

## **CAPITOL ASSOCIATES**

**Moderator: Bill Finerfrock**  
**September 30, 2011**  
**1:00 pm CT**

Operator: Good day and welcome to the Rural Health Clinic's Technical Assistance National Teleconference Series, Change, What Does It Mean for Rural Health Clinics? Today's conference is being recorded.

At this time, I would like to turn the conference over to Mr. Bill Finerfrock. Please go ahead, sir.

Bill Finerfrock: Thank you, operator and appreciate that introduction. I want to welcome everyone to today's call entitled Change, What Does It Mean for RHCs?

In addition to being the moderator, I'm also the speaker on today's call and I am Bill Finerfrock. I'm the Executive Director of the National Association of Rural Health Clinics.

One of the things we're going to be talking about is reviewing some of the changes that have been called for in the Patient Protection of Portable Care Act, Healthcare Reform, and how these may or may not impact on the RHC community. We're going to talk about accountable care organizations, bundled payments, value-based purchasing. These are all terms that enter into the Healthcare Lexicon in the past few years. Well, what do they mean or might they mean for Rural Health Clinics, and is there a role for RHCs in the future?

The format for today's program is approximately 45 minutes for my presentation, and then the remaining time allotted for your questions. I want to point out this series is sponsored by the Health Resources and Services Administration, Federal Office of Rural Health Policy, in conjunction with the National Association of Rural Health Clinics.

I'm pleased to report that this project has just recently been renewed for another year, so you can count on at least six calls during the next 12 months on topics of interest to the RHC community.

Today's call is the 43rd in a series, which began in 2004, and during that time nearly 11,800 people have participated on the bi-monthly RHC National Teleconference. As you all know, there is no charge to participate in this series and we encourage you to refer others who might benefit from the information to sign up to receive announcements regarding dates, topics, speaker presentations.

The Web site you can go to is [www.HRSA.gov/RuralHealth](http://www.HRSA.gov/RuralHealth) -- on word -- /Policy/C-O-N-F-C-A-L-L/I-N-D-E-X.html. There will be a Q&A period at the end of the call, as I said, and we request that callers please provide their name and city and state location prior to asking your question. If in the future you have ideas for topics, please feel free to email them to Info -- I-N-F-O -- @NARHC.org and put RHCTA, topic, or question if you have questions about the series in the subject line.

At this point, we're going to start the presentation and we'll go, and then as I said, we'll open it up for questions.

So the future of healthcare delivery, where are we, what's going on, and why? I think first it's important to acknowledge that what is largely driving the changes in our healthcare delivery system that we're seeing at both the national level and what you may be seeing at your community level are concerns about both cost and quality.

We want to get more of one and less of the other. We want to get more quality and we want to try and do it at less cost. And that clearly raises a question of whether or not cost and quality are mutually exclusive in healthcare. Is it possible to get better quality at a lower cost or are they linked together so that in order to get improvements in quality you're by definition going to have to increase costs.

Will they be in balance? Is it a one to one relationship? These are some of the things we're going to explore a little bit today as we talk about some of the new initiatives. Some of the specific things we'll be talking about are ACOs or Accountable Care Organizations, bundled payments, and value-based purchasing. Now, ACOs and bundled payments sometimes we also hear those referred to as shared savings initiatives, but we're going to be specifically talking about them as either ACOs or bundled payments.

With respect to ACOs, in the spring of this year the Centers for Medicare and Medicaid Services published a proposed rule outlining the requirements for an organization to become an Accountable Care Organization. Now, I will say that those proposed standards were not well received by the provider community.

There were many organizations throughout the United States that were expected to immediately grasp and seek to become an Accountable Care Organization, but after reviewing the proposed rules many of those same organizations have said they're going to take a wait and see attitude. Many of the - you are probably familiar, depending upon the region of the country you're in, with some of those systems. We're talking about people like Geisinger in Pennsylvania, Mayo in Minnesota, Ochsner down in Louisiana, Intermountain Base out of Utah, and other large multi-specialty vertically integrated healthcare delivery systems.

They had many complaints about the some of the payment methodologies, some of the ways that quality was going to be measured. And so, I think today we find that the ACO movement is going

a little bit slower than folks had anticipated, and in fact some would argue is in some level of trouble, at least as it relates to the Medicare program.

