# Nevada
# State Innovation Model (SIM)

Joint Meeting

All Task Forces and Work Groups

June 24, 2015

Nevada Department of Health and Human Services
Division of Health Care Financing and Policy

# Meeting Purpose

- To provide back to the stakeholders for validation, the relevant themes that have emerged from this project thus far;
- To affirm or redefine the primary drivers identified to promote transformation;
- To hear from stakeholders regarding the completeness and appropriateness of the inventory of problems and solutions; and
- To develop a clear and focused agenda and assignment for each workgroup and taskforce for the upcoming July and August meetings.

# Background

## CMS Triple Aim

- Improved Health Outcomes
- Lower Cost
- Improved Patient Experience

## Nevada Aim

- Improve Nevada's Health Status Ranking From 39th to 34th by 2019 While Maintaining Expenditures <= 2% of GSP

## Target Areas

- Obesity
- Smoking Cessation
- Diabetes
- Behavioral and Mental Health
- Heart Disease/ Stroke

**DRIVER DIAGRAM CONNECTS AIMS TO TARGET AREAS**

# Primary Drivers

Improve Health Ranking From 39th to 34th While Controlling Costs

- **Improve Access to Care**
- **Redesign Delivery System**
- **Foster and Develop Health Information Technology and Data Infrastructure Development and Adoption**
- **Improve Patient Experience**

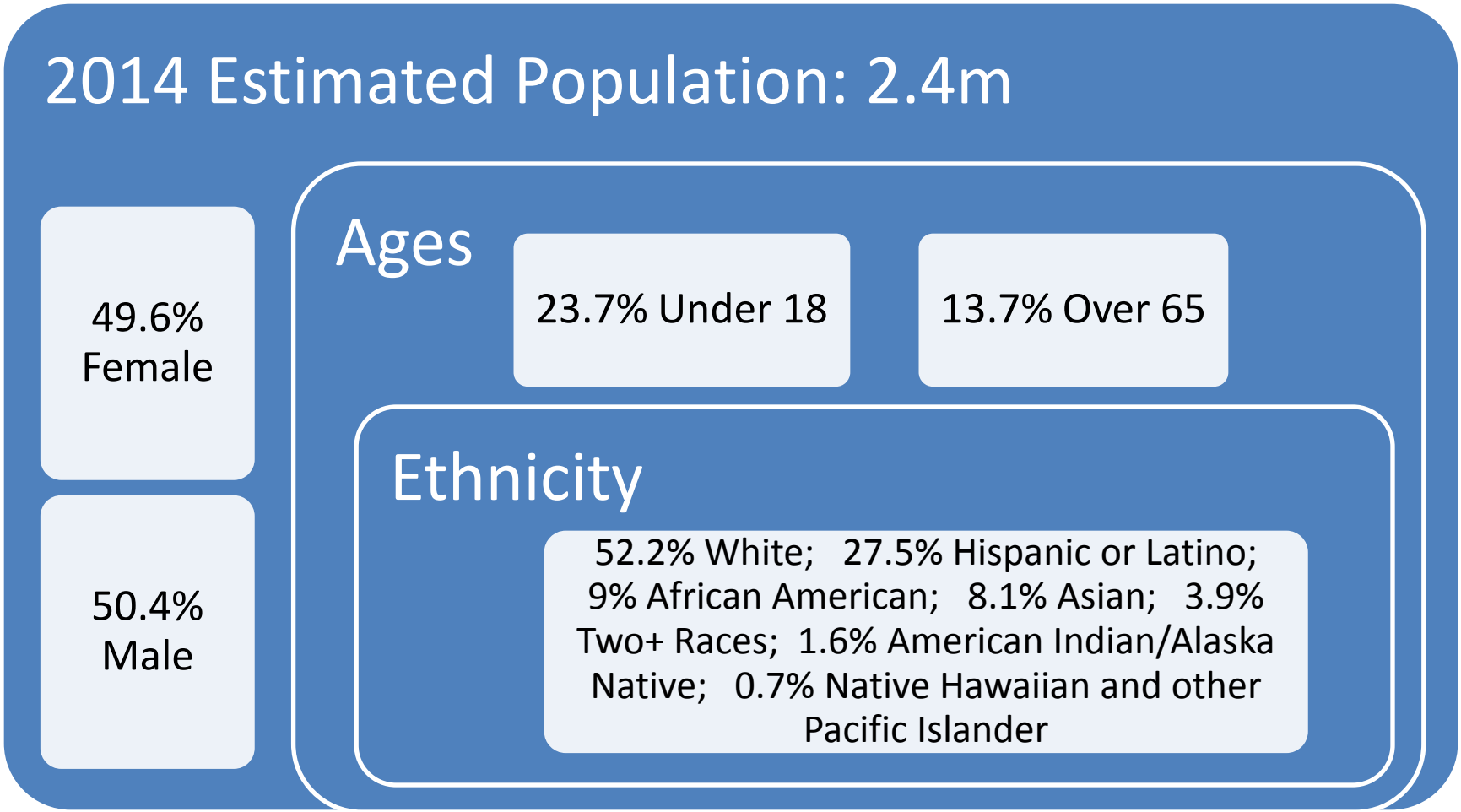
# Payer System Collaboration

- Medicaid/CHIP
- Public Employees Health Benefit Program
- Indian Health Services
- Culinary Health Fund

