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November 30, 2017

Emmett Ruff
Division of State Demonstration and Waivers
State Demonstration Group (SDG)
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244
Voice: 410-786-1315

Re: Nevada Comprehensive Care Waiver (NCCW), Project Number: 11W-00284/9

Dear Mr. Ruff:

Please accept the following submission requirement: "Quarterly Operational Reports", as outlined in the Special Terms and Condition (STC) 55 of the approved Nevada Comprehensive Care 1115 Research and Demonstration Waiver. Per STC 55, the state must submit progress reports in the format specified in Attachment A, 60 days following the end of each quarter. The attached report is for the period of July 1, 2017 – September 30, 2017, or Federal Q4/2017.

Should you have any questions regarding this submission please contact Gladys Cook, Program Specialist, at (775) 684-7596 or via email at gladys.cook@dhcfp.nv.gov.

We look forward to continuing to work with you and your staff.

Sincerely,

[redacted]

Marta Jensen
Administrator

Cc: Shannon Sprout, Deputy Administrator

Nevada Comprehensive Care Waiver (NCCW)
Section 1115 Quarterly Report
Demonstration/Quarter Reporting Period:
Demonstration Year 4 (DY4): (7/01/2016 – 6/30/2017)
Federal Fiscal Quarter 4: (7/1/2017 – 9/30/2017)

Introduction

On June 28, 2013, the Nevada Division of Health Care Financing and Policy (DHCFP) received approval for the Nevada Comprehensive Care Waiver (NCCW), (Project Number 11W-00284/9) from the Centers for Medicare & Medicaid Services (CMS) in accordance with section 1115(a) of the Social Security Act. Approval for the NCCW is effective from July 1, 2013 through June 30, 2018.

Under the NCCW, the DHCFP has implemented mandatory care management services throughout the State for a subset of high-cost, high-need beneficiaries not served by the existing Managed Care Organizations (MCOs). This subset of beneficiaries will receive care management services from a Care Management Organization (CMO), named the Health Care Guidance Program (HCGP). This entity will support improved quality of care, which is expected to generate savings/efficiencies for the Medicaid program. Enrollment in the HCGP is mandatory for demonstration eligible Fee-For-Service (FFS) Medicaid beneficiaries with qualifying chronic health conditions. The HCGP launched on June 2, 2014.

The NCCW demonstration will assist the State in its goals and objectives as follows:

Goal 1: Provide care management to high-cost, high-need Medicaid beneficiaries who receive services on a FFS basis.

- **Objective 1.1:** Successfully enroll all Medicaid beneficiaries who qualify for the NCCW program.
- **Objective 1.2:** Stratify all enrollees into case management tiers according to assessed needs.
- **Objective 1.3:** Complete a comprehensive assessment of enrollees with complex or high risk needs.
- **Objective 1.4:** Complete a comprehensive assessment of enrollees with moderate or low risk needs.
- **Objective 1.5:** Increase utilization of primary care, ambulatory care, and outpatient services for members with chronic conditions.

Goal 2: Improve the quality of care that high-cost, high-need Nevada Medicaid beneficiaries in FFS receive through care management and financial incentives such as pay for performance (quality and outcomes).

- **Objective 2.1:** Increase use of preventive services by 10 percent. [1-1]
- **Objective 2.2:** Increase follow-up ambulatory care visit after hospitalization by 10 percent. [1-1]

[1-1] The goal for all measures to increase performance by 10 percent refers to the hybrid Quality Improvement System for Managed Care (QISMC) methodology for reducing the gap between the performance measure rate and 100 percent by 10 percent.

Objective 2.3: Increase patient compliance with anti-depressant medication treatment protocols by 10 percent. [1-1]

Objective 2.4: Increase use of best practice pharmacological treatment for persons with chronic conditions by 10 percent. [1-1]

Goal 3: Establish long-lasting reforms that sustain the improvements in the quality of health and wellness for Nevada Medicaid beneficiaries and provide care in a more cost-efficient manner.

Objective 3.1: Reduce hospital readmissions by 10 percent. [1-1]

Objective 3.2: Reduce emergency department utilization by 10 percent. [1-1]

Goal 4: Improve NCCW enrollee's satisfaction with care received.

Objective 4.1: NCCW enrollee satisfaction improves over baseline.

Enrollment Information

Demonstration Populations (in person counts)	**Enrolled in Current Quarter** (07/31/17)	**Disenrolled in Current Quarter** (07/30/17)	**Current Enrollees** (09/30/17)
Population 1: MAABD	20,988	0	22,528
Population 2: TANF/CHAP	17,195	0	17,135
Total:	38,183	0	39,663

Note: * DHCFP uses the formalized process according to CFR 42 438.56; which states there are two ways in which a disenrollment occurs. The ways in which the disenrollment may be completed are that of the State requesting the disenrollment or the beneficiary submits a request for disenrollment. It is not considered disenrollment when someone is removed from the program due to eligibility status change.

Demonstration-Qualifying Conditions (in person counts)	**Enrolled in Current Quarter** (07/31/17)	**Disenrolled in Current Quarter** (07/31/17)	**Current Enrollees** (09/30/17)
Diagnosis 1: Asthma	6,406	0	6,817
Diagnosis 2: Cerebrovascular disease, aneurysm, and epilepsy	3,045	0	3,239
Diagnosis 3: Chronic obstructive pulmonary disease, chronic bronchitis, and emphysema	2,281	0	2,547
Diagnosis 4: Diabetes mellitus	3,661	0	4,065
Diagnosis 5: End stage renal disease and chronic kidney disease	1,184	0	1,321

Note: *

Demonstration-Qualifying Conditions (in person counts)	**Enrolleed in Current Quarter** (07/31/17)	**Disenrolled in Current Quarter** (07/31/17)	**Current Enrollees** (09/30/17)
Diagnosis 6: Heart disease and coronary artery disease	2,023	0	2,280
Diagnosis 7: HIV/AIDS	293	0	342
Diagnosis 8: Mental health	13,354	0	15,126
Diagnosis 9: Musculoskeletal system	4,585	0	5,227
Diagnosis 10: Neoplasm/cancer	350	0	384
Diagnosis 11: Obesity	4,664	0	5,058
Diagnosis 12: Substance use disorder	7,410	0	8,227
Diagnosis 13: Pregnancy	2,956	0	3,037
Diagnosis 14: Complex Condition/High Utilizer	750	0	864

Note: enrollees may be counted twice due to the ability to fall under multiple diagnoses categories at the same time.

Note: Methodology improved from prior reports to remove duplication of enrollees with multiple diagnoses within the same category. This primarily affects diagnosis categories 8 and 9 and has no effect on categories comprised of a single diagnosis.

Determinations

The following chart reflects data on demonstration eligibility determinations during Q4/2017 as required under STC 26:

# of Determinations (by methodology)	**Determination methodology (in person, telephonic, etc.)**	**Determination outcomes by determination methodology**
Approximately 60,000 eligible members provided to vendor.	Per vendors automated medical claims analysis and stratification	Approximately 39,388 enrolled beneficiaries at quarter ending 09/30/17

Disenrollment's

The following chart reflects data on demonstration disenrollments during Q4/2017 as required under STC 26:

# of disenrollments (by reason)	**Reason(s) for disenrollment**
0	N/A

Note: DHCFP uses the formalized process according to CFR 42 438.56; which states there are two ways in which a disenrollment occurs. The ways in which the disenrollment may be completed are that of the State requesting the disenrollment or the beneficiary submits a request for disenrollment. It is not considered disenrollment when someone is removed from the program due to eligibility status change.

Non-compliance

The following chart reflects data on beneficiaries determined non-compliant during Q4/2017 as required under STC 27:

# of recipients categorized as noncompliant	0

Note: The DHCFP requested guidance regarding the definition of noncompliant. It is the current understanding of the state that it is not considered to be noncompliant when a recipient is no longer enrolled in the program due to relocation or the member is deceased.

# of demonstration-eligible beneficiaries on CMO waiting list	**# added to waiting list since previous quarter**	**# moved from waiting list to enrollment in the CMO**
0	0	0

Enrollment Fluctuations

DHCFP reports the enrollment numbers for Q4/2017 with a steady monthly enrollment average of 39,388 members.

Outreach/Innovative Activities

The DHCFP continued CMO outreach activities with AxisPoint Health (APH) during Q4/2017. The following chart lists the outreach activities for Q4/2017.

Date	**Outreach Activity**	**Summary of Activity**
July 11, 2017	Northern Nevada Behavioral Health Coalition (NNBHC), Reno, NV	Meeting was canceled but Dr. Karen Torry Greene of Beacon was able to introduce herself as the new Program Director to some of the individuals attending the meeting. The NNBHC is a monthly meeting held to improve criminal justice outcomes for people with mental illness through

Date	Outreach Activity	Summary of Activity
		conversations and developing a short-term action plan.
July 13, 2017	Southern Nevada Oxygen 187 N. Gibson Rd. Suite 100 Henderson, NV 89014	AxisPoint Health (APH) met with Katina Bradon, Location Manager and Briel Matthews, Customer Service Representative at Southern Nevada Oxygen. Explained APH program and oxygen needs. Asked about any other Durable medical Equipment (DME) they provide. Southern Nevada Oxygen also provide Bent Metal which includes wheelchairs, hospital beds, walkers and beside commodes. Three years ago Southern Nevada Oxygen was purchased by AeroCare. Ms. Bradon explained that she has a preference for Medicaid as a pay source. She explained the needed documentation for portable oxygen tanks and portable oxygen concentrators for members who meet criteria. She also described what members need to do to discontinue service with current oxygen provider after APH stressed there cannot be a disruption in service. She provided APH staff with a pamphlet, "Navigating the Documentation Maze" as well as an Equipment Order form as a sample. Ms. Matthews stated she will email or fax an Equipment Order form for APH to use.

Date	Outreach Activity	Summary of Activity
		Southern Nevada Oxygen also has a COPD Program (Breathe A Little Easier) and staff was provided a flyer. APH staff described the difficulty members who are unable to push E-tanks and the need for smaller portable tanks as larger tanks cannot be pulled with walkers. Southern Nevada Oxygen reports they would refill up to 12 units per month and that other oxygen companies should be doing the same. Ms. Bradon stated that the salesperson for their company would contact APH regarding other DME needs.
July 17, 2017	Baby Bounty Lutheran Social Services 73 Spectrum, Las Vegas 89101	AxisPoint Health (APH) staff toured Lutheran Social Services facility and was introduced to their staff. Baby's Bounty has now joined Lutheran Social Services and is currently located in their building in 73 Spectrum, Las Vegas 89101. http://babysbounty.org Founder, Kim Amato, started Baby's Bounty™ in Las Vegas in July of 2008 to address the rise in homelessness among families with young children. Hospital and Clark County caseworkers confirmed that many families were leaving the hospital without a safe place to sleep, clothing and diapers. Now, each baby in need

Date	Outreach Activity	Summary of Activity
		receives a Baby Bundle with new and gently used infant clothing, receiving blankets, bottles, toiletries and baby gear, such as a pack ‘n’ play (portable crib), car seat, bathtub and a front carrier for a parent. APH staff met with the Director of Operations, Darlene Durham, who provided a tour of the Baby Bounty room where they provide car seats and pack 'n plays, diapers and clothing for infants six months and younger with a referral from a Social Worker. For those who are in need of a pack 'n play, they are required to attend Safe Sleep workshop. Lutheran Social Services now has a grant and will be moving to their own building off Desert Inn and Boulder Highway and Baby's Bounty will join them.
July 26, 2017	Commission Behavioral Health Children’s System of Care Behavioral Health Subcommittee Workforce Development Workgroup	AxisPoint Health (APH) staff participated over the phone.
July 27, 2017	West Care Reno, Community Triage Center 315 Record St. #103 Reno, NV 89512	Visit with Lindsey Robards, LSW and Ryan Ley, MD. West Care operates a 20 bed detox facility for both males and females. Alcohol, heroin, methamphetamines are the most common. Patients are not held against will and need to agree to services. Patients need to be transferred to Emergency Department (ED) if not agreeable for services. Police sometimes bring in people

Date	Outreach Activity	Summary of Activity
		to safely regain sobriety instead of detoxing in jail. The intake process was described to Axis Point staff. West Care usually begins developing discharge plan on second day of treatment. West Care initiates suboxone treatment (tx) for narcotics and usually keep patients on suboxone tx for five days but others tx are three days. Vital signs per protocol every 4 hours, if signs of instability more frequently and may need transfer to ED. They have transport capability. Find it difficult to work with MTM. No medical care available in transport so would need ambulance for medical care. Currently they bill Medicaid (all types) as well as commercial insurance. They transfer Amerigroup patients to Wellcare. Have behavioral health counselors present for sessions. Will be acceptable for other tours in future (like RNs, CHW etc. just contact Lindsay.
July 31, 2017	Elko County Library, 720 Court St. Elko, NV 89801	Met with Teresa to schedule a meeting for Vitality and HCGP to tour the facility and discuss collaboration. Vitality Center is a drug or alcohol rehabilitation center with a primary focus on substance abuse treatment. The facility provides detoxification and halfway house services to the public. The treatment center provides residential short-term

Date	Outreach Activity	Summary of Activity
		treatment and residential long-term treatment care.
August 1, 2017	Partners Allied for Community Excellence (P.A.C.E.) Rural Providers Coalition	Attendance: 34; Vicki Salazar, Access to Healthcare Network; Wanda Brown, Battle Mountain Counseling & Supportive Services; Rhonda Meyer, Division of Health Care Financing and Policy (DHCFP); Bobbi Shanks, Mary Headley, Elko County School District; Stacy Rice, Family Resource Center; Amanda Leaman, Friends In Service Helping; Antonia Roman, Health Care Guidance Program; Lidia Cortes, Justice for Stephanie; Drucilla Gatter, Rhonda Leahy, Nevada Division of Welfare & Supportive Services (DWSS); Amelia Marin, Nevada Office of Consumer Health Assistance; Brandolyn Thran, Nevada Outdoor School and Open Gate Foundation; Fabrizza Baeza, Northeastern Nevada Radiation Oncology Center; Jessica Ford, Northeastern Nevada Regional Hospital; Teri Lockie, Premier Adoption Agency; Lynette Vega, Survivors of Suicide Loss of Northeastern Nevada; Marion Davis, Jerome Washington, U.S. Department of Veteran Affairs, and Veterans Benefits Administration; Julie Woodbury, Jill Tingey, University of Nevada Cooperative Extension; Theresa Green, Brian Gomez, Vitality Unlimited; Amber Teats, Mireya Medina, The Children's Cabinet;

Date	Outreach Activity	Summary of Activity
		Dayna Kottwitz, Horizon Hospice; Kelli Boulette, Nevada Health Centers; Marianne Mckown, Committee Against Domestic Violence; Larry Clarke, Cynthia Stephenson, Mavis Salgado, Your Choice Behavioral; Michelle Rose, Vitality Integrated Programs; Rebecca Savala, Division of Child and Family Services (DCFS); Rebecca Byrns, Elko Counseling and Supportive Services PACE Coalition Director Laura L. Oslund, opened the meeting by greeting everyone who attended. She announced the National Night Out event, inviting listeners to attend. She announced that PACE has one full-time and one part-time AmeriCorps job opening. They make a living stipend and an educational award. Older people can give the educational award to immediate family. Mary Ann Martinez – PACE Coalition: She will be giving a Safe Talk suicide awareness training Aug. 31st from 9 a.m. – noon. at the Elko Area Chamber of Commerce if she can get at least 15 sign-ups. She will teach a diabetes management course starting Aug. 28th for anyone dealing with the disease or who is interested in learning about it.

