Transcript
An Update from the National Advisory Committee on Rural Health and Human Services

Kristine Sande
I'm Kristine Sande and I'm the Program Director of the Rural Assistance Center. I'd like to welcome you to our webinar today, An Update from the National Advisory Committee on Rural Health and Human Services. The Committee has recently issued several reports or policy briefs on rural health system infrastructure, as well as proposals for reform that we'll be discussing today, including the implications of proposed changes to rural hospital payments designations, some options for rural healthcare system reform and redesign, and also rural implications of the Center for Medicare and Medicaid Innovation.

We hope to have time for your questions at the end of today's webinar. If you have questions for our presenters, please submit them towards the end of the webinar and you can do that using the Q & A section of the screen directly beneath the slides. We will be muting your lines today, but we also ask that you mute your own lines at your phone just to ensure that we don't have excess noise on the line. We have provided a copy of the presentation on the RAC webinar page which is www.raconline.org/webinars. If you decide to go to this page during the webinar, please don't close this webinar window or you'll have to log back in.

If you have any technical issues during today's webinar, please contact our support area using the phone number listed on the information screen. If you are not seeing that screen, the number is 701-777-6305. Once again for any technical issues, the number is 701-777-6305.

Our first speaker today will be Ronnie Musgrove, who has served as the chair of the National Advisory Committee since 2010. He previously served as the Governor of Mississippi from 2000 to 2004, serving as the Lieutenant Governor prior to that. Governor Musgrove is only able to be with us for a few minutes today so we'll get right to his comments. Governor Musgrove.

Ronnie Musgrove
Kristine, thank you very much. I want to thank each of you for being on the call today and hope that it will be of some assistance to you as we look at these proposed policy changes. Kristine later will introduced three of the members of the Rural Advisory Committee and also, Steve Hirsch will go through the background of the committee's function and what our role is with the Secretary of Health and Human Services.

The reason the committee chose the issue briefs on the topics that Kristine just mentioned, is that they wanted their proposals to make some fundamental changes to Medicare and Medicaid reimbursement for rural healthcare providers. The committee wanted to act before changes are implemented to try to offer some guidance to the process. Cuts in payments or suddenly removing Critical Access status for some hospitals, could produce severe reductions in availability of health care in rural areas. The Center for Medicare and Medicaid Innovation is able to experiment with innovations that are intended to both improve quality of care and control or reduce costs. The committee wants to be sure that it offers some rural-friendly

demonstration programs and takes into consideration the special attributes practiced in rural areas.

Last, the committee does not believe that there is no need for reform, but wanted to offer some ideas and highlight some demonstration programs that can guide changes to rural health care. You will be hearing from three of our outstanding members of the Advisory committee and I believe you're in for a good webinar and some exchanges of ideas from them. Kristine, I want to say thank you to you personally, and to the RAC for hosting the webinar.

Kristine Sande
Thanks so much for that introduction to today's webinar. As you mentioned, during the remainder of the day's call, we'll be hearing from the Executive Secretary of the Committee, as well as three of the members, who will each speak about the Committee's findings on a specific topic.

First, we'll hear from Steve Hirsch, who is the Executive Secretary of the Committee and provides that support to the committee from the Office of Rural Health policy. Next, we'll hear from Karen Madden who is the Director of the Charles B. Cook Office of Rural Health for New York. In that capacity, Karen directs statewide rural policy development and implementation and also oversees programs totaling $18 million. She also served as a staff member to the New York State Public Health and Health Planning Council. Karen will discuss the implications of proposed changes to rural hospital payment designations today.

Then next, we will hear from Dr. John Cullen. Since 1994, Dr. Cullen has been a physician at the Valdez Medical Clinic, a four physician private practice in a medically remote area which is at the terminus of the Alaskan pipeline. He also serves as chief of staff at the Valdez Community Hospital and physician sponsor of the Valdez Emergency Medical Services. He's been a member of the Alaska Rural Medical Congress since 1998 and was named the Alaska Family Physician of the Year in 2008. Dr. Cullen will tell us today about some options for rural health care system reform and redesign.

Our final presenter will be Roger Wells. Since 1987, Mr. Wells has been a physician assistant at Howard County Medical Clinic in St. Paul, Nebraska. In addition to his physician assistant degree, he also holds a Masters degree in Physical Education and Athletic Training. Mr. Wells will give us an overview of the rural implications of the Center for Medicare and Medicaid Innovation or CMMI. With that, I'll turn it over to Steve.