**Approx. 25% of the State's Population**

- Other Payers (Phase In Over Time)

# State Population Demographics




*Source: Quickfacts.census.gov*

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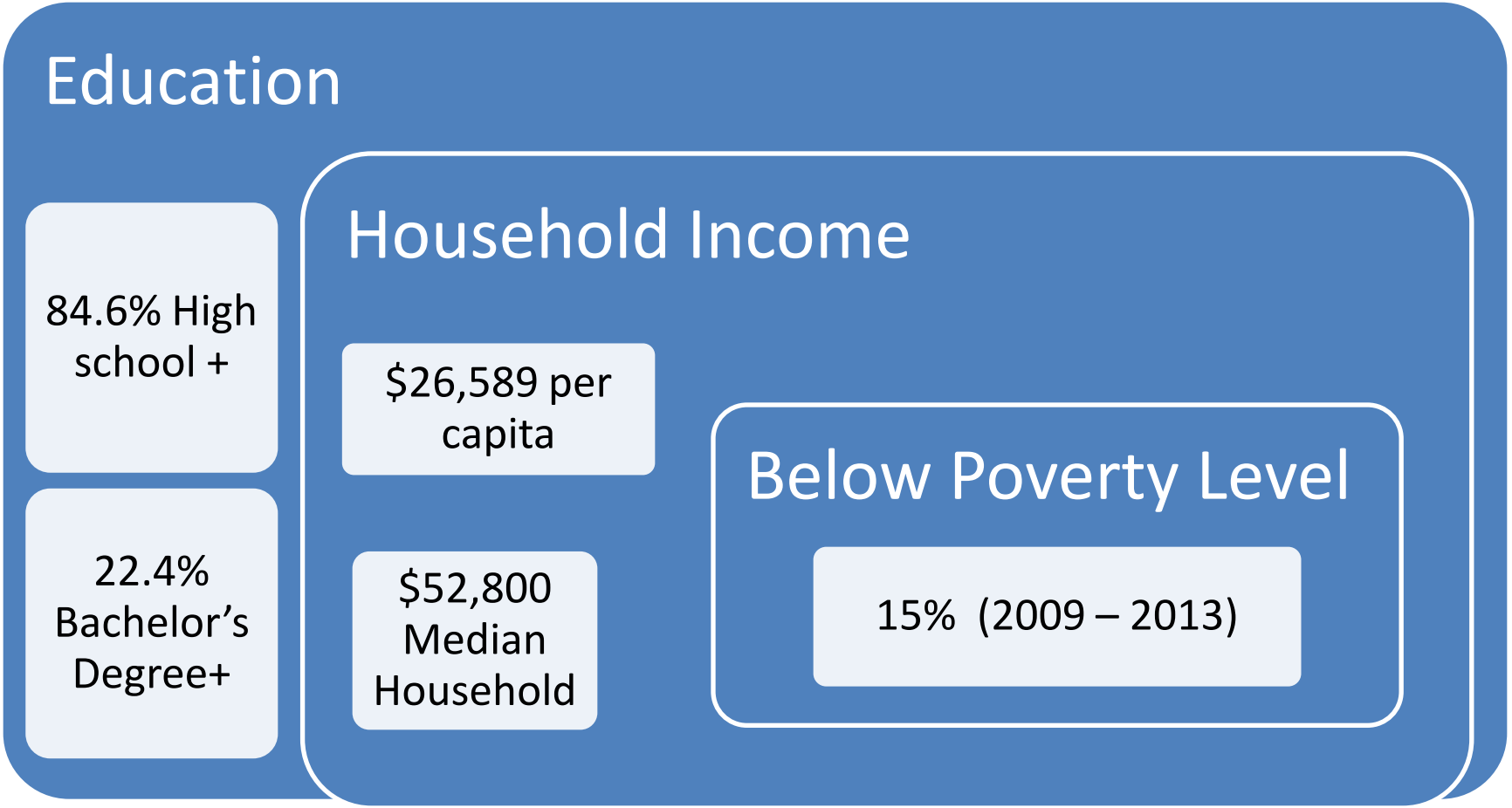


