Kristine Sande: All right, I think we'll get started. Thank you everyone for joining us today. I am Kristine Sande and I'm the director of the Rural Assistance Center. And I'd like to welcome you to today's webinar, a health update from the National Advisory Committee on Rural Health and Human Services. And I know that you're all eager to hear from our speakers today, so I'm just going to quickly run through some housekeeping items and then we'll get to their presentations.

We hope to have time for any questions at the end of today's webinar. If you do have questions for our presenters, please submit those towards the end of the webinar and you can use the Q&A section of the screen that's directly beneath the slides. We have provided a PDF copy of the presentation on the RAC website. And that's accessible either through the URL you see on your screen, or by going to the RAC webinar page, which is www.RAConline.org/webinars and then you can click into today's presentation. One warning, I guess, if you do decide to go and download those slides during the webinar today, please don't close this webinar window or you'd have to log back in. If you have technical issues please contact our support area using the phone number that's listed on the information screen. And if you're not seeing that screen, the number is 701-777-6305. Once again, for technical issues, the number is 701-777-6305.

And we've got a great slate of speakers today who will discuss the recent work of the National Advisory Committee on Rural Health and Human Services, including 3 recent policy briefs related to rural health care. And since the passage of the Affordable Care Act the committee has focused a great deal of its work on the implementation of ACA and what that means for rural America. The committee will discuss 2 briefs that cover enrollment in and pricing of insurance plans and premiums for rural populations on the 2014 health insurance marketplaces. And the 3rd brief they'll be discussing is about the provision of hospice to the rural population.

Our first speaker today will be Ronnie Musgrove, who serves as the chair of the National Advisory Committee and has been so since 2010. He previously served as the governor of Mississippi from 2000 to 2004, serving as the Lieutenant Governor prior to that. For more than 2 decades, he's taken a leading role in the state of Mississippi to improve education and to expand economic development. During his tenure as governor of Mississippi he helped create more than 52,000 new jobs, brought more than 14 billion dollars in new investments to the state, invested in creating rural jobs and brought Nissan to Mississippi, which was the largest economic development project in the state's history. He

also passed historic education funding reforms. Governor Musgrove will give us an introduction to the work of the National Advisory Committee.

And following Governor Musgrove we'll hear from Steve Hirsch, a long-time staff member of the Federal Office of Rural Health Policy, who served as Executive Secretary of the National Advisory Committee. And our next speaker is a current member of the National Advisory Committee. Christy Whitney is the founding president and CEO of Hospice and Palliative Care of Hope West, which is the hospice in Grand Junction, Colorado. Hope West provides comprehensive hospice and palliative care and grief related services to over 7,000 square miles, which has a population of 170,000 in western Colorado, through 4 sites.

So, now we'll hear from our first presenter, Governor Musgrove.

Ronnie Musgrove: Thank you Kristine, it's a pleasure to be with you all. Excuse my voice, I have had some of the same crud that people from all over the country, especially the upper northeast has had. But it's a pleasure to be with you. Today's webinar is one of a series that will review the policy brief that the media is preparing and sent to the secretaries in the last 2 years. The reason the committee has focused on the Affordable Care Act is to make sure that the rural population can accept the benefits of the act. Some of prior briefs and policies with ACA policies on primary care, provisions effecting the rural anomaly and reducing the health disparities in rural America. And technically, as Kristine said, there'd be 3 health care policy briefs discussed today.

Rural implications of the Affordable Care Act outreach, education and enrollment, Affordable Care Act plans and premiums in rural America, and rural implications of changes to the Medicare Hospice benefit. All 3 briefs cover important aspects of bringing healthcare to the rural U.S. We've just finished the second enrollment period for healthcare coverage on the health insurance marketplaces. The committee wanted to ensure that rural people would be able to accept the marketplaces and that the coverage offered there would include their local providers so that they wouldn't be expected to have to travel long distances to get care. The brief on hospices describes the challenges of providing in the black care in areas where the population is low and spread out over a great area.

Next week, we will cover the Human Services brief the committee had sent the secretary and I invite you to join us then as well. And of course all of the briefs are available on the Committee's website. And again, I thank you for joining us today, I think you will hear 2 great presentations and I hope you'll leave or walk away with the idea of being a little bit

more informed on the things that RAC has been doing. Thank you very much.