Steve Hirsch
Thank you, Kristine. I'm Steve Hirsch. I'm located at the Office of Rural Health Policy in Rockville, Maryland. At the end of the presentation, there's some contact information for people want to know more about the Committee, but I'll go through a brief description of what the committee is and what it does. The Committee's one of the independent advisory boards that can offer advice to the Secretary of Health and Human Services and does so by meeting several times a year. It's an independent external voice made up of people outside the

government who become members for a four-year term. The Committee usually prepares either an annual report and/or policy briefs or white papers and sends them to the Secretary.

In the past several years, we've been sending recommendations to the Secretary on the ACA, the Affordable Healthcare Act, trying to make sure that the changes that are implemented do to the ACA are rural friendly. The Office itself, and the Committee, was established back in 1987. In 2002, Secretary Thompson expanded the focus of the Committee, which up until then had just been rural health, to include rural human services. There are 21 members currently on the Committee and like the members we have on this Committee, they represent a broad geographical range from Maine to Alaska and includes people with very strong background in rural health and human services.

As you heard, former Governor Musgrove is the chairman. We have members from 16 states across the country. Last year, in 2012, the Committee held three meetings. The first was a winter meeting here in Washington, D.C. We followed that with two meetings, one in June and one in September to allow the Committee to hear directly from people out in the field. The two meetings that were held out in the field – one was in Kansas City, MO in June, and the other was in Austin, Texas in September. If you know anything about Critical Access Hospitals, you will realize I believe that well over 50%, probably close to 75% of Critical Access Hospitals are within a day's drive of Kansas City, Missouri. Texas is a very large state that has a very large number of Critical Access Hospitals as well. We took the opportunity to go out and visit some of the Critical Access Hospitals that were within driving distance of those two cities.

Rural America, as I'm sure everybody on the call knows, has about 20% of the population of the U.S. in about 80% of the land area of the U.S. But, it only has about 10% of the nation's physicians and out of the over 3,000 health professional shortage areas in the U.S., the vast majority are rural and frontier areas. The rural healthcare market is very dependent on individual markets, small businesses are the key employer and about one quarter of all rural adults are uninsured. There's a heavily dependence on the public programs such as Medicare and Medicaid.

Today's white paper topics are first, Implications to Proposed Changes to Rural Hospital Payment Designations, Options for Rural Health Care System Reform and Redesign and finally, Rural Implications of the Center of Medicare and Medicaid Innovations which is part of the Centers for Medicare and Medicaid Services. I will turn it over to Karen Madden who will present the first paper.

Karen Madden
Thanks, Steve. As you all can see on this slide, this paper was called the Implications of Proposed Changes to Rural Hospital Payment Designations and it was issued in December 2012. This paper was the result of the meetings that we had in Kansas City and Austin, discussing the many and varied implications of changes to the rural hospital payment. The two-part brief was a companion to the next policy brief, Options to Rural Health Care System and Redesign. While this brief takes a shorter-term data driven approach to examine several proposed changes to

the payment system for rural hospitals, the second paper looks at the longer-term rural health care system as a whole. The Committee believes properly examining these proposals requires a short- and long-term perspective.

The proposed changes to the rural hospital payment designation that we discussed were as follows.

- The Congressional Budget Office's mandatory spending option number 24 proposed eliminating Medicare payment designations for Critical Access Hospitals, Sole Community Hospitals and Medicare Dependent Hospitals. There exists among a broad range of possible options laid out by the CBO to reduce government spending. The CBO recognized the outright elimination of these designations might decrease health care access in rural areas, even if it would save money.
- The Administration proposed eliminating the low-volume add-on payment, reducing CAH reimbursements from 101% to 100% of allowable costs and revoking the CAH designation for CAHs within 10 miles of another hospital. That last part of revoking CAH designation for CAH's within 10 miles of other hospitals has been proposed again by the Administration.
- MedPAC suggested the higher costs at CAHs may not be necessary, citing that 16% of CAHs are within 15 miles of each other. While MedPAC did not endorse revoking enhance payment for CAHs within a certain driving distance from the nearest hospital, it did assert that Medicare should not pay higher rates to two competing low-volume providers in close proximity. Medicare appears to have assumed that nearby hospitals generally compete in overlapping service areas to attract inefficiently small patient volumes.

The Administration outlined three proposals to revise the CAH payment system in its FY 2013 budget. Those were: eliminating the low-volume add-on payment, reducing CAH reimbursements from 101% to 100% of allowable costs, and revoking the CAH designation for CAHs within 10 miles of another hospital. They estimated that these changes would save $6 billion over the next 10 years. MedPAC suggested the higher cost that CAHs may not be necessary, citing that 16% of CAHs are within 15 miles of each other.

The MedPAC June 2012 Rural Report suggested that the higher cost at CAHs near other hospitals may not be necessary, again citing 16% are within 15 miles of another hospital, and stated that Medicare should not pay higher rates to two competing low-volume providers in close proximity. But it did not address the issue of nearby providers are necessarily competing, and concluded that Medicare payments to rural providers is currently adequate.

