

Patient Protection Commission: Proposed Policy Bill Draft Resolutions

Over the past six months, the Patient Protection Commission (the “Commission”) has held five public meetings focused on understanding Nevada’s maternal and infant health system. This work has included identifying key challenges and exploring potential policy solutions. The Commission’s work is guided by “The 7 Steps to Effective Decision-Making” as published by Dartmouth.¹ Over the course of the Commission’s meetings, they have reviewed statewide data, research, and reports to identify barriers, gather evidence and information.

The Commission has also solicited ideas from local and national experts and evaluated best practices and various policy solutions for addressing the challenges identified through the review process. Meeting materials, presentations, and additional information regarding the Commission’s work are available on the [Commission’s website](#)

Additionally, the Commission actively sought stakeholder input through a public feedback submission process and regular opportunities for public testimony at public meetings. In total, the Commission received 58 unique policy recommendations related to improving maternal and infant health outcomes in Nevada. These recommendations were reviewed and organized into policy concept and problem summaries to support further discussion and evaluation by the Commission.

Collectively, these meetings, presentations, data review, and policy proposals informed the Commission’s understanding of Nevada’s perinatal health landscape and helped identify the following policy BDRs for the legislature’s consideration.

A. Pregnancy Medical Home

The measure proposed by the Commission requires Nevada Medicaid to seek all necessary federal approvals to develop and establish a pregnancy medical home model to improve maternal and infant health outcomes through enhanced care coordination, integrated health services, and stronger connections to community-based supports. The model is intended to address fragmented care, improve access to timely prenatal and postpartum services, reduce disparities and preventable complications, and promote more efficient use of health care resources for Medicaid-covered moms and babies.

Proposed BDR Language

Add new section to NRS 422 as follows:

NRS 422.XXX. Establish federal authority to cover medical home services for pregnancy

1. Nevada Medicaid shall seek all federal authority necessary to develop and establish a pregnancy medical home model eligible for Title XIX federal funds that focuses on expanding access to high-quality, coordinated maternity and perinatal care. At a minimum, the medical home model must provide for comprehensive clinical care, behavioral health integration, social needs navigation, care coordination, and culturally responsive services to

significantly improve maternal and infant outcomes, reduce preventable maternal deaths, and address persistent disparities in perinatal health.

2. In establishing the model, the Administrator shall take into consideration the costs and viability of extending coverage eligibility for the health home model to all pregnant and postpartum persons enrolled in Medicaid. However, the Administrator may initially implement the model for a limited population, including but not limited to pregnant individuals with serious mental illness and substance use disorder, to evaluate the new service model for expansion to additional populations over time.

3. The model shall include alternative payment arrangements for obstetric providers, group practices, health systems, federal qualified health centers, and other providers that agree to establish pregnancy medical home models as specified by Nevada Medicaid, including coordinating care across the prenatal, delivery, and postpartum periods, and utilizing innovative approaches to care delivery in a manner that improves maternal and infant health outcomes and reduces avoidable costs for such population. Alternative payment arrangements may include fee for service tiered payment models with incentive payments, pay for performance reimbursement models, or other value-based payment arrangements tied to outcomes, total cost of care or global payments.

Model Legislation:

- [Text - H.R.6698 - 115th Congress \(2017-2018\): Maternal CARE Act \(Section 4\)](#)
- [MN Statutes - Integrated Health Partnerships \(IHP\)](#)
- [Texas SB 748 - Pregnancy Medical Home Pilot Program](#)

B. Perinatal Quality Collaborative

To improve maternal and infant health outcomes, reduce preventable complications, and address variation in the quality of perinatal care across the state, Nevada must strengthen statewide collaboration and implementation of evidence-based practices. This measure intends to establish and support a statewide Perinatal Quality Collaborative (PQC) to bring together hospitals, providers, public health agencies, Medicaid, and community partners to identify improvement opportunities, implement data-driven quality initiatives, share best practices, and improve the quality, safety, and outcomes of care for mothers and infants throughout Nevada.

