HHS and HRSA Rural Summit

Room 425A, Hubert H. Humphrey Building
200 Independence Avenue, SW, Washington, D.C. 20201
January 28th, 2019; 1:00 p.m. – 3:00 p.m.

I. Introduction

The Department of Health and Human Services Administration (HHS) and the Health Resources and Services Administration (HRSA) convened a forum of rural health care stakeholders to discuss key challenges rural communities face in providing and accessing health care and opportunities for HRSA and HHS to address these challenges in the course of program and policy development.

Participant List

Association of Clinicians for the Underserved
Virginia State Office of Rural Health
National Association of Rural Health Clinics
Garrett Regional Medical Center, Potomac Valley Hospital, Maryland Rural Health Association
American College of Obstetricians and Gynecologists
Pennsylvania State Office of Rural Health
National Organization of State Offices of Rural Health
National Rural Health Association
Montana, North Dakota, Oregon and Washington State Hospital Associations
National AHEC Organization
Cecil G. Sheps Center for Health Services Research at UNC
American Hospital Association
Milbank Memorial Fund
National Association of Community Health Centers
Association of Maternal and Child Health Programs
North Carolina State Office of Rural Health
Mid-Atlantic Telehealth Resource Center at UVA
Rural Policy Research Institute
Rural Wisconsin Health Collaborative
National Governors Association
American Academy of Family Physicians

II. Discussion Summary

Secretary Alex Azar provided opening remarks, emphasizing that solutions to rural health care challenges should be economically sustainable. He noted that we have more advanced tools and technology, such as telehealth, at our disposal today than a decade ago to help make sustainable rural health care a reality. The Secretary said he is interested in suggestions on how to address rural health challenges.

The Secretary acknowledged a number of health care challenges in rural communities including access to care, financial viability and the important link between health care and economic development. He noted that it is important to ensure that one's zip code does not dictate their health status or access to key health care services.

The Secretary also discussed the need to modernize regulations and develop new financially sustainable models for health care delivery in rural communities that look beyond the current hospital model. He noted the challenge of practice restrictions at the state level in affecting the full utilization of clinicians, an issue highlighted in the recent White House report "Reforming America's Healthcare System Through Choice and Competition."

The Secretary told participants he is convening an inter-departmental group headed by Peter Urbanowicz, the HHS Chief of Staff, to see what the Department could do on a unified basis. The HHS Chief of Staff described the plan for the HHS Rural Task Force as an inter-departmental initiative

to ensure agencies are not duplicating efforts and are addressing rural health care issues in a unified manner.

Deputy Secretary Eric Hargan joined the meeting later and reiterated HHS's commitment to addressing rural health challenges. He cited HHS efforts to look at regulatory burden related to rules such as the Stark self-referral regulations that may inadvertently be hindering providers' ability to coordinate care for substance use disorder patients. Mr. Hargan echoed the Secretary's interest in telehealth and noted the need to better understand how the use of this technology can provide savings. He also discussed the unique health care challenges faced by tribal communities.

HRSA Administrator Dr. George Sigounas opened the discussion to participants by asking them what the basic needs were for rural communities regarding health care. After participants shared their insights, the Director of HRSA's Learning Institute, Kevin Zachery, focused on four additional topic areas, which had identified before the forum as priorities for discussion: workforce, system transformation, telehealth, and opioid use disorder HHS officials sought the individual views of the participants on the matters under consideration. The following is a summary of those individual views.

III. Topic Area Discussion

Access to Care

Challenges and Barriers

- **Defining Basic Needs:** Participants defined a range of essential access needs in rural communities starting with primary care and then moving to include mental health, pediatric care, emergency care, maternal and child health, dentistry and home health.

- **Rural health care systems often still reflect inpatient-centric models of care that may not fully align with current and projected health care needs in many rural communities:** Rural providers face the significant fixed costs of infrastructure. At the same time, they often face economic challenges that make overcoming these costs challenging. This can lead to a mismatch between the care available and the essential services needed in rural communities.

