

**Health Resources and Services Administration
Office of Rural Health Policy**

National Advisory Committee on Rural Health and Human Services

**Spring Meeting
Saratoga Springs, New York
April 16-18, 2018**

Meeting Summary

The 83rd meeting of the National Advisory Committee on Rural Health and Human Services was held April 16th-18th, at The Saratoga Hilton in Saratoga Springs, New York.

The committee members present at the meeting: Kathleen Belanger, Ph.D.; Kathleen Dalton, Ph.D.; Carolyn Emanuel-McClain, MPH; Kelley Evans; Barbara Fabre; Constance Greer, MPH; Octavio Martinez, Jr., MD; Maria Sallie Poepsel, MSN, PhD, CRNA; Chester Robinson, DPA; Mary Kate Rolf, MBA, FACHE; Benjamin Taylor, Ph.D., DFAAPA, PA-C; Donald Warne, MD.

Present from the Federal Office of Rural Health Policy: Tom Morris, Director; Steve Hirsch, Executive Secretary; Paul Moore, Senior Health Policy Advisor, Sahira Rafiullah, Senior Advisor and Normandy Brangan, Health Insurance Specialist.

Truman Fellows present from the Office of Rural Health Policy: Alfred Delena and Victoria Maloch.

THE SARATOGA HILTON – SARATOGA SPRINGS, NEW YORK

Monday, April 16, 2018

The meeting was convened by The Honorable Ronnie Musgrove, Chair.

WELCOME AND INTRODUCTIONS

Paul Moore, Senior Health Policy Advisor, The Federal Office of Rural Health Policy, welcomed the committee members and stated that the topics of the meeting are The Rural Context of adverse childhood experiences (ACEs) and Rural Health Insurance Market Challenges.

MEETING OVERVIEW AND NACRHHS KEY PRINCIPLES

Since the passage of the Affordable Care Act, the committee has offered recommendations to the Secretary on how to implement the legislation in rural areas. The meeting will focus more broadly on how insurance does and does not work for people living in rural communities. Adverse Childhood Experiences (ACEs) will focus on how social factors can influence health.

This includes chronic stress and trauma that are experienced in childhood and the long-term effects on health and wellbeing.

WELCOME AND INTRODUCTIONS

Kate Breslin
President and CEO
The Schuyler Center

Kate Breslin said she is honored to speak to the committee and thanked them for the work they are doing. The Schuyler Center is nearly 150 years old and was founded by Alexander Hamilton's great granddaughter, Louisa Lee Schuyler. She was a fiercely independent, civic minded, woman in the 1800's and served in the Sanitary Commission during the Civil War. She returned to New York State after the war. New York State institutionalized people when they were poor placing them in poor houses in rural and urban communities. Ms. Schuyler saw the horrid conditions in the poor houses and assembled her wealthy friends to create visiting committees to document the deplorable conditions. The visiting committee members went to Albany to demand change and won. There are still problems with public institutions and The Schuyler Center continues to identify areas where the state government needs to make improvements. The Schuyler Center assesses the same issues that the committee has examined; poverty, social determinants of health, adverse childhood experiences and access to quality health insurance coverage.

Saratoga is the gateway to the Adirondack Park and one of the last urban areas before going north to Canada. When people think of New York they often only think of New York City. About one half of the children in the state, children in foster care and people covered by Medicaid are located in New York City. This creates challenges in the response to efforts

There are many positive aspects of New York State. Ninety seven percent of children in New York State are covered by health insurance. The minimum wage was recently raised to fifteen dollars an hour. New York has one of the most robust paid family leave systems in the nation. New York City has universal pre-k but the rest of the state does not.

Children need economically stable families, healthy bodies and minds, safe homes and communities, and a sound education that starts at a young age. New York is viewed as a wealthy state and has the twelfth strongest economy in the nation, however, child wellbeing numbers are deficient. Sixty five percent of poor families have at least one parent who is employed. There are also very large disparities in school that causes challenges. The focus of The Schuyler Center is to prepare children to enter kindergarten so it is important to include the health system. Work is being done to strengthen and expand the New York State child tax credit and to quality childcare across the state. Fewer than twenty percent of families with eligible children receive childcare subsidies. Increasing full day pre-k outside of New York City is another Schuyler Center initiative.

Kate Breslin stated that before working at The Schuyler Center, she was employed with local Federally Qualified Health Centers. There is evidence that child and family health is intertwined

and there needs to be two generational approaches. The two-generational approach is not well addressed in the medical care systems and health insurance systems. A parent's health and wellbeing impact a child's but it is not considered in payment of health care services. The Schuyler Center is working with state agencies to do better at supporting family health and changes payment structures to support the whole family approach.

Social determinants of health affect everything about a person's wellbeing. The public health functions are often separate from the medical care functions. New York State is doing system redesign to get better outcomes and addressing the social determinants of health. The Schuyler Center created a state work group that was sanctioned by the Medicaid agency to address the social determinants of health. The work group consisted of different state agencies, providers of care, and advocates from community-based organizations.

New York State is moving toward value-based payment so the managed care organizations and providers will be expected to prove outcomes. The state work group recommends that providers and managed care organizations address at least one social determinant of health. Because the issues are different among communities, providers need to assess the need of their community. Providers need to know the entities available to address social determinants of health so there is an effort to support initiatives in communities to build a catalog of resources. Every provider has to include one community-based organization to address the social determinants of health. The state agency is working on metrics to track the success of the interventions. Providers and payers are beginning to work together to address social determinants of health and embracing the concept that it is more than just about medical care.

The health and child welfare system can assist with the issue of toxic stress. It is prevalent and can cause physical health problems for a lifetime if not addressed. Toxic stress causes human suffering and costs to the medical care system. Forty five percent of New York State children have had at least one or more adverse childhood experiences (ACEs) with thirty eight percent of children being between the ages of zero to five years old. The goal is that all children will grow up in safe, stable and supportive homes. New York City has done a great job of placing children in families but in other parts of New York State children are often placed in institutions. There is work being done with the state and county agencies to place children in more appropriate settings.

The Schuyler Center is doing work with children ages zero to three related to ACEs and toxic stress. There is more than one billion spent on Medicaid in one week in New York State. Nearly sixty percent of children ages zero to three are covered by Medicaid. The medical care system is the only system that is in contact with a child zero to three. The data shows that most of those children are seeing a family pediatrician and getting screenings and immunizations. The pediatricians office is a great platform to connect families to other services. Medicaid can change the trajectory for kids and families in the early years is doing this in New York through the First 1,000 Days on Medicaid Initiative.

Q&A

Kelley Evans asked about the child tax credit federal program and how many states are participating.

