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

Public Hearing June 29, 2021
Summary

Date and Time of Meeting:	June 29, 2021 at 9:47 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 WebEx Attendees
(Note: This List May Not Include All Participants, Just Those Who Identified Themselves)

Suzanne Bierman, DHCFP
Gabriel Lither, Senior Deputy Attorney General (SDAG)
Emma Curto
Kelly Woods, DHCFP
Antonio Gudino-Vargas, DHCFP
Michael Gorden, DHCFP
Gina Callister, DHCFP
Sarah Hunt, Nevada Hospital Association (NHA)
Gladys Cook, DHCFP
Jeffrey Murawsky, Silver Summit Health Plan (SSHP)
Agatha Lambey, Agape Family Enrichment Center
Yvonne Vestal, DHCFP
Rossana Dagdagan, DHCFP
Heather Lazarakis, DHCFP
Cheri Glockner, SSHP
Jill Lecheminant, Optum
Jovanna Leid, Gainwell Technologies
Steve Messinger, Nevada Primary Care Association
Natasha Powell
Abigail Bailey, DHCFP
Amanda Kiriakopoulos, Optum
David Olsen, DHCFP
Sarah Bellemare
Valerie Balen, Belz & Case Government Affairs
Nicole Figles, SSHP
Jessica Kemmerer, DHCFP
Briza Virgen, DHCFP
Kaelyne Day, DHCFP
Sheila Heflin-Conour, DHCFP
Sarah Dearborn, DHCFP
Crystal Biselli, DHCFP
Rocky B
Carin Hennessey, DHCFP
Timothy Ryan, DHCFP
Jaime Hutchison
Rebecca Inserra
Sarah Lamb, DHCFP
Loretta Cook, DHCFP
Eric Schmacker
Ellen Flowers, DHCFP
Tegan Luisiana, AmeriHealth
Alex Tanchek, Silver State Government Relations
Cara Lee, Optum
Kirsten Coulombe, DHCFP
Regina De Rosa
Alejandro Leon, ICAN Family Services
Kurt Karst, DHCFP
Kimberly Adams, DHCFP
Toni Inserra
Jeffry Majeske, DHCFP

Natasha Baker
Calvin Kam
Sussan Fung, Zane Medical Group
Shanna Cobb-Adams, DHCFP
Jackeline Obregon, DHCFP
Ramona Beasley, The Empowerment Centre
Brandon Ford, Best Practices Nevada
Temyka Miller, Anthem
David Hardy
Jimmy Lau, Ferrari Public Affairs
Candice Hill, Mission Treatment Centers
Amy Levin, Anthem
Theresa Carsten, DHCFP
Steven Hughey, UMC
Laurie Curfman, Liberty Dental

Introduction:

Jessica Kemmerer, HIPAA Privacy Officer, DHCFP, opened the Public Hearing introducing herself, Suzanne Bierman, Administrator of DHCFP and Gabe Lither, Senior Deputy Attorney General (SDAG).

Jessica Kemmerer – The notice for this public hearing was published on May 27, 2021 in accordance with the Nevada Revised Statute (NRS) 422.2369.

1. Public Comment

There were none.

2. Discussion and proposed adoption of changes to MSM Chapter 1200 – Prescribed Drugs

Antonio Gudino, Social Services Program Specialist for Pharmacy Services, DHCFP, presented on proposed changes to the MSM Chapter 1200 – Prescribed Drugs based on recommendations approved at Drug Use Review Board meeting held on January 28, 2021.

The proposed changes include the addition of new prior authorization criteria for Evrysdi® (risdiplam) within the newly proposed Spinal Muscular Atrophy (SMA) Agents section; addition of new prior authorization criteria for Vyondis 53® (golodirsen) within the new proposed Duchenne Muscular Dystrophy (DMD) Agents Section; addition of new prior authorization criteria for Qutenza® (capsaicin); addition of new prior authorization criteria for Fintepla® (fenfluramine) and lastly, technical changes to the Immunomodulator Drugs section to correct grammatical and inaccurate information.