Kristine Sande: Thank you Governor Musgrove. And I'd like to just remind everyone that you'll be able to submit questions through the Q&A box on your screens towards the end of the webinar and we'll address those questions once everybody has presented.

Next, Steve Hirsch will tell us some more about the committees work, specifically around the health insurance marketplace. Steve?

Steve Hirsch: Thanks Kristine. First I'd like to talk a little bit about what the National Advisory Committee is, it's an independent advisory board to the Department of Health and Human Services on a broad range of issues including, the provision of healthcare in rural areas and the availability of human services in rural areas, as well. So, it's an independent voice, which means it's made up of members from outside the government, who are not government employees. They bring a wealth of expertise in all sorts of different areas. We're very fortunate to have Christy Whitney on this webinar, she runs a hospice that covers a broad area in western Colorado, including really frontier areas beyond even the usual rural areas. The committee works by providing either annual reports or policy briefs to the secretary on key rural issues. In the past 4 years we've sent 18 policy briefs to the secretary, including recommendations on policy and regulatory matters, where changes would improve provision of services in rural areas. The committee was established in 1987 by the secretary of Health and Human Services and originally it covered rural health. In 2002 Secretary Thompson expanded the focus to include human services and Governor Musgrove joined the committee in 2010 as the chair and has been with us ever since. We usually meet in the fall and spring. We hear presentations from national- and state-level experts on the selected topics and we also do field visits out to rural areas surrounding the meeting site. The last 4 meetings have covered a good large portion of the country, Grand Junction, Colorado, where we visited Christy's hospice. We went out to Bozeman, Montana, Omaha, and Two Falls, South Dakota was the latest. And later on I'll mention where the next committee meeting will be held in case anybody wants to come participate. Rural challenges, rural America has almost 20% of the total population of the country, but has about 10% of the nation's physicians. And the physician shortage is especially acute for specialists. Specialists tend to practice far more in urban areas, than they do in rural areas. Meanwhile, the rural population has higher rates of chronic illness and poor overall health and unfortunately the uninsured rate is higher in non-metro counties than it is in metropolitan counties. And because of, one of

the reasons that the committee chose to particularly look at the health insurance marketplaces was because of the high uninsured rate and wanting to be sure that people in rural areas would be able to access health insurance coverage through the marketplaces. So these are the titles of the 3 briefs we're going to cover today, and I'll start with the one Rural Implications of the Affordable Care Act Outreach, Education and Enrollment.

As I just pointed out, rural residents are more likely to be uninsured, 18% of the non-metro residents were uninsured, compared to 15%. Obviously these are figures that come from before the opening of the health insurance marketplaces in late 2013 and the beginning of coverage, beginning in 2014. Though as population density and proximity to an urban area decreases, as you get further and further away from the urban areas, the uninsurance rate tended to increase. Obviously, outreach and enrollment activities are more difficult in rural areas because the uninsured are spread over a larger geographic area, it's harder to reach all of them. So the committee chose to look at this in their meeting in Omaha, Nebraska. They wanted to be sure that the, excuse me, this was actually the Bozeman, Montana meeting. We wanted to be sure that there would be effective outreach and enrollment activities going on in rural areas.

Because there are 3 types of marketplaces, there's not a national marketplace, there are state-based marketplaces, which states run. There are the federally, the facilitated marketplaces that are operated by the department. And then there are several state partnership marketplaces that are joint partnerships between the feds and the state governments. So you can see the numbers, 14 state-based marketplaces and partnerships, and there are 27 states where the federal government is running the marketplace for the state. In states where the department is running the marketplaces, that represent, those states, those 27 states, represent a large portion of the uninsured population, in fact, about 2/3 of the uninsured population in the country. In the state-based marketplaces, however, those states received a great deal, or a good deal more funding, to do outreach and enrollment activities, than the states where the federal government was running the marketplaces.

