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

Public Hearing September 30, 2025
Summary

Date and Time of Meeting:	September 30, 2025, at 10:01 AM
Name of Organization:	State of Nevada, Nevada Health Authority (NVHA), Division of Nevada Medicaid (DNM)
Place of Meeting:	Nevada Medicaid 1919 College Parkway, Suite #120 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, DNM
Lauren M. Driscoll, Regulatory Council
Gabriel D. Lither, Senior Deputy Attorney General (SDAG)
Alicia Roman, DNM
Kerisa Weaver, DNM
Jessica Hamilton, DNM
Rhett Hollon, DNM
Erica McAllister, DNM
Richard McFeely, DNM
Deidre Manley, DNM
Darlene Wolff, DNM
Jennifer Krupp, DNM
Carin Fox Hennessey, DNM
Sara Knight, DNM
Melody Hall-Ramirez, DNM
Ellen Flowers, DNM
Lindsey Bondiek, DNM
Krisann Taylor, DNM
Kimberly Smalley, DNM
Elizabeth Scott, DNM
Casandra Davis, DNM
Antonio Brown, DNM
Evette Cullen, DNM
Pablo Munoz, DNM
Marcel Brown, DNM
Todd Rich, DNM
Sarah Dearborn, DNM
Patricia Schille, DNM
Tashanae Glass, DNM
Mandy Coscarart, DNM
Lea Cartwright, Nevada Psychiatric Association

Introduction:

Casey Angres, Chief of Division Compliance, Nevada Medicaid, opened the Public Hearing introducing herself, Lauren M. Driscoll, Regulatory Council, and Gabriel D. Lither, SDAG.

Casey Angres – The notice for this public hearing was published on September 19, 2025, in accordance with Nevada Revised Statute (NRS) 422.2369.

1. Public Comments: There were none.

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

Subject: MSM Chapter 1200 – Prescribed Drugs

Ellen Flowers, Program Specialist, Pharmacy Unit, Nevada Medicaid, presented the proposed changes to MSM Chapter 1200 Appendix B, Section 5. Appendix B was renamed from "Standard Therapeutic Drug Classes" to "Physician Administered Drugs (PAD)" throughout the chapter.

The proposed changes were as follows: Section (A.) Abraxane, updated prior authorization guidelines; Section (B.) Anti-P-1 Monoclonal Antibodies, updated coverage for Opdivo®, Colorectal Cancer (CRC) and Hepatocellular Carcinoma (HCC); Section (D.) Bevacizumab, updated coverage for CRC, Appendiceal Adenocarcinoma, Colon Cancer, HCC, Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer, Vaginal Cancer, and Dosage Limits; Section (E.) Darzalex®, updated Multiple Myeloma (MM) and prior authorization guidelines; Section (F.) Darzalex Faspro®, updated MM and Dosage Limits; Section (K.) Kadcyla®, updated Universal Criteria, Central Nervous System (CNS) Cancer, Head and Neck Cancer, removed Quantity Limit (max daily dose), updated renewal criteria, and prior authorization guidelines; Section (M.) Long-Acting Granulocyte Colony Stimulating Factors, updated coverage for Pegfilgrastim; Section (N.) Pemetrexed, added coverage for Thyroid Carcinoma and updated Dosage Limits; Section (O.) Human Epidermal Growth Factor Receptor 2 (HER2) Inhibitors, under Perjeta®, updated coverage for Breast Cancer, CNS Cancer, CRC, Appendiceal Adenocarcinoma – Colon Cancer, Head and Neck Cancer, Biliary Tract Cancers (Gallbladder Cancer or Intra-/Extra-Hepatic Cholangiocarcinoma), Dosage Limits, and Recertification Requests. Under Trastuzumab updated coverage for Breast Cancer, Gastric, Esophageal and Esophagogastric Junction Cancers, CRC, Appendiceal Adenocarcinoma – Colon Cancer, Dosage Limits, and Recertification Request; Section (P.) CD20 Monoclonal Antibodies, under Rituxan®, Truxima®, Ruxience™, and Riabni™ updated coverage for Oncology Indications, IgG4-RD, Dosing Limits, and Recertification Request; Section (R.) Yervoy®, updated Dosage Limits; Section (S.) Zynlonta®, updated Dosage Limits and prior authorization guidelines; Section (T.) Osteoporosis Agents, under Prolia®, and Jubbonti® added Ospomyv®, Stoboclo®, Denosumab-dssb, and Conexxence®/Denosumab-bnht. Under Xgeva® and Wyost®, updated Dosage Limits.

