



Patient Protection Commission

May 22, 2026 Meeting

Dylan Malmlov, MPH

Executive Director, PPC



Agenda Item 2

Public Comment



Agenda Item 3

Introduction of New Commissioners



Agenda Item 4

For Possible Action

**Review and Approve
Meeting Minutes
from April 17, 2026**



Agenda Item 5

Informational

**Policy
Recommendations
to be Reviewed by
the PPC**

Progress Update

Building the Evidence Base

Over the past several meetings we have:

- Built a shared understanding of challenges, systems, programs, and opportunities
- Reviewed data and expert input

Gathering Policy Recommendations

- Collected and organized policy ideas from stakeholders, public input, and PPC discussions

Weighing the Policy Options

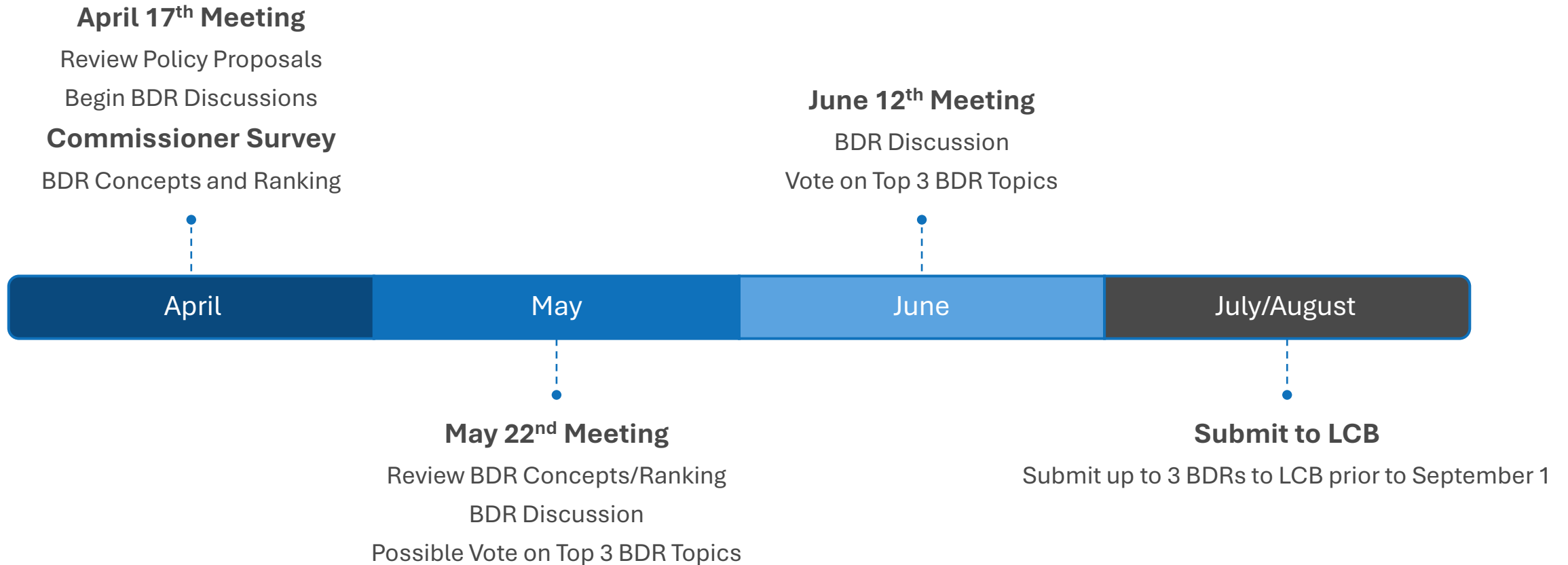
- Evaluating which policies to advance for BDR consideration



Source: 7 Steps to Effective Decision Making
https://www.umassd.edu/media/umassdartmouth/fycm/decision_making_process.pdf

BDR Development Process

High-Level Overview of the PPC's Upcoming Meetings



Policy Concepts Submitted By Commissioners

High-Level Themes Submitted by Commissioners

Payment Reform: Restructure reimbursement to better align payments with quality and access goals.

