Summary of Health Care Provider Recommendations Relating to Nevada Medicaid (Updated 8/9/2024)

- **18 submissions** received with recommendations
- 12 related to reimbursement and billing
- 6 related to credentialing
- 4 related to prior authorizations
- 2 related to limitations on sessions

Provider Recommendations		
ONGOING DISCUSSION (UPDATED 8/9/24)		
Submitter Name	**Subject Number**	**Policy Concept Description**
Credentialing		
Diana Saunders, Elements of Motivation July 1, 2024	1	Challenging Credentialing Process: Credentialing with Medicaid Fee-For-Service (FFS) and MCOs is often difficult and lengthy. Providers willing and able to work in Nevada can face delays of 6-9 months before being able to see patients due to the protracted credentialing process.
Jamie Kordich, Mindwell Counseling and Crisis Services July 1, 2024	2	You need to fix the process for mental health therapists to be credentialed with Medicaid. My agency submitted an application for Provider Type 14- Group. All parties in the group are individually credentialed already. We are waiting on the group credentialing in order to accept patients so that billing is accurately reflected. That application was submitted 2/27/24. It is 7/1/2024 and we are still in the process. When we called to inquire about status, they kept telling us that they cannot look into it. For 4 months the state sat on this application. We have turned away multiple patients a week due to not having this group approval. We finally got someone to help us and escalate the situation to a supervisor after it was stalled for 3 months at the same level. This is not the only instance I have seen with problems with provider type 14 approval. I have submitted multiple applications for coworkers and on average we would get 3-5 rejections before we get an approval. The rejections sometimes make zero sense and require no change in paperwork or submission data. To give an example: one rejection was because the provider initialed using first and last initial, but on their license, their middle name was listed, so the request was that all initials be used. This was fine for the other applicants. Medicaid is aware of the issue as they hosted a meeting about the problems with this provider type. Providers will not continue submitting applications over and over. I can see where they would give up before getting approval.
Sandy Friday, MSE Billing LLC	3	Stop returning documents requiring original signatures; accept the fill and sign feature in adobe or accept all signed and executed documents as original signatures. by law the signer is stating they have the authority to sign

July 3, 2024		are attesting that their signature holds them liable for any and all requirements. Therefore, requesting original signatures on documents that are being submitted and you CANNOT verify a wet signature makes no sense. Again, because you have to upload the document so you are never getting a wet signature AND the document states that whomever is signing is attesting to their signature.
Nancy S. Lindler, Ridge House Inc. July 9, 2024	4	It is a daunting task as a provider to be able to complete the credentialing and contracting process for any type of Medicaid. It should be revised that a provider should only have to complete this process ONE time, not 5 or 6 (depending on the current number of Managed Care organizations). A central credentialing for all avenues of NV Medicaid would be more efficient and less costly and cumbersome for providers. The MCO should not operate as independent organizations for credentialing and contracting purposes. At this time the provider type changes proposed for type 93 are requiring my organization to recredential/contract as an organization and by provider. This process is a significant administrative task that will take 3 to 6 months to complete. There are credentialing entities already in existent that private insurance uses to expedite the credentialing process because the data base is current and reliable- CAQH should be utilized to vet providers seeking to contract with Medicaid. Because clients who are covered by any form of Medicaid have the option to change their MCO plan and there is no retro-active coverage, this requires that a provider must be contracted with all in order to avoid losing revenue from denied claims. This process also requires constant verification and this takes a large administrative staff and constant training due to changes in processes by organization. None of these tasks support quality health care that reaches a single client.
Jennifer Campbell, Becoming Parents, LLC DBA Doula In Reno July 9, 2024	5	Provider Type 90 - Doula. First, making it easier and more streamlined to become a provider. We've made great strides, however, it could be further streamlined. Becoming a provider - creating one application that the state and all MCOs use, recognizing us as non-medical providers to streamline the application and utilizing an online application We use CAQH for some MCOs, and having a "one stop shop" to enter information for FFS and MCOs to "grab" the information they need would be helpful
Sarah Sentz, The LGBTQ Center of Southern Nevada July 23, 2024	6	Administrative hurdles that create barriers to recruiting health care providers to Nevada are numerous. Fortunately, NPs in the state of Nevada have had full practice authority since 2013 (VanBeurge & Walker, 2014), however, attempts at passing bills for Nevada to become part of the Nurse Compact failed in 2023. This creates a burdensome process for both registered nurses (RNs) and NPs to apply for and obtain Nevada licensure. Although there is no compact for NPs, every NP must obtain individual RN state licensure. The Nurse Compact decreases the barriers for this process. There is an ongoing need and desire for flexibility for nurses (which then extends to NPs) to practice across state borders (Zhong, et al. 2024). PAs in the state of Nevada have more restrictive practice requirements than NPs which creates barriers for PAs to be able to practice independently (State law chart, 2018). Ongoing work must be done to decrease barriers to PA care as has been done for many years to