Kate Breslin responded that the Center on Budget and Policy Priorities and Economic Policy Institute will have that information. She said she can find out and let her know.

Octavio Martinez stated that he is interested in the screening for Adverse Childhood Experiences (ACEs) and how it is being developed.

Kate Breslin said that there was a diverse work group and there was a debate over which tool to use. The Federally Qualified Health Centers has a pilot screening called PRAPARE that includes transportation, housing, nutrition. The state agency is not planning on coming up with a screening but utilize others that are already in use.

Barb Fabre said that data collection is an issue in many areas visited by the committee. It is great that New York has 60% of children covered. What about the other 40%?

Kate Breslin said that the rest have commercial coverage. The focus of the organization is on the people who are the most vulnerable. Since Medicaid is a program for low income families or children with disabilities it will cover the most vulnerable children. The other exciting thing about Medicaid is that it is the single largest payer for services. The way that Medicaid pays for services can drive how the whole system works. If there is a shift in how Medicaid does things it can have an impact on how providers do things.

Kathleen Belanger asked if there are sufficient community resources in the counties to link the health systems with the community resources.

Kate Breslin stated that Medicaid Matters New York includes individuals and organizations across the state. There has been encouragement from the state to medical providers to utilize community-based organizations and there has been funding to some of the larger medical care entities. The money has not flowed from performing provider networks to community-based organizations. Some of the work being done is on local levels because it is different in every community. Medicaid Matters has been working with different organizations to assist community-based organizations to join together. When getting policy passed there has to be consideration about the implementation.

Chester Robinson stated that health care professionals are forces to working with the super utilizers regarding social determinants of health issues. How do you get people to listen to you when they have so many demands in the public policy arena about a long-term solution?

Kate Breslin responded that policy makers have to think beyond election cycles. Some of the outcomes will not happen before the next election. Doctors are focused on the immediate needs so there has to be policy change. A technical assistance program that goes into the pediatrician office and works with the doctor and the person doing the billing is valuable. The policies can change but if the doctors are just meeting immediate needs there will not be change.

RURAL HEALTH INSURANCE MARKET CHALLENGES: NATIONAL PERSPECTIVE

Tim McBride, PhD, MS
Professor, Brown School
Co-Director, Center for Health Economics and Policy
Washington University

Tim McBride said he would share work with the committee through the Rural Policy Research Institute and talk about economic theory and rural specific issues in various markets. There has been attention called to the lack of health insurance options in rural counties and higher premium rates beginning in 2014. In 2015 and 2016, the premium growth rates were higher in rural than urban. In 2018, the growth rate was even in rural and urban.

There are similar rural areas that lost Medicare Advantage Markets and The Affordable Care Act Market Exchange plans in 2018. The Federal Health Benefits Plan was used as a model for the Affordable Care Act and it is throughout the country. Eighty-two counties have zero state specific plans and eight hundred and eight counties in the United States have only one state specific plan. In states with two to three state specific plans, the number of people enrolling in national plans goes from ninety-five to sixty five percent. When there is a move from two to three plans, the level of competition goes up and people are more likely to move to state specific plans.

In 1980's, after the implementation of Medicaid, Medicare, and FEHBP, there were concerns about containing health care costs, and making them a predictable part of the budget. This was one of the original motivations to contract with private companies via a capitated payment. Congress sought to increase consumer choice by establishing a market-like structure within each program that encouraged participation from multiple insurance firms competing against each other for business. The view was that competition worked well in many other sectors to contain cost, improve choices, while preserving quality.

Technological improvements over the last several decades led to increasingly expensive treatments that raised costs in the upper tail of the cost distribution. Private companies had increased incentive to behave strategically. When private firms became responsible for their enrollees health costs, the notion of actively managing care arose. The task of managing care implies a need to contract with a range of health care providers. It also includes finding ways to encourage enrollees' use of preventative care to save money in the long run. Managing care is also finding ways to manage healthy behaviors. This type of provider network is now an integral part of any discussion of health insurance.

An issue with economic theory is adverse selection. This happens when healthy individuals choose not to purchase insurance because it is not worth it to them and sicker people purchase more comprehensive coverage. The risk pool is sicker and more expensive. Regulators used screenings and risk segmentation to impact adverse selection. The government can place limits

within the market place to counteract adverse selection. Evidence shows that a market approach with the additional structure works well over all. However, Center for Medicaid and Medicare Services analysis shows that 83% of market approach enrollees who had access to a plan that charges zero additional premiums were urban and 47% rural enrollees.

Abigail Barker, PhD

Research Assistant Professor, Brown School

Faculty Lead for Data and Methods, Center for Health Economics and Policy

Washington University

Abigail Barker stated that she will share rural specific issues including risk pools and network formation. Health insurance the way it is today is to serve two distinct functions. From an economist point of view, it is a mechanism for sharing risk. It is also a means of access to a range of providers who are managing enrollees health. The current market-based insurance programs fall short in both areas because of the smaller populations and lower population density. There are fewer health care providers in rural communities.

Small risk pools are problematic because the risk adjustment formulas are imperfect. If there was access to a person's full claims history, it would only predict half variation in future claims. Adjusting for risk ex-post can be a risk adjustment but it makes the government the true insurer and it decreases the firms' incentive to manage care and control claims. Small risk pools are especially a problem because firms rely on the law of large numbers to forecast the sum of claims. Firms are pressured to show a positive return on investment on a regular basis and with managed risk there will be some negative and positive performance over time.

The second role of insurance is a means of access. Firms have to form a network of providers that will meet the needs and there are administrative costs that are greater and spread over a smaller number of enrollees. The standards combined with sparse providers in rural areas are creating opportunities for strategic behaviors by firms. When firms are exiting a rural area, they are justifying it by saying that rural providers are too expensive. Their reference point is the negotiated rate that urban providers are willing to accept. Fixed costs include facilities, equipment, and electronic medical record systems. The costs are recouped across all of the patients that are seen and fixed costs are higher in rural. Variable costs are flexible and may be recouped as part of the marginal cost of seeing a patient.

The market-based models encourage marginal thinking. The firm is being encouraged when negotiating prices to assess the cost of one more person against the benefit. The firm is thinking of a person they could enroll as not being to their marginal benefit. Even when premiums vary by geography, like Medicare Advantage, firms will still want to keep their premium as low as possible. That is creating an incentive to pressure rural providers to accept lower rates. If the provider is not needed to meet network adequacy, it is easier to omit the provider if they are not willing to accept the lower rate.

The geographic unit for Medicare Advantage is the county. Firms bid against a benchmark that comes from a complicated formula that is tied to prior data on fee-for-service Medicare costs in

the specific county. It encourages the firm to treat each county as a marginal decision. They can set a higher premium but they know they will not get as much enrollment or market share.