Date	Outreach Activity	Summary of Activity
		She announced that Walk a Mile in Her Shoes will be held Oct. 14th from 10 a.m. - noon Mike Magney – PACE Coalition: After introducing himself, spoke about his CADCA conference and those who attended with him: Deborah Anderson from NNRH, Jacob Park with the Veterans Resource Center and Aimee Cerda from DCFS. He described the type of sessions and training offered and how coalitions like PACE can leverage the resources available through partnerships with coalition members. Brandolyn Thran – Nevada Outdoor School: Brandolyn reported on the NOS camp season. Now they can prepare for fall activities. NOS supports Friends of the Ruby Mountains and their free family events called Cool Canyon Evenings. NOS wants to have weekly or monthly meetings for families to encourage them to get out in nature and teach them outdoor skills. Lynette Vega – Survivors of Suicide Loss of Northeastern Nevada: Lynette announced upcoming events. Aug. 29-30 will be ASSIST Training at the Elko County School District Office. There will be a Safe Talk Aug. 31 separate from the one Mary Ann is doing. The 12th Annual Walk

Date	Outreach Activity	Summary of Activity
		in Memory, Walk for Hope will be Sept. 9th. September 12th there is a program called Elko County Save Lives! Zero Suicides beginning from 5:30 – 7:30 p.m. preceded by a reception from 3 – 5 p.m. in the GBC Amphitheatre. From Aug. 15 – Sept. 15, there will be an exhibit with information about suicide at the college library. Marianne Mckown – Committee Against Domestic Violence: She introduced herself as the new director and said she wants to get her organization involved with more agencies. On Oct. 14th GBC will put on a benefit reading of August in Ossage County. Wanda Brown – Aging and Disability Services Division: She said she would do a presentation to the county commission and a radio show talking about Medicare Services. Medicare will begin using a new card with an 11-digit number replacing the social security number. It will start rolling out in April 2018 with delivery of new Medicare cards. Open Medicare enrollment will begin Oct. 15th. Lidia Cortez – Justice for Stephanie: One of Justice for Stephanie's long-term goals is to raise money to create a safe haven site for parental supervised visitations. There will be a

Date	Outreach Activity	Summary of Activity
		softball tournament in September. It is an annual fundraiser. Antonia Roman – Health Care Guidance Program (HCGP): Antonia gave additional information about Justice for Stephanie and the Softball Tournament. Then she spoke about the services the HCGP offers people. Jerome Washington – Veterans Benefits Center: He helps veterans around the state and northern California pursue benefits and helps them with financial assistance. Marion Davis – Veterans Benefits Administration: She does community outreach and wants veterans to know what benefits are available to them. If anyone knows of veterans who may need assistance, she asked to be contacted so she can help them. She is trying to get the Reno director to attend a meeting here. Jesica Ford – Northeastern Nevada Regional Hospital: She is the hospital's patient navigator, a new position in which she follows up with patients following their discharge, especially those at high risk for readmission, and tries to connect them with resources to support them. Fabrizza Baeza – Northeastern

Date	Outreach Activity	Summary of Activity
		Nevada Radiation Oncology Center: Fabrizza said her organization is trying to increase awareness of their facility's availability. She also mentioned NNROC's ongoing free monthly Nutrition Classes for anyone who has been touched by cancer. Vicki Salazar – Access to Healthcare Network: Her office will be available to help answer questions about the transition to the new Medicare cards. Teri Lockie – Premier Adoption Agency: She said November is National Adoption Awareness Month. She said she would be at National Night Out bringing awareness about how many children in this area need permanent homes. Jill Tingey – University of Nevada Cooperative Extension: She is with the Heart & Shield program. They will be interviewing for a new director. Those interested can be part of the process. Rebecca Savala – DCFS: There is a need for more foster parents and there will be a training for foster parents in Winnemucca the weekend of Aug. 20th. Brian Gomez, LCSW – V.I.P. Center, Vitality Unlimited: Center is on the bluff. They have three clinicians and are ready to accept

Date	Outreach Activity	Summary of Activity
		clients. Kelli Boulette – Nevada Health Centers: She is responsible for their immunization program. It is available for anyone who needs immunizations, including for school. She is also responsible for birth control working with the Title 10 grant. It covers people even if insurance won't pay for it. She counsels people about their options. Michele Rose – Vitality Unlimited: She is an occupational therapist and helps people with mental health issues get up and out again in the community, at work, etc. Dayna Kottwitz – Horizon Hospice: Dana is the office coordinator. She announced trainings in September and October for those interested in becoming hospice volunteers. Bobbi Shanks – Elko County School District: She is the School Nurse Coordinator. School starts Aug. 28th. Registration is ongoing. Stacy Rice – Family Resource Centers of Northeastern Nevada: She conducts the Teen Health Classes and announced the next classes. Abstinence and pregnancy prevention is taught. Kids who complete the classes

Date	Outreach Activity	Summary of Activity
		get a backpack. Amber Teats – The Children's Cabinet: Amber is the program coordinator. They do a home visiting program. They have an opening for a full-time home visitor. Rebecca Byrns – Elko Counseling and Supportive Services: Her office is hiring a new therapist. Julie Woodbury – University of Nevada Cooperative Extension: There will be a Heart & Shield fall session and an upcoming program demonstration in September Amanda Leaman – Friends in Service Helping: Amanda is the client services program manager. They offer services to low income people and the homeless. She also provides homemaking services to people over 60 to help keep them in their homes. Mavis Salgado – Your Choice Behavioral: They provide mental health services and teletherapy in Elko and Carlin. Larry Clarke – Your Choice Behavioral: They are a Las Vegas based office offering teletherapy and medication management services in the Elko area and are looking to expand their services. They work in conjunction with

Date	Outreach Activity	Summary of Activity
		the Family Resource Center. Amber Teats gave the presentation. She talked about The Children's Cabinet home visiting program called HIPPY U.S.A. It stands for Home Inspections of Parents of Preschool Youngsters. They work with parents of children from three to five years old. The program offers curriculums for Year 1, Year 2, and Year 3.
August 1, 2017	Your Choice Behavioral Service Providers, Elko County Library 720 Court St. Elko, NV 89801	Beacon Health Staff met with Mavis Delgado and Larry Clark, YCB (Your Choice Behavioral) plans to meet with clients in Eureka and appreciates the referrals from HCGP. The provider is now offering PSR and BST (Psychosocial Rehabilitative Interventions and Basic Skills Trainings) services in Outlying areas of Elko County. Will follow any questions with Antonia.
August 1, 2017	Survivors of Suicide, Elko County Library 720 Court St. Elko, NV 89801	Beacon Health Staff met with Coordinator Lynette Vega about upcoming Walk for Remembrance on September 9th in Elko. Event will take place behind Elko City Park. Gave Health Care Guidance Program (HCGP) info and left contact info.
August 19, 2017	Health Fair Carson Valley Medical Center	Beacon Health Staff held a booth and met with community. Provided education about Health Care Guidance Program (HCGP) services.

Date	Outreach Activity	Summary of Activity
September 8, 2017	Dignity Health/Wellness Henderson, NV	AxisPoint Health (APH) staff met with Mark Domingo Community Health Worker (CHW) and Manager; Holly Lyman, MPH, Manager; and Monica DeBrest, CHW. Monica is teaching CHW classes as part of the state sponsored blended CHW education classes. Facility is not physically connected to a health care facility and is set up for classes. Focuses on women's health, diabetes, breast feeding classes, and exercise classes. Well received by the older adults who are reported to develop friendships and connections in the classes. Consider having Lorna reach out to them to discuss about behavioral health. Not sure what they have available, some kinds of counselors but it wasn't clear what the availability or interest was. Said they do take Mediciad FFS. Skype webinar with CHWs-- to tell them about the program. Also could have someone visit with the Dignity wellness people and have a skype webinar at the same time. (a blended visit).
September 8, 2017	AeroCare	E-mail contact between AxisHealth Point (APH) staff and Christopher Maglaras, Sales Manager. APH staff was informed that AeroCare has a Regional headquarters in Nevada and has several sites in Southern Nevada and Ely. They have no locations

Date	Outreach Activity	Summary of Activity
		in Elko or Reno (Northern Nevada). They offer comprehensive Durable Medical Equipment (DME) at this site, all types of orthopedic and PT appliances through Bent Metal. They do not offer advance wound care. They specialize in respiratory care. They do not offer enteral or urology supplies yet. They have advanced RT stuff, including a new wearable ventilator, that provides PEEP type effect to wearer with air flow. Sounds good for COPD/emphysema patients. (Life, 2000h) studies show decrease emergency department and hospital admission as well as improved comfort/exercise tolerance. They reported that they are very interested in Medicaid business.
September 8, 2017	Life Change Center 1201 N. Stewart St. Carson City, NV 89701	Beacon Health staff attended an open house hosted by the Life Change Center in Carson. Met several staff members including the executive director and site director John Firestone. Discussed their Medication-Assisted Treatment Subtance Abuse program (MAT SA), needs, obstacles, funding, and billing , took a tour of the facility, and discussed the HCGP with them. Met the local NAMI (National Alliance on Mental Illness) coordinator, a Nevada Welfare supervisor, and a Carson

Date	Outreach Activity	Summary of Activity
		High School Safe School Professional. Introduced and discussed the HCGP and their respective programs with all above mentioned individuals.
September 27, 2017	Programs for All Inclusive Care for the Elderly Reno, NV	Beacon Health staff attended Programs for All Inclusive Care for the Elderly (PACE) conference in Reno. Met and exchanged information with Katie from Senator Dean Heller's office so that Katie would have a better understanding of the Health Care Guidance Program (HCGP). Katie did not have a business card with her, but promised to follow up with an email. Met with Misty Vaughan Allen, a suicide specialist for the state of Nevada, and exchanged information regarding respective programs. Misty asked Beacon Health Staff to attend the upcoming suicide conference, which is arranged. Beacon Health Staff met several other speakers and participants, made general conversation, paving the way for future encounters.
September 29, 2017	Social Worker Supervisory Training Reno, NV	Beacon Health Staff attended Social Workers Supervisory Training. Met Sandra Lowery, Interim Exec Director for Nevada Board of Examiners for Social Workers. No interaction regarding HCGP, but Beacon Health Staff learned about the Nevada Social Work Board and met some other social workers in the state, including

Date	Outreach Activity	Summary of Activity
		Carla Buckner (private practice), Christopher (private practice in Carson), Randy Hill (Air Nat'l Guard), Dale Capero (Carson Tahoe Outpatient), Betsy Glass (Human Behavioral Institute), Sharon Willins (Children and Parenting), AJ Cornella (Alta Vista Mental Health), Scott Cohen (Las Vegas VA), Pam Renado (Spring Mountain Hospital), Alexa Walden (Sierra Sage Academy), Donna Kudeslas (Northern Nevada Medical Center Intensive Outpatient Program), Melany Summersdan (St. Marys), Brian and Shelly Gomez (Vitality Clark County Behavioral Health Coalition Elko), Jillian Gold (Monte Vista), Juth Tolmen (Never Give Up), and Valerie Beonke Wood (St Marys/Carson Professional Group). From this class, Beacon Staff Dr. Karen Torry Greene became a LCSW/LISW supervisor, and pursued relationship with Brian Gomez. Dr. Greene met fellow (doctoral student) classmate, Brian Gomez, and his wife Shelly, who are with Vitality Unlimited, the Elko CCBHC. We discussed our respective programs, and Brian agreed to pass information on to their CEO (Chief Executive Officer). Dr. Greene followed up with email. Ester Qulici, CEO for Vitality Unlimited, followed up with phone call to Dr. Greene to determine appropriateness of

Date	Outreach Activity	Summary of Activity
		outreach. Discussed HCGP and CCBHCs. Agreed it would be appropriate and beneficial for HCGP to present during a one-hour all staff meeting with Elko HCGP staff in attendance, and Dr. McCrorey remotely. Ester will contact Dr. Greene with date
September 30, 2017	LBGTQ Community Health Fair 780 Del Monte Ln. Reno, NV	This event was not heavily attended by members, but had a good amount of providers and other resource facilities. Beacon Health staff was able to make some good connections and contacts. We did identify one member however that had mentioned he was avoiding our calls because he did not know who we were. He was trying to obtain services with a local psychologist and was not having any luck. He was also self hurting with visible signs and admitted that he was diagnosed with Bi-Polar disease. We were able to obtain his trust and he reassured us he will contact/answer calls from HCGP for himself and his sibling.

Note: for every provider outreach, team provides tools for immediate services such as; Real Time Referrals (RTR) forms, contact phone numbers to the 24/7 Nurse Advise Line, Enrollee Assessment, Provider Manuals and Access to the Provider Portal.

Operational Developments/Issues

The DHCFP held its Quarterly Health Care Guidance Program (HCGP) Meeting on July 25, 2017. Following the updated Quality Strategy Modules, AxisPoint Health (APH) presented the following:

- Program Updates, presented by; Cheri Glocker, HCGP's Executive Director, and Dr. Virginia Gurley, Chief Medical Officer, APH.

  - Key Accomplishments: APH continues collaboration with the states Medical Transportation Management (MTM) to resolve member issues. APH prepared proposal for DHCFP consideration for Amendment #6. APH worked on increasing contacts and engagement by enhancing ways to reach out to members. Staff went to Las Vegas and Elko for outreach activities and had a meet and greet meeting with the Elko hospital staff.
- Dr. Virginia Gurley discussed the work they are doing using Text Messaging, for digital health campaigns. Once APH has obtained cell phone numbers and permission from members to text them they will begin their pilot. First they will pilot with a breast cancer text campaign and then later in the year will be an influenza vaccination campaign. Dr. McCrorey, HCGP Medical Director will determine how this will benefit the HCGP.
- Quality presentation presented by Michelle Searing, Outcomes Operation Manager, APH.
  - Michelle Searing presented on Quality Module #5: Objectives 1.1 and 1.2 and Quality Module #6: Objective 1.5 and Module #7: Objective 2.1 and 2.2.
  - Quality Module #5: Objectives 1.1 and 1.2. At the state's request APH is to provide this module at every quarterly meeting. The modules consist of revised graphs presenting the new and existing enrollees. Objective 1.1 looks at the total enrollment, new and existing enrollees, and averaging from 800-1000 new members every month. New Members defined as never had been in the program. It also looks at the number of members dropped from the program due to TCM. Objective 1.2 looks at the enrolled persons vs. person actively receiving case management (CM) services.
  - Module #8: Objectives 2.3 and 2.4, reviewed the specified Non Pay for Performance (Non P4P) and Pay for Performance (P4P) clinical measures. APH was asked to describe the tools, interventions and evaluation processes deployed by the program to improve, reach target, and or sustain improvement for the measures as outlined in module 8 of the quality strategy. APH focused on medications prescribing and adherence, and monitor for quality improvement by conducting monthly review of medication compliance.
  - APH discussed the different interventions (objective 2.3 and 2.4) they have in place which are prioritize with the top being the roughly more important than the bottom (see slide deck page 10 of the NV HCGP APH Quarterly July 2017 presentation).
  - Brian Baker with Beacon Health presented on the identified causes and interventions that are more Mental Health Specific. Beacon identifies that there are not enough providers to care for the people we have. Some mental diseases such as schizophrenia leave people paranoid, which in turn mean they don't trust the system, providers or medication, lack of motivation. The team focuses on the medical health, clinical care alerts that occur on a monthly basis, 23,000 different rules get applied to the data that target medications. Another piece is the use of peer staff to counteract the stigma to having a behavioral health issue or being medicated for a behavioral health issue that can speak to the needs of taking medication and who use these medications.
- Outreach:
  - Dr. Thomas McCrorey, Medical Director for the HCGP provided an update on outreach activities.
    - A total of 21 formal meetings with major care providers such as clinics and hospitals.
    - Special focus on Certified Community Behavioral Health Center (CCBHC) outreach. As of July 19th, joint leaders meetings were held at 4/5 of the sites. Focus on mutual support and clarification of TCM billing to avoid working at cross purposes.
    - Provider Advisory Board (PAB), expanded to additional stakeholders. Next meeting in September 2017 to have discussion of Transitional Case

Management – presentation by Chief of Case Management from Valley Health and one of APH Care Managers.

- The DHCFP and CMS held bi-monthly calls on July 28, 2017 and August 25, 2017. At the July 28, 2017 meeting. Introductions took place. DHCFP acknowledge receipt of email regarding the different program authorities. August 25, 2017 meeting. Introductions took place. DHCFP continues to have internal discussions about the renewal of the program, discussed with CMS renewal process, including deadlines, and documentation. Updated CMS that the state will be providing an updated budget neutrality worksheet with the quarterly CMS report.
- On August 23, 2017, held a public hearing providing revisions to the Medicaid Service Manual (MSM) Chapter 3800. Revisions to MSM 3800 were proposed to ensure policy accuracy in alignment with the 1115(a) Nevada Comprehensive Care Waiver. Family Medical Coverage Categories were removed as these are no longer accurate and have been replaced with up-to-date categories due to the implementation of the Patient Protection and Affordable Care Act. The use of contractual language has been removed from the document as it is not necessary for the understanding of program policies and procedures.
- The DHCFP informs key staffs to the CMO are no longer with the agency; that staffs are Ms. Rachel Marchetti, Social Services Specialist II and Mr. John Kucera, Management Analyst III. These vacant positions have posed a challenge to the CMO program; however as of November 2017 positions are fully staffed and we welcome Ms. Julie Lindesmith, Social Services Specialist II and Mr. Marko Markovic, Management Analyst III.

Care Management Contracting

- The DHCFP continues to work with the CMO Vendor on Amendment #6. The purpose of this amendment is to be in compliance with CMS language to Attachment B of the Special Terms and Conditions (STCs) in that it reads "The state must submit a request for an amendment to Attachment B by June 30, 2017 to extend this timeframe if it anticipates that any payment will be made to the CMO's after June 30, 2018". On December 21, 2016, the DHCFP e-mailed CMS asking for guidance as to where the language should be included? To comply with this existing requirement in Attachment B of the STCs, the waiver period will need to be extended to December 2019 to allow for the required amount of claims lag, evaluation, and a potential incentive payment. The state has provided a revised word document of the approved NCCW Attachment B and revisions that will need to be made to "Table 1. Time Frames for State of Nevada Data Extracts" to be in compliance in the event CMS approves the extension. Amendment # 6 will also include updates on the P4P Quality Measures that have been retired and add new Non P4P measures that were identified during the 2015-16 Performance Measure Validation (PMV) Audit as non reportable measures, order of contractual precedence documents, and various revisions to the section of the RFP. Amendment#6 has not yet been submitted to CMS due to priorities within in the program.

Policy Developments/Issues

On March 6, 2014, the addition of the new Medicaid-eligible Modified Adjusted Gross Income (MAGI) individuals to the CMO-eligible population was discussed with CMS due to the implementation of health care reform. On March 12, 2014, per CMS guidance, the DHCFP submitted a technical correction to the STCs to address this new Medicaid population and align the eligibility charts (STC 17) with the revised medical assistance AID categories. As of today we have not received any additional feedback and/or final approval from CMS regarding MAGI.

Financial/Budget Neutrality Development/Issues

The DHCFP is submitting an updated budget neutrality work sheet as a requirement to the Special Terms and Conditions (STC's). The DHCFP team would like to bring to CMS attention that the worksheet cannot show any change in PMPM amount quarter-to-quarter due to program design; the program runs on a fixed Per Member Per Month (PMPM) rate of $15.35. The state will find out of the vendor is eligible for an incentive bonus payment after the annual program evaluation is complete, which is the only way the average per member per month cost of the program could change. There has been no incentive payment made from inception of the program to current and, as a result, the PMPM cost of the program in each month of operation has been $15.35.

Member Month Reporting

Demonstration Populations	Month 1 (July 2017)	Month 2 (August 2017)	Month 3 (September 2017)	Total Ending (October 2017)
Population 1: MAABD	20,988	23,097	22,528	23,055
Population 2: TANF/CHAP	17,195	17,222	17,135	17,417
Total:	38,183	40,319	39,663	40,472

Consumer Issues

There are no consumer issues to report for this quarter (Q4/2017).

Quality Assurance/Monitoring Activity

Per STCs 26 & 27, the State is required to report on demonstration eligibility determinations, the number deemed non-compliant and "on demand for noncompliance." For this quarter (Q4/2017), please see table on page 3 for "noncompliance".

