BRIAN SANDOVAL
Governor

STATE OF NV
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
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MICHAEL J. WILLDEN
Director

LAURIE SQUARTSOFF
Administrator

MCAC MEETING MINUTES

Date and Time of Meeting:	January 15, 2013 9:00 AM
Place of meeting:	Nevada State Health Division 4150 Technology Way, Suite 303 Carson City, NV 89706
Place of Video Conference:	Division of Health Care Financing and Policy 1210 S. Valley View Blvd. Suite 104 Las Vegas, NV 89102

Attendees

Board Members (Present)

Rota Rosaschi, Chairwoman
Tracey Green, Board Member
Peggy Epidendio, Board Member
David Fluitt, Board Member
Michael Ball, Board Member
Dr. Jade Miller, Board Member
Angie Wilson, Board Member

Board Members (Absent)

Carson City

John Whaley, DHCFP
Marti Coté, DHCFP
Jon Kirwan, DHCFP
Coleen Lawrence, DHCFP
Sherri McGee, DHCFP
Laurie Squartsoff, DHCFP
Lawanda Fred, DHHS Tribal Liaison
Julie Bertuleit
Dave Caloiaro, MHDS

Marta Stagliano, DHCFP
Darrell Faircloth, DAG
Elizabeth Aiello, DHCFP
Alexis Ulrich, DHCFP
Eric Pennington, DHCFP
Jennifer (Benedict) White, DHCFP
Tracey Woods, AGP
Joanna Jacob, Ferrari Public Affairs

Las Vegas

Gabriel Lither, DAG
Scott Larson, BMS
Manisy Saija, Pfizer

Robert Talley, NV Dental Assoc.
Bret Ferguson, Pfizer
Viki Kinnikin, Mojave

I. Call to Order:

Chairwoman Rosaschi called the meeting to order at 9:00 am.

II. Introduction of new Committee Members

Ms. Elizabeth Aiello introduced Mr. Jade Miller, DDS of Miller and Trujillo Pediatric Dentistry. Ms. Angie Wilson, Director of the Reno/Sparks Tribal Health Center was also introduced. Welcome and thank you for choosing to serve.

III. Roll Call

Chairwoman Rosaschi asked for roll call.

IV. Public Comment on Any Matter on the Agenda

None

V. For Possible Action: Review and Approve Meeting Minutes from July 17, 2012

The July 17, 2012 minutes were approved with the change of consolation to consultation in the last paragraph on page four.

VI. Administrator's Report by Elizabeth Aiello

Ms. Aiello introduced Ms. Laurie Squartsoff, the Division of Health Care Financing and Policy (DHCFP) Administrator. Ms. Squartsoff thanked the MCAC for their participation on the board. She trained as a pharmacist however most of her career has been as an administrator. She started with the Nevada Medicaid in the 1990's left Nevada and went to California where she worked for Medi-cal as a pharmacist in the contracting unit & supervisor in the northern pharmacy section doing the TAR review for the northern 48 counties. She also worked in the private sector as an account executive. She is delighted to be back in Nevada. With everyone's participation and conversation she believes this will be a great year.

Ms. Aiello reported on items in the budget. The DHCFP has requested increased waiver case loads for all waiver programs except the assisted living due to not having a wait list. The goal is to eliminate all wait lists.

There is a Technology Investment Request (TIR) for the second phase to improve the Medicaid Management Information System (MMIS) and developing a new MMIS system. The system was built with 1970's technology. A new system would not happen until 2019. The DHCFP needs upgrades to use the ICD-10 diagnosis coding and to connect to the Business Operations System (BOS) which is the system for the Silver State Health Insurance Exchange. The new eligibility engine is being developed with the Division of Welfare and Supportive Services (DWSS). The new eligibility engine will connect with Silver State Health Insurance Exchange, NOMADs and Medicaid. This will be working on October 1, 2013 for determining eligibility for the January 1, 2014 roll forward process with Health Care Reform and the new rules.

