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4070 Silver Sage Drive
Carson City, Nevada 89701
NVHA.NV.GOV

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Governor

Stacie Weeks, JD MPH,
Director

Ann Jensen
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Notice of Meeting to Solicit Public Comments and Intent to Act Upon Amendments to the Medicaid Services Manual (MSM)

Public Hearing December 30, 2025
Summary

Date and Time of Meeting:	December 30, 2025, at 10:03 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)

Kimberly Smalley, DNM
Lauren M. Driscoll, Regulatory Council
Jose I. Rivera, Deputy Attorney General (DAG)
Tonya Wolf, DNM
Bonnie Palomino, DNM
Erica McAllister, DNM
Shannan Canfield, DNM
Kirsten Coulombe, DNM
Elizabeth Scott, DNM
Mandy Coscarart, DNM
Deidre Manley, DNM
Lori Follett, DNM
Lucille Wroldsen, DNM
Patricia Beck-Weaver, DNM
Marcel Brown, DNM
Richard McFeely, DNM
Shelly Benge-Reynolds, DNM
Jessica Goicoechea-Parise, Washoe County
Joanna Mercado-Sotelo, DNM
Allison Genco Herzik, DNM
Matthew Winterhawk
Jennifer Cole, DNM
Lindsey Bondiek, DNM
Serene Pack, DNM
Sarah Dearborn, DNM
Sheri Gaunt, DNM
Patricia Schille, DNM
Blanca Iris Lanzas, DNM
Bernadette DeMars, DNM
Taylor-Rae Gonzalez, DNM
Krisann Taylor, DNM
Lea Cartwright
Donna Cabrera, DNM
Thomas Tilton, DNM
Joleen Walker, DNM
Casandra Davis, DNM
Tanya Benitez, DNM
Antonio Brown, DNM
Monica Schiffer, DNM
Melody Hall-Ramirez, DNM
Cloris Barrientos, DNM
Rachael Devine, DNM

Introduction:

Kimberly Smalley, Division Compliance, Chief, DNM, opened the Public Hearing introducing herself, Lauren M. Driscoll, Regulatory Council, and Jose I. Rivera, DAG.

Kimberly Smalley – The notice for this public hearing was published on November 26, 2025, and revised on December 8, 2025, in accordance with Nevada Revised Statute (NRS) 422.2369.

1. Public Comments: There were none.

2. Discussion and Proposed Adoption of the Creation of MSM Chapter 4500

Subject: MSM Chapter 4500 – Behavioral Health Training Clinic

Lindsey Bondiek, Program Specialist, Behavior Health Benefits Coverage Unit, DNM, advised that MSM Chapter 4500 - Behavioral Health Training Clinic (BHTC) was created as a result of Senate Bill (SB) 353 which was approved during Nevada's 83rd (2025) Legislative Session. This policy was presented to stakeholders at a Public Workshop on October 13, 2025.

Bondiek outlined the sections for MSM Chapter 4500, discussing the key points and summary for each section. Section 4501, Authorities, outlines the Authorities that govern the BHTC.

Section 4502, Policy, defines a BHTC as a service model operated by a Nevada accredited university, or pursuant to a faculty practice plan to which a university is a party, under the direction of a licensed physician. The BHTC has two functions: Providing behavioral health services to Medicaid recipients and providing supervision, training, and education to behavioral health trainees. All services must be provided pursuant to MSM Chapter 400 – Mental Health Services, and the supervision, education, and training provided to the trainees must be directly related to the requirements to obtain behavioral health licensure, certification, or registration. The BHTC and its providers must abide by the university and degree program's requirements, policies, and procedures. The university and degree program must maintain accreditation while enrolled with Medicaid.

