Si necesitas ayuda traduciendo este mensaje, por favor escribe a dhcfp@dhcfp.nv.gov, o llame (702) 668-4200 o (775) 687-1900

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

Public Hearing March 25, 2025
Summary

Date and Time of Meeting:	March 25, 2025, at 10:16 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
Charmaine Yeates, DHCFP
Nahayvee Flores-Rosiles, DHCFP
Kirsten Coulombe, DHCFP
Marcel Brown, DHCFP
Carin Hennessey, DHCFP
Dave Doyle, Eagle Quest
Amber Wilkins, Molina Healthcare
Gingi Robinson, DHCFP
Amy Levin, Anthem
Lindsey Bondiek, DHCFP
Jhoanna Presswood, DHHS
Minden Hall, DHCFP,
Gina Ward, DHCFP
Amanda Butler, Seven Hills Behavioral Health Hospital
Serene Pack, DHCFP
Nicole M. King, Silver Summit Health Plan (SSHP)
Joseph Haas, Washoe County
Brittany Loyd, Eagle Quest
Chloe Johnson, Eagle Quest
Alyssa Drucker, Gainwell Technologies (GWT)
Julie Peterson, Accessible Space
Kimberly Smalley, DHCFP
Christina Cobeo, DHCFP
Elizabeth Scott, DHCFP
Sheri Gaunt, DHCFP
Antonio Brown, DHCFP
Nicole Catoner, DHCFP
Ellen Frias-Wilcox, DHCFP
Kerisa Weaver, DHCFP
Zachary Laskey, Nevada PEP
Steve Messinger, Nevada Primary Care Association (NPCA)
Maria Curiel, DHCFP
Angelo Alford, Anthem
Linda Anderson, Nevada Public Health Foundation (NPHF)
Jonathan Figueroa, DHCFP
Susan Harrison, GWT
Blanca Iris Lanzas, DHCFP
Lori Follett DHCFP
Keri Kelley, Silver Summit Health Plan (SSHP)
Mandy Coscarart, DHCFP
Amy M. Cocoran, United Healthcare (UHC)
John McCandlish, Acentra Health
Brittany Acree, ADSD
Dawnesha Powell, SSHP
Frank Deal, SSHP
Sara Knight, DHCFP

Tina Bowman, DHCFP
Katie Pfister, ADSD
Celina Salas, Hope Christian Health Center
Chris Doss
Mary Paszek, Kids First Reno
Mckenna, Next Chapter Therapy
Cara Paoli, Washoe County School District
SG
Dominic Gaon, Anthem
De Yates
Kerry Harger, Molina Health Care
Nicole L. Figles, SSHP
Jessica Varela, SSHP
Evette Cullen, DHCFP
Lisa Caraway, Carelon
Wendy Montgomery, DHCFP
Gladys Cook, DHCFP
Sandra Stone, Division of Child and Family Services (DCFS)
Melissa Knight, DHCFP
Jason Drake
Pablo Munoz, DHCFP
Shelly Benge-Reynolds, DHCFP
Kathleen
Deborah Jordan, DHCFP
Brandon Ford, Best Practices NV, LLC
Megan Wickland, Nevada Aging and Disability Services Division, ADSD
Esther Badiata
Sheila Gerhard, Washoe County
Deidre Manley, DHCFP
Regina C. De Rosa, Anthem
Jennifer Harbor, DHCFP
Ellen Flowers, DHCFP
Bernadette DeMars, DHCFP
Sarah Dearborn, DHCFP
Kimberly A. Purinton, Centene
Michael Gorden, DHCFP
Monica Romero, Department of Education (DOE)
Kevin E. Murray, SSHP
Lisa Dyer, DHCFP
Estephania Jimenez-Sabree, DHCFP
Catherine Vairo, DHCFP
LaTanya Cash-Calhoun, DHCFP
Tami DeBonis, Molina Health Care
Jason Embra, Molina Health Care
Shelle Sponseller, Accessible Space, Inc
Jennifer Krupp, DHCFP
Amber Neff, DHCFP
Rianna White, Fidelis-Rx
Richard McFeely, DHCFP
Gina Studebaker, DHCFP
Maria Reyes, Fidelis-Rx
Teresa (Teri)
Angela Stewart, Elevance Health
Tara Burfoot, DHCFP
Carmon
Malinda Southard, DHCFP
Melody Hall-Ramirez, DHCFP

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 February 20, 2025, in accordance with Nevada Statute 422.2369.

