PRIMARY CARE ADVISORY COUNCIL (PCAC)
MINUTES
December 15, 2015
8:30 a.m.

COUNCIL MEMBERS PRESENT:
Carson City:
Nancy Hook
Betsy Aiello

Elko:
Gerald Ackerman

Las Vegas:
Dr. Amir Qureshi, Chairperson
Susan VanBeuge

COUNCIL MEMBERS EXCUSED:
Chuck Duarte

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH STAFF PRESENT:
Laura Hale, Manager, Primary Care Office (PCO)
Scott Jones, Health Resources Analyst, PCO

OTHERS:
Blayne Osborn
Connie Berry
Linda Anderson

Dr. Qureshi called the meeting to order at 8:43 a.m.

1. Roll call and confirmation of quorum.
L. Hale read the roll call and stated there was a quorum present.

2. Approval of the minutes from the September 17, 2015 meeting of the PCAC.

Motion: Dr. Susan VanBeuge
Second: Gerald Ackerman
Motion passed unanimously

3. Recommendation to the Administrator regarding J-1 Physician Visa Waiver Letter of Support for Dr. Amr Mohsen

S. Jones presented information from the J-1 candidate application for Dr. Amr Mohsen.

Dr. Qureshi verified with S. Jones that both proposed medical facilities were underserved. S. Jones confirmed.

L. Hale advised that Dr. Mohsen was now on the phone.

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Dr. Qureshi confirmed scope of practice as a general and interventional cardiologist with Dr. Mohsen on the phone.

Dr. Qureshi opened floor for motion. Dr. VanBeuge motioned to support application.

Motion: Dr. Susan VanBeuge
Second: Betsy Aiello
Motion passed unanimously

4. Recommendation to the Administrator on attestation of the service for Dr. Nadeer Pirani regarding completion of his J-1 Physician Visa Waiver Obligation

S. Jones reviewed handout with Council attendees.

Dr. Qureshi asked where the current practice site for Dr. Pirani is located. S. Jones advised Las Vegas Radiology since September 2013.

Dr. Qureshi asked if Las Vegas Radiology is a designated Primary Care HPSA Site. S. Jones confirmed it is a HPSA Site.

L. Hale informed Council that Dr. Pirani was on the phone.

B. Aiello asked what the Vancouver BC site is. S. Jones advised that Dr. Pirani has been flying to Canada to obtain his required hours in his home country due to his unknown J-1 status.

Dr. Qureshi asked Dr. Pirani the purpose of his travel to Canada. Dr. Pirani stated that he was under H1B status and unsure of the status of his J-1 Visa status so his attorney advised him to attempt to fulfill some hours in his home country. Dr. Pirani was traveling to Canada every other weekend for the last two years to take call and satisfy his home country requirements.

Dr. Qureshi asked Dr. Pirani if he has fulfilled his two-year return to home requirement. Dr. Pirani did not think he had but thought he was close to that goal. He has always wanted to fulfill his commitment in Nevada and has worked here steadily since 2012, except some time off when his son was born.

Dr. Qureshi stated he believed Dr. Pirani has met the requirements and fulfilled his obligation of the J-1 Physician Visa Waiver Contract. L. Hale agreed with that assessment.

Dr. Van Beuge thanked Dr. Pirani for his service. He noted his support from other J-1 physicians and the value of practicing in an underserved area. He intends to continue serving in an underserved area.

G. Ackerman motioned to approve attestation of service for Dr. Pirani regarding completion of his J-1 Physician Visa Waiver Obligation.

Motion: Gerald Ackerman
Second: Dr. Susan VanBeuge
Motion passed unanimously

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5. Review and consider approval of recommendations for the Nevada Conrad 30/J-1 Physician Visa Waiver Program.

