Health Resources and Services Administration
Office of Rural Health Policy

National Advisory Committee on Rural Health and Human Services

Washington, DC
February 23-25, 2011

Meeting Summary

The 67th meeting of the National Advisory Committee on Rural Health and Human Services was held on February 23-25, 2011 in Washington, DC.

Wednesday, February 23rd, 2011

The meeting was convened by The Honorable Ronnie Musgrove, Chairman of the Committee.

An introduction of new committee members included John Cullen, MD; Phyllis A. Fritsch; Shane Roberts and Roger Wells, PAC-C.

The Committee members present at the meeting were: Governor Ronnie Musgrove (Chair); Graham Adams, Ph.D.; April M. Bender, Ph.D.; Maggie Blackburn, MD; B. Darlene Byrd, MNSc, APN; John Stewart Cullen, MD; Phyllis A. Fritsch; David Hartley, Ph.D., MHA; Donna K. Harvey; Thomas E. Hoyer, Jr., MBA; Todd Linden, MA; Karen Perdue; Robert Pugh, MPH; Shane H. Roberts; John Rockwood, Jr., MBA, CPA; Maggie Tinsman, MSW; Roger Wells, PA-C. Mr. Dennis Dudley attended representing the U.S. Administration on Aging.

Present from the Office of Rural Health Policy were: Tom Morris, Director; Nicole Comeaux, Deborah DeMasse-Snell, Heather Dimeris, Michelle Goodman, Steve Hirsch and Paul Moore. Truman Fellows present were: Catherine Koozer and Natasha Scolnik.

2011 WORK PLAN

Tom Morris gave an introduction of meeting topics. He stated that they will be focusing on issues in the Affordable Care Act that are being implemented and the provisions that have the most impact on rural communities. The three topics that will be the focus of this meeting are the creation of the Health Insurance Exchanges, the Early Childhood and Maternal Home Visitation Program and the Community-Based Care Transitions.

Mr. Morris noted that the regulations have not been written for the Health Insurance Exchanges so there are opportunities to be part of the process. The challenge is that insurance exchange is a new topic for the committee and the committee will need to identify the rural issues within it. There will be speakers that will help identify targets of opportunity.

Mr. Morris stated that the other two programs are grants. The Maternal and Child Home Visitation Program money has largely been allocated but there are still opportunities for what they do in future funding and how the program is evaluated. Those could be areas of focus in order to have an impact in the future. The challenge is how to get the services into the rural communities.

The Community-Based Care Transitions Grant has largely been written by the centers for Medicare and Medicaid services. There is an opportunity to influence factors that they take into account as they review the grant applications. The evaluation is important because they are demonstrations and will inform future policy development. It is important to ask the speakers what are the targets of opportunity and how the committee can make sure that rural considerations are taken into account.

Mr. Morris stated that the white papers will begin being drafted during the sub-committee meetings on Thursday. During the sub-committee visits there will be a focus on key issues and possible recommendations. The goal is to complete the white papers completed and sent to the Secretary in two months.

Mr. Morris said that the next focus will be on the June meeting in Michigan. The committee will be looking at issues related to the Class Act which is the external insurance program for the elderly. Primary care issues related to the National Service Corps and a Teaching Health Center Grant Program and other physician related issues will be topics of discussion.

The Affordable Care Act has a requirement that mandates the Medicare Payment Advisory Commission issue a report on how it pays for rural services and the quality of rural services. A staff member will be discussing this with the committee during this meeting.

Mr. Morris noted that April Bender will also speak to the committee about workforce training and transitioning people from welfare to productive professions. One provision in the Affordable Care Act that has been implemented will be discussed. The committee will consider taking this as a formal topic and issuing a white paper or including it in correspondence to the Secretary.

Mr. Morris said in closing that there are opportunities for comments on regulations. There was a letter sent from the committee to the FCC on the Universal Service Program and a letter of comment on the accountable care organizations. There will be future opportunities to respond to issues that you would like to address.

HEALTH INSURANCE EXCHANGES AND OTHER ISSUES

Dr. Keith Mueller, Chair, Health Panel Rural Policy Research Institute

Dr. Keith Mueller began by speaking about the roles of the Health Insurance Exchanges. The legislative role of Health Insurance Exchanges is to certify qualified health plans that will be participating in offering insurance products. It includes assuring essential health benefits are included at four levels of coverage and to facilitate purchase by making choices

available and easily understood which includes an 800 line and web site. Monitoring the financial integrity is also the role of Health Insurance Exchanges.

Rural implications include development and enforcement of adequate network and access standards, development and enforcement of marketing standards and interactions with insurance brokers in rural communities. Selecting Navigators and establishing rating areas are also important issues to track in rural areas when evaluating the development of Health Insurance Exchanges.

Dr. Mueller stated that the RUPRI Panel commented on the Centers for Medicare and Medicaid Services Health Panel Exchange webpage. Some of the comments were regarding structure, functions, enrollment, choices and outreach. The text of the comments is available at: http://www.rupri.org/Forms/HealthPanelExchangeCommentsOct2010.pdf .

Dr. Mueller spoke about the structure and functions of rating areas. The larger the area, the less likely rural employers and individuals are adversely affected by risk rating. Segmenting rural employers could result in higher premiums. Risk adjustment methods for spreading risk across plans are preferable to address differences in risk across geographic areas and populations. There is a need of a differential rating area because within the state the health market can be different from one area to another and having the same premium becomes problematic. Rather than drawing smaller rating areas the panel suggests finding ways through risk adjustment to maintain a stronger integrity of a larger rating area.

Dr. Mueller said that to determine if a state is making sufficient progress there needs to be accountability mechanisms that include milestones in every area of the state. When looking at progress for programs that include rural and urban populations, many times the progress is measured by the population. In many states that could be done without meeting the milestone. The panel suggests that they have to be accountable in a way that forces activity across the entire geography of the state.

Dr. Mueller continued with another structure and function consideration involving certifying qualified health plans. The panel noted that segmentation through sub-state Health Insurance Exchanges could limit choices in rural markets. Exchanges combining individual and group products into single plans offer greater efficiency and convenience to businesses and individuals. Adequacy of provider network and access standards will be critical in ensuring plans offered in rural and urban markets are comparable. Marketing and enrollment materials and activities need to be monitored to ensure plans do not engage in practices aimed at selectivity enrolling individuals or firms.

Dr. Mueller said that factors to facilitate participation of a sufficient mix of qualified health plans includes structured exchanges to provide comparable choices throughout the Health Insurance Exchange market area in rural areas.

Dr. Mueller noted that important factors in establishing minimum requirements for actuarial value and level of coverage will include evidence that actuarial value of plans available in rural markets is less than urban markets. Allowing premiums to vary by geography may lead

to variation in plan choices and plan benefit structures, potentially limiting rural choices.

Dr. Mueller spoke about enrollment, eligibility and outreach related to online coordination with Medicaid. There are differences in broadband access, especially in the individual market. There will need to be physical outreach and enrollment strategies in rural areas. Coordination with Medicaid and other public programs is important in rural areas because of disproportionate reliance on those sources of coverage and frequent coverage transitions. Some populations will be eligible for Medicaid for the first time. There will need to be intensive outreach efforts to reach people in rural areas.

Enrollment, eligibility and outreach strategies that include tailoring strategies to the characteristics of rural populations and employers are necessary. Outreach strategies have to consider the audiences and how they typically receive information.

Dr. Mueller said that when coordinating between employers and exchanges, unique characteristics of employers in rural communities need to be considered. They tend to have fewer employees and pay lower wages and are focused disproportionately in certain industry categories that may face more employment risks. Rural employers may have less experience with employer-sponsored insurance market and rural employers are more likely to have brokers.

Dr. Mueller spoke about the National Association of Insurance Commissioners Model Act selected duties and the rural implications. A website where perspective enrollees can obtain standardized comparative information on plans is important. There needs to be assigned ratings for qualified health plans in accordance with criteria developed by the Secretary. It is necessary to have a standardized format for presenting health benefit options in the exchange. There should be entities selected that are qualified to serve as navigators and consult with stakeholders relevant to carrying out the activities required under the Act.

Dr. Mueller talked about the functions of the navigators. Their role includes public education activities to raise awareness of the availability of the qualified health plans and to distribute fair and impartial information concerning enrollment and availability of tax credits. Navigators will facilitate enrollment and provide referrals to applicable Office of Health Insurance Consumer Assistance or health insurance ombudsman. Navigators will provide information in a manner culturally and linguistically appropriate to the needs of the population served by the exchange.

National Association of Insurance Commissioners Model Act stakeholders include educated health care consumers who are enrollees in qualified health programs and individuals and entities with experience in facilitating enrollment in qualified health programs. Other stakeholders include representatives of small businesses and self-employed individuals, State Medicaid Offices and advocates for enrolling hard to reach populations.

Dr. Mueller closed by stating that there is a lot at stake when bringing a large number of people into health insurance and a lot at stake in rural areas for the people and the programs serving the people. There is a lot to monitor and an opportunity to influence an appropriate

rural roll out. Medicare Part D experience is instructive in looking at how to get people enrolled and the functions of what Health Insurance Exchanges are designed to do.

Q&A

Governor Musgrove asked where the comments were posted. He asked if they were on the panel website or Rupri website.

Keith Mueller responded that the comments were on the Rupri.org site. The Rupri Center website that is based in Iowa has some of the previous presentations.

John Rockwood said that the states regulate insurance in their own states and every state has an insurance commissioner. He said that it is confusing when you add the federal overlay to figure out who has what responsibility. He asked how to avoid a patchwork system throughout the United States and how to get continuity.

Keith Mueller said that the proposed rule layout is the best possibility for continuity. The proposed rule layout has minimums for Health Insurance Exchanges to include in the way qualified health plans are certified. The more that is specified in the proposed rule, the more a large plan can offer the same plan across multiple states because by federal rule each of the states will have a set of requirements. He stated that it is a gray area because federal legislation is entering into a regulatory arena that was exclusively a state regulatory arena. Dr. Mueller said that the committee could pose the question to the Centers for Medicare and Medicaid Services Officials and ask how it has worked on the Medicare side when the insurance product is offered and financed by Medicare but not being dictated by Medicare other than a certain set of minimum benefits. How that has been accomplished with Part D and also Part C may provide some lessons.

Tom Hoyer stated that the Act is similar to Federal Regulation of Medicare Supplement Policies which was enacted in 1981. He did the rule making in 1981 and got to know the insurance commissioners. It is the same model. It is a statute that tells the state what needs to be done but if the state doesn't do it, the federal government does it. The key is that if the states all do it, the insurance commissioners are a powerful group. The insurance commissioners and insurance infrastructure is in place to make this happen.

John Rockwood said that the issue is when do they make recommendations to the states and when do the rules state that it has to be done a certain way. He said that he understands that they are just recommendation and asked if that is correct.

