SIM Taskforce Meeting
Policy and Regulatory Taskforce
July 28, 2015 Meeting Notes

Date:	**July 28, 2015**	**Location:**	2310 S. Carson Street, Suite 3A, Carson City, Nevada
Time:	8:00am – 10:00am (PDT)	**Call-In #:**	Dial In#: 888-363-4735
Facilitator:	Catherine Snider,	**PIN Code:**	Access Code: 1329143

Purpose: Review regulations and policies that affect the initiatives/recommendations for areas of improvement to the Nevada health care delivery and payment system put forward by SIM workgroups. Problem-solve solutions to resolve potential issues regarding the recommendations.

Ms. Sisco offered a welcome and introductions were made.

- Catherine Snider gave an orientation to the purpose of the meeting and the agenda for the day.
- A review of some of the potential legislative items that have been brought up by various workgroups during the SIM process to date.
- SB 6
    - SB 6 passed this last session. It defined PCMH and we should keep those definitions in mind as we have discussions regarding PCMH. Ms. Snider relayed conversations from previous meetings regarding a PCMH-like practice which would not be recognized under the act, but may be included in some form in the SIM plan.
    - SB 6 creates an Advisory Council to study the health care delivery under PCMHs. This body has not been formed yet.
    - SB 6 also created the obligation to create a link to directories of nationally recognized PCMHs for patient/consumer reference.
- The Concept of a Multi-payer collaborative was introduced to the group. Part of the MPC will be to help with VBP and fiscal components of the PCMH model (funding and sustainability).
- Comments:
  Joan Hall pointed out that the national certification is very difficult and cumbersome. Practices with support have even taken 2 years to achieve recognition. Many providers claim they already do PCMH – most really do not. Catherine Snider asked if better education regarding what a PCMH is would be helpful. Ms. Hall said that would be helpful. There is also the struggle that FQHCs are paid per encounter, so if the FQHC is keeping the patient healthy, it has the negative impact of decreasing encounter billable opportunities. The incentive must offset the loss of billable events.

  Insurance companies not recognizing what gets established is problematic. For example, APRNs are able to practice independently but payers don't recognize the autonomous practice of an APRN. The nursing board believes the physicians are influencing this perspective. In PCMH and RFH/FQHC model, this becomes more problematic. Debra Scot with the nursing board suggested there be an entity that goes to the payers and discuss the issue. The recognition and resolution of this could improve access issues.

Catherine asked if multiple agencies within the Department would be involved. Jan Prentice mentioned that there is additional research that has to be done first before that is determined.

What other support could be offered to practices from a front line perspective to help facilitate the movement of a practice to a PCMH recognition? Greater understanding on what it means to be a PCMH. Joan Hall mentioned the need to have a fully developed state HIE to be able to support a PCMH. The use of the EHR system to its full capability to support the practice is also an opportunity. Training is not a one-time event. The need to continue training and retraining is important. Providers mentioned an issue with payers wanting written documentation and some payers and auditors are not recognizing output from an electronic system.

- AB 305 Paramedicine
    - Calls for integration of paramedicine into health and social services.
    - Rule making takes about 6 months
    - Quarterly reports are required and Joan Hall mentioned that the intent was believed to be that these would be made public.

- SB 489 Community Health Workers
    - Defines CHWs and local nature of the CHWs as an embedded part of the community.
    - There was a question about any concern that the CHWs may not be used by the facilities as envisioned. Joan mentioned the FQHCs have been looking at employing the CHWs and directing their activities as most needed by the facility.
    - Critical is to connect CHWs with Community Coalitions.
    - Periodic retraining and updates regarding new resources for CHWs will be important.
    - Deb Sisco mentioned a call with Minnesota last week to talk about their CHW program. CHWs receive reimbursement from payers through the physician's office who received the direct payment.

- AB 292 Telemedicine
    - A review of the components of the bill was offered.
    - Nurse licensure compact has been around for 15 years. NV has not joined because of the background check. The nursing board has been directed to explore the reciprocity across other states that are part of the compact. This would open up nurses to practice case management via telemedicine in NV. The 2017 NV Legislature would have to pass this. The compact would still require a national background check.
    - Dr. Vaughn mentioned this should be considered for physicians as well.
    - Nurses don't have to apply to NV at all – they practice in NV based on the licensure in a compact state.

- SB 251 Interstate Compact

- Streamlined the physician licensure process.
- This is a first step. Could be more robust like nurse compact
- There is an opportunity to get more awareness to the physicians about this new development.
- Another strategy is to help make sure that there are additional residency slots created in the state.
- This could also be helpful in expanding Project Echo.
- Joan suggested we work to find out/study why providers are not attracted to come back to NV.

- AB 489 Peer Support
    - There was a bill related to peer support for those with developmental disabilities which also passed. MSLC needs to do some additional research.

- SB 48 Statewide HIE
    - Passage of this bill removed the requirements of a former bill to create a state HIE. Permitted a non-state entity to create/operate a statewide HIE.
    - Joan offered that providers and insurers are not joining the HIE as quickly or exchanging Medicaid data to the extent that they should.
    - Slow adoption/mistrust of HIT are factors.
    - Consent process has also been a barrier for providers to exchange information.

Policy Levers and Influencers of Supply

- Residency Taskforce has been set up by the Governor.