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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:	April 15, 2014 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, Chairperson
Peggy Epidendio, Board Member
Angie Wilson, Board Member
David Fluitt, Board Member
Dr. David Fiore, Board Member
Darrell Faircloth, Board Member

Board Members (Absent)
Michael Ball, Board Member
Tracey Green, Board Member
Dr. Jade Miller, Board Member

Carson City
Laura Palotas, DHCFP
Karen Brasen-Corson, DHCFP
Cynthia Serrano, DHCFP
Tracey Woods, Amerigroup
Eric Pennington, DHCFP
Tracy Palmer, DHCFP
Sandie Ruybalid, DHCFP
Jennifer Frischmann, DHCFP
Tiffany Lewis, DHCFP
Scott Larson, BMS

Laurie Squartsoff, DHCFP
Erin Snell, Value Options
Marti Coté, DHCFP
Lindsay Wheeler, High Sierra Legal
Shannon Sprout, DHCFP
Jenni Bonk, DHCFP
Adrienne Navarro, DHCFP
Janice Prentice, DHCFP
Jeanette Belz, JK Belz and Associates

Las Vegas
No attendees present in the Las Vegas location.

I. Call to Order:

Chairwoman Rosaschi called the meeting to order at 9:10 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 November 8, 2013

The November 8, 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) has made an appointment within the Division and introduced Ms. Sandie Ruybalid as the new Chief of the Information Services Unit.

Ms. Squartsoff then commented the Medicaid expansion project is working; applications are making their way to the Division of Welfare and Supportive Services (DWSS) and applicants are becoming eligible. As of March 31, 2014, 434,819 Medicaid eligibles were reported. This is up from July 2013 when 325,000 Medicaid eligibles were reported. However, there have been more applications than anyone initially expected. As of this morning, there are 65,000 applications still pending in the queue. These applications are being taken care of as quickly as possible through the new DWSS eligibility staff. The DWSS is continuing to send staff through their academy so that the staff can be well trained and take care of the applications as quickly as possible. The expectation is that improvements will continue to be made in turnaround time for the applications and that more people will continue to apply.

The DHCFP will continue to work on outreach with the provider network to ensure adequacy of networks and providers to meet the increasing demand of the new Medicaid eligibles population. The Washoe County Medical Society approached the DHCFP recently and expressed interest in having ongoing discussions about what the program services are, how to improve the communication with the program and how to engage the conversation so that paperwork does not get in the way of access to services. The opportunity to continue to network and ensure adequacy of providers for Medicaid beneficiaries is of high priority and the DHCFP is continuing to make progress in that area.

Ms. Squartsoff reported she and Chairwoman Rosaschi had an opportunity to meet with the Legislative Committee recently regarding the structure and responsibilities of the Medical Care Advisory Committee (MCAC) as well as the MCAC advisory role regarding Medicaid and how that role has changed recently. More specifically, in terms of what other opportunities there are for Medicaid to consider as well as ensuring that the policies make sense with what the programmatic decisions are. The Legislative Committee expressed interest in how improvements can be made in the composition of the MCAC, specifically to work on ensuring the beneficiary community is represented within the MCAC. The DHCFP will work with the District Office staff to come up with a recommendation for an appointment.

Dr. David Fiore asked about the 65,000 Medicaid applications still pending and how that number compares to the number of people that have been added through the Medicaid expansion.

Ms. Squartsoff responded since January 2014, the number of Medicaid eligibles has increased approximately 60,000. However, the number of applications does not equally correlate to the number of eligibles; one application can be either for an entire family or simply one individual. Therefore, it is hard to project the number of Medicaid eligibles from the number of applications.

Dr. Fiore asked if statistics are available on how many applications have been successfully processed out of the 65,000 applications still pending.

Ms. Squartsoff responded the information available will report the number of people who have been determined eligible and not the number of applications processed; this is not a one-to-one ratio.

Dr. Fiore expressed his concern that the number of applications still pending is quite a bit larger than the ideal.

Ms. Squartsoff replied the DWSS staff is continuing to make improvements in application turnaround time and will continue to bring on more staff to help process the applications.

