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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:	November 8, 2013 at 9:00 AM
Place of Meeting:	The State of Nevada Legislative Building 401 S. Carson Street, Room 2134 Carson City, Nevada 89701
Place of Video Conference:	Grant Sawyer Office Building 555 E. Washington Avenue, Suite 4412E Las Vegas, Nevada 89101

Attendees

Board Members (Present)
Rota Rosaschi, Chairwoman
Peggy Epidendio, Board Member
David Fluitt, Board Member
Michael Ball, Board Member
Angie Wilson, Board Member

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

Carson City
Amy Crowe, DAG
Jenni Bonk, DHCFP
Theresa Carsten, DHCFP
Judy Kroshus, Pyramid Lake Clinic
Elizabeth Aiello, DHCFP
Grade Tarbuitar, Washoe County
April Caughron, DHCFP
Nancy Hook, GBCA
Charles Duarte, CHA
Dwight Hanson, NV. Hospital Association
Marti Coté, DHCFP
Michele Belkin, DHCFP
Jennifer Frischmann, DHCFP
Alex Tancheck, SK Belz and Associates
Lana Tarbuitar
Marta Stagliano, DHCFP
Steven Dente, SSHIE
Ecisa Cafferath, NAPPA
John Whaley, DHCFP
Laura Palotas, DHCFP

Las Vegas
Jim Parcells, UNSOM – Mojave
Vikki Kinnikin, Mojave
Judye Marshall, LVIC
Greg Gibbs, 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

No Comments

IV. For Possible Action: Review and Approve Meeting Minutes from July 16, 2013

The July 16, 2013 minutes approved as written.

V. Administrator's Report by Laurie Squartsoff

Ms. Laurie Squartsoff reported the Division of Health Care Financing and Policy (DHCFP) have made changes to improve communications. The Compliance Unit is now the Program Integrity Unit, the Audit Unit is the Fiscal Integrity Unit, the Program Services Unit is the Benefit Policy Unit and the Continuum of Care Unit is the Long Term Support Services Unit. She introduced Jennifer Frischmann as the new Chief of the Long Term Support Services Unit.

The DHCFP has continued to make changes to the Medicaid Services Manuals (MSM) in response to the Affordable Care Act (ACA). There are several State Plan Amendments (SPA)s that have been submitted to the federal government related to the Alternative Benefit Plan (ABP) and progress is being made. The DHCFP expects to be ready by January 1st. The DHCFP is expecting an additional 146,000 Nevadans who will become eligible for Nevada Medicaid through 2015. The DHCFP recently held the annual Hewlett Packard Enterprise Services (HPES) provider workshop. This year they provided an overview of Medicaid; the changes and challenges of the last few months; what the ACA has brought to the program. There were specialists to discuss provider outreach, the Medicaid Fraud and Control Unit (MFCU), Electronic Health Records (EHR) so providers understand the collaborative effort between the State, Federal Government and providers; and the additional resources available to assist them with the transition to electronic records.

Chairwoman Rosaschi asked about the number of participants at the provider workshop.

Ms. Squartsoff responded the number of participants reported is larger than has historically attended. With all of the changes happening with the ACA nationwide there are issues being brought to the forefront by providers in terms of continuity of care, access to providers, whether or not there will be sufficient numbers of primary care physicians and dentists to provide services. As the DHCFP has more time in the community they can get the input and provide the information to the Rates Unit and they in turn are doing evaluations on how those changes and what the impact on the provider network will be. It is important for all to have the conversation and talk about what can be done with the School of Medicine, Universities, and the J-1Visas to ensure that there is access to more providers.

Ms. Angie Wilson asked about getting access to Medicaid. She said in regard to Provider Type 47 it has been a challenge to get people access to Medicaid with the 64 page application and the trouble they have had in getting people signed up through the electronic system and accessing that. There is a lot of concern in regard to how is Medicaid addressing those issues with Nevada Health Link.

Ms. Squartsoff responded the next speaker Mr. Dente will be able to give additional information on Nevada Health Link. The DHCFP is working closely with the Division of Welfare and Supportive Services (DWSS) to ensure there is more outreach and if there is an opportunity for staff to be trained as Certified Application Counselors (CAC) the DHCFP can help coordinate it with Nevada Health Link or DWSS.

