SUMMARY—Requires Medicaid to provide coverage of certain treatments for obesity. (BDR 38-206)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State: Yes.

AN ACT relating to Medicaid; requiring Medicaid to cover certain treatments for obesity and the services of certain programs for the prevention of diabetes; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires the Department of Health and Human Services to administer Medicaid. (NRS 422.270) **Section 1** of this bill requires the Director of the Department to include under Medicaid coverage for: (1) intensive health, behavior and lifestyle treatment for obesity; and (2) certain surgical interventions to treat obesity. **Section 1** also requires the Director to include under Medicaid the services of certain programs approved under federal regulations for the treatment of diabetes for recipients of Medicaid who: (1) are eligible for such programs; and (2) have not previously participated in a diabetes prevention program while enrolled in Medicaid. **Section 4** of this bill requires the Department to notify recipients of Medicaid when such coverage becomes available. **Section 3** of this bill makes a conforming change to require the Director to administer the provisions of **section 1** in the same manner as other provisions governing Medicaid.

Existing law requires the Department to develop a list of preferred prescription drugs to be used for the Medicaid program. (NRS 422.4025) **Section 2** of this bill requires that list to include prescription drugs approved by the United States Food and Drug Administration with an indication for chronic weight management in patients who have been diagnosed with obesity. **Section 2** requires the Medicaid program to cover such drugs to the extent that the drugs are prescribed in accordance with the indications of the United States Food and Drug Administration.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 422 of NRS is hereby amended by adding thereto a new section to read as follows:

1. To the extent that federal financial participation is available, the Director shall include under Medicaid coverage for:

(a) Treatment for obesity, including, without limitation, coverage of:

(1) Intensive health, behavior and lifestyle treatment; and

(2) Any surgical intervention included in the most current Guidelines on Indications for Metabolic and Bariatric Surgery published by the American Society for Metabolic and Bariatric Surgery and the International Federation for the Surgery of Obesity and Metabolic Disorders; and

(b) The services of a diabetes prevention program for recipients of Medicaid who:

(1) Meet the eligibility requirements for the diabetes prevention program; and

(2) Have not previously participated in a diabetes prevention program while enrolled in Medicaid.

2. The Department shall:

(a) Apply to the Secretary of Health and Human Services for any waiver of federal law or apply for any amendment of the State Plan for Medicaid that is necessary for the Department to receive federal funding to provide the coverage described in subsection 1.

(b) Fully cooperate in good faith with the Federal Government during the application process to satisfy the requirements of the Federal Government for obtaining a waiver or amendment pursuant to paragraph (a).

3. As used in this section:

(a) "Diabetes prevention program" means a program that:

(1) Consists of structured sessions to create changes in behavioral health for the purpose of preventing or delaying the onset of type II diabetes;

(2) Is provided by an entity recognized by the Diabetes Prevention Recognition Program, as defined in 42 C.F.R. § 410.79, and is delivered in a manner authorized by that program; and

(3) Follows a CDC-approved DPP curriculum, as defined in 42 C.F.R. § 410.79.

(b) "Intensive health, behavior and lifestyle treatment" means an evidence-based, intensive, multi-component program to modify the behavior and lifestyle of a participant that:

(1) Supports healthy weight management;

(2) Meets current standards recognized by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services or current clinical standards of care; and

(3) Is provided:

(I) In person in an office or community-based setting; or

(II) Virtually or through telehealth, as defined in NRS 629.515.

Sec. 2. NRS 422.4025 is hereby amended to read as follows:

422.4025 1. The Department shall:

(a) By regulation, develop a list of preferred prescription drugs to be used for the Medicaid program and the Children's Health Insurance Program, and each public or nonprofit health benefit plan that elects to use the list of preferred prescription drugs as its formulary pursuant to NRS 287.012, 287.0433 or 687B.407; and

(b) Negotiate and enter into agreements to purchase the drugs included on the list of preferred prescription drugs on behalf of the health benefit plans described in paragraph (a) or enter into a contract pursuant to NRS 422.4053 with a pharmacy benefit manager, health maintenance organization or one or more public or private entities in this State, the District of Columbia or other states or territories of the United States, as appropriate, to negotiate such agreements.

2. The Department shall, by regulation, establish a list of prescription drugs which must be excluded from any restrictions that are imposed by the Medicaid program on drugs that are on the list of preferred prescription drugs established pursuant to subsection 1. The list established pursuant to this subsection must include, without limitation:

(a) Prescription drugs that are prescribed for the treatment of the human immunodeficiency virus, including, without limitation, antiretroviral medications;

(b) Antirejection medications for organ transplants;

(c) Antihemophilic medications; and

(d) Any prescription drug which the Board identifies as appropriate for exclusion from any restrictions that are imposed by the Medicaid program on drugs that are on the list of preferred prescription drugs.

3. The regulations must provide that the Board makes the final determination of:

(a) Whether a class of therapeutic prescription drugs is included on the list of preferred prescription drugs and is excluded from any restrictions that are imposed by the Medicaid program on drugs that are on the list of preferred prescription drugs;

(b) Which therapeutically equivalent prescription drugs will be reviewed for inclusion on the list of preferred prescription drugs and for exclusion from any restrictions that are imposed by the Medicaid program on drugs that are on the list of preferred prescription drugs; and

(c) Which prescription drugs should be excluded from any restrictions that are imposed by the Medicaid program on drugs that are on the list of preferred prescription drugs based on continuity of care concerning a specific diagnosis, condition, class of therapeutic prescription drugs or medical specialty.

