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

Public Hearing April 30, 2024
Summary

Date and Time of Meeting:	April 30, 2024, at 10:42 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:	Microsoft Teams

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

Theresa Carsten, Deputy Administrator, DHCFP
Gabriel Lither, Senior Deputy Attorney General
Casey Angres, DHCFP
Melissa Madera, DHCFP
Lori Follett, DHCFP
Keith Benson, DHCFP
Anjana Radhakrishnan, DHCFP
Holly L. Lewis, Silver Summit Health Plan (SSHP)
K
Stephanie Sadabseng, DHCFP
Nolan
Linda Anderson, Nevada Public Health Foundation (NPHF)
C
Keri Kelley, SSHP
Beth Slamowitz, DHHS
Troy C. Jorgensen, University of Nevada, Reno School of Medicine
Dominic Gaon, Anthem
Kathi Toliver, United Healthcare (UHC)
Tiara Floyd, Anthem
Evette Cullen, DHCFP
Sean Linehan, DHCFP
Jessica Vannucci, DHCFP
Dr. Keiko Duncan, DHCFP
Sophia Heinz, Gainwell Technologies (GWT)
Jennifer L. Cannon, Optum
Russell B. Wenzlau, Optum
Kenneth Kunke, Nevada Pharmacy Alliance
Dena Brennan, GWT
Arlene Forsman, Molina Healthcare
Elyse Monroy-Marsala, Belz & Case
Christy Nguyen, Fidelis-RX
UMC
Belz & Case Government Affairs-Scribe by Rewatch
Rianna White, Fidelis-Rx
Tashanae Glass, DHCFP
Dena Benson-Scearce, ZOLL Medical Corporation
Beth Ivester, Silver Summit Health Plan (SSHP)
Andrea Gregg, High Sierra AHEC
Allyson Hoover, Silver Summit Health Plan (SSHP)
Thomas L. Beranek, Centene
Meredith Adams, ZOLL Medical Corporation
Joy J. Marquez, Centene
Jeremey Hays, DHCFP
Tonya Hammatt, National Seating & Mobility

De
Colleen
Alexis Ward
Monica Schiffer, DHCFP
Cherneka Mooney, Optum
Mary Lou Fisher, DHCFP
Steve Messinger, Nevada Primary Care Association (NVPCA)
Shirish S. Limaye, SSHP
Edna Martin
Vimal Asokan, Anthem
Hannah Branch, Ferrari Reeder Public Affairs (FRPA)
Sarah Rubino Caldwell, Sellers Dorsey
Nancy J. Bowen, Nevada Primary Care Association (NVPCA)
Morgan Griffiths, Norco, Inc.
Sarah Dearborn, DHCFP
Amanda Lamborn, DHCFP
Renee Sweeney, DHCFP
Ellen Flowers, DHCFP
Alex Tanchek, Silver State Government Relations
Mary Gilbertson, UCare
Laura J. Deya Orona, Anthem
Jesus Padilla-Mungaray, Optum
Amy Hale, JANUS
Samantha DeAndrea**,** Doula Co-Op of Nevada
Edna Martin, Doula Co-Op of Nevada
Deborah Kolk, Anthem
Allison Genco
Maria Reyes, Fidelis-Rx
Morgan Biaselli, SSGR
Sarah Moses, DHCFP
Sam Wimbush, Anthem
Julia Humphrey
Dorothy C. Wilson, Optum
Regina C. De Rosa, Anthem
Angel-Leigh Fischer, Washoe County School District
Carissa Pearce, Children's Advocacy Alliance of Nevada (CAA)
Natalie Powell
Alisa Cadenhead, Anthem
Schelia Shinno, DHCFP
Joy Thomas, Anthem
Areli Alarcon,
Laurie Curfman, Liberty Dental Plan (LIB)
Jeana C. Piroli, Washoe Schools
Kaelyne Day, DHCFP
Jeanette Verdin, Washoe Schools
Emily Barney, Doula Co-Op of Nevada
Jennifer Campbell, Doula Co-Op of Nevada
Illia Ludwig, Doula Co-Op of Nevada
Andrea Sallee, Doula Co-Op of Nevada
Julie Humphrey, Accellence Home Medical
Morgan Powell, Doula Co-Op

Introduction:

Casey Angres, Chief of Division Compliance, DHCFP, opened the Public Hearing introducing herself, Theresa Carsten, Deputy Administrator, DHCFP, and Gabriel Lither, Senior Deputy Attorney General.

