RESERVED FOR FUTURE USE

1915(i) Home and Community Based Services (HCBS) State Plan Services

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

For Individuals with Chronic Mental Illness, the following services provided by a government entity:

☒ Home and Community Based Services (HCBS) Day Treatment or Other Partial Hospitalization Services for Individuals with Chronic Mental Illness

Partial Hospitalization - 1 unit per 60 mins
Intensive Outpatient Program - per Diem

Rate Methodology:

HCBS Day Treatment or Other Partial Hospitalization services provided by a state or local government entity for individuals with chronic mental illness are reimbursed according to a methodology used to certify costs as representing expenditures eligible for FFP and may be used only by providers who undergo all Medicaid cost identification, reporting, reconciliation and settlement procedures.

I. 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 HCBS Day Treatment or Other Partial Hospitalization 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 proscribed 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, based on the methodologies/steps described below; and
b. reconcile its interim payments to its total Medicaid-allowable costs.

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The methodologies/steps are incorporated in the approved Cost Allocation Plan (PACAP) to facilitate the accumulation of Medicaid allocable and allowable cost.

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

To determine the Medicaid-allowable direct and indirect costs of providing covered services to Medicaid-eligible clients, the following steps are performed:

A. Facilities that are primarily providing medical services

(a) Direct costs for covered services include unallocated payroll costs and other unallocated costs that can be directly charged to covered medical services. 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 costs must be in compliance with Medicaid non-institutional reimbursement policy and are accumulated on the annual cost report, resulting in total direct costs.

(b) The direct costs from Item (a) are reduced by any amount that is not in compliance with Medicaid non-institutional reimbursement policy and are further reduced by any federal payments for those costs resulting in adjusted direct costs for covered services.

(c) Indirect costs are determined by either applying the agency specific approved indirect cost rate to its net direct costs. If the provider has no approved indirect cost rate, the allocated indirect costs can be derived from the allocation process through the provider’s approved cost allocation plan. These allocated indirect costs are reduced by any unallowable amount based on Medicaid non-institutional reimbursement policy. The indirect costs details are accumulated on the annual cost report.

(d) Net direct costs (Item b) and indirect costs (Item c) are combined.

(e) A CMS approved time study is required when providers of service do not spend 100% of their time providing the Medical services described in the applicable section 3.1-A State plan pages and is used to determine the percentage of time that medical service personnel spend on direct medical services, general and administrative time, and all other activities to account for 100 percent of the time to assure that there is no duplicate claiming. This CMS approved time study methodology will be used to separate administrative activities and direct services.

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The direct medical services time study percentage is applied against the net direct and indirect costs.

(f) Medicaid's portion of total allowable costs is calculated by multiplying the result from Item (e) above to the ratio of the total units of service provided to Medicaid eligible clients to the total units of service provided.

(g) Total Medicaid allowable costs (Item f) is reduced by any revenue, e.g. Medicaid co-payments and TPL, received for the same service to arrive at the total Medicaid net allocable and allowable costs.

B. Facilities that are used for multiple purposes, and the provision of medical services is not the primary purpose

(a) Direct costs include unallocated payroll costs and medical equipment and supplies. Unallocated payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct care staff. These costs are accumulated on the annual cost report.

(b) The Direct costs from Item (a) are reduced by any amount that is not in compliance with Medicaid non-institutional reimbursement policy and are further reduced by any federal payments for those costs, resulting in adjusted direct costs.

(c) Indirect costs are determined by applying the agency specific approved indirect cost rate to its net direct costs (Item b.). If the entity has no approved indirect costs rate, the allocated indirect costs can be derived from the allocation process through the provider's approved cost allocation plan.

These indirect costs are reduced by any unallowable amount. For these facilities, allowable costs are only those costs that are "directly attributable" to the professional component of providing the medical services and are in compliance with Medicaid non-institutional reimbursement policy. For those costs incurred that "benefit" multiple purposes but would be incurred at the same level if the medical services did not occur are not allowed, e.g. room and board, allocated cost from other related organizations. The indirect cost details are accumulated on the annual cost report.

(d) Net direct costs (Item (b)) and indirect costs (Item (c)) are combined.

