County, up to 10% of total government funding. A Quality and Charity Trust Fund was established, with first year funding of $19.8 million, including: $14.8 million from the Commonwealth of Kentucky, $2.9 million from Jefferson County and $2.1 million from the City of Louisville. These contributions are to increase annually by the lesser of the Consumer Price Index or the rate of increase in state tax revenue. The subsidized care is limited to inpatient hospital care at Humana Hospital-University. Since May of 1983, Humana Hospital-University has provided a total of $20,734,000 in uncompensated care, with $4.0 to $6.0 million of this amount in losses in caring for the medically indigent.

The University of Kentucky Medical Center does not receive a state appropriation specifically for indigent care, but receives an allocation of funds as an educational institution from the Council on Higher Education. This appropriation was $7.1 million for Fiscal Year 1983-84 and is not segregated into educational and indigent care costs. The 1982 Kentucky General Assembly provided $4 million in a one-time appropriation for FY 1982-83 for operating deficits of the University of Kentucky and University of Louisville teaching hospitals, in response to rising uncompensated care.

In addition to the two university hospitals, Kosair Children's Hospital functions as the primary teaching facility for the Department of Pediatrics at the University of Louisville. All pediatric services except newborn services were discontinued in 1974 at the University Hospital in Louisville. Kosair Children's Hospital has city and county appropriations in the amount of $182,333 to provide indigent care to children.

RECOMMENDATIONS:

1. Group-rated insurance pools should be created to make affordable health insurance available to the unemployed and uninsured population.

2. Hospitals which are participating in the Fair Share Program should be encouraged to continue participation and hospitals which are not participating should be encouraged to begin participation.

C. Health Insurance Reform

The Kentucky health insurance statutes and administrative regulations have a significant impact on the extent of medical indigency in the Commonwealth. The states have authority to regulate private individual and group health insurance policies and health maintenance organizations, including regulation of minimum benefits (services) to be covered, the sale and advertising of insurance policies, solvency, and continuation and conversion of health insurance policies after termination of employment.[34]

Up until recently, the regulatory authority of the states has been considerably limited by the federal Employee Retirement Income Security Act of 1974 as amended, (referred to as ERISA[35]), which had been interpreted as superseding state laws regulating employee benefit plans. The practical effect of ERISA has been to exempt self-insured health insurance plans and multi-employer trusts (which may account for as much as 20% of the private health insurance market) from state regulation. This exemption was recently struck down by the U.S. Supreme Court with regard to mandated benefits provisions of state health insurance codes.[36] State insurance codes regulating the contents of health insurance now appear to be applicable to self-insured plans, as well as policies sold by private health insurers.

The policy option with regard to medical indigency is to expand state minimum benefits requirements, continuation and conversion requirements, and open enrollment requirements to insure that health insurance coverage is as comprehensive as possible, and

that as many employees and former employees as possible are covered. A corollary of this option is that as many employees, dependents and former employees as possible are covered at the group premium rate, since the cost of health insurance sold to individuals is often prohibitive.

Specific provisions of the Kentucky health insurance code which could be amended to expand both health insurance benefits and the number of persons covered under group policies include the following:

(1) Require continuous open enrollment by private health insurers for recently unemployed, married or divorced spouses, and dependents.

(2) Require non-profit health insurance companies, group health insurers, self-insured employee group health plans and health maintenance organizations to offer coverage from the first day of employment and without waiting periods for pre-existing conditions.

(3) Require employers offering health insurance coverage to employees to also offer dependent coverage to employees at group rates.

(4) Require non-profit health insurance companies, individual health insurers, group health insurers, self-insured employee group health plans and health maintenance organizations to offer dependent coverage at group rates up to age 24 (instead of age 21), if the child is chiefly dependent upon the policyholder.

(5) Require non-profit health insurance companies, group health insurers, self-insured employee group health plans and health maintenance organizations to expand the duration of continuation coverage for terminated employees, divorced spouses, widowed spouses and dependents from 9 months to 2 years at the group rate.

(6) Require non-profit health insurance companies, group health insurers, self-insured employee group health plans and health maintenance organizations to expand minimum benefits in conversion policies by: (a) raising minimum dollar amounts on coverage, (b) expanding minimum services to include physician services, if covered in the previous group plan, and (c) requiring coverage of pregnancy, childbirth and miscarriage (which are now specifically excluded).

(7) Specify responsibilities for notifying former employees of continuation and conversion privileges, and require that separate notice be given to former employees in plain language.

Impact of Health Insurance Reform in Kentucky. An estimated 85.5% of Kentuckians were covered by private or government health insurance in 1983.[37] Table 27 gives the estimated 1985 distribution by public and private health care insurers.

TABLE 27

Kentucky Health Insurance Coverage by Type of Insurance

Insurer	No. Persons	% of Total Pop.
Blue Cross/Blue Shield of Kentucky	1,127,212	29.5
Commercial Insurers[38]	1,164,862	30.5
Medicare[39]	490,000	12.8
Medicaid	336,940	9.1
Health maintenance organizations	135,000	3.6
Uninsured	553,217	14.5
Total Population	3,815,291	100.0

Coverage under Medicaid and health maintenance organizations is nearly comprehensive in the scope of benefits and most members incur only nominalcopayments or deductibles. Medicare coverage is less comprehensive; the Medicaid program pays Medicare supplement insurance for about 20,000 recipients; of the remaining Medicare population 28% are not covered by Medicare supplement insurance.

The comprehensiveness of individually purchased private insurance contracts (both Blue Cross/Blue Shield and commercial) varies moderately. Only 18% of private health insurance policies are purchased by individuals; the remainder are purchased through group contracts. Table 28 shows the percent of group health insurance policies offering each specific type of coverage.

TABLE 28

Group Insurance Coverage by Service

Type of Service	Percent of Contracts Covering
Hospital expense	100%
Surgical expense	94%
Physician expense	87%
Major medical[40]	84%
Dental	46%

Thus, the vast majority of private group health insurance contracts provide fairly comprehensive coverage. The problem, then, becomes one of assuring that as many spouses and dependents as possible are covered by group policies, and extending coverage as long as possible to former employees.

The long term impact of expanding state requirements would be to shift some of the costs of health care for the medically indigent from federal, state and local government and from health providers to employers and to persons actually covered by health insurance policies. Health insurance companies would be required to close some of the current gaps in health insurance coverage, and would increase their premium dollars as a result. The federal and state government would also share in the costs of expanding coverage through lost revenues due to tax deductions and exemptions for health insurance expenses and due to expanded coverage requirements for government employees. This loss would be mitigated by savings in the Medicaid, Medicare and other state and federal health programs.

Employer contributions for health insurance premiums comprise nearly 6% of total compensation. A 1983 survey by the U.S. Department of Health and Human Services found that the average annual premium for an individual employee was $816 and the average annual family premium was $2112. Premium increases since 1983 have averaged about 9% annually.[41] The average employer contribution was 92% of the cost for individual employees, and 84% for the family premium. Of probably more significance to Kentucky was the relatively small percentage of small companies providing health insurance benefits for their employees. Nationally, only 47% of firms employing fewer than 100 persons provide health insurance as a benefit, compared with 99% of medium sized firms (100-999 employees) and 100% of large firms (1000+). Insurance status is also closely related to the percentage of low wage employees in a company; nearly 30% of firms with more than 50% of employees at or below minimum wage do not provide health insurance benefits. In addition, very few employees working fewer than 30 hours per week are covered by health insurance policies, even when benefits are offered to full time employees. Employee health insurance is also less likely to be offered in non-unionized companies, and in the agricultural, mining, construction, wholesale and retail trade and service industries. Manufacturing, government, transportation and military employment are highly correlated with the provision of health insurance for employees.[42]

As of May, 1985, 7.5% of the Kentucky workforce was unemployed, and the majority of these workers have been unemployed for five weeks or more, thereby exhausting their employee health insurance coverage. Data is not available on the number of persons who do not opt for continuation coverage, or who have exhausted the nine-month period for continuation of benefits even if they had chosen to pay the continuation premium expenses. Even fewer unemployed persons would be in a position to utilize their conversion privileges, since premium costs are often double the cost of group coverage.

Despite the lack of data on the number of persons who would take advantage of expanded health insurance options, it can be reasonably assumed that making health insurance available to as many employed and formerly employed persons, dependents and former spouses as possible would be a useful tool in reducing medical indigency in the population. Other efforts to reduce gaps in health insurance policies, such as reducing waiting periods for pre-existing conditions, would insure continuity of care, which could be critical for people with chronic conditions. It would appear that existing statutes and practices do not provide adequate protection for persons who frequently change their place of employment, or for unemployed persons, pregnant women and young adults.

Advantages and Disadvantages of Health Insurance Reform in Kentucky

Advantages:

1. Increased numbers of persons would be covered by comprehensive health insurance policies at lower rates, thereby reducing the extent of medical indigency.

2. Closing gaps in coverage would provide opportunities for lower cost alternatives to hospital and institutional care.

3. Health insurance coverage would be provided through the private sector, probably the most cost-effective way to purchase health expense protection, and the risk of illness would be spread among the population as in any insurance arrangement.

4. Pressure on the already over-burdened public health insurance programs would be relieved.

5. Some medically indigent persons would be brought into the mainstream of the health care delivery system, slowing the trend toward separate health care delivery system development.

Disadvantages:

1. Extended continuation of benefits provisions would increase the burden on private employers and may cause some employers to reduce hiring or eliminate health benefits entirely.

2. To the extent that unemployed persons need and utilize health care services more than the employed population, expanding benefits could have an adverse selection impact and raise overall group health insurance premium costs.

3. The changes in health insurance requirements would pose an administrative burden on health insurers.

4. An undetermined number of employees and former employees would forego individual and dependent health insurance coverage even if continuation coverage beyond the current nine-month period and open enrollment requirements were expanded. Thus, increasing these requirements would not have the effect of entirely eliminating medical indigency.

RECOMMENDATIONS:

1. The Kentucky General Assembly should enact legislation to require continuous open enrollment by private health insurers for recently unemployed, married or divorced spouses and dependents.

2. The Kentucky General Assembly should enact legislation to require nonprofit health insurance companies, group health insurers, self-insured employee group health plans and health maintenance organizations to offer coverage from the first day of employment and without waiting periods for pre-existing conditions.

3. The Kentucky General Assembly should enact legislation to require employers offering health insurance coverage to employees to also offer dependent coverage to employees at group rates.

4. The Kentucky General Assembly should enact legislation to require nonprofit health insurance companies, individual health insurers, group health insurers, self-insured employee group health plans and health maintenance organizations to offer dependent coverage at group rates up to age 24 (instead of age 21), if the child is chiefly dependent upon the policyholder.

5. The Kentucky General Assembly should enact legislation to require nonprofit health insurance companies, group health insurers, self-insured employee group health plans and health maintenance organizations to expand the duration of continuation coverage for terminated employees, divorced spouses, widowed spouses and dependents from 9 months to 2 years at the group rate.

6. The Kentucky General Assembly should enact legislation to require nonprofit health insurance companies, group health insurers, self-insured employee group health plans and health maintenance organizations to expand minimum benefits in conversion policies by: (a) raising minimum dollar amounts on coverage, (b) expanding minimum services to include physician services if covered in the previous group plan, and (c) requiring coverage of pregnancy, childbirth and miscarriage (which are now specifically excluded).

7. The Kentucky General Assembly should enact legislation to specify responsibilities for notifying former employees of continuation and conversion privileges, and require that separate notice be given to former employees in plain language.

D. Medical Malpractice Reform

Medical malpractice is negligent care by a health care provider that harms a patient. Undesirable results of medical treatment do not constitute malpractice unless the practitioner negligently failed to adhere to prevailing standards of medical practice. Persons injured (or their relatives) who feel they have been the victim of negligence by a health care provider may seek redress by filing a lawsuit alleging medical malpractice. A 1972 Department of Health Education and Welfare study found that 7.5% of discharged hospital patients nationwide had been injured as a result of medical treatment and that 29%

of these injuries were due to malpractice. However, because many patients do not recognize malpractice or may consider the result as bad luck, only one in ten victims of malpractice files a claim. A Rand Corporation survey found less than 10% of malpractice claims in the United States were tried all the way to verdict, with the verdict favoring the defendant (provider) 75% of the time. The remaining cases were dropped or settled out of court.

