February 18-20, 2009, Washington, D.C.

Health Resources and Services Administration
Office of Rural Health Policy

Washington, D.C.
February 18-20, 2009

Meeting Summary

The 61st meeting of the National Advisory Committee on Rural Health and Human Services was held February 18-20, 2009, in Washington, D.C.

Wednesday, February 18, 2009

The meeting was convened by Governor David Beasley, Chairman of the Committee. Governor Beasley introduced two new members of the Committee: Dr. Larry Gramm from College Station, Texas, and Mr. John Rockwood from Maple City, Michigan.

The Committee members present were: Larry K. Otis (Vice Chair); Graham Adams, Ph.D.; April M. Bender, Ph.D.; Maggie Blackburn, MD; B. Darlene Byrd, MNSc, APN; Larry Gamm, Ph.D.; Sharon Hanson, Ph.D.; David Hartley, Ph.D., MHA; Donna K. Harvey; David R. Hewett, MA; Thomas E. Hoyer, Jr., MBA; Todd Linden, MA; A. Clinton MacKinney, MD, MS; Karen R. Perdue; Robert Pugh, MS; John Rockwood, Jr., MBA, CPA; and Maggie Tinsman, MSW. Mr. Dennis Dudley attended, representing the U.S. Administration on Aging. Deborah Bowman was unable to attend.

Present from the Office of Rural Health Policy were: Tom Morris, Director; Jennifer Chang, Executive Secretary of the Committee; Carrie Cochran; Michelle Goodman; Jenna Kennedy; Michelle Pray-Gibson; Sherilyn Pruitt; and Meghana Desale.

HHS Welcome

Elizabeth M. Duke, Ph.D., Administrator, Health Resources and Services Administration (HRSA)
Mr. Dennis Williams, Deputy Administrator, HRSA

Dr. Duke spoke about growing up in a rural area and expressed her appreciation for the agenda that the Committee has adopted for 2009. She emphasized that the country is facing severe shortages of health professionals in many geographic areas. The problem is measured in both absolute numbers as well as uneven distribution. In response, HRSA is planning a Primary Care Provider Workforce Summit later this year that will bring together about 300 leaders in health education and related areas. She also spoke about home-based care for seniors, a second item on the Committee's agenda. She suggested that telehealth technologies can contribute to progress in this area and that the Committee should consider how the emerging professions of health care workers can contribute to progress in rural health. She concluded by thanking the Committee for its work.

Todd Linden asked Dr. Duke to comment on how the Committee reports are utilized in the Department. Dr. Duke replied that while a Secretary may not read every page of each report, the reports are carefully reviewed and taken seriously. She cited examples of when the reports and recommendations have been influential during budget deliberations within the Department. Also, Departmental staff use the reports in other briefings to the Secretary on rural health issues.

Karen Perdue asked how the recently enacted stimulus package would affect HRSA. Dr. Duke reported that there are funds for construction and expansion of Community Health Centers to provide enhanced services to underserved communities, for loan repayment and scholarship programs through the National Health Service Corps, and for health information technology initiatives in HRSA. Funds are also provided for prevention and wellness programs. A committee has been established in the Department to help guide decisions on how the funds are allocated and used.

Maggie Tinsman voiced concern about coordinating early childhood education and health and human services at the local level. Dr. Duke replied that every administration tries to bridge the many funding silos in these areas, but not everyone wants to try. HRSA strives for progress in this arena.

Donna Harvey commented that many elderly people are not prepared for telehealth technologies and suggested using television to communicate on health issues. Dr. Duke agreed that the elderly are often not comfortable with new gadgets and pledged to consider the potential uses of television.

Dr. Adams thanked Dr. Duke for her recent visit to North Carolina and her significant contributions to the integration of programs and services within HRSA.

Approval of the 2008 Report

Governor Beasley explained the report preparation process for the benefit of new members and called for a motion to approve the 2008 report. The motion passed.

Jennifer Chang said that the clearance process for the 2008 report may be delayed by the change in administrations. She said that clearance could take about four months. Governor Beasley reminded the Committee that the report is not public until final clearance is obtained from the Department.

