DRAFT MCAC MEETING MINUTES

Date and Time of Meeting: Monday, October 31, 2022

Name of Organization: State of Nevada, Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (DHCFP)

Place Meeting: Microsoft Teams

MCAC Voting Member Attendance	
Member Name	
Rota Rosaschi, Chairperson	**X**
John Phoenix, Vice Chairperson	**Joined late**
Dr. Susan Galvin	**X**
Dr. Ryan Murphy	**ABS**
Dr. Kelsey Maxim	**ABS**
Kimberly Palma-Ortega	**X**
Non-Voting Member Attendance	
Dr. Ihsan Azzam	**X**

I. Call to Order

Chair Rosaschi called the meeting to order at 9:05 AM.

II. Roll Call

Chair Rosaschi asked for roll call. A quorum was established at 9:10 AM.

III. Public Comment

No public comment was made.

IV. For Possible Action: Review and approve meeting minutes from the meeting held on July 19, 2022

Chair Rosaschi called for a motion to amend or approve the draft minutes from the July 19, 2022, MCAC Quarterly Meeting. A motion to approve the draft minutes as presented was provided by Dr. Ihsan Azzam and a second was provided by Dr. Susan Galvin. Motion passed unanimously.

V. Administrator's Report

Administrator Suzanne Bierman provides the following information. She states CMS accepted Nevada's application for the 1115 demonstration waiver for the treatment of opioid use and substance abuse disorders. The application has been deemed complete by centers for

Medicare/Medicaid services and they are reviewing the application and working to create the standard terms and conditions by the end of the year. The team is working on the implementation plan that has to be done 90 days after the approval of the application. Administrator Bierman adds that the behavioral health team participated in the cross-agency teams. Eight states were selected to participate in the technical assistance program sponsored by the National Association of Medicaid directors. Representatives from DHCFP, along with public and behavioral health and DCFS went and are receiving technical assistance to help strengthen the state's behavioral health system.

Administrator Bierman adds an update for Dental. Nevada was recently awarded a 1.6 million grant to develop, recruit, and retain the dental workforce. They will be creating and developing a workforce pipeline to train high school students in rural counties. They will also be offering apprenticeships. The Nevada Dental Health collaborative will be created for dental therapists, hygienists, and predental students to foster interest in dental health. There will also be an office for oral health innovation that stood up as a part of this grant. It will conduct annual needs assessments, develop training for the dental workforce, and offer in-office support for dental professionals to advance practices around substance and opioid misuse independence screening and referral. There will also be a training component for school nurses to provide oral health assessments. Lastly, a community-based dental clinic in Tonopah will be in collaboration with the Nevada Dental Foundation in the Northern Nye County district. Administrator Bierman announces that they have hired a new dental officer, Dr. Keith Benson.

Administrator Bierman then updates that they are hosting weekly office hours for the public option. They are having it every Thursday and Friday through November 7th.

Administrator Bierman also announces that Deputy Phillip Burrell has left DHCFP. She then thanks Mr. Burrell for the many years of great work he did while he was with the Division.

Administrator Bierman then gives an update on Nevada's ARPA funding. The primary ARPA funding that has come to Medicaid is the Section 9817 Home and Community-based services ARPA funding. Administrator Bierman then adds that they've added to the current waiver services specifically home-delivered mail services which include a maximum of two meals per day and it must be prior authorized by DHCFPs partners Aging and Disability Services Division (ADSD).

She then announces that DHCFP is hosting weekly office hours for the public option. It began at the beginning of October 2022, and it is occurring every Thursday and Friday through November 7th, 2022.

Administrator Bierman then highlights that a public workshop was held to review proposed regulations to revise Chapter 39A of the NAC in accordance with Senate Bill 379 of the 2021 21st Legislative Session. The proposed regulation provides provisions for certain data elements which are required under SB 379 to meet requirements for the health professional shortage area designations through the federal health resources services administration. This will support the recruitment and retention of healthcare professionals in Nevada.

