Mr. Bill Jolley welcomed the meeting participants to Nashville, TN and thanked everyone for attending. Mr. Jolley reported that this meeting arose out of a desire to continue the work that was begun at the Redefining Rural Health Summit held in Oklahoma City, OK on April 28-29, 2015. He also thanked Mr.
Andy Fosmire of the Oklahoma Hospital Association for hosting the original meeting and for recognizing the need for colleagues at hospital associations to share their challenges, success and best practices in supporting rural healthcare. Mr. Jolley reported that this meeting has 35 attendees representing 22 state hospital associations and one office of rural health. Mr. Jolley introduced Mr. Craig Becker, President of the Tennessee Hospital Association, and asked him to say a few words.

Mr. Becker welcomed the attendees and thanked them for their time. He spoke of the valuable work done in Oklahoma City and indicated that the hospital association executives appreciate the hard work and effort put in to these discussions on the future of rural healthcare. He stated that the goal of this meeting would be slightly different than the goal of the previous meeting. Instead of sharing state specific reports and experiences, this meeting will discuss the question of how to keep rural hospital’s viable on a nationwide scale. Mr. Becker indicated that this should be a strategy meeting with its focus staying broad. With that in mind, Mr. Becker outlined the two main goals of the meeting:

1. Strategize on ways to keep rural hospitals viable in a changing reimbursement and delivery environment, with the ultimate goal of communicating the meeting’s findings with the American Hospital Association’s newly formed Ensuring Access in Vulnerable Communities Task Force;

2. Determine the future of this group following the meetings in Oklahoma City and Nashville and whether there is value in continuing to hold periodic strategic discussions.

Mr. Becker and Mr. Jolley then introduced the meeting’s facilitator, Ms. Cecilia “Cissy” Mynatt, a strategic planning consultant with Nashville’s Center for Nonprofit Management (bio attached). Mr. Jolley reported that he has worked with Ms. Mynatt for many years and values her approach to meeting facilitation and her insights into strategic and organizational planning.

Ms. Mynatt introduced herself and gave a brief synopsis of her background before asking the meeting attendees to introduce themselves and to identify one issue or driver negatively impacting hospitals in rural and/or vulnerable communities. A selection of participant comments follows:

- Excess governmental regulation
- Difficulty in maintaining rural hospital autonomy versus loss of identity if forced to merge with a system
- Impact of depressed local economy on volumes
- Lack of community cooperation in addressing lifestyle issues
- Decreasing and aging population
- One-size fits all mentality in terms of solutions to diverse rural issues
- Lack of a clear path forward, especially at the federal level
- Aging facilities
- Workforce issues/shortages
- Fee for service reimbursement model encourages volumes that rural can’t usually sustain
- Education needed at the local Board governance and legislative level
- Difficult physician recruitment
- Small rural hospitals don’t have the resources, capital or knowledge base to achieve triple aim/participate in ACOs
- Legislatures not expanding Medicaid
- Area Wage Index
Can’t convince communities they may need something less than a full service hospital
Reimbursement rewards high end procedures (e.g., bariatric surgeries) but community only wants/needs emergency services
“Collaborative disconnect” in rural areas between the different providers - hospitals, FQHCs, etc.
Low volume, inpatient utilization trends
Poverty
Payor mix
Need new ideas – “not same old thing” for fixing rural issues
“Reform Fatigue” - In Oregon CAH’s already moved off of cost based reimbursement and doing fairly well economically but are suffering fatigue
All of these issues are interrelated
Need to get stakeholders together to discuss “how to maintain infrastructure”
Need to define and focus on what are essential rural services
Need to fight the public perception that better care is provided in the urban hospitals
Some rural hospitals at a breaking point – Remember the patient in this equation
We hear all of these issues from states all across the country – need to let legislators know the good things rural hospitals accomplish and not just focus on the closures

Following the initial comments from attendees, Ms. Mynatt reviewed the agenda for the meeting (attached) and let the group know that a block of time during Day One will be dedicated to small group discussions, while Day Two will feature discussion of the information gleaned from today’s session and future steps for this group.

