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:	July 16, 2013 9:00 AM
Place of meeting:	Silver State Health Insurance Exchange 2310 S. Carson Street, Suite 3A 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
Michael Ball, Board Member
Dr. Jade Miller, Board Member
Angie Wilson, Board Member

Board Members (Absent)
Tracey Green, Board Member
Dr. David Fiore, Board Member

Carson City
Coleen Lawrence, DHCFP
Gloria Macdonald, DHCFP
Darrin Dykes, JK Belz & Associates
Laura Rich, DHCFP
Lindsey Dermid-Grey, DHCFP
Nancy Hook, GBPCA
Marta Stagliano, DHCFP
Patty Thompson, DHCFP
Scott Larson, BMS
John Whaley, DHCFP
Shannon Sprout, DHCFP
Laurie Squartsoff, DHCFP
Jennifer Frischmann, DHCFP
Cynthia Magaña, DHCFP
Marti Coté, DHCFP
Sherrie McGee, DHCFP
Kati Baumruck, DHCFP
Kurt Karst, DHCFP
Joanna Jacob, Ferrari Public Affairs

Las Vegas
Jason Bouchard, DHCFP
Ralph Kevin Spencer, New Progressions
Brendeen Spencer, New Progressions
Viki Kinnikin, Mojave
Jim Parcells, Unisom/Mojave
Dan Musgrove, Amerigroup

I. Call to Order:

Chairwoman Rosaschi called the meeting to order at 9:05 am.

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 April 16, 2013

The April 16, 2013 minutes were approved.

V. Administrator's Report by Laurie Squartsoff

- **Legislative Update**

Ms. Squartsoff reported the budget was mostly accepted as presented to the Legislature. The Division of Health Care Financing and Policy (DHCFP) will take all of the recommendations by the Legislature with State Plan Amendments (SPA) changes, program changes, and make the necessary requirements and updates to the program to meet all of the guidance from the Legislature for the next biennium.

- **Medicaid Services Manual Revisions**

There have been five updates in the last few months. Medicaid Services Manual (MSM) Chapter 600 Physician Services - the billing references have been moved to the billing section and have come out of the MSM; MSM Chapter 1200 Prescribed Drugs - additions were made to the manual pursuant to the guidance from the Drug Utilization Review Board (DUR) and there are also new criteria in the chapter related to the new medications added to the preferred drug list; MSM Chapter 1500 Healthy Kids – revisions were made to update the immunization and periodicity schedules and revised internet website addresses; MSM Chapter 2300 Home and Community Based Waiver (HCBW) for Persons with Physical Disabilities – there were some changes to the application process; MSM Chapter 3400 Telehealth Services – revisions were made to include clinical staff employed and determined by a state mental health agency to meet established class specifications for Mental Health Counselors, Clinical Social Workers, or Psychological Assistants.

- **Nevada State Plan Amendment Updates**

There are several State Plan Amendments (SPAs) that were submitted to Centers for Medicare and Medicaid Services (CMS).

SPA 13-005 Free-Standing Nursing Facilities and the adjustment in the $2.50 per day has an effective date of July 1, 2013.

SPA 13-006 Special Care Rates. This SPA was submitted with a requested approval date of July 1, 2013 regarding the reimbursement for Behaviorally Complex Add-on rates for

persons who are in nursing facilities. The categories are defined by numbers of hours of care required by each recipient and each one is evaluated on a case by case basis.

SPA 13-007 Ambulatory Surgical Centers – An update to the reimbursement for Ambulatory Surgical Centers has an effective date of July 1, 2013.

SPA 13-008 Rate Increases for Anesthesia, Obstetrics, and Pediatric Enhancement for Surgical rates. These rates were all approved by the Legislature; so the SPA was submitted to CMS for approval and has an effective date of July 1, 2013.

SPA 13-009 Emergency Transportation – a current rate increase of 15% will go into effect on July 1, 2013.

SPA 13-010 Dental Services – An increase in the dental rates will go into effect July 1, 2013.

Dr. Jade Miller asked what the increase was and is it by procedure or overall rate increase.

Ms. Squartsoff responded it is an overall increase in the conversion factor of 5.07%.

SPA 13-011 Disproportionate Share Hospitals (DSH) – Changes in the allocation to DSH hospitals will start to decrease as the DHCFP transitions with the Affordable Care Act (ACA). This will clearly define the process and implementation.

