DRAFT MCAC MEETING MINUTES

Date and Time of Meeting:	May 7, 2024 at 9:00a
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	**X (Joined late)**
Dr. Susan Galvin	**X**
Dawn Lyons	**X**
Sharon Moffett-Austin	**X (Joined late)**
Dr. Ihsan Azzam	**X**
Dr. Todd Gray	**ABS**

I. Call to Order

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

II. Roll Call

Chair Dr. Akbar asked for roll call. A quorum was established.

III. Public Comment

Julie Peterson then continues by sharing, that Medicaid ended comprehensive rehab services for persons with brain injury, Nevada has shown a spike in long-term care, re-hospitalization, homelessness, and mortality for this population. She states before this, they had a 95% return to home and community after appropriate rehab services were provided. Now, instead of paying for recovery and return to work and home after comprehensive rehab, the state is paying for a long-term housing and care plan solution that does not cover any remediation efforts. Patients don't get better because they don't get adequate therapy or case management; thus, this population continues to grow, and the qualification criteria for the non-skilled habilitation program, or 1915i, continues to become more and more narrow/stringent. For instance, a brain-injured person who does not know who or where he is can no longer speak, and has no memory to find his way around the block after an impulsive choice to take a walk in 120-degree sun would not qualify for the program. Worse, the people who determine qualification are not clinicians and have no background or formal education in any skilled therapy to know whether a person is truly in need or what those needs entail. Another example would be a person who has Aphasia and cannot use or understand language any longer. In more than one case we have experienced, the state worker has determined that the person did not show participation in the evaluation and thus did not qualify for services.

The patients we serve in our comprehensive rehabilitation program have been hospitalized long term, have lost their jobs, and most of them have lost their medical insurance and even sometimes their spouses and custody of their children. When the hospital discharge occurs, patients don't yet have a disability, social security, or Medicaid. There is also nowhere for them to go and no one to assist them. Far too often, the choices are back to the hospital, institutionalization, or to the streets. More than half of our brain-injured population in Nevada end up homeless. The current Habilitation program (1915i) does not assist brain-injured patients with any of these resources and does not pay for physical, occupational, or speech therapy or for much-needed case management.

There is only a very limited provision under PT34 for FFS Medicaid clients who are brain injured to get a limited amount of therapies, but these are one session at a time for each discipline and are not scheduled in accordance with one another or coordinated with medical care or case management, which is crucial at this point. After leaving the hospital, patients are in no condition to access these single therapy services which can be scheduled at different times and days of the week. These patients can't easily be placed in a car, can't easily or independently make a phone call to schedule a bus (which also causes them to miss medical appointments), can't drive, can't pay attention or remember their appointments, many times have no insurance so can't access Medicaid, and have no ability to communicate or understand how to access therapy or needed case management or medical services. That is where comprehensive rehab immediately following the brain injury would come in. We desperately need these services in Nevada.

Comprehensive Rehab Services are post-acute services set up using a per diem rate; one rate for a full day of rehab only (patients are transported from home), and one rate for a residential day (when patients require 24/7 assistance and supervision). Comprehensive Rehab Services include physical therapy, speech therapy, occupational therapy, case management, nursing, and additional medical management/oversight. These are not luxury services; these are necessary services that need to be coordinated for persons with brain injury. For patients who are fortunate enough to receive comprehensive rehab services, all medical care is coordinated for them with in-network providers in their discharge communities until they learn to and are able to coordinate their own care again. Patients who receive these services see a 95% discharge to the community, a 70% return to work, and a less than 10% return to acute. Unfortunately, patients who only receive the 1915i habilitation program are receiving 98% discharge to a state-funded Assisted Living Facility or higher level of care, <1% return to work, and a 30% return to acute. Nevada is only one of four states that does not have any Medicaid or waiver program for brain injury rehab which includes therapy. She states she urges the committee to please include comprehensive rehab services for persons with brain injuries in your annual letter of recommendations to Nevada Medicaid.

IV. New Committee Member Introductions

a. The new member, Dr. Gray, was not present at the meeting and will be introduced at a later meeting.

V. For Possible Action: Review and approve meeting minutes from the meeting held on November 30, 2023, and February 6, 2024.

a. Chair Dr. Akbar called for a motion to amend or approve the draft minutes from the November 30, 2023, and February 6, 2024, MCAC Quarterly Meetings. A motion to approve the draft minutes was made by Dr. Azzam and seconded by Dr. Galvin. The motion was passed.

VI. Administrator's Report

a. Dr. Malinda Southard, Deputy Administrator, DHCFP, presented the administrator's report. Dr. Southard discussed the Transforming Children's Behavioral Health care initiative noting DHCFP is seeking approval to implement home and community-based services for children with dual diagnoses of intellectual and developmental disorder.

VII. CMS Proposed Rule 2442-P Discussion

a. Monica Schiffer presented on the CMS Final Rule 2442-P as it pertains to the Medical Care Advisory Committee. This rule changes the the MCAC to the Medicaid Advisory Committee (MAC) with 25% of its members needing to come from a Beneficiary Advisory Committee (BAC) that will be formed in the coming year. The presentation on this discussion can be found here: 2024 MCACArchiveHome (nv.gov)

VIII. Discussion: Discussion of Annual Letter of Recommendations

IX. Public Comment

No public comments were made.

X. Adjournment

Chair Dr. Akbar adjourns the meeting at 9:45 am.