Todd Linden asked if there had been a retrospective review of the Committee's recommendations. Tom Morris responded that some recommendations have been enacted into law while others have not been appropriate for legislation. Jeff Human added that the influence of the Committee has been extensive since its creation in 1988. He cited several examples such as the legislation creating State Offices of Rural Health that followed a recommendation of the Committee.
Several members commented that the Committee has an obligation to make the public aware of its reports. One suggestion was to involve the State Offices of Rural Health.

Health Care Provider Integration

Chandra Branham, Esq., Associate, Arnold and Porter, LLP

Ms. Branham opened her presentation with a discussion of major issues in health care integration and a brief analysis of why integration is so important. She noted that in our highly fragmented system providers do not have the information they need to coordinate care, and it is difficult to align incentives across different groups of health care providers. The major barriers to integration relate to Federal and State laws, provider-based rules, and discrete provider payment systems. One potential barrier is the Physician Self-Referral Law (The Stark Law) that applies to physicians who refer Medicare and Medicaid patients to entities with which they have a financial relationship. Medicare provider-based rules for rural Critical Access Hospitals (CAHs) have been changed so that CAHs can have on-campus clinics or off-campus clinics that otherwise meet CAH distance requirements, but the rules can still restrict service integration. Different payment systems for physicians, hospitals, home health, Skilled Nursing Facilities, etc. make it extremely difficult to develop incentives for service integration. The speaker described a number of CMS (Centers for Medicare and Medicaid Services) demonstration projects designed to break down these barriers and improve service coordination. These include Physician Group Practice Demonstrations, a pay-for-performance initiative, and demonstration projects to test chronic care improvement programs for Medicare beneficiaries. A successful program has been

recently extended to assess care management models for high-cost Medicare beneficiaries in the traditional Medicare fee-for-service program. Other programs are demonstrating models for physician-hospital collaboration. Some of these demonstrations require that a certain number of participants are rural providers. There is also a program to standardize patient assessment information for different post-acute care settings and to examine outcomes in each type of setting. Several other projects were described in her handout materials. Ms. Branham concluded her presentation with a discussion of how bundled payments can encourage more collaboration between hospitals and physicians. CMS is supporting demonstrations of bundled payments to improve care coordination, enhance the quality of care, and strengthen accountability. She briefly reviewed recommendations on bundled payments from the Medicare Payment Advisory Commission.

Mr. Hewett asked if the Committee should be concerned with antitrust issues in its work on provider integration. Ms. Branham responded that some small steps have been taken on these issues and that bigger changes will require legislation.

Ms. Tinsman asked about the number of rural demonstration projects, and Ms. Branham agreed to supply this information to the Committee.

Dr. Blackburn asked what CMS can do to shift services toward primary care. The speaker replied that some progress has been made in the physician payment system and that CMS has some quality initiatives that emphasize primary care.

Mr. Rockwood raised the issue of transportation in rural areas, stating that we need to look at the issue from the perspective of patients who find it hard to access the care that is already available. Ms. Branham said that some demonstrations have been developed with this in mind and that transportation is always a difficult issue.

HHS Role and Health Workforce

Marcia K. Brand, Ph.D., Associate Administrator for Health Professions, Health Resources and Services Administration

Dr. Brand provided an overview of the role of the Department of Health and Human Services (HHS) in health workforce policy. She announced that $500 million is available in the American Recovery and Reinvestment Act (ARRA) for workforce programs. Policy levers at the Federal level include statutory authorities, grant guidances, regulations, research and analysis, workforce shortage area designations, and Advisory Committee reports. CMS spends about $7 billion per year on Graduate Medical Education, but there is limited support for rural training.