The following providers who prescribe, dispense, or administer this drug may be affected by this change, including but not limited to the listed provider types on the agenda.

There is no financial impact on local government known.

The effective date of these changes is July 5, 2021; just a friendly amendment, due to this day being a holiday, changes will become effective next business day, July 6, 2021.

The location and details of the changes start with Section K, titled "Zolgenma® (onasemnogene abeparvovec xioi)", the section title is being revised to create a new SMA Agents section, which will include new prior authorization criteria for Evrysdi® and the existing prior authorization criteria for Spinraza® (nusinersen). Lastly, revisions were made to the existing Zolgensma® prior authorization criteria to correct and conform with the approved criteria by the Board. The next change is found in Section L, titled Immunomodulator Drugs. This section has been revised to remove the use of symbols and improve readability. The next change is found in Section MMM. Titled "Exondys 51® (eteplirsen)." The section title is being revised to create a Duchenne Muscular Dystrophy (DMD) Agents section. Prior authorization criteria for Emflaza® is being relocated to be included within this section and new prior authorization for Vyondys 53® is added as approved by the Board. The next change is found in Section NNN, titled "Spinraza® (nusinersen)." The section title is being revised to create a new section for Qutenza®, which will include new prior authorization criteria as approved by the Board. The next change is found within

Section RRR, titled "Emflaza® (deflazacort)." As previously mentioned, the current criteria for Emflaza® is being relocated within the newly proposed "Duchenne Muscular Dystrophy (DMD) Agents section. This section is now "Reserved for Future Use." Lastly, Section BBBB, titled Anticonvulsants has been revised to include new prior authorization for Fintepla®.

At the conclusion of Antonio Gudino's presentation, Jessica Kemmerer asked Suzanne Bierman and Gabe Lither if they had any questions or comments, and they had none.

There were no public comments.

Jessica Kemmerer recommended the Administrator approve the proposed changes to MSM Chapter 1200 – Prescribed Drugs.

Suzanne Bierman approved as submitted.

Jessica Kemmerer – Closed the Public Hearing for MSM Chapter 1200– Prescribed Drugs.

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

Briza Virgen, Social Services Program Specialist, Medical Programs Unit, DHCFP, presented on revisions to MSM Chapter 2900 – Federally Qualified Health Centers are being proposed to clarify policy, add new policy language, and re-arrange the existing format to align with current MSM chapter conventions related to structure and content.

Section 2900 – FQHCs renamed to "Introduction." In addition, language was added to include FQHCs as a community-based and patient-centered care provider. Section 2901 – Authority, federal and state authorities and scopes of practice references expanded to include additional NRSs. Section 2903 – Health Services; renamed from "Health Services" to "Policy." Section 2903D – Policy Definition for an encounter expanded to include language on Licensed Qualified Health Professionals. Section 2903.1 – Coverage and Limitations, further defined medical, behavioral/mental health, and dental encounters by including listings of licensed qualified health professionals and including covered services within each encounter. Section 2903.4 moved categories of encounters from Section 2903.4 to 2903B

Section 2903C added language on FQHCs Service Specific Prospective Payment Systems (SSPPS) rates related to multiple visits in a day (medical, mental/behavioral health, and dental) Section 2903.3 – FQHC Pharmacies. Added new guidance to FQHC pharmacies who opt to bill for the administration of vaccines may do so through the point of sale as Pharmacy (PT 28). Section 2903.5 – FQHCs dually enrolled as Certified Community Behavioral Health Centers (CCBHCs): To require the provider to develop internal policies for determining appropriate placement for their respective recipients based on medical necessity and clinical appropriateness; The utilization of the CCBHC Allowable Services grid found in the CCBHC billing guide and care coordination to avoid duplication of services and/or billing; DHCFP Surveillance and Utilization Review (SUR) unit to monitor for duplication of services between the two service delivery models.

Section 2903.7B – Prior Authorizations added new language to include clarification for FQHCs not contracted with a Managed Care Organization (MCO), must follow the MCOs Prior Authorization policy.
In addition, throughout the MSM Chapter 2900 references to the appropriate MSM Chapters for services provided within an FQHC were added. Similarly, grammar, punctuation, and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and rearranging of sections were necessary.