Dr. Fiore asked if statistics are available regarding an approximate Medicaid application approval/denial ratio.

Ms. Squartsoff responded that information is not available at this time but she would be happy to follow up with the DWSS and/or have the DWSS give a presentation at the next MCAC meeting.

Dr. Fiore asked regarding the 65,000 pending applications, what impact does Medicaid anticipate the increased enrollment will have on its resources.

Ms. Squartsoff responded the staff at the District Office and the DWSS are in regular contact regarding the number of applications being processed and number of Medicaid eligibles. This staff is also in regular contact with the DHCFP's fiscal staff to ensure that as there are more eligibles in the program, there are adequate resources within the budget to make sure all the services get paid for. The number of eligibles in the program is slightly above projections; however, this is not to say there are any difficulties with where we are in terms of number of people covered in the program and where we are in terms of managing the resources.

Chairwoman Rosaschi commented it is important to keep track of the number of applications due to the budgetary impact. As caseloads continue to increase, how does this impact the DHCFP budget. If there should be a point where there are more Medicaid applications than anticipated, what is the consequence and what is the secondary plan in case that should happen.

Ms. Squartsoff responded the information requested will be brought to the next MCAC meeting if needed. Currently there are no budgetary issues however, it is only April. The DHCFP Chief Financial Officer may give a presentation regarding budgetary information at the next MCAC meeting if requested.

Chairwoman Rosaschi expressed concern that if the program starts to become stressed, the MCAC would be looking at a possibility of something happening to Medicaid services and then impacting the recipient. The MCAC would be greatly interested at that point.

Ms. Peggy Epidendio asked if the correct turnaround time for Medicaid application processing is 45 days.

Ms. Squartsoff responded there is a Federal mandate in place which states Medicaid applications must be processed within 45 days of receiving the application. It is also true there have been instances in which that timeline has been exceeded.

Ms. Epidendio asked what penalties the State incurs when the 45 day timeline has been exceeded.

Ms. Squartsoff responded she is not aware of what the penalties may be.

Ms. Epidendio asked if the applicants can apply online or on paper, and to please clarify when day one of the 45 day timeline begins for paper applications versus online applications.

Ms. Squartsoff responded day one starts the day the application is received. The process regarding online applications will have to be clarified through the DWSS as to when the date stamp is placed on the electronic application; regarding the paper application, day one starts as soon as the paper application is handed to the caseworker.

Ms. Angie Wilson commented in a recent meeting with Nevada Health Link, it was mentioned 145,000 Medicaid applications come through with over 400,000 eligibility determinations. Regarding the 45 day turnaround, this is an issue which has been addressed in regard to Nevada Health Link. It has been advocated to the Centers for Medicare and Medicaid Services (CMS) that there is some understanding in regard to the 45 day turnaround as Nevada moves forward with the exchange and Medicaid applications coming through that exchange. The Tribal communities really appreciate the strong relationship with the DHCFP and the DWSS in regard to assistance. There has been an increased outreach within the Tribal communities regarding the Managed Care Organizations (MCOs), especially Amerigroup. Additionally, the 65,000 Medicaid applications still pending are of concern, specifically the portion of pending applications which are from Tribal communities and what the average turnaround time is for those applications in particular.

Chairwoman Rosaschi commented her appreciativeness toward the DHCFP for working with the MCO community and striving to be proactive instead of reactive.

VI. Introduction and Presentation from our new Care Management Organization (CMO) Vendor by Karen Brasen-Corson and Erin Snell

Ms. Karen Brasen-Corson introduced herself as a Program Specialist for the DHCFP Business Lines Unit, and introduced the new CMO, the Health Care Guidance program. Ms. Brasen-Corson reported over the past few months, the care management outreach team at the DHCFP have been involved in outreach activity to educate stakeholders and medical providers about the CMO throughout the state of Nevada. The Health Care Guidance Program is designed to help improve health outcomes for Medicaid Fee-For-Service (FFS) recipients who live with chronic health conditions by offering additional support to enrollees and providers for transitional care coordination, follow up on appointments, support services, preventative health and use of health information technology. McKesson is the vendor for the CMO and Value Options will coordinate the behavioral health aspect of the contract. Ms. Brasen-Corson then introduced one of the newly hired program directors, Erin Snell, to go in greater detail about the role and goals of the Health Care Guidance Program.