1. Public Comments: There were none.

2. Discussion and Proposed Adoption of Changes to MSM Chapter 4100

Subject: MSM Chapter 4100 – Substance Use Disorder (SUD) Treatment Coverage and Services

Elizabeth Scott, Program Specialist, Behavioral Health Benefits and Coverage Unit, DHCFP, presented that revisions to MSM Chapter 4100 are being proposed to clarify that service description for substance use residential treatment services 3.1, 3.5, and 3.7 Withdrawal Management (WM) by adding language to explain that in order to be reimbursed for the residential daily rate, activity must be provided that aligns with the individual's treatment plan goals. Language was added to clarify that the program must be in compliance with criteria set by the Division of Public and Behavioral Health (DPBH), that a psychiatric

evaluation is to be completed when clinically indicated, and requirements on documentation changes for non-structured clinical activity. Grammar, spelling, and formatting corrections have been made throughout the chapter as needed.

Scott advised of the following changes: Coverage and Limitations, language was added to require providers who qualify to enroll as more than one substance use treatment group to use a unique National Provider Identification (NPI). Under Utilization of American Society of Addiction Medicine (ASAM) language was added to clarify daily requirements to be reimbursed for the daily bundled rate for ASAM residential 3.1 Level of Care (LOC). The service hour description for ACM residential 3.5 LOC was clarified that no less than 25 hours of structured activity is to be provided weekly. Of those 25 hours, 10 must be group or individual counseling. Language was added to clarify daily requirements to be reimbursed for the daily bundled rate for ASAM residential 3.7WM LOC. In Inpatient Alcohol Substance Use Policy Withdrawal Management and Treatment Services, language was added to clarify that a psychiatric evaluation is required when clinically indicated. Language was added to Documentation Requirements to require the lead clinician to review progress notes for structured nonclinical activities that are performed within a residential SUD treatment setting.

The proposed changes affect enrolled Medicaid providers qualified to deliver mental health and substance use services. Those Provider Types (PT), include but are not limited to Qualified Mental Health Professionals (QMHP) (PT 14, Specialty 300), and Behavioral Health Rehabilitative Treatment (PT 82, Specialty 300), Physician, M.D. (PT 20), Advance Practice Registered Nurse (APRN) (PT 24), Nurse Midwife (PT 74), Physician's Assistant (PA) (PT 77), Psychologist (PT 26), Pharmacist (PT 91), Substance Use Agency Model (PT 17, Specialty 215), Opioid Treatment Programs (PT 17, Specialty 171), and all substance use treatment specialties (PT 93).

There is no anticipated physical impact.

The effective date is March 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 4100 – SUD Treatment Coverage and Services.

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

Subject: MSM Chapter 400 – Mental Health Services

Sheri Gaunt, Policy Specialist, Behavioral Health Benefits Coverage Unit, DHCFP, presented the following revisions to MSM Chapter 400. Changes to Mobile Crisis Response Delivered by Designated Mobile Crisis Team (DMCT) section are as follows: Removed DHHS requirements for endorsement or credentialing, removed language regarding peer supporters being mandatory team providers, removed DHHS oversight requirements, removed the endorsement and certification requirement by DHHS, updated verbiage to read peer support specialist, removed the endorsement and certification in the section for DMCT Provider Eligibility Requirements, and language was removed from sections that allowed DHHS to be the only requester of records.

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.

4. Discussion and Proposed Adoption and Changes to MSM Chapter 100

Subject: MSM Chapter 100 – Medicaid Program

Charmaine Yeates, Policy Specialist, Provider Enrollment Unit, DHCFP, presented that revisions to MSM Chapter 100 are being proposed throughout the chapter to require reporting within 30 days to replace the current five-day timeframe per the method described within the Provider Enrollment Information Booklet. For example, the timeframe in Section 102A(5) now allows the state to align with Centers for Medicare and Medicaid Services (CMS) requirements. Changes have also been made throughout the policy to update language from 'shall' to 'may' in relation to the termination of providers or denial of applicants in occurrences of licensure action, payment suspension, criminal conviction, and other negative events or circumstances, and the requirement to report/disclose the events.

