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Director

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Administrator

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MCAC MEETING MINUTES

Date and Time of Meeting:	January 16, 2018 at 9:00 AM
Place of meeting:	Nevada State Legislative Building 401 S. Carson Street, Room 3138 Carson City, Nevada 89701
Place of Video Conference:	Grant Sawyer Office Building 555 E. Washington Avenue, Room 4412E Las Vegas, Nevada 89101
Teleconference:	North (775) 687-0999 South (702) 486-5260
Access Code	43606

Attendees

Board Members (Present)
Rota Rosaschi, Chairperson
Dr. Ryan Murphy, Board Member
June Cartino, Board Member

Board Members (Absent)
Dr. David Fiore, Board Member
Peggy Epidendio, Board Member

Carson City

Darrell Faircloth, SDAG
Theresa Carsten, DHCFP
Shannon Sprout, DHCFP
Tracy Palmer, DHCFP
Lisa Jolly, Health Plan of Nevada (HPN)
Tanya Phares, SilverSummit
Joan Hall, Nevada Rural Hospital Partners (NRHP)
Erica Bronder, DHCFP
Tom Sargent, DHCFP
Marta Jensen, Division of Health Care Financing and Policy (DHCFP)
Lynne Foster, DHCFP
Joey Turken, SilverSummit
Noreen Dentscheff, SilverSummit
Shelean Sweet, HPN
Veronica Alegria, DHCFP
Diane Smith, DHCFP
Casey Angres, DHCFP

Thomas McCrory, Health Care Guidance Program (HCGP)
Chris Johnson, Nevada Hospital Association
Blayne Osborn, Nevada Rural Hospital Partners (NRHP)
Lea Cartwright, Nevada Psychiatric Association (NPA)
Judy White, Division of Public and Behavioral Health
Katelyn Bruner, University of Nevada School of Medicine
Karen Gardiner, Amerigroup (Anthem)
Cheri Glockner, HCGP
Paige Barnes, Crowley & Ferrato
Michele Belkin, DHCFP

Las Vegas

Shawna DeRousse, HPN
Devan Ramirez, HPN
Michelle Guerra, HPN
Kelly Simonson, HPN
Ryan Bitton, HPN
Devan Ramirez, HPN
Mance Espinosa, HPN

I Call to Order

Chairwoman Rosaschi called the meeting to order at 9:05 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 Approval of Meeting Minutes from the previous meeting held on October 17, 2017 (See Attachment for Minutes)

Dr. Murphy set a motion to approve and Ms. Cartino seconded the motion. The minutes were approved.

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

Ms. Jensen began her report with a quick summary on nine new State Plan Amendments (SPA) and four policy changes. The bulk of the changes were requirements from the 2017 Legislative Session. In October, several SPAs were submitted for rate increases that were included in the budget. These were for Skilled Nursing, Adult Day Health Care and Pediatric Enhancement Surgeries. The increases were Nursing at 10%, Adult Day Health Care at 5% and Pediatric at 15%. The definition for Durable Medical Equipment limiting use to a home setting has been changed for broader use and matches Centers for Medicare and Medicaid Services (CMS) language is pending. A retroactive date of July 1, 2017 was requested CMS approval. CMS may establish an elective date of October 1, 2017, not July 1, 2017. If so, the changes will be retrospective to July 1, 2017 because Federal Funding is most of that portion payment.

Ms. Jensen continued that in October, the DHCFP submitted a SPA to adjust reimbursement rates for Durable Medical Equipment (DME). Currently, Nevada reimburses a certain percentage of billed charges if there is no rate assigned. Specialty providers were withdrawing from Medicaid as reimbursement was sometimes less than their cost. The SPA is with CMS for approval.

Ms. Jensen added the DHCFP updated the Policy Manual in the Hearings Section. Federal regulation changes were made to allow for an expedited hearing process, requiring a three-day time frame compared to the regular ninety days. This could be allowed if the delay of the hearing would cause life threatening issues.

Ms. Jensen continued with the update of Chapter 400 Mental Health and Alcohol and Substance Abuse Services. This addressed the disparity between access to mental health and substance use disorder service versus the medical and surgical services. Changes will allow the mental health and behavioral health equal access to services and align with Federal Regulations.

