Approved 2-18-92
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Carol H. Sader, Chairperson at

1:30 ~~a.m.~~/p.m. on February 4, 1992 in room 423-S of the Capitol.

All members were present except:

Tom Bishop, excused

Committee staff present:

Emalene Correll, Research
Norman Furse, Revisor
Sue Hill, Committee Secretary

Conferees appearing before the committee:

Elizabeth Taylor, Local Health Departments
Dick Morrissey, Deputy Director Bureau of Adult/Child Care Department of Health and Environment
Melissa Hungerford, Kansas Hospital Association.

Chair called meeting to order drawing attention to Committee minutes and asked members to read them carefully.

Chair recognized Rep. Wiard on a point of personal privilege. Rep. Wiard recognized former Representative Elaine Hassler who was present. Rep. Hassler once served as Vice-Chairperson of the Public Health and Welfare Committee during her tenure as a State Representative. Rep. Wiard now serves the District that Rep. Hassler did before her retirement. He welcomed her as did the Chair and Committee members.

Chair recognized Rep. Amos and noted he was newly appointed as her hatchet man. Rep. Amos noted he left an important meeting early in order to not be tardy for the Public Health/Welfare Committee since he is aware the Chair wants to begin on time, and many of the members of this Committee are late. As being newly appointed a member of the apple Committee in the House, he will use that authority to assess fines to late members. Point well taken.

It was noted by Rep. Carmody on a point of personal priviledge, how quickly power can go to one's head.

Chair then drew attention to the agenda. It was announced that **HB 2695** would not be discussed today. It will be taken up on February 6th.

Chair drew attention to minutes before the Committee.

Rep. Flower moved the minutes of January 28, 1992 be adopted as presented, seconded by Rep. Weiland. No discussion. Motion carried.

Chair drew attention to **HB 2694** and recognized Elizabeth Taylor, Association of Local Health Departments who requested time to comment on **HB 2694**.
Ms. Taylor noted she had been asked yesterday to give an estimated cost of providing enforcement for registered day care homes. She proceeded, there are 4250 registered family day care homes. If an agent was sent to inspect the cost would be $35 for each inspection, if additional inspections were done on immunizations records for example, the estimated cost would be $45 for that more comprehensive inspection. They would anticipate a 10% random inspection per year, plus inspections done upon complaints. She answered questions.

Mr. Morrissey explained rural networks, i.e., requirements; formal agreements on patient referral/transfer; communication between administrations, medical staff, board's employees; use telemedicine where available; networking EMS plan; emergency and non-emergency transportation; communication between providers and patients; meet state requirements for quality assurance/peer review; risk management; joint credentialing. He noted a high degree of communication capability will be required to allow networks to function. He then detailed the role of Emergency Medical Services in the Rural Health Network, noting this is one of the most difficult services to maintain because of the demands for 24 hour service.

It is hoped the networks will serve to offer more availability and accessability of 24 hr. emergency services as opposed to each facility having to maintain 24 hour service.

Melissa Hungerford, Kansas Hospital Association, gave an explanation of EACH/RPCH. The EACH concept was established as a federal program through OBRA, (Omnibus Budget Reconciliation Act). The EACH concept is a program of Medicare which allows designation of acute-care facilities as EACHs (Essential Access Community Hospitals) and RPCHs (Rural Primary Care Hospitals) referred to as "peaches". The program establishes new "conditions of participation" for RPCHs to participate in the Medicare program and provides reimbursement incentives for both EACHs and RPCHs in return for their participation in the program. This is a permanent program established in legislation and operated through regulations to be promulagated and monitored by the Health Care Financing Administration.

Ms. Hungerford explained the specifics for hospitals that are RPCHs; defined the rural health network; rural primary care hospital. The RPCH must offer emergency services through an emergency room during posted hours and via the network outside of posted hours; may, but not required to provide 24-hour emergency room care on-site; must have holding/stabilization services; must provide ambulatory primary care service/ancillary care services such as radiology, lab, pharmacy, dietary, either on-site-or via network arrangements; may offer obstetrics; outpatient surgery; long-term care, including swing-beds; home health; physical therapy; and respiratory therapy; may not offer inpatient services for patients who require those services longer than 3 days. There are exceptions in some specific instances.

Ms. Hungerford then explained specifics for hospitals that are EACH. There are two types of supporting hospitals, a supporting hospital to an RPCH may be a designated Essential Access Community Hospital. This facility must be rural; greater than 35 miles from another EACH referral center; if fewer than 75 beds must be 35 miles from any nonRPCH hospital. An EACH hospital is treated by Medicare as a sole community provider and is to be paid for the reasonable costs resulting from participation in and support of the rural health network.