Perinatal Quality Collaborative: Establish and fund a perinatal quality collaborative

Pregnancy Medical Home Model: Authorize and require Medicaid to develop a Pregnancy Medical Home Model

Perinatal Services Modernization: Expand coverage and reimbursement for perinatal care services

Perinatal Behavioral Health Integration: Integrate perinatal behavioral health into cross-agency innovation initiatives.

Campaign to Improve Prenatal Care: Launch a statewide prenatal care improvement campaign and support real-time referrals to care.

Birthing-Friendly Hospital Designation: Require birthing-hospitals to achieve and maintain the federal “Birthing Friendly” Hospital Designation.

Ensuring Expectational Health Care and Retaining Physicians in Nevada: Provide reimbursement parity at the 75th percentile of national averages to retain and attract physicians.

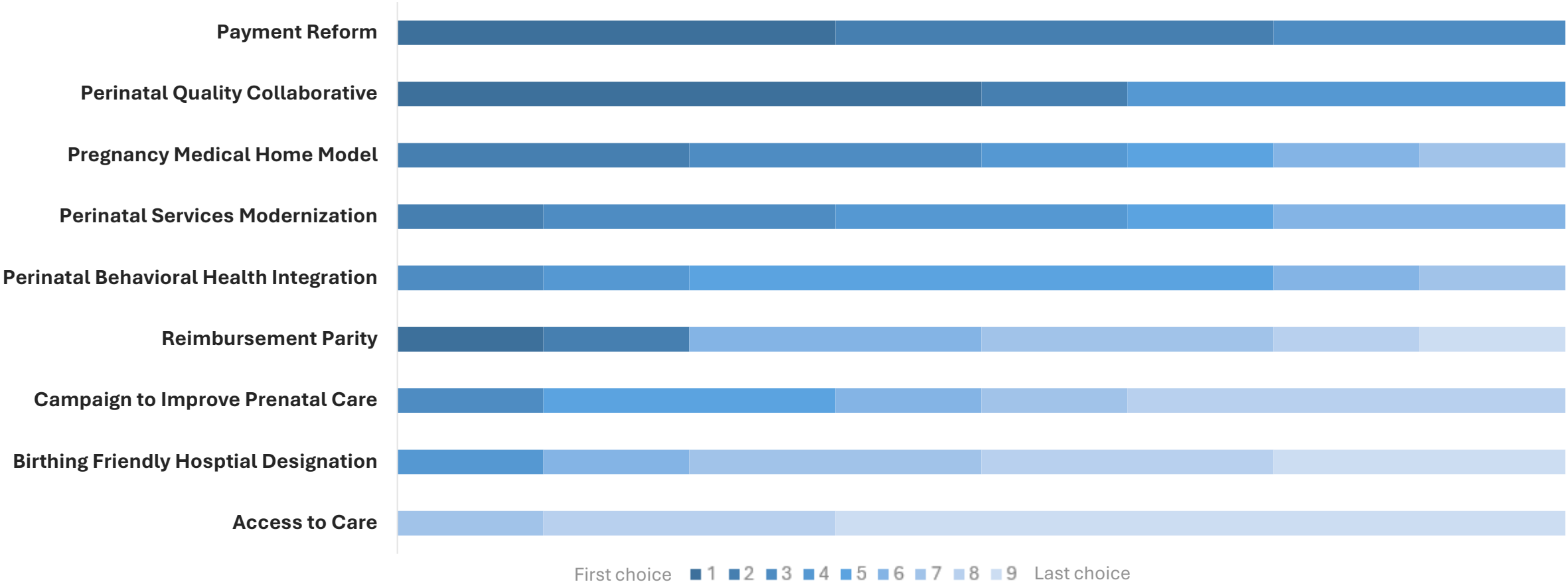
Access to Care: Require that on call hospital providers treat patients regardless of their ability to pay, to ensure access to needed hospital services.



You can find a full list of specific recommendations submitted by each commissioner [here](#).

Policy Concept Interest Ranked By Commissioners

Distribution of How Commissioners Ranked Each Concept



You can find the rankings submitted by each commissioner [here](#).

Nevada ACOG Feedback

Overview of the Letter Requested by Commissioners

Unbundling: Supported, but caution around administrative burden for OB practices, especially rural/small practices, and unintended consequences that may risk reduced access to maternity care if not designed carefully.

