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

Public Hearing October 29, 2024
Summary

Date and Time of Meeting:	October 29, 2024, at 10:14 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 4070 Silver Sage Drive Main 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)

Casey Angres, DHCFP
Wendy Messier, DHCFP
Kimberly Adams, DHCFP
Antonio Brown, DHCFP
Lucille Wroldsen, DHCFP
Catherine Vairo, DHCFP
Melody Hoover, DHCFP
Sean Linehan, DHCFP
Evette Cullen, DHCFP
De Yates
Sabrina Schnur, Belz & Case
Jason Drake
Lisa Glick, Fidelis-Rx
Jessica M. Stradford, Nevada Aging and Disability Services Division (ADSD)
Kelly Carranza, DHCFP
Christina Cobeo, DHCFP
Mary Bradley, DHCFP
Gina Ward, DHCFP
Rebecca Preddie
Katie Pfister, ADSD
Vanessa Justice, Division of Welfare and Supportive Services, DWSS
Serene Pack, DHCFP
Lauren M. Driscoll, Senior Deputy Attorney General
Theresa Carsten, DHCFP
Marcel Brown, DHCFP
Kerisa Weaver, DHCFP
Sarah Dearborn, DHCFP
Ellen Frias-Wilcox, DHCFP
Lori Follett, DHCFP
Elissa Secrist, McDonald Carano
Janelle Sindt, Nevada Aging and Disability Services Division (ADSD)
Brittany Acree, ADSD
Elizabeth Scott, DHCFP
Veronica Bean, DHCFP
Nhobelyn Kho, DHCFP
Victoria Ramirez, Specialized Alternatives for Families and Youth (SAFY)
Jacqueline McCoy, DHCFP
Kerry Cosmidis, Accessible Space
Christy Nguyen, Fidelis-RX
Bob
Dominic Gaon, Anthem
Allison Genco Herzik
Gina Callister, ADSD
Concepcion Martinez, ADSD
Donna Cabrera, DHCFP
Jarod Wolsey, Apple Grove

Shannon Ivy, ADSD
Sheri Gaunt, DHCFP
Ellen Flowers, DHCFP
Kristin Pointon
Lea Case, Belz & Case
Jerry Kappeler, Accessible Space
Bonnie Palomino, DHCFP
Cade Grogan
Casey Walker Melvin
Kyle
Kurt Karst, DHCFP
Kelsey Avery, Scan Health Plan
Regina C. De Rosa, Anthem
Marshall Smith, PoolPact
Russell Steele, DHCFP
Rocio de la O Pena, ADSD
Brian Evans, The Perkins Company
Chris Doss
Shelly Benge-Reynolds, DHCFP
Tamiko Henderson
Charmaine Yeates, DHCFP
Don Boyle, Freedom Care
Patricia Schille, DHCFP
Michael Della, ADSD
Keith Benson, DHCFP
Melody Hall-Ramirez, DHCFP
Mandy Coscarart, DHCFP
Jeremey Hays, DHCFP
Areli Alarcon, Carrara Nevada
Gingi Robinson, DHCFP
Pablo Munoz, DHCFP
Chris Bosse, Renown
Joseph Filippi, Division of Health and Human Services (DHHS)
Hilal Arshad, Elevance Health
Shauna Brennan, ADSD
Amy Levin, MD, Anthem
Danny Aldis, Revival Therapy
Jennifer Hailey, Carelon
Quang Nguyen, DHCFP
Deanna Torres, Community Counseling Center
Cissy Garic, DHHS
Amy Shogren, Black & Wadhams
Alisa Cadenhead, Anthem
Darlene Wolff, DHCFP
Melinda Rhoades, SAFY
Angela Stewart, Elevance Health
Shadi A. Ahmed, Carelon
Rianna White, Fidelis-Rx
Joy Thomas, Anthem

Introduction:

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

Casey Angres – The notice for this public hearing was published on September 26, 2024, and revised October 15, 2024, in accordance with Nevada Statute 422.2369.

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

2. **Discussion and Proposed Adoption and Changes to MSM Chapter 2200, 2300, 2600, 3500**

   Subject: MSM Chapters 2200 - Waiver for the Frail Elderly (FE), MSM Chapter 2300 - Waiver for Persons with Physical Disabilities (PD), MSM Chapter 2600 - Intermediary Service Organization (ISO), and MSM Chapter 3500 - Personal Care Services Program (PCS)

   Ellen Frias-Wilcox, Waiver Programs Supervisor, Long Term Services and Supports (LTSS) Unit, DHCFP, presented proposed changes to MSM Chapters 2200, 2300, 2600, and 3500.

