Health Resources and Services Administration
Office of Rural Health Policy

National Advisory Committee on Rural Health and Human Services

Omaha, Nebraska
April 28-30, 2014

Meeting Summary

The 75th meeting of the National Advisory Committee on Rural Health and Human Services was held April 28th – 30th, 2014, in Omaha, Nebraska.

Monday, April 28th, 2014

The meeting was convened by Tom Morris, Associate Administrator for Rural Health Policy. Tom Morris stated that the primary focuses of the meeting are: 1) The Affordable Care Act: Rural Plans and Premiums 2) Rural Homelessness.

The Committee members present at the meeting: Governor Ronnie Musgrove (Chair); Rene Cabral-Daniels, MPH, JD; Christina Campos, MBA, FACHE; Eugenia D. Cowan, PhD; John Stewart Cullen, MD; Barbara Fabre; Phyllis A. Fritsch, MS; Roland J. Gardner, MS; David Hartley, PhD, MHA; Michele J. Juffer; Karen Madden, MA; Barbara Morrison, MS; Wayne Myers, MD; Karen R. Perdue; Shane H. Roberts; Roger D. Wells, PA-C; Christy Whitney, RN, MS.

Present from the Office of Rural Health Policy: Tom Morris, Director; Steve Hirsch, Executive Secretary and Aaron Fischbach, Policy Coordinator. Truman Fellows present: Kristen Lee and Shoshana Shapiro.

NEBRASKA ORIENTATION

Jeff Gold, MD
Chancellor
University of Nebraska Medical Center
Omaha, NE

Jeff Gold welcomed the Committee to Nebraska. He said he would share two pieces of information with the committee: a perspective of the University and a snapshot of what the University is doing regarding rural health. Dr. Gold stated that the campus is literally a 500 mile campus crossing the state with the University of Nebraska as the base along with three other locations.

The population of Nebraska was 1,192,214 in 1910 and 1,826,341 in 2010. In 2010, nearly two thirds of residents live in metro counties. There is a major concentration of Nebraskans living in Omaha and Lincoln and less than 2 people per square mile in rural Nebraska.

The University of Nebraska has a Board of Regents of elected officials; a University President, James B. Milliken, J.D., and each of the four campuses has chancellors. The University of Nebraska Medical Center has 4,936 employees; the Med Center Clinical Enterprise has 6,183 employees. There are a total of 11,119 University of Nebraska employees.

U.S. News and World Report ranked the University of Nebraska's College of Medicine Primary Care 6 of 149 and College of Medicine Rural Health 9 of 149. Becker's Hospital Review named the Nebraska Medical Center as one of the 100 Great Hospitals in America.

There are 3,559 students attending the University and 76.2% are Nebraska residents. It is important to recruit students from Nebraska who will stay and work in Nebraska. Recruiting and retaining students from rural areas of the state is vital. They have family in the area and many will move back to their rural community to work as health care professionals. The University of Nebraska has community outreach that covers a 500 mile range. There are pipeline programs aimed at recruiting students from rural communities so they will return to rural areas and become part of the local health care workforce. Having the right workforce and educating the next generation is the key to the success of the health care workforce in rural communities.

There are five community outreach pipeline programs to recruit students from rural communities: Rural Health Opportunities Program, Rural Training Track, Virginia-Nebraska Alliance, Summer Medical-Dental Ed Program and the High School Alliance.

The Rural Health Opportunities Program was founded in 1990. Thus far, there are 420 graduates including: 86 medical students, 88 dentistry/dental hygiene students, 72 pharmacy students, 17 nursing students, 156 allied health students. 65 percent of the graduates remain in Nebraska. Of those, 73 percent are in rural areas.

The Nebraska Rural Training Track was founded in 1991. The students complete their first year of residency in Omaha while second and third years of residency are in the greater Nebraska community. As of 2014, there are 100 program graduates. More than 80 percent of the graduates practiced in a rural community for at least three years.

Another aspect of outreach is The Nebraska Provider Network. These are hospitals and clinics that provide 53 percent of the care across the state of Nebraska. There are also institutions that are not owned but linked to parts of Iowa and Missouri through infrastructure and information technology. This structure allows a better quality of care and more access to care in many communities.

Several groups participated in the Greater Nebraska trip to visit communities in rural Nebraska and gather information about rural health care delivery. It is important to customize health care to meet the needs of the individual community. There were several concerns voiced in these rural communities, including health care workforce issues. It is important to know where the next generation of physicians and nurses will come from because the current work force is aging out. There is also continuing educational and technology needs in rural communities. The rural

communities are excited about the Nebraska Network and are committed to securing a strong health care system in rural Nebraska.

Dr. Gold stated that Nebraska will lead the rural United States by being a model focused on population health. There will be a continued enhanced care delivery through better access, quality and workforce. Enhancing communication systems through electronic record share and telehealth is a priority. Keeping healthcare local instead of moving patients to other areas of the state for healthcare services will enhance the efficiency of healthcare.

Dr. Gold thanked the Committee for coming to Omaha, Nebraska and said he looks forward to learning from information collected by the Committee.

Q&A

Roland Gardner asked to have more information about the telehealth programs and those related to psychiatry.

Jeff Gold said that psychiatry and particularly child psychiatry had been most underserved in the State of Nebraska. Due to this issue, there has been seven or eight satellite locations developed across the state. A patient consultation occurs over a video link which results in diagnosis and treatment and may result in a patient transfer. It is used as a platform for other types of distance diagnostic services as well. It began similar to Skype and has become more sophisticated and the patients are registered formally. The system generates billing codes, access to medical records as well as follow-up visits.

Christy Whitney asked if they have broadband challenges across Nebraska when accessing DHR networks and telehealth.