As many of you on this webinar and many rural stakeholders throughout the country are very concerned naturally about these various proposals to reduce costs. They did an analysis of these proposals based on data drawn by the North Carolina Rural Health Research and Policy Analysis Center. Part of that data included a spatial analysis that showed that revoking the CAH designation would have a large ripple effect across the rural healthcare system, but because of distance-based designation criteria, full community hospitals would revert back to PPS if CAHs

were forced to revert to PPS as well. That I think is maybe one of those unintended consequences. The North Carolina data also indicated that Critical Access Hospitals nearby other hospitals have a higher average daily census than more isolated Critical Access Hospitals, which seems contrary to what you would just typically think of.

We have a chart that shows the number of hospitals affected by the changes or the proposed changes in distance criteria. I certainly won't to read through all the numbers because everyone can see that. If you go down to hospitals that are less than 15 miles apart, you'll see that there are 245 that would be converted, but that number changes drastically when you look at the hospitals that are less than 10 miles and it only impacts 55 hospitals and 13 Sole Community Hospitals. The total would be 68 hospitals. Naturally those numbers increase as the distance increases.

Based on this data, the committee brought a few assumptions into the proposals in question. Critical Access Hospitals near other hospitals did not appear to be competing for patients, and often received higher patient volumes than the average. Although Critical Access Hospitals comprised 28% of all hospitals in the U.S., they only account for 2% of overall Medicare spending. 19% of Critical Access Hospitals are at a mid-high to high risk of experiencing financial distress in the next two years. These hospitals are dispersed across the country and are both near and far from other hospitals so there are no connections that can be drawn.

This slide shows the average daily census distribution of Critical Access Hospitals based on distance from the nearest hospital. One of the things, again I won't read through all the numbers, but one of the things that I found most compelling is that if you look at hospitals that have an average daily census between five and less than 10 and those hospitals that are between 10 and 20 miles apart, there's 222 hospitals in that range which is quite significant. I think those numbers speak for themselves.

We concluded that the three proposed changes were too sweeping in nature and did not sufficiently consider the many nuances highlighted in our analysis. We also concluded that revisions to payment designations for rural providers should reflect a longer-term vision of the future of the rural healthcare infrastructure. Changes mounted primarily by fiscal measures may not best serve the needs of our communities or be sustainable over time.

One more point is the Research Center pointed out to us that over 70% of Critical Access Hospital revenue comes from outpatient, which is consistent with the emphasis on emergency services and the legislation authorizing Critical Access Hospitals. This may, however, note that the little data that described the roles of Critical Access Hospitals in addressing emergency and outpatient needs, areas in which distance and transportation issues are more important than for inpatient services. There is no reason to assume that the distribution of inpatient indicators by distance directly correspond to the need for geographically distributed outpatient services or emergency care.

I'll hand this back to Steve.

Steve Hirsch
Our next presenter will be Dr. John Cullen from Alaska and he'll be talking about the Options for Rural Healthcare Reform and Redesign.

Dr. John Cullen
Welcome everybody. This is John Cullen. What I'm going to be talking about is some of the APA implications for rural healthcare and then attitudes among health care providers regarding that. We're going to be talking about the Frontier Extended Stay Clinics and the FCHIPs, which is a new designation. I think the thing to remember is that there is a system in place that is working, that's the Critical Access Hospital system. I just remember a complaint by a physician in Texas that was wondering why is it that when something is working the government always wants to get rid of it?

In terms of the longer-term concerns of the Committee, we do see that there is a conflict in terms of what the long-term goal of healthcare reform, especially with regards to the Affordable Care Act. There are some provisions within the Affordable Care Act that we think that Critical Access Hospitals will actually do quite well with, especially with the value-based purchasing as long as the parameters for that are applicable to small hospitals in small communities. With that, we are concerned about the proposed changes with the Critical Access Hospital payment currently that are out there. Our big concern there is that it's going to take several years for the provisions for the Affordable Care Act to fully come into place that hospitals will fail to take advantage of. If we change that Critical Access Hospital designation, we may end up losing a fair number of Critical Access Hospitals, which, now let's face it, that is a big part of the safety net within rural communities.

There is a lack of awareness among rural providers about those provisions with the Affordable Care Act, and the other national trends as far as Accountable Care Organizations and things of that sort. Part of that is that, one is there is a shortage of healthcare providers in rural communities and the other part of that is within administration, there's all the same jobs as the larger hospitals, but everybody ends up having to wear multiple hats. For example, I'm the chief of staff of our hospital, I am also the head of EMS for our region, I am the head of the ER committee, the ICU committee and the operating room committee. There's a tendency for there not to be a lot of extra bench strength or of people that'll be looking at these provisions and what affects they're going to have on the rural communities.