The DHCFP will be transferring the eligibility portion of Nevada Check Up (NCU) to the DWSS. This will integrate everything into one process. There will be many points of

entry into the process but one engine. People will be able to apply for Medicaid through Access Nevada which is the web based interface. Some kiosks are currently available. The Silver State Exchange will be available October 1, 2013. In addition, people may walk in to the office or apply online through their home or library computer. Everything will all go into the eligibility engine whether they are applying for Medicaid, NCU, or a health insurance product on the health insurance exchange. The eligibility engine will process and reach out to the federal hub for information so they will not need to supply as much information. It will go out to the IRS, social security, homeland security and bring back the information. It should improve eligibility time.

Ms. Aiello presented the power point for the Health Care Reform. See attachment.

Dr. Tracey Green asked why a new child would come in on NCU and another would enter under expanded Medicaid.

Ms. Aiello responded because of the income level. Children from 138% to 200% will go into NCU. There will be children who are eligible for NCU now that will be entering the program due to parents needing insurance. Those currently in NCU will go over to Medicaid at their annual evaluation due to income level changes.

Dr. Jade Miller confirmed that the children at 138% and below will shift to Medicaid.

Chairwoman Rosaschi asked if she is applying online, she completes questions, she does not know where the information is going and behind the scenes they determine which category her file goes to.

Ms. Aiello responded correct. There is the standard application to complete and it will send to the eligibility engine for Medicaid, NCU or the Silver State Health Insurance Exchange.

Chairwoman Rosaschi asked how will the recipient know what they qualify for.

Ms. Aiello responded for Medicaid and NCU the notification will be the same as today when an eligibility determination is completed. For the Silver State Insurance Exchange, the recipient may be told a supplemental payment they qualify for as a premium assistance payment; then the recipient will have to determine which insurance product bronze, silver, or platinum they would like. The Silver State Exchange will have navigators. Navigators will help people determine which insurance plan best suits their needs.

Chairwoman Rosaschi commented she is concerned about the simplicity of the language so the recipients understand everything.

Ms. Coleen Lawrence responded the regulation just came out yesterday. Within the regulation there is a section on appeals and rights for the recipients for the exchange and for Medicaid. This is being discussed in the proposed regulation for that specific issue.

Chairwoman Rosaschi asked if DWSS can come and report what type of language will be used.

Ms. Aiello responded they will set up a presentation for the next meeting.

Ms. Angie Wilson asked about the exemptions; Indian beneficiaries receive certain incomes that may not be included in the determination of Medicaid; will that be a part of that process electronically as well.

Ms. Aiello responded they would need to check with DWSS the DHCFP does not process the eligibility. She is under the impression it is a single eligibility process for all.

Dr. Green asked if there will be a monthly reassessment. Will they have to reassess eligibility from the provider end? Will they be able to look this up, or is there a time period where they will not have to check income every month.

Ms. Aiello responded they will have to check with DWSS.

Dr. Jade Miller commented as a pediatric dentist he is aware there are pediatric dental oral health services within the Affordable Care Act (ACA) that includes pediatric services, but as he looked at eligibility, the new eligibility in Medicaid includes some childless adults and parents/caretakers at certain economic federal poverty levels. Will that new adult population be eligible for dental services? Provisions are for pediatric patients, however, there is new expansion into the adult population.

Ms. Aiello responded that Ms. Coleen Lawrence will be discussing the benefit plan. Not all of the questions have been answered as the new regulation just came out yesterday. The DHCFP is not expecting any changes to the children's benefit plan. The DHCFP will do essential health benefits for the new population.

Ms. Peggy Epidendio asked what the eligibility determination timeline is.

Ms. Aiello responded if the information is correct they should be able to process and have it back within a few days.

Chairwoman Rosaschi requested the Administrator keep the Council informed as to what is happening in the legislative session.

