DRAFT MCAC MEETING MINUTES

Date and Time of Meeting:	Wednesday, March 2, 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	**Present**
Rota Rosaschi, Chairperson	**X**
John Phoenix, Vice Chairperson	**X**
Dr. Aaron Dieringer	**ABS**
Peggy Epidendio	**ABS**
Dr. Susan Galvin	**ABS**
Dr. Ryan Murphy	**ABS**
Dr. Kelsey Maxim	**X**
Kimberly Palma-Ortega	**X**
Non-Voting Member Attendance	
Ihsan Izzam	**X**

Teleconference and/or WebEx Attendees
(Note: This List May Not Include All Participants, Just Those Who Identified Themselves)

Abigail Bailey, DHCFP
Aida Blankenship, DHCFP
Aodhan Downey
April Caughron, DHCFP
Ashley Barton, DHCFP
Ashley Jonkey
Athanasia Dalacas, DAG
Barry Gold
Broc Finlayson
Brooke Page
Cari Herington
Caroline Bergner
Casey Angres, DHCFP
Cathy Crocket
Chris Bosse
Christian Thauer
Christina Trovato, DHCFP
Krystle Daniels
Kyril Plaskon, DHCFP
Lacey Hour
Laurie Curfman
Lawrence Henry
Leann McAlliste, NVAAP
Linda Anderson
Lisa Swearingen, DWSS
Lori Follett, DHCFP
Luke Lim
Maggie Craney
Marlene Lockard
Melissa Boesen
Michael Barrett
Monica Schiffer, DHCFP
Phil Su
Kristen Tjaden

Colby Nichols
Connie McMullen
David Escame
Debra Kawcak
Diane Ross
Donalda Binstock
Dr. Amy Levin
Dr. Antonina Capurro, DHCFP
Dr. Lisa Thompson
Ellen Flowers, DHCFP
Emma Curto
Erin Lynch, DHCFP
Gladys Cook
Hardeep Sull
Jackie Matter
Jacqueline Hernandez
Jason Dworin
Jeana Piroli
Jeanette Verdin
Jennifer Atlas
Jessica Vannucci, DHCFP
Joan Hall
John Kucera
Kaelyne Day, DHCFP
Katie Allen
Keibi Mejia
Kirsten Coulombe, DHCFP
Phillip Burrell, DHCFP
Rachel Herzog
Regina De Rosa
Rianna White
Robin Ochsenschlager, DHCFP
Robyn Gonzalez, DHCFP
Rossana Dagdagan, DHCFP
Sandra Stone, DCFS
Sarah Hunt, NHA
Sarah O'Toole
Scott Allocco
Shannon Litz, DHHS
Sharon Austin-Moffett
Sheila Heflin-Conour, DHCFP
Stephanie Sadabseng, DHCFP
Steve Messinger
Susana Angel, DHCFP
Suzanne Bierman, DHCFP
Tanya Benitez, DHCFP
Tess Opferman
Theresa Carsten, DHCFP
Tiffany Saunders-Newey
Tina Caburnay
Tyler Shaw, FRPA
Valerie Balen
Vicki Jessup
Vimal Asokan

I. Call to Order

Chairwoman Rosaschi called the meeting to order at 9:03 AM.

II. Roll Call

Chairwoman Rosaschi asked for roll call. A quorum was established at 9:18 AM.

III. Public Comment

Barry Gold, Director of Government Relations for AARP Nevada, made the first public comment. The first topic of discussion was on the redistribution of beneficiaries and patients within the different managed care organizations. Mr. Gold stressed the importance of making sure the process and the information is really clear and timely, with an option to stay with the current managed care organization. The second comment was regarding the public health emergency unwinding plan. Mr. Gold would like to make sure that that there is a clear process in place for eligibility redetermination. There should be a consumer-friendly eligibility process in place, correct addresses for beneficiaries, and comprehensive outreach activities in place. Would like to make sure that the auto-enrollment process is in place and Nevada Health Link is involved. Mr. Gold advised that Nevada is one of only four states in the country that does not use ex-parte (or what Mr. Gold referred to as “auto-redeterminations”), although he has been assured that software has been purchased to allow for

auto-redeterminations. Mr. Gold's primary objective is to make sure beneficiaries and patients have access to quality, affordable health care through Medicaid.

