# MINUTES OF THE MEETING
# OF THE
# ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES

## Seventy-Eighth Session
## March 25, 2015

The Committee on Health and Human Services was called to order by Chair James Oscarson at 1:36 p.m. on Wednesday, March 25, 2015, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/78th2015. In addition, copies of the audio or video of the meeting may be purchased, for personal use only, through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

**COMMITTEE MEMBERS PRESENT:**

Assemblyman James Oscarson, Chair
Assemblywoman Robin L. Titus, Vice Chair
Assemblyman Nelson Araujo
Assemblywoman Teresa Benitez-Thompson
Assemblywoman Jill Dickman
Assemblyman David M. Gardner
Assemblyman John Hambrick
Assemblywoman Amber Joiner
Assemblyman Brent A. Jones
Assemblyman John Moore
Assemblywoman Ellen B. Spiegel
Assemblyman Michael C. Sprinkle
Assemblyman Tyrone Thompson
Assemblyman Glenn E. Trowbridge

**COMMITTEE MEMBERS ABSENT:**

None

**GUEST LEGISLATORS PRESENT:**

None

**STAFF MEMBERS PRESENT:**

Kirsten Coulombe, Committee Policy Analyst
Nancy Weyhe, Committee Secretary
Jamie Tierney, Committee Assistant

**OTHERS PRESENT:**

David Fogerson, Deputy Chief, East Fork Fire and Paramedic Districts
Alex Ortiz, Assistant Director, Department of Administrative Services, Clark County
Steven Tafoya, Manager, Emergency Medical Systems Program, Bureau of Preparedness, Assurance, Inspection, and Statistics, Division of Public and Behavioral Health, Department of Health and Human Services
Laurie Squartsoff, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Cheri Glockner, Executive Director, Health Care Guidance Program, McKesson Corporation
Amy J. Khan, M.D., M.P.H., Medical Director, Health Care Guidance Program, McKesson Corporation
Michelle Walker, Director, Provider Services, Health Plan of Nevada
Garyn E. Ramos, President and Chief Operating Officer, Behavioral Healthcare Options, Inc.
Allyson Hoover, M.S.N., R.N., Director, Provider Engagement and Contracting, Amerigroup
Pete Sabal, Regional Vice President, Provider Engagement and Contracting, Anthem Blue Cross Blue Shield
Pattie Gonzalez, Director, Provider Network Management, Anthem Blue Cross Blue Shield
Ty Windfeldt, Vice President and Chief Executive Officer, Hometown Health, Renown Health
Robert B. McBeath, M.D., President, Chief Executive Officer, Southwest Medical Associates
Eugene Somphone, M.D., Medical Director, Urgent Care/Telemedicine, Southwest Medical Associates
Nicole Flora, M.D., Chief Medical Officer, Nevada Health CO-OP
Scott J. Kipper, Insurance Commissioner, Insurance Division, Department of Business and Industry

Tracey Woods, Vice President, Government Relations, Anthem Inc., and Its Affiliates Including Anthem Blue Cross and Blue Shield; and Amerigroup Nevada

**Chair Oscarson:**
[Roll was taken. Committee rules and protocol were explained.] We are going to start with a hearing on a bill which was sponsored by this Committee. I will now open the hearing on Assembly Bill 425. Mr. Fogerson, I believe you are here to present, and I look forward to your testimony.

**Assembly Bill 425: Revises provisions governing emergency medical services. (BDR 40-702)**

**David Fogerson, Deputy Chief, East Fork Fire and Paramedic Districts:**
I am the deputy fire chief for East Fork Fire District and the chair of the committee on Emergency Medical Services (EMS), Division of Public and Behavioral Health, Department of Health and Human Services. This committee has come up with a few ideas through the years on how to adjust some regulations, and this was one that we were able to talk to some of your Committee members about and get your response, and we really appreciate that.

The committee comprises members representing the different types of emergency medical services throughout Nevada. [Mr. Fogerson continued to read from prepared testimony (Exhibit C).]

**Chair Oscarson:**
Any questions from the Committee?

**Assemblywoman Benitez-Thompson:**
In reference to the comments that you made about the lockbox. I appreciate the concept of the lockbox because you mentioned first responders having access to the lockbox information on advance directives and Physician Orders for Life Sustaining Treatment (POLST) documents. Is that something that can be readily and easily done if, for example, an ambulance pulls up to a house, logs into the site, and pulls up the name and address to see if there are such directives? How do you manage the application of this once you get the authority to access them?

**Dave Fogerson:**
Absolutely. I am sure you have heard a lot about the telehealth and community paramedic part, and that is where this piece would really come into play. Right now it is probably not going to be used much. That was at the point when

we found out we were not able to access the lockbox because we were not health care providers. We do not know how we are going to use that information yet, but we do see a very big nexus as we continue to evolve the health care field of emergency medical services.

Right now it is probably going to be more the home of a hospice patient and someone saying he is on hospice, or he has a do not resuscitate order (DNR), but we are not able to access it; so then we have to make base contact. This would allow us to make those decisions in a more timely manner on scene.

**Assemblyman Thompson:**
It looks like Assembly Bill 425 talks mainly about the composition of your committee. I wonder if you could share some of the core goals and achievements you have accomplished so far. I know you want to expand some things, but can you tell us about some of the great work you have been doing?

**Dave Fogerson:**
The EMS committee has been stagnant for the past four years. They have not done much of anything. We have rotated members of the group and have tried to do some things. We are trying to become the advocate voice for the EMS field. The state Emergency Medical Systems Program, Bureau of Preparedness, Assurance, Inspection, and Statistics, Division of Public and Behavioral Health, Department of Health and Human Services is the permitting and licensing regulatory agency for us, and we are trying to use the committee to advance our profession.

When we found out about POLST, the committee pushed it out to all the EMS providers in the state. We have been encouraging the state EMS program to look at more of the regulations for possible updating. We updated *Nevada Administrative Code* (NAC) Chapter 450B through committee process and took it to the State Board of Health for adoption after allowing the providers to have input. We are getting momentum going with these regulatory changes, especially NAC Chapter 450B, which had not been touched in about six years. That was probably the greatest accomplishment of the committee to date.

We have also made changes to the training curriculum and have provided advice and counsel to staff on how to make those changes. We are constantly discussing ways to make the system better and ways to become the voice for all the people in the state for emergency medical services.

**Assemblyman Thompson:**
How often do you or will you meet? I know you have been staggering your meetings.

**Dave Fogerson:**
We meet once a quarter. We always meet the third Thursday of the third month of each quarter.

**Assemblyman Sprinkle:**
Regarding the proposed changes, this really broadens who can be appointed to specific spots within that committee. Why broaden those positions as opposed to adding new ones? Although no one wants cumbersome boards, does this potentially limit hearing from those who would normally have filled those seats?

**Dave Fogerson:**
The committee currently has nine seats on it and has many ex-officio members. We are discussing adding an emergency medical dispatcher and rural providers who were not part of the fire services. Our worry is if we add more members, the board will get unwieldy and hard to get a quorum. We looked at leaving the decision to either a fire service organization or an EMS organization. We could always let the State Board of Health pick the best person for that position. The last three times we had openings, we had no one to fill these positions. This is my second term on the board because no one was willing to step up to be the fire department member. This opens it up to getting some fresh blood in there, and allows others to step back for a while.

**Assemblyman Sprinkle:**
I appreciate that. I wanted to make sure that nobody in particular was being eliminated. We are looking at adding emergency medical technicians (EMT) to the definition of health care provider. Are there any concerns about potential liability since we are now broadening the definition of who these people are and what services they provide? Should more protections be built in since they are being defined as health care professionals?

**Dave Fogerson:**
Those are good points. We—including lobbyists and lawyers—have looked at this to try to figure out what those protections are. So far, most of them appear to be the same as what we currently have. There would be more liability because our profession would now be considered health care professionals. Hopefully, this will make people realize that the EMS field is part of the health care community; however, I think most people already see us in that light. We might look at NAC Chapter 450B to determine if anything needs to be added. We might find additional issues in the next legislative cycle, but so far no one has found anything yet.

**Assemblywoman Titus:**
Thank you for bringing forth this bill because it really opens up access to board representation for the EMS, especially in the rural areas. A nine-member board is already a large board and sometimes it is a slow-moving barge. I appreciate that the fire service does need to be represented, but there are multiple other positions on the board that are fire service-related. Usually, if not always, EMS is connected with the fire service.

As far as the definition of provider of health care, already included are music therapists and athletic trainers. I certainly think that, under that definition, an EMS advanced paramedic and people with training that truly do administer hands-on health care should be included in that. They already have the liability when they go on a call. I appreciate all that, and I think this is a very good bill.

**Dave Fogerson:**
Thank you. I did not want to single out some of those names for that very reason.

**Assemblywoman Spiegel:**
Thank you for bringing this bill forward. Would this then create eligibility for Medicare and Medicaid reimbursements for EMT services?

**Dave Fogerson:**
Currently emergency medical services can bill Medicaid and Medicare. Everyone who transports is already billing, so that does not really affect it. Who knows where the future of health care will go and whether it will affect anything then, but currently there is no effect.

