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NEVADA HEALTH AUTHORITY

PATIENT PROTECTION COMMISSION

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MEETING MINUTES

NEVADA PATIENT PROTECTION COMMISSION (PPC)

April 17, 2026

The Nevada Patient Protection Commission (PPC) held a public meeting pursuant to NRS 241.020(3)(a) online and by phone on Friday April 17, 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
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); Joseph Filippi, Management Analyst 3 on behalf of Janel Davis, Exchange Executive Officer

Commission Members Absent Excused:

Ms. Marilyn Kirkpatrick; Theresa Carsten, Executive Officer, Public Employees Benefits Program (PEBP)

Staff Present:

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

Guests Present:

Malinda Southard, Deputy Director Administration; Jenniffer Krupp, Administrator; Jason Bleak; Agency Manager; Rose Sutherland, Management Analyst 3; Evette Cullen, Social Services Chief 2; Lynn Beaver, Management Analyst 3; Deidre Manley, Social Services Chief 1; Carin Hennessey, Social Services Program Spec 3; Jeremy Hays, Rate Analysis and Development; Richard McFeely, Federal Policy and Compliance; Jeanne Gerow; Jose Rivera, Attorney General's Office; Vickie St Ives, Health Bureau Chief; Adam Plain; Agency Manager; Gabriel Lithier; Autumn Blattman; Reginal

Coordinator; Patrick Kelly; Blayne Osborn; Gwyn Volk; Fay Roepcke; Linda Anderson; Christine Bredfelt; Alex Tanchek; Kim Nichols; Julia Marroquin; Shelly Capurro; Eileen Colen; Amy Schmidt; De Yates; Kristie Gore; Jesse Wadhams; Steve Messinger; Sabrina Petrel; Sarah Adler; Lea Cartwright; Katherine Villaseñor; Eduardo Martinez; Mari Nielsen; Lyndsay Knight; Paige McCall; Heather Goulding; Brian Evans; Chris Bosse; Zoe Houghton; James Wadhams; Donna Laffey; Aaron Stron; Emily Rigler; Carly Pasquale; Tomas Hammond; Erin Lynch; Reagan Hart; Elisa Cafferata.

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).*

Shelley Capuro, representing the Nevada Association of Health Plans noted that the association is a statewide trade organization representing 12 member companies that provide commercial health insurance and government program services to Nevadans. She thanked the executive director and PPC commissioners for the opportunity to comment on issues affecting mothers and babies in Nevada and referenced detailed written comments submitted on March 31. She summarized that with approximately half of births in the United States covered by Medicaid; state Medicaid programs are significantly affected by the financial implications of current trends.

Ms. Capuro outlined opportunities for Medicaid managed care programs to develop strategies addressing prenatal care management and postpartum coverage to improve health outcomes for pregnant individuals on Medicaid. She identified four key policies and program areas: prioritizing actions addressing disparities contributing to inequities in maternal health outcomes; ensuring access to comprehensive clinical and non-clinical services; advancing care models through enhanced digital modalities; and strengthening data sharing and incentivizing plans and providers to improve management of chronic and complex conditions, including substance use disorders. She emphasized that effectiveness of these strategies depends on sustained, adequate, and long-term funding to support implementation, maintain provider capacity, advance digital tools, and ensure access to needed services. She noted that without stable financial support, policies and programs cannot achieve meaningful or equitable impact for pregnant individuals and families. She concluded by stating that lasting improvement requires coordinated, ongoing financial commitment from the state and its partners, and she expressed the association's interest in collaborating with the PPC on future policy initiatives.

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

Agenda item 3 was dropped and may be included in future agendas as needed

4. **For Possible Action: Review and Approve Meeting Minutes from February 27, 2026, and March 13, 2026**
By: Bethany Sexton, Chair

The chair asked whether any commissioners had questions or edits to the minutes. Hearing none, the chair opened the floor for a motion to approve the minutes as written.