   DHCFP conducted a public workshop on May 6, 2024, to inform the public about the Senate Bill (SB) 511 mandating providers to adhere to wage requirements and DHCFP's audit process to ensure providers will comply with the wage requirements. However, due to issues with the Electronic Visit Verification (EVV) and delayed payments to providers, DHCFP decided to put a hold on submitting the policies for public hearing at that time, until now.

The proposed language is the same for all four chapters, except for the different authorities, Ellen Frias-Wilcox started with the changes for MSM Chapters 2200 - FE Waiver and 2300 - PD Waiver as they have the same Waiver authority, which was approved by Centers for Medicare and Medicaid Services (CMS) December 13, 2023, with an effective date of January 1, 2024.

MSM Chapter 2200 - Language was added under Provider Responsibilities "As mandated by Nevada statute, federal law, or any other applicable Medicaid authority, providers must adhere to all wage requirements established by federal or state law or applicable Medicaid requirements for direct care workers." Specific wage requirements are referenced in the Waiver for the FE in Appendix C – Participant Services and are outlined in the provider enrollment contract. The DHCFP Audit Unit will conduct audits to ensure compliance with wage requirements. As part of these audits, documents requested may include but not limited to: payroll records such as timesheets or timecards; detailed paystubs including hours and rates per direct care worker; employment documentation used to verify identification and authorization to work; and financial records needed to verify a provider's wage expense.

If a provider is determined to not be in compliance with paying their direct care workers a required wage, the provider will be subject to corrective action. Initial violations for non-compliance may result in provider education as well as recoupment of overpayment due to a provider not paying a direct care worker the mandated wage. Continued violations may trigger corrective action including additional penalties and up to termination.

MSM Chapter 2300 - Authority is Waiver for Persons with Physical Disabilities. Ellen Frias-Wilcox advised she would not read everything as it is the same wording as in MSM Chapter 2200.

MSM Chapters 2600 and 3500 - Authority is the State Plan, which was approved by CMS January 11, 2024, with a retro effective date of January 1, 2024. Language was added in Provider Responsibilities, which states "As mandated by Nevada statute, federal law, or any other applicable Medicaid authority, providers must adhere to all wage requirements established by federal or state law or applicable Medicaid requirements for direct care workers." Specific wage requirements are outlined in the State Plan Authority Section 4.19-B and adherence requirements also outlined in the provider's enrollment contract. The following documents will also be required by the DHCFP Audit Unit for audit purposes: payroll records such as timesheets or timecards; paystubs, including hours and rates per direct care; employment documentation used to verify identification and authorization to work; and financial records needed to verify a provider's wage expense. In terms of noncompliance, it will be the same as MSM chapters 2200 2300 where corrective action will be imposed due to noncompliance up to additional penalties and termination.

MSM Chapter 3500 – PCS language was added in Provider Responsibilities, which has the same exact verbiage and the same authority as in State Plan Section 4.19-B.

The affected provider types (PT) are Personal Care Services Program (PT 30), Waiver for the Frail Elderly (PT 48), Waiver for Persons with Physical Disabilities (PT 58), and Intermediary Service Organization (PT 83).

There is no financial impact on local government known at this time.
The effective date is November 1, 2024.

Public Comments: There were none.

Theresa Carsten approved the changes pending spelling and grammar changes.

Casey Angres – Closed the Public Hearing for proposed adoption and changes to MSM Chapter 2200 - Waiver for the FE, MSM Chapter 2300 - Waiver for Persons with PD, MSM Chapter 2600 - ISO, and MSM Chapter 3500 - PCS.

3. Discussion and Proposed Adoption and Changes to MSM Chapter 600, Section 603.4(f)

Subject: MSM Chapter 600 – Physician Services

Kerisa Weaver, Social Services Program Specialist II, Medical Benefits Coverage Unit, DHCFP, presented that MSM Chapter 600 - Physician Services is being revised to allow for coverage of medically necessary abortions. Prior authorization will be required for these services. The section also revised language regarding abortions due to rape, incest, and to save the life of the recipient.

The proposed policy updates may affect the following PTs, including but not limited to: Outpatient Surgery, Hospital Based (PT 10), Hospital, Outpatient (PT 12), Physician, M.D. and Osteopath, D.O. (PT 20), Advanced Practice Registered Nurse (PT 24), Ambulatory Surgical Centers (PT 46), Nurse Midwife (PT 74) and Physician Assistant (PT 77).