Keith Mueller said that the answer is yes and no. He said the regulatory activity is a state activity. The answer is no from the perspective of the Federal Government because of the use of federal dollars to subsidize to a certain level, and because of what else is in the statute. He noted that they are expecting the proposed rule to more thoroughly define what the bronze level package is. Either the proposed rule on Health Insurance Exchange's or another proposed rule is going to have to deal with what is the minimum benefit package necessary for the federal government to be involved in subsidizing the purchase of private health

insurance.

Todd Linden said that he is intrigued by the multi-state potential. It adds complexity in terms of what state commissioners can do across state lines. He asked Dr. Mueller to comment on the potential for multi-state exchanges and the complexity. He also asked about navigators. He said that a benefit of the Accountable Care Act is increased access for uninsured Americans. There is a role for rural providers to assist people with getting plans. He said that his hospital helps people get into Medicaid if they are eligible. There will be a role for providers because they will want people to get access to insurance to pay for healthcare.

Keith Mueller said that the idea of doing multi-state insurance exchanges is new for him. He does not know many details but has heard about people looking at the Utah Model that may work throughout the inner mountain region so they could converge around a single Health Insurance Exchange. He said that staff could contact a project officer at the state level for the Health Insurance Exchange grants in those states.

Keith Mueller said that the role of navigators is a critical component in rural areas. He is hopeful that there is a parallel to the set of partners that Centers for Medicare and Medicaid Services used with Part D. He noted there are hundreds of local organizations that would have one or two people learn how to navigate the website and choices and make them available at the right time and place to reach rural residents.

Maggie Tinsman asked who would be a Navigator in the rural area.

Keith Mueller said that there is likely to be an individual employed by the Health Insurance Exchange who will carry the title of Navigator and will have to make it work in the outreach activity. Examples in the communities may include Area Agencies on Aging, state chapters of AARP and Veterans Affiliated organizations. Organizations to consider are ones that are willing and have the resources to work with the central navigator.

Maggie Tinsman asked how they could have multiple plans in the rural area when there aren't providers.

Keith Mueller said that there are two types of activities. One is getting people enrolled in a plan that covers financial risk and the other is making sure that there is care available to them. The connection between the two occurs around the access and network standards that the exchanges will be developing to certify the qualified health plan.

Larry Gamm said in 2003 he wrote a piece on insurance related to rural areas and gave some model programs. They were based upon Community Access Programs that reached out to the uninsured and involved hospitals and other organizations and supportive care sometimes through free clinics. There was a heavy emphasis on the Navigator role to identify the uninsured and under-insured and to bring them into the programs. He said that he was wondering to what extent Centers for Medicaid and Medicare Services and others are learning from the Community Access Programs that have experience in being the Navigator.

He said that one of the roles of the people that did the outreach within the Community Access Programs was identifying social services support and other wrap around services within the community. When looking at the population outcome, the Navigator role could be a broader focus and could be a stronger linkage role that could deal with care coordination so that the plans that are working within the exchanges have the possibility to improve quality and increase efficiency. The goals of efficiency and quality need to be met and the navigator role may be able to be linked to other coordination activities.

Keith Mueller replied that being linked to other coordination activities is the key. There will be a health worker individual who is not part of the healthcare provider community and has the job of linking healthcare services and social services. That is another classification of employee. The challenge will be at a sub-state level to bring those two activities together.

Robert Pugh said an issue that concerns him is that many of the rural areas in Mississippi have tremendous issues related to broadband. To create user friendly systems for consumer education and the distribution of information through electronic means is still a challenge. This will need to be considered as they move forward.

Robert Pugh also asked about the four levels of coverage for qualified health providers. He stated that the legislation requires two and asked Dr. Mueller to expand on the support for four levels.

Keith Mueller said that the bronze level will have to be offered and they will need to offer one additional level. He said that he could get back to Mr. Pugh with more details.

Graham Adams said that he appreciates Dr. Mueller mentioning the Offices of Rural Health as a useful tool in helping to create the outreach. The capacity varies from state to state but collectively they could play a helpful role. He said that in South Carolina that they have a Medicaid Managed Care Broker that is responsible for educating patients about the different health plans. If most states have something like that will the Health Insurance Exchanges build upon that?

Keith Mueller responded that if it is being done through the state Medicaid program there are explicit requirements for coordination with the Medicare program. They will take advantage of an infrastructure that is already in place.

Rogers Wells said that his questions are related to providers. In rural healthcare, access is limited. Are critical access areas required to accept the exchange payment? With the increase in access, is there any thought to how the providers will deal with the influx of patients and is there really going to be increase in access when there are additional patients?

Keith Mueller responded that the exchange itself is not setting payment levels. A little less than half of the new enrollment will be through private health insurance. The problem may be confusion because there will be multiple plans offering their benefit package and their payment scheduling which may or may not be as low as Medicare or Medicaid. There is not a clear answer on that area. Some will be Medicaid but a large portion will be non-Medicaid

eligible people buying an insurance product that the exchange isn't selling. The exchange will be providing information on how to buy the product. For example United, Blue Cross or AETNA will be selling the plans. Addressing provider needs and data collection is not part of what the exchanges will be doing. It is a separate part of the Affordable Care Act support that is based on what is needed in electronic communications to make this not so burdensome on providers.

Roger Wells asked if anyone had looked at what will happen if there are twenty five percent more people who are insured in a town and coming in for primary care services.

Keith Mueller said that they have learned some from the Massachusetts experience. There was a spike in demand for primary care services. He said that he is anxious to see what happens over time. In Medicare legislation there was also a spike in demand for services and it leveled off at some point. Part of the Advocacy for Patients in Medical Homes would say that the new level will be at or below the current level because care will be delivered more effectively.

Shane Roberts said that his question is on the networks and provider panels that may be selected and how that will work. Supplemental Medicare coverage and Medicare Advantage was addressed. Some of plans in rural areas do not select the rural provider because it is a competitive advantage for an urban center. He said that he is concerned about states that may not even set up their own health exchange and wait for the Department of Health and Human Services to do it. He asked if they will be cognizant of using the provider panels in the rural areas.

Shane Roberts also asked if when the thirty two million people come into the system if they will have cost based year end settlement. He noted that if there is an increase in utilization from one year to the next, the implications of a settlement year-end can be drastic.

John Cullen said that he hopes that by decreasing the amount of un-reimbursed care that attracting providers to rural communities will be more palatable. Many rural providers and hospitals write off a tremendous amount. What is the minimum number of clients for an effective exchange? He said that he realizes that there needs to be multiple insurances and programs to provide competition.

Keith Mueller said there is no real set minimum number. The individual market is part of the exchanges and is selling one plan to one household at a time. The complexity will be the relationship between the number in the rating area and what a plan will consider being viable and marketing to that number within a rating area.

Governor Musgrove said that discussion about an exchange is abstract at this early point. He told the committee that he had asked someone to present to them on what an exchange really looks like and how it works. The committee will have the opportunity to pose questions to someone who has run an exchange in a private market.

HEALTH AND HUMAN SERVICES TOPICS REACTION PANEL

Maternal and Early Childhood Home Visiting Program
Jocelyn Richgels, Staff
Rural Policy Research Institute, Human Services Panel

Jocelyn Richgels is the staff director for the RUPRI Rural Human Services Panel. She discussed the Maternal, Infant and Early Childhood Home Visitation Programs. Some of the future work for the Human Service Panel relates to the Class Act and also about the future of Medicaid and its role as a social service provider.

Ms. Richgels stated that the goals of the Maternal and Early Childhood Home Visitation Program are to strengthen and improve the programs and activities carried out under Title V of the Social Security Administration, to improve the coordination of services for at-risk communities and to identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities. Ms. Richgels said that it is critical to find the right evidence-based home visitation models in rural communities and form collaborations of services whenever possible.

Ms. Richgels spoke about home visitation programs in Humboldt, CA and a Commonwealth of Pennsylvania. The Nurse Family Partnership Program in Humboldt County, California was used as a design model in the Commonwealth of Pennsylvania. The Nurse Family Partnership Program improves the outcomes of pregnancy, children's health and development, and parents' economic self-sufficiency. The program in the Commonwealth of Pennsylvania included 17 urban and 6 rural sites. The study found that younger mothers demonstrated greater benefit in rural agency locations compared with urban locations. The effect was twice as strong among younger rural women. Rural concerns are the cost of purchasing the program and the availability of nurses.

Ms. Richgels discussed the State Needs Assessment Criteria. Communities that meet the criteria have concentrations of premature birthrates, low birthrates, infant morality, poverty, crime, domestic violence, substance abuse, unemployment, child maltreatment and high rates of high school drop outs. A concern is to ensure that the criteria are tracked by location of need and not location of recording. Another concern is measuring direct outcomes verses indirect outcomes in rural communities. She spoke about the Maternal and Early Childhood Program State Needs Assessments done in Ohio and California. The needs assessment in Ohio was about resources needed for flexibility and an important acknowledgment of the struggle for sustainability in rural communities. The needs assessment was broader than just the home visitation program and included maternal and early childhood needs. The recommendation in the Ohio state needs assessment was to create easier access to resources and equity for smaller rural counties. The California needs assessment identified a greater need for family preservation, support services and preventative services in rural areas where geographic isolation is a challenge. There is a lack of readily accessible transportation, limited adoption services and a need for more culturally appropriate resources and multilingual services.

Ms. Richgels spoke about home visitation on the ground. The Mississippi National Center for Rural Early Childhood Learning Initiatives home visitation program is the Indianola My House Program. Important issues in Mississippi are the need for culturally appropriate staffing, staff training and use of extension services in rural family support. There is also an evaluation challenge in rural Mississippi.

Ms. Richgels talked about legislative language. She noted there is rural representation on the advisory panel. There are general concerns about measuring participant outcomes in rural areas. In the legislation it calls for intra-agency collaboration. She stated that it is also important to consider physical collaboration and waivers as options.

She said some rural concerns are challenges to usage of evidence-based models in rural communities. Other challenges in rural areas include community capacity, infrastructure, cultural competence and measuring performance.

Ms. Richgels spoke about the Kresge Foundation Rural Human Services Initiative. It is a new program that is an exciting opportunity for funding innovation in rural human service delivery. She asked the committee members to lift up some innovation delivery models to bring to their attention to help design the initiative.

Q&A

Maggie Tinsman said that they have been doing home visitation for over 12 years in Iowa. The area where she lives is a population of about 150,000. They are considered an at-risk community and everyone is offered home visitation and many times it is refused. Of the fifteen at risk communities in the state, eight of them are rural, three are urban rural and four are urban. She asked what to do when people do not want the home visits.

Jocelyn Richgels suggested finding community members to implement the program making it less threatening than a nurse going into the home. The nurse family partnership is a medical model based on a nurse going into the home. Almost all of the other models use someone who is not a medical professional.

Maggie Blackburn said that she works in an at-risk micropolitan area and there are multiple factors of difficulty. There are cultural issues and people do not report issues. She asked Ms. Richgels if she is aware of rural initiatives focused around schools because they break down some of the barriers. Evaluations are based on what can be measured and programs need to be evaluated for what is important and the children need to be the first consideration. Changing the culture in rural areas so that people will report abuse is important. Domestic violence in rural areas is an issue. Eventually everyone knows where the safe house is so that does not work well. She asked what areas they consider when evaluating what is important and culturally appropriate for the rural community.