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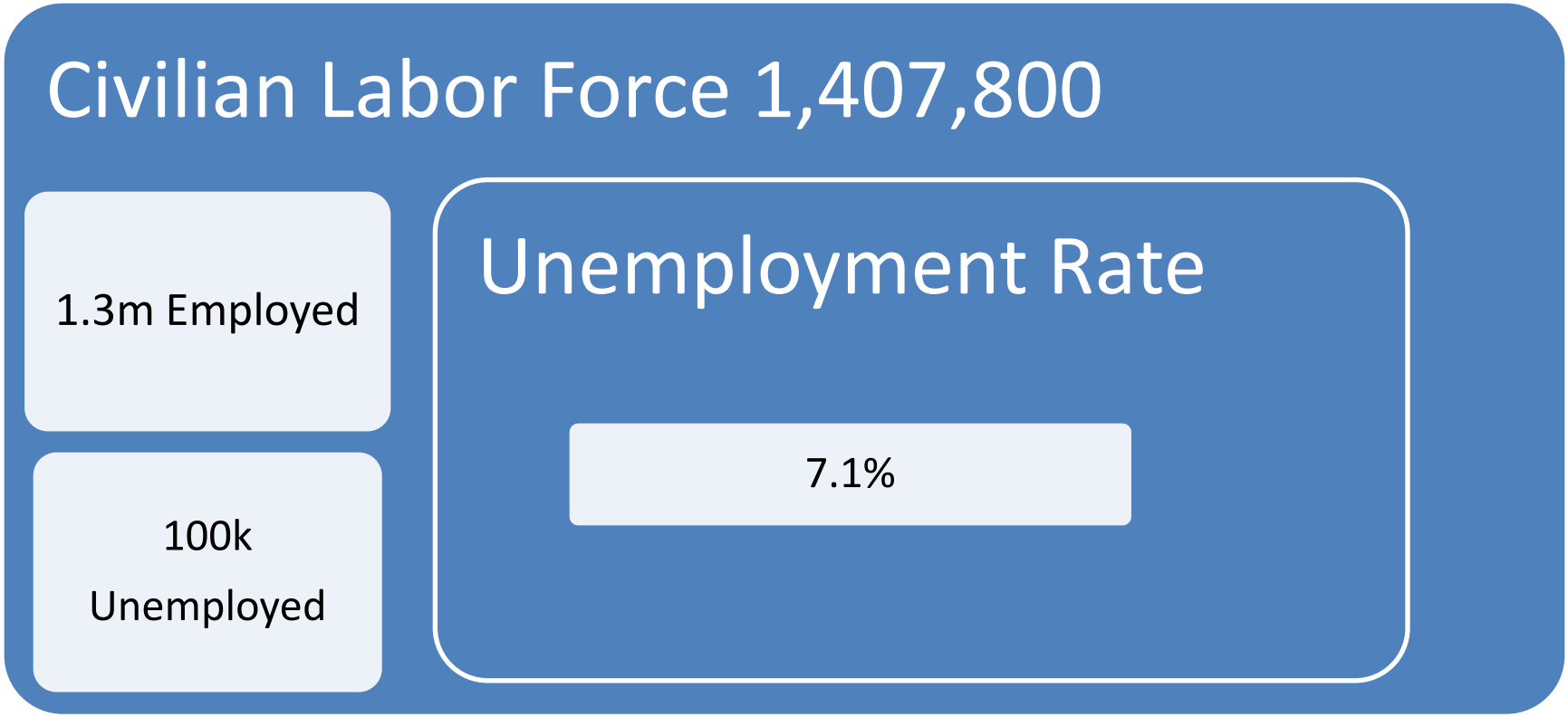



*Source: March 2015 U.S. Bureau of Labor and Statistics*

# State Demographics

**Counties with >100 People Per Square Mile**

- Carson City – 382.1
- Clark – 247.3

**With Between 50 – 100 People Per Square Mile**

- Douglas – 66.2
- Washoe 66.9

**With <50 People Per Square Mile**

- Churchill – 5.0
- Eureka – 0.5
- Lincoln – 0.5
- Nye – 2.4
- White Pine – 1.1
- Elko – 2.8
- Humboldt – 1.7
- Lyon – 26
- Pershing – 1.1
- Esmeralda – 0.2
- Lander – 1.1
- Mineral – 1.3
- Storey – 15.3