VII. DHCFP Reports

- **Overview of Dental Health Program by Jon Kirwan**

  Mr. Jon Kirwan reported the DHCFP would like to set up communications in regard to the different entities they oversee. As the DHCFP is developing trainings for the different programs, they want to make sure they are in touch with provider needs and how Medicaid and NCU support the community health system. The same thing is true with the Indian health programs. The DHCFP is working on a new chapter within the Medicaid Service Manuals for the Indian Health Services as well as a billing guide.

  Medicaid covers an array of children's services and early periodic screening and diagnosis. Currently they do cover palliative and emergency care for adults. They would like to explore palliative care.

  Dr. Miller commented one of the challenges he has come across is with children with disabilities. He will see them through childhood and then they become adults and age out. How can we address care for that segment of the population? Twenty

years have been spent on their oral health and they age out. This population is at risk of a significant amount of oral disease which will then get into the medical system and managing them from the medical system.

Mr. Kirwan responded some services are covered under the waiver unit. Some services have moved to the Health Division or other divisions within the state. This is a very good question and they need to expand on this and bring all of the partners in for a resolution.

Chairwoman Rosaschi commented a lot of children are going to school with their teeth hurting. How does the DHCFP connect with the children so they become eligible for programs?

Mr. Kirwan responded they do some identification of this at this time. The DHCFP would like to explore the uninsured population. This is an important issue and will require a number of partners.

Chairwoman Rosaschi asked Mr. Kirwan to come back and report how this is working and if they are coming together.

Dr. David Fluitt asked if there is a fee associated to the consumer.

Mr. Kirwan responded Medicaid does not have a fee.

Ms. Lawrence clarified NCU has a premium for enrollment for all services. The fees are posted on the website.

Dr. Miller clarified there is a premium; however, not a co-pay.

Ms. Aiello responded there is not a co-pay in Medicaid at this point. As a part of the Governor's recommended budget they are looking at a cost sharing. Children enrolled in the mandatory enrollment group, cannot have co-pays. Some of the specialty categories may be able to have co-pays if they are above the mandatory category. NCU has a premium currently. Tribal members are not charged co-pays in any program. There may be some discussion in the legislature for the future Medicaid expansion.

- **Update on the expansion population proposed Benchmark Benefit Plan for input by Coleen Lawrence**

Ms. Coleen Lawrence reported there are two categories in the essential health benefits. The State operated Silver State Health Insurance Exchange with ten plans on the website at: http://www.doi.nv.gov/ehb.aspx. On December 12, 2012 the state insurance commissioner announced the essential health benefits benchmark plan for Nevada. These are not Medicaid eligible recipients going to the essential health benefit plan. The benchmark plan everyone is going to compare to for the state exchange is by Health Plan of Nevada (HPN), the Point of Sale (POS) Plan located on the Silver State Health Insurance Exchange website at: http://exchange.nv.gov. The qualified health plan is for everyone who does not qualify for Medicaid.

For Medicaid everyone has to have these ten essential health benefits. Yesterday the DHCFP received the regulation for Medicaid. For Ambulatory Patient Services and emergency services, there is new proposed regulation regarding co-pays. There are a number of items regarding co-pays for the emergency room. Hospitalization, maternity and newborn care, is not new; mental health and substance use disorders, requires parity according to another act and the State of Nevada is already aligned. They have to be paired with ambulatory services. Pharmacy, does have some changes for the DHCFP, which is in Medicaid's favor. It allows the DHCFP to align with what is currently being done in Nevada's Medicaid Fee for Service (FFS), which puts the authority under section 1927 which is the current Medicaid FFS. It allows the DHCFP to operate the Pharmacy/Therapeutic (P&T) committee, the drug use review committee and allows the DHCFP to collect drug rebates which brings revenue back into the state for the newly eligibles. Rehabilitative and habilitative services and devices, the devices are the Durable Medical Equipment (DME) coverage. Clarification for rehabilitative and habilitative services was not received. The Centers for Medicare and Medicaid Services (CMS) said the state could operate the habilitative program in the way they need to operate it. This is an area for the DHCFP that causes confusion due to Medicaid and private insurance not operating services the same. The DHCFP is not congruent on what habilitative services are. In looking at what the newly eligible population is, they are mainly childless adults. Childless adults are not going to be looking for Applied Behavior Analysis (ABA) or autism. The DHCFP will need to speak with CMS and get more clarification. When recipients are in the exchange and they have a small change in their income, they will drop down to Medicaid. They had ABA services in the exchange and they come to Medicaid, they will expect some congruency between the services. The DHCFP would like some type of streamlining in services.

