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NEVADA HEALTH AUTHORITY

PATIENT PROTECTION COMMISSION

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MEETING MINUTES

NEVADA PATIENT PROTECTION COMMISSION (PPC)

February 27, 2026

The Nevada Patient Protection Commission (PPC) held a public meeting pursuant to NRS 241.020(3)(a) online and by phone on Friday, February 27th, 2026, beginning at 9:00 am. The agenda and meeting materials are available online at <https://ppc.nv.gov/Meetings/2026/2026/>.

1. Call to order: Roll call

By: Bethany Sexton, Chair

The meeting was called to order at 9:00 am by Bethany Sexton, Chair. Executive Director Dylan Malmlov proceeded with roll call, and it was determined that a quorum of the PPC was present.

Commission Members Present

Dr. Jonathan Chastain
Dr. Mark Glyman
Dr. Ikram Khan
Ms. Marylyn Kirkpatrick
Dr. Andria Peterson
Dr. Adam Porath
Dr. Travis Walker
Ms. Bethany Sexton

Advisory Commission Members Present:

Ned Gaines, Insurance Commissioner, Division of Insurance (DOI); Stacie Weeks, Director, Nevada Health Authority (NVHA); Kourtney Gresh on behalf of Executive Director Janel Davis.

Advisory Commission Members Absent Excused:

Theresa Carsten, Executive Officer, Public Employees Benefits Program (PEBP), Nevada Health Authority (NVHA)

Staff Present:

Dylan Malmlov, Executive Director, PPC; Stephanie Purnell, Policy Analyst, PPC; Alexandra Lopez-Duarte, Administrative Assistant, PPC.

Guests Present:

Allison Genco Herzik, Deputy Director; Malinda Southard, Deputy Director Administration; Jenniffer Krupp, Administrator; Rose Sutherland, Management Analyst 3; Monica Schiffer, Social Services Chief 1, Lynn Beaver, Management Analyst 3; Vickie St Ives, Health Bureau Chief; Brian Iriye; Janel Davies, Exchange Executive Officer; John Packham; Tabor Griswold; Sabrina Petrel; Stephanie Woodard; Eileen Colen; Steve Messinger; Dan Musgrove; Patrick Kelly; Eduardo Martinez; Jalyn Behunin; Zachary Laskey; Emma Rodriguez; Amy Schmidt; Kathy Triplett; Emily Rigler; Munachimso Emesobum; Rebecca Lopez; Zoe Houghton; Ned Gaines; Shannon Sullivan-Figueroa; Tray Abney;

Jazmin Orozco; Kourtney Gresh; Jose Rivera; Sarbyen Shen; Donna Laffey; Katherine Villaseñor; Shana Tello; Nancy Bowen; Natalie Gautereaux; Cameron Pfand; Donna Laffey; Jeanne Gerow; Reagan Hart; Tina Gerber-Winn; Stephanie Shamo; Farzad Kamyar; De Yates; Brian Evans

2. **Public Comment** *(No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item).*

Shannon Sullivan-Figueroa, speech-language pathologist and pediatric private practice owner in Northern Nevada, and Secretary for the Nevada Speech-Language Hearing Association (NSHA), provided an update on NSHA's current priorities following the 2025 legislative session.

She stated that the bill to join the interstate compact for licensure for speech pathologists and audiologists was successful; however, joining the operational compact system is stalled as the Nevada Board of Examiners for Speech-Language Pathology and Audiology is awaiting a response from the FBI regarding background checks. NSHA is requesting that the Board of Examiners actively inquire about background checks with the Nevada Department of Public Safety and the FBI.

She also commented that NSHA continues advocacy related to speech-swallowing codes that are not being reimbursed through Nevada Medicaid for Provider Type 34 (PT34): Therapy. She stated that CPT codes 92612, 92511, and 31579 are not included in the PT34 fee schedule but are included in Provider Type 20: Physicians. She noted that members have reported physicians in Nevada are not completing these procedures, creating a barrier to care, and stated that the procedures fall within the scope of practice for speech language pathologists and are reimbursed by private insurance.