Section 4502.1, Documentation Requirements, states that the BHTC must maintain a contract with the behavioral health trainee with the requirements for the contract being outlined in this section. The contract must be maintained in the trainee's file and produced if requested by Medicaid. Required recipient medical records are listed and must be kept in accordance with MSM Chapter 100 – Medicaid Program, and MSM Chapter 400. All documents must be signed by both the trainee and their assigned supervisor. Section 4502.2, Supervision Requirements, states that trainees must be supervised by a licensed professional. The supervisor assumes responsibility for the trainee and shall maintain documentation of supervision as required by their licensing board. The supervisor must review and sign all trainees' documentation. Section 4502.3, Eligible Providers, states that the BHTC team consists of a clinical medical director, licensed professionals, and behavioral health trainees. The clinical medical director is a licensed physician who provides behavioral health services and is practicing within their scope. Their duties are listed and can include providing medical direction, supervision, and medical orders as needed. Licensed professionals are responsible for providing supervision, education, and training for the trainees. Dependent on the BHTC's organizational structure, licensed professionals may retain operational oversight over the BHTC's written policies and procedures within their respective scopes of practice. The behavioral health trainees are seeking licensure, certification, or registration as a behavioral

health professional and are engaging in supervised practice. They must hold a bachelor's degree and are either a student enrolled in an accredited behavioral health program working to obtain a graduate degree and are participating in a supervised practicum or internship; or a person who has completed the academic requirements and is obtaining hours of supervised practice required by law or regulation.

Section 4502.4, Eligible Members, mentions that eligible members are diagnosed with a behavioral health disorder and have been identified by the BHTC as having a documented need for behavioral health services. Section 4502.5, Covered Services, states that there are two bundled rates for the BHTCs. The first is a non-medical services bundle, which includes behavioral health assessments, individual, group, and family therapy. The second bundle is for medical services, which includes all non-medical services in addition to evaluation and management services. The medical services can be provided by a trainee seeking a license to practice medicine as a psychiatrist or an APRN who provides psychiatric services. Section 4502.6, Non-Covered Services, lists non-covered services including, but not limited to, non-evidence-based practices, documentation, and transportation. Under Section 4502.7, Authorization Requirements, non-medical services can be used for up to 18 units for adults and 26 units for children annually before a prior authorization is required. The medical services do not require prior authorization. Section 4502.8, Billing, the two per diem codes for this service are H0037 for the medical services and H2020 for the non-medical services. Section 4502.9, Managed Care Members, includes information for managed care members.

This chapter affects all Medicaid-enrolled providers delivering outpatient behavioral health treatment services under this model. Those provider types (PT) include but are not limited to: Behavioral Health Outpatient Treatment (PT 14), Physician, MD, Osteopath, DO (PT 20), Advanced Practice Registered Nurse (APRN) (PT 24), Psychologist (PT 26), and Behavioral Health Rehabilitative Treatment (PT 82).

The estimated increase in annual aggregate expenditures for state fiscal year (SFY) 2026 is $756,916 and SFY 2027 is $2,377,660.

The effective date for this proposed chapter is December 31, 2025.

Public Comments: There were none.

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

Kimberly Smalley – Closed the Public Hearing for proposed adoption and changes to Chapter 4500 – Behavioral Health Training Clinic.

3. Discussion and Proposed Adoption and Changes to MSM Chapter 3600

Subject: MSM Chapter 3600 – Managed Care

Jennifer Cole, Contract Monitor, Managed Care and Quality Assurance Unit, DNM, presented that revisions are being proposed to align with the Statewide Managed Care implementation, the new Managed Care Contract, and the State Plan Amendment (SPA) that is effective January 1, 2026. All references to the Division of Health Care Financing and Policy (DHCFP) have been updated to reflect NVHA or DNM.

Cole outlined the proposed chapter changes. Section 3603.1, Eligibility Groups, this section has been updated to reflect who qualify for the statewide managed care, who are mandatory, excluded, and who are voluntary populations. Section 3603.2, Geographic Area, has been removed due to statewide implementation. Under Section 3603.3, Care Management and Care Coordination, requirements have been removed from individual sections throughout the chapter to create its own all-exclusive section.