Ms. Wilson said for the tribal health in their ambulatory health care programs this will be an issue; they want to make sure to have that consistency between their programs and the Medicaid recipients.

Ms. Lawrence responded the DHCFP will be working on the benefit design. They will attempt to be as streamlined as possible.

Ms. Wilson said they can certainly advocate in regards of the tribal health program to see the congruency between the tribal health and Medicaid.

Ms. Lawrence said there will be navigators. The navigators will have to educate the recipients so they know when they are on a Nevada Silver State Exchange plan, they will receive certain services and with a change in income they may go to Nevada Medicaid or NCU. The plans are going to change. The recipient will go from a private insurance looking plan in pharmacy down to what is available under Medicaid and NCU.

Preventative wellness and chronic disease management services, one thing CMS codifies is the Advisory Committee Immunization Practice (ACIP) is required under preventative services. The A and B coverage services for the United States Preventative Services Task Force is a requirement. Medicaid already requires this. Pediatric services including oral and vision care is specifically for pediatric services. CMS put it under the Early and Periodic Screening Diagnosis and

Treatment (EPSDT) plan. For the expansion population it did not expand dental services. Within the Governor approved budget, our Director, along with the Governor have made a decision that Medicaid is going to mimic the current essential benefits plan for these new eligibles to be exactly what is offered to the current Medicaid recipients.

Dr. Miller asked what age the pediatric population is up to.

Ms. Lawrence responded 21.

- **Update on the status of the 1115 Waiver and the CMO by Jennifer Benedict White**

Ms. Jennifer Benedict White reported the 1115 Research and Demonstration Waiver submitted to CMS in April of 2012. A copy of the written update provided to the legislature was provided for all members of the MCAC. This update is provided quarterly to the legislators. An 1115 Waiver allows the State to waive certain sections of the Social Security Act to research and implement new Medicaid programs. The goal of these waivers is to focus on quality while achieving cost neutrality; however the DHCFP hopes to achieve cost savings to the program. The waiver is called the Comprehensive Care Waiver which will be implemented in two different phases. Phase one begins with a Care Management Organization (CMO). CMOs provide medical care coordination and case management services whereas Managed Care Organizations (MCOs) provide actual medical services. Phase one is mainly limited to Medicaid FFS recipients with chronic conditions. However FFS recipients receiving Targeted Case Management, Home and Community Based Service Waivers and the Child Welfare System will be excluded to avoid duplication of services and disruption of a recipient's current care management program. The purpose of the CMO is to improve the health of Medicaid recipients with chronic conditions by coordinating their care and reducing use of avoidable medical services like emergency rooms. In addition the CMO will provide the infrastructure for small medical practices to become medical or health homes by developing links between community resources and providers and using electronic health information and other data sharing tools. This will allow practices to coordinate with other providers and hopefully improve health outcomes. The CMO payment model will be based on a per member per month rate. They may also be paid a performance bonus if they achieve cost savings and certain quality goals. Phase one will be looking at automatically enrolling eligible recipients into an MCO in certain situations to provide for a quicker return to continuity of care.

After the CMO is up and running and a few medical homes have been established the DHCFP will begin phase two. The DHCFP will evaluate the results of phase one to determine which methods were most successful, whether it be the CMO, the medical homes and/or the MCOs. In phase two benefit plans may also be changed to encourage the use of proper level of care and trigger assistance when recipients are determined at risk. The DHCFP will be looking at expanding care management to the excluded populations which may require consolidating services ensuring a coordinated and high quality care management program that is not duplicating services. However, if the program is successful and improves health outcomes and decreases costs, then the long-term goal will be to expand care management to all Medicaid recipients who would benefit from services.