Now, I want to say at the outset that we have not yet seen the final rules on the Accountable Care Organizations. The Federal Government published, as I said, proposed rules for Accountable Care Organizations in the spring. Organizations and individuals, such as the National Association of Rural Health Clinics, had an opportunity to submit comments on the proposal and make recommendations.

The National Association of Rural Health Clinics, like many others, did submit comments with respect to the Accountable Care Organization proposed rule, and we'll have to wait and see how the Centers for Medicare and Medicaid Services responds to those recommendations for change.

So some of the things I'm going to talk about here today could in fact change and make the program more attractive than some view it, but they could - the CMS could reject some of those proposals and we'll have to see how the marketplace responds to the ACO initiative as outlined under the Medicare program.

So what is an ACO? Well, I think in very simplistic terms an ACO is a group of healthcare providers who give coordinated care, chronic disease management, and attempt to improve the quality of care patients receive. The organization's payment is tied to achieving healthcare quality goals and outcomes with the intent of trying to reduce the overall cost of care.

As an example under an ACO, patients with chronic disease the expectation is that they would be better managed, and so individuals who have congestive heart failure or COPD, diabetes, would be better managed at a primary care level eliminating unnecessary ER visits, unnecessary hospitalization, and through that type of an initiative we can both improve the quality of care of the patient and reduce the cost of care because we've eliminated unnecessary hospitalization.

So those are some examples of the kinds of things that an ACO would seek to try and accomplish in an ideal world. Now, we do expect the CMS will issue the final rules for the ACO in the next few weeks, but it is not clear, as I said, what modifications and adjustments the agency will make to address the concerns that were raised by the provider community.

With respect to rural and rural health clinics in particular, CMS in their proposed rule established a minimum size for the organization. Under the proposed rule an organization seeking ACO status would have to have a minimum of 5000 Medicare beneficiaries assigned or enrolled with the Accountable Care Organizations. This is for a rural - and ACO that is located in a rural community. There are higher numbers if you're in a more populated area, in terms of the size of the Accountable Care Organization.

Now, clearly you know we're not - I'm not aware of any individual rural health clinic that has 5000 Medicare beneficiaries that they are currently providing care for; although, one could easily see a situation where multiple RHCs in conjunction with a hospital and other providers could meet that 5000 Medicare beneficiary threshold, and this - that 5000 threshold is exclusively within the Medicare program. The ACO wouldn't care exclusively for Medicare patients that's simply what it would take in order to gain the potential to be approved as an Accountable Care Organization.

We used the terms assigned or enrolled and technically in the proposed rule. It refers to these individuals as being assigned. It is not clear in - definitively how all of the assignment is going to occur, and there was some discussion as to whether or not it should be retrospective or prospective. In the proposed rule it is what is called a retrospective assignment. These are individuals who will have been seen and adjudged at the end of a 12-month period to have been seen by the Accountable Care Organizations, as opposed to a prospective assignment in which case the individuals would be identified and specifically linked to the Accountable Care Organization at the beginning of their year.

Now, in order for a patient to be “assigned” to an ACO, again under the proposed rule, that patient must have been seen by a primary care physician at least once during the previous 12 month period by a physician who is part of that ACO.

Now, I want to underline that the proposed rule stipulates that it must be a physicians, and as all of you know this here, this will immediately cause an issue for rural health clinics because all of our RHCs utilize the services of PAs and Nurse Practitioners, many have Nurse Midwives, but they all have at least a PA or Nurse Practitioner. And because they are currently not a recognized provider, for purposed of patient assignment it’s going to make it very difficult for rural health clinics who are heavy utilizers of PAs and NPs to be fully a part of an ACO.

So this was the first challenge that we identified as part of the shortcomings of the ACO proposed rule was the failure to recognize that PAs and NPs are appropriate primary care providers for purposes of assignment and care delivery within the ACO model.

One of the issues also that crops up with respect to the ACO is, who’s going to control the delivery of healthcare? Will it be hospitals, will it be physicians, will it be government, or will it be consumers? Under the ACO model the Accountable Care Organization can be made up of a single group of providers.

A group of physicians, for example, who would establish some type of an affiliation or contractual arrangement with hospitals for purposes of inpatient care could form an Accountable Care Organization. A group of hospitals who in turn would have contracts or affiliation agreements with physicians could form an Accountable Care Organization, or they could partner up and be equal partners in the Accountable Care Organization. So there’s a wide variety of opportunities for folks either as a group of like types of providers or to providers of different status to work together to form an accountable care organization.