Section 3603.4, Excluded Services and/or Coverage Limitations, has been updated to reflect the changes to Non-Emergency Medical Transportation (NEMT) based on service locations, and the addition of Non-Emergency Secure Behavioral Health Transport. The word 'calendar' was added to Nursing Facilities (NF), and Swing Bed stays, to clarify the number of days. School Health Services (SHS) Coordination Information has been updated. The Targeted Case Management (TCM), section was moved from Section 3603.4. Inpatient Hospital Services was removed from this section and placed in different parts of the chapter. Abortions section was added and the Severe Emotional Disturbance (SED) or Serious Mental Illness (SMI) section was moved to Section 3603.5(E). Throughout Section 3603.5, Special Requirements for Selected Covered Services, updates have been made to clarify existing language. Out-of-Network Providers was updated to add the radius and validation. Definitions for emergency services and urgent care services have been added. Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), and Certified Community Behavioral Health Center (CCBHC) have been combined to create one section that covers all entities. Seriously Emotionally Disturbed (SED)/Severely Mentally Ill (SMI) Members section has been moved from Section 3603.4. Obstetrical/Gynecological (OBGYN) services have been updated to include High-Risk Maternal Case Management and new enrollees within the last trimester of pregnancy. Throughout the chapter, prior authorization requirements were removed from their subsections and placed into Section 3603.5(I), Prior Authorization.

Section 3603.9, Pharmacy Services, has been expanded to include information regarding Pharmacy Ownership or Affiliation/Preferred Specialty Pharmacy, Prescriber Brand Certification Policies, Prescription and Pharmacy Transition Pharmacy Encounter Data for Rebates, Preventing 340B Duplication, Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act Compliance, Drug Utilization Review (DUR) Program, and Pharmacy Benefit Manager Agreements. Section 3603.15, In Lieu of Services or Settings (ILOS), was added. Section 3603.19, Member Information Requirements, has been updated to reflect a sixth grade reading level, and additional clarity on the member's handbook and newsletters. The Identification Cards and Information for Potential Enrollees sections have been removed as they are addressed in other areas throughout the chapter. Advance Directives section was added. and Additional Requirements for the Provider Directory section was added. Section 3603.22, Network Maintenance and Availability of Services, was updated to include additional details on Managed Care Organization (MCO) requirements, suspension, termination and other actions related to network providers, and provider termination. Section 3603.25, Retro Capitation and Capitation Reconciliation, was removed from the chapter and will be updated at a later date. Section 3603.25, Management Information System (MIS), was updated to include additional information on Health Insurance Portability and Accountability Act (HIPAA) requirements, eligibility data, encounter and claims records, and the Electronic Visit Verification (EVV).

Section 3603.26, Reporting Requirements, has been updated to notate the addition of the Reporting Requirements Exhibit from the managed care contract and unnecessary language was removed. Section Encounter Data Report Files have been updated to reflect the accuracy threshold and submission. The section for Dispute Resolution has been incorporated into Section 3604. Sales and Transaction Reporting has been added. Section 3603.26(E) has been renamed Member Experience Reporting and includes more information related to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

Section 3603.26(G) was renamed Program Integrity Unit (PIU) to incorporate the compliance program, verification of services, embezzlement and theft, fraud, waste, and abuse identification and referrals. Section 3603.26(H-I) are newly added reports for Autism Spectrum Disorder (ASD) and Applied Behavioral Analysis (ABA). Section 3603.27, Sanctions, Monetary Penalties, and Other Remedies, was added to specify corrections to the MCOs as a result of noncompliance. Part of the Sanctions section was previously located in Section 3603.31. The section for Information Systems (IS) and Technical Requirements was removed and is now included in Section 3603.25. Section 3604 Grievances, Appeals, and Hearings, was updated to expand on the requirements for the MCOs to assist both members and providers when they disagree with a decision or want to file a grievance. Section 3604(D), State Fair Hearings Process, was updated and expanded to include Section 36014(E), Expedited State Fair Hearing. Subsections for timelines, handling, and notices were also added.

The proposed changes affect all Medicaid enrolled providers and members. Medicaid Services will now offer two health plans in the rural areas throughout the State. The fiscal impact on local government is unknown at this time.

Public Comments: There were none.

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

Kimberly Smalley – Closed the Public Hearing for proposed adoption and changes to MSM Chapter 3600 – Managed Care.

4. Discussion and Proposed Adoption and Changes to MSM Chapter 1900

Subject: MSM Chapter 1900 – Transportation Services

Tonya Wolf, Policy Supervisor, Transportation Unit, Long Term Services and Supports (LTSS) Unit, DNM, stated that revisions to MSM Chapter 1900 are being proposed in preparation for the upcoming Statewide Managed Care implementation. Non-emergency medical transportation (NEMT) services for rural managed care members will transition from the Nevada Medicaid NEMT broker to the rural MCO's NEMT broker. Wolf advised that the planned updates to the Nevada Check Up (NCU) Manual 1000 have been postponed; however, the Division anticipates submitting for federal approval in the next few weeks. A public workshop was held on November 24, 2025.

