

CAPITOL ASSOCIATES

Moderator: Bill Finerfrock
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1:00 pm CT

Operator: Good day everyone and welcome to today's Rural Health Clinic Technical Assistance conference call. Today's call is being recorded. Now at this time, I'd like to turn the call over to Mr. Bill Finerfrock. Please go ahead sir.

Bill Finerfrock: Thank you, operator. And I want to welcome everyone to today's Rural Health Clinic Technical Assistance Call and point out that we have a number of other folks who are with us today. This is normally just for rural health clinics but because of the nature of the topic and the broad interest in this topic, we have folks who are critical access hospital. We have some federally qualified health center, state offices and hospitals, small rural hospitals. We want to welcome all of our friends and colleagues to this call.

I am Bill Finerfrock. I am the Executive Director of the National Association of Rural Health Clinics. And this is the 38th call in a series of calls that we do with the rural health clinics community. This is sponsored by the Federal Office of Rural Health Policy. And today, we're pleased to have our friends in the Bureau of Primary Health Care joining us to talk about this important new initiative to encourage collaboration between federally qualified health centers, community health centers, rural health clinics, critical access hospitals, small rural hospitals and certain other rural providers.

We're going to lead off today our first presenter speaker's going to be Jim Macrae who is the Director of the Bureau of Primary Health Care. Jim's going to kind of talk about this initiative from the community health center and the Bureau's perspective. And then he will have some of his colleagues talk about the initiative in greater detail. And then we're going to open it up afterwards for questions from the audience. So Jim, welcome and we appreciate the Bureau's support for this initiative and your work in getting out the advisory letter and look forward to hearing what you guys have to say about this important initiative.

Jim Macrae: Great. Thank you, Bill, and good afternoon and good morning to those folks way out west. Thank you all so much for participating, especially those folks who are in the mid west in blizzard conditions. Hopefully this will keep you warm in terms of collaboration and all of that activity. So, but all joking aside, as Bill said, we were very excited about being able to get out this information on health center collaboration.

We actually feel like that's really been at the heart of the program from its very beginning in terms of the community health center program. Really focusing on not only what the health center can do but also what it can do in partnership with other organizations, including other safety net providers as well as other social and health service providers.

We really do believe that that's a key focus for the program and really has been since its inception. However, we really felt, in particular, with the Affordable Care Act that we just needed to reemphasize or rededicate our focus on our real belief that collaboration is critical in terms of improving the health of a community as well as the patients that are seen within a health center.

And in particular, I think what reemphasized that for us was a provision that was added to the Affordable Care Act that expressly stated that health centers are allowed to contract with many types of providers, many types of rural providers for the delivery of primary health care services.

In fact, our own statute explicitly says that health centers may through, may deliver their services either through contracts and or cooperative arrangement. So again, we really do believe that it's important for the health center program to work with others. And through the Affordable Care Act and this new provision, we really do see it as an opportunity to encourage health centers to build on those collaborative relationships.

One other piece before I jump more particularly into the program assistance letter is that in terms of collaboration, we really do think it is critical. What I have shared with many of the health centers out there as well as our state primary care associations and now have the opportunity to share with you is that it really does make sense in terms of from where we sit to build on the existing infrastructure within a community as opposed to trying to reinvent the wheel or create something new.

We really believe the first step in any kind of expansion activity for health centers should be looking at what the current resources, what the current assets are and what the current service delivery arrangements are within a community. And we really believe any expansion should be built upon that framework.

Looking to see what we can build upon and leverage as opposed to potentially compete with or work potentially in, I won't say disagreement with, but in competition with. And we really do believe that it's important to build from what we currently have as opposed to trying to create something new from the get-go.

And so I hope you all have seen some of our efforts in this area. In particular, in our new access point application, which I hope many of you have seen or maybe even participated in the development of those applications. We have requested, as part of our application process this year, letters of support from not only other health centers in a particular area but also looking for letters of support from rural health clinics, health departments and or critical access hospitals.

Really trying to encourage from the very beginning that spirit of collaboration and cooperation. And what we hope through this program assistance letter is even encouraging folks to go beyond just basic support but to actually try to integrate and potentially contract for certain services that are available through the Affordable Care Act.

In particular, we also increase the level of points that are available for collaboration. It had always been a part of our application but this year we actually pulled it out separately and said that up to 10 points would be available for those applicants that could demonstrate a strong level of collaboration within their community.

We are very excited about what's going to be happening. I've already received probably more letters of support and collaboration than I've ever received in my entire tenure here in the Bureau of Primary Health Care. And so we really are hopeful that it will, from the very beginning, help support that level of collaboration.

In particular, and I'm going to ask the staff to sort of walk through some of the specifics with respect to contracting, but we are asking as part of the review process that the objective review committee members look at how an organization is really supporting that level of collaboration within their community, building upon that existing level of support and coordination.

In particular, we also are really focused on this idea of not duplicating service. We've encouraged our objective reviewers to look at that as they're reviewing applications. We intend to look at that from where we sit. And I know we will not be perfect but that's our intent to try to do the best that we can to support the expansion of care to serve more patients rather than just building on what currently exists or potentially threatening that.

The last thing I'll say before we turn it over to specifics around contracting is that we really do believe it's important for health centers to look at not just other primary care providers. That is important and that is something that we focus on in our new access point. We've also encouraged it in our expansion opportunities that we made available just about 6 weeks ago onto our existing health centers.

But we also really are encouraging our health centers to look at the full continuum of care. Not just looking at preventive and primary care but also working to develop strong relationships with specialty care providers as well as in patient hospitals and other outpatient organizations as well as in patient organizations.

We really do believe that that's absolutely essential as we move forward as we begin to think about developing accountable care organizations or potentially a new activity, which may be supported depending on what happens with appropriations, the community based collaborative care network, which really is a program that was authorized again by the Affordable Care Act. Not appropriated yet but really is an effort to encourage FQ8Cs and local hospitals, in particular, I believe critical access hospitals to collaborate their activities.

Because we know from where we sit that it's important to provide preventive and primary care but what you really need is to be able to provide that full range of service. And so we think it's absolutely essential that health centers reach out to not only provide the full range of primary preventive care but that they also develop those referral and other relationships with specialty care providers and in patient hospitals to provide that full range of service for the patients that we serve, which tend to be primarily the uninsured and low income patients in a community.

So we are very excited. We appreciate, Bill, the opportunity to participate in this call and Tom, for your support. We intend to continue this effort. This is not the last effort in this area for us. In fact, we've already gotten a number of questions about this program assistance letter that we realize that we probably need to do a more formal publication that will talk more about the intricacies of contracting and referral relationships. And how do you actually do that to maintain the 330 status?

And so we're going to be working on that and hopefully get something out in draft probably sometime after the first of the year in terms of getting that out so you all can take a look at it. Because we know many questions have come up. We've been able to answer quite a few of those but we realize we really do need some additional guidance. So again, this is not our first attempt in this area. But we really think it's an important step in terms of moving forward.

So with that, I will turn it over to (Beth Rosenfeld) to just go around some of the particulars around contracting. Just what some of the expectations are in terms of the aspects when developing contractual relationships between a health center and other providers.

(Beth Rosenfeld): Thank you, Jim. I just want to highlight too in addition to mentioning the goal of avoiding duplicating service, we also believe that it will better coordinate the care to the underserved population. So that's really the backdrop for the discussion.

And in the PAL, we discussed some of the major factors that I'm just going to go over briefly here and then we'll be more than happy to take questions from you. In terms of the factors that need to be considered by both the health center and the other provider when entering into a contract and that is, of course, that health centers are responsible for maintaining the oversight over all of the sites and services within the federally approved scope of project.

And so that includes ensuring that patients have access, as Jim mentioned, to the health center's full range of service. So that has to be a major factor in drafting up the contract and negotiating through that process.

