THE ADVISORY COUNCIL ON THE STATE PROGRAM FOR WELLNESS AND THE PREVENTION OF CHRONIC DISEASE
SUB-COMMITTEE ON PATIENT-CENTERED MEDICAL HOMES
[DRAFT] MINUTES
FEBRUARY 1, 2017
1:00 p.m.

The Advisory Council on the State Program for Wellness and the Prevention of Chronic Disease Sub-Committee on Patient-Centered Medical Homes held a public meeting on 2/1/2017, beginning at 1:00 p.m. at the following locations:

Division of Public and Behavioral Health
4150 Technology Way
Room 204
Carson City, NV 89706
(775) 684-4285

Division of Health Care Financing & Policy
1010 Ruby Vista Drive, Suite 103
Elko, NV 89801
(775) 753-1311

Bureau of Health Care Quality & Compliance
4220 S. Maryland Parkway
Building D, Suite 810
2nd Floor Small Conference Room
Las Vegas, NV 89119
(702) 486-6520

Northern Nevada Mental Health Services
Children's Cabinet
480 Galletti Way, Building 2A
Reno, NV 89513
(775) 688-1930 ext. 2198

MEMBERS PRESENT

Sam Bauzon, MD, MMM, CPE
Antonia Capurro, DMD, MPH, MBA
Cameron Duncan, DNP, MS, APRRN, FNP-C
Andrew Fraser, MD, MPH
Nancy Hook, MHSA
Assemblywoman Amber Joiner, MA
Tigger Mathis, MSN, APRN, FNP-BC
Tom McCoy, Acting Chairman
Daniel Spogen, MD
Will Sutherland, MBA, PMP, PCMH CCE

MEMBERS NOT PRESENT

Aubree Carlson, RN
Robert Pretzlaff, MD, MBA FAAP

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH STAFF PRESENT

Jenni Bonk, MS, Section Manager, Chronic Disease Prevention & Health Promotion (CDPHP), Division of Public and Behavioral Health (DPBH)
Karissa Loper, MPH, Deputy Bureau Chief, CDPHP, DPBH
Jeanne Broughton, Administrative Assistant III, CDPHPP, DPBH

Acting Chairman Tom McCoy called the Subcommittee on Patient-Centered Medical Homes (PCMH) meeting to order at 1:09 p.m. Ms. Broughton indicated the meeting was properly posted at the locations listed on the agenda in accordance with Nevada Open Meeting Law.

1. **Roll Call**
   Roll call was taken. Ten members were present.

2. **Recommend frequency and dates for future PCMH subcommittee meetings**
   Mr. McCoy stated he was Acting Chair simply because he is the Chairperson of the Advisory Council on the State Program for Wellness and Prevention of Chronic Disease (CWCD), which is the "parent" group of the PCMH subcommittee. The subcommittee members need to select a Chair and Vice-Chair, but that could not be done at this meeting. It will be put on the next agenda.

   Mr. McCoy said the statute which established the CWCD did not specify the number of meetings that should be held by the subcommittee, but recommended at least two meetings per year. That number could be altered by the subcommittee if they felt it necessary to meet more frequently. There should be at least one more meeting in 2017. There should be consideration for the members and their schedules as professionals. Ms. Bonk will send out an email to find a date, possibly in May, that works best for all the members.

   The purpose of this meeting was to get to know each other, gather more information about what needs to be done, and hopefully have information available for the 2019 legislative session.

   There was no public comment.

3. **Presentation of the state of PCMHs in Nevada**
   Ms. Nancy Hook, Executive Director of Nevada Primary Care Association gave a presentation about the state of PCMH in Nevada. Prior to beginning her talk, Ms. Hook said Nevada Primary Care Association is the primary membership organization for nine Community Health Centers in the state of Nevada representing 36 clinical delivery sites. Her presentation and comments are attached.

   Mr. McCoy suggested making comments about the presentation as part of agenda item four.

