Pre-Conference Policy Survey Results
<table>
<thead>
<tr>
<th>Concern</th>
<th>Percentage</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers struggling to remain independent</td>
<td>52.2%</td>
<td>60</td>
</tr>
<tr>
<td>Behavioral and mental health services access</td>
<td>44.3%</td>
<td>51</td>
</tr>
<tr>
<td>Changes in care delivery (clinical, scope-of-practice, etc.)</td>
<td>19.1%</td>
<td>22</td>
</tr>
<tr>
<td>Uncollected deductibles/copays; uncomp. care</td>
<td>14.8%</td>
<td>17</td>
</tr>
<tr>
<td>Reimbursement/payment changes (pay-for-performance)</td>
<td>13.0%</td>
<td>15</td>
</tr>
<tr>
<td>Public programs reimbursement (unsustainable)</td>
<td>10.4%</td>
<td>12</td>
</tr>
<tr>
<td>Broadband access and/or cost (for telemedicine, etc.)</td>
<td>7.8%</td>
<td>9</td>
</tr>
<tr>
<td>Transportation challenges (emergency, medical, non-med.)</td>
<td>7.8%</td>
<td>9</td>
</tr>
<tr>
<td>Dental care access</td>
<td>6.1%</td>
<td>7</td>
</tr>
<tr>
<td>Healthcare workforce shortages</td>
<td>5.2%</td>
<td>6</td>
</tr>
<tr>
<td>Rural communities struggling economically</td>
<td>5.2%</td>
<td>6</td>
</tr>
</tbody>
</table>
Given current budget/financial constraints, what do you think are the most successful strategies to best address these issues?

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Percent</th>
<th>Votes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Expertise and technical assistance</td>
<td>64.3%</td>
<td>74</td>
</tr>
<tr>
<td>2. Scope-of-practice changes to address workforce needs</td>
<td>39.1%</td>
<td>45</td>
</tr>
<tr>
<td>3. Regulatory reforms and streamlining</td>
<td>37.4%</td>
<td>43</td>
</tr>
<tr>
<td>4. Grants or low interest loans targeting rural</td>
<td>34.8%</td>
<td>40</td>
</tr>
<tr>
<td>5. Health care delivery changes (care coord., health care homes)</td>
<td>26.1%</td>
<td>30</td>
</tr>
<tr>
<td>6. More support for FQHCs and RHCs</td>
<td>26.1%</td>
<td>30</td>
</tr>
<tr>
<td>7. Fixing challenging elements of the Affordable Care Act</td>
<td>19.1%</td>
<td>22</td>
</tr>
<tr>
<td>8. Rural community planning &amp; economic development support</td>
<td>16.5%</td>
<td>19</td>
</tr>
<tr>
<td>9. Telemedicine &amp; mobile medicine outreach and support</td>
<td>10.4%</td>
<td>12</td>
</tr>
<tr>
<td>10. Other</td>
<td>7.0%</td>
<td>8</td>
</tr>
</tbody>
</table>
What current trends do you see in health care or government that cause you concern . . . ?

- Aging population
- Workforce shortages/challenges
- Changes in designation and support for CAHs
- Attempting to provide higher quality of care with decreasing revenues
- Continued consolidation of hospitals and clinics into large IDNs and ACOs
- Lower patient counts; higher copays and write-offs
- IT inequities (challenges of HIT, EHRs and Meaningful Use requirements)
- More people insured, but with worse coverage (high deductibles)
What current trends do you see in health care or government that . . . make you optimistic about the future of rural health care in Minnesota?

- Committed healthcare workforce and supportive communities
- Expanding telemedicine/telehealth and other innovations
- Greater collaboration/teamwork among providers
- “Changing landscape” of providers (PAs, NPs, APRNs) for primary & specialty
- Health care homes and greater care coordination
- Increased awareness about rural disparities in health and resources
- Increased diversity of healthcare workforce
- Young health care providers interested in returning to rural areas
Fundamentals of Effective Advocacy

• Dave Durenberger
  former MN U.S. Senator; Senate HHS Finance Committee
• Sheila Kiscaden
  former MN State Senator
• Erin Sexton
  Dir. of State Government Affairs, Mayo Clinic
• Steve Gottwalt
  Exec. Dir. of MRHA and former MN State Representative
Dave Durenberger  
*former MN U.S. Senator, Senate HHS Finance Committee*

**Empowerment**

- Grassroots Advocacy Is Important
- You Have Real Power
- Get Involved!
Sheila Kiscaden
Olmsted County Commissioner and former MN State Senator

Mechanics and Process
There Ought to be a Law!

