Delivery System and Payment Alignment Workgroup
Meeting Notes – from primary note taker

Date:	***June 3, 2015***	**Location:**	*4150 Technology Way* *Room 303* *Carson City, NV*
Time:	*10:00 am – 12:00 pm (PT)*	**Call-In #:**	*(888) 363-4735*
Facilitator:	*Jerry Dubberly*	**PIN Code:**	*1329143*

Purpose: Meeting to identify areas of focused improvement in the Nevada health care delivery and payment system.

After introductions Jerry Dubberly gave a presentation providing clarification on the State Innovation Model (SIM) objectives and Nevada's proposed goals (to date) for the State Health System Innovation Plan (SHSIP). Components from Connecticut's SIM Design were provided as examples to illustrate how their plan communicated Connecticut's aims and the related primary and secondary drivers affecting those aims, as well as actions steps necessary for to achieve their aims. The purpose in providing these examples was to ensure the workgroup understands how their contributions will impact the design of Nevada's Population Health plan and SHSIP.

Mr. Dubberly reviewed the topics discussed in the other Task forces and Workgroups. A separate document listing these topics was provided to the Tasks Forces and Workgroups.

Mr. Dubberly explained that the group needs to start thinking of solutions - the "to be" environment. For example, 'is the increase/presence/penetration of PCMHs to be included in the plan and defining their future role in the Nevada health care delivery system?'

Brenda Staffan stated in their experience in navigating 911. Often the calls are not an emergency situation and could be handled outside the emergency response system. Having a PCMH is critical to getting patients the care they need and being treated in the most appropriate setting. Patients with Substance Abuse (SA) and Mental Health (MH) crises are calling 911 frequently. Nevada needs to develop a mechanism to refer these individuals to the appropriate place to receive their behavioral health and primary care services.

Bethany Sexton said they find value in the PCMH philosophy and approach to care. They view adoption of the PCMH approach as more valuable than the certification. Certification indicates the pieces are in place but not that the practice is actually practicing that way.

Jerry Reeves has been involved with a PCMH/network of PCMHs for 4+ years. They are finding that most critical is not certification but engagement by the physician and the patient to activate and be fully engaged in their parts of the equation (appointments, meds, etc.). They have used incentives and monitored care plans that are mutually agreed to by the patient and the doctor. Health coaches have been helpful in closing care gaps. Improvements in health and patient engagement need to be aligned with incentives and consequences such that the patient has 'skin the game' and participates in self-management of their care. The formation of engaged care teams has helped ensure that proper care is provided and outcomes achieved. The attribution and assignment of a patient to a PCMH was suggested and referred to as a 'pick and stick' approach. Pick and stick is where patients pick a caregiver and stick with them for a minimum period of time before being allowed to switch providers.

The need to make sure payers are building a benefit plan that rewards compliance and has member consequences for not following through was also discussed. There was acknowledgement that this is difficult in the Medicaid and CHIP populations.

Chuck Duarte said one size does not fit all for patient engagement. We must look at different approaches and discern what works best for each population. Engagement should reach them at the easiest point of contact. The approach should include community health workers between primary care visits where appropriate to further assist with patient engagement among other positive benefits.

Mr. Dubberly indicated the group needs to determine "what is our goal?" What % of Nevada should be connected to PCMHs by a certain date? What is goal and how will we measure success must be determined by the group.

Jerry Reeves recommended a 10% increase in patient population engaged in PCMH within a defined time period, and of those engaged a 50% improvement of patient control of chronic conditions.

The question was asked 'what is baseline % of individuals statewide currently engaged in PCMHs?' The group believed there are between 60 – 111 locations, but the number of patients or percent of the population connected to those PCMHs was not known by the group.

There is a difference between PCMH and Health Homes. Health homes work with individuals with chronic conditions where PCMHs may work with individuals with or without chronic conditions. We need to ensure the terminology is being used consistently and appropriately. Chuck Duarte expressed that health home is expanded to include LTC support services and includes individuals with behavioral health diagnoses. A provider can be both a PCMH and a health home.

