BRIAN SANDOVAL
Governor

RICHARD WHITLEY, MS
Director

MARTA JENSEN
Acting Administrator

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MCAC MEETING MINUTES

Date and Time of Meeting:	April 18, 2017 at 9:00 AM
Place of meeting:	Division of Public and Behavioral Health 4150 Technology Way, Room 303 Carson City, Nevada 89706
Place of Video Conference:	Division of Health Care Financing and Policy 1210 S. Valley View Blvd., Suite 104 Las Vegas, Nevada 89102
Teleconference:	(877) 402-9753
Access Code:	7316372

Attendees

Board Members (Present)
Rota Rosaschi, Chairperson
Ryan Murphy, Board Member
June Cartino, Board Member
John DiMuro, Board Member
Peggy Epidendio, Board Member

Board Members (Absent)
David Fiore, Board Member

Carson City

Darrell Faircloth, Senior DAG
Marta Jensen, DHCFP
Shannon Sprout, DHCFP
Chelsea Heath, DHCFP
Adrienne Navarro, DHCFP
DuAne Young, DHCFP
Tracy Palmer, DHCFP
Gladys Cook, DHCFP
Kristina Jones, HPN
Karen Salm, DHCFP
Lynne Foster, DHCFP
Mia Williams, AETNA
Chuck Damon, DHCFP
Debra Sisco, DHCFP
Karen Salm, DHCFP
Rachel Marchetti, DHCFP
Scott Mayne, WC/CC
Kim Gahagan, HPN

Mike McKinney, SilverSummitt
Krystal Joy, Otsuka
Chris Johnson, NHA
Cheri Glockner, HCGP
Jackeline Obregón, DHCFP
Kara House, SilverSummitt
Jennifer Lauper, Bristol-Myers
Lea Cartwright, NPA
Thomas McCrorey, HCGP

Las Vegas

Mark Schwartz, GSK
Terry Weinstein, AGP

I. Call to Order

II. Roll Call

Chairperson Rota Rosaschi asked for roll call. A quorum was established. Chairperson Rosaschi stated that this meeting was duly posted and it meets the open meeting laws.

III. Public Comment on any Matter on the Agenda

No Comments.

IV. For Possible Action: Review and Approve Meeting Minutes from February 14, 2017 (See Attachment for Minutes)

Chairperson Rosaschi stated she gave minor changes to the secretary for the minutes. She said the changes were cosmetic and did not change the content. There was a motion to accept the minutes and a motion seconding the approval. The minutes from February 14, 2017 were approved.

V. Introduction of David Stewart, Deputy Administrator, Health Information, Technology and Analytics By Marta Jensen, Acting Administrator

Ms. Marta Jensen, Acting Administrator for the Division of Health Care Financing and Policy (DHCFP), introduced Mr. David Stewart who is the Deputy Administrator over the Health Information Technology and Analytics Unit. Ms. Jensen mentioned that Mr. Stewart joined the DHCFP in November 2016 from the Division of Welfare and Supportive Services (DWSS).

Mr. Stewart stated that he spent the last 10 years at DWSS working on the Affordable Care Act (ACA) and on large Information Technology (IT) projects. He said his background is mostly in the insurance and medical fields. He worked for Health Plan of Nevada (HPN), Dr. Donham and Stanford Medical Center, among various other positions.

Mr. Stewart spoke about his role at the DHCFP. He said he is currently working on the MMIS Modernization Project and for the Director's office, the Health Insurance Premium Payment Program (HIPP), the Health Information Exchange (HIE) and setting up the Centers of Excellence for Data Analytics to help the Department do data driven decision making.

Chairperson Rosaschi asked the committee if they had any questions and none were asked.

