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Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH CARE FINANCING AND POLICY

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Suzanne Bierman, JD MPH
Administrator

Notice of Meeting to Solicit Public Comments and Intent to ActUpon Amendments to the Medicaid Services Manual (MSM)

Public Hearing March 29, 2022
Summary

Date and Time of Meeting:	March 29, 2022 at 10:41 AM
Name of Organization:	State of Nevada, Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (DHCFP)
Place of Meeting:	DHCFP 1100 E. William Street First Floor Conference Room Carson City, Nevada 89701

Teleconference and/or Microsoft Teams Attendees
(Note: This List May Not Include All Participants, Just Those Who Identified Themselves)

Gabriel Lither, Senior Deputy Attorney General (SDAG)
Dr. Antonina Capurro, Deputy Administrator, DHCFP
Casey Angres, DHCFP
Frederick Gibison, Mercer
Jaimie Evins, DHCFP
Elisa Ashton, SCGUS
Michelyn Y. Domingo, Anthem
David Olsen, DHCFP
Amy Levin, MD, Anthem
Iman Eletreby, Anthem
Sandra Stone, Division of Child and Family Services (DCFS)
Jessica Vannucci, DHCFP
Lori Follett, DHCFP
Erin Lynch, DHCFP
Jessica Escobedo, DHCFP
Abigail Bailey, DHCFP
Kindra Berntson, DHCFP
Antonio Gudino-Vargas, DHCFP
Kaela Friedman, Silver Summit
Rebecca Vernon-Ritter, DHCFP
Sarah Dearborn, DHCFP
Theresa Carsten, DHCFP
Rossana Dagdagan, DHCFP
Vickie S. Ives
Adonica Iverson, Northern Nevada HOPES
Carin Hennessey, DHCFP
Amy Hyne-Sutherland, Carson Tahoe Health
Alissa Lucke, DCFS
Maribeth C. Capen, Anthem
Mary Wherry, Community Health Alliance
Gladys Cook, DHCFP
Monica Schiffer, DHCFP
Sheila Heflin-Conour, DHCFP
Vimal Asokan, Anthem
Christina Sapien, Behavioral Health Services
De
Maurice Cloutier, Silver Summit
Chris
Ashley Cruz
Ashleigh Papez, GWT
Tyler Shaw, FRPA
Christina Trovato, DHCFP

Maria Reyes, Fidelis-Rx
Steve Messinger, Nevada Primary Care
Susana Angel, DHCFP
Jameca Williams, Anthem
Loretta Cook, DHCFP
David Escame, Amerigroup
Cheryl Tempel, Nevada Rural Health Center
Becky Gonzales, ViiV Healthcare
Joy Cleveland, Anthem
Nicole L. Figles, Silver Summit
Blayne Osborn, Nevada Rural Health Center
Tracey Green, Molina Health Care
Michael Zarob, Alkermes

Dylan Shaver
Keibi Mejia
Michelle Guerra, Molina Health Care
Sandra Hartman, Community Health Alliance
Matt Robinson
Nicole Robling, Otsuka-US
Lawrence Henry, Fidelis-Rx

Denise Hanlin,
(SAFY)
Rianna White, Fidelis-Rx
Bryan Dillon, Otsuka-US
Jennifer Atlas
Meaghan O'Toole, Molina Health Care
Mitchell Moen, DHCFP
Laurie Curfman, Liberty Dental Plan
Marta Jensen, M Jensen Consulting
Rutu Ezhuthachan
Yvonne Vestal, DHCFP
Marcel Brown, DHCFP
Ritchie Duplechien, Silver Summit
Stephanie Sadabseng, DHCFP
Lisa Dyer, DHCFP
Kyril Plaskon, DHCFP
Kimberly Adams, DHCFP
Joseph Turner, DHCFP
Serene Pack, DHCFP
Robert Moore, DHCFP
Kaelyne Day, DHCFP
Jessica Flood Abrass, Northern Rural Hospital Partners
Casey Walker
Susan Harrison, GWT
Valerie Haskin
Tiffani Hart, Anthem
Melissa Roy, Otsuka-US
Lisa Thompson, MD, Anthem
Allyson Hoover
Life Change Therapy
Allyson Hoover, Silver Summit
Kim Donohue, Northern Rural Hospital Partners
Alyssa Kee Chong, GWT
Luke Lim, Anthem
Christian Thauer,