The second public comment was from Cari Herington, Executive Director for the Nevada Cancer Coalition, regarding Cologuard, CPT code 1815282. Executive Director Herington read a letter of support:

On behalf of Nevada Cancer Coalition (NCC) and our partners working to reduce the incidence of colorectal cancer (CRC) throughout Nevada, we request that you add Cologuard (CPT 81528) to a future agenda. The Nevada Preventative Services Policy states all United States Preventative Services Task Force (USPSTF) A or B recommended screening tests should be covered by Nevada Medicaid. Currently, Nevada Medicaid does not cover Cologuard which is a USPFTF Grade A recommendation. Covering Cologuard would increase access to life-saving colorectal cancer screening in our state. In Nevada, colorectal cancer is the third leading cause of cancer death for both men and women, with an estimated 1,430 persons projected to die of colorectal cancer in 2022. The United Sates Preventative Services Task Force (USPSTF), an independent advisory committee that informs national guidelines regarding prevention and early detection services to be considered for mandated insurance coverage, recommends everyone 45 years and older at average risk for colorectal cancer needs to get screened. The USPSTF awarded Cologuard a Grade A recommendation as an effective screening for colorectal cancer for adults 45 years and older who are at average risk for colorectal cancer. Cologuard screens for colorectal cancer by detecting certain DNA markers and blood in the stool. Nationally, Cologuard is covered on 39 state Medicaid programs encompassing more than 85% of Medicaid patients. Providing more screening options increases overall screening rates, effectively lowering late-stage diagnosis rates and increasing cancer survivorship. As an effective screening choice, nationally, Cologuard has proven to increase patient compliance by 67 % with a 90 % patient satisfaction rate for all participants. Patient preference is critical to increasing patient screening compliance. As evidence indicates, increased screening options will improve overall colorectal cancer screening rates, decrease late-stage detection, increase cancer survivorship, and decrease overall costs. As such it is recommended Nevada Medicaid provide Cologuard as an effective screening option to those of average risk and 45 years and older.

The final public comment was from Shawna Ross, State Advocate for Reimbursement for American Speech-Language-Hearing Association (ASHA). Ms. Ross read a letter of support:

On behalf of the American Speech-Language-Hearing Association and the Nevada Speech-Language-Hearing Association, we write respectfully to request that the Nevada Medicaid program reimburse speech-language pathologists for use of the following Current Procedural Terminology (CPT©) codes: 92612 Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording (FEES); 92511 Nasopharyngoscopy with endoscope; and 31579 Diagnostic laryngoscopy with stroboscopy. We further ask the Medical Care Advisory Committee (MCAC) to add discussion of these codes to their agenda for discussion and review. The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 223,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. There are over 970 ASHA members who reside in Nevada. The Nevada Speech-Language-Hearing Association (NSHA) is the professional state organization for speech-language pathologists and audiologists whose mission is to provide continuing education credits (CEUs) to members, educate the public about the profession, lobby for legislation that impacts the professions, and provide a network of students, clinicians, and educators in their fields. The flexible fiberoptic endoscopic evaluation of swallowing (FEES) procedure may be completed in an outpatient clinic or at a patient's bedside by passing an endoscope through the nose. FEES is used without concerns of radiation exposure and can be used within therapeutic contexts and for diagnostic therapy to assess current progress and effectiveness of swallowing therapy. SLPs do not require special certification to perform instrumental assessments. Like all distinct procedures, SLPs

