BRIAN SANDOVAL
Governor

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

LAURIE SQUARTSOFF
Administrator

MCAC MEETING MINUTES

Date and Time of Meeting:	April 16, 2013 9:00 AM
Place of meeting:	Nevada State Division of Health Care Financing and Policy 1100 E. William St., 2nd Floor Conference Room Carson City, NV 89701
Place of Video Conference:	Division of Health Care Financing and Policy 1210 S. Valley View Blvd. Suite 104 Las Vegas, NV 89102

Attendees

Board Members (Present)
Rota Rosaschi, Chairwoman
Peggy Epidendio, Board Member
David Fluitt, Board Member
Dr. Jade Miller, Board Member
Dr. Dave Fiore, Board Member

Board Members (Absent)
Tracey Green, Board Member
Angie Wilson, Board Member
Michael Ball, Board Member

Carson City
John Whaley, DHCFP
Darrell Faircloth, DAG
Jon Kirwan, DHCFP
Alexis Ulrich, DHCFP
Daniel Mathis, NVHCA
Tzeli Triantafillou, Viiv Healthcare
Lawanda Fred, DHHS
Scott Mayne, WC/CC
Jeanette Belz, NV Psychiatric Assn.
Joanna Jala, Ferrari Public Affairs NV. Dental Assn.
Scott Larson, BMS

Laurie Squartsoff, DHCFP
Elizabeth Aiello, DHCFP
Coleen Lawrence, DHCFP
Jennifer White, DHCFP
Bill Ross, Highland Manor
Steve Boline, NRHP
Diane Ross, The Continium
Julie Bertuleit, GSK
Jenni Bonk, DHCFP
Tracy Palmer, DHCFP
Josh Etchegoyhen, DHCFP

Las Vegas
Janet Belcove-Shelin, NV Disability Advocacy
Jim Parcells, Unsom/Mojave
Ralph (Kevin) Spencer, New Progressions

Bret Fergusan, Pfizer
Brendeen Spenser, New Progressions
Viki Kinnikin, Mojave

I. Call to Order:

Chairwoman Rosaschi called the meeting to order at 9:30 a.m. The meeting was delayed due to having to move the location in Carson City, NV which was announced at the original site along with the new start time of 9:30 a.m.

II. Roll Call

Chairwoman Rosaschi asked for roll call.

III. Public Comment on any Matter on the Agenda

None

IV. For Possible Action: Review and Approve Meeting Minutes from January 15, 2013

The January 15, 2013 minutes were approved with the following changes:
Page 5; change the "group 1 pos cxv 500 hcr" to the Silver State Health Insurance Exchange website and on page 9, remove the word "before" October 1, 2014 for ICD-10 codes to be in place.

V. Administrator's Report on the following items: by Laurie Squartsoff

- **Legislative Update**

  Ms. Laurie Squartsoff said they are currently at day 72 for the Legislature. They have been able to make a number of connections with Legislators. The bills are going through the process quickly. The turnaround time of getting information back from staff to Legislators or Legislative Counsel Bureau (LCB) has gone very well. When they had the budget meeting last week there were few questions for the Director.

  Chairwoman Rosaschi asked if there are any bills of concern.

  Ms. Squartsoff responded there are some bills that affect the Division of Health Care Financing and Policy (DCHFP) but at this point they seem to be making their way through the process and the amendments have been heard by the committees. AB8 clearly defines the differentiation between the Division of Welfare and Supportive Services (DWSS) and the DHCFP. This one has a companion bill AB450 that is related. AB450 is still working through the system. It has a different connection between the two agencies. The DHCFP is looking forward to having the clear differentiation of the roles of the DWSS and the DHCFP between the eligibility and medical pieces.

  Chairwoman Rosaschi requested clarification.

  Ms. Squartsoff responded at this time, there is some overlap in how the current regulations address the DWSS and the DHCFP. With the separation of the two programs, this was not clarified in statute. These bills are intended to make this clearer & update the language in terms of current references.