Jocelyn Richgels said that there is a program in Mississippi training low income, rural women through the Mississippi institute. The women go into early childcare settings and help with consultation and training to help improve the care. This helps women get jobs and helps

the centers.

COMMUNITY-BASED CARE TRANSITIONS: RURAL CONSIDERATIONS

Karla Weng, Program Manager, Stratis Health, Medicare Quality Improvement Organization, Bloomington, MN

Karla Weng said that her goal when speaking to the committee is to offer a brief overview of the Community-Based Care Transitions Demonstration, provide examples of current care transition work and offer recommendations for rural programs.

She said that rural providers have a great opportunity to be leaders in care transition efforts but based on program design it can unintentionally be a barrier to rural provider participation. The barriers are program eligibility, measurement criteria and if interventions are flexible enough to be implemented in rural communities.

Ms. Weng shared that care transitions are the coordination of care for individuals across settings and over time. Care transition is looking at an individual's total care over time and not just a single episode. She used her grandmother as an example of how there can be failures in the care transitions program. Her grandmother moved from the family farm in rural North Dakota to a home in a small town that is a block from the senior center. The reason she moved is because she had been hospitalized and received a pacemaker and returned home without much follow-up care. There were no family members who lived close to her. Three weeks after the hospitalization a family member talked to her and she seemed confused. She was found unconscious with a high fever. She was taken to a critical access hospital twenty miles away with an unfamiliar set of providers. She was treated for staff resistant pneumonia and in twenty four hours she was coherent and alert. The ten days in the hospital was damaging to her strength and mobility. They were unable to identify home health services in her area and could not provide her personal therapy. They found a retired nurse in the community and privately paid her to visit her. A month later she fell and was back into the hospital and in a nursing home. Ms. Weng said that year of her grandmother's life could have been different if there was a more supportive transition of care.

Ms. Weng said that care transition barriers include inadequate clinical information sharing, lack of shared processes and protocols among service providers, insufficient support for patient and family engagement and financial incentives.

In the Affordable Care Act, The Community-Based Transitions Program falls under Title III- Improving Quality and Efficiency and Part III- Encouraging Development of New Patient Care Models. It is specifically Section 3026: Directs the Secretary to establish a Community-Based initiative which provides funding to eligible entities that furnish improved care transitions services to high-risk Medicare beneficiaries.

Ms. Weng stated that the Community-Based Transitions Program encourages communities to work together to improve quality, reduce cost, and improve patient experience. The outcomes are reduced hospital re-admissions for high-risk beneficiaries and documented measurable

savings to the Medicare program. Examples of current care transitions that work are the QIO Care Transitions Project and Rural Palliative Care Initiatives. The QIO Care Transitions Project findings recognized that there are a wide variety of intervention tools available that are system-focused, community-based and patient activated. There is a need for cooperative, cross-setting, community wide population focused implementation.

Stratis Health is an independent, non profit, community-based Minnesota organization. The organization works at the intersection of research, policy and practice. The goal of the Stratus Health Rural Palliative Care Initiative is to assist rural communities in establishing and strengthening palliative care programs. That can be achieved by bringing together rural communities in a structured approach focusing on Community Capacity Development. The outcome of the initiative is that after eighteen months, six out of ten rural Minnesota communities are providing palliative care, team implemented program development and structural and clinical interventions. The Rural Palliative Care Initiative has continued efforts through the National Rural Health Association and implemented a pilot project in North Dakota, Mississippi and North Carolina to help organize community-based teams to focus on palliative care services. They are also working with twelve to fourteen rural communities in Minnesota. This is a measurement pilot project that is focused on rural community-based programs.

Community-Based Care Transitions and Rural Palliative Care are both about community capacity and how organizations work together to support the needs and goals of complex patients across settings. They are both structured processes to identify resources that work with healthcare delivery in the community while recognizing that the same solution may not work in every community.

Ms. Weng spoke about the Community Capacity Development Theory. It is based on the theory that communities tackle problems through collective problem solving. Change happens by enhancing the existing capacities. It is a strength-base approach requiring leadership and broad participation. This approach works well in rural communities because rural communities know their strengths and weaknesses and they know their culture. The providers in rural communities know their patients and they can identify solutions that best fit their work.

Ms. Weng said that if there were a formula for program development, it would include community data and a community-based team, access to national standards and intervention models and a structured process for development implementation. This creates a custom-designed community-based program.

Ms Weng gave care transitions rural recommendations. It is important with program design to make sure that the eligibility criteria allow rural providers to participate. The program design should consider evaluation criteria and if it is feasible for rural. They would recommend it be a population-based rate because it will be more applicable to rural communities where there are smaller numbers. Statistical significance can be an issue in rural communities. She said that rural programs should be evaluated but statistical does not fit in rural communities because there is not volume of population. Flexibility in interventions is

also a recommendation. If there are many good models it is important for communities to adapt them in a way that makes sense in that community.

Ms. Weng closed by presenting Care Transitions Program rural recommendations. She said that program implementation should include a guided process for program development and implementation, a focus on community capacity building, technical assistance and support and networking among peers.

Q&A

John Rockwood asked why this would not be coordinated through primary care physicians. There will be turnover in community groups and some people will be volunteers and also stating accountability as a concern.

Karla Weng said the QIO Care Transitions Program has a variety of people providing the care transition services and many times it is embedded in the hospital or medical center, especially the patient activation support. She does not know where that came from in the legislation. In palliative care, they typically have at least one physician very involved in the process.

Donna Harvey said they are trying to identify the connector piece between the medical world and the home world. They have found that there is so much re-hospitalization occurring because there is no connection back to the physician. Figuring out how to intersect the discharge with keeping the individual involved with the medical treatment plan is important. She said the planning needs to begin way in advance of applying for the funding and there needs to be guidance and technical assistance. The competitiveness is an issue because there is so much work to be done when applying for the funding.

Larry Gamm asked if under the exchange there is supposed to be prevention focus among the health plans. In the models that have been used, have there been efforts to coordinate among health plans or providers? Is there some record of who is in contact with the patient once they are discharged? It seems that if the activities were closer together so exchanges could encourage through the insurance commissions that the health plans work with the transition teams or hospitals.

Karla Weng responded that the Center for Medicare and Medicaid Services Community-Based Care Transitions Program is focused on fee-for-service Medicare beneficiaries so it may not have that health plan component to help coordinate. She said that in Minnesota they are a predominantly managed care state. Particularly the dual eligible population is through a program called Minnesota Senior Health Options and the program has a care coordinator They have talked to the communities that they are working with about how to link with the care coordinators to support the patients.

David Hartley said there are different requirements for services that are supposed to be included in their transitions system. There is a focus on patient education, patient empowerment and health care literacy and asked if that is truly the emphasis. If so, we are

focusing too much on the transition team, care givers and medical records and not thinking enough about the interaction with the patient. He noted that the previous speaker talked about cultural competency and making home visits and he asked how that can be evaluated.

Karla Weng said one of the key models is the transitions model that focuses on having a healthcare coach who is separate from the healthcare team and not a healthcare provider. They visit the patient in the home and they show them their medications. An example is if they have had heart failure, they tell the patient that they should call the doctor's office if they have a two pound gain. Most of the patients did not know how much they weighed when they came home from the hospital so they would not know if they have a two pound gain. Patient education and patient activation pieces are key to some of the models but also expensive to implement.

Tom Hoyer said that he thinks that many re-admissions are a direct result of poor discharge planning. There needs to be an effort to get the hospitals involved to do more effective discharge planning.

Karla Weng said that discharge planning is a key component in several of the hospital discharge model focuses. In rural areas, it is important to make sure that if the patient has a prescription that there is a place close enough for the patient to get the medication. Critical access hospitals have to understand that this circumstance is an important factor.

John Cullen said his hospital will do well with no re-admissions for months but with one re-admission it completely throws off their statistics. He said that it is important to give an evidence-base but it will be very hard to obtain in rural communities.

MATERNAL AND EARLY CHILDHOOD HOME VISITING PROGRAM PANEL

Audrey Yowell, Maternal and Child Health Bureau, Health Resources & Services Administration

Audrey Yowell began by stating that she would like to use the opportunity to get feedback from the committee. She works in HRSA but works out of the Maternal and Child Health Bureau which oversees the Maternal and Child Health Block Grant which is authorized under Title 5 of the Social Security Grant. That is the reason the home visiting program was authorized under the health reform bill as an amendment to Title 5. It gives it to HRSA to administer in collaboration with the Administration for Children and Families. She stated that the program has escalating funding over a period of five years. They began with one hundred million dollars to award this year which is a challenge because on March 23, there was six months until the end of the fiscal year. They needed to award all of the money for fiscal 2010 and produce guidance for the states conducting a needs assessment. The needs assessment had to be in and approved by the end of fiscal 2010 in order for them to receive their Fiscal 2011 block grant money. The first year funding was divided into three levels. Money was awarded to the fifty six eligible entities in July. It was in response to the applications that the states filed indicating their intent to apply for a full home visiting grant. Their governor

appoints a lead agency in the state to outline the planning process for submission.

In Title 5 most of the health departments were named lead agencies but not always. There is a lead agency for each state that is required to establish documented assurances that all the affected agencies will be working with them. The full Fiscal 2010 allocations were awarded to the states based on this formula. They restricted expenditure of all of the funds accept for five hundred thousand dollars that was available to each state for planning and developing their program. The remainder of the money is still restricted until their updated state plans are received.

Dr. Yowell said that the next step were the needs assessments. They issued guidance to the states for the needs assessments. They were not funding opportunity announcements; they were grantees so they were issued as a supplemental information request through the electronic handbook. They received all the needs assessments and they were approved.

Dr. Yowell said that the third step is for the states to complete their updated state plans. Earlier this month they issued a second supplemental information request with guidance on how the states should complete their updated plans. The updated state plans should include identification of their targeted communities at risk.

Many states identified all of nearly all of their communities as being at risk. There were thirty one of thirty three counties identified as being at risk in one state. Some of the Pacific islands have identified the entire territory as being at risk. The states can not provide home visiting services for all of these areas in need. They have to look at what areas of the community are at greatest risk and have the infrastructure to support a successful home visiting program.

There is maintenance of effort requirement to maintain home visiting funding but a side effect has been that other services to support home visiting have been cut. The first year has the lowest amount of funding so the states will have to consider which areas are in greatest need and have an adequate community support system. What evidenced-based model most adequately meets the needs of the community has to be considered. It needs to encompass an early childhood system and not make home visiting stand alone. It is part of developing an early childhood system in the states and needs to be promoted that way.

Dr. Yowell stated that there is interest in which of the home visiting models will be identified as evidence-based. There was a study to determine which were evidence-based and eleven models were identified. She said that seven of the eleven made the cut to be evidence-based home visiting models.

Dr. Yowell said they explained to the states how benchmarks will be measured. There are six benchmarks identified in the legislation that should be met by year five by each of the states. By year three the states have to show progress in four of the six benchmarks.