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Ms. Hungerford continued, a facility that is not an EACH may also support an RPCH. A non-EACH must be a rural referral center or an urban facility meeting rural referral center requirements; these facilities do not receive additional payments from Medicare; may have relationships with RPCH's or participate in a rural health network; may not be a primary supporting facility to a RPCH. Any EACH or non-EACH supporting facility must be a full service facility offering complete obstetrics, inpatient surgery, 24 hour emergency room staffed by physicians, medical/surgical intensive care/and or coronary care.

Ms. Hungerford and Mr. Morrissey both addressed the Joint Credentialing Process and Network emergency-medical services plan.

It was noted federal requirements are very specific on which facilities can be an EACH and which can be a RPCH.

Ms. Hungerford and Mr. Morrissey both answered numerous questions.

Chair drew attention to **HB 2710** and noted Committee will be dealing with this bill in a newly-drafted long form, not the bill that appears in the Committee Blue Bill book. The Revisor's office will have this available soon.

Chairperson Sader adjourned the meeting at 3:00 p.m.

Note: (Attachment No. 1, update on regulated facilities)
(Attachment No. 2), Each/PCH data).
The Kansas Rural Health Network Development Plan booklet is not recorded as an attachment, but is available through the Department of Health and Environment.

GUEST REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

Date Feb 4th, 92

Name	Organization	Address
Marvel Goldsberry	KDHE	Mills
Rita Kay Ryan	KDHE	
Linda Hagerhoff	KDHE	
Melissa Hungerford	KHA	
Richard Morrissey	KDHE	Topeka
ELIZABETH E. TAYLOR	ASSO. OF LOCAL HEALTH DEPTS	TOPEKA
Pat Johnson	Board of Nursing	Topeka
Marilyn Bradt	KINH	Lawrence
Karen Jemison	TAG EACH/RPCH.	Wa Keeney
Carolyn Counts	KMS TAG EACH/RPCH	Topeka
Marcia Budd	TAG EACH/RPCH	Sterling/St John
Richard Lamaker	TAG each/RPCH	Sterling KS
Linda Latten	TAG EACH/RPCH (KHA)	Topeka
Clyde McCracken	TAG EACH/RPCH	Ness City
Shirley Orr	KDHE	Wichita
Jill Brubaker	W.U. student	Topeka
Kathy Wormell	W.U. Student	Oskaloosa
Wendell Strom	AARP-CCTF	Topeka
Brian Gilpin	Tobacco Free Kansas Task Force	Topeka
Shannon Lyddane	W.U. Student	Topeka
Carol Robbins	W.U. Student	Topeka
Pamela [illegible]	W.U. Student	Topeka
Carmen R Smith	W.U. Student	Topeka

GUEST REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

Date _____

Name	Organization	Address
Rick Liby	Gehrt & Roberts	Topeka
Roger Kirkwood	AARP-CCTF-Topeka	"
Paula Herman	WU SW Student	Topeka
John C Wendling	KHA TAG	Topeka
Cleta Renyer	Right to Life of Ks	Salina

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

BUREAU OF ADULT AND CHILD CARE

CHILD CARE LICENSING AND REGISTRATION SECTION

NUMBER OF REGULATED FACILITIES AND AGENCIES AS OF 9/30/91

Registered Family Day Care Homes	4,250
Licensed Day Care Homes	3,769
Group Licensed Day Care Homes	408
Preschools	382
Child Care Centers	729
Family Foster Homes	1,877
Group Boarding Homes	50
Residential Centers	37
Attendant Care Facilities	38
Secure Care Centers	1
Detention Centers	6
Day Care Referral Agencies	15
Child Placing Agencies	40
Maternity Centers	1
Total	11,603

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VIEW THE NOTE E01

From: EGH6090 --LSOB03 Date and time 02/04/92 11:00:50
To: PJC1343 --LSOB03

From: egh6090
Subject: Briefing Paper
Laura Epler called for Dick this morning advising that based on this mornings appropriation meeting the briefing paper on Food, Drug and Lodging needs to be redone to reflect the governor's budget recommendation rather than C Level request. Dick was at the meeting so knows what other issues there were related to fee increases. I would have said something to Steve except Laura was pretty clear that she thought Dick needed to discuss it with him.

E N D O F N O T E

PF1 Alternate PFs PF2 File NOTE PF3 Keep PF4 Erase PF5 Forward Note
PF6 Reply PF7 Resend PF8 Print PF9 Help PF10 Next PF11 Previous PF12 Return
23-30 SA MW KS IM II S1 LANDON1 KB

Pkt w/ 2-4-92 attm #1. 3272.

The Development of Hospital Networks and Locally Integrated Systems of Care

Now that the TAG and the State of Kansas have written a Rural Health Plan, have outlined the regulatory design of EACHs, RPCHs, and rural health networks, have established a designation process for EACHs, RPCHs, and rural health networks, and have received federal designation as one of the seven EACH states in the country, it is time to turn attention to the development of hospital networks and locally integrated systems of care. This paper will put forward a conceptual framework for the discussion of networks and integration, will discuss the features of the EACH Program which affect the development of networks and integrated systems of care, and will conclude with a discussion of network and integration issues. In order to facilitate TAG discussions and decision-making, we have again used the heuristic device of asking a priori questions.