She further stated that NSHA continues to advocate for Medicaid pay parity between PT34 and PT20/60. She reported that codes under PT34 are reimbursed approximately 10–15% lower than the same codes under PT20 and PT60 and provided an example comparing reimbursement rates for CPT 92507. She stated that achieving pay parity would increase access to services across the state for early intervention and children.

She concluded by offering to provide additional information and stated that NSHA looks forward to continuing advocacy on these issues.

3. **Informational: Introduction of New Commissioners**
By: Bethany Sexton, Chair

The Chair introduced new and returning commissioners. The Chair provided a reminder that the Patient Protection Commission exists to systematically review issues related to the healthcare needs of Nevada residents, including accessibility, affordability, and quality of healthcare.

The Chair introduced Commissioner Marilyn Kirkpatrick, a Clark County Commissioner who has been reappointed to the Commission. The Chair stated that Commissioner Kirkpatrick represents a not-for-profit hospital in the county that spends the largest amount of money on hospital care for indigent persons. Commissioner Kirkpatrick stated that she previously served in the Legislature for 11.5 years, serves on the board of trustees for a hospital, as a county commissioner, and in the health district. She stated she also sits on NACO healthcare committees.

The Chair introduced Commissioner Dr. Andria Peterson, a pharmacist who has been reappointed as a member with expertise and experience advocating for people with special healthcare needs. Dr. Peterson stated she is a pharmacist by training and spent 13 years in maternal child health, particularly in NICU care. She stated she serves as the Chair of the Department of Bioethics, Humanism, and Policy at Roseman's College of Medicine.

The Chair, Bethany Sexton, introduced herself as the Chair of the Commission. She stated she represents a private not-for-profit health insurer with the highest percentage of insured individuals in the state who are adversely impacted by social determinants of health. She stated she has served Renown Health for 11 years in various roles, served as CEO of Hometown Health for the past three years, and will be serving as the health plan leader for Kaiser Permanente as it is established in Nevada.

The Chair expressed appreciation to Dr. Khan for his years of service as Chair of the Commission. Dr. Khan stated it had been his honor to serve.

The Chair welcomed new staff members. Stephanie Pernel was introduced as the Commission's policy analyst and confirmed she was present. Alexandra Lopez-Duarte was introduced as the administrative assistant and confirmed she was present. The Chair expressed appreciation for staff support.

4. For Possible Action: Review and Approve Meeting Minutes of December 5, 2025

By: Bethany Sexton, Chair

The Chair stated that the meeting minutes from December 5th were distributed to commissioners prior to the meeting for review. The Chair asked whether commissioners had any questions or recommended edits.

Commissioner Marilyn Kirkpatrick stated she would abstain because she was not an official member at the last meeting. Commissioner Dr. Andria Peterson also stated she would abstain for the same reason.

Commissioner Adam Porath stated he had reviewed the minutes and moved to approve them. Dr. Khan seconded the motion.

The Chair asked if anyone was opposed. Hearing no opposition, the Chair stated the minutes were approved.

5. For Possible Action: Discussion and Voting for PPC Vice Chair

By: Dylan Malmlov, Executive Director, PPC

Chair Sexton nominated Dr. Andria Peterson to serve as Vice Chair, noting her background and her work related to maternal child health. Dr. Peterson stated she would be honored to serve.

Dr. Glyman second the nomination and Executive Director Dylan Malmlov asked if there was any further discussion.

Executive Director, Malmlov requested a motion for Dr. Andria Peterson to serve as Vice Chair of the PPC for a one-year term. Dr. Glyman made the motion and Dr. Khan seconded the motion. Executive Director Malmlov asked if any were opposed, hearing none, the motion carried.