We are going to be looking at some of the new models and approaches for health care that take those rural considerations into account. Part of that, one thing I wanted to mention as far as the rural communities in particular is that there is a huge problem with n, where n is the number. We see significant statistical variations within health care when you have small numbers and that has lots of implications for design of a healthcare system. We talked in this Committee about the average daily census, but unfortunately, it's not that there are many people in the hospital at any one time, a lot of times there's nobody, and then there's more

than ten. There are these huge fluxes. This last week, actually, we had a gunshot wound to the chest in our emergency room. I haven't seen one of those in 18 years. There's a huge statistical variation, and yet within the small communities, you have to be ready for major emergencies at the drop of a hat. These may be things that you don't see on a regular basis.

Compounding that of course is the large distances involved in frontier and rural communities. One thing we found when we were talking at the site visits is that communities really do want a hospital. That seems to be one of the statuses of success throughout those communities. I think it is really important when we're considering all of this, is that we are trying to maintain a minimum level of emergency response and emergency safety net in that.

Some observations from the site visits – there is a huge amount of variation, in terms of health status and financial conditions, even between neighboring rural counties, and even between individual communities within those counties. There's a saying that when you see one rural community, you've seen one rural community. I think that's especially true within healthcare. Compounding that is that there's inter-penetration of various hospital systems and healthcare systems within those counties so that different communities may not even talk to each other because they're a part of different systems.

The one thing that we did find that was continuous across all the sites we visited was a very strong desire to take care of patients and I think that is especially true in rural and frontier communities. These are neighbors, friends and family so there's a very strong desire to do whatever is necessary to take care of people.

Rural communities are more vulnerable to boom and bust economies. There's two parts to that. One is that a lot of times there's not a diversification of employers, so if one employer leaves the community that can have an absolutely devastating result. Likewise, there can be a strong seasonal variation. A lot of communities in Alaska, for example, our community in Valdez doubles in the summertime because of fishing. That's something that makes it very difficult to plan for, and some other implications, as far as Accountable Care Organizations and assigning patients as beneficiary to those Accountable Care Organizations.

We did find lot of awareness of the ACA provisions and the models. Nearly everybody we talked to would rather stick with what they had, and again that makes sense given that the changes really have big implications as far as planning. There's just not a lot of administrative excess capacity to come up with these changes. Everybody is pretty much working hard as they can just with the current system, to make sure that the patients are being cared for.

On the other hand, we did see a fair amount of interest in exploring the potential of new models of care. The one thing we did hear is that, tell us what to do and we'll do it, but then don't change it. Once you tell us what to do, we'll figure it out because we always work around the system, but let's not change it in the near future.

One of the other things I'd like to talk about is the Frontier Extended Stay Clinics. The next community over from Valdez has a Frontier Extended Stay Clinic so I've been able to watch this from the inception. I've also talked with physicians and administrators at the other sites here in Alaska because four out of the five Frontier Extended Stay Clinics actually are in Alaska; the fifth one is in Washington.

Basically, what Frontier Extended Stay Clinics allow for is, it allows for communities without a hospital to have an emergency room and the ability to have a 48 hour observation. What's happening in these communities is they were basically providing those services out of necessity. The next town over in Glenn Allen is 120 miles from us. It's 150 miles from the next community of 4,000 people and about the same distance from La Sola, and so it's a very isolated community. There's moose and caribou on the road. It's icy, obviously it's Alaska. They were taking care of major trauma. Anyway, it's basically out of a clinic situation. Because of the cusp area they were able to actually expand their services. They've done a lot to stabilize the medical care within the community and in talking to the providers they see this as being a major improvement.

The main reason as far as cost savings for Medicare is that if you have a Frontier Extended Stay Clinic, not only does it improve the emergency safety net, but it also reduces the number of transportations. Within the rural and frontier communities, that's a major expense. Air ambulances can cost anywhere between $20,000 and $60,000 for transport. Anytime you can prevent that transportation, then that's going to save money. A lot of patients don't need a stay with a tertiary care hospital, especially with advances in telemedicine that they can be monitored quite adequately within the Frontier Extended Stay Clinic at least within that 24 to 48 hours before a decision is made about whether they truly need to be an inpatient or whether they need to be transferred. This hopefully would save costs.

I think it's also important to, again just in terms of maintaining that minimum safety net and also in terms of disaster preparedness from a regional perspective, in that if there is a regional disaster then the Frontier Extended Stay Clinics can extend that emergency response. In terms of the 48 hour observation, one of the other things that happens in rural/frontier communities, a lot of patients don't want to be transferred to the big city. Their family is in those communities, that's where their support is and that's a major disruption, not only for them, but for their entire family. Like I say, a lot of times that 48 hours is all you need to determine whether or not further care is needed.