Proposed BDR Language

Add new section to NRS 439 as follows:

NRS 439.XXX Establish Perinatal Quality Collaborative

1. In partnership with the Department of Human Services, the Nevada Health Authority shall establish, administer, and maintain a statewide Perinatal Quality Collaborative to improve outcomes for pregnant and postpartum persons and newborns through data-driven quality improvement, including advancing evidence-based clinical practices, reviewing data to identify and prioritize quality initiatives that reduce maternal and infant mortality and morbidity and address disparities.
2. The Director shall seek all necessary federal authority to receive federal matching funds under Titles XIX and XXI of the Social Security Act to support the administrative activities of the Collaborative as they support improved outcomes for Medicaid recipients.
3. The Director shall appoint a multidisciplinary steering committee to guide the Collaborative, with membership representing at a minimum:

- (a). Perinatal clinical providers including obstetric, maternal fetal medicine, and nurse midwife providers;*
- (b). Behavioral health providers or experts with experience in maternal or perinatal mental health and substance use;*
- (c). Hospitals and birthing facilities, including rural and frontier representation;*
- (d). Nevada Medicaid representative(s);*
- (e). Public health;*
- (f). Community-based perinatal organizations, including rural health clinics and federally qualified health centers;*
- (g). Tribal health programs or Indian health service providers serving Nevada tribal communities;*
- (h). Persons with lived experience*
- (i). State agency representation from the Department of Human Services and the Nevada System of Higher Education.*

The Director shall ensure that members appointed to the steering committee reflect the geographic diversity of the state.

4. *The Director of the Authority shall appoint the Executive Director of the Collaborative within the Authority. The Executive Director:*
- (a) Must have experience in public health, nursing, medicine, health administration, health policy, or a closely related field.*
 - (b) Is in the unclassified service of the State; and*
 - (c) Serves at the pleasure of the Director of the Authority.*

The Executive Director shall:

- (a) Perform the administrative duties of the Collaborative and other such duties as directed by the steering committee and the Director of the Authority or his or her designee; and*
- (b) To the extent that sufficient funding is available, for this purpose, appoint employees to assist the Executive Director in carrying out the duties prescribed in paragraph (a). Such employees serve at the pleasure of the Executive Director and are in the unclassified service of the State.*

The Board may:

To the extent that money is available for this purpose enter into contracts with consultants to assist the Collaborative in its duties.

5. *On or before July 1, 2029, each hospital and birthing facility operating a labor and delivery or neonatal intensive care unit shall participate annually in at least one Collaborative quality improvement initiative.*
6. *Each hospital and birthing facility operating a labor and delivery or neonatal intensive care unit shall submit, either directly or through a statewide association of hospitals, a minimum perinatal data set established by the authority, beginning no later than six months after it has been established, and on July 1 each year thereafter.*
7. *The Collaborative, in partnership with the Authority, shall develop and maintain a statewide perinatal dataset necessary to support the functions of the Collaborative. The Collaborative may receive and review data necessary to its function, subject to confidentiality protections with only de-identified aggregate information made public.*

8. The Collaborative may establish subcommittees and working groups consisting of members of the steering committee or other persons to assist the Collaborative in the performance of its duties. Each subcommittee expires 6 months after it is created but may be continued with approval of the steering committee. Not more than six subcommittees may exist at any time.
9. The Authority may, subject to available funding, establish a grant program to support facility participation, prioritizing rural, frontier, and high-Medicaid-volume facilities.
10. The Collaborative shall meet at least quarterly and hold at least one public meeting annually.
11. The Collaborative shall coordinate with the Maternal Mortality Review Committee, Medicaid, and Title V Maternal and Child Health; and report on or before January 1, 2029, and not later than January 1 each year thereafter concerning the state of perinatal health, recommended policy changes, and quality improvement initiatives to the Governor, Director, Department of Human Services, and the Director of the Legislative Counsel Bureau for transmittal to:
 - (1) In January of odd-numbered years, the next regular session of the Legislature
 - (2) In all other cases, to the Joint Interim Standing Committee on Health and Human Services
12. The Director may accept and expend grants, gifts, donations, or appropriations that would further the purposes of or assist in the establishment of the Collaborative.
13. As soon as practicable after the effective date of this act, the Director shall appoint members to the steering committee and perform any other preparatory administrative tasks necessary to establish the collaborative.
14. This act becomes effective upon passage and approval.

Model Legislation:

- [Sec. 145.9572 MN Statutes](#)
- [Colorado SB 24-175](#)
- [Delaware SB 201](#)

C. Perinatal Services Modernization

This measure intends to **provide Nevada Medicaid the authority to seek federal approvals to develop, expand, or modify perinatal services and care delivery models in order to improve perinatal health outcomes and access to care. This flexible authority is indented to allow the Administrator to respond to emerging evidence, best practices, and changes in the perinatal care delivery landscape over time.** ~~[establish and support Group Prenatal Care models within Nevada Medicaid to improve access to prenatal care, patient education, peer support, and care coordination. The goal is to improve maternal and infant health outcomes and reduce disparities. Additionally, this proposal would establish new Medicaid coverage for dyadic care models to coordinate services for moms and babies as a connected care unit, improve access to lactation consultation services, prenatal and parenting education group programs, and establish coverage for remote monitoring for high-risk pregnant and postpartum persons:]~~