4. **Discussion regarding how each member sees the future of PCMHs in Nevada and his/her role in moving it forward**

   Mr. McCoy said it would be a good time to see how each member sees the future of PCMHs in Nevada. He asked if there had been any evaluation within the federally qualified health

center (FQHC) model which has been going on for some time, and if there was any data that indicates what is happening.

Ms. Hook: The growth in PCMHs in Nevada has been so rapid in the last three years it is hard to keep up and everyone is at a different stage of development. In 2012, there were two FQHCs and now there are nine. Some of those are nowhere near implementing a PCMH model. There are some national cost-benefit studies, and Ms. Hook offered to research those and share information at a later meeting.

Mr. McCoy: Dollar savings is something that legislators, regulators, and the state would be appreciate knowing.

Ms. Bonk: Is there a PCMH bill going forward that we should be watching?

Ms. Hook: Senator Hardy sponsored Senate Bill Six (SB6) in the previous legislative session, and there is placeholder language. SB6 established this subcommittee and he is looking to the subcommittee to decide the next steps. A statute would define what a PCMH really is. But, we are a long way away from implementing any standards in the state. Many other states have implemented either Medicaid-wide or multi-payer-wide PCMH reimbursement programs in their state and have a champion for PCMH, but we are lacking in that regard. We do not have a carrier or health foundation interested in moving this model forward in Nevada. It is still a long road ahead before it is decided what is appropriate for Nevada.

Mr. McCoy asked if Ms. Hook knew of examples in other states where PCMH is working.

Ms. Hook: Oregon uses the PCMH model statewide and has gone through health reform since 2007. They use care coordination as a delivery system, as opposed to MCOs, and developed a payment mechanism to support the activities of PCMH. One of the biggest issues with PCMHs is there are certain activities that are not supported by fee for service for reimbursement, so while you are looking at delivery reform, you must look at payment reform.

Dr. Fraser: We echo your sentiments regarding payment reform. In New York, there is an enhanced reimbursement for a PCMH recognized practice, which we do not have in Nevada. And, it is quite expensive [to be recognized]. We talk about medical neighborhoods, but there is no one to collaborate with that is PCMH recognized. It is challenging to find other members to be on the team, even when you want to coordinate care.

Ms. Hook: The PCMH model is most often presented at the primary care location. However, the medical neighborhood is the next step.

Dr. Spogen: The University of Nevada, Reno (UNR) has developed a PCMH model, but have not gone so far as being recognized by any entities to call it a Medical Home. Part of the reason is it is a very expensive process to go through the reporting requirements to obtain National Commission of Quality Assurance (NCQA) recognition. That is one big hurdle, the cost of being recognized. The second reason is even if you go that far, you may not get paid more [for providing services]. That may change, because with the Medicare Access and CHIP Reauthorization Act (MACRA) this year at least one quarter of reporting must be a value-based model. And, PCMH fits that model. There might be bigger incentives this year for primary groups to get recognized.

Ms. Hook: That is a great point - the investment that must be made up front. One of the reasons the Community Health Centers are moving through the process is because not only did the Department of Health and Human Services (DHHS) make this a primary goal, it also funded the Bureau of Primary Care through the Health Resources and Services Administration (HRSA) with some investment dollars to support the process of recognition for the Community Health Centers. The investment must occur up front to see the cost savings down the road.

Mr. McCoy: PCMH is one of the best kept secrets in the medical field. Unless a patient is specifically involved with a PCMH, such as a Community Health Center, the public does not know what it is. It could be one of the subcommittees goals is to educate the overall population in Nevada. How do we do that with no money?

Dr. Spogen: This is very true in Nevada, but not sure it is true nationwide. There are other states that have done a very good job of marketing their PCMHs. For example, in Michigan a physician cannot practice primary care without being a recognized PCMH.

Ms. Hook: It really is about health literacy and making sure the patient understands they are a partner. Patient engagement is one of the main standards of the PCMH model. It takes cooperation between the provider and the patient.

Mr. McCoy: Is there a role that DHHS can play in disseminating information? Is there something we can do in Nevada to help people who want to learn? We have to start somewhere by helping people who want to know more about this.