**Assemblyman Thompson:**
I know that we are a policy committee; however, most of the time with boards, commissions, and committees there is a fiscal note. I am looking in Nevada Electronic Legislative Information System (NELIS), and I do not see one. Is there a fiscal note?

**Dave Fogerson:**
I would assume there would not be a fiscal note since we are not changing anything except to broaden who can be included on the committee. The committee already exists and the number of positions already exists, so the support services for them already exists. We are just adding definitions of who could fill that role.

**Assemblywoman Benitez-Thompson:**
As I look at *Nevada Revised Statutes* (NRS) 629.031 and who is defined as a health care provider, with the exception of a music therapist, the other professions listed are people who have postgraduate training. Even a marriage and family therapist, on top of graduate training, must have X amount of clinical hours. I am reading NAC Chapter 450B and wonder if the licensing to become a paramedic is in the same spirit as these other professions. Is it the same professional grade as some of the other professions?

**Dave Fogerson:**
As we continue to evolve the career field of EMS, right now the minimum requirement to be a paramedic is a high school diploma. Then there is very intensive schooling, an internship in a hospital, and an internship in an ambulance lasting approximately one year. We are looking at almost two years of schooling condensed down to one year because of the 24-hour shifts that most of the providers work.

Right now it is not a graduate-level education. It is more an associate-level education, but they are licensed. We have a certification process for the training, and a licensure process that goes along with that. It is definitely not on the same scope as a postsecondary education or graduate school. The difference between a paramedic and a nurse is that a paramedic operates under standing orders and can do the same skillsets that a nurse can do, but a nurse has to do it under a physician's supervision. In the field, an EMS intubates a patient—puts a tube into his throat down to his lungs—the same as the emergency room doctor would do. It is the same skillset but with just a little less education. As we continue to advance the career field, hopefully, those are changes that we can continue to make.

**Chair Oscarson:**
Are there any other questions from the Committee? [There were none.] Mr. Fogerson, did you know you were going to get so many questions? I am always pleased with the questions from this Committee about the intent of the legislation. We will ask you to step back for a minute and we will now ask for testimony in support of A.B. 425. Is there anyone in the audience, either here or in Las Vegas, who is in support of A.B. 425? Seeing no one, is there anybody in opposition to A.B. 425, either here or in Las Vegas? [There was no one.] Is there anyone neutral?

**Alex Ortiz, Assistant Director, Department of Administrative Services, Clark County:**
I want to thank the sponsor for considering our amendment to this bill (Exhibit D). As you can see in NELIS—since the Clark County Fire Department

does not perform this function—this amendment changes the definition of health care provider in NRS 629.065, subsection 1, where it says "Each provider of health care...", by adding "that performs or collects blood, breath or urine samples." Our fire department does not do that currently and so we request to be excluded from it. That is really as simple as it gets.

**Assemblywoman Benitez-Thompson:**
Could you please explain it again? You are asking for anyone who is an employee of the county that collects blood, breath, or urine not be included in the definition? Did I understand that correctly?

**Alex Ortiz:**
The bill expands the definition of health care provider in NRS Chapter 629 to include certified emergency technicians, advanced emergency medical technicians, or paramedics. We have those within our fire department, but they do not collect blood, urine, or breath samples; therefore, we are asking that the definition be amended to exclude those that do not collect them.

**Assemblyman Sprinkle:**
I am looking at NRS 629.031, and I do not see that. Is there a more specific place in statute where it says that?

**Alex Ortiz:**
What we are doing is amending A.B. 425, which amends NRS 629.065. It states "Each provider of health care shall, upon request, make available to a law enforcement agent or district attorney the health care records of a patient which relate to a test of the blood, breath or urine of the patient." If you look at section 2 of the bill, page 4, lines 14 through 17, it includes a "person who holds a license as an attendant or who is certified as an emergency medical technician, advanced emergency medical technician or a paramedic pursuant to Chapter 450B of NRS."

**Assemblywoman Titus:**
I am under the impression that although they are expanding the definition, that does not mean that they are obligated to do those. Certainly the optician, the music therapist, and the licensed family and marriage therapist do not collect blood or breath samples. What you are referring to is not germane to this bill because it does not mandate that you perform an act that you do not do in the first place.

**Chair Oscarson:**
Since this amendment came forward, we have been working on getting some information. Ms. Coulombe?

**Kirsten Coulombe, Committee Policy Analyst:**
Our Legal Counsel for the Committee has reviewed the amendment, and it is not germane to the bill. This amendment would not be considered for this bill.

**Alex Ortiz:**
We will withdraw our amendment.

**Chair Oscarson:**
Mr. Tafoya, I would ask, in neutral, if you would not mind clarifying the fiscal aspect of this?

**Steven Tafoya, Manager, Emergency Medical Systems Program, Bureau of Preparedness, Assurance, Inspection, and Statistics, Division of Public and Behavioral Health, Department of Health and Human Services:**
We did not attach a fiscal note to this because we already have this in place. We have nine committee members already, and just want to restructure them and what they do.

**Chair Oscarson:**
Is there any other testimony in neutral? Seeing no further testimony, I will close the hearing on Assembly Bill 425. Thank you Mr. Fogerson for your time and effort. We appreciate your testimony and will let you know when the bill is up for work session.

As a continuation of our prior presentation on access to health care for veterans, we will now have a presentation on access to health insurance for all Nevadans. I am very pleased and honored to have this group of professionals in our midst. They are going to discuss access to care issues in the state and the successes and challenges. There will be several brief presentations by this group. We have nine presenters, and with the Committee's indulgence, we will write down our questions and ask them at the end in order to get through the presentations. Is that acceptable to the Committee?

**Laurie Squartsoff, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:**
I am the administrator for the Division of Health Care Financing and Policy, also known as Nevada Medicaid. With me are Cheri Glockner, representing Nevada Medicaid-Health Care Guidance program (HCGP) from McKesson that provides services for fee-for-service Medicaid beneficiaries, Allyson Hoover from Amerigroup, and Michelle Walker from Health Plan of Nevada, the two managed care plans that provide services for Nevada Medicaid beneficiaries living in the urban counties.

The question this afternoon is about access to care. In your slide packet (Exhibit E) you will see a slide that is familiar to most of you because I have shared this in many presentations. As more Nevadans have access to a payer for health care services—including Medicaid—and the provider pool remains constant, access to health care becomes a statewide concern and challenge. We also have good news to share as a result of Medicaid expansion: we have reduced the uninsured rate from 23 percent to approximately 11 percent, giving more people access to care. The paid claims history for Medicaid shows that from November 2012 through November 2014 there has been a 24.5 percent increase in the number of fee-for-service claims.

Defining access to care is complicated. The hexagon on slide 3 shows how complicated it is to describe what access to care is. There are many determinants that affect access to health care, including workforce capacity. As we know, Nevada has a health care workforce shortage.

Other issues include increased enrollment as a result of Medicaid expansion, our reimbursement rates, the health care needs of recipients, the constraints of the health care system itself, and the discussion of increasing the use of preventative health services versus emergency room services for nonemergent health care needs. As you can see from this diagram, there is no single way to address the issues surrounding access to care concerns. It will take a combination of all of the above and a collaborative conversation to address these issues.

Medicaid beneficiaries can receive services through two care models: the fee-for-service model and our managed-care model. Any willing medical provider may apply to be a Medicaid or Nevada Check Up fee-for-service provider. Qualified providers can submit an enrollment application at any time to serve our patients. There are some qualifying and disqualifying conditions, such as being on a federal exclusion list or having committed fraud in Nevada. By and large, any qualified provider may sign up with the Division to receive payment for providing services within their scope of practice for both Medicaid and Nevada Check Up recipients.

Our credentialing process includes licensure verification and validations of other information disclosed on the application through various federal databases. That ensures that the provider has not been excluded from participation in either federal or other state Medicaid programs. The Division also contracts with two managed care programs that provide medical coverage for about 70 percent of our population. It is important to acknowledge that they may be more restrictive in developing their provider networks than fee-for-service because the Division requires the managed care organizations to provide proof of health care

outcomes while saving dollars. The Division regularly monitors access to care to ensure that enough providers are in each plan's network. I will leave any additional details to both Ms. Hoover and Ms. Walker.

If you move to slide 5, this shows the increase in the number of providers over the last three fiscal years. As you can see, the number of providers continues to grow. There are approximately 25,041 providers enrolled in the fee-for-service program as of February 2015. This includes individual providers and group entities. Some of the individual providers are enrolled to provide services through a group practice and do not see recipients on an individual basis. Providers are categorized by provider types and specialties. While we do have 25,000 providers listed, not all of them are currently taking new patients.

If you flip to slide 6, it shows the number of Medicaid beneficiaries for each of our urban counties—Washoe and Clark Counties—and a comparison of the number of providers we have to provide services. This gives us a better picture of the circumstances and challenges we all face.