Ms. Erin Snell reported the DHCFP has engaged McKesson and Value Options to provide this program to its sickest FFS program beneficiaries. Dozens of staff have been very busy building this

program since awarded in November 2013. As of today, the initial population has been identified and stratified into their appropriate levels and condition types. Several dozen nurses, peer educators, social workers and supervisors have been hired throughout the state. A full time medical director, Dr. Amy Khan (former chief medical officer for Saint Mary's Health Plan in Reno) has been hired to oversee the program from a medical prospective and build relationships with the provider community. A part-time psychiatrist, Dr. Ryan Ley (chief of staff at West Hills Hospital in Reno) has been hired to coordinate behavioral health care and build relationships with behavioral health providers. The Program is in the process of finalizing and printing enrollee and provider outreach materials and will issue a formal press release concurrent with the launch. A Program office is looking to be established in Carson City directly adjacent to the DHCFP offices. There will be quarterly updates to the MCAC on the progress of the Program.

Ms. Epidendio asked for clarification on which diagnoses would qualify for sickest FFS beneficiaries.

Ms. Brasen-Corson responded the sickest FFS would include diagnoses such as diabetes, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), coronary issues, etc.

Ms. Epidendio asked if the diagnosis of diabetes would include those individuals who have uncontrolled diabetes versus an individual with diabetes which is regularly controlled.

Ms. Brasen-Corson responded the diabetes diagnosis included in the sickest FFS beneficiaries would be that of a chronic diabetic condition.

Ms. Jenni Bonk commented there is a large component behavioral health conditions that would also fall under the heading of the sickest FFS beneficiaries including that of substance abuse and obesity.

Chairwoman Rosaschi asked if it was not correct that from the last presentation regarding behavioral health, one of the factors included in the sickest FFS category were the diagnoses that cost the most to Medicaid, so that those individuals can then be case managed.

Ms. Bonk replied there is a category for those ensuing $100,000 or more per year which, of course, would be a large amount of services. However, the decision to enroll them in the CMO cannot be based upon their costs. If an individual falls into that category, they will be included in the program.

Chairwoman Rosaschi asked about the crisis with behavioral health which has been so rampant in the media lately and how Ms. Bonk envisions behavioral health might work in the future.

Ms. Bonk replied each person who is enrolled in the CMO for their behavioral health diagnosis will have a care manager who will help integrate their care between appropriate providers including the needed behavioral health services. The care managers will be tuned into the behavioral health services that are available in their geographic areas and ensure that these individuals are receiving the services they need.

Chairwoman Rosaschi asked to clarify the working relationships between the Health Care Guidance Program, behavioral health with the Division of Public and Behavioral Health, and Child Welfare.

Ms. Brasen-Corson responded that program staff have done many outreach activities geared toward those agencies in particular. Furthermore, let it be stated that continuity of care is an especially important aspect of this Program.

Ms. Wilson asked how the Program will incorporate the Tribal communities currently under the FFS category, as a lot of the Tribal programs already incorporate behavior health components.

Ms. Snell responded the Program will work very closely with the current providers, as this is also a collaborative program.

Ms. Epidendio asked if there is an estimate of the initial number of enrollees expected.

Ms. Snell responded the initial enrollment number has been estimated at approximately 29,000.

Chairwoman Rosaschi commented the MCAC is looking forward to the quarterly updates and would like to request a report at future meetings regarding what the main accomplishments have been within that time period; is the Health Care Guidance Program truly being able to make an impact and a difference in people's lives.

Ms. Epidendio commented the MCAC would also be interested in any enrollee comments regarding the Health Care Guidance Program.

