

Community Meeting

The Primary Care Crisis:

State and Federal Perspectives, Issues, Information, Action Meeting Summary (draft)

Thursday, September 18, 2003

Presenters:

Panel Discussion with these State and Federal Health care Policy Experts:

Center for Medicare and Medicaid Services (www.cms.hhs.gov)

Penny Finnegan, State Program Coordinator for Colorado

Dennis DePizzo, Health Insurance Specialist in the Medicare
Administration Denver Branch

Colorado Rural Health Center (www.coruralhealth.org)

Lou Ann Wilroy, Critical Access Hospital Director

Colorado Consumer Health Initiative (www.cohealthinitiative.org)

Catherine Han Montoya, State Policy Director

Carrie Curtiss, Community Outreach Director

Expected Outcomes of the Meeting:

- A chance to learn specific information about federal and state health care policies, regulations and advocacy.
- An opportunity to get your health care state and federal policy questions answered.
- An opportunity for the community to identify any next steps.
- A follow up to the "Discussion of Primary Care in La Plata County" meeting held in July.

Agenda

- I) Introductions
- II) Brief Overview of the "Discussion of Primary Care in La Plata County" meeting held on July 7th, 2003
- III) Panel Discussion and Q&A
- IV) Identification and Discussion of Follow Up Actions
- V) Closing

Durango Community Access Television was thanked for filming the meeting and a tape is available for anyone by emailing: porternorton@animas.net

Introductions

Joanne Spina introduced herself as the facilitator and everyone was welcomed to the meeting. A list of attendees follows the meeting summary.

Joanne gave a background on this meeting, why it was convened and the expected outcomes (listed above). Joanne relayed that a meeting was held in July 2003 around the health care crisis in La Plata County. Over 60 people attended this meeting which was convened at by the Citizens Health Advisory Council or "CHAC". The CHAC is a broad umbrella coalition working on improving access to health care through education, advocacy, collaboration and projects. A fact sheet was handed out.

Joanne went on to say that at the July meeting, there were breakout groups around federal, state and local solutions -- the purpose of which was to help define solutions that could be actively worked on by interested citizens. In the federal and state breakout groups, it became apparent that more information was needed before any meaningful action steps could be defined. And so, that is why today's meeting was organized.

In the breakout groups around local issues back in July, it was decided that a health care district should indeed be explored. The Action Coalition for Medical Excellence and the CHAC have formed a joint committee to work on this. Also, it was determined that another local solution was that any displaced physicians should be helped by the community in setting up new practices in any ways possible (e.g. computer help, technical assistance, etc.).

Finally, it was announced at this meeting that there is a group studying the feasibility of setting up a local health care co-op (similar model to an electric co-op).

Center for Medicaid and Medicare Services (CMS)

The panel presentation then started with the Center for Medicare and Medicaid Services. The speakers gave this information and made the following points:

- The CMS is responsible for administering Medicare and Medicaid, and CHP+ which is a low cost health insurance program for low income eligible children.
- Medicare has a Part A program covers things like hospital care, skilled nursing facilities and hospice; and a Part B program covers clinical services, physicians assistants, doctor visits, lab work, wheel chairs, etc.
- In Colorado, we do have Medicare HMO's operating.
- The Medicare fee schedule is set by Congress and dictates what doctors will be paid for their services based on various factors. There are 7,000 MDs in Colorado who accept Medicare. The fees, while set Federally, can be adjusted locally. There is not an ability for local Medicare providers to set their own rates. For example, Durango's Medicare reimbursement rate is the same as Lamar's or Cortez's irregardless of the cost of providing services, number of providers or demand.
- For 2004, the projections for reimbursements are slated to go down 4.2%. This may change but that is what the current situation "looks like."