- **Economic factors in many rural communities complicate efforts to maintain financial sustainability:** Hospital closures may be occurring in areas where the need is greatest because the funding is not sufficient to support care due to economic constraints. Many rural communities have faced tough economic conditions in recent years, which relates to ongoing struggles around network adequacy, timely reimbursement, social determinants of health, and recruitment and retention of health professionals. One participant noted the importance of ensuring that rural hospitals and communities can retain essential services in their particular communities. Other participants raised the need to promote economic development in rural areas, as well as support specific services such as emergency medical services/ambulance, behavioral health, obstetric and neonatal care, and behavioral health.

- **Collaboration:** Several stakeholders noted the need for team-based care and pointed to potential models or ideas. Rural health clinics, by statute, are required to incorporate both physicians and other primary care providers such as nurse practitioners and physician assistants into their organizational structures. One participant noted the potential to enhance access to care for services such as gynecology and obstetrics by creating policy incentives for team-based regional care models. Others noted that HHS has a range of factors that link to access. One noted that grant funding such as Rural Health Outreach grants could play a key role in helping expand services in rural communities that can then become economically sustainable. Another pointed to programs such as 340B where the program savings helps to improve access to patients for prescription drugs while also easing some financial burdens on rural safety net providers.

- **Payer Mix:** Several stakeholders noted access is affected by the payer-mix of rural providers, which is heavily dependent on Medicare and Medicaid with fewer numbers covered by private insurance. Since rural providers tend to have a smaller private insurance base as part of this payer mix they also have less ability to cost shift losses from Medicaid or the uninsured. One commenter noted the importance of network adequacy requirements but even with those hospitals and clinics are facing challenges in contracting with Medicare Advantage or Medicaid managed care plans. Delays in reimbursement also create financial risk. One hospital administrator noted having to wait 19 months to get a physician qualified and able to bill under Medicaid, meaning the hospital had to cover those costs.

Recommendations

- **Federal entities should ensure that existing funding, particularly the 340B Drug Pricing Program, is effectively targeting rural communities:** Participants noted that the maintaining access to sufficient funding through the 340B Drug Pricing Program is critically important to the financial sustainability of many rural providers including hospitals and federally-qualified health centers (FQHCs). One participant expressed concern that in some cases, 340B savings are not actually going to the providers the program was intended to serve. In some cases, the funds are instead passing through these providers and going to for-profit organizations like contract pharmacies and pharmacy benefit managers who may be altering pricing to in appropriately account for the 340B price thereby reducing the savings afforded to 340B covered entities.

- **Define Access Broadly and Link to Community Need:** Rural communities are quite variable from one location to the other. HHS could look to existing work done by a range of rural stakeholder groups to understand better how to define key access factors in rural communities and the need for community input and engagement in defining access and matching that to policy solutions. Some participants mentioned reports and other materials developed by their organizations that highlight potential policy solutions. Participants noted that several of the organizations represented had developed reports on this topic. For example, the American Hospital Association issues a report on rural and underserved access issues.

Workforce

Challenges and Barriers

- **Recruitment and retention of clinicians is a serious, ongoing problem in rural areas:** Many participants cited recruitment and retention of health care professionals as a major workforce issue, with one participant noting outright that it is the number-one problem facing rural providers. Participants cited possible causes including struggling local economies, clinician isolation and burnout, and limited broadband access.

- **Policies that limit clinician scope of practice inhibit access to essential services in rural communities:** Multiple participants expressed concern about state scope of practice laws restricting the services that non-physician practitioners (NPPs) provide, even when NPPs are capable of providing these services. This limits access to services that are important but limited due to workforce shortages, including primary care and oral health.

- **Services like emergency medical services (EMS) are provided by an all-volunteer workforce in many rural communities, and this is not a strategy that supports long-term sustainability:** Multiple participants expressed concern that the volunteer workforce supporting EMS is strained and may ultimately limit access to these potentially lifesaving services. Multiple participants mentioned the loss of volunteer EMS providers and the recruitment and retention challenges for EMS providers who already face the issue of high fixed costs and low reimbursement rates.

- **Addressing Administrative Burden of Qualifying Clinicians:** Several participants noted the administrative challenges small rural hospitals and clinics face even after they successfully recruit clinicians. This includes issues like facing delays in credentialing or certified to bill for Medicare and Medicaid services. These delays create a financial burden, as the providers have to cover costs until their clinicians are able to bill for services.

- **Limited continuing medical education and training opportunities.** One participant noted the challenge of obtaining CME in rural areas and the need for collaborative models to overcome the isolation of rural providers and to disseminate information out to communities more broadly.