Wolf presented the proposed chapter changes. Under Section 1900, Introduction, Non-Emergency Secure Behavioral Health Transportation (NESBHT) was added to the list of transportation services, as it was not previously included and is a covered service. Within Section 1903.3, NEMT Services, language was added specifying NEMT services are intended to remove transportation barriers for Nevada Medicaid recipients. Service areas include urban areas (Clark County and Washoe County) and rural areas (the remaining 15 Nevada counties). NEMT service delivery is authorized depending on where the recipient resides. Fee-for Service (FFS) Recipients: NEMT services will continue to be provided statewide by the statewide NEMT broker, regardless of residence in an urban or rural region. Urban areas: NEMT services for MCO enrolled recipients will be provided by the statewide NEMT broker. Rural areas: NEMT services for MCO enrolled recipients will be the responsibility of the awarded rural MCO and provided by the MCO NEMT broker. "Ground Ambulance" was removed from the NEMT service examples to avoid confusion as ambulance transportation is outside the scope of the NEMT broker. Special Populations section added that the NEMT broker may override the public transportation mode for high-risk pregnant recipients, including those

beyond eight months of pregnancy and up to six months post-partum. Out-of-Area Travel section replaced the previous General Services Administration (GSA) Meal reimbursement rate with a per diem structure. This new structure is based on the length of travel within a 24-hour period and includes both half-day and full-day per diem rates. Rural Areas section clarified that a distance verification form is not required for long-distance travel to the nearest urban provider within Nevada or the surrounding catchment areas. Attendants to Recipients section removed the phrase "regardless of the parent's age" to avoid confusion. An exception allowing minors age 15 and older to travel without an adult when a signed parental consent form authorizes the unaccompanied travel was added.

There is no known financial impact on local government.

The effective date for proposed changes is January 1, 2026.

Public Comments: There were none.

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

Kimberly Smalley – Closed the Public Hearing for proposed adoption and changes to MSM Chapter 1900 – Transportation Services.

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

Subject: MSM Chapter 400 – Mental Health Services

Serene Pack, Health Care Coordinator and Policy Specialist, Behavioral Health Benefits and Coverage Unit, DNM, presented proposed revisions to MSM Chapter 400 regarding Rehabilitative Residential Mental Health Care (RRMHC) to align with the legislative requirements for Assembly Bill (AB) 514, passed in the 83rd Legislative Session. Legislation requires NVHA, DNM to ensure RRMHC services are covered and reimbursable services under Medicaid for providers with proper licensure and accreditation. The goal is to add a place to go as a critical element of the mental health continuum of care for people with complex behavioral health needs before they can return to their community. To ensure state compliance, Nevada Medicaid is proposing revisions to MSM Chapter 400 to create policy for RRMHC services. Changes were made throughout the PRTF section to align language for consistency with the RRMHC language and adjust references of DHCFP to Nevada Medicaid to align policy with SB 494, which was passed during the 83rd Legislative Session. The Division is proposing to have the new CRMHS policy to be within Section 403.7 - RRMHC. As a result, the PRTF policy and subsequent sections have been renumbered.

Pack presented the proposed language for this new PT, Community Residential Mental Health Services (CRMHS): They must be community-based, in a group home setting with no more than 16 beds, serving as a short-term rehabilitative step down from the more structured Psychiatric Residential Treatment Facility (PRTF). They can also be used as a step up from community rather than being placed within a PRTF initially. Unlike PRTFs, CRMHS facilities can also provide services for the adult population.

Pack outlined the proposed changes to the chapter. The Authority section is being updated to add state regulation citations pertaining to the addition of RRMHC from the 83rd Legislative Session. Chapter 449 of NRS was also amended in several areas. Section 403.7 –RRMHC, provides the general overview of CRMHS and covers what the definition of RRMHC is per AB 514 and what the objectives are for this level of care

(LOC), such as helping the recipients gain the necessary skills to return to the community and working with family and other support persons throughout the placement to improve their ability to care for the recipient in the home. The goal of CRMHS is to maintain the recipient's connections to their community yet receive and participate in a more intensive level of treatment in which the recipient lives safely in a 24-hour setting.

