Frontier Community Health Integration Demonstration Program: Alaska White Paper

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Alaska Office of Rural Health, Division of Public Health, Department of Health and Social Services

Alaska State Hospital and Nursing Home Association

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This Alaska White Paper represents the input and opinions of chief executive officers and chief finance officers from Alaska Critical Access Hospitals (CAH) that are eligible to participate in the CMS Frontier Community Health Integration Demonstration Program (F-CHIP). Through this AK White Paper, they have provided feedback on the F-CHIP authorizing language. They also provided comments on Montana's F-CHIP White Papers which proposed criteria and recommendations for implementation of the CMS F-CHIP demonstration. Many of the MT recommendations are acceptable to AK CAHs; however, there are additional recommendations presented in this White Paper that support AK's unique needs. The AK F-CHIP eligible hospitals' White Paper is provided to assure that the demonstration project will be workable in Alaska as well as Montana, Wyoming and North Dakota.

Hospital representatives provided input through conference calls, facilitated discussions, surveys and emails. Also contributing to the process were: Alaska State Hospital and Nursing Home Association, Alaska Department of Health and Social Services, Montana Health Research and Education Foundation, ACS Xerox, Health Resources and Services Administration- Office of Rural Health Policy, Center for Medicare and Medicaid Services-Center for Medicare and Medicaid Innovation, and Montana Critical Access Hospitals.

I. Executive Summary

The Frontier Community Health Integration Demonstration (F-CHIP) is authorized under Section 330A of the Public Health Service Act and guided by Section 123 of the Medicare Improvements to Patients and Providers Act (MIPPA). Its purpose is to develop and test new models for the delivery of health care services in frontier areas through improving access to, and better integration of, the delivery of health care to Medicare beneficiaries through a three year CMS demonstration project.

The F-CHIP endeavor developed in Montana, guided by the experience of Montana's smallest Critical Access Hospitals. Montana created a framework document and six White Papers. Alaska, Wyoming and North Dakota are also eligible for participation and each state was invited to submit responses to these papers or develop their own papers. Alaska's F-CHIP White Paper focuses on the seven Alaska Critical Access Hospitals (CAH) that qualify for participation in the demonstration. This paper describes their current operating environment, makes comparisons to the Montana F-CHIP model where appropriate, and proposes components of a framework for a more efficient and effective delivery system in Alaska. It represents the input and opinions of the Alaska hospitals eligible for participation.

The primary audience for this paper includes the US DHHS Health Resources and Services Administration's Office of Rural Health Policy and the Centers for Medicare and Medicaid Service's Center for Medicare and Medicaid Innovation.

Alaska's complex demographics, geography and history shape its correspondingly complex health care system. Tribal beneficiaries comprise 20% of the population and the military/Veterans comprise another 14%. Approximately 75% of Alaskan communities are inaccessible by road, as are five of the seven CAHs eligible for this F-CHIP Demonstration.

Alaska's eligible CAHs support Montana's Conditions of Participation (COP) modifications, and changes to telehealth regulations. In addition, Alaska's eligible CAHs have developed specific recommendations for payment modifications in the proposed F-CHIP demonstration, including:

1. Creation of a grant or other mechanism for upfront support of Electronic Health Records capital expenditures;
2. Creation of a grant or other mechanism for upfront support of Care Coordinators at the nursing or social work level;
3. Home health, specialty clinics and physician home visits to be included on the cost report as allowable expenses:
4. Waiver of telehealth restrictions contained in Section 1834(m), including:
    a. Allow telehealth service delivery and reimbursement in the home
    b. Allow Medicare reimbursement of diabetes education
    c. Increase the telehealth "originating site" facility fee
    d. Allow more flexibility in frontier telehealth privileging and credentialing
    e. Alaska specific recommendation: Grant or other mechanism for upfront support for a Telehealth Coordinator role

CMS investment in testing this budget neutral model will be modest due to the small number of participants. The returns will be significant, yielding valuable information towards increasing access to efficient care in our nation's most isolated communities.

II. Introduction and Background

The purpose of this White Paper is to provide an Alaska perspective on the proposed recommendations for the Frontier Community Health Integration Demonstration (F-CHIP).

No description of Alaska health care can start without first describing the size and demographics of the State. By far the largest state in the union, Alaska is 2.5 times the size of Texas. There are 722,718 residents making Alaska the fourth least populated state. Alaska has a population density of 1.08 persons per square mile, by far the lowest in the nation[1].

Alaskans receive health care through four distinct systems:

1. Private sector, providing a broad range of services.
2. Public system, funding some hospitals, public health nursing and behavioral health.
3. Tribal system, which includes 20% of the population, far higher than the U.S. average of 2%.
4. Military and Veterans' Administration; military accounts for 14% of the AK population[2].

The Frontier Community Health Integration Demonstration (F-CHIP) is authorized under Section330A of the Public Health Service Act and is also guided by authorization of Section 123 of P.L. 110-275, the Medicare Improvements to Patients and Provider's Act of 2008 (MIPPA). The purpose of the F-CHIP Demonstration is to develop and test new models for the delivery of health care services in frontier areas through improving access to, and better integration of, the delivery of health care to Medicare beneficiaries. The authorizing legislation defines a frontier Critical Access Hospital (CAH) as a CAH located in a county with a population of 6 people or fewer per square mile and a daily acute-care census of 5 patients or less. The legislation also identifies four "frontier-eligible" states: Alaska, Montana, North Dakota and Wyoming.

This white paper focuses on the seven Alaska Critical Access Hospitals that qualify for participation in the F-CHIP demonstration, describing their current operating environment, comparisons to the Montana F-CHIP model where appropriate, and proposing components of a framework for a more efficient and effective delivery system in Alaska.

Having multiple systems increase the challenges to cross-system coordination and economies of scale at the community level.

About 75% of Alaskan communities are inaccessible by road, creating demand for air service, water transport, and the occasional snow machine. Of Alaska's 27 hospitals, half are not on a road system and nearly a third of hospitals serve the Anchorage/Mat-Su valley. The AK Native Medical Center serves as Alaska's only Level II trauma center; the closest Level 1 trauma centers require a flight to Seattle. Of the seven eligible CAHs, only two are on a road system, four are island-based or obstructed by glaciers, and one is isolated by tundra.

Alaska has the second youngest population in the country. The 2010 census counted 7.7% of Alaskans over 65 years of age, far below the national average of 12.7%. This translates into a relatively low Medicare population, however, the over 65 population is the fastest growing segment of Alaska's population[3].