Dr. Yowell said that three percent is set aside in the legislation for research and evaluation. The Secretary of Health and Human Services is to convene an advisory committee on the national evaluation. There are design options being developed to present to the Secretary's

advisory committee to consider for the national evaluation. Later in the program they will be using the additional research resources to advance knowledge about evidence-bases for home visiting programs. They are interested in what works in areas that are rural. Dr. Yowell said she would like the committee's advice on what works in rural. Rural areas will have to be identified because there are difficulties in reaching rural families that need the services.

Q&A

Graham Adams said there are three Healthy Start sites in South Carolina. He stated that he does not see coordination at the local level between the different programs. They are funded through different avenues but all trying to achieve the same outcome. He questioned as they move forward and states can choose between the level models, what kind of encouragement will be given to the states to have different programs coordinating their activities. There has been a large amount of data collected through Healthy Start but it is not considered one of the more robust evidence-based programs. He asked what is being done about the Healthy Start model since so much tax money has been invested in it throughout the years.

Audrey Yowell said that Healthy Start is run out of their bureau and they coordinate closely with Healthy them. The problem with Healthy Start is that the decision was made to only look at the research focused on the home visiting component. Healthy Start is a more holistic program and involves the community. There is not research at the moment that looks at just the home visiting piece. She noted that she has ideas how to correct that in the future. The available research shows that Healthy Start is an affective program but they did not look at programs that had multiple components to them.

Audrey Yowell responded that developing continuity at the local level is a strong focus of the program. Home visiting is not a stand alone strategy but one component of an early childhood system. The needs assessment required states to identify existing resources in the areas in terms of home visiting. The updated state plans that are due in June require that the states look at the communities where they will implement the programs and look at the infrastructure to support them. Where there is not an infrastructure, at the state or community level, they are required to develop it. Not every dollar will go to implementing the home visiting program. There are federal project officers located in the ten HRSA regions who will make site visits and get to know the community and people. Since July they have been making technical assistance visits and helped with developing the plan. Some technical assistance contracts will be developed so there will be ongoing technical assistance throughout the five years of the program. The collaboration with the Administration for Children and Families is really supporting them.

April Bender asked if consideration has been given to connecting the departments conducting technical assistance and evaluation in rural areas so that they are informing each other.

Audrey Yowell said that the research people and the technical assistance people work together in her office. They have joint staff meetings and there is constant feed back of information.

Graham Adams said that the prior speaker stated that approximately 75% of the dollars are going to the approved models and 25% for promising practices. He asked if there is there a set aside for rural.

Audrey Yowell said that there is no set aside for rural but there are so many states that have rural areas in need so it is a big area of concern. They are determining how some of the states will get programs implemented in a useful way. The formula for how the funds were allocated is the Title 5 block grant formula. Some of the areas with the greatest geographic spread get some of the lowest amount of dollars. There will be areas where the expense to implement the programs will be the greatest so they are trying to be creative. One consideration is whether there will be an opportunity to pull some of the 25% promising program money across state borders.

Graham Adams said that unless there is a mandate, the funds often go to larger metropolitan communities with a larger sample size. That may be an appropriate recommendation to the Secretary to have a certain number of projects rural specific.

Maggie Tinsman said that they have been doing home visitation for over 12 years in Iowa and this will add to it which will be great. She said they have found that when home visitation is offered to new mothers that it is refused most of the time. She asked if everything is coordinated, what suggestions there are to get the consumer to allow home visiting.

Audrey Yowell said they are working with states that have had greater success and bringing them together with states having those types of issues. She is interested in what programs they are using to deal with the concern.

Maggie Blackburn said she is confused as to how the program is coming together. She looked at the Florida needs assessment and it does not focus on the priority areas. There have been home visitation programs through HRSA that have been run by community non-profits. She questioned how to find ways to make recommendations for the other 25% in model programs to go to rural areas.

Audrey Yowell said that the statewide needs assessment was a useful first step. The supplemental information request requires further information. Florida has been provided technical assistance. There is a limited amount of money and there will not be much funding the first year. Some of the models are more expensive than others. What are the community needs and which community can you serve with a small amount of money the first year and what model you can use to meet that? It is examining all of the pieces that need to fit together, especially for the first year.

Darlene Byrd asked if any of the approved models target the at-risk population prenatally.

Audrey Yowell said that the Nurse Family Partnership and Healthy Families target the at-risk population prenatally. HRSA and Maternal and Child Health Bureau have a strong focus on

life course health development. Prenatal health is really important and can be integrated into the home visit program.

John Cullen said that people doing the home visits have to be culturally, professionally and scientifically competent. It is important if they're collecting data for a three year period to establish benchmarks. Are you taking that into account? Is it really going to be evidence-based?

Audrey Yowell responded that when a state signs on with Nurse Family Partnership, they have to sign a contract. In order to be approved as a Nurse Family Partnership site you have to agree to their training program, technical assistance program and data collection program. The evidence-based programs have their training and supervision requirements and standards. There will also be technical assistance to assist the states beyond that.

COMMUNITY-BASED CARE TRANSITIONS

Juliana Tiongson, Centers for Medicare and Medicaid Services Office of Research and Demonstrations

Juliana Tiongson stated that it is a pleasure to speak to the committee about the Community-based Care Transitions Program. The Community-based Care was mandated by section 3026 of the Affordable Care Act and provides funding to test models for improving care transitions for high risk Medicare beneficiaries. The program will run for five years with the possibility of expansion beyond 2015.

The goals of the program are to improve transitions of beneficiaries, improve quality of care, reduce readmissions for high risk beneficiaries and document measurable savings to the Medicare program.

Ms. Tiongson stated that eligible applicants are statutorily defined as Acute Care Hospitals with high readmission rates in partnership with a community-based organization and community-based organizations that provide care transition services. There has to be a partnership between the acute care hospitals and the Community-based Organization.

A community-based organization provides care transition services across the continuum of care through arrangements with subsection (d) hospitals. The governing body includes sufficient representation of multiple health care stakeholders, including consumers.

Ms. Tiongson said that community-based organizations will use care transition services to effectively manage transitions, report progress and outcome measures on their results. Applicants will not be compensated for services already required through the discharge planning process under the Social Security Act and stipulated in the Center for Medicare and Medicaid Services Conditions of Participation.

Ms. Tiongson explained that preference will be given to proposals that include participation in a program administered by the Agency on Aging to provide concurrent care transition

interventions with multiple hospitals and practitioners. Preference will also be given to proposals that provide services to medically underserved populations, small communities and rural areas.

Ms. Tiongson said that applicants must address how they will align their care transition programs with care transition initiatives sponsored by other payers in the communities. They have to address how they will work with accountable care organizations and medical homes that develop in their communities.

Ms. Tiongson noted that consideration will be given to hospitals whose 30-day readmission rate on at least two of the three hospital compare measures falls in the fourth quartile for its state. Applicants are required to complete a root cause analysis.

Q& A

John Rockwood asked how this would work in rural areas when a hospital draws from dozens of communities within seventy five miles. In most rural communities they are sending patients from other areas. To set up a group in Ann Arbor, Michigan when the patients are coming from the Upper Peninsula, it does not solve the problem. It is difficult to see how this will work in a rural setting.

Juliana Tiongson asked if he thought there was an organization that would fulfill the definition of community-based organization that is closer to the beneficiary's homes.

John Rockwood said that each organization would have pieces of it but would be unique to the local community. Resources for patients are spread over a large area. How to get a group of people to represent all of the resources of patients in a large rural area that can be effective is difficult.

Juliana Tiongson said it will be interesting to see who applies. Rural areas are given a certain amount of preference. They only have to have as many representatives as they can bring together in their community.

Larry Gamm asked if federal qualified health centers can be the lead or a partner in the grant submission.

Juliana Tiongson said that they could be part of a larger collaboration.

Donna Harvey said she was with an Area Agency on Aging and now she is with the State Department on Aging. The Area Agencies on Aging are multi-county. Governing boards are a concern because they are based on the mission of the overall organization. It may be a benefit to have a group that focuses on care transition and not the bigger mission of an organization that would apply. She said they may want to make sure there are adequate barriers to make sure that all aspects of the human services side are met.

Juliana Tiongson replied that Area Agencies on Aging are more than welcome and it would be great if they have advisory boards that focus on care transitions. They would have to be

linked to the governing board so that there is the legal authority to control what is happening. Home health agencies do not qualify alone. They would have to establish a new organization and bring in partners to create a new governing board and legal entity to qualify for the program.

John Cullen said that a problem in small communities is that the same people are on many different boards. Coming up with a new governing structure is almost impossible in a small community. Is there a way that part can be addressed to make it an easier transition?

Juliana Tiongson asked if there is an organization, such as an Area Agency on Aging, which would have the board and be able to establish relationships with at least one Acute Care Hospital in the area? It does not require creating a new governing board. Hopefully it does not have to be done from the ground up in every rural area. They are trying to insure broad healthcare representation on the boards.

Roger Wells asked if a Public Health Department that is responsible for multiple counties and hospitals can be a community-based organization.

Juliana Tiongson said that if they meet the definition and are a legal entity and have the board with consumer representation and were proposing to serve in the community where they are physically located it should be acceptable.

David Hartley said that in Maine they have a consortium or rural hospital that has formed an organization interested in transitions. Would a program focusing primarily on transitions to the nursing home be appropriate? What would be the ideal community-based organization for a consortium that is primarily nursing homes and critical access hospitals?

Juliana Tiongson said that people going from the hospital to a nursing home and back to the hospital is a problem so focusing on the transition from hospital to nursing to prevent them going back to the hospital would be a very acceptable avenue. The legislation does not include critical access hospitals. It is only for acute care hospitals.

COMMITTEE DISCUSSION

Tom Morris discussed the formation of work groups for the sub-committees and the breakout session on Thursday. The subcommittee's topics are: Health Insurance Exchanges, Maternal and Early Childhood Home Visiting Program and Community-Based Care Transitions.

RURAL HEALTH UPDATE

Alan Morgan, CEO, National Rural Health Association

Alan Morgan thanked Governor Musgrove and the committee members for inviting him to speak. Mr. Morgan gave an overview of the key rural policy issues that National Rural Health Association is addressing. Mr. Morgan said that they have spent over one hundred

hours determining available data sets and proxies to identify access issues and barriers to healthcare.

Mr. Morgan said that as rural policy experts, the current political environment raises policy issues for them. Primary concerns are funding for key health programs such as The Rural Research Program, Outreach and Networks Small Hospital Improvement Program and the Medicare Rural Hospital Flexibility Program. Mr. Morgan said from an association standpoint they had thought that some of the programs would have already been eliminated. However, they were reduced the lines to 2008 levels.

Mr. Morgan said they have to maintain the rural health safety net and are optimistic about its future. He said he was surprised to see the reductions proposed for community health centers that have been successful in reaching underserved populations. There are many unknowns moving forward not only for the key safety net programs but also for funding some of the key issues in the Accountable Care Act.

Mr. Morgan said there are policy program regulatory opportunities that will be coming over the next six months that will have a dramatic impact on healthcare in rural America. The proposed rule on accountable care organizations and the Universal Services Fund that can help expand access in rural areas.