The downside of the Frontier Extended Stay Clinic is that, as opposed to a Critical Access Hospital, is you don't have as much of a trained staff to handle emergencies, and I'm speaking specifically about the nurses and staff and physicians and mid-levels that respond to an emergency. If you have a major trauma or multiple traumas, you'll need to have everybody possible. The other big issue is that they have yet to make up their upfront costs. I think that there's some problems with how that whole system is looked at. One problem is that private insurance really doesn't know how to reimburse for services that are provided at a Frontier Extended Stay Clinic. I was talking to one of the physicians in Dutch Harbor, who had a major

trauma there and ended up keeping the patient for a 24-hour period because of weather, they were unable to transfer the patient. Yet, they were basically only able to charge at clinic level for services that were quite extensive, which would have paid much greater if they had an emergency room designation. I think too that when looking at the cost or the benefits of FESC, the studies really did not take into account the true cost of transportation, which is, for rural communities, I think is one of the major costs.

The other model that we're going to talk about is the Frontier Community Health Integration Project (FCHIP), which I'm really excited about. Basically, what this is, is the formation of a frontier ACO that utilizes the Critical Access Hospital as the base. One of the problems with providing services in rural and frontier communities with Critical Access Hospitals is that setting the cost of home health care, or palliative care, has an adverse affect on the cost report, so a lot of Critical Access Hospitals are not offering the services. Yet, they are the primary caregiver within these communities. Without that, these services are not even being provided.

Essentially, what a FCHIP would allow for is integrating all those services within a community under one, basically, Accountable Care Organization and using the pay for quality and census. One of the other issues as far as hospice and palliative care and home health care is that a lot of times these seem to be separate administrations and there again, there's just not the bench strength within a lot of these communities to allow for that.

On the other hand, the Accountable Care Organizations, which is a great idea, has some difficulties in rural areas because, for example, in Valdez, I think we have 400 Medicare beneficiaries. If I were to set up an ACO, I would need to attract quite a number of other small communities if we were going to be an actual rural Accountable Care Organization. You need about 15,000 beneficiary lives in order to have any kind of statistical significance in terms of quality.

One more thing about the FCHIP, I've tried to get the hospitals in Alaska to be interested, but there may be some issues relating to the way the FCHIPS were designed in that they have less utility for example in Alaska because we don't have counties per se. I know that the rural hospitals in Alaska have limited utility at the moment. Yet, I think it has great you potential for offering a greater variety of services within the rural communities.

In terms of key recommendations, we think that the Secretary should continue to promote the benefits of the Affordable Care Act and broaden health care reform. That includes raising awareness among rural providers about the provisions and the models that we think that the Affordable Care Act will actually benefit these rural health care. I think that in particular the value-based purchasing, the Critical Access Hospitals may actually do quite well as long as the criteria are ones that Critical Access Hospitals can achieve.

Part of that is that we need to make sure that providers are part of the discussion and realize that for the most part, many of them are overwhelmed and are working as hard as possible just to maintain the services that they have currently. And, recognize that he current system is

actually working fairly well. I think we said earlier that 19% of Critical Access Hospitals are having financial difficulty, but when this system went into place, it really did stabilize the hospital system within rural and frontier communities.

We think that the Secretary should work with Congress to continue the Frontier Extended Stay Clinic demonstration, or at least continue it in some form. We don't think that the Critical Access Hospital should necessarily be downgraded to Frontier Extended Stay Clinics, but rather that these could be used to bolster the emergency safety net within communities that don't have hospitals and may actually reduce cost overall, taking into account the cost of their transportation which I don't think has not been looked at adequately.

Finally, we think that we should consider the full range of cost and savings when we're evaluating the Frontier Extended Stay Clinics and the FCHIPs, and that looking at the overall cost, not only the air transportation, but what would have been the cost had they been admitted to a tertiary care hospital versus the cost if they had stayed within the Critical Access Hospital or the Frontier Extended Stay Clinics.

Kristine Sande
Thank you Dr. Cullen. Next up, I'll pass it over to our final speaker, Roger Wells.

Roger Wells
Thank you very much. My topic will be Rural Implications of the Center of Medicare and Medicaid Innovation. I sure want to thank you for the opportunity to inform these interested participants about our work and our findings, and to encourage you to look forward the initiation of new innovations as it's probably one of the most opportune topics that we can discuss this afternoon due to the "administrative authority" given to the Secretary. My discussion will cover the background of the program, the present status and our future goals with this program.