OR

The law needs to be changed!
There are about 4000 bills introduced every two years.

How many pass?
2012-2015 Bills Introduced:

House - Senate verses Laws Enacted
HOW DOES AN IDEA BECOME A LAW IN MINNESOTA?

FILTERING PROCESS

BILL INTRODUCTION

FIRST HEARING

COMMITTEE DEADLINE #1 (passes all policy committees in one body)

COMMITTEE DEADLINE #2 (passes all policy committees in the other body)

COMMITTEE DEADLINE #3 (passes finance committees)

HOUSE & SENATE COMMITTEES

amendments made

author amendment possible

HOUSE AUTHOR

IDENTICAL BILLS

BILL

BILL

SENATE AUTHOR
HOUSE FLOOR
134 SEATS
___DFL, ___GOP

floor debate,
more amendments made,
vote

CONFERENCE COMMITTEE

negotiate differences
between bills

SENATE FLOOR
67 SEATS
___DFL, ___GOP

Some bills may get combined into an Omnibus bill: a mega bill, made up of many bills put together by the chair of the committee.

A FEW NOTES

The Conference Committee is made up of 3 to 5 members of both the House and Senate. Members must have voted for the bill and are assigned by legislative leadership.
A version of the bill in which differences between the House and Senate versions have been worked out.

...only a few hundred of the ideas become laws!
2012-2015 Bills Introduced:
House - Senate verses Laws Enacted
Problem: Public Recognition

Solutions: Viable, Visible Options

Politics: Public Opinion, Momentum
Legislators deal with lots of people
And lots of issues.....be patient.
Erin Sexton
Mayo Clinic
Director, State Government Relations

Making The Connection
Legislators are people too….. But with an election certificate

- Part-time legislators who want your advice, feedback and engagement - they are not experts on every issue
- Legislators are public servants who want to serve the needs of their constituents
- Refer to them as Senator or Representative unless they tell you otherwise
- While you may not always agree, disagree respectfully
Be Prepared

- Be able to explain your issue in a clear and concise manner
- Have materials to leave behind
- Best advocates can argue both sides of the issue but convince you that their side is best
  - In other words, be prepared to address issues of concern and opposition
- Get to know their staff person -
  - Manage constituent services/request
  - Set meetings and relay information
Show Up

- Community forums, town halls, fundraisers, etc.
- Host your legislators at your facility
- Come to St. Paul - participate in lobby days
- Email, letters, and phone calls
  - www.leg.state.mn.us
- Best time to connect isn’t always during the Legislative Session
Steve Gottwalt
ED, Minnesota Rural Health Association and former MN State Representative; former HHS Chair

Strategy and Relationships
Elevator Speech: Packaging your story

- Typically, there’s **not much time** . . .
- What **three points** do you want them to remember?
- What is your “**ask**”?  
  - Be firm, reasonable and respectful
- Bring along and leave with the legislator a **one-page summary** of important facts and points
  - Leave more extensive background and details with legislative staff if appropriate
- Send a personal “**thank you**” note
Strength In Numbers: Coalition building

Politics is a numbers game - There is strength in numbers!

Are there other individuals or organizations that share your issue, concern or idea for improvement?

Get together, combine forces, share resources and plan strategy

Be clear and realistic about objectives and areas of disagreement; focus on common ground

Consider retaining a lobbyist
It’s All About Relationships

- **Get to know** your legislators and staff
- People are more receptive to those they know
- **Understand** the pressures lawmakers face, and the legislative process
- Be knowledgeable, reasonable, firm and respectful
- Be *consistent, honest and ethical*
- Remember the power of **gratitude**
- It’s easier to build on a good relationship than to mend a broken one
Eight month certificate program on effective rural health advocacy (starts in July)
Get to know the legislative processes that impact your world and rural health
Build your own story and strategies for change
Learn from experts and use your knowledge at your State Capitol during the 2017 session

www.MNRuralHealth.org
Rural Advocacy Success Stories

• Buck McAlpin  
  Dir. of Government Affairs, North Memorial Health Care

• Mary Krinkie  
  Vice Pres., Government Relations, MN Hospital Assoc.