The geographical unit for Health Insurance Market places are different in different states. It is usually a group of 5-10 counties including a metro or micro area. State regulations vary and in some states a firm has to offer coverage throughout the rating area and in others states there is less regulation. In many states they prefer that coverage is offered throughout the rating area but the state will give an exception if needed. The larger rating area is overall a promising idea because there is the benefit of the larger risk pool. If there is a larger rating area it may be more difficult to form a network that can cover the area properly.

Negotiating reimbursement rates depends upon a number of factors including relative market power of the insurance firm and provider. If the firm is accustomed to reimbursing marginal costs only, it may refuse to contract with a rural provider who needs fixed costs covered. Bargaining power is weakened when they are heavily dependent on public-dollar programs. The more providers depend on Medicare and Medicaid for reimbursement, the more they feel there is no choice but to take what is being offered by a plan. Bargaining power of the firm is strengthened by policies that limit their exposure if they fail to contract with the provider.

There are many different healthcare services at varying degrees of complexity. Larger hospital systems have the incentive to behave strategically to undercut the smaller local providers. The hospital can offer marginal cost pricing or below on services than the smaller providers, such as critical access hospitals and rural clinics. This undercuts the smaller providers ability to stay in the market. This gives the insurer the impression that local providers are too expensive to include in the network.

Policy opportunities and recommendations include:

- Spreading risk across rural places
 - Across programs
 - Multi-state rating areas
 - Require the rating area to be the actual service area
- Provide incentives to form nationwide plans
- Adjust payment policy to reflect the reality of fixed costs in rural
 - Provider level
 - Clinic or hospital level
 - Public health department level
 - Invest resources into rural provider affiliations to lower firms' network formation costs

Network adequacy is so variable across different regions. It is important to be very transparent about what plans are offering. Rural people should be able to see what their network is and if it will be adequate for them. Rural people have to travel longer distances for specialty care but may have strong preferences for local providers being in-network for routine care.

Q&A

Octavio Martínez said that what was not part of the recommendations is that rural should be viewed differently than urban regarding health care. The providers could have accelerated depreciation to take care of their fixed cost expenses. Their interest rates should be lower and they should get a longer-term payout schedule. This will allow them to be competitive. Have you thought about those types of possible innovative programs?

Tim McBride said that sometimes aspects of care need to be directly subsidized. The point about accelerated depreciation touches on higher fixed costs in rural areas. Small risk pools and higher fixed costs versus variable costs in rural areas is an important issue.

Normandy Brangan asked if Tim and Abigail could talk about rating areas where plans are offered versus services areas.

Tim McBride responded that regarding the Affordable Care Act and Medicare Advantage, the policy makers have not paid enough attention to the issue of service areas and the real world where services are delivered. They use the political boundaries to divide payment. The Affordable Care Act leaves it up to the states so they can create rating areas that are a conglomeration of counties. Some states combined counties. In Missouri, the counties have been divided closer to services areas but in many states, they do MSAs plus one. In Florida, they just made counties the rating areas which is the worst scenario. Even if a state has a rating area, there are some states where plans can choose parts of a rating area to offer plans. This is recreating the adverse selection problem.

Abigail Barker said that she has studied Missouri's map. Missouri was one of two states that petitioned to have a greater number of rating areas than allowed by the statute. The supporting evidence was they wanted ten rating areas because it was the right number to match their service areas. They were approved so there should not have been a problem with firms coming in and only offering in ten out of fifteen counties in a certain rating area but it happened. It is an ideological choice that Missouri made to allow the firms to go where they want to go and not be restrictive of the requirements.

RURAL HEALTH INSURANCE MARKET CHALLENGES: STATE PERSPECTIVE

Donna Frescatore

Executive Director, New York State of Health

Medicaid Director, New York State Department of Health

Donna Frescatore shared that the New York State of Health is the brand name for the insurance market place that was created under the Affordable Care Act. It was created under Governor Cuomo's Executive Order and launched in October, 2013. There is a tremendous collaboration between New York State of Health and the insurance regulator.

The vision was for a single place for New Yorkers to shop for and enroll in coverage for qualified health plans, Medicaid, Essential Plan and Child Health Plus. Coverage is provided to

4.3 million New Yorkers which includes more than 1 in 5 New Yorkers. The uninsured rate has been cut by half since 2013. This equates to almost one million workers gaining coverage.

Eleven percent of New York State of Health enrollees reside in a county with a population less than 200,000. Nine percent of enrollees live in a Health Resources and Services Area designated zip code. In rural counties there has been a significant increase in enrollment in the market place since 2014. The increase from 2014 to 2018 was 127,000 to 461,000 enrollees. In all forty-four New York State counties with populations less than 200,000, enrollments increased. The increase included every rural county in the state. The biggest increases were in Ulster, Schenectady, Oswego, Rensselaer and Broome Counties.

The factors that reduced the uninsured rate are Medicaid expansion and the Basic Health Program option. The Affordable Care Act premium tax credits that lower monthly costs and choice of comprehensive plans also reduced the uninsured rate.

The Choice of Health Plans in New York rural counties has 5-7 choices of health plans. The Qualified Health Plan, Essential Plan and Medicaid are the most common plan choices in rural areas. New York permitted the traditional Medicaid insurers to provide qualified health plans in the essential plan. The goal was to have a choice of health plans across all of the programs. Minor fluctuations of income from year to year can change coverage from program to program. Enrollment in the Essential Plan is open all year long. In forty of the rural counties, at least one health plan participates in all programs. In 22 counties, two or more plans participate across all of the programs.

In Oswego County, a rural county in Central New York, with an income of \$16,753, there is Medicaid coverage for no cost. With the Essential Plan: Annual salary of \$18,090 there is no cost and with an annual salary of \$24,120 the cost is \$20 per month. The cost of the Qualified Health Plan: Annual salary of \$25,000 per year is \$17 per month, annual salary of \$35,000 per year is \$150 per month and annual salary of \$48,241 and above is \$451 per month.

Outreach and education has to be tailored for different communities. Each year there has been a funded advertising campaign. There are thousands of community outreach events at supermarkets, farmers markets, state parks, and food pantries. There are navigators, certified application counselors and licensed insurance brokers to assist those applying and enrolling in insurance plans. Navigators also make home visits to assist people who may not have transportation.

John Powell
Director of Rate Review, Health Bureau
New York State Department of Financial Services

John Powell stated that the New York State Department of Financial Services works closely with the New York Department of Health and with the marketplace and are the primary regulator of commercial health insurance.