VI. Administrator's Report, State Plan Amendments and Medicaid Services Manual Updates By Marta Jensen, Acting Administrator

Ms. Jensen spoke about new executive changes that have occurred at the Division. She mentioned that Ms. Karen Salm joined the Division in November 2016 as the new Chief Financial Officer (CFO) and that Ms. Shannon Sprout is the new Deputy Administrator. She informed the board that Ms. Betsy Aiello retired in March 2017. Ms. Jensen said that she would bring Ms. Sprout to the next meeting so the board can get familiar with her.

Ms. Jensen reported on updates regarding the DHCFP budget which was presented to the legislature on February 22, 2017. Ms. Jensen mentioned the Division held a work session last week, with the focus on the Federal Medical Assistance Percentage (FMAP) changes, case load projections and on the new positions the DHCFP is requesting. This budget has requested 12 new positions, most of which are to support the mandatory regulations from the federal government. One of these positions will include a person to do an access to care study. Before the Division can decrease rates, impacts to the network and stakeholders must be assessed. Also requested is a position to do quality oversight for Managed Care. Ms. Jensen commented since there are two new Managed Care Organizations (MCOs), it is important to add new positions to help with the process to get them up and running.

Ms. Jensen stated another position requested is an actuary. The Division is looking for better ways to do business, as Medicaid has been operating the same way for over 30 years. One way to do that is through the waiver services; waivers with Centers for Medicare and Medicaid Services (CMS) require budget neutrality. That is what an actuary will be able to determine.

Ms. Jensen mentioned that another position will be with Aging and Disability Services Division (ADSD). There was an audit where an oversight was found on some providers, which resulted in an overpayment that is due to the state. Medicaid will pay ADSD and ADSD will pay the providers. ADSD has requested that Medicaid add some additional staff in the Surveillance and Utilization Review (SUR) unit in the Las Vegas Medicaid office to oversee some of the ADSD Medicaid providers. The Division has requested three analysts and an administrative assistant.

Ms. Jensen went on to say the Division has also requested a Housing Coordinator. The Housing Coordinator is 100% grant funded through the Money Follows the Person grant. This position will assist the community to transition out of institutions and nursing facilities, into housing programs so the nursing facilities can concentrate on higher level care patients.

Ms. Jensen said the Division has also requested a Deputy Administrator who will provide additional support for the four or five units that report to Ms. Jensen. This will allow those units additional support as she is very busy with the legislative work and other activities.

Ms. Jensen noted that the DHCFP has not received push back from the legislature on these positions yet. They did, however, have questions about the actuary position requested.

Ms. Jensen said the DHCFP has a tentative close date of May 5, 2017 and the Division should know by the end of the close date where Medicaid's budget stands. The legislature did have some concerns about

Medicaid's caseload and FMAP.

Ms. Jensen reported the MCOs are staring on July 1, 2017. She mentioned that there will also be a Dental Benefit Administrator (DBA) staring October 1, 2017. More information in regards to that will be presented later today. Ms. Jensen stated there will still be dental coverage between July 1, 2017 and September 30, 2017. Coverage will be through the Fee-for-Service (FFS) program, which still exists in Nevada, except in the two urban areas. The two urban areas will fall into the FFS for the 90-day window.

Ms. Jensen commented that the Division has been working on coming up with some public facing dashboards. Ms. Jensen stated that throughout the legislative session, there have been some comments and concerns in regards to the DHCFP becoming more transparent with some of their utilization data and where the Division stands regarding mental and behavioral health. Ms. Jensen noted there will be a Public Workshop on April 21, 2017, and the DHCFP has asked stakeholders for input on ideas they would like to see happen with the Medicaid program. The MCOs and FFS program will provide this information.

Ms. Jensen spoke about how the DHCFP budget last year was around 3.2 billion dollars and 96 percent of that was put into the community through medical services and supplies. The budget this year is expected to be around 4.2 billion dollars and she said they expect the same percent this year to go towards the community services.