HRSA workforce programs are funded under Title III of the Public Health Service Act (National Health Service Corps), State Loan Repayment Programs) and Titles VII and VIII of the Public Health Service Act. Title VII authorizes forty programs including training for health care professions, Geriatric Education Centers, Scholarships for Disadvantaged Students, and several national advisory committees. She said that there are some timely opportunities to influence policy through:

1) Reauthorization of Titles VII and VIII to provide more flexibility on how programs are funded and administered;
2) A new HHS "Mega" Advisory Committee that has been established to address health workforce issues;
3) The American Recovery and Reinvestment Act that provides millions of dollars in new health care resources; and
4) Health care reform. Dr. Brand said that a new Health Workforce Information Center has been established as a one-stop shopping point for health workforce information. In addition, a rural and underserved Primary Care Provider Workforce Summit will be held this fall.

Governor Beasley suggested that the Committee might make recommendations on how the stimulus funds are allocated. Dr. Brand responded that the Committee would have to act quickly for its voice to be heard.

Primary Care Workforce, Key Provider Groups

Daniel J. Ostergaard, MD, Vice President for Professional Activities, American Academy of Family Physicians
Shawn Martin, Director of Government Relations, American Osteopathic Association
Jan Towers, Ph.D., NP-C, CRNP, FAAN, FAANP, Director of Health Policy, American Academy of Nurse Practitioners
Sandy Harding, Director, Federal Affairs, American Academy of Physician Assistants

Dr. Ostergaard stated that nearly ten percent of all physicians are in rural practice and that, historically, rural areas have depended more on Family Physicians than other specialties. Family medicine is the only specialty that is distributed geographically in the same proportion as the general population. Currently, 22 percent of the U.S. population is rural and 20 percent of Family Physicians are practicing in rural areas. Past research has shown that medical schools located in rural areas graduate substantially more rural physicians. Participation in the National Health Service Corps (NHSC) doubles the likelihood that a student will later serve in a rural area, even after their obligation is completed. Attending a public medical school is associated

with a 77 percent increase in the odds of students choosing to practice as Family Physicians and a 66 percent increase in the odds of practicing in a rural area. Attending a medical school located in a rural area triples the likelihood of rural practice. Dr. Ostergaard made several recommendations to the Committee. His recommendations are:

1) Expand the NHSC opportunities to trade debt for service;
2) Work with state and regional government entities to encourage expansion of rural primary care loan repayment;
3) Expand funding for Title VII;
4) Encourage or directly support medical school expansion in rural locations; and
5) Support longitudinal rural training experiences in medical school and residency.

Governor Beasley asked Dr. Ostergaard for a letter on his recommendations to the Committee for use of stimulus funds. Dr. Ostergaard agreed to send a letter.

Mr. Martin expressed concern about our capacity to train new physicians and stressed the need for training in communities where we want them to practice. He said that community-based training is more prevalent for Osteopaths than for other physicians. He strongly supports expansion of the NHSC and improved medical markets for primary care providers. He made recommendations to the Committee to change and clarify the regulations for non-hospital-based training and suggested use of the tax code to assist students in financing a medical education.

Dr. Towers spoke from the perspective of rural Nurse Practitioners (NPs). She said that 20 percent of NPs are in rural areas and that 85 percent of the six-thousand NPs that graduate each year select primary care. Over 80 percent see Medicare patients and the uninsured. She discussed some barriers that NPs face in rural areas, including an inability to authorize home health care and hospice care for their patients. Also, they cannot order diabetic shoes and are often subject to cumbersome physician oversight requirements. They have no access to Medicare information technology incentives. States exercise discretion in recognizing NPs as primary care providers, often creating administrative delays in some states. NPs want to be consulted on health care reform and need access to the financial incentives that are now only available to primary care physicians. They are also seeking more participation in demonstration projects. There are about 250 nurse-managed clinics in the country that are funded by HRSA, most of them located in university settings. She advocates increased funding for these clinics, especially considering their likelihood to be placed in rural settings.

Dr. Blackburn asked if there are training programs where various health professionals are working together. Ms. Harding responded that some opportunities in team care are in place. Several Committee members mentioned examples of team training from their own experiences.

Mr. Hewett inquired about the number of primary care providers in the training pipelines. Dr. Ostergaard said that the pipeline for Family Medicine is drying up, but there is a glimmer of hope from recent matches in residency programs.

