



BRIAN SANDOVAL
Governor

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
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RICHARD WHITLEY, MS
Director

MARTA JENSEN
Acting Administrator

APPROVED MCAC MEETING MINUTES

Date and Time of Meeting: January 19, 2016 at 9:20 AM

Place of meeting: Public Utilities Commission of Nevada
Meeting Room B
1150 East William Street
Carson City, Nevada 89701

Place of Video Conference: Public Utilities Commission of Nevada
Meeting Room B
9075 West Diablo Drive, Suite 250
Las Vegas, Nevada 89148

Teleconference: (877) 336-1829

Access Code: 8793897

Attendees

Board Members (Present)

Rota Rosaschi, Chairperson
Dr. David Fluitt, Board Member
Peggy Epidendio, Board Member
Dr. Tracey Green, Board Member
Dr. Ryan Murphy, Board Member
Dr. David Fiore, Board Member

Board Members (Absent)

Michael Ball, Board Member
Angie Wilson, Board Member

Carson City

Mr. Darrell Faircloth, Senior DAG
Cheri Glockner, HCGP
Thomas McCrorey, HCGP
Shannon Sprout, DHC FP
Rachel Marchetti, DHC FP
John Kucera, DHC FP
Jaime Collin, Amerigroup
Kim Gahagan, HPN
Laura Palotas, DHC FP
Coleen Lawrence, DHC FP
Elizabeth Aiello, DHC FP
Lynne Foster, DHC FP

Jenni Bonk, DHC FP
Jan Prentice, DHC FP
Bridget Vanetti, HCGP
Jamie Rodriguez, Lewis & Roca
Gladys Cook, DHC FP
Joanna Jacob, Ferrari Public Affairs
Christina Galan, HPN
Kathleen Conaboy, McDonald Carano
Lea Cartwright, J.K. Belz & Assoc
Erin Snell, HCGP
Marta Jensen, DHC FP

Las Vegas:

Elizabeth Wilson, HPN

Teleconference:

Allyson Hoover, Amerigroup

I. Call to Order

Chairwoman Rosaschi called the meeting to order at 9:20 AM.

II. Roll Call

Chairwoman Rosaschi asked for roll call. A quorum was established.

III. Public Comment on Any Matter on the Agenda

No Comments.

**IV. For Possible Action: Review and Approve Meeting Minutes from April 21, 2015
(See Attachments)**

The April 21, 2015 minutes were approved as written.

**V. Administrator's Report, Present State Plan Amendments and Medicaid Services
Manual Updates by Marta Jensen**

Ms. Jensen presented State Plan Amendments and Medicaid Services Manual updates (see attachments).

Chairwoman Rosaschi asked if Presumptive Eligibility had a budget Impact.

Ms. Jensen replied that the Division of Health Care Financing and Policy (DHCFP) hadn't received that information yet and that from the provider perspective it's been successful and helpful in areas of large population.

Ms. Jensen continued to provide an overview of the Managed Care Expansion Project. She reported that two Managed Care contracts expire 6/30/17; a Request for Proposal (RFP) should be released this fall. After an evaluation process the DHCFP hopes to have a vendor by January so there can be a transition if necessary.

Ms. Jensen reported that the division is looking at the role of Managed Care with a wider perspective. The caseload increased from 323,000 in December 2013 to 609,000 in December 2015, with 82% in Managed Care. Under consideration is rolling Long Term Support Services (LTSS) into the Managed Care contract, transitioning to 100% Managed Care across the state, regionalizing it, leaving it as is in just the two urban

areas. Additional options include evaluating the carve-outs that we have within the Medicaid system, and considering reducing them, or rolling them into Managed Care, or retaining some as carve-outs. That includes LTSS, juvenile justice, foster kids, orthodontia and non emergency transportation. Another consideration is allowing more than two Managed Care Organizations (MCOs).