		decrease NP barriers. Again, NP and PA care has been shown to be similar in quality and outcomes to physician care.
Limitations on Sessions		
Diana Saunders, Elements of Motivation July 1, 2024	1	Limitations on Sessions: Medicaid often imposes limits on the number of sessions allowed per client, which can restrict the ability to provide long-term care for chronic or severe mental health conditions. Commercial insurance does not require this.
Jennifer Campbell, Becoming Parents, LLC DBA Doula In Reno July 9, 2024	2	As far as changes to the current legislation, for visits, we're not allowed to have more than one visit in a day - which can be challenging. We also are not allowed to work with more than one person at a time. For example, it would be amazing to be able to see several women in a group and have 3 prenatal appointments one after the other, and to bill individually. This is more necessary in rural areas where travel is required, in substance disorder facilities, when a woman's due date is sooner, etc... To bill all 5 women individually for 3 prenatal appointments for example - in one day and to have the appointments in a group setting. It would save on time when necessary, and even fosters relationships between other pregnant women.
Prior Authorizations		
Diana Saunders, Elements of Motivation July 1, 2024	1	Complicated PARs: Prior Authorization Requests (PARs) are required for many services and vary by Managed Care Organization (MCO). Learning to complete each correctly can be time-consuming, and often requires multiple revisions or peer-to-peer reviews, which takes clinicians away from client care.
Michael Connolly, Connolly Care Home Health, Connolly Care for Children, & Connolly Care Hospice July 1, 2024	2	We believe removing prior authorization from NV Medicaid would increase provider engagement drastically. Or increasing the initial window to submit prior authorization for care. The current window is 5 days from Start of Care to a signed order submission. An increase to 10 or 14 days would greatly help as well. If you are unable to eliminate. Medicare and Aetna are both large payors without prior authorization.
Nancy S. Lindler, Ridge House Inc. July 9, 2024	3	The prior authorization needs to be streamlined for a universal process. Consistent guidelines, a universal form, and time frames will remove many of the current barriers to obtain prior authorization for higher levels of care. Just like contracting, 5 to 6 different processes require an administrative army to accomplish all the tasks to submit a successful claim through to the payment process.
Sarah Sentz, The LGBTQ Center of Southern Nevada July 23, 2024	4	Additional administrative hurdles that create unnecessary burdens for all types of healthcare professionals include prior authorizations for medically necessary medications and specialty referrals. Bills have passed from the last legislative session including SB 439 and SB 163 to help ensure we, as healthcare providers, can properly provide medically necessary care to our patients. a. For example, per SB 439 Nevada's statute for Medicaid NRS 422.4025 lists drugs excluded from restrictions from prior authorizations (NRS: Chapter 422, n.d.). HIV prevention medications are on this list. Therefore, it seems that requiring prior authorizations (restrictions) for Descovy or Apretude is in violation of the Medicaid NRS 422.4025. This medication and care are documented in the patient chart as necessary for the prevention of HIV, otherwise known as pre-exposure prophylaxis or PrEP. Despite