Recommendations

- **Expand Physician Residency Training In Rural Areas:** Rural stakeholders noted the limited amount of residency training taking place in rural communities, particularly in the Pacific Northwest and upper Great Plains. Limitations in current Medicare Graduate Medical Education regulations is a limiting factor in expanding residency training in rural communities.

- **Enhancements for the NHSC:** Participants noted that the National Health Service Corps (NHSC) program plays a key role in addressing recruitment and retention but noted several challenges. Currently, demand exceeds supply and the program is over-prescribed. These commenters are also

concerned that changes in the scoring of automatic Health Professional Shortage Areas (HPSA) designations may also affect the ability of some providers to qualify for NHSC support. Other groups believe the statutory definition of which providers receive support needs to be expanded.

- **Scope of practice policies should allow non-physician practitioners to practice at the top of their licenses:** Participants expressed concern that excessively restrictive state scope of practice laws limit access to care in rural areas but noted that these were at state discretion.

- **Community-Driven Solutions:** Rural communities see longer-term workforce pipeline programs as a potential way to grow their own health professionals. In addition to the traditional clinical needs, participants noted the need for more family caregivers and para-professionals given the demographic trends facing rural areas with depopulation and a growing share of the elderly population.

- **Using Technology to Enhance Retention:** Several participants noted the important role technology could play in supporting rural clinicians. A number of the stakeholders cited the Project ECHO model as a way to both improve care and engage rural clinicians in a way that reduces professional isolation. One participant called for the development of ECHO models focused on maternal and child health. At the same time, a number of participants expressed concern about how to sustain the model economically. One participant also noted that while telehealth can be an important tool it is not a panacea and there is still the need to have the clinicians available to provide the services through this technology.

Rural Health System Transformation

Challenges and Barriers

- **Adapting to New Models:** Several participants noted the needto focus on new and sustainable models. Rural communities are interested in a range of proposals for new ways to deliver care. This included proposals where hospitals would drop inpatient services and focus instead on emergency and outpatient care as well as expansion of clinics that could offer broader services such as urgent care, depending on community need. Free-standing emergency departments have been proposed as options but rural stakeholders expressed concern about the viability of this model because of volume and payer mix concerns. One participant noted that while it was important to develop new models there was still an urgency to maintain the current infrastructure, particularly given the closure of rural hospitals and Rural Health Clinics. Another commenter said there are innovative and creative models already in place in rural areas that may be worth examining.

- **Transformation is complex and resource-intensive:** Having access to upfront capital and ongoing revenue is necessary for health system transformation, as is the expertise needed to support transitions to new models of payment and care delivery. Rural hospitals and communities could benefit substantially from support to implement, restructure, and maintain systems needed to participate in value-based payment models.

- **Existing transformation models may offer incentives that do not add up for many rural providers:** Some participants noted that current innovative payment models might have unintended consequences in rural communities. One participant noted that existing models often encourage reduced utilization, but maintaining volume is how many rural hospitals and providers survive. Rural providers are adapting to these changes in ways that may not necessarily be the most efficient or effective options. Another participant noted how in Maryland, global budgets have not yet led to reduced emergency department visits or decreased costs in rural hospitals.

Recommendations

- **Technical assistance, "glide paths," and other supports can help rural providers transition to value-based care models:** Participants noted that the disadvantaged economies of many rural communities make it difficult for rural providers to reorganize how they provide care. Participants recommended that HHS (e.g., through CMS or HRSA) consider options for providing technical assistance to rural providers on value-based care. Participants also pointed towards grant funding as ways to help rural providers initiate and maintain the transformation to value. Models that support rural transformations of care should also support quality metrics that are meaningful to rural communities and in alignment between payers. CMS has supported a number of efforts in this area through the National Quality Forum and these report findings need to be factored into any demonstrations or models that HHS considers.