Yeates advised there were several updates to the risk level for providers per CMS guidance. The Skilled Nursing Facility (SNF) PT risk level has been increased from limited risk to high risk for newly enrolling providers and to moderate risk for revalidation enrollments. The Hospice PT risk level has been increased from moderate risk to high risk for newly enrolling providers, and to moderate risk for revalidations. Updates were made regarding action taken should a provider be listed within the CMS Data Exchange System (DEX) or excluded for cause from any Medicaid or Medicare program. Notation has been made regarding Nevada Medicaid's evaluation on a case-by-case basis to include review of level, nature, age, or recurrence of convictions and/or the provider's conduct.

In Conditions of Contract Terminations, language has been added to note that immediate terminations may occur unless mandated by state or federal policy and that the required 20-day notification of advance notice termination may be extended if found to be in the best interest of the Nevada Medicaid Program or its recipients. Deactivation of provider NPI has been added to the list of Administrative Contract Terminations reasons. Language additions to Re-enrollment Conditions of Reenrollment included the Nevada Exclusions List to note that providers may request re-enrollment reconsideration at the end of the sanction period.

A public workshop presenting these proposed revisions to stakeholders was held on November 13, 2024, with no recommendations or updates made.

Changes specific to risk level affect Hospice (PT 64), and SNF (PT 19). All other proposed changes affect all PT applicants and providers.

The known financial impact of these changes is limited to the cost of initial screenings for providers at a high-risk level when a Federal Criminal Background Check is required but has not been completed by CMS.

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 100 – Medicaid Program.

5. Discussion and Proposed Adoption and Changes to MSM Chapter 2100

Subject: MSM Chapter 2100 – Home and Community Based Services (HCBS) Waiver for Individuals with Intellectual and Developmental Disabilities (ID)

Nicole Catoner, Program Specialist, Long Term Services and Supports Unit (LTSS), DHCFP, presented the proposed revisions to MSM Chapter 2100. DHCFP LTSS conducted a public workshop on these proposed changes on March 4, 2025.

The purpose of these changes was to align the policy with the approved ID Waiver renewal that was effective on October 1, 2023, and the amendment that was approved by CMS on December 13, 2024, which was effective January 1, 2025.

Catoner outlined the following changes: Person-Centered Plan (PCP) has been changed to Person-Centered Service Plan (PCSP) to align with the Final Rule. Changes were made to remove Service limitations in some of the services, this will prevent frequent updates to the policy as limitations often change.

In the section Behavioral Consultation, Training, and Intervention, Coverage and Limitations, the annual limitation of $5,200.00 was removed and replaced with the current limit. In Counseling Services, Coverage and Limitations, the annual limit of $1,500.00 was removed and replaced with the current limit. In the section Non-Medical Transportation, Coverage and Limitations, the monthly fee limitation of $100 was removed. In Nutrition Counseling Services, Coverage and Limitations, the annual limit of $1,300.00 was removed.

For Dental Services, all language stating prior authorization has been removed as prior authorization for dental services is no longer a requirement. The following was added under Coverage and Limitations "Dental services may not exceed the current limit per rolling year, per recipient." Prior authorization was removed from Provider Responsibility as it is no longer required.

In the section Waiver Services, two new services were added – Individual Directed Goods and Services, and Benefits Counseling. Individual Directed Goods and Services are services, equipment, and supplies that address an identified need in the participants' PCSP that are not otherwise provided through the Medicaid State Plan. Goods and Services must be requested through the PCSP and linked to a specific need. Prior to any purchases, cost estimates must be provided to the ADSD Regional Center for review and approval by the Regional Center Agency Manager. Coverage and Limitations, Individual Directed Goods and Services, has been added for consistency throughout the policy. Some Individual Directed Goods and Services include, but are not limited to: Memberships and fees that may be associated with health memberships such as fitness and weight loss programs and gyms, bed bug extermination, and home adaptations, which include the installation of ramps and grab bars, widening of doorways, and bathroom modifications. Goods and Services cannot exceed the current limit per year per recipient and must obtain authorization from the Regional Center Service Coordinator. There is a complete list of the

services in this section. Provider Responsibilities and Recipient Rights and Responsibilities has been added for consistency throughout the policy

Benefits Counseling service was approved due to Assembly Bill (AB) 259 that was passed during the 82nd (2023) Nevada Legislative Session. Benefits Counseling services are designed to assist recipients and their families with understanding the potential impact of employment on the recipient's public benefits such as Supplemental Social Security Income (SSI), Social Security Disability Insurance (SSDI), Medicare, Medicaid, food and nutrition programs, and any other federal, state, or local benefits they may be receiving. This will provide assistance to recipients in developing a work incentive plan, provide information on how to obtain employment, and earn income while maintaining the benefits they need and to make an informed choice about pursuing employment, changing jobs, or career advancement. Benefits Counseling Services are limited to a maximum of 60 (15-minute) units. This equals 15 hours per recipient, per rolling year. In addition to the Provider Responsibilities listed, providers of benefits counseling must hold a Certified Work Incentives Coordinator (CWIC) Certification, or a Work Incentive Practitioner Certification (WIP-C).