Now, there's no indication here with respect to the government's role and it's not anticipated that the government would have a formal role in the formation of Accountable Care Organization. Although, it is certainly possible that a local level you could have a local health department or local government-owned clinic that might be a part of an ACO, but it's not anticipated that at the state or the national level that there would be any ownership or control.

In terms of consumers, again there's nothing that would preclude consumers from being part of an ACO's Board and controlling organization, but it's largely expected that these entities will be controlled by either hospitals or physicians.

I - as I alluded to earlier, patients can be assigned to the ACO either prospectively or retrospectively, and this is a significant decision that is going to have to be made by the Centers for Medicare and Medicaid Services as to whether or not patients should be assigned prospectively or retrospectively.

As I said, a prospective assignment is at the beginning of the plan year. The individuals who are going to be part of that ACO, the beneficiaries, are specifically identified, their care is tracked and monitored through a record and data keeping system, and at the end of the year there's an assessment or determination of whether or not the ACO was able to provide care at less than what it would have cost Medicare or whether more, and whether or not there were any shared savings.

Retrospectively, there are some issues with - that the patients would not be assigned to the ACO until the end of the year. And so, the - literally the ACO would not know who their patients are who are part their ACO until the end of the year, and then there would be a retrospective look back.

Now, from provider or an ACO standpoint, organizations have said, "We want it to be prospective." The government has said that they prefer it to be retrospective. And the reason that the government wants it to be retrospective is they're afraid that if it's prospective there will be cherry picking. That the providers will go out and identify those individuals in the community who are the healthiest, who are the least likely to avail themselves of care within the healthcare delivery system, and exclude those individuals who are high consumers of healthcare services, and therefore high consumers of healthcare dollars in order to be able to meet the - both the quality and the cost markers that the ACO will have to meet.

If it's retrospective you don't know who the patients are. The provider doesn't know who the patients are, and so it's going to have to try and treat all patients equally in terms of the volume of services, the focus in terms of the attention, because the provider doesn't know which patients are going to be assigned to the ACO.

So there are arguments on both sides as to whether it should be prospective or retrospective, and we'll have to see how CMS makes that determination. And it doesn't matter whether you're a rural ACO or an urban ACO, these - the decision on retrospective or prospective should apply uniformly.

Now specifically, how will ACOs affect RHCs in other so-called safety-net providers? Certainly, as I said, rural health clinics, federally qualified health centers, critical access hospitals can be a part of an Accountable Care Organization. So as a - as the entity is looking to get - to put together it's network of providers there is nothing that would prohibit that organization from including rural health clinics, federally qualified health centers, and critical access hospitals into the ACO organization. The law and the proposed rules are very clear that this is open to any provider who is legally available to provide services to the Medicare population.



In addition, if a rural health clinic and a FQHC or a CAH do choose to participate, and participation is voluntary, if they choose to participate you can continue to receive cost-based reimbursement from Medicare. You are not required to change to some other form of reimbursement such as a fee schedule as a pre-condition for being part of an Accountable Care Organization.

Now, that's the good news. The bad news may be that because you get cost-based reimbursement you're not a particularly attractive provider for the accountable care organization, because one of the things that we know is that rural health clinics through cost-based reimbursement typically get paid more to provide care to a Medicare patient than they would have received under the traditional fee-for-service payment methodology, which means that going in we're already talking about a situation where you are what would be classified as a higher cost provider even though the quality of care that you're providing is every bit as good as what might be provided by a non-RHC provider.

And the reason that you're being paid on a cost basis has nothing to do with quality, but a lot of other factors in terms of the size of your community, economies of scale, but because you're paid cost and you're paid more it's conceivable that you could be a less attractive candidate for the Accountable Care Organization because they are going to be measured at the end of the year on both cost and quality.

I mentioned the issue of how a patient will be assigned or attributed to an ACO could affect RHC and FQHC participation. One of the issues, as I said, in order to be assigned the patient had to have been seen by a physician within the previous 12 months - of the 12-month covered by that ACO contract year. The problem that has arisen, with respect to rural health clinics, is that when an RHC claim is submitted, when your UB04 claim is submitted it does not necessarily identify who saw the patient, whether the patient was seen by a physician, a PA, or a Nurse Practitioner.