This is a court-ordered change that must be implemented. At the time of posting the agenda, the fiscal impact was unknown. As of October 29, 2024, there is an estimated impact for State Fiscal Years (SFY) 2025-2027 of $171,053. A full fiscal impact has not been finalized yet.

The effective date is December 16, 2024.

Previous language has been removed and replaced with the following: Language outlining the covered abortion services due to life endangerment, pregnancy that resulted from rape or incest, and adds coverage for medically necessary abortions. Prior authorization requirements for medically necessary abortions have been outlined. Outlines prior authorization requirements for abortion services that are performed in an inpatient setting. Covers the mandatory reporting laws related to pregnancies resulting from the sexual assault or rape of a minor. Requires the use of signed certification forms for abortions due to rape, incest, and to save the life of the mother.

Public Comments: There were none.

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, Section 603.4(f).

4. Discussion and Proposed Adoption and Changes to MSM Chapter 600

Subject: MSM Chapter 600 – Physician Services, Appendix A

Marcel Brown, Program Specialist, Behavioral Health Benefits Coverage Unit, DHCFP, advised DHCFP is proposing edits to MSM Chapter 600 to align the chapter in response to feedback received as a result of

the June 21, 2024, public workshop on the addition of the Collaborative Care Model. The Collaborative Care Model is the result of the passing of Assembly Bill (AB) 138 which provides authority to include Medicaid coverage for certain behavioral health integration services and to make appropriation and authorization of certain expenditures for these services. Policy was approved during the July 30, 2024, Public Hearing. Revisions were made to add clarification on who is eligible to be a Behavioral Health Professional, what Licensed Behavioral Health Professionals can provide services, and the elimination of references to a patient registry to align with current Nevada practices. Further clarifications were made to specify Non-Covered Services Section adding Target Case Management to avoid any potential duplication. Throughout the section updates were made to synchronize terminology for consistency and clarification.

The following changes were made to the Treating Practitioner (Billing Provider) section; Moved examples listed of "Physician, Advanced Practice Registered Nurse (APRN), Certified Midwife, or Physician's Assistant (PA) right after management codes. When adopted, the duplicated line will be removed. Bullets were changed to numbering or lettering for more precise referencing.

Changes to the Behavioral Care Manager section were made to include that the Behavioral Care Manager's bachelor's degree would need to come from an accredited college or, an addition was made to include that a Behavioral Care Manager could have a degree in a field outside of Human Services but would need to understand outpatient treatment and rehabilitative services. Removal was made for Behavioral Care Managers to meet the minimum qualifications of a Qualified Mental Health Associate. Addition of Licensed Behavioral Health Professionals that can be considered Behavioral Care Managers. Removal of the maintenance of a registry for tracking patient follow-up and progress.

The following changes to the Psychiatric Consultant section: Primary Care Team is replaced with Care Manager for Coverage and Limitations, as well as Follow-Up Psychiatric Collaborative Care Model, removal was made from tracking patient follow-up in a registry. Updates were made to change and synchronize references from "Mental" to "Behavioral" health.

An addition was made for services considered Targeted Case Management in the Non-Covered Services section.

These proposed changes affect all Medicaid-enrolled providers qualified to deliver Behavioral Health Integration Services. Those PTs include but are not limited to Physicians (PT 20), Advance Practice Registered Nurse (PT 24), Nurse Midwife (PT 74), Physician's Assistant (PT 77), Federally Qualified Health Centers (PT 17, Specialty 181), Rural Health Clinics (PT 17, Specialty 180).

There is no increase in annual aggregate expenditures related to these changes.

The effective date is October 30, 2024.

Public Comments: There were none.

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, Appendix A.

5. Discussion and Proposed Adoption and Changes to MSM Chapter 400

Subject: MSM Chapter 400 – Mental Health Services

Wendy Messier, Program Specialist, Behavioral Health Benefits Coverage Unit, DHCFP, presented that DHCFP is proposing edits to Medicaid Service Manual Chapter 403.9B-Provider Responsibilities to update the reference to align with July policy updates, chapter, and section numeration changes.

Previously, Section 403.10B was removed and numeration changes were made due to the policy updates in July of 2024 with the creation of MSM Chapter 4100. Provider Responsibilities was updated in the Policy to replace "Please consult Section 403.10B of this chapter for provider responsibilities" with the language from the reference section (which is now located in Section 403.8B).

There is no estimated increase of annual aggregate expenditures.

The effective date is October 30, 2024.

Public Comments: There were none.

Theresa Carsten approved the changes pending spelling and grammar changes.

Casey Angres – Closed the Public Hearing for proposed adoption and changes to MSM Chapter 400 – Provider Responsibilities.