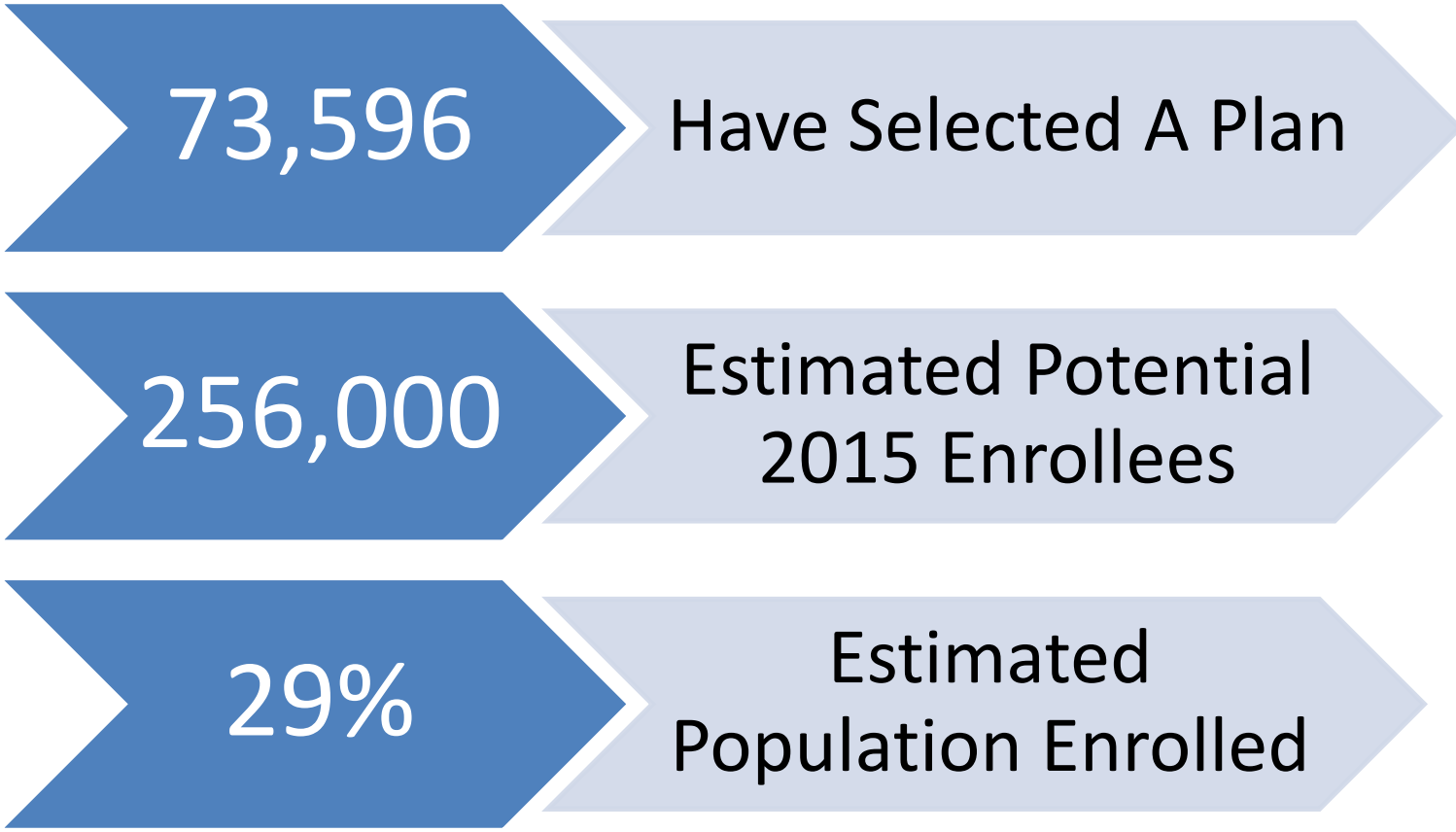
*Source: U.S. Census Bureau - 2010*

# Payers in Nevada and US

| Payer | Nevada | US |
|---|---|---|
| Uninsured | 20.5% | 14.5% |
| Employer/Military | 52.0% | 51.0% |
| Individual | 4.0% | 5.4% |
| Medicaid/CHIP | 8.7% | 13.4% |
| Medicare | 14.9% | 15.8% |