The Fragmentation of the Rural Health System

The rural health system is fragmented. It is characterized by competition rather than cooperation, isolation rather than association. With many of its players acting in ways disconnected from one another, it is a system in name only. Because some providers target their services to specific segments of the population, even the community as a whole can not serve as the common variable which links together the various parts of the system. The primary consequence of fragmentation is duplication, unnecessary cost, lack of coordination, and compromised quality.

The fragmented rural health system grew out of the legitimate and commendable

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goals of legislatures, organizations, and individuals to provide for the health care needs of rural residents. However, the programs and services added to the system over a period of years were created in a piecemeal, uncoordinated fashion. They have different funding sources, unique governance structures, distinctive statutory and regulatory requirements, and their own organizational missions, all of which act as barriers to cooperation. More commonly than not, the imperative that organizations garner and protect resources (money, personnel, patients) places provider members of the rural health system in opposition to one another. In communities where many resources are scarce, there is a heightened degree of competition among providers. Decision makers, who are concerned with protecting the integrity of their organizations, look upon other provider members of the system less as potential partners and more as competitors.

As the resources available to the rural health system continue to dwindle, it is desirable to develop strategies that foster cooperation instead of competition. Cooperation tacitly recognizes that resources are finite and that to maximize their potential to serve the public, they must be allocated in a planned and coordinated way. Two such strategies are networking and integration. Although similar, the two strategies are conceptually different, and, in operation can be quite different. The next section attempts to distinguish between the two.

A Primer on Networks and Organizational Integration

The concept of networks has been used in communications, transportation and engineering for quite some time, but its introduction into the field of organizational theory is relatively new. Traditional organizational theory is based upon the notion of hierarchy. Organization charts are designed in the shape of a

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pyramid, and power and communication flow from the top of the pyramid to the bottom in an orderly, progressive way. Information processing and decision making in these organizations is slow, and the flow of ideas and innovations from the base of the pyramid through dense layers of bureaucratic resistance and "noise" to the top of the pyramid is often difficult.

The evolution of information processing and communication technology, by the mid-1970s, dismantled the pyramid and replaced it with networks. According to Naisbitt, in his 1982 best seller *Megatrends*, "Simply stated, networks are people talking to each other, sharing ideas, information, and resources." According to another authority, networks are the "keys to supplying limited resources to limitless problems" (Mueller). In contrast to typical pyramid organizational structures, networks place every member at their center. Networks are horizontal linkages among loosely coupled members -- networks provide ideas, information and resources for resolving problems without the obstacles imposed by hierarchies and bureaucracies. Increasingly, the field of organizational theory is recognizing the importance of interorganizational linkages, that is, the dependence that independent organizations have on other independent organizations to successfully accomplish their goals and objectives. The "mapping" of these dependencies is called network analysis (Perrow).

The point is frequently made that the word "network" is both noun and verb. This point is usually made antecedent to the claim that the *process* of information/resource sharing and decision making is more important than the *outcome* of the activity. The process is defined by the *communication* that creates the *linkage* between people and clusters of people.

The nature of networks is best defined by their participants and the nature of linkages between and among them. Interorganizational networks do not constitute a formal integrated organization, although they may be the predecessor of one. Although the linkages between and among network members may vary along a continuum in terms of their strength, they stop short of merger into a single organization. Every member retains its own autonomy. The retention of individual autonomy presents networks with a wide range of possible decision-making behaviors. The process can be monolithically goal-directed, or its direction can emerge as merely the product of the multiple interests and uses of its members.

Networks are concerned with the bi-lateral and multilateral relationships of independent units. Networking is akin to the concept of *coordination*, which means, "to place or arrange things in proper position relative to each other; to bring into proper order." Therefore, we will use networks to describe "various efforts to alter or smooth the relationships of continuing, independent elements such as organizations, staffs, and resources" (Morris and Lescohier).

In contrast, integration means "to put or bring together parts or elements so as to form one whole; to combine into a whole." An integrated unit is one which is undivided. We will use integration to mean "action which brings previously separated and independent functions and organizations (or personnel, or resources, or clientele) into a new, unitary structure" (Morris and Lescohier). Networks stress coordinated behavior by independent actors, and integration stresses the coalescence of independent actors into a single, unitary structure.

Within the context of the EACH Program, networks are formal relationships between hospitals, that is EACHs and RPCHs. The hospitals are required to act in certain ways (described in more depth below), yet they maintain their organizational integrity. The degree of linkage (the strength of coupling) between and among members is left to each network to determine. In contrast, the EACH program only expands the opportunities for service integration through the Medicare reimbursement program.