Jeff Gold responded that they do have those challenges. They are going to co-locate their data management function onto the largest dark fiber network in Nebraska. It will be moved from university property into an off campus site. Because of the growth of information technology in Scottsbluff, there is fiber already in place and more is going in. Co-locating the data management to the hub will offer numerous advantages.

Rene Cabral-Daniels asked if their electronic record sharing is a health information exchange.

Jeff Gold said that there is a state wide system data repository. The relationships with the provider network and accountable care alliance are built on sharing and analyzing data. They work together to predict health care utilization, particularly in high risk populations.

Keith Mueller, PhD
Director
RUPRI Center for Rural Health Policy Analysis
Former NACRHHS Member
Des Moines, IA

Keith Mueller welcomed the Committee to both Nebraska and Iowa. He shared that there are 93 counties in Nebraska and 91 counties in Iowa. In Nebraska, there are some counties that are very large. The distance across Nebraska is the same as from Portland, Maine to Washington, D.C. Iowa is a traditional agricultural state. The northwest quadrant of Iowa is the most sparsely populated area.

Across the states, there is a range of small healthcare facilities to larger healthcare facilities in metropolitan areas. Nebraska and Iowa are highly populated with rural health clinics. There are over 130 in the each two states. In the last two years, there is a greater spread of federally qualified health centers.

Health insurance rates in both Nebraska and Iowa are modest in 2014. In Iowa, the uninsured rate is at 10% and 13% in Nebraska. Around 53% of residents in each state are insured through their employer. 16% of Iowa's population is in the Medicaid program and 11% in Nebraska. Medicare is about 13% of the population in each of the states. Among the insured population, Iowa has a higher penetration of those in the Medicaid Advantage program.

The median household income in Nebraska and Iowa is just under $51,000. Families making below $25,000 is 22% in Iowa and 23% in Nebraska population. The population in each state in rural areas is aging which is typical for rural populations nationwide. In Iowa, the population 85 years and older is 2.5 percent of the population in rural Iowa it is 3.2 percent.

There are issues in both states related to distribution and health profession shortage areas. In Nebraska, there is a concentration of entire counties considered health profession shortage areas, but much of the rest of the designation is partial counties. In Iowa, there are more entire county designations of profession shortage areas in primary care. In Nebraska, the programs started in 1990 and 1991 at The University of Nebraska Medical Center have been beneficial in supporting the needs of the health profession shortage areas. Iowa has initiated similar programs in the last couple of years. Because of the distribution of some of the modest size cities in Iowa; access to primary care is feasible given ground transportation and the location of the cities.

There is variation in the rural communities in Nebraska and Iowa and while there are unique differences there are some similarities. Both states do reasonably well regarding primary care service areas considering the variables of: aging, poverty, unemployment, uninsured, minority population, facilities and provider resources. The primary care service area is defined using the primary care provider as the core and the surrounding population that is served. The states are reasonably well served even though there are lingering problem areas.

The health care culture in the states of Nebraska and Iowa reflect a history of collaboration and quality improvement through a provider network and the development of integrated systems. Both states brought hospitals and providers together through network systems. The Iowa Healthcare Collaborative is an example of collaboration of the hospital association and medical association to finance a corporation in Des Moines whose focus is on quality improvement across both hospitals and physicians in the state. The Nebraska Flex Program and the Iowa Safety Net Provider Collaborative are also two important programs. The Nebraska Community

Action Program has a long history of collaboration across many of the community action agencies in the state.

The health care culture in Nebraska and Iowa includes networks developing a hub basis but not with an interest in owning various facilities but rather a model of affiliation and providing patient care in the rural community. Telemedicine assists in keeping patients in their community. It is important to be supportive of critical access hospitals and local primary care services and there is still a large independent provider presence in Iowa and Nebraska.

Q&A

David Hartley said that he wondered about the growth in number of federally qualified health centers recently among the rural health centers. There are some parts of the country where there are more likely RHCs and other parts where there are more likely to be FQHCs. There is some sort of culture factor that makes this happen. Is there a recent change that is making the FQHCs show up in these areas?

Keith Mueller said that there has been increased federal funding. The federal funding is spreading the presence of FQHCs and it is happening in Nebraska and Iowa. It is happening in a collaborative manner in these two states.

Shane Roberts asked how critical it is that hubs are on the same electronic health records system.

Keith Mueller said that it is a major advantage to be on the same electronic health record. In Iowa, the university is paying for the installation of the system. However, it is not a complete barrier to be on different systems because there are software packages that enable shared information.

Barbara Morrison asked how the health profession shortage areas are defined.

Keith Mueller said that it is a primary care provider per population ratio measure. First they look at the entire county to see if they meet the designation. Then there are ways that a part of a county can meet the ratio designation. The measure accessed is done through the primary care offices in each state.

HHS UPDATE: REFLECTIONS ON THE INITIAL ENROLLMENT PERIOD

Stephene Moore
Regional Director
Office of the Secretary, Region VII, US DHHS
Kansas City, MO

Stephene Moore thanked the Committee for inviting her to speak and shared that she resides in Kansas. She shared that she grew up in small town America, along the Mississippi River in Pike County, Illinois, with a population of 4,000 people. She stated that rural is dear to her heart and it

is important that the Committee, who has first-hand experience, provide recommendations to the Secretary of Health and Human Services.

Ms. Moore stated that a higher proportion of the non-elderly, rural population is uninsured in rural communities compared to their urban counterparts. Health reform is critically important to those individuals and the providers who care for them. Out-of-pocket costs and people not being able to afford care are deterrents to people getting services. People should be able to get affordable health care no matter where they live. Before the passage of the Affordable Care Act, the coverage of rural America was not a pretty picture. In 29 states, including most rural states, a single insurer dominated the market. This type of insurance market created a monopoly in which insurers could charge whatever they wanted and make their own rules.

