Rural Health Coordinating Council (RHCC)

April 18, 2013, 8699 SW Sun Place, Wilsonville, OR

Members in attendance: Gary Brooks, Bruce Carlson, Andrea Fletcher, Craig Hostleter, Kevin Miller, Judy Ortiz, Candye Parkin, Michael Patrick, Charles Wardle

Oregon Office of Rural Health (ORH) Staff: Robert Duehmig, Scott Ekblad, and Eric Jordan

Guests: Erick Borland, Tiffany Brooks, Stacey Durden, Leslie Huntington, Diane Lund, Kim Torres

Q = Question, A = Answer, C = Comment

Roll Call & Introductions

Andrea Fletcher, Chair, began the meeting shortly after 10 AM. Introductions went around the room.

Approval of Agenda

Motion to move the Policy Update to a time before lunch, while retaining the rest of the agenda as written was moved and approved.

Approval of Minutes

Motion to accept the January 2013 minutes as written was moved and approved.

Old Business

No old business was reported.

Apple A Day Grant Program Advisory Group Report

Mr. Ekblad provided background on the program, and then outlined the process of funding the full ask amounts for Sherman County Ambulance, Elgin Volunteer Ambulance Service, North Lake County EMS, Cove Rural Fire Protection District/Quick Response Team, Imbler Rural Fire Protection District, Falls City Volunteer Fire and EMS, and Wolf Creek Rural Fire Protection District.

Dr. Brooks raised the question of how his own agency has a training budget that is approximately ten-times that of the applicants. He wonders why they were asking for so little, when their budget is so sizable. He said he would speak to them about that issue.

Q: Will the agencies that did not receive funding be able to apply for future awards?
A: Yes, most definitely.

Mr. Ekblad reported that he received information suggesting that one of the grantees from a previous AAD grant cycle may have misrepresented their need for grant funds, and possibly used the funds to make a profit off of the training paid for with grant funds. Wayne Endersby did some research and recommends that Mr. Ekblad request an accounting from that site.

Policy Update

<u>SB 440 - Loan Repayment</u>
This program has moved to Ways and Means. ORH has begun to work on rules with the OHA to make sure that the program will get up and running quickly, as there is $4,000,000 budgeted over four years.

Q: Will this program be administered by the ORH?
A: The program is technically at the Oregon Health Authority (OHA) but, should all go well, will be contracted out to ORH. We still need a signed Memorandum of Agreement in place, but that looks to be the case.

Q: Will existing ORH staff administer this?
A: We will definitely need to hire a full-time employee, but don't know if it will be an internal hire or an external hire.

Q: What do you want this program to look like?
A: The intent of the Centers for Medicare and Medicaid Services' (CMS) is that these funds go to those providing primary care, specifically providers who will expand access to care for Medicaid recipients. This will most likely look like one of the other federal loan repayment programs, such as the National Health Service Corps (NHSC) program.

Q: Are you hopeful that this will help fill some of the recruitment holes in Oregon?
A: Yes, we certainly are.

Q: Is every other state going to have this program?
A: Right now we're the only state with a program like this one, although there are other states with loan repayment programs.

Q: Will this apply to dentistry?
A: If Medicaid pays for that dentistry, then yes.

<u>SB 324 - EMT Tax Credit</u>
SB 324 would extend this credit as it exists to December 31, 2019. The effort to include volunteer firefighters did not succeed due to the unwillingness to expand any tax credit programs.

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SB 325 – Rural Practitioner Tax Credit

This credit sunsets December 31, 2013. SB 325 would reauthorize the program with a new sunset of 2019. The leadership of the legislature's Tax Credit Committee has a goal this session to cut the financial impact of tax credit programs. Some proposed changes in eligibility criteria for this program:

- Requirement that recipients see a minimum level of Medicaid and Medicare patients;
- Requirement that recipients practice in a qualifying area for a minimum of twenty hours per week (averaged over a month); and
- Instituting an income cap of $250,000 for individuals, or $500,000 for joint filings.

There is also a concern at some Rural Referral Center hospitals that some of their practitioners are not eligible for the credit, so amendments are being drafted to change this restriction.

HB 2858 - Primary Care Loan Forgiveness

Requests continuation funding for the program, which gives student loans to medical students, physician assistant (PA) students, & nurse practitioner (NP) students who are enrolled in an approved rural training program. Those loans are then forgiven if the graduate provides services in an eligible rural setting. This is currently sitting before Ways and Means.

