

The Kansas Health Foundation, United Methodist Health Ministry Fund, and the Kansas Hospital Association & the KU Public Management Center present:

# A CONVERSATION

ABOUT

## The Future of Rural Health Care in Kansas



### Project Partners

Presented by:



Facilitated by:



Content Expert:



## Why this Conversation?

- Kansas Health Foundation and United Methodist Health Ministry Fund support work that improves the health of Kansans
- Ensuring sustainable health care in rural communities is a top priority
- We value engagement – sharing information and receiving feedback is critical to informing future of rural health and our work



Health care in rural Kansas  
faces many challenges...



# Demographics: An Important Factor

Kansas Population is Growing... Older, Slower, and only in Cities



## Rural depopulation impacts the demand for health care

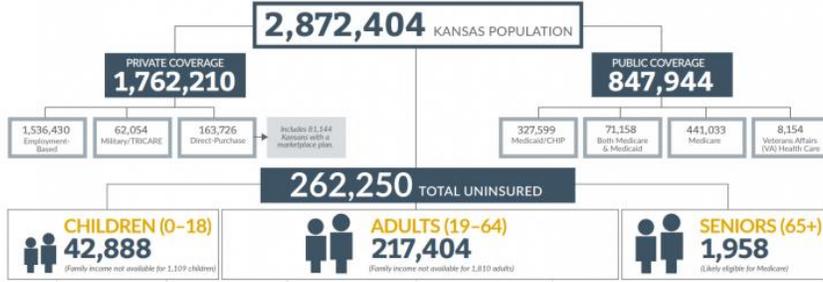
**22%** Projected Population Decline in Rural and Micropolitan Cities (between 10-50K) by 2064.

**0.4%** Annual projected average growth in Kansas for the next 50 years.

**69%** Of Kansas population growth will be in the over-65 demographic. Approx. 1 in 4 Kansans will be over 65 by 2064.

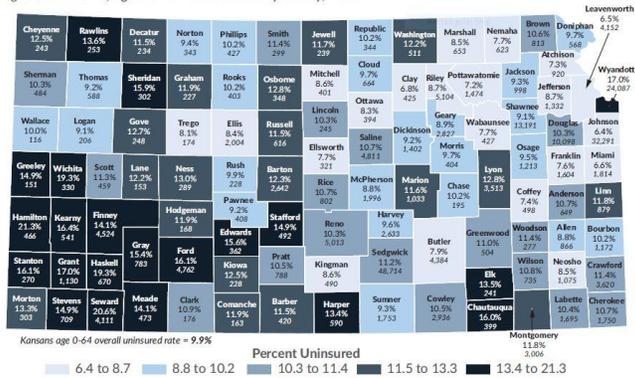


# Health Insurance in Kansas 2019

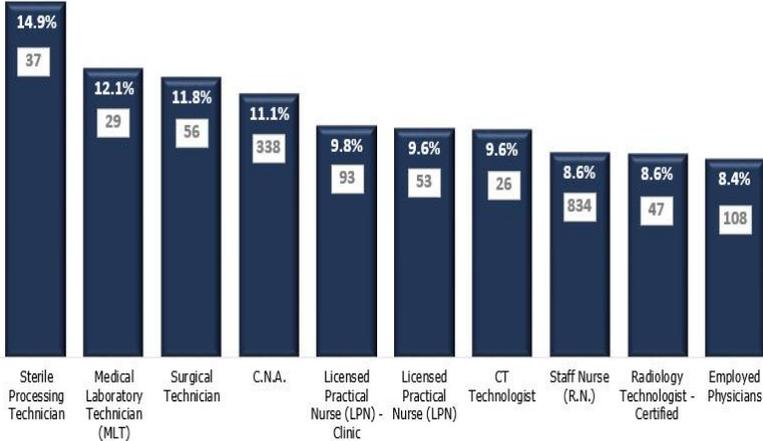


## The Number of Uninsured Patients Continues to Grow in Rural Areas

Uninsured Rate Varies Widely Across Kansas Counties  
 Figure 5.1 Kansans, Age 0-64: Uninsured Rates by County, 2016



## Workforce Challenges -- Vacancy Rates and Vacancies for Select High Demand Positions



FTE VACANCY FOR SELECT HIGH DEMAND POSITIONS | 2019\*  
The ten selected positions depicted below are in high demand across Kansas. .

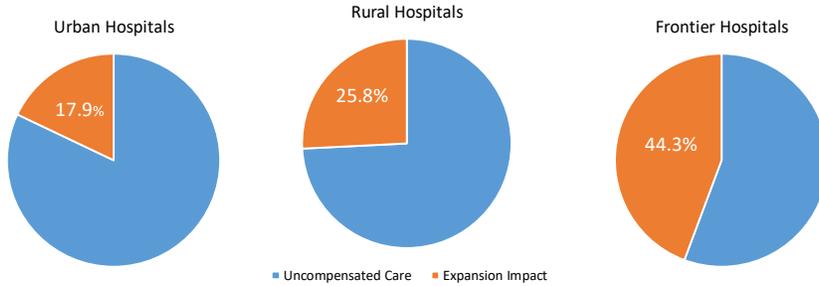


## Public Health Funding

- Kansas ranked #40 in public health spending
- The top state spends 4.5x more than Kansas
- Kansas spends \$60 per person while the top state spends \$281



# Medicaid Expansion Would Help Rural Hospitals



Hospital Type	# of Hospitals	Avg. Benefit per Hospital, per Year	Avg. Annual 10-year Benefit per Hospital, per Year
Critical Access Hospital (CAH)	82	\$255,469	\$370,255
Rural, Non-CAH	17	\$913,418	\$1,323,828
Urban	27	\$6,255,445	\$9,256,302



## More about Medicaid Expansion

- The states ranked in the top 18 of health rankings have expanded Medicaid
- The states with the greatest increases in their rankings have expanded Medicaid
- The states with the greatest decreases in their rankings have not



# The Result:

### OVERALL KANSAS HEALTH RANKINGS



Of all the states in the US, over the past 30 years, **Kansas has seen the greatest decline** in its health rankings.