Proposed BDR Language

Add new section to NRS 422 as follows:

NRS 422.XXX Coverage of additional perinatal services

1. *To the extent sufficient funding is available, the Administrator may seek State Plan and any necessary federal ~~[waiver]~~ authorities needed for federal approval to receive federal matching funds under Titles XIX and XXI of the Social Security Act **to develop, expand, or modify perinatal services and care delivery models in order to improve perinatal health outcomes and access to care** ~~[for the following perinatal services]~~ for eligible persons.*
2. ***In the process of complying with this section, the Administrator may consider opportunities to cover under Nevada Medicaid:***
 - (a) Group prenatal care delivered in accordance with an evidence-based model for group prenatal care **at** ~~[-The Division shall establish]~~ a fee schedule rate of reimbursement ~~[for group prenatal care]~~ that is greater than the reimbursement for an individual prenatal visit and may condition the enhanced rate on a provider accreditation or pending accreditation in a recognized group prenatal care model;*
 - (b) Dyadic intervention services that deliver integrated physical and behavioral health screening and services to an infant and the infant's parent or caregiver together including screening for behavioral health needs, maternal mental health conditions, interpersonal safety, and health-related social needs, and referrals to appropriate follow up care;*
 - (c) Clinical lactation Consultation as a distinct, separately billable fee schedule service rather than bundling it into a global maternity or office-visit payment for services rendered to eligible persons;*
 - (d) Prenatal and parenting education services as a distinct, separately billable fee schedule service rather than bundling it into a global maternity or office or facility visit payment; and*
 - (e) Remote patient monitoring services for high-risk pregnant and postpartum persons enrolled in Medicaid.*
 - (f) Increase Medicaid reimbursement for perinatal and maternity care services provided in rural and frontier areas in a manner that will incentivize provider participation, support the sustainability of rural providers and services, and improve access and outcomes for pregnant and postpartum persons in underserved areas of the state;***
 - (g) Establish and fund incentives that increase:***
 - a. Utilization of prenatal and postpartum care;***
 - b. Screenings and brief interventions for maternal and postpartum behavioral health needs; and***
 - c. Screenings for social determinants of health.***

Model Legislation for Group Prenatal Care:

- [P.L. 2019, c.317 \(S3159 1R\)](#)
- [2025-SEBS-0414.pdf](#)
- [S20v6.pdf](#)

Model Legislation for Dyadic Care:

- [California-2021-AB133-Chaptered](#) (Section 392)

Model Legislation for Lactation Consultation:

- [89\(R\) HB 136 - Enrolled version](#)

Model Legislation for Prenatal and parenting education:

- <https://apps.leg.wa.gov/wac/default.aspx?cite=182-533-0390&pdf=true>

Model Legislation for Remote Patient Monitoring:

- [S7110](#)

[D. Maternity Payment Incentives]

This measure requests an increase to Medicaid reimbursement for perinatal services in rural and frontier areas to strengthen provider participation, improve access to essential healthcare services, support the sustainability of rural providers, and improve health outcomes for rural Nevadans.

In order to improve maternal and infant health outcomes and reduce preventable complications, Nevada must increase access to and utilization of evidence-based preventive services throughout pregnancy and the postpartum period. This measure intends to establish incentives that encourage engagement in timely prenatal and postpartum care, behavioral health screening, and brief intervention, and routine screening for social determinants of health. The goal is to promote early identifications of health and social needs, strengthen connection to appropriate services and supports, improve care coordination, reduce disparities and support healthier outcomes for moms and babies.

Proposed BDR Language

Add new section to NRS 422 as follows:

NRS 422.XXX Establish payment incentives for improving access to perinatal services for Medicaid recipients

1.—To the extent that sufficient funding is available, the Administrator shall implement the following changes to reimbursement for perinatal services and prioritize such changes in the order that follows:

(a) Increase Medicaid reimbursement for perinatal and maternity care services provided in rural and frontier areas in a manner that will incentivize provider participation, support the sustainability of rural providers and services, and improve access and outcomes for pregnant and postpartum persons in underserved areas of the state;

(b) Establish and fund incentives that increase:

a. Utilization of prenatal and postpartum care;

b. Screenings and brief interventions for maternal and postpartum behavioral health needs; and

c. Screenings for social determinants of health.

Model Legislation:

- ~~89(R) HB 18 - Enrolled version (sec 5.b)]~~