

- A. Targeted case management activities that are an integral component of another covered Medicaid service.
- B. The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.
- C. Activities integral to the administration of foster care programs.
- D. Activities, for which an individual may be eligible, that are integral to the administration of another non-medical program, except for targeted case management that is included in an individualized education program or individualized family service plan consistent with section 1903(c) of the Social Security Act.

Service: Targeted Case Management in accordance with 1915(g) of the Act.

1. Target Group: Non SED/Non SMI

- A. Children, Adolescents and Adults who are Non SED/SMI are persons who are not seriously mentally ill or severely emotionally disturbed, have a significant life stressor, and:
 - ~~1.i.~~ A ~~DSM Axis I~~ current International Classification of Diseases (ICD) diagnosis, diagnosis from the current Mental, Behavioral, Neurodevelopmental Disorders section including ~~VZ~~ codes 55-65, R45.850 and R45.851, ~~that~~ which does not meet Seriously Mentally Ill or Severely Emotionally Disturbed criteria.
 - ~~2.ii.~~ A Locus score of Level I or II, or
 - ~~3.iii.~~ A CASII Level of 0, 1, 2, or above, ~~and.~~
 - ~~4.~~ ~~DC:03 Axis I diagnosis or DC:03 Axis II PIR GAS score of 40 or less.~~

2. Geographic area to be serviced:

- Statewide
- Limited geographic area

3. Service:

Services are not comparable in amount, duration and scope.

Targeted case management services are services furnished to assist individuals, eligible under the State plan that reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services. The assistance provided through this service are:

- A. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services.
- B. Development (and periodic revision) of a specific care plan based on the information collected through the assessment; specifies goals and actions to address services needed; activities insuring active participation of the individual and others in developing goals; and identifies a course of action to respond to the needs of the individual.
- C. Referral and related activities to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

Service: Targeted Case Management in accordance with 1915(g) of the Act.

1. Target Group: Children with a Severe Emotional Disturbance (SED)

~~A. Children with SED are persons:~~

~~1. From birth through 48 months who currently or at anytime during the past year (continuous 12 month period) have a:~~

~~i. DC:03 Axis I diagnosis; or~~

~~ii. DC:03 Axis II PIR GAS score of 40 or less (40 is "Disturbed"); or~~

~~2A. Persons~~ Children with SED are persons ~~from 4~~ up to 18 years of age who currently or at any time during the past year (continuous 12 month period) have a:

~~1.i.~~ i. Diagnosable mental or behavioral disorder or diagnostic criteria that meets the coding and definition criteria specified in the ~~DSM current ICD~~ (excluding substance abuse or addictive disorders, irreversible dementias, mental retardation, developmental disorders, and ~~VZ~~ codes, unless they co-occur with a serious mental disorder that meets ~~DSM current ICD~~ criteria); and have a:

~~2.ii.~~ ii. Functional impairment which substantially interferes with or limits the child from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative or adaptive skill. Functional impairments of episodic, recurrent, and persistent features are included, however may vary in terms of severity and disabling effects unless they are temporary and an expected response to stressful events in the environment. Children who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

2. Geographic area to be serviced:

Statewide

Limited geographic area

3. Service:

Services are not comparable in amount, duration, and scope.

Targeted case management services are services furnished to assist individuals, eligible under the State plan that reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services. The assistance provided through this service are:

A. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services.

B. Development (and periodic revision) of a specific care plan based on the information collected through the assessment;

Service: Targeted Case Management in accordance with 1915(g) of the Act.

1. Target Group: Adults with a Serious Mental Illness (SMI)

~~1-A.~~ Adults with SMI are persons:

- ~~1-i.~~ 18 years of age and older, and
- ~~2-ii.~~ Who currently, or at any time during the past year (continuous 12 month period);
 - ~~1-a.~~ Have a diagnosable mental, behavioral or emotional disorder that meets the coding and definition criteria specified within the ~~Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)~~ current ICD, excluding substance abuse or addictive disorders, irreversible dementias as well as mental retardation, unless they co-occur with another serious mental illness that meets ~~DSM-IV~~ current ICD criteria;
 - ~~2-b.~~ That resulted in functional impairment which substantially interferes with or limits one or more major life activities; and
- ~~3-iii.~~ Have a functional impairment addressing the ability to function successfully in several areas such as psychological, social, occupational or educational. It is seen on a hypothetical continuum of mental health-illness and is viewed from the individual's perspective within the environmental context. Functional impairment is defined as difficulties that substantially interfere with or limit an adult from achieving or maintaining housing, employment, education, relationships or safety.

2. Geographic area to be serviced:

- Statewide
- Limited geographic area

3. Service:

Services are not comparable in amount, duration, and scope.

Targeted case management services are services furnished to assist individuals, eligible under the State plan that reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services. The assistance provided through this service are:

- A. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services.
- B. Development (and periodic revision) of a specific care plan based on the information collected through the assessment; specifies goals and actions to address services needed; activities insuring active participation of the individual and others in development goals; and identifies a course of action to respond to the needs of the individual.
- C. Referral and related activities to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational

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Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rates were set as of July 1, 2013 and are effective for services provided on or after that date. All rates are published on the agency's website at <https://dhcfp.nv.gov>.