Ms. Jensen reported on the division's listening sessions to gather feedback in both urban and rural areas of the state. Turnout has been great; attendees include recipients, concerned citizens, providers, and MCOs. The next step is to create some focus groups, narrowing the scope of the conversation to a recipient or citizen perspective or provider. The division is also hiring a consultant (targeted to start in the summer) to help us with this lengthy process to help facilitate these conversations, gather information, pull information from other states, and perform research. The next step is a report to the Interim Finance Committee (IFC) to determine how we will move forward. Once that's completed the DHCFP will release a Request for Information (RFI) based on what we learned from the marketplace, to determine what MCOs can offer, then move forward with an appropriate RFP after the 2019 contract. The next MCO contract will be for a two year term, then the division will probably have to go back out for another RFP if we want to expand those services.

Chairwoman Rosaschi asked if this effort relates to the rurals and trying to get all the right services to the clients who may have limited resources.

Ms. Jensen acknowledged that rurals are where the biggest challenge is going to be. One option to consider is regionalizing or expanding current service areas, depending upon what the market can sustain. Providers have indicated reluctance to engage with MCOs because they are another entity to deal with, and because rates can be negotiated from the Fee-for-Service rate.

Chairwoman Rosaschi asked if transportation is included in the research.

Ms. Jensen explained that the DHCFP is considering how non-emergency transportation may fit in. It is currently carved out of MCO coverage. She reported that the DHCFP recently entered into a contract with a new non-emergency transportation vendor, MTM, which will take over the services from Logisticare on July 1, 2016.

Chairwoman Rosaschi asked what kind of feedback is coming from the clients.

Ms. Jensen said that access to care seems to be their biggest issue, however this is feedback from one session. She stressed that there may be some reluctance to provide input in a large forum such as the listening session, and that is why the DHCFP will conduct focus groups. Ms. Jensen went on to say that there are concerns about relinquishing control over your own care, as in a Fee-for-Service (FFS) model, to managed care.

Mr. Fluit requested comment on telehealth.

Ms. Bonk explained that the DHCFP has expanded the telehealth policy, opening it to any provider type with no geographical barriers.

Ms. Lawrence added that the telehealth policy applies to both FFS or Managed Care. The division is revising the policy based on provider input and taking billing formats into consideration.

Chairwoman Rosaschi stated her understanding is, that as of December 1, 2015, both MCOs did run primary care clinics through telehealth.

Mr. Fluitt asked if the consultant would be able to vet out the unique needs of our state, given the two large metropolitan areas and such a vast area of small populations.

Ms. Jensen clarified that the DHCFP has not yet hired the consultant, it is in the RFP stage. The division will take the state's unique demographic into consideration.

Dr. Green clarified that part of the description in the RFP requests such information and knowledge base; during RFP presentations the applicants come forward and respond to those types of questions.

Chairwoman Rosaschi followed up on the question as to there being confidence that there are candidates that can meet the DHCFP's criteria.

Ms. Jensen affirmed that it became clear that we're not the experts in that area of writing an RFP and doing the RFI for something of this magnitude. It's not a matter of staff capabilities, it's an additional task requiring a careful process. That is why the DHCFP decided to engage a consultant, and also to slow down the process and take two separate paths so we can get as much input as possible before we go forward to the governor and to the legislature.

Dr. Green asked about the requirement for all providers to submit billing using with ICD-10.

Ms. Bonk said that it is covered. She indicated one "clean-up" State Plan Amendment in process with the Centers for Medicare and Medicaid Services (CMS). All billing language and policies have been changed for ICD-10.

Dr. Green asked if there are any provider issues with ICD-10.

Ms. Lawrence said that there were issues with some fee codes, which were corrected in the system for that. She said she doesn't believe the MCOs had the issues the DHCFP did.

Dr. Green asked if HPES would provide training or assistance to providers if they're having any difficulty in the transition from ICD-9 to ICD-10.

Ms. Bonk responded that they would, and reported flawless ICD-10 training and few problems.

Dr. Green complimented the DHCFP and HPES during the difficult transition.