VII. DHCFP Reports

- **Update on the Dental Anesthesia Issue by Laurie Squartsoff**

  Ms. Laurie Squartsoff reported the DHCFP has recent updates from the Reno Health and Wellness Center (HAWC) regarding the waitlist. As of April 10, 2013 information was provided that HAWC currently has 67 patients in the process of completing the necessary paperwork and medical clearance procedures. There are 30 Medicaid beneficiaries scheduled for dental services between April 11, 2014 and May 15, 2014. The current average wait time is 36 days. Three patients were triaged as dental emergencies and had wait times between ten and 32 days. The current breakdown is as follows: there are six FFS patients waiting for care, 13 patients who are covered by Health Plan of Nevada (HPN) and 11 patients covered by Amerigroup. The DHCFP has also just received an update from staff regarding those pending cases under both the Managed Care plans. Amerigroup has six cases scheduled for services in April and four in May. Four of those are emergent; their services were to be completed last Monday. HPN has seven cases scheduled with HAWC for services in April and six scheduled in May. One case, that of an eight year-old child, was noted as emergent; that child's care will be completed by this Friday. The remaining two emergent cases have been referred to their pediatric dentist. The DHCFP will continue to have conversations with the pediatric anesthesiologists and work toward changes regarding accessing care. Nevada happens to have only seven pediatric anesthesiologists who provide care throughout the state.

  Mr. David Fluitt asked how reimbursement issues with the anesthesiologists were being addressed by the DHCFP.

  Ms. Squartsoff responded questions about reimbursement for services were brought to attention of the DHCFP Rates Unit who have been working very carefully with the staff at each one of the physician's offices so that the DHCFP has a better understanding of how to better work with the providers to get them properly reimbursed for their services.

  Ms. Epidendio asked what the definition is of emergent, as some of the timelines for completing services for emergent cases seemed lengthy.

Ms. Squartsoff responded the definition of emergent in the context of HAWC is unavailable at this time. Generally emergent means that services need to be provided most optimally within 24 hours. It is assumed that in the context of HAWC, emergent means these services are urgent rather than an emergency.

Chairwoman Rosaschi asked if the providers are at least managing the pain so that if there is any type of a wait for emergent services, these children are not suffering.

Ms. Squartsoff responded there are no reports from HAWC regarding the immediate needs of a patient and not being able to provide services or ancillary services.

Ms. Tracy Palmer commented the community health alliance is working directly with the Managed Care plans to make sure the enrollees who have pain are not in pain.

Ms. Squartsoff commented in the past couple months the communication between the provider network and division staff has improved and access to care has improved as a result of that.

- **Update and Discussion on the Need of Doctors to Perform Disability Determinations by Jennifer Frischmann**

Ms. Jennifer Frischmann reported since the last meeting, there has been one physician who expressed interest in performing disability determinations. Additional providers are greatly needed.

Chairwoman Rosaschi asked what is causing the physicians to not be interested in performing disability determinations.

Ms. Frischmann responded it has been extremely hard to get the word out to target physicians, along with technology limitations involved in the program. The Long Term Support Services (LTSS) Unit has been trying to incorporate the medical files electronically which is a very time-consuming process. Currently, the physicians have to physically go to the Carson City office and pick up the files. Also, the physicians may have to potentially testify and are not fairly compensated for their time.

Chairwoman Rosaschi asked if there has been any feedback from the physician's performing the disability determinations.

Ms. Frischmann responded there has been no feedback from physicians actually performing the disability determinations. The biggest hurdle the physicians face is the medical documentation not being clear and/or all inclusive, not the actual disability determination based on the criteria.

Chairwoman Rosaschi asked how the physicians get reimbursed in this program.

Ms. Frischmann responded the physicians are contracted through Envizion who has a master service agreement with the State of Nevada to perform these types of services. The physicians are reimbursed through Envizion; this is an administrative cost, not a medical cost.

Ms. Epidendio asked if LTSS has thought about recruiting retired physicians to perform the disability determinations.

Ms. Frischmann responded LTSS has not and will look into that as a real possibility in the very near future.

