BRIAN SANDOVAL
Governor

STATE OF NV
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
1100 E. William Street, Suite 101
Carson City, NV 89701
(775) 684-3600

ROMAINE GILLILAND
Director

LAURIE SQUARTSOFF
Administrator

DRAFT MCAC MEETING MINUTES

Date and Time of Meeting:	January 20, 2015 at 9:00AM
Place of meeting:	The State of Nevada Health Division 4150 Technology Way, Room 303 Carson City, Nevada 89701
Place of Audio Conference:	Division of Health Care Financing and Policy (DHCFP) 560 Hammill Lane Reno, NV 89511

Attendees

Board Members (Present)
Rota Rosaschi, Chairperson
David Fluitt, Board Member
Dr. Tracey Green, Board Member
Sarah Mannee, Board Member
Dr. Ryan Murphy, Board Member

Board Members (Absent)
Michael Ball, Board Member
Peggy Epidendio, Board Member
Dr. David Fiore, Board Member

Reno
Angie Wilson, Board Member

Carson City
Darrell Faircloth, Senior DAG
Diane Smith, DHCFP
Cheri Glockner, HCGP
Tammy Moffitt, DHCFP
Betsy Aiello, DHCFP
Rachel Marchetti, DHCFP
Gladys Cook, DHCFP
Tracy Palmer, DHCFP
Joanna Jacob, Ferrari Public Affairs
Coleen Lawrence, DHCFP
Shannon Sprout, DHCFP
Laurie Squartsoff, DHCFP
Scott Mayne, Washoe County/Clark County
Debra Sisco, DHCFP
Janice Prentice, DHCFP
Dr. Amy Khan, McKesson
Dr. Ryan Ley, Value Options
Tracey Woods, Amerigroup
Julie Bertuleit, GSK
Erin Snell, Value Options

I. Call to Order

Chairwoman Rota Rosaschi called the meeting to order at 9:20 AM.

II. Roll Call

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

III. Public Comment on Any Matter on the Agenda

No Comments.

IV. For Possible Action: Review and Approve Meeting Minutes from October 21, 2014 (See Attachment for Minutes)

The October 21, 2014 minutes were approved with the change of Dr. David Fluitt to be listed as Mr. David Fluitt and Cheri Glockner to be listed with the organization HCGP instead of HCG. Minutes approved as corrected.

V. Administrator's Report, Present State Plan Amendments and Medicaid Service Manual Updates by Laurie Squartsoff

Ms. Laurie Squartsoff reported that the Division of Health Care Financing and Policy (DHCFP) is looking at a budget for this next biennium that is close to seven billion dollars and will be covering services for in excess of 577,000 Nevadans. Ms. Squartsoff stated that the DHCFP is looking at new programs; one is a major budget initiative for children with autism spectrum disorder. The DHCFP will also provide a report on the State Innovative Model (SIM) grant.

The DHCFP has been working on two National Governors Association special task force projects; one is leveraging Medicaid for statewide health care transformation. This project is working on behavioral health and screening for children. Dr. Tracey Green, Dena Schmidt, Jenni Bonk and I are headed to Washington D.C. at the end of this month to meet with the Centers for Medicare and Medicaid Services (CMS) to discuss the funding authority for this project. The DHCFP is also working on a controlled substance abuse project which will address the continued and ongoing concerns regarding controlled substance abuse, particularly with adolescents. A stakeholder meeting for those across the state is being scheduled. This is an opportunity for Nevadans to look at what the opportunities are for addressing the statewide concern and making a difference in the lives of people who are affected by drug abuse.

Another major project that DHCFP is working on is the Housing and Urban Development (HUD) project. Clark County is the first project of its kind in the country, where those who are involved in housing and health care providers are having joint conversations to include housing as part of the discussion about health care. Where people reside and where those services are delivered, is important to the continuity of services for health care and to ensure better outcomes.

- **Nevada State Plan Amendment Updates**

  There are several State Plan Amendments (SPAs) that were submitted to CMS. (See attachment)

  SPA 14-006 State Plan Administration Designation & Authority – This SPA updates the name from DHR to DHHS and has a requested effective date of October 1, 2014.

