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DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH CARE FINANCING AND POLICY

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

Public Hearing February 25, 2025
Summary

Date and Time of Meeting: February 25, 2025, at 10:10 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: Department of Public and Behavioral Health
4150 Technology Way, Room 301
Carson City, Nevada 89706

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

Casey Angres, DHCFP
Lauren M. Driscoll, Deputy Attorney General (DAG)
Theresa Carsten, DHCFP
Marcel Brown, DHCFP
Charmaine Yeates, DHCFP
Kirsten Coulombe, DHCFP
Christina Cobeo, DHCFP
Krisann Taylor, DHCFP
Nancy Brooks, Clark County School District (CCSD)
Alyssa Drucker, Gainwell Technologies (GWT)
Gingi Robinson, DHCFP
Amy Levin, Anthem
Lindsey Bondiek, DHCFP
Rebekah Graham, Rite of Passage (ROP)
Noel Lopez, DHCFP,
Joleen Walker, DHCFP
Jennifer Frischmann, (DWSS)
Karen Stoycoff, DWSS
Shawna Derousse, United Healthcare (UHC)
Patricia Schille, DHCFP
Antonio Brown, DHCFP
Kerisa Weaver, DHCFP
Dr. Marcia Tinberg, DHCFP
Serene Pack, DHCFP
Nahayvee Flores-Rosiles, DHCFP
Heather Koehler, Division of Welfare and Social Services (DWSS)
Mark Du, DHCFP
Shelly Mirato, Desert Winds Hospital
Julie Peterson, Accessible Space
Kimberly Smalley, DHCFP
Vincenzo Variale, Prime HealthCare
JC Flowers, Nevada Rural Health Center (NVRHC)
Rhett Hollon, DHCFP
Linda Anderson, Nevada Public Health Foundation (NPHF)
Jonathan Figueroa, DHCFP
Lisa Glick, Fidelis-Rx
Todd Rich, DHCFP
Lori Follett DHCFP
Lambert Wu A., United Healthcare (UHC)
Mandy Coscarart, DHCFP
Seth Wray, UHC
Janine A. Sala, UHC
Shaneka L. Wiley, Elevance Health
Nicholas Hollister, Molina Healthcare
Angela Bryant, Transitions Services
Sara Knight, DHCFP
Monica Schiffer, DHCFP
Katie Pfister, Aging and Disability Services Division, (ADSD)

Melissa Pagarigan
Angi Nasso
Erin Lynch, Nevada Hospital Association (NVHA)
Tashanae Glass
Tiffany
Dana
Angela Stewart, Elevance Health
De Yates
Angelo Alford, Anthem
Philip Ramirez, Molina Healthcare
Veronica Bean, DHCFP
Evette Cullen, DHCFP
Allyson Hoover, Silver Summit Health Plan (SSHP)
Kristen Wall, Molina Healthcare
Lucille Wroldsen, DHCFP
Elizabeth Scott, DHCFP
Sandra Stone, Division of Child and Family Services (DCFS)
Nima Alinejad, Molina Healthcare
Jason Drake
Pablo Munoz, DHCFP
Mageena Tom, LCSW
Daniella Boris CCSD
Deanna Torres, Community Counseling Center
Shelly Benge-Reynolds, DHCFP
Mollie Colon
Deborah Jordan, DHCFP
Brandon Ford, Best Practices NV, LLC
Alicia Hines, Clark County Nevada
Rachel E. Rosensteel, UHC
Mark D. Peterson, UHC
Deidre Manley, DHCFP
Michelle Joy, Carson Tahoe Health
Kaelyne Day, DHCFP
Ellen Flowers, DHCFP
Bernadette DeMars, DHCFP
April Caughron DHCFP
Shadi A. Ahmed, Carelon
Sevil Monge, DHCFP
Kendra Edwards, American Heart Association
Casey
Lisa Dyer, DHCFP
Darlene Wolff, DHCFP
Robin Ochsenschlager, DHCFP
Jaimie Evins, DHCFP
Barbara A. Scaturro, Centene
Laurie Curfman, Liberty Dental Plan (LIB)
Susan Harrison, GWT
Christopher Aquinde, DHCFP
Amber Neff, DHCFP
Rianna White, Fidelis-Rx
Patricia Beck-Weaver, DHCFP
Alicia Roman, DHCFP
Maria Reyes, Fidelis-Rx
Maria R
Sarah Paulsen, Carelon
Tara Burfoot, DHCFP
Elizabeth Augustine, DWSS
Diana F. Marchetti, DWSS
Niani Cooper, DWSS
Melody Hall-Ramirez, DHCFP
Lenamarie Alaimo, DWSS

Introduction:

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

Casey Angres – The notice for this public hearing was published on January 23, 2025, and revised on February 3, 2025, in accordance with Nevada Statute 422.2369.