And so, what CMS has articulated is that it is not clear that RHC patients can at all be assigned to an ACO simply because they have no ability to verify that that patient was seen through a claims-based process, that that patient was seen during the previous 12 months by a physician.

We have suggested that you expand the definition of primary care provider to include PAs and NPs, as well as Nurse Midwives; therefore, you would know that whenever a claim came in for the face-to-face encounter between an RHC and a recognized provider that that provider had to be a physician, a PA, a Nurse Practitioner, or Nurse Midwife even though that particular individual provider might not be identified on the RHC claim.

This is one of the issues we're waiting to see how CMS rules to determine whether or not it is at all going to even be feasible for rural health clinics to participate in the ACOs, and the same thing would largely be true for federally qualified health centers as well. Now, RHCs and FQHCs, again technically will be allowed to form an RHC that is exclusive to a group of RHCs or an FQHC, an exclusive ACO, but as a practical matter, for the reasons I've already mentioned, it's not clear that that is going to occur.

Now, I will say that a few months ago the National Association of Rural Health Clinics, the National Association of Community Health Centers, and some other healthcare provider organizations representing, what is broadly defined as the safety-net, were invited to participate in a meeting with the Centers for Medicare and Medicaid Services on creating innovative and creative ways to establish accountable care organizations for communities largely served by safety-net providers.

We had a very healthy and lengthy discussion about some of the things that one would want to do, how one would structure it, and CMS is actively looking at whether or not they can establish under some of the authority that they were given under the Patient Protection and Affordable Care Act to establish RHC or FQHC or collaborative RHC and FQHC Accountable Care

Organization in which the patient attribution, patient assignment, provider recognition, et cetera, would be reflective of the way that RHCs are reimburse, the way that data is currently or could be collected, and reflective of the types of providers who are available in the RHC environment.

We've not heard anything back from CMS specifically, but I did want you to be aware of the fact that they are actively looking at whether or not we can create or they can create an accountable care organization that would be relevant and appropriate for rural underserved areas.

I wanted to talk a little bit about payment. I mentioned previously that the Accountable Care Organization or entities, providers who participate if it's a rural health clinic, you would still be able to be reimbursed on a cost basis. Providers who are reimbursed on a fee schedule could continue to be paid on a fee schedule basis as part of the ACO, and hospitals that are paid either on a cost basis or on a DRG perspective payment basis can continue to be paid on that basis.

However, it should be noted that if you look at the long-term goal of the Accountable Care Organization and the way that the rules are established, it's clear that ultimately Medicare as a payor would like to move to some form of capitation or partial capitation as a means of compensating the provider. Now, when you begin to use the word capitation suddenly it conjures up visions of HMOs and managed care.

This is a payment methodology that was largely advanced and promoted by the managed care, by the HMO community, and so it raises the question: Is an ACO, is an Accountable Care Organization merely a modern day, a 2011 version of the 1990's or 1980's Health Maintenance Organizations?

I think that those are legitimate questions to ask. I certainly don't have an answer for you on that. I think each person can look at it and try and draw their own conclusions. What I want to do, and I'm going to talk about it in a larger context in a little bit, but I just wanted to kind of walk you

through some of the general parameters, some of the issues. I will say that one of the other challenges for RHC participation specifically in ACO has to do with the data collection component.

I mentioned that the goal here is to improve quality and reduce costs. Well, one of the ways that they're going to measure quality is by looking at the claims data. What was the primary purpose of the individual seeking care, and what specifically occurred during the course of that patient's treatment, whether it be in the inpatient setting or the outpatient setting? That presents certain challenges for the rural health clinics community because as you know the UB04 does not require you to identify the specific - by code - the specific services that were provided during that encounter.

We collapse all of our services into a single all-inclusive rate, and as a consequence, unless you voluntarily choose to do it, you don't report the specific CPT/HCPCs -related codes that were provided during that encounter. But - that is the very data that will be used by CMS to go back and evaluate and determine the quality of care. Were the services delivered during that encounter appropriate for the principle diagnosis for which the patient sought care? And because RHCs do not report that data on the claim form that represents another barrier for the ability of RHCs to fully participate.

Now again, in our comments to CMS we made some suggestions on how that could be addressed, what CMS could do to allow for that type of reporting to occur, for those RHCs that wished to participate in Accountable Care - in an Accountable Care Organization, but we'll have to see what happens when the proposed rule comes out.