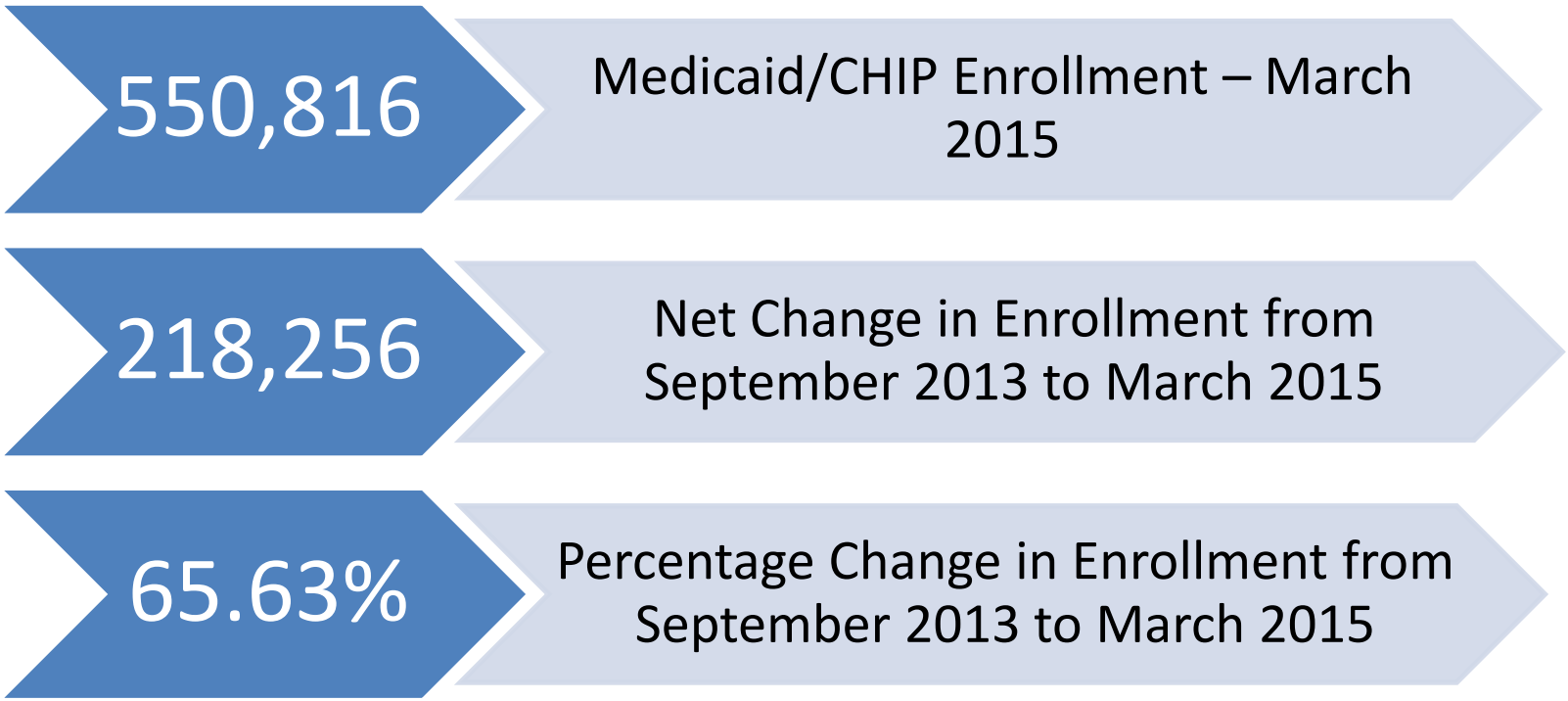
*Source: Data from 2013, SHADAC analysis of American Community Survey (ACS), Nevada State Profile (revised April 2015), page 10*

# Healthcare Marketplace Enrollment




*Source: Kaiser Family Foundation – Health Reform Indicators – 2015*
*As of February 22, 2015*

# Medicaid and CHIP Enrollment after Medicaid Expansion




*Source – Medicaid.gov, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/nevada.html*

# Nevada Provider Access Statistics

- Most regions of rural and frontier Nevada are primary care Health Provider Shortage Areas(HPSAs)
- 142,500 rural residents (51%) live in a primary care HPSA
- 816,000 urban residents (32%) live in a primary care HPSA.  This includes 612,000 residents of Clark County

# Physician Graduate Retention Rates

- 36.8% of Physicians retained in State from Undergraduate Medical Education,  2012
- 55.8% of Physicians retained in State from Graduate Medical Education, 2012
- 79.1% of Physicians retained in State from UME and GME combined, 2012
- Nevada ranks 5$^{th}$ in the nation in physician graduate retention rate

*Nevada ranks 48$^{th}$ in nation for number of active physicians per capita*

# Population Health Statistics and Focus Areas

Nevada Department of Health and Human Services
Division of Health Care Financing and Policy

# Population Health Statistics

- 2014 Edition of America's Health Rankings placed Nevada 39th overall

| Primary Contributing Factors | | |
|---|---|---|
| Lack of Health Insurance | Smoking | Heart Disease |
| Shortage of Primary Care Physicians | Lack of a Dedicated Health Care Provider | Social Determinants |
| Obesity | Seniors Who Did Not Get Flu Vaccines | Poor Access to Care |

*Source: America's Health Rankings*

# Population Health Statistics

## Obesity

- 12th Lowest in the nation
- 26.2% Adults
- 11.4% Youth
- 39% African American Population
- 26.4% White population
- 26.1% Hispanic or Latino Population
- 8.5% Asian Population

*Source: Health.nv.gov*

# Population Health Statistics

## Smoking

- 9th Highest in the nation
- Smoking among adults decreased 15% from 2010 to 2012 (22.9% to 19.4%)
- 3,430 smoking-related deaths in 2012
- 8.1% of mothers in NV reported smoking during pregnancy

*Source: Health.nv.gov*

# Population Health Statistics

## Diabetes

- 22nd Highest in the nation
- 6th leading cause of death in NV
- Increased risk with aging
- 11.1% of population with per capita income of <$15k
- 6.4% of population with per capita income of >$75k

*Source: Health.nv.gov*

# Population Health Statistics

## Behavioral Health (Including Mental Health and Substance Abuse)

- 89k adults diagnosed with severe mental illness
- 28k children diagnosed with serious mental health conditions; only 27% of estimated need for treatment was provided
- Suicide is the 6th leading cause of death in NV