1. Public Comments: There were none.

2. Discussion and Proposed Adoption of Changes to MSM Chapter 1100

Subject: MSM Chapter 1100 – Ocular Services

Kerisa Weaver, Social Services Program Specialist, Medical and Dental Benefits Coverage Unit, DHCFP, presented that MSM Chapter 1100, Section 1103.1 is being revised to define routine and medical eye exams. Grammar and terminology changes were also made throughout this section for consistency across policy.

The proposed policy updates may affect the following Provider Types (PT), including but not limited to Physician, M.D. and Osteopath, D.O. (PT 20), Advanced Practice Registered Nurse (APRN) (PT 24), Optometrist (PT 25) Optician (PT 41), and Physician's Assistant (PA) (PT 77).

Entities Financially Affected: None.

Financial impact on local government: None.

The effective date: February 26, 2025.

Weaver outlined the following changes: Coverage and Limitations was revised to summarize available ocular services; Healthy Kids subsection has grammar changes and terminology updates for cohesiveness across policy; a section for Examinations was added to define the types of eye exams that are considered routine, along with the coverage limitations for these routine exams; a section was added to define examinations due to medical conditions of the eyes; Coverage Limitations are also listed for these services based on the provider of service; Lenses section has had a minor terminology change for cohesiveness across the policy

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 1100 – Ocular Services.

3. Discussion and Proposed Adoption of Changes to MSM Chapter 400

Subject: MSM Chapter 400 – Mental Health Services Psychiatric Residential Treatment Facility (PRTF)

Serene Pack, Health Care Coordinator and Policy Specialist, Behavioral Health Benefits Coverage Unit, DHCFP, presented the revisions that were done to align with federal requirements for PRTF, including the additional requirement of obtaining the Centers for Medicaid Services (CMS) PRTF Certification and the strengthening of language to help support youth, families, and providers. Additionally, changes were made throughout the chapter to replace the language of Residential Treatment Center (RTC) with PRTF. The prior policy generally aligned with the federal requirements for PRTFs except for its references to RTCs and lack of specification regarding the need to obtain CMS PRTF certification.

Pack clarified with the removal of substance use policy done to MSM Chapter 400 last year, the PRTF policy is now within Section 403.7 instead of Section 403.8, and the layout for PRTF policy has been adjusted for clarity to now have five main sections instead of the original three. Much of the original policy remains the same but has been re-arranged with the language strengthened and revised to the new sections.

The proposed changes affect all Medicaid enrolled providers delivering inpatient psychiatric residential treatment services outlined in MSM Chapter 400. Those PTs include but are not limited to PRTF (PT 63), Hospital, Inpatient (PT 11), and Psychiatric Hospital, Inpatient (PT 13).

No financial impact on the local government is expected.

The effective date is February 26, 2025.

Pack proceeded with the revisions to the chapter. The Authority pages were updated to add more federal and state regulation requirement citations. These include: the addition of Code of Federal Regulations (CFR) 441.184 which are the Emergency Preparedness requirements; the addition of 42 CFR Part 456 for Utilization Control along with Subpart G, since this is specific to the Psychiatric Services Admission and Plan of Care (POC) requirements for Individuals under Age 21; the addition of Subpart G to 42 CFR Part 483 regarding the Conditions of Participation for PRTFs related to Restraint/Seclusion requirements; the addition of a citation to the State Operations Manual as well as the Nevada Administrative Code (NAC) for PRTFs; the Nevada State Plan, Section 4.19-A information was fixed to reflect the pages that relate to inpatient psychiatric services.

In Section 403.7 the definition of a PRTF has been added along with the intended function and ages served and the Level of Intensity of Needs Grid was removed.