One of the phrases I've heard people ask is, "Will ACOs lead to the Wal-Martization of American healthcare, or will it truly reform the healthcare delivery system in a way that is beneficial to

patient?" And I think at this point one could look at the ACO and you could envision one or the other scenario from occurring.

An ACO could easily be a wonderful organization where an individual comes in the front door of the rural health clinic and it's his or her portal of entry into a vast array of healthcare services through a vertically integrated healthcare delivery system.

So that they're not just simply walking into the front door of an RHC, but that front door of the RHC can lead to the critical access hospital, the community hospital, the tertiary care center, the academic medical center, and then seamlessly bring that patient back to the RHC at the conclusion of his or her episode of care, depending on what level of care he or she needed.

That's the idea, and one could certainly envision that as being a wonderful benefit, not only for patients, but also for the providers.

But, one could also envision a scenario in which cost becomes a more significant factor than quality, and as a consequence of that rural health clinics are left on the outside and patients served by rural health clinics are left on the outside.

Patients - payments to provider payments are gradually squeezed over time. They're changed over time to a model that may not be particularly conducive to rural underserved areas, and as a consequence we see providers closing their doors in smaller rural health communities in order to establish clinics in larger communities where they can achieve better economies of scale, but for those communities previously cared for by a rural health clinic but now travel to a larger community. Much the same way as we've heard complaints from some local hardware stores, grocery stores, and pharmacies say that, you know, they have had to close because business was moving to a Wal-Mart that was opened 10, 15, 20 miles away.

Which vision becomes the correct vision or the one that is the reality? Well - it remains to be seen. I think it's something that as rural health clinics you should keep an open mind about, but make sure that whatever decision you make with regard to participating or not participating in an ACO, should that opportunity arise, you look at what is in the best interest of your patients and what is in the best interest of the existence of your clinic and its ability to continue to provide care to the patients in your communities.

I'd like to spend a few minutes now talking about bundled payments. You know people have said, "Well, aren't bundled payments the same as Accountable Care Organizations? And the answer to that is a resounding, no. In August, CMS announced the establishment of a national pilot program geared towards inpatient care that would pay the provider a bundled payment.

Now, I want to emphasize that this is a pilot or a demonstration program. There are going to be a limited number of contracts that CMS will enter into with these - with organizations who opt to go for a bundled payment. I think the best way for folks to understand the concept of a bundled payment, at least in my mind, is to think of it as a super DRG, a super diagnosis-related group. But, instead of the payment covering simply the inpatient hospital portion of the care that bundled payment will, depending on which model the entity opts for, will cover a broader array.

So there will be a single payment that will be made to cover care in - depending upon again the type, it will cover care provided immediately prior to admission, during the admission, and post-hospital care, whether that be SNF or home health.

So in late August CMS issued what was formerly called a Request for Proposal, which was a message out to the provider community saying that they were interested in entertaining proposals from organizations that were willing to be paid on a bundled payment. This demonstration is to test out this model of paying entities for the episode of care. That's another term that you're going to hear probably a lot more is the concept of an episode of care.

There are four models of bundled payments that CMS wants to test out. One model would set the payment prospectively, and the other three would set payment retrospectively. And again, this is - these are models that in theory will allow for the participation of rural health clinics, so it's conceivable that you could be approached by a hospital most likely who would be interested in moving to a bundled payment arrangement, some type of a shared savings arrangement with Medicare and seek your participation.

Now, under the retrospective arrangement of bundled payments, CMS and providers would set a target payment amount for a defined episode of care and applicants would propose the target price discounted from the historical cost for that episode of care. Participants in these models would be paid for their services under the original Medicare program.

So it could be fee schedule, it could be cost-based reimbursement, but at a negotiated discount. It may be 10% less than your cost-based payment. And at the conclusion of the episode of care, the total amount would be compared with the target price. If you came in below the target price there would be an opportunity for shared savings. It's not clear what happens if you come in and your cost of care is above the target price.

Now, three of the options; first is option one, which would be hospital services provided to a beneficiary during an acute inpatient stay where physicians are partners in improving care. And the physician's payment, the Part B payment, would be collapsed into this super DRG and it would be up to the hospital or whoever it would - in this case it would be the hospital, who is paid the total amount and the hospital would in turn make a payment to the physicians. If the physicians were employees of the hospital there would be no separate payment.

