DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Care Financing and Policy
*Helping people. It's who we are and what we do.*

**MCAC MEETING MINUTES**

Date and Time of Meeting: Wednesday, May 25, 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** | **No longer MCAC member** |
| **Peggy Epidendio** | **No longer MCAC member** |
| **Dr. Susan Galvin** | **ABS** |
| **Dr. Ryan Murphy** | **X** |
| **Dr. Kelsey Maxim** | **X** |
| **Kimberly Palma-Ortega** | **ABS** |
| **Non-Voting Member Attendance** | |
| **Dr. Ihsan Izzam** | **X (Had issues joining, joined during agenda item V.)** |

**I. Call to Order**

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

**II. Roll Call**

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

**III. Public Comment**

Kerry Harrington, Nevada Cancer Coalition (NCC), made the first public comment. The first topic of discussion was on reducing the incidents of colorectal cancer (CRC) throughout the state. Ms. Harrington stressed the support NCC has for the addition of Cologuard as a Medicaid service as it will increase access to care in the state of Nevada. The second comment was regarding the Nevada Preventative Services Policies. United States Preventative Services Task Force (USPSTF) recommends screening tests should be covered by Nevada Medicaid. Providing more screening options increases overall screening rates effectively reducing late-stage diagnosis by capturing potential colorectal cancers earlier when they are more effectively treated, and often, even completely prevented. As an effective screening choice, nationally this option has proven to increase patient screening compliance by 67%. Patient preference and choice in colorectal screening options is critical in Nevada, so it is truly

recommended that Medicaid adds Cologuard as an effective screening option to those that average risk in 45 year or older.

The second public comment was from Paula Cook, representing Nevada Occupational Therapy Association (NOTA). The first public comment was regarding NOTA having concerns about the capitation between Silver Summit and Matt Smith Therapy Providers, especially regarding the pediatric population. There are some carve outs for pediatric providers, but some families weren't notified. And when they tried to get evaluations at these locations, these families were told that they'd be put on a waiting list. Ms. Cook stated that it may seem like there is a lot of providers looking at the numbers, but NOTA doesn't know if those therapists are part time, per diem, or full time. NOTA doesn't know their workload and they are not meeting the access needs of their Medicaid beneficiaries by limiting the number of providers they can access, especially for kids with developmental delays. NOTA is asking to open up all pediatric therapy providers to continue seeing there SilverSummit HealthPlan patients.

## IV. For Possible Action: Review and approve meeting minutes from the meeting held March 2, 2022

Chair Rosaschi called for a motion to amend or approve the draft minutes from the March 2, 2022, MCAC Quarterly Meeting. A motion to approve the draft minutes as presented was provided by Dr. Kelsey Maxim and a second was provided by Dr. Ryan Murphy. Motion passed unanimously.

## V. For Possible Action: Review of By-Laws and Discussion of Possible Amendments

Chair Rosaschi called for a discussion of the revised MCAC by-laws to discuss the changes made. Chair Rosaschi went through each section's changes.

John Phoenix raised the notion that the by-laws should be more gender inclusive and change language to *their* or *his/her* throughout. Chair Rosaschi called on the Deputy Attorney General (DAG), Sia Dalacas, for confirmation that the by-laws can be voted on today. Ms. Dalacas confirmed that this notion would not hinder the Committee being able to vote on the by-laws during today's meeting.

John Phoenix also raised a question about providing the three agenda items, DAG, Ms. Dalacas, responded that the potential agenda items can be noted to the Division. And that this is not a requirement, but a recommendation.

A motion to approve the by-laws as amended and proposed was provided by John Pheonix, and a second was provided by Dr. Kelsey Maxim. Motion passed unanimously.

## VI. Committee Member Updates

Dr. Kelsey Maxim, Community Health Alliance (CHA), provided the following updates about the pharmacy department increasing vaccine access. CHA is in the process with the state for a grant to help offset some of the cost to increase vaccine access to the community for pediatric COVID-19 vaccines. The process with the state started in December and CHA is still waiting to get approved.