The effective date is October 6, 2025.

Public Comments: There were none.

Lauren M. Driscoll approved the changes pending spelling and grammar changes.

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

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

Subject: MSM Chapter 400 – Mental Health Services, Section 403.6D

Krisann Taylor, Program Specialist, Behavior Health Benefits Coverage Unit, Nevada Medicaid, presented the proposed revisions to MSM Chapter 400, specifically related to Assertive Community Treatment (ACT) Services. Taylor advised updates were implemented following the 83rd Legislative Session (2025) and the passage of Senate Bill (SB) 501, which establishes the current Medicaid budget and includes dedicated funding for ACT services. The proposed changes affect all Medicaid-enrolled providers delivering ACT services.

Under Section 403.6D the name of the service was changed from Program for Assertive Community Treatment (PACT) to Assertive Community Treatment (ACT). Taylor explained that ACT Is a multidisciplinary, team-based approach focused on delivering intensive, community-based services to individuals with serious and persistent mental illness. The approach is specifically designed for those who struggle with basic daily functioning and have not responded well to traditional treatment methods. The ACT team delivers comprehensive psychiatric care and supportive services with the goal of helping individuals remain in their communities and avoid hospitalization or other institutional settings.

Section 403.6D(1), added Eligible Providers, which states an ACT Team should have a 1:10 staff-to-participant ratio in urban areas and 1:12 ratio in rural areas. Regardless of the size of the participant pool, an ACT team must start with a minimum of six full-time employees, and they must be available 24/7 to assist participants in crisis. Section 403.6D(1)(a)(5) states that an ACT Team must include the following four key personnel: Team Leader, who is a practicing technician, as well as the administrative and clinical supervisor of the team and must be a licensed professional who holds a Nevada clinical license in one of the behavioral health fields listed; Psychiatric Prescriber, who may be a psychiatrist or psychiatric nurse practitioner, are responsible for managing the psychiatric medication needs of participants; Registered Nurses (RN), who provide a wide range of treatment, rehabilitation, and support services with a focus on psychiatry, versus medical; Supportive Employment and Education Specialist, who work closely and collaboratively with the team and integrate vocational and educational goals and services within the participant's treatment plan. Section 403.6D(1)(a)(6) has a detailed description of the remaining ACT team members which may include Substance Use Disorder (SUD) Treatment Specialists, Case Managers, or Certified Peer Support Specialists (PSS).

Section 403.6D(1)(b) covers Operational Requirements and includes details on Admission Criteria, Daily Team Meetings, Individual Treatment Plans, and the Service Delivery model. The Service Delivery model dictates that the majority of ACT services should be delivered outside of a clinical or office setting. ACT services are delivered "assertively" meaning that staff proactively engage with participants to "go above and beyond" to ensure their needs are met. Section 403.6D(2), Eligible Members, states that to qualify for ACT, individuals must be diagnosed with a Serious Mental Illness (SMI) with or without co-occurring substance use and demonstrate high service needs that cannot be effectively addressed through traditional treatment methods. Section 403.6D(3), Covered Services, explains that ACT provides a comprehensive array of services that are individually tailored to each participant's goals and clinical needs. Section 403.6D(4), Noncovered Services, lists services that are not covered for ACT participants and are not included in the bundled rate. Section 403.6D(5), Authorization Requirements, explains that ACT services do not required prior authorization for eligible Medicaid participants. Section 403.6D(6), Billing, outlines the claims submission requirements for ACT services; providers will utilize the group daily rate code H0040 and include the appropriate place of services (POS) code to accurately reflect the location

where services were delivered. Finally, Section 403.6D(7), Managed Care Members, ensured alignment with Nevada Medicaid guidelines and Managed Care Organization (MCO) requirements.

These changes were previously presented during a Public Workshop on August 18, 2025, where stakeholders were invited to provide input and feedback.

The estimated fiscal impact is estimated at $12,040,087 for the State Fiscal Year (SFY) 2026 and $14,147,982 for SFY 2027.

The agenda indicates the effective date of these changes is July 1, 2025; however, the correct effective date is October 1, 2025, pending CMS approval.

Public Comments: There were none.

Lauren M. Driscoll approved the changes pending spelling and grammar changes and noted for the record the effective date of October 1, 2025.

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 4400

Subject: MSM Chapter 4400 – Crisis Services

Krisann Taylor, presented the proposed removal of Crisis Services from MSM Chapter 400 – Mental Health Services, and the creation of MSM Chapter 4400, Crisis Services.

