SIM Workgroup Meeting
Delivery System and Payment Alignment
July 27, 2015 Meeting Notes

Date:	July 27, 2015	**Location:**	4150 Technology Way, Carson City, NV
Time:	10:00am – 12:00pm (PDT)	**Call-In #:**	1-888-363-4735
Facilitator:	Catherine Snider	**PIN Code:**	1329143

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

Deb Sisco opened the meeting with introductions.

- Catherine Snider provided a diagram to remind the audience of the SIM project including CMS triple aim, NV aim, and target areas for specific focus. The audience was reminded that SIM is a multipayer initiative and which payers have committed to the SIM project.
- The Population Health Measurement Strategy and its alignment with national quality steward measures, implementing a VBP approach, building strong HIT and Data strategy to address the population health improvement effort were reviewed.
- The keys to successful delivery system reform presented enabling coordination and support; enhancing data infrastructure and quality measurements, developing financing and payment incentives. These were discussed across the State, community, payer, and provider domains.
- The concept of a Multi-Payer Collaborative (MPC) was introduced. The goals of the MPC were discussed in further detail. The MPC as a framework within which some degree of payer flexibility is maintained was discussed. There is a strong need to ensure administrative simplification is maintained to the extent possible.
- A review of the PCMH and Health Home components were discussed –highlighting the differences between the two.
- A discussion of the goal of 80% of Nevadans connected with PCMH by December 31, 2019 and the validity or ability to achieve this. This goal was seen as unrealistic. SB6 identified PCMHs as having national certification. Chuck Duarte mentioned the need to recognize that some practices operate as PCMHs but have not pursued and may not pursue certification.
- Components of a PCMH program from Arkansas, Colorado, and Washington were presented. All three states were multipayer efforts. Minimum patient thresholds, payments/incentives, as well as a downside in Washington.
- Ms. Snider offered a Nevada PCMH approach draft for the workgroup's feedback. This included a requirement to achieve NCQA accreditations, multipayer approach using a FFS component with a care coordination payment and an incentive payment. The draft proposed an adjustment according to the PCMH level. The feedback from the Executive Committee focusing on a youth-focused VBP approach was presented. The Washington approach of an additional payment to help support infrastructure development was pointed out. The group was about an add-on PMPM vs lump one-time payment without feedback.

- The PCMH approach was questioned as to its applicability to the PEBP population within a HDHP/HAS environment. There appears to be a misalignment of incentives.
- Medicaid has very limited patient copayments. And that was discussed as limiting the ability to drive patient behavior.
- Chuck Duarte believes that an infrastructure payment would be helpful to incentivize participation. HRSA uses both lump sum as well as PMPM. There is no recoup if you do not meet the certification.
- Brenda from REMSA stated they have various levels of certification and they find the NCQA cost is too high to make it interesting for them to pursue. Their accreditation with NCQA is not as PCMH, but does demonstrate the barrier NCQA costs can present.
- Brenda desired a definition of care coordination (what's included/what's excluded). VBP principle important to them is if they assume risk, they need to have control.
- Ms. Snider reviewed the components of health homes under the ACA.
- Chuck Duarte said they are opening a center for complex care next month. Risk-stratified patients and moving patients with uncontrolled chronic conditions and behavioral health. The goal is to lower their acuity level and move them back to primary care.
- Medicare coordination with Health Homes has been problematic. It was mentioned that CMS' Technical assistance team has offered help with this issue, but nationwide there has not been a lot of improvement in Medicare/Medicaid coordination in the health home program.
- A concern was mentioned regarding panel size of patients attributed to a provider for purposes of VBP. Ms. Snider mentioned the concept of virtual practice groups working together in a VBP model. Chuck Duarte mentioned that the size probably depends on the patient population you are going after through the health home.
- SAMHSA representative brought up the opportunity to build suicide prevention into the model using the health home model.
- A question was asked regarding whether providers not recognized as PCMHs but practicing in that way or working to achieve that recognition would be included in the PCMH and payment program. Ms. Prentice said there is a natural step to have a track to incentivize achieving the PCMH model if not recognition.
- The discussion moved to VBP including PCMH reimbursement, health home payments, bundled/episode payments, etc.
- A VBP model structure was presented using the MPC creating a standard VBP approach for all payers with some flexibility by payer. This would also include a common set of performance standards would be deployed as well.
- Ms. Snider presented a potential model for phasing in VBP. This model starts with process/participation measures and progressing to quality reporting capacity and compliance (pay for reporting), and then to pay for performance based on outcomes. Past that, payments could move to shared savings and ultimately to a shared loss model.
- There was a question as to whether only payers would be on the MPC or if providers would be involved. There was a discussion that it was envisioned that payers would lead and providers

would be a subgroup that would report back to the MPC and provide input/feedback regarding decisions that are to be made.

- Integrated behavioral health and physical health needs to be part of payer discussion regarding the payment models today that do not support truly integrated care. SIM was encouraged to work with the state regarding the CCBHC grant application and opportunities to further integrated care.
- A review of the HIT Plan that must be part of the SHSIP was discussed.