Section 403.7A, Coverage and Limitations, states that services must be medically necessary, clinically appropriate, and recommended by a physician or other licensed practitioner. Language was added to explain what is covered under the CRMHS all-inclusive rate, such as psychiatric and psychological services, crisis assistance services, medication management and education, psychoeducation services, and family and natural support services. Additionally, language was added to explain what is considered non-covered, which includes room and board. These non-covered services that are Medicaid benefits must be billed separately by that particular service provider and may require prior authorization. There is also language regarding the requirement for MCO recipients to obtain prior authorization and reimbursement directly from the MCO, as well as provisions related to non-discrimination. Therapeutic Leave Days (TLD) are encouraged to be used as part of discharge planning to support a more successful outcome at discharge. The language used for this policy is the same as for the PRTF TLDs, which includes information on when to submit pass requests, length and guidelines to adhere to for reimbursement, and information regarding documentation to be kept in the recipient's medical record for both when the recipient is leaving and when returning. This section covers Individualized Treatment Plan (ITP), when it must be developed and updated, what its intention is, the need to include the recipient and support persons in its development, components that must be present within the treatment plan, things that must be documented, and documentation must indicate that a copy was provided to the recipient and/or guardian. Within Section 403.7B, Eligible Provider Requirements, requirements for providers to become eligible to enroll, or remain enrolled as a CRMHS provider are listed, including the need for a separate National Provider Identification (NPI) for each facility if there are multiple locations. This section establishes the bed limit of no more than 16 beds in order to not be considered an institution for mental disease (IMD), as this service will be reimbursable for adults. This section explains the appropriate licensure issued by Health Care Quality and Compliance (HCQC) and the need for accreditation. Providers need to be in compliance with MSM Chapter 100 – Medicaid Program, Conditions of Participation, along with language regarding criteria for exclusion from becoming an eligible provider. Section 403.7C, Eligible Recipients, establishes criteria to be met for an eligible recipient to receive services in a CRMHS LOC, such as meeting the criteria for SED or SMI determination, having a Child and Adolescent Screening Intensity Instrument/Level of Care Utilization System (CASII/LOCUS) Level V, which is a non-secure, 24-hour service with psychiatric monitoring, unlike the PRTF requirement of a Level VI for a secure 24-hour service setting. Recipients do not require acute level or emergency care or cannot effectively receive services in an outpatient community LOC.

Section 403.7D, Admission, Continued Stay and Discharge, states that prior authorization is required before admission, including when Third Party Liability (TPL) exists, with certain exceptions, and it is in these cases, only, where authorization must be submitted within 10 business days of the re-admission. These are elopements from the facility that last longer than 24 hours, observation/emergency room (ER) stays lasting longer than 24 hours, and a re-admission of a recipient back to the CRMHS facility of record following an inpatient hospital stay. Prior authorizations can be submitted up to 30-day increments. The Quality Improvement Organization (QIO) vendor reviews for medical necessity, verifying CASII/LOCUS level, the ability for the recipient to rehabilitatively benefit from services, and that a treatment and discharge plan are in place. The CRMHS provider will develop its admission criteria and ensure that it has

the staff and resources available to meet the needs of referred recipients. Similar language was proposed for Continued Services, for the Residential Substance Use Disorder (SUD) services, which discusses criteria for ongoing services at the CRMHS LOC, as well as criteria for a transition of care to either a higher or lower LOC. Lack of post-discharge plans alone will not be considered a valid basis for a continued stay. The discharge section covers discharge planning beginning at admission with permanency and stability within the community as a priority for discharge planning. The CRMHS provider will assist in the transition to a less restrictive home and community setting, including the arrangement of follow-up care in the community. This section clarifies when the QIO vendor may issue a full or partial denial such as not meeting medical necessity, not meeting a CASII/LOCUS Level V, the recipient or family/guardian are non-participatory in treatment, and/or are not making progress despite persistent efforts to achieve this, etc. Added language for what must be provided to the recipient and/or guardian at discharge, along with discharge summary requirements, including the need to submit to the QIO-like vendor within 30 days of discharge. This section outlines requirements for when recipients are transferring to another program and for elopements, which includes the need for a safety plan for repeat elopements, along with consideration into whether a more secure placement is needed.