- **New models of payment and care delivery should recognize the economic factors at play in rural communities and allow for increased flexibility in the use of funds:** Participants noted that the health needs of rural communities increasingly lie outside of the traditional inpatient hospital setting – in primary care and in addressing socio-economic factors that affect health and health care. Global budgeting is a promising approach to provide predictability and flexibility of funds to address these areas. State-based and regional approaches to transformation, like global budgeting models already underway in Maryland and Pennsylvania in partnership with CMS, may help provide solutions to localized problems.. Several participants noted that as HHS considers new models it consider grants or other financial support perhaps through a base payment to cover high fixed costs and that it identifies new payment approaches it take into account ongoing volume variability. Others mentioned that HHS could identify new models that focus on regionalization of care. Other participants felt regulatory reforms could also enable transformation and help rural providers provide better care through enhanced partnerships or additional supports for rural beneficiaries (e.g., updates to Stark and Anti-Kickback rules).

Telehealth

Challenges and Barriers

- **Allow RHCs and FQHCs to be distant sites for Medicare telehealth reimbursement:** Multiple participants expressed concern that RHCs and FQHCs cannot receive reimbursement for distant site telehealth services provided to Medicare beneficiaries, particularly to patients seen within the RHC and FQHC networks. Allowing RHCs and FQHCs to serve as distant site providers would allow them to be more efficient in their workforce allocation and increase access to care..

- **Telehealth for OUD remains challenging:** Participants acknowledged telehealth's role in expanding access to mental/behavioral health care, but noted staffing and workforce challenges. One participant stated that while tele-behavioral health "provides great infrastructure," it is difficult to find providers to serve as the "base practitioners" at the originating sites.

- **The challenge lies in developing platforms that enable clinicians to reach out and collaborate with patients wherever they live:** One participant noted the challenge of not being able access real-time data from devices, such as a fetal monitoring device. Another participant expressed the need to improve access to telehealth services for children with special health care needs.

- **Overly restrictive policies on clinician licensure and credentialing at the state-level inhibits access to care in sparsely populated areas with workforce shortages:** Several participants raised the issue of licensure portability, and that the ability for clinicians to practice seamlessly across states is an important component that supports access to telehealth services for care not available in the community.

- **Experiencing limited adoption of and broadband capacity for telehealth:** One participant noted that broadband utilization is within the hospitals, schools; however, utilization in homes is limited. Others noted that although broadband is an economic driver, the lack of broadband or the affordability of broadband as a limiting factor for telehealth. Other stakeholders thought clinicians and their teams needed more training on telehealth equipment utilization to address adoption challenges.

- **Limited evidence-based research to support cost-effectiveness of telehealth utilization:** Telehealth is touted as a cost-effective alternate to face-to-face encounters where access to care is compromised due to the lack of available service providers in geographically isolated areas. However, the challenge is how do we demonstrate improved outcomes and cost-savings with telehealth utilization?

Recommendations

- **Encourage additional research to develop a stronger evidence base for telehealth:** Participants noted that additional research would be helpful to show that telehealth not only can improve access for rural residents while also assessing the longer-term costs on payers.

- **HHS and the Federal Communications Commission (FCC) should work more closely together on telehealth issues:** The field would benefit from closer collaboration between FCC, which can help fund broadband-related deployment and offset high costs, and HHS, which is a major payer and funder of telehealth efforts across the country. Stakeholders also thought closer collaboration with USDA could also provide benefit given it supports both telehealth and broadband programs.

- **Expand education for rural providers around specialty and sub-specialty services:** One participant noted the need for and potential benefits of HRSA creating a maternal and child health track/series for Project ECHO.

- **Modifying regulations to improve use of telehealth in rural areas:** Multiple participants shared recommendations to modify telehealth related regulations, including:
  - Standardizing licensure and provider eligibility for telehealth across states;
  - Updating policy to support the appropriate coverage of and payment for telemedicine services;
  - Defining and building consensus around the definition of telehealth; and
  - Aligning the definition of rural to across federal agencies.

Opioids

Challenges and Barriers

- **Opioid funding is challenging to navigate:** One participant cautioned that some rural communities feel overwhelmed by the number of opioid-related funding and emphasized the importance of coordinating funding across the government. Another noted that it is not beneficial to have separate programs for methamphetamine, alcohol, and opioids, as people with OUD are often polysubstance users. Finally, another participant stated that opioid-related funding does not always reach the "pockets of rural America that need it the most."

- **Negative stereotypes of rural America:** Some participants said that it is important that rural America not become synonymous with the opioid epidemic, as negative stereotypes could discourage businesses from opening and staying in rural communities.

