DIVISION OF HEALTH CARE FINANCING AND POLICY
CLINICAL POLICY TEAM, BEHAVIORAL HEALTH PROGRAM
BEHAVIORAL HEALTH TECHNICAL ASSISTANCE (BHTA)
Minutes – Wednesday, November 9, 2022
10:00 - 11:00 a.m.

Facilitator: Carin Hennessey, DHCFP, Behavioral Health Unit (BHU), SSPS II

1. **Purpose of BH Monthly Calls**:
   The BHTA call offers providers guidance and updates on DHCFP Behavioral Health policy. The TEAMS meeting format offers providers an opportunity to ask questions using the chat feature and receive answers in real time. The webinar is recorded. If you have questions prior to or after the monthly call, submit requests directly to the behavioralhealth@dhcfp.nv.gov.

   - Introductions – BHU, Provider Enrollment, SUR, Gainwell Technologies

2. October 2022 BHTA Minutes:
The minutes from last month's BHTA are available on the DHCFP Behavioral Health webpage (under "Meetings"). You'll want to navigate to this page and click on "Behavioral Health Agendas and Minutes." You can find information from previous and current meetings. Please review if you have questions and if you were not able to attend the BHTA last month; this is a great place to check up on what we discussed.

- Behavioral Health Updates
- Chapter 400 Updates
- QBA and QMHA Enrollment Checklists

3**. Related DHCFP Public Notices:**
Link for upcoming Public Hearings, Meetings, and Workshops related to Behavioral Health http://dhcfp.nv.gov/Public/AdminSupport/PublicNotices/.

Public Workshops
- **11/10/2022 --** MSM 2700 and Certified Behavioral Health Centers SPA

Public Hearings
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4. **DHCFP Behavioral Health Updates:**
Behavioral Health Web Announcements (WA):
https://www.medicaid.nv.gov/providers/newsannounce/default.aspx
(Please refer to this link for a complete list of web announcements)

- **WA#2931** – Medicaid Services Manual Chapter 400 Updated

- **WA#2929** – Attention All Providers: Top 10 Claim Denial Reasons and Resolutions/Workarounds for September 2022 Claims
- **WA#2925 –** Attention All Providers: Form FA-29 Required to Report Change in Recipient's Prior Authorized End Date of Services
- **WA#2924 –** Medicaid Management Information System Updated with NCCI Quarter 4 2022 Files
- **Volume 19 Issue 3 –** COVID-19 UNWIND: Nevada Medicaid and Nevada Check Up News (Third Quarter 2022 Provider Newsletter)
- **WA#2916 –** Attention Providers of Behavioral Health Services: Procedure Code 90875 Prior Authorization Requirement
- **WA#2913 –** Attention Individual Providers: Tax ID Information When Registering for the Electronic Verification System (EVS) Portal
- **WA#2911 –** Attention All Providers, Delegates and Staff: Upcoming Training Sessions for December 2022

Carin Hennessey, SSPS II

- BH Updates –
    - For the NV SPA (State Plan Amendment) 22-0005 – Regarding Reimbursement Methodology for Crisis Stabilization Centers -- This SPA is on RAI (Request for Additional Information), which essentially pauses the 90-day clock under CMS review. The latest discussions involve adding the methodology to different pages within the state plan since the services provided under a crisis stabilization center are outpatient based and may fit better under the rehabilitative services area rather than the hospital reimbursement pages where we originally placed them.
    - Nevada Medicaid's consultant, Health Management Associates (HMA), has conducted one-on-one interviews with dozens of key stakeholders to conduct an environmental scan and develop recommendations to address the behavioral health needs of children and youth and their families. These one-on-one meetings helped to prepare for the meeting that brought stakeholders together in person and virtually to collaborate around goals, timelines, and desired outcomes for this effort to improve Medicaid services and for the overall system of care for children and youth with behavioral health needs and their families. An all-day meeting was held on September 19, 2022. Additional public and stakeholder engagement will be forthcoming with recommendations from HMA.
    - MSM 2500 (Case Management) and MSM 2700 (CCBHC- Certified Community Behavioral Health Centers) -- DHCFP is proposing revisions to ensure that duplication of services is not occurring for a single Medicaid recipient who is enrolled in a Medicaid Managed Care Organization (MCO) and receiving case management services through a CCBHC. Language in MSM 2500 and 2700 is proposed to clarify the role of the Lead Case Manager. When a recipient is eligible for Medicaid through an MCO, it is the responsibility of the Lead Case