Chairwoman Rosaschi asked if the budget is on track with their expectations or are there any discussions of cuts.

Ms. Squartsoff responded at this point everything is going as it has been presented.

- **Medicaid Services Manual Revisions**

  There have been four updates in the last few months. Medicaid Services Manual (MSM) Chapter 500 – revisions for behaviorally complex qualified recipients; MSM Chapter 800 – revisions to update the term PKU so it is more reflective of what is happening in the community; and MSM Chapter 3500 – revisions to the current flexibility of service delivery policy, to clarify information of what is covered and the hours that are covered by those services.

- **Nevada State Plan Amendment Updates**

  There are several State Plan Amendments (SPAs) that have been submitted to Centers for Medicare and Medicaid Services (CMS). The first one is related to End Stage Renal Disease (ESRD) Rate Changes. The second one has to do with the Primary Care Physician (PCP) rate increase that is a reflection of the changes in the Affordable Care Act (ACA) and the 36% bump in the rate for PCPs.

  Dr. David Fiore asked if this is supposed to take place January 1, 2013 and clarified it is not being paid at this time.

  Ms. Squartsoff responded correct, they are waiting for the SPA to be approved. The self attestations from the PCPs were due to us for the retroactive bump by March 15, 2013. The DHCFP can continue to receive those attestations. Right now there are 1135 PCPs who can send in the attestation; as of last week 1124 has submitted them.

  Dr. Fiore asked if there is an anticipated date that will be in place.

  Ms. Squartsoff responded CMS has said soon.

  Dr. Jade Miller asked about oral healthcare providers and if there is any intention of any rate increases.

  Ms. Squartsoff responded they are looking at some other rate increases as a result of budget issues they have been able to make adjustments on. Those have been presented and the DHCFP is waiting for a response.

  Dr. Miller asked if this particular issue is one that is being evaluated.

  Ms. Squartsoff responded there are four or five and she will review and get the information to Dr. Miller.

  Ms. Elizabeth Aiello responded there is a small bump. It is very small because of the cut in dental. The rates in the Governor's budget are to restore some of the rate cuts. The dental was cut at approximately .78 so that is what will be restored.

Ms. Squartsoff continued with the third SPA which is Part D for the coverage of benzodiazepines and barbiturates. The fourth SPA has to do with preventative services. This is not really a policy change but it is an update in accordance with the immunization schedules.

Dr. Fiore asked for clarification. It is his understanding Medicaid currently does not cover adult well visits which seem to be in conflict with the ACA and preventative services.

Ms. Coleen Lawrence responded the ACA requires the DHCFP to cover the A and B preventative services and immunizations for adults. The DHCFP covers office visits for adults. Under the A and B the DHCFP covers the entire schedule of the A and B. The change was made last year.

Dr. Fiore said they are not able to code it as a well visit for an adult and it has to be coded as an E and M visit.

Ms. Lawrence responded the DHCFP covers all E and M. They are looking at the policy.

Dr. Fiore said if a healthy person comes in for a well visit and they do not have any issues that they are being seen for. If a diagnosis is placed in the E and M code as well visit, they will reject it. They have to have an ICD-9 code to justify.

Ms. Lawrence responded there would be a diagnosis. They are coming in for something. They have a preventative services policy. The DHCFP covers the services according to the United States Preventative Services Task Force. The DHCFP covers all of those services now. There are some preventative codes on there for office visits. The SPA gives the State a 1% increase in the Federal Medical Assistance Percentages (FMAP) for covering all of the adult immunizations and the schedule that is recommended.

Ms. Peggy Epidendio asked if they can expand on the SPA for the benzodiazepines and barbiturates.

