Sustaining Rural Health Care in Kansas
The Primary Health Center Model

Rural Hospitals – National View

• 90 hospitals have closed since 2010
• 673 hospitals are considered vulnerable
  Represents over 1/3 of all rural hospitals
• 41% of rural hospitals are operating at a loss
Kansas at a Glance

• 3 hospitals have closed since 2010
  – Central Kansas Medical Center – Great Bend
  – Mercy Hospital – Independence
  – Mercy Hospital – Fort Scott

• 73% KS hospitals are operating at a loss
• Median days cash on hand for KS CAHs is 46.57
• 66 counties have fewer than 10 persons per square mile

Use of Inpatient Beds Declining

<table>
<thead>
<tr>
<th>Average Daily Census</th>
<th>2013</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 patient per day</td>
<td>18</td>
<td>19</td>
</tr>
<tr>
<td>1 – 1.9 patients per day</td>
<td>15</td>
<td>26</td>
</tr>
<tr>
<td>2 – 2.9 patients per day</td>
<td>19</td>
<td>12</td>
</tr>
<tr>
<td>3 – 4.9 patients per day</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>5+ patients per day</td>
<td>61</td>
<td>60</td>
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Vision and Principles

**Sustainable Rural Health System**

- Improve Health
- Provide Access
- Encourage Collaboration
- High Quality
- Promote Efficiency and Value
- Embrace Technology
- Financed Fairly to Address Population Health

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Model Development

**Kansas Rural Health Visioning**

- Developed model based on principles
- Worked with KHERF to develop a way to test the model in actual Kansas hospitals
- Retained Tommy Barnhart to develop and test financials – led a team of Kansas CPAs already working with test sites
- Retained two nurses to review and document clinical data
- Five hospital volunteers: Washington, Neodesha, Fredonia, Ellinwood and Kinsley
- Produced report including estimate of potential costs to be included in a budget based payment model
- Began working with other states: Oklahoma, New Mexico, Colorado
- Continue to educate hospitals and boards about potential model
- Continue conversations with CMMI on project opportunities
Overview of the Model

New Health Care Option for Rural Communities

**CORE SERVICES**
- Primary health care, including prenatal care
- Urgent care
- Emergency care
- Emergent and non-emergent transportation
- Observation (Part of Transitional Care)
- Outpatient and ambulatory services
  - Minor procedures
  - Ancillary services to support primary care and basic diagnostic
- Care coordination, chronic disease management and other approaches to population health
- Active telemedicine (All emergency care patients – may include access to specialist for emergency purposes)

**OPTIONAL SERVICES**
- If unavailable locally, may be included in the payment model:
  - Rehabilitative services
  - Subacute care (Transitional Care)
  - Behavioral health
  - Oral health
  - Specialty care (via telemedicine or visiting specialists on site)
- Other services needed within a reasonable distance (Must be consistent with community need and documented in data)

**Staffing:**
- RN(s) on site during hours of operation
- Physician, APRN, PA on call (Note: physicians not required)
- Active Telemedicine (emergency support, supervision if no physician)
Partner Organization

- Required
  - CAH or PPS Hospital
  - Acute Care
  - Physician
  - Surgery
  - Transfer and transportation Plan

- Willingness
  - Clinical Integration and shared protocols to improve quality and care coordination
  - Share/provide operational resources to provide efficiencies and reduce costs

- Optional
  - Based on local and regional resources and need
  - Obstetrics
  - Financial support
  - Trauma system participation
  - Ownership or management
  - Common medical staff
  - Other services as needed

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
    - Operational efficiencies
  - Clinical Relationships
  - Local and Regional Service Providers

- Off Ramp ... Return to current status if model doesn’t work
Kansas Paper Test: Clinical Findings

946 Cases Reviewed
70% ER

Patient Age - All Cases

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;18</td>
<td>9.42%</td>
</tr>
<tr>
<td>19-44</td>
<td>24.87%</td>
</tr>
<tr>
<td>45-64</td>
<td>42.65%</td>
</tr>
<tr>
<td>&gt;65</td>
<td>23.07%</td>
</tr>
</tbody>
</table>

Patient Transportation (All Sites)

- 7.20% Ambulance
- 0.50% Law Enforcement
- 92.30% Private Car

70-75% of patients could be served in New Model – more with transitional care?

