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Governor

NEVADA HEALTH AUTHORITY

PATIENT PROTECTION COMMISSION

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MEETING MINUTES

NEVADA PATIENT PROTECTION COMMISSION (PPC)

March 13th, 2026

The Nevada Patient Protection Commission (PPC) held a public meeting pursuant to NRS 241.020(3)(a) online and by phone on Friday, March 13, 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 [time] 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); Janel Davis, Exchange Executive Officer; Theresa Carsten, Executive Officer, Public Employees Benefits Program (PEBP), Nevada Health Authority (NVHA).

Advisory Commission Members Absent Excused:

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; Ann Jensen, Administrator; Jason Bleak; Agency Manager; Rose Sutherland, Management Analyst 3; Monica Schiffer, Social Services Chief 1, Lynn Beaver, Management Analyst 3; Vickie St Ives, Health Bureau Chief; Adam Plain; Agency Manager; Gabriel Lithier; Autumn Blattman; Reginal Coordinator;

Joseph Filippi, Management Analyst 3; Brian Iriye; Rebecca Lopez; Sally Mabon; Carl Mueller; Jamila McLean; Kourtney Gresh; Linda Anderson; Jason Drake; Hart Reagan; Areli Alarcon; De Yates; Zachary Laskey; Maya Holmes; Emma Rogriguez; Jesse Wadhams; Cade Grogan; Nayeddi Badillo; Ashely Jonkey; Jalyn Behunin; Andy Wagner; Jess Angel; Nancy J Bowen; Chris Bosse; Lea Case; Melissa Mannon; Steve Messinger; Jeanne Gerow; Tray Abney; Brian Evans; Donna Pfister.

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).*

No public comment was made during this agenda item.

3. **For Possible Action: Review and Approve Meeting Minutes from February 27, 2026**
By: Bethany Sexton, Chair

Agenda item 3 was dropped and will be brought back at the next meeting.

4. **Informational: Presentation on National Trends and Best Practices in Perinatal Health Care**
By: Representatives of Princeton State Health and Value Strategies

Sally Mabon began with an overview of State Health and Value Strategies, a program housed at Princeton University and funded by the Robert Wood Johnson Foundation. She explained that the program provides technical assistance to states through webinars, publications, and one-on-one support, with a key focus on sharing lessons learned across states to help advance health system transformation. The presentation reviewed strategies implemented in other states to improve perinatal care, based on a scan of academic literature and publications from peer organizations. Noting the importance of considering social drivers of health, such as food insecurity and housing, when evaluating perinatal care quality. She then introduced common payment reform models used across states, including maternity bundles, episodes of care, blended payments, pay-for-performance arrangements, and reduced or nonpayment policies. Additional sections of the presentation covered the pregnancy medical home model, accountable care organizations with dedicated perinatal quality metrics, and the upcoming unbundling of global obstetric codes set to take effect in 2027.

Outlining several workforce strategies used by states to improve access to perinatal care, particularly in underserved and rural areas. Speakers noted that expanding midwifery is supported by strong evidence, with certified nurse midwives associated with lower intervention rates and better outcomes. These include expanding midwifery by addressing licensing, scope of practice and Medicaid reimbursement, as well as considering licensure for certified midwives and certified professional midwives. Nevada currently licenses certified nurse midwives with independent practice authority but does not license certified midwives or certified professional midwives, which may limit access for some communities. Presenters also highlighted opportunities to expand reimbursable services for midwives, noting that many states reimburse for broader services such as behavioral health screening, family planning and infant care. Training and retention strategies from other states included grants to expand midwifery programs, rural training tracks, loan forgiveness and malpractice coverage solutions.

They then reviewed doula workforce strategies, noting that Nevada has recently expanded Medicaid reimbursement and increased rates, including additional incentives for rural areas. Examples from other states showed innovations in postpartum doula reimbursement, flexible visit allocation and incentives tied to clinical referrals. System-level approaches such as hospital doula rights legislation, credentialing pathways and citywide doula initiatives were also highlighted. Funding models for doula training vary across states and include grants for training, certification support, reimbursement navigation and development of centralized hubs. Finally, broader workforce strategies included cross disciplinary training programs, expanding physician assistant scope of practice, improving licensure

mobility through interstate compacts, and leveraging telehealth for remote monitoring, behavioral health integration and specialist consultation.