So, HHS made 67 million dollars in grants for navigators to assist their population in enrolling through the marketplaces. The department also awarded 150 million dollars in health outreach and enrollment assistance awards. And we also made, through the office of Rural Health Policy, 1.3 million dollars in supplemental awards to 52 rural health organizations to do outreach, specifically focused on rural areas. USDA also participated in

setting up a cooperative extension service of educators in the 12 federally facilitated marketplace states, to help them uninsured. I'd like to say, one of the visits we made in Montana was to a community health center that had received one of the outreach awards to do rural enrollment activities. So, reaching rural uninsured, the key recommendation the committee came back from the meetings in Bozeman and made to the secretary were, was to be sure to target all the subsequent all the outreach enrollment and education efforts. Learn from what was done in the first period, from the 2013 through the end of the, in 2014, of the enrollment period. The feeling of people that we heard from directly, who were directly involved in Montana in doing outreach to the rural communities, was that mass campaigns through the direct mail, phone calls, state-wide media, those aren't effective in reaching rural people. Rural stakeholders emphasized the importance of trust and personal relationships. Hearing directly from someone they trust, such as their position, someone in the school system, someone in their church, who can either assist them or direct them to someone who can help in enrolling. That is a much more effective way of reaching people in rural areas than through mass market kind of campaign.

The committee believes that it's critical to develop a strong base-line assessment of how marketplace enrollment went in the first year and examine enrollment data and analysis by geographic location. And actually we recently got some analysis of enrollment last period, for the 2014 year, only through the federally facilitated marketplaces and some of the partnership marketplaces. It was about 18% of the enrollees came from rural areas and 82%, obviously, were from the urban zip codes. That's pretty close to the level, to how the population is distributed between urban and rural areas. So that's not bad, you know, however, there are, as we said, the uninsured are concentrated in the states that have state-based marketplaces.

One of the other key recommendations was that the rural hospitals be aware, when non-profit hospitals are reporting on the IRS form 990, something that they have to do to maintain their non-profit status, that doing outreach and enrollment activities to help uninsured people in their market area become enrolled is something they can declare as a community benefit. And this was a proposed rule at the time that the committee made its recommendation, and since then the IRS rule has been made permanent. So, this is something that rural hospitals can do and can use as a community benefit declaration on their form 990. So if you are in a rural hospital, your local rural hospital could, should be aware of this, if they're not, so they can both engage in outreach and

enrollment activities and declare it on the IRS form. We also advised the secretary that they, the committee advisory panel that advises CMS on outreach and education, should track how rural enrollment is going and to look for what the effective strategies are in rural areas.

On to our, this is our meeting in Omaha, Nebraska, where we met with insurers and went out to rural hospitals to hear how things were going. This meeting took place in 2014, people had already received insurance under the ACA and so we were able to hear a little bit about how things were going. One of the things the committee wanted to be sure is that network adequacy, that means, were local providers included in healthcare networks that were covered by the plans available on the health insurance marketplace. Rural residents have historically-based barriers to accessing providers and private health insurance options. We heard a lot from RUPRI, the Rural Policy Research Institute, they gave us some preliminary findings and I'll mention those. The RUPRI found that there were 4 important factors on how premiums were priced on the marketplace. Rating area design, what area the plans will cover, the medal level of the plan, obviously there are bronze, silver, gold plans, effective age, family status and tobacco use, and the cost of the, the cost of living in the rating area had an important influence on how much the premiums cost.

So states, when they were setting up their plans, or making regulations on their plans, could choose essentially 4 ways of designing rating areas, using whole counties, using zip code areas, using MSAs, and non-, that's metropolitan areas and non-metropolitan areas, or some combination of them. This table shows how the different states set their rating areas up. Some states only had one statewide rating area, like Delaware, Hawaii, New Hampshire, New Jersey, Rhode Island, Vermont. And then there were a bunch of different ways of doing it, you can see, groups of counties, zip code areas. There were 3 states that allowed every county to be its own rating area. And then there were a bunch of states that had the MSAs plus, metropolitan areas plus one area for all the non-metropolitan areas in the state.

RUPRI tried to analyze how this effected, how rurality effected the setting of premiums and found that states that had a small total population, but a large amount of that population who lived in rural areas tended to have higher premiums than other states. It doesn't look like a big deal but it's about $22 on average higher in the more rural states versus the least rural states and that's per month for the premiums. So the way the rating areas were designed definitely seemed to have an impact on how the premiums were set. And the states that used individual counties saw

higher premiums than states that had either multiple counties or used zip codes or MSAs non-MSAs. Smaller rating areas with the resulting lack of competition, could be linked to higher insurance areas, rates. So having a larger area rather than a smaller area, allowed, brought premiums down it seems. The committee recommended that the secretary educates states on what rating area design, how that could affect premium pricing. And recommended that the secretary make sure that rural health clinics were included as essential community providers. And finally, recommended that the secretary evaluate all marketplace data by rurality and then provide hospitals and other health care providers with maximum flexibility to conduct outreach and enrollment.