Also health centers must assure that all services within the federally approved scope of project, including those that are performed via the contract are available to patients regardless of the ability to pay. And as you all know, the health centers are required to offer services to the uninsured and under insured on a sliding fee scale basis. And we can go over questions around that if you have them.

In addition, you know, as health center grantees, they must comply with departmental regulations around procurement of goods and services. And there's a lot of detail in that but if you care to look at that as a resource, 45CR does give direction around contracting as non-profits and also state and local government entities.

In addition, the benefits that are afforded to health centers, which I know folks are very interested in, also have criteria that go with those various programs like FTCA and 340B and reimbursement as an FQHC. So it's really important to understand all those rules around those benefits as you enter into contractual negotiations. That's just a quick summary.

Bill Finerfrock: Let me ask just a couple of questions here if you could expand a little bit. The language in the Affordable Care Act stipulates that an entity with whom the FQHC or CHC contracts is not required to be able to provide all of those services. You talked about the full range of services. So many of the providers don't, for example, provide dental services. Or there may be certain services that they can't. The FQHC would be permitted to contract with that entity for the services that that particular type of provider can deliver though. Is that not correct?

(Beth Rosenfeld): Right. It is the health center that's responsible for the provision of the full range of services.

But a few things need to be taken into consideration if you're bringing in new patients and those new patients have to be, have access to the full range of services that the health center is provided. So that's just a consideration that the health center would have to take some thought with.

Bill Finerfrock: But you can contract with different entities to provide a range of services. The health center would just have to find other arrangements to be able to provide the fuller range or potentially do something through... They could do the primary care with rural health clinic, the dental services with a dentist, mental health services with a mental health provider. All of whom may be community based providers. So the patient would have access to all those but coming through different contractual arrangements?

Jim Macrae: Yes, that's definitely a possibility in terms of how to approach it. It... You know, I think that's part of what, you know, when we started to talk about this and we started to get some of the questions, we realized we needed to do even a more formal guidance to help with this. But the general answer to your question is yes, they may.

Bill Finerfrock: Okay. Go ahead on. I'm sorry, just wanted to get that point clarified.

Jim Macrae: Well that's no problem. The other piece, which I didn't know whether Tom wanted to just mention for a moment is we did send out earlier this year, I think, the Office of Rural Health Policy actually sent it out, was the whole piece around collaboration of FQHCs and critical access hospitals. And just some best practices in terms of that. I don't know whether you wanted just to mention that briefly since we had the opportunity.

Tom Morris: Sure. I mean we have a manual. It's up on the web site and you can still get it. You've got the drill down to the Office of Rural Policy's portion of the HRSA web site at www.hrsa.gov. You can easily do a search and find that manual. And it might give folks some ideas about some of the ways they can partner because it includes three community based examples where they've been able to work together pretty thoroughly.

Jim Macrae: All right. So that's the quick overview, Bill. We figured we'd open up for questions. Because we figure that's where we would get the most of. So ...

Bill Finerfrock: Okay. Operator, you want to open up the phone lines and we'll take questions? And whatever level of detail we can get to, we'll get to and as many questions. So go ahead.

Operator: Thank you. Today's question and answer session will be conducted electronically. If you would like to ask a question, you may do so by pressing the star key followed by the digit one on your touch-tone telephone. A voice prompt on your phone line will indicate when your line has been opened. We ask that you please state your name and city, state location you are calling from before posing your question. Once again, press star one at this time.

Bill Finerfrock: The one other thing while we wait for questions that I did just want to mention is we have just recently within the last several months created a new tool that was actually highlighted in our program assistance letter. It's called the UDS Mapper tool. It's actually something that we've contracted with the Robert Graham Center to help us with.

And what's useful about that tool is that it provides a lot of information about where current health center patients are receiving their care as well as potential gaps in terms of the care that's provided by health centers. We have found it an enormously valuable tool for us to really identify where pockets of need are all across the country.

We've also found it to be very helpful because the Graham Center's actually been over, able to overlay other providers, including National Service Core providers. I believe rural health clinics are also included. Are critical access also? I'm not sure whether we've been able to get that data included in that resource tool but that's something we're looking at doing.

And so it provides a really rich resource of looking at basic demographics and looking to see where health center patients are being served. And then where other providers are within the community. So if you haven't had the chance, I would encourage you to take a look at that. It's available on www.udsmapper.org and you are basically asked to register and then you can go in there and basically play to your heart's content in terms of doing different cuts on the data.

But it's been definitely a resource that we've found valuable from where we sit. But I believe many of the communities out there have been utilizing it to identify what potential collaborative partners there are as well as where potential needs are. So it's another resource that we've recently made available and may be helpful in terms of that partnership that we're trying to create. Okay. Operator, do we have any questions lined up?

Operator: Yes. We'll take our first question.

Bill Finerfrock: Go ahead caller. If you could identify your name and where you're calling from, we'd appreciate it.

(Maryanne Coatney): Yes. My name is (Maryanne Coatney). I'm calling from Salisbury, Missouri. And I came across a term in the invitation that you used several times, critical access hospitals.

Jim Macrae: Yes.

(Maryanne Coatney): What does that exactly mean?

Jim Macrae: Tom, you guys want to describe that or I mean I can give it a shot but you probably have somebody there who's better at it than I am.

Tom Morris: It's a, yes sure. Critical access hospital is a Medicare term. And it's a designation under Medicare by which a hospital with 25 beds or less, 35 miles from another hospital is classified as a critical access hospital. Provide the full range of basic hospital services, inpatient, outpatient and ER. And they get cost based reimbursement and some relaxation on their, on their condition to participation. But it's just another term for rural hospital. There are 1,300 critical access hospitals in the country. There are about 2,000 total rural hospitals, so most of the rural hospitals out there, a good number of them are critical access.

(Maryanne Coatney): Thank you.

Bill Finerfrock: And the explicit piece of authorization that was included in the Affordable Care Act basically says that, it's sort of an interesting way they worded it but it really, it's meant to foster collaboration, but it says, "Nothing in this section shall be construed to prevent a community health center from contracting with a federally certified rural health clinic, a low volume hospital, a critical access hospital, a sole community hospital or a Medicare dependent share hospital for the delivery of primary health care for services that are available at the clinic or hospital to individuals who otherwise would be eligible for free or reduced care, if that individual were able to obtain care at the community health center." So it really is that range of different, of rural safety net providers that health centers are permitted and encouraged to contract with.

Tom Morris: Each of those terms are a Medicare designation that a facility can obtain if they meet the appropriate criteria.

Bill Finerfrock: Right.

(Maryanne Coatney): Okay. Thank you.

Bill Finerfrock: Next question.

(Larry Reynolds): Hi. Good morning. We're trying to...

Bill Finerfrock: Your name and where you're calling from?

(Larry Reynolds): I'm sorry. (Larry Reynolds), ((inaudible)), Washington. And we're looking...

Bill Finerfrock: Great. Go ahead, (Larry).

(Larry Reynolds): We're looking at creating a new access point. And we've had a series of community meetings. There were some concerns brought up by a couple of, a local tribe and some other RHCs primarily based around our county becoming a mandated managed care county. We've worked with the state to get assurances that the FQHC in and of itself won't generate the tipping point for our county to become a managed care county.

But as a result, the local RHCs and their tribes and the associations that they have with their rural hospital has created a situation where they will not offer letters of support because of fear of how things might transpire in the future. What kind of, we're really concerned that that could be something that holds up the FQHC from being accepting the application.

Jim Macrae: That's a good question. We've been hearing a lot of different things as we've encouraged, as I've said, letters of support. It is our first preference to get letters of support. However, we do create the opportunity for folks to be able to explain why a particular letter of support is not able to be received.