To protect themselves from malpractice claims, health care providers obtain professional liability insurance. The cost of premiums is based on experience rating for the medical specialty and geographic area, with surgeons, obstetricians and anesthesiologists paying the highest premiums, due to the risks inherent in their practices. In the mid-1970's, a number of public and private bodies concluded that a crisis in medical malpractice existed. Obtaining adequate malpractice insurance coverage at a reasonable price became increasingly difficult, as many malpractice insurers were withdrawing from the market, citing the increasingly higher amounts of malpractice settlements and awards by juries. As a result, many states, including Kentucky, took action to limit malpractice awards and provide malpractice insurance at a lower cost.

The 1976 Kentucky General Assembly enacted Senate Bill 248 in an attempt to reduce the cost of malpractice insurance and ensure its availability. The main provisions were as follows:

(1) Eliminates the Ad Damnum clause in a malpractice complaint (prohibits asking for a specific dollar amount for damages).

(2) Makes evidence that a practitioner offered payment on a malpractice claim inadmissible in trial and specifies that any payment made will be used to offset a damage award.

(3) Permits a jury to apportion damages among several malpractice defendants.

(4) Requires a warranty or guaranty by a health care provider to be in writing or signed before it is admissible as evidence in a malpractice action.

(5) Requires the Commissioner of Insurance to approve any out of court settlement in a malpractice action.

(6) Creates the Patients' Compensation Fund to require every health care provider to carry insurance in the minimum amount of $100,000 per occurrence and $300,000 per year, or to qualify as a self-insurer; pay the excess when a settlement or judgment exceeded the $100,000; assess all doctors and hospitals to capitalize the fund; and rely on the Commonwealth's General Fund if the Patients' Compensation Fund were exhausted.

In the 1977 case of *McGuffey v. Hall,* the Kentucky Supreme Court found that the funding system for the Patients' Compensation Fund violated Sections 50 and 177 of the Kentucky Constitution. (Section 50 prohibits the legislature from authorizing a debt without a vote of the people and Section 177 prohibits the State or any of its agencies from pledging the Commonwealth's credit.) The court also found that a "blanket mandate to in-

sure'' may invite constitutional trouble if there is no limitation on the price of mandatory insurance. These and other problems led the court to reject the provisions relating to the Patients' Compensation Fund in their entirety. Any future legislation would have to address the price-limitation problem and could not rely on the General Fund as a backup, unless a referendum were held.

The portion of the legislation forbidding plaintiffs from stating a specific sum of money in the prayer for damages in their complaint was held unconstitutional by a Kentucky court in 1981. The court held the law ''clearly unconstitutional'' as an invasion of the courts' rule-making powers and violative of Sections 27 (separation of powers), 28 (one department not to exercise power of another) and 109 (judicial power vested in the court) of the Kentucky Constitution.

From 1976 to 1983, average physician premium expenses grew 51% nationally (from $4,700 to $7,100 per year), as compared with the 100% increase in the Medical Care Price Index for the same period. The American Medical Association reports physicians' average malpractice premiums were 4.4% of gross income in 1976, compared with 3.7% in 1983. Despite the apparent reductions in premiums of the past few years, malpractice rates have recently increased from 10% to as much as 45% nationwide, with rates varying greatly from state to state. Among the factors attributed to the current rise in premiums are rapid rises in health care costs; increased use of dangerous and invasive medical procedures; greater degree of specialization in medicine; higher number of claims for birth-related problems; poor doctor/patient communication leading to unrealistic expectations of treatment; increased willingness to sue in general and the corresponding greater sophistication of malpractice attorneys.

A number of critics maintain that there is no medical malpractice insurance crisis and that insurers are profiting unfairly. They note that from 1977 to 1982, national major malpractice insurers earned net premiums of $7.2 billion while paying losses (through settlements or jury awards) of only $1.7 billion. Insurance companies maintain their cash reserves are for future liabilities, while malpractice attorneys point out that insurance companies have earned over $1 billion in investment income on these reserves. The Kentucky Academy of Trial Attorneys notes that the growth rate in malpractice claims is only about 3% over the last decade and that claims paid by Kentucky's largest malpractice insurer increased 8.4% from 1981-1984, as compared with a 13.3% increase in health care expenditures for that period. Trial attorneys also argue that the rise in malpractice premiums is not due to more claims being filed or higher awards, but is a result of less than sound underwriting practices and a decline in the investment portfolio of the property/casualty insurance industry as a whole.

While the causes of the recent rises in malpractice insurance premiums remain in question, the fact remains that practitioners are again faced with rising premiums. The following amendments to the Kentucky Revised Statutes could be enacted to moderate the size of malpractice awards and encourage a more expeditious review of malpractice claims:

(1) Permit victims of malpractice to voluntarily submit claims to arbitration panels in lieu of a jury trial. The decision of the panel would be binding on both parties.

(2) Abolish the contingent fee system as a method of paying attorney's fees in malpractice cases and provide for a sliding fee scale system instead. For example, an attorney might be entitled to 30% of the first $100,000 of an award, 25% of the next $100,000 and 20% of the balance.

(3) Require a party to a malpractice suit to pay the other party's legal fees if it is found the party acted frivolously in filing suit.

(4) Establish statutory qualifications for expert medical witnesses in malpractice actions.

(5) Allow structured settlements in malpractice cases, whereby damages are paid in installments throughout the plaintiff's lifetime.

(6) Require all malpractice claims to be reviewed by a pre-trial screening panel to review the merits of the case and to encourage a settlement before the action may be tried in court.

(7) Establish a statutory legal standard of medical care to be applied in all malpractice cases.

(8) Re-establish the Patients' Compensation Fund (KRS Chapter 304) and address the constitutional problems cited earlier.

(9) Limit the size of malpractice awards.

(10) Amend the collateral source rule of evidence to allow evidence in a medical malpractice case that the plaintiff has received compensation from other sources (such as health insurance) and require the amount of collateral payment be deducted from any malpractice award.

Impact of Policy Option. In Kentucky, medical malpractice insurers are required by statute to notify the Commissioner of Insurance of settlements or judgments against a health care provider in a malpractice case. The Commissioner is further required to report the name of the practitioner against whom the settlement or judgment is made to the appropriate licensure board for possible disciplinary action. For fiscal year 1984, this data reveals a total number of 100 claims paid against physicians and surgeons at a total amount of $3,496,479.85; 18 claims paid against hospitals and health care facilities at a total of $644,203.32; and 12 claims paid against dentists at a total of $40,712.64. The number of claims filed has increased approximately 25% since 1983 and the amounts awarded have increased approximately the same percentage. The information gathered by the Department of Insurance is limited in that it does not include surplus line insurers, insurers in other states not known to the department or any pending cases.

Kentucky currently has approximately 6,500 licensed physicians, 2,700 licensed dentists and 121 hospitals. It can be safely assumed that most carry some type of malpractice insurance and would be affected by any change in premiums.

Advantages and Disadvantages

Advantages:

1. Arbitration panels are better equipped than juries at handling complex malpractice cases and render more equitable decisions.

2. Limiting attorney's fees will discourage doubtful cases and encourage out of court settlements.

3. Spurious claims statutes will discourage weak or frivolous malpractice claims.

4. Statutory qualifications for expert witnesses will encourage uniform standards statewide instead of differing standards from court to court.

5. Structured settlements would encourage lower payments and decrease the tax liability for the plaintiff on a single large award.

6. Pre-trial screening panels would help to expedite the review of malpractice cases and would encourage timely resolution.

Disadvantages:

1. Arbitration panels may be biased because they often contain a provider and may pose constitutional problems, due to the sections of the Kentucky Constitution guaranteeing free access to courts.

2. Attorney fee regulation may limit access to the legal system for persons with difficult cases to prove.

3. Statutory qualifications for expert witnesses may be interpreted as an invasion of the rule-making authority of the courts.

4. Structured settlements may involve higher administrative and court costs, because the awards would be paid over time, and they would deny victims the interest a large award would earn.

5. Pre-trial screening panels would involve increased administrative costs and might present constitutional problems cited earlier.

6. Limiting the size of malpractice awards would violate Section 54 of the Kentucky Constitution. ("The General Assembly shall have no power to limit the amount to be recovered for injuries resulting in death, or for injuries to person or property.")

RECOMMENDATIONS:

1. The Kentucky General Assembly should enact legislation to permit victims of malpractice to voluntarily submit claims to arbitration panels in lieu of a jury trial. The decision of the panel would be binding on both parties.

2. The Kentucky General Assembly should enact legislation to abolish the contingent fee system as a method of paying attorney's fees in malpractice cases and provide for a sliding fee scale system instead. For example, an attorney might be entitled to 30% of the first $100,000 of an award, 25% of the next $100,000 and 20% of the balance.

3. The Kentucky General Assembly should enact legislation to require a party to a malpractice suit to pay the other party's legal fees if it is found the party acted frivolously in filing suit.

4. The Kentucky General Assembly should enact legislation to establish statutory qualifications for expert medical witnesses in malpractice actions.

5. The Kentucky General Assembly should enact legislation to allow structured settlements in malpractice cases whereby damages are paid in installments throughout the plaintiff's lifetime.

6. The Kentucky General Assembly should enact legislation to require all malpractice claims to be reviewed by a pre-trial screening panel to review the merits of each case and to encourage a settlement before the action may be tried in court.

7. The Kentucky General Assembly should enact legislation to establish a statutory legal standard of medical care to be applied in all malpractice cases.

8. The Kentucky General Assembly should enact legislation to re-establish the Patients' Compensation Fund within the Department of Insurance (KRS Chapter 304) and address the constitutional problems cited by the 1977 Kentucky Supreme Court which ruled it unconstitutional.

9. The Kentucky General Assembly should enact legislation to limit the size of malpractice awards.

10. The Kentucky General Assembly should enact legislation to amend the collateral source rule of evidence to allow evidence in a medical malpractice case that the plaintiff has received compensation from other sources (such as health insurance), and require that the amount of collateral payment be deducted from any malpractice award.

CHAPTER V.

INDIGENT CARE PROGRAMS IN OTHER STATES

Although the states have various individual approaches to addressing the problem of medical indigency, these approaches generally fall under two major headings: policies designed to extend coverage under governmentally-financed health care programs to more persons, and policies designed to make commercial health insurance coverage available to more persons, thereby, reducing governmental expenditures needed to fund programs for the medically indigent.

Firstly, in attempting to extend coverage under governmentally-financed programs to more persons, a large number of states with small "Medically Needy" components or no "Medically Needy" component under Medicaid have chosen to expand their Medicaid program to cover this population.

In addition to expanding their Medicaid program, many states have chosen to establish a program using state funds only for the medically indigent. Among states with such programs, trends are toward centralizing funding and administration of the program at the state level and providing coverage for a rather comprehensive range of medical services. However, state programs generally fall into three categories.

The most popular type of program is statewide, state-administered, and state-funded. Eligibility and reimbursement standards are set at the state level and every county or locality in the state operates essentially the same program.

Another type of program, sometimes referred to as a state optional program, is usually funded jointly between the state and the locality. Usually, the locality buys into a uniform state eligibility and reimbursement system by pledging a certain percentage of its local tax assessments. In most such states, the state also processes claims from providers; however, some states require the locality to provide for care of the medically indigent, but allow the locality to determine in what manner to deliver these services. Under such systems, programs vary widely from county to county in their eligibility, reimbursement and services.

In the final type of program, the state provides funding for programs for persons with a specific disease or condition.

Secondly, in attempting to make health insurance more accessible to their citizens and to reduce the level of government funding for programs for the medically indigent, some states have concentrated on statutes requiring continuation or conversion of group health insurance policies when an employee is terminated or laid off and on establishing risk sharing pools for high risk uninsurables.

A more detailed discussion of these approaches to addressing the problem of providing health care to the medically indigent and of the states' experiences in carrying out these policies follows.