Ms. Moore said that she would speak to the Committee about the progress of the Affordable Care Act after the 1st period of enrollment. Eight million Americans signed up for private insurance plans through the Marketplace during the first enrollment period. For states with federally facilitated marketplaces, 35% of those who signed up are under the age of 35 and 28% are between the age of 18 and 34 years of age. Three million individuals have enrolled in Medicaid coverage. Five million people also enrolled in plans that met Affordable Care Act standards outside of the Marketplace.

The numbers reflect dedicated hours of outreach, education and enrollment in rural communities. As Health and Human Services prepares for next year's enrollment cycle, the Committee's recommendations will help reach millions of uninsured Americans in rural communities who were not able to find coverage in the first enrollment period. The Committee has excellent timing in examining the topic of premiums and plans in the Marketplace. Health and Human Services needs to know what consumers are finding in terms of affordability, the level of coverage and type of insurance plans. The Committee's work will be highly appreciated.

The Congressional Budget Office previously estimated that the Affordable Care Act will reduce the deficit by 1.7 trillion dollars over two decades. It concluded that lower than expected Marketplace premiums will cut the deficit by 104 billion dollars in the next ten years.

The Affordable Care Act has changed the structure of insurance. There are more choices of health insurance plans, numerous consumer protections, greater transparency from insurance companies and a more standardized range of covered services. Small businesses have benefited through tax credits and they can enroll in a plan through the Small Business Health Options Program in the Marketplace.

With the influx of individuals who are newly insured, small rural hospitals and clinics are likely to see a reduction in bad debt which means health care providers will benefit from the law as well. For so long, people have been uninsured and underinsured for so they do not feel that coverage will ever be within their reach or are unaware of what options are available. Before the next enrollment period, more work should be done to better connect to the rural uninsured. The most effective strategies start with trust and must be community driven.

Region 7 of Health and Human Services covers Kansas, Missouri, Nebraska and Iowa. Iowa has extended Medicaid but Kansas, Missouri and Nebraska have not at this point. In Kansas, they are losing 1.4 million dollars per day from the federal government by not expanding. Missouri is losing 4.9 million per day which could be used to help insure people and allow physicians to bill for some of those services. Nebraska is losing 840 thousand dollars per day due to not expanding Medicaid.

There is an increased focus on reimbursement tied to quality of care and outcomes. The work towards improving the health insurance marketplace is ongoing and it is important to have feedback from rural stakeholders as well as the Committee's recommendations. With all of the changes in 2014 there needs to be a focus on what it means to rural America. There are always ways to work together to make sure that rural communities have access to high quality health care.

Q&A

Rene Cabral-Daniels said that Federally Qualified Health Centers in rural areas are facing an unintentional consequence related to assisting with outreach and enrollment. Virginia FQHCs participated in outreach and enrollment and health plans can tier the different type of providers. Some patients now have to pay a deductible at FQHCs when they did not before. The FQHCs assisted their patients in signing up for the qualified health plans and now they are losing patients because they have to pay a deductible at the FQHC.

Stephene Moore said that she would connect Rene Cabral-Daniels with the appropriate person to talk to about this issue.

Michele Juffer asked if there was an estimate of the cost it has taken to sign up the eight million individuals.

Stephene Moore said that they will be able to tally the amount of grants to the different states for the rollouts.

Aaron Fischbach
Policy Coordinator
Federal Office of Rural Health Policy, US DHHS
Rockville, MD

Aaron Fischbach shared the rural Affordable Care Act implementation challenges. The challenges include: lower population density, fewer health resources, less insurance coverage and state variability in Marketplace and Medicaid implementation. Some providers do not qualify as Essential Community Providers. Rural residents are more likely to qualify for Medicaid; however states with more rural areas are less likely to expand Medicaid.

Marketplace establishment included state-based, state partnership and federally-facilitated exchanges. Sixteen states and DC have established their own state-based exchanges and twenty

seven states have federally facilitated exchanges. Seven states are working in partnership with the federal government.

The Marketplace must have a process to ensure that each qualified health plan service area meets the minimum criteria. Qualified health plans must cover a minimum geographic area that is at least the entire county or a group of counties. They must be established without discriminatory factors, including those that exclude specific high utilizing, high cost or medically underserved populations.

Geographic rating areas must be based on the geographic boundaries of counties, three-digit zip codes and metropolitan statistical areas and non-MSAs. The Affordable Care Act requires that the only rating factors that can be used to vary premium rates are family size, geographic rating area, age and tobacco use.

Qualified Health Plans must include in their networks essential community providers that serve predominantly low income, medically underserved individuals. Qualified Health Plan issuers must have a sufficient number of geographic distributions of essential community providers, to ensure reasonable and timely access to a broad range of such providers. An issue for rural communities is that rural health centers are not considered essential community providers.

Qualified Health Plan issuers must ensure that a provider network of each of its plans includes essential community providers and maintains a network that is sufficient in number and types of providers. In the past plans were marketed to people in which networks established required enrollees to travel long distances to reach in-network providers.

The Affordable Care Act directs the Office of Personnel Management to contract with private insurers in each state to offer multi-state plans. Coverage will be available through the Marketplace. The multi-state program is modeled after the Federal Employee Health Benefits Program.

The Affordable Care Act directs the Secretary to establish a basic health program for family incomes between 133% and 200% of the federal poverty level. States may enter into contracts to provide standard health plan coverage to eligible individuals in lieu of offering them coverage through the Marketplace. States must ensure that the monthly premium and cost sharing amount does not exceed the monthly premium eligible individuals would have paid in the Marketplace.