Mr. Morgan said as they move forward, someday there will be a pay for performance system for all hospitals including critical access hospitals. There will have to be rural relevant quality measures. He also noted that measuring quality with such low volumes is never going to be an easy task and getting there is going to be problematic.

Mr. Morgan said that the impact of rising gas prices in rural communities two years ago is an example of unknowns that can be most troubling moving forward. He stated that the amount of uncertainty and unclear direction in communities is at a high level. Anything that can be done from a policy standpoint to help rural communities navigate, work together and help the Department of Health and Human Services understand issues in rural communities is important.

Tom Morris, Associate Administrator, Office of Rural Health Policy, HRSA, DHHS

Tom Morris presented an informational overview of the Office of Rural Health Policy to the committee. He noted that there are new committee members and a HRSA update and overview of the Office of Rural Health Policy that would be beneficial to understanding the core rural infrastructure.

The Office of Rural Health Policy is a "voice for rural" within the Department of Health and Human Services. The Office of Rural Health Policy gives a rural-focused review of the Department of Health and Human Services regulations, has rural specific grant programs and works jointly with The Centers of Medicare and Medicaid Services on rural demonstrations.

Mr. Morris spoke about ways the Office of Rural Health Policy is working to build an

evidence-base for rural community health. The 2011 focus is to identify best practice models, push for sustainability, measure performance and provide tools for building an evidence-base for rural community health.

The Rural Assistance Center is building a home for the emerging rural community health evidence-base. This allows everyone to benefit from the information and not just the people who get funded. Resources that are available are web-based services and customized assistance. Communities can view what other communities are doing that is successful and learn how to replicate it. Some of the new tools that are being created are an economic multiplier calculator for community-based programs that will be available on the Rural Assistance Center in early 2011.

Mr. Morris said that the Rural Training Track Technical Assistance Center is a way they support residency training in rural areas. Research shows that seventy percent of the graduates in the rural training tracks practice in rural. They work with the twenty five rural training tracks to add support. This is a model that works and sustainability can be created by creating new training tracks. Workforce training is an important consideration for rural communities.

Hospital-State Division is working with small rural hospitals. This year they are looking at how to improve the Medicare beneficiary health status. Most are working with critical access hospitals through the Flex program. They are developing new rural relevant measures through a three or four year phased project that will be looking at medication reconciliation.

The Office for the Advancement of Telehealth is in the Office of Rural Health Policy. The Office of Rural Health Policy is working with the USDA Distance Learning Telemedicine Programs.

Mr. Morris said that key policy issues the Office of Rural Health Policy is tracking are accountable care organization regulations, exchange regulations, rural Health Information Technology challenges, workforce and more rural-relevant quality measures for Medicare.

Key partners of the Office of Rural Health Policy are the National Health Association, the National Organization of State Offices of Rural Health, Rural Recruitment and Retention Network and the National Center for Rural Health Works.

Mr. Morris stated that this is a broad overview but gives a base level of what they are doing in the Office of Rural Health Policy.

PUBLIC COMMENT
There were no public comments and the meeting was adjourned.

Thursday, February 24th, 2011

CALL TO ORDER AND DEPARTMENT OF HEALTH AND HUMAN SERVICES UPDATE

Governor Musgrove opened the meeting by welcoming Secretary Sebelius to the National Advisory Committee meeting on Rural Health and Human Services. Governor Musgrove also welcomed Dr. Mary Wakefield who introduced Secretary Sebelius to the committee.

INTRODUCTION OF SECRETARY KATHLEEN SEBELIUS

Mary K. Wakefield, PhD, RN, HRSA Administrator

Dr. Wakefield began by thanking the committee members for serving and stated that it was not many years ago that she served on the National Advisory Committee and at her current position she has an even deeper appreciation for the importance of the expertise that the committee brings to the rural health issues as they advise the department on rural health concerns.

Dr. Wakefield stated that they are fortunate to have Secretary Sebelius at the National Advisory Committee Meeting. Dr. Wakefield shared that Secretary Sebelius had been the Secretary of the Department of Health and Human Services for almost two years. Since her confirmation in April of 2009, she has been relentless in her work and focused on keeping Americans healthy and insuring that regardless of who they are and where they live that they had access to a high quality of care. She is not just focused on healthcare but also access to human services. The Secretary's leadership on health and human services did not begin in her current position. She has been a leader on healthcare and human services issues for over twenty years beginning in her home state of Kansas. There she was a member of the State's House of Representatives and later served for eight years as the State's insurance commissioner. During her tenure she earned a strong reputation as an advocate for consumers. She then served as Governor of Kansas for six years so she is no stranger to the healthcare concerns of the nation's rural states.

Dr. Wakefield said that in the two years that she has served as Secretary of the Department of Health and Human Services that she has presided over the department's implementation of the recovery act and has shown leadership in communicating with the public about the dangers of the H1N1 pandemic and she has guided the department's efforts to bring much needed health care reform to the nation through the Affordable Care Act.

Dr. Wakefield asked the committee to join her in welcoming Secretary Sebelius.

SECRETARY SEBELIUS - ADDRESS TO THE COMMITTEE

The Honorable Kathleen Sebelius
Secretary, U.S. Department of Health and Human Services

Secretary Sebelius began by thanking the committee for their focus, attention and willingness to provide insight on strategic initiatives.

Secretary Sebelius said that she is thrilled to have Mary Wakefield, Administrator of Health Resources and Services Administration, as a senior leader in the department and that she brings a unique expertise since she is from rural North Dakota. Secretary Sebelius noted that Dr. Wakefield is the highest ranking nurse in the department and represents a critical component of the provider workforce and one that is going to play even a more important role as they shift from acute care to wellness and preventive care. She said nurses need to be empowered and enabled throughout the country to step up and practice to the scope of their training and provide important wrap-around care. Secretary Sebelius stated that Governor Musgrove is a colleague who is from the rural state of Mississippi and was a CEO so he has experienced the challenges up close and personal.

Secretary Sebelius stated that the agenda the committee has chosen is an important and on-target focus of the aspects of the Affordable Care Act that can impact rural areas. The opportunities to have the discussions in field hearings and give the Department of Health and Human Services policy recommendations are vital when implementing this historical act to assure there is always a focus on rural areas. She said that when she was Governor of Kansas they had the same problems as other rural states. There are urban areas with challenges but the western two thirds of the state of Kansas is one congressional district with more cows than people. Access to healthcare and affordable insurance are challenges that go along with being in a rural community. Secretary Sebelius stated that a shortage of workforce and critical care hospitals in rural communities is familiar territory. She said from her experience that two ways to kill a town in her state of Kansas was to close a hospital or a school.

Secretary Sebelius said from her time as insurance commissioner she knows the challenges of the rural population with insurance products. Secretary Sebelius stated that the part of the system that is broken in the insurance market is when people are purchasing insurance on their own. They have no leverage, minimal information and no real protections in place which creates a cowboy market where anything goes so people can be medically underwritten or thrown out. The other part of the market that is very unstable is the small group market and employers who are running small businesses. When thinking about rural communities, typically people are in one of those two markets. Farm families or small business owners are often shopping for themselves or families. Secretary Sebelius said that she knows lots of people in farming in her home state of Kansas where family members got jobs off of the farm simply to get insurance for their family. She noted that the new exchanges are about fixing that portion of the marketplace.

The law is written so that the exchange opportunity is aimed at the part of the market that has little competition, did not have rules previously, and where people did not have the leverage buying power of larger employers. People can become part of a pool and can choose from plans that compete on the basis of price and quality as opposed to who can medically underwrite the best. That is what the exchanges are about.

Secretary Sebelius stated that the kind of workforce attention that the Affordable Care Act provides has never been a focus until the recovery act. There is finally the recognition that there will not be the number of providers needed ten to fifteen years from now. There is a looming retirement of nurses and providers and not enough primary care nurse practitioners, particularly when you look at the baby boomers that are aging and needing more care but want to age in place. The provider shortage is serious and the Recovery Act and Affordable Care Act will try and fill to pipeline.

Secretary Sebelius spoke about a new set of insurance rules that will be beneficial for everyone, not just individuals and small businesses. These rules include making it illegal to rescind policies that allow people to be dumped out of their policy even if they were paying their premiums. Companies made it a business of targeting breast cancer victims, AIDs patients and others in order to find ways to weed them out.

Secretary Sebelius noted that the medical loss ratio is a key area and is less understood. The medical loss ratio that begins this year mandates companies spend eighty to eighty five cents of every dollar for health related benefits. The Federal Government did not make these rules rather the nation's insurance commissioners who are appointed and elected from every state in the country. They made a unanimous recommendation to the Department of Health and Human Services about what the categories should look like and the Department of Health and Human Services adopted it without changes. For the first time consumers have some transparency about where their premium dollars are going and consumers are owed a rebate if companies do not meet the medical loss ratios.

Secretary Sebelius said she knew that the committee would be focusing on two areas with huge opportunities which are the Community-Based Care Transition Program and Maternal and Child Health Visitation Program. The Community-Based Care Transition Program offers one of a series of strategies that has the potential to lower cost and improve the quality of care, particularly around chronically ill patients and patients that are released from the hospital without ample follow-up care. At the other end of the spectrum is the Maternal and Child Health Visitation Program which is an investment that is known to pay off in areas where the strategy is already in place. This program works by providing parenting assistance and identifying health issues early on.

Secretary Sebelius stated that not only does The Department of Health and Human Services take the committee's recommendations seriously but that Dr. Wakefield is part of a group that sits at the table on health implementation. There are forty representatives of Health and Human Services that meet on a weekly basis. Everyone from the Mental Health Services Agency to Centers for Medicare and Medicaid Services to Health Resource Services Administration is in attendance. There are lenses from across the

department in every aspect of the bill, every regulation being written, and every step along the way. The Indian Health Service is also at the table. The Department of Health and Human Services does not want this to be a siloed operation because it is a comprehensive and transformative opportunity to shift the health system and the assets of the department. It is critical that they get the policies right.

Secretary Sebelius thanked the committee for serving and told them that they are not having three meetings a year to just have a dusty report that goes on a shelf somewhere and that their input and ideas inform policies and the budget decisions of the department. She said that this is an interesting time in terms of the budget and implementation strategies and it is her goal to continue to move ahead. This is an important mission in getting health services and critical human services to the most vulnerable population. She said that with the committee's input and support they will make sure that all Americans have an opportunity to achieve their full potential. Secretary Sebelius closed by thanking Governor Musgrove and the committee and welcomed questions.

Q&A

Todd Linden stated that it is a pleasure to have Secretary Sebelius at the meeting and that it is a pleasure to be a voice for rural healthcare. It is a dynamic time in healthcare and one of the issues that is important is the opportunity for testing in rural environments so that we can be ahead of things and not have to repair things after the fact. Mechanisms that work well in urban may not work well in rural. We are looking forward to advising on some of those kinds of opportunities. Can you tell us one or two things that are most valuable to you as Secretary that this committee can focus on?