Manager to ensure that the identified MCO is notified of the recipient's participation in Targeted Case Management (TCM), in addition to coordinating all care with the MCO.

- The Mobile Crisis Planning Grant Project and Core teams continue to work on developing how Nevada will build mobile crisis teams that will be eligible under enhanced FMAP (Federal Medical Assistance Percentage) offered through Section 1947 of the SUPPORT Act. We have been working with our consultant agent, Mercer, on this project and they have delivered their final recommendation report to the state. We are working through these recommendations and making determinations regarding moving forward. For example, it is likely we will pursue a state plan amendment rather than a waiver to ensure our already covered crisis intervention services include the requirements needed and outlined for qualifying mobile crisis teams who will receive enhanced FMAP. We have a tentative timeline to propose new MSM policy and state plan amendment in April 2023. We are also determining how we will delineate these teams from other mobile crisis or crisis intervention that does not qualify for the enhanced FMAP, for example, identifying if a possible certification would be needed, development of a new provider type and using other system updates to include modifiers for qualifying services.
  I will try to offer more information regarding the crisis continuum to this forum. Providers are encouraged to bring up questions. Regarding a concern raised a few months ago regarding wait times when calling 988, there are connection issues that related to the nationwide 988 call center. Some calls that are received in Nevada call center may be routed over into the Nationwide network. The connection issues are being addressed. Please email and reach out during the BHTA with questions and concerns in connecting individuals to crisis services.
- 1115 Substance Use Disorder Demonstration Waiver -- The majority of work being done through the SUPPORT Act Post Planning grant has been related to the 1115 Substance Use Disorder Demonstration Waiver and getting that was resubmitted to CMS. Our focus, while we are simultaneously answering questions from CMS on the specific application, is the development of the Implementation Plan. The Implementation Plan is an adjoining document to the 1115 application, that details how states will meet the milestones and goals of the Demonstration. It outlines how the current and future state will function and identifies actions needed for the future state activities to be completed. CMS has indicated they are working on development of the Standard Terms and Conditions (STCs) which is great news indicating approval may be coming. There is still no timeline for approval, and we are still targeting a 1/1/23 implementation date. Nevada Medicaid is working on system development, adding new codes for these levels of care, and applying rates to these codes.

Next month, Abigail Bailey, Program Specialist, Substance Abuse Agency Model, will be updating us on the monthly SAPTA providers call that has been scheduled. If you have questions on the Demonstration waiver, please forward them to the BH inbox.

- Chapter 400 Updates – MSM 400 Chapter Updates have been approved. Mental Health and Alcohol/Substance Abuse Services, Provider Qualifications, have been updated the MSM Chapter 400 language to clarify the roles of Individual Rehabilitative Mental Health providers. These providers currently deliver Outpatient Mental Health and Rehabilitative Mental Health services under a Behavioral Health Outpatient Treatment model (PT 14) or they deliver RMH services under a BH Rehabilitative Treatment model (PT 82). There was a public workshop held in June and Public Hearing was held on September 27, 2022. Updated Enrollment Checklists have been posted 10/6/2022 and a Web Announcement has just been posted to provide guidance.

  If we look at the chapter, you'll see that the information has not changed much; however, the page numbers for the sections have been bumped down. You'll see where the Outpatient Service Delivery Models have been updated. The BHCN has been updated. The Independent Professionals includes the LCSW, LMFT, LCPC under the PT 14; they also include providers enrolled under other Provider Types, like PT 20 (Psychiatrist), PT 24 (APRN), PT 26 (Psychologist).