6. Informational: Presentation on the Perinatal Healthcare Workforce

By: Dr. John Packham, Nevada Health Workforce Research Center, Office of Statewide Initiatives, University of Nevada, Reno

Dr. Packham stated that the aim of the presentation was to frame subsequent discussions on behavioral health issues, fertility and birth rate trends, and statewide challenges in maternal and child health. He explained that much of the information was based on data collected by his office over nearly three decades and referenced listed resources. He announced the release of the eighth edition of the healthcare careers manual, noting that hard copies would be available soon and an online interactive version could be accessed through a QR code. He defined the perinatal healthcare workforce broadly as health professionals and support staff caring for pregnant individuals and infants from conception through the first year postpartum. The workforce increasingly consists of diverse, multidisciplinary teams, including licensed medical and nursing clinicians, mental and behavioral health staff, support staff, and allied health workers in hospital based and community-based settings. He referenced a no

exhaustive list of occupations included within this definition, noting several roles are new compared to 15–20 years ago and are now more widely incorporated across rural, frontier, and remote areas.

The demand for perinatal healthcare workers in Nevada is increasing despite flat or declining birth and fertility rates. He identified rising clinical complexity, growing mental and behavioral health needs, and the expansion of maternity care deserts as drivers. Historically, approximately 12–13 rural hospitals offered labor and delivery services; currently, only Ely, Fallon, Elko, and Winnemucca serve as rural hubs for labor and delivery. He described these service lines as sometimes unprofitable and noted that facilities face financial and legal liability challenges as policy and reimbursement changes expand who receives care and for how long. He reported increased complexity and volume of care resulting from advancing maternal age and comorbidities, including chronic disease and prenatal/perinatal mental health and substance use issues. This trend increases demand for specialized care, care coordination across maternity care deserts, more frequent consultations, and additional screening and diagnostics. He referenced increased federal attention to these concerns and newly available funding through rural health transformation grants.

Dr. Packham emphasized Medicaid's importance, stating that Medicaid finances "a little over half" of Nevada births, including in rural and frontier areas. He referenced state level policies such as continuous postpartum eligibility, reimbursement for doulas and community health workers, and increases in reimbursement rates, while noting that hospital administrators often report reimbursement below cost. He expressed concern about future Medicaid changes associated with the One Big Beautiful Bill Act or HR1, stating these changes would begin after the 2026 election and could reduce Medicaid spending if not addressed by Congress. He cited an estimate that approximately 100,000 Nevadans, or about 12–13% of current Medicaid enrollees, could lose coverage if provisions take effect, with resulting impacts on access and provider capacity due to increased uninsured rates.

He described workforce supply and shortage issues, stating that available data relies on licensure counts and state and federal employment projections, which include gaps. He reported evidence of growing provider and practice shortages and noted that impending retirements, particularly in nursing, will increase attrition. Dr. Packham described a new Health Resources and Services Administration designation for identifying areas with shortages of maternity care, health professionals and unmet need. The methodology includes factors such as the female population ages 15–44, availability of obstetricians and certified nurse midwives. As well as poverty levels, distance to maternity care, fertility rates, and a maternal health index incorporating behavioral health indicators, prenatal care, diabetes, and obesity. He noted that this designation builds on existing primary care and mental health shortage data.

Shortage area estimates were provided, noting that a little over 2 million residents, or approximately 65% of Nevadans, live in a primary care shortage area, including both urban and rural regions. Twelve of fourteen rural and frontier counties are entirely designated as primary care shortage areas. A little over 3 million residents, or about nine in ten Nevadans, live in a federally designated primary care Health Professional Shortage Area, including all fourteen rural and frontier counties. He provided workforce gap estimates, stating that reaching national averages would require 11,000 new jobs in both the ambulatory care and hospital sectors. Nevada would need approximately 2,300 additional physicians and 5,000 additional nurses, including labor and delivery, antepartum, postpartum, and NICU nurses. He reported a need for approximately 80 OB/GYN physicians, noting that establishing an OB residency program would produce three new OB/GYN physicians in three to four years.