Ms. Jensen then commented that in December there were updates to Chapter 1200 Prescription Drugs, resulting from the Drug Utilization Review (DUR) meeting in August. She continued that they are working to keep up to date on recommendations. In January, SB 233 passed that would allow contraceptives to be given in a 12-month period. CMS did have concerns as prescriptions may be given to Medicaid recipients for 12 months, however, they may lose eligibility and Medicaid would still be paying for the 12-month prescription. Conversations continue and any updates will be reported.

Continuing, Ms. Jensen described legislative requirements for coverage of Adult Podiatry and Medical Nutrition Therapy by registered dietitians. These services have been effective since January 1, 2018. A retroactive effective date was requested so that those coverages could be reimbursed.

Ms. Jensen went on to talk about the modernization of the Medicaid Management Information Systems (MMIS). The target date for completion is February 2019. She expressed that there is a seven-month delay, but one to be expected with changes implemented during Legislative session. Due to necessary changes, a code freeze would not be possible for the original timeline. Since updating changes, the new code freeze will occur in August of 2018.

Ms. Jensen commented that the last item was the budget build, saying this is when the Division formulates its requests. The Division will begin meeting in February to establish ground rules and what to expect. Ms. Jensen continued that they have not been given guidance on what to expect, but the Division should be getting that information late February or early March. She also ensured that the DHCFP is open to comment on ideas for rate increases and coverages.

Chairwoman Rosaschi asked about oral health and stated she knew of the added cleanings and bite wing, but wants to know if cavity fills and other similar procedures will be done.

Ms. Jensen responded it is something that is considered every two years and with the previous budget of $25 million, only preventative is covered. However, it is something that will be considered and it is based on available funds.

Chairwoman Rosaschi then stated that the studies are out about the relation to oral health and physical health.

Chairwoman Rosaschi then asked if there was any public comment on Ms. Jensen's report. No comments were made.

VI Overview of Fee-for-Service Prior Authorization
By Shannon Sprout, Deputy Administrator

Ms. Sprout started her overview by stating that at the previous MCAC meeting, there was a request for an overview of prior authorizations and procedures. In her overview she informed the board that prior authorization acted as a security measure when managing pharmaceuticals. Prior authorization is also the tool that is used to determine medical necessity, and for cost containment. Managed Care Organizations (MCO) must follow the state plan and implement their own procedures. For Fee-for-Service (FFS), DXC oversees the process. Denials can be appealed via their internal process.

Ms. Sprout continued that DXC monitors trends in prior authorizations. This identifies opportunities for training and possible issues with policy.

Ms. Sprout also said that the division reviews the codes for the highest volume of prior authorizations to determine what may or may not need prior authorizations due to medical necessity.

Ms. Sprout continued that the Division also monitors this through Hearing and Appeals. The Division is given a monthly report and the policy specialist sits in on the appeals and makes sure that those prior authorization are needed and input is given.

Ms. Sprout continued that the Division also has monthly meetings with DXC to ensure a global approach.

Ms. Sprout stated when building new policy, they are including the Managed Care Medical Review and the Fee-for-Services Medical Review teams into the building of the policy. This encourages prior authorization criteria across all the medical reviews. This better helps streamline the process of prior authorization.

Ms. Sprout then talked about the prior authorization alignment project that started about a year ago. The goals are to review and align policy and to streamline forms. She stated that this project looked at existing policies and working to align with Managed Care and this was used to help streamline the forms.

Chairwoman Rosaschi asked if there were any questions. She asked about the multiple prior authorizations that are being approved, and if these were being addressed and deemed necessary as a prior authorization. She asked if they looked at these to be added into the budget request.

Ms. Sprout concluded they do look at a budget aspect, especially for those that are 100% approved. The Division will continue to look at these to make sure that prior authorization is necessary.

Chairwoman Rosaschi then thanked Ms. Sprout.

VII Overview of MCO Prior Authorization
By Cody Phinney, Deputy Administrator, Amerigroup, Health Plan of Nevada and SilverSummit

Ms. Phinney began by stating that each MCO Provider has representatives present that will be explaining their prior authorization processes. She continued to say that they would start with Amerigroup who is changing their name to Anthem.