Medicare cost reimbursement is built around traditional hierarchical organizational structure. Providers who integrate their services with hospitals report their costs on the hospital's Medicare cost report and are considered "subproviders" for the purpose of the program. The services must be provided as an "integral and subordinate" part of a hospital for Medicare Part A and Part B to provide reimbursement for them. Integration through the hospital forces the other services providers to be subsumed by the hospital. This relationship may be by employment or by agreement, but the hospital is the sole recipient of reimbursement. The hospital in turn pays the other providers as either employees or contractors.

The integrated organization, the Medicare Program hypothesizes, is better able to rationally structure a delivery system than a handful of separate actors, each working with a separate, perhaps conflicting, agenda.

Cost-based reimbursement is the inducement to local service providers to integrate. However, cost reimbursement may not be a sufficient inducement to overcome organizational and constituency resistance to the loss of institutional

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identity. It may be possible to achieve the coordination benefits of integration through simple networking. By a network relationship, however, local providers give up their claim to cost reimbursement through the hospital.

The risk inherent in integrating all local health services into a unitary structure is that the organization may fail. Even a streamlined, well-organized system is susceptible to poor operational management or malfeasance. Should the integrated organization fail, the community may be left without any health services.

Local communities need not choose among networking, integration, and doing nothing. There is a middle ground: there is also the possibility of forming a mixed model in which an integrated organization, say a hospital-SNF-home health agency-RHC combination, networked with a local public health clinic and mental health service. The network relationship could stipulate referral patterns, information sharing, group purchasing and so on.

The EACH Program: Networks and Locally Integrated Health Care Systems

The EACH Program *requires* the establishment of rural health networks composed of essential access community hospitals (EACHs) and rural primary care hospitals (RPCHs) and *encourages* the development of locally integrated health care systems through RPCH Medicare reimbursement. The distinguishing characteristic of both networks and locally integrated health care systems is formal linkages between and among health service providers. In the case of networks, the linkage is between or among hospitals. Two hospitals which have a formal relationship may be considered a network. However, a network is not limited to two hospitals and

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may feature as many hospitals as the network's internal systems can support. Locally integrated health care systems (within the context of the EACH Program) are formed when RPCHs form linkages with local non-hospital providers. Examples include long-term care, primary care, mental health, and public health.

RPCHs that establish linkages with other hospitals and with local providers create locally accessible, case-managed entry points for a continuum of health care services. Patients need not shop around for various local service providers, or leave the community to initiate contact with providers of services that are not locally available. Through these facilities, patients have access to a wide variety of service options, provided either locally or by network partners.

The Mechanics of EACH Program Integration

The EACH program is unambiguous about the formation of rural health networks. They are composed (at a minimum) of one EACH and one RPCH who agree to refer and accept patients, share data, and communicate. While the EACH program creates the floor for the linkage between the EACH and the RPCH below which the agreement may not drop, there is effectively no ceiling to the degree of linkage between EACH and RPCH clinical and administrative programs.

On the other hand, the EACH program provides no direction about the formation of locally integrated health care systems, but it does provide *an incentive* for their formation. The incentive is found in the methods of reimbursement for Medicare. Medicare Part A reimburses hospitals for the costs of skilled nursing and home health agency services provided through the hospital. The EACH legislation also created a Medicare Part B (outpatient) reimbursement incentive.

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Outpatient RPCH services will be covered under Medicare Part B. Prior to 1993, RPCHs may select either of two payment methods:

- a cost-based facility service fee with reasonable charges for professional services billed separately, or
- an all-inclusive rate combining both the professional and facility service components.

The law calls for an outpatient prospective payment system to developed by January 1, 1993, but it is unlikely that the target date will be met.

With modifications for the development of prospective payment for some outpatient services, hospitals are currently reimbursed according to the first option. Hospitals are paid for the technical component of providing outpatient services to Medicare beneficiaries, and physicians are paid separately for providing the professional component. The all-inclusive rate option for RPCHs would combine the technical and professional components into a single rate that would be paid to the RPCH. The RPCH would then have the responsibility for paying the physicians.

This option places the provision of primary care by (or through) an RPCH on a cost basis. RPCHs can employ a physician and/or mid-level practitioner and/or other health care provider such as a physical therapist, pay his or her salary, and be assured of reimbursement equal to Medicare's fair share of the cost. In many rural communities, physician reimbursement for Medicare services is significantly below cost. If the elderly population is large and Medicare

utilization is high (as it is in many rural communities), a physician's income is significantly depressed. To combat the low reimbursement for office visits, a physician may offer laboratory and radiology services and other diagnostic procedures through his office. Because the margin on ancillary services is more favorable than that on office visits he may order ancillary services out economic need and not out of medical need. The consequence of this behavior is two-fold. First, third party payers are asked to pay for services which are not medically necessary and patients are exposed to unnecessary discomfort and risk. Second, the hospital -- the traditional provider of ancillary services -- is deprived of ancillary service revenue for those procedures which <u>are</u> medically necessary. The ability to pay a physician a fair wage should reduce his or her dependency on ancillary income, increase his or her satisfaction, and improve the prospects for recruitment and retention.