- CMS is always trying to reduce regulatory burden. MDs have to spend a lot of time on paperwork. There is a lot of talk about changing long-standing rules and requirements. Some issues are beyond the control of CMS but if there is a problem and we hear it from a number of consumers, we do communicate those problems to the elected officials.
- We prosecute providers for any false claims. Medicare has a huge educational system built in. We work with providers to make sure they understand rules and regulations. We have to manage the Medicare Trust Funds and manage them correctly.
- There is a lot of work being done at the Congressional level. Medicare is 38 years old. So, we have 38 year of laws and regulations and policies. Medicare has not kept up with the reality of medical practice. When it was formed, patients usually ended up in the hospital and there were few drugs. That all has changed. Now, you have a lot of different drugs that enable more patients to stay out of hospitals.
- Thus, the CMS supports reform. We need to bring Medicare up to the 21st century and handle the payment side of health care for our beneficiaries. Like everyone else, we need Congress to do some hard work on reform.
- Congress is now working now on a reform package. Various bills are ‘on the table’. There is a conference committee working on the various pieces of the legislation. We are understanding that they are making some progress. Many opinions out there and of course, differences exist between the Senate and House. They are pushing to get this done this year. Some are skeptical that it will happen.
- One of the issues with Medicare is the idea that we don’t pay enough to providers. We don’t have control over this. There is a formula that we are required to use and it is complex. One of the things around Medicare reform is obviously changing the formulas to set MD fee rates higher. CMS supports this because we feel there is a flaw in the formula. We are hoping that this will occur with the current legislation so that we can have a permanent fix to fee schedule.
- *Note: Valley Wide Health Services reports one of the reasons they had to lay off so many MDs is that they cannot cover their costs with the current Medicare fee schedule.*
- On the State level, as many know, there are many problems around employer insurance. Businesses are seeing double digit increases in premiums every year. A bill passed in the last legislative session that allows business to offer a “Chevette” version of health care versus a “Cadillac” version. In the legislation, there is a stipulation that this bill’s results have to be studied to find out if this intervention (i.e. offering the scaled-back benefit package) is indeed cutting premiums and/or getting more people covered through their work.
- Another issue is the idea of Federal funds and their availability to help with your local crisis. CMS is under the Department of Health and Human Services (Federal). This organization does provide a variety of grants and funding to various agencies. CMS does not do a lot in terms of grants and

other funding. Usually, Congress will pass a law saying: CMS, and other entities like our's, will provide grants related to 'such and such.' We can, however, provide answers to a questions about funding as can the Colorado Rural Health Center.

- One of the issues presented in the local co-op model being looked at is: Are your co-op services going to cost more money than CMS actually covers? But, as it's been described to us, we think there might be possibilities or funding a study. My suggestion is that you look at private foundations whom have a quick turn around. Getting funding to study your co-op model is key. It's a good idea to explore this route as government agencies are open and looking for new possibilities and models for providing health care services. The idea of a co-op is something to explore

Lou Ann Wilroy, Colorado Rural Health Center (CRHC)

Lou Ann's bio information was given and she made these points and offered a lot of information through a Power Point presentation.

- The Colorado Rural Health Center is the State of Colorado's rural health care office. We are one of five states where this office is functioning as a non-profit versus a government entity. We are not part of State government which we are grateful for as it gives us more flexibility. CRHC is funded through two federal grants and memberships plus donations and private foundations.
- A handout was given on statistics and information about what rural health care 'looks like' in Colorado.
- The CRHC is a clearinghouse of information regarding legislation about health care; we have meetings and workshops on topics that affect rural health care; CRHC hosts an annual conference in June that moves around to different communities; we have grant programs; we help rural communities with needed equipment through swap programs; we provide technical assistance; and we have grants and services to place providers in rural Colorado.
- Recruitment and retention resources, Lou Ann said, will be the main topic she'll cover since that is such an issue for Durango/La Plata County.
- The provider shortage is not just in Durango but across the State. This is not really a problem in resort areas but it is the southern part of the State, the Arkansas and San Luis Valleys and the Eastern Plains. There are resources to help.
- To be eligible for many provider services, you must get a certain designation. There are two (read on). These are Federal designations. There are also rural clinic designations available that can be considered to help bring in providers and services.
- These designations could "net" our community services, increased reimbursement rates and/or more providers if we are eligible; if we have applied; and if we are granted the resources.