Slide 7 shows the rural counties' fee-for-service providers and clients. Even with Esmeralda and Eureka Counties with one and nine providers respectively, there are 114 and 131 clients who may need services from them. There are 11,525 clients in Carson City who need services with 726 providers. I hope this picture gives you a better understanding about the concern for accessing services. For your reference, on pages 11 through 16 of (Exhibit E), there is a list of all the providers by provider type and county for each one of your respective districts.

The steps we have taken to address the issue of improving access to care are: maximizing our existing network, contacting physicians who may not have sent in their contract renewals, and being more proactive in assisting providers who have seen clients in the past and may be restricting the number of new clients. We have increased the accountability of our managed care partners. The Division contracts with an external quality control review organization, currently Health Services Advisory Group, to regularly monitor and report on the quality of services from both managed care organizations, including health outcomes and access to medical providers. The managed care organizations are contractually required to allow current treatment that began during a fee-for-service span to continue with the same provider regardless if they are currently enrolled in a managed care network. After a transition-of-care period, the recipient is required to use an in-network provider. The Division considers evidence of proper health, as well as managed care organizations meeting their contractual requirements for timely access to care, to be indicators that there is

an adequate network of providers. We continue to engage in provider outreach opportunities.

Medicaid and program staff have taken many steps in the last year and a half to address the access to care issue. Network expansion includes the implementation of the telehealth policy change and the expanded use of advanced practice registered nurses. We have made several process changes to address the accountability of the program, including discussions with physician groups regarding the alignment of the prior authorization requirements between fee for service and managed care. Specifically we have had many meetings with pediatricians to address their concerns, and we have worked to ensure that high-need, fee-for-service recipients are working with our care management organization. We were able to increase the inpatient psychiatric rates and implement the "in lieu of" option for managed care beneficiaries to better access mental health services.

We continue to look at ways to improve access to quality health care. Ensuring access to care is not easy and something that Medicaid alone cannot solve. I am hopeful that we will be able to work together on ways to make improvements in the health care system starting with this conversation. Thank you for the opportunity to share some of the details surrounding access to care for fee-for-service Medicaid beneficiaries. Cheri Glockner will now present on the Health Care Guidance Program.

**Chair Oscarson:**
Thank you, Ms. Squartsoff, for a very honest assessment of where we are, where we need to go, and for starting the dialogue.

**Cheri Glockner, Executive Director, Health Care Guidance Program, McKesson Corporation:**
I am representing the Health Care Guidance Program (HCGP). We are not an insurance product; we do not maintain a network. We are an added benefit to a subset of fee-for-service Medicaid members whom I will discuss in more depth. This is a high-need population that has never had this level of attention, so keep that in mind as I go through the program.

We are the HCGP. It is actually known as the Care Management Organization, but we have branded it as the HCGP. Our goals are to improve care quality, improve health outcomes, patient satisfaction, and ultimately provide value and reduce costs. We are a Centers for Medicare and Medicaid Services (CMS) approved demonstration waiver. We are approved for up to five years to show that this level of attention to this population can meet the goals of the CMS waiver. We are a statewide program. We launched June 1, 2014, so we are

about 7 1/2 to 8 months into a five-year program. I am actually employed by McKesson. We are contracted with the state of Nevada and work through the Division of Health Care Financing and Policy (Medicaid) to deliver this program.

We determine eligibility by historical claims. The program is capped at 41,500, with a minimum of 37,000. To date, we are averaging about 38,000, but have been above 39,000. We are hoping to get to that 41,500 soon.

The qualifying conditions are on page 2 of (Exhibit F). McKesson has a very sophisticated algorithmic process that we go through to look at these historical claims. Then we determine eligibility and put them into one of eight care programs. Our medical director calls these the usual suspects, and I will have her come up and finish the presentation in a moment.

Once we have identified these members that would fall into one of eight buckets for care management, we then stratify them into a risk level. The CMS was very clear that there is a population of this fee-for-service Medicaid that is not able to participate in our program. This excluded population is listed on page 2, so I will not read those to you.

The slide I would like to show you that sets the stage for who we serve is also on page 2. You can see the entire population represented in the three circles: the Medicaid population, the fee-for-service population broken out even smaller, and the HCGP, which delivers our services to about 7 percent of that full fee-for-service population. Again, these are the traditional fee-for-service Medicaid beneficiaries who have never had a level of service for care management delivered to them, so it is a very needy population.

On page 3 are the services that we provide. The HCGP is very mission-driven; we take our responsibilities to the enrollees and eligible members very dear to heart. The services that we provide to providers are an extra level of support to ensure that the providers recognize they are not in this alone, and that we are there to follow up their care plan. We will show you the resources that we have dedicated to this population and how very diverse the services are that we provide. With that, I am going to introduce Dr. Amy Khan, who will show you a case study to help illustrate more of the care management organization services.

**Amy J. Khan, M.D., Medical Director, Health Care Guidance Program, McKesson Corporation:**

I work to ensure not only the clinical quality of our program, but also work very closely with our providers—the rare few participating Medicaid providers that are taking care of this fragile, medically complex, fee-for-service population.

I want to close our presentation by sharing with you a flavor of how we interface with not only the high-need, high-risk individuals, but also with our providers to develop and optimize a care plan that can be understood, is actionable, and drives optimal health and health outcomes.

This case in brief is a middle-aged member who was identified and included in our program because the individual had one of the qualifying conditions. I want to mention that we assess the member population every month and stratify low, medium, high, and complex risk. We know that health is a dynamic state and there are some individuals who may be low risk, but through additional diagnosis or complications with chronic conditions end up stratifying to a higher risk, which then dictates more intensive intervention.

In this particular case, not only was it difficult to find this individual—these are people who do not always have a stable domicile—but the individual did not have a stable primary care relationship, was not taking medications as prescribed, did not understand what those medications were, and had challenges in transportation and getting to appointments. This is why our providers are often frustrated by this population when they fail to keep appointments. We deployed one of our disease management nurses who was initially unable to find the patient. One of our community health workers went to the last known address and was able to find out from a neighbor that the patient had been taken to the hospital. Ultimately, we met the patient—who had been admitted for noncompliance to their chronic condition—at the hospital.

During that hospitalization, we were able to engage the individual and establish a rapport that was effective and meaningful to the individual. We assisted the member with transition when the person was ready for discharge and continued to work with the individual to identify an appropriate primary care relationship. We reviewed medications, spent some time educating the individual about self-management skills and how to manage the conditions, and then provided the kind of support the individual needed to start looking at a couple of other issues. Substance abuse issues were also identified as part of the conditions that the individual had been struggling with.

We procured transportation for that patient to medical appointments and, in this case, accompanied the member. In some cases this is essential to drive home the understanding of the appropriate care plan. Then, we ultimately worked to identify some resources so that person could be stable in the current housing situation. I wanted to highlight this case to demonstrate the work of a care-management organization in support of our Medicaid providers—whom we truly appreciate—and to better the outcome and the health of the individuals that we serve.

**Cheri Glockner:**
Thank you again for the opportunity to tell you about the HCGP, and we look forward to questions at the end of the presentation.

**Chair Oscarson:**
We now have Michelle Walker, director of provider services at Health Plan of Nevada, and Mr. Ramos, president and chief executive officer of Behavioral Healthcare Options, Inc.

**Michelle Walker, Director, Provider Services, Health Plan of Nevada:**
In order to save some time, we are going to mix in a little commercial and Medicaid in our presentation. Most of our monitoring mechanisms are the same, so we will try to transition smoothly between the two different product lines. For us, health care is really defining access when the member needs it.

Our commercial network structure for Health Plan of Nevada is in service areas of Clark, Esmeralda, Lyon, Mineral, Nye, and Washoe Counties. [Continued to read from (Exhibit G).]

**Garyn E. Ramos, President and Chief Operating Officer, Behavioral Healthcare Options, Inc.:**
I have included in the next two slides (pages 5 and 6, Exhibit G) some information regarding our commercial provider delivery system for behavioral health, as well as our Medicaid system, to really show the difference between the provider counts and to explain a little bit of that.

You can see for the commercial line of business that we have 125 participating psychiatrists, and I will focus on the psychiatrists at this time. If you compare that with the Medicaid population of providers, we have 94 participating. As it is now, we are paying a premium to try to solicit provider participation to see the Medicaid membership. It is a difficult population to deal with because they are sicker, they take more time, and they have a higher no-show rate. Oftentimes they have more accompanying paperwork and things to coordinate with the member. Compare that with the commercial membership: they have a higher show rate, have less paperwork, and are typically easier to treat.

We have to actually reach out and try to connect with the providers to solicit them and pay a premium to get them to open up access and to see the members. You will see we were successful in doing so. We do meet all the access standards that are given to us, but it is difficult. As we move forward, we do not have as many providers in our specialty in the pipeline. So while we are struggling now to maintain these access and availability standards, it is

going to be even harder in the future. In a moment I will talk about some of the things that we are going to be doing to help ease that pain in the future.

**Michelle Walker:**
We just went over our network structure. Some of the mechanisms we use to monitor access are: the member to provider ratios that are put upon us; the travel distance metrics, miles and minutes; we do GeoAccess mapping so we can look at our member population and see the distance from their residence to a certain provider type. We also look at open and closed panel status. Because a provider has participated in our network, we try to validate whether they are accepting new members. We do secret shops and work closely with our providers to make sure if we are publishing them, that they are accepting new patients.