• Sue Abderholden  
  Exec. Dir., National Alliance on Mental Illness - MN
Buck McAlpin
Dir. of Government Affairs, North Memorial Health Care
15 years ago, we explored the CP concept to fill unmet health care needs

- Support from the Office of Rural Health and Primary Care enabled establishment of a curriculum and pilot project with the Mdewakanton Sioux Health Services
- Over the next few years, we began to explore an expanded role for advanced paramedics
- CPs could fill a role in health care gaps and reduce the cost of overall health care expenditures by preventing unnecessary, costly treatments, reducing stress on vulnerable patients and hospital readmissions and emergency department utilization
State Regulatory Environment Pre-CP Law

- Physician Oversight Model
- Scope of Practice Exempt
- Independent Practitioners
- Function under EMS Medical Director’s License
- Paramedics Certified, not Licensed
Ripe for Health Care Reform

- Health Care Task Forces
  - Recommendations for increased access, care integration and payment reform, prevention and public health and preparing the Minnesota health workforce of the future
- Penalties for Hospital Readmissions
- Rewards for Keeping Patients Healthy
  - Emphasis on Increased Primary Care
Initial Obstacles and Considerations:

- **Needed a Defined CP Deliverable**
  - Initially not an easily understood solution to health care shortage
- **Needed Sharp CP Talking Points**
  - Required clearly articulated and repeatable message
- **Needed Credible CP Training Standards**
  - Opportunity for curriculum, clinical and testing standards
- **Needed to Dispel Territory Worries**
  - Initial opposition to perceived competition
- **Needed a ‘Paramedics 101” Education Effort**
  - Elected officials and general public had misperceptions of paramedicine.
Step 1: S.F. 119 Established CP Certification

- 2 Years Experience as a Paramedic
- Completion of Board-Approved CP Course
  - Accredited College of University
- Practice under Ambulance Medical Director Supervision

*Continuing Education in Primary Care*
Enabling Legislation

Section 1. Minnesota Statutes 2010, section 144E.001, is amended by adding a subdivision to read:

Subd. 5. Emergency medical technician-community paramedic or EMT-CP.

“Emergency medical technician-community paramedic,” “EMT-CP,” or “community paramedic” means a person who is certified as an EMT-P and who meets the requirements in section 144E.25 for additional certification as an EMT-CP as specified in section 144E.28, subdivision 9.

EFFECTIVE DATE. This session is effective July 1, 2011.

Sec. 2. Minnesota Statutes 2010, section 144E.28, is amended to read:

Subd. 2. Community paramedic.

(a) To be eligible as an EMT-P as an individual shall:

(i) complete a board-approved application form.

(b) A community paramedic must practice in accordance with protocols and supervisory standards established by an ambulance service medical director in accordance with section 144E.265. A community paramedic may provide services as directed by a patient care plan if the plan has been developed by the patient’s primary physician or by an advanced practice registered nurse or a physician assistant, in conjunction with the ambulance service medical director and relevant local health care providers. The care plan must ensure that the services provided by the community paramedic are consistent with the services offered by the patient’s health care home, if one exists, that the patient receives the necessary services, and that there is no duplication of services to the patient.

(c) A community paramedic is subject to all certification, disciplinary, complaint, and other regulatory requirements that apply to EMT-Ps under this chapter.

EFFECTIVE DATE. This section is effective July 1, 2011.
Step 2: S.F. 1543 Established CP Payment

- Authorized Coverage in Medicaid for:
  - Health Assessment, Immunizations and Vaccinations, Chronic Disease Monitoring and Education, Laboratory Specimen Collection, Medication Compliance, Hospital Discharge Follow-up Care, Minor Medical Procedures as Approved by Medical Director
- Primary Care Provider Order Required
- Medical Director Bills Medicaid
Section 1. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 60. Community paramedic services. (a) Medical assistance covers services provided by community paramedics who are certified under section 144E.28, subdivision 9, when the services are provided in accordance with this subdivision to an eligible recipient as defined in paragraph (b).