In addition however, we do plan within the next month or so, I would say probably within the next month, to have an opportunity for a planning grant to develop new health centers. And that may be something that you will want to explore in your particular community to help work through a lot of those different issues.

As I've actually shared with a couple of groups this morning, the planning grant is a great sort of first step in terms of the development of FQHC, in particular, a community based delivery system. And we anticipate having that opportunity available within the next month. And so that may be something also to explore.

In addition, for those who are potentially not ready or would like to work with us and are maybe a little bit beyond a planning grant stage, there is the FQHC look-a-like program, which is an opportunity to basically submit an application whenever you're ready. You do not receive grant dollars for an FQHC look-a-like application. But you can receive enhanced reimbursement from Medicare and Medicaid as well as discounts on 340B and other benefits of being an FQHC.

And we found for many organizations that were interested in becoming ultimately a health center, it's been a great step for them in that progression. So, those are a couple of opportunities. I would say again in your particular case, I would encourage you to continue to work with the local providers as well as the county to try to work through those issues and I would just document that within your application, if you've submitted it.

Male: Yes, (Larry), what is the – I'm a little confused on what the concern or what it is that the RACs or the Indian Health Facilities are concerned about and what would happen if what you want to do were to occur?

(Larry Reynolds): Well we're concerned about – we're kind of confused about that ourselves. Like I say, we work with our state department primary health to get assurances that the RHC status or the reimbursement mechanism that RHC and the tribes currently maintain won't be changed.

I think it's primarily based around uncertainty for the future with FQHC in the local community. So it's just been a huge concern of ours because we really try to address the concerns of these RHCs ...

Male: Are you bringing in new providers and is the concern that the area would lose its shortage area designation?

(Larry Reynolds): Well the need is pretty – I mean we've documented the need well. I think that's probably one of the concerns although we're not going to reach tipping point as well from what our needs assessments are.

Male: Okay. Okay, as Jim said, I mean I would encourage you to continue to work with the folks. Perhaps contracting is – could be part of that initiative to bring them in as partners to work with you to kind of you know become collaborative partners through some type of contracting arrangement where they have a vested interest in the success as opposed to what they may have perceived as you know competition or bringing in what you know in their mind may not be some needed infrastructure but to look at ways in which you can incorporate them through some type of a contracting arrangement into this initiative.

(Larry Reynolds): Yes, we've been trying to do that. It's hard to even get them at the table.

Male: Okay, well if we can be any help at the national association level, we're happy to try and communicate with them and help to understand and see what we can do but I think keep working at it. The whole point here is to try to encourage people to work together.

(Larry Reynolds): And so how do we contact or what's the address for the national...

Male: You can contact at info I-N-F-O@narac.org. There is also a very active Washington State Association of Rural Health Clinics.

Male: Right.

Male: If it's an issue that extends beyond just your area, I would encourage you to reach to them as well.

(Larry Reynolds): Thank you very much.

Male: Yes. Next caller? Go ahead caller.

(Kevin Drisen): This is (Kevin Drisen) from my Arizona Rural Hospital Flexibility program. And I'm wondering out of the primary healthcare is there a letter, just an encouragement letter or something official that would be available that we could use to inform and encourage our local, both the rural health clinics, the community health centers and critical access hospitals of this encouragement to develop collaborations.

Is there some kind of an official letter that we might be able to use?

Male: Yes, actually, we just sent out – at the end of November, what we call a program assistance letter and we can definitely make sure that Bill is able to send this out or Tom is able to make this available to everybody.

But basically it's a four-page letter that talks specifically about health center collaboration and encourages health centers to work with other safety net providers, in particular rural health clinics, critical access hospitals and other rural safety net providers. So absolutely and that's an official letter from us.

Male: You know we can – just one of the things we need to be careful of because we have folks from a variety of different venues who are on this call, I don't necessarily have – I have the availability to communicate

with the folks who are on the rural health clinic list or the rural health clinics but we are going to need to have others so perhaps one of the best ways to do it is to post that letter Tom on the RHP Web site.

Tom Morris: Yes.

Male: And we actually do a direct link from that.

Male: You know and then we can refer people ...

(Kevin Drisen): Yes. Perfect.

Male: ... to the Web site. Whoever – whether it's over OHP to your contact, our contacts ((inaudible)).

Tom Morris: Sure and we can absolutely do that.

Male: Okay. Next question? Okay caller.

Operator: If you are using a speakerphone depress your mute function.

(Betsy): Hi, this is (Betsy). I'm CFO for a critical access hospital in Oregon. And I have come from a FQAC in Minneapolis and I'm interested in looking at working either with collaboratively with FQAC in our town or forming one. Have you – do you see other arrangements where critical access hospitals have worked with FQACs or formed one also?

Male: Examples of where a FQAC has formed a hospital to come together formally you mean?

(Betsy): Yes.

Male: Yes. There are a couple of examples in West Virginia and (Minnie Hamilton) actually has one single Board that controls both the hospital and the community health center. There is a similar one in Springfield, Vermont and I just learned of one in North Carolina. There are also folks who have able to collaborative without necessarily you know sharing ownership.

There is all sorts of different opportunities to do it and the manual that we posted on the Web site sort of talks – will walk you through different ways to get at that.

(Betsy): Okay. And can you give me that web address again. I ...

Male: Sure.

(Betsy): ... the very last part of it.

Male: No problem. Its www.hrsa.gov and we'll put a link on that too.

(Betsy): The ORHP Web site?

Male: Yes, our Web site just in case. It's not the first, second, or third thing that comes up.

(Betsy): All right. Thank you.

Male: Thank you.

Male: Okay, next caller?

(Natalie Gonzales): (Natalie Gonzales), Washington State. I actually have a couple of questions. the first one is in the announcement for this conference call, it said that the pal that went out points out the health centers are required under the Public Health Service Act to work to establish yada, yada, yada.

But you've been saying permitted and allowed. It is required or just encouraged?

Male: Woo, that's a great question. It is an expectation and requirement that health centers collaborative with other providers within their community. One of the questions that has come up though repeatedly is health centers actually permitted to contract for a portion of their services with other providers and that was really the piece of the Affordable Care Act addressed.

And we hope made it clear that it is Absolutely permissible and acceptable and just to reinforce that that's why we sent out this program assistance letter that just documented that and encourages folks to explore because there has been a lot of and I think Bill can talk to this mythology about what health centers can and cannot do. And we just want to make it perfectly clear that people are also permitted and I know that's a little odd but it's sort of the reality we've been dealing with.

(Natalie Gonzales): Okay and then the other part is you had mentioned that like FQAC could go say into a rural town, rural area and contract with say a private dentist for services, mental health.

So let's say they go in and contract with a dentist to provide the dental health, who would get the reimbursement. Would the FQAC get the reimbursement and would the contract then be – they would determine how much money of that reimbursement would go to the private entity with which they are contracting or how does – how will that work?

Female: If that were – would depend on the nature of the contract that's established. There is no singular way it could work. It all depends on how the contractor structure between the organizations. What we can tell you is the FQAC cannot give its FQAC status or ability to bill to another organization.

So it would have to be all set – the payment between the two providers would have to be established in that contract.

(Natalie Gonzales): Okay.

Female: But it basically can't transfer FQAC status to another organization.

(Natalie Gonzales): Thank you for that clarification.

Male: But along those lines if the dentist for example said you know I'll contract for a flat fee, you know whatever services you pay me \$50. And then they submit an invoice to the FQAC. The FQAC in turn would bill for that encounter however, the FQAC would whether it was a Medicaid patient for example or perhaps a non-compensated care situation, and it would be part of their grant dollars.

Is that correct?