Entities that are financially affected are HCBS Waiver Services (PT 38) and Dentist (PT 22).

The effective date is April 1, 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 2100 – HCBS Waiver for Individuals with ID

6. Discussion and Proposed Adoption and Changes to MSM Chapter 2500

Subject: MSM Chapter 2500 – Case Management Services

Christina Cobeo, Program Specialist, Behavioral Health Benefits and Coverage Unit, DHCFP, presented the revisions to MSM Chapter 2500 that are being proposed to add Medicaid coverage of Target Case Management (TCM) for incarcerated adults and youth. The. Consolidated Appropriations Act (CAA) of 2023 requires Medicaid to cover services for certain justice involved populations. This update is being made in conjunction with the previously reviewed State Plan Amendment (SPA).

Cobeo outlined the following changes: Updates have been made to the Authority section to add the CAA 2023, updates to the coverage and limitations grid have been made to add service limitations for target population eligible juveniles, criteria for the new target group eligible juvenile has been added, covered services has been added which describes the TCM services provided to high-risk Medicaid eligible juveniles in Nevada who face medical compromise due to various conditions and lack access to necessary support, and Provider Qualifications details of requirements for organizations providing case management services were added, including experience working with target population, coordination with other programs, administrative capacity, qualified staff, referral systems, and qualifications of individual case managers. The Eligibility Determination section specifies that Medicaid eligibility of recipients is determined by the county or state juvenile adult carceral facility, or detention center. Service Criteria mandates that services

are for Medicaid eligible recipients under the care of a correctional facility or detention center and must adhere to federal regulations.

Currently, there is a state fiscal impact of $144,760.20 for state fiscal year (SFY) 2025 and an anticipated financial impact of $146,296.60 for SFY 2026.

These proposed changes affect all Medicaid enrolled providers delivering TCM services. These PTs include, but are not limited to, TCM (PT 54).

The effective date is March 26, 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 2500 – Case Management Services.

7. Discussion and Proposed Adoption and Changes to MSM Chapter 2300

Subject: MSM Chapter 2300 –HCBS Waiver for Persons with Physical Disabilities (PD)

Ellen Frias-Wilcox, Waiver Program Specialist, LTSS, DHCFP, presented the proposed changes to MSM Chapter 2300. Language was changed from Plan of Care (POC) to PCSP throughout the chapter to align with the Final Rule. Some sections have language revisions, additions, and deletions for clarity. Other sections have added references to other sections to avoid language duplication.

During the 81st (2021) Legislative Session, AB 495 passed which had DHCFP adding Financial Management Services (FMS) as another self-directed service delivery option for PD recipients who want to direct their own care. CMS approved the addition of FMS to the PD Waiver on December 3, 2024. Prior to CMS approval and during the development of FMS, DHCFP LTSS conducted the first public workshop to introduce FMS on January 4, 2023. After procuring a vendor to manage the FMS, DHCFP conducted an in-person training to all case managers in collaboration with the vendor for two days on February 11, 2025, and February 12, 2025. Additionally, DHCFP held a town hall meeting to PD recipients on February 17, 2025, and February 21, 2025, to provide details of what FMS is and the process of enrolling with FMS, as well as the difference between FMS and Intermediate Service Organization (ISO).

Frias-Wilcox outlined the following changes and additions: In the section Waiver Services, Provider Responsibilities, added ISO and FMS, also known as Employer Authority and Budget Authority respectively, which are the two types of self-directed models available for PD recipients. If recipients select FMS as their service delivery model, they would be able to determine wages for, hire, fire, or train the caregivers. The procurement of the vendor falls under the FMS Vendor Responsibilities. Responsibilities of the vendor are to assist the recipients in Budget Authority, in developing the spending plan, assisting the employer recipient in hiring staff, and doing all regulatory functions of being an employer.