We also monitor appointment availability standards. Most of these are outlined for us: for example, a routine appointment within 30 days. We monitor these via secret shops and satisfaction surveys, to make sure that our providers are offering access at a point in time that is relevant.

We also look at afterhours care, ensuring that our primary care physicians are available to our members 24 hours a day. We ensure that at night, when the member calls the provider office, they actually are given the option to either speak with a physician or get connected with someone at the clinical office to ensure their care is available 24 hours a day.

We also look at patient satisfaction results and patient concerns. For any complaints that would come in to the plan, we look at those and reach out to the providers to figure out how to ensure better access.

On slide 8, we go over network maintenance, how we maintain our network. We review incoming letters of intent which come from providers who wish to join our networks, whether for commercial or for Medicaid. We also receive inquiry letters from members who want to be able to see a certain provider who is not in our network, so we review those. We ensure that all of our providers successfully meet credentialing criteria. We always monitor for new providers who might move to the service areas.

Along with monitoring access, our network comes with some challenges which are on slide 9. [Continued to read PowerPoint presentation (Exhibit G).]

**Garyn Ramos:**
On page 11 (Exhibit G) I have listed some of the solutions we have created on the behavioral health side. We are going to have to collaborate and get creative

in order to meet the demands of the expanded population. This is a list of some of the things that I have done within our organization and will continue to do.

Telepsychiatry was originally slated for a February 2015 effective date. I have now pushed that back to April, and possibly May, because of the difficulty we are having recruiting people from out of state, that have a Nevada license, to practice telepsychiatry. We have our challenges, so other legislation we are working on to expand the pool of contract providers will certainly help.

The use of peer support programs and getting peers involved in our treatments is another attempt to treat the population. We have a number of ways of getting creative to meet the demand.

Lastly, there is a focus on accessing the right provider at the right time for the right service. This includes member education and providing care at a lower level so we are not clogging up the emergency rooms.

**Allyson Hoover, M.S.N., R.N., Director, Provider Engagement and Contracting, Amerigroup:**

We are the managed care program for Medicaid, and I would like to give you a brief update of what Amerigroup has been doing over the last year with network adequacy.

Network adequacy has been a priority for Amerigroup since the beginning of 2014, especially since we tripled our population in 2014. We have previously provided services mainly to moms and babies as needed, but now we are finding we have a new generation of members. Those members are in need of different services, so we need a network able to supply those members.

Network adequacy is always a priority for us. My team works continually on network adequacy monitoring to assure that there is sufficient access to services for Amerigroup members. [Continued to read from (Exhibit H).]

We provide regular reviews of GeoAccess. We pull up hot zones in ZIP codes where we need access for our members to ensure adequacy. If there are not enough services, we look at who is available in that area to supply those services.

We provide close monitoring daily of single-case agreements to look for trends. If we are providing single-case agreements for fee-for-service members, we may need to reach out to them and bring them onboard. We have secret shoppers who then call the provider to ask the following: if she is a primary care physician, a behavioral health provider, or a specialist; when she sees new

members; how long it takes for a new-member appointment; how long wait times are; what her hours of access are; does she see patients after hours; does she have an open or closed panel, and why; and may we come talk to the provider to see how we can help her.

As you may know, in Clark and Washoe Counties, our providers move around so we must keep track of them to assure our directories are up to date for our members. With that in mind, the next slide gives a sample of the most recent wait time in days. [Continued to read from (Exhibit H).]

Amerigroup ensures that our members have an adequate number of network providers through provider accessibility surveys. The survey analysis looks at the member population—a different population than what we previously have had—and what their needs are, what we can do to help the providers meet those needs, and the adequacy of the network. In other words, we are looking at the quality of the providers. Over 51 percent of our membership speak Spanish, so do we have enough Spanish-speaking providers in the network? That can be a challenge.

Moving on to slide 5, I want to provide some numbers to show the growth we have had between 2013 and 2015. In the behavioral health component, Mr. Ramos actively ensures we have appropriate access for our behavioral health members. We aggressively think outside the box in order to assist the providers and members with their challenges and to provide more access to more providers for our members. When a member has a problem accessing a provider, he is assigned a member liaison who follows him from the beginning of the issue until the member has received the required services, even if we have to reach out to a nonparticipating provider.

Moving on to network contracting strategies, we work together and get very creative, thinking outside the box in providing primary care physicians (PCP) and specialists. Right now we are working on introductions with behavioral health and PCPs so they can establish a working relationship within our communities, both in Washoe County and in Clark County. We offer network provider education through the Substance Abuse Prevention Treatment Agency (SAPTA). Our SAPTA providers have a strong need for us to sit with them, so we got out to visit them. They can also log in for web instruction on the services they provide to Amerigroup. We have found that to be very successful with our SAPTA providers in particular.

Our providers have not utilized the translation services that we offer free of charge. Some of our members do not go to providers because they fear they will not be able to communicate with them. With that in mind, we are working

with the provider network—as well as the acute facilities hospitals—to encourage them to go through new provider orientation, which we monitor.

Finally, we have member education. There are creative options for the members. We speak with our members to ensure they know they have translation services available to them. We also have member meet and greets; we meet at apartment complexes and local CVSs. We provide specific education to our Amerigroup members, which seems to help them understand their benefits better.

**Chair Oscarson:**
We will now hear from Mr. Sabal and Ms. Gonzalez from Anthem Blue Cross Blue Shield.

**Pete Sabal, Regional Vice President, Provider Engagement and Contracting, Anthem Blue Cross Blue Shield:**
We are going to talk about adequacy on the commercial side. You are going to hear a lot of the same stories from all the presenters, but the one thing I want to impress upon the Committee is network adequacy in the state of Nevada. I am sure some areas are very fluid, but, to throw out a number, in the state of Nevada we make over 600 demographic provider changes on a monthly basis; that is about 7,200 changes per year. Those include changes of address, doctors moving from one panel to another, updates to contracts, and changes to national provider identifier (NPI) and tax identification numbers.

Health care is unique in that it is very fluid and not at all static. As quickly as we make changes, there are people making other changes. That is going to be a consistent challenge for anyone rendering services.

**Pattie Gonzalez, Director, Provider Network Management, Anthem Blue Cross Blue Shield:**
We will be speaking about network adequacy for Nevada. Our network structure is statewide, and our networks are available online at <www.Anthem.com> at Find a Doctor. Members have really easy access: they put in the state, their network, the provider they want to see, and the ZIP code. The system then brings up the information they need. We review our standards based on adequacy, appropriateness, and timely provider network access for our members. It is not just numbers. [Continued reading (Exhibit I).] We have increased the number of urgent care facilities that are available to our members, and have open-access practices—97 percent of our providers have open access.

We have conducted surveys, used secret shoppers, and have member surveys for wait times; everybody is meeting the standards for routine care. [Continued to read (Exhibit I).] We monitor possible member complaints and, if there are any, we follow up and answer questions.

In the urban counties, we have met 95 percent of our member to primary care provider ratio goals. Where we have had issues is in the rural areas; pediatricians are scarce, so family practice and internal medicine doctors are providing that service. [Continues reading from (Exhibit I).] For behavioral health in the urban areas, we meet the standards for medical and nonmedical doctors and mental health facilities, but some rural areas need psychiatrists and substance abuse facilities, which just are not available. It is not in our control, but we are trying to think outside the box to ensure the members get what they need.

We have an appeals process when services are lacking. Members can call customer service and they will look for a physician or for whatever the member needs. If one cannot be located, they normally contact our unit to locate a provider for them. If services are available in the state, the member goes there. Sometimes the member has to go out of state to receive certain services, and we allow that. We are in constant communication and make sure the member got what he needed.

**Ty Windfeldt, Vice President and Chief Executive Officer, Hometown Health, Renown Health:**

At the risk of sounding repetitive, I will go through the presentation and then answer questions. Our mission at Hometown Health is to make a genuine difference in the health and well-being of the people and communities we serve. We strive to achieve this in many ways. [Continued to read from (Exhibit J).]

We are asked to define access to health insurance, but that is a very personal question. The definition of access to health care is based on a number of individual factors; however, we often look at it in the three ways most individuals say is important to them. Typically, the first thing is how much is it going to cost me? Next is, are my providers on the list? The third question is, what are the benefits? Times have changed: many years ago the number one question was, is my provider on the list? As costs have gone up significantly over the years, cost has become the most important.

When we look at access to health care, our objective is to ensure our members have timely access to high-quality, medically-necessary care. Obviously we want to look at location and ensure it is within a reasonable distance from the member's home. The time frame to be seen is important and an area we

constantly monitor to ensure the providers are available within a reasonable length of time. Reasonableness would be determined by urgency and necessity to be seen on the same day. If it is preventative or a follow-up, it could be in a number of days. [Continued to read from (Exhibit J).]