- (America's Health Rankings, December 6, 2019)



# Impact of COVID-19...



## COVID-19 Has Highlighted Challenges

- Rural Americans are at higher risk of severe illness from COVID-19
- Health disparities are exacerbated during a pandemic
- Outdated facilities and support services makes response harder
- Workforce supply can't meet demand for care
- Public health departments have limited resources
- Telemedicine/distance learning challenges due to insufficient broadband



# Challenges for Rural Hospitals



## Services Delivered Differently

- Many common procedures do not require an overnight hospital stay
- Technology and specialists needed for complex procedures – delivered regionally
- 37 Kansas hospitals have fewer than 2 patients staying overnight



## Service Delivery Has Changed, but Payment Methods Have Not

Cataract Surgery, 1970s	Cataract Surgery, 2000s:
1 hour surgery	10 minute procedure
1-2 days hospitalization	Outpatient surgery centers
Provided only to worst case patients	Available to most patients



## Health Care Finance Challenges

- Health care finances are different than many industries
  - What other industry willingly accepts 20 to 30% of a bill...and is happy?
- Some unique aspects of health care finance
  - Highly regulated by government
  - Make the most money when patients stay in hospital
  - Very capital intensive
  - Low profit margins



## Biggest sources of revenue don't pay the true "cost" of services



Medicaid  
pays \$55

Medicare  
pays \$99

In addition, some patients are uninsured and provide no payment



## Financial Pressures

- **47%** of rural hospitals nationally are operating at a financial loss
- **75** Kansas rural hospitals are operating at a financial loss and in danger of closing

Chartis/Vantage 20200  
CHQPR 2020



## Regulatory Challenges

- Rules about how space in the hospital can be used
- Restrictions on telemedicine
- Rules governing overnight stays
- Prohibition of home visits prior to an inpatient stay
- Rules governing EMS



## Options for Rural Communities



## Option #1

### Partnering with Others

#### Financial Position & Stability

The hospital can't sustain itself financially over the long-term.

#### Facilities & Equipment

The poor financial position of a hospital makes borrowing money challenging. Patients do not want to come to an old facility with outdated equipment.

#### Workforce

The ability to recruit and retain physicians and nurses to sustain services that the community needs is deteriorating.



## Option #2

### Maintaining a Clinic

The **majority** of health care needs in a community can be addressed in a **physicians' office or clinic** instead of a hospital.



#### Clinics can provide many services:

- Wellness/Preventative Care
- Immunizations
- Chronic Disease Management
- Diagnostic Labs and Imaging
- Family Planning and Prenatal Care
- Prescription Assistance



# Kansas Develops a New Model

- Kansas hospitals have been researching and working on a new model **since 2012**
- Goal is **sustainable care** for rural areas with a focus on
  - preventive and primary care
  - chronic disease management
  - emergency services (24/7 health care)
- Research showed **more than 75%** of patients using the emergency room would be **fully served** by the new model



## Option #3 Primary Health Center



Clinic

Limited hours  
No Emergency Services  
No Overnight Stays  
Primary Care



Primary Health Center

Open 24/7  
Emergency Services  
No Overnight Stays  
Primary Care



Hospital

Open 24/7  
Emergency Services  
Overnight Stays



## Services provided by PHC

### CORE SERVICES

- Primary health care, including prenatal care
- Urgent care
- Emergency care
- Transportation
- Minor outpatient procedures
- Management of chronic conditions
- Telemedicine

### OPTIONAL SERVICES

If unavailable locally, may be included in the payment model:

- Rehabilitative services
- Behavioral health
- Oral health
- Specialty care (via telemedicine or visiting specialists on site)



## Benefits of the Primary Health Center

- A Kansas solution that **changes the way** health care services are delivered and paid for.
- A health care approach that provides **flexibility so a community can get the services it needs** even when they aren't services typically provided by hospitals.
- A place where **24/7 health care** is available.
- An approach to the health services that **ties financing to keeping people healthy**, not to keeping them in the hospital.



# Moving Forward



## Next Steps for the PHC Model

- Build off Federal legislation that establishes the Rural Emergency Hospital (part of Consolidated Appropriations Act)
  - The REH is very similar to the PHC concept
  - REHs can operate starting in January 2023
- State legislation to ensure Kansas can have REHs
- Engage stakeholders and communities in conversations about the future



## Starting the Conversation Regionally

- Feb 9 – Southwest
- Feb 11 – Northwest
- Feb 24 – North Central
- Feb 28 – South East
- March 2 – South Central
- March 4 – Northeast

*All conversations will be held virtually and take place from 1:30 to 3:00 p.m.*



## Regional Conversation Objectives

- Current state of hospital/health delivery system
- Discuss essential services
- Review options for the future
- Identify communities that want to talk more



## Community Conversation Success

### Decatur Health, Oberlin Kansas

March 4, 2020

- 80 community members participated
- 92% of attendees recommend other communities have a conversation
- 69% felt the primary health center could meet the communities needs



## Community Conversation Success

“They came to realize that change can be challenging and even scary, but finding stability is critically important. The people appreciated us reaching out to them, getting them involved, and having input into ideas that help maintain access to care in Decatur County.”

*Kris Mathews, COO Decatur Health*



# Additional Information



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December 22, 2020

## Detailed Summary of Health Provisions in Consolidated Appropriations Act, 2021

*Legislation includes helpful changes to Provider Relief Fund, elimination of some Medicaid DSH cuts and Medicare sequester cuts, and provisions to address surprise medical bills, among other issues*

The House and Senate last night approved the [Consolidated Appropriations Act, 2021](#). The legislation includes roughly \$900 billion in COVID-19 relief, including a number of provisions beneficial to hospitals and health systems, and \$1.4 trillion in spending that will fund the federal government for fiscal year 2021. President Trump is expected to sign the legislation.

**AHA Take:** In a statement, AHA President and CEO Rick Pollack said, “America’s hospitals and health systems, and our heroic front-line caregivers, appreciate the continued support from Congress as our ongoing battle with the COVID-19 pandemic enters its second year. While this legislation is welcome news for patients and their families, and the hospitals that provide them and their communities with essential services, there is no question that additional relief will be necessary as we continue to battle the pandemic.” [View AHA’s full statement that was shared with the media yesterday detailing its comments on specific provisions included in the legislation.](#)

A detailed summary of provisions important to hospitals and health systems included in the 5,500-page legislative package follows.

### Key Takeaways

Among other health care-related provisions, the package:

- Provides helpful flexibility in Provider Relief Fund (PRF) reporting, including allowing the use of “budgeted-to-actual” lost revenue calculation and transfer of “targeted distributions” within a health system.
- Adds \$3 billion to the PRF.
- Eliminates \$4 billion in Medicaid DSH cuts that were scheduled to go into effect in FY 2021 and further eliminates the DSH cuts in the two subsequent years.
- Eliminates the 2% Medicare sequester cuts through March of 2021.
- Protects patients from receiving surprise medical bills.
- Lifts the cap on Medicare-funded physician residency positions in teaching hospitals by 1,000, effective in FY 2023.
- Provides billions in funding for COVID-19 vaccines, testing and contact tracing.
- Establishes a new Rural Emergency Hospital Medicare designation.
- Provides approximately \$3 billion in increased payments for physician services under the Medicare Physician Fee Schedule for 2021.
- Extends the availability of funds provided to states and localities by the Coronavirus Relief Fund through December 2021.

Notably, the legislation does not contain harmful provisions related to the Occupational Safety and Health Administration.