		this statute, we continue to run into the burdensome process of prior authorizations especially with Medicaid plans. Due to lack of reimbursement and lengthy prior auth processes, some patients are not able to access crucial HIV prevention care in the state of Nevada. As healthcare providers who work in HIV prevention and HIV care, these barriers are real and ongoing for quality patient care and disproportionately impact people of color (Sullivan, 2024). The uptake of PrEP is also inequitable in Nevada and the United States (Sullivan, 2024) and therefore we need to decrease these insurance denials so we can better prevent new cases of HIV. Additionally, medications that are lifesaving for people living with HIV oftentimes require prior authorization and are challenging to access for patients. Healthcare providers spend a great deal of time and energy trying to work around these barriers to provide quality care. b. Certain Medicaid plans are not reimbursing visits for medically necessary gender affirming care. SB 163 was passed during the last legislative session and outlines that gender affirming care (GAC) must be covered by health insurance policies including Medicaid policies for "the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence" (Sheible, Harris, & Spearman, 2023) However, some Medicaid plans report that they will not cover visits for gender affirming care and they are declining claims. This is discriminatory as well as against the SB 163 law. Additionally, some insurances require that only certain prescribers (i.e. endocrinologists or WPATH certified providers) are able to get coverage for hormone therapy. The SB 163 bill outlines all the providers who can provide & prescribe which is more inclusive than what insurance is requiring. Medicaid companies should be held accountable for these discrepancies.
Reimbursement/Billing		
Holly Armstrong, In-House Home Health, Inc July 1, 2024	1	I owned another home health agency and provided services to Medicaid patients (skilled not pca) and we were never paid for any of the services we provided. We stopped taking Medicaid patients because we were owed over 20k (never received a penny). In addition, the billing for home health services is unnecessarily complex. Your rates are also less than what we pay our staff, so we lose money either way. We would love to be able to take these patients if we could get paid a reasonable rate, and actually got paid.
Benjamin Gallegos, Home Health care/Personal care services/Pulmonary rehab July 1, 2024	2	Increase out pay to agency to give higher rate to applicants, with gas prices high and inflation they refuse to go to father patient to give services.
Diana Saunders, Elements of Motivation July 1, 2024	3	Low Reimbursement Rates: Medicaid reimbursement rates are significantly lower than the cash rates that providers charge in private practice. Many fully licensed providers feel that their training, experience, and expertise warrant higher rates than what Medicaid offers, which does not account for these differences.

		Comparatively Lower Rates: Reimbursement rates in Nevada are lower than in other states for the same services. This discrepancy has led some providers to reside in Nevada but seek licensure in other states with higher reimbursement rates, such as Utah.
Michael Connolly, Connolly Care Home Health, Connolly Care for Children, & Connolly Care Hospice July 1, 2024	4	Also increasing reimbursement always helps to increase provider utilization.
Julie Peterson, Accessible Space, Inc. July 1, 2024	5	For Provider Type 55, Nevada Medicaid requires the provider to pay $125.00 for every Direct Care Professional we hire due to new training requirements which must be via the BIAA (Required BIAA Brain Injury Fundamentals Certification for every DSP). For Provider Type 34, Nevada Medicaid doesn't pay half of what it costs us to pay our skilled therapists per hour. The rates are so low for therapy codes that we can't recruit PTs, OTs, or Speech Pathologists.
Ted Cohen, Ted Cohen, DPM July 3, 2024	6	You need to increase reimbursement for services
Nancy S. Lindler, Ridge House Inc. July 9, 2024	7	I am not a policy writer. I am a health care professional, native to NV with 25 years of experience. I have worked in the south and the north. I have had my own private practice as a mental health professional and struggled to receive any successful payments from Medicaid in the past and in the present. Now as an administrator of a non profit, SUD and MH treatment center, I am faced again with the daunting task of contracting and attempting to have a successful claim be paid. The reimbursement rates for NV are too low to support the administrative work required to generate any revenue separate from paying for any service performed by a provider. I was currently advised by DHHS in Reno NV that the rates that are in effect are from 2016. There is not one single aspect of the economy today in 2024 that resembles anything from 2016. A licensed mental health professional with two college degrees (bachelors and masters degrees are required) and a professional license (that takes on average 3 to 5 years to obtain) cannot perform quality healthcare at 2016 prices. A mental health professional would be more successful financially as a bartender or a hairdresser with those rates. The percentage of Medicare rates that are being used by NV to set the Medicaid reimbursement rates needs to reviewed and adjusted. This process needs to be expedited it is to be effective. A 5 year plan will not be helpful.
Jennifer Campbell, Becoming Parents, LLC DBA Doula In Reno July 9, 2024	8	For doulas - provider type 90 – We've found an agency to do billing, but that was the single biggest hurdle and we're not through it yet. Billing support for smaller provider types who work as individuals (Lactation Consultants, CHWs, Peer Support are other examples). The next hurdle is completing the updated fee schedule. This process has been arduous at best.