Ms. Jensen said the DHCFP has asked for rate increases. There are three areas in which the Division is looking at for rate increases. The first one is for the adult day health centers (ADHC). Some of these places are having to close due to the previous rate decrease. The ADHCs have not an increase since 2002. The ADHCs need to be recognized as they provide a valuable service to individuals, allowing the recipient to be in a safe place while the family member goes to their employment or do what they need to do during the day.

Ms. Jensen stated the Division is looking to do a five percent rate increase in the area of assisted living. This field also has not had a rate increase since 2002. The DHCFP has added a behavioral complex rate to assisted living because dementia or other mental health and behavioral conditions are harder to work with.

Ms. Jensen commented that the Division has also requested a 10 percent increase for skilled nursing facilities. The thought being, the lower level of need people will be transitioned from the nursing facility, and more of the acute care people from the hospitals will be transitioned to the nursing facility. She said if the skilled nursing facilities are going to be handling a higher level of need, they should be compensated for it.

Ms. Jensen spoke about giving a 15 percent increase to pediatric surgeons. Ms. Jensen referenced that there are only four pediatric surgeons in Nevada, three in southern Nevada and one in northern Nevada. She said that is not enough for all the children in Nevada. These surgeons have reduced their services to emergency only, they are not doing any elective surgery. The Division is hoping that with the rate increase more surgeons will come to Nevada.

Ms. Jensen commented on the four bills in the legislature session that specifically address rate analysis. She mentioned that there are comments that the DHCFP does not review their rates on a frequent basis.

Ms. Jensen said that this is not true, the DHCFP reviews the rates on a rolling five-year calendar. The problem is the Division does not always have the appropriate budget authority to increase the rates. Ms. Jensen said going forward, she has asked staff to show the date the rate was implemented and when the rates were last reviewed. The Division has 258,000 rates which is a lot to look at. Ms. Jensen noted that on AB108, it asks for these rates to be reviewed on a rolling four-year calendar. Also, SB28 asks for this rates to be reviewed yearly. Ms. Jensen stated on SB28, she put a fiscal note on it, as she would need additional staff to look at all the rates. The other two bills are SB95 and SB96 which ask for an analysis on community-based services. This analysis refers to the current rate compared to the rate it should be, compared to what it costs to do business. After that, the Division would submit a report to the Director to propose a rate change. Ms. Jensen said the Division would need to hire a contractor as the Division does not have the resources to do this.

Ms. Jensen remarked that the other health care bills that are coming through are already maintained in the ACA. She believes that is because of the "repeal and replace" movement. There have been a lot of services put into place that the Division does not want to lose if the ACA goes away. She is concerned if the ACA goes away, the federal funding would go away also and the state would be responsible for it.

Ms. Jensen reported that there are several bills on prescription drugs. The bill the Division submitted would eliminate the sunset date for anticonvulsants, antidiabetics and antipsychotic medications. The sunset date for the PDL was set to expire in 2013 and again in 2017. There has been an agreement to put the sunset date two more years out.

Ms. Jensen said that another bill (SB509) deals with provider tax. Currently, this works with the nursing facilities. The provider puts money into a provider tax, the DHCFP matches it with federal funds and then redistributes it back to the providers. This bill allows the state to enter into discussion with other provider groups in between sessions. Ms. Jensen stated if an agreement was made with a provider group, the Division would access a fee, then the process would be put into regulation.

Chairperson Rosaschi asked the committee if they had any questions.

Dr. DiMuro asked Ms. Jensen if it was known what sub specialties the four pediatric surgeons represent.

Ms. Jensen replied she did not have that information.

Dr. DiMuro wanted to know what type of surgeons there were, such as pediatric neurosurgeons, pediatric general surgeons or pediatric urologists.

Ms. Jensen responded she would find out.

Dr. DiMuro also inquired about the cost of referrals to the adjacent states and how many times Medicaid is having to refer to other entities. Since Medicaid is paying for those transfers, he was interested in seeing how much money Medicaid was spending on this.