Ms. Lawrence responded there was not any policy change. In the State of Nevada, because of Senior Rx, the DHCFP was picking up the co-pays and deductibles. The DHCFP was processing them for Senior Rx; however, not paying them. The DHCFP was processing the co-pay for them. When part D originally came out, the plans did not have to pay for benzodiazepine and barbiturates. With the ACA it changed and CMS told part D plans that they need to cover benzodiazepine and barbiturates. The DHCFP had it in their SPA that as a payer of the last resort part D would need to start picking this up. CMS wanted an assurance in the State Plan stating the DHCFP would not pay for benzodiazepine and barbiturates. This is not a policy change because the DHCFP is the payer of last resort.

Ms. Squartsoff continued a SPA was approved that addressed the Recovery Audit Contractor (RAC). For those RACs that wanted to do medical recovery audit contracts that they need to have a full time medical director.

The DHCFP continues to have regular meetings in regard to the health exchange. They are having more meetings within the different divisions to look at the issues

that affect more than just the Medicaid where there is an interaction between mental health, health division and other divisions.

Ms. Squartsoff asked for any questions.

No further questions were asked.

VI. Presentation on The Implementation of Nevada's State Based Exchange by Jon Hager

Mr. Jon Hager went through the presentation. See attached.

Dr. Fiore asked if they will consider showing the premium and if there is a way to hone down on how accurate it is. As people put in more information will it narrow the range or will certain plans give you a more predictable outcome.

Mr. Hagar responded not in the first year. Right now they are trying to provide as much as they can. October 1, 2013, is 168 days away. It is a great idea for a future year. For premiums it will be the exact premium. The Advance Premium Tax Credit (APTC) is based on what they expect your income to be that year. The APTC can change when people do their taxes on actual income. If income changes or if family dynamics change, it needs to be reported so there are not major tax issues at the end of the year. For the out-of-pocket costs it would be helpful to have a range. People are going to want to know what the three best plans are and be able to choose. Each plan has an actuarial value. This does not cover the premiums, deductable or the out-of-pocket maximum. The actuarial value is designed to allow comparison of similar plans.

Ms. Lawanda Fred asked how the Indian population will be affected.

Mr. Hagar responded if a person's income is between 138% and 400% of the Federal Poverty Level (FPL), then they are eligible for a tax credit. For tribe members, the APTC applies; they will still have to pay the amount. For tribe members who are under 300% FPL, there is no cost sharing for any plan that they choose. They will likely choose the Bronze plan, it is the less expensive plan and the entire deductable will be paid by CMS. Regardless of the income level if they go to a tribal clinic or tribal health center there will be no cost sharing no matter what the income level is. When a tribal member goes to an organization that is 100% paid by CMS the health plan will pay 100% of the cost and they will calculate what they would have paid and will bill CMS that amount. The final benefit to tribal members is they are allowed to enroll in a different plan every month. Most of the population is on an open enrollment once a year. There is a delay in the enrollment between 15 and 45 days. Tribe members do not have an open enrollment or special enrollment period; they can enroll once a month. They will still have a 15 to 45 day delay. Tribe members need to be aware every time they change plans the plan accumulators reset to zero. For individuals that are under the 300% FPL it does not make a difference. For more information on tribes go to 45 Code of Federal Regulation (CFR) 155.350.

Dr. Fiori has heard there is going to be a 6-8% increase. He is not sure this is going to reduce the Emergency Room (ER) visits unless the recipients will be seen quicker.

Mr. Steve Boline responded the rural hospitals are already seeing the majority of these people in the ER. There may be some outlying rural people accessing care through

Nevada Rural Health Centers. There is good to reasonable access to primary care in rural Nevada. It may have to be through the ER. In the rural hospitals, the ER is staffed by a family practice doctor or an internal medicine doctor. Each hospital only uses one ER physician at a time. Right now there is capacity. There are very few of the rural care primary care physicians that are seeing patients which would be quantified on a volume as being full time utilized. He believes there should be limited to no concern about them being able to take the patients and see them in a proper setting which would be a clinic setting.

