



DRAFT MCAC MEETING MINUTES

Date and Time of Meeting: October 15, 2019 at 9:06 AM

Place of meeting: Nevada State Legislative Building
401 S. Carson Street, Room 2134
Carson City, Nevada 89701

Place of Video Conference: Grant Sawyer Office Building
555 E. Washington Avenue, Room 4406
Las Vegas, Nevada 89101

Teleconference: (888) 363-4735

Access Code 1961395

Attendees

Board Members (Present)

Rota Rosaschi, Chairperson
Peggy Epidendio, Board Member
Dr. Ryan Murphy, Board Member
Dr. Aaron Deininger, Board Member
Kelsey Maxim, Board Member
Dr. Ihsan Azzam, Board Member
Kimberly Palma-Ortega, Board Member

Board Members (Absent)

Sharon Chamberlain, Board Member
June Cartino, Board Member

Carson City

DuAne Young, Division of Health Care Financing and Policy (DHCFFP)
Blayne Osborn, Nevada Rural Hospital Partners (NRHP)
Homa Woodrum, Deputy Attorney General (DAG)
Theresa Carsten, DHCFFP
Stephanie Robbins, DHCFFP
Brady Flygare, Desert Care Facilities
Kirsten Coulombe, DHCFFP
Jordan Hinckley, Public
Joan Hall, NRHP

Cody Phinney, DHCFFP
Jodi Patton, DHCFFP
Chris Ferrari, Ferrari Public Affairs
Madison Huntley, Governor's Office
Erin Lynch, DHCFFP

Las Vegas

Erika Marquez, University of Nevada Las Vegas (UNLV)

Suzanne Bierman, DHCFP

Chaz Fernandez, JK Belz & Associate

I. Call to Order

Chairwoman Rota Rosaschi called the meeting to order at 9:06 AM.

II. Roll Call

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

III. Public Comment

No Comments

IV. For Possible Action: Review and approval of meeting minutes from the previous meeting held on July 16, 2019

Dr. Ryan Murphy motioned to approve the minutes and Ms. Peggy Epidendio seconded the motion. The minutes were approved.

V. Administrator's Report: Review of Medicaid Services Manual (MSM), Medicaid Operations Manual (MOM), Nevada Medicaid Office (NMO) Form and State Plan Amendments (SPAs) updates for July through September 2019 By: Suzanne Bierman, Administrator for the DHCFP

Ms. Suzanne Bierman, advised of changes to MSM, MOM, NMO and SPAS:

Ms. Bierman started with revisions to Chapter 400 – Mental Health and Alcohol/Substance Abuse Services. These changes are being proposed to align with the intent of Senate Bill (SB) 162 from the 2017 Legislative Session that revises provisions relating to psychological assistants, psychological interns and psychological trainees to render services under the supervision of designated licensed psychological supervisors as identified in the Nevada Administrative Code (NAC) and the Nevada Revised Statute (NRS) 641. These changes will expand provider qualifications and allow the three qualifications to enroll independently. Additionally, the proposed policy change will allow assistants, interns and trainees to enroll under the Psychologist Provider Type (PT) 26 and will remove them from under the current structure of the Behavioral Health community network PT 14, allowing for appropriate supervision as identified through the Board of Psychological Examiners. The effective date of these changes was July 31, 2019.

Ms. Bierman advised the DHCFP has proposed to add the definition of Permanent Institutional Status to MOM Chapter 800 – Cost Savings Program. This change is being made to clarify the status. The effective date of this change was July 31, 2019.

Ms. Bierman reported revisions to MSM Chapter 300 – Radiology Services to remove prior authorization (PA) requirements from medically necessary magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), magnetic resonance spectrography

(MRS) and positron emission tomography (PET) scans. These changes were effective September 1, 2019.

Ms. Bierman further reported revisions to MSM Chapter 100 – Medicaid Program Section 104.3 to move to the state’s new MOM Chapter 900 – Cost Avoidance Programs. The content of the Health Insurance Premium Payment’s Program (HIPP) has been removed to better align with in-house operations. These changes were effective August 28, 2019.