Commissioner Dr. Glyman motioned to approve them and commissioner Dr. Chastain second.

The chair conducted a vote, during which commissioners present responded "aye."

No opposition was stated. The minutes were approved.

5. **Informational: Presentation on Perinatal Health Policy Consideration from a Hospital Perspective**
By: Representatives from the Nevada Hospital Association (NHA) and Nevada Rural Hospital Partners (NRHP)

Patrick Kelly, president and CEO of the Nevada Hospital Association, and co-presenter Blaine Osborne, president of Nevada Rural Hospital Partners and a member of the state assembly, presented information related to perinatal care from a hospital standpoint. Mr. Kelly reported that 16 hospitals in Nevada provide labor and delivery, including 11 acute care hospitals and three critical access hospitals. Those are Humboldt General Hospital, Winnemucca, Banner Churchill in Fallon, and William B. Ryrie in Ely, and two sole community hospitals (Carson Tahoe in Carson City and Northeastern Nevada in Elko). He stated that 23 hospitals do not provide these services, comprising eight acute care hospitals, 10 critical access hospitals, and five neighborhood hospitals in Clark County operated by Dignity Health Common Spirit. He stated there are 10 NICUs in Nevada, with eight in Clark County and two in Washoe County. He added that Nevada has higher rates of low birth weight, higher pre-term births, and more women who do not receive adequate prenatal care compared to national figures.

Mr. Osborne then discussed workforce challenges, noting Nevada ranks near the bottom among states in OBGYNs per capita, with 367 OBGYNs statewide, equating to 54 per 100,000 versus a national average of 80 per 100,000. He stated the average age of OBGYNs in Nevada is 56 and almost half are over 55, raising concerns about retirements and replacements. He referenced accreditation received in February of 2026 for the University of Nevada, Reno School of Medicine and Renown Health OBGYN residency, which is expected to begin in July of 2027 with three residents. He described nursing workforce issues, noting that approximately 40% of Nevada nurse licenses are held by nurses with out-of-state addresses, which he stated likely reflects lingering effects from the COVID period. He outlined challenges staffing obstetric units due to unpredictable patient volumes, variable labor lengths, emergent situations requiring all hands-on deck, and limited specialized labor and delivery staff. He reported a recent increase in births occurring in emergency rooms at rural critical access hospitals.

Mr. Kelly then outlined financial pressures on hospitals, that births in Nevada are paid by Medicaid (42%), commercial insurance (51%), other government (4%), and self-pay/private pay/charity care (3%), noting Medicaid was over 50% a year prior. He stated that, in almost all categories except commercial, payments do not cover the actual cost of care and cited a base Medicaid per diem for newborns of \$327. Which covers room and board, nursing care, supplies, medications, newborn screening, operating rooms, and equipment, with NICU and mother rates higher but still limited. He stated that a 2008 Medicaid methodology using 34% of the prior year's hospital billed claims data would yield higher per diem rates today (e.g., approximately \$1,731 for newborns), and credited Medicaid leadership for developing supplemental payment programs, including the Private Hospital Provider Tax Program benefiting 43 hospitals. He explained that hospitals basically tax themselves, funds go to the state and receive an enhanced federal match, and return as higher payments, with benefits tied to care provided to Medicaid patients. He distinguished private (non-governmental) hospitals such as Renown and Carson Tahoe from public hospitals such as UMC and some public district hospitals, which have separate supplemental programs. He stated that HR1, referred to as "the one big beautiful bill," significantly reduced supplemental payment programs for hospitals, with anticipated reductions of approximately \$15 million starting in state fiscal year 27 and approximately \$57 million by state fiscal year 29. He referenced a Rand study indicating Nevada is among three states expected to see the largest Medicaid budget reductions, with reductions of more than 15% of Medicaid budgets and a potential reduction of about \$10 billion by 2034.