A. Expansion of the Medicaid Program

Perhaps the most popular means of addressing the problems of the medically indigent has been to expand the state's Medicaid program by deciding to make more medical services available to recipients or by expanding eligibility guidelines to cover more people, or both. The primary reason for the popularity of this approach is that it allows the state to receive matching federal dollars for every dollar the state spends. In simple terms, the state gets more for its dollar by tapping into these federal dollars.

Currently, the federal government requires the state to provide eleven specific services under its Medicaid program and allows the state the option of covering many other medical services. Similarly, the federal government requires that Medicaid be available to certain categories of people referred to as the "categorically needy" and allows the state the option of covering other specified categories of people referred to as the "medically needy." Only 33 states, including Kentucky, have chosen to have a "medically needy" component.

The scope of services and the categories of persons covered under Kentucky's Medicaid program are nearly as extensive as is allowable under Federal law. Although there is little room for expansion to cover additional services or groups of people in Kentucky's program, many states have covered more persons because their income eligibility limits are higher than Kentucky's limits; Kentucky's income eligibility limit currently ranks thirtieth among the 33 states operating a "medically needy" component. Kentucky's Medicaid program and areas where the program can be expanded are discussed in greater detail in Chapter III (Part C) of this report.

B. State-Funded Programs for the Medically Indigent Providing Comprehensive Services

Currently, thirty-one states have a statewide indigent health care program. These programs take many forms, the most popular form being a sort of state-administered and state-funded Medicaid program. Typically, these types of programs are statewide and state-administered, with eligibility criteria identical to the Medicaid program, except that they cover categories of people for which Medicaid cannot receive matching federal funds, i.e., single adults and married couples without minor children, who are able-bodied and between the ages of 21 and 65. Because of this fact, these programs are financed entirely by the state or jointly by the state and locality.

In choosing this means of "expanding Medicaid," the states and localities are mimicking a move they have also taken with their AFDC programs. Finding that the AFDC program did not offer the flexibility to cover all persons in their states needing financial assistance, many states and localities chose to set up cash assistance programs for persons not eligible for AFDC, i.e., single adults and married couples without minor children, who are able-bodied and between the ages of 21 and 65. As a logical evolution, many states ad-

minister their statewide program for the medically indigent in conjunction with the state's or locality's general assistance program (as these cash assistance programs are commonly called), using eligibility standards for their general assistance program as the standard for the medical assistance program. Although most states operating such programs have an existing general assistance program, a few states do not. Maryland's indigent care program is an example of a program which is closely linked in services and eligibility criteria to Medicaid and is administered in conjunction with its general assistance program.

Among the thirty-one states with a state indigent health care program, wide variations exist in the following areas:

- Program Administration—Fifteen states administer all aspects of the program, while the remaining fifteen states share responsibility, e.g., for conducting eligibility determinations, with the counties.

- Eligibility Guidelines—Eighteen states set statewide eligibility standards as well as setting the range of services available under the program.

- Funding—Fifteen states totally fund their program with state dollars, while sixteen are jointly funded by the state and local government. The state funding percentages range from 50% to 92% state funds, with 75% representing the mid-range.

Generally, these types of programs are more comprehensive in scope of coverage and services than other types of state programs for the medically indigent. However, because these programs do not receive matching federal funds and rely totally on state and local funds, such programs are operated predominately in the more industrialized and populous states, which can afford to make a large commitment of state and local funds.

C. State-Supported Local Programs

Several states use more individualized means of administering programs for the medically indigent, which are explained in more detail below:

1. California, in January, 1983, discontinued its state-funded program for the indigent through the Medi-Cal program and shifted responsibility for the indigent back to the county. The state reallocated to the counties 70% of the funds previously paid out under Medi-Cal's Aid to the Medically Indigent program to the counties for funding of the county-based programs. The counties can design and administer their programs to suit local needs by contracting directly with providers for care, providing the care themselves, or making referrals to providers for care. Whichever option is chosen, the county makes payment to the provider. Counties with a population of less than 300,000 have an additional option of contracting back to the state for administration of their indigent care programs.

2. Louisiana provides funds to its nine state hospitals for providing medical care to the indigent. Citizens needing emergency and primary medical care receive it through one of these hospitals. This system was originally established in the 1930's.

3. Iowa requires counties to be responsible for their medically indigent population. The state provides funds to the University of Iowa's hospitals and clinics for the purpose of allotting a certain number of slots for each county. Residents of rural counties are provided a statewide transportation system to take them to the University hospital.

4. Utah and Illinois allow the counties to buy into a state indigent care program by paying an assessment to the state. In return for the county funds, the state sets eligibility and reimbursement standards for the program and processes providers' claims.

D. State Programs Funding Specific Diseases or Conditions

Fourteen states operate indigent care programs designed to reach a small target population suffering from a specific disease or condition and unable to obtain medical care. Generally, these programs cover such diseases or conditions as renal disease (Wisconsin), sickle-cell anemia, cancer (Missouri), hemophilia (Wisconsin), tuberculosis and pregnancy. Five states (Maine, Pennsylvania, Illinois, New Jersey, and Maryland) have a program providing coverage of prescription drugs for the elderly and disabled.

Recently, increased attention has become focused at the state and local levels on programs targeted on pregnant women and children. These types of programs fund prenatal and perinatal health care for high risk mothers and are attempting to reduce high infant mortality rates associated with a lack of adequate prenatal care. Their focus on preventative orientation is somewhat unique. Florida, Missouri, and Washington currently operate programs targeting pregnant women and newborns.

Programs focusing on specific diseases or conditions are usually intended to supplement rather than replace programs covering more comprehensive medical care.

E. Continuation and Conversion of Group Health Insurance Policies

The goal of both continuation and conversion provisions of group insurance policies is to increase the number of people with health insurance coverage and, thereby, reduce the governmental expenditures needed to fund programs for the medically indigent. Thirty-one states, including Kentucky, require employers to offer employees who are being terminated or laid off the option of converting their group health insurance policy to an individual policy. The employee pays for the policy at the higher individual policy premium rate.

By contrast, only nineteen states require employers to provide continuation of health insurance coverage to an employee after termination or layoff. Continuation provisions enable the employee to elect to continue insurance coverage at the lower group rate for a period ranging from one to eighteen months.

Such provisions have not lived up to expectations. Although they provide a mechanism for making health insurance available to the unemployed, many unemployed

persons have not opted to take such coverage even at a group rate. The primary reason for this reluctance is one of simple economics. If a person has no job and, consequently, little or no income, that person is more likely to use available funds to pay shelter and food expenses than to purchase health care coverage.

F. Risk-Sharing Pools for High Risk Uninsurables

Seven states have established state risk-sharing pools for high risk uninsurable persons who have difficulty obtaining health care coverage, primarily due to their age or health. Although Connecticut allows anyone to purchase through the pool, most programs require a person to have been turned down by one or more insurers before becoming eligible to purchase through the risk-sharing pool.

Although such programs do make insurance available to difficult to insure persons, premiums under these programs range from 125 to 200% of premiums available under most group insurance packages. Presumably because of the high premiums, few people are enrolling in the programs. Minnesota found that between 1977 and 1981 only .05% of the state's uninsured individuals were covered. Connecticut estimates only 4% of its uninsured population is covered under its program.

Despite the cost of premiums, states have found that these premiums do not generate enough income to finance the program, thus requiring an infusion of state funds to keep it afloat. In the period from 1977 to 1981, Minnesota's program paid out $2 million more in claims than it received in premiums.

G. Programs Funding Catastrophic Health Expenses

Four states have attempted to operate catastrophic health insurance programs. The goal of such programs is to reduce destitution by assisting persons in paying bills resulting from a lengthy illness or costly treatment program. These programs are targeted primarily to middle-income individuals with health insurance who have a serious health problem. In order to benefit from these programs, persons must exhaust any health insurance benefits they have and pay substantial deductibles and co-payments from their own pockets.

Only three states are currently operating a catastrophic health expense program. Minnesota discontinued its program in 1981, because of a dramatic increase in program expenditures coupled with a downturn in the state's economy. All states have had to modify their programs since implementation, by further restricting eligibility and increasing deductibles and copayments, in an effort to control expenditures and provide coverage to more beneficiaries.

On the whole, this type of program has been found to be expensive, providing benefits to a very small number of persons. Although the programs attempted to serve middle-income families, **Minnesota** and **Rhode Island** found that 70% of beneficiaries had annual incomes of less than $10,000 and **Maine** found that 90% had annual incomes of less than $5,000. Expenditures under all programs went predominantly to pay for hospital care.

APPENDIX A

FOOTNOTES

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3. Pamela J. Farley, "Who are the Uninsured?" National Center for Health Services Research, 1984.

4. Barry A. Gold and Elizabeth Donahue, "Health Care and Bankruptcy," *Journal of Health Politics, Policy and Law* (7)3, 734-739, 1982.

5. See Karen Davis and Diane Rowland, *Uninsured and Underserved: Inequities in Health Care in the United States*, Milbank Memorial Fund Quarterly 61(2), 1982.

6. Gail R. Wilensky, "Solving Uncompensated Hospital Care," *Health Affairs* (3) 4, 50-62, 1984.

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10. Emergency Room Utilization Report, Kentucky Medical Assistance Program, 1978.

11. Committee to Study the Prevention of Low Birthweight, Institute of Medicine, *Preventing Low Birth Weight*, National Academy Press, Washington, D.C. 1985.

12. Madera Community Hospital v. County of Madera, 201 Cal. Rptr.; and Washoe County v. Wittenberg, 676 P. 2d 808 (Nev. 1984).

13. Katherine Swartz, Ph.D., "People Without Health Insurance: How Did Their Characteristics Change Between 1963 and 1983, and Why Has Their Number Increased Since 1980?" Presentation at the American Health Planning Association's Fifth Annual Conference, March 12, 1985, p. 7-8.

14. *Ibid.*, p. 1.

15. Judith A. Kasper, Daniel C. Walden and Gail R. Wilensky, "Who Are the Uninsured?" (Washington, D.C.: National Center for Health Services Research, 1983).

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17. Robert Wood Johnson Foundation, "Updated Report on Access to Health Care for the American People," *Special Report*, No. 1, (Robert Wood Johnson Foundation, 1983).

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19. Committee on Ways and Means, "Background Report on Poverty in the U.S.", 1982.

20. Pamela J. Farley, Ph.D., "Who are the Underinsured?" Presentation at the 1984 Meetings of the American Public Health Association, November 13, 1984.

21. Katherine Swartz, Ph.D., "People Without Health Insurance: How Did Their Characteristics Change Between 1963-1983, and Why Has Their Number Increased Since 1980?" Presentation at the AHPA Fifth Annual Conference, March 12, 1985.

22. Roeder, Phillip W. and Whitler, Elmer T., "Access to Health Care in Kentucky: An Examination of Survey and Medicaid Data," James W. Martin Graduate Center for Public Administration, 1984.

23. Commission on the Study of Indigent Medical Care, *A Long Range Plan: Medical Care for Indigent Persons in Kentucky*, 1957.

24. U.S. Department of Health and Human Services, *Social Security Bulletin: Annual Statistical Supplement*, 1983, p. 201.

25. Correspondence from John R. Rowan, Director of Medical Administration Services, Veterans' Administration Hospital, Lexington to Karen Shrock-Jones, 14 November 1985.

26. *Ibid.*

27. Interview with John Lowe, Chief of Medical Administration Services, Veterans' Administration Hospital, Louisville, 11 November 1985.

28. Cabinet for Human Resources, Office of Health Data, *Vital Statistics Reports*, 1974-1984.

29. Committee to Study the Prevention of Low Birthweight, Institute of Medicine, *Preventing Low Birth Weight*, National Academy Press, Washington, D.C. 1985.

30. Reynolds, Richard C., M.D. "The Loss of Charity in the Practice of Medicine," *The American Journal of Medicine*, Aug., 1981, p. 196 (pp 196-198).

31. Gordon Scott Bonham, *Volume I: Characteristics of Use and of Users*, Kentucky Physicians Care, A voluntary Program of the Kentucky Medical Association Aug., 1985 (pages iii and iv.)