6. Discussion and Proposed Adoption and Changes to MSM Chapter 3200

Subject: MSM Chapter 3200 – Hospice

Rachael Devine, Policy Specialist, Hospice Services, LTSS Unit, DHCFP, presented revisions to MSM Chapter 3200 are being proposed to add a fourth Hospice Category of "Service Intensity Add-On (SIA)." This fourth category is a federal option that allows for the Hospice provider to bill for the last seven days of life when Routine Hospice Care is provided by either a registered nurse or social worker. The service limitations are up to four hours a day and cannot be done through telehealth. A public workshop presenting these proposed revisions to stakeholders was held on September 26, 2024.

These proposed changes affect all Medicaid enrolled providers delivering Hospice services including Hospice (PT 64).

There is no known financial impact on local government.

The effective date is November 1, 2024.

The following are the proposed revisions to MSM Chapter 3200; Hospice Categories - Service Intensity Add-On to be defined as routine home care days that occur during the last seven days of a hospice election ending with a patient discharged due to death are eligible for a SIA payment for visits made by a social worker or registered nurse. The SIA payment is in addition to the routine home care rate. The SIA payment shall be equal to the continuous home care hourly payment rate, multiplied by the amount of direct

patient care actually provided by an RN and/or social worker, up to four hours total per day and cannot be done through telehealth.

Public Comments: There were none.

Theresa Carsten approved the changes pending spelling and grammar changes.

Casey Angres – Closed the Public Hearing for proposed adoption and changes to MSM Chapter 3200 – Hospice.

7. Discussion and Proposed Adoption and Changes to MSM Chapter 1200

Subject: MSM Chapter 1200 – Prescribed Drugs

Antonio Brown, Pharmacy Services and Durable Medical Equipment (DME) Unit Chief, DHCFP, presented the proposed revisions to MSM Chapter 1200 – Prescribed Drugs, based on recommendations approved at the July 18, 2024, Drug Utilization Review (DUR) Board Meeting.

The proposed changes include the following: Updates to existing clinical prior authorization for Casgevy® (exagamglogene autotemcel) under the "Sickle Cell" therapeutic class which requires that the medication is prescribed by, or in, consultation with a Hematologist and requires the prescriber attestation that patient is a candidate for hematopoietic stem cell transplant (HSCT). Addition of new clinical prior authorization criteria for Yimmugo® under therapeutic class "Immune Globulins (immunoglobin)." Updates to the existing prior authorization clinical criteria to Jemperli® and Keytruda® under therapeutic class "Antineoplastic-Anti-Programmed Cell Death Receptor-1 (PD-1)." to include new indications for coverage. Updates to the existing prior authorization criteria for Yervoy® (ipilimumab) to include requirements when therapy is used in combination with other agents. Throughout the document prior authorization links and the "Last Reviewed by DUR Board" date were updated.

Providers who prescribe, dispense, or administer these drugs may be affected by these changes, including but not limited to the listed PTs on the agenda.

There is no financial impact on local government known.

The effective date is November 4, 2024.

Public Comments: There were none.

Theresa Carsten approved the changes pending spelling and grammar changes.

Casey Angres – Closed the Public Hearing for proposed adoption and changes to MSM Chapter 1200 – Prescribed Drugs.

8. Discussion and Proposed Adoption and Changes to MOM Chapter 1300

Subject: MOM Chapter 1300 – Private Hospital Provider Tax Program

Case Angres advised for the record the attachment for this agenda item references this chapter as part of the Program Operations Manual (POM). The Division is currently working on migrating from the Medicaid Operations Manual (MOM) to a new POM. However, this change has not yet occurred. Chapter 1300 shall be adopted into the MOM at this time. The Division plans to present the change for MOM to the POM at a future public hearing.

Kimberly Adams, Administrative Services Officer, Fiscal Services Division, DHCFP, presented that revisions are being proposed to MOM Chapter 1300, Private Hospital Provider Tax Program.

This policy is being added to the Medicaid Operations Manual to establish the necessary policies and procedures for the operations of the private hospital provider tax program.

The overall financial impact for the majority of private hospitals is in the positive with the new tax program amounting in more than $600 million in new supplemental payments for private hospitals on inpatient and outpatient services. There were four hospitals that experienced a net negative impact of no more than $2.5 million in total for SFY 2024. Over time, the provider tax program will vary in the impact on hospitals and depends on how many Medicaid patients are served. The more Medicaid patients served, the more likely the net impact for a hospital will be in the positive each SFY.