These proposed changes were discussed at the public workshops conducted on November 5, 2019, October 28, 2020, and February 2, 2021.

These proposed changes affect all Medicaid-enrolled providers delivering FQHC encounter type services. Those PTs include but are not limited to, FQHCs (PT 17, Specialty 181); CCBHCs (PT 17, Specialty 188); FQHC Pharmacies (PT 28); and Pharmacy, and Managed Care Organizations (PT 62).

No financial impact is anticipated for local government.

The effective date is June 30, 2021.

At the conclusion of Briza Virgen's presentation, Jessica Kemmerer asked Suzanne Bierman and Gabe Lither if they had any questions or comments.

Gabe Lither advised Steve Messenger pointed out a grammatical error.

There were no public comments.

Jessica Kemmerer recommended the Administrator approve the proposed changes to MSM Chapter 2900 – Federally Qualified Health Centers.

Suzanne Bierman approved as submitted.

Jessica Kemmerer – Closed the Public Hearing for MSM Chapter 2900 – Federally Qualified Health Centers.

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

Briza Virgen advised revisions to the MSM Chapter 600 - Physician Services are being proposed to clarify policy, add new policy language, and re-arrange the existing structure and content. Additionally, throughout the chapter, included language in which providers shall follow current national guidelines, recommendations, and standards of care when rendering services to Nevada Medicaid recipients.

Emergency Medical Technicians, Advanced Emergency Medical Technicians, and Paramedics with community paramedicine endorsement to the list of health care professionals within this policy were also added to Section 600 – Introduction. Clarifying language to recognize Physician Assistants (PA/PA-C) who possess a National Commission on Certification Physician Assistants certification and who also work in a Military Treatment Facility as Nevada Medicaid providers. These physician assistants will not be required to be licensed in the state of practice. In addition, Advance Practice Registered Nurses (APRN) and Physician Assistants (PA) with a specialty in general practice, family practice, internal medicine, pediatrics, obstetrics/gynecology, or nurse midwifery are also recognized as "primary care providers" throughout the chapter.

Section 601 – Authority expanded the Federal and State authorities for reference to include additional sources.

Section 603.1A – Coverage and Limitations states "Incident to" is not a reimbursable billing mechanism. Added clarifying language to specify, Nevada Medicaid will not reimburse for professional billing of services or supplies rendered by anyone other than the provider whose name and provider number is on the submitted claim. This is to ensure providers enroll into their designated provider type and bill for the services they rendered. Section 603.1A(6) – Federal Emergency Services Program (also known as Emergency Medicaid Only) was included to provide reference to federal and state policy for the definition of a covered service under this program. Added Section 603.2B(8) to include new language related to Medication-Assisted Treatment (MAT) services provided by a provider with a DATA 2000 waiver are

available for recipients who meet medical necessity with an opioid use disorder. Section 603.2D - Hospice, further defines how adult recipients enrolled in hospice waive the rights to Medicaid payments for any Medicaid services related to the terminal illness and related conditions for which hospice was elected. Added clarifying language in Section 603.2H- Vaccinations, to include all childhood and adult vaccinations, per the latest recommendations of the Advisory Committee on Immunization Practices (ACIP), are covered. Added new Section 603.2I – Ordering, Prescribing, and Referring (OPR) Providers, OPR. Providers do not bill Nevada Medicaid for services rendered, but may order, prescribe, or refer services/supplies for Medicaid recipients.

Section 603.3A – Prior Authorization (PA) is not required for the following: Remove the terms "annual" and "for family planning" with reference to pap smears; Reword "birth control devices" to "FDA approved birth control drugs and delivery devices/methods"; Add a note to remind provider when it is time for an IUD device to be removed, the woman may no longer be Medicaid-eligible; Add clarifying language on billing for contraceptive injections administered in the providers office; Add vaginal contraceptive suppositories; contraceptive dermal patch and contraceptive ring and/or other birth control methods do not require a PA; and Include reference to the QIO-like vendor website to access the FA-56 Sterilization Consent Form, which is also the HHS-687 form for vasectomy or tubal ligation.