Ms. Bierman stated MOM Chapter 900 – Cost Avoidance Programs is a new chapter and encompasses the following categories to improve the organization of content and to place contents regarding internal DHCFP programs into the MOM: HIPP, Incarcerations, Medicare Advantage Plan, Medicare Premium Buy-In and Public Assistance Reporting System (PARIS). These changes were effective August 28, 2019.

Ms. Bierman spoke of revisions to MSM 1200 – Prescribed Drugs Appendix A. These changes reflect recommendations that were approved April 25, 2019 by the Drug Use Review (DUR) Board. The changes include revisions to the existing policy on agents used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactive Disorder (ADHD), Transdermal Fentanyl, Buprenorphine Naloxone and Vivitrol (naltrexone). The changes also include the addition of new PA criteria for Lucemyra (lofexidine) and Xyosted (testosterone enanthate). The effective date of changes was September 2, 2019.

Next Ms. Bierman talked of changes to MSM Chapter 2200 – Home and Community Based Waiver for the Frail Elderly. The revisions include mandates under the 21st Century Cures Act. In December 2016, Congress passed HR 34, which mandates all states require the use of an Electronic Visit Verification (EVV) System for all Medicaid funded personal care services that are provided under a state plan or a waiver of the plan, including those services provided under Section 1915(c) Waivers. The effective date of this change was September 25, 2019.

Ms. Bierman related changes to MSM 2300 – Home and Community Based Waiver for Persons with Physical Disabilities to include the Mandate under the 21st Century Cures Act. The effective date of the change was September 25, 2019.

Ms. Bierman reported revisions to MSM 2600 – Intermediary Services Organizations (ISOs). She advised ISOs are being proposed to add language due to the passage of the 21st Century Cures Act. The effective date of the change was September 25, 2019.

Ms. Bierman said MSM 3500 – Personal Care Services Program has been revised to add language due to the passage of the 21st Century Cures Act. This change is effective September 25, 2019.

SPAs Summited to CMS

Ms. Bierman advised several SPAs have been submitted to CMS between the period of July 2019 and September 2019.

Ms. Bierman stated the first proposed amendment is to SPA 19-005 – Early Periodic Screening Diagnostic and Treatment Services (EPSDT). This amendment is to remove the

section on school-based child health services and add more general language to the State Plan allowing any EPSDT service covered in a non-school setting to also be performed in a school-based setting. This SPA was submitted on July 31, 2019, with a requested effective date of September 1, 2019.

Ms. Bierman reported the DHCFP proposed changes to SPA 19-008 – Nevada Checkup (CHIP) Section 4.1.3 Income, of each separate eligibility group due to the Bipartisan Budget Act of 2018, Section 53103. This change covers the treatment and budgeting of lottery winnings and other lump sum income for purposes of income eligibility under CHIP. This SPA was submitted on June 25, 2019 with a requested effective date of July 1, 2019.

Per Ms. Bierman, the DHCFP is proposing to amend SPA 19-010 – Certified Community Behavioral Health Centers (CCBHC) to include services in reimbursement methodology for the continuation of the CCBHC services. The Division is proposing adding State Plan pages outlining proposed changes to the following areas: Attachment 3.1-A, Page 6c, and Attachment 4.19-B, Page 8. The proposed change affects all Medicaid enrolled providers delivering CCBHC services, Special Clinics PT 17, Specialty 188. The estimated change in annual aggregate expenditure due to this change is \$17,531,400 for State Fiscal Year (SFY) 2020 and \$21,883,846 for SFY 2021. This SPA was submitted on August 28, 2019, with a requested effective date of July 1, 2019.

Ms. Bierman said the DHCFP is applying to CMS for a 1915(b) Waiver, which is related to the Integrated Health Services provided by the Certified Community Behavioral Health Organizations (CCBHO), previously known as the CCBHC. This allows Nevada to limit the number of providers that Medicaid members can receive services from. The state currently has three CCBHOs and expects to certify an additional seven by the end of the year. If approved, this waiver will allow Medicaid to expand service coverage from the CCBHOs to ten as budgeted in the current budget. The CCBHO services will be available to all Medicaid members as medically necessary. The following MSM Chapters will be revised to address CCBHO services as outlined in the waiver: 400, 2500, 2700 and 3600. Additionally, the Division needs to update State Plan Section 3.1-A, Supplement 1 to Section 3.1-A and Section 3.1-F. This SPA and waiver were submitted on July 24, 2019