The Center for Medicare and Medicaid Innovation authorization is actually within the CMS and it's to test innovations in the payment and the services model. Of course, it is to reduce expenditures and preserve or enhance the quality of care, but they're also to address a defined population for which there are deficits of care leading to poor clinical outcomes or potentially, avoidable expenditures. To accomplish this goal we must first define the population. Of course, in rural America we have 20% of the population. In rural care, we have 30% of the dual eligibles, which are 15% of our Medicare and Medicare beneficiaries. These are in the rural area, which is our highest cost expenditures.

Also, the total cost of Medicare for the Critical Access Hospitals is 2% of the budget. So it's a double-edged sword, they're actually looking at us as a small token as how do you decrease a 2% budget to save money on a larger scale? Certainly, the larger scale areas of expenditures, were in the largest populations, directly proportional to the number of lawyers.

I believe we still have the most challenging population with the most elderly and the most morbidity and the least amount of specialists. Therefore, the challenges, much like our two previous speakers, to come up with innovations that will help us in the future and at the same time, be cost neutral or lesser. The big issue with that is to look at unique changes that we could look at with budget neutrality and it only applies to a continuation, or a formal option, for adoption of projects.

When I look at this and this small Committee, we look at it more in a focus of the rural population as being a continuum of care from the rural to the urban. The Innovation Center is able to modify Medicare and Medicaid programs without Congressional processes, as we spoke earlier, and it only needs Actuarial confirmation with direct implementation available if we can prove these products are actually cost effective.

It's very important to us to be in line with the research projects and to observe all the studies, even though there may or may not be rural implications, the potential benefits and/or deleterious effects that can occur. There's no restriction to the depth of any investigation or to the width of the area of the study. What we need to do is watch very closely, which the Committee has done with the initiation of these projects and continuing to do. Our promising early projects for the Center of Medicare and Medicaid Innovation is that actually 26 awards were some of them actually had a rural dimension.

The Federal Qualified Health Centers had an Advanced Primary Care Practice demonstration. This indicates at least a start in recognition of the rural community and an initial partial medical home type model. It identified teams of care and management of patient outcomes that were actually reimbursable, so what I'm saying is the management aspect was a reimbursable aspect to the cost support as an income for the participants.

The Advanced Payment Accountable Care Organization was open to the rural areas; however, because of the cap of $80 million and the limitations on available participants, Critical Access Hospitals have a hard time being an Accountable Care Organization. Now many communities are joining with larger institutions in what we call a Continuation of Care.

The Partnership for Patients is a transition program for hospitals engaged in networks and communication is one part of it, and the other part was a Community-based Care Transition program, which really had nothing to do with the Critical Access Hospitals, but the errors in reporting and reduced cost certainly could be in documentation for future.

The Health Care Innovation Challenges were $1 billion, and is broken down to $1-3 million projects for innovation models in health care and they do have rural implication. As we go through these, we are eventually going to be indicating some of these costs reflections, because we transfer patients to these advanced centers and will eventually receive some of these patients back who will be in these models and we may be ending up in some kind of a treatment program with them in the future.

With this tremendous opportunity, we have to be astute to what is happening in the rural communities, as well as what's happening in the Center for Medicare and Medicaid Innovation. We recommended to the Secretary direct this CMMI to offer preliminary advice to the rural facilities. Just as Dr. John Cullen demonstrated a little bit ago, we do not have the ability or the technical ability to write grants and/or innovation projects to the Innovation Center. And, certainly with some kind of advanced knowledge, or technical assistance, we would be doing much better. The application process just for a grant would take a tremendously astute person a number of months.

To the Secretary, direct the Center to extend the FQHC Primary Practice demonstrations to rural health clinics. As we stated before, it gets a better understanding to the impact and the feasibility of the program, and it's also because of the investment costs for IT, administration etc., qualified staff, it may be more restrictive than anyone thought, or it actually could be more beneficial in the final outcomes.

We also recommended that the Center for Medicare and Medicaid Innovations establish a group of rural advisors. Within the Center there are 200 advisors. These advisors represent finance specialists, insurance specialists, physicians, mid-levels, administration etc., nursing, and within this population, very few are within the rural community. As we discussed previously, the Advisors usually are from administrative models or are in large corporations, and again do not have that rural voice. A rural advisor program, at least in representing the percentage that we have within our community, 20%, would help us, as far as the insight to appropriate treatment and/or outcomes that may be intentional or unintentional with new programs and/or interventions that are placed into new models that would be reimbursable.

One of the key recommendations for the Center for Medicare and Medicaid Services has developed a specific evaluation and measurement incentive to encourage urban and rural collaboration, including a preference driven grant scoring. The issue with this is that when we started looking at the collaboration, which is now occurring, many areas, even one state is now offering two hospitals and 14 Rural Health Clinics and Critical Access Hospitals to join with a continuum without walls to be able to contact individuals, use and interact with their medical health information etc., and share their information freely, but with no patient contract, they're going to send each patient like an ACO.