SPA 14-007 Special Care Rates - This SPA updated rates and language and has a requested effective date of November 14, 2014.

SPA 14-008 Indian Health Services - Requested an increase in face-to-face encounters from three to five and has a requested effective date of January 1, 2015.

SPA 14-009 Primary Care Physician (PCP) - Rate increase extension for primary care physician that will extend through June 30, 2015 and has a requested effective date of January 1, 2015.

SPA 14-010 Pharmacy Services - Proposed a change to the dispensing fee to include the national average drug acquisition cost in the definition of actual acquisition cost and has a requested effective date of January 1, 2015.

The SPA's recently approved include:

SPA 14-004 Supplemental Rebate Contract Renewal - Language was updated.

SPA 14-005 Removal of barbiturates, benzodiazepines, and smoking cessation agents from the exclusion list.

In addition, The DHCFP has had several stakeholder workshops and hearings related to Medicaid Service Manual updates. (See attachment)

- **Medicaid Services Manual (MSM) Revisions**

Chapter 600 - Revisions were made to add a new policy, #6-16 School Based Health Centers. Also, revisions were made to policies related to bariatric surgery for those that are morbidly obese.

Chapter 1200 – Revisions were made in the Lock-In program for pharmacy services. Chapter 1200 also had changes to Drug Use Review (DUR) board and its recommendations for several medications to be added to the preferred drug list.

Chapter 1800 – Revisions were made regarding provider enrollment qualifications.

Chapter 3000 – Revisions were made to face-to-face encounters for services at Indian Health Services (IHS) clinics from three to five.

Chapter 3400 - Revisions were made regarding the removal of geographic barriers for originating sites for telehealth services.

Nevada Check Up (NCU) Chapter 1000 – Revisions were made to transfer NCU eligibility to the Division of Welfare and Supportive Services (DWSS) and to remove references to eligibility in Section 1003.1A. These changes are effective January 1, 2015.

Chairwoman Rosaschi asked if Ms. Squartsoff is at liberty to discuss any new initiatives through the session or budget ramifications.

Ms. Squartsoff commented that the major initiative is the autism spectrum disorder project and working with Aging and Disability Services on the coordination of the program development for children. Increases in provider rates are included in the budget, changing the base of 2002 Medicare values to 2014, and changes in reimbursement for Neonatal Intensive Care Services.

Chairwoman Rosaschi asked if Ms. Squartsoff anticipated any kind of advocacy, anything that the board can do and are there any bills that have any controversy.

Ms. Squartsoff stated that there is not any controversy that the DHCFP is aware of and that the DHCFP always welcomes the board's expertise as its advisory group as they bring a great deal of wealth of knowledge and insight that may be helpful for the legislators.

Ms. Angie Wilson commented that the tribes will meet with the State Legislature on February 10, 2015 and tribes will lend support in advocating on behalf of Medicaid. Also, Ms. Wilson stated that she sits on the National CMS Tribal Technical Advisory Group that will be meeting the week of February 17, 2015 and will be a voice advocating for statewide funding for the alcohol and drug abuse program.

VI. Updates on Health Care Guidance Program (HCGP) By Cheri Glockner, Executive Director and Dr. Ryan Ley, Behavioral Health Medical Director

Ms. Cheri Glockner reported that the HCGP is a care management organization, branded as the HCGP that operates under a demonstration and waiver grant and reports to the Business Lines unit through the DHCFP. The program launched June 1, 2014 and has a cap per the waiver at 41,500. The average per month has been about 39,000 so there is still room for more growth. There has been a lot of provider outreach; HCGP has been to 42 hospitals around the state to help them understand how the program can guide them and help them manage the subset of Fee-for-Service Medicaid population (about seven percent). We have eight identified programs under the auspices of the HCGP, of which one of them is behavioral health. Ms. Glockner then introduced Dr. Ryan Ley, Medical Director of Behavioral Health Services (BHS).