  The new sections for the Individual Rehabilitative Mental Health (RMH) providers is under MSM 403.3 Provider Qualifications. We have QBAs, with everything listed – all the training (initial and in-service), all of the requirements. There is a section for Peer Supporters. This is not new information as much as it has been shifted into this section. Then you see the background checks and the tuberculosis screening, as we talked about earlier.

  We have the revised qualifications for QMHAs, all the trainings, requirements, the background check and the TB screenings.

  And our Qualified Mental Health Professionals (QMHP). Some clarifications and revised information related to service-specific assessment tools. Information regarding Interns, background checks, and TB screening related to these individuals as they are linked and billing services underneath the agency/entity/group to which they are enrolled.

  All of the RMH providers must be enrolled individually and then they must be linked to a BH group (like a BHCN, a BH Rehabilitative Treatment, and so on for other BH agencies or under a group enrollment that uses these providers to deliver services).

  There was a small update to our Psychologist sections. And a small clarification on the Outpatient Mental Health (OMH) services.

  The chapter is now organized with the models for service delivery, the qualifications for the providers under those models, and then the services (under OMH section and RMH section). Hopefully this will be easier to navigate.

6. **DHCFP Provider Enrollment Unit Updates:**
   Nevada Medicaid Website: https://www.medicaid.nv.gov/providers/enroll.aspx
   DHCFP Website: http://dhcfp.nv.gov/Providers/PI/PSMain/
   Contact Information: providerenrollment@dhcfp.nv.gov

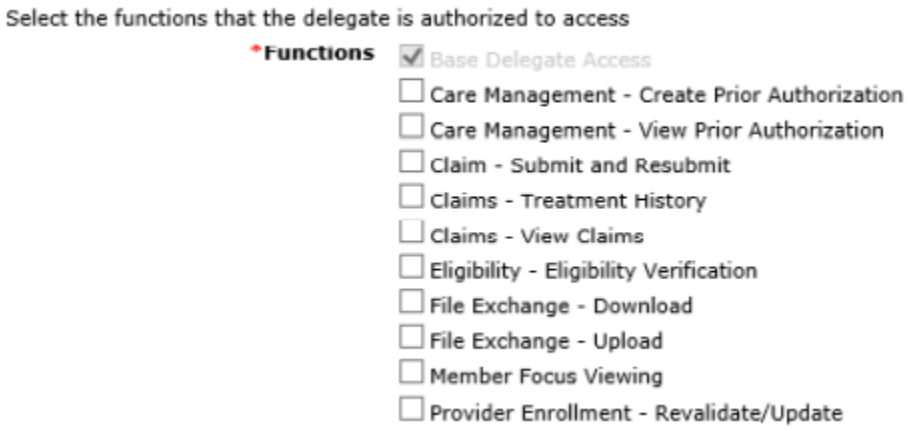
7. **DHCFP Surveillance & Utilization Review (SUR) Updates:**
   Report Provider Fraud/Abuse http://dhcfp.nv.gov/Resources/PI/SURMain/
   Provider Exclusions, Sanctions and Press Releases http://dhcfp.nv.gov/Providers/PI/PSExclusions/

8. **Gainwell Technologies Updates:**
   Billing Information https://www.medicaid.nv.gov/providers/BillingInfo.aspx
   Provider Enrollment https://www.medicaid.nv.gov/providers/enroll.aspx
   Provider Training https://www.medicaid.nv.gov/providers/training/training.aspx
   Contact Information
   Nevada Medicaid Customer Service: (877) 638-3472
   NVMMIS.EDIsupport@gainwelltechnologies.com
   nv.providerapps@gainwelltechnologies.com
   Prior Authorization Information: (800) 525-2395
   nvpeer_to_peer@gainwelltechnologies.com
   Field Service Representatives: nevadaprovidertraining@gainwelltechnologies.com