VI. Nevada Health Link Update by Steven Dente

Mr. Steven Dente presented the update for Nevada Health Link. They launched 17 minutes after they had anticipated. They were able to get people through the application process and enroll and pay for plans. There were some account creation and identity proofing issues. This adversely affected people creating accounts easily and quickly. Most of the issues were remedied in the subsequent days. Through October 15th, they were focusing on smoothing out the process. They were taking the information they were getting from consumers, CACs, navigators, brokers and agents as to the issues they were having with the portal. Nevada Health Link passed along the information to the developers to implement new information into the system. They have been working with the media to cover both positive and negative aspects of Nevada Health Link. Due to some of the issues they have delayed the call to action. It has been pushed to November in order to ensure customers have the best possible experience on the website. They want to guide consumers to in person assistance if they are having issues. They have over 1600 appointed insurance agents and brokers working with the clients that have been trained through Nevada Health Link. They have 140 navigators and enrollment assisters as well. CACs are constantly increasing as well. All of these people are in communication with Nevada Health Link to ensure the issues are being heard. The marketing wrapped up on November first. The message is get covered and be covered by January 1st. The door-to-door campaign is starting. They are going to see a huge push of people going into Medicaid and Nevada Health Link. They still have roadmap for feature implementation that is in development, features of the website and out of pocket costs calculator. As of October 30, 2013, there have been 228,598 unique visitors to the website, 15,556 applications, 2 million single streamline application page views and 27,278 calls fielded at the call center. As of November 6, 2013, they have 8,800 applications covering 14,819 people. The goal is still 118,000 individuals by March 31, 2014 and 3,500 individuals through our small business health options program. That will close out the open enrollment.

Ms. Angie Wilson asked how many CACs have completed the certification.

Mr. Dante responded he is not sure on the CACs as he has not received an updated number. As of November 6, 2013, they had approximately 50. He clarified these people have taken the Nevada Health Link training but not fully passed through the Division Insurance Licensure and AD Banker course. That is just one part of the process.

Ms. Wilson asked how many have completed all of the requirements.

Mr. Dante responded he less than 50.

Ms. Wilson asked for clarification. They are getting a number of calls in the Tribal Programs for Non-American Indian or Alaskan Native beneficiaries. They are receiving a number of calls for a population they do not serve.

Mr. Dante responded people being sent everywhere. People need to go through the call center for Medicaid or for qualified health plans on Nevada Health Link. They are making sure the people are trained and not passing the calls along and making sure they are the last stop. There are exceptions. Everyone needs to go through the call center first and foremost.

Ms. Wilson sits on the CMS National Technical Advisory Group. She will be doing a presentation in approximately two weeks. One of the things they have asked is for a report on how Nevada Health Link has been implemented and the impact to American Indians and Alaskan Natives within the state. There are specific provisions for American Indians and Alaskan Natives that are enrolled members of the federally recognized tribe. The information on the Nevada Health Link doesn't clearly detail the difference between enrolled members. In the law the definition of an Indian is an issue. For enrolled members the provisions are basically cover enrolled members. The descendents which is a huge issue in the Indian country were not covered with the definition of an Indian, so President Obama signed a waiver exempting the descendents of federally recognized tribes to be exempt from the individual mandate. The problem is the information on the Nevada Health Link isn't very clear and doesn't address the hardship waiver for descendents. There are a lot of questions they are getting at a tribal level, at the individual clinics asking what they are supposed to do, will they be fined. The provisions are different for Indians, so that needs to be a little clearer. There is no information at all as to whether they are supposed to apply for the statutory exemption for enrolled member or the hardship exemption for descendents within this state. That information is coming out and is everywhere in regard to Indian country for the federal market place; however, there has been nothing that has come out on the state based exchange. In the meeting they were told they don't need to do anything but show their tribal ID card and then a few minutes later they were told they need to file for an exemption but there is no information regarding that. When they go to the Nevada Health Link there is no information on the link in regard to tribal sponsorship of the premiums. These are concerns for Provider Type 47. There are serious concerns regarding this.

Mr. Dente responded that was the whole purpose of their tribal consultations. Unfortunately, there is so much happening and they have to work with their business operating system to make sure there is functionality in place to give credence to all of the information they are receiving. He suggested submitting the concerns in writing to ensure they receive the information and can address the issue. The operating officer and developer will work to ensure the information is consistent and clear as to what they are asking for from the tribal population to prove their federally recognized status so they are eligible for the same benefits the ACA has outlined for the first generation federally recognized tribe members.