I want to point out that since we had the meeting that was in April, 2014, RUPRI has issued several policy briefs on health insurance in the marketplaces in rural areas. I'll mention a couple of them that are up on the RUPRI website. One's a guide to understanding variations in premiums in rural health care marketplaces and another is geographic variation in premiums in health insurance marketplaces. They've done more detailed work than they could present at the time, they had more data and they had, by that time the enrollment had been complete for a while. So, there's a little more detail there if you want to pursue looking at how premiums might differ between urban and rural areas.

And I should also mention that we, the committee suggestion about rural health clinics was implemented for the 2016 marketplace insurance plan year a medicare certified rural health clinic. Now it is included in the non-exhaustive essential community provider lists, if it meets 2 requirements, first based on acceptation, essentially rural health clinics says it accepts patients regardless of the ability to pay and offers a sliding fee schedule. Or, its located in a primary care health professional shortage area, and for those of you who know the ins and outs of HIPSAs, it can be a geographic population, or automatic HIPSA, primary care HIPSA. And the rural health clinic accepts patients regardless of coverage source, which means Medicare, Medicaid, CHIP marketplace plan, etc. And that actually there are more than 3,300 rural health clinics that currently meet those requirements and so will be included on the 2016 list of essential community providers. If you're at an RHC and you're not sure or you're not on the list, you can seek to be added to the list, so I would start probably by contacting your state office of rural health or the National Association of Rural Health Clinics and asking how to be added to the list.

Now, that brings to a close, my part of it and now I'd like to turn it over to Christy Whitney to talk about the brief on Medicare hospice benefits.

Christy Whitney: Good afternoon. Can everybody hear me okay? Hello?

Steve Hirsch: Yeah, we can hear you.

Christy Whitney: Okay, good, all right, great.

Well, as you see on the slides, we focused one of our meetings on hospice and particularly rural issues here in Grand Junction. And we heard testimony from people who ran really almost frontier hospices as well as some mixed urban, not urban, but mixed rural and MSA metropolitan areas, as well as some highly frontier areas that were visited aware that there was only a rural health clinic an hour away from any hospital. So, I think the committee had a good overview of some of the rural issues and some of the challenges that happen with hospice in the rural area.

But just to give you a background about the Medicare hospice benefit I wanted to start by talking about the fact that in 1983, the hospice benefit really came as one of the rare changes to Medicare beneficiaries in terms of their coverage. For hospice care that really, in the United States, evolved in the 70s as an all-volunteer kind of a movement, social reform movement that really was dedicated to this notion of a comprehensive set of services delivered by an interdisciplinary team that looked at the whole person, as well as the needs of the needs of the family, as well as the patient. And those central tenets as well as the tenet of volunteerism was really brought forward into the integration into the healthcare system as a formal benefit. The number of hospices in 1983 was about 200, today we have, I think, almost over 4,000. The number of beneficiaries choosing hospice care has increased dramatically over the years. And the Medicare hospice spending has doubled since the year 2000.

One thing I might mention is that hospice is a comprehensive benefit, much like a Medicare advantage plan where a pace model, where there is one payment for a beneficiaries for their day of service by a hospice, and that payment should be all inclusive of all of their needs related to their terminal illness. Anything that's not considered part of the terminal illness, would be covered under regular Medicare. And that kind of gives an idea of how the money flows, so not only are hospices paying for people, they're paying for drugs or equipment and tests and chemotherapy, radiation and in some cases IV therapy, blood transfusions, those kinds of things. So as it's grown the spending has increased as well, 14.7 billion, and so what started as a little bit of budget, the hospice benefit has grown to be significant. The increase in

hospice spending reflects both the higher number of beneficiaries as well as more cost per enrollee, and those, more cost per enrollee, really reflect the, I think, the development of hospice in-patient facilities across the United States, where a hospice would receive $650 a day for the care of that patient in a bed that would be considered as a substitution for a hospitalization level of care. And even though it's quite a difference in cost savings to Medicare over a hospital day, that growth has been substantial in the sector of hospice. Hospices are paid for 4 levels of care based on where the patient resides, if they're at home or a nursing home or assisted living facility, they are in what's called routine home care, which is approximately $150 to $160 a day. And if they're in an in-patient facility for in-patient general acute care, whether it be a hospital or nursing home or hospice facility those levels of care are paid at $650. Respite care on an in-patient basis is paid about the same as routine health care. And then there's an hourly payment for staff who are in a home or residence for more than 8 hours.