Dr. Packham described funding and program developments, stating the Rural Health Fund is expected to bring \$180 million per year for five years, with 40% earmarked for workforce development. He referenced a HRSA primary care enhancement grant that will support rural capacity among family medicine physicians, physician assistants, and nurse practitioners in prenatal care, labor and delivery, and complex pregnancies, clarifying that these roles do not substitute for hospitals. He stated that the UNR School of Medicine and Renown will launch an OB residency program next July, producing three OB trained physicians with rural rotations. He closed by expressing concern about Medicaid's future impacts over the next several years and stated that Nevada's perinatal health workforce will

be affected by congressional action or inaction, while also expressing optimism that available funding may help address workforce challenges.

Questions and Discussion Following Presentation

Commissioner Kirkpatrick noted that Dr. Packham had discussed northern and rural areas and asked whether Southern Nevada is included in the dialogue, stating that Mesquite and Laughlin are rural communities despite being within Clark County and are often overlooked. Mesquite is financially stable but recently discontinued labor and delivery services, requiring travel to St. George for care. Adding that Logandale, located 26 miles from Mesquite, has a high birth rate but now lacks nearby labor and delivery services. Ms. Kirkpatrick asked that rural areas within urban counties be considered in future discussions.

Dr. Packham reiterated that maternity care deserts affect all regions of Nevada and acknowledged mentioning northern Nevada due to greater personal familiarity. Some rural hospitals that can maintain services have additional revenue sources, such as net proceeds from mining taxes, which typical rural hospitals do not have.

Dr. Walker asked whether there was any data or information on reproductive health and preventive services, such as family planning and Title X programs, that help prevent high risk pregnancies and support healthy pregnancies. Dr. Packham had no specific data but expressed concern about potential impacts to family planning services through Medicaid or other federal funding sources due to HR1. That some federal grant programs appear secure and noted cautious optimism regarding the federal fiscal environment.

Dr. Porath asked whether there was any sense of when HRSA's work on maternity care target area designations would be completed. Dr. Packham explained that designations had been in comment phases for years but expressed confidence the work would proceed, noting its importance for federal programs such as the National Health Service Corps. That political conditions in 2025 slowed federal rulemaking and offered to provide updates to the Commission when available.

Dr. Chastain asked whether Nevada has the infrastructure to support additional workforce in rural areas or whether service lines need to be restored sustainably. Dr. Packham stated that alternative approaches exist for providing prenatal care in rural areas, referencing the Rural MOMS (Rural Maternal and Obstetrics Management) demonstration project, which incorporates telehealth, Project ECHO style training, and coordination with rural hub hospitals. These approaches are not substitutes for full obstetric services but can expand capacity while Nevada continues to grow its perinatal workforce. Also, the rural health transformation program may support innovative proposals in the coming year.

Dr. Peterson asked whether loan repayment programs have made an impact on workforce shortages and whether they are being fully utilized. Dr. Packham stated that the program administered by his office has operated since 1989, receives consistent federal funding, and is matched by state or county sources. It's the strongest retention tool available, citing that in Ely, 19 of 20 supported providers remained in the community after completing their service commitments. The program receives sufficient qualified applicants and spends funds quickly but noted CMS guidance prevents the rural health transformation program from using its funds for similar loan repayment efforts.

7. Informational: Maternal and Child Health Needs Assessment: Maternal, Perinatal, and Infant Health By: Vickie Ives, Bureau Chief, Child, Family, and Community Wellness, DPBH