- **Update on Private Duty Nursing and Home Health Programs by Adrienne Navarro**

Ms. Adrienne Navarro reported the Home Health and Private Duty Nursing programs through Medicaid are currently being looked at to revise and update the policy. This is a bigger project than was initially expected due to the need to redefine the intent of the program and make that clear within the policy. Two major problems have been identified to move forward. First, the Home Health rates are quite low and have not been updated in many years. LTSS has been working with the Accounting Unit and the Rates Unit to assess the rates. Secondly, there is an issue with the program data. Home Health and Private Duty Nursing are two different programs within Medicaid, but are under the same provider type. Therefore, the data is bundled within that provider type. LTSS has been working with Hewlett Packard Enterprise Services (HPES) to obtain reports regarding specific program data. LTSS is working on redefining the programs, revising the policy and updating the forms involved in each program.

Ms. Frischmann commented many years ago Private Duty Nursing and Home Health were singular and independent of one another. Approximately six years ago they were combined and Home Health and Private Duty Nursing were used interchangeably. Through research working to redefine the program, it was noted that these are indeed two separate and distinct programs. Private Duty Nursing is looked at being defined as four or more hours of continuous skilled services, whereas Home Health may be intermittent. Home Health may be ongoing for many years but it is for a very short duration of time each time it is utilized. These two programs are available for everyone, not just pediatrics as previously thought. There will be a couple of workshops scheduled soon to get more input from the provider community to make sure the definitions match appropriately.

Chairwoman Rosaschi commented as individuals continue to get older, their needs continue to increase. If an individual has a tremendous amount of Private Duty Nursing or Home Health being utilized, are they then going to be shifted over to this new case management; how will that transition be managed.

Ms. Frischmann responded certain populations within the CMO will not be focused upon, such as dual eligibles. Specifically, when referencing the elderly and more medically frail population, those individuals tend to be dual eligibles (eligible for Medicare and Medicaid) and therefore exempt from the CMO. Private Duty Nursing and Home Health are far below institutional costs. In regard to pediatrics, the care involved is of a very high level nature and children affected would otherwise be institutionalized.

Chairwoman Rosaschi expressed concern there have been cases in the past where the individual's level of care has become so high that they have been invited to an institution against their will.

Ms. Frischmann responded that if the CMO is aware of situations where people are being forced to be institutionalized against their will, that is a separate issue from the Private Duty Nursing and care issue. CMS has been advocating to get people out of institutions, avoid institutions, and remain active in the community.

- **Update on MMIS Replacement by Eric Pennington**

  Mr. Eric Pennington reported on the status of the long term project to replace the Medicaid Management Information System (MMIS). The current system is utilizing programming code that was developed in the 1970's; it is a mainframe system and very difficult and costly to configure for changes in business processes and policies. There are increasing standards and conditions which must be met for CMS. Enhancements to the systems are based on meeting CMS' seven standards and conditions. One condition in particular, the Medicaid Information Technology Architecture (MITA) condition, is the driving factor behind replacement of MMIS. The MITA condition refers to the standard that business drives the technology. CMS has recognized this standard and has mandated all states go through a MITA self-assessment. Our current system falls short regarding CMS standards of the MITA assessment. Currently, the DHCFP Information Services Unit is in phase two of project: the planning phase of MMIS replacement. This has involved an alternative analysis regarding seven options available to the MMIS procurement strategy. The first option involved retaining the current MMIS and Fiscal Agent, however this is not a viable option due to the fact it cannot perform to the standards of what our business requires. The second option is to design and develop a completely new system for Nevada from the ground up which has the potential to be extremely expensive and time-consuming. The third option is to transfer and configure a proven system from another state and configure it into our business needs for Nevada. The fourth option is that of a service based solution. For instance, Arizona and Hawaii have an agreement whereas Arizona runs MMIS and Hawaii then purchases services from Arizona. The fifth option is medical claims brokering wherein business is taken to a MCO, someone already processing claims in that state, and have that entity perform the services for Nevada. The last option looked at was a multi-state consortium. Michigan and Illinois are collaborating for a single MMIS, however there are some legal issues around that particular project. After looking at all alternatives, best practices and considering all the issues, the DHCFP Information Services Unit has elected to transfer and configure a proven solution from another state and configure it to Nevada. When the project timeline was previously drafted, a completion date of June 2014 was anticipated. However, due to factors outside of the agency's control, the completion date must be extended until at least June 2015.