To the extent that other service providers in the community, such as the public health department, duplicate services offered by physicians or hospitals it may be possible to eliminate duplicative programming. If the resources of other service providers are inappropriately utilized (eg., an agency is over-staffed <u>or</u> under-staffed), it may be possible to establish internal equilibrium by coalescing staff and services. The combining of functions where possible creates greater efficiency. In some cases, coalescing services at an RPCH may improve reimbursement. At the very least, linking with an RPCH will improve the use of administrative and general personnel and reduce the costs of overhead. (RPCH overhead costs are an allowable program cost.)

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Network and Integration Issues

Despite the fact that the EACH Program is a federal initiative there are many opportunities for the states to play a significant role in shaping the program. It is an excellent example of the federal/state partnership that is federalism. States have the authority to encourage and/or establish networks and locally integrated health care systems. Because the state has broad authority to build integrated systems of care, the relevant policy issues center on the role that the state *should* play in establishing networks. Policy makers must decide whether fully integrated models are worth the cost of implementing, and if they are, how they are best implemented. They must chose between mandates and incentives to establish networks and locally integrated health care systems, and finally they must evaluate the need for and make changes to the laws and regulations governing organization, payment, professional practice, licensure, and quality assurance. In other words, if policy makers conclude that it is in the best interests of the citizens of the state to form fully integrated health care systems at the regional and local level, they must be prepared to facilitate that change by establishing a subset of policies that support that conclusion.

The level of state involvement may well vary from state to state as policy makers answer the key public policy question differently.

Issue #1: Policy Objective

All public policy should be aimed at achieving some policy objective. What is the inherent social benefit of a locally integrated health care system? Is it being done to lower costs or to increase access? Is its purpose to provide "one-stop shopping" or to provide a focal point for managed care? It is important to know

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what you are trying to achieve with a policy for two important reasons: (1) by defining the problem area, policy makers are able to suggest specific solutions by which the problem can be solved, and (2) clear policy objectives provide the only way by which success can be measured. Once the policy objective is identified, policy makers must consider if the policy under consideration, in this case either the passive or active promotion of locally integrated health care systems, is the right one to do the job.

A Priori Question #1: What is the inherent social benefit of a locally integrated health care system that drives and directs policy making?

Issue # 2: State Involvement at the Local Level

The EACH Program requires the designation of rural health networks; the State of Kansas has already decided how to designate them. To date, the inducement to form rural health networks (in addition to cost-based reimbursement and somewhat relaxed licensure and certification criteria) has been federal grant money. Some $3.3 million in federal grant monies will pour into Kansas as the result of this program. Once the inducement of grant money is no longer present, will the inducement of reimbursement and relaxed licensure criteria be enough to promote the formation of rural health networks without state involvement? If it is good public policy to form networks, and from the actions taken to date, one must assume that is the conclusion, what will be done in subsequent years to encourage their development? The question is one of the degree of passivity the state should display in promoting networks. Is the role simply to remove barriers to their formation, or is it to remove barriers and assist in formation, or is it to establish networks by fiat?

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Locally integrated health care systems may be formed around RPCHs, but there is no federal requirement that they must be. The federal program only provides the Medicare reimbursement incentive to integrate. If it is good public policy to establish locally integrated health care systems, how best can those systems be established? The EACH Program grantees may use some of their grant monies to develop feasibility studies and develop local consensus for resource sharing, but newly established RPCHs may not have federal grant dollars to draw on. What role should the state play in establishing locally integrated health systems? Should the state merely remove the barriers to their formation? Or should the state provide information about the advantages of integration? Should it provide technical assistance on the formation of integrated systems? Or should it require locally integrated health care systems as a condition of rural health network designation? Should locally integrated health care systems be encouraged outside of rural health networks? In considering the role the state should play in the formation and operation of locally integrated health care systems, should the TAG revisit the Rural Health Plan?

The formation of rural health networks is protected from anti-trust prosecution by the state action doctrine. The creation of locally integrated health care systems may not enjoy the same protection. What can the state do to protect communities that chose to engage in local integration?

A Priori Question # 2: As locally integrated health care systems develop in response to the incentives of Medicare reimbursement and the EACH Program, what role should the state play in their formation?