Ms. Bonk: We could have something on our Nevada Wellness website. We have a list so we can e-blast the information. We could also poll people and find out what they know about PCMHs.

Ms. Hook: Part of the language in SB6 said consumers could go to the website and get a list of recognized PCMHs.

Mr. McCoy: I remember attending a seminar where Dr. Spogen was one of the speakers, and they were talking about PCMHs. It was very exciting. In my work with the American Cancer Society, I saw how this could be very beneficial to our constituents. But, in the everyday Nevada marketplace of medical care, one does not hear the term PCMH that often. Is anyone here actively promoting what this concept is about?

Ms. Hook: The Community Health Centers certainly do. Southwest Medical Associates and Renown both have recognized providers, but what they do in terms of promotion is unknown.

Dr. Fraser: I am with Southwest and promoting that we are a recognized PCMH is a hallmark of our practice. If a patient comes to us we provide comprehensive and coordinated care with evidence-based guidelines. Patients are generally aware of what PCMH entails, but may not know terminology. They do know they want their care coordinated and want the doctor to have all the notes from all the other doctors and specialists available.

Ms. Hook: The patient portal and being able to communicate with the patient outside of actual medical encounters is an element of PCMHs. I would suspect everyone recognizes they have access through their portal to a PCMH.

Dr. Bauzon: One of the biggest keys to success of the PCMH model at Southwest is the integrated Electronic Medical Record (EMR) system, where all of the providers from specialists to nurse practitioners are all accessing the same medical information for a patient. All people involved in patient cared are trained. The patients are being trained to go to the web portal and effort is made to get them engaged, not only face-to-face, but virtually as well. I was involved in the Healthy Nevada program a while back, and one of the biggest hurdles was the smaller primary care groups were having trouble starting their EMR systems, because there was so much work to be done. One of the largest parts of the PCMH model is reporting. Some sort of EMR support would certainly help the process in the state of Nevada.

Dr. Spogen: One thing that is not understood is just because you have an EMR does not mean you have the reporting capability to report the necessary things to become recognized.

Mr. McCoy: Like we said before, one of the roles of this subcommittee would be to get the word out about PCMHs. There are public access television and radio shows available to do an informational campaign. Maybe some of the people from this committee would be able to appear on these shows to get word out. Anyone who is receiving any type of care, especially older people, would benefit from PCMH program information. We have sliced bread, but how do we tell people we have sliced bread?

Going forward, what do each of you think the future of PCMH is for Nevada and what are the barriers?

Dr. Spogen: One of the barriers is the cost [of becoming recognized], but the reporting is quite time consuming. Even if a system is set up to run the reports, it is difficult. It is just not an easy process and many primary care providers do not think it is worth it, especially since they are not going to get paid better.

Mr. Sutherland: Many people have mentioned the headache and difficulty of putting the reports together. Reports required for NCQA recognition are the same that are required for meaningful use. Strong guess is that anyone with an EMR should also have the ability to run meaningful use reports. Meaningful use is how physicians are reimbursed for EMR use. The point is if a physician can do meaningful use reporting, then PCMH reporting should not be a problem.

Dr. Fraser: The medical transformation process can be very difficult, especially for solo practitioners who must extend hours.

Mr. Sutherland: I agree that a huge barrier is reimbursement. The cost of recognition is not an enormous cost, but the real expense is the additional staffing and the amount of time a provider must spend away from seeing patients. There needs to be an innovative payment model to reimburse providers for the time spent away from seeing patients as well as the staff, for example, care coordinators, social workers, and medical workers who make outreach phone calls, etc. Without the reimbursement, it is asking the provider community to bear a substantial expense.

Mr. McCoy: What are we seeing from health plans across the country?

Ms. Hook: It depends, some health plans reimburse on a per member per month (PMPM) for PCMH recognition as an incentive bonus. Some are complete capitation, so they have an opportunity to support those services that are not tied to a face-to-face provider.

Mr. McCoy: Logically for health insurance people, the cost of providing services through providers of this model is that they can save some money.