(e) A CMS approved time study is required when providers of service do not spend 100% of their time providing the medical services described in the applicable section 3.1-A State plan pages and is used to determine the percentage of time that medical service personnel spend on direct medical services, general and administrative time, and all other activities to account for 100 percent of the time to assure that there is no duplicate claiming. This time study methodology will be used to separate administrative activities and direct services. The direct medical services CMS approved time study percentage is applied against the net direct and indirect costs.

(f) Medicaid's portion of the total net allocable and allowable costs is calculated by multiplying the result from Item (e) above to the ratio of total units of service provided to Medicaid eligible clients to the total units of service provided.

(g) Total Medicaid allowable costs (Item f) is reduced by any revenue received for the same services, e.g. Medicaid co-payments and TPL, to arrive at the total Medicaid net allocable and allowable costs.

3. Cost Reconciliation Process

Governmental providers will be responsible for reconciling total allowable 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. The cost reconciliation process must be completed within twenty four months of the end of the reporting period covered by the annual Cost Report.

4. Cost Settlement Process

If a governmental provider's interim payments exceed the actual, certified costs of the provider for services to Medicaid clients, the 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, the DHCFP will pay the federal share of the difference to the provider in accordance with the final actual certification agreement.

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

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1915(i) Home and Community Based Services (HCBS) State Plan Services

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

For Individuals with Chronic Mental Illness, the following services provided by non-governmental entities and governmental entities who do not undergo the Medicaid cost identification and reporting procedures:

☒ Home and Community Based Services (HCBS) Day Treatment or Other Partial Hospitalization Services for Individuals with Chronic Mental Illness

☐ The billable units of service for HCBS Day Treatment or Other Partial Hospitalization Services for Individuals with Chronic Mental Illness are:

☐

☐ Partial Hospitalization - 1 unit per 60 mins
☐ Intensive Outpatient Program – per Diem

☐

Rate Methodology:

The rate is market based. This model is developed to reflect service definitions, provider requirements, operational service delivery and administrative considerations. The following elements are used to determine the rate:

- Wage information is taken from the Bureau of Labor Statistics (BLS). The wage is based on similar occupations reported by BLS and identified by Medicaid staff as comparable to services provided under the intensive outpatient program and partial hospitalization program.
- Employee related expenses (ERE) percentage of 27% was based on input from the Task Force members and Medicaid Staff. It includes paid vacation, paid sick leave, holiday pay, health insurance, life insurance, disability, workers compensation, and legally required payroll taxes.
- Productivity adjustment factor which accounts for the amount of non-billable time spent by staff. This includes the time staff needs to complete required documentation and record keeping, time associated with missed appointments and average travel time by the provider.
- Program Support costs – costs based on average of 4 hours per day. This is to assist with paperwork and follow-up related treatment.
- Allowance for supervisory time – costs for the time directly spent in supervising the medical professional providing these services.
- Allowance for capital costs – the costs is not included in the Administrative overhead. It includes the average hourly expense for building rental and maintenance, equipment leasing and utility expenses.
- Administrative overhead, 10%, is the percentage of service cost that should result from non-direct care activities. It includes insurance, administrative staff, operations and management activities and office supplies. Capital and related expenses is not included. It also does not include staff training.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

The following steps are used to determine the rates:

1. The State will use Nevada-specific hourly wages from the Bureau of Labor Statistics as of May 2004 inflated to June 2006.
2. The hourly amount is increased by the 27% ERE.
3. A productivity factor is applied to the hourly compensation calculated in Item 2 to equal the hourly rate.
4. The hourly rate per individual is the hourly rate (Item 3) divided by the number of individuals based on staffing ratio assumption.
5. The adjusted hourly rate per individual is the hourly rate per individual (Item 4) increased by the program support costs per hour per individual, allowance for supervisory time and capital costs per hours.
6. Administrative overhead 10% is applied to the adjusted hourly rate per individual (Item 5).
7. Total hourly rate is the sum of the adjusted hourly rate per individual before administrative overhead (Item 5) and the administrative overhead (Item 6).
8. Total hourly rate is scaled to the proper unit based on the billable unit of service.

These rates have been compared to other private sector fee-for-service rates. Documentation of the assumptions used, rate development methodology, and fee schedule payment rates will be maintained by the DHCFP.

The agency's rates were set as of January 1, 2006 and are effective for services on or after January 1, 2006. All rates are published on the agency's website at: http://dhcfp.nv.gov