[1] www.census.gov
[2] Alaska Health Care Commission 2009 Report: Appendix A, Health Care in Alaska.
[3] Alaska Commission on Aging, 2009 http://www.alaskaaging.org/assets/SeniorGrowth.pdf

III. Vision

Alaska's seven facilities meeting criteria for inclusion in this demonstration are:

- Cordova Community Medical Center;
- Norton Sound Regional Hospital;
- Petersburg Medical Center;
- Providence Seward Medical and Care Center;
- Providence Valdez Medical Center;
- Sitka Community Hospital; and
- Wrangell Medical Center.

Alaska's F-CHIP eligible hospitals seek to participate in the CMS Demonstration, increasing access to and improving the adequacy of payments for essential health services. The hospitals support the Triple Aim[4] and seek to provide collaborative, coordinated and increasingly integrated care. A fragmented approach to care delivery cannot be meaningfully improved without shared incentives for access, cost and quality. Residents and providers in rural and frontier Alaska understand access issues - as a matter of life or death when weather prohibits air travel – and also for the practicality of cost savings from avoided air travel. Medical evacuations from these hospitals to a Level II Trauma Center can cost $70,000, far exceeding the cost of a 96 hour inpatient stay locally.

Alaska's participation in the Frontier Health System model as proposed by Montana is compromised by the complexity of the local health care systems, reimbursement system differences, and population scarcity compromise. Nevertheless, Alaska's eligible CAHs support Montana's Conditions of Participation (COP) modifications, and changes to telehealth regulations. In addition, Alaska's eligible CAHs have developed specific recommendations for payment modifications in the proposed F-CHIP demonstration.

Given the dramatic isolation faced in most Alaskan communities, preserving and sustaining access to care is paramount. Often lauded for its innovative programs and services, Alaska still faces significant issues related to health care access and cost. One of the biggest challenges facing Alaska's frontier health care delivery system(s) is integration. Funding silos separate three of the distinct aforementioned systems; authority sectors create further fissures. To the extent this CMS Demonstration project can incentivize greater integration; community members will receive more efficient care.

Alaska recommends a CMS demonstration project that increases local capacity and encourages its integration, further decreasing the volume of patients requiring inpatient stays or costly medical evacuations to more expensive hospitals. Alaska's eligible hospitals already retain 49% of their inpatients locally, the same proportion as Wyoming and far more than Montana or North Dakota. With CMS support in a demonstration, these Alaska facilities believe they can reduce the volume of medical evacuations by a minimum of 5% and reduce total inpatient stays by 2%, resulting in savings of over $1 million annually.

The demonstration project's success would be measured in overall cost savings for Medicare beneficiaries, including changes to the Medicare Average Daily Census. Upfront support for Electronic Health Records, Telehealth Coordinators and Care Coordinators, and inclusion of home health, specialty clinics and physician home visits in the cost report will support the additional local capacity. In addition, modifications to telehealth payment regulations will further reduce costs to CMS.

[4] *The Triple Aim: Care, Health, and Cost*, by Donald Berwick, Thomas Nolan and John Whittington. Health Affairs, May 2008, Volume 27, number 3. Pages 759-769.

IV. Alaska Frontier Critical Access Hospitals: An Overview

Complexity of Alaska's Health Care System

The current complexity of Alaska's health care system can best be described from a historical and demographic context. The system functions with four distinct sectors. Purchased in 1867, the U.S. Government initiated its public health campaign in the early 1900s under the Bureau of Education with nurses on ships traveling to coastal areas and along major rivers. The hearty nurses provided care to isolated tribal populations. The Bureau of Education shifted tribal care to the Bureau of Indian Affairs in 1931, with the development of regional tribal hospitals. From Indian Affairs to the Indian Health Service to participation in Public Law 93-638, the tribal system remains separately funded, serving about 20% of the population.

Concurrently, maritime nursing became the foundation of Alaska's public health system. Today, the 125 public health nurses in 21 public health centers in the Department of Health and Social Services provide services throughout Alaska. With statehood came public funding to behavioral health counseling in communities statewide. Non-tribal hospitals in frontier areas are community-owned, with AK Medicaid and Medicare swing bed funding helping to keep them solvent.

Military involvement commenced with statehood. Alaska's easy access to Asia ensures a strong military presence, currently representing about 14% of the population. Military personnel and their dependents receive health care separately from the civil population. Private sector services exist primarily in the larger communities of Anchorage, Juneau and Fairbanks as well as the areas where the F-CHIP eligible CAHs are located. In summary, these funding and authority branches result in complex systems of care at the community level.

Frontier Hospitals

Five of the seven frontier CAHs in Alaska are not connected to a Level II trauma center by road. Air transport, weather permitting, provides the critical linkage to higher level care. Of the CAHs with road access, Seward requires driving 90 miles on a predominantly two lane road and over a major mountain pass. Valdez requires driving 306 miles on a predominantly two lane road, or a one hour flight, weather permitting. Valdez made national news last winter for 36 feet (437 inches) of snowfall. Air and car travel were severely hampered. State acknowledgement of this geography will be referenced later in regards to the emergency department standards for CAHs that exceed the requirements of federal regulation.

Table 1: Service Area Population and Access/Distance

Hospital	Service Area Population	Population Density	Road	Distance to nearest hospital	Distance to Level II Trauma Center
Cordova	2,270	0.3	No	160 air miles	160 air miles
Norton Sound	9,730	0.3	No	183 air miles	541 air miles
Petersburg	3,000*	1.1	No	31 air miles (CAH)	609 air miles
Providence Seward	4,752*	3.1	Yes	90 miles, 2 lane road	125 miles by road
Providence Valdez	4,000	0.3	Yes	306 miles 1-7 hrs (air vs auto)	306 miles 1-7 hrs (air vs auto)
Sitka Comm Hospital	7,000	3.1	No	3 miles to IHS facility	600 air miles
Wrangell	2,411	0.9	No	31 air miles (CAH)	705 air miles
Average	*4,738*	*1.3*		*115 miles*	*435 miles*

* Seward includes Lowell Point, Bear Creek, and Moose Pass. Nome includes surrounding villages.

It is worth noting that the AK CAHs serve larger populations than the MT CAHs in this project. The AK CAHs serve 2,200 – 9,730 residents, with an average of 4,738 people. In contrast, the MT hospitals serve populations of 644 – 3,790[5] with an average of 1,765 people. Partially because of their geographic isolation, and partially due to the size of the populations they serve, Alaska frontier CAHs provide a relatively broad range of services - especially diagnostic – that exceed the services reported by the Montana F-CHIP participants. As shown in *Appendix B: Services Available in the Community*, Alaska's eligible hospitals provide emergency department services, CT and radiology; several provide mammography and all have telehealth capacity. Ambulance services are all owned by the municipalities, and staffed primarily by volunteers.

Alaska CAHs face special staffing challenges because residents seek full-time employment, while hospitals often have a need or funding only for a part-time person. It is difficult to fill part-time positions and the distance between facilities and travel challenges make shared positions an unrealistic option.