		NOT using Availity. Their support is terrible, the system and process is overwhelming and clunky, and the MCOs seem disconnected from their process Streamlining the coding system. It seems ludicrous that the very agency we're billing refuses to give us codes. We are provided procedure codes and the modifier, however, we are NOT provided the ICD-10 codes (diagnostic codes) and to make that more challenging, each MCO can use different codes. If doulas had our own billing codes and FFS and MCOs ALL USED THE SAME CODES - it would be far easier. BILLING! We are all individual people each running our own businesses and are non-medical. This means we don't bill in a group and can't afford 3rd party platforms or our own billing employee. Billing has been the biggest struggle - in part due to coding and in part due to a lack of support and easier billing platform. Doula Co-op of Nevada just helped gain access to individual doulas to use The Doula Network for billing and I personally billed over 12K in past and current billing for Medicaid because I wasn't able to be reimbursed through the provided portals and systems. Whether we are able to continue using TDN or bill individually, one of the reasons billing has been such an issue is the "back end" of each MCO isn't set up to approve us. We're a newer provider type and it seems as though they wait for us to be denied and then know what to fix on the back end but this has been extremely frustrating and time consuming. We then get denials for "timely filing" because 180 days have passed. MCOs have said they are willing to waive the timely filing but again - this has been a slow and cumbersome process. (I could say a lot more on this topic) If we streamlined some of the process, it would be easier to use training videos, etc... so doulas wouldn't have to send emails and ask questions and have the process take much longer.
Rachael Roberts, Carson Tahoe Health July 8, 2024	9	Medicaid coverage for Medical Nutrition Therapy (MNT) is limited to Provider Type 15. This allows dietitians in private practice to accept Medicaid patients should they choose to enroll in Medicaid fee-for-service. However, when dietitians work for outpatient health systems, in a hospital-based model, billing occurs under the hospital tax ID number. Expanding Medicare to cover MNT for hospital-based billing will create access to more nutrition therapy providers.
Sarah Sentz, The LGBTQ Center of Southern Nevada July 23, 2024	10	Nevada's Public Option bill, SB420, is a step in the right direction as it requires that Advanced Practice Registered Nurses (APRNs), aka Nurse Practitioners (NPs) be reimbursed the same as physicians for providing the same service for Medicaid fee-for-service (FFS) patients. Unfortunately, there are limitations to payment parity as the bill leaves room for interpretation "to the extent that money is available" and not including Medicaid managed care programs. Per the bill language: Sec. 27. 1. To the extent that money is available, the Director shall include in the State Plan for Medicaid a requirement that, except as otherwise provided in subsection 2, the State must provide reimbursement for the services of an advanced practice registered nurse, including, without limitation, a certified nurse-midwife, to the same extent as if the services were provided by a physician. 2. The provisions of subsection 1 do not apply to services provided to a recipient