CHA also does a big back to school push. Dr. Maxim stated that in the state of Nevada there has been a change in immunization requiring Menactra for incoming high school seniors. CHA is working with Washoe County School District (WCSD) and the Health Department to offer vaccine clinics in the community for the summer. CHA went to Hug High School and is planning to go to Incline High school in the next couple of weeks. Over the summer CHA is going to visit Reno, Wooster, and McQueen High Schools as well. Also, CHA is having Saturday clinics with the Health Department, which impacts a lot of their pediatric population and potential patients that are Medicaid eligible.

Dr. Ryan Murphy announced that he has been contacted by perspective dental insurance companies that apparently want the upcoming contract for Medicaid. It is not official, but more information should come out in the next couple of meetings.

Dr. Ihsan Izzam, Nevada Chief Medical Officer, provided the final committee member update. The goal of surveillance and disease tracking is no longer preventing every single case. The goal of the Nevada Department of Health and Human Services (DHHS) is to prevent severe illness, protect the health care system from being flooded with cases, and protect the vulnerable.

**VII. 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. Administrator Bierman announced that DHCFP has hired a new Deputy Administrator, Stacie Weeks.

It is expected that the Public Health Emergency (PHE) will be extended once again. The PHE remains in effect, and DHHS will continue to provide a 60-day notice to states before any possible termination or expiration. DHCFP believes that there will be another extension of the federal PHE. It is important for Medicaid because many of the policy flexibilities that Medicaid instituted are tied to the PHE, as is the continuous coverage requirement.

Nevada is one of five states that was awarded to join the Aligning early childhood and Medicaid Learning Community through the Center for Health Care Strategies (CHCS). The cross-Division team began meeting with the CHCS team and the project runs until November 2022. The team includes DHCFP and the Division of Child and Family Services (DCFS) Administrator Dr. Cindy Pitlock, Rhonda Lawrence, and Vickie Ives with the Division of Public and Behavioral Health (DPBH). The policy areas selected are expanding maternal Substance Use Disorder (SUD) Supports and Home Visiting Programs to better support families and prevent infant out of home placement. It is centered on enhancing and coordinating health care delivery, early childhood programs, and family services in ways that can equitably improve child and maternal health care.

Administrator Bierman also stated that Christina Trovato is no longer with DHCFP and until her replacement can be found, Aida Blankenship will provide Committee support.

Chair Rosachi questioned the emergency declaration that Administrator Bierman provided an update earlier on, since Governor Sisolak declared there is no longer an emergency in Nevada. Administrator Bierman stated that they are two separate states of emergency, the Governor did declare that there is no longer an emergency in the state of Nevada, but Administrator Bierman confirmed that the federal PHE is still in affect and an extension was declared at the discretion of the Sectary of HHS.

DHCFP has been working on the expansion of the access of Doula's and the changes to the MSM Chapter 600 and physician services for Doula's were effective April 1, 2022. It is still pending for the Centers for Medicare and Medicaid Services (CMS) approval and certification by the Nevada Doula Certification Board. The Division has been working with the Nevada Doula Certification Board on certification requirements to help with implementation. The Division has provided a new provider type for those services and those are reflected in Chapter 600 for Doula's. This is related to Assembly Bill (AB) 256 from the 81st Legislative session. Doula services are going to include education, emotional and physical support during pregnancy, labor, delivery, and postpartum period.

There will also be revisions to MSM Chapter 2900 for Federally Qualified Health Centers (FQHC). It is pending CMS approval but looking at an effective date of April 1, 2022. FQHCs are being proposed to add new provider doula types to FQHC. Administrator Bierman also stated that there are changes to MSM Chapter 400 related to mental health and alcohol substance abuse services. This is a revision to

ensure that crisis stabilization services provided at hospitals with a crisis stabilization center endorsement are covered and reimbursable under Nevada Medicaid. This results from Senate Bill (SB) 156 during the 81st Legislative Session and the goal of this legislation is to add a place to go as a critical element of the crisis continuum of care, to support the survey of crisis services.

There has also been changes related to third party liability (TPL) and this is primarily to stay in compliance with federal regulations. A state plan amendment (SPA) was submitted to stay in line with the changing federal requirements around the TPL Program.

Administrator Bierman also added that there have been reimbursement changes. The SPA reimbursement methodology pages have been changed to allow for reimbursement crisis stabilization centers.

DHCFP has a SPA to allow participation in the national Medicaid pulling initiative model for subliminal rebate agreements. This was submitted to enter in the Michigan Multi-State Pulling Agreement for Subliminal Rebate Agreements for Drugs provided to Nevada Medicaid Fee-For-Service (FFS) beneficiaries.