There was a brief discussion regarding behavioral health and physical health integrations. Co-location is great but it is much better to truly integrate care in a practice. Chuck Duarte mentioned they are opening chronic are center in August that is integrating BH services, and SAMHSA and CMS have come out with a definition for Community Mental Health Homes.

The Regional Extension Center (REC) has worked with 700 practices (and continues to work with practices) in the state to drive meaningful use and improve work flow. Nevada is not starting from ground zero. Health plans in NV are supporting the development and implementation of PCMHs. The certification standards and incentive payments help drive action.

The topic of mobile clinics and reimbursement was brought up. According to one participant, mobile clinic reimbursement issues exist. The issue raised that payers do not always recognize/enroll the mobile clinics as providers. It was suggested that the FQHCs discuss their experience. The FQHC representative stated there is a semi-mobile clinic stationed at a high school. It is a recognized site and reimbursed like stationary provider. Mobile dental services are reimbursed the same way. There was some concern raised about mobile clinics (especially for dental care) and the follow up care that may be needed after the mobile clinic has left.

During the review of the current payer status in Nevada, it was found that there are reportedly 4 ACOs in Nevada. However, it was questioned if they are all operational due to trouble reaching the organizations at their registered phone numbers. The question was asked if the NV SIM project should include a strategy to expand ACOs in the state.

Bethany Sexton stated her organization has been a Medicare ACO and has expanded to other insurer populations as well. They currently have about 35,000 lives and are geographically centralized in Washoe and some adjoining counties. The start-up work to establish an ACO and get it running is very challenging. A start-up ACO needs assistance in establishing proper workflow and other technical assistance. It takes a long time to reach the desired results. It would be great to have a payment methodology structure that supports ACOs, recognizes the start-up costs, and drive towards mutually established goals and performance.

Jerry Reeves stated that it takes a 20% profit margin for 3 years to cover the investment of a start-up ACO before seeing savings and a return. It was also acknowledged that allocation and attribution models for knowing the patient population are problematic. In an ACO, many doctors do not know who their patients are, and patients do not know they are in an ACO.

The importance of data in an ACO model was also discussed. The challenge early on in receiving data from Medicare to manage patients in the Pioneer ACO model was offered as an example.

The discussion turned to using EHRs for clinical and administrative decision-making. Claims data is critical in driving results. Process flows and decision making components need to be considered when integrating the EHRs into this process. Providers need a resource for protocols and best practices that are agreed to across payers. The cost of connecting and EMR to practice software can be expensive. One participant cited a cost of $18K to develop an interface to push data out of their EHR.

The group discussed the topic of bundled payments. Dr. Wadhwa suggested that we look at what other states are doing. Ohio, Arkansas, and Tennessee are three states that have bundled payment initiatives. Nationwide, over 6,000 providers are reportedly enrolled in bundled payment initiatives. A caution was offered that we need to be sure we have data on what baseline costs are and what will be included in a bundled payment program. The FQHCs have some experience with bundled payments and are interested in this approach. There was a brief discussion regarding the ability of payers to develop bundled payments with similar criteria and reimbursement without violating anti-trust provisions[i]. This is being referred to the policy and regulatory taskforce.

The question was asked if the scope of SIM is just on Medicaid or statewide? The participants were reminded that the initiative is statewide and is to include multiple payers.

One participant suggested creating an inventory of payment reforms implemented or attempted by various payers. While others were supportive of this suggestion, there was a concern that we may not be able to get payers to share their information. It was decided that a survey should be created, and Jerry Reeves will help design the survey.

The need to have a team-based approach to health care – especially for the seriously ill or homebound patients - was discussed. Telemedicine and home monitoring are options to consider in supplementing the team approach. Another option to consider in managing and coordinating chronic conditions is to enable pharmacists to delivery chronic care monitoring and interventions with those patients within their scope of practice. This circled back to a previous discussion encouraging that health care professionals practice at the top of their scope of practice and payers recognize and reimburse for those services.

[i] Refer issue to the policy and regulatory taskforce.