Casey Angres – The notice for this public hearing was published on March 28, 2024, and revised on April 22, 2024, in accordance with Nevada Statute 422.2369.

1. **Public Comments:** There were none.

2. **Discussion and Proposed Adoption and Changes to MSM 600**

Subject: MSM Chapter 600 – Physician Services

Evette Cullen, Medical Benefits Coverage Chief, DHCFP, presented pursuant to the passing of Assembly Bill (AB) 283 during the 82nd (2023) Legislative Session, Nevada MSM Chapter 600 – Physician Services Section 603.4E is being revised. This update will add prior authorizations for medically necessary doula services after the initial service limits have been exhausted.

This proposed policy update may affect the following Provider Types (PT) including, but not limited to:

Doula Services (PT 90).

The effective date is May 1, 2024.

Public Comments:

Emily Barney, Doula Advisory Committee, advised she is a birth postpartum and death doula and a subject matter expert. She became a Medicaid provider on December 24, 2022, and is currently an executive director and cofounder for the Doula Co-Op of Nevada, a nonprofit organization that supports, educates, and advocates for doulas in Nevada. Emily Barney said as a doula she works with and across many interdisciplinary agencies to implement the Medicaid dual benefit since 2021. Emily Barney advised she has several concerns with Nevada's program at this time and more than several recommendations that may interest DHCP. However, she advised she wants to specifically discuss the proposed changes to MSM Chapter 600, and the inclusion of prior authorization for medically necessary additional dual services. Emily Barney agreed with the proposed change to remove the language for a maximum number of visits of doula services. As many as 18 doula visits have been approved in Minnesota, with an average of 8 to 12 visits being standard across other states currently implementing Medicaid benefits. However, she and other doulas in her organization in Nevada are unclear about the impact that adding prior authorization for additional visits will place on them as providers, and ultimately the individuals who are in need of their services. She said she wanted to remind individuals that doulas are non-medical providers who primarily tend to and address the emotional, educational, and community resource needs for families in the critical early weeks and months of postpartum. There is concern among doulas and stakeholders that placing prior authorization requirement would place undue responsibility on these medical providers, who may be untrained on the scope of their services and may not see or understand the need to recommend their services, as there is no direct medical necessity for clients to see a doula. However, there are numerous mental, physical, emotional, and relational needs that they do address with their clients, and those should be prioritized over a prior authorization of medical necessity.

Jennifer Campbell advised she agrees with Emily Barney's comments. She advised that she was the first doula in the state of Nevada to become a Medicaid provider on December 1, 2022. She has been the Medicaid liaison for the Doula Co-Op of Nevada, helping doulas become Medicaid providers. Currently, the states in the United States have approved the ability for doulas to have visits. Two of these visits out of six are already contingent, one for two prenatal physician appointments, and one for dental services. Doulas already want those visits for their clients and encourage them to have the visits, but in order to bill, they must send their clients with an FA-111 form to have the dentist or physician fill out and return to the doula in order to attach it to a claim to be submitted. Jennifer Campbell said she could always do the extra visit based on physician attendance as all her clients have had at least two appointments with their physician, though she rarely completed the second visit because most clients cannot get into the dentist. She stopped doing both extra visits due to the process. Many of the clients within the Medicaid population are experiencing social determinants of health and have limited access to transportation, childcare, and other barriers that would otherwise make it easy to get to appointments. It is not because the clients do not care, or are not trying, clients often do not have a way to get to visits they would otherwise want to attend, or cannot get into appointments for dental due to there being only one dental provider, or the appointments simply are not available. Currently, with only her completed clients ready to bill, she is owed over $10,000. She has 16 billable clients and four of them have been partially paid. She has submitted one client claim 12 times, which has been denied each time. She said she has had great conversations with people working for the MCOs that do not always equate to billing success, and is consistently in touch with MCOs weekly and with billing and has been told by different people to hire

someone to process claims, which is not an affordable option for doulas, to purchase an ICD-10 book to figure out the codes, or take a class to understand medical coding, and that it is not the MCO's responsibility to assist with billing. Having more visits would make an amazing positive difference to the women who need their services; however, a concern is that requiring a recommendation from a doctor could mean more time, effort, and energy for the doula, the patient, and the provider to offer additional visits and may be more challenging to build something that is already extremely challenging for doulas.