Female: Right. It depends again on how the contract is structured but it could work that way. IF there is a lot of assurances about you know the patient records, the information that's available to both organizations those kind of things but there are a lot of nuances around how the contract is established but that is certainly one way that the contract could be structured.

Male: Okay, is that helpful, (Natalie)? She may have already gone.

(Natalie Gonzales): Yes. No, that answered the questions.

Male: Okay, great. Did you have any others? Okay, next caller.

(Jerry Comeaha): (Jerry Comeaha), Hillsboro, Texas.

Male: Did you say Jim?

(Jerry Comeaha): (Jerry).

Male: Go ahead, (Jerry).

(Jerry Comeaha): In terms of the private pay patients and those patient that you know inability to pay, would it be – how would the RHCs, if they already had a fee, a sliding fee schedule set up in order to accomplish.

I know it's just an added thing that allows for the contract to probably be created a lot easier but with the FQAC entity need to approve these sliding fee schedule or it would be one of those things that each facility and each entity would contract among themselves and say okay we have this established for our private pay/low income patients.

At that time the FQAC or community health center, would they just say yes, that'll work for us or would they have to input their own recommendation based on their rules and regulations to accept the sliding fee schedule that the contracting entity comes up with.

Female: Not to sound a little bit like a broken record but it does again depend on the nature of the relationship. If essentially the health center is actually going to purchase the provision of service from the rural health clinic then the health center would use their sliding fee scale and that's the billing – and the billing would come from the health center.

Male: Oh, the (rural health) center.

Bill Finerfrock: You confused me there. I don't know if that was (Beth) or (Tanya). Say that again?

Female: The health center would actually take care of the sliding fee scale for the purchase of a particular service if that's the way the contract was constructed.

Male: So in theory, the RHC doesn't have to come up with any kind of sliding fee schedule.

Female: Again, it depends on exactly what is being purchased by the health center from the rural health clinic. Maybe it's a single service, perhaps, but the health center needs, and it works out well, to be purchased

from the rural health clinic. And so they may pay the rural health clinic a flat fee no matter who it is that comes to see – no matter what insurance or non-insurance that a health center patient may have.

And then the health center would be the one who would manage the payment, whether it's billing Medicaid or charging a self-pay fee according to their sliding fee scale.

Bill Finerfrock: I think for most RHCs, because of the billing arrangements, they would probably stay as an RHC for purposes of Medicare and Medicaid and that, for most there, we're talking about the individuals who would come in under a sliding fee care, the uncompensated care.

And that would – that could be a direct negotiated flat rate. So for example, the RHC could say, "Well, my Medicare rate is \$75, and I get paid an all-inclusive rate. So I'm going to contract with the FQHC on the same basis, an all-inclusive rate, \$75, and I will – you know whatever that patient's needs are during that encounter, I will take \$75." And then they would submit an invoice to the FQHC for that amount.

I guess the question is the application, then, of a sliding fee scale. If the RHC already has a sliding fee scale and says that you know up to 100% or 200% of poverty, but the FQHC has a different sliding fee scale for these uncompensated care, whose sliding fee scale – would the RHC have to do away with theirs and adopt the FQHC's? Or could they have sliding fee scales that weren't identical, but the fact the fact that the RHC had a sliding fee scale be sufficient?

And that may be getting into a lot more detail than we can deal with here, and maybe that's one of the things that needs to be done in this kind of next iteration and perhaps take some examples, some FAQs, or examples, of different arrangements.

Jim Macrae: You got it, Bill. Because we're starting to get asked those exact questions, and right now we're trying to deal with them as best we can on a case-by-case basis, but I think generally speaking, if we can provide some – a little bit more guidance than what we provided in this program assistance letter, I think everybody would be appreciative, so that's what we're working toward.

And like I said, we'll put that out for public comment so folks can take a look at it.

Male: Okay, all right. Next caller?

Maria Alonso: Yes, this is Maria Alonso. I'm with Citrus Health Network. We're a federally qualified health center in Florida. And my question was also about whether FQHCs would be required to contract with

local providers, for example community mental health centers, if they did not have that available to their population.

Bill Finerfrock: If you, as an FQHC, would be required to contract with a local community mental health center?

Maria Alonso: Yes, if we do not have mental health available. For example, we do – we have mental health, but there's a lot of – there's a lot of FQHCs throughout Florida that do not have mental health services. So if now there's new direction coming from HRSA that we need to provide comprehensive services, is that going to be a requirement for an FQHC to contract with a local provider that could provide that service to their patients?

Jim Macrae: Well, and this is where it gets complicated and we'll have to talk a little bit more about the contracting piece, and this will be in this subsequent panel, we are encouraging folks to look at what the current provider mix is within their community.

But for example, in new access points, the expectation is that the FQHC will see additional patients, so it's actually above and beyond, maybe, what's even the current community mental health center may be able to see. Or it may be an expansion of a service to their current patients, and that would need to be something that would be factored in in a contract.

I think in terms of the specifics, ultimately the decision about contracting comes down to the individual FQHC and the other providers.

Maria Alonso: Right.

Jim Macrae: We want to make sure that folks are, where they can, collaborate first and foremost, and then second, to know that contracting is an option. So it's not a requirement, per se. We do expect people to collaborate, and if they can't, to provide letters to show why they cannot, but it's not a requirement, per se, to contract with a particular entity.

Maria Alonso: Okay, that helps. I think it would also be very helpful if we would have follow-up on the different types of collaborative arrangements that we can enter into. That's always been confusing to us, particularly around our responsibilities with FTCA and the 340B pharmacy and all of those other requirements that we want to make sure that we abide by.

So if we could talk about maybe more specific different types of scenarios in the types of contracting, I think that would be very helpful in other conferences.

Jim Macrae: Absolutely, we've been asked to do that, and it's part of what we're trying to develop in terms of this policy is to provide a little bit more specificity around that. Even the whole issue of sliding fee discounts ...

Maria Alonso: Yes.

Jim Macrae: Talking about, so a PIN or a PAL on that very soon, too, so absolutely.

Maria Alonso: Yes, particularly since many of us are state-funded as well. And for example, in the state of Florida, we are required to use a very specific sliding fee scale that is in actual rule for the unfunded clients and people that have no insurance versus the flexibility that we have with HRSA. So I mean those things you know would be very helpful if they were taken into consideration.

Jim Macrae: No, it's good feedback.

Maria Alonso: Okay.

Bill Finerfrock: Thanks, Maria. Next question?

Les Lacy: Yes, this is Les Lacy. I'm calling from Cheyenne County Hospital out in St. Francis, Kansas. And the FQHC's model and critical access models have been in place for some time. My question is how many cases are there where an FQHC and critical-access hospital have been successfully collaborating in a small frontier community? And when I say "small frontier," I'm talking about a county population of under 4000.

Tom Morris: You know, I don't think we have a – you know a quantifiable number of how many have done it successfully. We tend not to hear about the ones where they're getting along swimmingly. And we do hear about the ones where maybe they don't play in the same sandbox.

But I think there are examples in every state where they work together. I think if you contacted your state office of rural health or your PCO – your PCA and just about every state, I'll bet they could say at least one example where it's working well. There are models out there. If you come up empty on that, please feel free to follow up with me, and I'll connect you with somebody. My e-mail address is T Morris, M-O-R-R-I-S at HRSA dot G-O-V.

Les Lacy: Say that again, please?

Tom Morris: T Morris, T-M-O-R-R-I-S at HRSA dot G-O-V.

Bill Finerfrock: And Les, I think you know one of the things that we're hoping is that, through this collaborative effort, whether it's through contracting or some other arrangement, the numbers of people – critical-access hospitals, rural health clinics, FQHCs, that are working together will grow significantly.