So the [inaudible 00:00:00] hospice, they have a couple of provision pertaining to hospice, one is the expansion of the quality of reporting requirements to the hospice industry, the second was that beneficiaries have a face-to-face visit with the hospice physician or a nurse practitioner, prior to re certification for a third benefit period or any subsequent period. And that means, if somebody's in hospice a period of 180 days or longer, every 60 days they would receive a face-to-face, in person visit, from a physician and or nurse practitioner, however, even with a nurse practitioner there has got to be sort of a sign-off for eligibility for, that a patient still has a 6 month prognosis. So that has a significant impact on hospices, particularly rural hospices that have, are in sufficient shortage areas, certainly aren't large enough to be employing physicians. It's one thing to have a volunteer come to your team meeting once a week but something else to ask the physician on a volunteer basis to go out and certify your patients. So, that's been a very difficult provision for rural hospices. It also offers CMS to design a Medicare hospice concurrent care demonstration program which is still in process, I hear rumor that they may be rewarding those contractors in the next few months. So hopefully that will come along. And so there were other provisions that really focused on, that really required CMS to take a focus on long lists of patients in hospice that also has impacted hospices quite a bit across the country in terms of prepayment reviews and the implementation of those reviews taking a number of years and tying up the resources that small, quite independent rural hospices have been particularly hit by the cash impact of that, and some of the struggles around when to pay.

The rural hospices, a good percentage of Medicare receivers elected hospice, 45% across the country and you can see that the rural patients are a lesser percent but that there is a great presence of hospice in rural areas even though there are challenges to maintaining that. The number of hospices in urban areas is growing as the number hospices in rural areas are declining. One of the things that you see is that the more regulations, the more complexity in implementing regulations that occurs, there's less and less resources in rural areas to really be able to comply with that, including some of the technology that is required to comply with data submission, etc. It's just going to be difficult for small rural, particularly independent providers, they have the infrastructure to meet those expectations. So what you see is, really a decline of those providers and you don't see any growth in terms of new providers. There are still many frontier and rural areas across America that don't have access to hospice services. And it's quite limited in any place that has a population, I would say of less than 25,000 people.

The ownership you can see on the slides, it has in the margins, from a policy perspective there has been quite, it would be understated to say quite a lot of angst, around the for-profit profit margins, you can see the non-profits do not have the same kind of profit margins. And I think as the regulations are implemented to try to do something about those, what they feel are extraordinary margins in the privately held or Wall Street traded sector of the hospice industry, I fear that the unintended consequences may be a disappearing line of non-profit hospices. And every report we see, the shift, the last report I saw, which is not in the MedPAC report, was that 70% of the hospices in the U.S. now are privately held or traded on Wall Street, only 30% are left non-profit. So this is, I think a disturbing trend that we see as most of the rural hospices are non-profit hospices. The margins actually are difficult, sometimes the rural areas have the problems that are part of hospital-based services, and so sometimes those financial margins that are reported are actually not as easy to define as a free-standing hospices.

There's also quite a big shift, a big differentiation between what hospices in rural areas are paid versus hospitals. In policy we have given a lot of protections to rural hospitals and clinics and thoroughly qualified health centers. Those same protections don't exist for hospice. There's provisions for reclassification for wage index for hospitals, there's not such a thing for a hospice. And so that same wage index that we see with some hospitals that are within the borders of far away from the next closest area, has a very similar cost in terms of personnel, etc. But the wage index doesn't really reflect that. And so, they have a provision for

applying to be classified, those kinds of provisions don't really exist for hospice and that has been a challenge, I think, for rural hospices. People in rural areas are more likely to receive their care in homes than urban patients, care provided patient's homes may need a greater number of visits, with longer travel time and certainly we see that travel time to patients can be upward of an hour. My urban counterparts would say that sometime traffic in D.C. will be for 7 miles an hour, but certainly the long distances that are prevalent everyday in the work of hospices in rural areas are significant. And many rural hospice patients receive really one level of care and that is routine health care. They don't really have an option for continuous care, because small hospices have a very difficult time staffing that continuous care and they may not have an in-patient facility option. So those are some of the big issues that have been facing rural providers.