Add new section 603.3F to explain "a pelvic exam or pap smear is not required for self-administered birth control."

Added new policy to Section 603.4 on maternity care services being provided in the home, office, hospital, or obstetric center settings. The providers' scope of practice and licensure must be considered. Additionally, indicate home and obstetric center births and corresponding services are appropriate for recipients with low-risk pregnancies, intended vaginal delivery, and no reasonably foreseeable exception of complication. Also added reference to the NRS and Nevada Administrative Code (NAC) to define "obstetric center." Added language to clarify non-emergency antepartum care is not a covered benefit for non-US citizens/aliens to Section 603.4A – Stages of Maternity Care. Necessary steps will be taken to comply with all state and federal requirements. New Section603.4(2)(c) - Provider Responsibilities for the initial newborn examination and subsequent care, these examinations may be done in the home, obstetric center, or hospital. Also, newborn hearing screening referral may be provided by the nurse midwife if born in the home and not having the necessary equipment to conduct it. Finally, Newborn screening blood analysis testing is included in the facility per diem rate, both screenings may be refused by parent or legal guardian.

Language was added to Section 603.4B – Maternal Diagnostic, title was replaced by Fetal Non-Stress Testing for providers to follow current national guidelines, recommendations, and standards of care for the indications, techniques, and timing of the appropriate antepartum fetal surveillance methods and management guidelines. For this reason, clinical indications and the non-stress testing schedule table was deleted. Section 603.4A - Coverage and Limitations for ultrasound coverage was moved to renumbered 603.4C(1). Section 603.4C(1) – Coverage and Limitations, language added to clarify an initial screening ultrasound due to late entry prenatal care is a covered benefit. Section 603.4C(1) – Coverage and Limitations, the table offering guidelines for biophysical profile was removed as providers are referred to the American College for obstetrician gynecologists (ACOG) guidance for a list of qualified indications for fetal ultrasounds. Section 603.4B – Provider responsibility for repeat evaluations was moved to renumbered 603.4C(3).

New language was added to policy proposals for new Section 603.4D – Prenatal Screening and Diagnostic Testing detailing screening, which includes first and second trimester screenings; the manner through

which diagnostic testing is to obtain specimens; coverage of comprehensive patient pretest and post-test genetic counseling if provided by physicians (MD/ DO), physician assistants, APRNs or nurse midwives and prenatal chromosomal screening and diagnostic testing should not be ordered without informed consent.

Added reference to the form FA-57 Certification Statement for Abortion to Save the Life of the Mother under Section 603.4E – Abortion/Termination of Pregnancy. This form is to be used when a provider has attached a signed certification to the claim on the basis of his/her professionals' judgement and supported by adequate documentation if the life of the mother would be endangered if the fetus were carried to term. Added reference to the form FA-54 – Abortion Declaration (Rape) and the FA-55 Abortion Declaration (Incest). These forms are to be used when a provider is seeking reimbursement for induced abortion services resulting from a sexual assault (rape) or incest. The Nevada mandatory reporting laws related to child abuse and neglect must be followed and providers are still required to report the incident to Child Protective Services (CPS) or, in some localities, through County Child Welfare Services.

Reference to Form FA-50 Nevada Section 603.5– Hysterectomy Medicaid Hysterectomy Acknowledgement. A medically necessary hysterectomy may be covered. Added clarifying language to Section 603.6 – Gynecologic Exam to include the exams and screenings included in a gynecologic exam, pelvic exams and pap smears are not required for self-administered birth control. Providers shall follow current national guidelines, recommendations, and standards of care. Clarifying language added to Section 603.11 – Provider Services in outpatient setting regarding out-of-state transportation for ESRD. Services must be initiated by the physician or the facility to the non-emergency transportation (NET) broker.

Examples of when a Prior authorization is not necessary for an admission for Section 603.12 – Services in the Acute Hospital Setting has been removed and provided reference to MSM Chapter 200 – Hospital Services.