Ms. Jensen introduced the topic of paramedicine. During the last legislative session, paramedicine use throughout the state was approved. The DHCFP is working in tandem with the Department of Public and Behavioral Health (DPBH) on the policy and rates. Although it is an aggressive timeline, the DHCFP anticipates an effective date of July 1, 2016. Ms. Jensen said that she and Assemblyman Oscarson met with the community and fire departments at a conference in January, educating them on the benefits to communities. If the model is adopted it would be an ER diversion, which would be most helpful to the hospitals. A lot of the expanded Medicaid population did not have primary care and would wait until health issues are urgent, then they would present to the emergency room. Because we have access to care issues, they would continue to use that service as their care model. The DHCFP can deploy paramedicine and reimburse for certain services in those smaller communities, divert from the ER, and improve the health of the citizens through more immediate and appropriate care. Evaluation and health assessments, disease prevention, monitoring and education, medication compliance, laboratory specimen collection, hospital discharge, follow up care, and minor medical procedures are within the scope of paramedicine.

Not covered is travel time, mileage, facility fees, services related to a hospital acquired condition, medical response to a medical emergency, and duplicated services. It is a good model to start with. One challenge is billing, as some of these entities typically don't bill Medicaid. REMSA in Washoe County does this very well and has offered to assist the smaller communities.

Dr. Green added that Steve Tequoa with State Emergency Management is helping rural Nevada with paramedicine.

Ms. Jensen reiterated the Department of Health and Human Services' (DHHS's) new director, Richard Whitley's focus to improve the lives of Nevadans. Medicaid's focus is towards preventive and early intervention services. The DHCFP is looking towards data it has on the over million claims per month it processes and Electronic Health Records to establish baseline health data.

The DHHS is creating a Health Information Technology Unit within the next six months; the placement within the Department is unknown. The purpose is to engage the provider community to participate in a Health Information Exchange. Ms. Jensen indicated that this is a large undertaking which will have long term benefits. At the same time, the DHCFP is creating a Data Analytics Unit. This will enable the division to use the data it captures from the perspective of health outcomes. Within the next six months the division will have either additional biostatisticians or economists on staff.

Mr. Fluitt identified Preventative Medicine and Medication Therapy Management as two areas that pharmacists put in the forefront and indicated potential benefits of a data warehouse.

Chairwoman Rosaschi pointed to the benefits of early screening for children and inquired about an adult model.

Ms. Jensen replied that with priorities and the expanded population, with their unique set of ailments, it will take time to identify trends.

Ms. Lawrence indicated that the DHCFP's Clinical Policy Team has already worked on Medication Therapy Management.

Ms. Aiello said that there are several proposed federal regulations which focus on benchmarking core adult health measures.

Ms. Lawrence pointed out that there are misconceptions regarding Medicaid coverage of preventive services which were covered even before the ACA. She replied to a question from Chairwoman Rosaschi that Medicaid is among the best coverage for preventive medicine for adults.

Ms. Prentice indicated that part of the State Innovation Model (SIM) grant is population health statewide.

Mr. Fluitt expressed concerns that the consultant may be biased by input from specialists.

Dr. Green recapped many attempts to engage providers and that meetings tend to be not well attended. Input identified problems and benefits aren't discussed. Public forums have been attended by the same providers delivering similar messages. She asked for input on the best way to reach .

Dr. Fiore offered a contact that has been successful in getting a group of specialists together and offered to do outreach. He recommended involving business offices as well as the physicians.

Mr. Fluitt suggested gathering perspectives from providers as well as their aides. He suggested different technology, such as webinars.

Ms. Jensen asked for suggested dates and times.

Mr. Fluitt suggested brief, 15 - 20 minute sessions during lunch or after office hours.

Ms. Epidendio offered her perspective from working in a physician's office. She also suggested meetings prior to office hours.

Ms. Jensen summarized that short webinars at various times would be recommended.

Mr. Fluit supported that and recommended having archived webinars available.