Prenatal Access Improvements: Strong support for group prenatal care and remote patient monitoring.

Perinatal Quality Collaborative: Strong support, but difficult to implement, must mandate participation.

Behavioral Health Integration: Critical priority, behavioral health and SUD are major contributors to maternal morbidity and mortality.

Additional Policy Priorities: Reduce cost burden by limiting co-pays/deductibles, expand menopause coverage, reduce PFA exposure, require folic acid fortification of corn mesa.



May 18, 2026

Dylan Malmlov, Executive Director
Nevada Patient Protection Commission
Nevada Health Authority
Carson City, Nevada

Dear Mr Malmlov:

Thank you for inviting American College of Obstetricians and Gynecologists, Nevada Chapter (ACOG NV) input to the Patient Protection Commission's (PPC) discussion relative to maternal and perinatal health policy. We commend the depth of your investigation and discussion. We put your priority input list out to the ACOG Advocacy Team and received a few in depth responses which we summarize here.

1. **Unbundling.** This refers to the action that will be accomplished as of January 2027 replacing one-size-fits-all "global billing" with multiple individual procedure codes. This is a policy action agreed to by ACOG and the American Medical Association and there will not be an option to select global billing vs. individual codes on a patient by patient basis.

The benefit will be that providers can be reimbursed for a wide range of care needs during the prenatal and perinatal periods, including screening for behavioral health needs and, for behavioral health providers, treating those needs.

The concern is that insurance providers may delay the provision of care or challenge the need for care as part of their management practices, thus limiting access to care. Additionally, while prenatal care is currently classified as "preventative" and 100% covered, with unbundling, some care may be classified as "problem response" and subject to co-pays; thus this could increase the cost of maternity care.

Specifically, we received the feedback pasted at the end of this memorandum from Jeff Snyder, Executive Director, OB/GYN Associates of Reno. The policy action may be to review implementation of the new codes by reviewing payor utilization management practices.

2. **Improving Access to Prenatal Care.** Two of the PPC priority items received the most ACOG support – reimbursing for group-based prenatal care, which may be particularly helpful for patients needing to build knowledge, confidence, and trust in the pre and perinatal care system, and remote patient monitoring, which can be really important for rural patients and those lacking individual means of transportation.
3. **Perinatal Quality Collaborative.** This is a very important initiative, yet it will not be simple to create one. The primary difference between a PQC and a hospital that adopts the AIM (Alliance for Innovation on Maternal Health) principles, or is deemed a birthing friendly hospital, is that the



Agenda Item 6

For Possible Action

Review and Discussion of Bill Draft Requests (BDR) Topics

Purpose and Overview

Goals of this Discussion

To develop a working understanding of each policy area and identify 3-4 priority topics to carry forward for deeper deliberation and BDR development during our June 12th meeting.

Under each policy area, commissioners should consider:

- What problem does this solve, should it be prioritized by the PPC this session?
- Should this advance as a BDR, or is it better pursued through other levers?
- What design questions or tradeoffs need to be considered or resolved?

Payment Reform

Policy overview of concepts submitted relating to payment reform.

Legislative

Enhanced Rural Reimbursement

Differential payment uplift for OB and perinatal services delivered in rural/frontier counties or designated maternity care deserts.

State and Federal Landscape

- [NV Rural Health BH Rate Uplift](#)

Considerations

- Design Flexibility
- Scope: Which providers, services, geographies qualify
- Alignment with other programs such as RHT

Administrative/Programmatic

Unbundling

Separate reimbursement for antepartum, labor management, delivery, and postpartum care, moving away from global bundle.

State and Federal Landscape

- [AMA CPT® 2027 Maternity Care Services code changes](#)
- Nevada currently uses [bundled codes](#)

Considerations

- System Readiness: Claims and billing systems to process unbundled codes
- Timing: Implementation time to give payers and provider a runway to adapt without destabilizing OB participation
- Unintended Consequences

Eliminating Out-of-Pocket Costs

Zero cost sharing for pregnancy related and perinatal preventative services across state-regulated markets.

State and Federal Landscape

- ERISA preempts regulation of self-funded plans
- [New York](#): Eliminated OOP costs for pregnancy-related benefits on the essential plan and other qualified health plans.
- Pending Legislation: [Washington, S.1834 - 119th Congress \(2025-2026\)](#)

Considerations

- Fiscal barriers limit legislative feasibility
- Scope: Services covered, how long coverage extends, what market?