Ms. Wilson commented they have submitted it in writing several times and have not received any response as yet. She will go to the board meeting. They are trying to get a better understanding as to how Nevada Medicaid applications are happening within the state. They work closely with DWSS but it seems like the change has happened over to Nevada Health Link in regard to sending those applications through. They have discussed different application processes they would use for Nevada Medicaid. At the most recent tribal consultation they were instructed it would be a 64 page application. The questions from the tribes have been where do they to get the applications; are they supposed to print out one for every applicant; what is happening with the electronic system and is Medicaid now going

through Nevada Health Link. Tribal members are being told they need to send off their original tribal id cards along with their original birth certificates and send those to Nevada Health Link that there was no way around that.

Mr. Dente responded they do not want the originals. They want copies of identity proofing or income verification. The idea is Nevada Health Link is a one stop shop whether the person is Medicaid or Qualified Health Plan (QHP) eligible. Unfortunately, there were issues with the system in the beginning and there was an instant need for people that were working for Medicaid clientele to use the paper application. There is an issue with that because the application is 64 pages and takes 45 days to process so people in need of immediate care is not going to get that from the paper application. Ultimately, the applications are going to DWSS whether they are sent via the system or by paper. The paper application has to be entered into Nevada Health Link first and be manually input into the system which is quite tedious. Then the information is given to DWSS in order for a case worker to contact the person once their information is processed. Unfortunately, the paper application has become the go to for people who are having issues with the computer system. The goal is to use the computer system whenever possible to avoid the paper application.

Ms. Wilson commented there have been major issues regarding the electronic system in getting people through it for Medicaid. She realizes Nevada Health Link's primary purpose is to sign people up for health insurance that is over the 138% FPL and under the age of 65. Have they been looking at the process of signing people up for Medicaid through the electronic system? When they call Medicaid the Medicaid offices are refusing to take applications. The instruction being received is the applications have to be sent via Nevada Health Link and the Medicaid offices cannot accept them. This is very frustrating. How are they addressing Nevada Medicaid expansion if they can't get people signed up.

Ms. Squartsoff responded she will take the concerns to DWSS and see what else can be done. The link through Nevada Health Link is the principle portal for the application process and the length of the application certainly is an issue that people are addressing and having conversations with Centers for Medicare and Medicaid Services (CMS). When a person applies for insurance and is appropriately eligible for Medicaid, the application should be routed to DWSS for review. They have made changes in where the offices accepting the paper applications are located so they are where the population is. The message across the board should be if a person needs to apply for assistance, the first way into the system is Nevada Health Link; however, if they need to do a paper application they can turn those into the Welfare offices and staff is doing what they can to process them. If there are places where they can better support the clinics in terms of how do people apply for Medicaid, they can continue to have outreach in terms of what phone number people need to contact for the call center

Ms. Squartsoff offered to assist in having a representative from DWSS attend the next tribal consultation and provide additional information.

VII. DHCFP Reports

- **Discussion of Provider Outreach and Marketing Strategies by Jennifer Frischmann**

  Ms. Jennifer Frischmann reported they have attempted to take steps internally to address these issues and make sure they do not encounter access to care issues.