Ms. Janet Belz asked for clarification regarding the standards that are going to be later blended in with what the insurance commissioner does with other plans. Each of those is an independent process, so how are you assuming those are going to be the same.

Mr. Hagar responded they are hoping they will be the same. The Division of Insurance (DOI) has attempted to vet the standards with the insurance industry and with certain providers. They hope to have most of the public process done by the time the board makes its decision next Wednesday. There will still be a public regulatory process at the DOI as soon as statute goes through. There is a possibility that some of the standards may change.

Mr. Dwight Hanson asked how concerned they are with the federal hub and being able to test it before October.

Mr. Hagar responded wave one testing started approximately two weeks ago. There is a testing schedule going forward so by October 1, 2013 all areas will be tested.

Mr. Hanson asked what is being done to prevent churn between Medicaid and the Exchange.

Mr. Hagar responded there are two parts to churn. One is the number of people that churn and the other is the impact of the churn on the individual. They have required in the Request for Proposal (RFP) for the Medicaid Managed Care Organization (MCO) that the two vendors that provide a Medicaid MCO also provide a MCO transition Quality Health Plan (QHP) that has some characteristics of the Medicaid plan and the ability to transition people off the Medicaid plan on to a commercial product. They have similar networks so they are compatible.

Ms. Aiello responded the DWSS answered that the process has not changed historically. People are looked at once a year; however people have to notify the DWSS if there is a significant change.

Mr. Hagar responded all of the populations can go through the exchange. They will be notified if they are Medicaid eligible or Exchange eligible.

VII. DHCFP Reports

- **Nevada's Long Term Support Services Vision by Elizabeth Aiello**

  Ms. Elizabeth Aiello went through the presentation. See Attached.

  No questions asked.

- **Update on the Fee-for-Service Dental Program by Jon Kirwan**

  Mr. Jon Kirwan introduced Josh Etchegoyhen. Mr. Kirwan responded to the question from the last meeting as to how they can assist families who may be underinsured. He has reached out to Northern Nevada Oral Health, the Advocacy Committee for Oral Health (ACForOH) and the DWSS asking how they can assist families. He is working on identifying what codes the dental hygienists can bill in the billing guide. They do have to bill within the scope of practice. Mr. Etchegoyhen will be working on the school based project and he will be going through the Medicaid Management Information System (MMIS) dental code to ensure payment is being made as intended.

  Dr. Jade Miller asked what they will be looking for.

  Mr. Kirwan responded MMIS has a number of edits that states pay under these conditions. Mr. Etchegoyhen will be verifying the edits listed is what is intended in policy.

  Dr. Miller commented as a pediatric dental practitioner there is the population that requires general anesthesia. Approximately two years ago there was a significant reduction in reimbursement to the anesthesiologist and the hospital services. It has created a crisis. There are anesthesia groups that will no longer provide care.

  Ms. Aiello responded this is one of the areas they have a partial rate restoration in the budget.

- **Update on the status of CMS's Approval on the 1115 Research and Demonstration Waiver Application by Jennifer White and Jennifer Bonk**

  Ms. Jennifer White introduced Ms. Jennifer Bonk.

  Ms. Bonk reported the DHCFP submitted a request for an 1115 Research and Demonstration Waiver to CMS in April 2012. Once it is approved, the DHCFP will develop and implement programs for the Medicaid Fee-for-Service (FFS) population, specifically those with chronic conditions or high risk service utilization patterns who can most benefit from care management.