Dr. Ryan Ley provided a presentation on BHS Update. (See attachment)

Chairwoman Rosaschi asked what BHS is doing to improve the challenge regarding connecting people with access to care in an effort to prevent them from going into crisis.

Dr. Ley stated that it depends on each individuals specific circumstances, however, they follow-up with what kind of after care plan an individual has; do they have a provider, do they have a therapist etc., talking with a discharge planner, ensuring patients are aware and understand how it can help them. However, it continues to be a problem because access to providers is difficult.

Dr. Tracey Green offered to provide assistance. She uses the global assessment of functioning and offered to share her information and also suggested that consultation through Echo might help the delivery of services for his clients. Dr. Green stated she would extend the opportunity for working together as they currently share clients. In addition, she made a suggestion that a committee with Medicaid and Managed Care Organization (MCO) be formed to begin focusing on addressing the concerns of connecting clients with access to care.

VII. DHCFP Reports

- **Report and Discussion on the new State Innovative Model (SIM) Grant that was awarded to the State of Nevada by Janice Prentice, Chief, Rates and Cost Containment**

  Ms. Jan Prentice introduced Ms. Debra Sisco, Supervisor of Cost Containment and the project lead on the SIM grant. Ms. Prentice gave a presentation on the SIM Grant. (See attachment) She reported that CMS awarded Nevada a design model grant in the amount of two million dollars. There are two models of the grant; the design grant and the test grant. CMS is in the second round of funding for this. The DHCFP applied for the design grant and has one year, which will begin on February 1, 2015

through January 31, 2016, to create a design model for the state innovative model. CMS provides financial and technical support to states to design a health care payment and delivery service model. It is a statewide collaborative effort; however the DHCFP is taking the lead and is working with all of the Department of Health and Human Services (DHHS) divisions. The design will be for health care payment and service delivery models and per CMS requirements, they must be innovative, multi-payer and statewide. Programs, when implemented, must achieve better care, better health outcomes and lower costs.

The DHCFP is currently working with a consultant, Myers and Stauffer. They have helped other states design their models. A couple of states are in the test phase. The DHCFP will require broad statewide support and have already reached out to health care providers, public health officials, industry associations, consumer advocacy groups, medical centers, researchers and other stakeholders. The DHCFP is currently in the process of setting up a listserv by gathering names of people willing and interested in working on committees and workgroups.

The communication plan will include public stakeholders and will identify the stakeholders and interested parties, describe the outreach education and communication with stakeholders and will identify milestones and activities during this year of the design. The DHCFP has had stakeholder meetings allowing stakeholders to actively engage with the division regarding their perspectives and initial direction. Subsequent meetings will include weekly and/or bi-weekly meetings with CMS and quarterly stakeholder meetings, stakeholder focus groups and committee meetings. The DHCFP currently has completed the Justification to Fill (JTF) two temporary positions being hired through Manpower. In addition, the DHCFP created a rates email inbox and have been collecting emails and consulting with Myers and Stauffer. Also, the initial introductory webinar with CMS has been completed and we have also teleconferenced with the designated program officer.

Future plans include webinars, face-to-face meetings and bi-weekly teleconferences; these have been scheduled as placeholders. The plan is to post the grant application to the DHCFP website and set up an independent website with a link to the DHCFP website.

Dr. Green asked Ms. Prentice to provide the committee, at the next meeting, with an overview from Meyer and Stauffer of what has been implemented by other states.

Ms. Prentice responded by stating there has been some research done in other states and updates will be provided at the next meeting; it is wide and varied. Ms. Prentice asked if the committee would be involved in committees, subgroups and workgroups as we need and want active participation as well as ideas.

Chairperson Rosaschi stated that previously in this meeting there was discussion regarding mental health and the lack of psychiatrists. If reimbursements are part of these challenges, is this the project that will look at those problems and other potential challenges to make recommendations.

Ms. Prentice responded that some states have set up incentive payments as part of the SIM grant. You can do a lot of things with this grant as long as you are achieving the basic goals that CMS is asking which is reducing costs, increasing value, and quality outcomes.