The waiver was submitted to CMS in April 2012 and has not been approved yet. In the meantime, the DHCFP released the CMO Request for Proposal (RFP) and is currently finalizing the negotiations with the winning vendor and hope to have a contract ready for the spring Board of Examiners (BOE) meeting. Once the contract is signed the DHCFP will work with the vendor to get the program off the ground as quickly as possible. The first priority will be to partner with the vendor to educate providers and community members across the state on the program. If the DHCFP does not have the community's buy-in and support from the beginning the program will have a hard time being successful. The DHCFP is also hoping to use the expertise of the MCAC because the DHCFP really needs community providers and input throughout the life of this program.

Ms. Aiello commented one of the big keys that makes a good strong care management program which Nevada has not traditionally had is the integrated care management program that looks at the medical, social and behavioral health so the lead physician is informed through case management of what issues are going on in behavioral health, social, medical, pharmacy, diet, etc. This is an infrastructure to help the physicians be more of a health home or medical home without the physician having to have all of the work in their office. In some states there have been large decreases in no-show rates. In speaking with specialists they say 40% of their caseload is Medicaid and 20-30% is no-show rates. The DHCFP is hoping to have this be a win-win where the clients are getting the services they need. The physicians are decreasing their no-show rates getting the information they need to help make full decisions. It will not work if we do not have community buy-in and support.

Chairwoman Rosaschi asked if Child Welfare is involved in this.

Ms. Aiello responded at this time Child Welfare is excluded.

Ms. Peggy Epidendio asked what is considered a small medical practice; how is the medical practice chosen and how many small medical practices will be chosen.

Ms. White responded those decisions have not been made yet. The first step is to get the CMO up and running. As the DHCFP is educating people on the CMO they will be asking what type of options and what they should be thinking about when they do the medical home portion.

Ms. Wilson commented what is being described is the tribal health care delivery system. The tribal health centers have medical, dental, pharmacy, behavioral health including mental health and drug and alcohol, public health, diabetes, optometry, a surgeon that comes in once a quarter, chiropractic, audiology and physical therapy. They are looking at endocrinology and orthodontics. People see the tribal health center as their primary care provider because the health care services are provided there. Now that medical home is something they are looking into with the Accreditation Association for Ambulatory Health Care (AAAHC) she wonders if maybe the DHCFP can look at the tribal health centers as an addition to the demonstration project.

Ms. White responded they definitely want to talk with the tribes across the state and find out what things are working for you and what is not. She believes it is optional in the waiver for the tribes to be allowed to choose to participate or not.

Dr. Miller asked if they are going to be contracting out to a private company for the CMO or is this a state agency.

Ms. White responded the DHCFP is contracting a private company.

- **Update on the ICD-10 transition and Provider/Contract Impact by Eric Pennington**

Mr. Eric Pennington reported the DHCFP has the responsibility of ensuring the state Medicaid agency is in compliance with the federal ruling on the ICD-10. In January 2009 Health and Human Services (HHS) issued a ruling mandating the use of ICD-10 for all Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entities that are transmitting health information electronically. The compliance date set at that time was October 1, 2013. The DHCFP entered into a contract amendment with Hewlett Packard Enterprise Services (HPES) who is the fiscal agent, running Medicaid Management Information System (MMIS) to remediate for ICD-10 with a compliance date of October 1, 2013. In August 2012, HHS revised their ruling and pushed the compliance date to October 1, 2014. The DHCFP is moving forward with the technical solution for October 1, 2013. Once the solution has been implemented the DHCFP will shelve the solution until the October 1, 2014 compliance date.

In regard to the technical solution, the vendor is making some major changes to MMIS. Everything the ICD-10 diagnosis or procedure code touches within the system needs to be remediated. In October 2012 the DHCFP started the internal process for remediating the business solution and that includes looking at all of the policies and processes, basically the entire business of Medicaid and determining where it is touched by ICD-10. There have been notifications that have been sent by HPES. The DHCFP is trying to determine the best process of determining where the providers are in the entire process.