SB 2 - Scholars for Healthy Oregon

We hope that Loan Forgiveness will parallel with this one, which will pay for tuition at Oregon Health & Science University (OHSU) in exchange for service in rural and underserved Oregon communities.

HB 2902 NP Parity

This is to make sure that insurers pay NPs at the same rates as physicians, as long as the same billing code is used. This has passed the House and is on to the Senate. This seems likely to pass.

C: The Doctors of Osteopathy (DO) Association is onboard with NP parity. We encourage members to speak out on this whenever and wherever.

SB 483 Patient Safety and Defense of Medicine Act

It did pass the Legislature and has been signed by the Governor. This is something that is attempting to limit liability in Oregon. It is not a cure-all, but is a good start.

SB 569

This charges the OHA to come up with a list of requirements for small or rural sites to credential physicians.

SB 604
This will centralize other sets of credentials through the OHA.

HB 2348
This creates a Public Health Taskforce which will focus on regionalization.

Today is a big deadline date. If a bill is not out of its originating committee today, it is dead.

Mr. Hostleter was asked for his comments. The Oregon Primary Care Association (OPCA) is working on a bill that deals with the Insurance Exchange and its "churn" rate. Some payers on the exchange already have relationships with providers, but others do not, so we are sending messages to all to keep sight of the January 1, 2014 date looming and join the necessary panels as soon as possible.

Q: How does one contact the Exchange?
A: One would contact the Insurer to make sure that you are included on the Panel for that patient.

Air Ambulance Discussion

Both air-transport companies were asked to present and join in the discussion on the nature of dual-memberships in areas where their services overlap. There used to be reciprocity in these areas, so people needed to only purchase one membership. The concern is that maintaining dual memberships creates a financial burden upon some members of the population.

Stacy Durden presented on behalf of AirLink and mentioned two reasons that they are not able to provide reciprocity with Life Flight:

1. AirLink used to be a non-profit business, but has converted to a for-profit business. The program governing reciprocity (which AirLink helped to form) has bylaws which allow reciprocity, as long as the entities are non-profit.

2. AirLink accepts Medicare for payment, which comes with its own set of rules regarding co-pay reimbursements. Now that AirLink is a part of a larger network, they are able to reciprocate with others in that network, because the Medicare funds are all equal within it. But since Life Flight is not a network member, and CMS guidelines are vague, AirLink is erring on the side of caution by not reciprocating with Life Flight. If the guidelines out of CMS were clearer, things might be different.

Q: Did you say Medicaid or Medicare guidelines?
A: Medicare. If someone has *Medicaid*, we do not sell them memberships.

Q: Is your service covered by Medicaid? If you transport a Medicaid patient, do you get anything out of it?
A: Yes, not much, but we basically accept payment as full.

Another thing with *Medicare* is that if people have Medicare B and supplemental or co-insurance, we encourage them to contact their supplemental or co-insurance to see if they will pay for 100% of whatever Medicare does not pay. If they do, then they most likely do not need a membership. One caveat to that is if Medicare denied the transport, the patient would be on the hook for the cost of the transport. This reality is something that makes the $50-$60 a year for membership a better option for most families.

Erick Borland then presented on behalf of Life Flight.

Q: How could reciprocity work, generally?
A: One option is an insurance-like add-on product, so there is a lot of red tape, but Golden Hour is working on this add-on to either Life Flight or AirLink to provide some level of reciprocity. That being said, they've been trying to get it launched for about two years now.

Q: What do we tell our legislators to change?
A: Clear guidelines from CMS on the Medicare co-pay waiver. I'll (Stacey) see if I can get that language from our lawyer.

Q: Does profit versus non-profit status factor in?
A: Initially yes, but it is really CMS guidelines that are the issue.

Q: How is it that St. Charles could not continue this program, but a for-profit could?
A: St. Charles is good at administering healthcare, but they are not set up to run a non-profit air transit system. They really struggled with keeping it afloat while it was at St. Charles.

Q: I remember when this transition happened last year. Is there a chance that you all could do another education round, say via rural newspapers, for the service areas?
A: I agree. There are so many people still confused by who covers what.

EMS Trauma Mobile Training Unit (MTU) Survey

Leslie Huntington presented results from a recent survey on Oregon's MTU program.

Q: Are there factors that limit agencies from using your services?
A: Traditionally, we have served rural and suburban agencies, so there is still a sense of that is all we do. While we are still limited to only two MTU Trainers for the entire state, meaning we have to prioritize and schedule our requests, we serve all agencies state-wide.

Q: Do you have the funds to conduct webinars?
A: We do. We are already set up with GoToMeeting as our webinar vendor.