with appropriate training and competence in performing FEES are qualified to use this procedure independently for the purpose of assessing swallowing function and related functions of structures within the aerodigestive tract. Nasopharyngoscopy with endoscope is a diagnostic procedure used for examining the nose, throat, and airway. A scope is inserted through the nose and slowly advances to the back of the throat where pictures are taken. During a diagnostic laryngoscopy with stroboscopy, the provider is viewing the vocal fold vibrations by using high speed flashes of light timed to the patient's voice frequency. Photos are taken to show the vibration of vocal folds during sound production, a critical aspect of voice function. The Nevada Practice Act does not require physician supervision of SLPs while performing these services or any others within their scope of practice. Forty-five states recognize these services. as within the scope of practice for speech-language pathology and does not require physician supervision. Many state Medicaid programs include coverage of these codes. The Medicaid programs in Colorado, Utah, and California cover FEES provided by SLPs. California's Medicaid program also covers nasopharyngoscopy with endoscope. In June 2011, Dr. Don Berwick, then Director of the Centers for Medicare & Medicaid Services (CMS), acknowledged that "while physicians perform these diagnostic procedures, speech pathologists also perform these procedures to evaluate and treat a patient's functional/use problems." Dr. Berwick's correspondence removed all supervision levels previously assigned to the procedures. Thus, CMS declared that SLPs were qualified to perform these services. The importance of covering the above-mentioned codes for SLPs cannot be underscored enough. These procedures are important for determining a patient's swallowing and voice abilities and/or assessing therapeutic progress. These codes are on the Nevada Medicaid physician fee schedule and populated with values there. Given that these procedures are part of the scope of practice for speech-language pathology and there is no physician supervision requirement, it is appropriate that Nevada include these codes on the Medicaid fee schedule for SLPs.

IV. For Possible Action: Review and approve meeting minutes from the meeting held October 19, 2021.

Chair Rosaschi called for a motion to amend or approve the draft minutes from the October 19, 2021, MCAC Quarterly Meeting. A motion to approve the draft minutes as presented was provided by John Phoenix, and a second was provided by Dr. Ihsan Izzam. Motion passed unanimously, with a note to correct the spelling of Chair Rosaschi's last name in the document.

V. For Possible Action: Discussion of Vice Chair Position, Including Nominations and Possible Vote

Chair Rosaschi opened up this item for discussion. There hasn't been an MCAC Vice-Chair in quite some time. This person would stand instead of the Chair should the Chair not be available to hold a meeting. John Phoenix requested clarification on requirements to be the Vice Chairperson. Chair Rosaschi advised that the only requirement would be that the individual is already a member of the MCAC.

A motion to nominate John Phoenix as Vice-Chair was provided by John Phoenix, and a second was provided by Dr. Kelsey Maxim. Motion passed unanimously

VI. Administrator's Report

Suzanne Bierman, Administrator of the Division of Health Care Financing and Policy (DHCFP), spoke to the Medicaid Services Manual (MSM) and State Plan Amendment (SPA) updates. The Nevada State Plan Attachment 3.1-A is being updated to reflect a change in the coverage for Tobacco Cessation Counseling. Nevada State Plan Support SPA 6.3 Behavioral Health Coverage requires the coverage of Tobacco Cessation for all Nevada Medicaid recipients. Nevada State Plan Attachment 3.1–A is being revised to remove language reflecting Tobacco Cessation coverage for Pregnant Women Only. A change to encounter limitations is being added to no more than 24 sessions per calendar year. No changes are being made to Tobacco Cessation products. Revisions to MSM Chapter 200 are being proposed to update the Authority page to reflect accurate titles and descriptions. In addition, as a result of the passing of Assembly Bill 287 from the 81st Legislative Session, language updates

