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DRAFT MCAC MEETING MINUTES

Date and Time of Meeting: February 6, 2024 at 9:00a-12:00p

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	
Dr. Adnan Akbar, Chairperson	**X**
John Phoenix, Vice Chairperson	**ABS**
Dr. Susan Galvin	**ABS**
Dr. Ryan Murphy	**ABS**
Dawn Lyons	**X**
Sharon Moffett-Austin	**X**
Dr. Ihsan Azzam	**ABS**

I.

II. **Call to Order**

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

III. **Roll Call**

Chair Dr. Akbar asked for roll call. A quorum was not established.

IV. **Public Comment**

No public comment was made.

V. **For Possible Action: Review and approve meeting minutes from the meeting held on November 30, 2023.**

Chair Dr. Akbar called for a motion to amend or approve the draft minutes from the November 30, 2024, MCAC Quarterly Meeting. A motion to approve the draft minutes was not presented due to a quorum not being established.

VI. **Administrator's Report**

Administrator Stacie Weeks begins her administrator's report update. As of now, they have submitted about 25 State Plan Amendments (SPA). She states that they have been experiencing delays from the Federal level. The Federal government has the same challenges as the Division. For example, new staff, staffing shortages, and turnover as well.

VII. **Managed Care Expansion Overview & Updates/Medicaid Fee for Service vs Managed Care Overview**

Jaimie Evins, Social Services Chief III, begins her presentation on Managed Care Expansion and the Medicaid Fee for Services vs Managed Care overview. She then begins by stating that Nevada Medicaid has two delivery models. They have a Fee for Services (FFS) and a Managed Care Organization (MCO) System. Under the FFS model, the state sets rates and pays providers directly per service. It rewards providers only for the volume of services provided. This is a risk to the state budget and has no utilization management. Populations covered under the FFS model include home and community-based waiver recipients and the aged, blind, and disabled.

Under the managed care delivery model, the state contracts with managed care organizations (MCOs) to manage cost, utilization, and quality of care. The MCOs are paid a capitation rate which is a fixed dollar amount per member, per month. The MCOs are responsible for developing provider networks, sufficient for providing services to their enrolled population. In developing their network, MCOs negotiate rates with their providers.

Jaimie then adds that MCOs must provide the same amount, frequency, duration, and scope of services as provided to recipients under FFS. Some services are "carved out" of Managed Care. This means the services are paid for/authorized by Fee for Service instead of Managed Care Organization. Some of the services carved out of Managed care include non-emergency transportation, ground emergency transportation, orthodontics, nursing facility stays over 180, etc. In addition to the medically necessary state plans covering services, MCOs have the flexibility to offer value-added benefits. Value-added benefits (VABs) are additional services offered by an MCO that are not covered by FFS and are at no cost to eligible members. VABs are paid for with MCO profits, not Medicaid dollars. There are some federal restrictions on VABs including prohibitions on providing members large gift cards to box stores, like Amazon or Walmart. Jaimie then adds that another flexibility that's available under managed care is In Lieu of Services (ILOS). ILOS are optional services that if approved by CMS allow Medicaid funds to pay for the services. They must be cost-effective and replace an otherwise covered service. The state is requesting ILOS coverage for housing supports, and services as a replacement to ER visits and inpatient stays for the homeless population. Housing transition supports will assist Medicaid Recipients with securing housing. House-related deposits will help Medicaid recipients with identifying, securing, and/or financing one-time services and modifications necessary for establishing a household. Housing sustainment services will be offered to support Medicaid recipients in sustaining safe and stable tendencies once housing is secured. Lastly, specialized case management for homelessness will support Medicaid recipients who do not have a home and have high medical and behavioral health needs to improve continuity of care in the transition from inpatient, correctional, or institutional/residential settings.

As of January 1, 2026, about 75,000 more Nevadans will receive coverage through Medicaid Managed Care Plans. The expansion will not include certain FFS enrollees who fall under these eligibility categories; Katie-Beckett program for children, children in the welfare system (foster care and juvenile justice), individuals with disabilities, seniors (ages 65 and older), and people in home and community-based waiver services.

Chair Akbar then asks Jaimie, when someone transitions to hospice, they are rolled out of an MCO and get automatically enrolled into FFS, what is the transition period looking like for the beneficiaries? Jaimie then answered, that as soon as the level of care is submitted to DHCFP fiscal agent, they put in the benefit line that identifies that the member is on hospice. That's when they get dropped to FFS, so it depends on how quickly the

provider submits that request to the state. Jaimie then adds that a recipient has 90 days to request a switch of MCOs.

VIII. **Medicaid Budget Overview**

Administrator Stacie Weeks then begins her presentation on the overview of the Medicaid budget. Nevada Medicaid plays a critical role in the lives of over 900,000 Nevadans, which is about one in four Nevadans. Medicaid covers the cost of health care for these Nevadans and their families. It also covers 1 in 2 births in Nevada. Almost half of the recipients are children. Since the COVID-19 pandemic, the size of the Medicaid population has grown by about 40%. Administrator Weeks then states that the federal government pays a guaranteed share (%) of costs for services when "matchable" – covered by state plan or waiver authority. The amount of federal share varies by state and is based on Federal Medical Assistance Percentage (FMAP). Nevada's FMAP is about 60% but varies based on population or other factors. For example, covered services for the newly eligible population (Medicaid expansion) receive 90% FMAP. Also, states must be able to cover the state's share of the program's costs (entitlement benefit); the federal government audits states for compliance. Regarding FMAP, service must be matchable (eligible for federal share), or Medicaid cannot reimburse the provider.

Administrator Weeks then continues discussing Medicaid Provider payments. She states all enrolled Medicaid providers are eligible for the base payment rate per service or encounter. Base payments are based on a methodology. Some providers may receive supplemental payments per claim based on certain arrangements in FFS or Managed care (upper payment limit supplemental payments and state-directed payments). Also, bonus payments are less common and reflect value-based payments that reward providers for achieving efficiencies or specific levels of quality or outcomes.

Administrator Weeks then continues with her update on budget planning for the 2025 legislative session. To increase provider rates and add new services or spending to their approved base spending levels, the Division must request additional state funding (budget authority) from the legislature. This occurs every two years during the biennial legislative session; the Division is planning for the governor's budget proposal for the 2025 session. Like other agencies, they do not know at this time how much (if any) the Division will be able to request in new funding/spending or enhancements. Administrator Weeks then continues by adding that the information about the development of the budget proposal and the Governor's final budget package is confidential until released before the session. She states that they're seeking public input on areas of focus for any new spending.

IX. **Public Comment**

No public comments were made.

X. **Adjournment**

Chair Dr. Akbar adjourns the meeting at 10:08 am.