Added new language for Section 604.2 – Community Paramedicine Coverage and Limitations to include community paramedicine services which may be delivered according to a recipient-specific plan of care under the supervision of a Nevada licensed EMS agency medical director and coordinated with a primary care provider (PCP). This includes the direction of when a recipient does not have a PCP, the plan of care must include establishing a medical home with a PCP. Additionally, the plan of care is to be developed after an assessment and does not have to be in place before receiving community paramedicine services. Added mental and behavioral health/crisis intervention as a non-covered service for community paramedicine services.

The following policy proposal is to move Organ Transplant Services from 603.11F – Ambulatory Surgical Centers (ASC) into its own section, 605 - Organ Transplant Services. Added language to clarify non-citizens/Aliens are not eligible for organ transplants. Additionally, include language to clarify a separate authorization is required for inpatient/outpatient harvesting or transplants, both in-state and out-of-state.

Added new language to Section 607 – Gender Reassignment Services to indicate the two letters required prior to beginning stages of surgery are not required to continue surgical procedures when a recipient has previously had one or more initial surgical procedures.

Corrected language to Attachment A, Policy 6-13 – School Based Health Center to state a SBHC operates as a separate delivery model from School Health Services provided through a Local Education Agency (LEA) or State Education Agency (SEA) (in lieu of an Individual Education Plan (IEP); removed IEP from policy). Reference is made to MSM Chapter 2800 – School Health Services.

These proposed changes were discussed at a Public Workshop conducted on January 20, 2021.

Throughout MSM 600, the term physician or health care professional was changed to provider for consistency. Additionally, throughout the chapter, grammar, punctuation, and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

The proposed changes affect Medicaid enrolled physicians and other licensed professionals. These PTs include but are not limited to: Registered Dietician (PT 15), Special Clinics (PT 17); Physician/Osteopath (PT 20), Podiatrist (PT 21), Advanced Practice Registered Nurses (PT 24), Community Paramedicine (PT 32 Specialty 249, Chiropractor (PT 36), Nurse Anesthetist (PT 72), Nurse Midwife (PT 74), Physician Assistant. (PT 77).

Financial impact on local government is unknown at this time.

These changes are effective July 1, 2021.

At the conclusion of Briza Virgen's presentation, Jessica Kemmerer asked Suzanne Bierman and Gabe Lither if they had any questions or comments, and there were none.

Sussan Fung asked if an APRN (PT 24) can work in a clinic with a PT 20.

Briza Virgen answered that is correct. An APRN does not have to work under the licensure of a physician of a (PT 20) but they are allowed to work in the same clinic.

Jessica Kemmerer recommended the Administrator approve the proposed changes to MSM Chapter 600 –Physician Services.

Suzanne Bierman approved as submitted.

Jessica Kemmerer – Closed the Public Hearing for MSM Chapter 600 - Physician Services.

5. **For possible action:** Discussion and adoption of changes to MSM Chapter 1900 – Transportation Services

Kelly Woods, Policy Specialist for Transportation Services, Long-Term Services and Support (LTSS) unit, DHCFP, presented on revisions to MSM Chapter 1900 – Transportation Services. These changes are being proposed resulting from changes made to the Non-Emergency Medical Transportation vendor contract in order to restore benefits that were either reduced or removed from policy as a result of changes that were approved during the July 29, 2020 public hearing. Minor revisions are also being proposed to the emergency transportation policy section within MSM Chapter 1900.

Throughout the chapter, grammar, punctuation, and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

This proposed change affects the following provider types: Provider Types: Ambulance, Air, or Ground (PT 32); Nevada Medicaid's NEMT vendor: Medical Transportation Management, (MTM).

There is no known financial impact on local government at this time.

The effective date of these proposed changes is July 1, 2021.

The service "Non-Emergency Transportation," (NET) name was changed to "Non-Emergency Medical Transportation," (NEMT). This reference and abbreviation of NEMT has been updated throughout the entire chapter.