Mr. David Fluitt asked how the SIM program promotes Governor Sandoval's core healthcare priorities such as child wellness.

Ms. Prentice stated that the DHCFP does want it to correlate to the governor's primary aims and will be looking at any ideas and projects that could achieve that goal. This is a design model so we will be

taking all ideas, all plans and project plans looking to see how they fit into this grant. It must, however, be new and innovative.

Ms. Angie Wilson asked who she can contact if she has suggestions.

Ms. Prentice responded by providing an email address rates@dhcfp.nv.gov.

Dr. Ryan Murphy suggested that when looking at issues with access to care, look at the red tape and not just reimbursement fees. If you increase fees but it takes office staff 50% more time to collect reimbursement, an increase in reimbursement does not necessarily mean you will get more providers.

- **Updates on new Home and Community Based Services (HCBS) Regulations by Betsy Aiello, Deputy Administrator, DHCFP**

Ms. Betsy Aiello reported on behalf of Ms. Jennifer Frischmann. (See attachment) Last March, CMS came out with final regulations that they have been working on since 2009. The goal was to look at what truly are home and community-based services vs. institutional services and were the states under their home and community-based waiver programs and Medicaid funded community-based services truly providing community-based services or were they mini institutions built within the community. CMS gave the states five years to make the changes. Basically it is to maximize opportunities for individuals to access the benefits of community living, ensure that Medicaid recipients receive services in the most integrated settings, provide opportunities to seek employment and work in competitive integrated settings engage in community life and control personal resources. Settings must optimize and not regiment individual initiative autonomy in independence in making life choices including but not limited to daily activities, physical environment and with whom to interact. CMS is providing tool kits to help determine if a facility is a mini institution. The state had to develop a transition plan that is due to CMS by March 17, 2015. States were given the first year to develop their plan to help identify whether or not regulatory changes, definition changes or industry changes were needed. The DHCFP held four public workshops and with input from that the DHCFP put out draft ideas for a transition plan. In addition, the DHCFP had a steering committee and sent letters to100% of Medicaid recipients that are in the home and community-based waiver programs to let them know about these changes and the ability to give input. A website also was developed that is linked on the DHCFP website. These changes need to be completed by 2019.

Dr. Green asked if this pertains to the Fee-for-Service only population for home and community-based waiver.

Ms. Aiello stated that it is all home and community-based services. The waiver is just in Fee-For Service right now. It would be Adult Day Health Care (ADHC) which is not just in the Fee-for-Service population. It is funding, and the regulation not only covers the 1915c but it covers the 1915i services which are ADHC and some of the brain injury. It is some of the regulations that are outside of regular state plan services. The two it affects is the 1915c and 1915i services.

- **Update and discussion on Applied Behavioral Analysis (ABA) by Shannon Sprout, Program Specialist, Clinical Policy Team**

Ms. Shannon Sprout provided a presentation and update on Applied Behavioral Analysis. (See attachment)

Dr. Green asked if they mentioned Early and Periodic Screening, Diagnosis & Treatment (EPSDT) in their next steps.

Ms. Sprout responded that they will be under EPSDT as the coverage authority and are working with CMS to gain some clarification on how to connect that with other licensed practitioners; we are referencing this across to make sure we are meeting what they need for the State Plan Amendment.

Dr. Green asked if that means that it is the primary entry point for the authorization of services or will there be another route.

Ms. Sprout stated that the entry point will be under EPSDT for children under the age of 21with the diagnosis of autism spectrum disorder or for another condition which ABA would be evidence based and an appropriate treatment model.

Ms. Coleen Lawrence, Chief, Clinical Policy Team, clarified that there is not a hard screen for EPSDT that is required for this service. You do not have to have an EPSDT referral form to access these services. When we say it is EPSDT, it is EPSDT authority underneath the state plan services. It is the entry point for the legal authority under the state plan. It will be referred by a licensed practitioner, must be prescribed by a physician, Advanced Practice Registered Nurse (APRN); we have that authority within the policy. The treatment plan must be under the supervising practitioners that are on the treatment plan. You do not have to channel it through an actual EPSDT referral. EPSDT is the legal authority in the state plan.