The New York rural markets are not all the same. There are regional markets with different characteristics including different payer mix, different provider mix, impact and competition and innovation differences, and differences in proximity to urban areas which can impact accessibility. The New York Health Foundation did a report on variation of hospital prices. The study had to be done on a regional level because there is such variation in regions. Policy is mostly done on a state level but it is important to know how the dynamics work on a local level.

New York does not regulate provider reimbursement but does have approval authority over individual and small group rates. Federal law requires a single risk pool in individual and small group markets. That has aided rating by pulling together larger pools. Pure community rating means that premiums must be the same regardless of age, gender, occupation and health statuses. Under the Affordable Care Act, age rating is allowed so there can be higher rates for older people. The Premium Plan Rating in New York has allowable rating adjustments. Three are standardized rating regions for health care plans. Adjustments to premium rates can be done between regions. Rural counties are not just in one confined area but are all over the state. The competitive cost is very different in each region.

Consumer protections include network adequacy and making sure that premium rates reflect the local area. Insurers are required to maintain a provider network that is sufficient to meet the health needs of the insured and provide an appropriate choice of provider. Insurers must give information to the insured that permits them to determine out-of-pocket costs for out of network services. If an insurer does not have an out of network provider needed by a patient, the patient is allowed to see an out-of-network provider at an in-network cost-sharing. This keeps the patient from having to be in the middle of the conversation between the provider and insurer.

Time and distance standards for primary care providers in metropolitan areas is thirty minutes by public transportation and in non-metropolitan areas is thirty minutes or thirty miles by public transportation or by car. Rural areas have travel challenges so transportation can exceed these standards. It is preferred that an insurer meet the thirty minutes or thirty-mile standard for other providers that are not primary care providers.

Models for Innovation are the Adirondack Medical Home and Adirondack Accountable Care Organization. Nine payers and many primary care facilities and physicians worked together to increase payments to PCPs for care coordination and electronic health record capabilities. The New York State Innovation Model (SIM Grant) was used to develop the New York Primary Care Medical Home Model. There has been extensive work developing the New York PCMH Model based on a regional theme with various stakeholders including payers and primary care providers as partners in the initiative.

Challenges are that the New York Primary Medical Homes are centered around urban areas. The Adirondack Medical Home is in Glenn's Falls but farther north it is more rural so it does not work as well in that area. Density of population is necessary for the investment to be worth it if insurers and providers.

Q&A

Benjamin Taylor stated that from 2015-2017-time period there were many insurers dropping out of the market places. How did you mitigate your losses and make your market places so viable with such a strong showing?

John Powell responded that when premium rates go up, as the regulator of commercial insurance, we are also responsible for solvency to make sure that carriers are solvent and that is the biggest form of consumer protection.

Donna Frescatore said that there were two health plans in New York that are no longer in existence and it can cause challenges for consumers. The decisions in New York to use the same subset of insurers across Medicaid Managed Care, the Essential Plan and Qualified Health Plans has created economies of scale, especially since the Essential Plan has grown. The Essential Plan is the basic health program and is a hybrid that is open all year. With tremendous growth in health plans, people in the lower income bracket, even with tax credits, were not signing up. The uptake rate was not the same as it was at higher incomes. Over 90% of the people who get an eligibility determination in the Essential Plan do sign up. That helped build the markets and added additional insurer volume. There is not a requirement that the health plans have to be in all the programs but it is strongly encouraged and they have found that it has worked from a business model stand point.

Chester Robinson asks what criteria was used to establish regions. Some regions are much larger than others. It seems that the health insurers would have determined regions very differently.

John Powell stated that they looked at Medicare and Medicaid regions and then talked to the insurance companies. The actuaries looked at rating regions and made some necessary changes and talked to the insurers also. The insurers agreed with the benefit of being standardized between carriers because it allows them to compete.

Sallie Poepsel asked to hear more about the innovation in the primary care market. What is the payment structure for reimbursement and are there time constraints built in?

John Powell responded that value-based payment programs vary by contract. It is a matter of negotiation and there can be quality metrics involved. It varies by insurer and every insurer in New York has a primary care innovation program but they are all different. Insurers have invested in health information technology systems to collect measures for payment. There is an effort within the State Innovative Model Grant Initiative to create a common set of quality metrics.

ADVERSE CHILDHOOD EXPERIENCES – PART I

Elizabeth Crouch

**Assistant Professor, Department of Health Services Policy and Management
Faculty, South Carolina Rural Health Research Center
University of South Carolina's Arnold School of Public Health**

Elizabeth Crouch shared that in the past two to three years, The South Carolina Rural Health Research Center has had a relationship with Children's Trust South Carolina who has funded the Adverse childhood experiences (ACEs) questionnaire survey in South Carolina.

Adverse Early childhood experiences (ACEs) are traumatic events and are linked to risky behaviors in adulthood as well as chronic conditions. Adverse Early Childhood experiences are also intergenerational so if parents experience ACEs it leads to their children experiencing them. Four or more adverse childhood experiences have higher levels of risky behaviors and chronic health conditions.

Those with four or more ACEs are more likely to engage in risky drinking behavior such as binge drinking and heavy drinking. Those who have experienced ACEs continue to smoke with a diagnosis of a smoking exacerbated illness and have poor self-reported mental health and physical health in adulthood.

The Center for Disease Control Behavioral Risk Factor Surveillance System (BRFSS) eleven-question ACEs survey is given to adults to report about their childhood. The questions include household mental illness, depression, substance abuse, heavy drinking, exposure to drugs, domestic violence, incarceration and divorce. It does not ask some of the questions that the National Survey of Children's Health includes that possibly relate more to rural. An example of questions that are exempt is about racial discrimination or economic hardship. The NSCH questionnaire is answered by parents and guardians who may be hesitant to report ACEs about their children.

There are limited and mixed findings about adverse childhood experiences in rural areas. The Maine Behavioral Risk Factor Surveillance System (BRFSS) ACEs questionnaire using eleven states that included rural and urban, reported similar burdens of ACE exposure. South Carolina BRFSS found that rural adults are less likely to report any adverse childhood experiences than urban adults.

The 2016 data from the National Survey of Children's Health found that a higher proportion of children from rural areas experienced more ACE compared to their urban counterparts. The total observations were a little over 27,000 and there were probably parents who did not respond. It is interesting that parental divorce is much higher in rural. Household incarceration is much higher in rural. Children who experienced household violence and economic hardship were higher in rural. These results are different than other ACEs surveys. The degree of nonresponse can vary so ACEs could be higher than the results of the surveys. Rural males with less education are the less likely to respond.

The effects of poverty are one of the greatest problems facing children today. Child poverty is higher and more persistent in rural America. Many risk factors are not directly related to geographic location, but to the demographic characteristics of those who live in rural areas.