Section 403.7E, Provider Responsibilities, states that CRMHS providers will comply with other requirements within MSM Chapter 400 that pertain to all providers, along with other applicable MSM chapters. They will also follow any federal and state regulations and protect and promote patient rights. Section 403.7E(2), General CRMHS Provisions, discusses the general CRMHS provisions, such as the treatment and services to promote necessary skills to assist in the reintegration back into the community, active family involvement services to help families/guardians maintain and enhance functioning care and relationships with the recipient, and the need to ensure other aspects of care, such as dental and medical treatment are provided. Section 403.7E(3), Critical Events/Serious Occurrence Reporting Requirements, includes information to include within incident report submissions and what information will be needed to document in the recipient's medical record. This has the same language as the PRTF policy regarding imposing a ban on admissions and removing recipients currently at the facility if they are reasonably believed to be in danger and that the facility must provide needed documentation upon request. Language was added outlining requirements for emergency preparedness, Quality Assurance/Quality Improvement (QA/QI), fingerprint-based criminal background checks, and Tuberculosis (TB) testing. Medical record requirements have been added which includes ensuring documentation supports psychiatric services that were provided along with any medical, nursing, social, and other related treatment and care. These records include items such as evaluations/assessments, treatment plans, doctor's orders, progress notes, critical events/serious occurrence reports (SOR), the discharge summary, etc., along with language to refer to MSM Chapter 100 for more information on the medical record documentation requirements that pertain to all providers. Staff Qualifications were added indicating that the treatment is delivered by a multidisciplinary team under the oversight of a licensed clinical mental health professional. The facility must have sufficient staff to provide clinical assessments, therapeutic interventions, ongoing program evaluations, and adequate residential supervision 24 hours a day, seven days a week, and be appropriately licensed, trained, and experienced in providing mental health and residential treatment. A section was added on staff training to ensure that the CRMHS provider has qualified personnel that meet or exceed the requirements for pre-service and in-service trainings with respect to facility objectives, policies, services, community resources, state and federal policies, and best practice standards.

The PRTF policy has been moved to Section 403.8 due to CRMHS policy now being in Section 403.7; citations were adjusted throughout the section to match the new section number. The section header name has been revised and NPI language added for consistency with the language used in CRMHS policy.

Section 403.8B(1)(f) has been added to reference MSM Chapter 100, ensuring consistency with the CRMHS policy. Section 403.8E(5) was revised to reflect Nevada Medicaid to align the policy with SB 494. Language referencing the state licensing agency has been incorporated. Reference to MSM Chapter 100 was added for consistency.

The proposed changes affect all Medicaid-enrolled providers delivering psychiatric services. Those PTs include but are not limited to: Hospital, Inpatient (PT 11), Psychiatric Hospital, Inpatient (PT 13), PRTF (PT 63), Crisis Services (PT 87), Behavioral Health Outpatient Treatment (PT 14), Specialty Clinics (PT 17), and Psychologists (PT 26).

There is a financial impact for SFY 2026 of $302,726 and for SFY 2027 of $817,732.

The effective date of these proposed changes is January 1, 2026.

Public Comments:

Jessica Goicoechea-Parise asked if there is anything that indicates if the RRMHC must be locked or unlocked.

Pack replied that there are no specific requirements for that.

Lea Carwright mentioned the 16-bed limit for the IMD exclusion. Cartwright advised that there was a waiver for the IMD exclusion for SUD as well as an amendment to expand that to SMI. Cartwright then asked if this applies to this specific chapter.

Pack responded stating that as far as her understanding for the waiver that was put in for the SUD, it is more applicable to the PT 13, and it is very specific based on the revenue codes that get submitted with the prior authorization submissions. Providers specifically providing substance use, may be more interested in looking into Substance Use Treatment (PT 93).

Matthew Winterhawk, self-identified as a resident of Clark County, expressed concern over different positions opening up. Winterhawk explained that the concern is with different positions opening up, recent fraud and situations that are happening and being opened up in Minnesota such as being grifted. Winterhawk then asked where is the oversight and places that citizens can look into the spending to make sure that the dollars are being sequestered and used for the fundings, the facilities being opened are actually being in use, and make sure that millions of dollars are not grifted from Nevadan taxpayers.