  Chairwoman Rosaschi commented regarding the concept that business drives the technology, this concept is unique. Just today, the MCAC has been given the example of the struggle with signing up physicians to participate in providing disability determinations because medical records cannot be electronically transferred. Is this an example of where technology would be incorporated within the new system to streamline the process of electronically transferring the medical record anywhere in Nevada.

  Mr. Pennington responded yes that is indeed correct. A business need is recognized and a system requirement is developed to suit that business need.

  Chairwoman Rosaschi asked what ranges of caseloads are required to have a disability determination in specific time periods.

  Ms. Frischmann responded there is no definite caseload per week. On average there are approximately ten to 12 files needing disability determinations per month. There is no current backlog of files needing disability determinations.

Mr. Pennington also responded the records specified are health records and the current MMIS is designed specifically for communicating claims and not health records.

- **Presentation and Approval on Managed Care Marketing Materials by Laura Palotas**

Chairwoman Rosaschi commented this particular agenda item had not been posted correctly; it was decided to go forward with presentations and advised that no actions would be taken. A special MCAC meeting will be called for possible action on this particular agenda item.

Ms. Laura Palotas, Program Specialist for Medicaid open enrollment for the Business Lines Unit, reported open enrollment periods between HPN and Amerigroup are held yearly in which all MCO enrollees are given the opportunity to switch their health plan. This is also the time of year each MCO is given the opportunity to market to the members outside of their plan. It is asked that each MCO provide us with all marketing materials for approval. The materials provided have been approved by the DHCFP and now pending MCAC approval.

Ms. Wilson asked what time frame is involved for the open enrollment period.

Ms. Palotas responded the open enrollment is July 1 through September 30. Open enrollment notification letters are mailed the first Tuesday in July. Members then have until September 30 to signify any changes they request to their health plan. The health plan lock-in period begins October 1.

Chairwoman Rosaschi expressed concern the Amerigroup marketing materials look as though they are not in draft form and essentially ready to be sent out to Medicaid members. More specifically, if the MCAC requests any changes can they be made at this point. A marketing poster references 130% of poverty level and the general population is not aware of what income level that is referencing. Is it possible for the document to reference a more specific income level. Regarding a second marketing poster referencing a meeting in which Amerigroup is requesting Medicaid members attend, there is no offer of transportation or child care.

Ms. Palotas responded she will bring those concerns and advised revisions to Amerigroup.

Chairwoman Rosaschi commented regarding a tri-fold marketing document in which Nevada state resources are listed, specifically the Nevada state operator, that particular number is not a good resource for Medicaid recipients.

Dr. Fiore commented the provider list included in the packet of marketing materials lists many physicians who have since moved offices or are no longer seeing patients.

Ms. Palotas responded updated provider lists will be mailed out to recipients on July 1. If a list of known physicians who are no longer seeing patients is provided, that information will also be included on updated provider lists.

Chairwoman Rosaschi commented in the future the marketing materials will need to be provided to the MCAC much earlier in the year and in draft form as this is a very formalized process required to approve the materials and time needs to be appropriated so that any changes advised will have time to be included in the final materials submitted to MCO members.

Ms. Wilson commented Amerigroup does indeed address new eligibles for Medicaid. Therefore, even if there is no choice but to go through with the current materials provided, the materials are at least explicit in their drafts and information.

Ms. Palmer commented Amerigroup is aware there could be changes and that they may need to revise materials before they are sent out to the public.

Ms. Epidendio commented in the future the marketing materials need to be received in draft form to avoid such a large cost involved.

Ms. Palotas responded she will take that concern to Amerigroup as well.

VIII. Public Comment

No Comment.

IV. Adjournment

Chairwoman Rosaschi adjourned the meeting at 10:29 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.