Collecting data on adverse childhood experiences is a way find out why adults have long-term, chronic illnesses.

Michael Compton, MD, MPH
Medical Director for Adult Services
New York State Office of Mental Health
Professor of Clinical Psychiatry
Columbia University College of Physicians and Surgeons

Michael Compton said that he would share the social determinants of mental health with the committee. There are four take home messages. Adverse Childhood Experiences are one of many types of social determinants of health and of mental health. The social determinants model provides a framework for addressing health inequities and for pursuing prevention. Some social determinants of health may be especially problematic in rural settings.

The social determinants of health are societal, environmental and economic conditions that impact and affect health outcomes across various populations. These conditions are often shaped by the distribution of money, power, and resources at a global, national, and local levels, which are themselves influenced by policy choices. The social determinants of health are prominently responsible for health disparities and inequities seen within and among populations.

The Robert Wood Johnson Foundation has done work on how to talk about social determinants of health. Health begins where we live, learn, work and play. Your zip code may be more important to your overall health than your genetic code.

The social determinants of health are predominately responsible for health disparities and inequities. Health disparities are differences in health status among groups of the population including differences that occur by gender, race or ethnicity, education or income, disability, or living in various geographic localities. Health inequities are disparities in health that result from systematic, avoidable, and unjust social and economic policies and practices that create barriers to opportunity.

The social determinants of mental health are no different than the social determinants of physical health but need special emphasis because mental health conditions are prevalent and disabling. Mental health conditions are high-cost illnesses and have been largely neglected. Mental illnesses are not only created by social determinants of health but lead to social determinants that worsen outcomes.

There is a wealth of health problems related to adverse childhood experiences including: alcohol use disorders, depression, illicit drug use, suicide attempts, teen pregnancies, smoking, COPD, fetal death, ischemic heart disease, liver disease, hearing voices, risk for intimate partner violence, multiple sexual partners, STDs, unintended pregnancies, early initiation of smoking, early initiation of sexual activity and early mortality.

Michael Compton published a book about the social determinants of mental health and some of the adverse early life experiences including: discrimination, social exclusion, poor education,

unemployment, underemployment, job insecurity, poverty, income inequality, neighborhood deprivation, food insecurity, poor housing quality, adverse features of the environment and poor access to health care.

What are driving individual level behavioral risk factors? We need to be asking why we have these societal problems, food insecurity, discrimination and income inequality. It is based on unequal and unfair distribution of opportunity. There are public policies that legislate unequal and unfair distribution of opportunity. Social norms drive public policies and how we view one another.

About 80% of schizophrenia is genetic but the social determinants do drive the prevalence of schizophrenia. The expression of genetics can interact with social determinants so that adverse childhood experiences can express the genetics differently. Social determinants can impact genetic risks through epigenetics. Environmental factors can actually change the expression of your genes. The social determinants are the fundamental causes of disease.

Without mental health, there can be no health. Mental illness is a major cause of morbidity, disability, and mortality. Addressing social determinants will help eliminate health disparities and inequities.

Q&A

Donald Warne said that epigenetics is the scientific platform to better understand mechanisms. Have there been recent advances in specific methylation patterns or epigenetic indicators to bad outcomes

Michael Compton responded that he did not know about advances in methylation patterns or epigenetic indicators but in mental health it is in its infancy in terms of understanding how the environment changes gene expression and it is also inheritable.

Donald Warne asked if there are specific recommendations for policy changes regarding interventions that may be useful. Is the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV) making progress in South Carolina? Have you thought about policy changes to make home visitation or community health workers billable under Medicaid?

Elizabeth Crouch responded that she is not familiar with the Medicaid billing, The Maternal, Infant and Early Childhood Home Visiting Program (MIECHV) has eighteen benchmarks but most of them do not incorporate ACEs. There is a proposal to begin to doing the ACE survey with parents of the children who are receiving home visiting services.

Kelley Evans said that she appreciates the discussion of adverse childhood experiences being related to suicide. The advisory committee meeting in Boise, Idaho was based on the prevalence of suicide in rural areas. The committee may need to underscore the connection between ACEs and suicide again because it is so important.

Michael Compton responded that suicide rates are not decreasing but increasing in recent years despite the fact that suicide prevention efforts have been increasing in the past decades. ACEs is an important driver. In order to prevent suicide there needs to be ACEs prevention.

Kathleen Belanger asked if you had \$100,000 what would you do with it in your rural community?

Elizabeth Crouch stated that most parents in The Maternal, Infant and Early Childhood Home Visiting Program are low income. Most of the MIECHV locations are in urban areas and the program needs to be expanded to rural sites in South Carolina.

Michael Compton said that he would work with the local community to choose a single ACE and find ways to prevent it. The concept of ACEs is a big umbrella and the ten that are usually measured are limited. There are so many more ACEs that aren't measured. If one can be eliminated it would be huge progress.

ADVERSE CHILDHOOD EXPERIENCES - PART II

Priti Irani, MSPH
Research Scientist
Office of Public Health Practice
New York State Department of Health

Priti Irani said she will speak about working with rural communities to understand and respond to Adverse Childhood Experiences (ACEs). The State Health Improvement Plan collected Behavioral Risk Factor Surveillance System (BRFSS) to collect ACEs data statewide.

The New York State Prevention Agenda's goal is to improve the health status of New Yorkers with emphasis on primary prevention and some secondary prevention. Communities are working together to reach a consensus of priorities and to do collective action. The vision is for New York to be the healthiest state across all ages.

Local health departments and hospitals in New York State are required by law to submit planning documents to the New York State of Department of Health to identify the health priorities they are addressing. Every county in New York State is working collectively to prevent chronic disease and more than half of the counties share the priority of promoting mental health and preventing substance abuse. Adverse Childhood Experiences will be identified in the priorities of Promoting a Healthy Environment and Promoting Healthy Women, Infants and Children, and Preventing HIV, STDs, Vaccine Preventable Diseases and Hospital Acquired Infections.

In 2016, there was an expanded Adverse Childhood Experiences Behavioral Risk Factor Surveillance System Survey with the largest sample size to obtain county level data. The questionnaire included core questions, optional questions, and state added questions. In New York, three different versions of BRFSS were used with different sets of questions to maximize topics. Some challenges relating to the survey are that some people are unwilling to provide

ACEs information, phone service is not always available and the survey only measures categories and not severity or frequency of each adverse childhood experience. The survey combined landline and cellphone weighted response rates with 36.3% for a total response of 35,334. The questionnaire with the ACEs model was used with 11,236 residents. Of these, 80.3% answered all 11 ACEs questions and were included in the analysis.