Overview of Payment Methodology

- Based on an inclusive budget encompassing all services
  - Budget neutral from historic cost reimbursements (adding new services and reducing acute inpatient)
  - Incentivize clinical integration through relationship with Partner Organization
  - Allow flexible use of limited staff and resources to adjust to day-to-day changes in volume and service needs
  - Payout in fixed and encounter payments – to assure cash flow as volume fluctuates
- Ideally, all payers participating to determine exactly how model can balance the support of access and optimal health for a community with incentives for efficiency and high quality
- To sustain low volume rural access: Additional funding for emergency infrastructure (facility and transportation) from annual federal grant and local support
- To move to value: Value Incentive tied to fixed payments to assure accountability and improvement
PHC Base Budget Assumptions
Estimated By CPAs Based on Kansas Test Findings

• PHC Base Costs
  – Total estimated budget 24 Hour: $6.1m
  – Does not include Optional Services

• Integrated Budget 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)

Payment Methodology

$ Fixed Payments
- Tied to inclusive budget for all services with capital allowance
- Portion of budget paid monthly 1/12th, no back-end reconciliation
- Operational incentive to be efficient and effective to meet budget
- Could be determined as set % across all settings or site specific

$ Encounter Payments
- New fee schedule to account for fixed payments paid by participating payers
- Traditional fee schedule reimbursement for non-participating payers
- Co-pays and deductibles tied to encounter amount and collected in traditional manner

$ Grants
- Annual federal grant to ensure access to emergency services
- Annual local financial support at a minimum of 10% of federal grant
- One-time, transformation grants to support moving to new model

$ Value Incentive
- +/- 2% Risk/Reward of fixed payment
- Based on accountability measures, aligned with scope of services and operations
- Phase in – Report, Reward, Risk
Win, Win, Win, Win

Quality Improvement
- Accountability for quality and operational efficiencies
- Measures = Services/Size
- Value Incentive – Risk and Reward
- Regional Care Coordination
- Common Protocols with Partner
- Embedded community and pop health

Cost Savings
- Up front budget expectations
- Fixed payments during low volume
- Patient co-pay tied to encounter
- Budget based Transitional Care payments
- Reduced administrative burden related to regulatory requirements
- Eliminate or repurpose unused acute beds
- Better align physician and facility incentives

Preserve and Improve Access
- Core services for less mobile populations
- Transitional/sub-acute care
- Community health and care coordination
- Preserved access to emergency transportation and care
- Added local services to provide transportation for care coordination
- Potential for improved access to oral and mental health services

Financial Sustainability
- Cash flow addressed through fixed costs
- Reduction in acute services and costs
- Simplification of payment program
- Regional operational efficiencies
- Engaged commercial payers
- Federal grant support for emergency transportation and care
- Local support for emergency transportation and care

Recent Activity

- Renewed interest by KDHE
- Attended State Policy Academy on Global Budgeting for Rural Hospitals – May 30, 2018
- Continued dialogue with CMMI
- Congressional Delegation Conversations
Key Takeaways

• State based project – KDHE must be the lead
• Must demonstrate improved population health
• Payers beyond Medicare and Medicaid need to come to the table
• 1-2 years from application to demonstration

Next Steps

• Gain commitment from Governor, KDHE, Kansas Legislature and Congressional Leaders
• Continue to tell the story
• Identify payers willing to participate
• Detail further the delivery and financial model
• Develop and submit a proposal
Resources

Find tools for board discussions and other resources at https://www.khanet.org/CriticalIssues/RuralIssues/

Thank You!