  The goal is to improve healthcare quality to the chronically ill FFS Medicaid recipient without increasing costs, ensure maximum efficiency of resources and reduce duplication of services. The waiver will be implemented in phases. In the first phase the Care Management Organization (CMO) will design a program in which individuals with qualifying health conditions will be automatically enrolled in care management and be assigned to a care manager. The care manager will be a qualified nurse who will provide numerous services to the enrollees. The plan was to implement medical and health homes once the CMO was in place; however, CMS has decided not to approve this part of the waiver at this time. The DHCFP will pursue CMS approval following the establishment of the CMO. Once the CMO is established and a few medical homes are implemented, the next step will be an evaluation of the initial phase. They will look at which methods produced the best results. Then an expansion of the CMO to the excluded populations will be considered. Discussions continue between Nevada and CMS

regarding the approval of the Waiver. Once the Waiver is approved, The DHCFP will sign a contract with the approved CMO vendor, and begin by educating providers and members of the community across Nevada. As this program is implemented, the Medical Care Advisory Committee (MCAC) will be relied upon as a valuable advisory resource.

Dr. Fluitt asked how they determine at risk patients.

Ms. Bonk responded they have a list of qualifying conditions. The recipient would need to fall under one of the categories eg: cancer.

Ms. White responded they have some other triggers as well eg: high utilizers over $100,000.

Ms. Aiello commented this group will be helping people when they transition out of hospital admits, ensure they get to medical appointments, etc. This will be a tool for physicians to use. It will be important that the physicians are involved. The DHCFP will be asking this committee for assistance in reaching out to the physicians.

Ms. Epidendio asked why it is taking so long.

Ms. White responded they have been told it can take two years plus for a demonstration and research waiver. They are actually right on track.

Ms. Aiello responded this is very different than the 1915c waivers.

- **Update on Behavioral Health Program by Alexis Ulrich**

Ms. Alexis Ulrich reported they are updating policy. They are looking at day treatment, substance abuse and individual versus group therapy. They will be clarifying language and strengthening policy.

Ms. Lawrence commented they will be strengthening the milieu in day treatment. The population is very different for adults and children. They will be strengthening policy which will also help to defer fraud. Individual versus group is to defer fraud. Substance abuse is an outreach policy. It is already in policy however it is hard for people to see. They have had mental health parity for at least the last 12 years. They will restructure the writing for clarification.

Mr. Scott Mayne asked regarding the monthly calls happening with behavioral health.

Ms. Lawrence responded they will start again next month.

Mr. Mayne asked if there were changes in the family and group rates.

Ms. Lawrence responded the rates transferred over with the new codes. There were no changes.

- **Health Care Reform – DHCFP Benefit Design Update by Coleen Lawrence**

  Ms. Coleen Lawrence reported they are currently reimbursing for well exams. It is web announcement 580.

  Ms. Lawrence presented the DHCFP Benefit Design update (see attached).

  The goal of the DHCFP is to create an alternative benefit plan for the newly eligible's. They are the required essential health benefits that were defined in the PPACA in section 2001. There are ten categories. The current Medicaid plan was built on Social Security Act, Section 1905. The new regulations are from Social Security Act, Section 1937. By choosing ten different statutes there is an immediate difference in the wording of the coverage service. Congress gave different categories. There are two options. One is the benchmark. The second option under Section 1937 is a benchmark equivalent. All of the services have to be included. The actuarial requires the DHCFP to contract out. This benefit would have CMS make the DHCFP use actuarial standards and not be at the service level comparison. Medicaid covers more expansive social services. Medicaid should be actuarial sound compared to the commercial market. Medicaid will still have to add the habilitation service because it is an essential health benefit. The DHCFP has contacted CMS to see how they are reading the regulation.

  Ms. Aiello commented the goal is to be able to offer the Medicaid product because that is what the DHCFP has worked with everyone and is what is in the budget.

  Mr. John Whaley asked if this will affect Nevada Check Up (NCU).

  Ms. Aiello responded it will not affect NCU.

VIII. For Possible Action: Review and Possible Approval of Marketing Materials for Managed Care Open Enrollment by Tracy Palmer

Ms. Tracy Palmer presented the proposed open enrollment marketing materials for HPN and Amerigroup.

Approved for dissemination.

IX. Public Comment

None

X. Adjournment

Ms. Peggy Epidendio adjourned the meeting on behalf of Chairwoman Rosaschi at 12.00 pm.

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