## HIGHLIGHTS OF PROVISIONS IMPORTANT TO HOSPITALS AND HEALTH SYSTEMS

The legislation includes a number of provisions important to hospitals and health systems. We have organized the major provisions in the following sections:

- [COVID-19 Provisions](#)
- [Surprise Medical Billing and Transparency Provisions](#)
- [Medicare Provisions](#)
- [Medicaid Provisions](#)
- [Rural Health Provisions](#)
- [Prescription Drugs](#)
- [Additional Public Health Provisions](#)
- [Parity in Behavioral Health and Substance Use Disorder Benefits](#)
- [Extenders](#)
- [Appropriations Provisions](#)
- [Other Provisions](#)

### COVID-19 PROVISIONS

**Provider Relief Fund (PRF).** The legislation includes helpful changes to the PRF reporting guidelines. Specifically, as requested by the AHA, it would allow providers to calculate lost revenues using the Frequently Asked Questions guidance released by the Department of Health and Human Services (HHS) in [June 2020](#), which specified that providers could use “any reasonable method” for the calculation. The legislation clarifies that such methods include the difference between budgeted and actual revenue if such budget had been established and approved prior to March 27, 2020.

In addition, the legislation clarifies that health systems may move all PRF distributions within their system. Specifically, a parent organization may allocate any or all of its subsidiary organizations’ PRF payments, including “targeted distributions,” among subsidiary eligible health care providers of the parent organization.

Finally, the legislation also includes \$3 billion in new dollars for the PRF.

**Medicare Physician Fee Schedule Payments.** The legislation provides a 3.75% increase in payments under the Physician Fee Schedule for 2021, or about \$3 billion in increased payments for physician services.

**Medicare Sequester Cuts.** The legislation eliminates the Medicare sequester cuts through the first three months of 2021. The 2% cut to all Medicare payments was supposed to resume Jan. 1, 2021.

**Vaccines and Therapeutics.** The legislation includes approximately \$30 billion for the federal government to assist with the purchase and administration of COVID-19 vaccines and COVID-19-related therapeutics. This includes:

- \$8.75 billion to the Centers for Disease Control and Prevention (CDC) to plan, prepare for, administer, monitor and track coronavirus vaccines and ensure broad

distribution and access. Of this amount, \$4.5 billion must be allocated to states, localities and territories, with \$1 made available within 21 days of enactment. In addition, \$300 million must be allocated to high risk and underserved populations, including racial and ethnic minorities and rural communities.

- \$19.7 billion to the Biomedical Advanced Research and Development Authority (BARDA) for the manufacturing and procurement of vaccines, therapeutics and diagnostics, as well as the ancillary supplies needed to support them.
- \$3.25 billion to support procurement of vaccines, therapeutics, diagnostics and related supplies to the Strategic National Stockpile.

**COVID-19 Testing and Tracing.** The legislation includes \$22 billion that will be sent directly to states for testing, tracing and COVID-19 mitigation programs. This includes \$2.5 billion for a targeted effort to improve testing and contract tracing in underserved populations.

**National Institutes of Health (NIH).** The legislation provides NIH with \$1.25 billion to support research and clinical trials related to the long-term effects of COVID-19, as well as the NIH's Rapid Acceleration of Diagnostics program.

**Coronavirus Relief Fund.** The legislation extends the availability of funds provided to states and localities by the Coronavirus Relief Fund through December 2021.

**Child Care.** The legislation provides an additional \$10 billion for child care providers through the Child Care and Developmental Block Grant program with the intent of both helping the child care providers remain open, as well as providing care for dependents of essential workers.

## **SURPRISE MEDICAL BILLING AND TRANSPARENCY PROVISIONS**

**Surprise Medical Billing Patient Protections.** Beginning Jan. 1, 2022, patients will be protected from surprise medical bills that could arise from out-of-network emergency care, certain ancillary services provided by out-of-network providers at in-network facilities, and for out-of-network care provided at in-network facilities without the patient's informed consent. Patients will be required to pay only the in-network cost-sharing amount, which will be determined through a formula established by the HHS Secretary and will count toward the patient's health plan deductible and out-of-pocket cost-sharing limits. Providers will not be permitted to balance bill patients beyond this cost-sharing amount. Both providers and health plans will be required to inform patients about these protections. Violations could result in state enforcement action or federal civil monetary penalties of up to \$10,000.

In certain instances, an out-of-network provider still may be permitted to bill a patient more than the in-network cost-sharing amount for care. However, the provider would need to give the patient notice of their network status and an estimate of charges, as well as obtain the patient's written consent, prior to the delivery of care.

### **Provider Reimbursement and Independent Dispute Resolution (IDR) Process.**

Health plans will be required to reimburse out-of-network providers for the services subject to surprise medical billing protections (or issue a denial notice) within 30 days, and patients will be shielded from any payment disputes that may arise between plans and providers.

The amount an insurer pays the provider may be subject to state law or policy, such as in states with an all-payer rate model or in states with laws regulating how certain out-of-network claims or surprise medical bills are handled. In states where such laws are in effect, state laws will continue to apply to state-regulated products, and the reimbursement and IDR provisions of this legislation will apply only to health plans regulated by the federal government, such as those regulated under the Employee Retirement Income Security Act of 1974 (ERISA).

If a provider is dissatisfied with a payment made by a health plan, it will be able to initiate a structured process to resolve the dispute. First, the health plan and provider will have 30 days to attempt to resolve the dispute through negotiation. If a settlement cannot be reached during that period, the involved parties will be able to access an IDR process conducted by an unbiased entity approved by the federal government. This process must be triggered within four days of the end of the negotiation period. Each party would submit a final offer for consideration by the arbiter (also known as “baseball-style arbitration”), along with supporting information.

The arbiter will be directed to consider a wide range of relevant information, including: the median contracted in-network rate; the provider’s training and experience; the patient’s acuity and the complexity of care provided; the facility’s teaching status, case mix and scope of services; any demonstration of good faith effort or lack thereof to resolve the dispute; prior year contracted rates; and other information brought forward by the involved parties. The arbiter will not be able to consider provider charges or the rates paid by public programs such as Medicare or Medicaid.

There will be no minimum disputed payment threshold to enter the IDR process, and similar claims within a certain timeframe could be batched together to ease administrative burden. The arbitration process will need to be concluded within 30 days, and the losing entity will be required to pay the fees to participate in the process. However, if the dispute is resolved by the parties before the arbiter makes a decision, the parties share in the cost. Following the determination by the IDR arbiter, the parties involved could not initiate another IDR process for the same item or service for a 90-day period.

Many of the provisions will require rulemaking over the next 6-12 months by the departments of HHS, Treasury and Labor to implement. For example, the departments will need to establish via rulemaking the operational details for the IDR process, how cost-sharing will be calculated, and the notice and consent process, among other provisions.

**Application of Protections to Ambulance Services.** Patients using air (but not ground) ambulance services will be accorded similar protections against surprise

medical billing as previously described, and providers of air ambulance services and health plans will be accorded a similar process for resolving disputed claims as outlined above. Air ambulance providers also will be subject to new cost- and claims-reporting requirements to both HHS and the Department of Transportation. An advisory committee will be established to review and make recommendations on policy related to air ambulance quality and patient safety. In addition, a separate advisory committee will be established to review ground ambulance billing practices and recommend consumer protections regarding balance billing.