Adding another 230,000 people within 16 months will put a strain on an already stressed health care system. The DHCFP wants to try and recruit new providers. They are reaching out to current providers and encouraging them to extend their services to additional Medicaid recipients and dispel some of the myths and stereotypes that providers may have regarding Nevada Medicaid and Nevada Medicaid recipients. In August the DHCFP was able to work with some people from DWSS. DWSS is working on a large outreach campaign to educate providers, the community and community resource partners as to the best way to apply for Medicaid benefits. In August they met with representatives from the State Board of Nursing for Advanced Nurse Practitioners and the Clark County Medical Society. They had field representatives from HPES with them. HPES has field representatives in the north and south that will help providers with their billing, enrollment, questions, and training on the web portal. It was an open meeting and very candid. The Provider Services Unit makes state staff accessible, so if there are questions and providers have exhausted their resources with HPES, they have someone direct to contact. In September they met with Northern Nevada HOPE and discussed their services and what the DHCFP can do to become better partners with them. The DHCFP also spoke with Great Basin Primary Care and Red Rock Meadows Medical Group, and at the annual Medicaid conference. The DHCFP presented at the Children's Medical Advisory Committee in Las Vegas in September. They had the opportunity to speak with Ms. Angie Wilson for the Tribal Directors meeting in October. The DHCFP is attempting to dispel the myths of the Medicaid patient being the hardest patient. The Care Management Organization (CMO) is coming on board, so hopefully individual recipients become more invested in their health care and take a more active role keeping their doctor appointments and understanding the benefit of preventative care. Medicaid has some of the lower reimbursements but they cover many services that commercial insurance packages do not. The DHCFP has a budget of approximately 2.5 billion dollars per year and less than 4% of that goes to administrative costs. They are the largest payer in the state. It is spread over 22,000 providers. In regard to slow reimbursements, years ago that was true; however, now the DHCFP has a weekly payment cycle to reimburse. Of course, the claims have to be accurate and clean. A number of commercial insurances reimburse on a monthly basis.

There are times when the current Medicaid Management Information System (MMIS) cannot handle certain things. The DHCFP is currently in the process of procuring a new MMIS system. That is a mega project and will not be completed, certified and implemented until roughly 2018. To put money into a system that is being replaced and is already antiquated sometimes doesn't make the best sense. Something that may be considered a simple change in actuality may cost the DHCFP $500,000. She asked for other avenues they can pursue for provider outreach and determining the issues the providers are facing and if they can maybe rectify them.

Ms. Wilson commented they appreciate the work they do. The DHCFP has been very responsive. They have had a great relationship with Medicaid.

Dr. Michael Ball asked what the thoughts and reasoning is behind the greater scope of coverage under the plan as opposed to a narrower scope and increasing the rate of reimbursement for the current and future providers.

Mr. John Whaley responded Medicaid is recipient focused more than provider focused. They want to get as much coverage to the recipient as possible. That is

where the concern is, that is why there is a wide array of services offered to the recipient. If the DHCFP offered half as many services, then they could increase the payment to providers significantly; however, but they choose to look at the frail and needy population in Nevada and offer them as much as possible.

Dr. Ball responded it can be recipient based but if they do not have the providers then it is not. If they do not meet the expectations of providers, then the providers will not step up and provide the services.

- **Discussion on Possible Coverage for Breast Cancer (BRCA) Testing by Marti Coté**

Ms. Marti Coté reported part of the ACA Section 106 discusses improving access to preventative services for eligible adults in Medicaid. That includes the services that are part of the United States Preventive Services Task Force (USPSTF). The USPSTF has recommendations A and recommendations B. As part of ACA they recommended any clinical preventive services assigned a grade of A or B by the USPSTF be covered. Currently what is covered is counseling for BRCA screening. Currently the USPSTF only recommends the actual counseling and not the testing. The task force has a draft recommendation for the actual testing be covered. The DHCFP will have a definitive recommendation between December and April. The DHCFP has included a draft policy in the meeting packet. The draft policy speaks to what the BRCA1 and BRCA2 genetic mutations are, what the policy would be, the coverage and limitations. In the research the DHCFP found that only 2% of the general population has the possible BRCA gene mutation. It will require prior authorization because they want to make sure that only those who fit the criteria are going to be covered by this. It is mandatory for genetic counseling to be done by this also. She asked for recommendations.

Dr. Ball asked what the science behind the advantage of doing this testing in terms of someone who hasn't had the testing and is treated for breast cancer.

Ms. Coté responded the testing is done two ways. It is done on those who have already had breast or ovarian cancer and have the gene mutation or for those who have a family history. Those who tested positive for the gene mutation may choose to have a prophylactic mastectomy thereby not needing the coverage for chemotherapy, radiation and subsequent hospitalizations and all that goes along with it.