The next item on the agenda called for Mr. Andy Fosmire to give a summary recap of the Redefining Rural Health Summit held in Oklahoma City on April 28-29, 2015. Mr. Fosmire spoke of the genesis of the meeting as the Oklahoma Hospital Association’s (OHA) desire to investigate the latest thinking on the future of rural healthcare. The OHA knew that some other states had moved forward with innovative new models to assist rural hospitals and it also knew that many of its own CAH’s were at-risk. Mr. Fosmire had heard of the initiatives tried and challenges faced by other states and thought it would be beneficial to everyone to come together to share their experiences. State specific reports were given by the hospital associations of Kansas, Washington, Illinois, Tennessee, Minnesota, Oklahoma, Mississippi, Colorado, Nebraska, California, Texas and New Mexico. At the close of the meeting, the participants expressed appreciation for the opportunity to hear about models and innovations happening across the country and wished to meet again in Nashville to continue the work.

Ms. Mynatt polled the room and discovered that about a third of the attendees had been present at the Oklahoma City meeting. Several of the Nashville attendees, who had not attended the meeting in Oklahoma, referenced the summary notes from the meeting as a valuable resource for their members and associations (See Report from the Redefining Rural Health Summit – attached). The senior executives present also agreed that the report put a tangible focus on the issues facing rural healthcare and helped to inform and initiate policy discussions.
Following Mr. Fosmire’s recap, Ms. Priya Bathija gave a report upon the creation and goals of the American Hospital Association’s (AHA) newly formed Ensuring Access in Vulnerable Communities Task Force. The task force was charged with two main goals:

1. Confirm the characteristics which make up a vulnerable community, both urban and rural

2. Identify strategies and federal policies to help ensure access to care in these areas

Ms. Bathija reported that the task force has thirty members and will be split into urban and rural subcommittees (membership list attached). The membership was carefully chosen to ensure broad stakeholder representation. The task force plans to hold four in-person meetings between September 2015 and April 2016 and also will hold conference calls as needed. The first task force meeting will be held on September 25, 2015 in Washington, DC. Ms. Bathija also indicated that state hospital associations are welcome to offer feedback and advice to the task force through venues such as the State Issues Forum scheduled for September 9, 2015 in Washington, DC, the Allied Rural Listserv scheduled to go live in the fall and the newly redesigned AHA Rural Update calls.

There were several questions that arose regarding the task force:

1. Will the urban and rural subcommittee findings be consolidated into a single recommendation?

   It is unclear at this point in time.

2. How will this specific group get its information and recommendations to the task force and will the task force provide updates to the group?

   Ms. Bathija laid out several ways in which state associations will have feedback in the task force process – including the following:

   - Participation in this group’s meetings going forward
   - State Issues Forum – Sept. 9 in Washington, DC
   - Task Force kickoff meeting – Sept. 25 in Washington, DC (State hospital association executives invited to attend educational session from 8-11:30 am)
   - Allied Rural List Serve
   - Rural List Serve Monthly Calls.

   Additionally, she will provide reports to the group on the progress of the task force.

3. Will anyone be able to attend the meetings or are they closed?

   Ms. Bathija does not have an answer to this question yet, though the state hospital association executives are invited to attend an educational session at the opening meeting on September 25, 2015 from 8:00 AM to 11:30 AM.

4. How was the task force selected and if by recommendation, what entities provided the recommendations?
The task force was designed to represent many constituencies including state hospital associations, urban and rural hospitals and small and large hospital systems. The member selection included consideration of recommendations from state hospital associations.

5. If the end product is a report to be issued some time in 2016, what about the current legislation already before Congress? For example, a state hospital association would not want to wholeheartedly support legislation such as the REACH Act if the task force report later determines that it does not support it.

There is no good answer to this question and Ms. Bathija will ask the task force for feedback on the issue.

The attendees agreed that it would be useful if an early focus of the task force was to endorse or issue a recommendation about one or both of the bills currently before Congress (the REACH Act or the Save Rural Hospitals Act.)

After discussion about the task force concluded, Ms. Bathija gave a PowerPoint presentation about the current rural legislative landscape, focusing on the REACH Act, the Save Rural Hospitals Act and some regulatory relief (presentation attached.)

