

Testimony of Jim Beckwith, NEK-AAA

Secretary Greenlee:

I am Jim Beckwith, of the Northeast Kansas Area Agency on Aging. I wish to share concerns with you today, in preparation for your work on the KDOA budget for FY2008.

Rural healthcare, especially for elderly Kansans, is a critical concern. According to the Kansas Hospital Associations 2005 Annual "Stat" Report, more than 58.5% of the physicians statewide counted (using unduplicated counts) practice primarily in Johnson, Sedgwick or Wyandotte counties. When one adds Shawnee and Douglas counties, that total rises to 68.9%. That means the remaining 100 Kansas counties must do with just 31.1% of the physicians in the state.

There are 5 (five) counties reporting no physician, and another 19 (nineteen) counties reporting just one or two (1-2) practicing physicians. That means over 20% of Kansas, all rural areas, have very little available medical care.

To compound the lack of medical professionals, there are only 127 community hospitals in KS. (There also are 10 state/federal hospitals, 23 specialized hospitals, and 2 Psychiatric Hospitals, for a grand total of 162 hospitals. Those all together have a total of 10,326 staffed beds). There are 12,899 beds total in the 127 Community Hospitals, 9,918 of which are staffed. There are nine (9) Kansas counties without Community Hospitals.

In 2004, these hospitals reported 2,006,048 total inpatient days, and 5,745,899 outpatient visits. There were 144,467 Medicare Inpatient discharges, and 780,165 Medicare inpatient days (39.3% of total).

The Average Length of Stay for people under age 65 was 3.53 days statewide, and for those people over 65, LOS was 5.24 days statewide.

Total 2004 Medicare charges were \$3,118,434,249, with an average charge of \$20,609.

Medicare had 49.3% of inpatient days, when looking at source of payer.

It is the rural Planning and Service Areas (PSAs) where there are fewer physicians, yet greater percentages of seniors, who often need more healthcare. There are a growing number of medical professionals who will no longer accept new Medicare and Medicaid patients. The system has become too cumbersome and too costly for the small reimbursement provided.

In rural Kansas, seniors are more likely to have care from either Home health Agencies or from Nursing Homes.

Based upon KU School of Social Welfare 2003 data, just 25.8% of all NF inpatient days statewide were provided in Johnson, Wyandotte and Sedgwick counties (compared to the 58.5% of physicians). Adding Shawnee and Douglas counties, the NF rate rises to just 35.1% of the

statewide total, (compared to the 68.9% of the physicians). If the medical professionals are not there, is it any wonder people end up in a nursing home?

Statewide, there are just 177 licensed Home Health Agencies, and only 133 are Medicare certified. There are many rural home health agencies that are the only agency provider within their county. Some are the only provider for as many as six counties.

Home health agencies cannot run on air. Gasoline costs six (6) times what it was when HCBS-FE services began, yet providers have had just a 4% HCBS-FE rate raise in eight years, and that just recently. Home health providers are not paid either for their time or mileage to serve their clients.

Small rural pharmacies are being squeezed to the point of financial ruin by large drug companies and the new convoluted Medicare part D prescription drug benefit. Some have waited for months to get reimbursed by Medicare.

A significant number of nurses are nearing retirement age. Many nurses have found that they can earn more money commuting to metropolitan areas, than they can working in rural areas, where they may be most needed.

Nutrition providers have felt a large “hike” in costs, primarily due to increased fuel costs to their suppliers. There are some rural meal sites where they may be the only place in town to get a meal. There are no other options available, especially for homebound seniors. Medical transportation is an entirely different problem.

We are on the verge of a major crisis – one that must be addressed at both the federal and state levels. Rural care providers – Doctors, hospitals, nurses, home health agencies, and Area Agencies on Aging cannot continue to provide necessary care using rates that significantly lag behind simple inflation.

We need a comprehensive look at the unique problems of delivering care to rural Kansans. We need to bring a variety of players to the same table, and “lay all our cards out” to really see the magnitude of the problem. Then we need to find ways, to fix those problems. Some of that may not take any new money – only new ideas. Other may take additional funding.

I ask that you, in concert with other cabinet secretaries, work to convene a major study on the care for rural seniors in Kansas. I also ask that you support annual provider rate increases equal to, or greater than, inflation.

Thank you – I’ll be glad to stand for any questions you may have.

Testimony of Jim Beckwith, NEK-AAA

Good afternoon, Dr. Nielsen and Members of the Kansas Health Policy Authority:

I am Jim Beckwith, of the Northeast Kansas Area Agency on Aging. I wish to share concerns with you today, as you look at the direction for the Kansas system.