I think there's a recognition, at least at a national level, that folks cannot exist as an island in terms of health care and health care delivery. And whether it's because there's been confusion over whether folks could work together and how they could work together, or their – you know whatever barriers may have existing in the past, the hope is that, by getting the buy-in from all parties – the bureau, the Office of Rural Health Policy, the rural health clinics, the FQHCs, the critical-access hospitals – that we can really foster these kinds of relationships.

And so 2 years from now, or a year from now, folks aren't going to be looking or having to search around for examples. They're going to be very evident and well known, and people can replicate those. But for too – for too long, we've been hearing – the FQHCs have said, "You know the RHCs don't want to play with us in the sandbox." The RHCs have said, "The FQHCs don't want to play with us in the sandbox," critical-access hospitals, you know on and on.

And so you know part of this was to say, "Folks, you know we have to work together. If we're going to successfully meet the health care needs of populations, particularly in rural populations, it serves no one's interest to have folks competing, putting in duplicative infrastructure, and let's try and figure out how we can get people to work together."

And as Jim said, this is the first in what will be a series of explanations and information about how to work better and how you can develop these successful relationships. So you know I think the numbers in the past have not been great in terms of the number of examples, but we're hopeful that the number of examples of folks working together successfully will grow exponentially in the next year or two.

Les Lacy: You know my question comes from the fact that we're one of two hospitals in the state that actually operates a county health department as a department of the hospital. We also do O.B. that is to our detriment on our cost report. We have a provider-based rural health clinic, and we've been trying to provide some other community services (that) understand our reimbursement under the FQHC program.

And in light of that, we're having an FQHC pro forma done on our facility to identify how that would work for us. And so, as I look at that, I'm thinking also that we have, in our history, (Stateline) Health Network

was in our community many years ago, probably back about 1995 or so. And that FQHC did not survive here with the hospital.

And I really would like to see something work effectively, and Kansas is a state that has, I think, 40 frontier counties, and we haven't been able to identify one, and have been asking around, haven't been able to identify one. That's why I ask. And it's not for lack of desire. I think there may be some other issues around that specifically regarding the need to support critical mass in the community when you have to divide that between an FQHC and a critical-access hospital, there may be a bit of a problem.

And so the only model I can think of that would be successful is somewhat of a joint governance model, which you have already spoken about. But those models that I have looked at that came out in that collaboration paper back in March were all fairly large communities, some as large as 30,000, which doesn't sound large to a lot of people on the call here, but that's huge out here in western Kansas. And so that's where my question comes from.

Bill Finerfrock: Well, and I think what we're hoping here is to get some of those creative – and maybe there may be different models, something that can be made to work in your community, where perhaps a community health center and FQHC, you know that's some distance away, could contract with you, local dentists, local mental health, to provide those services.

You know what we hear from a lot of rural providers is, "You know, I just don't have the money to be able to provide the kind of care or the volume of care necessary for individuals who don't have the ability to pay. How do I get access to the resources to help me do that?" They can become an FQHC, or just as in something that would be workable, so you know maybe there are more creative ways in which we can get resources through these kinds of collaborative and contracting relationships to the facilities to allow them to meet their needs in their community.

Les Lacy: Thank you.

Bill Finerfrock: Next question, next caller?

(Ron Nelson): Hi, this is (Ron Nelson) from Michigan. A couple of concerns in some of the comments. I'd just like some clarification on the issue of the participating providers. I thought I heard Mr. Macrae make a statement that an option, if they can't get the collaboration is to look at an FQHC look-alike. So the question is, are the look-alikes not part of this collaboration process?

Male: No, there's definitely an expectation for that. It's just in terms of the timing, I was talking about. Because my understanding was the organization was struggling with being able to get an application in, and they were worried about the collaboration piece. The look-alike, there's still the same expectation in terms of collaboration, it's just there's no set timeframe or deadline in terms of that application. So as things evolve within the community, they have that opportunity. Sorry I didn't make that clear enough.

(Ron Nelson): And does that apply also then to expansion grants, people who are expanding when you refer to new access points?

Bill Finerfrock: We do ask people to collaborate. Within our expansion opportunities, it's however their existing sites, so it's a little bit different, but we do, again, encourage folks to collaborate. The new access point is really the opportunity, in terms of additional grant dollars, though, for people to work with new sites or new organizations. The expansion really is to expand capacity at existing sites.

Bill Finerfrock: So you might want to – an existing FQHC may want to hire an additional primary care provider or mental health provider who would work within the four walls of the existing facility versus a new access point, which would be going into a community where they've never been before.

(Ron Nelson): That's right.

Bill Finerfrock: Okay, then, because I had a note, and a new CHC, that would be a different program, a different pool of money. That's actually available within what we call the new access point. The new access point supports both new health centers as well as satellites for existing health centers.

(Ron Nelson): Got you, okay.

Male: Traditionally, about 40% of the applicants for new access points have been completely new health centers, and about 60% have been satellite.

(Ron Nelson): Finally, are you looking at any kind of (at a station), I mean knowing what some of the contracting requirements are. There's portions of that that an RHC would be able to attest to performing. Is that part of the process of this discussion? And I know there's a lot of details yet to be worked out, but ...

Male: Yes, one of the ...

(Ron Nelson): ... I'm concerned about the onerous kinds of things that could come up that become a barrier to really getting facilities to collaborate.

Jim Macrae: Sure. One of the things we have in our new access point guidance as well as just as part of the regular application process is what we call affiliation agreements, which is – it's basically a one- to two-page form that we ask folks to fill out that just talks about how they're contracting or affiliating with another organization to provide service. How is that provided?

And there's a series of questions that we ask. Some folks think it's onerous. Some folks think it's not so bad. That's sort of the blueprint, you know not too hot, not too cold. We feel like we've sort of hit the right piece. But that is sort of the way we get at it, (Ron).

(Ron Nelson): Okay, great, thank you.

Bill Finerfrock: Okay, next question?

Oh, just – Jim, before – how much money is available for a new access point or a new CHC, these dollars? It's a fairly significant amount of money. I don't recall the appropriation off the top of my head. I'm sure you have it, but ...

Jim Macrae: It's \$250 million for this year that's available. And we expect to support about 350 new access point awards.

Bill Finerfrock: Okay, and is that – is that money, that's just for this year, for this fiscal year. And then the next fiscal year, the next couple fiscal years, there will be money available as well, assuming something doesn't happen with appropriations. But the Affordable Care Act forward-funded those, didn't they?

Jim Macrae: There is money available in 2012, 2013, '14 and '15. The increase from 2011 to 2012, just in the Affordable Care Act portion, is about \$200 million overall. For 2013, the overall increase is approximately \$300 million. For '14, it's been \$700 million, and then for 2015, it's \$1.5 billion.

Bill Finerfrock: So the – my point is, folks, that there is a significant amount of money that will be available and a lot of pressure, in some respects, to basically spend this money, spend it wisely, and really meet the needs of the community. And so this isn't something where it's a theory that, here it is. There's real money out there, and there's real opportunity out there for folks to do some neat things and become very responsibly creative in the way that we try and improve access to care for uninsured populations.

Jim Macrae: Yes, and I – just to reinforce that, that's one of the reasons why we wanted to put the planning grants out there was so people can have that opportunity, because you know this is the first, as you said, of what we hope to be many opportunities.

But again, having the planning grant money has proved extremely beneficial. The look-alike has also been another opportunity for folks to utilize. And we encourage folks to use all those different things, as well as to work with their state primary care associations, their state primary care offices, as well as their state offices of rural health to coordinate all of this activity, so absolutely.

Bill Finerfrock: Okay, operator, next call – next question?

(Noel Ramas): Yes, this is (Noel Ramas); critical-access hospital administrator in Alaska and a former flex director is what I come to you as far as experience. First of all, I just wanted to thank Mr. Macrae for being – and all of HRSA, really – for talking about this, what has been kind of, in some ways, and elephant in the living room for a while for a lot of us.