They're trying to loosen up some of these activities. With the collaboration of the rural and the urban facilities starting to occur, our recommendation is, with grant writing to scoring, to actually look at these small community activities and see if we can prevent the duplication of services and identify successes and failures, rather than let a huge number of the workforce try to innovate themselves, we could actually come up and save billions of dollars by not having reproduction of inappropriate activity.

The Secretary also had evaluation of urban rural demonstrations on a systematic basis, so that the small increases in the rural cost may be offset by a wide improvement. In other words, the cost of the investigation per patient may be much higher in the initial resource allocation,

however, it may actually save costs at the urban level due to the reduced duplication of services and/or better transportation or information. Just like Dr. Cullen has talked about at Valdez, when they had observation in their intensive care unit being done by a larger facility, it has saved thousands of dollars in the transportation of a patient who may or may not need further intervention and just observation.

These same things cannot be tested, because if we send the patient off to a facility in an urban area, that person gains the population of a pneumonia or an MI etc., as a success. If the 92-year-old stays in our facility and passes away, that's in our facility scoring a higher loss. To use the system-wide improvement with the appropriate evaluation tools is very important because I think the integration of these two are already occurring and it's somewhat skewing some of the reports we've just recently seen.

Number six is finally the Secretary should direct CMS to review the Committee's 2001 recommendations that CMS buy in quality and cost, and set up payments for rural hospitals from actuarial projected savings of increased efficiency. These payments are from data represented outcomes based on rural-based performance. An ACS patient transferred, as we talked about earlier, to a rural center with PTCI etc., and salvage, is represented on a cost savings of one individual. Again, these cost savings are not reflected. Also, the quality and the cost of these incentive payments for rural hospitals, may actually show up as a high cost initially because of the administration utilization of new IT equipment, communication devices, webcams, etc. Actually, we may be saving money in the long run because of the decreased costs by better care to the patient.

In summary, the Center for Medicare and Medicaid Innovation is probably the bright spot. The dark shadow is we have not used it more effectively, and hopefully, the Secretary will look at some of our recommendations. Also, the utilization of our participants today looking at these models and contacting the Center, which we actually had the opportunity to speak to their director, and was very open to some of our issues and is looking at some of the modifications that may be able to be occurring because of our face-to-face meeting.

I think this is the bright spot in the day, that we have a huge amount of opportunity to step forward and say “You may want to cut us, but we could actually save you and show you better forms of integration models by utilizing appropriate transfer services, appropriate intervention of technology and interfacing, and appropriate communication systems that will already be in place, that are not available in urban community where we have large hospitals that are competing against each other.”

With that, I think I'll stop and ask Mr. Hirsh, thank you for allowing me to participate with this, to further conclude the question and answer aspect.

Kristine Sande
Thank you Roger. Before Steve talks a little bit about some of the future activities of the Committee, I'd like to remind folks that we'll have just a few minutes at the end for question

and answers. If you have a question, now would be a great time to go ahead and enter your question in that Q & A box down in the lower left-hand corner of your screen. Steve, I'll let you take it away.

Steve Hirsch
Thank you Kristine. I'll talk a little about what we've been doing this year. In 2013, the Committee has held one meeting that was a couple weeks ago in Grand Junction, Colorado. We looked at hospice and palliative care services in rural areas. We met at the hospice in Grand Junction. We're working on a policy brief that should be sent to the Secretary and be public by this summer. Later in the year, September we're going to be in Bozeman, Montana and we'll be looking at outreach enrollment efforts around the ACA, as well the Department's programs and how they intersect with rural poverty on the human services side.

The meetings of the Committee are always open to the public and they're always announced ahead of time in the Federal Register and on the Committee website. The committee will send these recommendations along to the Secretary, and these policy briefs and annual reports from recent years are posted on the website. Anyone is free to use the information there. It's public access, it's public information. There's a good deal of background information on the issues that the Committee has covered and a lot of statistics that you might not find elsewhere, so please feel free to take a look at the website. You can email me or call me here in Rockville if there are any questions.

Kristine feel free to go ahead now.

Question and answer
Kristine Sande
It looks like we do have one question. One of our guests is asking one of the members to please say more about the dangers about making any CAH reimbursement changes too hastily. Would someone like to address that?

Dr. John Cullen
I think that we've all talked about the big danger is that before the provisions of the Affordable Care Act actually come into play, which is going to take at least another two to four years before a lot of them are in place, if we make the changes to the CAH reimbursement we may end up losing a significant number of Critical Access Hospitals. That has enormous implications as far as the emergency safety net.