Alyssa Drucker, Provider Relations Field Service Representative - North
Susan Harrison, Provider Relations Field Service Representative – South

- Enrolling Delegates – starting with the Electronic Verification System (EVS) User Manual, https://www.medicaid.nv.gov/providers/evsusermanual.aspx, Chapter 1: Getting Started, pg. 20, you will see screen shots directly from the portal. It is most secure and safe to have everyone have their own logins and delegate access. We see often people who share the Admin login and don't create delegates, information is changed unintentionally. Or someone leaves and takes the passwords with them, and others are not able to access the information. No one knows the security answer (i.e., the name of the high school of the old office manager's mom). Having your own delegate access is very important and granting that access to each individual.
  Sometimes you will see someone already has a delegate code, which is a four-digit code; they used to work at a different office or they work at your office now. Their old access is made inactive at their former group and you add them to your group.

Figure 1: EVS User Manual, page 20, Delegate functions



These functions will allow the delegate to have access to particular functions. If you have an office with many people, for example, the staff that are only involved in verifying eligibility will never need to see claims, never need to see the payment for the entire group – when you add that delegate, you will only give them the function of "Eligibility". There has been a request to explain what each function (above) does.

- If you are familiar with prior authorizations, everything is done under the "Care Management" tab; if you select only "View Prior Authorization" for a delegate the only function they will have when they log in will be to view the prior authorization.
- Some offices handle different functions; for example, some only do "Claims". You may identify only and/or all the aspects that a delegate deals with for claims.

You always want to make sure, if someone leaves your office and they are a delegate for your group, you have to set them to inactive. The worst nightmare you can imagine is that if someone leaves your office and they have access to information – like payment information – they can still go in there and make changes to your group. You don't want that; you always want to make sure that anyone who has left your office does not have access to this information.

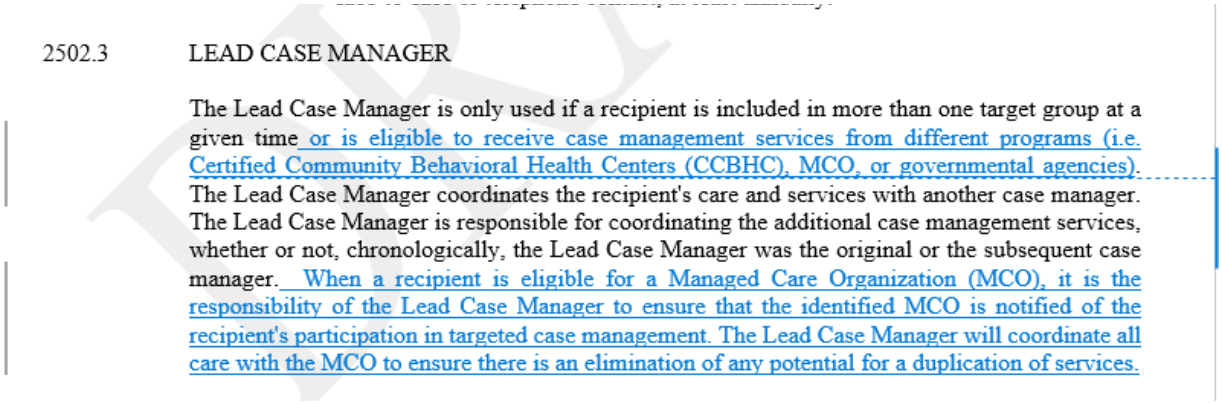
9. **Behavioral Health Provider Questions:**

The Behavioral Health Policy TEAMS meeting would like to address provider questions each month. This will allow us to address topics, concerns, questions from the Behavioral Health providers and make sure the specialists are focusing training and educational components to your needs and gathering your direct input from the BHTA TEAMS meeting. The previous month's questions with answered on the posted minutes for the meeting.