- **Alternative Benefit Plan Update by Elizabeth Aiello**

Ms. Elizabeth Aiello reported in the ACA they are instructed to do an ABP. This has to meet the requirement of the ten essential categories or the ten essential health benefits. In the ABP the DHCFP had to look at the ten essential health benefits as well as some benchmark plans. Originally they received feedback from the stakeholders that they really wanted the expansion population to have the same Medicaid coverage as the current Medicaid population. The DHCFP also wanted the behavioral health coverage for the expansion population that is in Medicaid. The federal government said they were not able to adopt a Medicaid benefit plan and that the DHCFP had to choose one of the benchmark options in healthcare reform which was federal employees health benefit, state HMO, state employees coverage and

small business group coverage. The DHCFP chose the federal employees benefit plan because it looked closest to the Medicaid coverage Nevada has. The DHCFP had to look at each essential health benefit category and ensure they were all in Medicaid except for habilitative services which was prohibited under Title XIX and is now required in the ABP program. In the ACA some people who have never been covered would be expected to get Medicaid or exchange coverage, so some of the grants the federal government has been giving for uncovered care are going to decrease. The federal government plan allowed the DHCFP to substitute in an actuarially sound manner across the categories. The plans will not look exactly the same. The DHCFP ended up with a look a-like plan with habilitative services added. The DHCFP has been working with the Substance Abuse Prevention and Treatment Agency (SAPTA) providers in the state to refine the current substance abuse coverage. The Title XIX population will benefit from the ABP.

- **Substance Abuse Services Update by Theresa Carsten**

  Ms. Theresa Carsten reported the DHCFP is revising the medical coverage policy for substance use coverage, as a result of healthcare reform the Division of Public and Behavioral Health experienced a reduction to their federal SAPTA block grant. SAPTA agencies will now bill Medicaid for alcohol and drug services. Under current policy few SAPTA certified and funded agencies met the behavioral health community network model, thereby limiting their services, provider qualifications and reimbursement. The DHCFP has worked in collaboration with SAPTA and the Division of Public and Behavioral Health as well as the stakeholders to develop an evidence-based model structured from the American Society of Addiction Medicine (ASAM) that will support and enhance SAPTA provider qualifications and services. There have been three public workshops to date. On August 20, 2013 the DHCFP met with providers and discussed services are offered, who are the providers and what are their qualifications. The DHCFP provided the draft policy created from the ASAM model and asked if there was anything missing. They also reviewed the level of care grid. On the September 30, 2013, the DHCFP did a more specific inventory of provider qualifications and services for the detoxification providers. Providers also reviewed a draft of billable alcohol and drug codes; the draft proposed policy revisions and discussed clinical supervision standards and opioid maintenance therapies. The final public workshop was October 30, 2013, and they discussed rates and utilization management; had a final review of draft policy revisions with the providers regarding opioid dependence treatment and the difference between the newly developed substance abuse model and the behavioral health community network models. The final steps are to submit the substance use coverage policy for internal review. The public hearing date for Medicaid Services Manual Chapter 400 revisions is scheduled to be held January 9, 2014, and will be effective January 10, 2014 if approved. All of the forms provided at the public workshop are on the website provided to the Council.

  Chairwoman Rosaschi asked if the providers had discussed capacity with all of this. She is concerned there are always waiting lists and do they feel this process will alleviate some of those.

  Ms. Carsten responded this provider is for the current SAPTA certified and funded agencies. They had a minimal concern because right now the current policy is based around co-occurring disorder and not substance use only disorder. Some had concerns

about how they would treat mental health only. The DHCFP is working with them to finalize that section.

Ms. Aiello responded she believes the concern about provider capacity is for the Medicaid expansion population. These providers have been serving this clientele though there may be waitlists for a long time; however, the majority of the Medicaid expansion population will be going into the Managed Care Organizations (MCO)s. The expansion population will be going into MCOs with the exception of those in rural areas. The DHCFP has been working with the MCOs on a monthly basis in regard to network and capacity. The DHCFP is analyzing them with the external quality review organization. CMS is requiring the DHCFP to do a network adequacy study with the MCOs and where there are inadequacies they will be working to develop capacity. The DHCFP is bringing providers into the Medicaid network that has not been a part of it before. The DHCFP is expanding the provider qualifications that they are covering and working with the MCOs and their behavioral health networks to help develop capacity.