**Provider Price Transparency.** Health care providers (both individual practitioners and facilities) will be required to share “good faith estimates” of the total expected charges for scheduled items or services, including any expected ancillary services, with a health plan (if the patient is insured) or individual (if the patient is uninsured). The language is unclear whether these estimates must be provided upon patient request or for every scheduled service. The estimate will need to include the expected billing and diagnostic codes for all items and services included in the estimate. The provider would need to determine the patient’s health coverage status and develop the good faith estimate at least three business days before the service is furnished and no later than one business day after scheduling, unless the service is scheduled for more than 10 business days later. In those instances, the provider will need to furnish the information within three business days of a patient requesting a service or scheduling a service. This requirement will go into effect Jan. 1, 2022.

In addition, the HHS Secretary is required to establish a “patient-provider dispute resolution process” to adjudicate any disputes over pricing for uninsured patients that receive a substantially higher bill than the good faith estimate provided prior to service.

The legislation does not include a provision from earlier drafts that would have established new timeframes for patient billing and required facilities to bill on behalf of independent providers.

**Health Plan Price Transparency.** Health plans will be required to send patients an “Advanced Explanations of Benefits” (EOB) prior to scheduled care or upon request by patients looking for more information prior to scheduling. The Advanced EOB requirement is triggered by the provider sending the “good faith estimate” required in Section 112 to the plan. The Advanced EOB will need to include:

- Whether the provider and facility are in-network and either the contracted rate for the item or service (if in-network) or information on finding in-network providers for the item or service (if out-of-network);
- The “good faith estimate” provided by the provider (see above), with a delineation by the health plan of the portion the patient should expect to pay and the portion the health plan is expected to pay;
- An estimate of the amount the patient has incurred toward their deductible and cost-sharing limits;
- Information on any medical management (i.e., prior authorization) required for the item or service; and

- A disclaimer that all information included in the notice is an estimate and subject to change.

Health plans will need to share this information within three business days of receiving a request or notice that a service had been scheduled, as long as the service was scheduled for at least 10 business days after the notice. If scheduled for less than 10 days after the notice, the health plan will need to provide this information within one business day. The HHS Secretary will have the authority to modify the timing requirements for services deemed to have low utilization or significant variations in costs. This requirement will go into effect for plan years beginning on or after Jan. 1, 2022.

In addition, health plans would need to maintain online price comparison tools that would allow patients to compare expected out-of-pocket costs for particular items and services across multiple providers. Health plans also would need to provide price comparisons over the phone. Health plans would need to offer such price comparisons for plan years beginning on or after Jan. 1, 2022.

**Other Provisions to Help Patients Access Care.** The legislation includes certain other provisions to help patients access care, including requirements around access to obstetrical or gynecological care, as well as the ability of a patient to select a pediatrician as the child's primary care provider. In addition, the legislation protects continuity of care for patients when health plans change provider networks, particularly for individuals with complex care needs.

**Provider Directories.** Health plans will be required to ensure their in-network providers are up-to-date. This requirement entails a verification process that patients can access online or within one business day of an inquiry. A patient that relies on a health plan's inaccurate provider directory will be responsible only for the in-network cost-sharing amount if the patient provides documentation they received incorrect information.

**Disclosure of Cost-sharing.** The legislation requires that health plans include on any physical or electronic health plan or insurance identification card issued to an enrollee the amount of the in-network and out-of-network deductibles and the in-network and out-of-network out-of-pocket maximum limitations. Plans also will be required to include information on how consumers can seek further assistance.

**All-payer Claims Databases (APCDs).** The legislation provides grants to states to build or improve APCDs and direct the federal government to develop a standard for voluntary self-insured plan reporting to state APCDs. States that receive grants would be required to provide access to data for researchers, employers, health insurance issuer, health care provider, or other stakeholder for the purpose of quality improvement or cost containment, although states could apply for waivers of those requirements.

**Reporting and Audits.** The legislation includes a number of instances where the government is directed to audit health plans and providers for compliance, conduct evaluations of the impact of certain provisions, and publicly release data. For example, the legislation directs an evaluation of network adequacy and whether plans have a history of routine denials, low payment, down-coding or other abuses. Other evaluations

focus on the impact of these provisions on health care costs and consolidation, among other areas of focus.

**Health Plan and Provider Contract Requirements: Sharing of Price and Quality**

**Data.** The legislation disallows contract terms between health insurers and providers that would directly or indirectly restrict the insurer from providing provider-specific cost or quality data through a consumer engagement tool or other means to referring providers, the plan sponsor (e.g., an employer), enrollees or individuals eligible to become enrollees. In addition, insurer and provider contracts could not include provisions that would bar access to de-identified claims and encounter data on a per-enrollee basis. The legislation does not include a provision from earlier drafts that would have disallowed certain contracting terms related to tiered networks and patient steering.

**MEDICARE PROVISIONS**

**Additional Graduate Medical Education (GME) Residency Slots.** The legislation lifts the cap on Medicare-funded physician residency positions in teaching hospitals by 1,000, effective in FY 2023. It lifts the cap by 200 positions per year until the slots are filled. This provision is based on an AHA-supported bill, the Resident Physician Shortage Reduction Act of 2019 (S. 348/H.R.1763).

**GME Funding Opportunity.** The legislation amends the Medicare GME Rural Training Tracks (RTT) program to provide greater flexibility for rural and urban hospitals that participate in RTT programs.

**GME Rotator Fix.** The legislation eliminates the Centers for Medicare & Medicaid Services' (CMS) penalty imposed on certain community hospitals that have hosted "rotator" residents for brief periods, and allows those hospitals to establish new residency programs without limitations on the number of residency slots.

**Moratorium on Payment under the Medicare Physician Fee Schedule (PFS) of the Add on Code for Inherently Complex Evaluation and Management Visits.** The legislation freezes payment until 2024 for G2211, the visit complexity add-on code that CMS finalized in the calendar year (CY) 2020 PFS final rule and modified in the CY 2021 PFS final rule.

**Temporary Freeze of Alternative Payment Model (APM) Payment Incentive Thresholds.** The legislation freezes the current payment and patient count thresholds for physicians and other eligible clinicians to qualify for the 5% advanced APM bonus payment in payment years 2023 and 2024. It also freezes the partial qualifying APM participant payment threshold and the patient count threshold at current levels for performance years 2021 and 2022 (and payment years 2022 and 2023).

**Expanding Access to Mental Health Services Furnished through Telehealth.** The legislation waives the geographic and originating site requirements for mental health services delivered via telehealth, allowing beneficiaries to receive tele-mental health services in their homes and in any area of the country. To take advantage of this flexibility, beneficiaries will be required to receive at least one in-person mental health

service during the six months prior to the first telehealth service; Congress authorizes the HHS Secretary to develop additional in-person requirements.