1. The REACH Act (Rural Emergency Acute Care Hospital Act)
   - Creates a Rural Emergency Hospital (REH) designation to allow facilities in rural areas to provide emergency medical services without having to maintain inpatient beds
   -Introduced to help rural hospitals stay open while meeting the needs of rural residents for emergency room care and outpatient services
   -This bill amends title XVIII (Medicare) of the Social Security Act to designate as a rural emergency hospital any facility that as of December 31, 2014, was:
     - a critical access hospital (CAH) or a hospital with (at most) 50 beds located in a county in a rural area or treated as located in a rural area, or
     - one of such hospitals that ceased operations during the period beginning five years before enactment of this Act and ending on December 30, 2014.
     - A rural emergency hospital:
       - must provide 24-hour emergency medical care and observation care not exceeding an annual per patient average of 24 hours or more than 1 midnight,
       - does not provide any acute care inpatient beds and has protocols in place for the timely transfer of patients who require acute care inpatient services or other inpatient services,
       - has elected to be designated as a rural emergency hospital,
       - has received approval to operate as one from the state, and
       - is certified by the Department of Health and Human Services (HHS)
   - Payment
Rural emergency hospital outpatient services and transportation services would be paid 110% of reasonable costs.

Telehealth services—costs of having a backup physician available via a telecommunications system considered reasonable costs.

Payment will be decreased by coinsurance amount, which will be calculated in the same manner as the coinsurance amount for outpatient services at a CAH.

2. **Save Rural Hospitals Act**
   - Introduced by Reps. Graves and Loebsack
   - Focuses on four areas:
     - Rural hospital stabilization
     - Rural Medicare beneficiary equity
     - Regulatory relief
     - Future of rural health
   - Elimination of Medicare sequestration for rural hospitals
   - Reversal of “bad debt” reimbursement cuts
   - Permanent extension of enhanced low-volume adjustment and Medicare-dependent hospital program
   - Reinstatement of sole community hospital “hold-harmless” payments
   - Extension of Medicaid primary care payments
   - Elimination of Medicare and Medicaid DSH payment reductions for rural hospitals
   - Establishment of meaningful use support payments for rural facilities struggling to maintain meaningful use compliance
   - Permanent extension of the rural ambulance and super-rural ambulance payment
   - Beneficiary coinsurance obligations for outpatient services at CAHs are calculated based on total CAH charges
   - Typically higher than reasonable costs associated with these services or the OPPS rates; and result in higher coinsurance obligations for beneficiaries
   - This legislation would require beneficiary coinsurance obligations to be calculated based on allowed Medicare charges instead of total charges

3. **Regulatory Relief**
   - Elimination of CAH 96-hour condition of payment
   - Direct supervision (PARTS)
   - Allows a default standard of “general supervision” for outpatient therapeutic services
   - RAC audit and appeals process
     - Elimination of contingency fee payment system
     - Elimination of one-year timely filing limit to rebill Part B claims
     - Medical documentation considered
There was considerable discussion following the presentation and the point was made that in this political climate no legislation can move forward without a clear idea of where funding will come from. The removal of Medicare sequestration from rural hospitals may mean that non-rural hospitals ultimately bear the cost. Other attendees indicated that the Save Rural Hospitals Act is a standard rural wish list and will be popular with rural members who may become frustrated if their hospital association supports the REACH Act instead. All attendees agreed that the REACH act looked like a good first step; however, other issues still need to be addressed, such as post-acute care and ambulatory services. In addition, the cost and sources of funding need to be identified. The consensus ultimately was that there won’t be a single legislative solution to the rural healthcare crisis, each community is different and that is why it is important that the AHA task force is focusing on the definition of vulnerable communities, not just saving the rural hospitals.

Ms. Mynatt asked the participants to break into pre-assigned small groups and complete two assignments:

1. Identify and list guiding principles for developing new rural healthcare models;

2. Describe all of the emerging models and innovations that the team could identify.

After an hour of small group collaboration, the teams reported on their discussions. Several themes emerged as each of the teams reported their list of guiding principles for developing new rural models:

- Community and population based health approach needed - The patient comes first
- Ensure access to adequate and appropriate care based on each community’s needs
- Access to core/essential clinically integrated health and social services for all populations
- A scalable and sustainable model with a viable payment system at the state and federal level
- Transparent and accountable model, driven by community needs at the population level, as defined by data and community input
- Reimburse fairly with potential for new payment models to be developed
- Use and incentivize technology (telemedicine, etc.)
- Collaboration is needed among all providers in a community/region to establish a continuum of care
- Focus on quality healthcare - participation in Quality initiatives and focus on outcomes
- Enlightened and educated governance and leadership at local/regional level – state hospital associations can help with education

The teams were also able to identify a number of emerging models and innovations in the rural landscape:

- Primary Health Center – integrated Behavioral Health
- Co-Community Clinic with Emergency Care
- FESC, RCH, PACE
- FQHC with ED and Monitoring/Obs
- Free-standing ED
- Free-standing ED plus: Obs, Swing beds, Ambulatory Care
- Rural community medical campus (with or without silos)
- In-patient hospital without ED
- Integrating Primary Care and moving to out-patient services (centrally located ED and FQHC/RHC)
- Collaboration of CAHs or Rural PPS that focus on specific service lines and don’t compete
- CAH/FQHC partnerships/ownership
- Dual site/single provider number CAHs/PPS
- Virtual ACD
- National Rural ACO
- Rural Hospital Networks
- Co-ops for IT services/HIT
- 3 bed hospital license
- Primary Health Center
- Telemedicine collaboratives for non-affiliated hospitals

Discussion followed the reporting and the point was made that the decision to move toward community based health is a hospital problem, not a community problem. The meeting participants expressed optimism that the trend is moving toward identifying and changing the root causes of healthcare vulnerability in rural communities instead of focusing on reimbursement changes to prop up failing hospitals. There was a lot of discussion about collaboration between local providers and co-location of services as a necessary component of shoring up rural healthcare. The teams all agreed that no single model will solve all of the rural healthcare issues. A continuum is needed in most cases and some communities will need to make difficult decisions about which services they can sustain. In addition, most participants felt that the payment system needs reform before any innovative changes can occur and that the reform strategies cannot all revolve around cost cutting measures.

The meeting adjourned at 5:00 PM and will reconvene the following day.

**Day Two**
**August 19, 2015 8:00 AM**

Mr. Craig Becker welcomed the group to the second day of the meeting and gave a summary of the main issues, guiding principles for reform and new healthcare models which were identified during the previous day’s discussions.

**Main Issues**

1. The big issues impacting the health of rural hospitals are;
   - Lack of money
   - Declining volumes
   - Excess governmental regulations
   - Medicare and Medicaid cuts
   - Workforce shortages
   - Lack of Medicaid expansion

2. Continuity of care and provider collaboration is urgently needed in rural communities but there is a “collaborative disconnect” in many instances
3. Community lifestyle issues are effectively turning rural hospitals into social service agencies

4. Rural hospitals are suffering from “reform fatigue” as rapid legislative and community changes force small staffs to have to adapt and change practices – not enough staff members to share the load of reform

5. Communities need to determine which services they need and can realistically support

6. Communities and hospital associations cannot sit back and wait for the federal government to save rural healthcare – action is needed now

Guiding Principals

1. Community and population based health are the future of rural

2. Access to appropriate care is necessary – eg., no need for bariatric or orthopedic surgery in most rural hospitals

3. Hospitals must be adequately financed, especially with the aging national infrastructure - the Hill-Burton Act is getting old and needs revision

4. Collaboration amongst providers in a region is imperative

5. Major focus needs to be on quality of care and providing the best value for the community’s healthcare dollars

6. Enlightened leadership is crucial, not just at the hospital level but in the legislature as well

New Healthcare Models

1. Many models were identified and discussed during yesterday’s meeting but it became clear that there is not a one-size-fits-all solution. This is an instance where enlightened leadership will be useful.

Mr. Becker pointed out that important questions are still unanswered; especially concerning reimbursement and funding and that a single rural solution is not likely. He requested that Ms. Priya Bathija share the discussion at this meeting and the meeting in Oklahoma City with AHA and the task force. “Desperation or inspiration make people move.”

Ms. Cissy Mynatt thanked Mr. Becker for his comprehensive recap and opened the floor for discussion.

The first point of discussion centered on reimbursement and the fact that most rural hospitals are still on a fee for service model. The group talked about how rural hospitals have little incentive to change to value based reimbursement until there is clear guidance from the federal government. However, the payors are focused on quality and efficiencies and value based reimbursement is driving hospitals towards a Center of Excellence model in order to reach quality standards that are included in federal reimbursement models. The main challenge is how to move rural hospitals off of the fee for service
model while maintaining budget neutrality. There was general consensus that no new rural healthcare models can be successfully developed or implemented until the reimbursement system is determined.

A question arose about whether legislators really believe that access to care in rural areas should be preserved. Some anecdotal evidence was shared where state legislators provided media soundbites about commitment to rural healthcare but did not actually act to preserve it. Discussion flowed around the different demographics in each state and that legislators with primarily urban constituents would naturally spend their energy advocating for urban healthcare issues.