Section 403.7A, Coverage and Limitations, has several changes: Covered and non-covered services language have been expanded into subsections for better visibility; language was added to strengthen policy and provide clarity; a PRTF CFR reference was added; medications were changed from covered to non-covered with Applied Behavior Analysis (ABA) services being added to non-covered; a new section for Arranged and Concurrent Services with definitions was created with the caveat that if the services are not part of the PRTF all-inclusive services, they may be billed separately and may require prior authorization according to the particular PT requirements; transportation was added to this section; rate negotiated language was removed due to the move to a flat rate now for PRTFs as was presented at the December public hearing; new language was added regarding when recipients have Managed Care Organization (MCO) coverage; new language was added in Non-Discrimination section, the prior Criteria for the Exclusion section was removed, simplified, and moved to the new Section 403.7D; Therapeutic Home Passes language has been revised from Therapeutic Home Passes to Therapeutic Leave Days; information was added regarding documentation to be kept in the recipient’s medical record for Therapeutic Leave Days both for when the recipient is leaving and when the recipient returns.

Section 403.7B is the new section for Provider Requirements: it discusses the requirements for providers to become eligible to enroll or remain enrolled as PRTF providers; additional information has been included to expand upon the licensure requirements; in-state PRTF providers need PRTF licensure through Health Care Quality and Compliance (HCQC) which is needed for the equivalent of this for out-of-state providers; language has been added regarding documentation needed if the PRTF designation is not clearly stated on an out-of-state provider’s license; Accreditation is still required due to Medicaid having added a PRTF CFR reference regarding this, and Medicaid requiring the additional step of CMS PRTF certification which is obtained from a state survey agency that Nevada HCQC performs; language was revised and added regarding the PRTF CFRs along with language for the federal requirement of having annual attestations submitted by July 21 or the next business day if it falls on a weekend or holiday along with requiring a new Letter of Attestation if a new person takes over the position of the facility director. A link to a template for this attestation form can be found on the Provider Enrollment checklist website, next to the link for the PT 63 enrollment checklist.

Section 403.7C is the new section for Eligible Recipients which added: criteria to be met for an eligible recipient to receive care in a PRTF Level of Care (LOC), such as age range, diagnosis, and Seriously

Emotionally Disturbed (SED) determination; language regarding recipients not needing an acute LOC or having symptom severity to a degree where services cannot be obtained at the community level and require inpatient services under the direction of a physician; language stating PRTF services are expected to improve, or sustain without regression, a recipient's condition.

Section 403.7D is the new section for Admission, Continued Stay, Elopements, and Discharge. Some of the added language in this section is: stating that prior authorization is still needed before admission to a PRTF, including when Third Party Liability (TPL), or Other Health Care (OHC) exists, with certain exceptions, and it is in these cases only in which authorization must be submitted within 10 business days of the re-admission; language was adjusted and new language added regarding what is required on the Payment Authorization Request (PAR) form (this had been listed under the Certificate of Need (CON) sub-section in the prior policy); language was revised for the comprehensive psychiatric assessment for clarity and for what the CON is certifying, per the PRTF CFRs, including the team certifying the need for services; language for the Criteria for Exclusion was moved and simplified as all PRTF prior authorizations have always been reviewed on a case-by-case basis and it is the PRTF's responsibility to ensure that their admission criteria and staff and resources can safely and clinically accept a recipient referral; language was clarified regarding lateral transfer requirements which is a transfer from one PT 63 to another and are generally discouraged unless there is a valid need for this; language regarding retro authorizations for when eligibility has lapsed was clarified; language was added regarding the recommendation to submit concurrent PARs in a 5 to 15-day window prior to the current PAR end-date; language was added regarding what the QIO-like vendor reviews and criteria used when making a determination of medical necessity approval to strengthen this aspect of policy; language regarding lack of post-discharge plans alone will not be considered a valid basis for a continued PRTF stay was also added; the Discharge section added new language regarding permanency and stability within the community which is a priority for PRTF discharge planning due to the need to include the recipient and parent/guardian in the development of the treatment plan with short and long-term goals identified as per PRTF CFR requirements; language was broadened to specify the appeals process per the Billing Manual since prior policy had only addressed reconsiderations; newer language was added to this subsection regarding non-participation by the recipient or family/guardian, along with not making progress, as being reasons why a full denial or partial denial for medical necessity would be received on a prior authorization request; there is language regarding the discharge summary requirements, including the need to submit this to the QIO-like vendor within 30 days of discharge.