And so having the discussion and seeing the PAL come out mentioning it is really wonderful to a lot of us. Our hospital board is very clear they're really just wanting to work from a do-no-harm model with our FQHC that is here in town.

At one point, our UDS Mapper I looked to the other day, having seen the link, I didn't see us listed in there. And the FQAT actually resides inside our building. So that was one question, is – as this UDS Mappers looked at or used, will the review committees be able to now look and say what other resources are available that maybe absent in a FQAT's application. That you know historically you're only to look at the application, not take any other information into the room.

And secondly as this policy or look at assigning points for collaboration. Again, thank you. Will we see that in future applications, not only for new access points, but ongoing health center funding and also capital you know building funds, would we see it in that as well?

Jim Macrae: Well, in terms of your first question, it's something we're definitely exploring. We – we've put it out, I think – I'm trying to remember the person that actually worked on the UDS Mapper actually just had to leave the room, unfortunately. But I believe we put it out in June and we put in what we knew we had and then we've been adding to it. I think as we get more information added into it, it's definitely something that we're considering in terms of potentially a resource to the ORC. At this point it's not.

At this point though we felt that it was important enough to get out there to help people with planning and development. Ultimately, though, it could be definitely a resource that objective reviewers as well as staff here use when looking at issues of service area overlap, or collaboration or coordination. It's definitely something that we're exploring. And we've talked to Tom about getting access to some of the data in terms of making that available.

In terms of your second piece which was points. Yes, we do plan to include collaboration in the other announcement that we put out there. In fact for our – what we call our service area competition we do have that included in our next set of rounds around that. You'll see that definitely in our planning grant, that expectation. So we really are trying to mirror this, not just in the new access point, but in the different guidance's that we put out there.

Male: Jim, you – we've been talking about the points here and you had mentioned before 10 points.

Jim Macrae: Yes.

Male: Can you put that in some degree of context of like in an overall application ...

Jim Macrae: It – yes ...

Male: ... ((Inaudible)) does 10 points mean?

Jim Macrae: Oh it's roughly 10% of the application. Applicants can receive up to 100 points. There are additional priority points that folks can get if they're sort in a high poverty community, or serving a special pop – a mandated special population, or even a sparsely populated population. But roughly, it's 10 points out of 100, so roughly 10%, which is not an insignificant amount. In fact ...

Male: That was the point I wanted to get across. It's not insignificant. And just so folks understand, and the way that that would work is that every application is an assigned a point value and placed on a linear scale, if you will, based on the number of points. And then however far down you're able to fund, based on where they ranked, till the money runs out. So the higher the point value a project has, the greater chance it has of being funded.

Male: Yes, that's – yes, that's correct.

And I think what it's done is it's encouraged folks on the front end to focus on collaboration and coordination, which is what we really wanted. So you know it's you know I know all of us have the same experience.

It's sometimes so hard just to do right in front of you, and the thought of having to work sometimes with other folks can be daunting. So we wanted to create the incentive right out of the gate to have people actually reach out in the very beginning. And so while it's always been in expectations of ours, we really felt like adding the points was important. And again, will be a significant factor in the scores and, ultimately, in the funding decisions that we make.

Male: Okay. Great. Next caller, next question?

(Betsy): Yes, this is (Betsy) from Florida. This is a simple question to start with. But is a rural health clinic allowed to apply to get this CHC status?

Male: The short answer is yes. But you have to meet the requirements of becoming a 330.

(Betsy): Okay. And those who would include the additional services like dental and psychiatric?

Male: And governing board requirements, ((inaudible)) fee and annual audits and all of those kinds of things, yes.

(Betsy): Okay.

Male: And there's a set of ...

(Betsy): You can still be independent and for profit and apply to be a CHC?

Male: No.

Male: No, not if you're a – no, I'm sorry. I thought you might be a not for profit.

(Betsy): No.

Male: Sorry.

(Betsy): I'm a rural health clinic independent.

Male: Okay.

(Betsy): So they're not eligible?

Male: They are not. I'm sorry.

(Betsy): Okay. So, what is their role with the whole – they're just in a collaborative role?

Male: Yes, or as it was pointed out in the Affordable Care Act, there are opportunities for health centers to be able to contract to provide a certain portion of their services.

Male: So you, you know if you had a need within your community, you had a significant number of uninsured patients, you could reach out to the FQHC in your service area, if there was one, and seek to engage in a contractual relationship to be able to provide the primary care services that would be required of those populations.

(Betsy): Okay. So you're talking about getting a contractual relationship with our FQHC where they could reimburse us for uninsured patient.

Male: Correct.

(Betsy): I see. And that's about our major role with this if we're independent?

Male: I'm not sure there, I don't know how answer that question. But that's certainly a significant piece of it, yes.

(Betsy): Okay, thank you.

Male: Next question.

(Richard Garza): (Richard Garza), (DI) Medical Clinic in Texas.

Male: Go ahead, (Richard).

(Richard Garza): The reason – question I had is rural health being a for profit organization, collaborates with FQHC, which is non-profit and once we collaborate and FQHC identifies that it has enough census to go

ahead and expand into our area, what protect the RHC from the FQHC doing this? Creating competition for ourselves and our own location?

Male: Well it – we are asking as entities go into new communities that they reach out to the existing infrastructure and receive letters of support. If they cannot provide a letter of support, we are asking for true justification for why they are not able to do that. We still have situations where folks go in, and it's not just in service areas served by rural health clinics, it's also other health centers.

And the way we look at it is basically we do a determination about whether there's enough unmet need within that community that could support an additional clinic without having a significant, detrimental impact on the existing provider. And so we would apply ((inaudible)) criteria in that situation.

(Richard Garza): The only reason is that I know for a fact that in my area you can't apply for another RHC license. But I knew – know that with a FQHC and the way they work, they can expand into my area. So I collaborate with them and then we identify our data, they'd identified that you know, hey, there's a good opportunity for us to go and open up a location over there and here I am collaborating, working with them, and ...

Male: But if you're already meeting that need. If they've contracted with you to meet the need, then they would have to demonstrate why there would be a need for a new facility, or an additional facility in light of the fact that they have a contractual arrangement with you to meet those needs. So I think what the answer was, is that you know I mean I – to me that's going to be very difficult for them to ...

(Richard Garza): Right.

Male: ... do, to be able to demonstrate these even more need for a new facility as opposed to being able to meet that need through contracting. The other is that you know you cannot establish a rural health clinic or an FQHC unless you are in a medically underserved area, health professional shortage area for the RHC, or you're serving a medically underserved population, the case of the FQHC.

So the data – what you're almost suggesting is that even though you're meeting the need, either the data is not reflecting that or the data is showing that despite all of that there's still an additional need. So there's an aspect of this that you need to look at the data to determine what is the extent of the need, even if there's contracting or not contracting, and what can be met.

There's nothing that prevents anybody from being a bad actor, or doing things whether it's an RHC or a FQHC. But what the hope is here again is that folks who have a common interest to meeting the

healthcare needs of uninsured populations can figure out a way to work together to make this a win, win situation for each of the providers, but more importantly, for the patients if both providers are saying they want to be able to serve or make sure that they have access to care.

(Richard Garza): Okay. I appreciate it. Thank you.

Male: Next question? Okay, caller?

Operator: If you're using a speakerphone, depress your mute function.

(Patsy Jensen): Yes, this is (Patsy Jensen) in Carterville, Illinois, an FQHC, (Shawnee) Health Service.

And I'd like to move on to another piece of the Affordable Care Act which we're now involved in, which is the establishment of accountable care organization. And Jim do you see contractual language coming from the Bureau which will help FQHCs working hospital systems that are formulated PHOs and establishing ACOs? Will there be some language in which FQHCs can use for being a part of that kind of network?