Dr. DiMuro also wanted to know if the state was involved in recruiting efforts, was this a financial burden to the state and is it something that needs to be addressed.

Ms. Jensen responded that it is a financial burden as more than 50 percent of the births are Medicaid babies. Ms. Jensen noted that there is a concern in pediatric surgery since they stopped doing elective surgery. She does know what actions have been taken, but she will confer with staff to see what has been done.

Dr. DiMuro asked Ms. Jensen to return with data of how much money Medicaid is spending quarterly and annually on out of state referrals for pediatric surgery, and breakdown by ICD-10 codes.

Dr. DiMuro inquired about the actuary position. He wanted to know if this has been previously contracted out.

Ms. Jensen replied that this service was contracted out to a national vendor.

Dr. DiMuro inquired how much money Medicaid was spending on this service annually.

Ms. Jensen answered she did not know the amount, because they do all sorts of activities for the Division. She said it depends on what project it is. Ms. Jensen asked Dr. DiMuro if he was looking for an annual total of all the services they provide.

Dr. DiMuro replied he is. He wants to know if the state was to hire an actuary, then they could determine the cost savings and justification.

Ms. Jensen responded that this was done when they did the analysis, and she will get that information for him.

Chairperson Rosaschi asked the committee if there were any other questions and there were none asked.

Chairperson Rosaschi commented to Ms. Jensen that the Legislature was keeping her very busy and asked if she had any input or concerns the board could provide.

Ms. Jensen responded she did not have anything in particular at this time, as no decisions from the legislature have been made.

VII. For Possible Action: Review and Comment of Managed Care Member Handbook By: Aetna Better Health – Mia Williams (see handbook)

Ms. Mia Williams presented material for Aetna Better Health.

Chairperson Rosaschi wanted to know if this handbook was tested for reading ability and comprehension. She had concerns that perhaps this handbook was not of third- to fifth-grade reading ability.

Ms. Williams replied that this handbook was tested to be below the eighth-grade requirement that is required.

Chairperson Rosaschi asked Ms. Williams when the enrollees receive this handbook.

Ms. Williams responded that the enrollees receive the handbook and ID card within five days of enrollment.

Ms. Jensen apologized to the committee and to the Managed Care Organizations (MCOs). She stated there was a breakdown in communication and the handbooks were not provided in advance for the meeting. Ms. Jensen stated the handouts will be posted on the DHCFP website and the committee members we will be receiving handbooks also.

Chairperson Rosaschi commented to Ms. Jensen that they cannot proceed and give meaningful input without the proper handbooks ahead of time for review.

Ms. Jensen replied that this item should be postponed for another time.

Chairperson Rosaschi apologized to the other MCO representatives.

Dr. DiMuro asked Ms. Williams how many providers are there in Aetna's Better Health network.

Ms. Williams replied she was not sure. Ms. Williams mentioned that Mr. Mike Easterday, the CEO of Aetna Better Health, was on the phone, and may have the answer. If not, then she will contact the Provider Services Department and get that information for him.

Dr. DiMuro added he would like it to be broken down into primary care versus specialists. He also wanted to know how Aetna is currently working their contract for remuneration rates with providers. He was interested if they are basing it on Medicare or Medicaid Numbers.

Ms. Williams responded that was also a question for Aetna's provider network.

Dr. DiMuro asked Ms. Williams if Aetna was aware if Medicaid provider numbers in Nevada were going up or down.

Ms. Williams replied she did not have that answer, but she would get that information to him also.

DiMuro was curious about Aetna's lock-in program. He wanted to know if there were exceptions in this program.

Ms. Williams stated the lock-in program was operated by the Medical Management Department. The program is about surrounding medications, and paying attention to which medications members are filling and if they are going to different pharmacies to get them.

Dr. DiMuro wanted to know if in the lock-in program was for specific scheduled drugs or on all drugs.

Ms. Williams stated she thought that it is for specific scheduled drugs, but she was not sure. She would check on that and get back to him.