Ms. Bierman presented proposed changes to SPA 19-013 – Behavioral Health Community Network (BHCN) for the supervision requirements of a peer supporter within the BHCN. These changes will consolidate the supervision of the peer supporter under the clinical supervisor within the BHCN and remove the requirement for medical supervision. This proposed change affects Medicaid enrolled providers delivering mental health and alcohol/substance use services. The Behavioral Health Outpatient Treatment PT 14, Specialty 814, will no longer be required to contract a medical supervisor. The Physician Osteopath PT 20 will no longer be required to provide medical supervision for the BHCN. These changes do not result in any estimated changes in expenditures This SPA was submitted on September 25, 2019, with a requested effective date of January 1, 2020.

Ms. Bierman reported the DHCFP is proposing to amend SPA 19-014 – Financial Eligibility Section 2.6-A. State Plan, Section 2.6-A, Page 26a and 2.6-A Supplement 13 federal rules allow the state the option of choosing the federal minimum, federal maximum or amount in between when determining the community spouse resources for individuals living in an institutionalized setting. With this change, the Division of Welfare and Supportive Services will be able to approve Medicaid for recipients living in

institutionalized settings, or those considered institutionalized, whose resources exceed the minimum but are less than the maximum of \$126,420 without requiring a court order spousal division of resources. This SPA was submitted on September 25, 2019, with a requested effective date of September 25, 2019.

Ms. Bierman concluded with the amendment to SPA 19-019 and 1915(i) Waiver – Quality and Prevent Strategy to change 1915(i) Home and Community Based State Plan Services, Attachment 3.1G, Page 41a and 41b, regarding the Quality Management Strategy. Changes incorporate federal quality measures as required by 42 CFR 441.710 for Home and Community Based Services & Regulations, specifically relating to the settings requirements. Updates also included addition of eligibility requirements, discovery evidence used and system improved activities. This SPA was submitted on September 25, 2019, with a requested effective date of September 25, 2019.

Chairwoman Rosaschi asked if anyone had any questions. There were no questions.

VI DHCFP Reports

Coverage of Blood Lead Testing

Ms. Jodi Patton, Chief I in the Medical Programs Unit, DHCFP, introduced Dr. Erika Marquez, with the Nevada Institute for Children’s Research and Policy, located within UNLV School of Public Health, who presented on Coverage of Blood Lead Testing. (See presentation.)

Overview of Where Nevada Medicaid Stands in Coverage of Lead Testing for Children Under the EPSD Provision

Ms. Patton presented on Medicaid Coverage of Lead Testing for Children under the EPSDT Provision. (See presentation.)

Chairwoman Rosaschi asked if anyone else had any questions.

Dr. Aaron Deininger asked for data on the prevalence of children with elevated blood levels in this state and where those might be concentrated. He also questioned with such a low percentage of children being screened, what kind of outreach is going to providers to increase that.

Ms. Patton responded that from a Medicaid perspective, Medicaid offers the presentation of services provided. She also advised that Medicaid also coordinates with the Department Public Behavioral Health (DPBH), Clark County and other entities to gather requested information. The providers determine what services are necessary. If it is determined that a child is at risk for lead poisoning, Medicaid wants to ensure coverage is provided. Ms. Patton advised that additional outreach and coordination can be implemented to determine if there is a need. She advised if there are any thoughts or input, she would be more than happy to be a conduit for increasing that conversation.

Chairwoman Rosaschi posed a question regarding the way the CMS reads in the presentation: “All Children enrolled in Medicaid, regardless of whether coverage is funded

are required to receive blood lead screening during these intervals”. She said she was confused as the presentation states “all.” Per the presentation, blood testing is recommended but not required. Ms. Rosachi also inquired if this is what drives the numbers so low.

Ms. Patton stated she could not attest to what a doctor chooses to perform in practice. It is important to insure the coverage, but doctors are not mandated to provide that service.