Section 403.7E is now the Provider Responsibilities section that had originally been in Section 403.7B with a few changes: language was added regarding PRTF providers needing to comply with other requirements within Chapter 400 that are applicable to all providers; a new section for General PRTF Service Provisions was added which discusses the need for an on-grounds educational component, active family engagement services, parental involvement services, and need to ensure other aspects of care such as dental and medical treatment are provided; new language was added regarding what information to include within incident report submissions including the need to document in the recipient's medical record that appropriate agencies with names of the person(s) to whom the incident was reported are documented and must be maintained in the recipient's record.

Additionally, new sections and language were added and revised from previous policy: the section Emergency/Disaster Preparedness was added and includes the PRTF CFR citation to refer to for further information; the section Fingerprint-Based Background Checks was added and includes a requirement for employees within, or contracted with, from an outside provider, to provide services to recipients in a PRTF; CFR references that had been in the original Federal Requirements section were removed; the new

section Documentation was added which discusses medical records requirements including ensuring documentation supports psychiatric services that were provided along with any medical, nursing, social, and other related treatment and care; language was added per DHCFP policy requirements discussed in MSM Chapter 100, Section 103.13, regarding that all providers are to keep a record of services performed for a minimum of six years from date of payment for the specified service; the section Staff Qualifications was added with new language to ensure enough staff is in place 24 hours a day, seven days a week and that the medical director must be available on a regularly scheduled basis to support the program and conduct regular onsite, in-person visits at the PRTF to assess the overall quality of care being provided; new language was added regarding the interdisciplinary team, including the PRTF CFR reference; new language was added regarding the two monthly face-to-face/one-on-one sessions and 24-hour availability including this being able to be done by either a psychiatrist or a psychiatric APRN; the section Staff Training was added which references PRTF CFR requirements as it relates to de-escalation and cardiopulmonary resuscitation (CPR) training including training in the use of non-physical and non-restraining intervention skills and safe and appropriate restraint and seclusion techniques, along with the ability to respond to signs of physical distress.

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– Mental Health Services, PRTF.

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

Subject: MSM Chapter 400 – Mental Health Services, Biofeedback and Neurotherapy Services

Marcel Brown, Program Specialist, Behavioral Health Benefits Coverage Unit, DHCFP, presented that DHCFP is proposing edits to MSM Chapter 400 to make typographic and enumeration corrections, along with removing Occupational Therapy as a billable service and reintegrating Neurotherapy back into policy.

Brown outlined the following changes: Supervision Standards, the use of the word assure has been updated with the correct term "ensure". Outpatient Mental Health Services, updated to reintegrate Neurotherapy back into policy. Mental Health Therapeutic Interventions updated the direct services for the Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP). Occupational Therapy has been removed as a billable service for these programs to align with State Plan Amendment (SPA) updates from July 2024. Those updates clarified and removed services from IOP and PHP. Language has also been updated for clarification of the all-inclusive rate pertaining to PHP and IOP. Rehabilitative Services, updated references from MSM Chapter 1500 to the correct MSM Chapter 3700 as ABA policy requirements are now located within that chapter. Peer-to-Peer Services updated prior authorizations to align with State Plan. At this time, prior authorizations are required for services above 18 hours/72 units. Provider Responsibilities made enumeration and typographical corrections, as well as simplified the section to instruct providers to comply with Omnibus Budget Reconciliation Act (OBRA) and Patient Self Determination Acts (PSDA) of 1990 by removing the directions of how to comply with those Acts.

A public workshop was held on January 13, 2025, to present changes to stakeholders.

There is currently no anticipated fiscal impact.

The effective date is February 26, 2025.

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 – Mental Health Services, Biofeedback and Neurotherapy Services.

5. Discussion and Proposed Adoption and Changes to MSM Chapter 1800

Subject: MSM Chapter 1800 – 1915(i) State Plan Option - Adult Day Health Care and Habilitation