The following sections have been removed in their entirety from MSM Chapter 400 – Mental Health Services: Section 403.6H, Crisis Intervention Services, Section 403.6I, Mobile Crisis Response Delivered by Designated Mobile Crisis Team (DMCT), and Section 403.6J, Crisis Stabilization Center (CSC). Most of the original policy remains intact but has been re-organized with strengthened and revised language throughout the new chapter.

Taylor explained that MSM Chapter 4400 was created to consolidate and clarify policies related to Nevada Medicaid's crisis services and providers. Updates made throughout the chapter included the following: Duplicative content was removed with language being simplified; "Patient" or "Subscriber" was replaced with "Participant"; "Catchment Area" was replaced with "Coverage Area"; references to the Division of Health Care Financing and Policy (DHCFP) were updated to Nevada Medicaid or DNM; language was added to prioritize first responders for expedited admission whenever possible; guidelines for telehealth services were added; the Eligible Provider subsections were updated to reflect upcoming revisions to the definition of a Qualified Mental Health Professional (QMHP); collaboration protocols were established, including guidance on the use of a Memorandum of Understanding (MOU) to support coordinated care; language was expanded to include the expectation that crisis providers complete at least one follow-up contact after discharged. Additionally, MSM Chapter 4400 was organized using a consistent structure to enhance the useability and readability. Each section of the new chapter includes the following standardized subsections: Introduction, Eligible Providers, Eligible Members, Covered Services, Noncovered Services, Authorization Requirements, and Billing.

Taylor then advised on the key additions and outline of the policy. Section 4401, Authority, outlines the legal and regulatory authorities that govern crisis services. Section 4402, Definitions, lists definitions related to crisis services that were not already defined in the MSM Addendum. Section 4403, Managed Care Members, ensures alignment with Medicaid guidelines and MCO requirements.

Under Section 4404, Crisis Intervention (CI) Services, the summary was expanded to provide a clearer explanation of CI services. The most significant revision was made to Section 4404.2, Eligible Providers, aligning with the revisions to the QMHP definition. The Service Limitations chart was removed from Section 4404.3, Covered Services, due to duplication with information in the Billing subsection. Section 4404.4, Noncovered Services, was updated to exclude CI services delivered without a risk-of-assessment and to exclude room and board. Additional clarifying language was included to Section 4404.5, Authorization Requirements, and Section 4404.6, Billing, was introduced.

Within Section 4405, DMCT, the summary was updated to describe the two different DMCT models: one is designed for governmental agencies and Emergency Medical Service (EMS) providers, and the other is for Certified Community Behavioral Health Clinics (CCBHC) that elect to deliver mobile crisis services under the DMCT model. Section 4405.1, Eligible Providers, was revised to reflect the updated definition of a QMHP and to include enrollment guidance for CCBHCs operating as DMCTs. Section 4405.1(D) introduces the Quality Assurance and Quality Improvement (QA/QI) requirement, which remains in effect until certification is obtained from the Division of Public and Behavioral Health (DPBH). Section 4405.1(E)(15) clarifies and expands guidance on medical record documentation requirements. Section 4405.3, additional clarifying language was added to the Eligible Members, Covered Services, Noncovered Services, and Authorization Requirements subsections. A billing chart for both DMCT Specialties is now included in Section 4405.6.

Section 4406, Mobile Crisis Teams (MCT), was developed to mirror the closely aligned DMCT policy, with a few key distinctions. Section 4406.1(A)(4) states that MCTs are community-based MCTs. The Eligible Provider subsection was also updated to include law enforcement as an allowable team member. This section also outlines circumstances when MCTs may deploy a single-team-member response, including the use of telehealth, when clinically appropriate. Section 4406.1(D) describes the QA/QI requirements for MCTs; this requirement is in place until certification from DPBH is obtained.

Section 4407, Intensive Crisis Stabilization Services (ICSS) facilities, closely followed existing policy for CSCs, with a few differences. The most distinct difference is that they are community-based facilities and are not endorsed by a hospital. Section 4407.1(E), ICSS facilities have a QA/QI requirement that will be in place until certification is obtained from DPBH. Section 4407.3(B) describes the ICSS Bundled encounter rate. The remaining 4407 subsections closely mirror the corresponding CSC policy provisions.