Mr. DuAne Young also responded to the question by advising that when CMS makes a requirement, it is part of the EPSDT Program, and thus must be covered as part of the program that is offered in-state; however, neither CMS, or the State Medicaid Program can require physicians to perform these services. The testing is recommended to be part of the early periodic diagnosis, screening and treatment package so physicians can do the testing during the well-child visits. However, a parent can object, a youth can object, and a physician can considerably not offer those as part of the package, but it is recommended for the doctors and required in the State Plan.

Dr. Marquez elaborated on the initial question about what outreach and education efforts are being implemented and what the prevalence is. Dr. Marquez advised that the state uses an academic detailing model that is predominately used in the pharmaceutical industry to do one-on-one education or small group education with providers in the clinics to cover the new evidence of low doses of traditional and non-traditional exposure. The tendency is to think lead comes from older houses, but it also comes from nontraditional sources of exposure; such as, occupational, cultural practices and things brought into the homes. She advised that information is given to providers, so they are able to make better decisions regarding how to encourage testing. By offering Capillary Testing onsite, instead of the Venus Draw, parents are more likely to want to do a blood test. She advised that in terms of the prevalence, of the 8,000 children looked at over two years, there is about 250 that are at the five micrograms per deciliter or above.

Dr. Ihsan Azzam followed up on Dr. Deininger’s question as to how the prevalence is compared to other states. He advised 250 out of 8,000 is low, yet it is known that there is no safe level of lead in blood. He asked how much that level was and is it consistent in every state and is Nevada’s prevalence of blood lead comparable to other states.

Dr. Marquez answered that southern Nevada’s response is sometimes at 10 micrograms per deciliter in terms of if a child has an elevated blood lead level. A response from the health district does not occur at 10 micrograms per deciliter, but some responses do occur at five micrograms per deciliter and the recommendation from The Center for Disease Control (CDC) Advisory Committee is five micrograms per deciliter. She advised that families and providers are being educated regarding this. Dr. Marquez reported she could provide additional information as to how it compares to other states, but she did not have it on hand. However, she advised that testing rates are low. There are about 260,000 children under the age of six and only a very small portion of that population is captured.

Dr. Marquez clarified they are in the process of doing more targeted outreach. There are plans to start targeting the more at-risk population. More is being learned about non-traditional sources of exposure. There are children, and even an entire family, in southern

Nevada who have been exposed to cultural practices that have resulted in elevated blood lead levels. Emphasis is to target communities both on the traditional and non-traditional sources of exposure. Per Dr. Marquez it is not just the house structure but also items that are brought into the house that may cause elevated blood lead levels.

Dr. Azzam wanted to know what the title of the presentation meant, Lead From M To N.

Dr. Marquez clarified the title means from Medicaid to Nevada, it was just a play on the title.

Mr. Young reminded the committee that it is important to realize that prior to SB 90, this was not a requirement state wide, this is something southern Nevada had forged and done. He also advised that this was a structural and housing issue for it is important to understand the nuances as the doctor from UNLV pointed out that children growing up in the 1980s in the Midwest this was very much a structural and housing issue that also migrated to the toys that were made, especially for those who loved the little classic hot wheels cars. Nevada did not necessarily have some of those structural issues, but it has had some of the other things that have been brought into homes. This has been a prevalence and a push on the west coast, much like it was a push in the 1980s in the Midwest to test the children. Mr. Young advised he thinks the intent of SB 90 and Senator Pat Spearman was really to push this beyond southern Nevada because of the growing infrastructure that is in the rural area and the northern part. However, Medicaid has never received those test results, even when they were collected by Southern Nevada Health District and is not something that would be received as part of our data or tracking. The positions that they are linked to enable the ability to share the information. This bill will allow for some of that sharing and will be regulated by the DPBH, not necessarily Medicaid. Medicaid will continue to focus on the coverage aspect, and partner with the agencies in the communities for the outreach aspect.

Chairwoman Rosaschi remarked that per SB 90 if testing is done it must be reported. She expanded that as only 8% of all children are eligible or actively receiving any kind of testing, it is very difficult to say whether there really is an issue with lead. Thus, she recommended that if information were to be generated through a bulletin to the providers reminding them of the availability, benefits and why the test needs to be done, it may encourage the providers to do more testing. This would improve the reporting

Chairwoman Rosaschi asked if everybody was okay with that and if anyone else had any thoughts.