There is no deadline for states to decide to expand Medicaid. Many states made the decision on the January 2014 start date in order to take advantage of the federal subsidy levels. There may be significant variation across states and overtime because each state can decide if and when to expand Medicaid.

Medicaid expansion is being implemented in twenty six states and DC in 2014. In twenty of the states not expanding Medicaid, eligibility levels for adults with children will remain below 100% if the federal poverty level. Maine and Wisconsin reduced Medicaid eligibility for adults. In states not expanding Medicaid, five million uninsured adults may fall into this coverage gap with limited affordable health coverage options.

Seven and a half million individuals enrolled through the Marketplace for insurance benefits. Three million enrolled in Medicaid and Children's Health Insurance Program. There are several research projects underway to analyze coverage and access issues.

ACA MARKETPLACE PLANS AND PREMIUMS: RESEARCHERS PANEL

Timothy D. McBride, PhD
Professor
Washington University in St. Louis Institute for Public Health
St. Louis, MO

Timothy McBride said that the RUPRI center has produced a large database on Marketplaces. The data base obtained data on all plans in the health insurance marketplaces (HIM) and linked to other data at the geographic level.

The Projected enrollment (October 2013 through April 2014) of total uninsured individuals covered through the Marketplace is 38.1%. States that chose to have a state-based Marketplace and accepted Medicaid expansion are projected to have the highest percentage of uninsured covered at 60.2%.

The Marketplace offers different metal levels of plans ranging from bronze, silver, gold and platinum. Premiums reflect the value of the plan and benefits offered. The bronze and silver plans have a much higher deductible. Urban areas are more likely to offer platinum plans than rural areas. A slightly higher proportion of rural plans are catastrophic or bronze.

The premium analysis preliminary findings suggest that premiums are higher in states with lower populations. Areas with higher premiums characterized by smaller populations also have shortages of health care providers and are more likely to be found in the Midwest. Premiums seem to be affected by rating area design.

To make proper comparisons across geographic areas it is important to compare similar types of plans (by metal level) and people who are the same age. It is important to understand the context of how the rating areas are set and adjust for cost of living. There has to be an understanding of the total costs that consumers face beyond just the premiums.

Preliminary results suggest that higher premiums may be an issue for rural residents under certain conditions. This may be an issue with states with federally-facilitated Marketplaces, in rural areas that have fewer providers per square mile of land, in sparsely populated states with lower overall populations and when rural areas are individual counties.

It is important to monitor these issues in the future to see how rural areas and people are affected. There may be future Medicaid expansion decisions and Marketplace changes forthcoming.

Keith Mueller, PhD
Director

RUPRI Center for Rural Health Policy Analysis
Des Moines, IA

Keith Mueller said that on a state-based exchange**,** there are 43 rating areas in states that are using the active purchaser model compared to 38 in states that are not using the active purchaser model. It is important to look at the differences being realized in the market relating to the variation of the state-based exchanges. What national policy making should be considered for setting what states are allowed to do and what the parameters should be when setting rating areas.

ACA MARKETPLACE PLANS AND PREMIUMS: INSURERS PANEL

Dave Lyons
Founding Director and Chief Executive Officer
CoOpportunity Health
West Des Moines, IA

Dave Lyons said he would give some information about what CoOpportunity Health experienced in Iowa related to the Affordable Care Act Marketplace enrollment and speak about some of the challenges.

A co-op is a consumer operated and oriented plan that is a 501C 29 plan authorized by the federal government through the Affordable Care Act. It is member owned and operated and the only co-op that is multistate which includes Iowa and Nebraska. They chose to be multistate for three reasons: the scale of the two states combined created a medium sized market, Western Iowa and Eastern Nebraska are essentially one medical market, and there was not an entity that was going to apply from Nebraska.

CoOpportunity Health built the plan on the existing health care infrastructure in Iowa and Nebraska and worked with Midlands Choice which is the largest noninsured owned network in Iowa and Nebraska. They also worked with HealthPartners which is the administrative medical management back office for CoOpportunity Health.

Affordable Care Act implementation changes how people buy healthcare, how health insurance companies design health care and how providers deliver health care. The process was not as smooth as planned but CoOpportunity Health enrolled over 74,000 in membership for the two states. This demonstrates that co-ops are able to have a market presence that is large enough to be economically and membership sustainable.

There are differences between the markets in Iowa and Nebraska. There was more enrollment growth early on in Nebraska than in Iowa. Iowa's Marketplace enrollment was poor. The take-up rate of subsidies is significantly below the national average and Iowa is in the bottom five in relationship to adequate utilization in the federal Marketplace.

The eligible number of Marketplace enrollees in the two states was similar. A reason there may have been differences in numbers of enrollees is because Iowa was more aggressive from a

regulatory perspective on allowing noncompliant plans and early renewal. The dominate carrier in Iowa is aggressive in relationship of maintenance of noncompliant plans. This did not happen in Nebraska.

Subsidy gaps can occur because of the second lowest priced silver plans. In Iowa there were narrow network approaches in the Marketplaces. A narrow network price was being quoted for subsidization verses in Nebraska where there was not as narrow network activity. A person could earn more in Nebraska and qualify for a subsidy than in Iowa.

Iowa did a modified implementation of Medicaid expansion. Between 1% and 100% of the federal poverty level goes into and expanded Iowa Medicaid program called the Iowa Health and Wellness Program. Between 101% and 138% of the federal poverty level goes into the Iowa Marketplace Choice Plan.

Some rural challenges are poor user support, lack of Navigators and the lack of technological support. Poor carrier outreach was an issue as well. Federal money was not allowed to be used on marketing and advertising and that caused limitations in communication. The dominate carrier in Iowa did not participate on the exchange and did not do outreach. The dominate carrier in Nebraska participated in advertising and provided vital information about the Exchange.