VIII. Discussion on the Implementation of the ACA Requirement for Ordering, Prescribing and Referring Providers for Pharmacy Benefits by Marta Stagliano

Ms. Marta Stagliano reported through the ACA it is required that the DHCFP has anyone that prescribes or refers Medicaid recipients for a service or a pharmacy prescription enrolled or registered with Medicaid. CMS's implementation date is now January 6, 2014. They will be implementing hard edits for the clinical labs for ordered tests, imaging centers for ordered imaging procedures, DME prosthetics, orthotic and supplies and also the part "A" home health agency. The DHCFP has been actively working toward an implementation; however, will not be ready on January 6, 2014. The DHCFP is looking at changes to the MMIS for the hard edits on Fee-for-Service (FFS) for professional claims only and Point of Sale (POS) system for the prescriptions. One thing the DHCFP found is when CMS implements this across the board for their Medicare claims, those claims will not be sent through the MMIS system because they will be denied. Providers will not be able to bill Medicaid the primary payer because they received a denial from Medicare. If they dropped it through clearinghouse or through paper and it came through Medicaid, it would still deny it because Medicaid has Medicare on file. There will not be an increase to the Medicaid expenditures because the providers have not gone into Medicare and have the referring providers known at that time. The DHCFP is asking how far in advance they should do soft edits, what type of outreach they can do. This has a huge impact to the Medicaid recipients and providers because this referring provider may not be known to Medicaid. What else can be done to make this as seamless with the least ramifications to the recipients and providers by the time the hard edits start.

Ms. April Caughron reported they are currently in the middle of implementing this project. They want to make sure that they take every step necessary to make sure and get the communication out. The DCHFP is making changes to the MMIS so they can identify the providers in this population before they move forward with hard edits. The first implementation will be what is considered a soft edit or an informational edit and then the hard edit.

Ms. Stagliano added they are trying to pull claims and data on file to find out if the providers referring are known to Medicaid, inactive or not known to Medicaid and not enrolled. The outreach to those individual groups will be different. When the DHCFP looked at the inactive

and not enrolled there were not the large numbers anticipated. The DHCFP is planning a smaller version application for those who want to be enrolled but not active, which means they will not be able to submit claims, they will be known to the MMIS or POS as a referring physician. There will be a new specialty type in the MMIS that will recognize this is not a billing or service provider; however, they can pass through a referral.

Chairwoman Rosaschi asked how this looks from the recipient's perspective.

Ms. Stagliano responded if a recipient goes to a non-Medicaid provider and receives a prescription. Now they go to the pharmacy and the request can be filled. The pharmacy would receive a soft edit stating the referring physician/provider is not known to Medicaid. Once the hard edit takes effect, the claim would be denied. The recipient would not receive their medication or if they did, the pharmacy would not receive payment.

Ms. Caughron requested feedback to assist in contacting the providers. They do not want to implement anything that will have a negative affect for the recipient or the providers.

Ms. Peggy Epidendio asked if they have any idea how many inactive providers there are.

Ms. Caughron responded approximately 200.

Ms. Stagliano commented another concern they have is providers may be using dump codes and they are trying to determine which providers are using these codes so they can correct it.

Ms. Wilson commented she will ask at the next directors meeting, all of the tribal clinics to look through their contract health providers and check which do not accept Medicaid.

Ms. Stagliano asked what would be a reasonable amount of time for a response for the soft edit prior to implementing the hard edit.

Mr. Fluitt responded from a pharmacist point of view that it needs to be a very short interval. He is interested in working with the DHCFP to determine they may be able to improve this from a pharmacist perspective. One of the complaints from providers is the rate of pay and that the pay is slow.

Ms. Stagliano responded when they implement a soft edit it would eliminate over the 45 days. They would have to gather the appropriate NPI's because on the 46th day a hard edit would go into place and if they continue to use a code that is not registered with Nevada, the claim will deny.

Ms. Stagliano asked if any of the MCAC members would be interested in participating in the stakeholder meetings for the MMIS replacement. It is a very long process and they are in the very beginning stages.

Chairwoman Rosaschi requested Ms. Stagliano give the information to Ms. Rita Mackie and have her distribute the information to the Council. Then members can respond accordingly.

Ms. Amy Crowe commented as a reminder if all of the members of the MCAC show up at the meetings, please do not go offline and start talking and making MCAC decisions.