Language was simplified and references to “behavioral health condition” and “serious physical harm to self or another person” has been removed in section 1903 due to the Non-Emergency Secure Behavioral Health Transport model where these types of transports are found. Language regarding prior authorization has been removed as there is already an entire section dedicated to the authorization process.

Language has been removed regarding the facility-to-facility transfer of a Seriously Mentally Ill adult or Severely Emotionally Disturbed child to remove confusion to Section 1903.1A(2)(c) Non-Immediate Medically Necessary Transports #3 as these transports should now fall under the Non-Emergency Secure Behavioral Health Transports model. The reference of transports provided by the NET broker has also been removed. This section is speaking to emergency transportation.

The language for Section 1903.3, Non-Emergency Medical Transportation (NEMT) is being cleaned up for clarity, removing the unnecessary reference to specific waiver services. For MTM’s upcoming contract, they will now be required to operate Monday through Saturday, instead of Monday through Friday, which is why the reference to weekends is being removed in respect to after-hours scheduling. Rail Service and Transportation Network Companies (such as Uber or Lyft) has been added to this section as an approved mode of transportation and rearranged the modes in a more logical order.

Program Eligibility Criteria in Section 1903.3A, Coverage and Limitations, has reformatted the list of Medicaid recipients who are not eligible for NEMT services. Language has been removed referencing special payment arrangements with the NEMT broker, as it was unnecessary language to the MSM transportation policy and more appropriate to just be in the contract with the vendor. The section under Coverage and Limitation’s Qualifying Conditions has been revised by removing the reference to Legally Responsible Individuals (LRIs) unwillingness to provide transportation as this is not a component to NEMT services. A new subsection #3 “Scheduling Timeframes” has been added. New language in 3(a) specifies that transportation should be requested no less than three days in advance of the recipient’s medical appointments for local, non-urgent trips, which has been reduced from the previous requirement of five days in advance. Examples of types of trips that should be scheduled at least three days in advance of the appointment whenever possible has been added. Exceptions can be made when medically necessary. “Same Day Services” has also been added with moved language stating that transportation services for a recipient, as a result of a hospital discharge, must be provided within three hours, which has been reduced from the previous eight-hour time span; and included examples of types of trips that could be provided as a same day service. The reference to Nevada Checkup has been removed as this aid category is not eligible for NEMT services.

Language to “Special Populations” which specifies that certain Medicaid populations, such as those with an intellectual disability can be allowed to select their preferred provider within their authorized mode of transport was added. Also, language that the NEMT vendor may bypass public transportation for recipients who are considered to have a high-risk pregnancy or are past their eighth month of pregnancy and should be authorized a higher mode of transport. This last paragraph within Special Populations states Emergency Medical Only recipients who are authorized to obtain dialysis services are subsequently eligible for NEMT, but only to and from their dialysis appointments.

“Gas Mileage Reimbursement” has renamed the term “Volunteer Drivers” to “Community Non-Professional Drivers” and included family members and friends as individuals authorized to receive gas mileage reimbursement when taking a recipient to access Medicaid services. Language clarifying that recipients who are assigned to public transportation, whether it be a fixed route or paratransit, may also utilize gas mileage reimbursement if it’s determined to be cost-effective has been added. The previous