We want to ensure that the providers we contract with provide high-quality care. Our credentialing committee is apprised of physicians on the provider network that are not employed by Hometown Health. One attribute that we want to impress upon you is that the contracted providers go through the credentialing committee and are approved by their peers; they are not approved by employees of Hometown Health.

There are different plans within the structure of provider networks. [Continued to read from (Exhibit J).] However, within the health maintenance organization closed network, we do provide exceptions. We know there are some types of care that cannot be received in northern Nevada, so Hometown Health also contracts with centers of excellence throughout the region, mostly in the California market. We will always find services for a member when needed at the in-network benefit.

As far as network standards, we use two different standards: we apply the CMS and also the Utilization Review Accreditation Commission standards. The standards look at a number of different factors [Continued to read from (Exhibit J).]

We do ensure we have adequate networks, and we monitor these networks using GeoAccess, which is an industry software tool that is used by most of the network providers. We monitor this on an ongoing basis. [Continued to read from (Exhibit J).]

As I mentioned about the exceptions and appeals, in certain instances we will send our individual members outside of the network. We constantly monitor that those services are available when they are not provided within our network.

Lastly, we continue to monitor a number of other areas that provide access for members, including services such as health hotlines. We provide a nurse health line to all of our members. We also provide coverage for telemedicine for individuals in rural markets who may not be able to travel to receive services, as well as virtual visits—which we launched this past January—so our individual members have the ability to talk to the provider through a virtual setting. This could be through either a smartphone or a computer where they can have a conversation with a provider. That is a covered benefit as well.

**Chair Oscarson:**
We will now hear from Dr. McBeath and Dr. Somphone in Las Vegas.

**Robert B. McBeath, M.D., President, Chief Executive Officer, Southwest Medical Associates:**
I have been asked to give an overview of our organization and then speak to some of the efforts that we have made over the last years to address the access issue. I will then discuss our telemedicine program.

Southwest Medical Associates is a multispecialty group of 300 physicians that has been serving southern Nevada since 1972. As part of the UnitedHealth Group acquisition of Sierra Health Services and Health Plan of Nevada in 2008, Southwest Medical became part of Optum care delivery system, which is the health care delivery system arm of UnitedHealth Group.

Currently, of our 300 physicians, about 60 percent operate out of the primary care specialties across 21 locations in the southern Nevada area, including our Pahrump clinic. [Continued to read from (Exhibit K).] All of the facilities use integrated electronic medical records, so it does not matter at which facility the patients are seen. The physician or provider caring for them at that facility can see their complete medical history, medication list, problem list, et cetera.

Southwest Medical Associates essentially grew up with Health Plan of Nevada. We are a dedicated delivery system servicing all of their lines of business, which includes their SmartChoice managed Medicaid product.

The next slide depicts our care model, which essentially provides medical services for the needs of the patients. For our healthy patients that are doing well, we focus on preventive services, immunizations, and screenings. As they become more complex medically, we move all the way into interdisciplinary care teams. This is emphasized on an outpatient ambulatory basis, and all of the clinics have the National Committee for Quality Assurance (NCQA) level III certification for patient-centered medical homes.

Slide 6 (Exhibit K) is a depiction of a map of southern Nevada. Improving access to medical care remains our most serious challenge and our highest priority. As you have heard from many of the speakers today, this is primarily driven by the general physician shortage and the difficulty in recruiting physicians into southern Nevada. This has all been exacerbated by massive growth in our Medicaid population. We have opened five new medical facilities in the Las Vegas area, and those are depicted by the red clinics that you see on the slide. These were strategically located along bus routes because a lot of the Medicaid population does not have transportation. They are focused around

moms, babies, adult medicine, and urgent care. The Civic Center/Lake Mead site has all four clinics in it.

We witnessed a greater than 100 percent increase in our Medicaid visits in the last 12 months. We are trying to absorb those along with a fixed provider population that displaces other people in the other payer lines. To give you an idea, Southwest Medical currently has 60 open physician requisitions as of today. One of the additional ways that we try to approach the access issue is through innovation and technology. In January 2014, we operationalized a 24/7 365-day telemedicine service line. I am going to take this opportunity to introduce the medical director of on-demand care, Dr. Eugene Somphone, who oversees this program and will tell you more about it.

**Eugene Somphone, M.D., Medical Director, Urgent Care/Telemedicine, Southwest Medical Associates:**

I oversee Southwest Medical's NowClinic, which is our telemedicine platform. Telemedicine exists in different forms. Ours is a direct-to-consumer version where patients may access care to a provider through a video FaceTime-type technology for simple, or acute care needs, that are noncritical. The average response time is about six minutes; the provider comes on and conducts a history, a video exam, and makes a diagnosis. If a prescription is necessary, we will send that electronically.

We launched this in January 2014 and to date we have seen almost 7,500 virtual visits. We are on pace this year to see over 10,000 visits. We have been very pleased with the results. Patients love the service. We have a 95 percent patient satisfaction rate. We have had zero cases come before our quality board. As a managed care organization, we believe in the motto, "right time, right place, right level." We are always looking for creative ways to provide cost-effective care with similar outcomes to traditional, more expensive care. The health plan views this as a way to divert patients away from more expensive urgent and emergency care. We conduct surveys at the end of the visits, and more than 80 percent of our patients state they would have gone to urgent care had this not been available to them. Every major insurer in the United States has a telemedicine practice in the works, so we are well ahead of them right now.

Overutilization is not a concern with our health plan. Most of these patients would have gone to more expensive areas of care had they not come here. We are very judicious with our prescription rates; only about 60 percent of patients receive a prescription. We are very good with antibiotics. We all recognize that Nevada faces challenges in terms of medicine, but I can tell you very proudly that telemedicine is not one of them. In our 15 months of

existence, we have seen more visits virtually than just about any other state. This year, we are looking to expand this to our Medicaid and senior populations.

**Nicole Flora, M.D., Chief Medical Officer, Nevada Health CO-OP:**
We at Nevada Health CO-OP define network adequacy based on customer satisfaction, and we believe that is where we stand out with our service levels. We meet or exceed the state-set guidelines, as well as the CMS guidelines for distance and ratio of providers to members, except in areas where there is excessive scarcity of providers, particularly in some subspecialties in our rural and frontier regions.

We offer multiple plans across the state, and we have multiple networks that allow our members to access health care via different delivery models, so we have different networks associated with them. We partner with different organizations across the state in order to develop our networks. Our most basic plan—what we refer to as our Simple Plan—is point-of-service care; members are not required to have referrals. We have a broad-access network of over 1,000 primary care providers in our northern regions and over 1,500 specialists. In our southern Simple products we partner with the Culinary Health Fund to access their network of providers. Our members can see 750 primary care providers and over 2,300 specialists.

We also offer a couple of different delivery models. We work together for our Star products with the WellHealth Accountable Care Network. Through this, we offer our Star products, which are two-tiered products. On the first tier, our members can access the Accountable Care Network, which consists of approximately 180 primary care providers and approximately 350 specialists. If members cannot find a provider that meets their needs within this more selective network, they have the option to go outside of that into our more broad Simple networks so they have the full 2,300 specialists and an additional 750 primary care providers if needed.

We also offer what is called Connected products, which is a true selective network product. This is in conjunction with the WellHealth Accountable Care Network. It is truly a selected network, meaning that the members can only access the in-network benefits of the Accountable Care Network, again about 180 primary care physicians and 350 specialists.

Lastly we offer what we call our VIP product. This is a two-tier product. We offer this product in conjunction with Turntable Medical Group and the Nevada Health Centers. This is a very narrow primary care network for tier-one services. Members that utilize the tier-one services have no out-of-pocket costs when they access services through these providers. In addition to these

providers, members are able to access our secondary Simple network of providers at a moderate cost. They have this to fall back on if they prefer to see someone outside of tier one. They can see anyone in that group of 750 primary care providers, as well as the broad network of specialists.

We offer telehealth services to augment our access across the state. We offer acute care and nonurgent visits for people who are sick with sore throats, sinus infections, et cetera. We also work with Turntable Medical Group to expand these services to include more chronic care, as well as patient education and group visits. We also work with WellHealth Quality Care and we are working to expand chronic services, specialty visits, and behavioral health services through our telehealth.

We evaluate our networks quarterly. We base our evaluations on our NCQA requirements; we are NCQA accredited. In addition to the ratio of providers to enrollees, we look at things like wait times—not just time until the next visit, but also wait times in the providers' offices. We look at customer satisfaction surveys, and we survey the providers on their availability for time for new patients, as well as established patients. As part of our evaluation, we have continuous quality improvement.

We have a provider advocacy department whose job is to work with members who encounter problems within the network and are seeking services that may not be in our network. Their job varies: sometimes it is to get members to centers of excellence, sometimes it is to get single case agreements with providers, and sometimes it is to facilitate the transition-of-care periods.