Jim Macrae: We are currently working with our colleagues, both in the centers for Medicare and Medicaid who are responsible for developing the regs on the program. As well as our colleagues – I only know the acronyms, I apologize. The Office of Consumer Information and Insurance Exchange, something like that, OCIO, on the expectations around accountable care organizations.

One of the big issues that we've been having discussions with our colleagues role of governance and, as you're developing these accountable care organizations, how does the role of consumers on the board of a health center continue to be – have oversight over the primary care aspects of the operation?

So, we've been working with them on that. We hope to have the regs out fairly soon. That's more in our CMS counterparts realm, but I know they're working on it. And there will be some information about health centers involvement in ACOs.

Male: I think those regs – we had originally anticipated that CMS would at least have the proposed rules out in December. The latest I've heard is that it will be sometime in mid-January is their goal for releasing the proposed rules. Which should help to you know answer, at least preliminarily, a lot of questions.

They'd still be proposed rules and not final rules, but I think will help to answer a lot of questions, not just for FQHCs, but for a lot of entities who are trying to figure out whether ACO makes sense, doesn't

make sense. What kind of – what are some of the anti-trust issues? You know the potential for creating a monopoly. You know there's a whole range of things that need to be addressed, but that should start taking some shape come, hopefully, mid to late January.

(Patsy Jensen): Okay, thank you. I have a follow up question, as well.

Many of the – I'm listening to our counterpart rural health partners and one of the things is kind of perplexing to me is that we collaborate with our behavioral health, public health departments. We have not had a request from rural health clinics to participate in serving the uninsured. Many of the FQHCs, and particularly in our area, are already exceeding our grant funds in terms of serving uninsured. In fact, upward – to some organizations, upward to 175, 185% of their grant dollars being used already to serve uninsured, and that number is growing, particularly in Illinois.

And so you know I'm a little concerned about this assumption that FQHCs have additional money beyond what they're currently using without developing new access points, or expansions. So, could you address that area for me, please?

Male: I think it's a good point. I think what we're talking more about is the opportunity, especially with the new resources coming in. And we do recognize that health centers seeing a growing number of uninsured patients. We also expect that as people get insurance, actually more patients will arrive for their primary care at health centers. So we definitely recognize that from where we sit.

I think, in particular, we're more focused on additional resources as they become available. How best to utilize those resources, going forward. So, that was really the context within which we're talking in terms of additional resources, but I don't know what Bill you want to add to that?

Bill Finerfrock: No. I think that that's right. And that was the reason I'd ask the question is that there are significant amounts of new money being made available through the community health centers program to try and improve access to care.

But at the same time as Jim mentioned you know once the healthcare reform kicks in, many of the individuals who are currently uninsured will be showing up at providers with some way of paying for their care. I think we – even within the FQHC community, the data shows that there'll be a significant decline in the number of uninsured patients who are being cared for, who are showing up at FQHCs without any ability to pay.

But with respect to the new money being available you know the RHC community has historically never had any ability to get compensated, unlike the FQHCs for the care that they provide to the uninsured. So you know many of our RHCs see significant percentages of individuals who are uninsured and they pay for that out of their dollars. They get no Federal grants; they get no Federal support for doing that. And it's becoming an increasingly difficult strain on them.

The idea here is that is there an opportunity with new money – we've been advocating this before the new money was available. But now, in particular with the new money being available are there opportunities for RHCs to collaborate with FQHCs where there's a mutual interest. If the FQHCs don't want to do it, or the RHCs don't want to do it at this point, no one can force people to work together.

But to the extent that there is a mutual interest in doing so there are some new dollars that are available to try and improve expand services to areas where they previously hadn't been available. Let's try and use this opportunity to encourage collaboration where there's, as I said there's that mutual interest.

Female: Thank you.

Male: Next question, next caller.

(Dave Jones): Hi, my name is (Dave Jones) I'm (with some FQACs) up here in north eastern California. And actually the previous caller talked about collaboration, we actually provide medical staff to the local critical access hospitals. But on another note we're, we have a RAC in an adjoining service area that would like to contract with us and us with them. But we're wondering is there a possibility do you think down the road we can contract with an RAC as a new access point?

Female: It's possible based – but you'd have to describe in an application how what, how you're going to expand services that are available through that new access point, that location so it would have to be a discussion of what's currently going on there and then what you would do to expand access out of that location, so adding new patients, expanding the availability of certain services that may not be available and how that would be integrated into your larger service delivery system that you're creating in your existing service area now to that new service area. So it would have to describe how you're expanding that.

And then you get into the technical – so that's sort of the big picture about what would have to be described for the basis of the application but then it gets more complex about how the two organizations would relate on a, sort of organization to organization as well as a fiscal relationship whether it would be

a contract around staffing, (lease or lessee) for facilities, all kinds of things like that that would be the complex part of establishing that relationship as part of the application.

But it's certainly something that has been done and could be done again in the future.

(Dave Jones): Okay, thank you.

Male: Operator, how many questions do we have yet?

Operator: We have 10 questions in the queue.

Male: Okay, keep going, go ahead next question. Okay caller.

(Mike McCloud): Okay I am a, okay I'm (Mike McCloud), I'm a freestanding RHC physician owner in south Texas, we have the exact situation you were just talking about occurring, we have an FQHC in an adjoining community who is seeking to establish an access point within our service area which would (in essence) duplicate a lot of services that we're already trying to provide.

I guess our question now that you've answered some of them is who will be in charge – and I know there's probably many agencies that would be in charge of reviewing these contracts and saying what's permissible and not, that's one of the onerous parts of this for us and them.

And I guess the second question is their clinic would offer us the opportunity if we collaborated or contracted to then provide enhanced reimbursement for our non-reimbursed patients now but also for our Medicaid and Medicare as they get much better reimbursement for those. Would that be an allowable provision in such a contract that we would be able to take advantage of some of that enhanced reimbursement?

Male: I think it depends on the specifics in terms of the contract and that could be something that we would look at. In terms of the contracts themselves we review them here in the bureau of primary health care. We also have a set of lawyers that look at different aspects of these contracts to make sure that all the T's are crossed and all the I's are dotted.

We could defiantly provide some technical assistance to help you with your particular situation.

Female: And the first thing is to have local council of course, always (with these) contracts to make sure that it's, they're being done in accordance with state and other laws first before it even gets to – and that it's

approved by governing boards of the respective organizations and done under the federal requirements for contracting (the staff) identified in terms of the code of federal regulations 45 CFR Part 74, in particular.

So to make sure that they're all in compliance with all of those and that's a great step forward, thank you (Charles as well). Overviews are taken place even before it gets to the federal level (of appeal).

Male: And again we are going to put out some more guidance around the whole area of contracting sub-recipients and that piece so be on the look at for that too.

Male: To the, to the other question though I'm not sure that you could do a pass through on your Medicare or Medicaid payments, that might be a bit more problematic.

Male: That's correct you cannot transfer FQHC status to another entity.

(Mike McCloud): Okay.

Male: So you would continue to get your ((inaudible)) whatever your rate is for Medicare and Medicaid as an RHC but here you would have an opportunity to get some resources to help you provide care to the uncompensated, the care you're providing to the patients who don't have the ability to pay.

(Mike McCloud): And I think the other part of the relationship we were very interested in is some of the services they can provide such as dental and mental health. We have a very profound deficiency in our community so is it possible for an FQHC to extend out just certain services such as dental to a community who doesn't have adequate dental services?

Male: As long as they as part of the contract have relationships to be able to provide that primary care, yes they can.

Male: So you could, if you had an RHC for example at a, some available space they would contract with the, in this case the physician to provide care, primary care to the patients, uninsured patients who need that and then they may be able to provide some equipment and staff to use some of that available space for putting in a part-time dental clinic.