She then adds an update on State Plan Amendments (SPAs). DHCFP has an approved SPA for critical access hospital maternity rates. She states that they have received approval for a provider-specific interim rate for maternity services for critical access hospitals and the goal of this change is to get money flowing in a timelier manner to critical access hospitals to lessen the amount when cost reports are submitted and audited. The provider types that will be affected by this change are provider type 75 and the critical access in-patient rates. Administrator Bierman then adds that there is another Section 1117 demonstration waiver that they have submitted to CMS, this one is for Oral Health services and implements legislation passed in 2019 in Assembly Bill 223 that required the Department of Health and Human Services (DHHS) to apply to this waiver from CMS. The purpose of this is to implement a demonstration program to provide dental coverage to adults with diabetes who are

enrolled in Nevada Medicaid and who are receiving services from participating federally qualified health centers. The goal here is to improve the health of adult Medicaid enrollees with diabetes by ensuring that they have access to oral health services.

Administrator Bierman then gives MSM updates. She states that they have amended the MSM at their public hearings for March through May. The following chapters have been updated, 400, which is mental health and substance abuse services. Proposing revisions there to provider qualifications for individual rehabilitated mental health providers to clarify qualifications, competencies and training requirements for enrollment into Nevada Medicaid. Additional clarifications were made to this chapter for outpatient services delivery models under which the out patient mental health and rehabilitative mental health services outlined in Chapter 400 are delivered. They had a public workshop on this Chapter on June 2, 2022. There were no identifying concerns from the public. The date of the revision is September 28, 2022. She then adds the updates to the Prescription Drug Chapter 1200. These updates reflect the recommendations approved at the April 28th, 2022, Drug Utilization Review Board (DUR) meeting. The proposed revisions include a title change to the Monoclonal Antibody Agents section to read as respirator and allergy biologics agents. Added new clinical criteria for Zolar for indication of nasal polyps. Added new clinical criteria to Hetlioz for indication of nighttime sleep disturbances in Smith-magenis syndrome. The creation of a new section titled movement disorder agents which combines the existing Austdedo, clinical criteria to one section as well as the addition of new clinical criteria to Ingrezza for the indication of Tardive Dyskinesia and lastly the addition of new prior authorization criteria for Vuity. All of these have an effective date of August 1, 2022.

VI. Pay for Performance

Deputy Administrator, Stacie Weeks, then gives an overview on the Division's new Pay for Performance program, It will begin January 2023 and will be every year after until the contract period ends on December 2025. In January, every year as provided in the states contract managed care plans, the Division will withhold about 1.5% of every capitation payment made to each plan for the year. This funding will create an incentive pool and will be based on quality improvements for the program. So, during the calendar year each plan has been asked to increase its improvement by a certain percentage for two quality measures for this new payment program. The first is around preventative services. Those that might be familiar with the HEDIS measure for adults' access to preventative services. It's including children as well, six and up so she just wanted to make note of that. Its really focused on seeing if plans can improve access to prevention and preventative services and for their members over the year. If their members do meet that metric, they are eligible for that payment. The other metric they are following is another HEDIS measure that is to follow up after emergency department visits for mental health services. If an individual comes in for mental health needs in the ER, there's a follow up of seven days or 30 days tracking both to ensure someone is following up with that individual to make sure they are getting services after their ER visit.

She then states if plans improve in that metric, they also are eligible for their withhold. For a plan to earn all of their withhold payment for the year they must achieve at least 2.5% improvement on this metric as compared to the benchmark here. It typically would be the year before that they are looking at based on most current data which would be from 2020. MCO's that cannot achieve this level of improvement may be eligible to receive half of their withholding payment if their efforts at least result in .5% improvement for each measure as compared to the benchmark. The Division will track performance results for quality payments based on measurement year 2023 at the mid-year mark for calendar year 2024.

VII. Unwinding Updates

Vanessa Rahme, Project Manager, then gives the unwinding updates. The COVID-19 Public Health Emergency (PHE) declaration has now been in place for more than two years since January 2020 and has been renewed 11 times. In March 2020, federal COVID-19 legislation established the "continuous enrollment condition," which gave states extra federal Medicaid funding in exchange for maintaining enrollment for all individuals, even if they are no longer eligible through the end of the month that the federal COVID-19 PHE ends. While the continuous enrollment condition does not apply to CHIP, many states implemented temporary policy changes that had similar impact on CHIP enrollment. After the PHE, states will resume normal operations, including restarting full Medicaid and CHIP eligibility renewals and ending coverage of ineligible enrollees.