But it would cover, unlike now where the DRG payment only covers the inpatient cost services, it does not cover the Part B services provided during that stay, under this model it would cover all of the services; the hospital's Part A, as well as the physicians Part B.

Model two would be where a hospital, physician, post-acute provider, skilled nursing facility or home health agency, and other Medicare covered services provided during the inpatient stay, as well as during recovery after discharge to the home or another care setting.

So as I said, it could be home health, SNF, if it's a rehab situation the rehab care that might be provided by physical therapist or an occupational therapist it would collapse the entire episode of care. Whereas the previous model would begin with admission and end with discharge, this would begin with admission but it would not end until the absolute conclusion of care where it was determined that the patient was no longer in need of skilled nursing facility, home health or some type of rehabilitative care.

And again, providers would be paid as they are under current Medicare, and then there would be a determination at the end of the year whether or not they had met their cost targets or not.

And then, the final model here would be the hospital, physician, post-acute provider, other Medicare services beginning with the initiation of post-acute services after discharge. So this would be exclusively a post-discharge super DRG. The inpatient services, the physician services during the inpatient stay would continue to be paid. It would not be part of this. But, this would be a super DRG that would kick in once the patient was discharged, either to a skilled nursing facility or a home health agency, and would be all inclusive of services that were provided post-discharge.

And then in the final model, CMS would make a single prospectively determined bundled payment to the hospital that would encompass all services furnished during the inpatient stay by



the hospital, physicians, and other practitioners. Here we're bringing in PAs and NPS. Physician and other practitioners in this case would submit what are called no-pay claims to Medicare and would be paid by the hospital out of the bundled payment.

So in this case, it is a prospectively determined payment covering all of those services, and then the hospital would divvy up who gets paid what during that course of care. The key - one of the keys I want to point out here, again is this concept of a no-pay claim. You're still going to generate, if you're a rural health clinic who's going to participate in this model, you're still going to generate a claim for services and there will be an accounting for that so that there can be a pro - retrospective review. You simply will not get any payment from Medicare for that claim; it will simply be a data collection, data reporting exercise.

So what do ACOs and bundled payments have in common? Is - are they so different that it is - it's not worth talking about them together, or is there a common thread? Well, I think what I want to point out is the common thread here. I said at the outset that the drivers here are cost and quality and those two are going to continue to be drivers for healthcare for the foreseeable future.

The payors, whether it's a commercial payor, a governmental payor, or individual consumers are finding it increasingly difficult to be able to pay for healthcare and they're looking for ways to reduce the cost of healthcare, and they're looking for ways to improve. We know that there's a lot of unnecessary healthcare that gets delivered at times, patients could be better managed in order to avoid unnecessary hospitalization, ER utilization, but the current payment system does not necessarily incentivize providers to do less or do what's the most efficient.

When you're paid on a fee-for-service basis the emphasis there is on services, so the expectation on the part of the payor is that if you're going to pay me for a service or pay someone for a service they're simply going to provide more of it in order to increase the revenue, instead of necessarily doing perhaps what is - would be better for the patient. Again, those are - that is the

speculation of the payor. I'm not advocating that that's correct or fair or right, I'm just saying that that is the perspective.

And the other part, and this is where the ACO and the bundled payment component come in, is that there's no incentive to try and integrate care that we have a system where by and large rural health clinics operate independently of any system. Physician's offices practice independent of systems. Critical access hospitals act independently of other providers, community hospitals, tertiary care, so we have this Balkanization, if you will, of healthcare into various silos.

So there's a physician silo, a hospital silo, a nursing home silo, a home health silo, and the goal here is to - through payment policy - try and encourage those entities to integrate with one another. Share information, talk about the care, and do things so that you either don't have duplication of effort, the hospital duplicating something that was perhaps done in a physician's office, the nursing home duplicating something that was done at the hospital. And instead integrating and looking at the episode of care, as I said, and trying to make sure that the patient got the highest quality with the most efficient delivery system that is available.

So I think as you look at rural health clinics, and even those of you who are affiliated with providers, whether they're small hospitals or critical access hospitals, I think what you have to start thinking about as we move forward here is what opportunities are there to integrate to affiliate? Now, that doesn't mean that you have to be owned by a hospital, it doesn't mean that you cannot continue to operate as an independent business, but what you want to look for are how can you integrate and coordinate your care with other providers in your area?