The DHCFP reports zero (0) number for those deemed non-compliant and "on demand for noncompliance". The DHCFP sent CMS an e-mail on August 19, 2015 for guidance on the definition of noncompliance to assure reporting is done adequately. The program has been operating since June 2, 2014, and has a zero count. The DHCFP is awaiting the response from CMS to ensure that this measure is being accurately reported.

Demonstration Evaluation

The DHCFP draft Evaluation Design Plan for the NCCW was submitted to CMS on October 14, 2013. On February 2, 2014, DHCFP received feedback from CMS. The DHCFP re-submitted the Evaluation Design Plan for the NCCW to CMS on March 5, 2014, incorporating CMS feedback. On February 24, 2015, the DHCFP received feedback from CMS. The DHCFP received feedback from CMS on January 12, 2017. CMS has additional questions. The DHCFP submitted responses to CMS questions on January 24, 2017. On January 31, 2017 during the Nevada Comprehensive Care 1115 (a) Demonstration Bi-Monthly Monitoring Call, CMS confirmed receipt of January 24th e-mail. On April 26, 2017 CMS followed up with the DHCFP and request that the state provide an updated evaluation design plan that accurately reflect the

current/actual pre-and post analytic methodology and data sources the state is using to measure the impact of the this demonstration. The state plans on submitting updated evaluation design in January 2018 if not sooner.

Enclosures/Attachments

- 20171120 Updated member months for budget neutrality calculation
- FINAL Budget Neutrality Template for Nevada – Updated November 28 2017
- Minutes for HCGP Quarterly Meeting 04-25-17
- MSM PH 08 23 17 Minutes
- Sign in sheet HCGP Qtrly Mtg 07252017
- NV HCGP APH Quarterly July 2017 final
- NV Quarterly Meeting Agenda 07252017
- Sign in Sheet for HCGP Qrtly Mtg 07252017
- June 2017 Provider Advisory Board (PAB) Meeting Minutes
- HCGP Jun17 PAB update

State Contact(s)

DHCFP Staff

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Lisa Koehler Contract Manager	Management Analyst III	775-684-3708	775-684-3643	1100 E. William St. Carson City, NV 89701

Date Submitted to CMS

November 30, 2017

Nevada Division of Health Care Financing and Policy
Health Care Guidance Program
Membership Using STC Criteria

TANF/CHAP

	PY14	PY15	PY16	PY17
Current	199,982	221,233	210,724	202,986
Prior	221,730	230,599	239,823	202,950

ABD

	PY14	PY15	PY16	PY17
Current	234,696	259,918	260,251	264,508
Prior	234,967	244,366	254,141	263,503

Note:
Payment years are June - May
Prior numbers are on a SFY (July-June) basis

HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY DEMONSTRATION PROJECT

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION

MEDICAID POPULATIONS (Should be blank-filled if no existing Medicaid populations will be in the demonstration.)

ELIGIBILITY GROUP	BASE YEAR SFY 2013	DEMO TREND RATE	DEMONSTRATION YEARS (DY) SFY 2014	SFY 2015	SFY 2016	SFY 2017	*SFY 2018	TOTAL WW
TANF/CHAP Pop 1								
Eligible Member Months	213,202	4.00%	**199,982**	**221,233**	**210,724**	**202,950**	**51,552**	
Care Coordination PMPM Cost	$ 20.46	0.00%	**$ 15.35**	**$ 15.35**	**$ 15.35**	**$ 15.35**	**$ 15.35**	
Total Expenditure			**$ 3,069,724**	**$ 3,395,927**	**$ 3,234,613**	**$ 3,115,283**	**$ 791,323**	$ 13,606,869
MAABD Pop 2								
Eligible Member Months	225,930	4.00%	**234,696**	**259,918**	**260,251**	**263,503**	**66,613**	
Care Coordination PMPM Cost	$ 20.46	0.00%	**$ 15.35**	**$ 15.35**	**$ 15.35**	**$ 15.35**	**$ 15.35**	
Total Expenditure			**$ 3,602,584**	**$ 3,989,741**	**$ 3,994,853**	**$ 4,044,771**	**$ 1,022,510**	$ 16,654,458

NOTES

For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. This is the default setting.
New hypothetical populations are shown in both without-waiver and with-waiver projections.
New non-hypothetical populations only appear in the with-waiver projections. The State must show offsetting Medicaid savings to achieve budget neutrality.
Demo Trend Rates' are a blended rate reduction that accounts for Waiver and Non-Waiver polpuation and Waiver Capitation payments to achieve budget nuetrality.
*SFY 2018 numbers are numbers for actual for first quarter of state fiscal year.

Please provide historical cost and eligibity data on existing Medicaid populations that will be included in the Demor

5 YEARS OF HISTORIC DATA

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP SERVED:

	SFY 2007	SFY 2008	SFY 2009	SFY 2010	SFY 2011	5-YEARS
TANF/CHAP Pop 1						
TOTAL EXPENDITURES	$ 70,654,141	$ 75,689,808	$ 75,582,668	$ 86,563,696	$ 99,096,227	$ 407,586,542
ELIGIBLE MEMBER MONTHS	97,157	120,198	141,620	173,527	197,117	
PMPM COST	$ 727.22	$ 629.71	$ 533.70	$ 498.85	$ 502.73	
TREND RATES		**ANNUAL CHANGE**				**5-YEAR AVERAGE**
TOTAL EXPENDITURE		7.13%	-0.14%	14.53%	14.48%	8.83%
ELIGIBLE MEMBER MONTHS		23.72%	17.82%	22.53%	13.59%	19.35%
PMPM COST		-13.41%	-15.25%	-6.53%	0.78%	-8.82%
MAABD Pop 2						
TOTAL EXPENDITURES	$ 325,002,881	$ 337,074,721	$ 334,044,247	$ 357,440,867	$ 358,505,007	$ 1,712,067,724
ELIGIBLE MEMBER MONTHS	159,387	174,300	183,712	199,533	208,885	
PMPM COST	$ 2,039.08	$ 1,933.88	$ 1,818.30	$ 1,791.39	$ 1,716.28	
TREND RATES		**ANNUAL CHANGE**				**5-YEAR AVERAGE**
TOTAL EXPENDITURE		3.71%	-0.90%	7.00%	0.30%	2.48%
ELIGIBLE MEMBER MONTHS		9.36%	5.40%	8.61%	4.69%	7.00%
PMPM COST		-5.16%	-5.98%	-1.48%	-4.19%	-4.22%

HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY DEMONSTRATION COST DATA

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION

MEDICAID POPULATIONS (If no existing Medicaid populations will participate in the demonstration, leave blank.)										
ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR SFY 2013	TREND RATE 2	DEMONSTRATION YEARS (DY) SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	TOTAL WOW
TANF/CHAP Pop 1										
Eligible Member Months	4.00%	24	213,202	4.00%	221,730	230,599	239,823	249,416	259,393	
Care Coordination PMPM Cost	0.00%		$ 20.46	0.00%	$ 109.30	$ 109.30	$ 109.30	$ 109.30	$ 109.30	
Total Expenditure					$ 24,235,984	$ 25,205,424	$ 26,213,640	$ 27,262,186	$ 28,352,674	$ 131,269,908
MAABD Pop 2										
Eligible Member Months	4.00%	24	225,930	4.00%	234,967	244,366	254,141	264,306	274,878	
Coordination PMPM Cost	0.00%		$ 20.46	0.00%	$ 109.30	$ 109.30	$ 109.30	$ 109.30	$ 109.30	
Total Expenditure					$ 25,682,887	$ 26,710,202	$ 27,778,610	$ 28,889,755	$ 30,045,345	$ 139,106,799

NOTES

"Base Year" is the year immediately prior to the planned first year of the demonstration.

"Trend Rate 1" is the trend rate that projects from the last historical year to the Base Year. The default is to use the 5-year historical average trend.

"Months of Aging" equals the number of months of trend factor needed to trend from the last historical year to the Base Year. If the base year is the year immediately following the last historical year, Months of Aging" will be 12.

"Trend Rate 2" is the trend rate that projects all DYs, starting from the Base Year. The default is to use the 5-year historical average trend.

For hypothetical populations, without-waiver estimates are set by default to equal the with-waiver extimates.

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	
TANF/CHAP Pop 1	$ 24,235,984	$ 25,205,424	$ 26,213,640	$ 27,262,186	$ 28,352,674	$ 131,269,908
MAABD Pop 2	$ 25,682,887	$ 26,710,202	$ 27,778,610	$ 28,889,755	$ 30,045,345	$ 139,106,799
TOTAL	$ 49,918,871	$ 51,915,626	$ 53,992,251	$ 56,151,941	$ 58,398,018	$ 270,376,706

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	
TANF/CHAP Pop 1	$ 3,069,724	$ 3,395,927	$ 3,234,613	$ 3,115,283	$ 791,323	$ 13,606,869
MAABD Pop 2	$ 3,602,584	$ 3,989,741	$ 3,994,853	$ 4,044,771	$ 1,022,510	$ 16,654,458
TOTAL	$ 6,672,307	$ 7,385,668	$ 7,229,466	$ 7,160,054	$ 1,813,833	$ 30,261,328

TOTAL	$ 43,246,564	$ 44,529,958	$ 46,762,784	$ 48,991,887	$ 56,584,186	$ 240,115,379

Exhibit 1
Budget Neutrality Evaluation - Comprehensive Care Waiver
Payments to CMO and Cost to State

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	Notes
Overall PMPM	1,108.26	1,102.21	1,096.27	1,090.43	1,084.71	(1)
Savings @ $5.1M	11.17	10.74	10.32	9.93	9.55	(2)
CMO Cost	20.46	20.46	20.46	20.46	20.46	(3)
Assuming 15% Savings						
Gross Savings - PMPM	166.24	165.33	164.44	163.57	162.71	(4)
"Excess" Savings - PMPM	134.61	134.13	133.66	133.18	132.70	(5)
Max Payout - PMPM	88.84	88.53	88.21	87.90	87.58	(6)
PMPM for Budget Neutrality	109.30	108.99	108.67	108.36	108.04	(7)

(1) Current FFS costs, taken from original budget neutrality calculation
(2) Contractually required savings ($5.1M), converted to a PMPM basis
(3) Base PMPM cost paid to CMO, including amount initially withheld
(4) Assumed savings as on a PMPM basis. Calculated as (1) x Savings Percentage
(5) = (4) - (3) - (2)
(6) = 66% x (5), assumes 100% quality score
(7) = (3) + (6)
Represents the "with waiver" cost to be put into the Budget Neutrality calculation

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION

MEDICAID POPULATIONS (If no existing Medicaid populations will participate in the demonstration, leave blank.)										
ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR SFY 2013	TREND RATE 2	DEMONSTRATION YEARS (DY) SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	TOTAL WOW
TANF/CHAP Pop 1										
Eligible Member Months	4.00%	24	213,202	4.00%	221,730	230,599	239,823	249,416	259,393	
Care Coordination PMPM Cost	0.00%		$ 20.46	0.00%	$ 20.46	$ 20.46	$ 20.46	$ 20.46	$ 20.46	
Total Expenditure					$ 4,536,592	$ 4,718,056	$ 4,906,778	$ 5,103,049	$ 5,307,171	$ 24,571,646
MAABD Pop 2										
Eligible Member Months	4.00%	24	225,930	4.00%	234,967	244,366	254,141	264,306	274,878	
Coordination PMPM Cost	0.00%		$ 20.46	0.00%	$ 20.46	$ 20.46	$ 20.46	$ 20.46	$ 20.46	
Total Expenditure					$ 4,807,429	$ 4,999,727	$ 5,199,716	$ 5,407,704	$ 5,624,012	$ 26,038,588

NOTES

"Base Year" is the year immediately prior to the planned first year of the demonstration.
"Trend Rate 1" is the trend rate that projects from the last historical year to the Base Year. The default is to use the 5-year historical average trend.
"Months of Aging" equals the number of months of trend factor needed to trend from the last historical year to the Base Year. If the base year is the year immediately following the last historical year, Months of Aging" will be 12.
"Trend Rate 2" is the trend rate that projects all DYs, starting from the Base Year. The default is to use the 5-year historical average trend.
For hypothetical populations, without-waiver estimates are set by default to equal the with-waiver extimates.

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION

MEDICAID POPULATIONS (Should be blank-filled if no existing Medicaid populations will be in the demonstration.)

ELIGIBILITY GROUP	BASE YEAR SFY 2013	DEMO TREND RATE	DEMONSTRATION YEARS (DY) SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	TOTAL WW
TANF/CHAP Pop 1								
Eligible Member Months	213,202	4.00%	221,730	230,599	239,823	249,416	259,393	
Care Coordination PMPM Cost	$ 20.46	0.00%	$ 20.46	$ 20.46	$ 20.46	$ 20.46	$ 20.46	
Total Expenditure			$ 4,536,592	$ 4,718,056	$ 4,906,778	$ 5,103,049	$ 5,307,171	$ 24,571,646
MAABD Pop 2								
Eligible Member Months	225,930	4.00%	234,967	244,366	254,141	264,306	274,878	
Care Coordination PMPM Cost	$ 20.46	0.00%	$ 20.46	$ 20.46	$ 20.46	$ 20.46	$ 20.46	
Total Expenditure			$ 4,807,429	$ 4,999,727	$ 5,199,716	$ 5,407,704	$ 5,624,012	$ 26,038,588

NOTES

For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. This is the default setting.
New hypothetical populations are shown in both without-waiver and with-waiver projections.
New non-hypothetical populations only appear in the with-waiver projections. The State must show offsetting Medicaid savings to achieve budget neutrality.
Demo Trend Rates' are a blended rate reduction that accounts for Waiver and Non-Waiver polpuation and Waiver Capitation payments to achieve budget nuetrality.

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	
TANF/CHAP Pop 1	$ 4,536,592	$ 4,718,056	$ 4,906,778	$ 5,103,049	$ 5,307,171	$ 24,571,646
MAABD Pop 2	$ 4,807,429	$ 4,999,727	$ 5,199,716	$ 5,407,704	$ 5,624,012	$ 26,038,588
TOTAL	$ 9,344,021	$ 9,717,782	$ 10,106,494	$ 10,510,753	$ 10,931,183	$ 50,610,234

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	
TANF/CHAP Pop 1	$ 4,536,592	$ 4,718,056	$ 4,906,778	$ 5,103,049	$ 5,307,171	$ 24,571,646
MAABD Pop 2	$ 4,807,429	$ 4,999,727	$ 5,199,716	$ 5,407,704	$ 5,624,012	$ 26,038,588
TOTAL	$ 9,344,021	$ 9,717,782	$ 10,106,494	$ 10,510,753	$ 10,931,183	$ 50,610,234

TOTAL	$ -	$ -	$ -	$ -	$ -	$ -

Health Care Guidance Program Meeting Minutes, Face to Face				Date: 04/25/2017
DHCFP Attendees: Jessica Mandoki, Rachel Marchetti, Gladys Cook, John Kucera, Gloria Macdonald, Lisa Koehler, Amy Roukie, Marta Jensen, Shannon Sprout				
Organization Attendees: DO: Charmaine Yeates, Heather Lazarakis, Shawna Vollmer, Linda Bowman, Kristen Schadegg **HCGP:** Shawn Donnelly, Margaret Flaum, Cheri Glockner, Dr. Thomas McCrorey, Dr. Tim Moore, Michelle Searing, Brian Baker, Dr. Ryan Ley, Lorna Lizotte, Summer Smith, Virginia Gurley **HSAG:** Gretchen Thompson				
Topic	**Discussion**	**Recommendation/Action Plan**	**Responsible**	**Due Date**
Welcome and Introductions	**Welcome and Introductions** **Gloria Macdonald**, Chief Research & Development (PRD) opened the meeting			
Approval of Minutes	**Approval of Minutes** Date needs to be updated, once completed minutes are approved.			
Program Updates	**Program Updates** **Cheri Glockner** Our new CMO, Dr. Gurley is transitioning in and Dr. Moore is transitions out. Worked with our PRD team on MTM issues, they suggested spreadsheet of issues. Summer and I have currently been working on that and will get that to you. Amendment 6 should be going out soon Executed renewal with Beacon Health Attending Legislative Meetings Presenting quarterly rates- have learned so much about these measures. Quarterly Assurance Report was delivered 2 weeks prior to this meeting. Will start review of PY2 quality report **Dr. Moore** Just a few comments, Ron, team and I have worked hard to create a smooth transition. Dr. Gurley is very well educated and will benefit the program. She will discuss our digital work we are working on right now. **Gloria Macdonald** Thank you for your dedications and hard work, pleasure working with you. **Virginia Gurley** Developing a new strategy at AxisPoint Heatlh, believe this will help stay connected with Medicaid community. Digital strategies, allow communication with beneficiary, so they can get back to us when it's			

DHCFP Attendees: Jessica Mandoki, Rachel Marchetti, Gladys Cook, John Kucera, Gloria Macdonald, Lisa Koehler, Amy Roukie, Marta Jensen, Shannon Sprout

Organization Attendees: DO: Charmaine Yeates, Heather Lazarakis, Shawna Vollmer, Linda Bowman, Kristen Schadegg **HCGP:** Shawn Donnelly, Margaret Flaum, Cheri Glockner, Dr. Thomas McCrorey, Dr. Tim Moore, Michelle Searing, Brian Baker, Dr. Ryan Ley, Lorna Lizotte, Summer Smith, Virginia Gurley **HSAG:** Gretchen Thompson