Illia Ludwig is a full-spectrum doula and became a Medicaid provider in March 2023. Illia Ludwig agrees with the previous commenters and personally thinks it is great to add additional visits with the prior authorization because there is so much value in it. However, she is concerned because as of right now, she has 15 claims that she has not been paid for. She has filed five of her clients for five visits for each client, for a total of 25 claims that have all been denied. It has been a struggle to get the FA-111 form signed by providers for the two additional visits. She has been denied all her claims and has filed several times. She has also been in contact with the MCOs weekly trying to get her claims figured out and approved. No one has been able to help her receive compensation. The MCOs either cannot share billing information due to unknown policies, or they do not know how to accommodate doulas because they are unlike healthcare providers in ways that this system is not set up to accommodate. Illia Ludwig stated she is a single mom of three boys and not getting paid for the work already done, makes it hard to keep working without the compensation needed to sustain her family.

Samantha DeAndrea advised she is a full-spectrum doula and a cofounder, as well as the education director for the Doula Co-Op of Nevada. She became a Medicaid provider in January of 2023. She also agrees with the previous doulas who spoke. She currently has three unpaid client claims for Medicaid clients. She has served over the past four months and has the same issues as those previously stated. She stated they are grateful to hear the raising of maximum visits will be revised to create more accessibility to dual services, though she would like to focus her comments on concerns with the prior authorization process. The current policy of requiring prior authorization is concerning for the following reasons; As doulas they are non-clinical providers that happen to make clinically significant beneficial differences in maternal health outcome, which leads to them being misunderstood in their scope and impact in a clinical environment and to their points of contact within these institutions not knowing all the ways to help them through a medical system which focuses on clinical care. Doula services benefit everyone without bias to whether they have a clinical diagnosis to warrant further care. Most healthcare providers are untrained in the ways tools can be effective in supporting clients and families. If they do not understand how we can improve experiences in all scenarios and limit us to medical necessity, then they are at risk of having restrictions placed on the impact they can make on midterm health and the risk of Medicaid recipients unduly being denied holistic care. It is policy that creates more red tape for doulas to negotiate while they are also trying to navigate a system that was not built for them and is not supporting them efficiently at this time. It will greatly inhibit their ability to support the community, as well as create burnout in the doula Medicaid provider community and workforce.

Andrea Sallee is a doula with the Doula Co-Op of Nevada, reiterated and agreed with what the previous commenters stated.

Morgan Powell, Doula Co-Op of Nevada, also agreed with all the previous commenters and the situation with the Medicaid system.

Edna Martin, Doula Co-Op of Nevada, advised she is a Medicaid doula provider in Las Vegas. She served more than 20 clients in 2023, and she wanted to echo what everybody else was saying and how she has

had difficulties with trying to find the right person to assist her with claims and even getting multiple denials with no end and no support. She was hoping to get this streamlined so they can improve the way they care for everybody. The way they serve their clients and doula work is very important work as already stated. She 100% agrees with her fellow doulas who spoke before her.

Theresa Carsten advised the participants in the conference room to give their contact information to Evette Cullen and someone will follow up with their billing issues. Theresa Carsten also said as we move forward in the division, DHCFP will be working on possible doula work groups, so contact information will be taken for that as well. Theresa Carsten advised she wanted to address the billing issues because she heard repeatedly that they had no help, and the Division will get them help.

Theresa Carsten approved the changes pending spelling and grammar changes.

Casey Angres – Closed the Public Hearing for proposed adoption and changes to MSM Chapter 600 – Physician Services.

3. Discussion and Proposed Adoption and Changes to MSM 1300

Subject: MSM Chapter 1300– Durable Medical Equipment (DME), Prosthetics, Orthotics, and Supplies

Jessica Vannucci, Social Service Program Specialist, Durable Medical Equipment Services Supervisor within the Pharmacy Unit, DHCFP, presented the proposed revisions to Medicaid Services Manual, 1300 DME, disposable supplies and supplements. Revisions to MSM Chapter 1300 are being proposed to ensure clarity around coverage criteria provider and recipient responsibilities, noncovered statements and exclusions, face-to-face time frames to match code of federal regulations, and trial period added to speech generating devices. Entities financially affected include but are not limited to Outpatient Hospitals (PT 12), Physician Services (PT 20), Special Clinics (PT 17), Nursing Facilities (PT 19), Home Health (PT 29), Adult Day Healthcare (PT 39), Swing Bed (PT 44), School Health Services (PT 60), Personal Care Services (PT 83), Podiatrist (PT 21), Ambulatory Surgery Centers (PT 46), Hospital Outpatient (PT 12), Therapy (PT 34), and Durable Medical Equipment Providers (PT 33).