Dr. Marcia Tinberg, Social Service Program Specialist, DHCFP, presented the updates that the 1915(i) Home and Community Based Services (HCBS) State Plan Option is proposing for MSM Chapter 1800 to align with the SPA which will be effective, March 1, 2025. The following are the major updates to MSM Chapter 1800: expanding the needs-based eligibility criteria to add language to clarifying the type of assistance needed for Activities of Daily Living (ADL); added an additional risk factor #4 to focus on those targeted recipients with a brain injury; added additional requirements for Serious Occurrence Reporting to include and align with CMS verbiage, including verbal, sexual, psychological, and emotional abuse, as well as, misuse or unauthorized use of restrictive interventions and seclusion; Provider Staffing and Training requirements for Day Habilitation and Residential Habilitation now include specific certification and training for all staff who provide direct care for recipients diagnosed with Traumatic Brain Injury (TBI) and Acquired Brain Injury (ABI) while also requiring a minimum of one designated staff in the organization to be a Certified Brain Injury Specialist (CBIS) or a Certified Brain Injury Specialist Trainer (CBIST) to provide support to staff; added clarification and denial reasons including; if there is no willing providers to accept the new referral, if the applicant failed to choose/select a 1915(i) enrolled Medicaid provider and death of the applicant. Updated Program Procedures with additional language to New Referrals, Transfers, Person-Centered POC and Notice of Decision (NOD) for services.

There is no change in annual aggregate expenditures.

The effective date is March 1, 2025.

Public Comments:

Julie Peterson, Accessible Space, commented that there was a change noticed in 1803.5B and some other sections showing that Medicaid requires residential facilities for groups to meet and adhere to all requirements of Nevada Administrative Code (NAC) 449 as applicable to licensure. Prior to this the provider has been responsible to meet this under HCQC Licensing agency, to which the provider would be accountable. Medicaid is now taking on this requirement as well under 1915(i) MSM Chapter 1800, Services, which would include Senate Bill (SB) 298, requiring facilities providing at least a 30-day notice before involuntarily discharging a resident from a residential facility for groups. Because 1915(i) services do not cover case management for this vulnerable population, many lose their Medicaid due to not being able to follow through with necessary mail handling, paperwork, and executive functioning skills, which are required for renewal. When a resident loses their Medicaid, it leaves the providers responsible to pay

for the care of these vulnerable individuals. Peterson asked as Medicaid is now directly requiring adherence to the 30-day notice required, will Medicaid also reimburse this 30 day required notice as well?

Dr. Marcia Tinberg advised she will reach out to Julie Peterson after meeting.

Casey Angres advised Julie Peterson to send her contact information to the Document Control email address on the agenda.

Theresa Carsten approved the changes pending spelling and grammar changes.

Casey Angres – Closed the Public Hearing for proposed adoption and changes to MSM Chapter 1800 – 1915(i) Home and Community Based State Plan Option Adult Day Health Care and Habilitation Services.

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

Subject: MSM Chapter 1200 – Prescribed Drugs

Antonio Brown, Chief of Pharmacy and Durable Medical Equipment (DME), DHCFP, presented the proposed revisions to MSM Chapter 1200 – Prescribed Drugs, based on recommendations approved at the July 18, 2024, and January 16, 2025, Drug Utilization Review (DUR) Board Meeting.

Brown outlined the following proposed changes: A new section for Fasenra® has been added under Respiratory and Allergy Biologics to include its use in treating Eosinophilic Granulomatosis with Polyangiitis (EGPA), along with updates to the age and weight criteria. Additionally, the age criteria for Dupixent® in treating Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) have been revised. New sections for Tezspire™ and Adbry® have also been added. In the Functional Gastrointestinal Disorder Agents category, diagnostic criteria have been updated, and clinical criteria for Linzess® has been added for the treatment of Functional Constipation in pediatric recipients. For Duchenne Muscular Dystrophy (DMD), the age requirement for Elevidys® has been updated, and the ambulatory requirement, as well as exon restrictions, have been removed. The hierarchy within Elaprase® has been corrected. Several updates have been made under Zynlonta®, including the removal of the recommendation to avoid direct natural or artificial sunlight, the addition of Universal Criteria, and the revision of "Large B-Cell Lymphoma" to B-Cell Lymphoma indication. Additionally, Diffuse Large B-Cell Lymphoma (DLBCL) has been expanded to include DLBCL not otherwise specified, DLBCL arising from low-grade lymphoma, and HHV8-positive DLBCL, not otherwise specified. Other additions include Histologic Transformation of Indolent Lymphomas (follicular lymphoma or marginal zone lymphoma) to DLBCL, as well as Monomorphic Post-Transplant Lymphoproliferative Disorders (PTLD). The recertification request criteria have also been updated. Lastly, the approval criteria for Tymlos® under Osteoporosis Agents have been updated.

There is no financial impact on local government known.

The effective date is March 3, 2025.

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.

7. **Adjournment**

There were no further comments and Casey Angres closed the Public Hearing at 10:55 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.