In addition, there has also been changes to related to coverage for clinical trials. It was recently required by federal law, and DHCFP is updating the state plan and the alternative benefit plan to align with the changes to allow Medicaid recipients to have coverage for teen patients cost for items and services for nurse and connection with participation and qualifying clinical trials and makes coverage of the new benefit mandatory under the state plan and the alternative benefit plan.

## VIII. Managed Care Update

**a. Managed Care Organization Redistribution**

Theresa Carsten, Social Services Chief III, Managed Care Quality and Control, DHCFP, states that the Managed Care contracts were implemented in January 2022, all members were provided a choice period for 90-days, which ended at the end of March 2022. All members are considered locked into their current Managed Care Organization (MCO) through January 2023. The open enrollment period, where they will be presented another choice period, will be held October 2022 and any changes recipients request will not be applied until January 1, 2023.

b. **Dental Benefit Administrator**

The proposals for the Dental Benefit Administrator (DBA) contracts have been received and are being reviewed. Currently waiting for the notice of awards to be dispensed.

Chair Rosaschi questions when it is anticipated. Ms. Cartson states that she believes in June.

## IX. Review of MSM for Long Term Supportive Services Unit

**a. Chapter 500**

Kirsten Coulombe, Social Services Chief III, Long Term Services and Supports (LTSS), DHCFP, reviews the updates and revisions of MSM Chapter 500. Ms. Coulombe shares the table of contents to review MSM Chapter 500 which is for the nursing facility. Both Chapter 500 and Chapter 1600 are considered institutional services for LTSS, which gives a high-level overview for the services. Chapter 500 is mostly for individuals who need 24-hour care, typically nursing services, but there is variety of acuity that individuals may have that will need nursing, medical, rehabilitative, etc. services. Ms. Coulombe states that the authority is helpful, which defines what federal code of regulation and what kind of state authority Medicaid has.

A pre-admission screening and resident review (PASRR) must be done for any individual that will be going to a nursing facility to ensure they don't need any additional specialized services. In addition to PASRR, there is also level of care that is done for each individual. To determine what their level of care within the nursing facility will be.

Once someone is admitted, there is different standard levels of care for which they have a standard nursing facility, ventilator dependent, pediatric specialty care, and behaviorally complex care program.

Another big component of nursing facilities is nursing facility tracking forms, to help track individual's care. It is a requirement for the providers to submit that information.

The chapter also covers therapeutic leaves of absences and for individuals that are in institutions, they have a patient liability that is determined by the Division of Welfare and Supportive Services (DWSS), which determines what percentage the individual must contribute. Often, individuals that are in nursing facilities will receive $30 +/- a month in their personal trust fund.

Lastly, Ms. Coulombe sums up the discharge requirements and Minimum Data Set (MDS). MDS is a quality assurance process that occurs, and it is identified in detail in attachment A, on pages 41-61.

Chair Rosaschi offered the MCAC and/or the Public to speak if they have any questions on Chapter 500.

Angela Berg, ProCare Hospice, asks if Chapter 500 is the introduction to each of the sections to be talked about and/or updated. Ms. Coulombe states that they are working on specific updates for the MSM. To her knowledge she is not sure all the sections talked about will be updated. The process is to have a public workshop specific to the MSM Chapter, an agenda will be posted publicly once a draft is ready to present to the public.

Bob, fundamental, asks if Chapter 500 reflects on policies that help work through the authorization processes. Ms. Coulombe answers that any type of limitations on the MCO side is going to be captured in MSM 3600 or Medicaid's state plan/contract. Ms. Coulombe will work with Theresa Carsten to see if those updates were already made or where they might be in the process.

**b. Chapter 1600**

Chapter 1600 is for the intermediate care facility for individuals with intellectual and developmental disabilities. It was last updated July 2011. The introduction has an overview of individuals with intellectual and developmental disabilities that cannot reside in a community-based setting and have a higher level of care which they need to reside in an institutional setting.

Chapter 1600 includes, provider and recipient responsibilities, readmission procedures, and authorization process, etc. There is a in state process they must exhaust before out of state placement occurs because they don't want individuals to be apart from their family. They do have a process in their policy to address out of state placements because it does occur.