throughout MSM Chapter 200 and MSM Chapter 600 renaming birth centers and obstetric centers to freestanding birthing centers. Lastly, the removal in MSM Chapter 200 of two accreditation organizations and Memorandum of Understanding requirements for freestanding birthing centers. Revisions to MSM Chapter 400 (Attach C) are being proposed to remove the language "for pregnant women only" from any association with Tobacco Cessation. Revisions to MSM Chapter 3600 are being proposed to align with the new contract held with the contracted Managed Care Organizations (MCOs). The proposed changes include revisions and clarification to existing policy related to MCO responsibility and coverage of Certified Community Behavioral Health Centers (CCBHCs); Residential Treatment Centers (RTC); and Population Health program. Revisions to MSM Chapter 600 are being proposed to add a new provider, Community Health Workers (CHWs), a result of the passage of Assembly Bill (AB) 191 and Senate Bill (SB) 420 during the 81st Legislative Session. CHWs provide recipients culturally and linguistically appropriate health education for the prevention and management of chronic disease under the supervision of a Nevada Medicaid enrolled Physician, Advanced Practice Registered Nurse (APRN) or Physician Assistant (PA).

Administrator Bierman provided an update on previous NICU topic. DHCFP did not move forward with proposed policy changes outlined in the October 2021 MCAC meeting due to feedback from the group, but instead is focusing efforts on further data collection/research to evaluate Nevada's neonatal trends and statistics. DHCFP will be doing further evidence-based research to shore up future policy decisions.

VII. Managed Care Update

a. Managed Care Organization Redistribution

Theresa Carston, Social Services Chief III for Managed Care Quality and Control, gave a status update on the MCO distribution process that occurred during the onboarding and implementation of the new MCO contracts, which began on January 1, 2022 and will run through and expire on December 31, 2025. The division assigned 25% of the head of household assignments equally across the 4 MCO plans, which is approximately 160,000 members to each plan. Members were notified that they have a 90-day choice period, which allows them to switch their plans to an alternative MCO through March 31, 2022. To date, 68,380 members have exercised their choice to switch plans and the majority of those choices were made in the month of January. Approximately 96% of those members that made a choice selected to a return to Anthem or Health Plan of Nevada. In the month of January 2022, the division held Command Center meetings with participation from each MCO on a daily basis twice per day and all issues were documented and tracked to completion in February 2022. The command center meetings were decreased from daily to every other day as issues were winding down. To date, 184 issues have been identified in total and 180 of those issues have been resolved. The top 3 reported issues were members in need of assistance in scheduling services, members that were switched health plans and needed assistance with scheduled surgeries, and members in need of assistance in obtaining prescriptions. Once the member choice period ends on January 31, 2022, all MCO members will be locked into their current MCO until the next open enrollment period begins in January 2023 and will be held.

All members were notified of the MCO changes starting in October 2021 and notified again in December 2021. There was also a social media campaign in conjunction with the MCOs and DWSS to notify members and also try to obtain updated addresses.

b. Dental Benefit Administrator

Theresa Carston, Social Services Chief III for Managed Care Quality and Control, gave a status update on the Dental Benefits Administrator request for proposal (RFP). The division submitted the RFP to Purchasing in December 2021 and Purchasing should have it posted in the coming weeks. The exact posting date is TBD.

VIII. For Possible Action: Enrollment and Expansion Discussion and Possible Recommendations regarding communication plan

a. General Update from Division of Welfare and Supportive Services (DWSS)

Lisa Swearingen, Chief of Eligibility & Payments Unit at the Division of Welfare and Supportive Services, provided an updated on the redetermination strategies for the Public Health Emergency (PHE) Unwinding. Based on the currently redetermination process, all Medicaid programs require a renewal of eligibility once every 12 months. Medical redeterminations (RDs) are mailed out 60 days prior to end of the current 12-month eligibility period. Completed redeterminations (RDs) received timely are processed to avoid an interruption on coverage. RDs not returned before the deadline have an additional 90 days to submit a completed packet but may experience an interruption in coverage. During the Public Health Emergency (PHE), DWSS has maintained eligibility for all households that fail to respond to the requested RD packet. Additional opportunities exist to complete an RD for households on active SNAP or TANF cases. DHHS and its Divisions have increased efforts to inform participants of the need to ensure their address and contact information is up to date in our systems. Individuals are encouraged to sign up for electronic communications through Access Nevada. Returned mail is the biggest single issue, which is being addressed DWSS developing a dedicated unit for mail processing, leveraging other assistance programs such as SNAP and TANF to share data, and a public awareness campaign. Timeframe for action: CMS has authorized 12 months after the PHE ends to process redeterminations for all Medicaid enrollees. DWSS strategic planning has called for a shorter timeframe of 6 months to avoid delay in returning to normal operations. However, this will most likely extend to 9 months due to processing timeframes. DWSS remains flexible due to staffing and system limitations. DWSS is in the process of securing a contract to implement ex-parte renewals for our Medicaid households.