Telehealth emerged as a key workforce extender across several state examples. Presenters noted its value in supporting high risk pregnancies through remote monitoring programs, as seen in multiple states, including California, Kentucky and Alaska, which implemented remote self-monitoring and remote fetal monitoring to increase access and early intervention. Telehealth was also highlighted as an important tool for expanding perinatal psychiatry access and integrating behavioral health into perinatal care. States additionally use telehealth enabled e-consult platforms to help rural providers connect with specialists when local resources are limited. Project ECHO in New Mexico was cited as an example of tele-mentorship that allows clinicians in remote areas to develop skills and receive specialist guidance virtually.

Questions and Discussion Following Presentation

Bethany Sexton invited questions from the commissioners. Dr. Peterson commented on the earlier discussion regarding midwives and doulas, noting that these providers typically serve very low-risk patients. She emphasized the importance of keeping in mind the large number of high-risk patients who would likely require clinical care rather than those services. Ms. Lopez acknowledged and appreciated this clarification.

5. For Possible Action: Health Workforce and Rural Access Initiatives - Statewide Healthcare Access and Recruitment Program (SHARP), Graduate Medical Education (GME), and Rural Health Transformation Program (RHTP) By: Representatives of the Division of Nevada Medicaid, NVHA

Malinda Southard, Deputy Director, presented an overview of three major workforce initiatives: the Statewide Healthcare Access and Recruitment Program (SHARP), the Graduate Medical Education (GME) grant program and the Rural Health Transformation Program (RHTP). SHARP was created through Senate Bill 5 in the 2025 special legislative session and provides \$60 million in onetime funding, available after July 1, 2026, to support statewide healthcare workforce capacity. She also described current work to develop the application process, scoring rubric and required biennial assessment report, with a draft request for applications planned for May and final publication anticipated in mid-July. The GME section outlined the role of the 13-member advisory council responsible for evaluating applications, recommending awards and advising on physician retention and Medicaid federal participation opportunities. Senate Bill 262 added new priorities, including leveraging federal funds, supporting rural rotations and addressing housing and transportation needs for trainees. Providing a timeline for GME Grant Round 8, with applications open through late April, review occurring in May and subawards expected by June 30.

SHARP and the Graduate Medical Education (GME) program operate as separate funding streams, but both fall under the oversight of the Nevada Health Authority, which allows for coordination across their respective workforce initiatives. Noting that while the programs cannot combine or intermingle funds, collaboration occurs through shared leadership, aligned planning timelines, and coordinated strategy development to ensure both programs support statewide health workforce needs. This coordination helps identify opportunities where GME training expansion, rural rotations, or retention strategies may complement SHARP-funded workforce projects, particularly in high need areas such as rural health and perinatal care. Challenges in collaboration between SHARP and GME include the statutory requirement that funds “cannot be intermingled or overlapped,” which limits joint financing of shared projects and necessitates parallel—but separate—administration.

Jason Bleak then detailed the RHTP, a five-year federal program providing nearly \$180 million to Nevada in its first budget period to support sustainable rural health transformation. Staff described four initiatives: the Rural Health Outcomes Accelerator Program, the Flex Fund for rural infrastructure, the Workforce Recruitment and Rural Access Program and a smaller allocation for the presidential fitness test in alignment with state priorities. Examples were provided of how RHTP funds could support perinatal and prenatal care in rural areas through coordinated care pathways, expanded diagnostics, remote monitoring, EMS training and tele-health enabled specialty support.

Program requirements emphasize sustainability, documentation and adherence to federal terms and conditions. Staff noted recent public workshops, the establishment of a 15-member steering committee and upcoming RFAs for multiple program components.

Questions and Discussion Following Presentation

Melinda Southard presented the first discussion question and asked whether the commission had ideas on how the state could strategize to leverage state funds to best support the perinatal workforce, including through GME funding or other state funding sources. Dr. Chastain asked whether a model used in Indiana, in which addiction medicine fellowships received subsidized increased stipends for fellows in ACGME-accredited programs and expanded fellowship size, would be applicable under the GME initiatives. Southard responded that this was not specifically identified in the current year but noted that there may be sufficient flexibility within the parameters of the request for application to support similar programs.