When a community loses its hospital, it takes a lot to get one back again. There's several reasons – one is just the loss of the infrastructure, most of time if you have a hospital shut down you can't just restart it. There are a lot of changes that occur as a result of that. In addition, the trained staff is something else that's absolutely critical. That includes physicians, the nurses, administrators – it's a whole group who, obviously if there is closure of a Critical Access Hospital, they're going to go elsewhere. What I've seen, at least within my experience as being a rural physician, is that once you leave there, you don't get it back. The example in

Glennallen was a unique one, where they developed the Frontier Extended Stay Clinic after losing their hospital, but it's been a rough road. This has been something that's been going on since 1994.

Roger Wells
I'd like to add to that also. Many of the hospitals are now switching to inpatient-based to outpatient-based. When you start looking at the cost for a hospital, no one's looked at outpatient benefits services as a benefit. There's no information about the benefit to the outpatient services for physicians coming in, especially clinics from long distances rather than patients traveling back and forth, and the utilization of these services to enhance health care and if that's beneficial or not in the global sense.

I think as we look forward with changing our status right away, we may not be called Critical Access Hospital, but Critical Access Centers where we're actually preserved by using information from the Community Needs Assessment. We'll make modifications according to the needs of the community. Until that's sifted out, I think it's dangerous to try to make recommendations, or what's good and bad for us, because we're all sitting in that teeter-totter wondering what to do. The best is to do nothing, but become a very good planners as far as being good with our communication, our interventions by being able to transfer, and using our best healthcare team model that we can come up with locally with our services and care, especially our higher end cost patients.

Kristine Sande
Thanks. We have another question. Rebecca asks do you have any specific plans at this time to help educate folks on the rural health care system in terms of the reform and redesigned that was discussed? If you'd like to do a webinar with health networks about the topic, it's Rebecca Davis at NCHN and she'd be happy to set one up. What are your specific plans in terms of educating folks on the reform and redesigned?

Steve Hirsch:
I can say that we make these reports available and everyone on the call should please feel free to distribute the information that's available on the website as widely as you can if you think it's useful for people to know. You can also communicate with us here. Committee members sometimes can go out and speak to groups. We don't have a travel budget that allows us to help with the cost of traveling, but if they're interested and they are able to, they can go out and do presentations.

Roger Wells:
I think the other issue is that we're trying to break down the ACA into parts, rather than to take on a whole specific aspect. Our next meeting is in Bozeman, Montana where we look at the intervention of the navigator and how it's affecting the health care, either successfully or unsuccessfully, and see how that's responding. I think to the global issue, or probably not well represented, on specific issues where we've developed white papers in the highest area of need, I think we can do a fairly good job by these webinars. Also, by input from other

individuals saying I need help with this, actually helps us with our agenda and picking the agenda looking forward.

Steve Hirsch:
That's true and we welcome input on issues that the Committee should look at as well.

Dr. John Cullen:
I do think that it is going to be a challenge though. We're going to have to talk loudly and often about this. As I said, a lot of the healthcare providers are just working as hard as they can just to take care of the patients and really don't have a lot of extra time to be investigating a lot of these new options. It's like the story about the guy standing by the river and seeing people float by and he sees somebody floating in the water so he dives in, saves him, pulls him out over the water, and looks up and there's somebody else floating down the river, he dives in and saves him, too. He's so busy jumping in the river and pulling people out that he doesn't have time to find out who's pushing people up in the river upstream.

I think we really do have to work on the education component because a lot of, especially rural providers, just don't have the extra time in order to be looking at this. It's unfortunate, but I think that's the way it is. I do a lot of education within the American Academy of Family Physicians and these are all topics that we've been talking about intensively for the last few years and yet, most of our members, I think, are still very unsure what it is that these provisions will entail.

Kristine Sande
One last question. Can you say more about the ability to build population management learned through the APCP demonstration project? Is anyone familiar with that? The Advanced Primary Care Program?

Roger Wells
Steve that was mine. Excuse me that was billable services – according to the guidelines that we reviewed. There were billable services actually available for Medicare recipients who were being managed in the FQHC model programs that were involved in the programs only, not on every FQHC, but just in the model programs.

Kristine Sande
Thank you. It looks like we're out of time. That brings us to the close of the webinar. On behalf of the Rural Assistance Center, I'd like to thank our speakers today from the National Advisory Committee. This was a great update on your work and some important issues. I'd also like to thank our participants for joining us. Please note that a survey should open on your screen as you exit the webinar today. We encourage you to complete the survey and to provide us that feedback we can use for future webinars.

Once again, the slides from the webinar are currently available at www.raconline.org/webinars. In addition, a recording and a transcript of today's webinar will be made available on the RAC

website and also sent to you by email in the near future. The survey link will also be included in that email for anyone who was not able to complete the survey today. Thanks again for joining us and have a great day.