32. Health Care Access Committee, "Report and Recommendations," September, 1984.

33. *Ibid.*

34. The health insurance statutes which are relevant to this policy option paper are as follows:

    KRS 304.17 Health Insurance Contracts
    KRS 304.18 Group and Blanket Health Insurance
    KRS 304.32 Nonprofit hospital, medical-surgical, dental and health service corporations.
    KRS 304.32-300 Self-insured private employer group health plans.
    KRS 304.38 Health maintenance organizations

35. 29 U.S.C. 6, 1001.

36. Metropolitan Life Insurance Co. v Commonwealth of Massachusetts, U.S. Law Week 84-325, 84-356.

37. Health Insurance Association of America, *Sourcebook of Health Insurance Data: 1982-83, 1984 Update*, 1984.

38. Includes self-insured, administration-only contracts. The Department of Insurance in correspondence dated July 22, 1985 estimated that 57% of private group insurance contracts were self-insured by employers. The Health Care Financing Administration estimates the national private health insurance market as follows:

Commercial insurance companies:	41%
Blue Cross/Blue Shield:	35%
Self-insured plans:	18%
Health maintenance organizations:	6%

39. Includes Part A only. About 72% of Medicare beneficiaries also carry Medicare supplement insurance, which is not reflected in this table.

40. Among policyholders of major medical expense policies, 89% have maximum benefits of $50,000 or more, 73% had maximum benefits of $250,000 or more, and 46% had maximum benefits of $1,000,000 or more. Generally, major medical expense benefits are subject to deductible or coinsurance payments by the policyholder.

41. "Health Spending Trends in the 1980's: Adjusting to Financial Incentives," *Health Care Financing Review*, Spring 1985, p. 12.

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APPENDIX B

THE PROBLEM OF MEDICAL INDIGENCY

Scenarios

Scenario 1

Susan and Michael are farmers living on 700 acres of land in Eastern Kentucky. They have three children and after farm expenses had $16,000 in net income last year. They are not affiliated with a farm organization, and thus cannot obtain health insurance at a group rate and cannot afford the $268 monthly family rate. The children have never been to a doctor. They owe the local hospital $4000 from the birth of their third child and Susan has been neglecting a gall bladder condition because of the potential costs. One night her condition worsens and she is refused treatment at the local hospital. They drive to the University Hospital where she has gall bladder surgery. She stays in the hospital for 8 days, incurring $7800 in additional medical expenses.

Scenario 2

Jenny Smith is a 17 year old high school student. Her father works as a janitor in a local warehouse with an annual income of $8000. He receives health insurance for himself through his employment, but is unable to afford dependent coverage for his wife and daughter, which would cost an extra $90 per month. Jenny is pregnant but doesn't eat much so she doesn't have to tell her parents. Finally they discover her pregnancy in the fifth month and visit a local physician, who requires a $250 deposit for prenatal and delivery services. In addition, they are advised that the hospital will require a $1200 deposit prior to admission. The Smith's cannot afford these deposits. Jenny's father tries to add her to his health insurance policy but is told she has a pre-existing condition and the policy would not cover the pregnancy of a dependent minor anyway. In her seventh month of pregnancy, she is referred to a local health department, which accepts her for prenatal1care and arranges for her to enroll in the Medicaid program. The child is born prematurely with multiple handicapping conditions and incurs $85,000 in neonatal intensive care charges. $30,000 is reimbursed by Medicaid and the state Maternal and Child Health Program covers 53% of the remainder, leaving the hospital with $29,150 in uncollectable bad debt. Eventually the child is placed in a state institution at an annual cost of $30,000.

Scenario 3

John and Martha are a young couple with two children. Martha has a congenital heart condition and cannot work. John is an unemployed GE worker, is receiving $580 in unemployment compensation and union benefits. They cannot afford to continue their

health insurance benefits even though that option is available to them. Martha applies for AFDC, SSI and Medicaid but does not qualify because they are an intact family with "excess income" and her condition isn't severe enough to qualify her as "disabled." She receives care from her family physician on a charity basis, but does not have enough money for drugs or cardiovascular testing. On one of her daily walks Martha has a heart attack. She is sent to a cardiac intensive care unit in Louisville and partially recovers after heart bypass surgery and a two-month hospital stay, incurring $100,000 in hospital and physician charges. After her discharge from the hospital, the family try to care for Martha at home but find they are unable to do so. Home health services cost $50 per visit and Martha still doesn't qualify for Medicaid or SSI. Martha enters an intermediate care facility. After 30 days she becomes eligible for Medicaid since she is now considered living apart from her family. Meanwhile, her husband has been reemployed but declares bankruptcy after being unable to pay the hospital bills. John becomes severely depressed. The children eventually go live with their grandparents.

Scenario 4

Hilda and Ned are a 70-year-old married couple who live in a $180,000 house which is paid off. Ned is a retired coal company executive and receives Social Security and a pension, which is their only income. Two years ago on the advice of their attorney they transferred their savings, CDs and other assets to a trust fund for their grandchildren. Ned receives renal dialysis services paid for by Medicare at an annual reimbursement of $26,000 per year. Ned goes to his physician, who conducts blood tests at each weekly visit and bills Medicare on a fee-for-service basis. When Ned's condition worsens, he is placed in a skilled nursing facility. When his Medicare length of stay limit runs out, he qualifies for Medicaid. After three years in the institution, costing the state Medicaid program $54,000, Ned dies. Hilda sells the house and moves to Florida.

Scenario 5

Tony is a 19 year old high school graduate working 30 hours a week at Wendy's and living with friends. He has no health insurance. In high school he played football and badly injured his knees. He now needs surgery and qualifies for the University Hospital indigent care fund. Tony sees the physician at the University, who tells him the surgery must be performed on an outpatient basis. He is advised that the indigent care fund does not cover outpatient care, and the surgery will cost him $2,000. He decides not to have the surgery despite the constant pain.

Scenario 6

Jim is a married 38 year old man working in a chemical factory. He develops a rare form of blood cancer known to be associated with contact with the chemicals his plant produces. He is fired and files suit against the company. He does not qualify for Worker's Compensation or Social Security benefits. After one year, his option to con-

tinue his health insurance benefits runs out and he cannot qualify for any other health insurance, due to his medical condition. He drives to an oncologist in Cincinnati to receive his radiation therapy treatments and incurs $1500 per month in medical bills. A collection agency obtains a judgment against him and garnishes his wife's wages. Jim is hospitalized and dies. His wife is left with $50,000 in medical bills. The lawsuit against the company is still pending.

Scenario 7

Dr. Jones is a 58 year old general surgeon in solo practice in rural Western Kentucky. During his 30 years of practice he has always treated anybody in need, regardless of their ability to pay. The only other physicians in town are two National Health Service Corps physicians who plan to leave as soon as their federal obligation is met. His caseload has always been about 20% charity care, with the remainder covered under private insurance, Medicare or Medicaid. Recently the nearby car plant negotiated a contract with a private clinic 30 miles away requiring all their employees to use the clinic or face substantial copayments. He loses about one-half of his privately insured patients as a result. Medicaid advises him he must perform more surgery on an outpatient basis and that he must pre-authorize all hospital admissions. The local hospital administrator informs him that the hospital is losing money on Dr. Jones' Medicare patients due to DRGs, and asks him to discharge patients earlier. He begins to run a deficit at his office, and becomes overwhelmed with indigent patients after the National Health Service Corps doctors leave. Frustrated and overworked, Dr. Jones decides to retire early, leaving the community without a doctor.

Scenario 8

Regional Hospital is a 250-bed, nonprofit hospital in a metropolitan area. The hospital has a major obstetrical unit and performs 4000 births per year. 500 of these births are for Medicaid recipients, for which the hospital is paid 98% of its costs. 300 of the births are for indigent patients. The insurance companies assist in covering charity care and bad debt, and the hospital breaks even in its obstetrical unit. However, a significant proportion of Medicaid and indigent patients deliver premature and, other low birth weight infants, which are then transferred to the hospitals neonatal intensive care unit. In addition, other hospitals refer indigent children requiring a tertiary level of care to Regional Hospital. Medicaid will not pay for hospital care beyond the 14 day limit, although the average length of stay for neonatal care is 23 days. Regional Hospital runs a $2,000,000 deficit in its neonatal intensive care unit and a $3,000,000 deficit in its other infant care units. Fortunately, a private philanthropic organization covers the losses. Meanwhile, a local hospital chain offers a new insurance program requiring their members to use the chain's hospitals or incur substantial copayments. In addition, many insurance policies offer substantial rewards for mothers leaving the hospital 24 hours

after birth. Regional Hospital loses 20% of its privately insured patients and is no longer able to totally shift the uncompensated costs of its Medicaid and indigent patients. The private philanthropic organization underwriting the charity care advises the hospital that it can no longer afford to subsidize the neonatal and infant care units at existing levels. Other hospitals continue to refer indigent obstetrical patients, neonates and infants to Regional Hospital.

Scenario 9

A federally-qualified nonprofit HMO provides comprehensive health care services for 1000 indigent patients under a federal grant for that purpose. In addition, it serves 500 Medicaid patients on a prepayment basis under an agreement with the state Medicaid program. A private for-profit HMO Corporation purchases the HMO, and the federal government advises the Corporation the federal grant will cease. The HMO disenrolls the Medicaid and indigent patients, after being unable to renew the prepayment arrangement with state government. The patients are referred to the local health department and other state programs for health care, but there are significant gaps in available services. Some of the Medicaid recipients are unable to find a physician who will accept the Medicaid card. The HMO grows substantially, and soon has a sufficient market share to negotiate more favorable rates with local hospitals. The hospitals lose their ability to shift nearly $1,000,000 in charity care costs to the HMO.

Scenario 10

A large commercial insurance company has always prided itself on its willingness to help provide for people without health insurance through covering a substantial proportion of bad debt and charity care in its rate setting program for hospital reimbursement. In the last five years it has faced stiff competition for members by other insurance companies and new competitors such as preferred provider organizations and health maintenance organizations. Feeling pressure from employers to compete with the lower premiums of these organizations, the insurance company decides it will cover only its pro rata portion of bad debt and charity care costs and will negotiate up to 14% hospital discounts for its members. The hospitals are infuriated, and publicly blame the insurance company for having to deny care to charity patients. Meanwhile, the hospitals contract with HMO's and PPO's at even lower rates in order to keep their beds full.

APPENDIX C

Kentucky Revised Statutes Relating to "Indigent Persons"

KRS 31.100: Defines "needy person" or "indigent person" as "unable to provide for the payment of an attorney and all other necessary expenses" of legal representation.

KRS 31.120: Sets forth the procedure for determining whether the court should provide legal counsel to represent indigent persons. Sets forth an "affidavit of indigency" to be used in such procedure.

KRS 31.240: Authorizes counties to compensate legal advocates for indigent persons. Requires the county to pay any amounts in excess of state contribution for legal services.

KRS 156.455: Authorizes local school boards to furnish "indigent children" with textbooks (indigent not defined).

KRS 160.330: Authorizes school boards to furnish "indigent children" with school supplies (indigent is not defined).

KRS 194.090(3): Relating to citizen advisory bodies attached to the Cabinet for Human Resources - Creates the Council for Social Insurance to, among other duties, represent "the poor" (not defined).

KRS 205.520(2): "The General Assembly . . . recognizes and declares that it is an essential function, duty and responsibility of the state government to provide medical care to its indigent citizenry; and it is the purpose of KRS 205.510 to 205.630 (Medical Assistance Act) to provide such care." (No definition of indigent.)

KRS 212.370: Relating to local boards of health, states: "The board (referring only to the Louisville and Jefferson County Board of Health) shall, except as otherwise provided by law, have exclusive control and operation . . . of all matters relating to institutions safeguarding the public health, including city or county hospitals . . . medical care of the indigent." (No definition of indigent.)

KRS 212.628: "The board (Lexington and Fayette County Board of Health) may control, operate or monitor all matters within the county affecting public health including institutions established to safeguard the public health which may encompass city or county medical facilities, nursing homes, medical care of the indigent, and laboratories and clinics necessary for the promotion of public health . . . ."

KRS 215.310: Relating to the care of an "indigent" person in a tuberculosis sanatorium. (No definition of indigent.) (Repealed effective July 1986.)