She then goes on stating the Federal Department of Health and Human Services (HHS) and Centers for Medicare and Medicaid Services (CMS) are working closely with states to ensure they are ready when the PHE ends. HHS has committed to 60 days advance notice to states prior to ending the PHE. On October 13, 2022, Secretary Xavier Becerra renewed the COVID-19 PHE declaration. The assumption is COVID-19 PHE will be extended for a full 90 days, through January 11, 2023. With this assumption in mind, keys dates going forward are as follows: If this is the last renewal, then the 60-day advance notice of the end of the PHE would be issued on November 12, 2022. If this is the last renewal, then the PHE would end on January 11, 2023. If this is the last renewal, then the Medicaid continuous enrollment requirement would expire on January 31, 2023 and then first date on which a Medicaid coverage termination could be made effective is February 1, 2023. If this is the last renewal, then the 6.2 percentage point FMAP enhancement will extend through March 31, 2023.

Vanessa Rahme then adds the Nevada Department of Health and Human services (DHHS) is the Single Sate Medicaid Agency that oversees the Division of Welfare and Supportive Services (DWSS) the agency tasked with processing Medicaid eligibility decisions and the Division of Health Care Financing and Policy (DHCFP) the agency responsible for administering the plan. Nevada Health Link is the online state-base insurance marketplace operated by Silver State health Insurance Exchange (SSHIX). DWSS, DHCFP, and SSHIX are collaborating with other stakeholders and have established feedback loops, coordinated outreach, shared messaging, report progress and triage issues. The project is being overseen and directed by Sandie Ruybalid, Deputy Administrator at the request of the Governors office.

The Silver State Health Insurance Exchange (SSHIX) is the state agency that operates the online Marketplace known as Nevada Health Link. The SSHIX mission is to increate the number of insured Nevadans by facilitating the purchase and sale of health insurance that provides quality health care through the creation of a transparent, simplified marketplace of qualified health plans. She then states to ensure a smooth transition and accessing affordable health insurance by: Assessing the current date received electronically from DWSS as part of Account Transfer (AT) process. Working wit DWSS to obtain contact information for Exchange referrals that were denied/terminated for Medicaid. Conducting outreach to consumers with contact information. Connecting consumers to one of the representatives from Nevada who can assist the consumer in enrolling in a qualified health plan. As well as following up as needed to help consumers who started an application but did not complete enrollment. Some accomplishment to date were approval of American Rescue Plan Act (ARPA) funding and vendor contract to upgrade the Division of Welfare and Supportive Services (DWSS) eligibility system to automate the Medicaid renewal process (Ex-parte). This allows for electronic verification of data to auto enroll without needing to return paperwork. She also announces that they have gained CMS approval for a waiver under Section 1902 (e)(14)(A) authority to allow DWSS to update contact information received from the Managed Care Organizations without having to first reach out to the recipient to reverify the information. Also, Nevada is among 6 states to provide all 6 key documents or

information elements (posted publicly) in preparation for the unwinding for the Medicaid continuous coverage protection at the end of the public heath emergency. It is also stated that CMS may revert to original April 2020 interpretation of the Families First Coronavirus Response Act (FFCRA), which requires Medicaid agencies to maintain amount, scope, and duration of benefits instead of a tiered coverage system. On August 31, CMS released a new proposed rule, "Streamlining the Medicaid, Childrens Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes. The proposed rule seeks to strengthen existing eligibility, enrollment, and renewal operational processes to close gaps and support states in preparing for the end of the Medicaid continuous coverage requirement. Comments on the proposed rule are due no later than November 7, 2022. A heavy lift operationally if required to implement during the unwinding period with limited and strained resources.

Chair Rota Rosaschi then adds a question for Vanessa, She asks if she had an idea how much the exchange is going to be on a average. Vanessa adds that they don't have that information yet. Deputy Administrator Sandie Ruybalid then adds that there is various subsidies available so it is possible it can be free, just a matter of income level, etc. Chair Rosaschi then asks if there are providers in rural Nevada that can handle the volume of clients. Vanessa adds that it is still a challenge.

JC Flowers then asks if there are member rosters so they can know when they will sending a notice to certain specific patients so they can also assist in case they've seen those patients. Vanessa adds they unfortunately don't have roster they are communicating broadly and very generic. The members will be renewed based on there renewal date. If they weren't eligible, they continued eligibility and DWSS would then give them a 6 month renewal. Vanessa adds they've made a QR code for Access Nevada and to the member webpage.

John Phoenix then asks if there has been an increase in staffing to handle the volume that is going to occur while the unwinding happens. Robert Thompson, DWSS Administrator then states that the Welfare Division has many vacant positions, and their vacancy rate has been at an all-time high.