Unlike their Montana counterparts, Alaska's frontier CAHs developed a mechanism to retain their nursing home beds. The community based care keeps residents and employment in the community. The fiscal underpinning underscores state support for this capacity; CAHs spread the recurring costs of LTC beds across several, legitimate hospital services. The daily rate for nursing home beds keep the CAHs from operating at an even greater financial loss.

Table 2: Overview of CAH's Licensed Beds

Hospital	# Licensed Beds	# Acute Beds/ Avg Daily Census	# LTC Beds/ Avg Daily Census LTC	Avg Daily Census Swing	# Acute Inpt Discharges 2011	Medicare Daily Census 2011
Cordova	23	13/0.23	10/8.9	1	35	.071/ acute .36/swing
Norton Sound	18	18/6.0*	15/15	0	490	NA/ acute 0/ swing
Petersburg	27	12/1.01	15/13.08	3.05	138	0.51/acute 2.72/ swing
Providence Seward**	46	6/0.8	40/32.6	1.4	91	0.42/ acute 1.09/ swing
Providence Valdez**	20	10/1.24	10/9.93	3.08	416	.29/ acute .54/swing
Sitka Comm Hospital	12	12/2.02	15/12.65	1.43	280	1.2/acute 1.8/ swing
Wrangell**	22	8/1.07	14/13.24	NA	137/ acute 48 / swing	0.68/ acute 1.58/ swing

*Includes labor & delivery and post-partum care.
** FY2012

Emergency Department Standards for Alaska CAHs

Alaska employs stricter provider standards for the Medicare Rural Hospital Flexibility Program than required under federal statute. Specifically, federal law allows CAHs located in frontier areas and having no greater than ten beds to be staffed with a registered nurse. Further, the emergency response time can be up to 60 minutes.

[5] Framework for a New Frontier Health System Model, MHREF. October 2011, Appendix B.

In recognition of Alaska's unusual geography and the need to assure 24 hour availability of emergency services at the local level, the State created its own emergency department standards for CAHs. As stated in the *1998 Alaska Rural Health Plan* for participation in the Medicare Rural Hospital Flexibility Program:

> "A CAH must provide Level III emergency medical services, as defined in the fourth edition of *Alaska EMS Goals: A Guide for Developing Alaska's Emergency Medical Services System*, February 1996. Level III services require that the emergency department be staffed on a 24-hour basis by a physician, mid-level practitioner, or Registered Nurse with appropriate medical training, equipment, and supplies and that physicians with specialized emergency care training are available on-call."

In response, each of Alaska's CAHs attempts to maintain at least three physicians on staff or contract at all times to meet this standard. If a hospital elects to close their emergency department at certain times, they must develop and submit a plan documenting that a registered nurse would be on duty at all times.[6]

Behavioral Health

Access to behavioral health services plays a significant role in Alaska's health delivery system. As referenced in Appendix B, behavioral health services exist in all of the CAH communities, whether within a Community Health Center (CHC), tribal organization, or stand-alone counseling centers. According to a recently released report in the AK Dept of Health and Social Services, alcohol and substance abuse cost Alaska $1.2B in 2010, with $250M of those funds going to health care and social services.[7] In the report, alcohol/substance abuse and related injuries/illnesses caused 45,500 days of hospital care and 2,239 days of long term care. Alaska's mental health challenges loom every bit as large. The Alaska suicide rate for youth aged 15-24 was 46/100,000 in 2010, compared to national rates of 7.8/100,000.[8]

Alaskans understand that early diagnosis and prevention needs to occur at the community level; hence, the local investment into counseling services. Psychiatric services remain elusive; according to the most recent statewide health workforce assessment (2009), the vacancy rate for psychiatric nurse practitioners was 20.5% and for psychiatrists was 12.7%[9]. None of the CAH communities have these positions. Critical access hospitals do not have the staffing or facilities to adequately provide inpatient psychiatric services. An expansion of tele-behavioral health would help bring psychiatric care to these isolated communities, providing the broader range of services needed to reduce hospital stays and residential services.

[6] Alaska Administrative Code, 7AAC 12.612. Licensure of critical access hospitals.
[7] The Economic Costs of Alcohol and Other Drug Abuse in Alaska, 2012 update, http://www.hss.state.ak.us/abada/pdf/EconomicCostofAlcoholandDrugAbuse2012.pdf
[8] AK Dept of Health and Social Services website, Press Release 9/17/12, accessed 10/30/12. http://www.hss.state.ak.us/press/2012/suicide_%20prevention_%20grant.pdf
[9] 2009 Alaska Health Workforce Vacancy Study, published by the UAA AK Center for Rural Health – Alaska's AHEC, http://acrh-ahec.uaa.alaska.edu/projects/pdf/2009workforce09.pdf

V. Rationale

Challenges

Alaska and Montana share many similarities. Geographic isolation and low population density are the most obvious. These characteristics result in challenging secondary factors, such as:

a. Low patient volume, resulting in a weak reimbursement base for supporting necessary infrastructure;
b. Barriers to the recruitment and retention of health professionals;
c. Limited home health, hospice, and rehabilitation services, resulting from (a) and (b), essentially these services are reimbursed on a PPS system that is not congruent with low volume CAH facilities; and
d. Challenges in providing telehealth services, resulting from (a) above and due to regulations providing inadequate support to the originating site.

Looking forward, new models for value-based reimbursement currently being developed such as accountable care organizations, bundled payments, and value-based purchasing may not translate well in rural markets, given rural providers' unique regulatory confines and low population density. Also, low patient volumes make it difficult, if not impossible, for rural providers to assume the risk as these models demand.[10,11]

Five critical distinguishing factors may compromise Alaska's participation in the F-CHIP Demonstration as proposed by Montana in their Framework document. Those factors include:

1. Increasing the bed limit from 25-35, adding 10 swing beds: The proposed additional swing beds are designed to provide access to nursing home services and increase volume to support budget neutrality necessary for the demonstration's feasibility. In Alaska, all of the frontier CAHs have separately licensed nursing homes; reasonable Medicaid reimbursement for these beds play a crucial role to the hospitals' financial stability. Alaska CAHs do not oppose the bed expansion, but it is highly improbable they will engage it within the current environment. Thus, expansion of swing beds will not support Alaska CAHs to *achieve budget neutrality in a CMS F-CHIP demonstration.*

2. Exclusion of Selected Psychiatric Inpatients from Length of Stay (LOS) Limits: North Dakota's F-CHIP sites often retain their psychiatric inpatients longer than the 96 hour limit. Waiving the 96 hour LOS requirement is beneficial for keeping patients close to family, and in facilities with a lower daily rate. Alaska's F-CHIP eligible communities all have social workers and other behavioral health professionals. Unfortunately, their psychiatric rooms do not include a camera, thus requiring a dedicated clinician with the patient at all times. Further, only three hospitals in Alaska are certified for Evaluation & Treatment, none of them CAHs. An expansion of tele-behavioral health would strengthen the provision of local services, but none of them consider it prudent to retain psychiatric patients over 96 hours.