There is a limited care infrastructure, especially in rural communities. If people are signing up for health care coverage, there have to be new patient capacities in the communities. There is a lack of competition to drive innovation such as patient centered medical homes, value based reimbursement and shared savings programs. Poor governmental coordination is a problem and the political inability to needed changes is an issue.

Steve S. Martin
President and Chief Executive Officer
Blue Cross and Blue Shield of NE
Omaha, Nebraska

Steve Martin started by sharing that Blue Cross Blue Shield of Nebraska is a not-for-profit community benefit organization and mutual insurance company. They are an independent plan provider licensed to serve Nebraskans. For the last decade the average pricing has been 1% over cost.

There has not been a challenge providing coverage for all the counties in Nebraska. The more the communities work to keep margins low and keep costs down, the programs and discounts are lower. Blue Cross and Blue Shield offered a variety of plans with an emphasis on a wider selection of lower cost plans. They offered mostly bronze plans, but also silver and gold level products. The same plans were offered on the public and private Marketplace.

Prior to 1960, BCBS of NE was guarantee issue which means it is offered to people without them providing their health status. It was state legislatures who took away guarantee issue and moved to give a lower price for healthy people. That was a fallacy and BCBS of NE long advocated for return to guarantee issue. In the Children's Health Insurance Program pool in

Nebraska, 5,000 people have 70 million dollars in claims. Another 5,000-10,000 people could not afford the expense premiums even though the Children's Health Insurance Program pool was subsidized by 40 million dollars in premium tax; there were still expensive premiums because of the small pool. There were at least 10-15 thousand of those using subsidies who would enter the pool but the penalties would not be enough to attract young consumers for the first several years.

Blue Cross Blue Shield of Nebraska did not have difficulty with networks. It was not a problem to meet all of the Centers for Medicare & Medicaid Services standards for adequacy and access. BCBS of NE have a rural health advisory board that includes representation from rural hospitals as well as physicians and mental health providers to help guide decisions about access. The overall desire is to keep the broadest access possible in rural Nebraska but in most of the select networks that is not likely. There is only one major provider per rural community or region.

Blue Cross Blue Shield of Nebraska chose to participate in the Marketplace because they felt that their existing and potential customers would benefit from the subsidies. There are many members in small business and rural family farms that have the ability to get a health plan for their entire family. BSBC of NE found that they did not see 100% of these family members enrolled. As the Marketplace becomes more familiar in these communities, there should be more participation.

There were strong sales in Affordable Care Act plans on and off the Marketplace. There was a strong surge at the end of open enrollment. BCBS of NE offered 12 plans: 8 bronze plans, 2 silver plans, 1 gold plan and a catastrophic product. All of the plans incorporated the pediatric dental and vision features. They offered temporary insurance to people who missed open enrollment. The department of insurance authorized BCBS of NE to allow customers to keep their existing plan. 80% of the individual customers renewed. Nebraska plans to prohibit noncompliant plans. There will be a rate increase when transferring to a new, compliant plan but some people may benefit from the tax credits. Many of them will not benefit and will be the most vocal against it.

Insurance plan pricing in 2014 was a challenge. In some rural areas, there were more benefits offered than there was capable to be delivered. As an example, there is not a delivery system for the increased mental health benefits. Another factor is local ratings and rural pricing. Lower populations with higher prices can be dependent on the local delivery systems. Carriers have an impact on rural pricing in some instances, such as when there are competing carriers. In urban markets there is excess specialty care capacity than there is human need, so pricing is competitive. This is not the case in rural communities.

Q&A

John Cullen said the Committee was considering whether or not it would lower the cost of premiums if there were more insurance carriers in the marketplace in rural communities and if the premium costs truly reflect the medical care costs.

Steve Martin said that most likely no. The terms of Patient Protection and Affordable Care Act sustained and the guarantee issue and medical loss ratio would mean that most likely no. With

15% – 20% remaining for all administrative services, it will depend on what is qualified as a quality program that can move under claims and not administration. When there are multiple carriers and there is a delivery system like in urban markets, the prices and margins are higher. It depends on the marketplace and the contractual cost and the carrier cost. The medical loss ratio limits that variability going forward. What carriers will compete in is service to consumers. North Dakota has only one carrier for the market but it is one of the lowest rates in the United States.

Shane Roberts asked about dealing with the tribes and what the experience has been with their enrollment, with no cost sharing in the ACA up to 300% of the poverty level for people belonging to a federally recognized tribe. Have you seen a lot of people enrolling?

Steve Martin said not a lot but some brokers have reached out. The marketing team is brainstorming to find ways to provide support into the organization so there could be trusted Navigators inside the community to assist.

Dave Lyons said that the Latino-Hispanic sign up is lower than hoped. There must be a way to take a complex issue and make it more into the natural conversation for these cultural communities.

Shane Roberts said that would be a huge number of people who would benefit drastically.

RURAL HOMELESSNESS

Moderator: Jocelyn Richgels
Director for National Policy Programs
RUPRI
Washington, D.C.

Jocelyn Richgels thanked the Committee for visiting Nebraska and stated that she would look at rural homelessness from a human service stand point and also speak about the health impact including prevention, mental health and improving health care costs. The rural homeless are more likely to be doubled up with friends and family or living in vehicles, and there are more rural homeless families than in urban areas. The 2008 National Alliance to End Homelessness analysis suggests that almost 50% of the homeless population in mostly rural areas is made up of families with children. The rural homeless are more likely to be working, experiencing homelessness for the first time and less likely to get government assistance.

The rural homeless are more difficult to identify and count. People take shelter in abandoned cars, seasonal hunting cabins or trailers and are not visible to the general public. The lack of visibility makes it difficult to engage the community to take action or persuade government officials to invest public resources in affordable housing and services for the homeless.