- Valley Wide Health Services has explored and “gone after” some of these designations already. For example, they are a Federal Qualified Health Center (FQHC).
- **Possible ways to get providers to our area...**
- A couple of years ago, the CRHC started the Colorado Provider Recruitment Program. This program was launched by a group of organizations interested in helping get providers to areas that need them. The program has placed 14 providers in last 18 months (e.g. dentists, PAs, MDs). The RHC has a data base of providers across the country who want to work in rural Colorado. The CRHC is the only entity who can access the data base. This is a Federally funded program. Providers can search for opportunities and we post them. That’s where we get most of candidate leads to place in rural Colorado. We also do outreach to residency programs, dental schools, PA training programs and we talk with students and encourage them to either locate to rural Colorado or do their residencies there. The CRHC found that rural salaries are very competitive in the facilities. Lifestyle is usually the barrier, not the salaries.
- Another provider recruitment resource is the National Health Services Corps (NHSC). Again, a Federal program. What it does is match providers with underserved areas and places them in those locales. It also offers loan and scholarship programs. So, if a provider is interested and commits to giving time after their training, NHSC will pay for their loans once the MD is done with his/her training. If they want a scholarship, they apply before they do their training. They have to agree to serve a certain number of years in an under-served area that has been designated as such.
- Loan repayment programs are another great incentive for recruiting providers. There is also a State of Colorado health professional loan repayment program. Colorado receives almost \$400,000/year for this program and it is administered through CU. A community has to apply if it’s trying to recruit a provider through this program. Communities can apply any time and a review committee makes the decision.
- The Colorado Rural Outreach Program (CROP) is another option for loan repayment. This program is administered by the CRHC. It is for loan repayment or temporary payment to bring someone in when a rural provider takes a vacation, etc.
- Another option is the J1 VISA Waiver Program. This program places providers in rural areas who are from foreign countries. If they provide care in a rural area, they are able to stay here in the US but they have to provide care for three years, and must see Medicaid, Medicare uninsured and underinsured populations. They have to provide care in a HPSA or MUA/P (read on for details on these designations). These are MDs who attended medical school in a foreign country. They get to stay here longer to work. We have a lot of J1 VISA Waiver enrolled in the program and some are family MD’s, not just specialists. Sometimes there are cultural and language barriers but often, we have them from Canada, England, Australia. They are very well

trained. This program has been actually very successful and we've placed quite a few in Colorado. Many stay permanently.

- **Next topic....**
- Shortage designations, and there are a number of them, are very important because rural communities cannot access certain programs and services without being eligible or “designated.” These designations are granted by the HRSA – Bureau of Health Professions Center for Workforce Analysis. These designations are administered by the Federal government but there is a person who provides technical assistance in Colorado -- her name is Kitty Stevens. Kitty helps us assess and get connected to the various forms, procedures, processes, etc. that may lead to a designation.
- Getting one of the designations is quite an arduous and complicated process. Our State recently contracted with a consultant to develop software to make it easier.
- There are three types: 1) HPSA or “Health Professional Shortage Area”; and 2) MUA (Medically Underserved Area) or 2) MUP (Medically Underserved Population).
- A HPSA is a geographic area, population group, public or non-profit facility that has a shortage of health professionals. The criteria is that an area must be rational for the delivery of health services; a population to provider ratio must be 3500 to 1; and health care resources must be offered in a contiguous geographic area, or shown to be over-utilized, excessively distant or otherwise inaccessible. Where a geographic area does not meet the criteria, a population group designation (such as low-income) may be possible. In some cases, facilities such as prisons may be designated.
- MUA is a geographic area where residents have a shortage of health services. MUP is a population group that faces barriers to health care. The criteria for both is that the area must be rational for the delivery of health services; and a population provider ratio is 3500 to 1. Specific geographic areas – such as census tracts or populations within the service area may be designated.
- A score for an MUA or MUP is given based on poverty, an area’s population over 65, and its infant mortality rate. A score of 62 or less is required to be eligible. Our county currently is scored at 72.
- Perhaps consultants can help us figure out how to lower the score...ethically and legally of course.
- The benefits of being a MUA, for example, is that you could access the National Health Service Corps or J1 VISA programs discussed earlier plus services offered by rural health clinics, Federally Qualified Health Centers, Title X Family Planning monies and CPR Services are waived. The point is: if we can get the proper designations and scores perhaps the current shortage of services and providers could be alleviated.
- **Next...**
- There are several primary care options. Starting a Rural Health Clinic is one of them. Valley Wide is such a clinic. Such clinics must be located in a non-urbanized area; located within a HPSA or HUA; may be freestanding or provider-based; cost based reimbursement for Medicare and Medicaid is used

(versus the standard fees) so, providers can get more money to provide services and get closer to the breaking even point.