Chairwoman Rosaschi asked why they are going to place this on the shelf for a year and not implement it.

Mr. Pennington responded it is not required until October 1, 2014. At that point the DHCFP will go into dual processing. The rule is ICD-10 codes must be used for all procedures and diagnosis dates of service by October 1, 2014. This may also put a lot of pressure on the provider community to have their remediation in place and the DHCFP is not certain the providers are ready at this time.

Chairwoman Rosaschi asked once they shelve this will new changes be made.

Mr. Pennington responded yes the plan is to make any changes that occur. The DHCFP found out yesterday that the American Medical Association (AMA) sent a letter to the Associate Director of HHS requesting a reversal of the ICD-10 decision. The DHCFP does not anticipate it will change.

Mr. Miller asked if the October 1, 2014 date is not only for federal and state but private providers as well.

Mr. Pennington responded yes.

Ms. Epidendio commented the increase in the number of the codes is in the tens of thousands.

Mr. Pennington responded yes the approved codes set for the United States contains approximately 69,000.

Ms. Wilson commented in regard to the tribal health programs ICD-10 is a huge issue. Indian Health Services at the area office, federal level, is working with tribes across the nation to implement training and work on developing the codes internally. They are not ready in the slightest. It is definitely an area of concern for the tribes.

Mr. Pennington responded it is a very large effort for providers and the hope is that everyone has already started or gets started quickly.

Dr. Green commented as a workforce enhancement goal, the Health Division is in the process of looking at train the trainer programs and is awaiting the AMA decision.

Chairwoman Rosaschi commented the physician is going to be looking at the computer more than the patient with 69,000 codes. She cannot even begin to guess what that will look like in the future.

- **Update on the Recovery Audit Contractors (RAC) by Marta Stagliano**

Ms. Marta Stagliano reported through Health Care Reform in 2010, the DHCFP is required to contract with at least one RAC to help the state identify improper payments through billings for under and/or overpayments. The DHCFP entered into a contract with HMS effective last January. The first set of letters went out in November. Providers know they are being reviewed all year long from various entities. The DHCFP has audits happening from Surveillance and Utilization Review (SUR), Audit, the federal contractors Medicaid Integrity Contractors, Payment Error Rate Measurement (PERM), and then add RAC. The job in SUR is to make sure they coordinate the efforts so they are not in the same place at the same time. The DHCFP started relatively small and right now there are six separate scenarios. HMS is performing these activities in 33 other states and they come to the DHCFP and say this is what is happening in other states, do you want this item looked at in Nevada. The DHCFP takes the information to all of the partners, the SUR unit and Medicaid Fraud Control Unit (MFCU). Then the DHCFP either approves or disapproves the scenario. HMS does data analysis on the claims data and something that may be happening in another state they come back and run it against Nevada's data and report to the DHCFP things being done well. The DHCFP wants to see what is working and what is not. The SUR unit focuses on fraud and is doing individual investigations. The RAC can do data analysis and a more comprehensive clinical record review because they have that expertise. Five out of the six scenarios are an automated process where it is all data analysis so they are not bothering the client asking for a clinical review. The

DHCFP chose this to get HMS' name in the community and to hone the process to make sure the steps actually work. The DHCFP is looking at outpatient hospitals, some DME, some physicians, ambulatory surgical centers and radiology services. The DHCFP is looking for duplicative payments or on the radiology side, how they bill; global versus the technical component. These are easy types of reviews that do not require a record review. This also allows the DHCFP the opportunity to test the appeals process. The last review is a complex review happening in long-term care. In a complex review they will ask for additional records. How does the clinical review look how does it look from a records request? HMS is very provider-friendly so if the provider needs more time, they can contact HMS and negotiate a new time. There are basic timelines of when things need to be turned in. The DHCFP has minimal recoupment at this point. The goal is to hone the process and make sure it is working. It also gives the DHCFP a place to identify where there may be holes in policies, internal procedures or in the system.