Q: Do you have an outreach marking plan?
A: We do not yet, because we have only just begun working on the data from the survey.

Q: Was there any insight on having an MTU based in Portland?
A: We did not pose that question. That being said, we have actually seen an increase in requests for training since that MTU moved to Portland.

Q: How much can be done without being hands on?
A: That depends, based on what type of training it is that they need. Some exams require an in-person component to certify the level of understanding, some do not.

C: I have actually heard that there is an issue with getting the MTU out in Eastern and Central Oregon.
A: Within the Agency, we are already looking at how we schedule and prioritize training to maximize coverage. In addition to overcoming the cultural hurdle of hosting some training online, we also face an older hurdle of an agency allowing neighboring agencies to piggy-back their training, so that we can maximize the number of attendees within a region.

Staff Reports

ORH Staff Reports were omitted from the agenda to make room for the day's guests and their discussions.

Q: What is the status of rural health in Oregon?
A: I think it is the challenge that has changed. I think we are only slightly better off than when I started in this field twenty years ago. We are getting better data now, that much is certain. Where we used to talk about community demographics, now we look at provider services and availability, so it is worth noting that the overall scope of rural health has changed.

With Jo Johnson's imminent departure, we are surveying our constituents and third year residents to see how we can fine-tune our recruitment efforts.

Member Reports

Bruce Carlson, Oregon Medical Association

<u>Eastern Oregon Coordinated Care Organization (CCO)</u>
The Eastern Oregon CCO Community Advisory Council will probably be representatives numbering one for each of the twelve member counties (which have their own Community Advisory Councils), with a super-council subset then reporting to the CCO Board.

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One issue we have in our area is that ODS Health (now known as Moda Health) does not have a history of contracting some of the case management work out locally. Dr. Hoffman from Baker City held meetings on how to move providers to Medicaid and what that repayment will look like.

The state has stated that under the CCO model, they want all Medicaid providers to become Patient-centered Medical Homes. It will likely prove to be difficult for one-hundred percent of rural and frontier clinics to convert to a Patient-centered Medical Home because they already have limited operations hours based on the need and low census in their communities.

Pendleton

A new Medicaid clinic opened in mid-February. It is now open three days a week, with an increasing patient population. They are looking at how they can change how health care services are utilized in the community. The hope is to be able to reduce Emergency Room visits through case managers.

Q: Where will they go to hire a case manager? Have guidelines been set?
A: That has not yet been sorted out. I personally think it takes a creative person with people skills who has a reasonable amount of intelligence.

Oregon Academy of Family Physicians (OAFP)

It came to my attention at the recent OAFP meeting that OHSU is considering changing the curriculum for doctors, cutting back on family practice rotations and clerkships, specifically rural rotations and clerkships. These decisions seem to be coming from the University management, without input from faculty. One of the state representatives caught wind of this and has brought the Oregon Legislature into this discussion, so it might be that these curriculum changes might not be so great after all.

Another interesting tidbit from this meeting was a recent poll that showed more than half of OAFP members are employed, rather than self-employed. This will continue to be an issue with recruitment in rural areas with private practices going up for sale or partnership. For today's students, it is next to impossible for someone to buy or buy into a practice when they are already carrying such a massive debt load.

Candye Parkin, Oregon Association for Home Care

I've been noticing that common sense has been creeping into the CCO model, especially regarding mental health and home health. Although there are still bumps in the road, this is a positive development.

At the Oregon Association for Home Care, we will be focusing on CMS allowing NPs to refer to home health.

Another area of concern is the "face-to-face" requirement that mandates a patient to be seen by a physician either 90 days prior or 30 days after. This impacts the truly home-bound and places an extra burden upon their physician. The Association would like to see this rule lessened for this patient population, or possibly removed altogether.

Gary Brooks, Oregon Dental Association

Medical Teams International has five dental vans in Oregon. They are targeting adults not covered by OHP. The Tooth Taxi is serving about 200 people a week. 70% of physicians in Yamhill County are now employed by a hospital. Indian Health Service utilization is still at 27%. In 2014, the tuition at the new dental school on the SW Portland waterfront will be $97,000 annually.

Q: What happened with the mid-level dental provider?
A: It just never gained much traction in the Oregon Legislature, even with an annual push from some big national players.

Mike Patrick, Oregon State Board of Pharmacy

St. Charles has expanded into Prineville and is looking to build a new hospital there.

New Business

The RHCC agreed to continue holding its meetings for the next four dates at the Oregon Dental Association. Mr. Jordan already cleared all four dates with the ODA.

Adjourn