Dr. DiMuro wanted an explanation about Aetna's Medication Assisted Treatment options.

Ms. Williams replied she works in the member services department and will get the information from upper management.

Dr. DiMuro said he would appreciate Ms. Williams getting the requested information back to him. Ms. Williams replied that she would.

Chairperson Rosaschi asked Dr. DiMuro if he wanted all those questions answered by all the other providers as well.

Dr. DiMuro replied he would.

Chairperson Rosaschi asked Dr. DiMuro to repeat all the questions.

Dr. DiMuro's first question was how many providers are currently in their network and what is expected by July 1, 2017 start date.

Dr. DiMuro's second question was how are the MCOs basing their remuneration rates when they contract with Medicaid providers.

Dr. DiMuro's third question was directed toward Ms. Jensen. He inquired if Medicaid provider numbers were going up or down. He said a few colleagues have told him that they are opting out of Medicaid.

Ms. Jensen replied she did not see a decrease in Medicaid numbers. She stated that the numbers have increased over the last year and a half. Ms. Jensen thought that some providers were not opting out, they were just not accepting new patients.

Dr. DiMuro's fourth question was for the MCOs to expand on the lock-in program, especially for scheduled drugs.

Dr. DiMuro's last question was what the Medication Assisted Treatment benefits are going to include, are they going to require pre-authorizations for medications. He wanted to know if suboxone and buprenorphine containing products will be exempted and how many days will be given for an initial dose.

Dr. DiMuro stated that these questions are a very large issue in the state and he would like answers to these questions.

- **SilverSummit – Kara House, Pulled from agenda**
- **Health Plan of Nevada – Kristina Jones, Pulled from agenda**
- **Amerigroup – Allyson Hoover, Pulled from agenda**

VIII. Update and Discussion on the Health Care Guidance Program
By Cheri Glockner, Executive Director, Health Care Guidance Program, and Dr. Thomas McCrorey, Medical Director, Health Care Guidance Program (see attached presentation)

Ms. Glockner and Dr. McCrorey presented material for the Health Care Guidance Program (HCGP).

Dr. DiMuro asked Dr. McCrorey to give an example of the non-Pay-for-Performance measures.

Dr. McCrorey replied that these 89 measures are very comprehensive going across the spectrum of health care. There are clusters of non-Pay-for-Performance measures that include getting well-child checkups for children before age two, as well as teenagers getting in to see the doctor and other needed specialty care. He explained that they are not providers, and these measures are based on provider actions. Dr. McCrorey stated that CMS wanted to look at the overall health of the population change, when there are care management services.

Chairperson Rosaschi commented to Ms. Glockner and Dr. McCrorey that she hoped they would be around for another year, as she would like to see membership numbers increase since they have more experience from when they started.

IX. DHCFP Reports

- **Presentation on Dental Benefits Administrator and the 1915(b) Waiver**
  By Chuck Damon, Health Care Coordinator II (see attached presentation)

Mr. Chuck Damon presented the Dental Benefits Administrator (DBA) and the 1915(b) Waiver material.

Chairperson Rosaschi asked for a better understanding of what the dental care covered services entail.

Mr. Damon responded that for all Medicaid children, it covers cleanings, exams, crowns, medically necessary orthodontics, oral surgery, etc. He said for adults it is limited to emergency care and special circumstances for dentures. For pregnant women, it covers additional cleanings and restorative care during pregnancy.

Dr. Ryan Murphy wanted to know who the dental provider will be for the DBA.

Mr. Damon stated the contract is at state purchasing and is still being reviewed.

Dr. Murphy replied that he was under the impression that it was originally awarded to Delta Dental, then he heard it was taken back. Dr. Murphy said that he has been contacted by other agencies requesting him to participate.