The following SPAS have been approved by CMS for the quarter of April – June 2013:

SPA 11-016 Adult Day Health Care (ADHC) – There was a change in the reimbursement methodology.

SPA 12-003 – Non-Emergency Paratransit Transportation Services – Cost-base Services.

SPA 12-008 Personal Needs Allowance and TANF – The effective date is April 1, 2013, this SPA updates the personal needs allowance and income disregards so all are current.

SPA 13-002 Primary Care Physician (PCP) Rate Increase – Allows for the PCP to receive the increase as a result of ACA also known as the “PCP Bump” effective January 1, 2013.

SPA 13-004 Preventive Services – Clarifies the coverage of adult vaccines so the agency is eligible for the additional 1% FMap to cover the services.

Ms. Peggy Epidendio asked if the new information on the periodicity schedule in MSM Chapter 1500 Health Kids had changed.

Ms. Squartsoff responded the periodicity schedule that was in the MSM was one that was several years old.

Ms. Marti Coté responded the DHCFP refers to the Georgetown Bright Futures periodicity schedule so it will always be an updated periodicity schedule.
Ms. Epidendio asked how the behaviorally complex long term care recipients would be evaluated on a case-by-case basis and will it be done by paper submission, staff

evaluation, on-site checking of the recipients and how it is determined they are behaviorally complex and qualify for reimbursement.

Ms. Squartsoff responded these are done by staff at the facility and the review is done by the specialist when they go and do the assessments at the nursing facilities.

Chairwoman Rosachi asked what the process is when the DHCFP submits the SPAs to Centers for Medicare and Medicaid Services (CMS) and how long it takes for a response.

Ms. Squartsoff responded once the SPA has been submitted CMS has 90 days to respond. It can take six month to a year to get final approval from CMS if they have additional questions, due to each request having its own timeframe.

Mr. Mike Ball asked if there is certain criterion the behaviorally complex individual has to meet in order to qualify as behaviorally complex or is it done by a competency evaluation.

Ms. Squartsoff will send the requirements to Mr. Ball.

Dr. Miller commented the increase of the .07% is a reinstatement of cuts from earlier. In looking at the ACA and the 150,000 or so new children that will be coming on board, his concern for pediatric dental services and ensuring the children are taken care of. The concern is the children not having access to providers. Unlike the physician, where in many cases, hospitals have technology and services, in a private practice situation, they have to create this, so the business overhead is higher and in his experience for every dollar of Medicaid that the patients he treats, he is losing approximately 20 cents. He does not get reimbursed to cover his cost. The private practice patients are helping supplement to cover those patients. Another issue they are facing is they are not getting reimbursed for topical fluoride because there has not been a fee assigned to it and that's a provided benefit. Since January that is over $8,000 of unreimbursed services.

Ms. Coté asked Dr. Miller to provide her with the code he has been using to bill the topical fluoride service.

Ms. Squartsoff responded they are all concerned about the impact with the ACA and the expansion population and the 156,000 new beneficiaries expected to come into the program are those adults who have been uninsured between the ages of 19 and 64. This is where the DHCFP expects the bulk of the impact to be on the program; however, there are concerns statewide in terms of access to providers. Nevada is not like most states where the provider group is going to continue to stay fairly static, but they are all going to have more people accessing the programs and that is an issue for everyone, whether they are Medicaid of FFS because providers are going to be seeing more people. Whatever ideas you may have, let us know. The DHCFP is cognizant of the fact that for the last several years they have had cuts to reimbursements. The DHCFP will do what they can and make proposals within the program. The legislative session has ended and as soon as the bills are signed, the DHCFP will be expanding roles of different programs and working on improving the efficiencies of the programs.

Dr. Miller commented that he is excited about the expansion because this population did not have access to services previously.
Ms. Squartsoff responded this group principally received their services in emergency rooms where their coverage was not reimbursed by a primary payor. Nevada is on target

for having everything set in place, working with the Exchange, the Division of Welfare and Supportive Services (DWSS) received their approval for their additional 411 staff for eligibility workers. There are a number of programs expanding, so if there is someone else the DHCFP needs to meet with or if there are other ideas you may have, please feel free to share them.