Topic	Discussion	Recommendation/Action Plan	Responsible	Due Date
	most convenience for them. Digital engagement campaign: new policy-route-digital strategy: Text Many low income people have smart phones more issue in rural area. Land lines are still a component. We are partnering with a company that specializes in digital technology. Developing Programs and Researching campaign focused on preventative services but will be branching out to focus on gaps in care. Automated responses, working on a different responses activate new questions, won't sit in a Que. Piloting in Santa Clara Valley with Valley Health Plan this summer. Need to pay attention and choose where we focus this technology service. Very early development could be very beneficial. Will get data from control panel and analyze. **John Kucera** Questions; You are making a lot of effort to locate and track people down, are you making a change to get reliable cell phone numbers **Virginia Gurley** Yes, that is an enhancement we are working on. Currently have the ability to store multiple numbers, working other system enhancements. Have put extensive efforts into cell phone company regulatory, some data providers can identify cell phone numbers. Also working to get list of those, risk is who should be higher. Working on another program, using social determinants data to determine benefits of health. **Shawn Donnelly** ROI Analysis – Background on analysis and how it matches up, during PY1 work with Milliman team through many details behind calculations. Use code to analyze data, come up with these results and matched to member list. What could cause this difference? We don't start with the exact same raw claims data, we worked with them on matching that but we couldn't back 100%, had a 93.6% match. And didn't match risk			

Topic	Discussion	Recommendation/Action Plan	Responsible	Due Date
	score adjustments. What does that mean, In PY1 calculated a total of $19.3 million total in gross savings and Milliman calculated 16.8 million in savings. What could cause that, 0.5% difference in risk score can cause about a 2 million dollar in savings amount. Process for PY 2, these are preliminary. We have 6 months of claims run out, the final results use 12 months of claims run out after the year ends. Graph shows Yr over Yr PMPM costs, (purple line at top) for group we are responsible for providing savings on. The line below is the group we use as a proxy. Both graphs go down year over year; however the one we are responsible for has dropped more than the other one year over year and that's where you see savings from the program. What does that mean? (using a dual axis chart to describe). Net savings in millions vs ROI, PY1 actual is posted, preliminary results for PY2 show improvement in both. **John Kucera** Questions: Your reconciliation population, the baseline piece we see a decrease from PY11 to P Y2, these are risk adjusted numbers correct? **Shawn Donnelly** We made these numbers apples to apples for all three years under the same bases, there is an idiosyncrasy within the contract, for risk scores you make everything equivalent to what the risk scores were at the baseline so that's what we did here. For a category and county residence. **John Kucera** Consensually speaking your group went down less as a total percentage then the trend group so I am trying to figure out how you coming up with a net savings when the trend population decreased as a % of the PMPM cost more than your population. The first year, your group went down more than the baseline, so that's why you had a gross and a net savings but here the trend population went down			

Topic	Discussion	Recommendation/Action Plan	Responsible	Due Date
	more than your reconciliation population so I am curious how you came up with the gross savings. **Shawn Donnelly** That's part of getting all three years under the same bases. Could be a difference in member months per each year. It is a really small difference within the year over year thing, can result in a few million dollars difference in savings amounts. Will share both spreadsheets behind numbers with John so he can review **Gloria Macdonald** Is there an easy way to explain how you did the calculation for the ROI? How are you calculating that? What does the calculation look like? The entirety of the information, or from year to year? **Shawn Donnelly** At a really high level an ROI equation is the gross savings divided by total cost of program. ROI = Gross savings/total cost of program ROI =1 Budget Neutral (meaning if you paid us 7million we reduced your claim cost by 7 million) ROI = 2.36 increase budget neutral (This means we have been above budget neutral) More into the detail of how that happens look at previous line chart. The gross savings number is calculated by comparing that program period 2 PMPM of 1182 to the base line PMPM of 1295. Now if you just took the difference between those two and applied it by the size of the population we are responsible for, you would end up with a pro savings number that's really large. But in fact when you look at the line below it, you see that the people not affected by the program costs have been going down too, we take that drop and adjust the top line. **Dr. Moore** The cost of program in our calculations are for the fees you pay us, it doesn't include the states time.			

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Topic	**Discussion**	**Recommendation/Action Plan**	**Responsible**	**Due Date**
	Cheri Glockner If you'd like more explanation we can have inner meeting between us and with Shawn. **Shawn Donnelly** The people our program is responsible for, we need to figure out how much they would have cost if the program didn't exist. That's the number we need to figure out. Best way is to look at what's happening with the healthy people and comparing that to what our people cost before the program started.			
Quality	**Quality** **Michelle Searing** The first objective we are reviewing is a repeat, one we review each quarterly. We review these metrics regularly, Nov-Feb. Pretty consistent of the total population being at 39,000. Slide 16 looks at enrollment population and who were existing and who are brand new to the program. You can see the greater portions of our enrollment are existing. If we look at March, we had about 500 people brand new to the program. Meeting in January regarding how to better address the TCM folks that come in and out of our program regularly. We are coming up with a better methodology for identifying those folks who may better be served or at least give a choice HCGP rather than a TCM provider for those folks that have intermittent care. **John Kucera** There are a good chunk of folks who would be eligible for the HCGP who are excluded because they have an existing T1016 or T1017 (Target Case Management claims), we didn't include any of this, we had a quick adjustment excluding everyone with a claim within 30 days, then we got to a methodology of any claim in the last 90 days we would exclude and that became too wide a net, over the last couple months we have been looking at a subset of folks that have been excluded (specifically due to T1016), started looking at the around 2500 members who would have been excluded and applied different methodology, test samples, the recommendation I came up			

Topic	Discussion	Recommendation/Action Plan	Responsible	Due Date
	with was instead of looking at 1 every 90 days, I suggested looking at 4 claims in 90 days. We are excluding about 75% of the correct people. This is going to allow those folks who receive one (1) TCM claim every 6 months, these are the members being incorrectly billed and will allow them into the HCGP. This will allow a few hundred more people into the program. **Margaret Flaum** Just to be clear, are these people you think really don't qualify for TCM? **John Kucera** These are people who receive one (1) claim every other month who are not in a real TCM program, these are people who are going to other centers receiving services and are also being billed for TCM, likely incorrectly, however not doing a medical records claim review. They appear to not be receiving assistance care from another group; they are more likely eligible for the HCGP program. **Gladys Cook** Will require a procedure memo (not an amendment). There is one in place and will be modifying to read 4 in the last 90 days. **Michelle Searing** That memo update, leads to me updating the program design update which tells the how and why. The other part where the member may elect TCM or HCGP is not contractual. **Shawn Donnelly** Answer to Johns question (why the trends did not match up with the net savings in regards to direction) – Simple explanation, in the trend graph that is all AxisPoint Health numbers, in the ROI net savings chart PY1 was Millimans numbers and PY2 are APH preliminary. We pointed out our internal gross savings for PY1 were higher than Millimans and that is why, our gross savings number does go in the same direction as that trend. **Michelle Searing**			

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Topic	**Discussion**	**Recommendation/Action Plan**	**Responsible**	**Due Date**
	Slide 17, new view as a result to January's meeting, to dig deeper into numbers coming and going each month. Evolved from the TCM conversation. Which programs and which risk levels and the folks that are lost and which levels they are falling into. The actual number, a report we get each month after identification stratification we showed a 900 person increase (new people) to the program. However due to the TCM flag we end up with a lot smaller number. As far as the folks that are lost in the program each month it is things like the pregnancy care coordination, vast majority are in urban Washoe or Clark County, usually roll off into MCO. On this note of lost folks, we saw a much larger loss in the month of April, would like to discuss April findings during co ops meeting, and are currently looking in a little deeper. **John Kucera** Yes, send me some examples and details and we can find out what's going on, will look up eligibility and benefit programs, and could just be a redetermination that was done. **Michelle Searing** Slide 18 breaks down total enrollment. Looking at Dec through January. Left to right description. For each month the far left hand gives total enrollment population. The lower portion in gray that is the risk level 1 the largest subset of our total population, purple risk level 2, green risk level 3 and blue risk level 4. Stack bar in middle of each month are those just enrolled in 2s, 3s and 4s. Far right are those that are actively being managed. Fairly consistent month over month. **Shannon Sprout** Is there a chart that shows those who would have moved from a level 1 to a higher level and those who have moved out of, you said there is a shift and I would like to see that shift. **Cheri/Michelle** Yes we can add that. Will get you that info soon and will add to next			

Topic	Discussion	Recommendation/Action Plan	Responsible	Due Date
	quarterly **Gretchen Thompson** Question: Geographically the number of enrollees actively managed, that 39,000 month over month is everyone enrolled, correct? And based on the previous two graphs most of the people are continually enrolled every month. **Michelle Searing** That's correct. We net anywhere from 500 to 700 new enrollees and we lose anywhere from 2500 to 3500 (net numbers) **Gretchen Thompson** For some of your higher risk levels do you have any folks in those levels who have been continuously enrolled for more than 6 months but have not had an assessment done? **Michelle Searing** Yes we do and for multiple different reason such as breaks in eligibility. If you look as someone who has been enrolled for 6 months with no breaks in eligibility, could be demographics issues such as not being able to locate them, or we locate them and set up a meeting with the nurses and then the nurses are unable to locate them, or members who we come in contact with may keep repeatedly putting off our nurses. We have developed a pretty rigorous process in capturing people as soon as they are enrolled and posting them for locate however they are a whole roll of reasons why the assessments can't be done. Question: For the digital campaign is that for people who are assessed and have a treatment plan or for everyone? **Virginia Gurley** Digital campaign is for everyone who meets criteria not just those actively cared for **Gretchen Thompson** Is there a mechanism to add some discussion or digital conversation			

Topic	Discussion	Recommendation/Action Plan	Responsible	Due Date
	regarding the need for a comprehensive assessment? **Virginia Gurley** That could be its own campaign and have the campaign logic address the issue and the barrier. Some people are afraid if they go through the assessment they are going to lose their benefits. **Michelle Searing** Where we have seen issues in the past is when the outreach is purely telephonic, there is a larger success rate when you see the person face to face. (Slide) Clinical measures First few measures are repeats from January, was suggested we bring theses back in front of everyone. Paid for Performance (P4P) HIV Aids – Milliman base line vs Milliman remeasurements P Y1 results, Question is why didn't these reach the baseline/target). Looking at 3 measures HIV Aids (decrease), Substance abuse (increase) (Slide 20) is more narrative to that. **Marta Jensen** What are the targets? **John Kucera** We use a Quality Improvement System for Managed Care (QISMC) method so we take the difference between the baseline rate at 100%, we then take 10% of the difference and that is our new goal. **Gretchen Thompson** Baseline goal remains the same over yrs, once set it stays. **Dr. McCrorey** We can get you guys a baseline spreadsheet this comes from, may be helpful.			

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	Michelle Searing Looking at HIV Aids, in the interest in answering the questions per the quality modules. Given the results what tools did you use to review progress today? What causes did you identify? What interventions were put into place? And what are you doing to evaluate the process. You will notice a formula for each measure that answers each of those questions. Is a very formulaic approach. In November we went measure by measure, this measure really jumped out at us. **Cheri Glockner** Developing MOU with Planning Mid May with Clark county detention Center specifically targeting HIV positive inmates. Working with MTM to get rides to and from jail. To work with HCGP members who are in the jail. Very face to face interaction to get them to their doctor. **Michelle Searing** For substance abuse 1.1 and 1.2, this one is a more of a challenge for us to address in that substance abuse members are largely within the vital mental health program. Depending upon other dynamics with their mental health profile, they can have a whole host of physical conditions. When looking at the extensive reporting, I have to really dig into the details to get those substance abuse folks. We do have substance abuse risk scores that help drive the behavioral health team to these individuals however depending on what is going on with these members we may focus on other needs. This requires a different level of behavior change, they have to want the help. **Marta Jensen** That is actually one of the things we have done with Amy, Amy works for the Division of Public and Behavioral Health (DPBH) specializing in the mental health substance abuse area, and one of the things we have done here at the division, and we struggle with the same thing on a policy perspective but at the end of the policy is a list of members. Amy has deployed from DPBH, to come in and start			

Topic	Discussion	Recommendation/Action Plan	Responsible	Due Date
	leading on the behavioral health side, we have a chief and the staff but now Amy's role is to eliminate the gap between other agencies so we can wrap our hand around this population as well. Also with the MCOs **Amy Roukie** The reality you are facing, finding the risk is identified based on their medical symptoms is a reality on most substance users. You won't find many substance abusers who don't have chronic medical issues that have neglected over time while they have been in their substance use. So having to drill down and find them, which came first doesn't really matter however for this could help identifying them as well. CDCD – working with to eliminate gap in health for released inmates **Gretchen Thompson** This is why the assessment is so critical. Face to face assessments could tell you so much more about other social issues that are going on with the members. You are able to identify what other behaviors the person is engaging with. Very critical to get the outreach and have the assessment performed. **Virginia Gurley** How many providers know there is a benefit for this treatment on the medical side, for instance for many years Medicaid didn't cover substance abuse. Providers working with medical health or mental health issues may know substance is a major issue but may still believe there is no benefit from Medicaid for treating those issues. **Amy Roukie** In Nevada there has been a lot of conversation around the Affordable Care Act and remain consistent in having the Affordable Care Act, from a state wide perspective there has been a lot of conversation about that perspective and on parity. The information exists however it's always helpful the providers understand there are access points. Trying to move them away from state hospitals. It's difficult for community as a whole to accept change.			

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Topic	Discussion	Recommendation/Action Plan	Responsible	Due Date
	Michelle Searing For substance abuse there are variation changes from baseline to re-measurement. Do remain rather consistent. We will have a really nice history of data points. **Cheri Glockner** Will also include that narrative to help "tell the story" **John Kucera** This is exactly what we are looking for a couple reasons, we don't expect all measures to go up all the time we know that, but to have the actions taken behind it and the interventions to explain even the increases is exactly what we are looking for. And having an idea of what our final program evaluation is going to look like before it happens without surprise via these intermediate 3, 6 month over views. **Michelle Searing** Slide 22 –We are looking at a subset of Non Pay for Performance (Non P4P) measures. Those measures that reached the project and then sustained improvement through program Y2. Multiple data points/sets of results, because we have included quarterly and Milliman's results, now adding PMV rates. Based around HEDIS and Pay for Performance (P4P) Measures. As a result of audits we have learned more and are able to generate results. So what you are seeing the Milliman baseline, Milliman re-measurement, APH generated performance measure rates run for audit. It was requested we look at it this way. 1st measure, 12m-19yr who have had a visit with PCP, looking at first 12 to 24m of life. That CAP.1 measure, showed an increase to re-measurement 1, rates for PY2 showed a decline from re-measurement PY1. The next W15 are the well child visits, **Dr. McCrorey** These are just selected measures out of a set of numbers. W15			

Topic	Discussion	Recommendation/Action Plan	Responsible	Due Date
	addresses, did the kid see a doctor during that time. Intent is the more visits the better. Just one selected measure out of a host of measures. **John Kucera** There is enough of a difference that we have solicited HSAG to do secondary Audit of Milliman's rates and numbers. Due to a significant differences, we need a consolidated third party to determine yes these are good and this is how you found the numerator and the denominator. **Gretchen Thompson** Why did we include Milliman's re-measures, not part of the module? **Michelle Searing** That speaks more to a need for us to huddle before we have these quarterly reviews. We went back and forth on which data sets to include on these slides and we talked through that. Need to better define reaching the target for PY1. Begs the question should we have a layout review. **John Kucera** The direction you were likely given was put more information on there rather than less. For these modules the exercise is to compare baseline with PMV rates HSAG saw. Just gives additional insight on this. **Cheri Glockner** You did, you were very fair with us in helping understand and make sure everyone was on the same page. **Gretchen Thompson** Discussion of modules where all assignments were provided is solely based on the baseline not Milliman's re-measures. So I want to make sure that I didn't have access to Milliman re-measures when creating the module.I want HCGP to get used to looking at the data they have and looking at quarter over quarter and not waiting for information to			

Topic	Discussion	Recommendation/Action Plan	Responsible	Due Date
	come from Milliman. HSAG is conducting a source code review. Not the same review as done at APH. **Gloria Macdonald** Another perspective, yes now reporting on ongoing operational measures. But the measurement PY1 measures do exist and now we are coming up with Measures PY2 so now there will be 2 complete sets. **John Kucera** Baseline and re-measurement 1 are applied to Millimans perspective, some of the uncertainty we may have could be cleared out by including this information. However we do want to get comfortable receiving and being comfortable with APH numbers. So this is a hybrid approach should be able to move forward as HSAG expected. **Dr. McCrorey** Let me just give you the overview, which all are important health measures – highlights of our impacts. There are certain measures that are decided upon to make special lists for contacts, this decision is made on a higher level due to the criticality of these members getting their meds or needing them more urgently. So most of these green boxes explain members and how we address their needs. It is clear the social determinants of health have to be addressed to care for their health needs. Sometimes we have to address that first. We have community outreach. Some metrics have more focus on/some have less. A lot of metrics on here we do have influence over. We have discussed more measures are focused on the PCP side. **Shannon Sprout** Page 25, looks like you have gone down in every area. **Michelle Searing** These were selected for that reason. They called out roughly 8 measures where we declined and said explain what you are doing to improve and what interventions are put into place. If you look at			

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Topic	**Discussion**	**Recommendation/Action Plan**	**Responsible**	**Due Date**
Provider Outreach	narrative slides for each measure, there is more explanation and how we did improve. **John Kucera** Michelle that's the exact narrative or my intent as part of this to see your rates at 3 months of runoff, but that doesn't tell the whole story but the narrative and the re-measure does. **Gloria Macdonald** Was just explaining how much we do like going over the measures and the importance of them. Will not continue to go through all the measures however will continue during our operations meetings. **<u>Provider Outreach</u>** **Dr. McCrorey** Not all finished projects (Slide 46), some inside on what we are doing to make our jobs and your jobs easier. We did start working and still are with behavioral health section and care management for those in out of state treatment facilities. When they come back to Nevada, this is a very difficult change. There are facilities in state as well we will be working with. Beacon team has clinical care works that reach out to all providers who are possibly over prescribing narcotics. We have been trying to minimize the amount of turn due to TCM, still working on. Since last quarter working with HPE to understand an impact of the ED super users. Super users is ED patients who have been to the ER more than 25 times a year. Rough estimate, average person goes every 5 to 10 years; a high user is 2 to 4 uses per year. Brief overview, the ones over 25 times per year looks like the same population, severe alcoholics = 20%, treatment for them would be getting them treatment. In those cases all have pretty much rejected any of our services and outreach. The other 80% may have some type of emotional need to be in the ER. This is very hazy however the care managers who have outreached to them can't identify what brings these people to the ED, almost all have depressions, a mental issue, IBS, prescriptions for Narcotics, and a lot of anti anxiety meds.			