Mr. Pugh commented that opportunities for additional training resources have been lost due to turf battles among licensing boards and other issues that restrict entrance to health professions. Mr. Martin agreed that this is a problem, but that some professional groups are beginning to work together and recognize each other's worth.

Several Committee Members commented on the need for more training in geriatrics. Mr. Martin mentioned legislation that has been introduced to provide incentives for hospitals to start new residency programs.

Public Comment Period

Governor Beasley called for public comments. There were no comments and the meeting was adjourned until Thursday.

Thursday, February 19, 2009

The meeting was convened by Mr. Larry Otis, Vice Chairman of the Committee.

Partner Perspectives on Topics

Joanna L. Hiatt, Senior Associate Director, Policy, American Hospital Association

Ms. Hiatt spoke about rural hospital issues and Rural Health Clinics. She recommended that the rural hospital impact statements required before the issuance of Federal regulations could be improved and expanded. She cited one example of a rule on Rural Health Clinics that did not contain sufficient analyses of how many RHCs might be negatively affected by the rule. She urged the Committee to recommend that rural impact analyses be included in all rules, particularly those that are "rural-centric". She talked about the HRSA process for designating Health Professions Shortage Areas, commenting that it is a complicated process that tends to favor states with more experience in the application process. There is a need for better data and measures for underserved, since the number of primary care physicians alone is not an accurate measure. The availability of transportation and other access barriers need to be considered. She recommended that the Committee should also think about how to solve the "revolving door" provider turnover issue for underserved areas. She noted that the ARRA has funds for health information technology (HIT), but that hospitals and other entities can only receive the funds if they already have "meaningful" adoption of HIT. The definition of

“meaningful” (yet to be developed) could be too restrictive for rural hospitals and might exclude them from access to the funds. She said that in crafting this definition, the Federal government should consider the unique financial circumstances of rural hospitals.

Dr. Hartley noted that some regulations that lacked rural impact statements had been analyzed by Rural Health Research Centers in the past.

Home-based Care Options for Rural Seniors

John Wren, MPA, Deputy Assistant Secretary for Policy and Management, Administration on Aging
Gale Arden, Director, Public Programs, Research and Planning, Federal Programs, Blue Cross/Blue Shield, Tennessee
Wayne H. Giles, MD, MS, Director, Division of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion, CDC

Mr. Wren discussed the role of the federally supported aging network in serving rural America and noted that the agency will implement a large infusion of stimulus funds. Programs of the Agency are based on the Older Americans Act of 1965. The principal goal is to help elderly Americans maintain independence in their homes. The vehicle for program implementation is a national, state, and local network of agencies on aging supported by the agency. They serve over ten-million individuals each year and are able to leverage $2.00 for every Federal dollar spent. Services provided include congregate meals, in-home services, transportation, health promotion and wellness, and many others. There are about ten thousand service centers in the U.S. and territories. Funds are distributed according to population, with exceptions for some groups that have unique problems and needs. Rural areas receive 35 percent of Federal funds. New priorities of the agencies are to make it easier for consumers to learn about existing services and support and to help high risk individuals who are not Medicaid-eligible to avoid nursing home placement. Legislative amendments in 2006 called for evidence-based programs to reduce seniors’ risk of disease and the development of aging and disability “one stop shop” resource centers. Twenty states are working with CMS on a program that allows consumers to make their own decisions about the care they want. Mr. Wren suggested that this approach could help rural areas to increase the supply of local caregivers.

Ms. Arden spoke about home and community-based care from the perspective of the Medicaid program. About 40 percent of long term care was paid by the Medicaid program in 2004. Institutionalization (i.e. nursing homes) was the norm for past generations. This generation wants more choices in community-based living. Medicaid is a leader in home and community-based care and there are unique challenges to be addressed in rural areas. Maintaining an adequate workforce in rural areas is a critical issue. Transportation and accessible housing are

equally problematic. Medicaid is responding through consideration of personal assistance and self-direction initiatives, including hiring family members as care givers. Medicaid is also looking at the development of a uniform needs assessment for long-term care and the need for broader coverage of transportation for medical needs. Other initiatives involve automated applications for the program, quality assurance for community-based programs, the use of matching dollars to encourage deinstitutionalization, and other new approaches. States are also becoming more interested in using managed care approaches for long-term care services. There is little experience with this in rural areas. With respect to these developments, there are still major questions to be addressed involving payments to legally responsible relatives for home care and measuring the cost effectiveness of community placements. Ms. Arden asked the Committee to think about the rural issues of housing and transportation and the role of managed care in rural areas. She also raised the possibility of severing the link between the need for nursing home care and eligibility for home- and community-based services.