Rural healthcare, especially for elderly Kansans, is a critical concern.

According to the Kansas Hospital Associations 2005 Annual "Stat" Report, more than 58.5% of the physicians statewide (using unduplicated counts) practice primarily in Johnson, Sedgwick or Wyandotte counties. When one adds Shawnee and Douglas counties, that total rises to 68.9%. That means the remaining 100 Kansas counties must do with just 31.1% of the physicians.

There are 5 (five) counties reporting no physician, and another 19 (nineteen) counties reporting just one or two (1-2) practicing full time physicians. That means over 20% of Kansas, all rural areas, have very little available medical care.

To compound the lack of medical professionals, there are only 127 community hospitals in KS. There are nine (9) Kansas counties without Community Hospitals. (There also are 10 state/federal hospitals, 23 specialized hospitals, and 2 Psychiatric Hospitals, for a grand total of 162 hospitals.) Those all together have a total of 10,326 staffed beds. There are 12,899 beds total in the 127 Community Hospitals, 9,918 of which are staffed.

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It is the rural Planning and Service Areas (PSAs) where there are fewer physicians, yet greater percentages of seniors, who often need more healthcare. There are a growing number of medical professionals who will no longer accept new Medicare and Medicaid patients. The system has become too cumbersome and too costly for the small reimbursement provided.

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statewide total, (compared to the 68.9% of the physicians). If the medical professionals are not in the rural areas, is it any wonder people end up in a nursing home?

Statewide, there are just 177 licensed Home Health Agencies, and only 133 are Medicare certified. There are many rural home health agencies that are the only agency provider within their county. Some are the only provider for as many as six counties. Several HHAs have “quit” in the last few years – some even giving up Medicare Home Health care - as they were losing too much money. In the last 18 months, I’ve had three hospital HHAs and one Nursing Home HHA in my area that ceased their in home services.

Home health agencies cannot run on air. Gasoline costs six (6) times what it was when HCBS-FE services began, yet providers have had just a 4% HCBS-FE rate raise in eight years, and that just recently. Home health providers are not paid either for their time or mileage to serve their clients.

Small rural pharmacies are being squeezed to the point of financial ruin by large drug companies and the new convoluted Medicare part D prescription drug benefit. Some have waited for months to get reimbursed by Medicare.

A significant number of nurses are nearing retirement age. Many nurses have found that they can earn more money by commuting to metropolitan area hospitals, than they can working in rural areas, where they may be most needed.

Nutrition providers have felt a large “hike” in costs, primarily due to increased fuel costs to their suppliers. There are some rural meal sites where they may be the only place in town to get a meal. There may be no other options available, especially for homebound seniors. Hot, nutritionally balanced meals and the socialization of other seniors gathered at local senior centers have been proven to be a vital component to personal health.

Medical transportation for those who live in rural areas is another problem. If an elderly rural Kansan must see a specialist in a metropolitan area, it is often at least a full day adventure. First, one must find another person who can take the time, and effort, to drive to and from the specialist’s office. Then there is usually an x-ray or some type of preliminary lab work, followed by a delay to process the results. Finally, usually after lunch, one does get in to see the specialist. But that may be followed by more tests or lab work, and then a trip to the pharmacy. By the time the “patient” gets back home, he/she is normally “out of patience”, as is their driver, and all are exhausted. There also may be poly-pharmacy issues as a result of this visit.

The eleven Kansas Area Agencies on Aging, which provide a wide array of services for all Kansas seniors, work with home health agencies, Independent Living Centers, and Community Mental Health Centers, to arrange for client specific care. Although our services are based on a social model, we feel that we are an integral part of the Kansas Health Care System. Indeed, it is our main effort to keep frail, elderly Kansans living in the least restrictive, most cost effective environment, for as long as they are able to do so.

We are on the verge of a major crisis – one that must be addressed at both the federal and state levels. Rural care providers – Doctors, hospitals, nurses, home health agencies, and Area Agencies on Aging cannot continue to provide the vital care necessary, using rates that significantly lag behind simple inflation. Any “moral subsidy” in rural care was used years ago – good will and being “neighborly” won’t pay the bills.

We, all of us involved in Kansas Health Care, need a comprehensive look at the unique problems of delivering care to rural, primarily elderly, Kansans. We need to bring a variety of players to the same table, and “lay all our cards out” to really see the enormous magnitude of the problem. Then we need to find ways, to fix those problems. Some of that may not take any new money – only new ideas. Other may take additional funding.

I ask that you, in concert with state cabinet agencies, convene a study on the care for rural seniors in Kansas.

Thank you – I’ll be glad to stand for any questions you may have.