Introduction:

Casey Angres, Manager of Division Compliance, DHCFP, opened the Public Hearing introducing herself, Dr. Antonina Capurro, Deputy Administrator of DHCFP and Gabe Lither, SDAG.

Casey Angres – The notice for this public hearing was published on February 24, 2022 and revised on March 9, 2022 in accordance with Nevada Statute 422.2369.

1. **Public Comments:** None

2. **For possible action:** Discussion and adoption of changes to MSM Chapter 600 – Physician Services

Briza Virgen, Social Services Chief I in the Medical Programs Unit, DHCFP.

The addition of Doula services within MSM Chapter 600 – Physician Services, Section 603.4E, as a result of the passage of Assembly Bill (AB) 256 and Senate Bill (SB) 420 during the 81st Legislative Session. New proposed policy includes the following:

The definition of a Doula (a Doula is a non-medical trained professional who provides education, emotional and physical support during pregnancy, labor/delivery, and postpartum period); Lists the Doula qualifications as a Doula certification from the Nevada Certification Board; Identifies covered services which includes providing emotional support, physical comfort measures, facilitation to access to resources, advocacy, and evidence-based education and guidance; Classifies travel time and mileage and services requiring medical or clinical licensure as non-covered services; Service limitations are limited to four visits during the prenatal and postpartum period and one visit at the time of labor and delivery; and prior authorization is not required for these services.

These proposed policy changes were discussed at a public workshop conducted on August 5, 2021. This proposed policy update may affect the following Provider Types (PT), including but not limited to: Doula (PT 90); Special Clinics (PT 17); Physician, M.D., Osteopath D.O. (PT 20); Advanced Practice Registered Nurses (PT 24); Indian Health Programs (PT 47); Nurse Midwives (PT 74); and Physician Assistants (PT 77).

The effective date of this new policy is April 1, 2022, pending Centers for Medicare and Medicaid Services (CMS) approval of the State Plan Amendment (SPA).

At the conclusion of Briza Virgen's presentation, Casey Angres asked Dr. Antonina Capurro and Gabe Lither if they had any questions or comments, they had none.

There were no public comments.

Dr. Capurro approved the changes, pending spelling and grammar checks.

Casey Angres closed the Public Hearing for MSM Chapter 600 – Physician Services.

3. **For possible action:** Discussion and proposed adoption of changes to MSM Chapter 2900 – Federally Qualified Health Centers

Susana Angel, Social Services Program Specialist in the Medical Programs Unit, DHCFP.

The addition of Doula services as a reimbursable provider under the encounter within MSM Chapter 2900, Federally Qualified Health Centers (FQHCs), is being proposed as a result of the passage of AB 256 and SB 420 during the 81st Legislative Session. Doula services include education, emotional and physical support during pregnancy, labor/delivery, and postpartum period. New proposed policy includes the following: Under Policy Section 2903(D)(2)(b), the addition of "Doulas"; Under Coverage and Limitations Section 2903.1(A), the addition of "Doulas" to the list of approved providers and the addition of item (i) Doula services as defined in MSM Chapter 600 – Physician Services. The policy for addition of this new PT was discussed at a public workshop conducted on August 5, 2021.

This proposed policy update may affect the following PTs, including but not limited to:
Doula (PT 90); Special Clinics (PT 17) and Specialty 181 Federally Qualified Health Centers.

The effective date of this new policy is April 1, 2022, pending CMS approval of the SPA. DHCFP will notify the providers via Web Announcement and Direct Email once that approval is obtained.