Mr. Kelly addressed medical malpractice pressures, stating premiums have tripled since 2015, with rate increases in 2024, and that OBGYNs are among the top specialties with the highest premiums. He stated payout ranges of approximately \$400,000 to \$1 million for moderate injuries, up to \$10 million for serious injuries such as cerebral palsy, and higher for catastrophic injuries, and he noted these pressures affect decisions by older OBGYNs regarding practice scope. He stated the Nevada legislature increased the cap on non-economic damages in medical malpractice cases from \$350,000 to \$750,000 per cap. Mr. Osborne added that financial pressures can arise suddenly; citing recent financial instability in White Pine County and a threats to William B. Ryrie Hospital in Ely, which could have forced closure of obstetrics and delivery services, and stated the county and hospital are working on solutions.

Mr. Kelly then presented potential solutions and policy ideas: creating a one-stop website for mothers to locate health care providers, transportation assistance, insurance eligibility information (commercial and Medicaid), and basic pregnancy information. As well as using a QR code for outreach on postcards and social media, conducting a social media campaign to reach young people, and encouraging urban providers to travel to rural areas two to three days per month with enhanced reimbursement when traveling 20–30 miles or more, to expand access to prenatal services. Mr. Osborne stated that Medicaid is evaluating unbundling prenatal services from the bundled delivery rate, which is of particular interest to rural hospitals. Mr. Kelly concluded that supporting hospital capacity and improving Medicaid funding will be needed given anticipated HR1-related reductions, and both presenters expressed appreciation for the commission’s focus on the issue and willingness to collaborate on solutions.

Questions and Discussion Following Presentation

Dr. Glyman thanked the Nevada Hospital Association for its longstanding support of the Medicaid population and expressed appreciation for Renown’s new OB residency program. He noted challenges retaining residents in Nevada due to limited incentives and suggested evaluating selection processes and retention efforts. He described significant increases in medical malpractice premiums, stating his own premiums had tripled in a year with no incidents, and reported that hospitals are losing various specialties due to financial pressures. Dr. Glyman stated that reimbursement disparities, particularly between Nevada and states such as California and New York, drive physicians out of state, and he emphasized broader system issues related to payment structures.

Dr. Glyman provided an example of reimbursement disparities, stating he receives \$242 from Medicaid for a craniofacial surgery procedure while receiving approximately \$400 for a dental extraction. He stated these discrepancies discourage providers from performing complex procedures, including obstetric services, and contribute to decreased availability of specialty care. He added concerns about hedge funds purchasing practices and then financially supporting lawsuits through trial attorneys, which he stated contributes to rising malpractice premiums. He emphasized the relationship between reimbursement, liability risk, and the state’s ability to attract and retain providers, noting the connection between healthcare access and economic development.

Director Weeks thanked Dr. Glyman for his comments and acknowledged his statement that not all issues stem from Medicaid. She described ongoing rural hospital tours conducted every two years. She noted that low patient volume in rural areas makes it difficult to sustain OB services and stated that Medicaid is evaluating unbundling components of the bundled delivery rate to increase funding for prenatal and postpartum care. She stated that under the current structure, hospitals that cannot provide deliveries also do not receive payment when they provide only prenatal care, and she emphasized the goal of aligning payment with the full continuum of maternal care.

Director Weeks added that unbundling may require legislative approval, as well as funding and that a recommendation from the commission could be helpful. She indicated Medicaid is working with Milliman and could bring additional information to a future meeting. Commissioners discussed the need to understand fiscal implications to avoid duplicative or conflicting recommendations. Director Weeks described potential longer-term savings if prenatal care investments reduce costs associated with high-risk pregnancies and stated that a home-health model could support care coordination and social service needs, with 90% federal funding available during the first two years. She noted, however, that the model requires significant infrastructure and staffing commitments from providers, though some FQHCs may be well positioned to participate.