The findings are that six out of ten adults, 59.3%, in New York report experiencing at least one ACE, and 13.1% experienced 4 or more ACEs. Emotional abuse, parental separation/divorce, and substance abuse are the most reported ACEs. New York is comparable to other states but many of the states have larger samples, and several combine data from multiple years to get a larger sample size. Small sample sizes made it difficult to conduct analysis of ACEs with some of the health outcomes and health risks. ACEs is lower in the 65 years and older group. People with a household income of \$15,000 or less have an ACEs score of three or higher. Adults in households with children are more likely to have reported ACEs than households without children. ACEs are higher among women, Hispanics and multiracial groups. An ACE score of three or higher is significantly higher among the LGBT group compared to the heterosexual group. There are no significant differences in ACE scores between urban and rural. An ACE of three or higher is higher among those who did not graduate from college or technical colleges.

A correlation matrix shows that there is a relationship between different ACEs. Domestic violence is strongly correlated with physical, emotional, and substance abuse. Substance abuse is also correlated strongly with incarceration and mental illness. Several health outcomes have increased odds of occurrence among individuals with three or more ACEs. A person with an ACE score of three or more is six times more likely to be at risk for depression and three times more likely to be living with a disability. A person with an ACE score of three or more is almost four times more likely to engage in HIV risk behaviors, which includes intravenous drug use, a sexually transmitted disease, transactional sex for drugs or money, unprotected anal sex or having four or more sexual partners in the last year as compared to a person with no ACE.

Adverse Childhood Experiences are common and tend to co-occur or cluster. ACEs questions are personal and may be difficult for someone to answer. Some people respond more easily to ACEs with resilience and some people can learn to be resilient and thrive.

Ways to support rural communities is to have cross cultural and cross sector collaboration to build awareness and education. New York State is just beginning to work on ACEs and there is a need for dialogue and education. Collecting information and data is important for people implementing ACEs to evaluate what is working.

Rahil Briggs, PsyD
National Director, HealthySteps
Associate Professor, Albert Einstein College of Medicine
Director, Pediatric Behavioral Health Services at Montefiore Medical

Rahil Briggs said that she grew up in a very rural community in Southern Colorado and the grocery store was seventy miles away. She understands the context in which the committee works and much of the trauma and ACEs in urban settings is as pervasive in rural.

Substance Abuse and Mental Health Service Administration's (SAMHSA) four R's are: Realization (entire organization had a basic realization about trauma and its effects), Recognize (organization can recognize the signs of trauma), Responds (language, behavior and policy changes, taking trauma into consideration), Resist Re-Traumatization (avoiding organizational trauma). The question is how to measure whether an organization has the basic realization about trauma and its effects. There is a variance of ideals of what it means to be trauma informed.

Montefiore's Trauma-Informed Care North Star approaches in healthcare settings aim to acknowledge the role that trauma has played in patients' lives, shifting the question from "What is wrong with you?" to "What happened to you?". Everyone at Montefiore sites from the front desk, security staff, nurses and providers were asked to change this question. Montefiore has an integrated health service with a staff of about eighty people and practice integrated behavioral health across the lifespan.

Montefiore created a three-part plan to implement trauma informed care. The plan included educating clinic staff to understand stress and trauma, and the manifestations of trauma at the individual patient and organizational levels. Staff also received education regarding burnout, secondary traumatization, and compassion fatigue. An Adverse Childhood Experiences screening program was developed. There was training concerning taking care of clinical staff.

Adverse Childhood Experiences are not only important because they lead to negative behaviors but also early death. It is important to prevent ACEs from occurring. The more ACEs a person has the more likely they are to suffer mental health concerns. ACEs are synonymous with trauma and each trauma a person experiences can be devastating. Different people respond to trauma differently. When a person experiences a traumatic event, they interpret some future experiences as threatening or harmful even though they may not be harmful. The traumatic beliefs are triggered and that can evoke feelings of helplessness or being overwhelmed and the person is reacting instead of being in the present moment. They are reexperiencing the traumatic incident. Trauma embeds itself in the body and brain functioning of many people.

The frontal lobe of our brain is for decision making, planning, and problem solving. The lower brain is for survival and emotions. The fight or flight experience from trauma is in our survival and emotional part of the brain. If a person goes into survival mode over and over again because of trauma, the brain becomes practiced in using the survival and emotional response. This causes a person to become hypersensitive and view too many things as potentially dangerous and leads to problems with physical, emotional and psychological health.

Rahil Briggs is the National Direct of HealthySteps. HealthySteps is an evidence-based, interdisciplinary primary care program that integrates child development and family support professionals into pediatric and family practices to ensure that babies and toddlers have nurturing parenting and healthy development. The professionals connect with families during well-child visits as part of the primary care team. HealthySteps offers screening and support for common

and complex concerns that physicians often lack time to address. Parenting guidance, support between visits, referrals and care coordination are provided, specific to families' needs. Robust screening includes social determinants of health, autism, child development and maternal depressions. There are robust interventions and for families that are most at risk of exposure to ACEs, there are comprehensive services offered.

There is universal ACEs screening for parents of newborns that allows assessment for parental trauma, an important risk factor for children's social and emotional wellbeing as well as long term health outcomes. Children of mothers with one or more ACEs who had HealthySteps intervention, the child's social and emotional development at age three was well under the limit.

Heather Larkin, PhD
Associate Professor
School of Social Welfare
University of Albany – State University of New York

Heather Larkin said that she worked for seven years as a social worker in rural New Hampshire. She did not have the language of Adverse Childhood Experiences but was interested in how to think more comprehensively in serving the high-risk population groups.

A whole person approach to addresses ACEs in a flexible way to be able to do cross sector work and support the development of ACE and trauma informed care in ways that would work best in different systems.

Adverse Childhood Experiences created a common language throughout services so the response could be addressed in a holistic way. ACEs is not only about the people being served but about everyone. The people who are providing the services need to be included in the conceptualization of the holistic response. The providers of care are the ones doing the role modeling and engaging in the relationship building as they are delivering services. There has to be promotion of self-care for the providers as well.

Each program provides different services but there are common elements. One program may be for adolescent males and another for older adults with high ACE scores. The common elements are to identify ACE characteristics of the population served, integrate resilience and recovery knowledge into the program, transform systems and empower people.

A whole person approach recognizes that people are not just the sum of their problems and there are many strengths that can be built upon. People are body, mind and spirit. It is important to engage and support leaders and reach policy makers to direct resources to support program and community development in a comprehensive way. Social networks are an important way to create peer supports and promote health and healing. It involves the whole community and everyone can have a role in building protective factors.