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Issue #3: Organization and Governance

What is the structural definition of a locally integrated health care system? The minimum linkage of a rural health network is defined in law: it is a contractual relationship. EACHs and RPCHs have *written agreements* to transfer, to treat, to share, and so on. Should the minimum linkage of a locally integrated health care system be set in state law? Should the minimum linkage type required of a locally integrated health care system be greater than that required for a rural health network? For example, should the state require integrated systems to have common ownership or common governance? The economic inducement of reimbursement is a major reason why local providers will coalesce into a system of care. However, there are some providers who will not benefit from reimbursement policies. Should these providers be treated differently from other providers when defining a locally integrated health care system? Does the type of linkages extant in the locally integrated health care system really matter? Do the linkage types make a difference in terms of commitment, coordination and service?

A Priori Question # 3: In regard to the organizational structure of locally integrated health care systems, should minimum standards of linkage be established to assure permanence and the identification of roles and responsibilities?

Issue #4: Locally Integrated Health Care System Service Mix

Within the rural health network, a comprehensive array of primary and secondary acute care services are provided by the EACH and the RPCH. Within certain rural health networks, even tertiary services may be provided. In addition, RPCHs are required to provide ambulatory care services and to make available 24-hour

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emergency medical services. Should policy makers also establish the minimum service mix for a locally integrated health care system? For example, should a locally integrated health care system be required to provide low-intensity acute care (RPCH), primary care (physician or MLP), and long-term care (nursing home or home health agency)? If so, through what mechanism should they be required (see "Licensure" below)?

A Priori Question # 4: Should locally integrated health care systems be required to provide a certain mix of patient and community services or should local decision-making determine the mix of services?

Issue #5: Licensure

If the state wants to shape and direct locally integrated health care systems, the most effective way of doing so is through a certification and licensure process by which it can stipulate players, services, and standards of performance. Should the state develop a coordinated licensure category or should current individual licensure rules apply? The state of Wisconsin is developing a new *provider type* called the rural medical center (RMC) that would coordinate a variety of health care and health care related (eg., congregate elderly/disabled housing) services and promote the most efficient use of health care services. The scope of services provided would be chosen by local communities and the services would be provided directly by the RMC, or on a contractual or collaborative basis. The services a community selects may or may not include acute inpatient care (there will be two levels of licensure -- one for RMCs with acute care and one for RMCs without acute care). The new category of licensure would have a combined, stream-lined licensure survey. The RMC considers the locally integrated delivery

system as a single organizational entity. The state of Washington has also created an integrated service provider called the rural health care facility. The Washington plan is at a greater stage of development than the Wisconsin plan, even though no facilities have yet been licensed in Washington. Washington has published rules defining and regulating the integrated model. A copy of an explanatory pamphlet for the Wisconsin plan and the administrative rules for the Washington plan may be found at the next Tab in the book.

Coordinated licensure is the opposite side of the coin from integrated reimbursement. If integrated facilities are recognized as being one for the purposes of reimbursement, perhaps they should be considered as one for the purposes of licensure. Currently, some of the integrated providers, receive no licensure inspection, and other providers receive unique inspections. Some integrated systems could entertain a parade of surveyors passing through the institution every year. Would the system benefit from a single unified survey process? Is continuity of care (and quality of care) improved by the creation of unified policies and procedures which create a continuum of care from ambulatory primary care through institutional long-term care? Are there ways to achieve coordination of licensure without actually creating a new category of provider? What are the advantages and disadvantages of each approach?

A Priori Question # 5: As hospital-based locally integrated health care systems are developed, should the state develop a coordinated licensure category or should a single license per service remain the norm?

Issue #6: Locally Integrated Health Care System and Rural Health Network Relationships.

If an RPCH forms a locally integrated health care system, what is or should be its relationship to the rural health network? Is the locally integrated health care system an autonomous entity? Should the individual parts of the system retain their separate identities based upon service mission? Is the locally integrated health care system subsumed in the rural health network? Who should be charged with the responsibility for case management? These questions address the structural relationship of the local system to the regional network. Policy makers will need to evaluate the benefits of formalizing structure (coordination, communication, ease of decision-making) in comparison to its costs (loss of autonomy, unwillingness to participate).

A Priori Question # 6: In thinking of the relationship between the locally integrated health care system and the rural health network, how should responsibility for decision making, communication, and coordinationbe allocated? What is the appropriate role of the state in monitoring those decisions?

Issue #7: Community Development

When the hospital in Caney closed, the Jane Phillips Caney Clinic formed a locally integrated (non-acute) health care system that was networked with a secondary hospital in Bartlesville, OK. As a result of these changes, the facility experienced a net gain of employees, and assured their continued employment in the community. How does the locally integrated health care system relate to community development? Are there community development criteria that should

guide the development of locally integrated health care systems? If so, what are they? Community development was not explicitly mentioned as a goal in the Rural Health Plan. Should the TAG revisit the Plan and consider the issue of community development?

A Priori Question #7: How should creation of the locally integrated health care system relate to community development?