Mr. Osborne added that on the rural hospital tour, the team had completed visits to all critical access hospitals providing obstetric services in the northern region and that no additional such hospitals would be seen on the remainder of the tour. He reiterated the use of family practice obstetricians where feasible. Commissioners asked about AMA’s proposed unbundling of global obstetric codes, and Mr. Osborne stated they are reviewing the changes and will work with Medicaid. Mr. Malmlov added that the next agenda presentation will address related AMA changes.

Dr. Peterson asked whether unbundling requires legislative approval, and Director Weeks confirmed that legislation and funding are needed. She suggested bringing Medicaid leadership and consultants to present further details, including financial modeling. Additional discussion addressed combining unbundling with the pregnancy health model, potential fiscal impacts, provider readiness, and the need to evaluate tradeoffs. Director Weeks noted that early federal funding could help offset initial costs and that long-term savings would depend on uptake and care improvements. She stated the health home model focuses heavily on coordination of social and community-based support. Commissioners expressed interest in receiving additional information at a future meeting.

6. Informational: Perinatal Health Payment Reform: Overview and Opportunities
By: Representatives of Milliman, on Behalf of Nevada Medicaid

Jeremy Hayes, chief of rates for Nevada Medicaid, was joined by partners from Milliman, who support Medicaid in this work. He outlined the agenda, which included an overview of the NVHA maternity payment strategy approach, a review of AMA changes to CPT codes, a maternity care payment incentive state scan, and an opportunity for feedback.

Mr. Hayes described the roadmap for maternity care work, stating the goal is to ensure payment structures support high-quality, comprehensive care for Medicaid members. He explained that immediate priorities include reimbursement review and assessment of how care is financed today. That they are evaluating reimbursement for freestanding birth centers, including ensuring transfer payments are fair and seamless when patients move from a birthing center to a hospital. He added that professional billing across the full spectrum of care—antepartum, delivery, and postpartum—is being reviewed, with exploration of enhanced payments to incentivize prenatal and postpartum visits. Mr. Hayes stated Medicaid is preparing for upcoming CPT coding methodology changes, transitioning from bundled codes to more granular billing, with implementation planned for January 1, 2027, and noted providers will be given time to prepare. Hayes stated long term goals include moving away from pure fee-for-service toward alternative payment models that reward outcomes rather than volume. He added that ongoing monitoring of maternal health outcomes and utilization trends will allow future adjustments, and that all decisions are driven by program data to ensure changes meet the needs of Nevada’s population.

Gwyn Volk from Milliman introduced herself and co-presenter Christine Bredfeldt, stating they would review AMA unbundling changes and discuss the initial state scan of maternity related payment incentives. Ms. Bredfeldt explained that the AMA is restructuring maternity care service codes, eliminating global and bundled codes and replacing them with service specific billing. Ms. Bredfeldt further explained that these changes were discussed in a March 2 webinar and will take effect January 1, 2027. Noting that CMS is developing relative values for the new codes, with proposed values expected in July and final values in November. Ms. Bredfeldt stated NVHA plans to transition to the updated codes on January 1 and that rates for antepartum, delivery, and postpartum visits are being assessed.

Ms. Bredfeldt described the new coding structure, which divides maternity care into four phases: antepartum, labor management, delivery, and postpartum care. That prenatal visits will be billed using evaluation and management codes with a TH modifier and that separate codes will distinguish normal from abnormal pregnancies. She explained that labor management will now be billed separately from delivery, with codes distinguishing straightforward and complex cases and initial versus subsequent days. She reviewed new delivery codes for vaginal and cesarean procedures, including distinctions for previous cesarean deliveries, varying degrees of laceration repair, and whether a hysterectomy is performed. She stated postpartum care will also use evaluation and management codes based on visit complexity, and that a new code for uterine tamponade will be added. She also reviewed the list of codes being discontinued and those being added.