*Source: Health.nv.gov*

# Population Health Statistics

## Behavioral Health (Including Mental Health and Substance Abuse) - Adolescents

- Within 1 month of being surveyed:
  - 11.7% of NV adolescents aged 12 -17 years admitted using illicit drugs
  - 77.6% of NV adolescents aged 12-17 years perceived no risk in having 4-5 drinks once or twice a week and no great risk in smoking marijuana once a month.
  - 5.7% of adolescents admitted to using tobacco
  - 14.7% of NV individuals aged 12 -20 years admitted to binge drinking

*Source: Health.nv.gov*

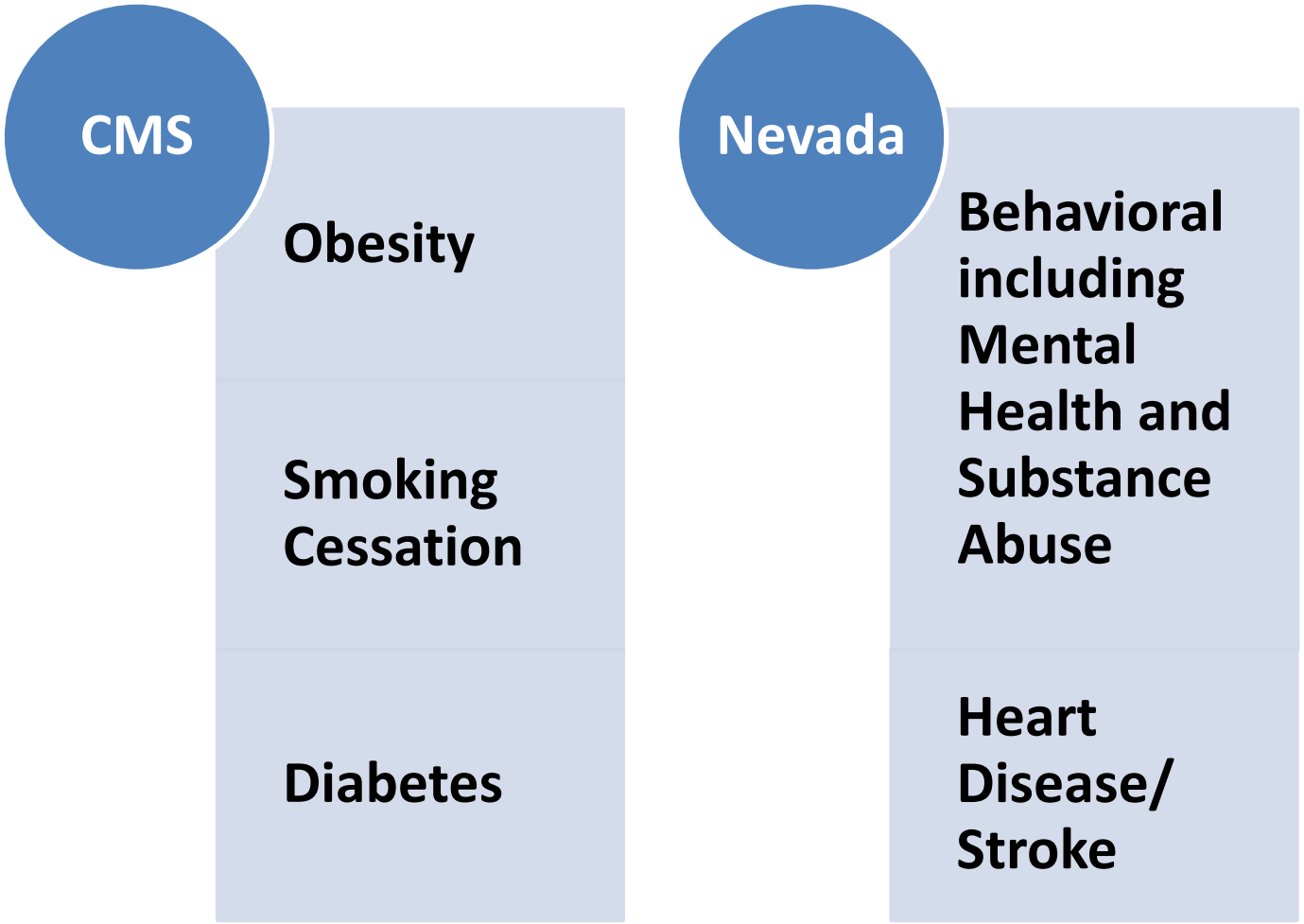
# Population Health Statistics

## Heart Disease/Stroke

- 36th Highest in the nation for cardiovascular deaths
- Diseases of the Heart are the leading cause of death in NV
- Stroke is the 4th leading cause of death in NV and account for 17% of cardiovascular disease deaths
- High percentage of patients develop long-term disability