S. Jones reviewed handout of proposed changes to the J-1 Physician Visa Waiver Program.

L. Hale introduced Connie Berry and gave an overview of her credentials as the former PCO Manager for Texas, which has a very successful J-1 Program. The NV PCO contracted with Ms. Berry to review specific policies and procedures and to make general recommendations to improve recruitment and retention under the J-1 program. C. Berry spoke to her experience with the J-1 Program in Texas, which has tracked waivers by state for the last 15 years, reflecting how the program has evolved to include flex slots and subspecialty providers. A Yahoo group was set up among state program administrators to share best practices. Every state can set up the program in a way that best meets their specific needs.

The interface with Department of State and US Citizenship and Immigration Services is somewhat unique for state health departments. Most J-1 physicians work closely with immigration attorneys to guide them through the process.

C. Berry asked what the intent of the waiver program should be; to focus on how many waiver applications the state receives and how many the state can recommend or more narrowly focus on specific shortage or underserved areas. In Texas, there were so many shortage areas, their focus was to recommend as many waivers as they could. They don't use subjectivity or an advisory committee; they don't look at percentage of underserved because providers are already in a shortage area. They must demonstrate enrollment for Medicare and Medicaid, but no percentage data is required. States can make independent decisions regarding goals. States smaller than NV recommend 30 waivers; some larger recommend 5 or fewer waivers – there is no set requirement.

L. Hale stated there has never been any intent to constrain the application numbers in Nevada and we would like to try to recruit more. We have been trying to figure out how to recruit more and how to repair our reputation and let J-1 physicians know it's a welcoming place to come.

Dr. Qureshi asked C. Berry if any of the big states like Texas ask the federal government why only 30 slots are allowed per state. Why not base it on population?

C. Berry said the history is that Senator Conrad who authored the legislation wanted to be sure that the smaller states had the opportunity to get applications as well. He thought if applicants had the opportunity to go to the bigger states they would.

Dr. Qureshi noted that originally, there were only two agencies doing the J-1 waivers, US Department of Agriculture (USDA) and Housing and Urban Development (HUD). HUD pulled out of the program then USDA pulled out, but when they were running the waiver program there was no limit on applications. The Conrad program was intended to buffer whatever was not fulfilled through USDA and HUD.

C. Berry added that Texas had 230 waivers through USDA and was not compelled to use the Conrad program for a much lower number. But when USDA pulled out, Texas had a major interest in getting a waiver program up and running. That was when the program went from 20 to 30 applications. The advocacy groups have talked about getting the number increased or a way to redistribute the unused slots to other states.

C. Berry confirmed that all 30 slots are still being filled in Texas on the first day of the program year. Dr. Qureshi stated that in the 90's Nevada had all the slots full, then things changed. After 9/11 foreign physician entry was somewhat limited which is part of the reason for a decline in applications. Also filling applications for the small states was harder because everyone wanted to go to the big states. When he

was looking, he looked at the big states as he thought there was more opportunity instead of looking at the opportunity in the small states.

C. Berry noted that attorneys say physicians will look at the states they know they can get a waiver in before looking at other states. They don't want to go through an intensive application process and be rejected three months later. New Mexico is an example of a small state that fills all of their slots.

Dr. Van Beuge suggested there is a general challenge for recruitment to Nevada, which they also see in academia.

C. Berry noted that Nevada has a higher percentage of international medical graduates (IMGs) in practice than the national average. She suggested using the Nevada Medical Association to create a focus group to help with recruitment. Success breeds success and the IMGs living in Nevada can help recruit through word of mouth. Comprehensive provider networks have evolved in Texas communities over time.