(b) For purposes of this subdivision, an eligible recipient is defined as an individual who has received hospital emergency department services three or more times in a period of four consecutive months in the past 12 months or an individual who has been identified by the individual's primary health care provider for whom community paramedic services identified in paragraph (c) would likely prevent admission to or would allow discharge from a nursing facility; or would likely prevent readmission to a hospital or nursing facility.

(c) Payment for services provided by a community paramedic under this subdivision must be a part of a care plan ordered by a primary health care provider in consultation with the medical director of an ambulance service and must be billed by an eligible provider enrolled in medical assistance that employs or contracts with the community paramedic. The care plan must ensure that the services provided by a community paramedic are coordinated with other community health providers and local public health agencies and that community paramedic services do not duplicate services already provided to the patient, including home health and waiver services. Community paramedic services shall include health assessment, chronic disease monitoring and education, medication compliance, immunizations and vaccinations, laboratory specimen collection, hospital discharge follow-up care, and minor medical procedures approved by the ambulance medical director.

(d) Services provided by a community paramedic to an eligible recipient who is also receiving care coordination services must be in consultation with the providers of the recipient's care coordination services.

(e) The commissioner shall seek the necessary federal approval to implement this subdivision.

EFFECTIVE DATE. This section is effective July 1, 2012, or upon federal approval, whichever is later.

Presented to the governor April 5, 2012
Signed by the governor April 9, 2012, 01:05 p.m.
Mary Krinkie
Vice Pres., Government Affairs
MN Hospital Association

The MN Telemedicine Act
Advancing Telehealth through the Minnesota legislative process
Governor Dayton re-elected in 2014. MHA had a positive working relationship with DHS. Medicaid staff wanted to expand access to services, telemedicine viewed as an appropriate vehicle.

MN House majority party status changed with the 2014 elections.

- 72 Republicans and 62 DFL
- There were 26 new legislators in total, 15 from open seats and 11 from Republican candidates defeating DFL incumbents
- Of the 11 freshman Republicans that defeated DFL legislators, 10 were from outside of the metropolitan area

No state senators were up for re-election in 2014

- 39 DFL and 28 Rs.
Why 2015?

MHA member-driven policy initiative:
- More MHA members providing telehealth services, frustrated by inconsistent payer policy
- MHA members wanting to know payer policy before investing in providing telehealth services

Support from both rural and urban hospitals:
- Rural providers more concerned about access and maintaining a high level of quality; efforts to keep patients in their home communities
- Access in urban communities - more focused on the Medical Assistance population and unmet service needs, like mental health

The year of addressing rural health care needs!
Great Resources

- American Telemedicine Association
  - State Telemedicine Gaps Analysis (2014 information)
    - MN Parity - Private Insurance: Grade “F”, Medicaid: Grade “B”, State Employee Health Plan: Grade “F”

- Example: Avera “e” CARE. Purpose:
  - 1. Better access to care
  - 2. Better care and better outcomes
  - 3. Lower costs
  - 4. Rural workforce sustainability

Legislative Leg Work

- Great bill authors:
  - Overcame many legislative hurdles
- Bi-partisan legislative support
- Continued effort to generate media coverage
  - Hungry for positive, bi-partisan health care initiative.
  - Pro-patient perspective. Emphasis was not about the payment or the provider.
- Support from the Department of Human Services
- Sustained outreach, Minnesota Rural Health Association. Valuable advocacy partner.
Original Themes For a MN Telehealth Bill

Telehealth technology can reduce health care costs, increase access to health care services, and improve health outcomes.

- **Message consistency and simplicity:**
  - The best way to “jump start” greater use of telehealth is to ensure that health plans reimburse providers for delivering care through this technology.
  - Telehealth services should be paid for at the same rate as in-person care.
  - Some of Minnesota’s health plans pay for certain telehealth services. But coverage for these services is not consistent across insurance companies and the types of providers eligible for reimbursement are too narrow.
  - 21 states had some form of a telemedicine parity law for private insurance.
  - Within state Medicaid programs, 23 states do not specify a patient setting or patient location as a condition for payment of telemedicine. 21 states recognize that the home can be an originating site.
  - States are increasingly using telemedicine to fill provider shortage gaps and ensure access to specialty care. 15 states do not specify the type of healthcare provider allowed to provide telemedicine as a condition of payment.
Stakeholder Outreach