Jason Bleak presented a discussion question regarding how RHT funds could be leveraged to strengthen the rural workforce. Dr. Walker suggested that combining the use of RHT funds with GME funding could help support rural workforce development, citing needs related to chronic disease management, older populations giving birth, and limited access to rural health services. Mr. Bleak noted that the funds must remain separate, though efforts are aligned to benefit rural and frontier Nevada.

Dr. Porath commented on the potential to better leverage pharmacists in rural communities and suggested roles such as smoking cessation support, hypertension and diabetes screening, mental health screening, and referral. Mr. Bleak agreed and noted opportunities for expanded pharmacy services. Bethany Sexton commended the state for supporting funding cycles that allow for grassroots approaches and encouraged flexibility in funding windows to support creative, community-driven proposals. Mr. Bleak highlighted requirements in current RFAs and RFPs that emphasize rural-based commitments and ensuring funds benefit rural and frontier Nevada.

Dr. Peterson asked whether there had been discussion of a pregnancy health home model to support sustainability, particularly given references to case management. Staff indicated they were not aware of related conversations but supported including such considerations in applications. Ann Jensen added that Medicaid is exploring relevant models, including health homes, and would present more information shortly. Dr. Walker noted that some states have advanced practice models for pharmacists and asked whether such models could be relevant to expanding workforce capacity. Mr. Bleak responded that the program's five-year timeline allows for flexibility and phased planning if certain models are not ready to implement immediately.

Dr. Porath explained the current reimbursement limits for pharmacists providing clinical services, noting that activities are tied to specific disease states such as HIV prep, medication-assisted treatment for opioid use disorder, and oral contraceptive dispensing. They suggested that expanding reimbursement opportunities for chronic disease management could strengthen pharmacist involvement.

6. For Possible Action: Overview of Programs and Opportunities in Nevada Medicaid By: Representatives of the Division of Nevada Medicaid, NVHA

Ann Jensen, Medicaid Director, provided an overview of Nevada Medicaid and its role in the state's healthcare system. She explained that Medicaid provides medical, behavioral health, pharmacy, and dental benefits to eligible Nevadans based on income, disability status, or other health needs. Enrollment is approximately 730,000 individuals, representing about one in four residents. The biannual budget is \$5 billion in state and federal funds, with roughly 60% typically funded federally. Medicaid regulations reflect shared state and federal oversight, approximately 53% of births in Nevada are covered by Medicaid, equating to 16,000–17,000 babies annually.

Ms. Jensen described Nevada's managed care structure, which now includes five managed care organizations operating statewide as of January 2026. She noted that nearly all pregnant women and infants are enrolled in

managed care, with fee-for-service accounting for 8–10% of beneficiaries, primarily individuals with disabilities, seniors, and youth in foster care. Managed care organizations maintain provider networks, coordinate care, and operate additional support programs such as community reinvestment initiatives. Summarizing Medicaid's covered maternal health services, including medical and behavioral health care, reproductive and preventive services, doulas, community health workers, genetic testing, Nurse Midwife services, high-risk pregnancy coordination, housing and meal supports (through managed care), labor and delivery services, postpartum care, breast pumps, and lactation consultation. Nevada provides 12 months of continuous postpartum eligibility.

She then reviewed the state's Medicaid Quality Strategy, a federally required framework detailing statewide quality goals, measures, and monitoring processes for managed care organizations. The strategy incorporates national metrics such as HEDIS and CMS core measures and includes performance improvement projects and external quality review findings. To supplement these broad federal requirements, Nevada created the Medicaid Quality Collaborative, which includes private hospitals and managed care organizations. This group identifies focus areas, shares best practices, and provides guidance on developing value-based care initiatives. The collaborative has selected maternal and infant health and care transitions as its two primary focus areas.

Carl Mueller and Melissa Mannion of Mercer provided an overview of value-based care terminology and the Health Care Payment Learning and Action Network (LAN) framework. They explained distinctions between value-based purchasing, alternative payment models, episodes of care, population-based payments, and provider accountability structures. They described the continuum from fee-for-service models to advanced risk bearing arrangements and emphasized the need for alignment among purchasers, health plans, and providers.