VI DHCFP Reports

- **For Possible Action: Discussion, Review and Possible Approval of Managed Care Marketing Materials**
 - **Discussion of approval timeframe of Managed Care Marketing Materials**

By Laura Palotas, Program Officer I/Managed Care Enrollment Specialist

Ms. Palotas explained that once a year the Managed Care Organizations (MCOs) market to Managed Care recipients who have a option to change their MCO. The MCOs are required to submit new or revised material to the state for their review and approval. Amerigroup submitted two different copies because they are in the process of rebranding and they want to be sure that both the Amerigroup and Anthem formats are approved. The language is the same, it's the branding that is different. She informed the committee of its obligation to review for honesty, accuracy and appropriateness.

Chairwoman Rosaschi questioned the scenarios on Health Plan of Nevada.

Mr. Faircloth advised the committee of their charge to ensure that the marketing materials are accurate, and don't mislead, confuse or defraud the beneficiaries. There is also some provision that they ensure that the MCOs don't mislead or indicate that beneficiaries must enroll in this particular plan or to assume benefits overall from the Medicaid program.

Dr. Fiore inquired about a page that compares the benefits between the two MCOs.

Ms. Palotas said that there is a comparison chart but it was not brought because it isn't part of the marketing materials. It is generated annually and goes out with the open enrollment letter.

Dr. Fiore asked if the DHCFP staff reviews the material to make sure it is accurate before it gets to the committee, and Ms. Palotas replied that they do.

Dr. Fiore expressed his concern about Medicaid recipient access to specialists and asked if the state is tracking to see how long it takes to get in to see a certain specialist?

Ms. Palotas explained that there are network adequacy workgroups that are part of the DHCFP.

Ms. Aiello pointed out that Medicaid is supposed to have access to the same as the general population and that sometimes there is little access to the general public.

Dr. Fiore indicated that this is a big issue.

Chairwoman Rosaschi agreed to add it to a future agenda.

Ms. Palotas indicated that presentation of marketing materials and their approval were separated into two meetings should anything need to be changed. If not, the DHCFP could take away approval today.

Ms. Epidendio asked if the grid for Amerigroup, is written at an eighth grade level and intended for recipients. A discussion ensued surrounding listing of services and coding of certain infection. Amerigroup representatives stated they would look into the list and provide a response that day.

Dr. Fiore asked if it is correct that for the wellness visits, if the provider feels there's a reason to have a wellness Early and Periodic Screening, Diagnosis & Treatment (EPSDT) for a child over three more than once a year.

Ms. Lawrence responded that is correct, if it is medically necessary.

Ms. Gahagan said that it is a challenge submitting the marketing materials in December, as they want to include all changes or additional benefits right before open enrollment. Submitting so early does not always allow for that.

Dr. Fiore asked the MCOs if they preferred provisional approval, with any changes being brought before the committee in April

Ms. Palotas asked if that would work for both the committee and the MCOs.

Ms. Hoover responded that they would support that.

Dr. Green pointed out that both packets include the Welcome Call Questionnaire and asked the plans if that is used by recipients and if there are alternative means to contact them. Ms. Gahagan said that a welcome call goes out to all new members and that they also get a mailing.

Ms. Collins said her plan makes three attempts if they aren't able to reach somebody.

Dr. Fiore said he noticed that both groups give out free cell phones and asked about the origin of that service.

Ms. Collins indicated use of a program called SafeLink. Dr. Fiore asked who is funding it and if it was an ACA mandate.

Ms. Collins replied that she believes her plan is and that they have always offered cell phones.

Ms. Hoover said that Amerigroup hands out cell phones with a limited number of minutes that are specific to those patients that are in crisis, as well as the SafeLink opportunity.

Dr. Green asked if Health Plan of Nevada (HPN) has a sheet like Amerigroup that shows benefits.

Ms. Palotas explained that the division creates a benefit grid, with one plan on the top half and the other on the bottom half, for both the north and south, and in Spanish and English. It was not included in the marketing materials because it is generated by the division and sent with open enrollment letters. She indicated it would be beneficial to have it available on the web.