Secretary Sebelius responded that there is a two way communication opportunity. She said that the Department of Health and Human Services will make sure they are getting the committee the information about what is pending on the horizon so the committee can give them feedback on how that will impact rural areas and what barriers and challenges are unique to rural areas. She said that it is also beneficial for the committee to continue to be messengers about the positive benefits of what is on the horizon and how it can help change the footprint of what is happening in rural areas. A challenge of the Affordable Care Act is that it is comprehensive, implemented over a ten year period of time and with lots of pieces to it. It does not lend itself to quick sound bites. The more the committee can have conversations in communities about the features of the Affordable Care Act, the more valuable it will be.

Secretary Sebelius said that she thinks that people have an idea that the Affordable Care Act is about insurance markets but there is not an understanding about the delivery system changes which are necessary in the country and the opportunity for change what is broken about the current system. There are several different mechanisms and models that are specifically outlined in the bill. Bundled care payments for doctors and hospitals and the medical home model lends themselves well and is already in place in a number of rural communities. She also spoke about the Innovation Center. She said that she hopes that the committee members will encourage the most innovative care providers in their

areas to be part of the grant application process for the Innovation Center. The Department of Health and Human Services does not want theoretic rural participation but they want people in the door. Rural communities are often hot spots of poorly delivered care or of overly expensive care. If there are projects working to improve the quality of care then this is an opportunity to get those projects tested and taken to scale. The way the law reads is if they work, there is legislative authority to implement those successful strategies across the country. There does not have to be permission from Congress. There has never been such an opportunity and there has always been limited demonstration project authority with Centers for Medicaid and Medicare Services but now the door is open.

Secretary Sebelius said there will be a real focus on the dual eligible population. Eight and a half million people in the country qualified both for Medicaid, because of their income, and for Medicare, often because of their age. Some are severely disabled so they qualify for both but most are older, poor and chronically ill citizens often with multiple conditions. That population represents forty percent of Medicaid spending across the country and they are now over one third of Medicare spending and rising. Looking at better coordinated care delivery in terms of cost focusing on serving people in communities when there is not easy access to care is extremely important. The challenge is how to coordinate care when there are not many wrap-around services. Those kinds of creative strategies at the state level or with providers could be enormously helpful.

David Hartley told the Secretary that he directs a research center in Maine. He said that an issue that the committee often discusses is replicating practices that are known to work which is evidence-based practice or evidence-based policy. With every issue that is discussed practically, often the demonstrations and research can not do an adequate job of measuring outcomes in rural populations because of the small numbers. It is something that is a struggle. Is there a way within the Department of Health and Human Services that someone can be watching when there is a demonstration, evaluation or research RFP to question if the smallest rural areas are being systematically shut out because it is difficult to see the results? Is there a way to compensate for that perhaps something that can be done methodologically? He stated that he knows that Dr. Wakefield keeps an eye on this and is sensitive to these issues and he said that he would like to think there is a systematic approach.

Secretary Sebelius responded that it is an ongoing challenge and is not only a conversation about rural populations but also in health disparity work. How to get a large enough sample group to make sure people are adequately included and represented in research is an issue. There are two agencies that need to look at this more strategically. One agency is the Center for Medicare and Medicaid Services because so much of the demonstration effort and project effort are going on through their auspices and they have more authority than ever. She said that she has asked Center for Medicare and Medicaid Services to go back and do a better inventory of what has been funded in the past and what has worked across the country. She said that she will give more emphasis on some of the rural projects where people got a rural grant. The other entity is the Agency for Research and Quality. There is an opportunity to have the leaders strategize to make sure

that accountable care organizations include models that work in rural areas and that Innovation Center projects are not just looking at large scale but also smaller scale. The medical home models lend themselves well and Maine and Vermont are already well underway. There can be a set aside or an outreach that encourages a special training session for rural providers.

Roger Wells stated that he is a physician assistant from Nebraska and he said that an issue that is seen throughout the United States is commission's task forces or community health providers getting together in rural states trying to find generalized assistance protocol or assistance in development of rural access for medical providers. Forty five to fifty percent of providers are pre-retirement and will be gone within the next ten years. There is no pipeline that will come close to providing this type of recovery. What can the committee do to assist in this kind of replacement? People are coming out wanting salary shift jobs and there is no shift job in a small town with a population of two thousand. They will be required to work night and day and nobody wants to take that job. Two percent of people in internal medicine go into primary care. How can we help you try to initiate a project or goal to help direct these kinds of disparities?

Secretary Sebelius said that this has been a looming challenge for a long time. There are some pipeline issues that have been funded such as doubling the National Health Service Corps, paying off some of the scholarships and moving some of the graduate medical slots with a focus on primary care providers. There are new incentive payments that are changing for Medicare primary care providers changing the formula of payment and new training for nurses and nurse educators which are critically important. Secretary Sebelius said that the scope of practice issue needs to be raised. There are lots of trained providers who are not able to practice to their scope of training. The scope of practice is often a state based issue and raising the visibility higher is important. Dr. Wakefield is in charge of putting together a workforce commission to look at accurate mapping of where providers are, where they are needed and how they are matched. They are also focusing on making sure that they can address issues from education to placement. Secretary Sebelius said she is eager to look at the pipeline, the overall placement and use some of the leverage tools available, and she welcomes recommendations.

Maggie Blackburn said that healthcare disparities are a huge issue in rural populations and there are large populations with persistent poverty in the south and other areas. The increasing Hispanic population in all rural communities creates other barriers to care. She asked the Secretary to inform the committee how it could help influence, as a rural advisory committee, help in addressing healthcare disparities as they move into Healthy People 2020.

Secretary Sebelius said that there is a new disparity report about to be released that comes from two years of work with stakeholders. She has asked the leadership team to focus on specific recommendations and present an action plan. There will be more universal access starting in 2014 and there is the need to figure out what the pipeline should look like in the meantime, what levers need to be in place and what type of outreach needs to be done. The work that is underway with Community Strategies on

Wellness and Prevention need to be ramped up in rural areas. She said that she is eager to find out what is working and implement it into other areas. Smoking and anti-obesity initiatives in the long run have a chance to payoff in terms of wellness and cost. She stated that she wants to make sure that rural areas are not overlooked. Secretary Sebelius said they have a one year summary from Dr. Frieden of the Centers for Disease Control about initiatives around the country, what the projects look like and what is underway. Having that summary shared with the committee and getting strategies back at this early juncture will be beneficial. There are mayors and school districts that are eager to participate. Your ideas about getting others engaged in the strategies would be appreciated.

Governor Musgrove thanked Secretary Sebelius for addressing the committee and said that the committee appreciates being an advising source as she moves healthcare forward.

HEALTH INSURANCE EXCHANGES: RURAL IMPLICATIONS

Krista Drobac, Center for Consumer Information and Insurance Oversight, U.S. Department of Health and Human Services

Krista Drobac started by giving information about the Center for Consumer Information and Insurance Oversight. The Center for Consumer Information and Insurance Oversight started as an independent office in the Office of the Secretary. There are four divisions within the office and they are the Office of Consumer Support, The Office of Insurance Programs, The Office of Oversight and The Office of Insurance Exchanges. The Office of Insurance Exchanges is working on a regulation that will be released in late spring that will answer questions about qualified health plans.

Ms. Drobac works in the Center for Consumer Information and Insurance Insight Office which merged with Centers for Medicare and Medicaid Services. They are a center within Centers for Medicare and Medicaid Services. She said that they have a lot to learn from Medicare and Medicaid so it is great that they are under the same roof.

Ms. Drobac said the positive impact on rural communities is similar to what they want in the larger markets which is access to quality, affordable health insurance. People need accessibility to providers and for it to mean something when they have it. There are challenges in the rural markets. Exchanges in rural markets are going to create an opportunity for consumers to shop in a competitive market place. With the qualified health plans, there is an expectation that there will be a competitive market place for people in rural areas to choose a product. These products will have to be presented in an organized format and certified. For the first time there will be uniform standards and there will be a toll free hotline for consumers to call for information. There will also be new quality ratings that have never been available. There will be a single door for Medicaid and private insurance. This will assure that people have the opportunity to search for every option that is available to them. Tax credits are a big part of the affordability and many small businesses in rural areas that are already benefiting from the tax credit. The tax credit will only be available in the exchanges so many small

businesses will want to access the exchange to take advantage of the tax credit.

Ms. Drobac said that a key question with the marketplace that is created in 2014 is the geographic area for the rating structure. She said they are hoping that the idea of the competitive market place will create a reduction in adverse selection for people in rural areas because there will be a larger marketplace for rural consumers. There is flexibility built in for local market conditions. The rate review provisions are taking effect now but will be fully in effect in 2014. If an insurance company has an unreasonable rate increase a state can bar them from participating in the insurance exchanges.

Ms. Drobac said that their responsibility is to establish the certification criteria and the marketing requirements for the qualified health plans. They are also defining the essential benefits package and regulations should be prepared in late fall. Regulatory standards on network adequacy are being developed and that is very important to rural communities assuring that there is sufficient choice of providers including essential community providers. They are developing regulatory standards on quality accreditation. A consumer can log in, enter their information and find insurance products for their family and also find quality ratings. A regulation for a uniform enrollment form is another project they are working on. They are developing a rating system that will rate qualified health plans within each benefit level on price and quality. The regulatory standards on the enrollment periods are also being developed.

Ms. Drobac said funding was immediately sent to states because it is a state and federal partnership and many of the policies need to be made at the state level. They have agreed to fund the exchanges until they are self running in 2015. In September they awarded planning grants to forty eight states and the District of Columbia. States are hiring staff, doing gap analysis on Information Technology systems and developing partnerships with community organizations to make sure that stakeholder information is received in the exchange process. They are also planning for consumer call centers and developing performance metrics.

Ms. Drobac stated that they released a funding opportunity for the second phase of the planning grants. Some states are very far along and other states are still in the stakeholder process and not yet ready for more funding. The money is being released in two parts. The third funding opportunity is the early innovator grants. Many states are saying that they want flexibility except on Information Technology where they want guidance and there has to be a strong IT system. There were seven grants awarded to early innovator states who have agreed to develop prototype and share with other states. The states that received the grants are Kansas, Maryland, New York, Oklahoma, Oregon, Wisconsin and a group of New England states.

Ms. Drobac said they are struggling with how to make markets work better. Having better consumer choices and better competition and having more plans is the goal. There is a balance working with insurance companies and reminding them they have to be better actors in the new marketplace. How to enhance patient quality and health with the exchanges is an important issue. Working with the public and private sector to improve

patient health and safety is essential along with ensuring an effective partnership with states is another important issue. Alaska has announced that they will not be seeking federal funding for exchanges but they are hoping that other states will move ahead.

Ms. Drobac closed by welcoming questions from the committee.

Q&A

John Cullen asked what the implications are for the states that do not participate in the planning process.

Krista Drobac responded that the Affordable Care Act requires that if the state does not set up the exchange that the federal government will set up the exchange. Another state from the west coast could offer regional exchange that would include Alaskan consumers. The unfortunate part is that if a state does not apply for the planning grants, later options are closed. The federal funding options will be limited in the future.