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Focus for Next Quarterly	They hop to different ERs, these are people looking for substance abuse. This isn't an effective way to evaluate that. There is something else, another type of need. We haven't come up with a plan on how we will engage and make a difference with these folks. We are concerned they won't respond well to our efforts. About 300 people in the state and about 60 in our program. **Shannon Sprout** So out of that 60 as individuals are you laying out their claims data to figure out what it is they are accessing in that period. I would like to see that break down. If this person visited the ER 25 times they may need the emotional visit but they may be visiting other doctors or treatment centers, where are we paying for help that isn't working. **Marta Jensen** Would like to go over this information with our executive team. **Dr. McCrorey** It is important to remember this is a small percentage. The vast majority are using the ED appropriately. Are also doing outreach into the home. Are always trying to coordinate with instate facilities. **Shannon Sprout** Can you separate when you do your data for those that are behavioral health as far as other diagnosis as far as discharge planning? **Amy Roukie**We have leverage working with hospital situation. If you have a particular hospital you are having an issue with please let us know. I know Renown is one of them. **Cheri Glockner** Will get updated information for legislation Working with Gladys to finalize amendment 6 Will put together trends and date that isn't part of the set			

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	Will have data by July, will see at next Quarterly. Las Vegas next week, Elko mid May **Margaret Flaum** Glad to meet all of you Helpful for us to know, what are you hearing out there on the program? **Marta Jensen** We are looking at homeless population now, just ran numbers. People who have an address that is matching or close to a shelter. Our population = less than 1% homeless compared to whole state really focusing on the mental health and behavioral health, will start with this then once we have a model will look at procedural health. **Amy Roukie** We have found that the perception is difficult to access to health care in Nevada. Working on a website/dashboard. **Shannon Sprout**			
New Business	1 Page dialog/sheet about HCGP for leadership staff **New Business** Gloria Macdonald Amendments PY2 Results			

BRIAN SANDOVAL
Governor

RICHARD WHITLEY, MS
Director

MARTA JENSEN
Administrator

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Division of Health Care Financing and Policy
Notice of Meeting to Solicit Public Comments and Intent to Act Upon Amendments to the Medicaid Services Manual (MSM)

Public Hearing June 28, 2017
Minutes

Date and Time of Meeting:	August 23, 2017 at 1:03 PM
Name of Organization:	State of Nevada, Department of Health and Human Services(DHHS), Division of Health Care Financing and Policy (DHCFP)
Place of Meeting:	Nevada State Legislative Building 401 S. Carson Street, Room 3138 Carson City, Nevada 89701
Place of Video Conference:	Grant Sawyer Office Building 555 E. Washington Avenue, Room 4406 Las Vegas, Nevada 89101
Teleconference:	(877) 402-9753
Access Code:	7316372

Attendees

In Carson City, NV

Lynne Foster, DHCFP	Darrell Faircloth, SDAG
Marta Jensen, DHCFP	Gladys Cook, DHCFP
John Kucera, DHCFP	Gloria MacDonald, DHCFP
Cheri Glockner, HCGP	Cody Phinney, DHCFP
Elisa Cafferata, NAPPA	John Sande, Argentum Partners
Dr. Karen Torry Green, HCGP	Rachel Marchetti, DHCFP

Introduction:

Ms. Lynne Foster, Chief of Division Compliance of the DHCFP, opened the Public Hearing introducing herself, Ms. Marta Jensen, Administrator of the DHCFP and Mr. Darrell Faircloth, Senior Deputy Attorney General (SDAG).

Ms. Foster – The notice for this public hearing was published on July 20, 2017 in accordance with the Nevada Revised Statute 422.2369.

1. Public Comment

- No Comments.

2. For Possible Action: Review and approve meeting minutes from the July 26, 2017 public hearing

Ms. Foster asked if any staff members have any proposed corrections to the minutes for this public hearing and none were received.

Public Comments

- No Comments.

Ms. Foster – Recommended the Administrator approve as written.

Ms. Jensen – Approved as written.

3. Discussion of proposed changes to MSM Chapter 3800 – Care Management Organization

Ms. Gladys Cook:

Revisions to MSM Chapter 3800 are being proposed to ensure policy accuracy in alignment with the 1115(a) Nevada Comprehensive Care Waiver. Family Medical Coverage Categories have been removed as these are no longer accurate and have been replaced with up-to-date categories due to the implementation of the Patient Protection and Affordable Care Act. The use of contractual language has been removed from the document as it is not necessary for the understanding of program policies and procedures.

Entities Financially Affected: Contracted Care Management Organization.

Financial Impact on Local Government: There is no expected financial impact on local government.

The effective date is August 24, 2017.

At the conclusion of Ms. Cook's presentation, Ms. Foster asked Ms. Jensen and Mr. Faircloth if they had any questions or comments.

Ms. Jensen's Comments:

Ms. Jensen complimented Ms. Cook on getting through the entire chapter.

Mr. Faircloth's Comments:

Mr. Faircloth did not have any questions about the chapter but requested the Administrator allow staff time to make grammatical and punctuation changes.

Public Comments:

Dr. Karen Torry Green requested that "patient centered" be used with a hyphen. She also requested staff insert an Oxford comma on Page 27 (c)(1) after "acute mental health problems." She would like to see a timeframe indicated on Page 11 (B). Dr. Torry Green pointed out on Page 38, that "participation" should be "is verified," not "are verified." She went on to Page 41 (2) and stated that "out posted" should be one word. She finished up with Section 3804 Page 2, the formatting is incorrect. There are two (d)s instead of a (d) and an (e).

Ms. Foster – Recommended the Administrator approve as submitted with the following changes:

- Section 3801, remove period and add comma and lower case "t" so the sentence reads "…of the Medicaid statute, the DHCFP may…"
- Section 3803.2(B)(1), add an "s" to "parent" to make it plural.
- Section 3803.2(B)(2), remove "Poverty Level Children and."
- Section 3803.2(B), paragraph under (6), need to reformat paragraph so it is not subordinate to (6).
- Section 3803.2(B), paragraph under (6), change "this" to "these" and add an "s" to "population" to read "…screens these populations." Remove "being utilized."
- Section 3803.2(C), change title to read "Re-enrollment Process."
- Section 3803.2(C)(1), change section reference to "3803.2G."
- Section 3803.2(C)(2), replace "auto-assigned" with "re-enrolled." Remove period after "Medicaid eligibility" and add a comma. Replace "This is based on if" with "as long as."
- Section 3803.2(D)(6), replace sentence with "Recipients enrolled in an MCO."
- Section 3803.2(E), remove "Native" from the beginning of the paragraph.
- Section 3803.2(F), change "amount" to "number."
- Section 3803.2(G)(1)(g), add "Refer to Section 3804."

- Section 3803.2(G)(2)(c)(1), replace "request for" with "the."

- Section 3803.2(G)(3), remove the word "final," remove the apostrophe from "disenrollment's," remove "Title XIX," replace "American Indian/Alaskan Native" with "AI/AN," remove "be automatic and," remove "no later than," remove "first" before "month" and change "request for disenrollment" to "the determination."

- Section 3803.5(A)(5)(m), add "/or" to the end of the sentence.

- Section 3803.6(B)(5), add "the" so the sentence reads "…changes within the beneficiary handbook…"

- Section 3803.6(D)(2)(a)(5), remove "Title XIX."

- Section 3803.8(A) second paragraph, remove second reference to "Title VI."

- Section 3803.9(E)(3), change "pursuit" to "pursuant."

Ms. Jensen – Approved as amended with the stipulation that suggestions by Dr. Torry Green be considered with the exception of the request for a timeframe to be established. That would have to be done on a later revision. Ms. Jensen agreed with Mr. Faircloth to allow staff one last chance to review for spelling, grammar, formatting and punctuation.

Ms. Foster – Closed the Public Hearing for the MSM Chapter 3800 – Care Management Organization.

4. General Public Comments

- No Comments.

5. Adjournment

There were no further comments and Ms. Foster adjourned the public hearing at 2:47 PM.

An Audio (CD) version of this meeting is available through the DHCFP Compliance office. For more detailed information on any of the handouts, submittals, testimony and or comments please contact Ellen Felsing at Ellen.Felsing@dhcfp.nv.gov or (775) 684-3684 with any questions.

Sign-in Sheet for Health Care Guidance Program (HCGP) Quarterly Meeting July 25th, 2017

NAME	ORGANIZATION	PHONE NUMBER	E-MAIL ADDRESS
Gladys Cook	DHCFP	47596	gladys.cook@dhcfp.nv.gov
Rachel Marchetti	DHCFP	43617	Rachel.Marchetti@DHCFP.NV.Gov
Gloria Macdonald	DHCFP	7-8407	
Jessica Mandoki	DHCFP	Unavailable	
John Kucera	DHCFP		
Lisa Kocher	DHCFP		
Mary Mastrandrea	Beacon BH	(410) 303 7972	mary.mastrandrea@ beaconhealthoptions.com
Gabriella Collins	Beacon	714-713 8530	Gabriella.collins@ beaconhealthoptions.com
Briana Duffy	Beacon	781-710-2394	Briana.Duffy@ Beaconhealthoptions.com
Summer Smith	Beacon/ HCGP	775 291 7218	Summer.Smith@ beaconhealthoptions.com
Kris Schadegg	11	276-0507	Kristen.schadegg @beaconhealthoptions.com
Karen Torry Green	11		karentorry.green@ Beaconhealthoptions.com

Sign-in Sheet for Health Care Guidance Program (HCGP) Quarterly Meeting July 25th, 2017

NAME	ORGANIZATION	PHONE NUMBER	E-MAIL ADDRESS
MCCrorey	HCGP	434 1874	thomas.mccrorey@axispointhealth.com
Brian Baker	Beacon	785-207-1563	brian.baker@beaconhealthoptions.com
Virginia Gurley	APH	720 · 876 · 8976	virginia.gurley@axispointhealth.com
Cheri Glactner	APH	775 ~~434~~ 431-1876	Cheri.glactner@axispointhealth.com
Marta Jensen	DHCFP	775-684-3677	marta.jensen@dhcfp.nv.gov
Karen Salm	DHCFP	684 3668	Ksalm@dhcfp.nv.gov
Michelle Searing	APH	720413-2152	
Margarette Flaum	APH	303-885-1759	
Shawna Vollmer	DHCFP	Call in	
Heather Lazarakis	DHCFP	Call in	
Linda Bowen	DHCFP	Call in	
Lorna Lizotte	DHCFP	Call in	
Gretchen Thompson	HSAG	Call in	

AXISPOINT HEALTH

Health Care Guidance Program
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Health Care Guidance Program

Cheri Glockner
July, 25 2017

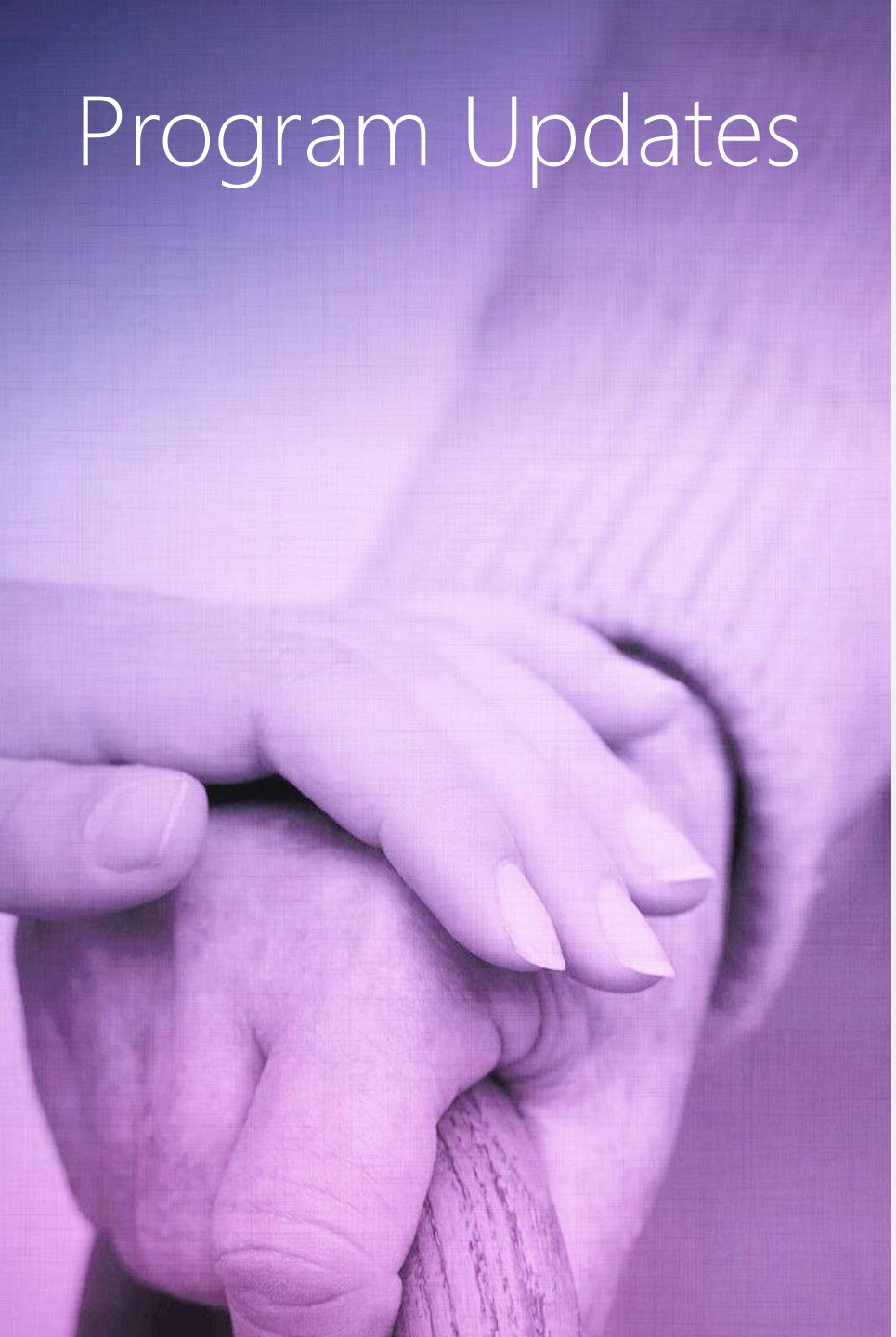
AXISPOINT HEALTH

Today's Agenda

1:00 p.m. – 4:00 p.m.	
Welcome and Introductions/DHCFP	Gloria Macdonald, Chief, Program Research and Development, DHCFP
Approval of Minutes	Gladys Cook, Social Services Specialist III, DHCFP
Program Updates	
Executive Director Comments	Cheri Glockner, HCGP Executive Director, APH
AxisPoint Health Update	Dr. Virginia Gurley, Chief Medical Officer, APH
1:30 p.m. to 2:45 p.m.	
III. Quality	Michelle Searing, Outcomes Operations Manager
Module 5, Objective 1.1 and 1.2	
Module 8, Objective 2.3 and Objective 2.4	Dr. Thomas McCrorey; Medical Director, APH
2:45 p.m. to 3:00 p.m. BREAK	
3:00 p.m. to 3:45 p.m.	
IV. Provider Outreach	Dr. Thomas McCrorey; Medical Director, APH
V. Focus for Next Quarter	Cheri Glockner, HCGP Executive Director, APH
3:45 p.m. to 4:00 p.m.	
VI. New Business	Gladys Cook, Social Services Specialist III, DHCFP

AXISPOINT HEALTH

Program Updates



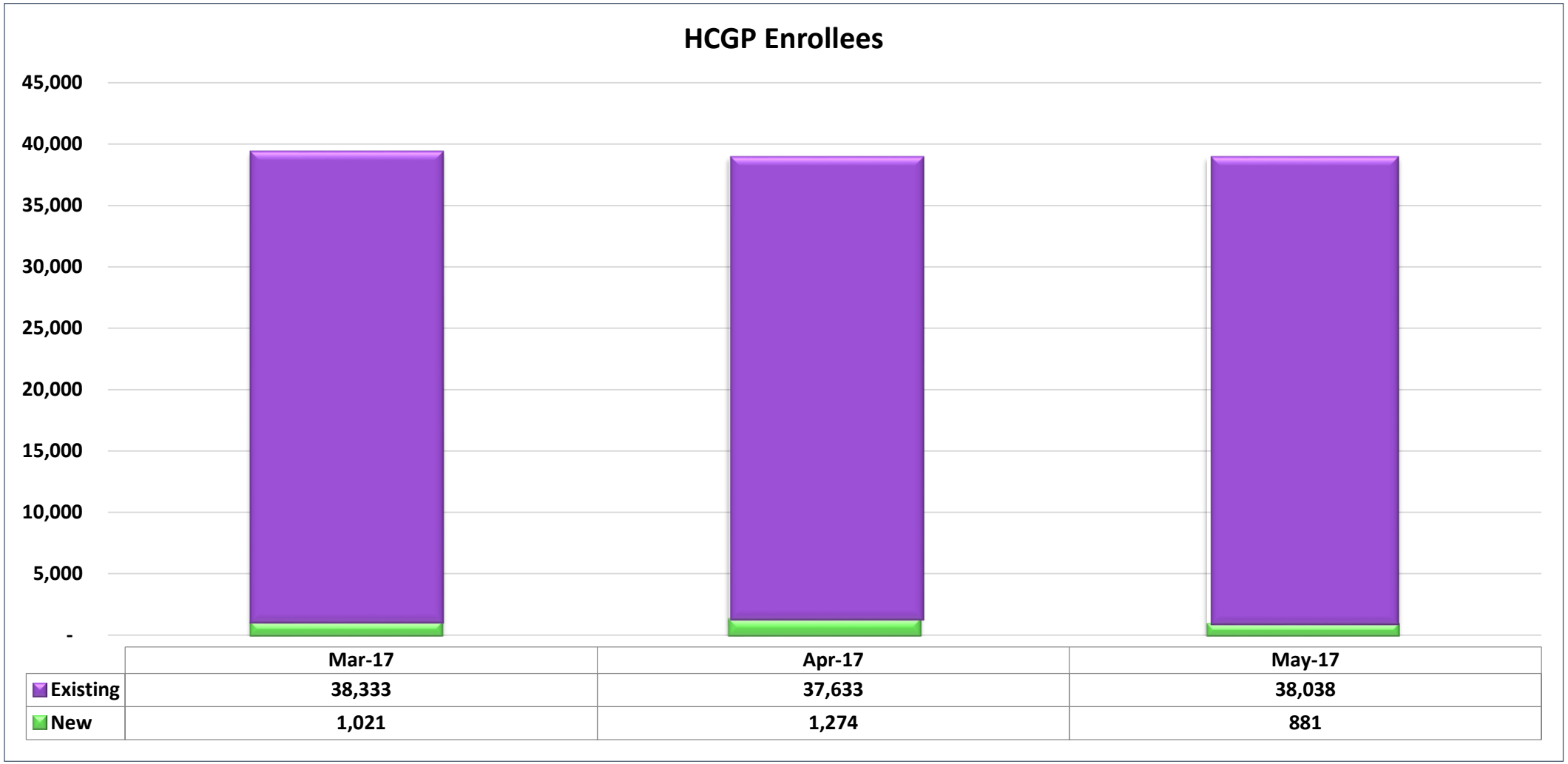
Key Accomplishments

- Continue to work with MTM on meeting Member needs
- Prepared APH proposals for DHCFP consideration for Amendment #6
- Monitored legislative hearings and responded to inquiries related to HCGP
- Supported operations team as strategies to increase contacts and engagement continue to be deployed
- Provider outreach trips to Las Vegas and Elko
- Hired more rural staff and increased northern Nevada staff to increase outreach from Fernley to Battle Mountain
- Delivered and discussed Quarterly P4P/Non-P4P Clinical Rates