The HEARTS Initiative is a coalition of Capital Region service providers who are strengthening social networks within and across agencies. The initiative is building community capacity

through workforce development, policy advocacy and educational presentations. HEARTS Initiative began with a group of social service providers who worked together doing some workforce development policy advocacy and educational presentations to raise awareness.

IN 2015, The University of Albany, School of Social Welfare, was invited to join The Mobilizing Action for Resilient Communities (MARC) Project. The Health Federation of Philadelphia identified communities around the country that had developed ACE specific collaboratives to build community resilience and track the impact of the collaboratives.

Adverse Childhood Experiences training and new practices have been adopted in child welfare, public assistance, mental health and law enforcement. The New York State Department of Health has added the questions to the BRFSS. New cross system policies are emerging. The Chief of Police, Bob Sears, presented at the Mobilizing Action for Resilient Communities Symposium in Philadelphia about The Handle with Care Program. The police inform the school when a child has experienced their parent being arrested. The school can make sure that they treat the child with care and have a better understanding if they do not have their homework or need extra assistance.

Policy Entrepreneurs are community residents who are current or former services users with an interest in ACEs and resilience. The policy entrepreneurs work on a grassroots level as ACE knowledge brokers. They host peer based informational sessions on ACEs with community and agency groups.

Q&A

Donald Warne said that American Indians and Asian Americans were not included in Priti Irani's data. Is this because the numbers were too small?

Priti Irani responded that was correct. The number were too small.

Donald Warne said that across Health and Human Services community health workers are paid for in various capacities with grants. It is very rarely billable under Medicaid. Is there billable in home visiting and parent skills training in your programs?

Rahil Briggs stated that the challenge is that the billing is based on diagnosis and prevention of mental health or trauma is not covered. That is an oversight in how money is being spent. If a baby has a diagnosis, some of the services are covered. There are some innovative things being done around dyadic treatment being billed to the babies Medicaid based on the mother's maternal depression diagnosis.

Kathleen Belanger said that the committee is focused on rural communities. How have you implemented your programs in the rural areas?

Rahil Briggs responded that HealthySteps has about one hundred and twenty sites across the country and thirty-nine in New York. Twenty are in New York City but the New York Department of Public Health funded the expansion of HealthSteps to seventeen sites around the

country. They are all over the state in urban and rural areas. The program model is the same and as long as there is a medical practice to partner with there can be HealthySteps.

Heather Larkin stated that it works in rural and urban areas by identifying key elements and engaging local stakeholders to build the programs that work best in each community. There is a flexibility for programs to be different in different communities.

Barb Fabre said that by informing and empowering parents it will help change the course of future generations. What can HHS do on a Federal level to assist the work you are doing?

Rahil Briggs said that prevention a priority. The youngest citizens need to be a focus and prevention of ACEs through their parents. Prevention needs to be tied to policies and payment related to ACEs.

Heather Larkin stated that working together in collaboration to respond to ACEs and social determinants of health is important. Policy makers can change how things are done so that systems can be redesigned. Funding incentives can be set up for Collaborative arrangements instead of working competitively.

Priti Irani said that it is important to remember that adult's brains can change too so there needs to be a focus on resiliency for adults with ACEs. The Model of Wellbeing shows the connection between social determinants of health and personal resources.

Tuesday, April 17th, 2018

Tuesday morning the subcommittees depart for site visits as follows:

HEALTH SUBCOMMITTEE

RURAL HEALTH INSURANCE MARKET CHALLENGES (Glens Falls, New York)

Adirondack Health Institute

Subcommittee members: Kate Rolf (Subcommittee Chair), Kate Dalton, Kelley Evans, Marie Poepsel, Chester A. Robinson, and Ben Taylor.

Staff Members and Guests: Paul Moore, Steve Hirsch, Abigail Barker, Normandy Brangan, Victoria Maloch, and Tim McBride.

Community Panelists and Attendees

Panel 1

Becky Preve - Director, Franklin County's Office for the Aging

James Button - Chief Operations Officer, Interim CEO, Citizen Advocates

Beth Lawyer - Behavioral Health Services Director, Citizen Advocates

Joyce Porter - Enrollment Assistance Services and Education Manager, AHI

Ann Abdella - Executive Director, Chautauqua County Health Network

Panel 2

June Castle - CFO, Nascentia Health

Andrea Lazarek-LaQuay - Chief Clinical Officer, Nascentia Health

Cheryl Manna - COO, Nascentia Health

Stephen Knight - CEO, United Helpers

Sylvia Getman - CEO Adirondack Health, Hospital and Health Network

Tracy Mills - Vice President - Planning, Glens Falls Hospital

Sarah Colvin - Health Home Program Manager, AHI

HUMAN SERVICE SUBCOMMITTEE

ADVERSE CHILDHOOD EXPERIENCES (Cobleskill, New York)

Schoharie County Head Start and St. Vincent de Paul Catholic Church

Subcommittee members: Donald Warne (Subcommittee Chair), Kathleen Belanger, Carolyn Emanuel-McClain, Barbara Fabre, Constance Greer and Octavio Martinez.

Staff Members and Guests: Tom Morris, Sahi Rafiullah, Alfred Delena, Shannon Wolfe and Elizabeth Crouch.

Community Stakeholder Panelists

Dawn Bialkowski, Med - Gilboa - Conesville Central School

Richard Bialkowski – Cobleskill Police Department

Susan M. Cimino-Cary – Schoharie Hypnosis and Reiki

Susan Emerson, MD – Bassett Healthcare

Miguelina Germán, PhD – Montefiore Medical Center
Richelle Gregory, Med - Clinton County Mental Health and Addiction Services
Jane V. Hamilton, RN – Bassett Healthcare Network
Linda Hill, RN – Schoharie County Department of Health
Jennifer Hurlburt, MA – Agri-Business Child Development
Carol A. S. Morris, PhD – SUNY Cobleskill
Sarah A. Nies, MHC-LP - Schoharie County Office of Community Services
Amy Pricolo-Brown – Child at Risk Response Team of Schoharie County
Marcia Rice, RN, MS – New York State Office of Mental Health
Lisa Scott – Schoharie County Child Development Council
Karen Simmons- Schoharie County Department of Health
Angela Smith- Catholic Charities of Delaware, Otsego, and Schoharie Counties
Eileen Thrush – Schoharie County Child Development Council
Gayle Wheeler, LCSW-R – - Bassett Healthcare Network
Kathy Wright, LCSW-R – Parsons Child and Family Center at Malta
Siri Young, LCSW – Schoharie County Head Start
Katie Zuber, PhD – Rockefeller Institute of Government

The subcommittees' returned to Saratoga Hilton in Saratoga Springs, New York, to discuss site visits.

PUBLIC COMMENT

There was no public comment.