3. Complex Community System of Care: In Montana, the frontier CAHs often serve as the primary, and often only, source of community-based care. Public health and other services

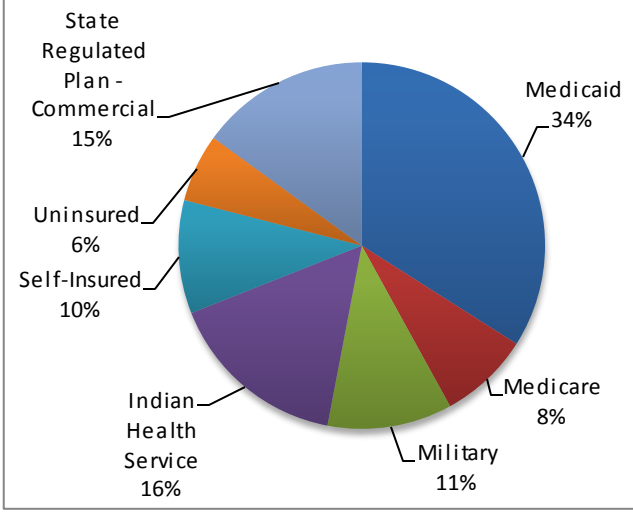
[10] Anticipating the Rural Impact of Medicare Value-Based Purchasing, RUPRI Rural Health Panel, April 2012
[11] Comment Letter from The Rural Wisconsin Health Cooperative to Dr. Donald Berwick, CMS administrator regarding CMS-1345- Accountable Care Organizations & Medicare Shared Savings Program, June 6, 2011

are often contractually managed through their organization. In Alaska F-CHIP communities, diverse and separate organizations comprise the health care system. All have stand-alone behavioral health services and public health offices. Two communities have stand-alone 330 CHCs or tribal clinics. Some have private pharmacies and physicians in private practice. The CAHs provide inpatient care, coordinate specialty care services, and offer outpatient services. They collaborate with other community service providers rather than manage them. Alaska needs help with incentivizing collaboration, coordination and finally integration. *An Accountable Care Organization (ACO)-like structure would be prohibitively difficult for the CAH to enact in this environment.*

4. Rural Health Clinics and expanded Visiting Nurse Services: Alaska's eligible frontier CAHs face barriers to securing rural health clinic status. In order to ensure access to quality care 24 hours per day, seven days a week, they attempt to maintain at least three mid-level or physician providers on staff. Most AK communities with CAHs have low populations and too many primary care physicians to qualify as a Health Professional Service Area (HPSA). Some communities use community health centers or tribal health clinics to serve the HPSA/MUA outpatient needs of the population, and they are separately owned and operated. The sole exception is Nome's Norton Sound Health Corporation, the singular tribal hospital of the 71 F-CHIP eligible CAHs nationwide. *Most Alaska CAHs are not eligible for Rural Health Clinic status.*

5. Payer Mix: Alaska's health care payer mix varies from that of other states, primarily due to the demographics of a younger population and large Alaska Native/American Indian population. As evidenced in the payer mix graphic, Medicare covers 8% of Alaskans. The Indian Health Service covers 16%, and Medicaid covers 34%. Private insurance covers approximately 15%. From a statewide perspective, Medicaid plays the single largest role in paying for Alaskans' health care. However, in rural areas, Medicare is a much more significant payer of hospital care. For the separately licensed nursing homes that are part of Alaska CAHs, Medicaid is the largest payer.

Figure 1. Alaska's Unique Payer Mix



Source: Percent of Insurance Coverage by type, All Payer Claims Databases, Presentation to the Alaska Health Care Commission, Freedman Healthcare, LLC, 10/11/12.

The table on the next page outlines the role of Medicare in funding inpatient and outpatient care to the F-CHIP eligible CAHs. All eligible CAHs, other than Nome with a large tribal population, depend on Medicare as an important payer. Clearly, Medicare's financial relevance speaks to the importance of testing new delivery models in frontier areas.

Table 3: Payer Mix: Inpatient and Outpatient Combined

	Medicare	Medicaid	Commercial	Private Pay	IHS
Cordova	73.1%	18.3%	5.0%	3.7%	
Nome/Norton Sound	6%	58%	3.5%		32.5%
Petersburg	35%	26%	30%	8%	
Prov Seward	70.2%/IP 22.8%/ OP	6.0%/IP 13.7%/OP	17.2%/IP 38.9%/OP	5.2%/IP 14.7/OP	
Prov Valdez	13.4%	36.8%	38.3%	9.5%	
Sitka C.H.	43.9%	4.4%	44.2%	7.5%	
Wrangell	61.2%/IP 41.3%/OP	15.0%/IP 14.1%/OP	12.2%/IP 39.3%/OP	11.7%/IP 5.3%/OP	

Source: Reported from hospitals for all patients

Approximately 90% of nursing home care is funded by Medicaid. The tremendous state support for community-based nursing home services improves the likelihood of the elderly staying close to family, friends and familiar surroundings. The Medicaid payment is such that nursing home services must be excluded from discrete costing.

Table 4: Montana-Proposed Waivers to CAH Conditions of Participation

MT Proposed Change	AK Response
Increasing the existing CAH 25-bed limit to 35 beds for Frontier Health Systems (FHS)	No harm: AK F-CHIP sites already have sufficient nursing home beds
Allowing FHS hospitals to exempt inpatient psychiatric services with specific diagnostic codes from the annual LOS calculation	No harm: Alaska does not have sufficient psychiatric capacity in frontier areas to meaningfully retain these patients.
Expansion of RHC VNS services to allow reimbursement of visits to Medicare beneficiaries for physical therapy, occupational therapy and speech therapy services	No harm: AK F-CHIP sites do not have Rural Health Clinics. However, allowing discrete costing when allocating overhead to Home Health would make this valuable service financially more feasible.
Permitting a 35 mile waiver for Frontier ambulance services in a few Frontier communities to preserve access to pre-hospital emergency medical services for beneficiaries	No harm: Ambulance services in the AK F-CHIP communities are owned by their municipality and staffed with volunteers.
Modifying productivity screens for RHC medical providers practicing in FHS'	No harm: Even with reduced productivity screens, five of the AK F-CHIP sites will not qualify for Rural Health Clinics, as they can't qualify as HPSAs.
Allowing flexibility in discrete costing when allocating administration and general costs for Medicare reimbursement	No harm: Implementation of this change would be helpful for Alaska CAHs **if and only if** there is no change to the current method for allocating cost to the nursing home.