Ms. Jensen then reviewed Nevada's value-based payment roadmap. She explained that the Health Authority seeks alignment across Medicaid, the health insurance exchange, and the public employee benefits program. Nevada Medicaid will require managed care organizations to develop value-based payment arrangements with hospitals, specialists, primary care providers, and additional provider types using a standardized menu of state selected quality measures. She stated that the intention is to progress providers along the LAN framework toward more mature risk sharing arrangements over time. Outlining the maternal and infant health value-based initiatives under development. A hospital quality partnership will begin in January 2027, requiring managed care organizations to implement pay-for-performance or higher-level arrangements with birthing hospitals focused on labor, delivery, and immediate postpartum care. Quality measures for this program include process, outcome, and structural metrics designed to support evidence-based practice and care coordination. A pilot value-based model for community maternity care providers will launch in the coming year, with quality measures still under development.

She also described a prior pilot program conducted by two managed care organizations and participating hospitals in 2025 to improve postpartum visit rates. The program standardized discharge workflows to schedule postpartum appointments before hospital discharge, provided informational materials to patients, and connected mothers with managed care support services such as transportation and food or housing assistance. Which resulted in significant increases in completed postpartum visits during the four-month pilot, and the managed care organizations and hospitals are continuing the work. As well as reviewing the timeline for value-based care implementation. Stakeholder feedback and model development will continue through 2026, with managed care contracting requirements taking effect in January 2027 and expanding in subsequent years. Future priority areas include behavioral health and primary care. She noted ongoing state-directed payment programs for hospitals that incorporate aligned quality measures.

Questions and Discussion Following Presentation

During the discussion on the value-based payment approach, participants were invited to provide feedback on current maternal health measures in the hospital program and to share considerations for the long-term direction of the work. Bethany Sexton wondered how preliminary results from value-based contract efforts and pilot work would be shared and whether there would be broader visibility into the findings at a high level. Ms. Jensen stated that detailed information had been shared during quality collaborative meetings and that updates had also been

presented at Medicaid Advisory Committee (MAC) and Beneficiary Advisory Committee (BAC) meetings. She anticipated continued sharing in these forums and noted the suggestion to include updates later in the year, including the possibility of broader dissemination options such as dashboards or other accessible formats.

Ms. Sexton highlighted the potential usefulness of this data for hospital partners as they consider program design and infrastructure to support performance in such initiatives. She also made suggestions regarding having a centralized location for accessing information and insights. Ms. Jensen noted that quality collaborative meetings and hospital association quality meetings are existing venues for data sharing and agreed to consider other ways to improve access.

Dr. Chastain referenced previous discussions about perinatal quality collaboratives and other advisory groups, noting that such structures may help guide measure definition, selection, and ongoing evaluation to ensure alignment with recommended practices. Ms. Jensen agreed that establishing benchmarks and evaluating progress are both critical components and expressed interest in continuing collaborative work on these issues.

Ms. Kirkpatrick raised questions about the broader vision for maternal health and how various statewide efforts align, referencing infrastructure funding, workforce needs, housing availability in certain counties, and the impact of fragmented efforts. She requested clarity on gaps identified by the agency, how different committees contribute to maternal health goals, and how a comprehensive overview or diagram could help situate the PPC's role. Ms. Jensen acknowledged the need for a broader maternal health strategy, noting that the Nevada Health Authority's strategic plan outlines components of this work. Emphasizing the goal of improving access to prenatal, postpartum, and labor and delivery care, as well as addressing social needs, and committed to coordinating with leadership on tools such as resource or asset maps for inclusion in the semiannual report.

Dr. Walker asked about challenges created by varying Medicaid service manual chapters for different provider types, noting that differences in covered services may impede integration across pediatric, primary, maternal, and behavioral health care. Ms. Jensen expressed interest in further discussion to understand where disconnects exist and reiterated support for integrated care models that reduce silos and better reflect patient needs.