Payment Reform

Discussion Questions

If the PPC pursued a payment reform bill, what would the goal of the changes be, what are the intended outcomes?

- Improve access to prenatal and postpartum care?
- Remove barriers to care?

Are there any unintended consequences that should be considered?

Are commissioners interested in pursuing other options under the payment reform topic:

- Incentives for access to prenatal and postpartum care?
- Incentives to complete behavioral health screening and referrals?

How should we consider timing for implementation to allow time to develop and implement effectively?

Are commissioners interested in advancing these policies for further consideration or advanced as formal recommendations for administrative actions?

- Should these be pursued individually or combined into one bill?
- Can any of these be done administratively rather than mandated through legislation?

Pregnancy Medical Home

Policy Overview

What is a Pregnancy Medical Home?

A PMH is a Medicaid model where a designated practice coordinates the full pregnancy episode and receives enhanced payment tied to specific activities and quality standards. Designs differ, but contain the following core elements:

- **Accountable Practice:** A provider is responsible for the pregnancy
- **Care Coordination:** Connected prenatal-postpartum care with support accessing services
- **Whole-Person Integration:** Behavioral health, substance use, and social needs addressed within routine care.
- **Quality-Linked Payment:** Incentives tie to performance on quality measures

State Examples and Outcomes

	North Carolina	Wisconsin
Participants	OB Providers (Voluntary)	HMO-contracted clinics in targeted ZIPs
Eligible Pop.	All Medicaid pregnant + 60 day postpartum	High-risk pregnant members
Payment	Enhanced bundled payment for vaginal births with incentives on process measures (risk screen, postpartum visit)	Enrollment bonus and bonus for positive birth outcome
Outcomes	• LBW ↓6.7% across all Medicaid births (2011–14) • PMH women 20% lower LBW • ~70% first-trimester care vs. <40% statewide. • (North Carolina Pregnancy Medical Home)	• Behavioral health visits ↑~30% by year. • postpartum visits 61.4%→85.5% (2013–15). • No impact on birthweight or gestational age. • Evaluation • Wisconsin-Case-Study-Final.pdf

Considerations

- Program design flexibility
- Eligible population
- Implementation timeline/Phased Implementation

Pregnancy Medical Home

Discussion Questions

What are the benefits and barriers of a pregnancy medical home?

If implemented, what impact would you hope that pregnancy medical homes would have?

Are there any unintended consequences that should be considered?

How should we consider timing for implementation to allow time to develop and implement effectively?

Are commissioners interested in advancing this policy for further consideration?

Perinatal Services Modernization

Policy overview of concepts submitted relating to coverage or benefit expansion.

Group Prenatal Care

Group-based prenatal model (e.g., CenteringPregnancy) combining individual clinical assessment with facilitation, group education, and peer support. Evidence base strongest for reducing preterm birth particularly among black women.

State and Federal Landscape

- Several state Medicaid programs reimburse separately for group prenatal care ([Group Prenatal Care](#))

Considerations

- Provider Readiness and Uptake: Space, Facilitators, and scheduling infrastructure needed

Dyadic Intervention

Integrated care models that address the parent-child dyad together supporting parental mental health and child development in the same visit (e.g., [HealthySteps](#)). Typically embedded in pediatric primary care.

State and Federal Landscape

- Several states cover some type of dyadic interventions ([Best Practices in the Coverage and Delivery of Maternal Health](#))

Considerations

- Coding/Billing: Systems not built for dyadic encounters
- Defining the dyad: Who is covered and for how long?
- Workforce: Behavioral health providers, particularly in rural counties, are limited

Lactation Consultation Expansion

Expand access to lactation and breastfeeding support services across hospital, outpatient, home, and telehealth settings, addressing both clinical coverage gaps and the workforce/billing structure limiting access.

State and Federal Landscape

- 15 states cover the full array of breastfeeding supports, education, hospital lactation consultations, outpatient and home consultations, and electric and manual pumps. ([KFF](#))
- Nevada does not cover outpatient or home-based lactation consultations, and reimbursed as part of an office visit, NV Medicaid does not directly cover breast pumps; pumps are provided through WIC program. ([KFF](#))

Considerations

- Scope: Outpatient and home-based support as separately reimbursable services

Perinatal Services Modernization

Policy overview of concepts submitted relating to coverage or benefit expansion.