Dr. Giles presented the mission of his Agency, which is to prevent death and disability from chronic diseases and to promote healthy personal behaviors. These goals are accomplished in partnership with health and education agencies, voluntary associations, and the private sector. His presentation included a selection of maps showing geographic differences on such measures as flu shots, mammograms, colonoscopies, and high blood pressure. The maps showed wide disparities among geographic locations of the country on these measures. The Healthy Aging program at CDC is working to enhance the ability of States and communities to recognize and deal with these issues. A network of Prevention Research Centers was formed in 2001 to identify interventions that promote healthy aging. They are located at thirty-three universities throughout the country. Dr. Giles discussed some examples of community-based programs supported by the Agency. The programs are addressing such issues as the prevention of falls, delivery of pneumonia vaccines, and chronic disease prevention. He highlighted a program in South Carolina that has fostered a 54 percent reduction in amputations among African American men with diabetes. Dr. Giles reviewed the tools available to communities through the CDC, as well as training opportunities that are offered.

Mr. Linden asked about CDC activities in stress reduction. Dr. Giles said that the CDC is developing a surveillance capability in mental health and expanding its work on stress and other mental health issues.

Dr. Adams asked how to apply for the “REACH” grant program mentioned by Dr. Giles. Dr. Giles answered that the next competition will be held in three years and that the demand for these and other grants has been enormous. There is a CDC web site where grant opportunities are posted.

Dr. Hartley asked about interagency cooperation on transportation issues. Mr. Wren responded that his agency has been cooperating with the Federal Department of Transportation (DOT) to disseminate information and provide technical assistance on transportation programs and issues. He commented that some agencies are easier to deal with than others. Ms. Arden added that these issues suffer when states are having so much difficulty with rising Medicaid costs.

Ms. Tinsman commented about the difficulties of moving senior care from institutions to home- and community-based care. Two speakers responded that its all about having the political will and that the Committee should identify successful states and find out what they are doing. Medicaid does not reward successful states and the suggestion was made that the Federal match could be use for this purpose.

Home-based Care Options for Rural Seniors (Continued)

Sandy Markwood, Chief Executive Officer, National Association of Area Agencies on Aging
Virginia Dize, Assistant Director, National Center on Senior Transportation

Ms. Markwood described the role of the Aging Network in helping millions of Americans to maintain their independence. The Network currently serves about ten million seniors, 33 percent of whom live in rural areas. Many of the local agencies are independent entities, some are part of a county government, and there are other arrangements as well. Services include nutrition, transportation, family caregiver support, home-based care, benefits counseling, and legal assistance. A large part of the financial support comes from local and State governments, including Medicaid. Ms. Markwood reviewed the data on aging of the population, saying that Medicaid spending for long-term care will be $3.7 trillion in the next twenty years. She said that virtually all seniors want to “age in place” and her organization is urging the expansion of home- and community-based services. They have a policy proposal with three major components:

1) Person-centered access to information for anyone interested in long-term care;
2) Evidence-based disease prevention and health promotion; and
3) Enhanced nursing home diversion services.

She estimates that these components can result in major cost-savings for the Federal government.