Ms. Sexton asked whether centering programs are covered under Medicaid. Ms. Jensen stated that the centering model is not currently a directly reimbursable benefit under the fee-for-service program, though some MCOs may be utilizing the model. Stating that they would need to follow up with additional information on existing use and potential opportunities for expanded coverage. Ms. Sexton also commented on the infrastructure needs associated with value-based care models and asked whether there are ways to support or "pre-fund" infrastructure that is not traditionally reimbursable, emphasizing the importance of sustainable models for providers and hospitals. Ms. Jensen acknowledged this gap and noted constraints within Medicaid regulations regarding infrastructure grant opportunities. She referenced programs such as the rural health transformation grant and noted that MCOs may also assist with infrastructure support. Agreeing that creative approaches are needed to ensure providers have the resources, training, and support necessary to participate effectively in value-based care programs.

7. Informational: Discussion of Challenges and opportunities to Improve Obstetric Outcomes

By: Dr. Brian Iriye, High Risk Pregnancy Center

Dr. Brian Iriye of the High-Risk Pregnancy Center provided a presentation on challenges and opportunities to improve obstetric outcomes in Nevada. He stated that he is board-certified in maternal fetal medicine, has practiced in Nevada for 30 years, previously served as president of the Society for Maternal Fetal Medicine, and received the organization's Lifetime Achievement Award. He noted his ongoing involvement in research on preterm birth and cesarean reduction and that he authored the key quality measures paper for the national society. He currently serves as president of a women's healthcare organization in Nevada that operates under a value based maternity medical home model.

He expressed concern that Nevada lags behind in maternal and neonatal morbidity and mortality compared to national and international benchmarks. He noted that maternal death rates in Nevada are slightly elevated and that significant disparities exist for African American births. He also described comparable concerns for neonatal morbidity and mortality and characterized these outcomes as behind those of the developed world. He referenced data related to neurobehavioral abnormalities and special education needs associated with adverse outcomes.

As well as highlighting concerns regarding neonatal intensive care unit (NICU) de-regionalization in Nevada. He stated that one in twenty infants may die unnecessarily in NICUs with fewer than 100 very-low-birthweight infants per year and noted that only two NICUs in the state exceed this volume. He stated that some NICUs serve as high profit centers for hospitals and emphasized the need to return to a regionalized system consistent with recommendations from major professional societies. He then discussed the statewide shortage of OBGYN physicians, stating that Nevada ranks 46th in the country and that shortages significantly affect rural areas. He commented on discussions regarding doulas and stated that available evidence is limited. He summarized recent met-analyses reporting low quality evidence and wide confidence intervals for certain outcomes and noted that some findings applied to settings not comparable to Nevada. He also compared reimbursement levels, stating that doula payments range from \$900 to \$1,500, while physician reimbursement for vaginal delivery CPT code 59409 is \$882.

He then addressed value-based care models. He stated that he authored national quality measure guidelines and has reviewed updated payment guidance from the American College of Obstetricians and Gynecologists. He recommended caution in modifying value-based payment structures before implementation of revised CPT codes in 2027. He noted that these changes were intended to reflect evolving workforce roles and the complexities of low and high-risk maternity care. He stated that pregnancy is a long and dynamic episode of care, unlike surgical episodes, and that conditions such as gestational diabetes, preeclampsia, and preterm labor develop unpredictably. He emphasized that many value-based models do not account for evolving risk or the fact that maternity care involves two patients. He stated that value-based approaches should consider metrics beyond cesarean rates, including preterm birth and NICU admissions.

Dr. Iriye concluded by expressing concern about value-based models that rely on unadjusted outcome measures, particularly over a yearlong care episode. He stated that such models risk discouraging providers from caring for higher risk patients because benchmarks may not reflect underlying risk factors. He cited obesity and race associated risks as examples and encouraged the use of process-based metrics rather than outcome-based metrics for this reason. He ended his remarks noting the need to ensure providers deliver high quality care to all patients regardless of risk.

8. 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. To provide public comment telephonically, you may join the meeting by dialing (775) 321-6111 and when prompted to provide the Meeting ID, enter 981 401 478#. You may then press *5 to raise your hand during the public comment periods to provide your comment. Comments will be limited to three minutes per person. Persons making comment will be asked to begin by stating their name for the record and to spell their last name. Those who wish to provide a written comment may submit their comment by mail to 9850 Double R. Blvd., Reno, NV 89521, or email ppcinfo@nvha.nv.gov)*

No public comment was made during this agenda item.

9. Adjournment

By: Bethany Sexton, Chair

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

Meeting adjourned at 11:54 am