Lastly, Chapter 1600 also includes a patient liability (PL) process, which is determined by DWSS as well.

The nursing facility chapter that the MSM Chapter 1600 was updated for the 45 days to 80 days.

**X. Presentation and Discussion of Nevada's 1115 Demonstration Waiver Application for Nevada's Treatment of Opioid Use Disorders (OUDs) and Substance Use Disorders (SUDs) Transformation Project**

Sarah Dearborn, Social Services Chief II, Behavioral Health Unit, DHCFP, proceeds with the progress of the 1115 waiver and provides a background overview.

In response to the ongoing national opioid crisis, CMS has indicated a willingness to provide additional flexibilities to help states improve access to, and quality of SUD treatment through Medicaid 1115 Demonstrations. The 1115 SUD Demonstration Waiver options allows states to test coverage of a full SUD treatment service array in the context of overall SUD service delivery system transformation. During the 81st Legislative Session SB 154 was passed providing legislative approval to permit Nevada Medicaid to apply for a proposed 1115 Waiver. This waiver will allow CMS to treat costs that would not otherwise qualify for federal matching funds as allowable Medicaid expenditures. DHHS has requested from CMS, authority for a five-year, Section 1115 Demonstration Waiver to expand statewide access to comprehensive behavioral health services for the most vulnerable Nevadans, including those with opioid use disorders (OUDs) and substance use disorders (SUDs).

Enhanced Benefits requested that residential and withdrawal management services consistent with American Society of Addiction Medicine (ASAM) levels of care 3.1, 3.2, 3.5, and 3.7. The proposed 1115 Demonstration goals by CMS are increased rates of identification, initiation, and engagement in treatment, increased adherence to and retention in treatment, and reduction in overdose deaths, particularly those due to opioids, etc.

The proposed 1115 Demonstration Milestones were discussed.

The proposed 1115 Demonstration next steps for Nevada are Nevada's Section 1115 Demonstration Waiver entitled "Nevada's Treatment of OUDs and SUDs Transformation Project" submitted to CMS in November 2021. Also, summarizing Nevada's plan to meet stated demonstration milestones and goals, which the plan must demonstrate how cost will be budget neutral to CMS and the application will include all required information as mandated by 42 CFR 431.412. A 30-day public notice period required under 42 CFR 431.408. includes consultation with Tribal Nations and Tribal Health Clinics and needs to evaluate public input on the application prior to submission to CMS.

**XI. Discussion of the Division of Health Care Financing and Policy's Quality Strategy**

Jaimie Evins, Supervisor, Managed Care Quality and Control Designee, DHCFP, states that DHCFP is in the process of updating its quality strategy. It needs to be updated once every three years and DHCFP is asking for input from MCAC. The Divisions mission is to purchase and provide quality health care for members in the most efficient manner and to promote equal access to services and affordable costs. The purpose of the quality strategy is to articulate the state's priorities for the managed care program and to outline those goals and objectives DHCFP has identified to meet their priorities.

Ms. Evins then discussed the seven identified goals that align with DHCFPs strategic priorities. Ms. Evins asks the Committee to provide feedback no later than May 31, 2022, so that the draft can be finalized.

XII. **Presentation and Discussion of Legislative Updates**

a. **SB 211**

Preston Tang, Office of HIV Designee, provides an update on the progress the Office of HIV made with SB 211. The proposed regulations will update MAC Chapter 441a. The current regulations do not outline the requirement to consult with patients about whether patients would like to be tested for HIV or STD.

John Phoenix comments that the requirement of primary care providers, emergency departments, and hospitals to develop a process to educate counsel and offer testing to patients who present with non-life-threatening situations. As a result to this Mr. Phoenix states that there will be a financial impact that will hit providers as far as reimbursements. The push back providers are seeing is from the cost that is potentially going to be associated with Medicaid.

Lynell Collins, Health Program Specialist II, Office of HIV, also comments that he is not sure what the cost will be but states that at the recent Public Workshop nobody had any negative comments.

Mr. Phoenix then adds that a lot of the conversation about the push back with the cost that is potentially going to be associated with Medicaid was done after SB 211 came out as part of his presentation he had with medical staff from the hospital Mr. Phoenix is associated with. It is feedback from providers.