Dr. Green asked if a psychologist could not initiate the referral for services and then provide the services; is it the providers that are allowable under EPSDT that would make the referral or can a psychologist initiate the services.

Ms. Lawrence clarified that EPSDT has nothing to do with the initiation of the service; EPSDT is the authority for the state plan generation. It must be for a child under 21years old and the service must be medically necessary, meet best practice, evidence based services and meets the medical coverage guidelines. The DHCFP has written out that the service is behavioral intervention and the targeted intervention is ABA. It was written out what the coverage guidelines are. If we find another service that has a targeted diagnosis other than ABA for this behavioral intervention and it's for a child under 21years old and is medically necessary, because it is under the authority of EPSDT Medicaid must pay for it.

Ms. Wilson asked if we know how many children are diagnosed in Nevada with autism spectrum disorder.

Ms. Sprout responded that through the Department of Education they have averaged about 6000 children diagnosed within the state for autism spectrum disorder.

- **Status Report on Provider Re-Enrollment and Ordering, Prescribing and Referring (OPR) Provider projects by Diane Smith, Supervisor, Provider Services/Provider Support**

Ms. Diane Smith reported that the re-enrollment project is due to an Office of the Inspector General (OIG) audit which suggested that the DHCFP validate all providers within a 36 month period. This began in June 2012 and will end June 2015. As of November we have approximately 12,500 providers that have received notification for re-validation, of which approximately 8,000 providers complied, leaving a balance of about 4,500 left to re-enroll. This represents about a 64% compliance rate. Future plans are to become more in alignment with CMS requirements of doing a five year re-validation program. This will give us a nine month outreach process to reach these other providers that have not been compliant with our first round. The Affordable Care Act (ACA) requirement is all of

our provider base must be re-enrolled by March 2016. This timeframe will be used to do massive outreach; to date it is the physician provider types that are a majority that have not re-enrolled.

Per CMS rule regarding the ordering, prescribing and referring project, all physicians and practitioners who order, prescribe and refer Medicaid recipients must be enrolled in the Medicaid provider as either a fully participating provider or Ordering, Prescribing and Referring (OPR) provider. (OPRs, if they do not wish to be fully participating, do it for the sole purpose of ordering and referring but cannot submit claims.) System edits for the non pharmacy provider base were activated on October 29, 2014 with the exception of pharmacy. There were a few issues as we implemented on those edits. However, based on the magnitude of the project and the number of line item claims that come through a day, they have been minimal and the DHCFP has been able to work collaboratively with the information technology team to work out system fixes as they arise. Medicaid does not provide reimbursement to servicing providers unless the OPR is enrolled. Major outreach was being conducted to get them to fully participate. Information was placed on the applications asking them if they would be willing to become a full participant provider and if not, the reasons why so the DHCFP can determine what to do to help get new providers.

The pharmacy override has been put off because there were a few things that needed to be handled systematically. We also realized that's a huge access to care issue if claims start denying for pharmacy. That override period will end February 5, 2015 so we will be going live with those edits and until that happens we will not know the magnitude. The DHCFP is hopeful that with the extra outreach that has been placed to pharmacies and the community, that they are aware of these situations and can now get those ordering and referring providers enrolled with Nevada Medicaid. They do have a one time override per prescription. So we're hopeful that we'll be able to counteract any type of issues that come up quickly. As of December 20, 2014 there were approximately 379 OPR only providers enrolled in the Nevada Medicaid population. We believe that since we don't have that many claims being denied, that the majority of physicians and providers that are ordering are already fully enrolled providers.