Strategies Encouraging Alaska's Participation in F-CHIP

Alaska Frontier CAHs have identified potential changes that will improve their ability to retain more patients locally, and strengthen the coordination and integration of local services. Recommendations for the CMS F-CHIP Demonstration focus on the Triple Aim of improving access, improving quality, and reducing costs.

Grants or other Up-front Support

1. Electronic Health Records: The development and meaningful use of electronic health records (EHR) is revolutionizing the delivery of care nationwide. Alaska CAHs see this tool as fundamental to improving the coordination and eventual integration of services in their isolated communities. EHR capital costs are allowable expenses on the cost report; unfortunately, CAHs lack the fiscal resources to front the large capital investments. Alaska CAHs would like to see the F-CHIP Demonstration provide grants or other more timely financial assistance for the capital costs associated with EHR implementation including, hardware, software, training and related requisite products. The net cost to CMS is no different than inclusion of these expenses on the cost report, so *this request is budget neutral*. The expedited financial support makes the investment and its returns more feasible.

2. Care Coordination: Montana's white paper on Frontier Care Coordination discusses the value of community-level care coordinators. Alaska CAHs concur with the concept, and agree with data from the Congressional Budget Office indicating that the cost of care coordination programs must be smaller than the reductions achieved in Medicare expenditures.[12] Alaska CAHs believe care coordinators prepared in nursing or social work who can facilitate care between community agencies as well as higher level service providers in more urban environments are necessary. Because of the high volume of Medicare beneficiaries needing a myriad services, Alaska F-CHIP CAHs believe the service will pay for itself in reduced hospitalizations. Up front support of this capacity in a grant will make the service a reality.

Cost Report Modifications

Home health, hospice, specialty clinics, physician home visits and other services currently are reimbursed on a fee for service (FFS) payment system because these entities are perceived to not directly relate to hospital-based care. While these entities may be quite distinct in urban and suburban areas, they play a vital role in frontier health care delivery. Inclusion of specific entities in the cost report ensures their financial sustainability and ensures their provision at the local level. Only two of the F-CHIP eligible CAHs in Alaska provide home health, and they do so as a community benefit and at a financial loss. The program loses money because of the current payment formula, straining the hospitals' finite resources. Hospitals offer specialty clinics on a limited basis for the same reason; hospice and physician home visits, while needed, cannot be offered at all.

Alaska would like to see the following entities included in the cost report for this demonstration project: home health, specialty clinics, hospice, and physician home visits. Moving them out of the fee for service structure and into the cost report will increase the cost of their provision. It also makes their provision possible. *This financing modification is negligible compared to the avoided costs from fewer inpatient stays through increased access to needed services.*

Other Services Improving Access and Reducing Costs

Telehealth: As articulated in Montana's *White Paper #2: Case Study on Frontier Telehealth*, "Reimbursement to a frontier "originating site" (where the patient is) for approved telehealth medical practitioner patient visits is insufficient. The originating site in a frontier healthcare facility receives only a $24.44 telehealth site facility fee for hosting a patient visit with a specialty medical provider usually hundreds of miles away. This payment is inadequate to

[12] Freeman VA, Radford A. Why Use Swing Beds? Conversations with Hospital Administrators and Staff. North Carolina Rural Health Research & Policy Analysis Center, Findings Brief, April 2012.

compensate for nursing and care coordination time in setting up the patient visit with the distant site and telehealth practitioner."[13] Alaska benefits from some telehealth provisions that Montana seeks. But there are others, including the site facility fee, which would benefit Alaska and the other F-CHIP states. Alaska supports Montana's recommendations in their telehealth white paper as they pertain to waiving telehealth restrictions only for the CMS frontier demonstration project.

a. Allow telehealth service delivery and reimbursement in the home for frontier Medicare beneficiaries.
b. Allow Medicare reimbursement of diabetes education provided by a Certified Diabetes Educator provided via telemedicine.
c. Increase the telehealth "originating site" facility fee to provide fair and equitable reimbursement for the nursing and care coordination expense as well as technical cost of providing a specialty medical practitioner telehealth visit for frontier patients.
d. Allow frontier telehealth privileging and credentialing to consist of a letter from the "distant site" for each telehealth practitioner stating the practitioner is privileged at the "distant site" with a copy of the practitioner's current license and a list of privileges (at the distant facility) attached and with agreement from both sites.
e. In addition to the requests from Montana, an Alaska recommendation is to support a Telehealth Coordinator role. Given Alaska's geography, various organizations have sought and received grants to develop the infrastructure to bridge the vast distances. The hospitals have installed equipment which cannot be used to its full capacity partly because the Telehealth Coordinator role cannot be sustained financially. A grant specifically for this capacity, or an increase in the facility fee, or a waiver to include the Telehealth Coordinator in the CMS Cost Report would mitigate this barrier.

VI. Payment / Reimbursement Considerations

As our nation progresses in its efforts to incentivize a rational health care delivery system, CMS is to be commended for supporting demonstrations that recognize the different environments in which health care is delivered. Demonstrations also point to the importance of flexibility and innovation to maximize the Triple Aim of reducing cost, improving access, and improving quality.

Looking at Medicare charges for inpatient services across the eligible frontier CAHs, a strong cost-savings argument for retaining patients in the CAH community materializes. Averaging the four states, CAH charges per day amount to 55% of other in-state facilities and only 37% of charges at out of state facilities. Of course, patient severity and corresponding treatment intensity account for some of the higher costs. Nevertheless, Medicare inpatient charges are lowest in the frontier CAHs – even before considering the cost of medical evacuations - demonstrating that Medicare investments to keep the frontier CAHs financially viable and strengthen their capacity to retain patients locally is prudent fiscally. Avoiding inpatient stays via the provision of lower intensity community services further reduces costs to CMS.

[13] White Paper #2: Case Study on Frontier Telehealth, prepared by the Montana Health Research and Education Foundation, with funding from U.S. DHHS, Health Resources and Services Administration as a product for Cooperative Agreement Number H2GRH199966.

Table 5: Medicare Charges for Inpatient Services – Frontier CAHs

State	# Eligible CAHs	Service Area Patients Seen at Eligible CAHs		Service Area Patients Seen at Other Instate Facilities		Service Area Patients Seen at Out of State Facility	
		Average Chrgs/Stay	Average Chrgs/Day	Average Chrgs/Stay	Average Chrgs/Day	Average Chrgs/Stay	Average Chrgs/Day
Alaska	7	$12,853	$2,844	$55,933	$7,956	$57,160	$10,051
Montana	9*	$5,861	$1,861	$23,412	$4,930	$38,570	$6,870
N. Dakota	19	$6,916	$2,131	$22,472	$4,527	$43,040	$7,759
Wyoming	16	$11,607	$3,506	$37,411	$6,732	$43,422	$7,623
Total	**51**	**$9,674**	**$2,863**	**$26,031**	**$5,135**	**$43,465**	**$7,694**

Source: Xerox State Healthcare, LLC. Data from CMS Hospital Service Area File – CY2010

*Data was provided for the 9 CAHs participating in the Montana Health Research and Education Foundation Cooperative Agreement that produced the F-CHIP White papers and Framework Document. There are currently 35 CAHs eligible for the CMS demonstration in Montana.