Section 4408, CSCs, were relocated from MSM Chapter 400 and reworded to incorporate policy elements previously found in the Provider Enrollment Checklist and Billing Guide. Section 4408.1, Eligible Providers, was expanded to include Section 4408.1(B)(3), where clinical supervision guidelines, along with additional staffing criteria, was established to ensure appropriate oversight, consistent service delivery, and alignment with standards applied to other crisis providers. Section 4408.1(C), Provider Training was added to outline the required type and frequency of training for engaged staff, along with procedures for documenting and maintaining training records. Section 4408.1(D), Operational Guidelines, was expanded to align with other crisis providers and to emphasize the use of evidence-based treatment practices. The updates include the addition of preferred screenings, assessments, safety planning, and harm reduction strategies. Section 4408.1(F), Privacy and Confidentiality Protocols, was added to ensure compliance with

Health Insurance Portability and Accountability Act (HIPAA) and other applicable privacy laws, particularly in relation to data sharing practices. Section 4408.3, Covered Services, was revised to provide clearer guidance on allowable services as well as the minimum service requirements necessary to utilize the crisis encounter rate, including the appropriate use of telehealth. Additional clarifying language was added to the Eligible Members, Noncovered Services, and Authorization Requirements subsections. Section 4408.6, Billing, was fully revised to provide clearer guidance on the appropriate use of the CI and the crisis encounter codes, as well as to address the shadow billing requirements.

Appendix A, QA/QI Improvement Guide, was designed to support providers in developing a comprehensive and actionable QA/QI program. It outlines essential components to consider, specifies the types of data that should be collected, and includes a template with guiding questions to assist in building an effective QA/QI program; the QA/QI requirement remains in effect until the provider obtains certification from DPBH.

Appendix B –MOU Toolkit, this toolkit was added to provide best practices to assist providers in establishing collaborative agreements, or MOUs, with other crisis care providers. MOUs serve as a foundational roadmap for partnership by clearly outlining shared goals, defined roles, and mutual responsibilities. The toolkit also addresses key elements such as decision-making processes, conflict resolution strategies, and data-sharing protocols to ensure compliance with HIPAA.

These changes were previously presented during a Public Workshop on July 22, 2025, where stakeholders were invited to provide input and feedback.

The proposed changes affect all Medicaid-enrolled providers delivering Crisis services. The Provider Types (PT) include but are not limited to: Behavioral Health Outpatient Treatment (PT 14), Physicians (PT 20), Advance Practice Registered Nurse (APRN)(PT 24), Psychologists (PT 26), School Health Services (SHS) (PT 60), Physician Assistants (PA) (PT 77), Rehabilitative Behavioral Health (PT 82), Crisis Services (PT 87), and Substance Use Treatment (PT 93).

There is no anticipated fiscal impact at this time.

The effective date is October 1, 2025.

Public Comments: Elizabeth Scott, DNM, asked for clarification if QI/QA is required until they become certified by DPPH and if certification is required by DPBH to be an MCT.

Taylor replied that yes and that certification will be required eventually once DPBH have their certification guidelines in place.

Lauren M. Driscoll approved the changes pending spelling and grammar changes.

Casey Angres – Closed the Public Hearing for proposed adoption and changes to Chapter 4400 – Crisis Services.

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

Subject: MSM Chapter 400 – Mental Health Services, Section 403.4

Lindsey Bondiek, Program Specialist, Behavior Health Benefits Coverage Unit, Nevada Medicaid, presented the proposed revisions to MSM Chapter 400 concerning first episode psychosis (FEP). Revisions were made as a result of the Medicaid budget approval through SB 501 which included funding for the treatment of first episode psychosis (FEP). The following changes affect all providers delivering treatment services for FEP.

Under Section 403.4(D)(4) a service description for Coordinated Specialty Care as well as a definition for FEP was added. Coordinated Specialty Care is a comprehensive, multidisciplinary program of services which are expected to improve or maintain condition and functioning level of individuals experiencing FEP. The Coordinated Specialty Care program must ensure high-fidelity implementation of an evidence-based, nationally recognized model and hold certification from DPBH upon approval of their certification program. Section 403.4(D)(4)(a), Eligible Providers, states that Coordinated Specialty Care services are provided by a multidisciplinary team of Licensed Professionals, QMHPs, Peer Support Specialists, Case Managers, and Supportive Employment and Education Specialists under the direction of a team lead: the team lead provides ongoing consultation, coordinates treatment, screens recipients for admission, and oversees treatment among other duties; the Supportive Employment Education Specialist integrates vocational and mental health services, serves as the liaison with outside educators and employers, and works with the client in the community to enhance school or job performance; a description for the other team members is included and resembles language used to describe these providers elsewhere in the MSM.