Lauren M. Driscoll replied that a record has been created of his comment. Kimberly Smalley advised comments can be submitted to the Document Control email address located on the agenda so the Division can review and respond.

Winterhawk mentioned following-up with that then explained the concerns further as a Nevadan and a taxpayer. Winterhawk stated that with the recent hundreds of billions of dollars nationwide that are going into mental health services, treatment of addicts, child protective services (CPS), Division of Child and Family Services (DCFS), $253,000,000 last year alone for CPS and DCFS, it is important to know where the dollars are going and make sure that they are taking care of the people who need the services.

Smalley replied that if those comments are submitted, the Division will respond.

Jose Rivera, DAG, advised that comments are being placed in the chat and that if there is something that should be on record, the chat is not public record. He advised public record comments should be addressed in the designated public comment section.

Driscoll clarified for Winterhawk's comment that there is a record of his comments. They are submitted by virtue of his verbal comments provided at the hearing, but if he would like to provide contact information via the Document Control email address available on the agenda, the Division will contact him through that forum. Driscoll wanted to be clear that his comments have been received since they were provided verbally at the public hearing. The Division will provide a channel of communication if contact information is provided to the email address listed on the agenda.

Winterhawk advised he understood.

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

Kimberly Smalley – Closed the Public Hearing for proposed adoption and changes to MSM Chapter 400 – Mental Health Services.

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

Subject: MSM Chapter 1200 – Prescribed Drugs

Bonnie Palomino, Manager, Pharmacy Services, DNM, presented updates which include changes to Section 1203, Appendix A, and Appendix B, and will impact medication coverage, clinical criteria, and prior authorization guidelines.

Proposed updates to Section 1203 include: Coverage and Limitations, added language clarifying that preferred products may require verification of a Food and Drug Administration (FDA)-approved indication; Standard Preferred Drug List (PDL) Exception Criteria, updated language; maintenance medications, and added long-acting inhalers.

Proposed updates to Appendix A include: Section 1.(F.), was renamed to Narcotic Analgesic and Combinations, added clinical criteria previously located in Section 1.(G.) related to Immediate-Release Fentanyl Products, added clinical criteria for Prolate®; Section 1.(G.) was renamed to Metabolic Dysfunction-Associated Steatohepatitis (MASH), removed clinical criteria for Immediate-Release Fentanyl Products, added clinical criteria for Wegovy® and Rezdiffra™ for the indication of MASH; Section 1.(H.) updated clinical criteria for Hematopoietic/Hematinic Agents, added clinical criteria for Vafseo®; Section 1.(I.) removed topical agents Jublia® and Kerydin®; Section 1.(M.) added clinical criteria for Anzupgo®, updated Opzelura® clinical criteria to approve use for recipients aged two years and older; Section 1.(P.) updated clinical criteria for Dupixent®, added clinical criteria for Nemluvio® and Ebglyss™, added clinical criteria for Nucala® for the indication of COPD; Section 1.(S.) updated clinical criteria for serotonin 5-HT1 receptor agonists, added clinical criteria for Zavzpret®, updated age indication for Ajovy®, removed duplicate criteria; Section 1.(X.) updated clinical criteria for serotonin receptor antagonists; Section 1.(FF.) was renamed to Phosphodiesterase 5 (PDE-5) Inhibitors, updated clinical criteria; Section 1.(JJ.) added clinical criteria for Sajazir®; Section 1.(KK.) updated clinical criteria for Wegovy® and Zepbound®, added cross-reference to Section 1.(G.); Section 1. (UU.) added clinical criteria for Kisunla®; Section 1.(YY.) updated clinical criteria for GnRH Analogs; Section 1.(CCC) was renamed to Corticosteroids, added clinical criteria for Eohilia®; Section 1. (EEE) added clinical criteria based on FDA-approved age requirements to

Repatha®, updated clinical criteria for Praluent®; Section 1.(IIIII.) updated clinical criteria for Yorvipath®; Section 1.(JJJJJ.) updated section title; Section 1.(KKKKK.) added new section with clinical criteria for Bile Acid Agents; Section 1.(LLLLL.) added Niemann-Pick Disease Type C Agents; Section 1.(MMMMM) added new section with clinical criteria for Osteoporosis Agents; Section 1.(NNNNN.) added new section with clinical criteria for Reblozyl®.