Ms. Rosaschi commented they are anxious to hear when it all comes together and they can say it has been worth the time and effort. At this time the return has been very small.

Ms. Stagliano responded the return has been small. RAC is paid on a contingency basis. Even though it has taken a year to set this up, no payment has been made to HMS because it is based on 8.75% of their actual recoveries and then on underpayments identified are $100 per underpayment over $500. Most of the errors are not fraud-based. The DHCFP has implemented some performance measures to find out the reason for the billing error. The goal is better billings and partnerships. Overpayments typically come from incorrect billing which the DHCFP is recovering. Fraud cases will be referred from the RAC to the SUR unit and then to MFCU for follow up.

VIII. For Possible Action: Discussion on input/guidance for the combined Long Term Support Service Quality Committee

Ms. Aiello reported they have been working on this past year developing a combined Department of Health and Human Services (DHHS) long term quality assurance committee. There is representation from the Division of Aging and Developmental Services, Medicaid, and the Health Division Bureau of Health Care Quality and Compliance (HCQC). At this time they do not have Mental Health. It is more of the physical home and community based services long term support. The committee is trying to do two activities. The DHCFP has certain audit requirements for the federal government for the Home and Community Based Service (HCBS). Historically what has been called quality assurance has been provider review, recipient satisfaction, auditing and corrective action plans and reports to the federal government. If the provider is a provider for Personal Care Service, WIN Waiver, CHIP, they receive an audit under each and then licensure to recheck their license. These are more provider qualifications training services. Initially this group started in order to make a combined auditing process that can meet the needs as an overall HHS Agency and have licensure separate. It became apparent that quality improvement was needed also not just audit, outcomes and findings. Do they need to look and see what is putting recipients in the hospital, or look at a medical item i.e. falls and do more of a quality assurance process across the division? In the last few months the Center for Healthcare Strategies has been working with the committee to be a combined group and they are also using the Money Follows a Person

grant. This committee is meeting and looking at forms, processes, audits and how they want to do strong quality assurance. Every real strong quality assurance process needs to report up through all of the different division administrations. The committee wanted to know if the MCAC would like to be the leadership for this long term support service quality assurance process and the group can report at every meeting. The MCAC can give advice, help the group maintain audits and also transition into a quality assurance committee with quality improvement as part of the process. This is where the committee can really use some input.

Chairwoman Rosaschi asked how the reports would come to them so they can respond.

Ms. Aiello responded that is part of what they need. There are reports that go to each waiver program annually, but other than that she does not believe the committee has set up reporting or quality specific performance improvement projects.

Chairwoman Rosaschi commented the Aging Division has their own advisory board so how do they then coordinate input so there are not crossed wires.

Ms. Aiello said one of the reasons the DHCFP is taking the lead is CMS is the funder of the waiver, and the DHCFP has to maintain administrative control over the Medicaid waiver programs. The DHCFP is ultimately held responsible. The other agencies have been reporting this back to the DHCFP to report back to CMS. The DHCFP would like to be able to pull all of the information. The providers said they are spending too much money doing five audits a year on the same indicators.

Dr. Green said the Health Division has been using quality team techniques and one of the elements of the quality team models is to bring together groups being described here and creating reports using quality policy and procedures. Starting with some of the quality styles and measures might create a form and format which may streamline the process.

Ms. Aiello responded under the federal waiver program there are five assurances they have to report on. They wanted to start with a group that has standard federal requirements and build off from that.

Chairwoman Rosaschi commented before they commit the board, she would like to do a mock at the next meeting, so they can give better feedback.

Ms. Aiello will ask the group to provide the information they have.

Chairwoman Rosaschi commented that they would like to see if they can ask for advice on different areas so they can have responses.

IX. Public Comment

None

X. Adjournment

Chairwoman Rosaschi adjourned the meeting at 11:05 am

An Audio (CD) version of this meeting is available through the DHCFP Administration office for a fee. Please contact Rita Mackie at rmackie@dhcfp.nv.gov or you may call (775)-684-3681.