- **Update and discussion on Hospital Presumptive Eligibility by Diane Smith, Supervisor, Provider Services/Provider Support**

Ms. Diane Smith reported that that the DHCFP has partnered with the Division of Welfare and Supportive Services (DWSS). Qualified hospitals may make presumptive eligibility determinations for certain individuals based on preliminary information obtained from the applicant. Individuals receive full Medicaid benefits for a temporary period of time, if all eligibility criteria are met. A Qualified Hospital is a hospital that participates as a provider under the State Medicaid program and agrees to make presumptive eligibility determinations consistent with state policies and procedures. Each hospital electing to participate in the hospital presumptive eligibility program must have a contract amendment (Addendum) in place with the DHCFP. Hospital staff making the presumptive eligibility determination must be trained and certified by DWSS staff in order to obtain Hospital Presumptive Eligibility system access. The purpose of hospital presumptive eligibility is to provide a streamlined process for individuals to get access to immediate coverage and to promote ongoing Medicaid enrollment, by encouraging individuals to complete a Medicaid application. The DWSS has conducted one training for hospital employees that want to be qualified as a hospital; it is critical care inpatient hospitals. The first training was held January 12-15, 2015. There will be two more training sessions held in March. To date, five hospitals have signed up: UMC, Renown, Humboldt General, Pershing General and Valley Health Systems. UMC and Renown are the only ones that have returned their addendums signed so that they will be qualified to make those presumptive eligibility determinations and move forward once they get their security clearances through DWSS. The DHCFP has approximately 38 of this provider type, critical access hospitals and inpatient hospitals. There have

only been a handful of ones that want to participate. Preliminary feedback from DWSS states that there is a lot to learn to be able to do this; they have performance measures and standards they have to meet in order to maintain their ability to perform these eligibility determinations. The DHCFP is coordinating with them to outreach to be sure we get the signed addendum in place to go along with their servicing contract.

Mr. Fluitt asked about the hard edit that begins as it pertains to pharmacy claims for non OPRs; is there any way pharmacies can help identify those positions as providers through a feedback mechanism that may be helpful to alert them that they are non providers. For instance, give them an email address or application?

Ms. Smith responded they would welcome any way as an outreach to these providers to get them enrolled.

Mr. Fluitt asked if there was anything in process right now that collects that data.

Ms. Smith stated that it is all based on claims data. The DHCFP would have to go through with the pharmacy on the Point of Sale (POS) side and see what exist and work with our vendor, Catamaran, to see if they could collect some information through the claims processing and be able to target those that are coming through that are denying at that point.

Ms. Lawrence stated that a year ago they ran preliminary reports on the pharmacy side to see what the volume was of prescribers that were not enrolled in the program and did outreach initially to see if they could reach those providers on the Catamaran side. They did soft edits on the pharmacy side which have been done for 90 days. Interns, residents, etc. in hospitals are not part of this program for the pharmacy as they are exempt under the regulation. The DHCFP is currently running reports and monitoring prescribers on pharmacy side.

Mr. Fluitt asked what is the success rate in having physicians respond back to you, are they signing up for providership?

Ms. Smith stated that there are about 379 providers the DHCFP needs to take back to Hewlett Packard (HP) to find out which provider types they are. There has not been many claim denials so we assume they are fully participating providers.

Ms. Wilson inquired as to how it is affecting the provider type 47 and do they have to re-enroll.

Ms. Smith responded that as far as revalidation and re-enrollment, all providers do need to re-enroll with Nevada Medicaid.

Dr. Green inquired as to the definition of hospital; an IMD hospital or free standing psychiatric hospital would not be included.

Ms. Smith reported that these are only for inpatient and critical access hospitals.

Dr. Green asked if it is a Federal or State guideline.

Ms. Smith reported that it is a Federal guideline for only provider types 11 and 75.

VIII. Public Comment

Ms. Sarah Mannee, Medicaid recipient, stated she was able to go to a wonderful facility to do artwork for the Mansion in Reno and would like to see more funding for activities like this. Plans are to place this painting in the Legislature building and see what kind of funding could be obtained so that people with disabilities may be able to continue as it is an outlet to be able to go and paint. Artwork has been placed at the Very Special Arts (VSA) Museum in Reno.

IX. Adjournment

Chairwoman Rosaschi adjourned the meeting at 11:28 AM.

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