Sustaining Rural Health Care in Kansas
The Development of Alternative Models

Melissa Hungerford
Kansas Hospital Association
Quick Facts About Kansas

• 82,277 sq mi, 2.7 million pop
• 89 of 105 counties rural
  – 40 with pop density <10 p/sq mi
• 128 Community Hospitals
  – 10,029 Staffed beds
• 103 Additional Specialty/ASCs

• 300,000 Inpatient Statewide
  – 46% Medicare
  – 15% Medicaid
• 102 Rural
  – 84 CAH
  – 10 S/R PPS
  – 2 >35 miles from another hospital
Background

• 2012 Rural Health Visioning Technical Advisory Group
  – Established by KHA Board of Directors
  – All sizes and types of hospitals (urban and rural)

• Charge
  – Strategies for future of rural health delivery and structure
  – New models of rural health delivery – fit for Kansas
  – Education and resources for KHA members and the public
Principles for a Sustainable Rural Health System

✓ Improve Health
✓ Provide Access
✓ Encourage Collaboration
✓ High Quality
✓ Promote Efficiency and Value
✓ Embrace Technology
✓ Financed Fairly to Address Population Health
The *Case for Change* on Kansas
Educating Hospital Leadership

• Case for Change
  – Financing and Reimbursement Reductions
  – Reliance on Acute Services
  – Small, Rural Markets
  – Population is Older, Aging, Declining
  – Workforce Challenges Recruitment and Retention
  – High and Complicated Community Expectations
Why An Alternative Model for Kansas?

• Kansas 2013 Acute Patient Data
  – 18 hospitals <= 1
  – 15 more <= 2
  – 19 more <= 3
  – 13 more <= 5
  – Others 5+

• Kansas 2013 Swing Bed Patient Data
  – All hospitals: Highest ADC = 10
  – Hospitals <5 acute ADC: Highest SB ADC = 5
Consensus

• **Protect the rural foundation**
  – Rural communities are critical to Kansas
  – Hospitals are critical piece of the economic engine

• **Communities have common but distinct needs**
  – No “one size fits all” model of health care delivery
  – Services should match local need and sustainability

• **We need options**
  – New options must be developed and tested
  – Structural options lacking that align need and sustainable service

• **A “Sustainable” Choice: Primary Health Center**
  – Not traditional, sustainable hospital or CAH
  – Alternative between RHC and CAH
  – Financed differently than a CAH
New Choice for Communities
Primary Health Center

EMS Plan

Rural Health Clinic
Federally Qualified Health Center
Partner Organization
Critical Access Hospital

Primary Health Center - 12
Primary Health Center - 24
Partner Organization
Primary Health Center
Role in Regional System of Care

• Retain local governance
  – Also be strong partner in regional system
• Formal agreements
  – Partner Organization: outline expectations and mutual benefit
  – Clinical relationships: local, partner, telemedicine
  – Local and regional service providers (NH, BH, EMS, PH, etc.)
• Operational efficiencies
Primary Health Center
Service Characteristics

• Patients: up to inpatient admission criteria
• Services:
  • Traditional ambulatory, clinic services
  • Urgent, Emergency, Transport Services
  • Local/regional ancillary and other services
  • Strong Care Coordination and Disease Management
  • Transitional Care – and/or LTC (24 hour operation only)
  • Niche or regional services – depending on community need (behavioral, social)
• Staffing:
  • RN(s) on site during hours of operation
  • Physician, APRN, PA on-call
  • Active telemedicine
Paper Test
Can it work?

• Clinical
  – Nurse Reviewers
  – 3 High Volume Months
  – ER, Acute, Observation, Swingbed
  – Assume Ambulatory Stays the Same

• Financial
  – Local CPA/Auditors
  – Standard Cost Report and CPA/Hospital Files
  – Operational Assumptions in conjunction with CEOs/CFOs
  – Normalization
Paper Test Sites

Edwards County Hospital, Kinsley
Ellinwood District Hospital, Ellinwood
Fredonia Regional Hospital, Fredonia
Washington County Hospital, Washington
Wilson Medical Medical Center, Neodesha
Normalization

• Remove services not relevant/niche – Inpatient Psych, Wound
• Remove services inconsistent – EMS, RHC
• Add back in
  – Primary Care
  – EMS/Transportation
  – Telehealth/Telemedicine (no additional staff)
  – Care Management
  – Capital/Debt Service
Draft Results

- Actual Staffing: 40-111
- Staffing in Test Sites
  - 12 Hour: 33-67
  - 24 Hour: 42-92
- Base Staffing
  - 12 Hour: 33
  - 24 Hour: 43

- Actual Costs: $4.3m – $13.5m
- Normalized costs added: $190m
- Estimated Costs
  - 12 Hour: $4.0m – $8.5m
  - 24 Hour: $4.4m – $12.1m
- Base Costs
  - 12 Hour: $4.7m
  - 24 Hour: $6.1m
Payment Concept

• Budget Based
  – Federal Grant/Subsidy
    • Cover the cost of Emergency and Transportation services
  – Local Subsidy
  – Include funding for uninsured, bad debt and capital

• Interesting discussion
  – EHR incentive type method
  – Basic rate with formula
  – Plus subsidy amount
Legislative and Regulatory Barriers
Change is required for new models to work

**Priority Policy Changes**
- Revert back to CAH/PPS
- Participation Requirements*
- EMTALA Rules
- EMS Transport*
- Physician Supervision
- Telemedicine for ER Coverage
- Definition of Transitional Care*
- Maintenance of Part A
- Impact of RHC reimbursement
- Alignment of Medicare and Medicaid payment methods
- Subsidy for access to ER and other
- Low density population as “underserved”
- Impact on beneficiary outpatient costs

* Current “Straw Man” discussions

**Other Policy Issues**
- Reduced hours of operation
- Definition of emergency
- Handling patients at close of business
- Definition of Partner Organization
- EMS roles and responsibilities
- Joint Commission
- Scope of practice
- STARK
- Barriers to integration
- Ancillaries requiring on site providers
- CLIA
- Care coordination and prevention
- Cost report carve out issues
- Alignment of quality measures
- Access to SHIP and FLEX
QUESTIONS
Melissa Hungerford, SVP and CEO K-HERF
Kansas Hospital Association
Topeka, Kansas
785-276-3130
mhungerford@kha-net.org
www.kha-net.org