Ms. Hook: That is correct. They may have to invest in primary care up front, but the cost savings are seen in less emergency room visits, etc. What we do see in practices is once you are providing those services of care coordination, the enhanced role of the medical assistant is doing panel management. The provider panel can increase in size because the physician has more time to see patients who need to be seen by the doctor. (You) can use lower paid staff for efforts in other areas for less complex patient care.

Mr. Sutherland: It is doable to increase the panel size through the expansion of the managed care team. As far as managing a practice, there still may not be time for a doctor to see more patients. From a reimbursement perspective, the direct correlation may not be there yet. However, Medicare has put forward chronic care management, which has been the "flavor of the year" lately for primary care reimbursement. It may not be a sufficient amount to pay for the staff to do this type of managed care. It is, however, a way to get paid for different managed care functions. There is also transitional care management. Does this subcommittee have the ability to lobby Medicare from a final rule prospective and from their reimbursement prospective to further enhance the reimbursement for these different functions that are required of a PCMH, even if that means a complex managed care concept, or something that will pay for more than just 20 or 40 minutes per month? Some of these cases take up to an hour or two per month.

Ms. Bonk: I came from Medicaid, where they tried to become a recognized PCMH, but were told the infrastructure was not there to support it, so they designated it as a Care Management Organization. The idea was to manage the care of this population with chronic conditions, but did not include the expansion population. Managed care entities that have a clear majority of the Medicaid recipients are supposed to be doing their own care coordination. They are paid a PMPM and can handle their business however they want. We are looking at 660,000 people and probably 75% of those are Managed Care. There will be four managed care entities in July. They have been told there is no mechanism to reimburse this way, but have to continually be evaluated. Usually, Nevada Medicaid leads the way when it comes to reimbursement changes and others follow suit.

Mr. McCoy: Perhaps we can invite some of those people to the next meeting for a discussion.

Ms. Bonk: If we had someone like Health Plan of Nevada to come in, they also have the private side as part of United Healthcare. We could pursue that idea and see if they want to come and talk to us.

Mr. McCoy: How do the rest of the Committee members feel about the offer to bring others in to discuss this?

Dr. Spogen: It is a great idea.

Ms. Hook: Yes. It is a great idea. Mr. Sutherland was speaking about Medicare, which is going to value based purchasing with 85% of future payments being value based. PCMH Medicare has put a lot money into demonstration projects around PCMH for Medicare beneficiaries through the Capability Maturity Model Integration (CMMI) system. But, we do

not know what is going to happen with CMMI in the future. They have put a huge investment into PCMHs.

Mr. McCoy: We have no idea where Affordable Care Act (ACA) is going. In terms of how it is currently set up, how does PCMH fit into it now? What are the potential risks regarding any change?

Ms. Hook: This is my opinion. The PCMH model is not tied to the ACA. The ACA put in to place some innovation flexibility which allowed PCMH to occur. The Community Health Centers are not going anywhere. We have some major changes in the Medicaid program coming up. And as a state, we need to look at contingency plans regarding Medicaid, but there should be no impact on the PCMH model [or recognition].

Ms. Loper: Who are we proposing to come in and speak?

Ms. Bonk: Amerigroup, Health Plan of Nevada and Fee-for-Service people too. They should be included to be fair about the process.

Assemblywoman Joiner: I have been tracking this concept since working for the Nevada State Medical Association, and I lobbied for them in 2011. It is all very important to me.

Mr. McCoy: Those of you involved in PCMHs, how is the patient reaction?

Dr. Spogen: Most of the things that we do as a PCMH are hidden; it is not obvious to the patient. We have care coordination in place, behavioral health, nutrition, social work, etcetera, but it is behind the scenes. Patients may not notice unless they are a high-end user.

Dr. Fraser: Our experience is, when they go to the doctor, they expect to be coordinated. If they have a chronic disease, it becomes a little more obvious, since they expect a referral. It is in the back of their minds until there is a chronic condition.