Reviewing Medicare expenditures for Alaska's eligible F-CHIP facilities compared to expenditures in Montana, North Dakota and Wyoming, several observations bear mention. First, when comparing the ratio of inpatient/outpatient/physician payments across states, Alaska demonstrates the highest proportion of inpatient costs at 68%. Looking at the seven eligible Alaska facilities, the inpatient proportion ranges from 61%-87%; the highest ratio is in Nome, where Medicare outpatient expenditures reach only 3% of their total. This is primarily due to the limited outpatient services provided by the CAHs, underscoring the presence of other community providers mentioned earlier. Second, Alaska, like Wyoming, had 49% of their Medicare inpatient stays at eligible Frontier CAHs rather than other hospitals in-state or out of state. The proportion was 16% for Montana and 27% for North Dakota. For Alaska, this reflects the local provider capacity (as documented earlier, AK CAHs have too many providers to qualify for a rural health clinic) and hospital infrastructure for retaining patients locally.

Combined, these factors compromise the development of a Shared Savings ACO model in Alaska, as proposed by Montana. They also support the case for supporting and expanding Frontier CAH inpatient capacity to ensure the viability of local *access* to care and as a *cost*-saving tool, consistent with the Triple Aim.

VII. Recommendations and Conclusion

Consistent with Montana's experience, isolated frontier CAHs serving low populations struggle to remain viable under the current payment structure. Fiscal constraints compromise their ability to provide the broad range of community-based services requisite to ensure access to appropriate care and avoid costly hospital admissions. Alaska CAHs recommend the following components be included in the CMS demonstration:

Table 6: Requested Modifications to Current CMS Payment Policies

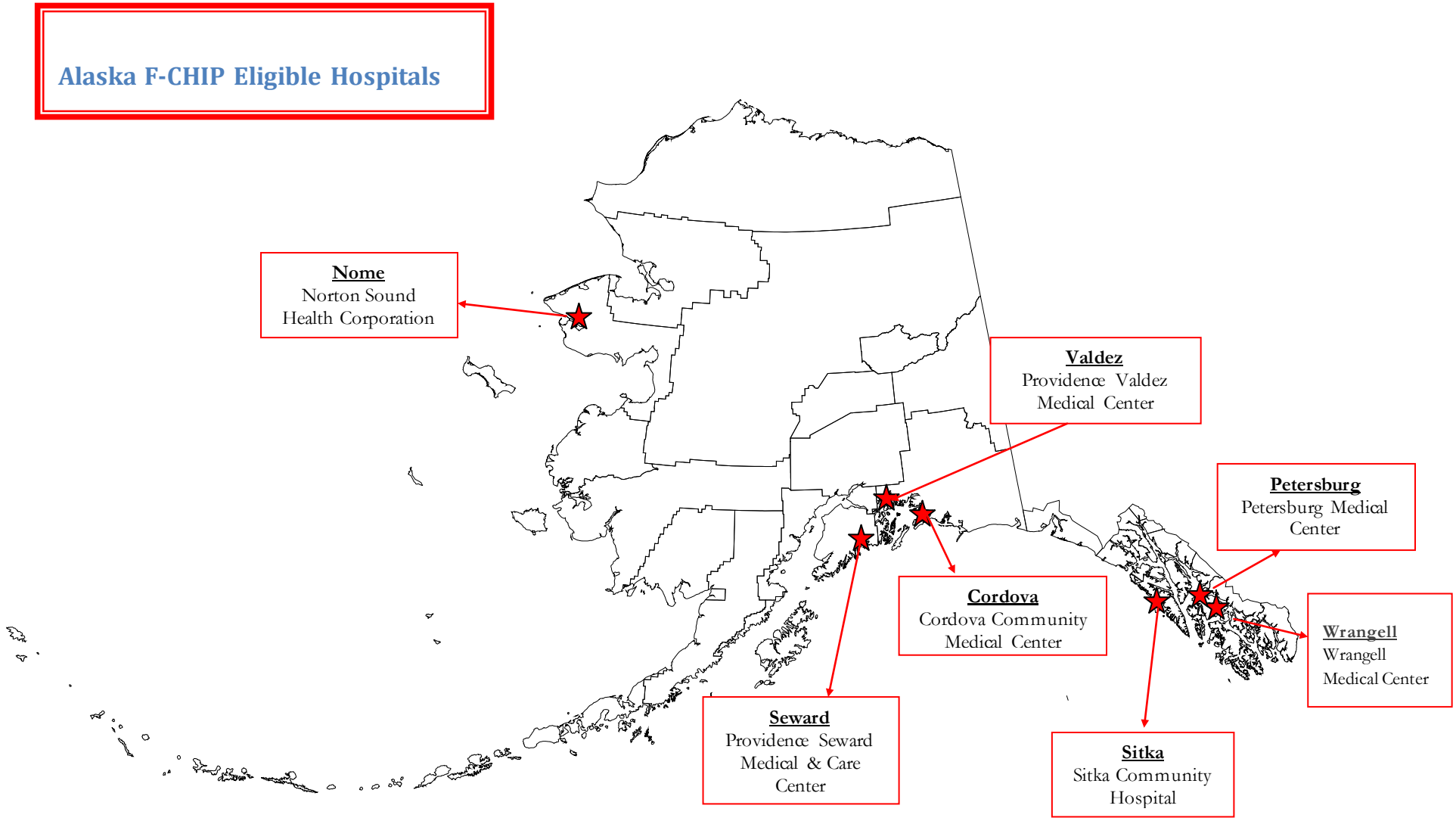
Proposed Payment Modification	Rationale
1. Grant or other mechanism for upfront support for Electronic Health Records capital expenditures.	1. The value of EHR is understood. Frontier CAHs lack the fiscal resources to fund the investment up-front. *Budget neutral*
2. Grant or other mechanism for upfront support for Care Coordinators at the nursing or social work level	2. Given the complexity of community service providers, a coordinator with clinical training can improve efficiency of local service provision and reduce admissions. *Cost will be balanced by avoided costs*
3. Home health, specialty clinics and physician home visits to be included on cost report as allowable expenses.	3. These services are either not available or minimally provided and at a fiscal loss in the AK CAH communities. Provision of this capacity will reduce inpatient admissions. *Cost will be balanced by avoided admissions*
4. Waive telehealth restrictions contained in Section 1834(m), including: a. Allow telehealth service delivery and reimbursement in the home b. Allow Medicare reimbursement of diabetes education c. Increase the telehealth "originating site" facility fee d. Allow more flexibility in frontier telehealth privileging and credentialing e. Alaska specific recommendation: Grant or other mechanism for upfront support a Telehealth Coordinator role.	4. These waivers and support for telehealth coordinators will increase the volume of telehealth provided. *Cost will be balanced by avoided costs from fewer medical evacuations*