- Valley Wide is a FQHC already. Our score was first too high but the Governor intervened on our behalf. FQHCs must be located in an area designated with an MUP or MUA and can be either urban or rural. FQHC's are non-profit and do comprehensive primary care including health care, dental, mental health services, transportation and social services. FQHC's can contract out their services but they do have to provide all of them. They have to implement a sliding scale fee scale. They receive a higher reimburse for Medicaid and Medicare than do, for example, stand-alone private practices. There is a cap on their fees as was discussed earlier. Some are eligible for 330 funding which is another source of Federal dollars.
- Lou Ann went through other options for delivering primary care including becoming a "provider based entity", and/or Community Clinic and Community Clinic and Emergency Care. The details of these options were presented. There are many technicalities but these designations and types of institutions allow for more funding, services and providers to flow to rural areas. Any questions can be directed to her.
- Of the 64 counties in Colorado, 52 are rural so we are a rural state. "Rural" means there are 6 or less persons per square mile.
- Community Health Clinics do not only exist to take care of underserved and uninsured. They can't survive if their only patients are in these categories. They do have sliding scale plans and do accept Medicaid and Medicare. But, they also have a patient mix that includes private pay so, that's how they survive. We have 108 of these in Colorado and 15 organizations run them.

Catherine Han Montoya and Carrie Curtiss, Colorado Consumer Health Initiative

Catherine said both she and Carrie were at the July meeting. People had questions so their presentation is to answer those questions. The CCHI came into existence about 3.5 years ago. Private foundations funded the CCHI including Caring for Colorado and the Rose Hospital Foundation. There was no comprehensive, unified voice for consumers. Carriers have an organization and lobbyist(s) as do businesses and hospitals but there was not an entity solely advocating for consumers. That's what the CCHI does.

One question was: *How does the Taxpayers Bill of Rights or TABOR affect health care?*

Catherine's answer:

- Medicare reimbursements are not covering the whole cost of care as has been outlined by the other speakers. This phenomenon has contributed greatly to Durango and LPC's current crisis.
- On the State level because of many things TABOR does, the State's ability to increase funding for Medicare is drastically harmed. TABOR also impacts both Medicaid and CHP+ for the similar reasons.
- TABOR is a constitutional amendment enacted in '92.
- Very simply -- TABOR allows voters to approve tax increases; limits how much money the State can spend and raise; and limits revenue options. The State

- budget can only grow at the level of State population growth plus inflation. Different formulas are in place for local jurisdictions' budget growth rates.
- The ratcheting down affect of TABOR makes it so we can never recoup the losses in State funding of health care that we lost during these past several bad economic years. It's like a reservoir that gets to record lows but can never really be re-filled.
 - We can only bring in as much money as was in last year's fiscal cycle plus 6% so we can't bring the budget back to pre-recession levels. This means many, many health care dollars are getting slashed and cut an can't be restored any time soon.
 - TABOR also put into effect permanently a previous law that said that General Fund can only grow 6% each year. This law (Arveschoug/Bird) was passed in the hopes of warding off TABOR. But, with TABOR passing, this law was codified into the constitution. So, no matter how much State government would like to change this 6% ceiling on General Fund, we are locked in because TABOR locked in all previous revenue limits.
 - Many other revenue options are limited under TABOR as well.
 - So, that's TABOR in a nutshell and here's how it affects Medicaid. Medicaid is a Federal entitlement program for low income people that is matched one/one dollar-dollar between the Federal and State Governments.
 - Medicaid is an entitlement so our State always has to fund it. It is growing faster than the consumer price index so every year, Medicaid is eating up (percentage wise) more of the State budget. This "crowds" out other programs like higher education, programs for youth, some highway dollars, etc.
 - Colorado is not unique in our Medicaid spending...but we are unique in that we offer the leanest Medicaid program in the nation meaning we have the fewest services; we have an asset test so if someone has a car, they can't get Medicaid; and we have the most rules. So, although Medicaid is growing, we're not expanding coverage; we're not expanding services...we're a bare bones package State.
 - Because of all these dynamics and the woes of the State budget, we're moving more and more people to being uninsured where no reimbursement exists.
 - The Colorado State budget has been dismal the last three years. In '02 and '03, the Legislature had to cut a billion dollars because of a very complicated "perfect storm" intersection of TABOR, Amendment 23 and Gallagher. In '03 and '04, \$800 million was cut and there might be more cuts to come. We're not sure how much will have to be cut next year -- '04 and '05.
 - Again, TABOR relates to all of this because we can only grow the budget based on past fiscal revenues and budgets. We can't go back to the good years and collect that level of revenue to fund health care. We have to start from the bad years.
 - Another outcome of the budget crises is that legal immigrants were cut off of Medicaid to balance the budget. Most of these are elderly folks and kids. This has been challenged in the courts and is pending. No one should be cut yet due to the court challenge. This saved 5.2 million.
 - CHP+ was capped at 53,000 on 11/1/03. There is no plan for what happens when we reach the cap.