KRS 215.390: Permits a county to use unexpended funds originally intended for a tuberculosis sanatorium for a "poor farm" instead. (Repealed effective July 1986.)

KRS 273.437: Requires community action boards to be organized so "the poor" can "influence the character of programs" administered by the community action agency. (No definition of poor.)

KRS 276.240: Authorizes common carriers (railroads) to provide transportation free or at reduced rates to "indigent destitute and homeless persons." (No definition.)

KRS 441.045: Requires county governments to pay for medical care for "indigent" prisoners in the county jail. Indigency is determined by the procedure set forth in KRS 31.120 in which the court certifies a person's indigency. This section also requires payment for prisoners who are "uninsured." (This is the only KRS that extends the definition of indigent beyond financial criteria to include persons with no health insurance.)

KRS 453.190: Relating to the payment of court costs, defines "poor person" as "a person who is unable to pay the costs and fees of the proceeding in which he is involved without depriving himself or his dependents of the necessities of life, including food, shelter or clothing." This section allows a "poor person" to file or defend any action or appeal without paying court costs.

KRS 530.050(4): Requires persons over the age of 18 to provide support for an "indigent parent" destitute of means of subsistence and unable because of old age, infirmity or illness to support himself or herself.

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KENTUCKY							
ANCHORAGE	JEFFERSON	210002	CENTRAL STATE HOSP	6	4	08/86	$ 450,000
BARBOURVILLE	KNOX	210006	KNOX COUNTY HOSP	1	3	01/86	141,318
BARDSTOWN	NELSON	210007	FLAGET MEMORIAL HOSP	1	1	11/95	441,419
BEATTYVILLE	LEE	210010	LEE COUNTY PHC	5	3	01/87	18,479
BEDFORD	TRIMBLE	210011	TRIMBLE COUNTY PHC	5	3	11/86	26,527
BELLEFONTE	GREENUP	210012	OUR LADY OF BELLEFONTE	1	1	08/86	$ 526,894
BENTON	MARSHALL	210013	MARSHALL CO HOSPITAL	1	2	01/86	474,772
BEREA	MADISON	210015	BEREA HOSP	1	1	02/91	395,500
BOONEVILLE	OWSLEY	210016	OWSLEY COUNTY PHC	5	3	09/87	13,000
BOWLING GREEN	WARREN	210018	BOWLING GREEN WARREN HC	5	6	04/83	42,925
BOWLING GREEN	WARREN	210017	MED CTR BOWLING GREEN	1	1	02/90	$ 1,200,000
BROOKSVILLE	BRACKEN	210019	BRACKEN COUNTY PHC	5	3	01/81	31,127
BURKESVILLE	CUMBERLAND	210020	CUMBERLAND COUNTY HOSP	1	3	03/85	225,000
CADIZ	TRIGG	210022	TRIGG COUNTY HOSP	1	3	10/88	346,412
CALHOUN	MCLEAN	210023	MCLEAN COUNTY HOSP	1	3	01/81	229,987
CAMPTON	WOLFE	210026	WOLFE COUNTY PHC	5	3	12/80	$ 19,954
CARLISLE	NICHOLAS	210028	NICHOLAS COUNTY PHC	5	3	05/85	26,165
CARROLLTON	CARROLL	210029	CARROLL CO MEM HOSP	1	3	04/92	416,808
CENTRAL CITY	MUHLENBERG	210030	MUHLENBERG COUNTY PHC	5	3	05/81	29,823
CLINTON	HICKMAN	210031	CLINTON HICKMAN CO HOSP	1	1	12/88	221,100
COLUMBIA	ADAIR	210033	W LAKE CUMBERLAND HOSP	1	3	01/81	$ 199,086
CORBIN	WHITLEY	210034	SO EASTERN KY BAPT HOSP	1	1	01/84	230,000
COVINGTON	KENTON	210037	MADONNA MANOR	0	1	12/85	179,200
COVINGTON	KENTON	210038	ST CHARLES NURSING HM	0	1	04/89	969,073
COVINGTON	KENTON	210039	ST ELIZABETH MED CTR	1	1	02/96	875,000

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KENTUCKY							
DANVILLE	BOYLE	210044	EPHRAIM MCDOWELL MEM	1	1	12/TT	$ 1,327,266
EDDYVILLE	LYON	210046	LYON COUNTY PHC	5	3	09/83	27,181
EDMONTON	METCALFE	210047	METCALFE COUNTY PHC	5	3	12/83	26,274
ELIZABETHTOWN	HARDIN	210048	HARDIN COUNTY PHC	5	3	01/83	66,880
EVARTS	HARLAN	210050	CLOVER FORK OP PROJ	9	1	09/98	261,094
FALMOUTH	PENDLETON	210051	PENDLETON COUNTY HOSP	1	3	06/87	$ 281,000
FLEMINGSBURG	FLEMING	210052	FLEMING COUNTY HOSP	1	3	02/89	496,500
FLORENCE	BOONE	210054	BOONE COUNTY PHC	5	3	05/92	40,000
FLORENCE	KENTON	210040	WILLIAM BOOTH MEM HOSP	1	1	08/92	347,000
FORT MITCHELL	KENTON	210055	REDWOOD SCH REHAB CTR	6	1	02/99	860,193
FORT THOMAS	CAMPBELL	210056	ST LUKE HOSP	1	3	07/83	$ 700,000
FRANKFORT	FRANKLIN	210057	FRANKLIN COUNTY PHC	5	3	10/80	99,290
FRENCHBURG	MENIFEE	210060	MENIFEE CO MED CENTER	9	1	04/96	671,566
GLASGOW	BARREN	210066	T J SAMSON COMM HOSP	1	1	11/90	687,073
GREENSBURG	GREEN	210068	J T CRAWFORD MEM HOSP	1	3	10/88	610,000
GREENUP	GREENUP	210069	GREENUP COUNTY PHC	5	3	02/86	$ 54,000
GREENVILLE	MUHLENBERG	210070	MUHLENBERG COMM HOSP	1	1	01/88	779,474
HARDINSBURG	BRECKINRIDGE	210071	BRECKINRIDGE MEM HOSP	1	3	01/85	257,682
HARLAN	HARLAN	210072	HARLAN APPAL REG HOSP	0	1	12/92	672,000
HARTFORD	OHIO	210075	OHIO COUNTY HOSP	1	3	09/86	287,596
HAWESVILLE	HANCOCK	210076	HANCOCK COUNTY PHC	5	3	11/81	$ 23,253
HAZARD	PERRY	210077	HAZARD APPALACHIAN REG	1	1	02/93	777,438
HAZARD	PERRY	210078	PERRY COUNTY PHC	5	3	01/82	52,448
HENDERSON	HENDERSON	210079	COMM UNITED METH HOSP	1	1	09/88	1,356,300
HINDMAN	KNOTT	210081	KNOTT CO HLTH CTR	5	3	12/80	28,039

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KENTUCKY							
HOPKINSVILLE	CHRISTIAN	210083	JENNIE STUART MEM HOSP	1	1	12/95	$ 1,557,971
HYDEN	LESLIE	210086	LESLIE COUNTY PHC	5	3	01/83	37,814
INEZ	MARTIN	210087	MARTIN COUNTY PHC	5	3	04/87	51,054
IRVINE	ESTILL	210089	ESTILL COUNTY PHC	5	3	01/81	27,985
JACKSON	BREATHITT	210090	BREATHITT COUNTY PHC	5	3	06/87	3,630
LANCASTER	GARRARD	210093	GARRARD CO MEM HOSP	1	3	06/88	$ 305,750
LEBANON	MARION	210095	MARION COUNTY PHC	5	3	01/85	36,952
LEITCHFIELD	GRAYSON	210097	GRAYSON CO HOSP	1	1	08/99	1,218,681
LEITCHFIELD	GRAYSON	210098	GRAYSON COUNTY PHC	5	3	11/80	27,113
LEXINGTON	FAYETTE	210099	GOOD SAMARITAN HOSP	1	1	01/98	3,656,101
LEXINGTON	FAYETTE	210100	LEXINGTON FAYETTE CO HC	5	6	12/TT	$ 1,092,773
LEXINGTON	FAYETTE	210102	UNIVERSITY HOSP	1	4	04/97	9,823,397
LONDON	LAUREL	210105	MARYMOUNT HOSP	1	1	12/92	1,195,000
LOUISA	LAWRENCE	210106	LAWRENCE COUNTY PHC	5	3	02/83	32,900
LOUISVILLE	JEFFERSON	210108	INSTITUTE OF PHYS MED	6	1	08/85	690,484
LOUISVILLE	JEFFERSON	210109	JEWISH HOSP	1	1	01/96	$ 2,194,800
LOUISVILLE	JEFFERSON	210110	KINGS DAUGHTERS HOME	0	1	07/86	794,621
LOUISVILLE	JEFFERSON	210058	KY INDUSTRIES FOR BLIND	6	4	02/90	440,440
LOUISVILLE	JEFFERSON	210111	LOUISVILLE GENERAL HOSP	1	6	07/79	1,000,000
LOUISVILLE	JEFFERSON	210112	LOUISVILLE JEFFERSON HC	5	6	07/99	909,300
LOUISVILLE	JEFFERSON	210113	LVILLE MEM PRI CARE CTR	1	3	12/98	$ 601,392
LOUISVILLE	JEFFERSON	210115	NORTON KOSAIR CHILD HSP	1	1	09/95	4,500,000
LOUISVILLE	JEFFERSON	210117	SS MARY AND ELIZABETH	1	1	12/94	2,310,000
LOUISVILLE	JEFFERSON	210118	ST ANTHONYS HOSP	1	1	09/97	2,954,863
LOUISVILLE	JEFFERSON	210121	U LVILLE DEPT OPHTHALGY	9	1	12/89	240,000

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KENTUCKY							
LOUISVILLE	JEFFERSON	210119	UNIV CANCER CTR	1	2	08/84	$ 280,000
LOUISVILLE	JEFFERSON	210120	UNIVERSITY HOSPITAL	1	4	11/TT	2,000,000
MADISONVILLE	HOPKINS	210122	REG MED CTR HOPKINS CO	1	1	05/88	1,486,458
MADISONVILLE	HOPKINS	210123	W KY HOSP LDRY & SERVIS	1	1	10/95	561,528
MANCHESTER	CLAY	210124	CLAY COUNTY PHC	5	3	03/91	150,727
MANCHESTER	CLAY	210125	MEMORIAL HOSP	1	1	08/92	$ 2,050,759
MARION	CRITTENDEN	210126	CRITTENDEN COUNTY PHC	5	3	11/83	31,834
MAYSVILLE	MASON	210128	HAYSWOOD HOSP	1	1	04/91	857,767
MCKEE	JACKSON	210130	JACKSON COUNTY PHC	5	3	03/82	30,516
MIDDLESBORO	BELL	210131	APPALACHIAN REG HOSP	1	1	12/92	1,254,880
MONTICELLO	WAYNE	210132	WAYNE COUNTY HOSP	1	3	02/95	$ 532,899
MONTICELLO	WAYNE	210133	WAYNE COUNTY PHC	5	3	10/79	26,809
MOREHEAD	ROWAN	210135	ST CLAIRE MEDICAL CTR	1	1	03/94	1,302,747
MT STERLING	MONTGOMERY	210137	MARY CHILES HOSP	1	1	11/90	624,000
MURRAY	CALLOWAY	210139	MURRAY CALLOWAY CO HOSP	1	6	07/T1	1,748,362
MURRAY	CALLOWAY	210141	SPECH HEAR CTR MURRY ST	6	4	10/96	$ 619,904
NEW CASTLE	HENRY	210142	HENRY COUNTY PHC	5	3	11/82	26,729
NICHOLASVILLE	JESSAMINE	210143	JESSAMINE COUNTY PHC	5	3	07/87	43,263
OWENSBORO	DAVIESS	210144	BRESCIA SPCH HEAR CTR	6	1	06/96	220,265
OWENSBORO	DAVIESS	210146	OWENSBORO DAVIESS CO	1	6	07/99	1,297,906
OWENSBORO	DAVIESS	210147	OWENSBORO DAVIESS CO HC	5	6	08/89	$ 24,875
OWENTON	OWEN	210148	OWEN CO MEMORIAL HOSP	1	3	05/83	111,442
PADUCAH	MCCRACKEN	210149	LOURDES HOSP	1	1	01/93	2,455,578
PADUCAH	MCCRACKEN	210150	PADUCAH MCCRACKEN CO HC	5	6	12/84	37,016
PAINTSVILLE	JOHNSON	210151	JOHNSON COUNTY PHC	5	3	08/82	39,778