There are fewer infrastructures to support the rural homeless. There is a lack of shelters and it is difficult for someone to access services if they do not have a home address. There is less data and

research to understand the characteristics and quantify the needs of the individuals experience homelessness.

Nearly 30% of rural, small family households are having major housing issues including affordability, quality or overcrowding. Over 370,000 rural households have 2 or more housing problems. Substandard homes are not as easily condemned in rural areas.

Pathways Vermont is a housing first program that has been adopted for the rural population. It is an evidence-based, rapid rehousing program and it uses a hybrid of community treatment and intensive case management. There are case managers with geographically based caseloads combined with intensive specialty services. The model is based on regional services where there is an emphasis on telehealth services. They have a housing retention rate of over 85% over the past 3 years.

Zebulon Beilke-McCallum
Housing and Economic Justice Coordinator
Iowa Coalition against Domestic Violence
Des Moines, Iowa

Zebulon Beilke-McCallum thanked the Committee and said that he would talk about the link between homelessness and domestic violence. Domestic violence is the leading cause of homelessness. It takes a family with two people making minimum wage to pay for minimal housing. It is impossible for a single parent making minimum wage to remain in a home. There is a lack of quality, affordable housing so some people are living in dilapidated trailers or cars. Rural survivors of domestic violence want live in a safe environment, free from abuse while remaining in their community. They rely on their community and do not want to transition to urban programs.

The Crisis Intervention and Advocacy Services serve the southwestern region of Iowa which is an expansive area. They provide counseling, assistance with protective orders, transitional housing and rapid rehousing. In 2013, they assisted 418 households in accessing emergency housing. They are on track to surpass those numbers this year. The people in this program are able to remain in their communities where they have a support network and attend work and school.

Much of the quality housing in Iowa is not affordable for many people so it takes work to find something in their budget. Most rural landlords do not advertise so it requires work to find housing and it is also important to be a tough negotiator. With the funding resources used to pay the renters, there are rules around habitability and standards. It is hard for advocates to say no to landlords because people are so desperate to get out of their situation but it is important to meet the standards.

Unconventional partnerships are important in rural communities. For people who need extra support, the community action agencies are helpful. Advocates have keys to apartments and when someone needs emergency assistance, they are able to do an intake and get them into an apartment. Rapid rehousing can be challenging but can also be very successful in rural

communities. There was a case of a woman and her children living in a barn and rapid rehousing was able to get her in a home within twenty four hours.

There is start-up resources available through Housing and Urban Development and can work in conjunction with victim service grants for supportive services. There is emergency shelter support funding for survivors of domestic violence. It would be helpful if that funding could also be used for rental assistance or non-construction home repair so they could remain in their homes when possible.

William Ming Liu, PhD
Professor
University of Iowa College of Education
President of the Board of Directors for Shelter House
Iowa City, IA

William Ming Liu shared that he is a professor of counseling psychology at the University of Iowa and the President of the Shelter House. The Shelter House is the transitional housing service in Iowa City. In 2011, the Shelter House collaborated with the National Alliance of Mental Illness of Johnson County on a project called the Lodge Project. Duncan Fairweather developed the model call the Fairweather Lodge in the 1960's. A grant allowed them to purchase a house and the house allowed them to begin training homeless men. Graduate students from the University Of Iowa College Of Education work with the men at lodge.

The Lodge provides a safe and healthy environment and gives the residence an opportunity to work towards independence. Some of the life skills taught include: cooking classes, exercise programs and courses on managing money. Working with peers allows the men to overcome barriers of homelessness, mental illness and to gain confidence. The program provides consumers as much autonomy as possible.

The Lodge is based on a training model and works with men who train in the house and later move to a permanent house. The ideal situation is that there is a training lodge with a live-in staff that is operated 24 hours. The permanent house is their house but is purchased by the shelter and the men work and pay rent to the shelter. In order to be eligible, they have to be diagnosed with two mental illnesses.

The Lodge started a janitorial business called Fresh Starts. They have overcome initial challenges and recently received a cleaning service contract with the University of Iowa Community Credit Union. Fresh Start also has other janitorial contracts in Iowa City.

The men have to be medication compliant and increase communication with one another as part of their training. They vote for each other to advance through 3 Tiers of training. When they reach tier 3, they move to the permanent house. They learn during training about each other's mental health problems so they are able to understand triggers and problems related to one another's mental illness.

The Lodge has been existence for three years and has overcome initial challenges by setting goals and tailoring programs to fit the needs of the participants. The program has become a successful model of what can work to address needs of the homeless in rural communities.

Mary Fraser Meints
Executive Director
Youth Emergency Services
Omaha, Nebraska

Mary Fraser Meints welcomed the Committee to Omaha. She stated that she will focus on youth homelessness. On any given night there are 300 young people living on the streets of Omaha. They couch surf, living under bridges and on the streets. Rural youth come to Omaha thinking they can get services but find themselves lost or overwhelmed. Youth Emergency Services go out 5 days a week to find the youth on the street and invite them to the emergency shelter. There is an emergency shelter to serve people who need immediate help and they have transitional housing and maternity housing.

Youth Emergency Services served over 1,000 young people last year. Homeless youth do not know how to access services. Many times they do not trust adults or medical professionals. There are many causes of youth homelessness including family problems, neglect and abuse. 50 percent of homeless youth say they were kicked out of their home or their parents knew they were leaving and did not care. Foster care youth are discharged from the state when they are 19 years old and do not have education, social support or income. 25 percent of teens are rejected by their families and end up homeless because of their sexual orientation.

The effects of being a homeless youth include: health issues, mental health issues, violence and substance abuse. Studies report that 75 percent of the homeless youth have dropped out of school or will drop out. One in four homeless youth have traded sex for food, shelter, clothing or other necessities.