- **Neonatal abstinence syndrome and maternal mortality remain issues:** Participants described the need for effective intervention and payment models for addressing neonatal abstinence syndrome and maternal mortality due to SUD.

- **Need to build capacity of SUD workforce:** One participant noted that there are "significant capacity building challenges" with regards to the SUD workforce, while another cited the need for more education around opioid use and prescribing practices for medical professionals.

- **DEA Waivers:** Participants noted some increasing flexibility emerging from the Drug Enforcement Administration regarding the process for clinicians to obtain waivers in order to be able to prescribe drugs such as buprenorphine. Despite those efforts, there is still some degree of confusion on this issue.

Recommendations

- **Ensure that opioid-related funding is coordinated across government agencies and that programs do not address opioid in a vacuum:** Funding opportunities should address SUD and mental/behavioral health more broadly and efforts should be made to help rural communities navigate the federal funding opportunities available to them.

- **Create opportunities for states and individuals to learn from each other about what is working in the OUD/SUD area:** Participants identified the ability to network with other entities that are facing similar challenges as being important to addressing the opioid epidemic on a larger scale.

- **Support education for rural providers around OUD/SUD:** One participant cited the benefits of distance learning education opportunities in particular (e.g., on topics like medication-assisted treatment (MAT)), since it is often difficult for rural providers to leave their practices to receive training.

IV. Publications Shared During the Forum

During the session, participants also recommended reviewing the following reports:

- **Alliance for Innovation on Maternal Health (AIM) Opioid Bundle**
- **"Quality Improvement in Maternal Health via Project ECHO," Association of Maternal and Child Health Programs**
- **"The Aging of the Baby Boom and the Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers," AARP Public Policy Institute**
- **"2019 Rural Advocacy Agenda," American Hospital Association**
- **"Modernizing Rural Health Clinic Provisions," National Advisory Council on Rural Health and Human Services**
- **Washington State Department of Health Project:**
  - **"Creating Connections: Addressing the Needs of Children with Autism and Other Developmental Disabilities Using Telehealth," Washington State Department of Health**
  - **"Creating Connections Strategic Plan: Moving Toward Telehealth Services for Children with Autism and Developmental Disabilities," Washington State Department of Health**
  - **Points of contact for project:**
    - Jean-Marie Dymond (jean-marie.dymond@doh.wa.gov) - Grant Coordinator at Washington State Department of Health
    - Ellen Silverman (Ellen.Silverman@DOH.WA.GOV) – Washington State Nurse Consultant who led the work on the strategic plan and capacity assessments
    - Leticia Manning (LManning@hrsa.gov) – MCHB Project Officer for the Innovation in Care Integration for Children and Youth with Autism Spectrum Disorders and Other Developmental Disabilities Program
- **"Reforming America's Health Care System through Choice and Competition," U.S. Departments of Health, Labor, and Treasury**

V. Full Participant List

HHS and HRSA Rural Summit Participants	
Allison Abayasekara *Association of Clinicians for the Underserved*	Colleen Meiman *National Association of Community Health Centers*
Heather Anderson *Virginia State Office of Rural Health*	Alyson Northrup *Association of Maternal and Child Health Programs*
Nathan Baugh *National Association of Rural Health Clinics*	Allison Owen *North Carolina State Office of Rural Health*
Mark Boucot *Garrett Regional Medical Center, Potomac Valley Hospital, Maryland Rural Health Association*	Amy Peebles *American College of Obstetricians and Gynecologists*
Lucia DiVenere *American College of Obstetricians and Gynecologists*	George Pink *Cecil G. Sheps Center for Health Services Research at UNC*
Jennifer Edwards *Pennsylvania State Office of Rural Health*	Karen Rheuban *Mid-Atlantic Telehealth Resource Center at UVA*
Teryl Eisenger *National Organization of State Offices of Rural Health*	Jocelyn Richgels *Rural Policy Research Institute*
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Bill Finerfrock *National Association of Rural Health Clinics*	Jennie Shaw *American College of Obstetricians and Gynecologists*
John Flink *Montana, North Dakota, Oregon and Washington State Hospital Associations*	Tim Size *Rural Wisconsin Health Collaborative*
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Joanna Kim *American Hospital Association*	Sandra Wilkniss *National Governors Association*
Christopher Koller *Milbank Memorial Fund*	Julie Wood *American Academy of Family Physicians*