Dr. Fiore asked how new and current Medicaid recipients get the grid the state produces.

Ms. Palotas explained that at the beginning of July, a mailing list of the entire managed care population is generated and that the state mails an open enrollment letter along with the comparison chart to all eligible managed care households. If they want to change plans, they send back the letter; all changes are effective October 1.

Dr. Fiore asked which plans offer service at which hospitals.

Ms. Galan said that HPN is at both hospitals and at Northern Nevada Medical Group, and Ms. Collins said her plan is at all three in Northern Nevada.

Dr. Green asked if HPN has an inpatient contract with Renown.

Ms. Galan replied that the contract is not full service. She indicated carve-outs in that contract. Exceptions are made on a daily basis; in an emergent situation there isn't a problem. She added that St. Mary's across the board sees all of their members.

Dr. Fiore asked if plan members can see a cardiologist for both groups, and both responded affirmatively.

Dr. Fiore made a motion to accept the packets as is and approve any future changes at a later date.

After a vote, Chairwoman Rosaschi affirmed that generic marketing materials had been approved, and requested any changes be brought to the board.

- **Update on Managed Care Enrollment**
By John Kucera, Management Analyst III

Mr. Kucera explained the chart he presented is a dashboard published monthly. It breaks down Fee For Service (FFS) and MCO enrollment, which is 70% penetration. As numbers become more current, the FFS will go up due to retroactive eligibility.

Non-Emergency Transportation (NET) reports show NET eligible as well as trip volume, unique riders and some of the cost matrix measured. He reported that these are important to track total cost to make sure the DHCFP has a reasonable contract in place. These numbers will be used by the division's new transportation vendor to take into account when establishing their provider base.

Dr. Fiore asked why the cost per trip is increasing as the volume increases.

Mr. Kucera explained that a number of factors increase the cost including additional rural trips, as well as increase in cost per trip. He responded to several questions, explaining that the increase in riders is a result of more same-day trips and more urgent care versus scheduled trips. After April, the cost per trip increases, and the division will be looking at seasonal trends.

Ms. Lawrence added that the DHCFP pays for transportation for children residing in Residential Treatment Centers (RTC) out of state with home passes. There are increases during spring and holidays.

Dr. Fiore asked if there is any risk on the transportation company.

Mr. Kucera explained that it's a shared risk model. Anything within plus or minus 2% of expected cost is borne entirely by the transportation vendor. The contract with the new vendor is an entirely risk based capitated model with the vendor bearing the entire expense. If the vendor saves money, the state will share in any additional savings past 10% of their net income. Mr. Kucera said that the division would like to look at the data with more frequency to attempt to determine why costs are increasing. He asked the board what information they would like to see on a monthly/quarterly basis. Dr. Fiore said he prefers more high level data.

- **Update and Discussion on the Health Care Guidance Program (HCGP) (See Attached Presentation)**
By Cheri Glockner, Executive Director, Health Care Guidance Program, and Dr. Thomas McCrorey, Medical Director, Health Care Guidance Program

Chairwoman Rosaschi asked if the HCGP services interface with the Managed Care Organizations.

Ms. Glockner explained that they do not. Target recipients are Fee For Service, identified through claims data as having specific criteria for chronic conditions as identified by CMS.

Dr. McCrorey sought confirmation that the Medicaid blind and disabled in the core population in Clark and Washoe counties are not in the MCOs. Ms. Glockner affirmed that that is the case.

Chairwoman Rosaschi asked if the HCGP is working with Medicaid on paramedicine. Ms. Glockner responded that they have been working with the rural hospitals.

Mr. Fluit said the committee is seeking data that supports the website statement that HCGP has decreased some of the obstacles and increased clinical knowledge. He asked about Tonopah Outreach.

Dr. Green asked about the referral process.

Dr. McCrorey indicated a tenuous struggle to maintain a real-time accounting of who's accepting referrals.

