# Policy and Regulatory Task Force
# Meeting Notes #2

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| **Date:** | ***June 3, 2015*** | **Location:** | *4150 Technology Way*<br>*Room 303*<br>*Carson City, NV* |
| **Time:** | *8:00 – 10:00 am (PT)* | **Call-In #:** | *(888) 363-4735* |
| **Facilitator:** | *Jay Outland* | **PIN 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.

In attendance –

NV – Deb Sisco, Jan Prentice, Chani Overli, Missy Sanford, Katie Baumruck, Gloria McDonald
MSLC – Jerry Dubberly, Jay Outland, Charlyn Shepherd

Laura Hale (Primary Care Office), Katie Ryan (Communications and Public Policy), Debra Scott (NV Board of Nursing), Robert Kidd (Perry Foundation), Elyse Monroy (Office of the Governor), Chris Bosse (Renown)

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.

Jay 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.

Jay explained that this task force is more retroactive than proactive based on information obtained from other workgroups.

A question was raised regarding how to aggregate data across payers to improve population health. A draft Population Health Plan was submitted to CMS last month.

Clarification was provided regarding information that Dr. Greenway utilized at CHIA. The data that Dr. Greenway obtains for analysis is not just Medicaid data. CHIA also has other state data, including data from counties. This data is not billing data, but other information such as immunizations.

A wide net was cast out to providers, payers, associations, and HIE, to participate in the SIM discussions.

Legislation was passed defining paramedicine, telemedicine, and community health workers.

There are inter-relationships between workgroups. To reform delivery system, data is needed. What data do you need and what clinical outcomes? Results in data sharing issues which feeds back into Policy group.

Jan Prentice commented that CMS is reiterating sustainability; How to implement and sustain the proposed models. NV can document cost savings/shifting to help pay for it initiatives defined in the SHSIP. Different groups are doing similar things. The SIM plan needs to get that information together for efficiency; how can we expand on it and tie it all together. It was explained that the driver diagram draft are just ideas that are currently being considered. Jan explained that Nevada has until the end of the year and if participants have ideas to let DHCFP know. If an idea isn't "do-able," it will need to go on back burner. Each idea needs to be vetted.

There was a PCMH bill (SB 6) that laid out parameters for how they are to be licensed.

There is an absence of data for children's oral health. A request was made to include dental care in the SHSIP.

Dental office personnel can help in emergencies; consider them as potential solutions in shortages of care providers. Chronic diseased can't be managed without proper oral care.

Keeping healthy teeth their whole life should be a stated goal. Trends are showing that seniors are keeping more teeth. Early childhood caries goal is to be caries free when kids go to kindergarten. Current stats on caries are not known.

Provide education and care for seniors. Educate DON and nursing staff in LTC and senior care settings because currently dental care is not happening. Trying to identify a CAN program that focuses specifically on dental care.

Integration of care is key to success. Some medications deteriorate teeth. Dentist can do blood pressure, too.

Oral care impacts qualify of life.

There are coverage shortages and professional shortages. There are 2 counties with no dentists. Telemedicine would be helpful in those areas.

There has been discussion about having mandatory dental exams for entry into school. This could be mandated, like immunizations.

Monitoring pregnant women with periodontal disease is important, too.

There are mobile dental clinics, such as the Ronald McDonald van and dental sealant mobile vans. Grant funds were cut so they do not have as far of a reach as they once had.

School-based locations would help with transportation issues. Have attempted mobile vans to some degree and they work and some degree they don't. For example if a child needs braces, that is sacrificed because follow-up visits can be a 6 hour drive away.

Fluoride varnish could be applied in medical offices.

Medical compact legislation was passed. Now MDs can get licensed more quickly. Governor put a bill where reciprocity is more quickly licensed. Nursing Board is going to 2017 legislature for same compact legislation. 25 states are part of compact. Need to make sure there are safeguards in place to prevent individuals with license restrictions from other states (i.e. criminals) from obtaining nursing licenses in NV.

There is tuition support for psychiatrists. There is a new psychiatric education program for APRNs. This new program focuses on producing more psychiatric APRNs. This program with take a family NP, 2 – 3 courses to be certified to provide psychiatric services.

Law states that APRNs do not need a collaborative MD or supervising MD to practice in NV. 87% of APRNS whose licenses were endorsed were from other states because they have full practice authority in NV. However, there is still a problem with payers reimbursing because policies require collaborative/supervising MD.

AB 242, creates 2 year legislative study on post-acute care. It was a nurse staffing bill that was converted to a study bill.

One of the plans and Medicaid FFS covers mobile dentistry sealants. They are covering schools with really high free/reduced lunch rates.

Public Health has one employee in dental – not a clinical position, but a State Dental Health Officer and 1 hygienist. Need to find continued funding. New position is effective 7/1/15.

Community Health Alliance has a school-linked clinic. A few others are starting to provide school-based services. Need to confirm with Chuck Duarte. Some are centrally located in schools and can serve families as well as children and they are quasi community health centers.

American Hospital Association makes a federal list of anti-trust/stark rules that play into partnerships and limit how practices can work together. The group was not aware of any NV specific laws.

When looking to modify delivery and payment there is a NV law that states providers can't take insurance risk for something they don't provide. IPA's took risk for hospital days, later determined to be illegal. Shared savings plans are fine.

On the enrollment/coverage side there are MCOs and facilities that in order to privilege an APRN they have to have a collaborative physician even though the law does not require it. It is to gain hospital privileges. If that rule could go away that would help with access.

NV can use out of state providers. NV Medicaid can place patients anywhere. Nevada is required to have to place them in the State first if they can, but sometimes it is cheaper out of state. Nevada can also send patients out of state when no one in the state will take them.

Renown feels the have to get NV denials before they can put someone in a CA facility, even though the CA facility is closer than the Las Vegas facility. The discussion was taken offline.

For telemedicine the rules are that the treating/diagnosing/ordering provider must be licensed in NV. Out of state providers can provide a consultation. The question of what payers will reimburse was asked. Need to get agreement. Bill has authorization, consent parity. Parity on paper vs. parity in reality is very different.

There needs to be a definition of "emergent care" for behavioral health. It could take 6 – 12 months for a family to get connected to behavioral health care services in a crisis situation.

The state established a rate that approximates cost for BH/MH services to increase access. This resulted in expanded beds; provided for free-standing facilities. MCOs can get a discount and set a higher rate bypassing IMD rule. People are staying for shorter times in acute beds. But need to work on care subsequent to discharge from acute bed.

Laura Hale worked on a task force that brought a lot of information together on the BH/MH issue. Laura Hale will share the report with the group. Laura Hale stated the report is a work in progress. Some recommendations have moved forward. She will summarize the report at the next meeting.[1]

There was an NGA project helping DHHS and Medicaid work with CMS for mandated BH screening for 7th graders, an 1115 waiver is planned. Program is called "Rising Risk." It identifies historical risk factors in a person's life. When working on Population Health Plan the rate of suicide among youth was high. The waiver would just cover the Medicaid population. It was recommended that they determine if the screening could be included as part of EPSDT since waivers are burdensome.

For CHWs, community paramedics, etc. is more legislation needed to operationalize? They need regulations. Current regulations do not allow for reimbursement. Regulations will need to spell out scope of practice. Need to ensure regulations make for safe; collaborative; avoid turf wards.

***Action Item for Next Meeting:***

[1] When the agenda is put together for the next meeting, add a time slot for Laura Hale.