I might just add that some of the increasing burdens, even in our program that we have, in our model, we centralize the hospice in a very small MSA and then really took that hospice program to areas as far away as an hour and a 1/2, with smaller populations. But we're seeing that the cost to expand that into some frontier areas, just is not sustainable, in fact, we estimate that it would cost us more money to actually implement the Medicare benefit, than it would be to provide free services and raise the entire budget from philanthropy. That's a very unusual thing to be saying after 35 years of running a hospice program, but we're in a place where small providers, without any protection from a policy perspective, are going to be pushed, I think, to not offer the hospice Medicare benefit at all, which is true in Rio Blanco County where we have an office where we simply do hospice and raise the budget without being Medicare certified. It will be true for places that are of that size, that cannot sustain the overhead and infrastructure, nor do they have the broadband required to operate some of the electronic health records and data submission required.

So some of the key recommendations of the committee that we talked about was first to acknowledge that we have a physician shortage across this country in rural areas and that the regulations that were written for hospice don't really reflect the reality that there may not be a physician in the community of the hospice. And that the burden to have face-to-face visits and to not be able to bill for hospice services is difficult for rural hospices. So we asked for expansion to allow for physician assistants and nurse practitioners to furnish and bill for hospice services. Just for an example, because of our physician shortage and qualified practitioners, we have a physician's assistant working 3 days a week in our in-patient

unit instead of a physician. The physician's visits we're able to bill for and be paid, but the physician's assistants visits to our patients we're unable to bill for. And that is a through a specific regulation that articulates that the hospice may not bill for a physician assistant.

So the second is a recommendation which allow telehealth consultations, we believe if we had telehealth operating at good capacity that we would be able to do a good job of fulfilling the face-to-face requirements, but that it would be able to be done telephonically with some video of the patient. And allow for a physician, just as you would have a physician serve 2 health clinics at the same time through telemedicine, that we could really expand the reach of our physicians work by allowing for more telehealth coverage. And then the third recommendation was that we look at greater flexibility in the cost reporting for cause because in rural areas there's almost always a critical access hospital as a partner of the hospice. Yet, they are punished financially, every time that they have a patient in the hospital as a hospice patient, or a general in-patient, care patient, level of care, which CER discourages the use of the hospice level of care and that often leads to discharging a patient from hospice to let them go into the hospital and be cared for, so that is a recommendation that we had. And then the last recommendation really was to take a look at what some of the, there’s a lot of assumptions in the wage index methodology of assigning payment that doesn't really allow for the amount of clinician time that is not in front of the patient and is simply windshield time. So those are some of the recommendations that we came up with.

Kristine Sande: All right, thank you very much Christy that was very interesting. Steve did you want to talk about the upcoming meeting?

Steve Hirsch: Sure, I'd love to.

Kristine Sande: Great.

Steve Hirsch: Blaine, Kentucky, that's April 29th through May 1st in 2015. If you're in the neighborhood and you'd like to drop in, it'll start about 9 am on April 29th, which is a Wednesday. And the topic this time is really sort of a broad one in the differential between life expectancy and mortality in rural versus urban areas. I'll mention that we've been looking at what's happening with mortality and life expectancy and are seeing the fact that where rural areas used to have life expectancy that was about the same or even slightly better than urban areas, that has not proven to be true in the last several decades, it's begun to change and the urban areas are pulling ahead in life expectancy. And we're even seeing life expectancy go

down in some non-metro counties across the country. So that will be the topic for the next meeting. Why is that happening and what can be done about it? This is just, you know the briefs which you can find on the next, I believe, slide, has the address for the committee's website, includes recommendations, include a lot of background information and a lot of the data you heard today on these issues as well as many others. As I said, since 2010, when Governor Musgrove became the chairman, the committee has concentrated on the Affordable Care Act. We have done other topics but there's been a lot of concentration on Affordable Care Act. To make sure that rural people are able to access care. So you can find those publications at the website. If you any questions that we don't handle today, you can feel free to contact me at my office here and through email or phone. And Kristine I'll throw it back to you.

Kristine Sande: Great, thanks so much. Now we'll open it up for questions, you can submit any questions you have in the Q&A tab that's right below the slides. And it looks like we do have one question already and it looks like it relates to outreach and enrollment. So Steve, this is probably yours. So the question is. Aren't governmental agencies forbidden to help enroll? We are a city-owned hospital and were told we cannot participate in helping our community members enroll. There was an external agency that came through town, but it was an unknown which is contrary to the trust factor, that you talked about Steve. Can you speak to that?