Ms. Jensen responded to Dr. Murphy that for the original Request for Proposal (RFP) they submitted a notice of intent to award. Then Medicaid found out they needed additional information within the RFP. Ms. Jensen stated once an RFP is submitted, any changes thereafter is done through an amendment and must be agreed upon by both parties. Ms. Jensen stated Medicaid wanted to add some value-added benefits to see what else could be offered in the state of Nevada, tighten up enrollment criteria and find out more about the Medicaid participation of the vendor. She wanted to make sure that someone had experience in the Medicaid market. The RFP went back out for evaluation, during which time vendors were possibly doing some networking trying to figure out who would be able to enroll in their network should they be selected as a vendor. Medicaid also found out that CMS requires a three-month readiness

review. The effective date of the dental contract was moved from July 1, 2017 to October 1, 2017. Ms. Jensen stated that the RFP is still waiting for state purchasing to approve.

Dr. Murphy asked if after October 1, 2017, as a provider, will he need to re-enroll with the four MCOs. Dr. Murphy also wanted to know who will be billed for services.

Ms. Jensen said that all billing services should be going to the dental benefit provider. She stated they do not have to enroll with the MCOs, but she will defer to Mr. Damon.

Mr. Damon stated if they are a Medicaid dental provider, they would need to enroll with the DBA, FFS or both.

Dr. Murphy wanted to clarify that he would not have to enroll with Aetna, for example, he could just enroll with the DBA.

Mr. Damon responded that as a dental provider, he would have to enroll with the DBA.

Dr. Murphy stated that some of his patients also need hospital dentistry procedures which the medical portion gets packaged in with the dental. This includes medical and anesthesia, and he is assuming that he would have to enroll with the individual MCOs.

Mr. Damon replied in those cases, they would have to enroll with the MCOs. The DBA does not have the capability of doing CPT codes, they can only do D codes. In that kind of situation, it would be beneficial to be enrolled with both the DBA for general dentistry and the MCOs for anything done in a hospital setting.

Dr. Murphy is concerned that unless it is a competitive fee schedule, a lot of dental providers will not participate.

Ms. Jensen responded that she understands it is important to have an adequate network population. She shares Dr. Murphy's concerns and the DHCFP will discuss the matter with the awarded vendor.

Chairperson Rosaschi stated that she is aware of services given to children. She wanted to know what are they doing for the population that needs dental work that is employment related, for people that need to get jobs and keep jobs. She questioned if anything was being done for those that were seeking or trying to retain employment other than emergency services.

Mr. Damon stated that in Medicaid Service Manual (MSM) Chapter 1000, there is a mechanism in place for employment dentures. Other than that, it would require additional policy and the Division would have to consider costs, etc.

Dr. DiMuro asked what delineates the difference between a medical plan and dental plan, such as a facial fracture or an oral abscess.

Mr. Damon replied if the recipient presents in the Emergency Room (ER) for dental problems, then it will be a medical claim, if they go to the dental office then it is a dental claim.

Dr. DiMuro questioned if dental claims cannot originate from a diagnosis in the ER.

Mr. Damon stated most of the procedures, such as a facial fracture or an oral abscess, would be considered facial trauma and would be covered in a hospital. These procedures would be covered under CPT Codes. If it is done in a dental office, it would be billed under D codes.

Dr. DiMuro wanted to know how much money is spent by Medicaid for dental related care in the ER**.**

Mr. Damon said he did not know, but would gather the data and get back to him.

Dr. DiMuro asked if general anesthesia would be negotiated by pedodontists or if it was a standard level of care.

Mr. Damon stated the anesthesia codes that were implemented last year are already available. He stated that when anesthesia is done in an ambulatory surgery center there is a prior authorization (PA) requirement for the center, and another PA for the actual services performed.

Dr. DiMuro inquired if it was done in a hospital would that be different.

Mr. Damon replied that he would get back to him on that question.

Dr. DiMuro wondered if there were any specific denial rates for general anesthesia in any pedodontists cases.