The following changes have been made: Section 1303.1(A)(4-5) clarified medical necessity, duplicate services, and direction for deluxe definitions were updated. Section 1303.1(B)(9) proof of teaching was added to be included in the recipient's record. Section 1303.1(C)(6) added examples of misuse and neglect of equipment, such as utilizing devices for transportation. Section 1303.2(A)(1)(a) updated acceptable timeframes for required face-to-face encounters to six months prior to the prior authorization start dates. Section 1303.2(A)(3) added required contents when submitting an invoice. Section 1303.2(B)(2-3) added verbiage requiring additional documentation that is required in the recipient's file. Section 1303.3 clarified the modifier requirements and the recipient choice of rental or purchase of equipment. Section 1303.4(A)(1)(c) removed the fax and mail option to submit prior authorizations, Section 1303.4(A)(1)(e) reworded the physician order requirements to support medical necessity for the clear coverage qualifications. Section 1304.A(6)(A)(1)(b) removed fax options and added electronic. Section 1303.5(A) reworded quantity limits and solicitation not being allowed. Section 1303.5(B)(2) added a "friendly edit deletion" to the Delivery Method, removed the thread that was added. Section 1303.5(B)(2)(b) delivery address was added and a "friendly edit deletion" to delete HCPC code that was added. Section 1303.9(C) clarified language to match custom features. Another "friendly edit deletion" of place of delivery on the claim under Section 1303.9(C)(2). Appendix A(1) added verbiage from other areas that are throughout the policy regarding comfort and convenience, clarified coverage exception policy, and added electronic

written requests. Appendix B verbiage was added within the main body of the policy for consistency and clarity. Cardioverter defibrillator added new coverage for the wearable defibrillators for interim treatment to pacemaker placements when compliant and continued medical conditions. Communication Devices is clarified the language that speech language pathologists cannot be employed by the durable medical equipment provider, and a trial period was added for the communication devices to ensure proper equipment are being delivered and provided and changed out for recipients when it is appropriate. Diabetic Supplies updated the supply codes. Disposable Supplies removed the limits and added billing guide reference for those limits. Mobility Assistive Equipment, Gait Trainers, added the codes and a note on who can provide the trial and medical necessity information. EPSDT verbiage for positioning seats for persons with special orthopedic needs to meet medical necessity was added. A specialized medical positioning device for a recipient in a vehicle or everyday life based on anticipated adverse medical outcomes. Verbiage regarding duplicate services if services are already in other programs to meet the medical need, for chapter consistency. Added language for elevating leg rest clarification with at least a reclining back. Orthotic and Prosthetic Devices added EPSDT verbiage for cranial remolding orthotic devices. The cephalic index table was added. Respiratory Services Bi-PAP and CPAP, a "friendly edit" to remove the drafted CPAP section for sleep study for hospital discharge, but the Bi-PAP Section is to remain. Sleep study for hospital discharge is clarified. It is not required to discharge from hospital to have a sleep study to get a Bi-PAP. Removed reference to the MSRP invoice, and a reference to arterial blood gas for Group II was removed. Verbiage for Pickwickian Syndrome was added under Group III and spelled out compliance for continued use for CPAP devices. Policy verbiage for Non-invasive Ventilator qualifications was added, which includes trial of a Bi-PAP. As clarification, if lesser failure is unavailable, this will not preclude medical necessity justification needed for a Non-invasive Ventilator.

The effective date of these changes is May 1, 2024.

Public Comments:

Dena Benson-Scearce, ZOLL Medical Corporation, expressed thanks to the Division for inclusion of the wearable cardioverter defibrillator for patients at risk of sudden cardiac arrest when they meet certain medical criteria. She also issued a special thank you to Jessica Vannucci, who was amazing and helpful in navigating through this process.

Julie Humphrey, the operations manager of Accellence Home Medical, a durable medical equipment company in Reno, advised she is extremely concerned about some of the changes, but specifically the changes related to Non-invasive Ventilation (NIV). She said two of the things that are extremely concerning are a tried and failed approach for the NIV. It is going to be extremely taxing on their patients, especially the neuromuscular patients that they service because Bi-PAP therapy is not the same as ventilator therapy. The other big concern about this policy is that it is included in a capped rental. NIV historically under Medicare is routinely a serviced item.