The 1115 Waiver presented almost two years ago to CMS received approval on June 28, 2013. This is the Care Management Organization (CMO) waiver and this program is intended to provide care management for Fee-for-Service (FFS) Medicaid beneficiaries. The DHCFP has two Managed Care Organizations (MCOs) that take care of the bulk of the beneficiaries. Currently it is approximately 68%, and with the expansion they expect it will go up to 85%. That still leaves 15% who continue to receive services for FFS so the CMO will help coordinate the care for those patients with the goal that will have improved outcomes and lower long term costs. The goal was to have this approved before July 1, 2013. This is the first portion of this waiver, the DHCFP is optimistic and energized by the fact it has the focus of the governor and his staff to make sure they are providing quality services to both the FFS and Managed Care beneficiaries. The Business Lines staff is making an effort to ensure the goals of this waiver are put into place.

Chairwoman Rosaschi thanked Ms. Squartsoff and Dr. Miller for his input as well.

VI. DHCFP Reports

- **Nevada's Long Term Support Services Committee by Gloria Macdonald**
  - **Money Follows the Person (MFP) Grant**
  - **Follow up on Long Term Support Service Quality Committee**

Ms. Gloria Macdonald presented the attached presentation. (See attached)

Chairwoman Rosachi commented the DHCFP has multiple agencies that were represented and while they have a like policy throughout, each organization must have an approval process. When it is brought to the MCAC committee, will it have completed the entire approval process? Once the MCAC gives input, how do they make sure everyone is in sync with the recommendation or if the MCAC likes what is being proposed to proceed?

Ms. Macdonald responded the MCAC can offer any comments and/or suggestions along the way. It is going to be a process and part of the process is going to be identifying those leadership participants that they will need to bring their recommendations to. Because there are so many programs, forms and processes to review, they are going to develop it along the way and eventually have their strategy to present and start pulling in those decision makers they will need to get buy-in for and present to them as well.

Chairwoman Rosaschi asked if the MCAC was a decision maker or not.

Ms. Macdonald responded the MCAC is considered to be an advisor and can participate however you see fit. They certainly would want to get the approval of the MCAC. Perhaps they can identify the MCAC as part of the leadership structure.

Dr. David Fluitt commented with all of the planning that has been done with the new program, Ms. Macdonald will be able to make decisions independent of MCAC input.

What would the priorities be with the new program? When they bring the priorities to the MCAC will the MCAC be able to be involved in that process.

Ms. Macdonald replied the Quality Assurance (QA) process is one of the benchmarks of the Money Follows the Person (MFP) grant. It was included in the operational protocol that they take a look at what is being done on a QA level and start unifying those processes across divisions. Providers have complaints and concerns about being hit four to five times a year by several different divisions for a review and if they ask them to implement changes, it can become tiresome for them. They need to collaborate and collectively develop a process. The QA unit is revising how they do things regarding the health and welfare of the participants. The DHCFP is collaborating with the different divisions, working with the waiver programs, and participants in a more collaborative approach.

Dr. Miller agreed with Dr. Fluitt in eliminating the barriers for providers and increasing the efficiencies across divisions. In looking at the timeline from May 2013 to April 2015 to integrate this on QA model, will there be three different entities doing their own QA plus this one running parallel or is the plan in April 2015 to discontinue the three QAs to one unified system.

Ms. Macdonald responded each division has their own forms and assessments, so they are working on all of that. Elizabeth Aiello is a key participant in the committee as well as the deputies in the other divisions. The MCAC is invited to come to the meetings.

Mr. Ball asked if this has to do with the Quality Indicator Survey (QIS) process for Long Term Care Facilities.

Ms. Macdonald responded she was not sure as she does not deal with the actual programs. CMS is trying to move states toward a national approach quality measures in general.

Chairwoman Rosaschi asked Ms. Macdonald when the next meeting will be held, so they can attend.

Ms. Macdonald will include the MCAC in the invite.

- **Overview and Presentation on the Audit Program by Patty Thompson**

Ms. Patty Thompson went through the presentation. (See attached).

Successful program integrity requires a comprehensive multi-pronged approach which means that almost every unit with the division performs some kind of program integrity activity. Program integrity is defined as setting policy and managing the program to insure that health, long term care and other services are provided to beneficiaries as effectively and efficiently as possible. This means all elements of the program must be functioning well; claims processing, provider payment, provider enrollment, provider education, quality assurance and clinical management. Program integrity starts with enrolling quality providers and continues with sufficient oversight and monitoring to know early on when provider or claims payment issues become problematic.
Dr. Jade Miller asked if someone wanted to know more about the Electronic Health Records (EHR) incentives, what they qualify for and/or the program, how they should be directed.