- **Status update on the approved 1115 Research and Demonstration Waiver and Care Management by Jenni Bonk**

  Ms. Jenni Bonk provided background information on the 1115 Waiver. On June 28, 2013 they received approval for the Nevada Comprehensive Care Waiver (NCCW). It is a research and demonstration waiver. The first phase has been approved, which is the Care Management Organization (CMO). The notice of award went out in October to the selected vendor. They did not receive approval for the medical health homes component. CMS responded they wanted to see the CMO work properly and then later they can include it under the waiver. This is a five year research and demonstration waiver. The contract being taken to the Board of Examiners (BOE) is a three year contract with the option to extend an additional two years. The CMO looks at Nevada's sickest Medicaid recipients. These recipients are not being care managed and they do better when they are care managed. There is a list of qualifying health conditions along with a list of exclusions. CMS set up an enrollment range of 37,000 to 41,500 and the DHCFP has to stay within that range. The DHCFP anticipates enrollment to be approximately 40,000. If the numbers are exceeded the DHCFP will have to establish a waiting list protocol. Care Managers will be provided for all of the enrollees. The care manager has to be a Registered Nurse (RN) under the direction of a medical director who will be a physician. The RNs will integrate care. They will look at the person's medical condition, behavioral health, pharmaceutical needs and social issues. They will attempt to improve the health outcomes for this population. The DHCFP believes the CMO will reduce the inappropriate emergency room visits, better adherences to pharmacological prescriptions and preventative care visits, which will reduce costs. The selected CMO has indicated they will save the DHCFP money. The DHCFP has requested they also improve quality. There is a quality measure for every condition.

  The DHCFP is reaching out to the providers. If the providers do not buy into this, it will not be successful. The DHCFP will meet with the vendor and discuss an action plan to meet with providers and discuss the how to make this work. The anticipated date of recipients being accepted is February 2014.

  Chairwoman Rosaschi asked if the recipients will be identified by a code.

  Ms. Bonk responded it will be a diagnosis code.

  Ms. Aiello commented the largest factor is provider buy in. The care managers will be RNs; however, they are required to have a team of pharmacists, physicians, dietitians, psych behavioral health, so the entity will be similar to a health home wrap for providers. The CMO will be providing services for the providers. They will have people in the hospital, so when a recipient discharges, they make sure they receive their pharmacy and follow up on their appointments. If people are concerned about how they will get their dinner, they may not be thinking about going to the doctor. This will get better outcomes for the highest need population ensuring they are receiving primary care instead of emergency room care and decreasing the readmits. Unfortunately, the DHCFP is not funding different money to the providers. This will help the provider's patients receive better outcomes. The providers are still the center of the care. The CMO will ensure the recipient gets to the appointments and receives the care they may not be able to do alone. She requested everyone take this information to their groups to help with the provider buy in.

Chairwoman Rosaschi asked if social services are part of this.

Ms. Aiello responded it is the social, behavioral and medical. One of the issues the DHCFP has is CMS is not allowing this to be done this with the expansion population. If they are successful after a couple of years then CMS will allow the expansion population. It is a research and demonstration waiver so they do not have any track data. The DHCFP wants this to be very successful with the current population and then roll it out for everyone.

Chairwoman Rosaschi asked if this waiver was shared during the annual training with the providers.

Mr. John Whaley responded they gave a presentation. There was concern there would be more utilization control. There will not be any utilization management done by this group. There was a concern that they would try to get lower rates. The CMOs will not be doing that. Then they asked how they could help. They seem interested in wanting to help us help people.

Chairwoman Rosaschi asked if they gave a sense that the no show rates would decrease.

Mr. Whaley responded the group was excited that one of the things that CMO will do is contact and assist the recipient in setting up a ride to get to the appointment. The CMO will contact the day prior to remind them about the appointment and if they are not going to be able to keep it they need to call the doctor and cancel.

Chairwoman Rosaschi asked if they are going to ensure that all of the recipients meeting this criterion have at least a lifeline type of phone so that they can make that call.

Mr. Whaley confirmed.

Chairwoman Rosaschi asked how they are going to know this is working.

Mr. Whaley responded they would like to have the vendor present at the next MCAC meeting. They will be sending information back and forth with the providers to ensure there are not any issues. In doing this they will gather information as to what is and is not working.

Ms. Wilson commented what they are describing is similar to the tribal health care delivery system. If a Native American were to look at enrolling in the CMO are you saying that their care would then have to be coordinated by the CMO vendor.

Mr. Whaley responded they do not want to duplicate the effort. They want to be able to care manage the people who need it and are not already receiving this type of service. CMS has set a limit and if the DHCFP goes beyond the limit CMS will not pay their share of it.

