Overview of Initiative

The Nevada Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (DHCFP) currently allows local education agencies (LEAs) and state education agencies (SEAs) to enroll as Medicaid providers, permitting these entities to receive Medicaid reimbursement for health services provided to Medicaid-eligible students. The Nevada school-based Medicaid program is administered by DHHS and is locally known as the School Health Services (SHS) program. DHCFP is working to improve program materials for LEA/SEAs and is creating a new user-friendly SHS Manual.

Background on Public Workshop

DHCFP facilitated a 90-minute public workshop on October 21, 2024 to gather comments and feedback related to the revised draft school health services manual in Nevada. The feedback and follow-up items from this session are recorded in the table below.

See Appendix A for a full list of attendees.

Feedback Notes

TOPIC	COMMENTS
General Notes	▪ DHCFP: Erika McAllister is the new school health services liaison for DHCFP. ▪ DHCFP: This manual is written to be easier for non-outpatient, non-clinical people to read and understand. ▪ Attendee question: Is this the same draft that was shared already? ○ DHCFP: This is the same version. The draft is also available online: https://dhcfp.nv.gov/Public/AdminSupport/PublicNotices/ ▪ DHCFP: *Reviewed layout of the document.* Requests comments and feedback on the layout.
Chapter One	▪ DHCFP: Any comments/questions on section one? ○ None.
Chapter Two	▪ DHCFP: Any comments/questions on section two? ○ None.
Chapter Three	▪ Attendees asked several questions regarding the timeframe for provider enrollment and requested confirmation that exhibit 3.2 detailing what provider types must enroll will be updated. ○ DHCFP: Nevada does not currently require individual SHS providers to enroll in Medicaid. There are requirements in the Social Security Act and from CMS that require our process to change. If you are a provider type that can enroll with Medicaid, you will need to be enrolled. DHCFP will develop a transition plan to allow time for all providers to be enrolled. ○ DHCFP: If the provider is a provider type outside of a PT 60, they would have to be enrolled with Medicaid to bill for services. If they are a type such as an RN, they will not have to enroll. Will still be able to bill under the LEA whether they are a required provider type or not. ▪ Attendees asked questions regarding supervision, specifically how an intern providing services works under supervision and how that work is billed. Does the intern bill under the supervisor's Medicaid number?

	○ DHCFP: There is a chart further down in the manual showing who needs to be supervised. ○ DHCFP: Will follow up on how interns would bill under a supervisor. ▪ Attendee question regarding timely filing and if that will be noted in the manual? ○ DHCFP: There was discussion on extending the 180-day timely filing limit. The division would have to extend timely filing for all provider types so have decided to continue with the 180-day timely filing limit. It will be noted in the manual. ▪ Attendee question about a complete list of codes and modifiers. Will this be added? ○ DHCFP: That is on the list of items to update. ▪ Attendee question regarding the effective date of the changes in this manual and for provider enrollment requirements. ○ DHCFP: The goal is to meet the December 24th public hearing for an effective date of January 1st. ○ DHCFP: Will develop guidance to help providers enroll and to not delay on the DHCFP side. Will aim to develop a ramp up period. Once the manual is finished, DHCFP will work on this.
Chapter Four	▪ Attendee question about requiring a medical diagnosis? For example, if there is a student with suicide ideation, do they need a diagnosis to do sessions with LCSWs? Or can this be done without an individual diagnosis? ○ DHCFP: In crisis situations or urgent medical situations, like a concussion, there is no expectation that a plan of care will be written before providing services. Some states allow for 30 days of service before a POC must be written in urgent situations. ▪ Attendee question regarding transportation coverage for special education students and when it would be able to be billed to Medicaid. Some discussion regarding what “modification of environment” really means. ○ DHCFP: Transportation for a Medicaid eligible student is reimbursable for the days the transportation is provided and they also have a Medicaid reimbursable service that day. ▪ Attendee comments: ○ Is an aide considered an adaptation or modification of the environment? Some people were of the opinion that it is, but some were not. Interpretation was that an aide is not, but a seatbelt is. Need to wait for guidance to come out and get clarification from the technical assistance at CMS. ○ Another opinion stated was that having anyone on the bus does not make it an adaptation. Something has to be physically modified to the vehicle. ▪ Attendee question regarding the scope of the manual, especially as it relates to transportation. Is it specific to FFS or does it include the Medicaid Administrative Claiming (MAC) and RMTS?