Ms. Ives provided an overview of the Nevada Title V Maternal and Child Health Block Grant Needs Assessment with emphasis on maternal, perinatal, and infant health. The Division of Public and Behavioral Health's mission to make lives healthier, happier, longer, and safer was outlined along with its organizational structure, noting its placement within the Department of Human Services and the bureau housing the Section for Maternal, Child, and Adolescent Health. Programs within the section include the Title V MCH Program, Pregnancy Risk Assessment Program, maternal mortality and severe maternal morbidity prevention, hearing and critical congenital heart disease

screening, home visiting, rape prevention, teen pregnancy prevention, and account for Family Planning, as mentioned by Dr. Walker. Additional bureau programs include WIC, the Immunization Program, Chronic Disease Prevention and Health Promotion, and the Office of Food Security. Key supporting maternal and perinatal programs were described, including WIC, which serves approximately 53,000 participants and provides nutrition and breastfeeding support. As well as the Home Visiting Program, which offers voluntary, evidence-based services to reduce infant mortality and support families. Other relevant programs include community health nursing, substance use services for pregnant individuals, immunization, and public health preparedness. Information was presented on Title V funding from HRA, which supports enabling and population level services in Nevada, along with recent areas reviewed by the Maternal Child Health Advisory Board.

Data highlights included the use of federal datasets to compare Nevada with national trends. Prenatal care data showed Nevada closely aligned with the U.S., with first trimester care highest among non-Hispanic Asian individuals and lowest among non-Hispanic American Indian or Alaska Native individuals. Postpartum checkup rates indicated a divergence from national figures. Breastfeeding data showed Nevada trending upward but lower than national rates, with exclusive breastfeeding at six months reported at 40.5%, and additional differences among racial or ethnic groups. Infant mortality trends showed Nevada performing better than the U.S. overall, except for American Indian or Alaska Native populations. Severe maternal morbidity data indicated slightly higher rates of renal complications and sepsis compared to national figures, with lower rates in other categories.

The needs assessment process for 2026–2030 was described, including statewide multilingual outreach, epidemiological analysis, surveys, interviews, focus groups, and priority setting activities. Participation included approximately 226 survey respondents, 60 individuals in the priority setting meeting, and 70 attendees in listening sessions. Priority needs included new measures to improve access to prenatal care and maternal health services, postpartum visits, nutritious foods and physical activity for school aged children, and sexual and reproductive health resources. Existing measures included breastfeeding, safe sleep, reducing substance use, promoting medical homes, and improving adolescent referrals. Focus areas within maternal, perinatal, and infant health include access to maternity services, safe sleep, breastfeeding, postpartum visits, substance use reduction, and access to sexual and reproductive health resources. Additional measures were described across women of childbearing age, perinatal health, child health, and children with special health care needs.

Information was provided on the Maternal Mortality Review Committee, which includes 12 appointed members and reviews all deaths during pregnancy or within 365 days postpartum. Definitions were presented for pregnancy associated death, pregnancy related death, and maternal death. Recent patterns showed Nevada's pregnancy related mortality rate at 22.7 compared with a U.S. rate of 23.5, with most pregnancy associated deaths occurring between 43 and 365 days postpartum. Disparities were highlighted, including a 3.2times higher pregnancy related death (PRD) rate among Black, non-Hispanic individuals compared with Hispanic individuals, and higher burdens in Clark County. Leading causes of death included drug overdoses within non-transport accidents for pregnancy associated deaths and hemorrhage and infection for pregnancy related deaths, with recent CDC data used as a comparison. Maternal Mortality Review Committee (MMRC) recommendations included mental health access, medication assisted substance use treatment, obesity counseling, warm handoffs to mental health services, screening, and protocols regarding aspirin use and anemia treatment. Additional recommendations from the Nevada Minority Health and Equity Council were noted. Such as system level opportunities identified for the perinatal space included establishing a Perinatal Quality Collaborative, expanding evidence-based home visiting with full federal match, exploring school-based services for pregnant and parenting youth, and strengthening pediatric specialist capacity.

Questions and Discussion Following Presentation

Dr. Walker asked about Nevada's participation in a perinatal quality collaborative (PQC) and what would be required to participate. Ms. Ives indicated that approaches vary nationally, with some states establish PQCs through statutory routes and others house them within hospital associations, universities, freestanding entities, or state agencies. Previous legislative sessions included budget and bill draft attempts to support PQC, but these did not pass. Funding

models in other states range from multi-million-dollar initiatives to smaller programs of approximately \$300,000 annually. Noting existing work in perinatal health and patient safety bundles and stated that a PQC could serve as an umbrella to coordinate data, subject matter expertise, and quality improvement efforts.