III. Quality

Module 5: Objectives 1.1 and 1.2
Module 8: Objectives 2.3 and 2.4

Module 5: Objective 1.1 New and Existing Enrollees



	Mar-17	Apr-17	May-17
Existing	38,333	37,633	38,038
New	1,021	1,274	881

Module 5: Objective 1.1 New and Existing Enrollees

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New HCGP Eligible's - Member's who are new to the program Mar 2017 - May 2017									
	Current Program								
RL	Care Management Interventions	Chronic Kidney Disease Program	Complex Condition Care Management	Disease Management Interventions	Health Care Management	Mental Health Program	Oncology Care Coordination	Pregnancy Care Coordination	Grand Total
4	-	1	10	3	3	1	-	-	18
3	2	7	5	26	47	88	2	35	212
2	5	8	1	71	98	173	1	64	421
1	22	13	1	301	2,423	619	7	280	3,666
Grand Tota	29	29	17	401	2,571	881	10	379	4,317

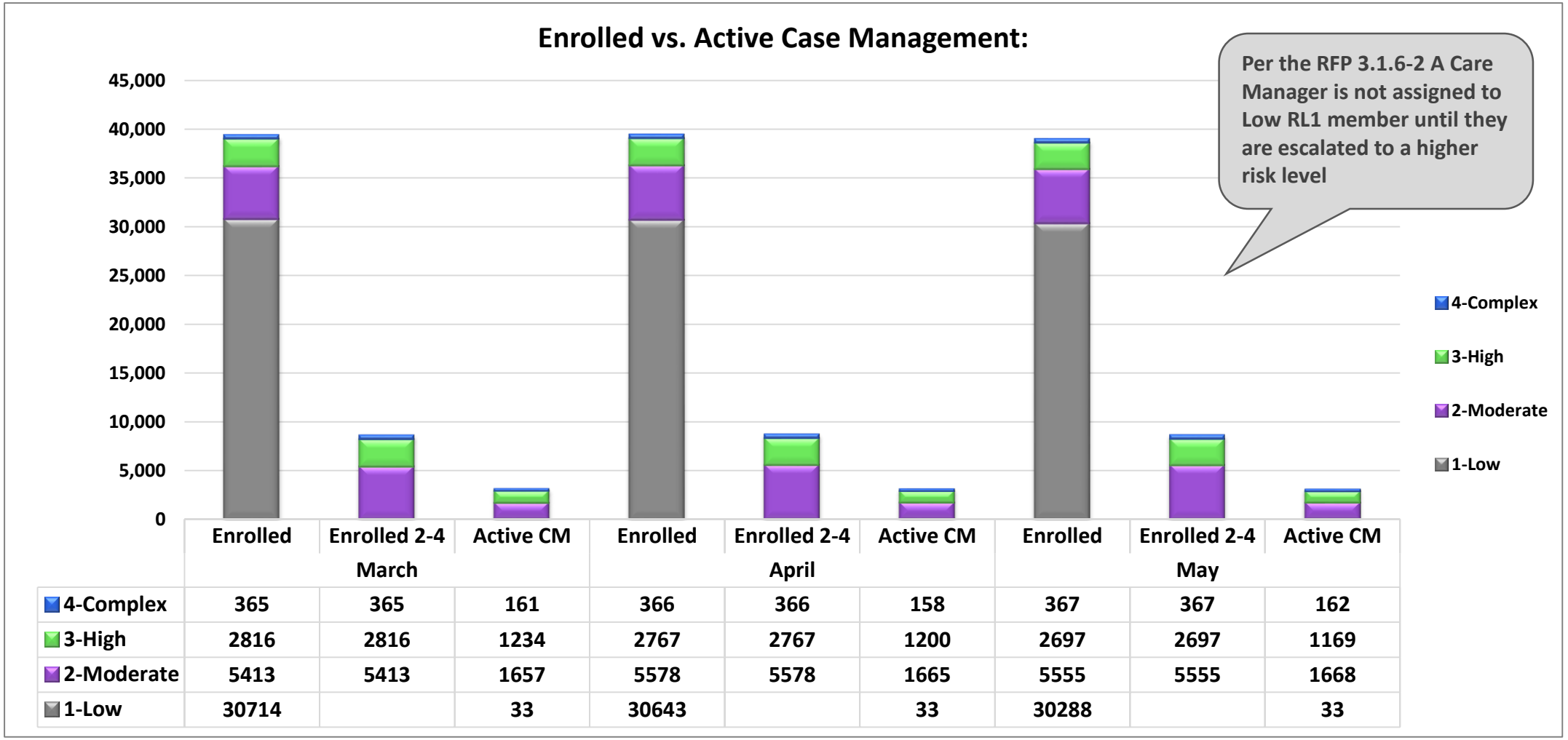
New HCGP Eligible's - Member's who were eligibile as of Feb 2017 but lost eligibility during the subsequent quarter (Mar-May 2017)									
	Current Program								
RL	Care Management Interventions	Chronic Kidney Disease Program	Complex Condition Care Management	Disease Management Interventions	Health Care Management	Mental Health Program	Oncology Care Coordination	Pregnancy Care Coordination	Grand Total
4	-	-	59	1	2	7	-	1	70
3	3	21	18	59	66	266	7	61	501
2	4	13	-	139	145	509	4	78	892
1	28	21	-	395	2,658	1,267	6	408	4,783
Grand Tota	35	55	77	594	2,871	2,049	17	548	6,246

Members Lost due to TCM	
RL	TCM
4	24
3	238
2	419
1	901
Grand Total	1,582

NOTE: The number of enrollees lost due to TCM claims activity in Q4 of PY3 is up from 530 compared to Q3 PY3

AXISPOINT HEALTH

Module 5: Objective 1.2, Enrolled vs. Persons Actively Receiving Case Management (CM) Services



	Enrolled	Enrolled 2-4	Active CM	Enrolled	Enrolled 2-4	Active CM	Enrolled	Enrolled 2-4	Active CM
	March			April			May		
4-Complex	365	365	161	366	366	158	367	367	162
3-High	2816	2816	1234	2767	2767	1200	2697	2697	1169
2-Moderate	5413	5413	1657	5578	5578	1665	5555	5555	1668
1-Low	30714		33	30643		33	30288		33

Module 8, Objective 2.3 and Objective 2.4: Review of specified Non-P4P and P4P Clinical Measures

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Please describe the tools, interventions and evaluation processes deployed by the program to improve, reach target, and/or sustain improvement for the measures outlined in Module 8 of the Quality Strategy.

Measure Category/ Measure #	Observations
Non-P4P Musculoskeletal: RA **Non-P4P Neurological: NEUR** **Non-P4P Musculoskeletal: OST** **P4P Heart Failure: HF.1** **P4P Coronary Artery Disease: CAD.1** **P4P Hypertension: HPTN.1** **P4P Mental Health: MH.1** **P4P Mental Health: MH.3.1 and MH3.2**	• The measures outlined in Quality Strategy Module 8 are largely focused on medication prescribing and adherence • Therefore the strategy for impacting these measures is largely the same across all measures. • This includes: – Quality Improvement (QI) Tools leveraged to assess progress – The Identified Causes for improvement or decline – Interventions implemented – Processes and tools used towards periodic evaluation

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Module 8, Objective 2.3 and Objective 2.4: Review of specified Non-P4P and P4P Clinical Measures

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Quality Improvement (QI) Tools and Identified Causes common to all Medication Compliance measures

Quality Improvement:

- HCGP conducts a monthly review of medication compliance via the Identification and Stratification process.
- Monthly review changes to risk levels for the entire population flagging changes for prioritization of our outreach efforts, based upon acuity.
- Quarterly operational workflow and value stream mapping.

Identified Cause(s):

- Prioritized by Maslow's Hierarchy: Security needs supersede needs associated with behavioral/medical conditions.
- 90+% of our enrollment population experiences ongoing social determinant needs related to food and shelter insecurities.
- Challenges with transportation.
- Poor access to providers/poor capacity.

AXISPOINT HEALTH

Module 8, Objective 2.3 and Objective 2.4: Review of specified Non-P4P and P4P Clinical Measures

HCGP Intervenes to Improve Quality across all Medication Compliance measures

Interventions:

- Identification and Stratification process escalates member for outreach based upon Gaps-in-Care identified for MD Visit Compliance.
- Identification and avoidance of roadblocks to medication compliance.
- Full medication review for complex risk members.
- Assistance on transportation to decrease missed appointments.
- Clinical care alert letters sent to all a member's providers and pharmacists.
- Coaching session frequency adjusted as clinically indicated.
- Regular staff consults and co-management of cases as needed to educate members.
- Staff carry pill boxes to assist members with medication organization and compliance.
- Establishing relationships with primary health providers, including daily updates on admissions and discharges from key facilities.
- Alert letters mailed and faxed to providers.
- Alert letters mailed to members.
- Clinical Rounds with Medical Director on difficult-to-manage cases.

Module 8, Objective 2.3 and Objective 2.4: Review of specified Non-P4P and P4P Clinical Measures

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Identified Causes and Interventions which are Mental Health-Specific

Identified Causes:

- Access to BH providers is particularly constrained across Nevada.
- Core symptoms of both bipolar and schizophrenic disorders (e.g. paranoia, lack of motivation, positive effects of not being medicated, etc.) which naturally inhibit medication compliance.
- Stigma associated with the diagnosis and medication of behavioral health disorders discourages some members from compliance.
- Medication side effects are frequently a disincentive to adherence.

Interventions:

- In addition to the interventions previously mentioned:
  - Clinical Care Alerts are especially focused on mental illness and drug abuse issues.
  - Use of Peer staff in coaching and mentoring positive behaviors and minimizing stigma about behavioral health and the need for medications.

AXISPOINT HEALTH

Module 8, Objective 2.3 and Objective 2.4: Please describe the interventions that were implemented that positively impacted measures.

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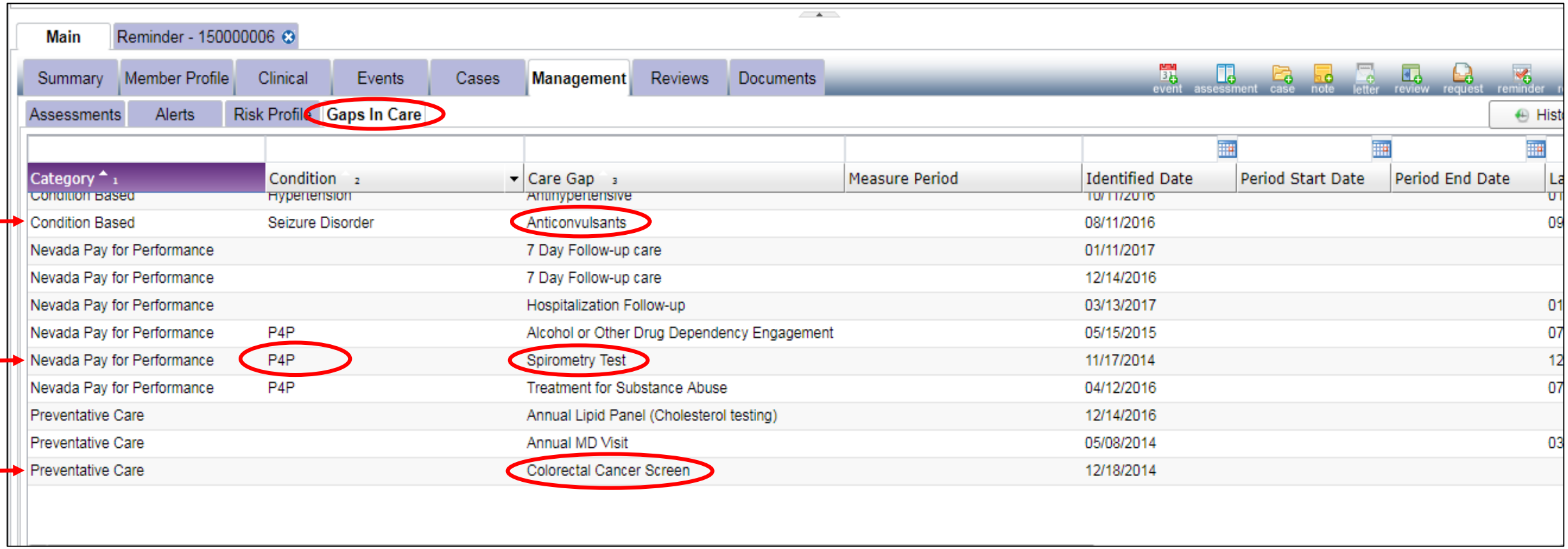
Example of Gaps in Care



Category	Condition	Care Gap	Measure Period	Identified Date	Period Start Date	Period End Date
Condition Based	Hypertension	Antihypertensive		10/11/2016		
Condition Based	Seizure Disorder	Anticonvulsants		08/11/2016		09
Nevada Pay for Performance		7 Day Follow-up care		01/11/2017		
Nevada Pay for Performance		7 Day Follow-up care		12/14/2016		
Nevada Pay for Performance		Hospitalization Follow-up		03/13/2017		01
Nevada Pay for Performance	P4P	Alcohol or Other Drug Dependency Engagement		05/15/2015		07
Nevada Pay for Performance	P4P	Spirometry Test		11/17/2014		12
Nevada Pay for Performance	P4P	Treatment for Substance Abuse		04/12/2016		07
Preventative Care		Annual Lipid Panel (Cholesterol testing)		12/14/2016		
Preventative Care		Annual MD Visit		05/08/2014		03
Preventative Care		Colorectal Cancer Screen		12/18/2014		

AXISPOINT HEALTH

Module 8, Objective 2.3 and Objective 2.4: Please describe the interventions that were implemented that positively impacted measures.

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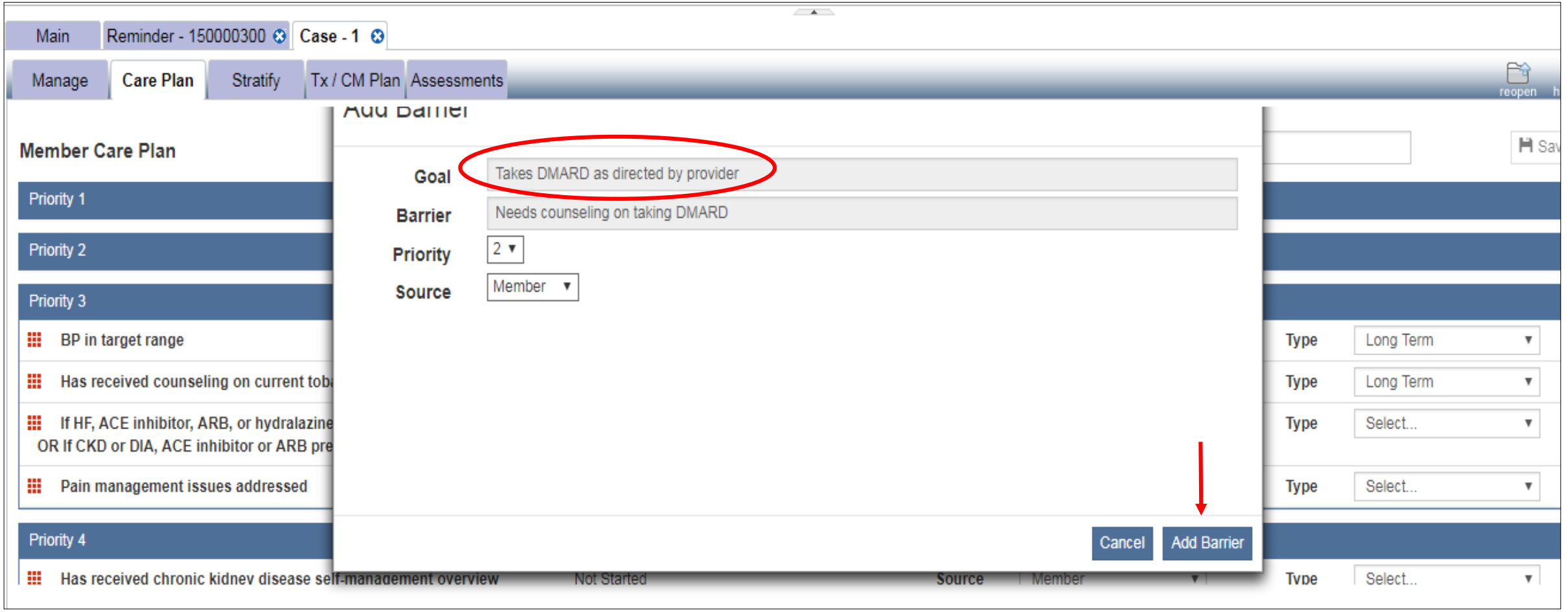
Barriers can be added to Patients Care Plan



AXISPOINT HEALTH

Module 8, Objective 2.3 and Objective 2.4: Please describe the interventions that were implemented that positively impacted measures.