Mr. Damon responded that it is a covered service but he would have to get back to him.

Dr. DiMuro asked if there were global fees attached to procedures with extractions or are they being paid per segment or quadrant.

Dr. Murphy replied that all dental procedures are billed by each specific procedure, each tooth and each surface, not globally.

Dr. DiMuro stated that in the medical field it is common when procedures are performed that subsequent procedures during the same treatment time are reimbursed at a significant discount. He wondered if it was similar in the dental field.

Mr. Damon replied no, as Dr. Murphy had stated that each procedure is billed and reimbursed on its own.

Dr. DiMuro asked what the costs were for dental last year or quarter necessitating the need for this benefit.

Mr. Damon responded that he has the FFS data and will give it to him. He said as to the actual costs under FFS and Managed Care, the DHCFP does quarterly dashboards that are posted on the DHCFP website which goes back to the year 2014. Mr. Damon said he would forward the link, so the information will be readily available.

- **Presentation on Personal Care Services Electronic Visit Verification (EVV) By Jackeline Obregón, Personal Care Services Program Specialist (see attached presentation)**

Ms. Jackeline Obregón presented the Personal Care Services (PCS) Electronic Visit Verification (EVV).

Dr. DiMuro asked if the Personal Care Aides (PCAs) are HIPPA compliant.

Ms. Adrienne Navarro from the Long Term Services & Support Unit (LTSS) asked Dr. DiMuro about the background of that question.

Dr. DiMuro wanted to know if PCAs are held to the same standards as other health care providers in the state.

Ms. Navarro replied that they are speaking to CMS in to regards to whether they fall in to the Code of Federal Regulations (CFR) for HIPPA regulations. Currently the Division has been told that they have to enroll with an Atypical Provider Number (API) for Medicaid, because they do not fall under HIPPA regulations. However, agencies sign a business associate addendum with Nevada Medicaid.

Dr. DiMuro asked if it was a difficult process to enroll as a PCA with Nevada Medicaid.

Ms. Navarro said if the PCA is required to get a National Provider Identifier (NPI), which is unknown at this time if they will need to, that would be the first step. This would be done on-line through the NPI Registry. The next step would be to fill out a Nevada Medicaid Enrollment Application. If no NPI is required, the PCA would be assigned an API number by the Division's fiscal agent. Ms. Navarro replied that it would not be a difficult process.

Dr. DiMuro wanted to know if the 145 PCS providers in the state are groups or individuals that subcontract other individuals.

Ms. Navarro said they are PCS agencies who are enrolled in Medicaid. The Division does not know how many PCAs are providing these services through the agencies. That is one reason the DHCFP would like the PCAs to enroll. It is one way to track the billing provider and servicing provider separately.

Dr. DiMuro wondered how the PCAs are vetted out by the agencies, is it out of Medicaid's jurisdiction or is it through the agencies themselves.

Ms. Navarro responded that NRS and the Nevada Administrative Code (NAC) regulate and monitor the PCS'. The agencies are licensed by the Bureau of Health Care Quality and Compliance (HCQC) and they are the ones who monitor the information.

Dr. DiMuro asked what the remuneration rates for these agency services are, and are they paid hourly or per patient.

Ms. Navarro said they are paid a rate of $4.25 per 15 minutes, or $17.00 per hour of service.

Dr. DiMuro inquired what the average length of time is for these services.

Ms. Navarro responded she did not know the average length of time, as Medicaid authorizes these services through a Functional Assessment Service Plan (FASP) and it is done by hours per week. The average hours per week is approximately 16. The maximum hours allowed per week is 36.5.

Dr. DiMuro wanted to know the patient demographics for these services.

Ms. Navarro explained that services vary, they can range from children to fully disabled recipients that require these in-home services.