Jessica Vannucci thanked Julie Humphrey for bringing this up and said she was sorry for missing this but advised there is a "friendly deletion." There is a note that was added and drafted for Rental to Purchase that was missed in the original draft. There is not going to be a Rent to Purchase, this is still going to remain a continued rental item.

Julie Humphrey advised she was glad to hear that as it would limit service drastically. She thanked Jessica Vannucci for deleting that. The other thing that she was confused about is the Division requesting an invoice instead of a quote. She advised historically they have submitted quotations, not invoices, and that

is a difference. For example, she is not sure how they can submit an invoice for custom equipment before a prior authorization (PAR) because an invoice is the bill that indicates that she has already ordered it versus the quote. That is a concern of how that is logistically going to happen moving forward. The other concern is regarding the custom wheelchairs for elevating leg rests. There is a notation that it must have a reclining back and the recipient must be alone for periods of two hours or more to allow for power elevating leg rest. She advised this indicates that children would not qualify for power elevating leg rests Children typically are not left alone for periods of two hours or longer and would not be independently able to elevate their own legs, which is a concern for independence in the home as well as at school. She said she did not know if it is plausible for the school systems to elevate the children's legs all the time when it could be done independently. Julie Humphrey also addressed the Bi-PAP from a hospital discharge without a sleep study. She said she thought the Division was on the right track in terms of allowing that because there are many times when a patient is hospitalized needing a Bi-PAP prior to discharge. The problem is that the wording allows for only for the initial rental period, which would only be 3 months, so that would indicate that the patient would then need to go in for a sleep study within that three-month period. Logistically that is an impossibility in Nevada. The waitlist for sleep studies is approximately 12-24 months to get in for sleep study.

Casey Angres advised Julie Humphrey the three minutes had been reached and strongly encouraged her to send in any additional comments.

Jenifer Graham read a question in the Chat "Can you please review the changes made to the face-to-face requirements from 60 days."

Gabriel Lither asked Jessica Vannucci to go over the other friendly amendment in response to the last public comment for the record as to exactly what the change is and where it is located.

Jessica Vannucci replied that the "friendly amendment" is under the Non-invasive Ventilator policy addition on Page. 75 on the right side. It reads: "Note: The NIV will be rented until the purchase price is reached; this includes the initial 3-month rental period." Jessica Vannucci advised that draft language is to be deleted from the policy.

Theresa Carsten approved the changes pending spelling and grammar changes.

Casey Angres – Closed the Public Hearing for proposed adoption and changes to MSM 1300– DME, Prosthetics, Orthotics, and Supplies.

4. Discussion and Proposed Adoption and Changes to MSM 3800

Subject: MSM Chapter 3800 – Medication Assisted Treatment

Dr. Keiko Duncan, Pharmacy Director for Pharmacy Services, DHCFP, reported the proposed changes to include addition of Section 3801 – Authority, to include NRS 639, NAC 453, 454, and 639. Added naltrexone to Section 3802 Requirements for Eligible Providers to prescribe treatment for opioid dependence. Added Section 3808 for the purposes of Medicaid reimbursement of a pharmacist who prescribes and dispenses treatment for opioid dependence. These requirements address conducting a patient assessment; developing and maintaining a treatment plan; coordinating treatment in line with care coordination standards; conducting periodic reviews; providing patient counseling; medication reconciliation standards; and other requirements as indicated in policy and federal and state laws related

to prescribing or dispensing controlled substances. Please note two friendly amendments in Section 3808.A(1) and Section 3808.A(3) to clarify that, when applicable, the pharmacist shall confer and coordinate with the referring or collaborating practitioner and ensure the treatment plan is accessible by such practitioner.

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

The effective date of these changes is May 1, 2024.

Public Comments:

Kenneth Kunke, Nevada Pharmacy Alliance, thanked the Division, and especially Dr. Keiko Duncan, for working with them and other stakeholders to make sure the language for the pharmacist amendments did get to where they are, and they support these changes.

Theresa Carsten approved the changes pending spelling and grammar changes.

Casey Angres – Closed the Public Hearing for proposed adoption and changes to MSM 3800 – Medication Assisted Treatment.

5. Adjournment

There were no further comments and Casey Angres closed the Public Hearing at 11:15 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** documentcontrol@dhcfp.nv.gov ***with any questions.