Section 403.4(D)(4)(b), Eligible Members, explains that eligible members are typically between the ages of 15 and 45 and have experienced FEP within the last 18 months, or who are experiencing early at-risk symptoms for psychosis, and have been identified by a professional as having a documented need for Coordinated Specialty Care. Section 403.4(D)(4)(c), Covered Services, states that the covered services for Coordinated Specialty Care include behavioral health assessments, individual therapy, group therapy, family education and support, supportive employment and education, case management, peer support services, crisis services, primary care coordination, medication management, and psychiatry. A description of family education and support, supportive employment education, and primary care coordination are included as these services are not defined elsewhere in the MSM. Section 403.4(D)(4)(d), Non-Covered Services, explains that the non-covered services for Coordinated Specialty Care include non-evidence-based models, documentation, room and board expenditures, transportation, caregiver services, and supervision. Section 403.4(D)(4)(e), Authorization Requirements, states that the Coordinated Specialty Care screening and introduction service can be used once per calendar year before a prior authorization is required. The weekly Coordinated Specialty Care services do not require prior authorization. Section 403.4(D)(4)(f), Billing, there are two team-based, bundled rates, billing codes for Coordinated Specialty Care, H2040 is the screening and introduction code and H2041 is the weekly services code. Section 403.4(D)(4)(g), Managed Care Members, includes information for managed care members.

These changes were presented to stakeholders at a Public Workshop on August 18, 2025.

An estimated increase in annual expenditures for SFY 2026 is $3,904,660 and SFY 2027 is $3,915,943.

The agenda indicates the effective date of these changes is July 1, 2025; however, the correct effective date is October 1, 2025.

Public Comments: Lea Cartwright, Nevada Psychiatric Association, thanked Medicaid, DPBH, and everyone involved who has been working with their child and adolescent psychiatry members since the

last workshop regarding these chapter changes. Cartwright commended the Division for recognizing the importance of coordinated specialty care for FEP, emphasizing that this was the evidence-based standard of care and it is important for Nevada families to benefit from this program and change the trajectory of mental illness in young people. Cartwright then advised that the current proposal diverges from national implementation standards in ways that put the fidelity of that model at risk. Team leadership and psychiatric oversight of this draft allows a broad-range of licensed professionals to serve as a team leader. National protocols, such as Navigate, specify that Licensed Clinical Social Workers (LCSWs), clinical psychologists, Clinical Processional Counselors (CPCs), and Marriage and Family Therapists(MFT) are not used in this role because team leaders must supervise others, including those with higher license types, and must oversee family education and psychotherapy for fidelity. Cartwright posited that psychiatric clinicians should be a distinct role within the team and not be merged into team leadership. Psychopharmacology for FEP is complex and requires expertise. APRNs have been part of Coordinated Specialty Care teams and they operate successfully with structured psychiatric consultation. Nevada Psychiatric Association recommends that a board-certifies psychiatrist or child and adolescent psychiatrist serve in the supervisory or medical director capacity, providing consultation and attending treatment teams. Additionally, PAs are not independently licensed and should not be primary prescribers, unless they have direct supervision from psychiatry. Cartwright pointed out program solvency stating that the current financial assumptions do not align with what it takes to run a high-fidelity Coordinated Specialty Care program. Then Cartwright addressed the eligibility criteria. This draft defines FEP correctly and then adds effective psychosis without making those age distinctions. Early-stage effective psychosis typically presents between ages 12 and 25 while the schizophrenia spectrum disorders more often present between 15 and 35. Cartwright explained that clarifying those two separate populations for eligibility is great but advised it is important to make sure those populations are understood. The Fidelity Monitoring National Coordinated Specialty Care programs mandate structured fidelity tools while this draft mentions continuous monitoring without detail, which needs to be added in some of the fidelity monitoring to make sure it is distinguishable from standard outpatient care. Cartwright advised that the Nevada Psychiatric Association stands ready to partner with the Division to make any of these changes. Cartwright recognized that they have working in the background on discussion on this and looks forward to working with the Division in the future. Cartwright emphasized the appreciation for the Division allowing these comments to be brough to public hearing.

Casey Angres thanked Cartwright and advised that the comments would be taken into consideration.

Lauren M. Driscoll approved the changes pending spelling and grammar changes and noted for the record the effective date of October 1, 2025.

Casey Angres – Closed the Public Hearing for proposed adoption and changes to MSM Chapter 400 - Mental Health Services.

6. Adjournment

There were no further comments, and Casey Angres closed the Public Hearing at 10:38 AM.

A video version of this meeting is available through the Nevada Medicaid Compliance office. For more detailed information on any of the handouts, submittals, testimony, and or comments please contact Jenifer Graham at** documentcontrol@nvha.nv.gov **with any questions.