Issue #8: The Role of Physicians

There are several issues surrounding the role of physicians in locally integrated health care systems when they serve as employees. Some of these issues concern federal law and regulations and others concern state law. State policy makers will want to be aware of both. On the one hand, policy makers need to be aware of the risks of running afoul of federal law and rules that are inherent in strategies that attempt to rationalize health care delivery systems. On the other hand, policy makers will need to be aware of a recent Kansas Supreme Court decision on the doctrine of the corporate practice of medicine and its implications for the use of physicians in integrated systems of care.

A Priori Question #8: In an effort to remove barriers to the formation of locally integrated health care systems, it is it desirable to provide limited immunity for certain acts concerning corporate practice of medicine and breach of confidentiality?

Issue #9: The Role of Mid-level Practitioners

Mid-level practitioners are permitted to practice in RPCHs. They are not required

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to do so. They are also not required in locally integrated health care systems. In other integrated models, or models which attempt to consolidate services, such as the rural health clinic, the presence of a mid-level practitioner is *required* at least half of the time the facility is open. Should there be a mid-level practitioner requirement at locally integrated health care systems? The use of mid-levels, would be a positioning strategy. It is highly likely that some RPCH communities will not be able to recruit and retain physicians in the future. Small numbers of patients and a limited supply of primary care physicians make the prospect that every community will be supported by a doctor highly improbable. Requiring mid-level participation in locally integrated health care systems will assure that medical services are available in the community should a physician leave and not be replaced. The mid-level practitioner can admit patients to the RPCH and would be supported by its EACH medical staff. Mid-levels are less expensive to employ than physicians, albeit the scope of their practice is also smaller. By phasing in the use of mid-level practitioners, a community would become acquainted with them as providers and would obtain a level of comfort with the services that they offer. Such a comfort level may be difficult to establish if mid-level practitioners are introduced to the community only after the physician leaves. The question for policy makers is whether the state should play an active role in promoting the use of mid-level practitioners, or whether the decision to use mid-level practitioners should be left to local option. A corrolary question to consider is, if the TAG decides to promote the use of mid-level practitioners, can it do so without licensing locally integrated health care systems?

A Priori Question #9: In thinking about the use of mid-level practitioners, should it be the state or the local community that defines the appropriate role?

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A Priori Questions

1. What is the inherent social benefit of a locally integrated health care system that drives and directs policy making?
2. As locally integrated health care systems develop in response to the incentives of Medicare reimbursement and the EACH Program, what role should the state play in their formation?
3. In regard to the organizational structure of locally integrated health care systems, should minimum standards of linkage be established to assure permanence and the identification of roles and responsibilities?
4. Should locally integrated health care systems be required to provide a certain mix of patient and community services or should local decision-making determine the mix of services?
5. As hospital-based locally integrated health care systems are developed, should the state develop a coordinated licensure category or should a single license per service remain the norm?
6. In thinking of the relationship between the locally integrated health care system and the rural health network, who should have responsibility for decision making, communication, and coordination?
7. How should creation of the locally integrated health care system relate to community development?
8. In an effort to remove barriers to the formation of locally integrated health care systems, it is it desirable to provide limited immunity for certain acts concerning corporate practice of medicine and breech of confidentiality?
9. In thinking about the use of mid-level practitioners, should it be the state or the local community that defines the appropriate role?

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The EACH Concept:
A Study of Rural Health Delivery Options

Funded in part by the Wesley Foundation

KANSAS EACH PROJECT

KANSAS BOARD OF EMERGENCY MEDICAL SERVICES
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KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
Dick Morrissey, Staff

KANSAS HOSPITAL ASSOCIATION
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Board of
Emergency Medical Services

KANSAS HOSPITAL ASSOCIATION

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Federal Initiatives

* * Rural Health Clinics (RHC)

* * Federally Qualified Health Centers (FQHC)

* * Essential Access Community Hospital (EACH)

* * Rural Primary Care Hospital (RPCH)

* * Payment Incentives

    * federal Health Personnel Shortage Areas (HPSAs)

    * Medicare dependent hospital

    * Sole community provider

    * Rural referral center

    * Geographic Reclassification

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Why is Kansas interested in alternatives?

* * Decreasing volumes of traditional acute care
    * Since 1983, rural hospital admissions dropped 56%
    * Rural patient days dropped 82%
    * 52 of 137 hospitals have ave. acute census of < 6 patients
    * 21 of the 52 have ave. acute census of < 3 patients

* * Difficulty in recruiting and retaining primary care physicians
    * 61 of 105 counties designated primary care medically underserved areas

* * Difficulty in coordinating services
    * Physicians, ambulatory care, acute care, LTC, EMS, HH, PH, MH, MR & DD, emergency & non-emergency transportation

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What is the Kansas EACH Project?