Dr. Bauzon: It has taken quite a bit of effort to educate patients. We have taken a team approach. We are all part of the team, all working on the same EMR system, and all working on the same page, so to speak. So, it is very difficult for patients to recognize the team approach. It does take extended hours to make it work. The big issue is how do small practices make this work?

Ms. Bonk: Community Health Workers (CHW) are an entity that could help with PCMH model implementation. The cost could be driven down by using CHWs because reimbursement is lower for them.

Mr. McCoy: Can you make a distinction between patients before and after PCMH.

Ms. Hook: At the Community Health Center level, which is predominantly low income, Medicaid, and uninsured, patients are experiencing more access to services. It can be something as simple as a Care Manager making a phone call. In the past, to get [the physician] paid, the patient had to go in and physically see the physician. The team approach at the Community Health Centers is expanding the role of medical assistants to do more outreach and panel management. Now, even low utilizers will get a phone call to remind them of a preventive visit or screening.

Mr. McCoy: So, if there was a poll on screening rates, it would be higher?

Ms. Hook: At the Community Health Centers with PCMH recognition, the preventive screening rates are higher. Of course, preventive measures are better. However, you can bring a horse to water, but can't make him drink.

Ms. Bonk: It can take up to ten years to see that savings.

Mr. McCoy: There is some type of value in having an informative hearing with the Legislative Health and Human Services Committee and sharing some of this information with the legislators. They need to know where we are with the PCMH concept and what some of the barriers are that were discussed today.

Assemblywoman Joiner: As Vice-Chair of the Health and Human Services Committee, there have been some discussions about which meetings to have, but there is a concern for the timeline for recommendations, or if it would be more informational. One of my questions is do we want to wait until after there is a bill before we make recommendations? I can ask the Chair if he would like to have an informational presentation and let you know.

Mr. McCoy: Senator Hardy has a Bill Draft Request, but we don't know where it is going. My understanding is that he is relying on us to present something so this can move forward.

Assemblywoman Joiner: This is our only meeting before those items must be presented, so this may be too premature for us.

Mr. McCoy: Is there something we can do legislative-wise that could help bring this to light?

Ms. Hook: We have to get people looking at reimbursement, but I do not know if there are legislative things that we are ready to do now. There may be regulatory things that could be looked at.

Mr. Sutherland: Reimbursement [reform] needs to be a focus of our efforts. Barriers include the Health Information Exchange in Nevada, and tracking down records for people who have already had certain procedures done. Information sharing is very important.

Ms. Hook: Reimbursement [reform] and investment are two key components. The smaller practices are having trouble.

Mr. McCoy: Are PCMHs an integral part of medical education now?

Ms. Hook: I believe it depends of the type of residency and medical school.

Dr. Duncan: The PCMH model lies more within sites where the students are training. If they are training in a private or small setting, it may not be available to them as a training area.

Mr. McCoy: We are going in spurts and there is no coordinated education concept either. An informational briefing to Senator Hardy would be a recommendation to give him an opportunity to see where his idea is going.

Ms. Bonk: We will wait and see what happens with Senator Hardy, and Assemblywoman Joiner can let us know.

Mr. McCoy: Are there any other comments before we adjourn the meeting?

Dr. Bauzon: We should look at other states to see if there is a successful PCMH model we can use so we do not re-invent the wheel. I would like to know what we can do in 2017 that will make the biggest impact on the PCMH effort.

Mr. Sutherland: I would like to hear from insurance companies about why there is no expansion of PCMH reimbursement for Nevada. We need a better framework.

Ms. Bonk: A panel would give perspective.

Ms. Hook: A large PCMH bill got killed in 2013; it was more complex and established PCMH at DPBH

Cameron: The MCOs may already have a program in place.

Mr. McCoy: Maybe someone from Division of Insurance would like to attend the panel discussion.

Ms. Bonk: I will reach out to them as well.

5. Public Comment

There was no public comment.

6. Adjournment

Ms. Hook made a motion to adjourn. Dr. Fraser seconded the motion. The meeting was adjourned at 2:15 p.m.