At the conclusion of Susana Angel's presentation, Casey Angres asked Dr. Antonina Capurro and Gabe Lither if they had any questions or comments, they had none.

There were no public comments.

Dr. Capurro approved the changes, pending spelling and grammar checks.

Casey Angres closed the Public Hearing for MSM Chapter 2900 – Federally Qualified Health Centers.

4. **For possible action:** Discussion and proposed adoption of changes to MSM Chapter 400 – Mental Health and Alcohol and Substance Abuse Services

Serene Pack, Health Care Coordinator and Policy Specialist for Residential Treatment Centers and Inpatient Psychiatric Hospitals in the Behavioral Health Unit, DHCFP, and now for the Crisis Stabilization Centers.

With the approval of AB 66 during the 2019 Legislative Session and SB 156 during the 2021 Legislative Session, DHCFP is proposing revisions to MSM Chapter 400 – Mental Health and Alcohol and Substance Abuse Services and the SPA, Attachments 4.19-A and 4.19-B (as presented earlier by Joseph Turner). This is being done to ensure that Crisis Stabilization Services provided at hospitals with a Crisis Stabilization Center endorsement are covered and reimbursable services under Nevada Medicaid. The goal of this legislation is to add a place to go as a critical element of the crisis continuum of care (along with 988 and mobile crisis) to support an array of crisis services critical in caring for individuals experiencing a behavioral health crisis. Crisis Stabilization Center s best patient outcomes may include immediate care and a positive behavioral health crisis response.

Crisis Stabilization Center s are a no-wrong door access. Per NRS 449.0915, Crisis Stabilization Center s will accept all patients without regards to race, ethnicity, gender, socioeconomic status, sexual orientation, or place of residence, any social conditions that affect the patient, the ability of the patient to pay, or whether the patient is admitted voluntarily pursuant to NRS 433A.140 or admitted under an emergency admission pursuant to NRS 433A.150. The proposed policy for Crisis Stabilization Center s will be in the new Section 403.6I.

Section 403.6I(1) outlines scope of service and primary objective for Crisis Stabilization Center s. The scope of services for Crisis Stabilization Center s is an unplanned, expedited service for an individual to address an urgent condition that requires immediate attention that cannot be adequately or safely addressed in a community setting. Their primary objective will be to promptly conduct a comprehensive assessment of an individual and to develop a treatment plan with emphasis on crisis intervention services necessary to stabilize and restore the individual to a level of functioning that can be managed at a lower level of care. Crisis Stabilization Center are behavioral health services designed to: De-escalate or stabilize a behavioral health crisis and, when appropriate, avoid admission of a patient to another inpatient mental health facility or hospital and connect the patient with providers of ongoing care as appropriate for the unique needs of the patient.

Section 403.6I(2) outlines the requirements for Crisis Stabilization Center s to include operating in accordance with established administrative protocols, evidence-based protocols for providing treatment and evidence-based standards for documenting information concerning services rendered to individuals with a policy structure in place to ensure that there are mental health professionals, including physicians, physician assistants, Advanced Practice Registered Nurses, etc., on-site 24 hours a day, 7 days a week, including the use of peer-support services as defined in NRS 449.01566 in order to deliver Crisis

Stabilization Center to all persons who come in the door, whether as walk-ins or drop-offs from law enforcement or a mobile crisis team. Crisis Stabilization Center s will use a data management tool to collect and maintain data relating to admissions, discharges, diagnosis, and long-term outcomes for recipients of Crisis Stabilization Center .

Best practices for Crisis Stabilization Center include Recovery Orientation (in a manner that promotes concepts that are integral to recovery for persons with behavioral health issues, including, without limitation, hope, personal empowerment, respect, social connections, self-responsibility, and self-determination), trauma-informed care, significant use of peer staff (since these are persons with lived experience who have something in common with recipients needing help), commitment to Zero Suicide/Suicide Safer Care, strong commitments to safety for consumers/staff, and collaboration with law enforcement.