Mr. Thompson responded there is a link on the DHCFP website, EHR Provider Incentive Payment Program.

Dr. Miller suggested more outreach as a number of providers are not aware of the program.

Suggestions included attending committee meetings, use of quarterly magazines through the Nevada Dental Association and the Northern and Southern Nevada Dental Society, newsletters for medical providers and tribal health outreach.

Dr. Fluitt commented that an outreach option may be to go to the hospitals that are buying out the primary care physician groups and the specialty groups. They have been developing their programs and medical records.

Ms. Thompson responded the regular physician has to have 30% Medicaid in volume compared to their total volume, so that may be a barrier since it is a federal regulation.

Dr. Miller asked if this is the same with dental providers.

Ms. Thompson responded yes and it cannot include Nevada Check Up, which is problematic.

Ms. Wilson asked for clarification as she has had this challenge. She was informed that they either had to have 30% of the population covered with Medicaid or they could use their non-covered population as well.

Ms. Thompson confirmed Indian Health Centers, Federally Qualified Health Centers (FQHC's) and Rural Health Centers are able to include the needy population, which includes Nevada Check Up and the sliding scale population. This only applies to those three entities.

- **Information Services Updates by Sherri McGee**
  - **ICD-10**
  - **MITA Assessment**
  - **MMIS Replacement Planning**

Ms. Sherri McGee went through the presentation. (See attached).

Chairwoman Rosaschi asked if this included the interface the DHCFP has with organizations such as the Division of Welfare and Supportive Services (DWSS).

Ms. McGee responded yes, it will be aligning the DHCFP interfaces with the DWSS as they are redesigning their eligibility engine and interfaces with the Health Insurance Exchange as well.

Dr. Fluitt asked if the assessment would be completed by the first of the year and asked if the committee will be notified as to what the assessment is.

Ms. McGee confirmed and responded the DHCFP will have some of the deliverable from the vendor that is on site by the next MCAC meeting in October. The complete recommendation will be available in January.

Ms. Epidendio asked if the DHCFP would have to go back to the Legislature for the approval of the implementation process even though they received approval for the planning process from the Legislature.

Ms. McGee confirmed.

Dr. Miller asked if the DHCFP is going to form a cloud-type format in this technology conversion.

Ms. McGee responded it will be based on a service-oriented architecture and they may have a private cloud; however, that will depend on the recommendations.

Ms. Angie Wilson confirmed they are looking for a provider representative for the ICD-10 Steering Committee and asked if it would be possible to consider a tribal representative for the committee as well.

Ms. McGee confirmed and will pass her contact information on to Ms. Squartsoff who is heading up that portion.

- **Provider Enrollment Changes from the Affordable Care Act (ACA) by Jennifer Frischmann**

Ms. Jennifer Frischmann reported she met with MCAC approximately 18 months prior regarding the ACA requirements for provider enrollment and screening. Nevada recognized provider screening including checking databases, validating licenses, on-site visits for providers that CMS has deemed as high risk such as Durable Medical Equipment (DME) companies and personal care agencies may be problematic and had implemented the site visits approximately five years ago. The DHCFP has been doing license verification checks and have unfortunately found providers or physicians will say they have an active license when it is actually suspended or revoked. This is not the norm and has already been addressed. The major concerns with ACA provider enrollment and screening have to do with application fees, the requirement that all ordering, prescribing, and referring practitioners are enrolled or registered with the Nevada Medicaid program; revalidation and additional information that need to be collected on ownership of providers.

Application Fees: CMS said it has not been finalized yet. Any institutional provider who enrolls in the Medicare program, i.e., hospitals, hospice agencies, larger provider groups have to pay approximately $512.00 if enrolled in the Medicare or Medicaid program. That fee is not applicable if they already enrolled in Medicare or another State's Medicaid program and paid the fee. The DHCFP is waiting for additional clarification from CMS.

Ordering, Prescribing and Referring (OPR) Practitioners: Anyone who orders prescribes or refers a service or prescription to a Medicaid recipient must be enrolled in the Medicaid program or the rendering provider will not get paid. The DHCFP has run some preliminary reports on the Point of Sale (POS) system for pharmacy and it is a very low number of providers who actually prescribe, but are not enrolled in the Medicaid system. Sometimes a recipient will reside in another state in a Long Term Care Facility (LTC) or a Residential Treatment Center (RTC) and they go offsite and have to get care and those providers are sometimes not enrolled. CMS has delayed implementation and they have

done some soft edits, so if the ordering physician isn't enrolled in Medicaid, the pharmacy will let them know. The DHCFP is working to develop system edits to identify when OPR is needed.