Dr. Porath referenced existing initiatives and highlighted the benefits of coordinated data review and quality improvement under a PQC structure. Wondering whether Title V block grant funding could support increased access to RSV protection, noting that only approximately one in five children in Nevada currently receive RSV protection and that maternal RSV vaccine access is limited to pharmacies. Ms. Ives has been involved in 3 previous five-year needs assessments and immunizations have not risen to a Title V priority. She described current resources, including limited state general funds used by the Nevada State Immunization Program for the cocooning program, which can purchase maternal RSV vaccine. Noting that the Vaccines for Children (VFC) program covers infant RSV vaccination but not maternal doses. Additional support may be available through the Account for Family Planning, which can provide immunizations for individuals unable to afford them.

Dr. Peterson asked about the current lag time for MMRC case review. Staff reported that two part time nurse abstractors are currently closing out 2022 cases and that permission was granted to hire an additional part time abstractor. Staff described the complexity of case abstraction, which requires reviewing medical, social service, vital statistics, and other records. Abstractors are currently working on 2021 cases, and all cases through 2024 have been received. Staff noted variability across states and ongoing efforts to improve timeliness, including changes to review processes that have increased case throughput.

Dr. Peterson asked how MMRC findings are communicated to clinicians and health systems. Ms. Ives advised that findings are shared through the biannual legislative report, a public facing dashboard maintained by the Office of Analytics, and various distribution lists. However, there are gaps in clinician-to-clinician communication and that hiring a full-time position with outreach responsibilities is under consideration and confirmed ongoing collaboration with the hospital association.

8. Informational: Presentation on Advancing Perinatal Behavioral Healthcare in Nevada

By: Dr. Stephanie Woodard, Principal Consultant, Sierra Health Strategies and Clinical Associate Professor in the School of Public Health, University of Nevada, Reno

Dr. Woodard opened the presentation by thanking state agencies, healthcare and behavioral health providers, child welfare agencies, and the women who shared their experiences while in perinatal behavioral health care. She referenced her broad, cross-system background and emphasized prioritizing pregnant and parenting women with mental health and substance use concerns. She noted that Nevada has made progress over the past decade through policy, payment reform, funding, and program implementation, but undetected and unmet perinatal behavioral health needs remain. Data from the Maternal Mortality Review Committee highlighted that 86% of non-transport accidents were related to overdose. She also referenced a Department of Human Services report on gestational exposure in utero, associated infant health outcomes, and increased child welfare involvement. The goal of the project was to identify what is required to implement policies effectively, so they lead to improved care and outcomes for mothers and infants. The review examined intersections across healthcare, behavioral health, child welfare, and early childhood systems to determine barriers to care.

Methods were presented by Sarbyen Sheni, including a literature and policy review of MMRC reports and other state documents, key informant interviews, focus groups involving approximately 100 participants, and geographic mapping of women's health and behavioral health resources using Office of Statewide Initiatives data. Stakeholders described challenges integrating behavioral health screening into maternal health services and the difficulty women face disclosing perinatal behavioral health or substance use concerns. Dr. Woodard described providers' apprehension to screen due to unclear warm handoff pathways, limited closed-loop referral options, and time constraints. Behavioral health providers with perinatal specialties were reported as not well connected to screeners, and referral processes were described as non-streamlined. Stigma was consistently reported by both women and

providers, with women citing bias, judgment, and fear of child welfare involvement that made disclosure feel unsafe.

Key findings indicated that unmet perinatal behavioral health needs contribute to adverse maternal and infant outcomes, including exposure to substances in utero, developmental concerns, child welfare involvement, and increased maternal morbidity and mortality due to overdose and suicide. Policy and funding expansions have increased screening, but this alone is insufficient to improve outcomes. Barriers included limited access to adequate prenatal care, reimbursement challenges for integrated care models, stigma, and fragmented or insufficient access to specialty perinatal behavioral health care. It was noted that some states designate specialty behavioral health providers to improve coordination.