Ms. Jensen added that Medicaid tried to implement this a few years ago and it was not well received. Now it is a federal requirement. She said the nice thing about this system is that a lot of the checks are done up-front. By the time the claim comes to the state, it should be a "clean claim." Any kind of edits should already be done. Right now, the claims come to the state, Medicaid pays them and the SURs unit reviews them. One of the things the Division looks for is if a bill comes in for two separate locations with the same person, a recipient is not getting their service and this is concerning. Another thing that is a concern is the small agencies in the rural areas. It will be burdensome for them to take on a system of this magnitude. Ms. Jensen said to expect the rates for the services to go up.

Chairperson Rosaschi inquired of Ms. Jensen what feedback was being given from the workshops regarding financial impact upon their organizations.

Ms. Jensen replied the feedback she received was from about five years ago at a public workshop and it was poorly received. She expects that since it is now a federal mandate, opinions may have improved.

Ms. Navarro responded there were around 13 to 17 providers that attended the most recent workshop. It was broadcast from Carson City to Las Vegas and Elko and there were no questions or comments at that time. She was not sure if there were no questions because it is now federally mandated or if they just have not processed it fully. One of the larger providers came to the office for a meeting and are concerned that their system will not tie into the one proposed.

Chairperson Rosaschi stated that some of the impact is going to be on the receivers of the services, and how would Medicaid get their feedback.

Ms. Navarro answered that they will need to be creative to get information to the recipients through the providers and on the DHCFP website, along with posting a public workshop. The Division is also getting guidance from CMS as to how to get the information out.

Chairperson Rosaschi asked Ms. Jensen if existing staff will need to absorb this.

Ms. Jensen replied yes, it happened after the Division's recommended budget was in place. Medicaid will do an analysis and if needed go to the Interim Finance Committee (IFC) to ask for additional staff. Ms. Jensen added that the DHCFP is re-structuring and the Division has also deployed Myers and Stoffard to look at the DHCFP's business process, to see if there is a way to do business more efficiently. With that there may be some transition of tasks.

Chairperson Rosaschi asked Ms. Jensen to come back once the DHCFP gets the re-structure done so the committee will know who's who.

Ms. Jensen responded that she will have more information in the coming months. She told the committee that the units have been co-located by service type in the hope that they could coordinate their efforts better and so the units could do some cross training. The units will still be reporting to the same supervisors.

- **Report and Update on Certified Community Behavioral Health Clinics (CCBHC) By DuAne Young, Social Services Chief III, Behavioral Health and Pharmacy**

Mr. Young informed the committee that his role came as a result of the re-organization Ms. Jensen mentioned, to give a specific look at behavioral health policies. He wanted to stress the importance of having an initiative like this in Nevada to address access to mental health. Since the last update, a policy was developed, it went through Review Manager and will go to public hearing on May 25, 2017. This policy will have a go-live date of July 1, 2017. He said the last round of certifications will take place in May 2017. This will be a joint effort between HCQC, the Division of Public and Behavioral Health (DPBH) and Nevada Medicaid. Medicaid has stepped outside of the role as just a payer and is focused on coordination of care, working with the sister agencies to make sure this is a success.

Dr. DiMuro wanted to know where the CCBHCs were located.

Mr. Young commented that the CCBHCs were in Reno, Las Vegas, Elko and Fallon.

Bridges - Las Vegas Metro
Westcare - Reno and Las Vegas
Vitality - Elko
New Frontier - Fallon

Dr. DiMuro asked what type of services are included in these CCBHCs. He wanted to know if there will be psychologists.

Mr. Young replied there will be psychologists. There are nine essential services that CMS and Substance Abuse and Mental Health Services Administration (SAMHSA) require, and each facility must meet the nine essential services which includes assessment, substance behavioral health and basic health care needs. Mr. Young said he will get the list of the nine essential services to the committee.

Chairperson Rosaschi replied that it would be good for them to have the list.

X. Public Comment on Any Topic

No Comments.

XI. Adjournment

Chairperson Rosaschi adjourned the meeting at 10:50 AM.