It is difficult to know how many homeless youth there are because many times they do not tell people they are homeless. In Omaha, the Metro Area Continuum of Care for the Homeless developed a youth taskforce. The youth taskforce partners with human service providers to assist in identifying youth who do not have stable housing.

Intensive case management and supportive services has worked in the panhandle and the northeast area of Nebraska. Teaching the youth independent living skills and giving them financial education and job training is an important component to their success.

Q&A

Eugenia Cowan stated that she is from California. In California there is a new generation of poor people whose poverty is situational. They are completely unaccustomed to what it means to be without resources. Some of them are facing homelessness because of the weather conditions and impact on farming. Homelessness for them is not an issue of mental health, mental illness or about domestic violence. What do we do for this new generation of poor people?

Jocelyn Richgels said that is a great question and the next panel may be able to better respond to it.

Christy Whitney said the youth homelessness problem in Colorado is almost about a culture of teenagers that want to avoid rules and choose to go out on their own until they get into major problems that typically involve drugs. She asked if they had seen similar cases in Nebraska.

Mary Frazier Meints responded that they usually see the youth once they get into the trouble. They may encounter the same person at least seven times before that person decides to accept help. There are case managers as part of the street outreach program who works with them.

Roland Gardner asked if they are having more success with single family shelters or multifamily shelters.

Zebulon Beilke-McCallum responded that they see more success when getting families into single family shelters or homes. It is more successful when people have their own home and can parent their children and feel safe.

RURAL HOMELESSNESS FEDERAL PARTNERS REACTION PANEL

Moderator: Jocelyn Richgels
Director for National Policy Programs
RUPRI
Washington, D.C.

Jocelyn Richgels stated that the federal partners would respond to the panelists and share how the federal agencies are working together to combat homelessness, particularly in rural communities.

Alicia Sutton
Policy Advisor
Administration for Children and Families
Department of Health and Human Services
Washington, D.C.

Alicia Sutton shared that she would give some context on why there is the discussion of homelessness at a Health and Human Services meeting. Many people think that homelessness is only a HUD issue. Four years ago, the U.S. Interagency Council on Homelessness created the first strategic plan to end homelessness and there were a couple of priority communities. Ending chronic homelessness and veteran homelessness by 2015 are priorities. Administration for Children and Families has been very involved in the priority of ending family and youth homelessness by 2020.

Administration for Children and Families specific pieces are working with the youth programs for runaway and homeless youth. On the family side, something specific to rural is employment

issues and Assistance for Needy Families can be helpful for these families. There can be guidance through ACF around employment supports and what TANF can do in local communities.

Family Violence Preventative Service Act is part Administration for Children and Families and it is important to consider that there is a higher rate of domestic violence in rural communities. Early childhood development is essential and a huge issue for children who are in homeless families. Often homeless families are young mothers with young children. Head Start and Childcare are focusing on these families and how to support them.

Jennifer Ho
Senior Advisor to the Secretary
Department of Housing and Urban Development
Washington, D.C.

Jennifer Ho stated that while working in managed care for Blue Cross Blue Shield, she attended a meeting about chronic homelessness, the high healthcare costs and poor healthcare outcomes of people living on the streets. She became the executive director of a non-profit called Hearth Connection. Hearth Connection worked with the Minnesota Legislature on the human services financing of supportive housing for families who had a long history of homelessness.

Ms. Ho worked with communities ranging from the Iowa border to the Canadian border to understand what homelessness looks like in different regions. When funding became available for rural homelessness programs targeted at families and single adults, communities began to respond. There was a demonstration project in Blue Earth County. The case manager of the program gave a tour of where the homeless people had been living before they were housed. The tour included an out-building of a large farm place, a moldy basement of a house, a location along the railroad tracks where people were camping, and the inside an old oil drum.

Individuals in the healthcare system are troubled by the housing and instability of some of their sickest patients. There needs to be a successful affordable housing campaign in this country. Healthy development outcomes for children and housing stability are connected. In rural areas land is not an issue but there needs to be investment. When Congress hears from people other than Housing and Urban Development that there is a need for affordable housing, they are more likely to listen. The number one cause of homelessness is the lack of affordable housing.

Rapid rehousing is an effective tool in getting people back into housing but the long-term success is not known but is being studied. Families being helped by rapid rehousing are not coming back to shelters. Permanent support of housing and Housing First is working. With the right investments and permanent support of housing, chronic homelessness will end. It has to be targeted to the right people and delivered in the right way. Vermont Pathways to Housing Model is a successful example. There is a growing evidence base but it is important to find out what are the different subpopulations and what works best for whom.

Tracey Farrigan
Geographer

USDA Economic Research Service
Washington, D.C.

Tracey Farrigan thanked the Committee and stated that she would talk about research and data that connects closely to the issues being discussed at the meeting. One of Economic Research Service's primary roles is to conduct policy relevant research on rural household wellbeing. It is done from two different perspectives: working with local stakeholders and trying to identify trends and bring to focus what policies should be addressed in the future. Homelessness is in both of the categories. How to do preventative work by looking at trends in poverty in rural areas is a focus. Rural areas have a lag response when there is a recession and when there is recovery. During the recovery period, urban child poverty decreases but rural child poverty does not decrease. When there is another recession, rural child poverty continues to climb even at an increased rate.

The new homeless population is very different than in the past. There is more diversity among the poor and there are more Caucasians that in the past who are living in poverty. There are more people with educations who are living in poverty. The issue of doubling up and living with other family members or in groups is becoming more prevalent, especially in rural areas. There is a larger group of the population who are at risk of homelessness that has very different characteristics than those who are being assisted at this time.

Many agencies do not have researchers to analyze data and find ways to answer questions. That is a role that the Economic Research Service can be involved in and would like the Committee's guidance.