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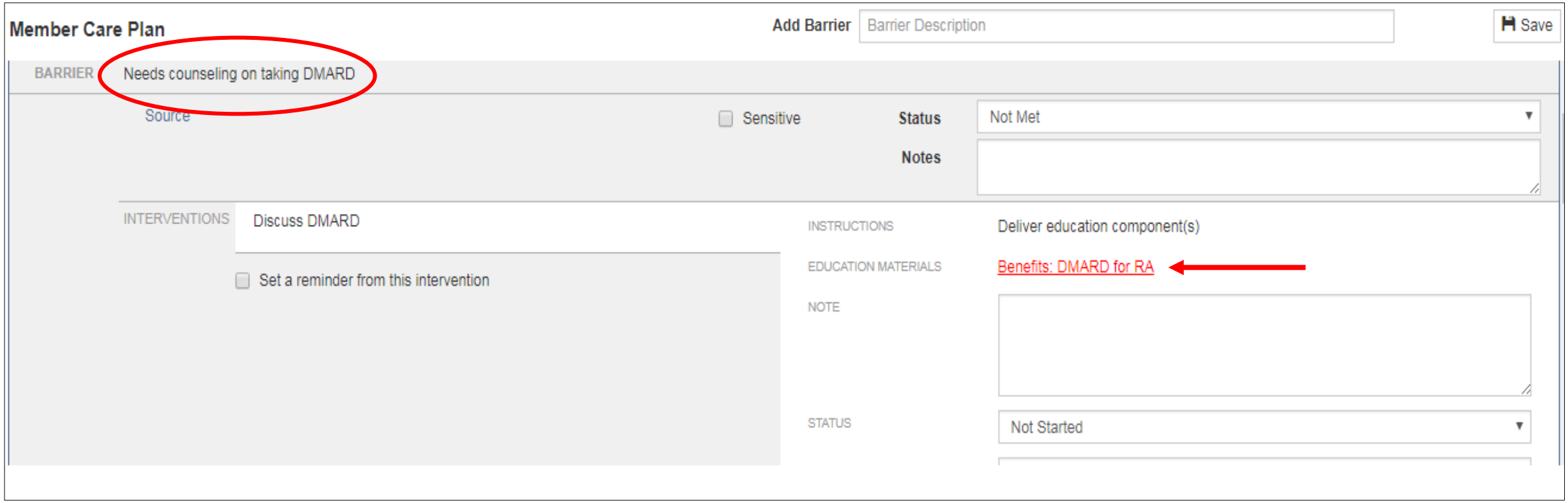
Discussing a Barrier with the Member



AXISPOINT HEALTH

Module 8, Objective 2.3 and Objective 2.4: Please describe the interventions that were implemented that positively impacted measures.

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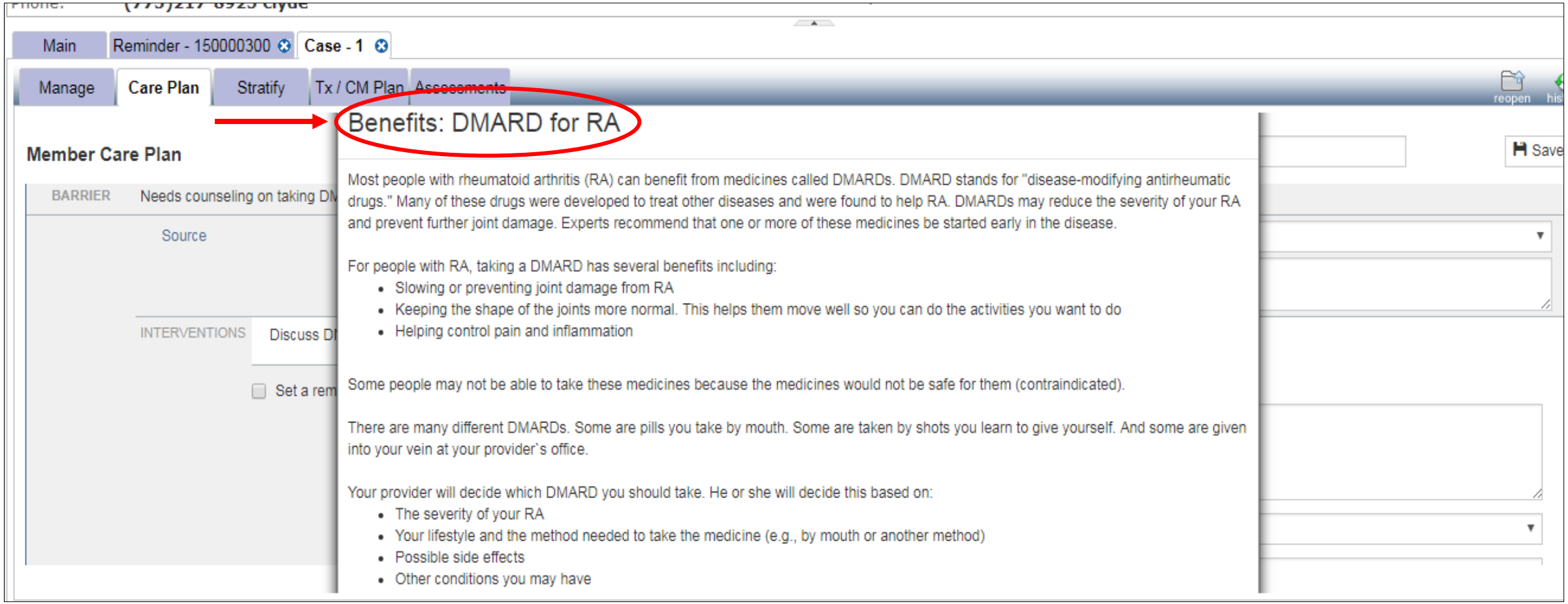
Educational Materials to be reviewed and/or mailed



AXISPOINT HEALTH

Module 8, Objective 2.3 and Objective 2.4: Please describe the interventions that were implemented that positively impacted measures.

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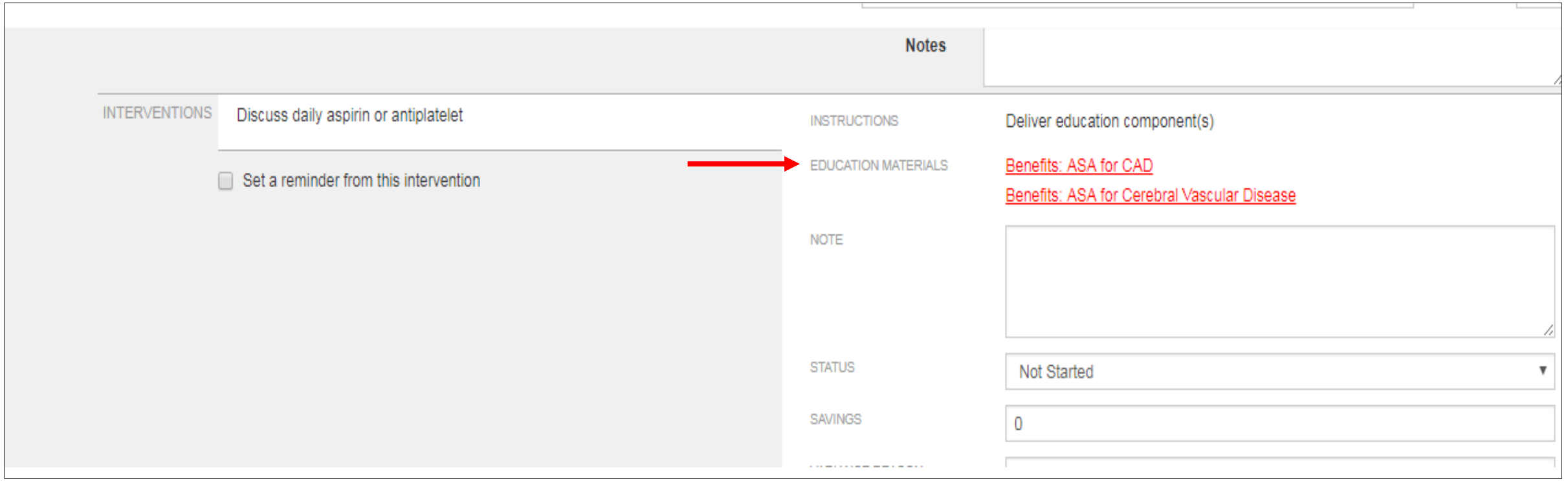
Educational Materials to be reviewed and/or mailed

Antithrombotic (anti clotting) therapy for Stroke/TIA patients on discharge



AXISPOINT HEALTH

Module 8, Objective 2.3 and Objective 2.4: Please describe the interventions that were implemented that positively impacted measures.

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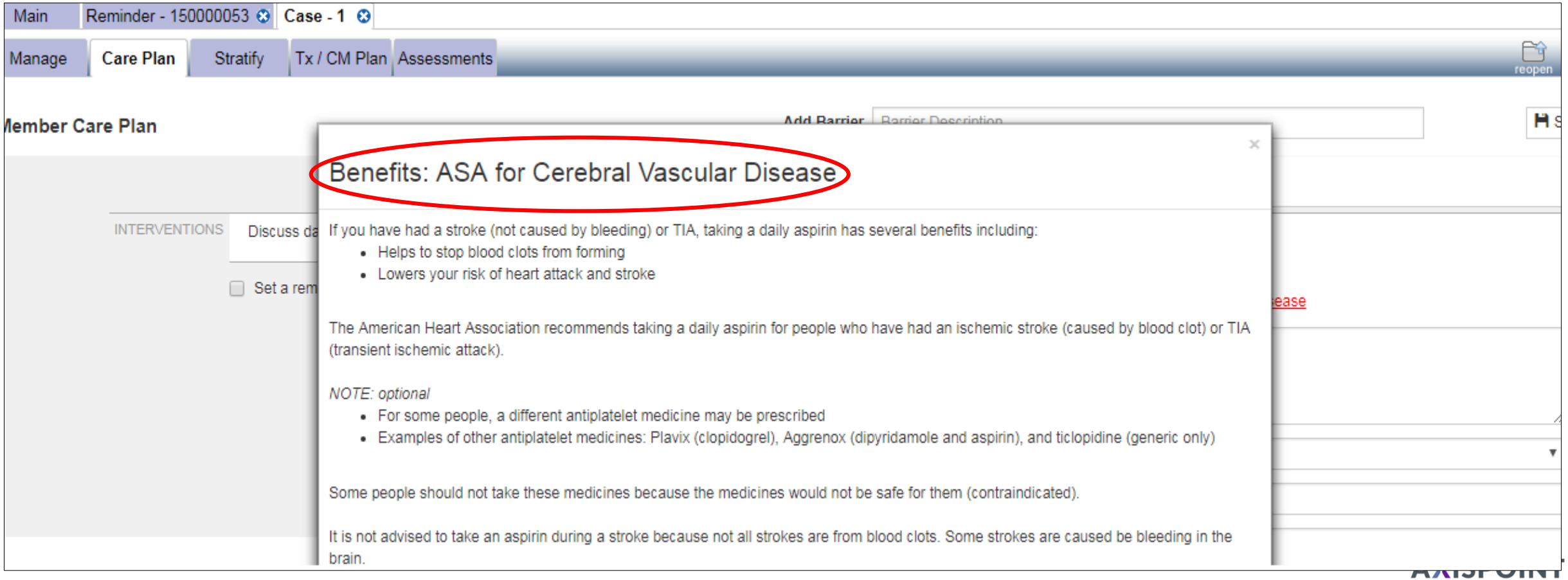
Educational Materials to be reviewed and/or mailed

Aspirin (antiplatelet) for Cerebral Vascular Disease



AXISPOINT HEALTH

Module 8, Objective 2.3 and Objective 2.4: Please describe the interventions that were implemented that positively impacted measures.

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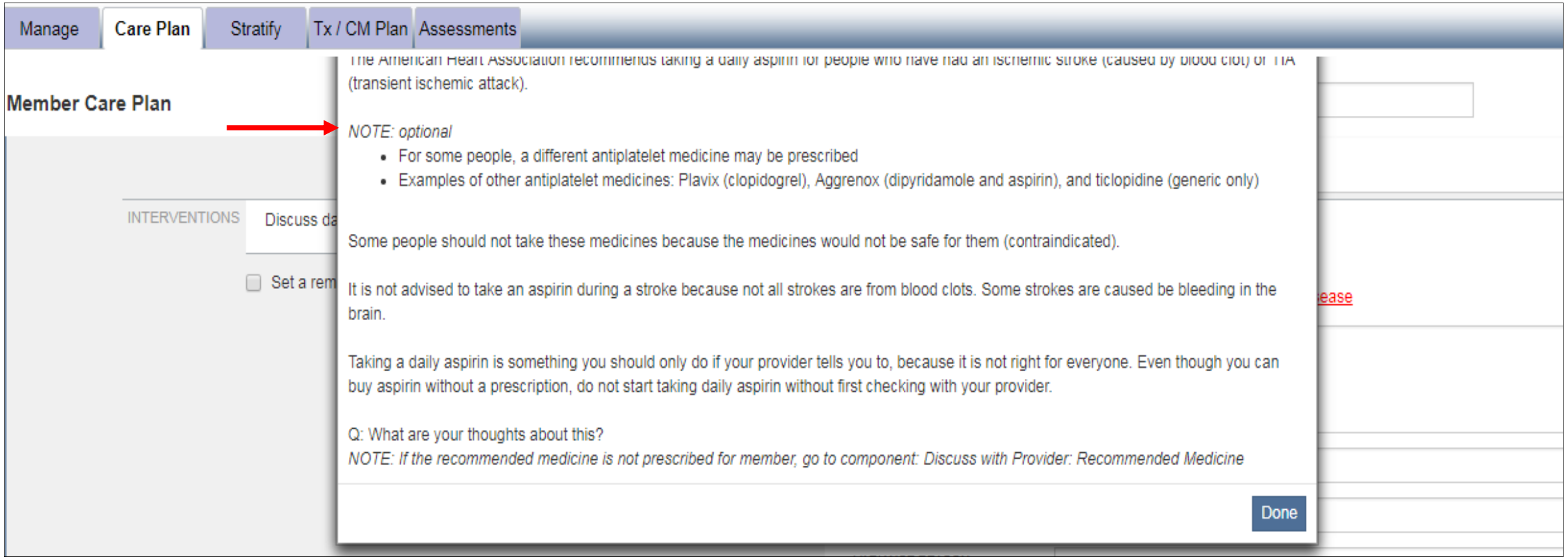
Educational Materials to be reviewed and/or mailed

Antiplatelet for Cerebral Vascular Disease



AXISPOINT HEALTH

Module 8, Objective 2.3 and Objective 2.4: Please describe the interventions that were implemented that positively impacted measures.

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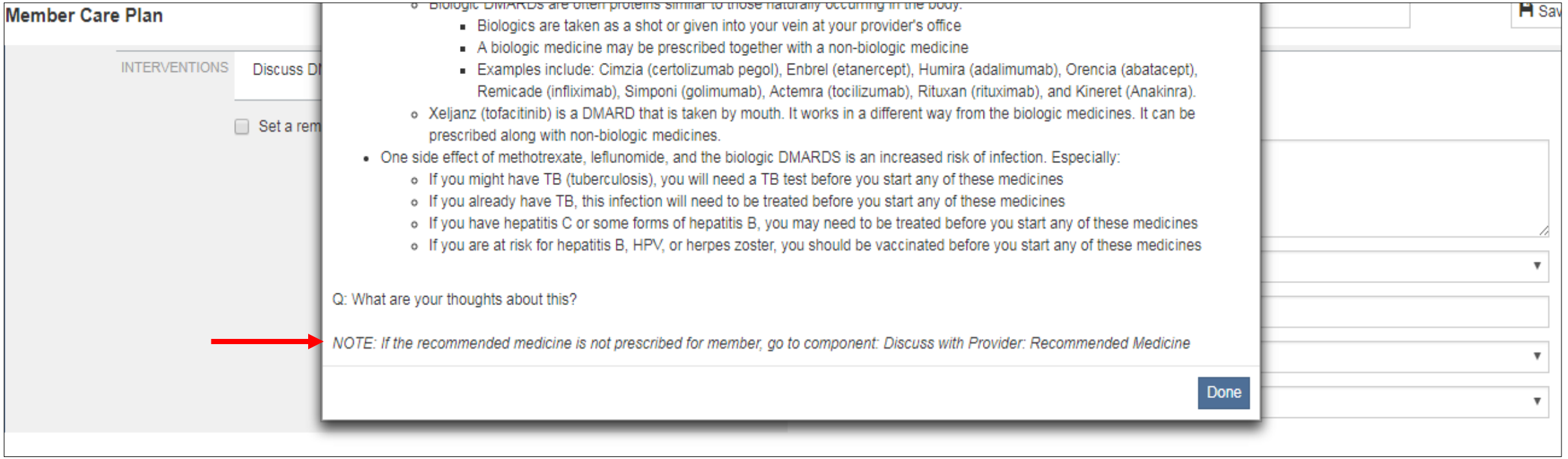
Instructions for when the recommended medicine is not prescribed



AXISPOINT HEALTH

Module 8, Objective 2.3 and Objective 2.4: Please describe the interventions that were implemented that positively impacted measures.