Ms. Volk presented the state scan of maternity care incentives, describing provider and patient incentive models identified across several states. She stated provider incentives include one-time payments, increased reimbursement rates, and payments tied to completion of specified prenatal or postpartum visits. She summarized examples such as North Carolina’s one-time payments for risk screening and group prenatal care; Illinois’ payments

for postpartum visits; Texas' rate increases for prenatal and postpartum care; and Mississippi's payment for postpartum risk assessment. She also reviewed managed care organization incentives, including payments for notification of pregnancy, centering pregnancy group visits, postpartum depression screening, and completion of two postpartum visits. Ms. Volk described patient incentives available through managed care plans, such as gift cards, reward points redeemable for items, and welcome gifts for home visits. She noted these incentives typically target increased attendance at prenatal and postpartum appointments. She invited feedback on additional approaches or models commissioners have encountered.

Questions and Discussion Following Presentation

Ms. Volk asked commissioners whether there were specific barriers related to reimbursement, billing, or access that the state should consider when developing rate options, and whether any local or out-of-state models might be of interest. Jeremy Hayes stated that feedback from the PPC would be valuable given the group's expertise. The chair noted earlier discussion regarding rural providers, including family practitioners who can deliver prenatal care but may not perform deliveries, and asked how reimbursement models could better support them. She observed that unbundling could help address this issue.

Dr. Peterson emphasized the importance of screening for perinatal mood and anxiety disorders and substance use, stating that overdose is the leading cause of pregnancy associated death in Nevada. She requested ensuring screening measures are incorporated into payment considerations. Mr. Hayes stated that Medicaid is analyzing the maternal health home model.

Dr. Porath asked whether models exist that incentivize more granular prenatal care tasks, such as prescribing prenatal vitamins or ensuring prenatal vaccination status. Ms. Volk stated they had not seen such models in the initial scan but could explore further and noted that lack of examples in other states should not preclude Nevada from considering such incentives. Commissioner Sexton repeated the requests for incentives related to prenatal vitamins and prenatal vaccination status.

The chair asked if there were additional comments. Hearing none, she noted the potential for future discussion regarding the maternal health home model and indicated the presenters may return for further dialogue. She thanked the team for the presentation, stating the information and examples from other states were useful for identifying approaches Nevada could adapt.

7. Informational: Policy Recommendations to be Reviewed by the PPC **By: Dylan Malmlov, Executive Director, Patient Protection Commission**

Mr. Malmlov provided an overview of how the commission reached this stage, stating that commissioners have heard more than 11 presentations from public health experts, clinicians, workforce and rural health representatives, NVHA leadership, hospital system representatives, national policy groups, and others, along with numerous studies and data presentations. He reported that this process generated 58 unique policy submissions through public forums and recommendations raised during meeting discussions. He explained that the commission is entering steps three and four of its decision-making framework through the review of these proposals.

Following the current meeting, commissioners will be asked to submit BDR concepts based on the policy proposals received. The next meeting on May 22 is intended to review those concepts and hold structured discussions, with the June 12th meeting continuing BDR discussions and including a vote on three BDR topics. He stated commissioners will need to approve the intent of the top three topics, after which staff will draft and submit them to LCB before the September 1st deadline. Additional meetings may be added if needed, but the goal is to finalize the selection by June 12th.

Mr. Malmlov summarized that the 58 policy proposals are grouped into seven problem areas: coverage and benefits, health literacy, payment reform, population health, behavioral health, rural health, and workforce capacity. He

noted that within the coverage and benefits category, proposals included expanding coverage for group prenatal care, dyadic interventions, home visiting, prenatal education, and unbundling services such as behavioral health screenings and postpartum long-acting reversible contraceptives, as well as enhancing perinatal supports including lactation support. In the area of health literacy, proposals concentrated on improving navigation and transparency of information, increasing educational support, and developing designations such as levels of prenatal care or birthing friendly hospital indicators.