Mr. Collins states that they haven't reviewed any negative feedback until this date. (May 25, 2022) He also states that their job was to strictly write into the Nevada Administrative Codes. He is unsure that they have any ability to do anything that has to do with costs at this point.

Mr. Tang adds that there might be an increase to Medicaid, but it is a preventative medicine that can prevent further cost if someone does become HIV positive.

Erin Lynch, Chief III, Medical Programs Unit, DHCFP, adds that there is a Fiscal impact on providing HIV and STD testing services. The Fiscal Impact from the year 2021-2022 was $248,000/+ and for Fiscal year 2022-2023 was $181,000/+. Ms. Lynch adds that that is fairly low compared to other services. Ms. Lynch agrees with Mr. Tang's previous comment on it preventing further costs.

Mr. Phoenix adds a final follow up question to Ms. Lynch's statement. He asks if they are receiving capitated payments or services from an ER visit, those tests may not be covered, so there is a potential revenue loss or negative impact on a revenue standpoint.

Ms. Carsten then adds that she is not aware of Managed Care entities being in a capitated arrangement for ER services.

b. **SB 379**

Erin Lynch, Chief III, Medical Programs Unit, DHCFP, summarizes SB 379. SB 379 requires the Director of DHHS to establish and maintain a database comprising of information concerning

providers of health care who are licensed, certified, or registered in the state of Nevada. It is to collect certain data points during their renewal process. It requires them to create a health care work force, working group to help organize the data that is collected. The data that is being collected by SB 379 relates to the health care professional shortage area survey that must be done with HERSA. SB 379 requires DHHS to collect information via survey through the licensure renewal process of certain kinds of providers.

Jeana C. Piroli asked if this applies to Provider Type 60 for school health services?

Ms. Lynch answered that this is done through the licensing board.

c. **SB 5**

Monica Schiffer, Social Services Program Specialist III, Medical Programs Unit, DHCFP, gave a brief overview of SB 5 regarding the audio only continuation of telehealth services. SB 5 passed during the 81st Legislative Session. DHCFP is removing restriction of using standard telephone for telehealth services to the MSM chapter and clarifying language that a provider is not eligible for payment as the originating site and distant site for the same recipient, same date pf service are being added. Also, DHCFP is updating information on what Behavioral Health services may be delivered via audio-only telehealth.

## XIII. For Possible Action: Consideration of Recommendation for Addition of Cologuard (CPR 81528) as a Medicaid Service

Kaelyne Day, Social Services Program Specialist III, Medical Programs Unit, DHCFP, is presented the Coverage of Colorectal Screenings. Not counting some skin cancers, colorectal cancer is the third most common cancer in men and women. It is the third leading cause of cancer-related deaths in the United States. Colorectal cancer is most frequently diagnosed among persons aged 65 to 74 years. It is estimated that 10.5% of new colorectal cancer cases occur in persons younger than 50.

Chair Rosaschi asked for clarification.

Brock Finlayson added that when you look at current screening rates, the screening rates in Nevada are the second lowest in the country. Nearly 72% have not been screened for colorectal cancer. The 72% is typically coming from Medicaid. It is a preventable disease if it is caught early and costs compound if found early.

Mr. Phoenix then proceeds to inform Chair Rosaschi that this is well adapted and well received to patients. Any increased access point will be a positive outcome for prevention.

Chair Rosaschi is asked for clarification if this test is easier or same as others?

The downside is that this test must be done every three years and it has a fairly high false-positive rate. If tests turn out to be positive, next procedure would be a colonoscopy.

Gina Thompson, states that the false-positive rate is 13%. If a negative is shown, there is no further testing. Ms. Thompson states that any test can show a false-positive. The recommendation for after any fecal test should be getting a colonoscopy done.

Chair Rosaschi called for a motion to amend or approve the draft minutes. A motion to accept the information as presented and add to the recommendations for inclusion of Nevada Medicaid was provided by John Phoenix and a second was provided by Dr. Isham Izzam. Motion passed unanimously.

## XIV. For Possible Action: Recommendations for Further Agenda Items

a. **Open Meeting Law Training Dates**

b. **July: Review of MSM for Medical Unit -** 3400-telehealth update, mental health and crisis, substance use disorder

## XV. Adjournment

Chair Rosaschi adjourned the meeting at 11:36 AM.