Several participants agreed that when the phrase “access to care” is used, legislators automatically think the discussion is about insurance coverage and that different phraseology should be considered when discussing infrastructure with policy makers.

A participant made the comment that it was easy to understand a rural community with a healthcare infrastructure in place transitioning to a different structure (for example if a rural hospital were to transition to a free standing emergency department.) What is less clear is what will happen under a new model if communities with no infrastructure in place find that they could support a provider less robust than a CAH. Should states plan to add infrastructure in rural areas?

The follow up question about the role of state hospital associations in spearheading change provoked a spirited policy discussion. Some participants were already seeing a struggle between the competing priorities of their urban and rural members and did not wish to become involved with making business decisions for their rural hospitals. It was pointed out that despite the fear of making business decisions for a member, it is often the rural hospitals, understaffed and without access to a pool of talent, who come to the hospital associations for operational assistance. Other participants, whose association membership is mainly large hospital systems, were concerned about devoting too many resources in a direction (rural) that didn’t reflect their constituency. It was also noted that often the larger hospital systems are interested in absorbing the rural hospitals and may not agree with the association working to preserve their independence.

The question arose as to whether the hospital associations will need to evolve to serve a broader constituency and whether operational support is something that could be provided to rural members. Some states have already started to shift their definition of membership to include such things as; long-term care facilities, ambulatory care, home health services and other health related entities. The comment was made that funding changes have led to a reduction in services from states offices of rural health resulting in more rural hospitals looking toward their associations for leadership. Another member commented that becoming proactive is difficult as it veers into the realm of making business decisions for the rural hospitals.

There was a statement made by a meeting participant that state hospital associations should lead the national policy discussion with Medicaid on rural payment reform. The thought is that if it is left to the politicians it won’t accurately reflect the needs of the rural providers.

One trend that emerged through brief discussion of individual experiences was that the state associations who were able to get their Board of Directors actively engaged in the fight to preserve rural healthcare had the most promising outcomes.
Ms. Mynatt posed the question of whether the attendees found enough value in this meeting to stay together as a group and to hold additional meetings. The participants agreed that the information shared at the two meetings has been helpful and difficult to find in any other context. Participants also appreciated the opportunity to interact with their peers at a meeting whose agenda was driven by the individual states and not on a national level. However, now that the initial work has been done, the participants agreed that the group should evolve into an A2 group, under the auspices of the AHA, which includes all 50 states.

Discussion turned to the future of the group and Ms. Bathija volunteered to let the participants know of the structure of some other A2 groups, as each is set up differently. Many questions were raised and ideas floated about the potential structure for the group. Ms. Mynatt guided the discussion and outlined the next step as it evolved.

**Next Step A2 Group**

1. A few people need to volunteer to be on a planning committee to do the initial work of forming the A2 group. This will include; proposing a face to face meeting location and date, setting up a regular conference call schedule, suggesting a structure for the group that may or may not include annual dues and an elected Chairperson and keeping the larger group in communication with each other. Volunteers for the committee were;

   - Priya Bathija American Hospital Association
   - Elizabeth Cobb Kentucky Hospital Association
   - Rebecca Dowdy Louisiana Hospital Association
   - Gail Finley Colorado Hospital Association
   - Andy Fosmire Oklahoma Hospital Association
   - Bill Jolley Tennessee Hospital Association
   - Beth Landon New Mexico Hospital Association

Following a break, Ms. Mynatt asked the attendees to break into small groups to discuss the purpose of the A2 group. Some main themes that arose:

- Collaborative - Join states together to leverage resources or take collective action; for example multi-state CMS pilot where one state alone would not offer enough savings
- Action oriented - Recommend policy changes and offer feedback to the AHA task force
- Educational - Share best practices, pilot program experiences, results, etc.
- Professional Development - Network and support colleagues nationwide

After discussion, the meeting drew to a close with all of the participants offering up gratitude and compliments to the Tennessee Hospital Association for hosting the meeting and to Mr. Jolley, Mr. Becker and Ms. Mynatt for their hard work and dedication. Mr. Jolley thanked everyone for attending and expressed his admiration for the commitment to rural healthcare demonstrated by his colleagues over the course of the meeting. Mr. Becker extended a special thank you to his peers in attendance for sending the message that the senior hospital association executives think that the rural issue is an important one.
The meeting adjourned at 11:30 AM and the participants will await notification from the A2 Rural Planning Committee of the next meeting time and date.