Ms. Karen Gardner introduced herself as the representative for Amerigroup, soon to be Anthem. She stated she oversees Clinic Areas in Nevada. She then continued with the prior authorization process presentation. (See attached presentation.)

After the presentation, Ms. Gardiner asked if there were any questions.

Chairwoman Rosaschi asked if multiple authorizations occur, are they looked at as to why they are on the prior authorization list.

Ms. Gardiner stated that it is something they consider and address according to budget and time. She also mentioned that Amerigroup was updating their portal to make it easier to process.

Ms. Phinney then introduced the next speaker for SilverSummit.

Ms. Noreen Dentscheff introduced herself for the record. She established she was the Vice President of SilverSummit Healthplan. She then proceeded with her presentation on the SilverSummit Healthplan Prior Authorization Process. (See attached presentation.)

Ms. Dentscheff added, that SilverSummit was evaluating high volume prior authorizations and they were unique in that they do not require prior authorization for specialty services. She stated that SilverSummit would be tracking this information, but currently do not have that much data. She concluded that they would be able to access their corporate trends and better their data on high volume prior authorization.

Chairwoman Rosaschi asked if there were any questions.

Dr. Ryan Murphy spoke to all the MCO's from a personal level as a Pediatric Dentist. His practice takes care of a lot of kids in the operating room; before it was easy to get prior

authorization, but since it was split and dental is now with FFS and Liberty Dental, the process is taking much longer. He commented what used to be a straightforward process has now become more difficult.

Ms. Dentscheff ensured she knows about the confusion and the frontline staff is looking at it.

Ms. Phinney added that Dr. Murphy made an excellent point and that we have had unusual and multiple changes in the dental procedures. The DHCFP can also aid in communication and clarification.

Dr. Murphy asked since this was something that he has been doing for 12 years and the majority of the prior authorization have been approved, is this something that is needed.

Ms. Phinney gave the response that the Division will take that back and address this concern, as well as communication.

Chairwoman Rosaschi asked if Dr. Bruner is in the audience. When confirmed, Chairwoman Rosaschi declared that Dr. Bruner was representing Dr. Fiore, and asked if the board was asking the right kind of questions or are there any other items that should be addressed.

Dr. Katelyn Bruner commented that the largest issues are referring patients for specialty situations and that these are not taking new Medicaid patients. There are no specialists available for Medicaid patients.

Chairwoman Rosaschi concluded she was not sure this was something that could be brought up as the meeting was about prior authorization, but it would be something that could be talked about in the media section. She thanked Dr. Bruner and then invited Heath Plan of Nevada (HPN) to present.

Ms. Shelean Sweet introduced herself as the representative for Health Plan of Nevada and the Director of Prior Authorization for Health Plan of Nevada. She first gave a brief overview of Health Plan Nevada's prior authorization process.

Ms. Sweet assured the availability of educational tools, and ensuring provider enrollment with Medicaid.

Ms. Sweet continued they have a web portal that is much more efficient than previous methods. She also confirmed they could take the claims by fax and phone, but would prefer not to take over the phone claims.

Ms. Sweet stated that Level I is a nonclinical approval, Level II is an RN approval and a Level III is an MD approval.

Ms. Sweet then talked about the denial categories; the most common denial is categorized as a benefit denial.

Ms. Sweet then brought up the common question on the multiple approved prior authorizations concluding that it is something that they consider on a regular basis.

Chairwoman Rosaschi then asked for questions. She saw that Dr. Bruner had a question and was invited up to speak on behalf of Dr. Fiore.

Dr. Bruner asked about specialists not taking new Medicaid patients and if it was possible to go through prior authorization to get the new patient in to see a specialist that may not be contracted, but could become contracted.

Ms. Sweet responded with two options. She determined it would be possible to call the Provider Advocate assigned and declare that there is not a provider that this patient can see, can they help find one. Or the second option is to call Health Plan of Nevada and ask if there is any provider type out there taking this type of Medicaid patient and from there HPN can reach out to providers and potentially find someone.

Dr. Bruner commented that the first thing that should occur is going to the Provider Advocate.

Ms. Sweet agreed and continued that would be the best way as the Provider Advocate can talk to the provider and see if they will take the Medicaid patient.

Dr. Bruner then asked if all the providers are saying no, theoretically a prior authorization can happen with an out of network provider.