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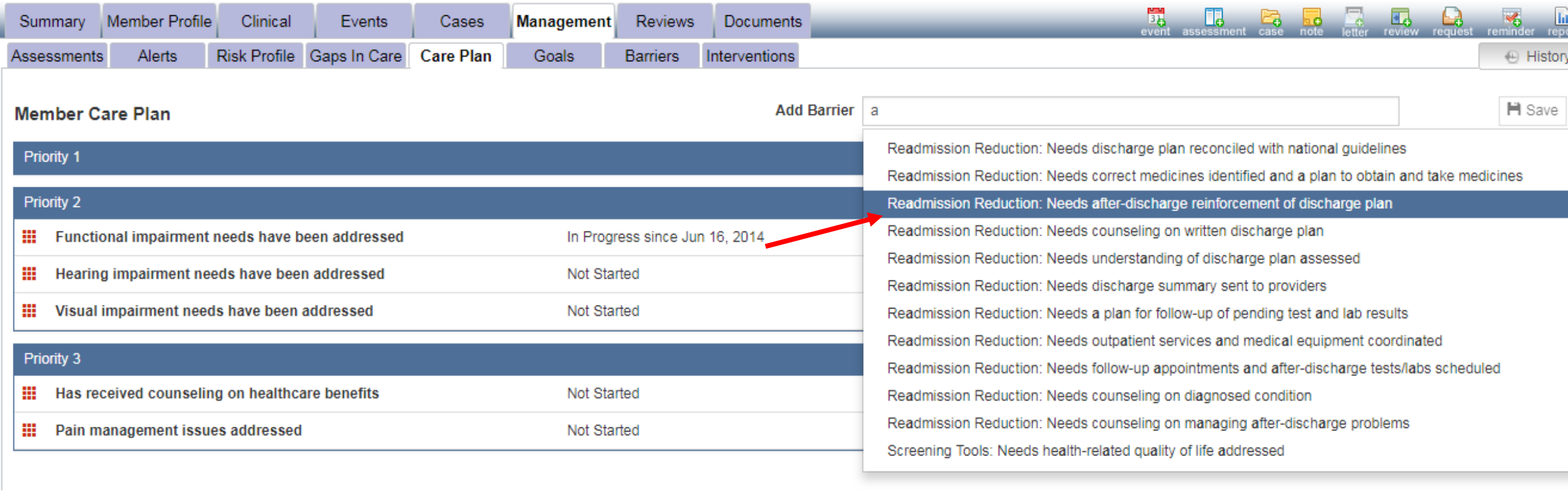
Readmission Reduction (post-discharge) - Medication Compliance



AXISPOINT HEALTH

Module 8, Objective 2.3 and Objective 2.4: Please describe the interventions that were implemented that positively impacted measures.

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Provider and Pharmacy Alerts

Health Care Guidance Program
Coordinating with you for better care!

P.O. Box 2127
Carson City, NV 89701

July 12, 2017

CM_PPST_06292017

Nevada Health Centers Inc
Attn: Managed Care Coordinator
762 14th St
Elko, NV 89801-3413

Dear Nevada Medicaid Provider:

You are receiving this report as the identified primary care provider (NPI provider) and/or Behavioral Health provider for one or more Nevada Medicaid Fee-for-Service (FFS) Health Care Guidance Program (HCGP) beneficiaries. The beneficiaries identified in this report have been seen in this clinic or by a provider in this practice.

The enclosed information highlights care improvement opportunities for participating HCGP beneficiaries that can be reinforced by your practice. The report details gaps in care or recommended interventions. This information is being sent to the primary care provider and if appropriate, the behavioral health specialist to ensure all identified patient providers are informed of patient needs and program recommendations. We encourage you to participate by providing feedback on the patient information that is captured here or prescribing further care management interventions.

As you review these assessments, please keep in mind the limitations of patient self-reported information. We welcome your input and any updated patient metrics or treatment recommendations that you may have for the listed patients.

The HCGP care managers will use the treating providers' feedback in upcoming coaching sessions with your enrolled patient(s). They cannot initiate treatment changes or take verbal or written treatment orders, but they will reinforce your treatment recommendations and help educate patients as an extension of your care team.

Your support and participation are vital to the success of the Health Care Guidance Program outreach to your patient(s). If you have questions or concerns, please call **1-855-606-7875, option 2**, Monday through Thursday 8 a.m. to 8 p.m., and Friday 8 a.m. to 5 p.m.

For additional information about the program, including the evidence-based guidelines used for the program, alert criteria and the Practitioner Bill of Rights and Responsibilities, please visit our secure website at **https://nvguidance.axispointhealth.com/providerportal/nev**. This website gives you access to secure patient information, registration for this site is required. You may also visit our general website at **www.nevadahcgp.com** for more information about the program, or call **1-855-606-7875, option 2**.

Sincerely,

Nevada Medicaid Health Care Guidance Program
Assessment Report

Page 1 of 2

Beneficiary Name:
Beneficiary Date of Birth:
Beneficiary ID:
Assessment conducted by: Debra Svab
Assessment date: 06/08/2017

This report indicates areas where patient self-reported information reveals possible needs identified during the program assessment.

Condition Management:

For your consideration, these possible gaps in care were identified. Medications are reviewed and adherence is discussed with patients during their calls. If you feel that the below self-reported assessment is incorrect or would like to give additional information regarding medications, barriers, and/or interventions that were not covered within the assessment, feel free to call the HCGP at **1-855-606-7875, option 2**, or use the fax sheet on the following page to provide your feedback.

- Patient with symptoms of not well-controlled asthma does not take a daily ICS or other controller.

Self-Reported Barriers:

The program care manager will work with your patient to provide education around the following barriers.

Needs to use inhaled medicines effectively
Needs medication review
Needs asthma self-management overview

AXISPOINT HEALTH

Module 8, Objective 2.3 and Objective 2.4: Please describe the interventions that were implemented that positively impacted measures.

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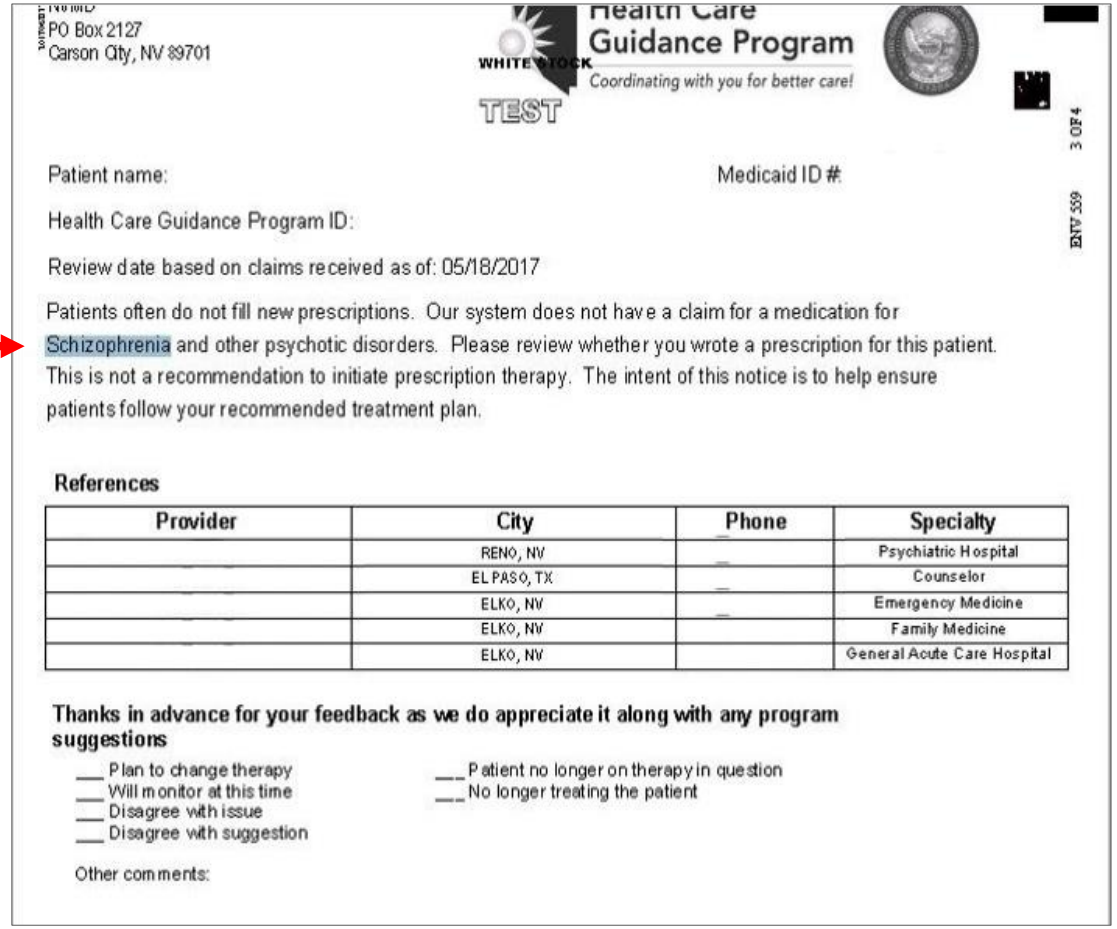
Provider and Pharmacy Alerts

- There are currently 7 types of Clinical Care Alerts sent to Providers on behalf of our members based upon monthly claims analysis:
  - Early Discontinuation
  - Under Use (Medication Adherence)
  - Overuse of Narcotics
  - Polypharmacy
  - Drug-Drug Interaction
  - Duplicate Therapy
  - Pediatric Age Limits
  - Admit No Follow up
  - Lab Monitoring
  - Conditions No Medications



PO Box 2127
Carson City, NV 89701

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TEST

Patient name: Medicaid ID #:

Health Care Guidance Program ID:

Review date based on claims received as of: 05/18/2017

Patients often do not fill new prescriptions. Our system does not have a claim for a medication for Schizophrenia and other psychotic disorders. Please review whether you wrote a prescription for this patient. This is not a recommendation to initiate prescription therapy. The intent of this notice is to help ensure patients follow your recommended treatment plan.

References

Provider	City	Phone	Specialty
	RENO, NV		Psychiatric Hospital
	EL PASO, TX		Counselor
	ELKO, NV		Emergency Medicine
	ELKO, NV		Family Medicine
	ELKO, NV		General Acute Care Hospital

Thanks in advance for your feedback as we do appreciate it along with any program suggestions

___ Plan to change therapy
___ Will monitor at this time
___ Disagree with issue
___ Disagree with suggestion
___ Patient no longer on therapy in question
___ No longer treating the patient

Other comments:

AXISPOINT HEALTH

Module 8, Objective 2.3 and Objective 2.4: Please describe the interventions that were implemented that positively impacted measures.

Health Care Guidance Program
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Educational Mailings and Interactive voice Response Campaigns

AXISPOINT HEALTH

IV. Medical Director

Provider Relations

IV. Medical Director- Provider Relations

- Provider Outreach Events: 21 formal meetings with major care providers such as Clinics and Hospitals
- Special focus on Certified Community Behavioral Health Center (CCBHC) Outreach:
  - As of July 19th, Joint leader Meetings were held at 4/5 of the sites.
  - Focus on Mutual Support
  - Focus on Clarification of TCM Billing to avoid working at cross purposes

- Provider Advisory Board
  - Expanded to Additional Stakeholders
  - Focus of meeting in June was the CCBHC program
  - Next Meeting in Sept to have discussion of Transitional Case Management—presentation by Chief of Case Management from Valley Health and one of our Care Managers.

V. Focus for Next Quarter

V. Focus for Next Quarter

- Work with DHCFP staff to finalize Amendment #6
- Prepare for and support September 2017 PMV audit
- Continue support of CCBHC's around the state
- Concurrent with Milliman responsibilities to calculate results, support APH Data and Analytics department in calculating Program Year 2 non-P4P measures. APH will also perform internal analysis on P4P and PY2 ROI.
- Revisit providers – hospitals and clinics – to reinforce program goals and leverage PY1 results to emphasize quality goals.
- Work with APH quality team to incorporate PY1 and PY2 results to ensure program improvement and enhancements

Health Care Guidance Program
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HCGP Quarterly Meeting July 25th, 2017
Location: Division of Health Care Financing and Policy (DHCFP)
1100 E. William Street (2nd floor conference room)
Carson City, Nevada 89701
Phone Number: 877-336-1829 Access Code: 8793897

1:00 pm – 1:30 am

I. Welcome and Introductions/DHCFP — **Gloria Macdonald, Chief, Program Research and Development Unit**

Approval of Minutes — **Gladys Cook, SSPS III, DHCFP**

II. Program Updates

Executive Director Comments — **Cheri Glockner, HCGP Executive Director, APH**

AxisPoint Health Updates — **Dr. Virginia Gurley, CMO, APH**

1:30 pm – 2:45 pm

III. Quality

Module 5: Objectives 1.1 and 1.2
Module 8: Objective 2.3 and 2.4 — **Michelle Searing, Outcomes Operation Manager, APH**

2:45 pm – 3:00 pm BREAK

3:00 pm 3:45 pm

IV. Provider Outreach — **Dr. Thomas McCrorey, Medical Director, APH**

V. Focus for Next Quarter — **Cheri Glockner, HCGP Executive Director, APH**

3:45 pm – 4:00 pm

VI. New Business — **Gloria Macdonald, Chief / Gladys Cook, SSPS III DHCFP**

*DIRECTIONS: For those who will be teleconferencing for this meeting, please call at the time scheduled for your agenda item. The dial in number is 877-336-1829. Key in the Pass Code 8793897.

* Should you need assistance during your conference, please press *# for a list of menu options and *0 to obtain Specialist assistance.

Health Care Guidance Program

Coordinating with you for better care!

Provider Advisory Board Minutes

June 9, 2017 12:00-3:00

Attendees:

Thomas McCrorey MD HCGP	Cheri Glockner HCGP
Taylor Ann Johnson APRN, CHA	Virginia Gurley, MD APH (not present)
Ryan Ley MD HCGP	Thomas Hunt, MD (not present)
Katherine Keeley, MD, DDS Sunrise	Gladys Cook, DHCFP
Allison Toigo, PharmD Banner C.H.	Rachel Marchetti, DHCFP
Gina Pierotti-Buthman, RN Valley Health System	Karen Salm, DHCFP
Guest speaker, Stephanie Woodard, PsyD	

Discussion and action items

Call to Order and Introductions	
Brief Update on the Program and Medicaid	Participants thanked Dr. McCrorey for his update, particularly related to legislative action and effect on providers around the state. He discussed the confusion around Managed Care expansion as related to fee-for-service beneficiaries. He told the board that FFS continue to be served in the current model and no decision related to transition is imminent. He asked the Board to help with messaging as there continues to be confusion related to this issue.
Discussion of the State of Mental Health Services in the US, and how we got here.	Presented by Drs. McCrorey, and Dr. Ley Presentation was well received. No questions from the Board
The Certified Community Behavioral Health Clinics Project	Dr. Stephanie Woodard presented to participants.
Discussion on the CCBHC	Participants were enthusiastic about the progress and the opportunity to work with CCBHC's. Dr. Durette asked detailed questions related to formal agreements between providers and the CCBHC's. Dr. Woodard assured her that CCBHC's will work collegially to ensure beneficiary needs are met in a timely, integrated manner, and this has been anticipated in the study design.

Next Meeting – September 7, 2017 Las Vegas DHCFP District Office	
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HCGP News

- Finished 3 years of program operation!
- Working on PY2 final financial and clinic results
  - **(12 month claims runout)**
- Ongoing focus on Disease Management and Complex case Management
  - **Majority of our engagements involve assisting with social resources**
- Program will function for at least 1 more year in the current configuration.
- Likely will continue in some fashion afterwards
- Provider Advisory Board Enlargement
  - **Non-provider stakeholders**

AXISPOINT HEALTH

Medicaid News –

- Deputy Director Betsy Aiello retired
- New Deputy Director for Medicaid
- Shannon Sprout-was chief of clinical policy
- Marta Jensen remains Acting Director
- Karen Salm, CFO
- Gloria MacDonald Program Research and Development

Medicaid News –proposed rate and policy changes

Legislature approved or recommended Medicaid funding for:

- Home Health and DME
- Adult non emergency Podiatry
- Dietician services
- Gender Dysphoria surgery

Increased Funding for:

- Adult Day Health Care
- Assisted Living for Behaviorally Complex
- Small hospital swing bed payments
- Pediatric surgery rates

AXISPOINT HEALTH

Medicaid News –Health Bills that passed

- Governors Opiate Abuse Bill (AB 474) passed
  - 14 day supply and < 90 MME/day
  - (Lower limits for Medicaid)
- Pharmacists can dispense opiate antagonist without a prescription
- APRNs can sign a POLST order (AB 199)
- Psychiatric care advance directives and consent (SB50)—signed by governor
- ER visits capped at 150% of Medicare rate (AJR 14) Constitutional amendment– will need to reviewed in next session)
- Funding and requirement DPBH Mobile Mental Health units in Clark and Washoe County to be available from 8 a.m. – 12 a.m., 7 days a week, (SB192) signed by Governor

Medicaid News –Health Bills that passed

- SB509 authorizes Medicaid to levy a tax on Health facilities-has not been signed by governor yet.
- SB325 waives the wait period for Medicaid eligibility for immigrant children –has not been signed by governor yet.
- AB374 "Medicaid for All" allows state to develop process for people to purchase Medicaid on the market or exchange. Would have same benefits for purchase (except NET) without means tested eligibility-has not been signed by governor.
- Periodic update of Medicaid rates (AB108) every 4 years Medicaid rate comparison to actual cost and propose update in the state Medicaid plan. (has been signed and will be law on July 1)

AXISPOINT HEALTH