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KENTUCKY							
PARIS	BOURBON	210153	PARIS BOURBON CO PHC	5	6	06/83	$ 49,213
PIKEVILLE	PIKE	210154	METHODIST HOSP OF KY	1	1	01/T1	3,175,464
PINEVILLE	BELL	210157	PINEVILLE COMM HOSP	1	1	05/97	2,114,998
PRESTONSBURG	FLOYD	210158	FLOYD COUNTY PHC	5	3	03/85	48,698
PRESTONSBURG	FLOYD	210159	HIGHLANDS REG MED CTR	1	1	04/95	4,118,400
PRINCETON	CALDWELL	210160	CALDWELL CO HOSP	1	3	10/87	$ 404,900
PRINCETON	CALDWELL	210161	CALDWELL COUNTY PHC	5	3	10/83	31,302
RICHMOND	MADISON	210162	MADISON COUNTY PHC	5	3	10/86	49,114
RICHMOND	MADISON	210163	PATTIE A CLAY HOSP	1	1	09/90	1,350,000
RUSSELLVILLE	LOGAN	210164	LOGAN COUNTY HOSP	1	3	05/84	558,315
SALYERSVILLE	MAGOFFIN	210166	MAGOFFIN COUNTY PHC	5	3	03/83	$ 27,676
SCOTTSVILLE	ALLEN	210167	ALLEN CO WAR MEM	1	3	05/95	375,000
SCOTTSVILLE	ALLEN	210168	ALLEN COUNTY PHC	5	3	01/80	27,669
SHEPHERDSVILLE	BULLITT	210170	BULLITT COUNTY PHC	5	3	02/87	31,539
STANFORD	LINCOLN	210175	FORT LOGAN HOSP	1	1	02/89	576,500
VANCEBURG	LEWIS	210178	LEWIS COUNTY PHC	5	3	09/80	$ 23,718
VERSAILLES	WOODFORD	210179	TAYLOR MANOR NRSNG HOME	0	1	07/79	302,434
WEST LIBERTY	MORGAN	210181	MORGAN CO APPAL REG HOS	1	3	04/95	1,301,124
WHITESBURG	LETCHER	210182	LETCHER COUNTY PHC	5	3	01/86	56,469
WHITLEY CITY	MC CREARY	210183	MC CREARY COUNTY PHC	5	3	03/94	89,244
WILLIAMSTOWN	GRANT	210185	GRANT COUNTY HOSP	1	3	10/84	$ 295,000
WINCHESTER	CLARK	210186	CLARK COUNTY HOSP	1	1	03/87	1,195,039
WINCHESTER	CLARK	210187	CLARK COUNTY PHC	5	3	05/82	38,418

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APPENDIX E

Special Medicaid Program Review
Advisory Committee Recommendations

Summary and Recommendations

Background:

Governor Martha Layne Collins' creation of a Special Medicaid Program Review Advisory Committee is a significant event in the history of the Medicaid Program. In view of the "alarming growth" in Medicaid Program expenditures in recent years the Governor asked the Advisory Committee to make a "comprehensive review of the entire Medicaid Program...to assure a cost effective and efficient system while emphasizing and maintaining the highest quality of support and care."

With this charge in mind, the Advisory Committee proceeded to receive testimony both in its Committee sessions and in its subcommittee sessions, all of which were open to the public. Testimonies covered topics pertaining to Medicaid eligibility, services and reimbursement, financing, the current and projected economic and demographic outlook in Kentucky, the need for broader health coverage, other states' attempt to deal with Medicaid and indigent health care funding, previous actions by the Cabinet for Human Resources to contain costs, and proposals for alternate delivery systems for providing health care.

Subcommittee and Advisory Committee deliberations have resulted in recommendations designed to meet the following objectives:

- To maintain a basic program for persons in Kentucky who are in need of health care but are unable to pay.

- To restructure the approach to and the reimbursement of health care services to eligible persons in order to contain the rate at which costs have grown.

- To ensure that basic, high quality medical services are available to all persons who are eligible for Medicaid today and in the future.

- To guarantee that the State does everything possible to eliminate all forms of fraud and abuse of the Medicaid Program.

- To implement all effective and efficient cost containment efforts and therefore, maximize Program benefits for recipients.

- To reform the present health care system to make it fiscally sound for the future; to include provisions for case management and shared dollar risk or other financial incentives.

- To maximize Federal financial participation in the provision of care to needy Kentuckians.

- To design a system of long term care services and incentives which discourages anyone from participating unnecessarily in the Medicaid Program.

- o To take advantage of all possible resources (liens, transfer of assets, revenue recovery, insurance, etc.) which will result in less dependence on State and Federal funds.

Summary:

Implementation of the Advisory Committee's recommendations would result in a number of changes in the Medicaid Program. The changes would affect recipients, potential recipients and providers, as well as management of the Program. The Program would expand its eligibility criterion to include additional groups of the indigent population. However, there remains an indigent population whose needs are not addressed through these recommendations.

A range of services would continue to be available to eligible recipients with the addition of hospice care and the increased availability of preventive care and other services. Additional home and community services would be available on a statewide basis for persons who would otherwise be eligible for SNF or ICF levels of care.

It is expected that one major impact would result in a shift in the emphasis of the Program from being a reimbursement agent to becoming a "prudent purchaser" of needed services. The delivery system would have an assigned case manager for each recipient with services based primarily on medical needs rather than social needs. It would contain some provisions of shared dollar risk or other cost containing options based on implementation experience. It would provide a range of services, which would be paid for at a reasonable rate. There would be opportunity for a wide variety of health care providers to participate.

Providers would be affected in several ways including the participation of some as case managers. Providers would also be affected by emerging financing and reimbursement options and reimbursement would be more equitable for certain medical providers. The number of long term care beds would continue to be restricted, however, there would be an emphasis on development of additional sources of payment for long term care. Some providers would also be affected by increased oversight relative to the quality and quantity of services provided, but they would be reimbursed accordingly.

Staffing within certain specified components of the Program would need to be increased, including those relating to fraud detection, abuse surveillance, quality assurance and eligibility determination.

The recipients of services would not only be the beneficiaries of some improvement in service availability but would have the benefit of additional health education. Consumers should have improved access to community based services and a greater range of choices for the provision of long term care services which should result for some in postponement or prevention of the need for institutional care.

Implementation of some of the other recommendations would continue coverage for current eligible groups and increase the number of eligibles in several instances: approximately 15,000 additional children in intact families up to age 18 (19 if in school) would be eligible; approximately 13,500 additional persons would become eligible by the increase in the AFDC payment level; and, several thousand additional persons would be potentially eligible with the change in spend-down rules and implementation of the Home and Community Based Services Waiver Project statewide.

Together, these changes should result not only in improved quality, coordination and continuity of health care for the eligible population, but should also provide for the establishment of a managed system which would have more predictable costs and more predictable outcomes.

The recommendations made by the Advisory Committee are divided into three Chapters; Structure, Redirection and Expansion.

Recommendations:

Structure

1. The Medicaid Program should continue coverage of the existing Categorically and Medically Needy eligible groups.

2. The Medicaid percentage increase in the General Fund should be at least the same as the percentage increase in the general tax revenue.

3. Efforts to eliminate fraud and abuse in the Medicaid Program should be intensified. Additional qualified personnel are needed.

4. The Committee endorses the efforts of the Cabinet for Human Resources to implement KenPAC and/or other cost effective programs. Incentive based utilization controls and quality assurances that impact both providers and consumers are essential to cost control and should be implemented throughout the Medicaid system. These systems should be based primarily on medical need rather than social need and must recognize and incorporate the following characteristics:

   a. Strong and effective gatekeeping capability with proper case management.
   b. Efficient use of the least expensive delivery options with assurance of quality care.
   c. Shared financial risk and/or other financing options which create incentives to control cost.
   d. Opportunity for a variety of urban and rural provider participation, i.e., solo, group, institutions and others.
   e. Applied to full range of services.
   f. Paid for at a reasonable rate for necessary services.
   g. With incentives to reduce costs and maintain quality.

5. Consultants independent of the Cabinet should be employed to: (a) conduct a management audit of the Cabinet for Human Resources which would include specific recommendations for organizational changes taking into account the significant changes

which have taken place in our health care system, the necessity to effectively manage our current and future dollars expended for health care and providing health care for indigent citizens of the Commonwealth; (b) conduct an actuarial study of the Medicaid and indigent care population to project the future costs of the program; and (c) develop, in concert with the Secretary for Finance and Administration, a unified approach for the selection and purchase of all health care services utilizing State dollars which shall incorporate appropriate financial monitoring.

6. The Advisory Committee recommends the implementation of the recommendations of the Special Drug Formulary Review Team Report of August 1, 1985.

7. The Cabinet should implement procedures to assure that transportation services are utilized appropriately, to include verification of client appointments.

8. All licensure standards should be reviewed for unnecessary cost escalating features.

9. A quality assurance mechanism should be developed to assure that people receive the care for which they have been certified and for which the Medicaid Program has been billed.

10. The Cabinet should examine the entire reimbursement system, particularly as it relates to depreciation and interest costs, to determine whether each element warrants reimbursement and at what rate.

    This examination should be completed within 60 days.

11. Attention should be given to maximizing the use of Federal funds wherever possible, especially for expensive specialized care.

12. The Cabinet should examine the practice of reimbursement for organ transplants and emerging technologies, taking fully into account the cost effectiveness of the procedures.

13. Fee schedules for professional providers of dental, obstetrical, primary care and other selected services should be updated based on 1984 figures. Annual adjustments in fees shall not exceed the increase in the Consumer Price Index (CPI). Professional providers (new and old) should be paid on the basis of the composite fee profile so that there is a uniform payment when the same services are rendered.

    Adjustments in fee schedules recommended herein shall be made as KenPAC and/or other cost effective programs, as described in Recommendation 4, are implemented.

14. The Cabinet should investigate revising home health caps from a per discipline cap to an aggregate cap and/or using median figures rather than a weighted median to determine caps.

15. The Cabinet should send a directive to the Department for Social Insurance field staff reinforcing the Agency's policy regarding Medicaid eligibility for pregnant women in intact families.

16. The Advisory Committee supports enactment of legislation to reduce the impact of malpractice claims on institutions and providers including, but not limited to, requiring a fixed fee schedule of reimbursement for legal fees.

17. In the short run, the long term care bed construction moratorium should remain in effect to permit the expansion of less expensive and more cost effective services.

18. All admissions to long term care facilities and services (home health, intermediate care or skilled care, etc.) should be prescreened for medical necessity including whether or not the service could be provided cost effectively.

19. The intermediate care facility (ICF) patient status determination criteria should be substantially constricted.

    The ICF level of care criteria should be revised to clearly exclude ICF coverage under the Medicaid Program for individuals whose needs can adequately be met in a personal care or other less restrictive setting.

    The State's contract with the peer review organization (PRO), under which the organization reviews and certifies individual eligibility for long term care facility services, should be explicitly worded and carefully monitored to ensure that the State's intent is fully met.

20. The Cabinet should: (a) assure that institutional services are provided only when less expensive community based services are not available or feasible; and (b) assure control over the information gathering and analysis portion of its case management system.

21. The Cabinet should amend the peer review organization contract to provide for a three (3) month review of patient status for intermediate care rather than the current six (6) month review.

22. The Cabinet should examine the feasibility of implementing a case mix reimbursement system for long term care providers.

    The feasibility study should be completed within 60 days.

23. Incentives should be developed that allow the supply of innovative and cost effective long term care services (home health, personal care, intermediate care or skilled care) to grow to reflect the needs of the population.

24. The Medicaid Program should independently establish its own demographic need criteria and apply them to requests to certify

long term care beds and facilities for Medicaid reimbursement. No additional beds should be certified for reimbursement.