*Source: Health.nv.gov*

# Target Areas for Improvements



# Population Health Measurement Strategy

- Start with nationally recognized quality stewards
  - Customize where necessary
- Develop Value Based Purchasing (VBP) Approach
  - May have to consider phased-in approach using process measures, reporting measures, and ultimately outcome measures
- Utilize a strong Health Information Technology and Data Strategy to support population health improvement
- Next steps
  - Define strategies to improve population health in these areas
  - Identify specific performance and outcome measures
  - Work with HIT & Data Taskforce on analytic needs

# Challenges and Opportunities

# Known Challenges/Opportunities

*What we have heard from stakeholders…*

- Health care provider shortages
- Licensing and reciprocity process cumbersome
- Limited availability of behavioral health services
- Not receiving care in the most appropriate setting
- Transportation
- Managing superutilizers
- Poor patient compliance and engagement
- Suboptimal payer reimbursement policies for wellness and prevention services
- Often insufficient access to historical patient medical information

# Potential Solutions

# Stakeholder Driven Roadmap

- Patient-Centered Medical Homes
- Health Home for Superutilizers
- Increased Telemedicine Sites and Appropriate Use
- Facilitate Project ECHO Expansion
- Paramedicine and Community Paramedics
- Expand the Use of Community Health Workers
- Regional Health Improvement Office
- Leverage Existing Initiatives
- Foster Health Information Technology Development

# Patient Centered Medical Home

- 80% of Nevadans connected with PCMH by December 31, 2019
- Covers all populations across a life span
- Multi-payer model
- Physician-led primary care practices, but may include some mid-level practitioners
- Team-based coordinated care
- Reimbursement is for care coordination, typically through a per member per month payment and may include additional payments through VBP model

# PCMHs in Nevada

- Stakeholder feedback: the nature of services provided outweighs strict certification requirements
- NCQA currently recognizes 293 clinicians/sites
- Questions:
  1. How many covered lives in PCMHs by which payers?
  2. What are payer reimbursement strategies and how can positive outcomes from PCMHs be better recognized financially?
  3. How many providers are providing core PCMH services and have not pursued NCQA certification?
  4. Are there geographic gaps in PCMH operations?
  5. Is the 80% figure of Nevadans connected with PCMHs feasible? What is the strategy?

# Health Home for Superutilizers

- Develop a health home program for superutilizers
- Enhanced approach to care coordination defined in Section 2703 of the Affordable Care Act
- Specific to Medicaid patients with multiple chronic diseases including mental health and/or substance abuse disorders
- Team-based clinical approach that includes the consumer, providers, and family members, when appropriate
- Connects consumers to community supports and resources
- Enhances coordination and integration of primary and behavioral health care

# Health Home for Superutilizers

- Questions:
  1. Definition of superutilizer?
  2. Distinction between health home and mere PCMH approach in Nevada?
  3. Payer recognition of health home model from a benefit package and reimbursement perspective?

# Increase Telemedicine Sites

- Telemedicine can increase access to health care professionals
- Increasing the telemedicine capacity
  - Increase number of presentation sites
  - Increase adoption as a health care delivery approach
- Questions:
  - Where is the greatest need geographically?
    - Mobile capability vs. fixed sites
  - Are clinicians necessary/available to fulfill presentation site responsibilities?
  - What policy/regulatory changes are key to addressing insurance coverage and reimbursement recognition?

# Project ECHO Expansion

- Link connecting university-based faculty specialists to primary care providers in rural and under-served areas
- Extends specialty care to patients with chronic, costly, and complex medical illnesses
- Moves knowledge instead of patients
- Questions:
  - What are the barriers to expansion today?
  - Funding sources for expansion?
  - How can the SIM project facilitate?

# Community Paramedicine

- Use of Emergency Medical Technicians and Paramedics as part of the health care delivery team
- Leverages their respected role and knowledge of the local health care delivery system
- Post hospital discharge home visits (vitals, medication reconciliation, wellness, compliance, etc.)
- Connecting people with most appropriate level of care
- Current Programs
  - Humboldt General Hospital EMS
  - REMSA

# Community Paramedicine

- Questions:
  - How can implementation be replicated statewide?
  - What is the paramedicine workforce planning and development model?
  - What data is available to illustrate cost savings, and can the pilots' results be extrapolated statewide?
  - How do paramedicine services get payer recognition?

# Community Health Workers

- Bridge gaps between individuals in their communities and the health care system
- Provide culturally appropriate and accessible health education and information
- Provide informal counseling and social support
- Advocate for individuals and communities within the health and social service systems.

# Community Health Workers

- May provide direct services (such as basic first aid) and administer health screening tests
- Questions:
  - How can implementation be replicated statewide?
  - What is the CHW workforce planning and development model?
  - What data is available to illustrate cost savings?
  - How do CHW services get payer recognition?