Wednesday, April 18th, 2018

DRAFTING OUTLINE OF POLICY BRIEF

RURAL HEALTH INSURANCE MARKET CHALLENGES

Subcommittee findings and possible recommendations include:

- Maximize insurer participation in rural areas. Health and Human Services should require the alignment of plan service areas with rating areas, utilizing models that integrate rural and urban areas together in a region to increase risk pool size.
- Minimize cherry picking of service areas within rating areas. Require full participation across rating and service areas of insurers.
- Incentivize plans to offer coverage over large areas while discouraging the county as unit of coverage.
- Encourage and support rural based innovative opportunities, demonstrations, and value-based payment pilots that provide enhanced flexibility to test or implement innovative solutions for insurers or providers.
- To maximize insurer participation in rural areas, allow more flexibility in the network adequacy standards in rural areas for Medicare and Medicaid plans.
- Educate providers and consumers on the availability of insurance products and models available to individuals and small employers.

- Mandate that states and exchanges streamline to provide a smooth transition from Medicaid to the individual market.
- Provide technical assistance for rural providers to be more effective in negotiations
- Set standards to improve the sharing of health care data of all types across entities.
- Systematically review and rationalize federal and state regulations that may inhibit innovation and competition.
- Incentivize providers and plans to find innovative solutions to improve access to care, improvement in quality and reduce costs to rural patients.

ADVERSE CHILDHOOD EXPERIENCES

Subcommittee findings and possible recommendations include:

- More ACEs training and trauma informed care for HHS and agencies that provide services like community health centers.
- Expansion of school-based health clinic startup funding.
- There is a lack of workforce in rural so there needs to be training for non-mental health workers and ACEs screening.
- There are data challenges in rural areas. American Indians and Asian Americans were not included in the data set. There needs to be adequate data for under represented populations.
- Looking at ways to implement evidence-based prevention measures. The ones that are the most promising are home visitation and parenting skills. The programs are usually funded by grants and not sustainable. Recommend that The Centers for Medicare and Medicaid Services at the state level encourage the states to have billable community health workers.
- Recommend that The Agency for Healthcare Research and Quality do an economic impact study. A study of a population of current incarcerated individuals and matched controls in the community, will probably show that the ACEs scores will significantly higher for those in prison. Preventing ACEs is not just a matter of personal health of an individual but a tremendous cost to society that has not been well quantified.

OFFICE OF RURAL HEALTH POLICY FEDERAL UPDATE

Tom Morris

**Associate Administrator, Federal Office of Rural Health Policy
Health Resources and Services Administration
U.S. Department of Health and Human Services**

Tom Morris said that Secretary Azar's priorities are to continue value-based transformation of the healthcare system, combating the opioid crisis, bringing down the high price of prescription drugs and addressing costs and availability of insurance.

The Office of Rural Health Policy had some reductions in the president's budget, but there was \$130 million increase in the congressional budget. One hundred million will go toward rural opioid abuse. The money will go directly to communities through planning grants and will be

creating coordinating centers to assist. There is the need for broad base coalitions so the efforts will be sustainable after community funding. There are two hundred and twenty counties vulnerable to HIV and Hepatitis C from opioid and drug abuse so those counties will be a focus of funding

Fifteen million will be for the development of rural residencies. The focus is to get rural residencies through accreditation process so they will qualify for Medicaid or Medicare and will be sustainable into the future. That funding will go out early in the next physical year. A family medicine rural resident is twice as likely to locate in a rural area relative to someone trained in an urban area.

There was an increase in funding for the black lung clinic program. This may be a topic for the committee. The incidents had gone down over the years but recently went up for younger miners and with a higher degree of severity. Coal mining is declining in certain areas but there are still miners at risk.

There are increases in the budget in telehealth funding and working with rural hospitals around quality and financial improvement.

FALL MEETING - POSSIBLE TOPICS AND LOCATIONS

FUTURE TOPIC IDEAS

- Chronic obstructive pulmonary disease (COPD) rates are higher in rural.
- Cancer treatment is more difficult in rural areas and people have to travel for chemo and treatment. Access to treatment and screening is an issue.
- Role of community action agencies as a catalyst for human services in rural areas
- Why rural areas have higher rates in the five leading causes of avoidable death
- Dental and oral health care for children

5 leading causes of avoidable death are higher in rural than urban

- Heart disease
- Cancer
- Stroke
- Unintentional injuries
- Lower Respiratory disease-COPD

POTENTIAL MEETING LOCATION FOR NEXT MEETING-SEPTEMBER

- West Virginia - Chronic obstructive pulmonary disease increasing in rural areas.
- Montana- Difficulties with cancer treatments in rural areas.
- Atlanta, GA - Rural data pertaining to five leading causes of avoidable death provided by the Centers for Disease Control.

PUBLIC COMMENT

Abby Nash

Senior Insurance Attorney

New York State Department of Financial Services

Good morning. I'm Abby Nash. I was a health insurance regulator here in New York. Currently, I'm a health care attorney/consultant and a health policy advocate.

I couldn't agree more with those of you who strongly support investments in population health management and preventive care for rural residents. With that in mind, I have a few recommendations for the Secretary.

I request the Secretary:

1. Engage--with other policy makers and stakeholders--in conversation directed toward flexibility in payment models that would include coverage of services that promote healthy living for rural residents and may include telehealth services and remote patient monitoring

Value based payment arrangements/bundled payments could help ensure rural residents have access to essential services currently not covered

2. Invest in programs that further educate rural primary care providers about early identification of chronic conditions including not only diabetes/asthma/heart disease but also neurologic conditions like Parkinson's and Multiple Sclerosis..., and keep those providers connected and engaged with other experts and supplemental resources
3. Promote the development and implementation of long-term wellness programs to keep rural residents active, engaged in community, and employed.
 - a. While cardiac rehab--including nutrition and exercise--can be very helpful, prehab for rural residents with heart disease, and education to prevent heart disease is likely to be more beneficial and cost effective
 - b. Another example ripe for investment is prehab for neurologic conditions because neurologic disorders are chronic, expensive to treat and result in high societal costs. I recommend providing long-term comprehensive services to neurology patients in rural areas--as soon as they are diagnosed-- to help slow the progression of the illness, with the ultimate goal of actual prevention.

This integrative approach should treat not just the illness but the comorbidities like anxiety, depression, and fatigue. Treatment should include education on nutrition and access to regular wellness classes including but not limited to meditation/Tai Chi/Yoga/Kickboxing/... case management, group therapy and more.

I know work force development changes can be challenging. But particularly when you obtain buy-in from the patients, providers, and other community advocates, there is great potential to improve health outcomes and quality of life for rural residents while bending the cost curve.

Thank you for your time and consideration!