Ms. Sweet responded with theoretically yes, and follows the medical necessity. This is two sided as a non-contracted provider must agree to the rate. This is when issues arise because they may be able to find them, but getting them to agree to the rates may be difficult.

Dr. Bruner asked if there is ever a change in the rate.

Chairwoman Rosaschi declared that Administrator Marta Jensen was present to help with Dr. Bruner's question.

Ms. Jensen added that each one is looked at from a unique perspective, Managed Care Organizations (MCO) are handled by HPN and Medicaid handles the Fee-for-Services clients. The Fee-for-Service program is required to have a network that is comparable to the commercial market. She stated there is a shortage and some providers are not willing to take new Medicaid clients. When this happens, Fee-for-Services is notified and the provider is contacted to see if an arrangement can be provided. In some cases, the patient has been sent out of state and have been reimbursed for that. She ensured there is a list that states which providers are taking Medicaid, but this system is not able to confirm if they are taking on new Medicaid patients.

Dr. Bruner commented that their referral person does this and often a message is received that no one is taking this insurance.

Ms. Jensen suggested that a call be put into the Medicaid District Office so that they could look for out-of-state providers, because the specialists are hard to come by. She then established that as for the rates, it depends on the service and the budget that is set for every two years. This proves to be difficult as there cannot be an increase across the board. Legislature is aware of this and it is something that will be discussed in the next session.

Dr. Bruner then thanked Ms. Jensen and Ms. Sweet.

Chairwoman Rosaschi asked if the other MCO's would like an opportunity to address Dr. Bruner's question. She also asked if Dr. Bruner felt the question was answered satisfactorily and offered that the other MCO's have the same ability to answer the question.

No further comments on Dr. Bruner's question.

Ms. Cody Phinney made a statement about a gentleman in Las Vegas attempting to comment or ask a question.

Mr. Ryan Bitton introduced himself as the Senior Director of Pharmacy in Clark County. He continued that in the previous meeting there were some questions regarding the pharmacy benefits and that he was available for questions if needed. He also established that they follow prior authorization and that they are doing similar checks for multiple approved prior authorizations. He stated he wanted to give a quick overview for the members of the board.

Chairwoman Rosaschi thanked him and let him know that it was appreciated.

Ms. Phinney said she would like to add to what Ms. Jensen had stated previously. She wanted to clarify that the District Offices do provide that resource for provider information. They are continuing to monitor this and provide the information needed. She also stated that while the Fee for Service rates are set, one of the benefits for the MCO's is that this program does have some flexibility based on those rates when services are needed. She further concluded that they would continue to work with the MCO's and find solutions.

Chairwoman Rosaschi stated that the ultimate is the service to the clients in need and is much appreciated when everyone works together. She continued that the meeting would now move on.

VIII Review and Comment on Managed Care Marketing Materials

- **Amerigroup (Recently changed to Anthem Blue Cross and Blue Shield)**

  Ms. Karen Gardner and Ms. Allison Hoover were both available for questions or comments about the presentation provided. (See attached.)

  Mr. Darrell Faircloth announced that the items had not been agenized as action items.

Chairwoman Rosaschi agreed with Mr. Faircloth and acknowledged that they would give feedback instead of approval. She continued with thanking Amerigroup soon to be Anthem for making the materials in a draft format. She concluded this makes it easier to make comments for changes. She continued to say that she did not have too much input but there was some information that was going to commercial and radio and she noticed something called "Books for Babies" and she purported she did not know what that was.

Ms. Gardner described that "Books for Babies" was one of the value-added programs and stated that a majority of this was not new material. These are being resubmitted with the new branding. The previous material has been approved but were needed to be seen with the new branding.

Chairwoman Rosaschi asked again what "Books for Babies" is.

Ms. Gardner stated that "Books for Babies" is partnered with a vendor for moms to help with children's reading. A mother can call in and essentially receive free books to promote this.

Chairwoman Rosaschi then continued she would like clarification of child care assistance. She asked if this meant that anyone could call them and get assistance.

Ms. Gardner acknowledged that no, this was not the case and that it would be considered for wording change.

Ms. Hoover also commented that it was useful information and thanked Chairwoman Rosaschi.