Ms. Erin Lynch advised that some outreach has been done and web announcements have been created. She advised they are more than willing to keep providing outreach advising that blood lead testing is covered, and encouraged, for this particular age group.

Ms. Epidendio also recommended this information be included to parents for services covered during open enrollment periods, or when the managed care organizations are looking at sending out more information.

Mr. Young replied that the Division has been working on some strategic priorities, and in the coming year, will be announcing some initiatives that are being geared specifically

towards children and looking at different ways to provide that outreach. He said they are in the process of hiring a Public Information Officer whose role will encompass such tasks as building and policy and measuring initiatives. Once the Public Information Officer is hired and properly on board, many more of those types of communication will be coming from Medicaid.

Chairwoman Rosaschi thanked everyone for the information and commented that she she recognizes the number as low and wants to raise the numbers.

Report on the Electronic Visit Verification Implementation

Ms. Stephanie Robbins presented an update on the Electronic Visit Verification System (EVV) System. The policy has been updated for the implementation of the 21st Century Cures Act. Congress mandated the act for all personal care services that are Medicaid funded as it relates to State Plan Personal Care Services and some waiver services as well. The EVV System went live September 29th. A phased approach was done to the system implementation. A group of about 200 agencies, which affects about 10,000 recipients who currently receive services, was worked with to implement the system. It has gone from a paper time-sheet system to an EVV System for personal care services that are performed in the home or community. In July, in-person trainings were done for the agencies to train the trainers, who in turn will train staff. Many personal care attendants will be utilizing the system. A question and answer session with recipients was also held and letters were sent out to everyone who was receiving personal care services. Five question and answer sessions were held in March. The recipients could call in and ask questions. The policy was updated effective September 25, 2019, to include the mandate for the EVV System.

Ms. Robbins further reported that trainings with the Medicaid District Offices and Aging and Disability Services were incorporated to engage the district offices and the case managers. This included State Plan Personal Care Services, as well the Physically Disabled Waiver and Frail Elderly Waiver. Ongoing support and maintenance of the system is being done as it relates to ensuring that all services are documented in the EVV System. In 2023, all home health services will be mandated in the EVV System

Ms. Epidendio asked if Private Caregiver Aides (PCA) are employed by an agency or does Medicaid have PCAs.

Ms. Robbins replied that there are two options for Personal Care Services. The first is the original agency where PCAs work for an agency. The second is the Intermediary Service Organization model, which is self-directed. Recipients can use their own PCAs. Intended caregivers would need to get employed through the Intermediary Services Organization model. The recipients oversee trainings and ensuring training are kept current.

Ms. Epidendio wondered if there are private PCAs, as opposed to those being employed by an agency, who would provide the EVV System for billing.

Ms. Robbins replied that the EVV System is a mandate. The Authentica Care System has been contracted for use. There are options for a mobile application that can be used by

PCAs with Smart Phones, tablets or the IVR System (landline). The Agency has different variations, depending on what is happening in the field, to do web-based claims if needed. However, the intent of the EVV System is to calculate GPS coordinates for check-in and check-out; thus, the mobile phone and IVR System are the options used.

Ms. Epidendio inquired what kind of feedback from either the attendants or agencies has been generated as far as claims being processed.

Ms. Robbins responded that the first Go Live is still in the testing process. Two agencies volunteered to do a Soft Go Live in August 2019. These agencies have been through the billing cycle and are working with Medicaid to identify any issues the system. The Authenta Care System does take the place of manually entering claims to Medicaid, so customers no longer need to go through the Payor Path Portal previously used. Authenta Care will do the billing.

Ms. Robbins elaborated that there have been some growing pains with the way billing is done. In the past there has always been a weekly span dated claim, which has now changed. Training and outreach are being given to providers for changes and what to expect with billing. No issues have been identified yet.

Chairwoman Rosaschi asked if there were any other questions or comments and there were none.