Proposed updates to Appendix B include: Section 5.(A) updated clinical criteria for Abraxane®; Section 5.(B.) updated clinical criteria for Bavencio, Imfinzi®, Libtayo®, Opdivo®, and Tecentriq®; Section 5.(C.) updated clinical criteria for Beovu®; Section 5.(D.) updated section title and clinical criteria for Bevacizumab Products; Section 5.(E.) updated clinical criteria for Darzalex®; Section 5.(H.) updated clinical criteria for Eylea®, Byooviz™, Cimerli™, Lucentis®, and Susvimo®; Section 5.(I.) updated clinical criteria for Immune Globulins; Section 5.(J) updated clinical criteria for Jemperli® and Keytruda®; Section 5.(L.) updated clinical criteria for Aranesp®; Section 5.(N.) updated clinical criteria for Pemetrexed; Section 5.(O.) updated clinical criteria for Perjeta® and trastuzumab products; Section 5.(P.) updated clinical criteria for rituximab products; Section 5.(R.) updated clinical criteria for Yervoy®; Section 5.(T.) added clinical criteria for Bonsity® reworded, and relocated the section to Appendix A.

These proposed changes are intended to align with current clinical practice, reflect FDA-approved labeling, and promote appropriate utilization of therapies within the Nevada Medicaid population.

There is no known financial impact to the local government.

The effective date is January 5, 2026.

Public Comments:

Winterhawk raised a concern about the chapter, stating that the document deserves clarity, not just assurances. Winterhawk explained that there are 346 pages of restructuring Nevada Medicaid drug policy effective January 5th, 2026, and that these pages are not just edits or cleanup; the changes are reorganizing drug classes, expanding prior authorizations, introducing new verification requirements, and changing how medications move between preferred and non-preferred, maintenance, and specialty status. Winterhawk explained that these real-world impacts are more prior authorizations, more documentation demands on doctors, more pharmacy delays, more forced substitutions, and a higher-risk of interrupted care for people who are currently stable with their medications. This matters most for chronic conditions like diabetes, respiratory diseases, neurological conditions, autoimmune disorders, migraines, mental health, and special therapies where stability is not option, it is lifesaving. Winterhawk explained that a key example of this was new language allowing verification of FDA-approved indication even for the drugs; it sounds minor but in practice it means new gates between a patient and their medication where they are normally being served. There were three things that Winterhawk requested to hear stated on the record, if possible: No Nevadan will lose access to a medication that they are currently stable on solely due to reclassification renaming or administrative restructuring; these changes will not delay access in a way that forces emergency care, hospitalization or clinical regression; and that the patients and providers will have clear, fast, and humane pathways when the system, not the patient is creating the barrier. Winterhawk stated that the fact remains that cost management is legitimate, administrative clarity is legitimate, but stability of care must be protected explicitly rather than implied. Winterhawk wanted to make sure Nevadans understand the consequences of policy decisions before they feel them at the pharmacy counters; self-identifying as someone to ask questions and represent Nevadans.

Antonio Brown, Chief, Pharmacy Services, DNM, took the comment, stating there would be a response provided through email. Brown clarified that the Division does have two advisory boards which help make decisions on prior authorization requirements and preferred and non-preferred status. Brown invited Winterhawk to attend the next Drug Utilization Review (DUR) Board meeting in January, stating that there is a group of physicians and pharmacists who make decisions regarding the prior authorization process, and at this point these are decisions the public has taken into consideration through the advisory boards. The information provided at public hearing is for cleanup.

Winterhawk replied that had been established and thanked Brown for the response. Winterhawk brought up the initial concern of 346 pages being re-established, stating that January 5 is just around the corner and that is scary. Winterhawk continued, stating that if there were just the slightest chance, not that anybody would intend for someone to lose coverage, but as a Nevadan, even one that does not rely on it, millions of fellow Nevadans do, and Nevada has an aging population. This is why clarification is being sought. Winterhawk thanked Brown for the invitation, stating the intent to attend future meetings.

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

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

7. Adjournment

There were no further comments, and Kimberly Smalley closed the Public Hearing at 11:07 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.