Chairwoman Rosaschi confirmed that she knew she read things literally and that the clients also read things literally. She then asked if there were any other questions or comments from others. No comments or questions followed. She again stated that a vote was not taken, but it looks like the market materials are on the right track.

- **Health Plan of Nevada - See presentation.**

Ms. Lisa Jolly introduced herself as the representative for Health Plan Nevada.

Chairwoman Rosaschi confirmed that she looked through the materials and did not have any comments. She then asked the rest of the members if there were any comments. None were given. She asked Ms. June Curtino is she had any comments.

Ms. Curtino stated she had no comments.

Chairwoman Rosaschi then concluded that it looked like HPN looked good to go. She again mentioned that it was not agenized and could not be moved forward, but there was no additional feedback.

- **SilverSummit - See presentation**

  Ms. Joey Turken introduced herself for the record.

  Chairwoman Rosaschi started with the $30 a month per household. She stated that this reads as a limit of only $30 a month. She then asked if that language could be massaged or better explain what that means.

  Ms. Turken continued that the $30 per quarter was an error and she would take that feedback.

  Chairwoman Rosaschi announced that there were other mistakes and since there were not page numbers it would be difficult to go over each one. She stated she would simply give her copy of the packet with her comments to SilverSummit. She continued with the minor corrections that are needed. She also asked for further clarification on transportation.

  Ms. Turken stated that corrections were made after the physical copies went out.

  Chairwoman Rosaschi continued that overall it was an excellent job, minus the minor correction. She mentioned again that is was not agenized and therefore could not be approved.

IX DHCFP Reports

- **Overview of the Access to Care Monitoring Review Plan (ACMRP)**
  By Tracy Palmer, Social Service Chief II

  Ms. Palmer began with her presentation. (See presentation.)

  Chairwoman Rosaschi declared that the percentages were up and that was good for data purposes. She added, as well, that on Page 27 it clearly stated that it was looking for input from the MCAC. She went on to state that Dr. Fiore had issues with the specialist and it was something that needed to be addressed.

  Ms. Palmer announced that it was noted and it was something that would be addressed and considered.

  Chairwoman Rosaschi then asked if there were any comments. No comments were made.

- **Presentation on Provider Enrollment and Revalidation**
  By Diane Smith, Chief of Provider Enrollment

  Ms. Smith introduced herself for the record. (See presentation.) After the presentation she added that the Division was working closely with other agencies. She also added

that the revalidation numbers have been increasing and it is all about how the previous revalidations have been. She mentioned there are monthly meetings to continue the outreach for these revalidations. She also commented that they did a quick analysis since July 2017 and they found they had about 972 terminations due to revalidation. Ms. Smith then said what was seen from this was that 546 of the 972 have turned around and re-enrolled. She stated that this shows the applications are turned in less than a week after termination.

Ms. Jensen added that she would like to commend Ms. Smith and her staff on all the work that they have done with a small staff. She also wanted to add clarification that the MCO providers need to enroll in Medicaid as FFS providers but the Managed Care are not required to enroll. She stated this causes concern because the providers want in but are not required to and she wanted to make sure that the committee are aware of that.

Chairwoman Rosaschi asked if there were any questions. No questions or comments.

- **Overview of the Dental Benefits Administrator (DBA) Onboarding**
  By Jack Zenteno, Social Services Chief I, Policy Development and Program Management (PDPM)

Ms. Sprout stated she would be filling in for Mr. Zenteno. She started out with the pediatric dentists which required a referral and how they could correct the language with Liberty Dental. A procedure memo was issued for Liberty Dental to move forward. The Division is still waiting for CMS approval on the contract and once approved, the DHCFP will make sure that all language is consistent so that a referral is not needed. In addition to that, the team also finalized all the practice guidelines.

Ms. Sprout then went on to say that on January 1, 2018, the DHCFP established a command center to ensure that they completed the Dental Benefits Administrator (DBA) implementation. This included a web page that offered FAQs. There were also web announcements and banners confirming they would need to credential with Liberty Dental. She mentioned they also gave information to sister agencies so that there would be a pathway if questions came up. She continued that from this point, the command center was set up. This command center is comprised of the DHCFP, the District Offices, Welfare and Supportive Services and Public and Behavioral Health, as well as the Directors Office. Ms. Sprout stated that the team began on a holiday and expressed her thankfulness for the team that was willing to gather on that day. She continued they had a live team for questions with DXC and Liberty Dental on hand. So far this has been a success and they have scaled down as fewer questions come in.