Ms. Dize talked about the transportation challenges faced by older adults in rural areas. She presented a list of approaches, noting that the options are very different depending on local needs and resources. In rural and frontier areas, long distances to medical appointments, road

conditions, state boundaries, and gas prices are significant challenges. Rural elders are more dependent on their cars, and one in five Americans over 65 either do not drive at all or must modify their driving patterns to accommodate health concerns. There is data showing that non-drivers make fewer trips to doctors and far fewer trips for social activities. Only one in 20 drivers in rural areas use public transportation, and nearly 40 percent live in communities without public transportation. Transportation funding is complicated and comes from a variety of sources. A few of the main funding sources are programs through the U.S. Department of Transportation, , States (including Medicaid), and local levies. Her organization noted that educational and training support for older drivers is an essential component of a senior transportation program. She also said that older people need easy access to information about their options. Her organization is supporting “one call” programs that provide transportation assistance, mobility counseling, and projects in order to break down geographic and program barriers to transportation services. She said that options can be expanded through volunteer training, pooling resources, and more coordinated use of existing resources. Her presentation included some examples of successful strategies adopted by several communities.

Ms. Tinsman asked about long-term care insurance and how we can expand it for seniors. Ms. Markwood replied that we need to support financial planning for those who are aging and to involve them earlier in the process. Area Agencies on Aging are working on this issue.

Partner Perspectives on Topics (Continued)

Alan Morgan, Chief Executive Officer, National Rural Health Association
John Sawyer, Director, Federal Affairs, Federal and State Affairs, National Association of Community Health Centers
Bill Finnerfrock, Executive Director, National Association of Rural Health Clinics
Jocelyn Richgels, Associate Director, National Policy Programs, Rural Policy Research Institute

Mr. Morgan spoke briefly about the National Rural Health Association, distributed some materials for consideration by the Committee, and offered several recommendations. First, he recommended that the Committee focus attention on the ARRA, particularly the significant funds for heath information technology. He agreed with a previous speaker that the “Stark” bill and provider-based rules need to be studied for their impact on service integration. Different payment systems are also an impediment to collaboration. He cautioned the Committee not to advocate payment bundling strategies that would reduce payments to rural providers. Along with other presenters, he asked the Committee to focus on primary care education and expansion of the NHSC.

Mr. Sawyer began with comments about the primary care workforce in rural areas. Current shortages may impede the expansion of Community Health Centers and other parts of the health safety net. He said that medical residents are not sufficiently exposed to rural areas, and the bias of the payment system toward medical procedures discourages careers in primary care. The National Association of Community Health Centers supports expansion of the NHSC, greater focus on primary care under Titles VII and VII of the Public Health Service Act, expansion of the J-1 Visa Program for foreign medical graduates, and development of an improved infrastructure for training primary care health professionals.

Mr. Finnerfrock talked about program integration issues at the Federal level and the need to support integrated systems of care. He said that the medical home concept should be expanded to encompass a "medical neighborhood." Since there is a need for specialists as well as primary care providers, the medical home must be viewed as the portal to other specialized services. He called for greater recognition of non-physician providers and said that we need to stop thinking about them as "second-tier" professionals. He has been interested in a demonstration project in the Northwest where patients are using computers in their homes to track such things as weight change and other personal parameters that can affect a heart condition.

Ms. Richgels spoke briefly about telehealth issues and the role of community colleges in workforce development. She distributed a publication (Focal Point) produced by the American Public Health Services Association that contains many specific recommendations related to the interests of the Committee. She drew particular attention to recommendations to reduce Medicaid emphasis on costly institutional care and to provide equitable eligibility standards for home- and community-based care and institutional care. The publication makes other policy recommendations related to program integration and workforce.

Dr. Blackburn asked if changes are needed in payments to Rural Health Clinics. Mr. Finnerfrock answered that there is a cap on payments that should be raised and mentioned some Medicare benefits that are not covered by the payments.

Mr. Rockwood commented on the need to consolidate physician practices in some rural areas. Mr.Finnerfrock referred back to his earlier comments on a "medical neighborhood" and noted that some Rural Health Clinics had formed rural networks. He also said that the current payment system does not support group practices.

Dr. Adams talked about barriers to collaboration between rural providers and the need for new models of service integration.

Dr. Gamm asked if Rural Health Clinics could benefit from HIT funds in the stimulus bill. Mr. Finnerfrock said that provider-based clinics or those with needy clients could potentially qualify for these funds.