Would that be a possibility?

(Mike McCloud): That sounds like pretty good match there as opposed to developing a completely new bricks and mortar clinic next door or something.

Male: Would that be an option Jim?

Jim Macrae: Again it gets very complex depending on the individual situation and how the two organizations would legally relate to each other. Especially in shared space environments you just occasionally have issues with Medicaid billing about the number of providers and there skips some – there's some complexities in it but we are happy to look at individual situations.

We also strongly encourage organizations to work through their primary care association, their primary care offices, offices of (rural) health to really discuss in greater detail that's the individual circumstances that organizations are considering because there may be some state based laws around those affiliations or contracts that we might not be as familiar with here at the federal level. So that's why doing a lot of this at the state level first is a good idea.

Male: But I think working back from what you would think is ideal and then trying to figure out whether we can do it from where we sit, I think is a great approach.

Male: I was just going to say I really want to encourage folks to be creative and look at you know in a perfect world you know what would work in this community, we would do this you would do that. You know be creative in terms of always with the goal of you know we're trying to improve access to care for a whole range of services.

If the lawyers or the laws or the regulations get in the way and you have to make modifications are whatever, you either make modifications or alternatively we look to see if there's a way to go back in and change a law or change a regulation that is impeding the ability of communities to collaborate for the, in the best interest of the patients.

So don't allow, don't self regulate or self restrict the creativity that you may have if that, if that gets stifled down the road we'll deal with it but at this point I think my view is let's see if we can't come up with a lot of different creative ways and then others can replicate it. If folks are self regulating and saying well I'm not even going to try, I'm not sure. You know we lose out on what (may) be some really great opportunities for improving access to care.

Next question, next caller. Go ahead caller.

(Sam Garlic): Hello this is (Sam Garlic) I'm out in Port Angeles, Washington in a rural health clinic.

Male: Go ahead.

(Sam Garlic): And my question is kind of a general question, we've talked a lot about the incentives to the community health clinics to collaborate. What are the general incentives for the rural health clinics to participate in this kind of collaboration other than the prospect of enhanced compensation for previously uncompensated care? Are there any other potential incentives either economic or otherwise for the rural health clinics to participate?

Male: Well I mean in my mind personally I think that's a fairly significant opportunity is you know to get some resources into the facility to assist you in providing care to patients for whom you currently not getting any compensation or that you feel that you know you're having to limit the volume of services your able to provide to that population.

But beyond that I guess there was some – one of the folks from the bureau in terms of FTCA or 340B would there be – and this maybe one of those ones that depends on the contract. But would there be an opportunity for the RAC to get access to for example the 340B program for patients if they have, if they establish a collaborative arrangement or through the – to FTCA if they have that type of arrangement.

Male: Yes I think that goes back to you can't (deem) sort of or designate FQHC status to another entity but again that would be part of this future contracting guidance that we're going to put out there to just clarify all of that.

I would say from where I sit I think the other opportunity is you know very similar to what we said to the health centers is that you know providing that full range of care, working with others to not duplicate service you know it's very similar in terms of I think benefits in the sense of you know really encouraging a more you know continuity of care, developing that relationship across the board.

You know I think where we've seen RHCs and FQHCs work together it really does have a benefit for the patients I think at both entities as well as the community as a whole. So I think there are real incentives. Of course there are monetary incentives but I think even more broadly than that there's incentives in terms of providing the best quality care to the patients and ultimately impacting the community positively.

(Sam Garlic): Okay.

Male: Okay? Next caller, next question.

(Beth): Hello this is (Beth) I'm from western Maryland.

Male: Go ahead (Beth).

(Beth): I just have a concern that I want to express. First though I want to thank you all for having this call today, certainly clearly demonstrates efforts of collaboration. The – but my concern is there is a, an expectation that we as an FQHC which is what I am, a requirement or an expectation that we have a letter of support from local partners, particularly for grant submissions for these expanded medical capacity that's out there right now.

My issue really is I'm concerned that at the state level our partners are it appears attempting to somewhat serve their own agenda and requiring us to adhere to certain expectations in order to obtain a letter of support.

And so I hear that the expectation also that we will be receiving points for collaboration and (a specification) for why we can't get a letter of support but if we're kind of being held hostage to certain requirements to get a letter of support. Do you have any suggestions or comments that you can offer me?

Male: Well I think we want to hear more and I think you've been in contact with some folks on our staff so we would defiantly want to follow-up with you on that particular piece.

(Beth): Yes.

Male: I think the overall goal of all of this, again is to support and to encourage folks to work together because we think ultimately that will be the most beneficial. We do however recognize that there are certain circumstances for whatever reason that it's just not possible or just not feasible, or just not for whatever reason can't.

And so that's why we do create the opportunity for folks to be able to say to us why in their particular circumstance they cannot or what they feel the parameters are such that it's just not acceptable or possible given what the expectations are for a letter of support.

So we do create that space and opportunity. I think as you said ideally we'd like to see the letters but then again if it's unreasonable in terms of you know the relationship or the potential partnership you do have that space and opportunity to describe that to us.

And you know we're not naïve where we sit; we recognize that you know in some cases we're asking a lot. But we'd prefer to be asking a lot on the front end again to encourage this and to try to work towards where we want to get to and then if we can't get there right now you know again as Bill said this is an opportunity over the next you know several years to create that collaboration.

I would say in your particular circumstance if you can contact your project officer or (Tonya Bowers) on our staff, you know we can defiantly try to follow-up on your particular issue.

(Beth): Okay, great thank you very much.

Male: And I'd offer the same thing as I did for the guy from Washington except we don't have any (raw) health clinics in Maryland so.

(Beth): Okay, thank you.

Male: Bill I apologize I think Tom and I are both going to have to run to another call, I think.

Bill Finerfrock: I think we're up on the time, I apologize for those that we're not going to be able to get to and to lose ((inaudible)). You guys still there?

Okay well I think we've lost the folks from the bureau and the office of rural health policy so with that I think we're going to have to call an end to today's call. As you heard we will be doing more on this in the future I don't know how soon they will have some of the more information, more of the information available and some of the details.

But again I think the point here is that this is the beginning of a process and it is to encourage collaboration, contracting between the various provider types that have been identified in the Affordable Care Act. It's not going to work everywhere for whatever reason as Jim alluded to, there may be circumstances that may preclude or make that difficult. But to the extent that we can encourage it and make it available and it can work we believe (in other) in many other areas of the country.

I want to thank the Office of Rural Health Policy for sponsoring this series and I want to thank the Bureau of Primary Health Care for their great work and working with us on this particular call. I want to

thank you as all of the callers and the participants for your great questions today and we look forward to your participation in the future.

A recording of the call and a transcript of the call will be available on the Office of Rural Health Policy website, I will give you that, it is www.ruralhealth.gov, that's H-R-S-A dot G-O-V forward slash R-A-C a transcript of the call and a recording of the call will be available hopefully in the very near future.

Again thank you for your participation and we look forward to your participation in the next Rural Health Clinic Technical Assistance call. Thank you.

Male: Thanks a lot Bill; this is Jim and Tom.

Bill Finerfrock: Okay, I thought we lost you guys.

Male: You did but we switched over to another phone but ...

Bill Finerfrock: Well if you guys want to make any concluding remarks, feel free.

Male: Well no, we just appreciate the opportunity and like we said this is the first step in a longer and larger effort so thank you.

Bill Finerfrock: Thanks guys.

Male: Yes.

Bill Finerfrock: Appreciate it.

Male: Bye-bye.

Bill Finerfrock: Operator?

Operator: Thank you. That does conclude today's conference call, thank you for your participation and have a nice day.

END