VIII. ARPA Request Updates

Dr. Antonina Capurro, Deputy Administrator then begins giving the ARPA Request updates. She states that they had 12 state ARPA funding requests and there was one request tied to there home and community based reinvestment ARPA funds and those were tied by priorities sent by the Governor offices in there Department of Health and Human Services (DHHS). Those work programs were created to help strengthen and enhance the services that are available to the growing number of Nevadans that are currently in Medicaid.

Dr. Capurro then adds a highlight that they have had a healthcare workforce scholarship. These scholarships are focused on there workforce shortages in medicine, nursing, behavioral health, and other health professions for there growing population across the state. The scholarships will provide financial relief to individuals and incentivize those pursuing licensure, application fees, trainings, and tuition for community health workers, doulas. Clinical rotation scholarships for student expenditures, as well as training for medical assistants. She then states that they have put forward an initiative for school based oral health services. This provides funding for individuals to create a school based Silla program which is a way to provide preventative services to Nevada's most neediest children at their school. They have also added an initiative around long-acting reversible contraceptives to expand access to these long acting reversible contraceptives (LARCs) within federally qualified health centers (FQHC) and rural health centers. By providing this funding, they will be able to reimburse their FQHCs

outside of the encounter rate for the device itself. She then states that another initiative that they are proud about is their tribal outreach. They have funding now to support tribal outreach and consultation activities. The centers for Medicare and Medicaid services requires that state Medicaid programs seek advice on a regular and ongoing basis for their Indian tribes related to Medicaid their CHIP policies and programs. This funding allows not only their Medicaid team, but their entire DHHS Division tribal liaisons to be represented at Quarterly Tribal Consultations on tribal lands.

Dr. Capurro then adds that there rural prenatal services request expands access to prenatal, labor and delivery, and postpartum services by addressing barriers that limit FQHCs and rural health clinics of services. This is a one-time funding for FQHCs and rural health clinics to build prenatal OBGYN programs. The last highlight is related to the home and community-based reinvestment fund and federal title 19 fund request. This is to temporarily expand dental benefits to individuals diagnosed with intellectual and developmental disabilities over the age of 21 years.

Olivia Smith then asks Dr. Capurro if for the funding can fund license social worker students. Dr. Capurro adds that there are several initiatives that they are funding, they have one that is a clinical rotation scholarships for students that is more open to social worker students. Dr. Capurro also states that they will be hiring a team to help write the competitive grant application and create the criteria. She states that once they have more information she can share with the committee, it is still in the early stages.

IX. Reviewal of MSM 2500 for Behavioral Health

Sarah Dearborn then gives an update on the reviewal of MSM 2500 for Behavioral Health. She states that case Management is an optional Medicaid service pursuant to federal regulations. It may be provided without the use of a waiver and the state may limit the provision of services to a specific target group or defined location in the state. States are allowed to limit the providers of case management services available for individuals with developmental disabilities or chronic mental illness to ensure that these recipients receive needed services. The receipt of case management services does not alter an individual's eligibility to receive other services under the State Plan and recipients must have free choice of any qualified Medicaid provider. The intent of case management services is to assist recipients eligible under the State Plan in gaining access to needed medical, social, educational, and other support services including housing and transportation needs. Case management services do not include the direct delivery of medical, clinical or other direct services. Components of the service include assessment, care planning, referral/linkage and monitoring/follow-up. Case management services are provided to eligible recipients who are residing in a community setting or transitioning to a community setting following an institutional stay. There are nine target groups eligible to receive this service. These groups are: children and adolescents who are Non-Severely Emotionally Disturbed (Non-SED) with a mental illness; children and adolescents who are Severely Emotionally Disturbed (SED); adults who are Non-Seriously Mentally Ill (Non-SMI) with a mental illness; adults who are Seriously Mentally Ill (SMI); persons with intellectual disabilities or related conditions; developmentally delayed infants and toddlers under age three; Juvenile Parole Population; Juvenile Probation Services (JPS), and Child Protective Services (CPS). All providers who participate in the Medicaid program must provide services in accordance with the rules and regulations of the Division of Health Care Financing and Policy (DHCFP), all policies and procedures described here in Medicaid Services Manual (MSM) Chapter 2500, as well as state and federal regulations and statutes.