Ms. Sprout then thanked the team for all the challenging work and the launch being done on time. She stated there were still trivial things that would come up and are ready to handle these questions. She concluded the next thing to consider is the ability to monitor the claims that are coming in once data is available.

Dr. Murphy gave some general comments that included his biggest concern with Liberty, assigning a dental home. He described that rather than the participant deciding

where to go, they are being assigned and if they chose to go to another provider, that provider that is not assigned is not being reimbursed. He also claimed that a substantial portion of the clients who came in stated they had not received a welcome packet and were not aware that they had five days to establish a provider or one would be assigned to them. Dr. Murphy asked why Liberty Dental was insisting on making these choices for the recipient. He continued this was just another hurdle for the recipient. Dr. Murphy then went on to say that Amerigroup (Anthem), Health Plan of Nevada and Fee-for-Service on the dental side had always been very good, process claims on time and was very user friendly overall.

Ms. Jensen acknowledged that per the contracts, Liberty Dental did have to complete claims in the same amount of time. She then asked if Liberty Dental was on the phone. There was no response. She commented they would get that answer as this was created to better the dental program and not create more administrative issues on the provider side. She then ensured that a call would be beneficial so that they could get ahead of the issue instead of catching up to it. She then provided her number for Dr. Murphy.

Dr. Murphy commented that things did not seem to be done on time; packets should have been sent out in a more timely manner. He mentioned that Liberty Dental had reached out to him as a provider just to check in and see how things were going. He understood the grand undertaking of this project, but maybe more should have been established for the recipients.

Ms. Jensen thanked Dr. Murphy for his feedback and pledged they would look back into that. She then stated that when it came to mail out open enrollment, they had an average of thirty thousand pieces of returned mail to Managed Care. She commented that Liberty Dental was committed to continuing this process.

Chairwoman Rosaschi announced that overall things seem to be going well and she congratulated the team on such a large undertaking. She then asked if there were any questions. No questions or comments were made.

- **Update on New Covered Services – Medical Nutrition Therapy (MNT), Podiatry and Transgender Surgery**
  By Shannon Sprout, Deputy Administrator

Ms. Sprout brought to attention that the SPA 17-022 ABP Gender, Podiatry and MNT had been submitted for a January 1, 2018 effective date. She continued that CMS has a new process and that within 15 days, a call is received to better troubleshoot any issues regarding the SPA. She commented that there were no questions or concerns on Podiatry and that we should be seeing an approval shortly. There were some issues on Registered Dieticians and that there were some things that would need to be redlined and from there an approval could occur. Ms. Sprout also announced that CMS has 90 days to approve, but in some cases, they had seen an approval in 36 to 45 days. She continued with Transgender Surgery and stated that this did not need a State Plan, but does require a change to the Alternative Benefit Plan. She ensures again that they would expect that response from CMS in the next 90 days.

Chairwoman Rosaschi then asked if there were any questions. No questions were asked.

- **Update on the Child Health Insurance Program (CHIP)**
  By Cody Phinney, Deputy Administrator

  Ms. Phinney acknowledged that currently Congress has not re-authorized CHIP. She continued there was temporary movement in Congress and with that, some additional funding. She went on to mention Nevada received the funding to allow fund redistribution that allowed Nevada to maintain the program. She declared that currently the program has been able to keep moving forward. There are also IFC meetings that could allow transfer of funds to also allow this program to keep going. Administration up to the Governor's Office are on board to keep this program going

  Chairwoman Rosaschi stated good luck.

  Ms. Phinney thanked Chairwoman Rosaschi for that.

  Chairwoman Rosaschi agreed that this was a sad sight, but was thankful that the local government was supportive of this.

  Ms. Phinney then announced that Ms. Smith was humble in the process that she presented. She wanted to congratulate them on their challenging work and getting the compliance work done.

  Chairwoman Rosaschi thanked Ms. Phinney for that information and stated that Ms. Smith could be humble.

X Public Comment on Any Topic

No public comments.

XI Adjournment

Chairwoman Rosaschi adjourned the meeting at 11:09 AM.