The payment reform category included structural billing updates such as unbundling, increasing or reassessing payment rates for specific services or facilities, and implementing alternative payment models, including pregnancy medical homes. Population health proposals addressed establishing a perinatal quality collaborative, adopting AIM patient safety bundles, and developing care coordination and related support for vulnerable populations. Behavioral health proposals focused on better integration of behavioral health into perinatal care, including increasing screening rates through unbundling and establishing pregnancy health models for specific subpopulations such as women with substance use disorders, along with adopting patient safety bundles and other best practices.

Rural health proposals comprised expanding access and readiness to care for mothers and babies in rural and under resourced areas. including expanding infrastructure such as ultrasound and other diagnostic equipment, improving telehealth technology, and enabling appropriate telehealth use. Workforce capacity and training proposals encompassed continuing education initiatives, use of telehealth to support the existing workforce, and strategies to increase the workforce through training or licensure expansion.

Mr. Malmlov proposed a framework for evaluating policies. He explained that one category includes items for BDR consideration, which require strong evidence, statutory changes, high impact, feasibility, or a need for legislative action to be implemented. The category of formal recommendations made by the PPC will be included in the semiannual report due on January 1st. They may also identify potential BDRs that another entity could carry forward when evidence supports the action, but the topic did not advance as a BDR for the PPC. Additional categories include programmatic recommendations that can be implemented without legislation, potential future recommendations requiring more time or analysis, and items the commission may choose not to consider further due to limited evidence or scope. He stated that the middle three categories would be addressed later in the process.

The chair sought clarification on how items placed in the BDR consideration category would be handled moving forward. Mr. Malmlov confirmed that anything placed in that category would be developed more fully through upcoming meetings, with support from staff and others to ensure the necessary information is gathered. The three items in the middle categories, however, may be formalized later in the process as the committee determines whether they should advance as formal recommendations or programmatic recommendations.

8. For Possible Action: Review and Discussion of Possible Bill Draft Request (BDR)
By: Bethany Sexton, Chair

The chair opened the next portion of the agenda for discussion, inviting commissioners to come on camera for a more interactive dialogue. She referenced materials provided in the meeting packet, including the policy proposals spreadsheet and the action priority matrix, which categorized items by potential impact and level of effort. She noted that proposals in the green quadrant were those appearing to offer strong impact with relatively reasonable effort, and she encouraged commissioners to consider whether some of the BDR concepts should come from that category, while also allowing for one higher effort option if justified.

Dr. Peterson revisited prior discussion regarding NICU regionalization, referencing earlier presentations on low volume NICUs and their association with higher mortality rates. She cited data indicating that in 2023 there were 445 very low birth weight infants statewide, with 340 in Clark County, and that dividing these among eight NICUs resulted in low patient volumes per unit. She raised the importance of ensuring sustainability of labor and delivery

units while also supporting evidence based neonatal care. The chair noted that NICU regionalization corresponded to [item 35](#) in the proposals list.

Dr. Peterson also asked whether proposals could be bundled together, such as combining unbundling of obstetric codes with the pregnancy health home model. Mr. Malmlov clarified that BDRs must focus on a single topic but could encompass multiple related provisions if they fall under one overarching theme. Clarification from the Deputy Attorney General was requested for a future meeting.

Commissioners expressed support for keeping certain items on the list for further review, including the general unbundling proposal ([item 57](#)). Dr. Walker highlighted workforce development and payment reform as major themes, suggesting that expanding rural residency and training tracks ([items 50 and 51](#)) could strengthen the provider pipeline. He emphasized improving capacity for prenatal care and creating stability through payment reforms.

Dr. Porath discussed [item 42](#) regarding the creation of a perinatal quality collaborative. Mr. Malmlov noted that Interim Health may be pursuing related initiatives, and commissioners agreed it could remain on the list, potentially as a recommendation if not a BDR. Commissioners also discussed proposals related to behavioral health, identifying [items 39](#) and [40](#) as potential additions to the list, with interest in linking behavioral health screening to unbundling efforts.