L. Hale asked S. Jones to go through recommendations on the handout one by one.

S. Jones reviewed recommendations, beginning with item #8 requiring additional documentation for specialists:

- Add hospitalists, and note their regular participation in Nevada's program.
  - B. Aiello, Dr. Qureshi and Dr. VanBeuge agreed with this recommendation.
- Clarify that documentation for physician to patient ratio is for the facility where the candidate will work.
  - Dr. VanBeuge and N. Hook supported this; B. Aiello asked about whether an overall goal should be defined and if there is a concern that the requirements are a barrier to recruitment. Dr. Van Beuge likes the data to support the application; Dr. Qureshi thinks the data request is not a deterrent.
  - C. Berry suggested data collection about the practice is reasonable, but if the physician or applicant is unsure if there is a cutoff point, that could be a challenge. If the data are used as a basis for rejecting an application or reflect hidden criteria, it gets a little fuzzy.
  - L. Hale referenced the chart showing trends for Medicaid coverage from past J-1 applications to Nevada. There are no set parameters, but the data is made public through the meetings of the Primary Care Advisory Council. Transparency regarding how the data are used is important.
  - Dr. VanBeuge agreed with clarification that there is no cutoff, but the data is there to support the need for the participant.
  - L. Hale referenced the subjectivity of individual applications where a specialist may be needed in a frontier community, even though the particular practice site might only serve a small percentage of Medicaid patients.
  - B. Aiello supports data collection, but wants to be clear about how it is utilized. We shouldn't create barriers given the degree of provider shortages in Nevada.
  - C. Berry noted that hospital-based providers don't control who their patients are because they serve whoever is admitted to the hospital. Also, there may be a huge need for providers in rural and metropolitan areas where the payer mix will be different.
  - S. Jones offered to draft language that we would only question the data if zero percent Medicaid is reflected in the application; otherwise, it is informational only.
  - C. Berry referenced requirements under the National Health Service Corps to accept Medicaid and Medicare, but they allow exceptions, such as state prison sites where they are not eligible for Medicaid. L. Hale referenced other exceptions for sites that don't serve children or seniors, and therefore don't accept NV Check-Up or Medicare.

- Dr. Qureshi suggested replacing the data request with an attestation that they serve Medicaid and Medicare, and ask for an explanation if they don't.
- Dr. VanBeuge still would like to see data; Dr. Qureshi suggested getting data from hospitals but maybe not from clinics; Dr. VanBeuge referenced what is applicable to a particular practice.
- N. Hook was concerned that we would miss the mark of serving the underserved population with 1 FTE provider, if we don't have the data to support it.
- C. Berry thought it made sense that states with expanded Medicaid coverage would ask what percentage of Medicaid is being served, but make it clear that it is for a profile of the practice rather than criteria for approval.
- N. Hook suggested that while you can't set specific parameters on an area with a low Medicaid population, there needs to be a point at which you really aren't serving the underserved.
- L. Hale noted that the PCO has received comments from applicants about the time it requires to collect the data, particularly with third-party contractors who don't control the environment. S. Jones also noted a problem with ambiguous requirements related to this data, suggesting that clarification regarding percentages and rules for justification would be helpful.
- N. Hook suggested that collecting data for payer-mix at practice locations should not be a hassle; they should be able to run a report for third-party payers through a simple query.
- Dr. Qureshi added that his practice can run those reports, and agreed with S. Jones that data should only be required for the facility where the physician will be working; data for multiple locations under a third-party contractor doesn't make sense.
- B. Aiello cited data from the current application from Dr. Mohsen, showing 6% Medicaid, 1% sliding fee scale and 0% charity care, and 48% Medicare. Having more providers in service helps relieve the caseload for other providers who take low-income charity care, although this particular application may not serve a high percentage of charity care.
- C. Berry and L. Hale noted that the high Medicare numbers balance out the application.
- L. Hale offered to work with S. Jones to draft language that would provide transparency for applicants and clarify how the overall payer-mix data is considered for the purpose of serving underserved populations. She asked Council members to also review this before the next meeting.
- G. Ackerman suggesting developing different criteria for hospital-based versus community-based practice; in Nevada the hospital numbers will be very high.

Dr. Qureshi asked to continue discussion on this issue at a later session.

6. Update on program, staff, grants and regulations

L. Hale notified council that a new Management Analyst I would be starting on January 4th, 2016. There was another manager position approved but an issue with state personnel still needs to be addressed. We are in the second year of the five-year PCO competitive grant. There is a J-1 regulation workshop coming up as well as a review of regulations for the Certificate of Need Grant.

7. Public Comment

None.

The meeting adjourned at 9:55 a.m.

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