Geographic mapping presented by Muna Emesobum showed OB/GYN providers concentrated in urban areas, with maternal care deserts identified. Nevada's statewide average was reported as 28 OB/GYN providers per 100,000, with the national average stated as 33 per 100,000. Counties exceeding the national average included Carson, Churchill, Lander, and Lincoln. Counties with no OB/GYN providers included Douglas, Eureka, Lyon, Mineral, Nye, Pershing, and White Pines. Urban locations were additionally strained because they serve rural and frontier populations. Perinatal behavioral health services were concentrated around Las Vegas, Reno, and Carson City, with more than half of Nevada's counties lacking dedicated services such as CCBHCs or FQHCs. Counties without such infrastructure included Douglas, Mineral, Esmeralda, Lincoln, Pershing, Humboldt, Eureka, Lander, and White Pines, resulting in fragmented care and delays.

High-level recommendations from Dr. Woodard included developing a statewide perinatal behavioral health strategic plan aligned with children's behavioral health transformation efforts and managed care quality strategies. Establishing regional perinatal behavioral health treatment networks to improve collaboration, resource sharing, continuity of care, and navigation to recovery supports. As well as increasing access to comprehensive, integrated perinatal behavioral health care across medical settings. Which also includes expanding access to coordinated specialty perinatal behavioral health services that are evidence based, culturally responsive, trauma informed, and DIAD-centered care. Supporting families affected by perinatal behavioral health concerns to remain together while strengthening infant and toddler development through connected early childhood systems.

Additional recommendations included aligning and connecting initiatives across agencies and systems through shared measures, standards, incentives, oversight, data reporting, surveillance, health information exchange, and evidence-based practice selection. Several recommendations could fall within a Perinatal Quality Collaborative structure, emphasizing developing a strategic plan for implementation and continuous quality improvement and identifying legislative priorities. Recommendations also included adopting patient safety bundles specific to perinatal behavioral health; incentivizing provider screening and follow-up through alternative payment models and reduced administrative burden. As well as creating clear warm-handoff pathways, establishing a perinatal access line for provider consultation, and supporting integrated care delivery models by aligning reimbursement policies and removing billing barriers. Challenges with a new collaborative care model under Medicaid were noted, including reimbursement and utilization issues. The universal bundled rate for pregnancy and postpartum care was described as restricting access to community-based OB services and postpartum follow-up, including at FQHC's and rural health clinics. Under this rate, when prenatal and labor/delivery providers differ, services were reported as non-reimbursable, limiting FQHCs prepared to provide OB care. Additional recommendations included creating a central repository of reliable patient education materials, enhancing perinatal behavioral health workforce competencies through preservice and clinical training. Promoting hospital-based dyadic care for infants with Neonatal Abstinence Syndrome (NAS) and reducing unnecessary NICU admissions through quality collaborative measures. Training improvements were recommended for assessment, treatment, recovery support, and family care planning. Establishing a rapid review process for MMRC data was recommended to improve timely surveillance and prevention strategies, with ongoing work noted to address review backlogs.

Dr. Chastain requested clarification on remaining policy barriers to reimbursement for integrated care models and asked for specifics. Dr. Woodard responded that implementation support remained the primary barrier, explaining

that integrated care can feel difficult for practices unfamiliar with combining behavioral health with medical care. Significant gaps persist between policy and implementation and cited the COCM model as an example. Noting that many organizations were unaware of reimbursement availability, uncertain about implementation, and needed workflow and clinical support. Dr. Peterson requested a presentation on the managed care quality strategy and asked whether it was planned for the upcoming agenda or included in future presentation.