- The State Legislature eliminated the pre-natal program within CHP+ that provided pre-natal health care for parents who were income eligible. This is the silliest thing in the world to do because of the terrible consequences of high cost babies and the low cost of the preventative service.
- Mental health really was hit hard. \$6.1 million was cut out of funds for uninsured persons for serious mental disorders. Several inpatient units were completely closed both at Pueblo and Fort Logan.
- The State cut transportation by 7 million.
- So, in summation – yes, the State budget woes dues to TABOR and many other factors (e.g. the economic downturn, Amendment 23 and Gallagher) all have made public funding for health care incredibly scarce. We're losing ground.
- **Next topic...**
- Carrie Curtiss: The Federal Government's Jobs and Growth Act of '03 included 20 billion in Federal fiscal relief to states. Some of this was for general "holes" in the states' budgets and part was to offset Medicaid costs at the state levels.
- CCHI lobbied really hard and Allard and Campbell supported this bill.
- Colorado will get 146 million in two payments. One was received in 7/03 and another one is coming. The Governor may have jurisdiction over how this is spent. He wants to put 90% in reserve funds because we don't know the revenue outcomes yet for next year. He then wants to use 10% to take the cap off of CHP+; to restore the pre-natal care benefit; and to fund other programs such as literacy and higher education. The Governor's plan is not a bad plan -- and we hope these services will be restored because they are preventive in nature. Folks get care either early or in ERs. So, this is a wise use of money to fund prevention. He did appropriate some of this money – some of which were for questionable priorities such as brass hand rails at the State Capital. CCHI wants the money to go to health services for low income folks.
- Colorado just netted 92 million in funds because our formula for calculating the State match to Medicaid was adjusted down. This is called FMAP. This money, of which many don't know about, will be very contentious in terms of how it's spent. The Legislature can appropriate this money and will be spent in the next session. The CCHI has pulled together a coalition of health care advocates to say that the intent is for health care for low income people (since it comes from re-adjusting the Medicaid formula). CCHI does not want it to be used to plug other State budget holes.
- CCHI is a statewide advocacy group and we are a partner with the local CHAC. We do advocacy 101 trainings; training around TABOR; etc. We need health care advocates now more than ever. Consider getting involved. Membership is free. You can get on action alert email list serves through the CCHI.
- One final point: We all need to care about the uninsured and underinsured because the costs just get spread if we don't have good services for the indigent.
- We need to look at this in the whole picture.

Questions and Answers

? = Is a co-op illegal under the current Medicare rules? Penny: Medicare and CMS do not have a legal designation for a co-op model. We do for HMOs but not for co-ops. I can't give you a legal opinion but we could explore how to pay co-ops. It may take legislative action. A study is needed.

? = If you are an FQHC, would you be eligible as a HPSA site? Yes, but you still have to apply and score correctly.