We have a formal appeals process that is governed by our NCQA principles, as well as the state requirements for appeals. The vast majority of issues are resolved either by our provider advocacy team, or the health advocates that work with members on things such as navigating the system, transportation, referrals, et cetera. We, just like everybody else, face similar network challenges in areas where providers are scarce. We continue to seek providers as they move around and change, but we are limited in quite a few of the rural and frontier areas. We also have experienced challenges in some areas where providers—because they may be the only provider in town—request rates that are significantly higher than rates in other market areas. This creates a challenge for us. One of our main goals is to keep the cost of health care affordable for our members and the state. When we run into these challenges, it certainly puts pressure on our premiums.

[Presented but not discussed is (Exhibit L).]

**Chair Oscarson:**
Our next presenter is Commissioner Kipper from the Division of Insurance. Hopefully you heard things you already knew, but were also enlightened to the challenges that these presenters all face—and we as consumers and legislators face as well.

**Scott J. Kipper, Insurance Commissioner, Insurance Division, Department of Business and Industry:**
We appreciate the opportunity to share the good work that the Division has been doing on the adequacy of networks. Before I start, I would like to echo what Mr. Sabal said in his comments that this is a very fluid situation with providers moving in and out. As we develop the network adequacy oversight, we are keeping in mind that this is an extremely fluid process.

I will give you a bit of history. The Legislature passed Assembly Bill 425 of the 77th Session, which granted the authority to regulate the adequacy of networks to the Division of Insurance (DOI). Keep in mind that this is a relatively small percentage of the population of the state of Nevada: roughly 22 to 25 percent. We do not regulate the adequacy of networks in Medicaid, Medicare, Taft-Hartley union groups, or very large groups; those are all done elsewhere. Given the authority, the DOI then went on to hold numerous meetings across the state with all affected stakeholders in places such as Reno, Las Vegas, Elko, Caliente, and Pahrump, to get as much input as we could on what consumers, stakeholders, providers, and hospitals wanted to see in network adequacy.

For calendar year 2014, federal law required the Silver State Health Insurance Exchange to be responsible for setting standards for those products that are sold within the exchange. I am happy to say the Division worked very closely with the Silver State Exchange staff in developing and crafting those standards. The standards that were developed at that time are essentially still in place; however, per A.B. 425 of the 77th Session, those standards are also applicable to off-exchange products, as well as those sold on the exchange. The Division currently has a regulation in development that is sitting at the Legislative Commission. This has been a yearlong effort with numerous public meetings. The Division has held four work sessions and had a regulation hearing in November to pass it on. Currently, the Division is using a vendor or a contractor to evaluate current networks for adequacy, the cost of which is being underwritten by those insurers who are utilizing those networks. There is no cost to the General Fund or to the DOI.

We believe flexibility is a key component of this and, as part of the development of that regulation, the Division will annually reevaluate and revisit those

standards. We believe this is a key component to striking a great balance, as far as what should be in this regulation. There is an appeals process in place for consumers who believe they should have a little more opportunity to deal with an in-network provider. We have enjoyed the cooperation of all stakeholders. This has not been an easy process so far, but we believe that we are closing in on a great solution but, again, it is a flexible one and we will be continuously evaluating this as we go forward.

**Assemblyman Trowbridge:**
As a consumer, I would simply like to ask what is happening with all the formularies? It seems like every medication I take is getting changed. Instead of it costing $4, it is now costing $30; and instead of being authorized to take two pills a day, they arbitrarily cut it down to one. What can a consumer do about that type of issue?

**Scott Kipper:**
That is an excellent question. We spent the better part of our morning discussing that very issue with the representatives from the insurance industry, and the providers and manufacturers of prescription drugs. It is an issue that is being tackled by another committee within the Legislature. There is a requirement for 2016, according to CMS, that each carrier on their website maintain a list of their formularies and what is available, so that consumers can more easily determine if the plan they are contemplating purchasing will cover that particular prescription drug and at what level or tier within that formulary; there is progress being made on that. I would also suggest that if you have current questions, most carriers now have a list of their formularies attached to their website. There is legislation contemplated that would allow the DOI to place a link on their website that would take the consumer to the individual health insurance plans' websites so that determination may be made a little easier and faster.

**Assemblyman Trowbridge:**
As a consumer, I am covered by one of the groups that is represented here today. I will not embarrass them with my personal problems, but it seems like my primary care provider is in cahoots with the pharmacy because, as soon I get prescribed a new medication, they adjust the level. Somehow they have me flagged.

**Scott Kipper:**
Assemblyman Trowbridge, I am not sure I have the wherewithal to address that comment.

**Assemblywoman Titus:**
My questions really apply to all of the insurance groups that are out there and not just any one. I have an observation for the rest of this Committee: this is a perfect example of how a presentation—and the public relations and advertising people who put these presentations together—does a good job of feeding you a product that really is not true. I am going on record as saying to the presenters who are here, who said all those things about adequacy of network and that all those providers are out there, I really have a hard time coming up with the same data that you do. This is especially true in Lyon County, where you said there are 283 providers signed up under Medicaid, but 283 providers is practically more than the population in my hometown of Yerington. I would be really curious who those providers are.

Second, in South Lyon Medical Center, where I am chief of staff, I have patients come in to see me whom I have been seeing for 30 years. More than one patient came in and said that they signed up on the Silver State Exchange and they could not see me anymore. I asked them why, and they said because I am not on the exchange. I went to our hospital administrator and asked him what was happening, why I am not on the exchange, and why we are not signed up. Apparently, two of the companies did not even offer us a chance to sign up, two came in with such lowball bids we would go broke by assuming them, and the Nevada Health CO–OP said they had to make sure that our fees were not too high and we had to adjust them. In the rural areas, we have to charge fees just to stay open, and when you offer us a nickel on the dollar or 25 cents on the dollar, that does not make it. We do not follow the Walmart model of just selling more product. We are going to go deeper and deeper in debt, so there are huge holes in this network adequacy, and I want to go on record as saying all that was presented today is not necessarily as accurate as it should be.

**Chair Oscarson:**
Hopefully those are questions that can be addressed by those in the room who may have access to that information. Commissioner Kipper, could you give me an idea if there is a complaint about an inadequate network, how that process works, and how people access it? It would seem there is some ambiguity about how to access that process and how that happens, so if you can, please expound on that. If you have a sheet that explains to consumers how to do that, please provide it to the Committee so I can disseminate that information.

**Scott Kipper:**
I will do that. The appeals process starts when a complaint comes in to us and we investigate. There are two areas that we will talk about. One is if the provider was not in the network by choice, or if the contract offer from the

carrier was inadequate as far as their remuneration. That is not an issue the Division would probably get into.

If they ask to see a particular provider, we try our best to get them there. The rural and frontier counties are our primary concern because of the provider shortage. We want to make sure we do not penalize or put Nevadans who choose to live in the rural areas behind the eight ball because they live in an underserved area. We investigate and visit the carrier to encourage them to work with the provider to make a contract possible. If the carrier proves that they made an effort to contract with the provider but were unable, there is nothing else we can do.

**Assemblywoman Benitez-Thompson:**
I believe we have a bill coming up on the expansion of managed care services. A lot of the questions that I have revolve around Medicaid contracts with managed care services: how contracts are bid, negotiated, amended, et cetera. I will leave those questions until we hear the other bill. However, for your foreknowledge, the questions I will be asking are about the actual services that are provided by the managed care organizations, about the contracting process, and about data and its collection. We heard one organization say they had 38,000 enrollees and were aiming for 41,000. How is this going to be accomplished? What types of professionals will be in those 3,000 additional providers? The experiences I have heard about with managed care are very different from what I envision. I know that some of these groups have ancillary businesses and arms attached to them, so I would be interested in knowing about the type of data collections that are negotiated in those contracts and who houses the data for the 38,000 Medicaid individuals that they are serving. Is that data exclusive to Medicaid? Can the data be used elsewhere? Those are the types of questions I will be asking.

**Assemblywoman Spiegel:**
There are two things I would like to ask about. Many of our colleagues on this Committee are new, so perhaps you could speak to the rental networks and explain what they are and how they work. I think it will help everybody gain a better understanding. Secondly, is there any way to do an assessment of network overlap? We have had several presentations from several insurance companies and providers who all say they have adequate networks, but if everybody's network is using the same physicians, we could have another level of issues that we are unaware of, or how to go about addressing it.

**Scott Kipper:**
Those are two very good and related questions. A network may be developed by an insurer or an independent entity, and then they rent that network to

different insurers or other entities, such as a Medicaid managed care program. The problem arises when those providers within the network do not realize that their network has been rented. A consumer will show up seeking services and present an insurance card, so the providers believe they will be able to charge a certain level of fee for that medical service. It turns out that they are going to be held to a contracted fee and be given a much smaller fee because of the agreement the network has with the provider or provider group. Those are the concerns that we have with the rental networks.

We have had a great deal of discussion on the assessment of overlapping. The regulation says the carrier must certify that the network is going to be adequate for the anticipated enrollment. If the enrollment goes over that, they must notify the Division. If they were designated for 10,000 but have 12,500 enrollees, they have to notify the Division and correct that by either adding providers or by doing whatever they can to correct the deficiency.

**Assemblyman Hambrick:**
Considering my background, I have a question about fraud and whether it is claimant fraud or provider fraud. I know you have a few very sharp people on your staff, but please address that and give us some highlights on how you are fighting this issue.