Public Comment Period

Ms. Marcie McLaughlin from the Rural Health Policy Institute introduced herself and announced that the Rural Community College Alliance has increased its membership significantly. The Alliance is involved with rural health workforce issues.

Ms. Jocelyn Richgels from the Rural Health Policy Institute expressed concern with the level of staffing provided to the Committee by the Human Services agencies within the Department. She believes that such agencies should make more of an attempt to provide resources and staff for rural issues.

Subcommittee Meetings

The Committee spent the remainder of the day in Subcommittee meetings. The new Subcommittees for 2009 are:

Rural Primary Care Workforce: Dr. Blackburn (Chair); Mr. Pugh; Dr. Gamm; Ms. Perdue; Mr. Otis; Ms. Byrd; and Dr. Bender.

Health Care Provider Integration: Mr. Linden (Chair); Dr. Hartley; Dr. Adams; Mr. Rockwood; Dr. MacKinney; and Mr. Hewett.

Home-Based Care Options for Rural Seniors: Ms. Harvey (Chair); Mr. Hoyer; Ms. Tinsman; and Ms. Bowman.

Friday, February 20, 2009

Vice Chairman Larry Otis convened the meeting and called for reports from the Subcommittees.

Dr. Blackburn reported for the Subcommittee on Rural Primary Care Workforce. Her group will focus on the designation criteria and process for Health Professions Shortage Areas, the National Health Service Corps, reauthorization of Titles VII and VIII of the Public Health Service Act, interdisciplinary training programs, the J-I Visa Program and CMS reimbursement policies for RHCs and FQHCs.

Dr. MacKinney reported for the Subcommittee on Health Care Provider Integration. This group will study barriers to provider services integration related to Medicare and Medicaid payment systems, regulatory requirements for providers, and cultural differences among the various provider organizations. The effect of bundled payments on rural providers will be a key issue.

Mr. Hoyer reported for the Subcommittee on Home-Based Care Options for Rural Seniors. This group will consider recommendations to expand community-based care options for seniors, to increase the information available to seniors on home-based care options, to facilitate the use of home and community-based waivers under the Medicaid Program, and to increase the use of case management services by States.

There was a brief discussion of topics that will be researched by staff and the need for more uniform chapters in the report for 2009.

The American Recovery and Reinvestment Act (ARRA)

Ms. Chang asked the Committee for recommendations on the use of funds in the ARRA. There was only time for Committee comments on the funding for Health Information Technology and Health and Wellness programs.

Health Information Technology: A critical issue is how to define “meaningful” adoption of HIT as a criterion for receipt of the stimulus funds.

Dr. Gamm said that rural providers could be excluded if it means more than the selection of a vendor.

Dr. Hartley and others suggested that interoperability must be a requirement for access to the funds, although this will be difficult to define given the complexity of HIT systems.

Mr. Rockwood said that a reasonable question to ask is how the systems will be maintained.

Dr. Bender said rural needs will not be met unless there are national standards for interoperability because so many patients cross state lines. She suggested that the Veterans Administration model may be a good place to start.

Mr. Hoyer said that it may be necessary to hold back a portion of the funds because some rural providers may not be ready yet.

Health and Wellness: The Secretary will have discretion on the disposition of these funds.

Dr. Adams said that the Committee should recommend a rural focus for some of these funds to ensure that rural areas are not overlooked.

Dr. MacKinney commented that most preventive care takes place in physician offices.

Ms. Tinsman suggested that school-based clinics would be a good place to start in rural areas.

Several members commented on the need to focus funds on community-based programs.

Administrative Issues

There was a brief discussion of plans for the next meeting to be held on June 9-11, 2009 in Rapid City, South Dakota. The fall meeting will be held on September 9-11, 2009 in Sacramento, California.

Letter to the Secretary

Dr. Bender suggested that the Committee letter to the Secretary on this meeting should comment on the necessity for greater Federal inter-Departmental and intra-agency collaboration in health care and human services.

Public Comment Period

There were no public comments and the meeting was adjourned.