* * Public/Private Partnership
    * Kansas Department of Health and Environment
    * Kansas Hospital Association
    * Kansas Board of Emergency Medical Services
    * Wesley Foundation
* * Technical Advisory Group (TAG)
    * Asked to participate by Partnership
    * Broad-based constituency representation
    * Function as working body to develop/test model(s)
* * Grant for $261,111 for Study of Rural Health Delivery Options
    * First task: Evaluate applicability of EACH Concept Design model to meet Kansas needs
* * Continuation Grant for $560,000
    * Implementation
* * Chosen as One of Seven EACH States
    * California, Colorado, Kansas, New York, North Carolina, South Dakota, West Virginia

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What is the Essential Access Community Hospital (EACH) concept?

* * Federal Programs

  * Omnibus Budget Reconciliation Act (OBRA) 1989 & 1990

    - Grants to seven states and facilities

    - Program to designate facilities as EACHs and RPCHs

  * Concept

    - Designates Rural Hospitals as Rural Primary Care Hospitals (RPCHs or PCHs)

    - Linked with larger supporting hospitals designated as Essential Access Community Hospitals

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What is a Rural Health Network?

* * Relationship

    * Rural Primary Care Hospital (RPCH)

    * Supporting Hospital (EACH, RRC, urban/RRC)

    * Other hospitals (Kansas)

    * Other health services (Kansas)

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What is required of a Rural Health Network?

* * Formal Agreements

  * Patient referral and transfer

  * Communication

    - between administrations, medical staffs, boards employees (Kansas)
    - patient data
    - telemedicine (if available)

  * Emergency Medical Services

    - Network EMS Plan (Kansas)
    - Emergency and non-emergency transportation
    - communication (provider and patient access)

  * Kansas requires arrangements for

    - quality assurance/peer review
    - risk management
    - joint credentialing

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Specifically, what is a Rural Primary Care Hospital?

* * Must be rural

* * Must meet current licensure requirements or have closed within last twelve months

* * Must have Medicare participation agreement

* * Agrees to meet requirements

  * Federal (upon fed. designation)

  * state/project (Kansas)

* * Has a primary relationship with one supporting hospital

  * EACH, RRC or urban/RRC

  * Responsibility of RPCH to select supporting facility (Kansas)

  * Must be within 75-mile radius (Kansas)

  * May have referral relationships with other hospitals (Kansas)

* * Reimbursed on a reasonable cost basis (ultimately per diem)

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Specifically, what is a Rural Primary Care Hospital?

* * Must offer:

* Emergency services
  - on-site during posted hours
  - via the supporting hospital outside of posted hours

* holding/stabilization services
  - Limited acute capacity
  - Prior to transfer
  - For primary care level definitive treatment

* Ambulatory primary care services

* Ancillary services
  - radiology, lab, pharmacy, dietary, housekeeping
  - on-site access (may be via supporting facility)

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Specifically, what is a Rural Primary Care Hospital?

* * May offer:

  * Low risk obstetrics (written utilization plan)

  * Outpatient surgery (written utilization plan)

  * LTC (including swing beds and distinct part skilled)

  * Home health, physical therapy, respiratory therapy, etc.

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Specifically, what is a Rural Primary Care Hospital?

* * May not offer:

* Inpatient services for patients > 72 hours
  - Exceptions process may authorize extension in specific instances

* Inpatient services for more than 6 acute patients

* OB services other than low risk (ex: Planned C-sections)

* Surgery requiring hospitalization for > 24 hours

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Specifically, what is a Supporting Hospital?

* * Essential Access Community Hospitals (EACHs)

  * Must be rural

  * > 35 miles from another EACH, RRC, Urban Regional Referral Center

  * > 75 beds or > 35 miles from any non-RPCH hospital

  * Treated as sole community provider with reasonable cost resulting from participation in rural health network

  * Full-service facility:

    - OB, inpatient surgery, 24-hour ER staffed by phys, medical/surgical intensive care and/or coronary care

  * No new licensure criteria

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Problems with Federal Rules

* * NPRM Distributed for Comments October 1991
    * Comment period ended December 24, 1991
* * Deal Breakers
    * Definition of an RPCH
        - Need distinct category
        - "Immediate & temporary" admissions
    * Issues of flexibility & patient care
        - Strict 6-bed rule
        - Strict 72-hour rule
    * Ability to continue swing-bed program
        - Limit on beds
        - 3-day prior hospitalization
    * Lower of costs or charges
    * Grant v. loan
* * Other Important Issues
    * MLP requirement
    * Urban participation
    * Multi-state networks
    * 12-month eligibility
    * EACH reimbursement
    * Medicaid

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Final Thoughts

* * Traditional Concepts in Health Care Delivery Changing

* * Communities Must Balance

    * Consumer desire and expectation with available resources

    * Rural desire for independence with concepts of pooling resources

* * Balancing Act Will Need Education and Leadership

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