Section 403.6I(3) outlines provider responsibilities, which includes the renewal of the endorsement per NRS 449.0915, maintaining a medical record for each recipient which will include, but is not limited to, the assessment/evaluation results and a statement of the circumstances under which the person was brought in along with the admission date and time, coordination with the person's current treatment provider, if applicable, strategies and interventions to resolve the crisis in the least restrictive manner possible with measurable goals for progress towards resolving the crisis and returning to an optimal level of function, and a plan for discharge.

Section 403.6I(4) discusses admission criteria, which includes performing an initial assessment on any patient who presents to the center, regardless of the severity of the behavioral health issues the patient is experiencing and having equipment and personnel necessary to conduct a medical examination pursuant to NRS 433A.165 and considers whether each patient would be better served by another facility and transfers the patient to another facility when appropriate. Case management services will assist patients to obtain housing, food, primary health care and other basic needs along with the coordination of aftercare for patients, including at least one follow-up contact with a patient not later than 72 hours after the patient is discharged.

Section 403.6I(5) outlines the authorization process, with a brief overview on rollovers to the inpatient level of care (LOC) (which is what the hospital that the Crisis Stabilization Center is under, whether a PT 11 or PT 13, would be submitting). Through a recent conversation with CMS, it has been clarified that a stay at a Crisis Stabilization Center could be longer than 24 hours if an order is written to admit the patient to an inpatient status per 42 CFR 440.2(a). This means they will be able to continue to receive reimbursement beyond 24 hours. Therefore, this section will be amended, by removing, the current proposed language within this section limiting Crisis Stabilization Center stays to 24 hours (the last two sentences in paragraph a) as well as the removal of the first paragraph regarding specifics surrounding the QIO-like vendor and prior authorizations as the Crisis Stabilization Center will not be submitting any prior authorizations at this point.

NRS 695G.320 has been amended per the SB 156 legislation to require managed care organizations (MCO) that provide health care services to recipients of Medicaid or the Children's Health Insurance Program (CHIP) to negotiate and enter a contract with hospitals that have received an endorsement for a Crisis Stabilization Center. MCO's will then need to include those hospitals in their network of providers under contract to provide services to such persons. NRS 695C.194 reads the same, though is worded for health maintenance organizations.

This proposed change affects all Medicaid-enrolled providers delivering Crisis Stabilization Center s. Those PTs include, but are not limited to: Hospital, Inpatient (PT 11), Hospital, Outpatient (PT 12) and Psychiatric Hospital, Inpatient (PT 13).

The estimated fiscal impact is anticipated to result in a savings of:

SFY)2022:	($816,333)
SFY 2023:	($12,122,807)

The proposed effective date of these changes is March 30, 2022.

At the conclusion of Serene Pack's presentation, Casey Angres asked Dr. Antonina Capurro and Gabe Lither if they had any questions or comments.

Gabe Lither advised as it is such an important change from what was originally posted he asked Serene Pack to highlight the language that is not being added at this time in Sections 403.6(i)(5).

Serene Pact responded under Number "5", under Authorization Process, the entire section that states: "The QIO-like vendor contracts with Medicaid to provide utilization….will be denied payment" the entire section will be removed since the Crisis Stabilization Center s will not be submitting prior authorizations at this time. In the next paragraph, under "a" it will only state "all recipients in a Crisis Stabilization Center may be rolled over for inpatient admission anytime the patient requires acute care services." This will be done by the actual hospital that the Crisis Stabilization Center is under, whether it is a (PT 11 or a PT 13).

There were no public comments.

Dr. Capurro approved the changes, pending spelling and grammar checks.

Casey Angres closed the Public Hearing for MSM Chapter 400 – Mental Health and Alcohol and Substance Abuse Services.

5. Adjournment

There were no further comments and Casey Angres closed the public hearing at 11:01 AM.

****An Audio (CD) version of this meeting is available through the DHCFP Compliance office. For more detailed information on any of the handouts, submittals, testimony and or comments please contact Jenifer Graham at jenifer.graham@dhcfp.nv.gov with any questions.***