**Scott Kipper:**
We have a staff of dedicated investigators that look at fraud. We work very closely with the Office of the Attorney General. If we develop a case, we turn it over to them for prosecution. The preponderance of medical fraud has always been out there, and I do not see it diminishing; our staff is quite busy with that. We work on tips from consumers, providers, and insurers who have been exposed to certain evidence. When they come to us, we follow up. Our caseload is significant; it is not all medical fraud, of course, but it is significant.

**Assemblyman Jones:**
From my perspective, health care is getting out of control. Last year my teenaged son dislocated his thumb while playing volleyball at high school. We took him to the closest emergency room and he, of course, sat there for about four hours. When I got the bill for a dislocated thumb, not a broken thumb or really anything—he just left the ER with a splint with a little bit of tape on it—the bill was $9,000. I had a $3,000 deductible. When he did his follow-up with the regular doctor, that cost about $150. How can it be $9,000 for a dislocated thumb, not even broken or casted?

**Chair Oscarson:**
As a former ombudsman, I encourage people when those situations occur to contact their carrier and have them research it. I do not think anyone would hesitate to respond to you, Assemblyman Jones, if you spoke with your carrier.

**Assemblyman Jones:**
I spoke with my carrier.

**Chair Oscarson:**
Would a complaint from somebody who was a member of a network be something the Commissioner's Office would be concerned about?

**Scott Kipper:**
Absolutely. We would take that complaint and look into it. We may deal with it directly, contact the carrier, and we may refer Assemblyman Jones to the Office for Consumer Health Assistance, Department of Health and Human Services. They do a very, very good job of consumer assistance. My sister who lives in Illinois had the same thing happen with her youngest son. It was not his thumb; I think it was an ankle problem, but it was $26,000 for basically the same sort of visit. I had constituents calling me from Illinois, as well as Nevada, but I would certainly encourage you to contact the Division. We have consumer assistance staff in both Las Vegas and Carson City. We would be glad to take that up for you.

**Assemblyman Jones:**
To add insult to injury—going back and forth and trying to figure out the billing statements six months later—after I had spent $3,000, I got dinged on my credit for a $129 bill which somehow fell through the cracks. When I went to buy a house, I was told I had an outstanding medical bill of $129; that after a $9,000 dislocated thumb. That is how well our health care system is doing right now.

**Chair Oscarson:**
Thank you, and there is an avenue for follow-up.

**Assemblyman Thompson:**
My district is North Las Vegas and parts of unincorporated Clark County, District 17. Due to the Affordable Care Act (ACA), a lot of people are now enrolling in health care. I also have a group of constituents who are providers, mostly type 14, but some 17s and 20s. They frequently tell me about the challenges they face and ask how they can get into the Amerigroup core network. They know they provide adequate, competent services. The key is,

once you have established relationships with clients, you want to keep them and not bounce them around, because you will lose them. That is especially true when you are dealing with families that are dealing with mental and behavioral health issues. What is the process, and what can they do to be on the list? They want to continue thriving and doing great work. They are seeing some challenges, and I want to try to help them.

**Laurie Squartsoff:**
I will start the answer to the question, and then I will defer to Allyson Hoover who can answer the question specifically for Amerigroup. With the expanding population and the medical needs for this particular population, we need to look at the roles of the different providers who are providing services. You may be referring to a group of either SAPTA providers or basic skills training providers who provided mental health services. With the expansion of population, especially with the SAPTA providers, we did see a change for them on how they were reimbursed for services. Historically they have been paid for services under SAPTA Block Grants from the Division of Public and Behavioral Health. With a transition for those patients moving from SAPTA to Medicaid, the providers needed to enroll with Medicaid as a provider, go through our enrollment process, and at the same time work with our managed care organizations to be a part of their provider network. There was a dual process that did take some time. We did a fair amount of outreach with our fiscal and intermediary staff, and the Division of Public and Behavioral Health staff, to help the providers understand the difference and help transition them from their previous payment process to becoming a Medicaid provider. In fairness, for some it was a challenge; for others it was going to the meetings, receiving help and getting information, and it was a fairly smooth transition. We have had a variety of concerns come up, but we have tried to work with those individual providers, answer their questions so they understand the process, and get through the transition.

**Assemblyman Thompson:**
I would really like to schedule a meeting offline. Some might be successful and do great work with clients, but some may not have that administrative acumen on the same level as others. When you do not have that, sometimes you lose out on a great provider. I would really like to schedule some time with the key players because it is always being brought up. I like to troubleshoot and problem solve, so hopefully we can come up with some solutions.

**Laurie Squartsoff:**
I would be happy to reach out to your staff and schedule a meeting.

**Allyson Hoover:**
Assemblyman Thompson, you and I have had the privilege of speaking before. We had a very nice conversation early one morning on our cellphones. Amerigroup is always open to recommendations for providers within areas. You are absolutely correct; there is a need within your district. We are very excited about accepting applications, which we have for some of the members that we have spoken to.

**Assemblyman Thompson:**
I think they were provider 20s only, and the core of mine were provider 14s. We will talk about it offline.

**Allyson Hoover:**
I am happy to schedule time.

**Assemblyman Araujo:**
I know there was an aggressive push to get people enrolled into the ACA. I appreciate your sharing the statistics on the uninsured rates going from 25 percent to 11 percent, but could you translate that in to actual real numbers so the Committee can see the real impact that this had on our state?

**Laurie Squartsoff:**
I would be happy to provide that information for you and, if it would be helpful, we can show the information from the year prior to the implementation of Medicaid expansion through the current month.

**Assemblyman Araujo:**
Since Amerigroup is in front of us, I have another question. You touched on the translating services and that you are trying to be proactive in getting providers to use it. I am curious as to what strategies are being used, because in many of the communities that I represent I am not seeing that. I am not sure where the disconnect is and how proactive we actually are being in that approach.

**Allyson Hoover:**
We have approached our primary care physicians, in particular, to work with them on the translation services. There are areas of need, and we are trying to reach out even more. We provide this information regarding translation services in our newsletters to the providers.

**Assemblyman Araujo:**
Have you ever considered finding a way to educate consumers that they can request those services from the providers? Again, it is just not connecting in the communities.

**Allyson Hoover:**
If you look at my last slide (Exhibit H), that is for member education. That is the number one priority. During the meet and greets we provide at Amerigroup, we provide that information and education to our members. We will emphasize that even more.

**Assemblywoman Benitez-Thompson:**
Many of us are begging the question of performance measures, performance goals, and how those are set. I am not sure if those are specifically outlined in contracts or how we know what success looks like. From a contractual basis for Medicaid with these organizations, what numbers are measures for success? At the end of the five-year waiver demonstration program, what is the expectation for the demonstration project? I believe it was Amerigroup who had a slide on measurements and performance goals. I do not know if those were contractual ones, or ones that your company self-identifies and then follows up on. I think we are all begging the same kinds of questions.

**Assemblywoman Titus:**
I have a question regarding your provider statistics and the 283 providers that you said are in Lyon County. I do not believe that you have 283 providers signed up in Lyon County. Are you including in your figures the providers who go out to the rural areas, such as the cardiologist who may have signed up? They are acknowledged as providers under Medicaid because they come to South Lyon Medical Center and see patients for us. However, these providers live in Carson City or in Reno and they come to our rural areas, but they do not actually reside there. Under your provider list, do you include all of the providers that are listed under NRS 629.031, which includes family therapists, clinical and professional counselors, and that whole broad span of what a provider is versus a true in-the-trenches health care provider? I question those numbers, unless you are including a lot of people whom I do not interpret as being health care providers.

**Laurie Squartsoff:**
I have requested a list of the providers that are there in Lyon County, and that will be available for you by the end of the day. It includes all of the providers, whether a physician, a hospital, or a behavioral health provider; it is all inclusive of those providers who have an address in Lyon County.

**Assemblywoman Titus:**
Would it be an overlap? That would really skew the numbers for the providers who have office space in Yerington where they come once a month. Perhaps there is a whole group and they also have office space in Reno and Carson City. Is there overlap that way?

**Laurie Squartsoff:**
If the primary office address is located in Lyon County, they would be on the list. I will have that information for you later this afternoon, so we can clarify which of those providers have other addresses on our file.

**Chair Oscarson:**
We will now bring Ms. Woods from Anthem Blue Cross Blue Shield and Ms. Walker from Health Plan of Nevada back to the table for questions.

**Assemblywoman Spiegel:**
I have a question about the network provider lists. Just about everybody keeps them online now and does not publish the big fat books anymore. I know that physicians can come and go in networks pretty quickly. One of the presenters mentioned that there are 68,000 or 70,000 changes to their networks a month, probably across the board. Are there standards in place for how quickly the online database gets updated so that patients can see whether a provider is in network or out of network? If so, what are those standards?

**Michelle Walker:**
I can speak for our plans. At Health Plan of Nevada we update our provider directories online biweekly. The feed goes to our online vendor to publish the new directories every two weeks.

