Sustaining Rural Health Care in Kansas
The Development of Alternative Models

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Kansas: A Year Later

- 82,277 sq mi, 2.7 million pop
- 89 of 105 Counties, 40 frontier
- 84 of 127 CAHs
- No KanCare Expansion
  - Significant Primary Election Results
- Hospitals at risk
  - Ivantage – 31
  - George Pink - 4
  - CliftonLarsonAllen – 25% of Kansas Population at risk

- Fragile inpatient infrastructure
  - 18 hospitals <= 1
  - 15 more <= 2
  - 19 more <= 3
  - 13 more <= 5
  - Others 5+
Kansas: A Year Later

- Rural Health Visioning TAG - Year 3
- Strategies for future of rural health delivery and structure
- Current Focus Areas
  - Telling The Story
  - Testing New Models In Kansas
  - Increasing Value and Impacting Population Health
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
Kansas – New Models in Action

- Harper – Merger
- Kansas Heart and Stroke Collaborative (CMMI Grant)
- Kansas Frontier Health Improvement Network (UMHMF)
- HOPD/ER, Independence
- CAH/FQHC, Hoxie
- International Fellowship – Physician Recruiting Strategy, Lakin, Southwest Kansas
- Telemedicine – Avera, Eagle, Others
- New approaches to affiliation
- Accountable Care Organizations (ACO) – Shared Savings models
- National Rural Accountable Care Organization (NRACO)
- KHA Primary Health Center
Exploring a New Choice for Communities: Primary Health Center
Primary Health Center Characteristics

- **Hospitals**: Critical Access Hospitals or rural PPS hospitals
- **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 (24 hour model 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
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 and Regional Service Providers
  – Operational Efficiencies
Paper Test Sites

Edwards County Hospital, Kinsley
Ellinwood District Hospital, Ellinwood
Fredonia Regional Hospital, Fredonia
Washington County Hospital, Washington
Wilson Medical Center, Neodesha
Paper Test
Methodology

- 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
Paper Test: Clinical Findings

946 Cases Reviewed

70% ER

Patient Age - All Cases

- <18: 9.42%
- 19-44: 23.07%
- 45-64: 24.87%
- 45-64: 42.65%
- >65: 4.87%

Patient Transportation (All Sites)

- Amb: 42.65%
- Law Enf: 23.07%
- Private Car: 24.87%
- Other: 19.64%

70-75% of patients could be served in Primary Health Center – more?
2014 Actual Staffing: 40-111

Staffing in Test Sites
- 12 Hour: 33-67
- 24 Hour: 42-92

Base Staffing
- 12 Hour: 33
- 24 Hour: 43

2014 Actual Costs: $4.3-13.5m

Normalized costs added: $1.9m

Estimated Costs in Test Sites
- 12 Hour: $4.0-8.6m
- 24 Hour: $4.4-12.1m

Base Costs
- 12 Hour: $4.7m
- 24 Hour: $6.1m
PHC Base Budget Assumptions
From Test Findings

• PHC Base Costs
  – 12 Hour: $4.7m
  – 24 Hour: $6.1m

• Includes
  – Primary Care ($1.1m – 8 FTEs all staff)
  – EMS/Transportation ($550,000 – 6 FTEs all staff)
  – Telehealth/Telemedicine ($100,000 – no staff)
  – Care Management ($150,000 – 2 FTEs)
  – Capital/Debt Service ($500,000)
“Improving efficiency and preserving access to emergency care in rural areas” published June 2016

- Cost-based payment models misdirect Medicare $$ and do not incentivize cost control
- Higher inpatient payments do not always keep ED doors open
- Coinsurance is higher at CAHs
- Medicare may achieve greater efficiency and financial stability by subsidizing emergency services rather than inpatient care

- Option 1: 24/7 emergency department
  - ED services, ambulance services, and primary care
- Option 2: clinic (FQHC) and affiliated ambulance model
  - Primary care and ambulance
- PPS rates plus fixed payment (grant)
Moving Forward

• PHC Refinement
  – Testing Payment Options (TAG Preferences)
    1. Global budget-based level monthly payments (Grant)
    2. FQHC-like with extended visit payments (Grant)
    3. Blended: monthly payments, fee schedule (Grant)
    4. Global cost-based approach
    5. PPS Fee Schedule (Grant) (MedPAC)

• EMS Regional Plan
  – Not just emergency!

• Strategies for the Future
  – Status quo, New Model, Conversion, Affiliation

• Swingbed Services and Payments
  – Can we show quality and cost value?
Thank You!

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