Frias-Wilcox explained that as recipients are the true employer, Employers' Responsibilities were added under Recipient Responsibilities. Some of their responsibilities include that they must cooperate with the FMS vendor; must adhere to the Electronic Visit Verification (EVV) requirements; hire, train, supervise,

and terminate employees; schedule and set wages for employees within program guidelines and within parameters identified by the FMS for each unique employer/employee relationship; ensure employees' time submissions are complete and accurate by the submission deadlines; review account statements from the FMS vendor and ensure that they are accurate and complete; and participate in regularly scheduled meetings with the case manager and the FMS vender.

Language was added for additional clarification on the effective date of waiver services. This is based on the date the PCSP was developed and approved by both the case manager and the recipient's representative or Legally Responsible Individual (LRI). Language was added to ensure the ongoing case manager's prior authorization is aligned with the intake recipient's temporary service plan dates for continuity of service specific to assisted living facility. An activity was added to Direct Case Management to participate in fair hearings related to adverse actions which include suspensions, terminations, and/or reductions. A section was added on participation in the FMS program meetings that will be held quarterly or as needed, assistance of recipients in transitioning from FMS to ISO, and that the prior authorizations must be approved annually and have a weekly frequency.

Case Management Provider Responsibilities was revised to add both the public and private provider qualifications that were approved by CMS on December 3, 2024. Professional licensure is optional; however, one must have at a minimum, a bachelor's degree from an accredited college or university in social work, gerontology counseling, nursing, psychology, human growth and development, special education, sociology, criminal justice, or a closely related social science or human services field. This change was made due to the difficulty in recruiting and hiring licensed professionals. The section Attendant Care Services, Coverage and Limitations added the indication that attendant care is not an extension of the State Plan PCS and the recipient chooses an LRI as a paid caregiver and/or the recipient chooses to direct their own care through the FMS. The section Assisted Living Services, Provider Responsibilities, added #3 to ensure the begin date of services aligned with the effective date of the PCSP so providers would get paid for the services rendered prior to the PCSP effective date.

Entity financially impacted is Physically Disabled Waiver (PT 58).

The effective date is April 1, 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 2300 – HCBS Waiver for Persons with PD.

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

Subject: MSM Chapter 1200 – Prescribed Drugs

9. Antonio Brown, Chief of Pharmacy Services and Durable Medical Equipment (DME), DHCFP, presented that revisions to MSM Chapter 1200– Prescribed Drugs, Appendix A and Appendix B, are being proposed to incorporate recommendations approved on January 16, 2025, by the Drug Utilization Review (DUR) Board.

Brown outlined the proposed changes beginning with Benlysta™ where new coverage criteria for the indication of lupus nephritis were added and age requirements were updated. In Respiratory and Allergy Biologics, clinical criteria for Dupixent® was updated to include indication of Eosinophilic Esophagitis (EoE). In the Anti-Migraine Medications section, the clinical criteria for Calcitonin Gene-Related Peptide (CGRP) Inhibitors have been revised to allow the combination of CGRP agents. Under Spravato®, the clinical criteria for initial approvals have been updated to include indication for Major Depressive Disorder. New sections for Voydeya™, Xolremdi®, Zynteglo™, Winrevair™, Beqvez™, polyneuropathy of hereditary amyloidosis agents which include Onpattro™ and Tegsedi™, and Primary Hyperoxaluria agents which includes Oxlumo™ and Rivfloza™ were added. In the section Anti-PD-Monoclonal Antibodies, the criteria for multiple cancer types was expanded and dosage limits, recertification requests, and prior authorization clinical guidelines for: Bavencio®, Imfinzi®, Libtayo®, Ocrevus®, Opdivo®, Tecentriq®, Beovu®, Avastin® (and biosimilars), and Darzalex® were updated. The section Anti-Angiogenic Ophthalmic Agents revised coverage criteria, dosage limits, and prior authorization guidelines for Eylea®, Lucentis®, Byooviz™, Cimerli™, and Susvimo®. The section for Anti-neoplastic and Anti-PD-1 Agents expanded coverage for Keytruda® to include additional coverage for multiple cancer types, revised dosage and clinical criteria guidelines. Under CD20 Monoclonal Antibodies coverage for Rituxan® (and biosimilars) was updated, including expanded oncology and non-oncology uses. Under Yervoy® (ipilimumab): prior authorization clinical criteria was updated to include coverage for various cancer types and updated dosage limits.

Providers who prescribe, dispense, or administer these drugs may be affected by this change.

There is no financial impact on local government known.

The effective date is March 31, 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.

10. Adjournment

There were no further comments, and Casey Angres closed the Public Hearing at 10:59 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.