**Tracey Woods, Vice President, Government Relations, Anthem Inc., and Its Affiliates Including Anthem Blue Cross and Blue Shield; and Amerigroup Nevada:**
Anthem has about the same time frame. We are starting to scrub them more often. As providers come on and off, we are getting better. It is challenging: providers move, retire, or leave a particular provider group. They do not always tell us, so it is a constant effort on our part to keep that updated.

**Assemblywoman Spiegel:**
If patients in a preferred provider organization (PPO) go to see a physician who they think is in-network because he is on the online directory as being in-network, and they pay their copay as if he is in-network, what happens if it turns out that he is now out of network? Since they were not given any notice, are they then responsible for the out-of-network fees, or are they grandfathered in because they were not provided notice?

**Michelle Walker:**
The answer could differ based on the situation, but we would always try to work with our providers. If they are in the PPO network and it is a provider

who is no longer there and he did provide services, we would always try to work with the provider to get him to accept a reasonable rate and process the members as in-network. The situation could vary, but we would always try to err on the side of the member.

**Tracey Woods:**
Same here for Anthem.

**Assemblyman Araujo:**
I would like to speak with Southwest Medical Associates and touch on the e-visits component. I see your numbers are increasing, and I want to be cautious in how I ask this. I want to make sure we are not taking away from the great quality of having in-person visits by deferring to e-visits on an ongoing basis. What is the routine for every patient? On average, how many in-person visits do you have versus how many e-visits they go through?

**Robert McBeath:**
In our organization an e-visit is an electronically secure email, which is a communication between the provider and the patient. That currently occurs about 6,000 times a month, so it is a major way of access and communication inside our organization. The telemedicine visit is what I think you are referring to, is that correct? Are you referring to the electronic email visit or the telemedicine visit?

**Assemblyman Araujo:**
It started with the electronic email visit, but if you could touch on the telemedicine component, I would love to hear that as well.

**Robert McBeath:**
The e-visits were a feature that we rolled out around 2011, the first year that this secure communication line to the patients was in effect. We did about 5,000 visits that year. Just like any new adoption or service line, it takes a while and now we see that many of the providers and patients prefer this method of communication. I said instead of 5,000 a year, they are now doing well over 5,000 a month. Does that answer the question?

**Assemblyman Araujo:**
Yes, but my question was actually pertaining to that drastic change. I want to make sure that we are not taking away from the potential quality in having a patient come in and get in-person treatment just for the sake of making it easier to check the box, for lack of better words.

**Robert McBeath:**
When we practice population health management and define access, it can come in numerous different forms. It can be face-to-face visits with the provider, a telephone call between a provider and a patient, a secure e-visit, or a virtual visit. Access to us, because we are responsible for our whole population, is kind of broadly defined. As long as we can solve the problem of the patient in a safe, high-quality, cost-effective manner, that is the direction the system needs to go. It is one potential solution for the lack of physicians and the very stressed provider workforce. It does not take a face-to-face visit for a patient to request a chronic medication that he has been on for three years. A simple e-visit accomplishes it very efficiently, and there are many other examples where historically it would have required a visit to the physician's office and a face-to-face encounter. We are learning to manage it in a different way. I think it is important to note that the significant increase in the number of visits is primarily driven by the patients, and once they learn how to sign up and utilize the technology, they almost always prefer it. This is consumer-driven in large part.

**Eugene Somphone:**
To echo that sentiment, telemedicine is not for every individual or every condition, but it certainly is for a vast number of conditions. For instance, we do not need to go to urgent care for a simple bladder infection or medication refill. The adoption rate has been tremendous in the last year. Like any new technology—telemedicine has the same adoptions—when patients try it, they really love it. Again, it is not for every individual and every condition, but it certainly is for a vast majority of patients and treatments.

**Assemblywoman Titus:**
To address your comment just now, regarding not needing to go to a provider necessarily for a bladder infection, I have a little concern over telemedicine. I would argue that there needs to be some interaction between provider and patient other than a quick comment and then a prescription. Telemedicine definitely has a role, and I absolutely believe that. I am not saying that it will work for one thing and not another thing because there are components of it that are absolutely necessary and we need to go forward with it. I agree with Assemblyman Araujo's comments about the face-to-face interactions. Sometimes just seeing patients and looking them in the eye and the laying on of hands makes for better interaction and a better diagnosis when you see the patient. I would be careful about some of the comments about what telemedicine and e-medicine can really do.

**Chair Oscarson:**
Having seen some of the pending legislation, and Assemblywoman Titus has worked on that significantly with us, there is no requirement that people use telehealth or telemedicine. It is an option for them to use, and they can choose to do that. Having seen the demonstration that UnitedHealthcare does, I know there are things that you will not see that specifically indicate that you need to see your doctor. Sometimes we facilitate that visit for you. As this technology and the process evolve, and we learn more about how we are doing it, some of the questions will be answered. Assemblywoman Titus is the kind of doctor that is face to face, and I love that. I have other physicians that are also like that, and I am very pleased. I think as we evolve and the process evolves, there will be more. It is going to take education for people to get away from having to go to their doctor's offices to do some of the things they do. Again, I think you and Anthem have done a great job in saying that we are not going to see you for that condition; you need to see your primary care physician and have a physical visit for the proverbial laying on of hands to see what is going on.

**Robert McBeath:**
You are exactly right. There is a very defined list of chief complaints that are appropriate for the telemedicine visit, along with additional safeguards on frequency of use and appropriateness. With regard to requests for controlled substances and whatnot, all of it is not allowed across that visit. The other thing that I would say to Assemblywoman Titus, regarding her comments, is that these are Southwest Medical providers so, while they are on the telemedicine visit, they are also looking at the patient's electronic medical record and have the full history of the patient in front of them. I often liken it to one of your partners covering you on call and getting a call from one of your patients. He or she has to deal with that patient over a phone call. For decades that is how we have managed it, using good medical judgment on what was appropriate treatment, and when to send the patient into urgent care or the emergency room. I see this as another tool. It is an easy-to-use access point for the patients. I truly believe that this is going to be consumer-driven; they are going to demand this of us.

**Assemblyman Thompson:**
You said there are about 6,000 e-visits a month, so that is about 72,000 a year. I sense that this is more of your stabilized clients or patients that you can work with. Is the billing significantly lower than the billing that would be required if you were doing a face-to-face visit? If so, do you know

approximately what that ratio would look like compared to a face-to-face visit? I see that could be a significant cost savings and further keeps our pot of money for Medicaid and such alive.

**Robert McBeath:**
There is no charge for the e-visit. It is very similar to the phone call that the physician would have handled after hours. There is no charge for the phone call and no charge for the e-visit. Sometimes it is just a simple medical question that the patients want to ask their physician, and it is a very efficient way to do that.

**Eugene Somphone:**
For the telemedicine visits, because it is an embedded benefit, the only charge incurred is a copay. We see it as a way to divert patients away from more costly areas so there is no additional charge aside from the minimal copay the patient will pay.

**Robert McBeath:**
I think it is also important to point out that the copay for the telemedicine visit is oftentimes the lowest copay option that is available to the patient, so it also saves them money.

**Assemblywoman Spiegel:**
Over the past decade or so we have had an increase in the proliferation of concierge medical practices. I know that a number of providers in those practices still say that they take insurance. Do those providers then also count in the network adequacy statistics that were presented today? Are they somehow counted separately, since the patient would have to pay a significant amount of money just to be a patient of that physician?

**Robert McBeath:**
If they take the insurance or contract with the insurance carrier, in addition to their concierge fee, they are counted inside that insurance network adequacy number because they have a provider contract with them.

**Chair Oscarson:**
Are there any other questions from the Committee? [There were none.] My thanks to all of you for being here.

Is there any public comment either here or in Las Vegas? Seeing none, the meeting is adjourned [at 4:04 p.m.].

RESPECTFULLY SUBMITTED:

_____
Nancy Weyhe
Committee Secretary

APPROVED BY:

_____
Assemblyman James Oscarson, Chair

DATE: _____

**EXHIBITS**

**Committee Name: Committee on Health and Human Services**

**Date: March 25, 2015** **Time of Meeting: 1:36 p.m.**

| Bill | Exhibit | Witness / Agency | Description |
|---|---|---|---|
| | A | | Agenda |
| | B | | Attendance Roster |
| A.B. 425 | C | David Fogerson, East Fork Fire and Paramedic Districts | Written Testimony |
| A.B. 425 | D | Alex Ortiz, Clark County | Proposed Amendment |
| | E | Laurie Squartsoff, Department of Health and Human Services | Presentation |
| | F | Cheri Glockner, McKesson Corporation | Presentation |
| | G | Michelle Walker, Health Plan of Nevada | Presentation |
| | H | Allyson Hoover, M.S.N., R.N., Amerigroup | Presentation |
| | I | Pattie Gonzalez, Anthem Blue Cross Blue Shield | Presentation |
| | J | Ty Windfeldt, Hometown Health, Renown Health | Presentation |
| | K | Robert McBeath, Southwest Medical Associates | Presentation |
| | L | Nichole Flora, M.D., Nevada Health CO-OP | Presentation |