Prenatal and Parenting Education

Structured childbirth, prenatal, and parenting education delivered through provider offices, community-based organizations, or home visiting programs.

State and Federal Landscape

- Several state Medicaid programs reimburse prenatal/parenting education as a distinct benefit ([KFF](#))

Considerations

- Eligible providers
- Complementary policies

Remote Patient Monitoring

Use of connected devices for at-home perinatal monitoring, with strongest evidence for postpartum hypertension surveillance

State and Federal Landscape

- 39 states reimburse for RPM ([State Telehealth Laws and Reimbursement Practices](#))
- Telehealth interventions have been found to have positive health outcomes for birthing people ([Best Practices in the Coverage and Delivery of Maternal Health](#))

Considerations

- Device cost and distribution
- Broadband access
- Alignment with other programs and initiatives (RHT)

SDOH Screening

Reimbursement pathway for screening for social determinants of health (food insecurity, housing instability, transportation, etc.) during perinatal visits.

State and Federal Landscape

- [ACOG](#) recommends prenatal SDOH screening as part of routine care
- CMS has provided guidance for integrating SDOH into care ([CMS](#))

Considerations

- Data and privacy
- Unintended consequences
- Referral infrastructure

Perinatal Services Expansion

Discussion Questions

If the PPC pursued a perinatal service expansion bill, what would the goal of the changes be, what are the intended outcomes?

- Improve access to prenatal and postpartum care?
- Remove barriers to care?
- Increase the health literacy of families
- Reduce disparities in care
- Increase breastfeeding rates

Are there any unintended consequences that should be considered?

How should we consider timing for implementation to allow time to develop and implement effectively?

Are commissioners interested in advancing these policies for further consideration?

- Should these be pursued individually or combined into one bill?
- Can any of these be done administratively rather than mandated through legislation?

Perinatal Quality Collaborative

Policy Overview

Perinatal Quality Collaborative

A state-based multidisciplinary network of hospitals, providers, groups, and community-partners that use data and evidence to advance maternal and infant health outcomes. PQCs share data and best practices across hospitals and translate data into clinical action. Nevada is one of two states without a PQC.

Conceptual Policies Combined with PQC

- **MMRC Modernization:** Faster case identification, staffing for case development and facilitation, and integration will improve the effectiveness of a PQC.
- **[Birthing-Friendly Hospital Designation](#):** CMS designation launched in November 2023 identifying hospitals and health system that participate in a state or national quality collaborative and implement evidence-based care to improve maternal health.
- **[AIM Patient Safety Bundles](#):** A national initiative providing evidence-based patient safety bundles for hospital implementation, currently covering obstetric hemorrhage, severe hypertension, sepsis, cardiac conditions, perinatal mental health, primary c-section, postpartum transitions, and treating SUD

Perinatal Quality Collaborative

Discussion Questions

We have been informed that Interim HHS will pursue this bill.

Does the PPC want to take any action?

- Include as a recommendation in the forthcoming semi-annual report?
- After the bill is introduced send a letter to interim HHS supporting the bill

Possible Action:

Include the perinatal quality collaborative as a formal recommendation in the PPCs semi-annual report due on July 1.

AND/OR

Issue a letter supporting the bill after it is introduced.

Other Policies Submitted

Policy overview of other concepts submitted by commissioners.

Behavioral Health Integration

Integrate behavioral health priorities into cross-agency initiatives

Campaign to Improve Perinatal Health

Launch a statewide prenatal care improvement campaign and create a hotline or dashboard to support real-time navigation to resources.

Access to Care

Require that on call hospital providers treat patients regardless of ability to pay, to ensure access to needed hospital services.

Reimbursement Parity

Provide reimbursement parity at the 75th percentile of national averages to retain and attract physicians.

Discussion Questions:

Do you feel that any of the policies listed above deserve more attention?

Are commissioners interested in advancing these policies for further consideration or moving into for consideration for a formal recommendation?



Agenda Item 7

Public Comment



Agenda Item 8

Adjournment

Thank you!

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