**Delay to the Implementation of the Radiation Oncology Model under the Medicare Program.** This provision delays the implementation of the Radiation Oncology Model until Jan. 1, 2022.

## **MEDICAID PROVISIONS**

**Eliminating Medicaid DSH Reductions for Fiscal Years 2021 through 2023.** The legislation eliminates the \$4 billion in Medicaid disproportionate share hospital (DSH) cuts that were scheduled to go into effect in fiscal year (FY) 2021 and further eliminates the DSH cuts in the two subsequent years. Additional cuts are added in FY 2026 and FY 2027.

**Non-DSH Supplemental Payment Reporting Requirements.** By Oct. 1, 2021, the legislation requires that the HHS Secretary establish a reporting system for states regarding their non-DSH supplemental payment programs. This new reporting requirement will be a condition of the state plan amendment. State reports must provide the criteria used to determine provider eligibility, a detailed description of the methodology used to establish the payment, an explanation of how the state is ensuring such payments adhere to the statutory “equal access” standard, and an attestation that hospital non-DSH supplemental payments do not exceed the Upper Payment Limit. The provision includes a definition of supplemental payment as any such payment that is in addition to the Medicaid base payment including payments made under 1115 waiver demonstrations. Lastly, the non-DSH supplemental payment information reported by the state will be publicly available through CMS’ website.

**Medicaid Shortfall and Third Party Payments.** For purposes of the calculations used to establish Medicaid DSH hospital-specific limits, the legislation defines how third party payments are to be treated. In general, all payments (including third party payments) received by the hospital would be subtracted from its costs in determining the hospital’s uncompensated care. The uncompensated care value would be factored in the methodology used to set the hospital’s Medicaid DSH payment limit. Indigent care payments received by a hospital from state and local governments would not count toward the hospital’s third party payment exclusion. In addition, hospitals treating very specific patient populations would have some of their third party payments exempted from this exclusion. This provision becomes effective date as of Oct.1, 2021.

**Medicaid Coverage of Certain Medical Transportation.** The legislation codifies current regulation that requires states to provide non-emergency transportation as a Medicaid benefit. The legislation also calls on the Government Accountability Office (GAO) to report to Congress on state oversight and program integrity measures.

**Other Medicaid Provisions.** In other Medicaid-related provisions, the legislation would restore Medicaid coverage for citizens living in Freely Associated States (the Federated

States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau). See “Extenders” below for other Medicaid-related programs extended by the legislation.

## **RURAL HEALTH PROVISIONS**

**New Rural Emergency Hospital (REH) Designation.** The legislation establishes a REH designation under the Medicare program that will allow existing facilities to meet a community’s need for emergency and outpatient services without having to provide inpatient care. Emergency services would be provided 24 hours a day, 365 days a year, and communities would have the flexibility to align additional outpatient and post-acute services with community needs. REH’s will receive a fixed monthly payment plus a 5% add-on to the Outpatient Prospective Payment System (PPS) rate for outpatient services. The fixed monthly payment will be 1/12<sup>th</sup> of the average annual payment critical access hospitals received in excess of the PPS (for all services – inpatient, outpatient, skilled nursing facility) in 2019. The fixed amount will be adjusted each year by the hospital market-basket update.

**Work Geographic Practice Cost Index (GPCI) Floor through 2023.** The legislation extends the work GPCI floor increases payments for the work component of physician fees in areas where labor cost is determined to be lower than the national average.

**Conrad State 30 Program through FY 2021.** The legislation extends the Conrad State 30 J-1 visa waiver program, which waives the requirement to return home for a period of time if physicians holding J-1 visas agree to stay in the U.S. for three years to practice in a federally designated underserved area.

**RHC and FQHC Hospice Services.** The legislation allows Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) physicians to provide hospice attending physician services for their patients if they elect the hospice benefit.

**Direct Billing of Medicare by Physician Assistants.** The legislation allows direct payment under the Medicare program to physician assistants for services furnished to beneficiaries on or after Jan. 1, 2022.

**Rural Community Hospital (RCH) Demonstration Program.** The legislation extends the RCH program for five years. This program allows hospitals with 25-50 beds to test the feasibility of cost-based Medicare reimbursement for inpatient services.

**Frontier Community Health Integration Project (FCHIP).** The legislation extends for five years the FHIP demonstration project, which tests several care delivery innovations, including cost-based reimbursement for telehealth services.

**RHC Payment Changes.** The legislation phases in an increase in the RHC statutory cap over an eight-year period, subjects all new RHCs to a uniform per-visit cap, and limits the annual rate of growth for uncapped RHCs whose payments are above the upper limit. RHCs with an all-inclusive rate above the upper limit will be constrained to the facility’s prior year reimbursement rate plus the Medicare Economic Index (MEI). Specifically, the policy raises the statutory RHC cap to \$100 starting on April 1, 2021,

and gradually increases the upper limit each year through 2028 until the cap reaches \$190. This brings the RHC upper limit roughly in line with the Federally Qualified Health Centers Medicare base rate. In each subsequent calendar year, starting in 2029, the new statutorily set RHC cap reverts back to an annual MEI inflationary adjustment.

## **PRESCRIPTION DRUGS**

The legislation includes a series of provisions focused on prescription drugs. Specifically, it requires health plans to submit information pertaining to the most frequently dispensed brand prescription drugs, as well as the most costly drugs and drugs that had the largest expenditure increases. Plans also will need to provide information around the impact of any remuneration received from drug manufacturers for specific prescription drugs. The legislation also revises and clarifies several provisions related to the Food and Drug Administration. Specifically, it includes an extension of priority voucher review for rare pediatric diseases and clarification regarding the applicability of the Orphan Drug Act. Further, the legislation makes changes to drug labeling provisions with a focus on increasing access to biosimilar products, making product label updates in the interest of benefitting public health and codifying the purple book for more transparency around biological product patents.

## **ADDITIONAL PUBLIC HEALTH PROVISIONS**

The legislation includes provisions that support public health initiatives. Specifically, it:

- Supports efforts to address vaccine-preventable illnesses by authorizing a national educational campaign to increase the awareness of vaccines to prevent and control the spread of diseases and disseminate evidence-based vaccine-related information. It also funds planning, implementation and evaluation grants to address vaccine preventable diseases.
- Strengthens and modernizes public health data systems by requiring HHS to award grants to state and local health departments to improve data collection, simplify provider reporting, create data standards in collaboration with the Office of the National Coordinator for Health Information Technology, and enhance interoperability of public health systems with health information technology. It also authorizes CDC to update and improve the agency's public health data systems.
- Promotes research, education and tools aimed at reducing obesity.
- Creates a program to award grants to evaluate, develop and expand the use of technology-enabled collaborative learning and capacity building models that will help to retain health care providers and increase access to health care services. The grants can be awarded for up to five years.