? = In terms of calculating our eligibility for underserved designation, do they count the total number of providers or just primary care providers? We have a lot of MDs but not many primary care MDs. How does this affect our ability to qualify? Lou Ann: We have a training program every Spring on how to apply. It is very, very complicated. There are experts we can access to help answer your questions. I believe there is a way to apply for a primary care HPSA where you count only primary care providers. I can get more information if you want it. It is really worth it to explore this and get the TA offered because there are ways, legally and ethically, to present the information and your case. Summit County has same problem you have – they have a lot of low-income workers in a wealthy county. They are currently looking at their application, designations and scoring to reflect this demographic dilemma.

? Did Valley Wide look at all possible shortage designations? George Maxted, M.D.: We looked at the primary care shortage designation only and became a FQHC.

? In talking about a medically underserved population, the problem we're facing is that the Medicare population is underserved or undeserved. Lou Ann: You can get an MUP for just your Medicare population.

? Is there anything that can be done to reduce paperwork and support MDs with some type of nonprofit group to take real costs out of the system. Catherine: The whole notion of cost shifting has been discussed for years and it is just now being understood by elected officials. There is a new entity called the Health Institute that is going to be studying this such as: what are the different segments of the pie; how much cost shifting is going on; how to solve it? Fortunately, the CMS has a very low admin cost of 2%.

Comment: My insurance is so complex, I spend most of my time trying to figure it out. I don't know what folks do who aren't retired. This is a full time job for me. It must be incredibly expensive for MDs to figure all that out.

Comment; There was an article published in *New England Journal of Medicine* that showed that 31% of our health care dollars go to pay administrative costs.

Penny: For part A and part B of Medicare, our CMS administrative costs average 2% which is far below what private insurance companies can do. There is a lot of discussion going on and some beginning activity with the idea of networking and providing for a

consolidation of computer systems across rural provider areas. This would mean more time could be saved. This has to be done in context of retaining privacy and centralizing. In most places, this idea is in an infancy stage. CMS is trying to figure out where we can cut paperwork and administration. We (Medicare) process 2 billion claims a year -- so it is a massive program but we're trying.

? How can I get those bills you talked about related to Medicare? Penny: You can go to www.congress.gov and get various Congressional bills related to health care.

Comment: I've been involved in politics a long time, I find that studies end up on shelves. The current crisis for seniors and children, should have been addressed a long time ago. A lot of greed has gone on along the way. Medicare was used the wrong way and now, we're paying for it.

? = Is the intent of the current legislation to put a cap on Medicare spending? Isn't the trend to drive Medicare to a fee program or some type of HMO? Penny: CMS is committed to providing as many options as possible. Privatizing Medicare does not necessarily increase services or coverage. We are committed to keeping the fee for service element. In rural communities, there are fewer managed care options. Bush has proposed Medicare reforms including a mix of fee for service and the traditional model. Now, it's up to Congress to figure all this out. Fee for service Medicare is not on the chopping block as far as CMS is concerned. It all gets complicated when you put Congress and politics in the mix of Medicare reform.

? and Comment: FQHC's cannot negotiate their fees as Penny stated. It was previously said that we (Valley Wide) could negotiate our Medicare fees. That isn't true. It's set and we don't have any say in it. I am talking about the reimbursement rates to FQHCs. Penny: There is overall a cap in Medicare. One Center may negotiate based on their expenses. That cap is set by Congress in law every year. No FQHC can go above the cap. Something needs to be done about this. FQHCs cannot provide Medicare and make it. It would take Congressional action to change the cap. ?= Why not make Medicare and Medicaid the same caps? Lou Ann: Since it is a Congressional decision, you have to go to them to raise the cap. They set it every year. Take this up with your legislators because they have the vote. You have the voice.

Time was starting to run out. Joanne encouraged everyone to email or call folks with any unanswered questions, and asked folks what action steps, if any, should be taken? Are there things people want to work on?

Comment: This presentation does point out certain things we have been aware of...and that is that Washington has its problems and the State has more and more problems and yet -- we have thousands of patients without MDs here in La Plata County. Let's get down to the basics. We have to come up with some type of plan or plans locally that can take care of our local problems. It takes too long to solve them waiting for the feds and/or state.

Joanne gave a clarification of the July meeting and noted that this meeting was to follow up on the state and federal advocacy pieces. Everyone recognizes that things need done locally but does anyone also want to work on state or federal advocacy? That is the question.