4. The list of preferred prescription drugs established pursuant to subsection 1 must include, without limitation:

(a) Any prescription drug determined by the Board to be essential for treating sickle cell disease and its variants; ~~[and]~~

(b) Prescription drugs to prevent the acquisition of human immunodeficiency virus ~~[.]~~ ***; and***

(c) Prescription drugs approved by the United States Food and Drug Administration with an indication for chronic weight management in patients who have been diagnosed with obesity.

5. The regulations must provide that each new pharmaceutical product and each existing pharmaceutical product for which there is new clinical evidence supporting its inclusion on the list of preferred prescription drugs must be made available pursuant to the Medicaid program with prior authorization until the Board reviews the product or the evidence.

6. The Medicaid program must cover a prescription drug that is not included on the list of preferred prescription drugs as if the drug were included on that list if:

(a) The drug is:

(1) Used to treat hepatitis C;

(2) Used to provide medication-assisted treatment for opioid use disorder;

(3) Used to support safe withdrawal from substance use disorder; or

(4) In the same class as a drug on the list of preferred prescription drugs; and

(b) All preferred prescription drugs within the same class as the drug are unsuitable for a recipient of Medicaid because:

(1) The recipient is allergic to all preferred prescription drugs within the same class as the drug;

(2) All preferred prescription drugs within the same class as the drug are contraindicated for the recipient or are likely to interact in a harmful manner with another drug that the recipient is taking;

(3) The recipient has a history of adverse reactions to all preferred prescription drugs within the same class as the drug; or

(4) The drug has a unique indication that is supported by peer-reviewed clinical evidence or approved by the United States Food and Drug Administration.

7. The Medicaid program must automatically cover any typical or atypical antipsychotic medication or anticonvulsant medication that is not on the list of preferred prescription drugs upon the demonstrated therapeutic failure of one drug on that list to adequately treat the condition of a recipient of Medicaid.

8. ***The Medicaid program must cover the drugs described in paragraph (c) of subsection 4 to the extent that such drugs are prescribed in accordance with the indications of the United States Food and Drug Administration.***

9. On or before February 1 of each year, the Department shall:

(a) Compile a report concerning the agreements negotiated pursuant to paragraph (b) of subsection 1 and contracts entered into pursuant to NRS 422.4053 which must include, without limitation, the financial effects of obtaining prescription drugs through those agreements and contracts, in total and aggregated separately for agreements negotiated by the Department, contracts with a pharmacy benefit manager, contracts with a health maintenance organization and

contracts with public and private entities from this State, the District of Columbia and other states and territories of the United States; and

(b) Post the report on an Internet website maintained by the Department and submit the report to the Director of the Legislative Counsel Bureau for transmittal to:

(1) In odd-numbered years, the Legislature; or

(2) In even-numbered years, the Legislative Commission.

Sec. 3. NRS 232.320 is hereby amended to read as follows:

232.320 1. The Director:

(a) Shall appoint, with the consent of the Governor, administrators of the divisions of the Department, who are respectively designated as follows:

(1) The Administrator of the Aging and Disability Services Division;

(2) The Administrator of the Division of Welfare and Supportive Services;

(3) The Administrator of the Division of Child and Family Services;

(4) The Administrator of the Division of Health Care Financing and Policy; and

(5) The Administrator of the Division of Public and Behavioral Health.

(b) Shall administer, through the divisions of the Department, the provisions of chapters 63, 424, 425, 427A, 432A to 442, inclusive, 446 to 450, inclusive, 458A and 656A of NRS, NRS 127.220 to 127.310, inclusive, 422.001 to 422.410, inclusive, ***and section 1 of this act,*** 422.580, 432.010 to 432.133, inclusive, 432B.6201 to 432B.626, inclusive, 444.002 to 444.430, inclusive, and 445A.010 to 445A.055, inclusive, and all other provisions of law relating to the functions of

the divisions of the Department, but is not responsible for the clinical activities of the Division of Public and Behavioral Health or the professional line activities of the other divisions.

(c) Shall administer any state program for persons with developmental disabilities established pursuant to the Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. §§ 15001 et seq.

(d) Shall, after considering advice from agencies of local governments and nonprofit organizations which provide social services, adopt a master plan for the provision of human services in this State. The Director shall revise the plan biennially and deliver a copy of the plan to the Governor and the Legislature at the beginning of each regular session. The plan must:

(1) Identify and assess the plans and programs of the Department for the provision of human services, and any duplication of those services by federal, state and local agencies;

(2) Set forth priorities for the provision of those services;

(3) Provide for communication and the coordination of those services among nonprofit organizations, agencies of local government, the State and the Federal Government;

(4) Identify the sources of funding for services provided by the Department and the allocation of that funding;

(5) Set forth sufficient information to assist the Department in providing those services and in the planning and budgeting for the future provision of those services; and

(6) Contain any other information necessary for the Department to communicate effectively with the Federal Government concerning demographic trends, formulas for the distribution of federal money and any need for the modification of programs administered by the Department.

(e) May, by regulation, require nonprofit organizations and state and local governmental agencies to provide information regarding the programs of those organizations and agencies, excluding detailed information relating to their budgets and payrolls, which the Director deems necessary for the performance of the duties imposed upon him or her pursuant to this section.

(f) Has such other powers and duties as are provided by law.

2. Notwithstanding any other provision of law, the Director, or the Director's designee, is responsible for appointing and removing subordinate officers and employees of the Department.

Sec. 4. Not later than 30 days after beginning to provide the coverage under Medicaid required by sections 1 and 2 of this act, the Department of Health and Human Services shall provide written or electronic notice to recipients of Medicaid of the availability of such coverage.

Sec. 5. 1. This section becomes effective upon passage and approval.

2. Sections 1 to 4, inclusive, of this act become effective:

(a) Upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and

(b) On January 1, 2026, for all other purposes.