There is no anticipated financial impact on local governments.

The effective date of the new policies and procedures is November 1, 2024.

Kimberly Adams briefly covered each of the sections within the new policy.

Section 1300 – Introduction provides the statutory citation allowing the Division to assess the new private hospital tax program if the majority of providers impacted voted in favor of implementing the assessment. The affirmative vote was held in 2023, and the provider tax program was implemented in SFY 2024.

Section 1301 – Statutory Authority reiterates the statute that gives DHCFP authority to implement the program.

Section 1302 – Definitions provides information on the definitions of terms used within the chapter as described in the Nevada Revised Statutes (NRS), Nevada Administrative Code (NAC), and Code of Federal Regulations (CFR).

Section 1303 – The Assessment describes the procedures for notifying impacted entities of the assessment amount due, how assessments are calculated and collected, and policies regarding payment of the assessment. This section also addresses the following: Method of communicating assessment amounts to providers and the timing of the notification. Describes how the assessment amount is calculated for each private hospital in the program. Describes how the assessment amount would be recalculated under various circumstances. Describes the frequency of assessment collection and communications to each hospital regarding the amount due. Describes the time allotted for private hospitals to make assessment payments and notes that each hospital is responsible for ensuring the Division has the correct contact information.

Section 1304 – Change of Ownership addresses the fiscal responsibility of each entity during a change of ownership and the necessary documentation that must be submitted to the Division if the new legal owner will assume responsibility for any previous assessments.

Section 1305 – Hospital Operating Status addresses how the private hospital provider assessment will be applied to new hospitals beginning operations in Nevada. Requires the operators of a hospital to notify DHCFP within 10 business days of a closure and indicates that the facility must pay a pro-rated assessment amount for the portion of the quarter the facility was open.

Section 1306: Penalties for Nonpayment describes penalties that will be imposed if a private hospital does not pay the assessed amount within the timeframes described in this chapter. If the assessment is not paid within the timeframe described in the notice, the hospital will incur a penalty of 1% of the assessment amount per day (up to 10 days). The Division may also charge the hospital interest of 1.5% per month. If the payment is not made within 30 days of the due date, a payment plan may be established. The assessment amount and any penalties may be deducted from future Medicaid payments. If the payment is not made by the second quarter following the assessment due date, the provider may be disenrolled as a Medicaid reimbursable provider in the State of Nevada.

Section 1307: Assessment Revenues and Uses describes how revenues from the private hospital assessment are utilized. Indicates that revenues must be deposited into a separate account and used solely for the purposes described in NRS 422.37945. This statute indicates that revenues are used to fund the state share of supplemental and state directed payments for Medicaid inpatient and outpatient services. Revenues are also used to cover the administrative costs associated with operating the program. A portion of the net revenues may also be utilized to improve access to behavioral health care for Medicaid recipients with serious behavioral conditions. The Administrative Purposes and Behavioral Health section indicates that no more than 15% of the assessment revenue may be utilized. The Budget Account Solvency section indicates that if the assessment revenues do not equal the state share of the amount used to fund the corresponding supplemental and state directed payments, DHCFP may delay, adjust, or reduce Medicaid payments to ensure solvency of the account.

Section 1308: State Directed Payments describes the requirements placed on private hospitals in order to ensure compliance with state and federal rules. Providers must participate in good faith each year in a value-based collaborative with DHCFP and the managed care organizations (MCO). Providers must sign an attestation indicating the provider will comply with all applicable federal laws related to the program. Providers must submit all data requested by DHCFP needed to calculate federally required quality metrics and validate claims and payments. Failure of a hospital to comply with Paragraph C could result in DHCFP delaying or recouping state directed or other payments to avoid federal penalties and sanctions on the state.

Section 1309: Federal Compliance indicates that the assessment must comply with all federal laws, regulation, and guidance. It also indicates that if the state determines that there is a risk of penalties being imposed by the federal government for the state Medicaid program, DHCFP may immediately terminate the program. If a federal disallowance occurs due to non-compliance of one or more of the impacted hospitals, the Division may impose a financial penalty or recoup all or a portion of the monies paid to the noncompliant hospital(s) to reduce or avoid financial risk to the state general fund or Medicaid budget as a result of the noncompliance.

Public Comments: There were none.

Theresa Carsten approved the changes pending spelling and grammar changes.

Casey Angres – Closed the Public Hearing for proposed adoption and changes to MOM Chapter 1300 – Private Hospital Provider Tax Program.

9. Adjournment

There were no further comments and Casey Angres closed the Public Hearing at 10:49 AM.

A video 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.