Whether it's in your immediate area or critical access hospital that may be 10, 15, 20 miles away, a rural hospital, whatever that may be, how do you integrate your care with others? How do you provide a better continuum of care? Does your responsibility and concern for the patient only

begin at the time an individual walks in your door as a rural health clinic and ends at the time that they walk out of there for that particular encounter, or does it extend beyond that?

Now, I would argue that despite what payment policy may suggest, in a rural community rural providers are in fact the - do provide - that continuum of care. You know your patients, you live in your community with your patients, you care about your patients, not just because of the type of individuals you are, but you see them in grocery store, you see them in the pharmacy, you see them at the school event, you see them at the soccer field on the weekend. You are in your community.

In urban areas there's less of that community connection, I think, often with patients, and so things that come to you naturally are perhaps some things that in more urbanized areas do not come as naturally with regard to healthcare providers and healthcare professionals. So in this case, I think you already have a major advantage over other providers because you already think of yourself conceptually as that provider of care in the continuum of care.

The other is I think, and it's a term I heard recently, but it's - we're moving to an industrial philosophy with regard to healthcare delivery. Now, that could have a negative or positive connotation, but in this case the particular speaker would put it into the context of - as an automobile.

I suspect that most of the people who are are listening to this call own an automobile, and when you went to purchase that car much of what you wanted was on that car was already determined. It was already there. You didn't go in and put the car together and say, "Well, I want to buy a steering wheel and I want to buy headlights and I want to buy a turn signal and I want to buy an engine, and I want to buy tires."

All of those things were there and you had various options to choose from, and then you had certain bells and whistles that you might add to that, but by and large the car was largely built. And you went in to buy an automobile and then you added a few little things on the side that you might have wanted because of personal preference.

Well, payors are starting to think of healthcare in that context. They want to buy a - as close as possible, a fully furnished automobile that's called healthcare. They don't want to necessarily be paying this for a headlamp, that for a turn signal, that for a steering wheel, that for a tire, that for an engine.

What they're saying is, "I want to come in and buy the automobile and I recognize that, okay, maybe there's some outliers, services, and some things and bells and whistles that we might want to buy that are outside the norm or that reflect patient preference. But, I want to get out of the business of paying for these individual units of service and move towards more of this integrated model of care where I'm buying an automobile with only a few choices beyond that."

So as you're thinking about your practice, as you're thinking about healthcare delivery, I think it's important to start thinking: are there ways in which you as a healthcare provider can be fully integrated into that system? And again, it doesn't mean that you have to become a part of a system any more than Ford Motor Company, as an example, employs everybody who builds an automobile. They have subcontractors, they have vendors, they have suppliers who provide various component parts that go into the automobile that is ultimately delivered.

So whereas a payor may contract with the person who is financially responsible for delivering that finished product, entities that participate in that continue to operate independent of that organization and provide services, provide components, provide pieces of healthcare, and still operate as an independent entity, but integrated into that larger delivery system.

So part of my point today is to try and get folks to start thinking at a community level of what opportunities exist to better integrate, to better collaborate, to provide greater continuum care to the patients in your community in order to ensure that going forward you're able to deliver the highest quality of care in the most efficient manner possible.

Now, one last thing I wanted to touch on briefly, and we're running out of time, is something that's called Valued-Based Purchasing. I just want to make you aware of it, it's something that's going to be coming down the pike in a couple of years, but at this point will not be applicable to rural health clinics. And so, I mainly want to bring it to your attention because it will not, at least in the near term, apply to RHCs.

Under value-based purchasing the government and ultimately other payors will be looking at the quality of care and doing comparative analysis between providers. How do you compare as a physician to other physicians in your region? How do you compare the PA to other PAs in your region? As a Nurse Practitioner, how do you compare?

And beginning in a few years Medicare is going to begin making payments to providers under the fee schedule based on that comparison. So providers who are in the top 20%, 25% of their peer group will get a bonus payment, providers who fall within the middle range of their peer group will get the predetermined fee schedule price for the service, and providers who fall in that bottom 20% to 25% of their peer group will see a reduction in their payment. And so, we're going to also be on the fee-for-service side moving into this era of value-based purchasing.