The efficacy of this CMS demonstration could be evaluated with the following:

1. Tracking changes (reductions) in the percentage of Medicare inpatient stays outside of the community – pre/post methodology;
2. Tracking changes (reductions) in Medicare Average Daily Census – pre/post methodology
3. Tracking changes (reductions) in Medicare medical evacuations and corresponding cost savings – pre/post methodology

Obviously, risks exist in testing this model on such a small population. A few outliers could skew the entire demonstration, causing dramatic shifts in overall expenses. Alternatively viewed, CMS' investment in testing this model will be modest, yielding valuable information.

Appendix A – Description of Alaska F-CHIP Eligible Hospitals



Description of Alaska F-CHIP Eligible Hospitals

Cordova Community Medical Center http://www.cdvcmc.com

The Cordova Community Medical Center (CCMC) is a critical access hospital owned by the City and operated by Providence Health System. CCMC, the only hospital in Cordova, has 13 acute/swing beds, 10 long term care beds, a two room Emergency Department and a Family Medicine clinic. Serving a population of 2,270 residents, Cordova is a Prince William Sound/Gulf of Alaska fishing community accessible only by plane or boat. The Eyak Tribe operates a 330 clinic in space previously occupied by the hospital's provider-based clinic. Fifteen percent of the population is Alaska Native. They are staffed with one physician and share a mid-level provider and behavioral health clinicians with the 330 clinic. CCMC does offer some rehabilitation services, but lacks home health. The Medicare daily census averages 0.071 for acute and 0.36 for swing beds.

Norton Sound Health Corporation www.nortonsoundhealth.org

The Norton Sound Health Corporation (NSHC) is a tribally operated critical access hospital. Located in Nome, which is accessible only by air or water, the NSHC, a tribal entity, owns and operates the Nome hospital which was not originally an IHS facility. It has 18 acute/ swing beds and 15 long term beds, and is the medical center for the Bering Strait region (23,000 sq. miles). Nome is the supply, service and transportation center for the region, which includes 15 villages and two island communities in the Bering Sea, with a service area population of 9,730 residents. Fifty-nine percent of the region's population is Alaska Native. The NSHC also runs an outpatient clinic in Nome, a long term care facility, supervises village clinics, and operates a community health clinic. NSHC is finishing construction of a new hospital. A medical evacuation to Anchorage costs approximately $55,000. Staffed with many physicians to serve the entire region, they do not offer home health services.

Petersburg Medical Center http://www.pmc-health.com

The Petersburg Medical Center (PMC) is a critical access hospital owned by the City and operated by an elected board. PMC, which has 12 acute/swing and 15 long term care beds - also supports an outpatient clinic; it is the area's primary healthcare resource for a service area of 3,000 residents. Petersburg, located on Mitkof Island and accessible only by air or water, supports a region that relies on commercial fishing and tourism. PMC is municipally owned, however is independently self-sustaining. With one federally recognized tribe in the community, 12% of the population is Alaska Native. A medical evacuation to Anchorage costs approximately $65,000. Staffed with four physicians, 24/7 coverage is assured. PMC offers limited home health and has rehabilitation clinicians on staff. The Medicare daily census averages 0.51 for acute and 2.72 for swing beds.

Providence Seward Medical and Care Center

http://alaska.providence.org/locations/psmcc

The Providence Seward Medical and Care Center (PSMCC) is a critical access hospital owned by the City and operated by Providence Health System. PSMCC is a small community hospital with 6 acute/swing and 40 long term beds located 125 miles from Anchorage by road, with a service area population of 4,752 residents. Seward, a Kenai Peninsula community, is located on Resurrection Bay at the southern terminus of the Alaska Railroad; it is primarily a transportation

center. The community has a grant to plan for a community health center. Over 21% of the population of Seward is Alaska Native. Air medical evacuations to Anchorage are uncommon, as the windy, two lane road is passable for most of the year. PSMCC staffing includes 4.8 physicians and 0.8 mid-levels. They offer rehabilitation, but no home health services. The Medicare daily census averages 0.42 for acute and 1.09 swing beds.

Providence Valdez Medical Center http://alaska.providence.org/locations/pvmc

The Providence Valdez Medical Center (PVMC) is a critical access hospital owned by the City and operated by Providence Health System. The PVMC, Alaska's newest hospital and Valdez's third, has 10 acute/swing beds and 10 long term care beds, serving a population of 4,000 residents. Located on the shore of a deep water fjord, Valdez is the southern terminus of the Trans-Alaska Pipeline and 305 road miles east of Anchorage. The closest health clinic (Cross Road) is located 120 miles away in Glennallen. There is an independent physician practice that provides ER coverage under contract. The new hospital was dedicated on September 18, 2004. The first hospital was destroyed by a tidal wave following the 1964 Earthquake. Although no federally recognized tribe is present in Valdez, some 10% of the population is Alaska Native. A medical evacuation costs $15,000-$70,000 depending on carrier. PVMC is staffed with four family practice physicians and an anesthesiologist. They offer rehabilitation services but no home health.

Sitka Community Hospital www.sitkahospital.org

The Sitka Community Hospital (SCH) is a critical access hospital owned by the City & Borough and operated by a Board appointed by the City assembly. SCH, located on Baranof Island, serves a 2,874 sq. mile region and 7,000 residents, has 12 acute/swing and 15 long term care beds, and runs its own outpatient clinic. The region relies on tourism and fishing, but is also an educational & health center, with a college, a state-supported boarding school, one of the nine state-owned assisted living facilities ("Pioneer Home"), a second acute care hospital (a 27-bed tribally operated IHS hospital), and a U.S. Coast Guard emergency support/medevac station. Originally a Native village and territorial capital of Alaska, there is a federally recognized tribe in Sitka, and 25% of its population is Alaska Native. A medical evacuation to Anchorage costs approximately $70,000. SCH is staffed with six physicians and an adult nurse practitioner. They offer home health and rehabilitation services. The Medicare daily census averages 1.2 acute beds and 1.8 swing beds.