IX. Public Comment

Mr. Charles Duarte congratulated Ms. Squartsoff and staff for doing such a tremendous job to move the DHCFP forward. They have worked extremely hard to do the things they are discussing today. One of the things that are a significant concern and significant component of improving the delivery system for FFS recipients with chronic disease was not approved and that was looking at enhanced reimbursement models and delivery models for personal patient centered medical homes. It is the trend across the US and it needs to be a key component of improving care. Where it is delivered how much it costs, reducing unnecessary care throughout the state for our Medicaid clients. Without financial support it will be extremely difficult to get the buy in of primary care practices throughout the state. One thing that is very important is the need to engage the providers. If you look at the summary what you see is that the diagnostic groups that are presented. Many of them are not necessarily directly treatable in a primary care setting. Primary Care Providers (PCP) would be involved and they will require the engagement of medical specialists throughout the state. Issues regarding reimbursement are a big concern and requiring specialists to take more time on their schedules to see Medicaid clients. It will probably require changes in reimbursement for specialty care as well as primary care. Hopefully CMS will approve some of the initiatives that were originally proposed. Without it there is a significant barrier to moving care management forward and improving the health of Medicaid recipients in Nevada.

Mr. Duarte continued regarding the new federal rules for ordering, prescribing, and referrals. His last day with the University of Nevada, School of Medicine (UNSOM) was October 31, 2013; he did bring this to their attention prior to leaving. They are very concerned this could complicate their operations and impact the services provided by over 400 medical residents. He recommended the DHCFP staff contact Dr. David Fiore and the UNSOM to discuss their concerns. This can have an operational affect on the way that resident physicians order, prescribe and refer for services.

An issue he became aware of when he started with the Community Health Alliance (CHA) was they have children waiting for hospital based dental services up to three months. Their current waitlist for children has the next appointment available in late March. In northern Nevada the large anesthesia groups are no longer taking these children or they are limiting their case lines to one or two per week, as these children are identified and being put on waiting lists. By the time they get into an Ambulatory Surgical Center (ASC) and have an anesthesiologist ready to go their condition of their teeth has degraded. In speaking with some of the dentists it is resulting in them pulling teeth instead of restoring teeth. This has to do specifically with reimbursement rates to anesthesia groups. There is only one anesthesia group in northern Nevada taking these children and they are only taking a few cases a week. Medicaid has the capacity to look at exception cases, not necessarily increasing rates across the board, but looking at exceptional cases, particularly with dental care for children.

He was happy to hear the DHCFP staff discuss with providers to ensure no shows are taken care of. The CHA runs a no show rate of approximately 20-25%. They are working with the two MCOs to get that resolved. For their FFS patients that will be an important initiative as well because that will be a significant concern if it occurs with new providers willing to take CMO patients.

CHA has put into the National Committee for Quality Assurance an application to be a Patient-Centered Medical Home (PCMH). They are very hopeful that the application will be approved in the next two months or so. It looks like they are going to be approved at a mid

level two PCMH by National Committee for Quality Assurance (NCQA). They will be one of the largest PCMH providers in northern Nevada.

He suggested the CMO reach out to the hospital CEOs. They are very interested in reducing inappropriate hospital and emergency room utilization. They can be real champions for this.

Mr. Whaley responded they have asked the MCOs regarding the anesthesiology and they are looking into it further. They have been told a many of the anesthesiologists have left the northern Nevada area. The increase in the need for anesthesia is in an inpatient setting for surgeries, so they do not really have the capacity at any cost to take care of this. They will respond as they find out more. Recently they have assigned one of the staff to look into the availability in Carson City and the ability to transport these children. They have heard Carson City does not have a similar shortage. Both of the MCOs have agreed in concept to contract with Carson City.

Mr. Duarte commented he will provide them with the information they have in regard to the delays they are experiencing. The other consequence of the delay is the children have to go through a physical examination and it has to be within 30 days of the surgery. They are losing their eligibility for surgerical services because they have to get another physical exam. So they have to get a physical exam every month as they are waiting to get chair time in the ASCs. It not only adds to the cost of surgical services, but also costs in primary care.

Chairwoman Rosaschi thanked Mr. Duarte for his comments.

X. Adjournment

Chairwoman Rosaschi adjourned the meeting at 11:07 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.