requirement to request NEMT for out-of-area appointments in the "out of Area Travel," section back to 14 days in advance of the medical appointment has been restored. The Meal and Lodging benefit for trips to out-of-area appointments, where an overnight stay is required, has been added back. Recipients must utilize free lodging when available, such as Ronald McDonald House, or the NEMT broker will arrange for lodging. Meal and lodging reimbursement shall be paid in accordance with the General Services Administration (GSA) rates. Subsection f, "Rural Areas" where specified that scheduling requirements for trips originating in certain rural counties will follow the standard scheduling process and will not be considered an out-of-area trip. Subsection g was renamed from "Companions to Recipients" to "Attendants to Recipients." Language to clarify that attendant travel is a covered expense only when a recipient is being transported, with the exception of family members needing to return to their residence, has been added. Language has also been added to specify if during travel, a recipient requires an overnight stay, one room is reserved for the recipient and the attendant is expected to share lodging in order to care for the recipient. When a recipient is admitted to an inpatient facility, the recipient would no longer be in travel status, therefore meals and lodging would not be provided for the attendant. Subsection h "Inpatient Treatment Facilities," has removed language and policy detail regarding therapeutic home visits to simplify it and state that transportation for therapeutic home visits must be in accordance with MSM Chapter 400 and 1600. Language has also been added to specify that the NEMT broker covers the transportation cost of an attendant when accompanying the recipient, if medically necessary. Attendant travel costs for facility staff are not covered when not accompanying a recipient. "Children in the custody of Child Welfare" as eligible out-of-state recipients has been included. "Non-Covered Services" definition of "deadheading," has been reworded to match the definition in the emergency transportation section. The reference of "escort" has been corrected to instead use the term "attendant" and clarified that oxygen tanks are allowed if portable and self-administered.

Section 1903.3B Assessment and Authorization Process, #3 has removed the reference to LRIs and included family members, friends, or community partners as individuals who may request NEMT on behalf on an individual.

Section 1903.3D "NEMT Recipient Responsibility," g through j(1) language has been cleaned up by removing the LRI reference and changed the requirement for recipients to schedule local, non-urgent trips at least three days in advance, which has been reduced from five days and no more than 60 days prior to travel, increased from 30 days, providing greater flexibility for recipients. Requests for paratransit rides from the vendor has been clarified and must be scheduled no more than three days in advance of the recipient's medical appointment, as the RTC currently requires a three-day scheduling window for paratransit.

At the conclusion of Kelly Woods's presentation, Jessica Kemmerer asked Suzanne Bierman and Gabe Lither if they had any questions or comments and there were none.

There were no public comments.

Jessica Kemmerer recommended the Administrator approve the proposed changes to MSM Chapter 1900 – Transportation Services.

Suzanne Bierman approved as submitted.

Jessica Kemmerer – Closed the Public Hearing for MSM Chapter 1900 – Transportation Services.

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

Sarah Dearborn advised that revisions to Medicaid Services Manual Chapter 400 are being proposed to eliminate Biofeedback and Neurotherapy services for the treatment of a mental health diagnosis. Neurotherapy is individual psychological therapy incorporating biofeedback training combined with psychotherapy as a treatment for mental health disorders. The elimination of these services is being made as a result of the approved DHCFP budget during the 2021 Legislative session in effort to reduce current costs to the Medicaid program and to address the Governor's mandated budget cuts.

Structural changes were made to the chapter including renumbering and re-arranging of sections. Section 403.4(C)(4) – Neurotherapy was removed.

This proposed change affects all Medicaid-enrolled providers delivering biofeedback and neurotherapy type of services. Those provider types include, but are not limited to, Hospital, Outpatient (PT 12); Behavioral Health Outpatient Treatment (PT 14); Physician, M.D., Osteopath D.O. (PT 20); Advanced Practice Registered Nurse (PT 24); Psychologist (PT 26); Physician's Assistant (PT 77); Behavioral Health Rehabilitative Treatment (PT 82), and Certified Community Behavioral Health Center (PT 17, Specialty 188).

The estimated financial impact to Local Government is a savings of:

$28,024,136 for State Fiscal Year 2022; and

$28,299,314 for State Fiscal Year 2023

The effective date of this change is July 1, 2021.

At the conclusion of Sarah Dearborn's presentation, Jessica Kemmerer asked Suzanne Bierman and Gabe Lither if they had any questions or comments and there were none.

There were no public comments.

Jessica Kemmerer recommended the Administrator approve the proposed changes to MSM Chapter 400– Mental Health and Alcohol/Substance Abuse Services.

Suzanne Bierman approved as submitted.

Jessica Kemmerer – Closed the Public Hearing for MSM Chapter 400– Mental Health and Alcohol/Substance Abuse Services.

7. Adjournment

There were no further comments and Jessica Kemmerer adjourned the public hearing at 10:44 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.