Dr. Green explained that, as an advisory board for Medicaid, it would be beneficial for the HCGP to identify where the struggles are so that they can make recommendations to Medicaid.

Mr. Fluit requested a further breakdown of how effectively the HCGP is treating schizophrenia, emotional disorders, depression, and data to direct future efforts. Further, he asked for data on referrals to nutritional consultants and medication therapy management.

Dr. McCrorey invited emails with ideas, questions, suggestions.

Committee members and Dr. McCrorey discussed the issue of pharmaceuticals as a large part of the cost of some psychiatric conditions, the cost of drugs, how they are prescribed and access to care affecting time spent with patients.

Dr. Green suggested that the HCGP could be a vehicle for enhancing telehealth, particularly telepsychiatry.

Mr. Fluit suggested email correspondence between committee members and the HCGP.

Mr. Faircloth addressed concerns with the open meeting law; approaching the entire committee via email essentially creates an unnoticed meeting, which could be a potential violation. Historically the manner in which folks like the HCGP have approached committee members has been individually, so they have targeted folks with expertise in a particular field with questions pertaining to that particular area of expertise rather than the committee as a whole. An email to all the committee members would very likely be a violation of the open meeting law. He confirmed that individual committee members could approach Dr. McCrorey individually, but that they could not send copies to the other members.

- **Update and Discussion on Applied Behavior Analysis (ABA) (See Attached)**
By Shannon Sprout, Program Specialist, Clinical Policy Team

Ms. Lawrence reported that the DHCFP is working with the psychological board in Applied Behavior Analysis (ABA) Developmental Services.

Dr. Green complimented the Clinical Policy Team on their development of expertise in the area within a short timeframe.

- **Update and Discussion on the State Innovation Models (SIM) Initiative (see attached)**
By Jan Prentice, Chief, Rates Unit

No Comments

- **Introduction of changes to 42 CFR 447, Methods for Assuring Access to Covered Medicaid Services**
By Ms. Aiello, Deputy Administrator

Ms. Aiello referenced Title XIX of the Medicaid Social Security Title Act, which requires that Medicaid payment rates must be consistent with efficiency, economy, quality of care and sufficient to enlist enough providers so that services are available at least to the extent that such services are available to the general population. A final regulation was published in November, effective January 1, 2016. It requires all Medicaid agencies to develop, only for Fee For Service, an access to care evaluation plan this summer. It requires states to review data and trends to evaluate access to care for covered services. The following types of care must be

addressed: Primary Care Physician (PCP), Physician Specialist, Behavioral Health, Obstetrics and Home Health. Rate changes or significant changes to rate methodology must also be evaluated. She indicated that Medicaid uses Medicare rates as a basis for some methodologies. There are challenges using private insurance rates because of anti-trust laws. She indicated that it appears as if rates may be linked to issues in access, CMS may require states to complete an investigative analysis and submit a response. States have informed CMS that the implementation timeline is challenging, and suggested putting this requirement forth in a legislative session and requesting funds for a contractor to develop a plan. States also informed CMS of challenges in identifying acceptable sources for commercial proprietary. Ms. Aiello also indicated that any change in service intensity or provider/recipient utilization is not always related to rates.

Ms. Aiello clarified that the plan, not the data, is due by July 1, 2016.

Mr. Fluitt suggested partnering with the main providers of healthcare, and the universities' Schools of Medicine.

VII. Public Comment

Mr. Fluitt explained that his organization is experiencing challenges getting their physicians credentialed by Amerigroup and HPN, for both Fee for Service and Managed Care.

Ms. Collins explained that the state required their providers be enrolled with Nevada Medicaid before they can be enrolled with Amerigroup.

Dr. Green suggested a root cause analysis, and Ms. Lawrence suggested providing the MCAC with an overview of the enrollment process.

VII. Adjournment

Chairwoman Rota Rosaschi adjourned the meeting at 12:20 PM.

Please contact Jenifer Hendrix at Jenifer.Hendrix@dncfp.nv.gov or (775) 684-3685 with any questions.