Outreach with Key Stakeholder Groups:
- Minnesota Rural Health Association
- NAMI
- WorkForce Minnesota
- Numerous health care provider organizations
- Support/neutrality with the MMA

Dealing with the opposition:
- Council of Health Plans --- negotiations upon negotiations. Numerous amendments. The slow NO.
- The Minnesota Chamber of Commerce - getting to a bi-fricated position. Opposed to the originating site fee. “Neutral” on the parity to coverage and payment.
Dealing with the Opposition

- “The bill increases the cost of telemedicine by mandating that health plans pay for telemedicine in the same way and with the same rate as all other coverage.” (Handout from the Council of Health Plans)

- “The bill mandates a higher level of payment for telemedicine than may be warranted and requires that providers are paid twice - both at the originating site and the remote site.” (Handout from the Council of Health Plans)

Question: Should we look at the costs of telemedicine, OR look at the costs of health care? Or, better still, the costs of health?

- The politics of the budget process.
  - Significant differences between the House bill and the Senate bill going into Conference Committee.
The Minnesota Telemedicine Act  
(Included in Chapter 71, 2015 H&HS Omnibus Bill)

Private Insurance Provisions:

1. Definitions for: Distant site, licensed health care provider, health plan, originating site, store-and-forward technology and telemedicine.

2. Coverage for telemedicine services:
   A. Must be medically necessary, must meet safety and efficacy standards, must be standard for billing practices.
   B. Parity between telemedicine and in-person services.
   C. Reimbursement for telemedicine services - “on the same basis and at the same rate as the health carrier would apply to those services if the services had been delivered in person by the distant site licensed health care provider.”

The Minnesota Telemedicine Act (Included in Chapter 71, H&HS Omnibus Bill)

Medical Assistance Provisions:

- Fiscal Note: $344,000 (2016-2017) and $1.47 million (2018-2019) WITHOUT the originating site fee.

- The commissioner shall establish criteria that a health care provider must attest to in order to demonstrate the safety and efficacy of delivering a particular service via telemedicine.
  - Licensed health care provider and criteria.
  - Must document each occurrence of a health service provided by telemedicine. Records must meet the attestation requirements for payment.

Next Steps

State:
- Originating site fee discussion - not in 2016. Possibility in future years?
- Make sure that attestation with DHS is not overly burdensome.
- Bringing Broadband to greater Minnesota.

Federal: Medicare policies need updating!
- Patients can only receive telehealth services if they are located in a rural area.
- Only 75 service codes out of 10,000 are covered under the Medicare Physician Fee Schedule.
- Medicare generally only pays for real-time video interactions, and NOT for other forms of communications --- like remote patient monitoring.

Trends:
- Increasing shortages of specialists; pushes demand and reform.
- More interstate licensure of health care providers.
- Greater consumer acceptance --- moves telemedicine to preference. Higher importance/value given to our time.
Sue Abderholden
Exec. Dir., National Alliance on Mental Illness - MN

School Linked Mental Health
School Linked Mental Health

- Half of all adults with a mental illness being experiencing symptoms before the age of 14
- Early identification and intervention result in the best outcomes
School Linked Mental Health

- Families faced countless barriers to accessing treatment for their children
  - Finding providers, transportation, long distances, taking off of work, etc.
- Schools complained about behaviors in schools
School Linked Mental Health

- Stakeholders came together to identify barriers and problems
- Stakeholders generated ideas
- Bill was part of larger transformation package in 2007
- Was its own bill in 2013
- Was nearly repealed in 2011
School Linked Mental Health

- Everyone recognized the benefits
- Had data to show impact
- Calls made by parents, teachers, principals, superintendents, mental health providers
School Linked Mental Health

- Obstacles to passage, increasing funding and the repeal
  - Nanny state
  - Costs
- Children don’t get mental illnesses
School Linked Mental Health

- Need to be in it for the long haul
- Never underestimate the power of personal stories
- Bring together natural allies and surprise allies
- Use your data and the media
- Gorilla theater
Policy Forum
Strengthening Rural Health Through Effective Advocacy

Questions and Answers
Policy Forum
Strengthening Rural Health Through Effective Advocacy

June 20, 2016
MN Rural Health Conference
at the DECC, Duluth