Point of Sale System (POS): The DHCFP already has this capability on POS system. They do not want to have pharmacies have their claims denied, so they have not done anything on the system.

Ownership and Disclosure Information: The DHCFP has always collected information on who owns the practice; however, CMS has expanded this. The DHCFP now needs to collect information on who owns the practice, anyone with a controlling interest, a list of all managing employers and employees for the business. The DHCFP will collect the name, date of birth and social security number of all individuals and will check federal databases, the Office of the Inspector General, the List of Excluded Individuals and Entities (LEIE), Excluded Parties Lists System (EPLS), now administered through the System for Award Management (SAM) which is a federal database that shows everyone who is prohibited from doing business with the federal government. The DHCFP also checks the Social Security Death Master File. If anyone shows up on the LEIE list, they are referred to the DHCFP for further review.

Revalidation or reenrollment: CMS recommended the DHCFP do a provider reenrollment. The DHCFP went with the 36 month recommendation from CMS and this started June 2012. During the first six months the return rate is approximately 17%. One of the barriers is getting the reenrollment notices to the correct addresses. CMS has deemed the entire State of Nevada as a state with access to care issues and it is a huge concern to all. The DHCFP is working with the fiscal agent to form a more streamlined and easier process for enrollment.

Dr. Fluitt clarified the DHCFP chose to not do the POS to deny a claim.

Ms. Frischmann responded the Pharmacy Benefit Manager has the capability of implementing the edit automatically if the NPI is not know on the POS system, they can deny the claim at the pharmacy; however, the DHCFP has not implemented it yet until CMS states it has to be implemented.

Dr. Miller asked if the fee will be for providers as well as for the institutional enrollee.

Ms. Frischmann responded the fee is for the institution providers.

Ms. Wilson commented most of the tribes have their own pharmacy on site as well. Tribes are looking at compacting those services outside of Indian Health Services and taking over those dollars to run their own tribal pharmacy programs. She asked that they do some outreach to the Tribal Health program because the regulation and how they operate are a little different than the rest of the health care population in the state.

Ms. Frischmann responded they can discuss the changes in their operating procedures and the billing. They can set up a consultation with the fiscal agent with billing questions. When implementation occurs they will have a public workshop and web announcements.
Ms. Epidendio mentioned Ms. Frischmann asked for suggestions for provider recruitment. She asked if it would be possible to make presentations at association meetings.

Ms. Frischmann responded yes.

Ms. Epidendio confirmed Nevada has the lowest incidence of providers nationally. She commented because of the difficulty the DHCFP has with securing providers she would ask them if it is because of the rates; are they available; and are they aware of what is out there for them as a Medicaid provider. Presenting that type of information may be helpful and the potential providers may not be aware.

Chairwoman Rosaschi commented the newsletters may be an opportunity for them.

VIII. For Possible Action: Review and Approval of Additional Marketing Materials by John Whaley

Mr. John Whaley reported four years ago the DHCFP implemented a lock-in policy for managed care, where if a member is in one of the two plans, they must stay there unless they have good cause to come out. Once a year the federal regulation states the DHCFP has to give the opportunity to switch, called the open enrollment period. During the open enrollment period is the only time during the year where the DHCFP allows the MCOs (AmericGroup and Health Plan of Nevada (HPN)) to send out marketing materials. The CMR 438.60 states the materials need to be reviewed by the committee and the MCAC did that at the previous meeting. Since that time the DHCFP found out that HPN had planned on doing a telephone campaign they did not think was marketing. The DHCFP believes it may cross the line of being marketing materials and therefore would like to get the approval of the MCAC to allow HPN to use the script.

Ms. Wilson commented sometimes it is confusing for the tribal members because they do not understand the difference between FFS and HMO and how it affects the tribal clinics.

Mr. Whaley responded this is their time of year when they get to keep people in their plan or get to convince them to switch from one plan to their plan. It is not a question of FFS or Managed Care; that is a very important issue and does need to be addressed, but not in this script.

Additional Marketing Materials approved.

IX. Public Comment

None

X. Adjournment

Chairwoman Rosaschi adjourned the meeting at 10:35 am

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