9. Informational: Presentation on Perinatal Health in Nevada Medicaid

By: Dylan Malmlov, Executive Director, PPC

Mr. Malmlov explained that the findings were from an ongoing exploratory mixed-methods study examining maternal and infant health in Nevada Medicaid. Although the full analysis is still underway, interim results were shared because of the commission's focus on perinatal health. Outlining the structure of the presentation, which included the introduction and context, study methods, key qualitative and quantitative findings, and structural patterns. Nevada continues to rank among the lowest performing states on perinatal health indicators, and despite progress, outcomes remain poor. Medicaid finances approximately half of all births in the state, and the study aims to examine factors influencing whether families receive timely and effective care.

Qualitative data were gathered through key informant interviews with clinicians, hospital leaders, managed care representatives, subject matter experts, and state leadership, along with a focus group of mothers enrolled in Nevada Medicaid. Themes centered on access, coordination, navigation, behavioral health integration, and regional variation. Quantitative data came from a retrospective analysis of approximately 33,000 Medicaid-covered births from 2022–2023 using linked claims, enrollment, and vital statistics data. Variables analyzed included population characteristics, social and clinical risk factors, and prenatal care utilization, and a regression model was used to identify system-level predictors of prenatal care engagement. Noting that the study identifies associations but not causation.

Stakeholders described difficulty navigating benefits, referral pathways, and plan-specific services, with variation across health plans causing confusion. First-time mothers and individuals with limited health literacy faced challenges with renewals and accessing services, and many families learned about supports informally. Stakeholders also described inconsistent behavioral health screening, limited perinatal-specific treatment capacity, coordination gaps, and stigma that affected engagement. Access to care was hindered by workforce shortages in obstetrics, pediatrics, and behavioral health. As well as limited Medicaid participation in some areas, and barriers such as work schedules, transportation, childcare, and housing instability. Administrative issues, including enrollment timing and eligibility continuity, further affected care. Care coordination across providers, hospitals, managed care organizations, community partners, and state agencies was inconsistent. Regional variation was noted, with differences in capacity, market structures, and collaboration, and rural and frontier communities experienced long travel distances and other geographic barriers.

Quantitative findings indicated a median maternal age of 28, with more than half of mothers under 30. Nearly half identified as Hispanic or Latino. Most births occurred in Clark County, and more than 8% occurred in rural and frontier regions. Most mothers were enrolled in managed care, with one in five in fee-for-service. Nearly two-thirds had a high school education or less. A Social and Economic Vulnerability Index was developed to measure neighborhood conditions, with higher vulnerability associated with increased barriers to care. Household context showed many mothers caring for young children with limited in-home support, and behavioral health risks appeared underreported. High rates of chronic conditions and pregnancy complications were identified, and external MMRC data suggested more severe outcomes for Medicaid-covered mothers compared to the general population. Preterm birth and low birth weight rates were elevated at 12.3% and 10.8%, and only 65.5% of mothers received early and adequate prenatal care, which was below national benchmarks. Postpartum visit rates were also low, with possible undercounting due to reporting gaps.

The regression analysis found that rural and frontier regions had a lower likelihood of early and adequate prenatal care compared to Clark County. Higher neighborhood vulnerability and lower education levels were associated with

reduced likelihood of adequate care, and racial and ethnic disparities persisted. Emphasizing that these findings should be interpreted within Nevada's workforce constraints and varying regional capacity. The data demonstrated engagement gaps associated with education, neighborhood vulnerability, and regional differences, and systemic navigation challenges may contribute to uneven access. Noting the influence of payment structures and that traditional bundled and per diem models may not account for coordination needs or behavioral health integration, and that payment design, accountability mechanisms, and data infrastructure shape care patterns.

10. Public Comment

Attendees were reminded that policy recommendations are being solicited. A form is available via the link provided in the meeting or by clicking [Here](#), and submissions are requested by April 1st to allow staff time to compile the information.

No public comment was made during this agenda item.

11. Adjournment

By: Bethany Sexton, Chair

Chair Bethany Sexton thanked the PPC and those who attended the meeting and adjourned the meeting.

Meeting adjourned at 12:00 pm