# Regional Health Improvement Office

- Checks the pulse of health care and social needs and services in communities and links health resources with community resources
- Considers other factors impacting health status, such as encouraging youth to enter health careers, recruiting and retaining local health workforce, bringing latest research and health care practices to the community workforce

# Leverage Existing Initiatives

- Previously mentioned:  Project ECHO, REMSA, Humboldt General Hospital EMS, CHWs

Plus:

- Division of Public and Behavioral Health Programs and initiatives (Ex. Quit Line for tobacco cessation)
- 2-1-1 Call Center
- Medicaid Incentives for the Prevention of Chronic Diseases (MIPCD) Grant
- Community Coalition Programs
- Indian Health Services Quality Projects

# Leverage Existing Initiatives

- Million Hearts Initiative
- Children's Heart Center Healthy Hearts Program
- Certified Peer Support Specialists
- Enhanced CNA training in LTC facilities
- Questions:
  - What other public or private initiatives directly or indirectly impact population health, improve patient quality, and provide cost savings?
  - How can they be supported or furthered though SIM?

# Foster Health Information Technology Development

- Promote increased adoption and meaningful use of Electronic Health Records (EHRs)
- Support the expansion of a single statewide Health Information Exchange (HIE)
- Endorse the integration of HIE information into practices
- Develop a population health analytics tool
- Utilize HIT and products to increase patient engagement

# Value-Based Payment and Service Delivery Model

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# VBP Approaches Discussed

- Objective

  Align payment for health care services such that at least 80% of health care reimbursement is based on quality and outcomes by December 31, 2019.

- VBP has been discussed by the workgroups as being part of:
  - Patient Centered Medical Home reimbursement
  - Health Home/Superutilizer model
  - Episode-based bundled payments
  - Provider population health management performance
  - Introduction of VBP and P4P concepts in public payer contracts

# VBP Actions Recommended

- Convene a Multi-Payer Collaborative to establish VBP construct for Nevada that includes quality initiatives, measures, thresholds and payment structure.
- Identify and establish a phased in approach for value-based purchasing (VBP) reimbursement.
- Start with VBP program for PCMHs.
- Develop uniform bundled payment criteria and methodology.
- Drive uniformity among payers for value-based purchasing requirements and administrative simplification.

# VBP and Service Delivery Model

Potential Phased Approach

1. Phase I: Process/Participation measures (approximately 6 months)
2. Phase II: Quality Reporting Capacity and Compliance (approximately 6 months)
3. Phase III: Outcomes and Performance (approximately 12 months)
4. Phase IV: Shared Savings
5. Phase V: Shared Loss

# VBP and Service Delivery Model

- Questions
  - How will VBP be administered?
  - Will provider performance be aggregated across payers or will each payer maintain their own measures?
  - Funding for VBP – Will funding be pooled across payer or will each payer make it's own payments?
  - How will provider practices be supported during implementation?
  - Can we define the general structure of VBP by the end of August 2015?

# Health Information Technology Plan

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# HIT Plan

- State Health System Innovation Plan (SHSIP) must contain an HIT Plan
- HIT considered a fundamental infrastructure support transformation
- Health care delivery and payment system redesign must be accompanied by the appropriate HIT strategy

# HIT Plan

- Needs Identified to Date:
  - Ability to electronically capture health care and related data for Nevadans
  - An analytics tool that can measure population health and related outcomes for Nevadans
  - More than just claims data – more than HIE data
  - Enterprise Master Patient Index
  - Strong privacy considerations

# HIT Plan

- Areas to be addressed regarding the solution:
  - Ownership
  - Authority
  - Governance
  - Policy/legal agreements
  - Technical architecture
  - Business and technical operations
  - Financing
  - Sustainability

# Regulatory and Policy Levers

# Policy and Regulatory Levers: 2015 Legislative Session

- AB 49: Peer Support Services
- AB 292: Telehealth
- AB305: Paramedicine
- SB 06: Patient Centered Medical Home
- SB 48: Health Information Exchange
- SB 84: Additional Providers of Health Care
- SB 251: Interstate Licensure Compact
- SB 498: Community Health Workers

# Regulatory and Policy Levers Questions

- What are the areas for legislative consideration next session?
  - Reinstitute BMI screening for school-aged children entering certain grades?
  - Dental screening for school-aged children entering certain grades?
  - HIE opt-in vs opt-out status?
  - Funding to draw down full GME available funds?
  - Other?

# Closing Points

# Closing Points

- Problems to be addressed under the SIM have been presented:
  - For purposes of this project, are the problems complete?
  - Other areas to be discussed?
- Stakeholder solutions have been presented:
  - Are these the 'right' solutions?
  - Are there other solutions not presented here?

# Closing Points

- Solutions presented need to be refined and presented at a much more granular level.
- A much greater level of specificity much be reached in the workgroup and taskforce meetings in July and August.
- Any concerns should be brought to our attention as soon as possible.

# Discussion