Comment: It seems apparent no matter how much you approach this issue that there is no silver bullet. It's like shuffling deck chairs on the Titanic. We're talking about a cost shifting situation that needs to be fixed. So, I agree with Dr. Withers, we can't rely on the state and feds to solve this. We have to find responsible ways to work this out.

Comment: Many seniors don't need to go to the ER. Many are told over and over "see your MD." We'd like to know where else to go but the ER?

Comment: The real crisis, as we all know, is Medicare and care of the elderly in terms of fees. Once you are 65 and you're expected to go under Medicare, it doesn't matter what policy you have, you are stuck in this system. That is where I come around to the cap, if we are going to do anything, it would be lobby Congress to increase the cap. This is the single issue that makes it complicated for rural health centers to serve older adults.

Comment: Beyond going to our legislators, is there anything that the local average citizen can do to help MDs get something going faster? Dr. Joan MacEachen: VWHS has made quite an attempt to help but they can't really address this without legislation which won't come any time soon. What might help is the co-op. That's what this community needs to keep attuned to and what we're talking about doing. This co-op would be patient owned and responsive to patients. There would be a fee and Medicare would be accepted. Other than getting such a program going and the displaced Valley Wide MDs opening their practice, no, there isn't much that can be done. The tax district will take awhile and we need a feasibility study on the co-op. We might need to ask you some questions about what you would expect; how much would you pay; is this a possibility? The MD's interested in the co-op can't make these decisions alone so people need answer a survey that will go out in the next two weeks.

Comment: So, I have to wait to get sick until all these studies are done?

Joanne again clarified that this meeting was about state and federal advocacy. She recognized that those without an MD want immediate answers but, unfortunately, there are no easy answers to these questions.

After more discussion, the following next steps were summarized:

- 1) Someone should create a central clearinghouse to keep the community informed of all local efforts towards resolving the health care/primary care crisis. The CHAC was identified as the group who should do this. Several volunteers offered to help (e.g. phone calls, computer work, etc.)

- 2) People should lobby their Federal elected officials to ensure that Medicare reimbursements are increased and brought up to the level at which a physician and his/her practice can break even.
- 3) Those wanting to advocate at the state or federal levels can get on the email list serves of the Colorado Consumer Health Initiative and the Colorado Rural Health Center. Their web sites are on page one of this document.
- 4) Any barriers to La Plata County getting all the available designations mentioned should be explored. For example, if we are too “rich” a county, let’s explore other ways to present our case or go after a MUP for underserved Medicare patients.
- 5) Attendees can help with the co-op by answering questions that will be posed to the community in the next two weeks.

Attendees:

Lou Ann Wilroy, Megan McCoy, Scott Mathis, Liz Yet, Joan Cornell, Penny Finnegan, Dennis DelPizzo, Rose _____, Bill Vega, Susan Arendt, Ann Norris, Ernie Norris, John Withers, Irmattofmami, Nora Tracy, Judity Aitken, Phyllis Yost, Betty Stevens, Carole Sparks, Mary Van Tayler, Bonnie _____, Jane Zimmerman, Lorraine Rombred, Rita Fowler, Jim Tatten, Meri Oyler, Ian Chartier, Grace Deltsdreff, Anice Meyer, Sue Herbst, Dorothy Newll, Sari Ross, Shaila Van Sickle, Jennifer Kostka, Katie Aggeler, Bob Conrad, Rita Simon, Deb Banton, Marv Collentine, Wendy Biner, Joan MacEachen, Tammy Pardum, Ken Bates, Roger Landgren, Tom Breed, Pat Hartman, Pete _____, CJ Gudim, Pat Kearney, Jill Patton, Kip Boyd, Greg Caton, George Maxted, Brenda Isgar, Josh Joswick, Angie S. John, Mary Durmetria, Sheryl Ayers, Lynn Westberg, Carl and Linda Curtiss, Joello _____, Carolyn Redwine, Emily Nagy, Kermit Knudsen, Julie Kane, Ellen Park, Cora Landgren, Charlotte Detes, Delpa Hayne, David Breuzeze, and Bern Heath.

(Please forgive any omissions or misspellings. This list was taken from the sign in sheet).

Submitted by Marsha Porter-Norton