Q: Is there a resource to read on the upcoming MCO Targeted Case Management changes?

A: The documents have just been submitted. We have not had a Public Hearing yet and it should be held at the end of December. Those documents will be shared officially when the Public Hearing is posted. Here is the section that is pending updates for 2500. If you have additional questions, please email the BH inbox.

Figure 2: Medicaid Service Manual Section 2502.3 on Targeted Case Management Lead Case Manager.



2502.3 LEAD CASE MANAGER

The Lead Case Manager is only used if a recipient is included in more than one target group at a given time or is eligible to receive case management services from different programs (i.e. Certified Community Behavioral Health Centers (CCBHC), MCO, or governmental agencies). The Lead Case Manager coordinates the recipient's care and services with another case manager. The Lead Case Manager is responsible for coordinating the additional case management services, whether or not, chronologically, the Lead Case Manager was the original or the subsequent case manager. When a recipient is eligible for a Managed Care Organization (MCO), it is the responsibility of the Lead Case Manager to ensure that the identified MCO is notified of the recipient's participation in targeted case management. The Lead Case Manager will coordinate all care with the MCO to ensure there is an elimination of any potential for a duplication of services.

Q: [O]n Chapter 400, regarding the background check results having to be submitted with applications? There is portion in Chapter 400 that says all applicants must have a criminal background check before they can enroll with Nevada Medicaid. Does that mean I have to submit copies of their background check when I submit their application to Medicaid?
A: No. This clarifies is that the background check is addressed prior to Medicaid enrollment. The background check is done when the Individual Rehabilitative Mental Health provider applies and is hired at the agency. The agency is required to do a background check on that individual provider, maintaining the request and results prior to submitting the application to Medicaid. Guidance emphasizes that it is the responsibility of the BHCN (or applicable Behavioral Health Agency); the agency should be background checking any employees that are working with recipients.

Q: For clarification, a little further along in the [background check] policy is says if asked we should have that information. So basically, for audit, we have to prove that the background check was completed, and we received the results prior to them completing any services and billing them through Medicaid. Am I understanding that properly?
A: The intention is to have the results prior to them enrolling in Medicaid because you want to make sure if they are providing services to recipients and billing them, they have cleared the background check. It's understood that some of these background check processes have been delayed. Agencies want to have that information in their staff files. You also want to have it if there is an issue with enrollment and a provider or agency need to verify what the issue is, or if you want to dispute any enrollment issues of the individual provider or the agency wants to dispute any issues that come up on that background check. Agencies will want to be able to discuss this with Medicaid so that they can get the providers enrolled. Not too much of the previous language was changed in the Chapter 400 policy update; changes, listed in red, are minimal.

Q: Has there been a change to the PT 14 Specialty 814 enrollment [related to the clinic name (as listed on the enrollment application) and how the agency/entity/group is enrolled with National Plan & Provider Enumeration System (NPPES) for its National Provider Identifier (NPI) number]?
A: Please email the Provider Training Inbox, nevadaprovidertraining@gainwelltechnologies.com, and include your NPI, we can have that assigned to a Field Service Representative. We can work with you on that issue.

Q: For File Exchange (when assigning delegate functions), is that needed for submitting prior authorizations, or is that something totally different?
A: "File Exchange" can be for prior authorizations, or if you are using a form like a FA-29B. It may also be used for you to download some of those letters that may come when you have a notice of decision (NOD) for your PA or claims submission. If you have someone that is working with Prior Authorizations, this function may be beneficial to them as well as the "Care Management".

Q: When the QMHP submit their applications to the Board, their results go to the Board. We don't have a copy of that.
A: There's an obligation for the agency and then there is an obligation for the individual intern underneath the Board. Please send an email to the BH Inbox, we can continue to have this discussion. We can continue to have discussions in future meetings.

Please email questions, comments, or suggested topics for guidance to BehavioralHealth@dhcfp.nv.gov