## **PARITY IN BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS**

Group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits are prohibited by federal law from imposing less favorable benefit limitations (i.e. stricter quantitative limits, like fewer covered visits, or

non-quantitative treatment limitations — NQTLs — like use of prior authorization) on those benefits than on medical/surgical benefits. This legislation would strengthen the family of laws imposing this prohibition by requiring plans sold on the individual marketplace, ERISA plans, and group plans to perform and document comparative analyses of their plan designs and applications of NQTLs.

Upon request of the applicable state authority, Secretary of Labor or HHS Secretary, these plans must supply a report documenting the specific terms regarding NQTLs and a description of the benefits to which the terms apply within 45 days. In this report, the plan would have to include the factors used to apply NQTLs to benefits (either medical/surgical or MH/SUD), as well as the evidentiary standards upon which those factors are based and the process used in the comparative analysis proving compliance with federal parity laws. The legislation stipulates that the relevant Secretary shall request these analyses for plans that involve potential violations or complaints regarding non-compliance and any other instances the HHS Secretary deems appropriate; the HHS Secretary would be required to request no fewer than 20 of these comparative analyses per year.

If the HHS Secretary finds the plan non-compliant, the plan must specify the actions it will take to come into compliance and provide a new comparative analysis demonstrating compliance within 45 days of the HHS Secretary's initial determination of non-compliance. If the plan is still found to be non-compliant, the HHS Secretary will notify all enrollees of the non-compliance within seven days. The HHS Secretary would have to submit a report to Congress with a summary of the comparative analyses received within a year of the bill's enactment and then no later than October 1 of each year thereafter.

The bill also directs the HHS Secretary to finalize guidance and regulations to implement the law within 18 months of the bill's enactment. These documents would have to include instances of non-compliance, fully explained real-life (but de-identified) illustrative examples, and clarification on the process and timeline to file complaints. The compliance guidance document must be updated every two years, and the HHS Secretary shall issue additional guidance to help plans satisfy compliance requirements.

## **EXTENDERS**

**Quality Measure Endorsement, Input and Selection.** The legislation authorizes three additional years of funding (\$66 million total) for CMS' contract with a consensus-based entity to carry out quality measure endorsement, and provide pre-rulemaking input on measures CMS is considering for future quality measurement and value programs. That entity currently is the National Quality Forum.

**Other Extenders.** In addition to the ones mentioned above, the legislation extends a number of other health care programs, including funding for outreach and assistance for low-income Medicare beneficiaries; Medicaid spousal impoverishment protections; the Money Follows the Person Demonstration program; and the community mental health services demonstration. It also expands the authority of Medicaid Fraud and Abuse Control units to all health care settings.

## APPROPRIATIONS PROVISIONS

The omnibus legislation includes all 12 appropriations bills that fund the government for FY 2021. The Labor, Health and Human Services, and Education appropriations bill for includes \$197 billion in funding for those departments.

**Labor/HHS Funding.** The bill provides \$97 billion for HHS, \$2.1 billion more than the FY 2020 enacted level and \$9.9 billion more than the president's budget. Specific increases include: \$1.25 billion more for the National Institutes of Health to focus on research and clinical trials related to long-term studies of COVID-19 as well as Rapid Acceleration of Diagnostics; \$110 million more for the Public Health and Social Services Emergency Fund; \$133 million more for the Substance Abuse and Mental Health Services Administration (SAMHSA); \$125 million more for the CDC; \$151 million more for the Health Resources and Services Administration (HRSA). Rural health programs would receive \$330 million, including increases for telehealth and rural hospitals.

**Funding for Addiction and Mental Health.** The bill appropriates funds to various agencies to address addiction and mental health issues, including \$554 million to the National Institute on Alcohol Abuse and Alcoholism, \$1.5 billion to the National Institute on Drug Abuse, \$2 billion to the National Institute of Mental Health, and \$1.8 billion to SAMHSA.

The SAMHSA appropriations are further delineated; in addition to several hundred million dollars for technical assistance and data collection, the bill provides:

- \$250 million for the Certified Community Behavioral Health Center initiative, extending the AHA-supported demonstration program through 2023.
- \$1.5 billion for State Opioid Response grants; \$50 million of this would go to Indian Tribes and tribal organizations, and 15% of the remaining funds would go to states with the highest opioid mortality rates. Otherwise, all 50 states and the District of Columbia would receive \$4 million.
- \$72 million for the National Child Traumatic Stress initiative.

**Children's Hospitals Graduate Medical Education (CHGME).** The legislation provides \$350 million, a \$10 million increase, for the CHGME program, which protects children's access to high quality medical care by providing freestanding children's hospitals with funding to support the training of pediatric providers.

**Health Equity.** The legislation appropriates \$62 million to the HHS Office of Minority Health and \$55 million for the Minority HIV/AIDS Initiative. In addition, it allocates \$80 million for the Research Centers in Minority Institutions (RCMI) program at the National Institute on Minority Health and Health Disparities (NIMHD).

**Social Determinants of Health.** The legislation provides \$3 million in funding to establish a Social Determinants of Health Pilot Program to create Social Determinants of Health Accelerator Plans, key provisions of which were taken from the AHA-supported

Social Determinants Accelerator Act (H.R. 4004/S.2986). The funding will help state and local governments develop plans to address the health and social needs of targeted populations.

**Maternal and Child Health.** The legislation provides \$44 million, an increase of \$5 million, for the NIH Office of Research on Women's Health, \$10 million for NIH research on premature births, \$63 million, an increase of \$5 million, for CDC efforts on safe motherhood, and \$975 million, an increase of \$32 million, for HRSA programs to improve maternal and child health.

## **OTHER PROVISIONS**

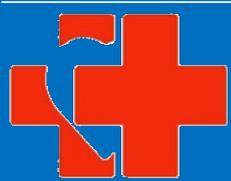
**Paycheck Protection Program (PPP).** The legislation commits an additional \$284 billion for the PPP and extends the program, with changes, through March 31, 2021. The legislation expands eligibility for the program to new types of entities, allows for certain smaller borrowers (300 or fewer employees) that have sustained a minimum threshold of financial losses to apply to receive a second PPP loan, and expands the types of expenses that may be eligible for forgiveness, including costs associated with securing personal protective equipment.

**Extension of Paid Leave Credits.** The legislation extends through March 31, 2021, the refundable payroll tax credits for paid sick and family leave that were established in the Families First Coronavirus Response Act.

**Flexible Spending Arrangements (FSA).** The legislation allows individuals to carry over any unused health and dependent care FSA benefits from 2020 into the 2021 plan year, along with other FSA plan flexibilities.

## **FURTHER QUESTIONS**

If you have questions, please contact AHA at 800-424-4301.



# Community Conversations: A Project Overview

Rural hospitals across Kansas face health care challenges as population declines, the number of uninsured patients rises, and reimbursement still favors inpatient over outpatient care which has become the norm. In many communities, people are unaware of the scope of these issues and the challenges they present to their local hospital.