Dr. Khan shared concerns that the state has repeatedly struggled for decades to improve access, reimbursement, and workforce challenges, and he expressed frustration about the slow pace of progress. He urged the commission to seek solutions that meaningfully shift priorities within state leadership and highlighted the need for increased revenue dedicated to healthcare. Commissioners discussed opportunities to coordinate with other legislative bodies or committees to strengthen proposals.

Dr. Glyman emphasized the broader economic impact of inadequate healthcare access and reimbursement, noting that the state's ability to attract new industries depends on improving healthcare infrastructure. Commissioners agreed that economic development perspectives may be valuable and discussed whether voices from business or industry recruitment organizations could inform future deliberations.

Commissioners next reviewed the action priority matrix and discussed focusing on items in the green quadrant as potential BDR candidates while categorizing others for recommendations or future consideration. Several commissioners expressed support for including the maternal health home model ([item 18](#)) despite its placement in the blue quadrant. They proposed developing separate lists for BDR concepts and recommendations. Items with low impact or lower relevance were proposed for removal due to limited bandwidth.

Mr. Malmlov confirmed that next steps include conducting a survey for commissioners to identify preferred BDR concepts. Commissioners discussed opportunities to bundle certain related proposals where feasible and stressed the need to avoid over bundling proposals in ways that might limit legislative support.

Dr. Khan suggested requesting additional insight from Medicaid leadership regarding potential revenue generating mechanisms that may support long term sustainability. Commissioners also raised the issue of MMRC review timelines and discussed including recommendations to expedite or time limit the review process.

Mr. Malmlov asked commissioners what additional information would be helpful moving forward. The chair requested detailed financial implications, including funding mechanisms, and commissioners requested information on unintended consequences, feasibility concerns, and potential administrative burdens. Commissioners suggested gathering feedback from obstetric providers or organizations such as ACOG regarding unbundling proposals. He invited commissioners to send further suggestions as needed.

9. **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).*

Amy Schmidt, director of health system improvement at Comagine Health, a national nonprofit healthcare consulting organization. She stated that she serves as the principal investigator and project director for the Integrated Maternal Health Services (IMHS) pilot program, currently funded by the Health Resources and Services Administration, and as operations director for the Southern Nevada Pathways Community Hub. She referenced public comments submitted on March 27 and provided a brief summary aligned with the day's discussion.

Schmidt stated that Comagine Health partnered with the UNLV Kirk Kerkorian School of Medicine Department of Gynecological Surgery and Obstetrics and the UNLV School of Public Health to launch the IMHS pilot in April of last year. She described the integrated care model as based on two evidence-based approaches: the pregnancy health home model and the Pathways Community Hub Institute model. She explained that the model focuses on early entry into perinatal care and social services through collaboration between OBGYN staff and community health workers to address health related social and clinical needs. She reported that the pilot is 12 months into an 18month period and is being implemented with more than 300 women receiving care at UNLV Health OBGYN clinics. She noted that planning is underway to scale and spread the program to additional OBGYN practices, contingent on funding and support.

Ms. Schmidt stated that based on prior presentations, Comagine Health understands that Nevada Medicaid intends to launch a maternity care provider pilot program addressing the perinatal continuum of care. She stated that the IMHS program is positioned to partner with Medicaid by building on the past year's implementation experience, and she noted Director Weeks' comments earlier in the meeting about the pregnancy health home model being a significant lift for practices. She stated that IMHS can support implementation for both practices and community health workers. She further stated that IMHS is positioned to be piloted as a Nevada alternative payment model when an allowable Medicaid outcome-based unit rate is authorized. She recommended that the PPC consider proposing legislation requiring Nevada to pursue Medicaid coverage for unallowable benefits. Including the pregnancy health model and community health worker services provided under the Pathways Community Hub, as well as funding for the IMHS pilot and other alternative payment model pilots.

10. **Adjournment**

By: Bethany Sexton, Chair

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

Meeting adjourned at 11:00am