Wrangell Medical Center www.wrangellmedicalcenter.com

The Wrangell Medical Center (WMC) is a critical access hospital owned by the City and Borough and operated by an elected board. WMC has 8 acute/swing, and 14 long term beds serving a population of 2,411 residents. Wrangell, located on the NW tip of Wrangell Island and accessible only by air & water, depends on commercial/dive fishing and timber. Originally a non-Native settlement, Wrangell later saw significant Native/settler conflict but now is the site of a federally recognized tribe. 24% of the population is Alaska Native. A consortium of local physicians and the community behavioral health center opened a community health clinic in 2005. A medical evacuation to Anchorage costs just under $65,000. WMC employs no physicians; doctors at the nearby 330 clinic have hospital privileges. They offer rehabilitation services but no home health. The Medicare daily census averages 0.68 acute beds and 1.58 swing beds.

Appendix B – Services Available

Services Available in the Alaska F-CHIP Community

	Petersburg	Valdez	Sitka CH	Seward	Cordova	Wrangell	Nome
Tele-health	Hospital	Hospital	Hospital	Hospital	Hospital	Hospital	Hospital – to villages
Pharmacy	Hospital	Hospital and other	Hospital & other entity	Other entity	Other entity	Other entity	Hospital
Ambulan/ EMS	Other entity	Other entity	Other entity	Other entity	Other entity	Other entity	Hospital
Home Health	Hospital	Not avail	Hospital	Not avail	Not avail	Not avail	Not avail
Hospice	Not avail	Not avail	Not avail	Not avail	Not avail	Not avail	Not avail
OT, PT, speech	Hospital	Hospital	Hospital & other entity	Hospital	Hospital	Hospital	Hospital (PT, OT only)
Nutrition	Hospital	Hospital	Hospital & other entity	Hospital	Not avail	quarterly	Hospital
OB	Not avail	Hospital	Hospital & other entity	Not avail	Not avail	Not avail	Hospital
Radiology	Hospital	Hospital	Hospital & other entity	Hospital	Hospital	Hospital	Hospital
CT Scan	Hospital	Hospital	Hospital & other entity	Hospital	Not avail	Hospital	Hospital
Mammo-graphy	Hospital	Other entity	Hospital & other entity	Hospital	Not avail	Hospital	Hospital
Surgery	Hospital	Hospital	Hospital & other entity	Not avail	Not avail	Hospital	Not avail
Emergency Dept Services	Hospital	Hospital	Hospital & other entity	hospital	Hospital	Hospital	Hospital
Public Health	Other entity	Other entity	Other entity	Other entity	Other entity	Other entity	Other entity
Specialty Care	Not avail	Hospital	Not avail	Other entity	Not avail	Hospital	Hospital
Mental Health/ SA	Other entity	Other entity	Hospital & other entity	Other entity	Hospital	Other entity	Hospital

Community Capacity and Provider Mix in Alaska F-CHIP Community

Hospital	Hospital & Nursing Home Providers	CHC in town/ region	Tribal clinics	Mental Health clinics	Public Health	Private Practice	Other
Petersburg	4 MD	-	-	2 MSW 3LCSW	1 PHN	-	4 DDS, 1 RPh
Valdez	1 ANS, 1 RPh	-	-	1 MSW 1 BSW 1 MFT 1 LPC	1 PHN	2 MD	2 RPh, 2 DDS, 1 Ch
Sitka Community Hospital	7: FP, OB, IM, GS, FNP	-	Tribal hosp: 22 MD; 1 DO; 10 APC	1 MSW 1LCSW other	2 PHN	2 MD, 1 ANP	3 DDS, 2 RPh
Seward	5.6: MD (4.8); ANP & PA (0.8)	-	1 MD	2 PhD psych 1 LPC 1 MFT 1 MSW	1 PHN	1 PA	2 DDS, 1 RPh
Cordova	1 MD	1 NP 1 PhD psych, 1 MSW			1 PHN	-	1 RPh
Wrangell	Privileges only	3 MD 2 LCSW 1 MSW			1 PHN		1 CH,1 RPh
Nome/ NS Region	9 FP, 2 O.D. 5 RPh, 3 Au.D. 4 DDS	All 15 villages have CHC funding	15 tribal clinics in region		4 PHN	-	

FP = Family Practice
OB = Obsterics
GS = General Surgeon
MD = Family Medicine Doctor
RPh = Registered Pharmacist
ANP = Advanced Nurse Practitioner
PHN = Public Health Nurse
OD = Optometrist
DDS = Dentist
ANS = Anesthesia
Au.D. = Doctor of Audiology
MFT = Marriage & Family Therapist
LPC = Licensed Professional Counselor
MSW = Master of Social Work
Ch = Chiropractor

Appendix C: Medicare Inpatient Stays

Medicare Inpatient Stays

	Seen at AK Eligible Frontier CAH			Seen at Other Instate Facilities			Seen at Out of State Facility			Totals by Location of Service		
	Stays	**Charges**	**Days**	**Stays**	**Charges**	**Days**	**Stays**	**Charges**	**Days**	**Stays**	**Charges**	**Days**
Cordova Community Medical Center	11	$97,869	38	34	$2,754,520	315	7	$985,935	30	52	$3,838,324	383
Norton Sound Health Corporation*	88	$1,247,176	292	91	$4,017,278	606	7	$285,448	21	186	$5,549,902	919
Petersburg Medical Center	55	$395,514	146	25	$1,430,094	119	37	$2,287,145	179	117	$4,112,753	444
Providence Seward Hospital**	30	$296,660	111	57	$3,162,080	362	10	$572,903	64	97	$4,031,643	537
Providence Valdez Medical Center	49	$653,550	178	27	$1,959,590	188	17	$711,718	86	93	$3,324,858	452
Sitka Community Hospital	222	$3,588,572	1,313	62	$3,801,999	546	79	$4,329,261	465	363	$11,719,832	2,324
Wrangell Medical Center	63	$444,629	218	37	$971,837	210	41	$2,145,223	281	141	$3,561,689	709
Totals	**518**	**6723970**	**2296**	**333**	**18097398**	**2346**	**198**	**11317633**	**1126**	**1049**	**36139001**	**5768**
Source: Xerox State Healthcare, LLC Data from CMS Hospital Service Area File - CY2010				Note: Sitka data includes inpatients to the tribal Mt. Edgecumbe Hospital								
* Expanded to include zip codes 99659, 99671, 99739, 99742, 99753, 99769												
**Expanded to include 99631												

Data for Sitka Community Hospital should be viewed with caution. Mt Edgecumbe Hospital, serving the tribal beneficiaries of SE Alaska, is located within the same zip code. Given time constraints, it was not possible to separate the Medicare beneficiaries with tribal affiliations to traditional Medicare beneficiaries. A tribal and non-tribal hospital within the same zip code is rare, underscoring the complexity of Alaska's health care system.