All of this, you're all familiar I'm sure with the PQRS, the Physician Quality Reporting System or Initiative. A lot of the data that is going to be used to make this comparative analysis is being drawn from the PQRI database. Again, as you all know, RHCs did not participate in that data collection initiative, and in many respects it's probably a good thing. Everything we're hearing from the physicians is it was costing them a lot more to report the data than they were able to

receive in the form of an incentive payment. But at this point, value-based purchasing does not affect rural health clinics.

There's some key days. In January, CMS will publish the quality and cost measures that they are going to use to evaluate physicians. January 2013, CMS will begin using a payment modifier and providing feedback reports to providers saying, "If we were actually actively live with value-based purchasing here's what you would have received. You fell in the top quartile, the middle range, or the bottom quartile." And then beginning in 2015, CMS will fully implement value-based purchasing.

So those are the things I wanted to chat with you about today, some of the things that are coming down the pike.

Now, one last thing - actually two things I want to mention. One is I hope that all of you are actively engaged in testing with your vendors, your clearinghouses, in terms of being compliant with the new 5010 Standards that come into effect in January with respect to claims submission.

It's the new platform that all claims will have to be on, in terms of being able to submit them to a payor. If you cannot submit a 5010 compliant claim, as of January 1 that claim will be rejected. So if you have not begun testing with your clearinghouses or with your payors, you need to be asking why not? There's just a couple more months before this system goes live.

The last thing before I open it up for questions, I just want to take note, I got word just before I got on the call today that a gentlemen who was described in the email, and I think rightfully so, as the Father of Rural Health, a gentlemen by the name of Al Grant passed away early this morning. Al was one of the early leaders in the rural health movement.

I remember watching him, and in some cases participating with him, (barnstorming) around the United States encouraging the establishment of State Rural Health Associations, as well as State Offices of Rural Health. Al had a long and wonderful and fulfilling life, he will be missed, but I just wanted to take a moment and acknowledge his contribution to improving access to healthcare in rural America.

With that, I'd like to open it up to questions if there are any questions from the audience, operator.

Operator: Thank you. The question-and-answer session will be conducted electronically. To ask a question, please press the star key followed by the digit 1 on your touch-tone keypad. You will be prompted to record your name. Please record your name and location. This will be played back when your line is opened. Again, that is star 1 to queue for questions and we will now pause to assemble the queue. And again, that is star 1 to queue for questions.

Bill Finerfrock: Hopefully we have a few questions. If not, it's a Friday afternoon and wherever you are you can go home early. You have my permission to take the rest of the day off.

Operator: And we have no questions at this time.

Bill Finerfrock: Okay, operator. Well, that's fine we can stay on. I will go ahead and - if there's anybody who does want to ask a question. I want to thank the Office of Rural Health Policy for sponsoring and hosting these calls. I want to encourage you if you know somebody who wants to sign you, you can also sign up by going to the Rural Health Clinic's Web site, [www.NARHC.org](http://www.NARHC.org) and follow the prompts there.

A transcript and a recording of today's call will -- excuse me -- will be made available hopefully within the next week and you can go to the Office of Rural Health Policy, the Web site I mentioned earlier, and download that. And I want to encourage you to encourage others who

might find this whole series of help to encourage them to sign up. Again, I want you to share your thoughts, suggestions for future call topics by contacting us at Info -- I-N-F-O -- @NARHC.org. The next RHC Technical Assistance call is tentatively scheduled for - it will be in either October or November.

It is our hope that for those of you who listened in on the August call, we had it on Patient Centered Medical Home, it had been our intent that that would be the call in September, unfortunately we had some scheduling conflicts with the speaker that we want to have for that. And so, we're hoping that we'll be able to find a mutually convenient time in either late October or November to schedule that call, the second on becoming a Patient Centered Medical Home. We will send a notice out about that call when the details are worked out.

Operator, anybody chime in yet?

Operator: No, we still have no callers in the queue.

Bill Finerfrock: Okay. Well, I want to thank everybody for listening today. Again, you have our email, if you any questions or comments, please feel free to send them to us. Have a wonderful weekend. The Government is not shutting down at the end of - today is the end of the fiscal year for Federal Government. Some people may be happy about that and other people may be sad, depending upon your perspective, but they did pass the continuing resolution so the Government is continuing to operator.

Have a wonderful weekend everyone and we'll talk to you soon. Thank you.

Operator: And that does conclude today's conference. Thank you for your participation.

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