25. Licensure standards for hospitals should be adjusted to accommodate the flexibility of dual licensure in a cost efficient manner.

26. The Cabinet should extend the Bluegrass Area Development District (ADD) Home and Community Based Waiver Project statewide. In order to ensure this Program will be available to those who wish to participate and would be eligible if in a Medicaid-certified long term care facility, the State should determine eligibility in the same manner as if the individual were institutionalized and establish an independent income standard (i.e., SSI income level) to achieve Medicaid eligibility in the home.

27. The Advisory Committee endorses the concept of hospice care and Medicaid reimbursement for such care.

28. A one (1) month spend-down period should be implemented as opposed to the current three (3) month period.

29. The Cabinet should place liens on real property of Medicaid clients receiving care in a skilled or intermediate care facility within the limits of what is allowable under Federal law and regulations. If necessary to implement, the Kentucky General Assembly should enact enabling legislation. The lien would be enforceable only upon the death of the recipient, and only if the amount of Medicaid benefits received exceeded $10,000. Consideration should also be given so that low income eligibles will not be adversely affected. The Cabinet should waive its lien if it is determined that the enforcement would result in substantial hardship to other dependents of the individual against whose estate the claim of lien exists. The lien would be dissolved if the recipient returns home.

30. The Cabinet should revise its financial eligibility policies to require caseworkers to review an applicant's income tax returns for the two (2) to five (5) year period prior to application for Medical Assistance to ensure that available income and/or resources are identified.

31. The Medicaid Program should raise the maximum ineligibility period from two (2) to five (5) years for persons who transfer assets, at less than fair market value, to become eligible for Medicaid. Consideration should be given so that low income families will not be adversely affected. The Cabinet should assure stringent enforcement of these provisions.

32. The Cabinet should submit a waiver to the Health Care Financing Administration (HCFA) requesting permission to establish a period of ineligibility for clients who have transferred assets at less than fair market value in the five (5) years prior to application for Medical Assistance.

33. The Cabinet should work through the Kentucky Congressional Delegation to effect a change in the Federal law which would make the family (parents, children, spouse or legal guardian) responsible for a portion of the costs of care of a person in a long term care facility, on a sliding income scale basis, which would result in a reduction of Medicaid costs. In addition, legislation should be enacted which would allow tax credits/deductions, or other tax relief, for these familial contributions for institutional care and for care of the functionally disabled at home.

34. The State should encourage the use of insurance as an alternative to Medicaid benefits, and endorse the private financing of long term care through concepts such as insurance, reverse annuity mortgages and tax incentives.

35. Sources of payment other than Medicaid should be pursued for room and board in various living settings including long term care facilities.

Redirection

36. Preventive services should include, at a minimum, children's immunizations, recommended vaccines for adults, Pap Smears, etc. If there are reimbursement restrictions under current law or regulation, efforts should be made to have these changed to permit the State to reimburse providers for these specific procedures.

37. A consumer education component that is preventive in nature and cost containing in impact should be implemented.

    All State sponsored patients should receive information on healthy life styles, home treatment of minor illnesses and emergency protocols.

38. The Advisory Committee recommends the enactment of a mandatory seat belt law which will include appropriate penalties.

39. The State should pursue the enactment of model living will legislation.

40. The Cabinet should implement additional work and training programs which encourage or provide employment for recipients. Such a system should not penalize a person for earning money by taking away total AFDC cash assistance and Medical Assistance benefits, but would possibly supplement the salary with cash assistance for child care and/or transportation, and continue the Medical Assistance coverage for a limited amount of time. Receipt of AFDC benefits should not be contingent upon willingness to participate.

41. The Cabinet should pursue a "grant diversion" program which would encourage employers to hire AFDC recipients with the State

supplementing the recipient's salary through payments to the employer, and continuing Medicaid benefits for a limited period of time.

Expansion

42. The Medicaid Program should extend eligibility in the Medically Needy Program to children up to age 18 (19 if in school) whom the State has authority to cover, given the options and constraints posed by Federal law and regulation.

43. The Kentucky General Assembly should increase the AFDC benefit level 33 percent during the 1986-1988 biennium, and additionally provide for annual adjustments to reflect inflation, plus five (5) percent until such time that the benefit level reaches the Federal Poverty Index.

44. The Cabinet should work through the Kentucky Congressional Delegation to effect a change in the Federal law to permit the separation of the Medically Needy Income Standards from the AFDC payment level.

45. The State should encourage employers to develop insurance coverage for minimum wage, low wage and part-time employees, and insurance companies should be encouraged to develop group rate health care coverage for persons who are temporarily unemployed.

46. The Kentucky General Assembly should enact appropriate legislation to provide additional revenues to meet the needs identified in this report.

MEDICAID SERVICES BY DATE OF IMPLEMENTATION

TYPE	SERVICE	DATE IMPLEMENTED	CALENDAR YEAR 61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86
MANDATED SERVICES																												
	INPATIENT HOSPITAL	1-1-61	*																									
	PHYSICIAN SERVICES	1-1-61	*																									
	DENTAL* (21	1-1-61	*																									
	SKILLED NURSING**)=21	1-1-63			*																							
	HOME HEALTH**)=21	7-1-66						*																				
	OUTPATIENT HOSPITAL	7-1-66						*																				
	LABORATORY & X-RAYS	7-1-67							*																			
	SCREENING (21	7-1-72												*														
	TRANS - EMERGENCY	7-1-72												*														
	VISION CARE (21	7-1-72												*														
	HEARING CARE (21	7-1-72												*														
	TRANS - NON-EMERGENCY	10-1-73													*													
	FAMILY PLANNING	1-1-74														*												
	RURAL HEALTH	5-1-82																						*				
	NURSE MIDWIFERY	7-1-83																							*			
OPTIONAL SERVICES																												
	PHARMACY	1-1-61	*																									
	MENTAL HOSPITALS	7-1-66						*																				
	MEDICARE PREMIUMS	4-1-68								*																		
	COMMUNITY M/H	1-1-69									*																	
	INTERMEDIATE CARE	7-1-71											*															
	ICF/MR	7-1-73													*													
	RENAL DIALYSIS	4-1-78																		*								
	PRIMARY CARE	7-1-78																		*								
	PODIATRY	7-1-79																			*							
	AMBUL SURGICAL CENTERS	9-1-81																					*					
	AIS/MR	7-1-83																							*			
	HOME & COM. BASED CARE	7-1-83																							*			
	ADULT DAY CARE	7-1-83																							*			
	NURSE ANESTHETIST	7-1-83																							*			
	BIRTHING CENTERS	7-1-83																							*			

* KMAP has limited dental coverage for the 21 and over age group.

** KMAP has no age restrictions on skilled nursing or home health servies, although they are federally mandated only for the 21 and older age group.

APPENDIX G

MEDICAID PROGRAM

Requirements and Options

A. Coverage of Eligibility Groups

1. Requirements. Must cover:

   a. AFDC recipients;

   b. Various AFDC subgroups:

      - children receiving IV-E payments;
      - families receiving 4 month extended eligibility when discontinuance results from increased earnings/hours of employment;
      - grandfathered AFDC recipients (July 1972 OASDI increase);
      - deemed recipients of AFDC, including those not receiving a cash payment because less than $10 month, pregnant women, and families in work supplement programs.

   c. SSI recipients unless electing the 1902(f) option to use more restrictive criteria for the aged, blind or disabled.

   d. Individuals receiving a mandatory state supplement.

   e. Grandfathered essential spouses meeting December 1973 requirements for eligibility.

   f. Grandfathered institutionalized persons who meet December 1973 criteria and have done so since that time.

   g. Grandfathered aged, blind, disabled recipients (July 1972 OASDI increase).

   h. Grandfathered SSI recipients eligible on basis of pass-through in OASDI cost of living increases since April 1977.

2. Options

   a. Coverage of Optional Categorically Needy groups. May include:

      - individuals who would be eligible for AFDC, SSI, or optional state supplementation but are not receiving benefits (not covered);
      - all or reasonable classifications of children under age 21, or 20, or 19, or 18 (we cover some of these, such as children in foster care, etc.);

- individuals who would be eligible if the AFDC state plan was as broad as permitted (we cover the unemployed under this heading);
- optional state supplementation recipients who would be SSI eligible except for income;
- individuals eligible under a special income level (not covered; applicable primarily for states without a medically needy program);
- certain disabled children who would be eligible if institutionalized (Katie Beckett type cases; not covered); and
- individuals receiving home and community based services under a waiver (covered: Bluegrass Area project and AIS/MR project).

b. Coverage of Medically Needy

- Medically Needy program itself is optional.
- Medically Needy groups may correspond to those covered in Categorically Needy groups, or be more limited (e.g., could cover AFDC related but not aged, blind or disabled).

  EXCEPTION: If a state has a Medically Needy program, it must cover pregnant women, children who would be eligible for AFDC except for income and resources, and all children under age 5 born after September 30, 1983 meeting income and resource requirements or limits.

  NOTE: Kentucky has chosen to cover the same groups that are covered as Categorically Needy.

B. Eligibility Conditions

1. Requirements

a. Recipients must meet technical eligibility requirements such as citizenship or legal alien, age, blindness, disability, deprivation factor (for AFDC related), or must fall into specific other grouping such as pregnant women.

b. A state must provide benefits to a resident of the state even though absent from the state.

c. Each individual covered must meet financial requirements.

d. For institutionalized individuals, patient income in excess of a nominal amount for personal needs (not less than $25) and amounts excluded for other specified reasons (such as uncovered medical expenses and family maintenance) must be deducted from the amount payable to the facility.

e. The medically needy income level set by the state may not exceed 133 and 1/3 percent of the AFDC payment level.

f. The income disregards of the cash programs must be used for the medically needy unless a variance is shown in the state plan (Kentucky has several variations from cash income methodology).

g. For the Categorically Needy, both the income and resource standards must be those of the related cash program.

2. Options

a. The state may set the resource levels for the medically needy.

b. The state may set the income levels for the medically needy so long as the amount does not exceed 133 and 1/3 percent of the AFDC payments level.

c. The state may vary from the cash payment methodology if shown in state plan prior to TEFRA amendments (1982) to Social Security Act.

d. The state may set the personal needs allowance for institutionalized individuals so long as it is not less than $25 per month.

NOTE: This outline should not be considered a complete listing of requirements and options.