Shane Roberts asked if the federal government does the exchange is there any guidance. Will they only take insurers that practice in that state?

Krista Drobac said there is a requirement in the law that the Office of Personal Management offers two plans that are multi-state so no matter what happens there will always be two plans available. There has not been guidance released on what the federal exchange will look like so that is forthcoming but the goal is to offer as many choices as possible.

Karen Perdue said it is not the best strategy to wait until 2013 to certify that they can not have an exchange in Alaska since they do not have the funding. If the State of Alaska is not moving forward through the official channels there should be discussions opened with nonprofits or other organizations that could allow the state to move forward.

Krista Drobac said that a nonprofit can be an exchange but the state has to apply for the funding. In late spring or early summer when the regulation comes out, the nonprofits in Alaska can look at it and could certify plans and become an exchange entity.

John Rockwood said that he is interested in the rating areas because the committee's job is to understand the effect on rural areas. Many large insurance companies have stayed out of rural areas because they are not as lucrative and the patients are more high risk. The smaller the rating areas the larger the problems will be and there need to be as many relationships through the insurance company as possible. How can large insurers be encouraged to pick up a large portion of rural areas and give them the same coverage that people in urban areas have available?

Krista Drobac said that it is up to the state to determine the geographic area. The state could define the whole state as the geographic area so an insurer would have to build a network in every area of the state. The state could determine that only a county is a

service area. It is up to the state to decide. There will be two plans that are multi-state plans offered in the exchange.

Robert Pugh said that Mississippi was one of the forty two states that received the gap grant. The funding has just been distributed and made available. He asked if there will be the ability for carry over or will funding continue to those programs?

Krista Drobac said that some states did not apply the money was redistributed in supplemental funds. There is no more funding.

Todd Linden said that multi-state exchanges are intriguing for rural states like Iowa. There is one large insurance company in Iowa that dictates payment levels. If there was competition in the marketplace it would be an interest to consumers and providers. Is there any insight that you are hearing about multi-state exchanges?

Krista Drobac said there is interest but it is necessary for a state to give up some control and it is difficult for a state to relinquish control. There would have to be agreements from legislatures in both states to make changes. Many healthcare market places are across state lines but the laws are of the state so they would have to give some amount of control. The New England states are trying to make this work and applied for an early innovator grant together. She said that over time she feels that some states will join together but probably initially states will operate their own to see how it works.

Ronnie Musgrove asked if there is a time frame for the information from states with the early innovator grants to be shared.

Krista Drobac said that it is an ongoing exchange of information.

Roger Wells said that many providers are negating to accept Medicare and asked if the preferred providers in small communities are required to accept the reimbursements offered through the exchanges or required to take the national reimbursement policy that is presented. He noted as an example that many times providers are going to lose money if they see the patients. In rural areas, you can not have an x-ray without driving 100 miles to avoid paying full price.

Krista Drobac said that the idea of the exchange is that it is a new market for many insurers and they want to participate. If they want to participate, they have to follow the network adequacy laws or they will not become a Certified Health Plan. The idea is that the market power may shift a bit some because the insurers want to participate and need network adequacy. If the state defines the geographic area as the entire state, then insurers are required to have network adequacy in every part of the state. This means they have to go to a critical access hospital that they may not have had in their network and negotiate a relationship and payment structure. It will not be an imposed change by the federal government.

Graham Adams asked what the committee can do pertaining to the issue of states not

carving out rural areas when defining their market area**.**

Krista Drobac said that they could encourage the advocacy community to ensure legislatures what can happen with risk selection if the geographic area is not large enough. It is a state-by-state discussion about what it means to define the geographic area small or large.

Tom Hoyer said that when Medicare had tried in the last decade to spread managed care that it always had trouble with rural areas because it requires an adequate network and it costs more to have an adequate rural network. If a state defines statewide areas and there is no choice but to go to rural, everyone will agree to a reasonable price with the rural hospitals. The problem will come years later when everyone is there and squeezing for nickels and dimes. The price will go up in the beginning and down gradually and then back up. The key is state-wide networks. There will be problems for rural areas if the states decide with the exchanges to segment the market to favor the urban market.

Krista Drobac said the transparency on quality is unprecedented. Some of the cost of healthcare is because of poor quality and hospital infections. Improving quality is improving patient health and giving patients a choice of providers. The exchanges can help with cost increases by allowing patients to choose based on quality.

Tom Hoyer said that is true except in rural areas there is no choice because there are only so many providers.

Darlene Byrd said when looking at the legislation, there is only one area that addressed providers being contracted in the network with the requirement that they implement quality improvement mechanisms. Is there an idea of what those mechanisms might be? She asked if anyone is making sure there are not any negative consequences in rural.

Krista Drobac said that they have had a discussion on quality and now they are part of Centers for Medicare and Medicaid Services and have a whole new staff for quality. It helps assure that they are aligned with Medicare and Medicaid standards. The idea is to try and make it as easy as possible for providers because it is easier to implement if it is easier for providers. It is all going into the regulation that will be released. She encouraged them to submit comments when the regulation comes out.

COMMITTEE DISCUSSION ON WHITE PAPER TOPICS AND CHARGE TO SUBCOMMITTEES

Tom Morris spoke to the committee about the presentations from the first day of meetings and using the information in their sub-committee meetings. He noted that the sub-committee meetings should be discussions on what to include in the white papers to the Secretary. Maternal and Early Childhood Home Visiting Program, Community-Based Care Transitions and Health Insurance Exchanges are the three sub-committee group topics.

EXAMPLES OF INSURANCE EXCHANGES

Chini Krishnan, Operating Partner, Bessemer Venture Partners
Chini Krishnan began by telling the committee that they are a private operating exchange that services a private marketplace across the country. A percentage of people serviced are living in urban and a percentage in rural areas. The issue of provider coverage in rural health and rural counties is an important issue they are facing.

Mr. Krishnan said that some of the functions of an exchange include certification of plans, operation of a toll-free line and maintenance of a website for that provides plan information to enrollees. Other functions are establishing a navigator program that provides grants to entities assisting consumers, assignment of price and rating plans and presentation of plan benefit options.

Mr. Krishnan said that some issues they face as an exchange are specific to rural customers. He noted that there is lower broadband penetration in rural areas and lower internet usage overall. He stated that according to a 2007 analysis by U.S. Department of Agriculture Economic Research Service, 63 percent of all rural households had at least one member access the Internet, compared with 73 percent of urban households. There are 2.5 times fewer specialists per capita in rural areas that in urban. There is lower income levels in rural areas and 14% live below the poverty level. There are more Medicare beneficiaries but much lower Medicare spending per capita in rural areas. Nearly a half of rural Medicare beneficiaries do not have drug coverage.

Mr. Krishnan stated that an Exchange needs to be an integrated front door that allows citizens to sign up for health insurance, CHIP, Medicare and Medicaid programs. For people living in rural communities it is important to be able to conduct eligibility determination via a toll-free customer support center.

Mr. Krishnan said it is important for customers to be able to compare plans and for rural customers it is critical to be able to offer those plan comparisons over the telephone. Customers may not have access to the internet and the ability to view the plan comparisons on the website. Discrepancies between urban and rural usage of technology and average income are causing a digital divide.

Customers must have the option to complete their application digitally or over the telephone. There has to be a way to track all submitted applications through automated feeds so that errors can be corrected and follow-ups can be made after submission. Customer support for rural customers needs to be proactive. Customer support issues need to be addressed post purchase.

Mr. Krishnan said that there needs to be a broad selection of health insurance plans so that customers can make a choice. Regional plans with low state or national market share need to be included to provide reasonable provider coverage in rural counties.

Q&A

Larry Otis said that Mississippi has a smaller number of people using the internet than the national average. Many people in Mississippi do not have credit cards or bank accounts. How would you work with that population?

Chini Krishnan said that the lack of the internet is a non-issue. They suggest that anybody that receives communication in the mail can receive communication to call a specific number.

It is problematic when people do not have credit cards or bank accounts. Many people that do not have credit cards at least have a checking account and they can get insurance. They would like to see people take cash instruments such as Western Union and money orders. Today, as a matter of policy, people who do not have a checking account are not accepted. He noted that they would like to take any payment instrument but are not allowed due to regulations.

John Cullen said that some insurance companies delay or deny payments to physicians. Is there a way to incorporate that information for certifying and decertifying insurance companies on the exchange?

Chini Krishnan responded that there is a way to incorporate that information. In California there is an office of patient advocacy and they rate plans according to a range of metrics. They are working with the state to take that data and share with customers. The customers will be able to choose plans according to the types of conditions.

Todd Linden asked how the exchange is paid.

Chini Krishnan said today they get paid a commission, but post 2014 it will be a form of assessment fee.

Todd Linden asked how the exchanges will stay neutral across plans in the future.

Chini Krishnan responded that from a regulatory standpoint the best way to do it is make sure that they get paid the same regardless of which plan they sell. If you put a customer on a wrong plan they will cancel and that is not good for anyone.

Todd Linden asked at what point does this eclipse brokers. He said that in rural environments local businesses may not be used which potentially begins to wash away the network and fabric of the communities.

Chini Krishnan said that in states like Mississippi 90% of the state will qualify for some form of subsidy. There will not be a brokerage level left because if they will receive a subsidy that is where they will buy. There needs to be a broker role to work with the exchange or be an advocate of an exchange.

Tom Hoyer asked if he said earlier that one of the functions of the exchange is to pay brokers and agents.

Chini Krishnan said that ultimately they will need to pay brokers if they need distribution.

John Rockwood stated that there will potentially be 30 million people coming into exchanges. They will be making the important decision of choosing a health plan. Health care is complicated. It is hard to understand what is covered and what is not. What type of training is needed to make sure they are making the right decision? It has to be more than filling out a questionnaire on the internet. Who explains their options?

Chini Krishnan said that plan structures have such diversity that it is hard to tell the difference between a good plan and a not so good plan. The notion of minimum benefits will help by eliminating most hidden information inside of plans. If benefits are designed so that all of the hidden exceptions are gone it will help. The overwhelming majority of customers want doctor co-pays, prescription benefits and hospitalization. If those are provided then they are willing to live without other benefits. There is not a perfect answer to that question. There needs to be work on mapping and helping customers understand the providers they can access. All the benefits are useless if it does not cover the providers that customers need to access. That is the largest problem and there is a lot to do to help by creating the right kind of data base and technology resources to help improve the quality of purchase.

WORKGROUP MEETINGS

The Advisory Committee Members attended subcommittee breakout sessions. The subcommittee group topics included Health Insurance Exchanges, Maternal and Early Childhood Visiting Program and Community-Based Care Transitions.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES TRAINING PROGRAM

April Bender, Committee Member

April Bender began by informing the committee members that the department released three hundred and twenty million dollars for primary care training. She said she would be providing information about the money allotted for health professional opportunity grants to serve Temporary Assistance for Needy Family recipients and low- income individuals. She shared information with the committee on the grantees so they could see what money went to their states and to rural areas.