Steve Hirsch: That's not what I believe is true. Unless there's some sort of local rule or regulation, and as I said, for non-profit hospitals they're able to do outreach and enrollment activities and use that as part of their community benefit report for the IRS. As far as I know, no there's no federal rule that I know of that would prohibit any hospital from doing outreach and enrollment activities and certainly over the years, many, many hospitals have tried to help people enroll in Medicaid or CHIP to make sure that they're covered in some way.

Kristine Sande: All right. Thanks Steve. All right and the next question looks like it pertains to the hospice portion of the presentation. And the question is, does the expanding the scope of nurse practitioners and physicians assistants have any effect on the quality of care?

Christy Whitney: I'm going to say yes, but then that would be a whole other webinar. I think that, I actually just had quite a conversation about prescribing ability for nurses that's quite at stake in the state of Colorado, and I'm sure there's a corridor where you could cross over and you might impact, you might lose a quality of care, certainly. But I think there's a lack of understanding of the education that these practitioners undergo, the

level of expertise they have and the results of the states who have expanded some of the scope of their practice. That they've had no incidents. I think that every state has some control over their practice, day to day, with prescribing authority and other requirements. But certainly for these particular things, that's really whether a patient is maintaining a status, a physical status. Whether is recertifying patients for hospice or actually providing physician's orders. Our practitioners are certified in palliative medicine and oncology. They have quite a level of ability, I would say, beyond the normal practitioner, to serve our patients more remarkably than some primary care physicians. So I think it's dependent and because these practitioners can be billed outside of hospice, physician offices bill their nurse practitioner every day. The oncology clinic bills their physician assistant every day. But because the patients are in a hospice facility, those people can't be billed is not quite equitable.

Steve Hirsch: Can I add one thing? Just in general, the quality of care provided by nurse practitioners and physician's assistants is rated quite highly by patients, at least as highly as physicians, I believe. We're talking about, pretty much, with the exception of hospice here, about primary care, and providing primary care, PAs and NPs do a really good job.

Kristine Sande: Thank you. It doesn't look like we have any other questions right now. So if folks listening have questions, now's the time to get those entered. And in the meantime, I will just give a quick plug for the webinar we're having next week on the human services work of this same committee, the National Advisory Committee. And that webinar is on Thursday, February 26th at 1 pm central. So same time as today. And you can register for that on the RAC website. All right, so it looks like we did get one more question here. And the question is, for the uninsured outreach program, my organization helps with insurance and healthcare education and assists a home-based organization not in rural. Can the church apply for the benefit program grant and can I partner with the church to help with the program?

Steve Hirsch: If you're talking about the rural grants, I believe those are finished and complete. Those were awarded before the initial enrollment period in 2013. So, as for the other grants, I'm actually not sure whether there's ongoing new awards happening.

Kristine Sande: All right, thank you. One other question. Let's see, it looks like it's probably also related to the hospice. Will expanding telehealth send a message to lawmakers that bricks and mortar facilities such as critical

access hospitals are less necessary? I've heard some scuttle that rural physicians are worried about this. So, either Steve or Christy.

Steve Hirsch: Oh, this is a great question, because our next policy brief is on telehealth in rural areas. It will probably be out within about 3 weeks on the website, give it a month on the safe side. But our last meeting was in Sioux Falls, South Dakota, that was back in September 2014. And we visited several sites to see how telehealth worked there. And I would say no, it doesn't mean that you can get rid of bricks and mortar, it means that using the facilities that are available in rural areas, that people there can access other care that may not be immediately available in their area.

Kristine Sande: All right. Thanks Steve.

Steve Hirsch: Okay. Thanks.

Kristine Sande: All right, I'm not seeing any other questions right now. I guess we can go ahead and wrap up. On behalf of the Rural Assistance Center I'd just like to thank our speakers for the great information that you shared with us today, as well as, thank you to our participants for joining us. I'd like to draw your attention to the fact that a survey will be emailed to all the participants following the webinar. And we hope that you'll complete that survey to provide us with feedback that we can use in hosting future webinars. Once again, the slides used in today's webinar are currently available and can be accessed at www.RAConline.org/webinar. In addition, a recording and a transcript of today's webinar will be made available on the RAC website and that will be sent to you by email in the near future, so that you can listen again and you can also share this presentation with your colleagues. So, thanks everybody for joining us and have a great day.