TOPIC	COMMENTS
	○ DHCFP: This is just for transportation as a service and not the MAC side. ▪ Attendee noted that the EPSDT periodicity schedule was not a direct link. ○ DHCFP: Yes, the current link is just to the main site, and you have to scroll to get to the schedule. This is flagged for a future change to the manual. ○ Attendee noted that the POC requirements being tied back to the 504 was confusing. Request clarity on this as some language contradicts the 504. ○ DHCFP: Will ensure the language is clear and what it states in one section is supported in the others.
Chapter Five	▪ Attendees provided comments about staff training and certification requirements being tied to a specific provider. Additional training requirements for staff are large barriers for school districts. In addition, many requirements are already being fulfilled by other training. For example, with CPR, we have no fewer than 10 people at a time on staff who are CPR certified, why do other staff need CPR training? Another noted example was peer support for rehabilitative mental health services. ○ DHCFP: Is this the same for other counties? ▪ Attendee comments: ○ Realistically, not being done now due to the barrier of the training. ○ We provide CPR and our nurse does direct personal care training. We are building a cohort of personal care aides (PCAs) so hopefully we can begin billing for them. ○ Yes, this is a statewide requirement. There should be people on campus who are trained, just not specified people in the manual. ▪ Comments regarding limitations under nursing services, they do not allow symptom-based assessment. Some interpret the policy to indicate that they cannot bill for chronic care like asthma, diabetes. If there is not a screening code or a diagnosis code, the nurse cannot bill. ○ DHCFP: This policy is reinforcing a plan of care for any of the services. We will review it for further discussion. ▪ Attendee requested clarification that school-based services do not affect the number of visits or service coverage that a student can receive in the community. Community providers and parents may not understand this. ○ DHCFP: Yes, this is a common misunderstanding. DHCFP is open to any suggestions on how to ensure this is clear. This is something that DHCFP is prioritizing communication on. ▪ Attendee question about the definition of a team conference and who can bill for it. ○ DHCFP: This information will be expanded. ▪ Attendee question about section 5.8 page 30. There is a link to the form requirements that a plan of care should have, and it still indicates the recipient ID number. ○ DHCFP: This will be removed in a future version of the manual.

TOPIC	COMMENTS
Chapter Six	▪ Attendee question about the possibility of considering not requiring school psychologists to work under supervision? As part of a psychologist's training and scope of practice, school psychologists have expertise in mental and behavioral health services and interventions. There are also concerns that in the rural areas there is a shortage of licensed clinical psychologists. School psychologists are in the schools and are experts in schools and behavioral and mental health. o DHCFP: This is part of the state plan amendment. That amendment would allow providers to act within their scope without having to meet additional requirements that a community provider would have to meet. ▪ Attendee question about the process for getting a code added to the fee schedule and what the process is when the code is not currently in the fee schedule, etc.? o DHCFP: If there is a service that should be a billable service, please first reach out to DHCFP. There may be a covered code that is suitable, or it may need to be considered for addition.
Chapter Seven	▪ No attendee comments.
Appendices	▪ Attendee comments regarding detailed information in the behavioral health section of the manual. Would like clarification on students declining services and discharge planning. o DHCFP: This will be clarified with the behavioral health team. ▪ Attendee question regarding documentation standards for supervisees. Will additional guidance be provided? o DHCFP: The division will not dictate what needs to be included in the notes. We reiterate that the documentation needs to support what was billed and is the responsibility of the supervisor. ▪ Attendee question regarding progress notes and if they require a signature. Is an electronic signature or health record that tracks entry good enough? What must be part of the progress note? In the actual documentation of the service, it says the goals and objectives that were discussed and covered during the time the services were provided. ▪ Attendee comments: o When a progress note is written, a practitioner will refer back to what objective and goal is being worked on. This will need to be referred to in the plan of care. This is a basic standard of progress notes in the behavioral health world to link back to the goal. o This can easily be automated with the EHR. o DHCFP: We will determine if this is a general practice or if updates are needed. ▪ Attendee question: Will an updated copy of the manual be available prior to the public hearing on December 24th? o DHCFP: Yes, that is the goal.

Appendix A: Attendance

Stakeholders:

- Alicia Prokasky
- Alyce Pagniello
- Amanda Mozes
- Ashley Greenwald
- Belz and Case
- Brian Evans
- Brian Hefferan
- Brittany Acree
- Ivy Burns
- Cade Grogan
- Alisa Cadenhead
- Carley Murray
- Cassandra Fox
- Chassity Mills
- Christina Sapien
- Christy U Ngyuen
- Claudia Means
- Cloris Barrientos
- Concepcion Martinez
- Cosette L.
- Daniella Boris
- Dawnesha Powell
- Sherron Dickenson
- Dr. Paul Lords
- Elyse Monroy Marsala
- Erica McAllister
- Dominic Gaon
- Gina Ward
- Jeannine Warner
- Jeremy Riddle
- Karen Mertz
- Kathryn Bervin
- Katie Metz
- Katie Pfister
- Kirsten Coulombe
- Deborah Kolk
- Laura Simeone
- Lauren R. Francois
- Lea Case
- Linda Anderson
- Lisa Dyer
- Loren Gonzalez
- Lori Follett
- Madalyn Larson
- Maria
- Kevin Meagher
- Melissa Pagarigan
- Nahayvee Flores-Rosiles
- Nancy Brooks
- Nancy Kuhles
- Naomi
- Nina McCartney
- Paige Beckwith
- Jeana Piroli
- Rachael Devine
- Ronnie
- Rose Steffen
- Ruth M.
- Sabrina Schnur
- Samantha Jayme
- Shanda R
- Shannon Ramirez
- Sheri Gaunt
- Sherri McPartlin
- Sherron Dickenson
- Stephanie Woodard
- Sydnea Hanses
- Selina Verdin
- Verona Sutton
- Tamara Roseberry

DHCFP:

- Malinda Southard
- Monica Schiffer
- Erika McAllister

Milliman:

- Natalie Angel
- Kaitlin Schoewe