Dr. Bender said that many of the states have multiple grantees and many of them are workforce investment boards. She noted that New York received a large amount of money but none of the money went to rural areas.

Dr. Bender said she would talk about Temporary Assistance for Needy Families and the Workforce Investment Act. She said they did research on both of those pieces of legislation and how they started back in 1996 and 1998. She informed the committee that if they would like rural background information on those pieces of legislation they can read *Connecting the Dots in the Service Constellations of the Rural Universe*.

Dr. Bender told the committee that she supplied them with handouts that have information for further reading. She would be also be referencing a piece by Rural Policy Research Institute titled *Leaving and Losing Jobs: The Plight of Rural Low-Income Mothers*. She said that if the committee members are looking for their workforce investment boards they could refer to *One Stop Centers: Service Locator.* Dr. Bender also shared that the *Office of Rural Health Policy Rural Guide to Federal Health Professions Funding* was recently released.

Two pieces of legislation that she referenced are *Personal Responsibility and Work Opportunity Reconciliation Act of 1996* and *Workforce Investment Act Laws and Regulations.*

Dr. Bender said that the grants offered included Temporary Assistance for Needy Families Administrative Agency, low-income Temporary Assistance for Needy Families recipients, grantees, employers and Health Professions Training Agency.

Dr. Bender shared recommendations around Title V, Subtitle B, Sec. 5507 to identify the return on investment to local, rural areas with respect to meeting the need for healthcare workers and in terms of Temporary Assistance for Needy Families. Use this information on return of investment to establish baseline outcomes for similar future funding.

Dr. Bender's second recommendation is that future funding opportunities require One Stop grantees and grantees working with their One Stops to demonstrate how they will provide access to training and other support services to rural participants as referenced in Title V, Subtitle E, Section 5403. This will help ensure those populations addressed in this subtitle are included.

Dr. Bender's third recommendation is that the evidence-based evaluation of this and future efforts include a rural lens that frames and focuses on specific challenges by rural Temporary Assistance for Needy Families and other low-income individuals participating in training for health professions in rural areas. Use this information to guide future related initiatives in rural areas and to share promising practices with the field.

Dr. Bender's final recommendation is to work with the Bureau of Labor Statistics, U.S. Department of Labor to collect, analyze and use data related to existing and projected changes in health related occupations in rural areas.

Q &A

Larry Otis said that there is a clause that allows a person who is receiving

unemployment compensation to be an entrepreneur. They can receive training and be unemployed drawing their compensation and start their small business and still be paid while they are starting their business. It requires some adjustment in state legislation. This is going to be done in Mississippi. It is an opportunity to build jobs.

April Bender noted that if the members are not aware of their One Stop Centers or Workforce Investment Boards they should access the website and locate them since they just received the grant funding.

MEDICARE PAYMENT ADVISORY COMMITTEE RURAL REPORT

Jeff Stensland, Ph.D., Staff, Medicare Payment Advisory Commission

Jeff Stensland thanked the committee for inviting him to speak to the committee and that he appreciates the work of the committee remarking that the 2008 report was a good review of the evolution and challenges of what is happening in rural health care. He said that the Medicare Payment Advisory Commission are employees of congress and look strictly at Medicare payment policy. Their objective is to set-up payment policy to get the best care for Medicare beneficiaries while also respecting the tax payer and the needs of the providers.

Dr. Stensland said that he will be talking about a mandated report as part of healthcare reform. The bill requires them to look at access to care, quality of care, special Medicare payments to rural providers and adequacy of payments to rural providers. The report is similar to one that was done in 2001 when they reviewed rural healthcare. There are two things that will come out of the report. One is data determining the service use in rural areas verses urban areas. The second is an additional explanation of different Medicare policies. How different payment rated affect the incentives. The commission may decide to make recommendations on changing payment policy. In the 2001 report a direction that was taken was to increase payment rights to rural hospitals. The other recommendation was that the QIO spend more time in rural areas focusing on quality.

Dr. Stensland said this year's report is due in June of 2012 and they want to listen to the committee and get ideas on improving policy in a way to change incentives and get more value for patients with the same or lower cost. There is a push to be patient centered and it can be difficult to do in research. He gave an example of going to rural communities and talk to providers to gain perspective and also having strong representation in Washington D.C.

Dr. Stensland stated that the difficulty is making sure the Medicare Payment Advisory Committee is listening to the patient and their concerns so they set-up rural focus groups. The focus groups were in areas such as Montana, Alabama and Kansas. Focus groups were set-up in church basement halls and civic centers. Overall, people appreciate the care they receive and feel they are getting sufficient care.

Dr. Stensland said they just met to discuss access to care to compliment the work they are

doing with focus groups. They also did an analysis of claims data from 100% of Medicare beneficiaries in rural areas to see what kind of care they are receiving relative to urban areas. Physician visits, hospitalizations and overall spending on ambulatory post acute care was similar in rural and urban areas. He said that this was also found in 2001 and he was surprised by the data. The volume of services did not vary on an urban, rural basis but on a regional basis. In certain areas of the country there was high service use among rural and urban people and they all tend to get the same kind of services and are tied into the urban delivery system. Going forward quality of care and creating incentives to make the quality better will be examined. They will be looking at who is getting the recommended care across rural verses urban areas. They will be looking at the special payments in rural areas and layout to congress what the special payments are and how they work. Many times people do not even know what the exact payment rates are within the different special payment policies.

Dr. Stensland said that he would welcome suggestions on how to improve the Medicare incentives to get better and more efficient care in rural areas.

Q&A

John Cullen said a consequence of the way Medicare is billed is to focus on one problem at a time per visit which is a huge problem in rural communities where patients have to travel a long distance for a visit. Some patients in rural Alaska have to travel 200 miles for a visit. Is there a way to allow that so they can manage multiple problems and do procedures during one visit and be compensated for it? Unfortunately, the patient does not come in with one problem but five or six problems.

Jeff Stensland said that bundling or a MA plan that could be done efficiently may be an option. Some sort of episode payment has been discussed. The question on big bundles is if they end up creating more bundles.

Roger Wells stated that the support staff is much less in rural areas. Medicare patients have less tolerance for providers trying to do one thing at a time. The provider gets evaluated through the work-ups by how high of a cost is billed out. As a physician assistant working mostly in internal medicine, I will be reviewed because of my numbers. When we see these issues, many of internal medicine providers have dropped Medicare patients. In rural health, there is a decrease of interest and there is no one refilling the pipeline of providers. Will you look at who will be taking care of the people five to ten years from now?

Jeff Stensland responded that they are looking at workforce issues and the commission is putting effort into getting the relative payments right. The focus in the past has been a specialty primary care differential rather than a rural urban differential. The commission is making the movement towards making primary care more attractive in rural areas. There is work to be done to create providers in local rural communities and there is good work being done by state medical schools to get people to make those decisions.

Maggie Blackburn said that as they look at patient-centered care and patient satisfaction issues that geography and traveling to see a physician are very important to patients. She said that she trains medical students and some of their satisfaction in practicing in rural areas is around the relationship and that needs to be valued.

David Hartley said he was interested that they were talking about access and quality as different issues and that can not be done because patients do not know how to distinguish levels of quality. To find if access is equitable, there is the need to know if it is access to the same quality.

Jeff Stensland said that is a good point. They would be weaving the access and quality research together. One challenge is to be respectful of the work physicians have done in rural areas and appreciate the physician and patient relationship while still looking for improvements.

PUBLIC COMMENT
There were no public comments and the meeting was adjourned.

Friday, February 25th, 2011

CALL TO ORDER
The Honorable Ronnie Musgrove, Chair of the Committee

LETTER TO THE SECRETARY
Mr. Morris said that the staff will be reviewing the issues that were discussed with the Secretary to include in the Letter to the Secretary. Tom Morris asked the committee to share any additional information that they may want to include in the Letter to the Secretary. Disparities and small numbers in rural areas were issues that were discussed. Mr. Morris asked committee members to forward further issues to him.

It was requested to have a separate letter to Dr. Mary Wakefield.

WHITE PAPER GROUP REPORTS AND TIMELINES

Exchange Subcommittee

Tom Hoyer gave the report for the subcommittee. He noted that the first concern was the Alaska issue. States that choose not to participate with the insurance exchanges deprive their citizens of the benefit of the planning. The committee suggests that every effort be made to encourage early participation. Since rural citizens have less access to health care and private insurance coverage, rural interest are best served if exchanges are large and at least state-wide. Because of the complexity of the market, complexities of the eligibility determination and subsidy determinations, the exchange model of the One Stop process is best suited for rural areas. Many rural citizens do not have access to credit

cards and checking accounts so many citizens may be shut out of the process if exchanges are not prepared to take cash or money orders. Language and literacy barriers need to be overcome by culturally competent exchanges and navigators. Those points need to be made in the regulations. There is a strong need for skilled navigators and public employees including school personnel and public health officials.

Mr. Hoyer said they were looking at a way to solve the problem of lining up providers. They suggest the Secretary use her authority to establish minimum benefits and specifications relating to location of services relevant to patients. The subcommittee noted their concern that some plans may establish minimal networks and indulge in predatory service pricing. Disparities between the economic strength of the providers and insurance companies may cause there to be networks that place the providers and patients at a disadvantage. These issues need to be monitored.

They will be following up with a conference call.

Maternal and Early Childhood Home Visiting Subcommittee

Maggie Blackburn gave the report for the subcommittee. She stated that the group felt they needed to have some further information to make recommendations. She said they would like to push for Promising Practices and some of the 25% allotted funds be designated for rural. They want to review the six evidence-based practices to see what is applicable to rural populations. They discussed rural populations and the need to use a different type of workforce that could include paraprofessional groups and other types of training rather than all medical model nurse based programs.

The subcommittee wants to push for the Promising Practices and building evidence that is valuable and makes sense for rural areas and to make sure it is included in the recommendations. When looking at the states needs assessments, each state was different and it was hard to tell what would happen in terms of rural verses urban areas. With more information the committee can make general recommendations and utilize the 25% for Promising Practices.

They will be following up with a conference call.

Community-Based Care Transitions

Larry Gamm gave the report for the subcommittee. He said they discussed a number of issues and some would be recommendations. The program excludes a large number of critical access hospitals and there is a need to assure that The Centers for Medicare and Medicaid Services innovations program gives consideration to rural areas in upcoming demonstration programs. One issue was the need to emphasize a regional approach. There is a need for clarification about who are the eligible entities. The sub-committee also discussed the need for a regional approach for testing and evaluating evidence-based models.

They would like to give advice on how the grants are reviewed. There should be some rural experts on the review panels. A good grant should demonstrate good working relationships with critical access hospitals, Rural Health Clinics and Agencies on Aging for example. The proposal should also address sustainability beyond the five year period.

They also stated that there is a need for an information exchange for tracking patients.

They will be following up with a conference call.

Tom Morris stated that they will be contacting committee members about organizing for the June meeting. They will be sending out information on the next topics which include value based purchasing, primary care issues and the Class Act Program.

PUBLIC COMMENT
There were no public comments and the meeting was adjourned.