b. Public Health Emergency Unwinding Communication Plan

Administrator Bierman highlighted the importance of the work that DWSS is doing around redeterminations and emphasized that DHCFP and DWSS are working closely together on this important matter. Since the beginning of the PHE in March 2020, the Federal Government put measures in place to ensure Medicaid recipients do not lose coverage. These measures are set to end with the PHE. There is a strong focus for both divisions on avoiding any inappropriate coverage loss following the end of the PHE.

IX. Legislative Updates

Dr. Antonina Capurro, Deputy Administrator of Policy and Programs at the Division of Health Care Financing and Policy, provided the following legislative updates:

a. AB 191

The purpose of this this bill is to allow community health workers (CHWs) to enroll as a Medicaid provider type. The state plan amendments (SPAs) were sent to CMS in September 2021, and we had a public hearing at the end of January 2022. Also, at the end of January, the Medicaid Service Manual Chapter 600 was updated with policy language and was approved for an effective date of February 1, 2022, pending CMS approval. A web announced was released at the end of January to inform community health workers of how they can move forward to enroll as a provider type. DHCFP will be holding a public hearing on March 11, 2022, to add the Community Health Worker policy language to MSM 2900, which is specific to federally qualified health centers.

b. AB 256

The purpose of this bill is to create a Medicaid-eligible provider type for Doulas. The Nevada Certification Board has agreed to become the certifying body for doulas in Nevada in order for them to become a registered Medicaid reimbursables provider type. We are currently pending

CMS approval and have a public hearing scheduled for March 29, 2022, to move forward with the policy changes to MSM Chapter 600 to add this new provider type.

c. SB 190 and SB 325

The purpose of these bills is to increase access to oral contraceptives and HIV preventative medications such as PREP and PEP through a pharmacy point of care and making those services billable to Nevada Medicaid when they're provided by a pharmacist. To implement these bills, DHCFP is creating a new pharmacist provider type working in compliance with the Nevada Board of Pharmacy. The Nevada Board of Pharmacy is working to create and approve regulations that pharmacists will follow, along with some specific certifications that will be set forth for individual enrollment. The State Plans have been submitted to CMS and are currently under review.

d. SB 156

The purpose of this bill requires DHHS to ensure that crisis stabilization services are provided at hospitals, with a crisis stabilization center endorsement, and that they are covered as reimbursable for their services under Medicaid. DHCFP is moving forward with the Chapter 400 policy changes. A public workshop was held earlier in 2022 and the public hearing is scheduled for March 29, 2022.

e. SB 329 and SB 379

These are bills that are new to DHCFP because in November of 2021 the Primary Care Office (PCO) was moved from the Nevada Division of Public and Behavioral Health (DPBH) to DHCFP. The PCO is now housed within the DHCFP Medical Programs Unit. The fiscal responsibilities of the PCO are currently being moved from DPBH to DHCFP. DHCFP is currently working with stakeholders to gather more information about these bills so that they can be accurate and effectively implemented.