Report on Quality Strategy

Ms. Theresa Carsten presented a synopsis of the Quality Assessment and Performance Improvement Strategy commonly referred to as the Quality Strategy. Historically, Nevada's quality strategy has served as the vehicle by which the state communicates quality goals and objectives for managed care to CMS as well as other stakeholders. The Quality Strategy also allows the state to continually assess and improve the quality access and timeliness of services delivered to Medicaid and Nevada Checkup members. The current quality strategy outlines seven goals, some of which include increasing access and utilization to preventative services, improving the health and wellness of new mothers and their infants, increasing the use of best practices for members with behavioral health conditions and increasing the utilization of dental services. The state monitors these goals by using Healthcare Effectiveness Data and Information Sets (HEDIS) to measure specifications for each outlined objective. The Division tracks the Managed Care Organization's (MCOs) performance for each of the required measures annually. Results can be found in the annual External Quality Review Technical Report (EQR). In addition to these HEDIS Measures, the DHCFP monitors the MCO's quality efforts by conducting annual compliance reviews, validating the performance improvement projects conducted and assessing and reporting on the MCO Consumer Assessment of Health Care Providers and System Surveys. These results are also located in the annual EQR Tech Report.

Revisions to the Quality Strategy are required at least every three years. The Division incorporates feedback from the public, the DHCFP staff, the MCO's, the DHHS and other divisions within the DHHS, as well as the MCAC when developing and revising the Quality Strategy Document. Current Quality Strategy and EQR Tech Reports are located

on the Division website and measures are routinely collected and reported on annually in the EQR Tech Report.

Ms. Carsten asked if the committee had any information, feedback and/or suggestions the committee may have to be included in the report. She advised even though the Quality Strategy Report is current, updates and revisions are ongoing as goals and objectives change.

Chairwoman Rosaschi inquired if areas of interest could be highlighted, such as, access to care, dental care and mental health issues and to advise what is going on from the time period of 2016 to 2019.

Ms. Carsten responded that unfortunately in Attachment B there are several measures such as Goal 1 (Access to Care and Increase to Preventative Services) that are broken out to each band. Thus, Objectives 1.1A Through D capture different age bands for those children. The statewide average referenced is based on data from HEDIS measurement year 2018. Anthem and Health Plan of Nevada (HPN) were the only entities being reported during this time. A combined average of the total measures for the two entities was used. The Minimum Performance Standard (MPS) statewide average is 94.37 for Objective 1.1A. Hopefully this will be increased in the next year by at least meeting the minimum performance standard. It is possible to go above and beyond the minimum performance standards.

Chairwoman Rosaschi questioned whether the report tells if goals are accomplished or not.

Ms. Carsten replied It does not. The results are reported in the EQR Tech Report, which does not come out until November.

Chairwoman Rosaschi further inquired if goals are generally on track or off track and if there is room for improvement.

Ms. Carsten said when compared nationally the results sometimes fall below the benchmark, though the focus is now on statewide as Nevada is so unique. The goal is to look at the statewide average and show improvement from there on. Ms. Carsten said overall, they are doing a pretty good job. When there are measures that are falling below, they may elect to conduct Performance Improvement Projects and Root Cause Analysis to try and figure out why there has been a percentage slip in the measures.

Chairwoman Rosaschi asked how to get those numbers. She asked if successes are measured, and if expectations are not being met, how is the problem worked around to improve talents.

Ms. Carsten responded that data is collected by the MCOs and reported based off the HEDIS Specifications within the system. Those are reported to the vendor HSAG, which serves as the external Quality Review Organization and validates that the measures are calculated and reported accurately. At that point, the MCOs attend the Quality quarterly meetings to present on improvements, or lack of improvements, and explain the Root Cause Analyses that have been done, and any quality efforts made for improvements.

Chairwoman Rosaschi asked if statistics can be gathered for Lead Blood Testing and discussions held to get the Lead Blood information out so reports can be done.

Ms. Carsten responded that a specification measure would need to be designed for lead testing. This is not in place at this time but may be something that can be added. There is a budget for a subset of measures. It goes back to the Division and the DHHS's goals for what should be captured and how much.

Chairwoman Rosaschi asked if there were any comments and there were none.

VI. Public Comment

No Public Comment.

VII. Adjournment

Chairwoman Rosaschi adjourned the meeting at 10:07 AM.