		of Medicaid who receives health care services through a Medicaid managed care program." (Cannizzarro et al, 2023). Payment parity across all Medicaid is important to recruit all types of primary care providers including NPs as well as Physician Assistants (PAs). NPs and PAs have been shown to provide high-quality care including primary care and specialty services to patients, so it is essential that reimbursement reflects this work. This strategy would incentivize and reward for better quality and value for the taxpayer dollar in addition to incentivize NPs and PAs to be recruited and retained to work in Nevada.
Sarah Sentz, The LGBTQ Center of Southern Nevada July 23, 2024	11	Telehealth is increasingly beneficial for patients and providers. Many folks in Nevada are traveling long-distances to Las Vegas for care. This is especially true for people living with HIV who may want to keep their status private from their community, or who cannot access proper care in rural areas. Telehealth is an excellent option for these patients; however, we do run into barriers as some Medicaid plans do not want to reimburse for these visits. This creates a barrier to offering more telehealth services as well as limited access for patients in rural areas, or even those who reside in Las Vegas but have transportation barriers.
Laura Deverse, MS, RD, LD, CDCES, Carson Tahoe Health July 2, 2024	12	A major consideration is in supporting Medicaid recipients with proactive medical nutrition therapy in both our pediatric and adult clients due to the strict limitations imposed by Medicaid for acceptable referrals that are reimbursable. At Carson Tahoe Health, myself and another RD educator are available to see clients for medical nutrition therapy for obesity and/or cardiovascular diagnoses but this is not a covered service as a hospital-based therapy. Ideally, by expanding options for the Medicaid population (adult and pediatric) to receive proactive nutrition and lifestyle interventions in this setting could potentially change outcomes and save money for the State. Medical nutrition therapy has been shown to be beneficial in the management of hypertension, obesity and weight loss, and cardiovascular disease as well as prediabetes, diabetes and chronic kidney disease.
Other		
Rebeca Inserra, South Lyon Medical Center July 1, 2024	1	The lack of specialists that accept Medicaid is a huge issue. Unable to get patients who are insured by Medicaid are unable to get the care as the only accepting providers are in the south of Nevada. Require more providers to have to accept Medicaid. Especially in both Northern Nevada and Southern Nevada.
Diana Saunders, Elements of Motivation July 1, 2024	2	Inconsistent/Transient Client Population: Clients often miss appointments, and Medicaid does not allow providers to charge a no-show or late cancellation fee, leading to financial instability for providers. Stigma and Misconceptions: There may be a perceived stigma associated with Medicaid patients, leading some providers to avoid accepting Medicaid (i.e. complexity or severity of cases typically seen in this population).
Larry I Clarke, Your Choice Behavioral Services July 1, 2024	3	There needs to be a work requirement to receive services and a copayment required-$20 per session
Leann McAllister,	4	I recommend significantly increasing the pay of pediatric residents in our state. At this time, pediatric trainees who work well over 40 hours a week caring for the most vulnerable children in Nevada are paid significantly

Nevada Chapter, American Academy of Pediatrics July 12, 2024		lower than peers in other states. If we want physician trainees to not only apply to match in our state, but then want to stay and be part of the community when their training ends, the state must invest significantly more in graduate medical education, specifically with more competitive salaries.
Jennifer Campbell, Becoming Parents, LLC DBA Doula In Reno July 9, 2024	5	For doulas - provider type 90 - If doulas are desired by Medicaid, we need to determine two things - FIRST: how to educate OB/GYNs, community partners, etc. on what a doula is and how we work as part of the care team. We aren't "visitors" in the hospital or extended family. We are professionals getting paid as part of the TEAM. SECOND: how to connect Medicaid members to doulas as a benefit. For deliveries: Doula Co-op of Nevada and Renown Medical Center have a Doula Access Program (I am the director currently) and I'd like it implemented in all hospitals in Nevada Creating a way to alert us that contacts have changed. There has been some turnover in people and positions and it's difficult for us to figure out what's changed and who to contact
Michael DiAsio, Visiting Angels July 17, 2024	6	The health care workforce shortage that I'm referring to is the Personal Care Attendant (aka caregivers or home care) shortage that the Media and Unions claim that there is. They use the word "crisis." My policy would solve or help solve this caregiver shortage, save this State of Nevada tax dollars from have to pay Medicaid PCA Waiver approved Agency's caregivers more and keeps caregiving costs for Private Pay Nevadans at an affordable price. 1.) Build a Medicaid PCA Waiver reimbursement rate for Home Care that has a reasonable profit for Home Care Agencies. This provides incentive for non-Medicaid Agencies to become a Medicaid provider. 2.) Discontinue the requirement that Medicaid providers must list caregivers on the National Provider registry which is where the SEIU gets the employee lists. The Agency has the license and is the provider. This scares away Agencies from becoming a Medicaid provider. 3.) Medicaid approved PCA Waiver Agencies should be required to have these family caregivers work for non-family patients and these patients should be required accept these non-family caregivers or they should not be counted in the shortage. 4.) Require caregivers of Medicaid Agencies work 30 hours per week instead of the 15 hours a week that they work now.
Larry I Clarke, Behavioral Health July 1, 2024	7	Should allow PSR for the rural areas via telehealth and clarify on what constitute an E signature and consideration of increasing the provider rate to reflect current inflection. Also, a data base to review if a provider is a Medicaid provider