X. For Possible Action: Grant Update

Dr. Antonina Capurro, Deputy Administrator of Policy and Programs at the Division of Health Care Financing and Policy, provided the following Grant updates:

a. HRSA 22-050

This grant is meant to support States in developing and implementing innovative programs to address the Oral Health Workforce needs of designated Dental Health Professional Shortage Areas (HPSA). This is a 4-year grant with award of up to $400,000 per year. With the movement of the PCO to DHCFP, this is a great opportunity to seek funding to build the program and to have a more robust structure to reach the workforce needs throughout Nevada. This grant was submitted at the end of January 2022 and had significant support from the State's Dental Benefit Administrators and dental partners throughout the state.

b. CMS-2Y2-22-001

This grant is meant to connect kids to health care coverage and provides funding to reduce the number of children who are eligible for but not enrolled in Medicaid or the Children's Health Insurance Program (CHIP). This grant should also help to improve retention of eligible children who are enrolled in Medicaid/CHIP. Also included is a focus on providing outreach and engagement efforts for pregnant women. This is a 3-year opportunity with a $500,000 award ceiling per year. The grant application is due at the end of March and the team that has been assembled is working on crafting the program to meet this deadline.

XI. Medicaid Home and Community-Based Services and American Rescue Plan Act Update

Kirsten Coulombe, Social Services Chief III of Long-Term Services and Supports within DHCFP, provided an updated on the American Rescue Plan Act (ARPA). DHCFP is currently working to implement initiatives that are included in the spending plan. Several of the initiatives went to the February Interim Finance Committee (IFC), including a request for supplemental payments related to the direct reimbursement to Home Care Workers of $500, a request for supplemental payment increases to providers who have home health agencies, personal care agencies, adult day care, adult day healthcare, and also a request to restore cuts from AB 3 from special session in 2020. Future plans include a request at the April IFC to expand waiver services to home delivered meals to the frail and elderly. Other requests for the April IFC include a request for a study to evaluate HCBS waiver and state plan option rate methodology and a request for technical assistance membership for evidence based medical and drug policy association, and finally a request for additional staff to support new initiatives and activities.

XII. For Possible Action: Presentation Regarding Processes for Handling Requests for Non-covered Services and Possible Referral of Contacts to Medical Care Advisory Committee, Including Review of Draft Letter Template

Erin Lynch, Chief III of the Medical Programs Unit at the Division of Health Care Financing and Policy, gave an update on the new process for handling requests for non-covered services and possible referral to the MCAC. Historically, DHCFP would conduct research, including Fiscal Impact Reports and SWOP (strengths, weaknesses, opportunities, and weaknesses) paper, for each of the request that was received. A significant amount of work could go into this research only to find out later that the request is denied due to lack of funding. Due to the high number of requests DHCFP receives and the lack of success using the old process, a new process has been assembled. A template letter has been created that directs those making these requests to gather specific information and submit it to the MCAC for review. The letter explains the lack of budget authority, provides details of the legislative sessions and requests that information be submitted to the MCAC for referral. Legislative approval will still be required for any of these requests, but the MCAC will have the opportunity to review the request and make referrals. Once a request for non-covered services is received, that will trigger the letter to be sent out to the requesting party.

Chair Rosaschi called for a motion to approve the new process for non-covered service requests and possible referral to the MCAC. A motion to approve was provided by John Phoenix, and a second was provided by Kimberly Palma-Ortega. Motion passed unanimously.

XIII. For Possible Action: Recommendations for Future Agenda Items

a. **Cologuard (CPT 81528)**
   Non-covered service request.

b. **April: Review of MSM for Long Term Supportive Services Unit**
c. **July: Review of MSM for Medical Unit**
d. **October: Review of MSM for Behavioral Health Unit**
   Reviews of MSM chapters that require MCAC feedback.

e. **Review of Bylaws and Discussion of Possible Amendments**
   The Bylaws have been amended and will be submitted for review and approval once the new DHCFP DAG has had the chance to review.

All future agenda items have been accepted. John Phoenix requested that SB 211 be added to the next agenda. SB 211 is a requirement for health care providers to have conversations with patients around sexual health and testing.

XIV. Public Comment

Barry Gold from AARP left a comment inquiring how many individuals were switched to a new MCO and then chose to go back to the original MCO. Theresa Carsten from DHCFP will follow up with Barry Gold to provide a response.

XV. Adjournment

Chairwoman Rosaschi adjourned the meeting at 10:46 AM.