PUBLIC COMMENT

There was no public comment.

Tuesday, April 29th, 2014

Tuesday morning the subcommittees' depart for site visits as follows:

HUMAN SERVICES SUBCOMMITTEE
Northeast Nebraska Community Action Partnership, Inc.
Subcommittee members: Eugenia Cowan, Barbara Fabre, David Hartley and Barbara Morrison.
Staff Members: Steve Hirsch and Shoshana Shapiro.

HEALTH SUBCOMMITTEES
Nemaha County Hospital
Auburn, Nebraska
Subcommittee members: John Cullen, Roland Gardner, Michele Juffer, Karen Perdue, Shane Roberts and Christy Whitney.
Staff Members: Kristen Lee and Aaron Fischbach.

Myrtue Medical Center
Harlan, Iowa
Subcommittee members: Christina Campos, Rene Cabral-Daniels, Phyllis Fritsch, Karen Madden, Wayne Myers and Roger Wells.
Staff Members: Tom Morris and Shannon Wolfe.

The subcommittees' returned to Bozeman and attended break-out sessions for discussions.

PUBLIC COMMENT

Michael J. Huckabee, MPAS, PhD, PA-C
University of Nebraska Medical Center
Director and Professor
Division of Physician Assistant Education

Michael Huckabee said that he respects the work of the Committee and thanked them for visiting Omaha, Nebraska. He shared that he is a physician's assistant and has been in practice for over 30 years. He invited the Committee to attend and share information about a national conference on Advancing Rural Primary Care. The conference aims to bring together health care leaders, managers, academicians, researchers, policy makers, clinicians and students to promote optimal primary care in rural communities by utilizing a team-based care approach including physician assistants. The conference will be held September 11-12, 2014 in Omaha, Nebraska.

Wednesday, April 30th, 2014

The Meeting was convened by Governor Musgrove, Chairman of the Committee. Governor Musgrove asked the Committee to prioritize a list of concerns related to rural hospitals. As a Committee they can have an impact moving forward with uniform ideas related to rural hospitals.

ORHP/HHS Update
Tom Morris, M.P.A.
Associate Administrator
Federal Office of Rural Health Policy, US DHHS
Rockville, MD

Tom Morris stated that the White House Rural Council is in its third year and continues to be a forum that enhances collaboration inside Health and Human Services along with other federal programs. Health care is the main focus for the Council.

Rural hospital viability continues to be a key concern. Important aspects are: the variable national picture, identifying and promoting successful interventions and monitoring "at-risk" communities. These issues were highlighted two years ago by the Committee in Missouri and Kansas.

The President's Budget FY 2015 will include funding to modernize graduate medical education, expanding the National Health Service Corps and extending enhanced Medicaid primary care payments. Other provisions include funding a new Rural Physician Training Grant Program.

Emerging rural population health issues focus on: rural-urban life expectancy, rural-urban mortality and prescription drug and heroin abuse in rural communities. It has been proposed for the Committee to focus on rural life expectancy at the future meeting.

Healthcare finance emphasis includes 2014 Medicare payment update highlights, concerns over the hospital outpatient panel and direct supervision and the sustainable growth rate fix and payment extenders.

The Affordable Care Act coverage to care is an important role for navigators and assisters. The enrollment period is now closed and people with new health care coverage need guidance on how to find a provider, when and where to seek health services, and the importance of prevention related to health care.

OVERVIEW OF SUBCOMMITTEE SITE VISITS

HUMAN SERVICES SUBCOMMITTEE

Northeast Nebraska Community Action Partnership, Inc. Site Visit
Subcommittee members: Eugenia Cowan, Barbara Fabre, David Hartley and Barbara Morrison.
Staff Members: Steve Hirsch and Shoshana Shapiro.

Rural Homelessness – Youth Shelter
Key points discussed during site visit included:

- Employment barriers and barriers to services– youth do not have IDs or addresses when applying for jobs or services.
- Some clients are "shelter hoppers" and do not receive available supports or services.
- Funding supports housing but needs to be more flexible to include assistance with utility bills and other preventions.
- Youth experiencing domestic violence is an issue.

Possible Recommendations:

- Interagency Council on Homelessness – demonstration to break down silos and connect programs.
- Flexibility of benefit eligibility standards for homeless youth who do not have an address.
- Building evidence-based research around rural homelessness.
- Call for Secretary to convene prevention committee.
- Smart phone access for human service applications.

HEALTH SUBCOMMITTEES

Nemaha County Hospital Site Visit

Auburn, Nebraska
Subcommittee members: John Cullen, Roland Gardner, Michele Juffer, Karen Perdue, Shane Roberts and Christy Whitney.
Staff Members: Kristen Lee and Aaron Fischbach.

Myrtue Medical Center Site Visit
Harlan, Iowa
Subcommittee members: Christina Campos, Rene Cabral-Daniels, Phyllis Fritsch, Karen Madden, Wayne Myers and Roger Wells.
Staff Members: Tom Morris and Shannon Wolfe.

Affordable Care Act Market Place – Plans and Premiums
Key points discussed during site visit included:

- Navigators need to have relationships in the rural community and be trusted to successfully assist people.
- People did not understand insurance and were confused about the different plans- need more education and direction.
- Need more promotional efforts before next enrollment period.
- Most people chose the Bronze level plan because of the lower premium – only looked at pricing. Possibly choosing a plan without any local providers in network.
- Need additional information about network availability – easily visible to people signing up via the Marketplace.

Possible Recommendations:

- Navigators and assisters need more training before next enrollment period.
- Community organizations need to be allowed to collaborate, hold information sessions for residents and assist people in signing-up at the same location.

PUBLIC COMMENT
There was no public comment.