SOURCE: Kentucky Cabinet for Human Resources, Division of Management and Development

APPENDIX H

Kentucky Medicaid Expenditures and Trends

ANALYSIS OF PROJECTED MEDICAID EXPENDITURES, FY 79 - FY 86
13-Aug-85

BY SERVICE

No.	Service	M	O	FY79	FY 80	FY 81	FY 82	FY 83	FY 84	(PROJECTION) FY 85	(ESTIMATE)* FY 86
1.1	Inpat. Hosp.	X		$64,312,845	$75,437,506	$98,758,078	$103,169,900	$118,735,500	$124,791,725	$149,564,275	$169,240,600
1.2	Mental Hosp.		X	$1,029,987	$2,147,272	$2,846,702	$3,983,900	$5,666,900	$9,094,071	$10,978,230	$13,069,500
2.1	Physician	X		$28,175,162	$34,470,360	$45,265,344	$44,929,800	$57,469,900	$53,013,859	$57,551,891	$65,392,800
2.2	Primary Care		X	$16,759,086	$2,871,406	$2,996,238	$3,520,000	$5,498,500	$3,430,476	$4,917,375	$6,129,700
2.3	Nurse Midwife		X	$0	$0	$0	$0	$0	$0	$23,006	$26,300
2.4	Podiatry		X	$0	$0	$0	$0	$0	$0	$3,425	$3,800
2.5	Nurse Anesthetist		X	$0	$0	$0	$0	$0	$0	$8,598	$10,000
3.1	Nursing Home	X		$28,686,681	$27,988,829	$30,696,490	$33,609,100	$29,344,300	$36,668,836	$41,317,800	$47,305,800
3.2	Intermediate Care		X	$61,138,327	$83,184,312	$100,894,218	$113,981,100	$95,504,300	$110,933,651	$120,185,854	$135,604,500
3.3	ICF-MR		X	$23,201,011	$17,651,925	$18,662,750	$35,470,700	$34,059,300	$34,743,000	$40,240,156	$46,072,200
4.1	Outpt. Hosp.	X		$9,709,514	$12,073,684	$18,275,044	$15,583,200	$22,518,100	$22,601,369	$26,047,002	$29,822,000
4.2	Renal Dialysis		X	$0	$0	$0	$0	$8,800	$1,195,255	$1,494,735	$1,711,600
4.3	Ambul. Surg. Center		X	$0	$0	$0	$0	$5,800	$207,251	$404,088	$462,400
4.4	Adult Day Care		X	$0	$0	$0	$0	$0	$26,300	$24,853	$28,200
4.5	Nurse Midwife		X	$0	$0	$0	$0	$0	$21,000	$23,006	$26,300
5.1	Home Health	X		$2,778,558	$3,366,839	$5,222,555	$5,481,100	$7,253,200	$8,893,952	$12,693,043	$16,031,700
5.2	Home/Com. Based Care	X		$0	$0	$0	$0	$0	$12,500	$242,037	$277,000
5.3	AIS/MR		X	$0	$0	$0	$0	$0	$4,159,200	$7,934,648	$10,084,900
6.1	Pharmacy	X		$13,484,200	$14,303,330	$16,416,363	$17,720,600	$20,144,600	$25,442,975	$32,269,236	$37,446,000
6.2	Lab. & X-Ray	X		$133,590	$135,988	$281,321	$391,600	$272,800	$526,050	$577,738	$661,600
6.3	Family Planning	X		$1,163,289	$1,687,165	$2,785,018	$2,385,200	$2,850,000	$2,851,040	$3,538,334	$4,051,000
6.4	Mental Health Clinic	X		$5,236,068	$7,903,689	$9,313,806	$9,112,700	$9,412,200	$10,178,557	$12,249,508	$14,524,800
6.5	Screening	X		$578,928	$800,366	$1,229,088	$589,200	$393,200	$281,180	$325,638	$372,800
6.6	Vision ((21)	X		$839,625	$1,132,658	$1,791,730	$1,703,900	$1,883,800	$1,896,203	$2,265,762	$2,594,400
6.7	Hearing ((21)	X		$46,835	$73,109	$91,493	$99,700	$66,000	$43,223	$94,639	$108,400
6.8	Trans. - Ambulance	X		$1,913,023	$1,984,344	$1,732,825	$499,900	$569,500	$627,778	$1,713,071	$1,961,600
6.9	Trans. - Non-Emerg.	X		$410,681	$404,915	$491,830	$1,710,200	$1,889,600	$2,279,000	$2,703,089	$3,095,000
6.10	SMI		X	$0	$6,800,369	$7,227,548	$8,029,100	$8,549,300	$9,440,000	$10,923,293	$12,506,200
6.11	Dental ((21)	X		$6,479,336	$8,192,743	$10,787,251	$8,052,900	$6,847,800	$7,202,583	$6,904,506	$7,905,200
TOTAL				$266,076,746	$302,610,809	$375,765,692	$410,023,800	$428,943,400	$470,561,034	$547,218,836	$626,526,300

* Actual expenditures depend completely on the leginate charges by vendors provided to eligible recipients for each allowable service in the respective fiscal year.

"Source: Cabinet for Human Resources, Division of Management and Development

COMMUNITY HEALTH CENTERS IN KENTUCKY

NAME	CLINIC SITES	# PATIENTS (1984)	# MEDICAL VISITS (1984)	# PATIENTS BELOW POVERTY	# PATIENTS WITH KMAP	SERVICE AREA
Buckhorn Lake Area Clinic	Buckhorn	1,032	2,822	402	268	Portions of Perry, Breathitt, Owsley Counties
Big Sandy Health Care	Salyersville Mud Creek	6,842	23,147	3595	1,617	Magoffin Co., Portions of Floyd and Pike Cos.
Covington Family Health Center	Covington	3,550	10,507	3,170	916	Inner City Areas, Kenton and Campbell Cos.
Health Help	McKee	2,451	7,780	1,299	711	Jackson County
Lewis Co. Primary Care Center	Vanceburg	1,443	6,699	Unavail.	736	Lewis County
Lexington-Fayette Co. Health Dept.	Lexington	13,251	43,681	5,234	2,451	Inner City Areas of Fayette Co.
Louisville Memorial Primary Care Ctr.	Louisville(2)	10,839	34,683	7,620	3,024	Portions of Western and Midtown Louisville
Mountain Comprehensive Health Corp.	Whitesburg McRoberts Leatherwood Jackson Booneville	17,582	59,176	8,264	4,044	Letcher, Breathitt, Owsley and Portions of Perry Co
Park DuValle Community Health Center	Louisville Taylorsville	16,343	42,880	9,888	2,239	Western Louisville, Spencer County
Totals		73,333	231,375	39,472	16,006	

ICB REQ #960775
UNDUPLICATED COUNTY PATIENTS
SERVED BY LOCAL HEALTH DEPARTMENTS
WHO ARE LOW INCOME AND NOT RECEIVED MEDICAID
TIME PERIOD 6/15/84 - 12/16/84

PATIENTS AT OR BELOW POVERTY LEVELS
BUT NOT KMAP ELIGIBLE

PUBLIC HEALTH PROGRAM	PATS LESS 101% OF P.L.	PER LESS 101% OF P.L.	PATS 101-150% OF P.L.	PER 101-150% OF P.L.	PATS 151-200% OF P.L.	PER 151-200% OF P.L.	NO. OF PATS INCOME NOT RETP	TOTAL PATIENTS
ALL	163153	60.433	4284	1.4135	1737	0.57314	112883	303067
702-INFECT-DISEASE	1776	51.108	52	1.4964	24	0.69065	1617	3475
705-VD	2790	58.101	108	2.2491	53	1.10371	1810	4802
712-PKU	250	41.946	10	1.6779	6	1.00671	330	596
721-GENETIC-DISOR	123	59.135	6	2.8846	4	1.92308	72	208
724-HEARING	494	39.775	32	2.5765	17	1.36876	693	1242
726-VISION	405	42.948	7	0.7423	6	0.63627	525	943
728-GLAUCOMA	204	48.456	13	3.0879	9	2.13777	192	421
731-REQUIRED ADULT EXAM	1837	38.383	208	4.3460	115	2.40284	2562	4786
741-GENIT-SX-DIS	230	30.544	1	0.1328	1	0.13280	521	753
761-SCOLIOSIS	64	43.836	10	6.8493	3	2.05479	68	146
762-MUSCULOSK-DIS	1	16.667	0	0.0000	0	0.00000	5	6
771-RABIES	7	33.333	0	0.0000	1	4.76190	12	21
799-OTHER UNREST MED	5894	52.298	170	1.5084	56	0.49689	5109	11270
821-REG-PEDIATRICS	632	73.918	1	0.1170	0	0.00000	220	855
822-PRENATAL	9035	85.778	33	0.3133	11	0.10443	1440	10533
824-MCH-NUTRITION SVS	2017	69.004	3	0.1026	5	0.17106	895	2923
825-DENTAL	1038	51.007	9	0.4423	0	0.00000	984	2035
829-IMMUNIZ	42904	45.891	1485	1.5884	519	0.55513	48283	93491
831-HOME-HEALTH	3599	58.435	73	1.1853	20	0.32473	2426	6159
834-DIASTERS	1	20.000	1	20.0000	0	0.00000	3	5
835-HEALTH ED RISK REDUCT	1	100.000	0	0.0000	0	0.00000	0	1
836-CRIPPLED CHILDREN"S PROG	7348	67.549	80	0.7354	26	0.23901	3406	10878
837-PREVENTACARE	333	66.335	0	0.0000	0	0.00000	168	502
838-HOME COMM. SERV. WAIVER	9	15.254	0	0.0000	0	0.00000	49	59
840-GENERAL PEDIATRIC SERVS	5263	47.079	125	1.1182	25	0.22363	5755	11179
841-FAMILY-PLANNING	53951	85.539	441	0.6992	134	0.21246	8454	63072
850-TB	20638	42.710	1363	2.8207	530	1.09663	25537	48321
851-WIC	50155	76.265	57	0.0867	15	0.02281	15513	65764
853-CANCER	4352	56.948	214	2.8003	97	1.26930	2957	7642
855-DIABETES	1861	52.437	52	1.4652	27	0.76078	1589	3549
856-GERIATRICS	482	46.257	18	1.7274	10	0.95969	529	1042
861-PREV CHILD HEALTH	7998	59.039	6	0.0443	4	0.02953	5531	13547
865-IN HOME SERVICES	516	84.452	4	0.6547	1	0.16367	85	611
870-HYPERTENSION	11943	40.743	613	2.0912	266	0.97568	16292	29313
872-EMER-MED-SER	0	0.000	0	0.0000	0	0.00000	1	1
875-SPECIAL-PROJ1	903	72.125	32	2.5559	15	1.19808	289	1252
876-SPECIAL-PROJ2	211	49.299	21	4.9065	20	4.67290	173	428
877-SPECIAL-PROJ3	74	81.319	0	0.0000	0	0.00000	17	91
878-MINOR-REST	1106	77.942	4	0.2819	1	0.07047	305	1419
877-SPECIAL-PROJ4	187	73.333	1	0.3922	0	0.00000	66	255
880-SPECIAL PROJ5	2	66.667	0	0.0000	0	0.00000	1	3
881-CEREBRO & HEART	320	52.202	19	3.0995	7	1.14192	265	613
883-SPECIAL PROJ6	1	100.000	0	0.0000	0	0.00000	0	1
885-INFANT-DEATH-SY	12	37.5	0	0	0	0	20	32

APPENDIX K

KENTUCKY MEDICAL ASSOCIATION

HOUSE OF DELEGATES

Submitted By:	Board of Trustees
Subject:	Kentucky Physicians Care Program
Referred To:	Reference Committee No. 1

WHEREAS, Kentucky Physicians Care was implemented, at the direction of the KMA House of Delegates, January 2, 1985, for a period of one year to gather data on access to health care by the indigent, and

WHEREAS, such data has been collected and analyzed on the first six months of the program, and

WHEREAS, 17,432 people have been certified eligible for the program (representing 96 percent of those applying for the program); 5,885 referrals have been made through the referral system; and 2,174 physicians participated in Kentucky Physicians Care through the first six months of 1985, and

WHEREAS, Kentucky Physicians Care provided needed care to one or more members of approximately 2,000 families who indicated they would not have seen a doctor had it not been for the Kentucky Physicians Care program, and

WHEREAS, there is documentation of a significant amount of care provided through Kentucky Physicians Care and the Fair Share program of the Kentucky Hospital Association, as well as by physicians choosing not to participate in Kentucky Physicians Care, and

WHEREAS, primary care appears to be the type of care needed most, and

WHEREAS, Kentucky Physicians Care has demonstrated that Kentucky physicians do care about the less fortunate members of society and has been well received by the public and their elected representatives,

NOW, THEREFORE, BE IT RESOLVED, that the Kentucky Medical Association continue the operation of Kentucky Physicians Care for one year (January 1, 1986-December 31, 1986), contingent on:

1. Program funding being continued, as appropriate, by the Kentucky Health Care Access Foundation, with KMA contributing in-kind services as done in 1985;

2. A continuing commitment from the Cabinet for Human Resources to evaluate program applicants for eligibility, as is currently being done;

3. Some modifications being made to the program by the Kentucky Physicians Care Operating Committee which will address problems inherent in some types of delivery, such as pre- and post-natal care;

4. The Kentucky Hospital Association continuing its Fair Share program as currently operated;

5. The Kentucky Health Care Access Foundation vigorously encouraging the active participation of free-standing emergency centers, health maintenance organizations, and all other health care delivery and/or financing organizations in Kentucky Physicians Care or the Fair Share program, as may be appropriate; and

6. The Kentucky Health Care Access Foundation making Kentucky legislators aware of the plight of those ineligible for Medicaid assistance solely because they do not meet the confusing and arbitrary requirements of the Medicaid Program, while working to broaden the societal financial obligation necessary to provide care to those in need of such assistance.

October, 1985