45 Hospitals in Kansas (out of 123)  
have fewer than 2 patients staying overnight per day

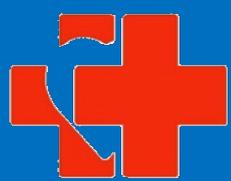
To help hospitals adapt to these challenges, the Kansas Hospital Association (KHA) has led the development of a new **Primary Health Center model** that better fits the realities of rural health care today.

The Kansas Health Foundation and the United Methodist Health Ministry Fund have joined with KHA to support a series of **community conversations**, to be convened in partnership with local hospitals. The purpose of the conversations is **to engage rural communities in a conversation about the health care needs** and concerns as well as **assess their support for exploring the Primary Health Center model** further.

The University of Kansas Public Management Center was engaged to facilitate the events.

## Elements of Each Community Conversation:

- **STAKEHOLDER MEETING** - A pre-meeting discussion with hospital and community stakeholders.
- **INFORMATION STATIONS** - Time for attendees to review five stations offering information about:
  - demographic shifts and issues impacting rural hospitals;
  - the hospital's financial status;
  - the Primary Health Center model;
  - local community health factors and outcomes; and
  - community identity.
- **LISTENING STATION** - A private place where attendees can share stories of their health care experiences.
- **PRESENTATION** - A joint presentation by KHA and the local hospital that shares the hospital's financial status and introduces the Primary Health Center model.
- **SMALL GROUP DISCUSSIONS** - Structured small group conversations that allow attendees to share their concerns and questions.
- **REAL-TIME POLLING FEEDBACK** - The use of "iClickers" to gauge audience response to the information presented.
- **NEXT DAY DEBRIEF** - A follow-up breakfast meeting with stakeholders to hear their reaction to the Community Conversation, learn more about the local health care concerns, and assess the community's interest in exploring the Primary Health Center model.



# Decatur Health, Oberlin, Kansas

In October 2019, the Kansas Hospital Association hosted a webinar to provide updates on the Primary Health Center model to hospital administrators and announce the opportunity for hospitals to host community conversations. Kris Mathews, Chief Operating Officer of Decatur Health in Oberlin, Kansas reached out immediately to express his hospital's interest.



*Kris Mathews, COO  
Decatur Health*

Recognizing the need to explore new models of delivering health care, Decatur Health, with the support of its board, signed on to host the first community conversation.

## Fiscal Responsibility in a Difficult Environment

Decatur Health has proactively taken a number of steps in recent years to address its stressed finances. These include: closing the local long-term care facility; joining several purchasing collectives to decrease costs and increase revenue; and insourcing its rural health clinic billing. In spite of these efforts, the hospital still faces declining revenues.

## March 4, 2020 | Gateway Center | Oberlin, KS

More than 80 community members joined the conversation on March 4 at the Gateway Center, the event affirmed the importance of access to health care to the Oberlin community. Most attendees were long-time residents of Decatur County; 57% had lived in the county more than 30 years. Nearly half of participants (44%) were between 46-65 years old; 37% were over 65.

Data presented by Decatur Health as well as that self-reported by attendees confirmed that Decatur County mirrors the situation statewide and nationally: today the hospital is primarily used for outpatient care. Most importantly, attendees indicated their willingness to explore piloting the Primary Health Center model once they better understood the challenges faced by their hospital.

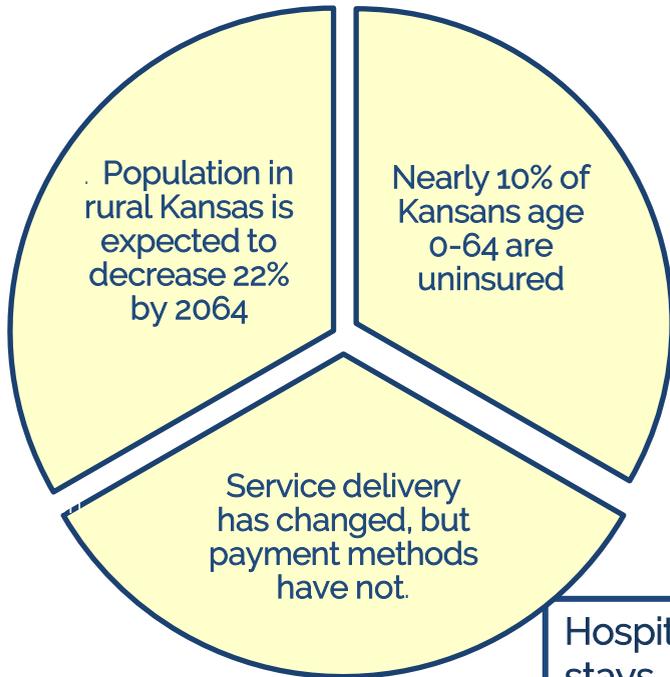


More than 80 residents of Decatur County attended the Community Conversation at the Gateway Center in Oberlin, KS on March 4<sup>th</sup>.

*Either we make decisions today to keep what we need, at least get the basics covered, or there will be a time that we don't even have that.*

- Kurt Anderson

# Current Environment



*Access to health care is critical to the future of rural communities, which is why we are committed to working with Kansans to develop a financially sustainable model that works for them. Central to achieving that goal is engaging communities in conversation.*

*The feedback we heard in Oberlin confirms their willingness to partner with their hospital and others in the state to improve how care is delivered. It was a great way to kick-off our Community Conversation Project."*

*- David Jordan, President, UMHMF*

Hospitals are still reimbursed the most for overnight stays, but 36% of hospitals in Kansas have fewer than 2 patients staying overnight per day.

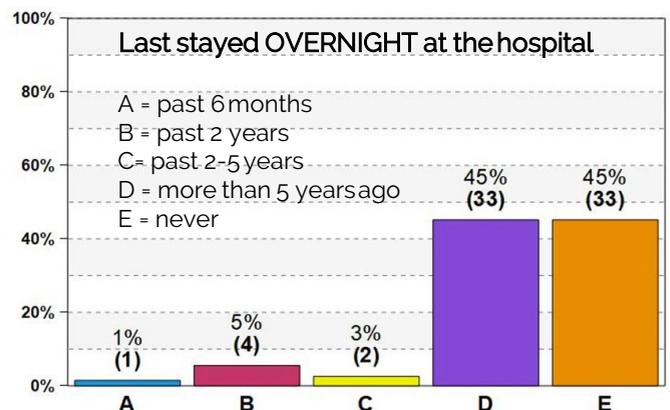
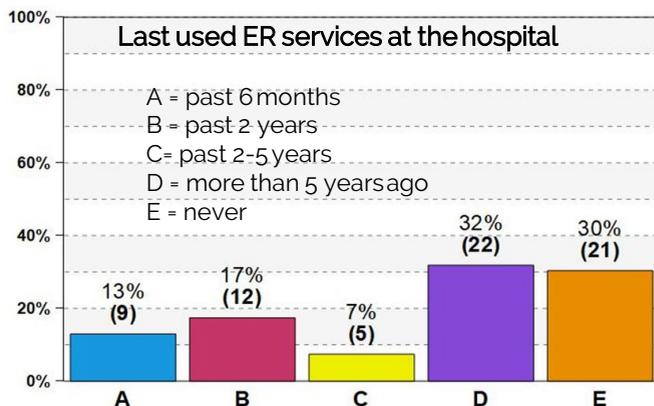
## Decatur Health is Used Differently Today

*I'm a big believer in supporting the businesses we have in town, and I get really frustrated when people go out of town to the doctor or hospital because it will hurt us all in the end. I think we ought to keep our money here and our health care here as much as possible.*

*- Susan Nelson*

Decatur Health's services have shifted to primarily outpatient services.