14. RESERVED

15. RESERVED

16. RESERVED

17. RESERVED

18. Prior to the beginning of each rate year, each of the governmental providers providing Emergency Transportation, ground ambulance or air ambulance services, must select one the reimbursement methodologies described below for reimbursement. For example, by April 30, 2015, governmental providers must select a methodology for the rate year beginning July 1, 2015. Once a selected methodology is determined for a rate year, governmental providers will not be able to change the selected methodology until the following rate year.

aI. Reimbursement Methodology for Emergency Transportation: Ground Ambulance or Air Ambulance services provided by a non-governmental entity and governmental entities who do not undergo the Medicaid cost identification and reporting procedures.

Emergency Transportation: Ground Ambulance or Air Ambulance (fixed wing or rotary aircraft): lower of: a) billed charge, or b) fixed basic rate plus fixed fee per mile. Effective July 1, 2013, the reimbursement rates will be increased by 15%.

II. Reimbursement Methodology for Emergency Transportation Services provided by a state or local government entity:

Emergency Transportation services provided by a state or local government entity are reimbursed according to one of the following two payment methodologies. The second methodology must be used by providers who undergo all Medicaid cost identification, reporting, reconciliation and settlement procedures.

A. the lower of: a) billed charges; or b) a cost based rate. The cost-based rate is an annual rate developed based on historic costs. Cost based rates will be calculated annually and are determined by dividing estimated reimbursable costs of providing Medicaid-covered services by the projected total direct medical service utilization for the upcoming fiscal period.

Each public provider will submit an annual operating budget and service utilization forecast at least 60 days before the start of the next fiscal year. The budget forecast must reflect a projection for allowable, necessary and proper expenses in providing Medicaid-covered services. Allowable costs are those direct and indirect costs deemed allowable by CMS which are incurred and are proper and necessary to efficiently deliver needed services. Direct costs include unallocated payroll costs and other unallocated costs that can be directly charged to covered medical services.

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Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct care staff. Other direct costs include costs directly related to the delivery of covered services, such as supervision, materials and supplies, professional and contracted services, capital outlay, and travel. These direct costs are accumulated on the annual cost report, resulting in total direct costs.

- B. the lower of: a) billed charges; or b) an interim rate. The Interim rate is the rate for a specific service for a period that is provisional in nature, pending the completion of cost reconciliation and a cost settlement for that period.

To determine the Medicaid-allowable direct and indirect costs of providing Emergency Transportation services the following steps are performed:

1. Interim Rates

Governmental providers are reimbursed on an interim basis for direct medical services per unit of service at the lesser of the provider's billed charges or a provider-specific interim rate. A provider-specific interim rate is an annual rate for the specific services for a period that is provisional in nature, pending the completion of cost reconciliation and a cost settlement for that period. Interim rates are based on program experience and cost data reported during the prior fiscal year.

2. Annual Cost Report Process

Each governmental provider will complete an annual cost report in the format prescribed by Nevada Medicaid in the Medicaid Operations Manual for all medical services delivered during the previous state fiscal year covering July 1 through June 30. The cost report is due on or before December 1 of the year following the close of the reporting period. The primary purposes of the cost report are to:

- a. document the provider's total Medicaid-allowable cost for delivering the medical services, including direct costs and indirect costs.
- b. reconcile its interim payments to its total Medicaid-allowable costs.

The annual Medicaid Cost Report includes a certification of expenditures statement to be completed, certifying the provider's actual, incurred allocable and allowable costs/expenditures. All filed annual Cost Reports are subject to audit by DCHFP or its designee.

3. Cost Reconciliation Process

Governmental providers will be responsible for reconciling total computable costs reported on the cost report to the provider's Medicaid interim payments for Medicaid services delivered during the reporting period as document in the MMIS, resulting in cost reconciliation.

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4. Cost Settlement Process

If a governmental provider's interim payments exceed the actual, certified costs of the provider for services to Medicaid clients, DHCFP will recoup the federal share of the overpayment using one of the following two methods:

1. Off-set all future claims payments from the provider until the amount of the federal share of the overpayment is recovered;
2. The provider will return an amount equal to the overpayment.

If the actual, certified costs exceed the interim Medicaid payments, DHCFP will pay the federal share of the difference to the provider in accordance with the final actual certification agreement.

DHCFP will issue a notice of settlement that denotes the amount due to or from the provider.

III. Non-emergency transportation:

1. Non-emergency transportation is authorized through a contracted NET Broker, as specified in Attachment 3.1-D.
2. Reimbursement Methodology for Non-emergency Paratransit services provided by the Regional Transportation Commission (RTC) operated by local government entities:
 - a. The lower of: a) billed charges; or b) a cost based rate.

The cost based rate is calculated annually using each public provider's annual operating budget and service utilization forecast and an applicable 10% indirect cost rate. Each public provider will submit an annual operating budget and service utilization forecast at least 60 days before the start of the next fiscal year. The budget forecast must reflect a projection for allowable, necessary and proper direct cost in providing services. The cost based rate is calculated as follows:

1. Direct costs include the costs for fuel, tires and subcontracted costs that are directly related in providing the non-emergency transportation services. These costs must be in compliance with the Medicare reimbursement principle and OMB A-87.
2. The total direct costs (from Item 1) are reduced by any federal grant funds received for the same services to arrive at the net allowable direct costs.
3. Indirect costs are determined by applying a ten percent indirect cost rate to the net allowable direct costs (from Item 2).