Sarah then states The Lead Case Manager is only used if a recipient is included in more than one target group at a given time or is eligible to receive case management services from different programs (i.e. Certified Community Behavioral Health Centers (CCBHC), MCO, or governmental agencies). The Lead

Case Manager coordinates the recipient's care and services with another case manager. The Lead Case Manager is responsible for coordinating the additional case management services, whether or not, chronologically, the Lead Case Manager was the original or the subsequent case manager. When a recipient is eligible for a Managed Care Organization (MCO), it is the responsibility of the Lead Case Manager to ensure that the identified MCO is notified of the recipient's participation in targeted case management. The Lead Case Manager will coordinate all care with the MCO to ensure there is an elimination of any potential for a duplication of services. Medicaid recipients are entitled to receive a maximum number of hours of case management services identified in the Service Limitation Grid, Section 2502.5 per target group, per calendar month, per recipient. (Maximum hours do not apply to providers who are paid a capitated, per member/per month rate). If the recipient requires more than the allotted hours per month, the case manager must thoroughly document in the recipient's case record the justification for the additional hours and submit a prior authorization request to the QIO-like vendor. Adults, who are Non-SMI, excluding dementia and intellectual disabilities, are recipients 18 years of age and older with significant life stressors and have: A current International Classification of Diseases (ICD) diagnosis from the current Mental, Behavioral, Neurodevelopmental Disorders section including Z-Codes 55-65, R45.850 and R45.851, which does not meet SMI criteria and a Level of Care Utilization System (LOCUS) score of Level I or II.

X. Medical Unit Update on Female Health & Immunizations

Erin Lynch, Chief, then gives a medical unit update on female health and immunizations. Erin then goes on and states that Nevada Medicaid covers all U.S Preventative Services Task Force (USPSTF), A and B screening recommendations such as: Gestational diabetes screen, Hepatitis B and C infection screen during pregnancy, Perinatal depression screen, Syphilis infection screen during pregnancy, alcohol and drug screen, tobacco screen, HIV screen, intimate partner violence screen, Preeclampsia screen, Colorectal cancer screen, B=breast cancer screen, BRCA genetic testing, cervical cancer screen, and Gynecological exams. Family planning services and supplies are for the primary purpose to prevent and/or space pregnancies. This includes office visits and FDA approved birth control drugs and devices) (i.e. –birth control pills, condoms, patch, intrauterine device (IUD), etc.) Sterilization by tubal ligation (age 21 years or older) is covered. A pelvic exam pap smear is not required for self-administered birth control. Family planning services are not covered for recipients, regardless of eligibility, whose age or physical condition precludes reproduction. Some other covered services are, Doula Services, lactation support and breast pumps. Breast pumps are available for those under 21 years of age if medically necessary through EPSDT coverage. WIC can also provide breast pumps to Medicaid recipients. Also, abortions, which are only available if due to rape, incest, or to save the life of the mother. Hysterectomies are also covered only if medically necessary. According to federal regulations, a hysterectomy is not a family planning procedure. Hysterectomies performed solely for the purpose of rendering a female incapable of reproducing are not covered by Medicaid. They also cover behavioral health services to support postpartum health. As well as vaccinations, dental, and prescribed drugs.

XI. Request for Applications for Open Positions

Chairwoman Rota Rosaschi then announces that there are three open positions for the MCAC. The first open position is "a member of a profession in the field of health care who is familiar with the needs of persons of low income, the resources required for their care and the availability of those resources". The second open position is "An administrator of a facility for intermediate care or a facility for skilled nursing", and lastly, the third open position is, "A member of an organized group that provides assistance, representation or other support to recipients of Medicaid."

Chair Rosaschi then announces that she will be retiring at the end of the year and her position will soon be open. Chairwoman Rosaschi then states that if anyone is interested in joining the MCAC, they can send in there resumes to Dr. Antonina Capurro or Angelica Velazquez Arias.

Dr. Capurro then expresses how grateful she is with Chair Rosaschi for the willingness she had to take on the chair position.

XII. Discussion and Approval of 2023 Meeting Dates (February, May, August, November)

The committee agrees to have these meetings the second Tuesday of every quarterly month 9:00am-12:00pm PST.

XIII. For Possible Action: Recommendations for Future Agenda Items

Chairwoman Rota Rosaschi asks the committee if they have any future agenda items. John Phoenix then adds that he sent his future agenda item recommendations to Angelica Velazquez Arias.

XIV. Public Comment

No public comments were made.

XV. Adjournment

Chairwoman Rota Rosaschi adjourned the meeting at 11:47am.