% of Revenue	2004	2019
Inpatient	38%	20%
Outpatient	45%	66%



# The Community Reaction

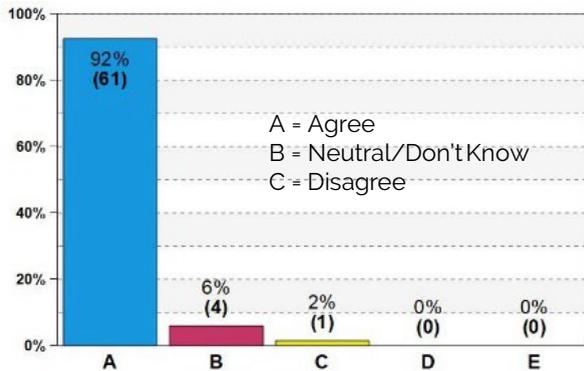
I am very grateful to be a part of the Decatur County Community. Over 80 residents came to the Gateway Center to listen, learn, and discuss ideas about new and innovative ways to deliver health care in the future in rural communities like Oberlin. They got an **open and honest look** at how the current reimbursement system operates and how the hospital gets funded.

The attendees asked questions and **shared feedback on what it means to them and were really engaged** in this "Conversation as a Community". At the end of the night, **they came to realize that change can be challenging and even scary, but finding stability is critically important**. The people appreciated us reaching out to them, getting them involved, and having input into ideas that help maintain access to care in Decatur County.

- Kris Mathews, COO Decatur Health

## 92% of attendees recommended other communities host similar conversations

The information shared tonight gave me a new understanding of the challenges facing our hospital.



Based on the information presented, attendees felt the Primary Health Center model would meet their needs.

69% agreed (47 attendees)  
29% were neutral/didn't know (20 attendees)  
1% disagreed (1 attendee)

*I want to be able to use our medical dollars here in this town. I'm very happy, as a landowner, to support our health care facility so that we have these services locally.*

-Mirla Coleman

## Health Care Priorities Expressed by the Community and Stakeholders

- ✓Transportation costs to nearby facilities
  - ✓Provisions for end-of-life care
- ✓Insurance coverage when crossing state lines
  - ✓Access to specialists (via Telemedicine)
- ✓Access to mental health care / addiction services
- ✓Focus on prevention – keeping people healthy, not waiting until they are sick



## These 3 things will make rural Kansas communities healthier

By [David Jordan](#)

Opinion Editorial

November 14, 2020

A strong health system is critical to thriving rural communities and the health of rural Kansans. Even before COVID-19 began [surging in rural Kansas](#), it was becoming more difficult to sustain health care services in a changing Kansas, where the rural health system is starved of resources with limited opportunity to innovate.

Significant shifts in population make maintaining health care and other important services in rural communities more tenuous each year. The 2018 Kansas Health Foundation Report, [“A Changing Kansas: Implications for Health and Communities,”](#) outlined dramatic double digit declines in population in rural Kansas between 1960 and 2016. Similar depopulation is projected for the state’s rural counties through 2066. Additionally, our rural communities are aging, with [16.3% of the population of Kansas age 65](#) and over.

One positive trend is that Kansas, including its rural communities, is becoming increasingly diverse. The only population growth in Kansas this century came from a 52.5% increase in the minority population (any group other than non-Hispanic White). This trend makes it critically important that Kansas addresses longstanding racial and ethnic disparities in health, poverty rates and educational attainment.

The [high rate of rural Kansans without health insurance](#) is another challenge. Fewer people with health insurance means that hospitals are serving a greater proportion of patients who are unable to pay all or part of their bill. In addition, rural hospitals’ bottom lines have suffered as care shifts from the inpatient to the outpatient setting. Since 2010, five rural hospitals have closed and 73% of the hospitals in the state are operating at a loss.

Longstanding health care workforce shortages throughout rural Kansas also present a challenge to delivering care.

Kansas needs strong policy changes to address the challenges. We must think big, aim to be bold, and center equity in the work to improve the health of rural Kansans. Here are three things policymakers should consider:

**Kansas must expand Medicaid.** [Expanding Medicaid](#) will cut the number of uninsured adults in half, address disparities and improve health. This budget positive policy solution will bring hundreds of millions of our tax dollars back to Kansas annually and create a payment mechanism to protect rural providers’ bottom lines. Expansion will also create thousands of rural jobs and offer employment opportunities to some of the young people who now leave rural Kansas.

**Kansas needs to reimagine the health care workforce.** Recruiting providers — especially culturally competent ones who meet the social, cultural and linguistic needs of patients — to rural Kansas is difficult. Other rural states have addressed workforce shortages by changing licensing and credentialing policies to make better use of providers such as physician’s assistants and [dental therapists](#) as part of doctor led teams. Adding culturally competent providers such as [community health workers](#) to Kansas’ workforce can help patients navigate the health system. Such changes will allow Kansas to grow our own workforce. Changes to licensing and credentialing policies will be met with resistance but experience from other states shows that these changes work.

**Kansas, and the federal government, needs to embrace innovation in care delivery and payment.**

Current payment models are stifling innovation. Fee-for-service payment requires providers to see high volumes of patients in person. The COVID-19 pandemic has led to a loosening of these rules and an expansion of telehealth. Sustaining these changes post-pandemic, particularly expanding telehealth, is one way to embrace innovation.

In rural communities, hospitals are tied to a financing model that limits opportunities to deliver care in ways that best meet the needs of each community. Loosening critical access hospital rules would benefit rural Kansas by allowing the Kansas Hospital Association to pilot the [Primary Health Center Model](#) they developed to offer a sustainable option to provide preventive and primary care, chronic disease management and emergency services.

We also know that health is more than health care. [Other states are exploring using Medicaid dollars](#) to address the social determinants of health — hunger, housing, transportation and early childhood education. Piloting this approach in rural Kansas can improve long-term health and reduce costs.

Having healthy residents and a sustainable health care system is critical to the vitality and viability of our rural communities.

Now, more than ever, [we need to be working towards the future of health](#) in our rural communities — a future that ensures all rural Kansans have access to care, uses rural residents as members of culturally competent health care teams, and innovates based on the needs of communities.

We cannot afford to lose time or another rural hospital. The future of rural Kansas is a stake.