PAYMENT FOR MEDICAL CARE AND SERVICES

1. This paragraph intentionally left blank.
2. Outpatient Hospital
   a. Payments for services billed by Outpatient Hospitals using Current Procedural Terminology (CPT) codes will be calculated using the January 1, 2014 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:
      i. Surgical Codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 90% of the Medicare facility rate.
      ii. Radiology Codes 70000 – 79999 will be reimbursed at 100% of the Medicare facility rate.
      iii. Effective February 15, 2012, Radiopharmaceutical and Contrast codes will be reimbursed at the 2012 Medicare Mean Unit Cost plus 5%.
      iv. Medicine Codes 90000 – 99199 will be reimbursed at 85% of the Medicare facility rate.
      v. Vaccine Products require a National Drug Code (NDC) and will be reimbursed according to the drug reimbursement algorithm set forth on page 3 of Attachment 4.19-B.
      vi. Evaluation and Management Codes 99201 – 99499 will be reimbursed at 90% of the Medicare facility rate.
      vii. Obstetrical Service Codes 59000 – 59999 will be reimbursed at 90% of the Medicare facility rate.
      viii. Anesthesia Codes 00100 – 01999 will be reimbursed based on the Centers for Medicare and Medicaid Services (CMS) 2009 base units for anesthesia. Payment is determined by adding the base units plus time units and multiplying the result by the CMS 2013 anesthesia conversion factor of $22.57. Anesthesia Codes 01967 – 01969 are occurrence-based codes that are paid a flat rate. Anesthesia Codes 99100 – 99140 are not covered.
      ix. Prescribed drugs (Page 3, Paragraph 12a).
      x. Outpatient laboratory and pathology services (Page 1a, Paragraph 3).
      xi. Dental services (CDT Codes, Page 2c, Paragraph 10).
      xii. Durable medical equipment; prosthetics and orthotics (Page 2, Paragraph 7c); and disposable supplies (Page 2, Paragraph 7d).

      Assurance: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both public and private providers of the service. The agency's outpatient hospital fee schedule rates were set as of January 1, 2017 and are effective for services provided on or after that date. All rates are published on our website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/.

   b. (This paragraph intentionally left blank.)

c. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

Nevada Medicaid uses a Prospective Payment System (PPS) for FQHCs/RHCs as required by S.S.A. §1902 (a) (15) [42 U.S.C. § 1396a (a) (15)] and S.S.A. §1902 (bb) [42 U.S.C. §1396a (bb)]. The PPS for FQHCs/RHCs was implemented and took effect on January 1, 2001.

Prospective Payment System (PPS) Reimbursement for Existing Facilities

On January 1, 2001, the State began paying FQHCs/RHCs (including "FQHC look alike clinics") based on a PPS rate methodology, per CMS requirements. The baseline for a PPS was set at 100% of the average of an FQHC/RHC per visit rate based on the reported reasonable and allowable costs of providing Medicaid-covered services during the FQHC/RHC fiscal years 1999 and 2000, adjusted to take into account any reported increase (or decrease) in the scope of services furnished during FY 2001 by the FQHC/RHC (calculating the payment amount on a per visit basis). Medicaid-covered services that are considered to be FQHC/RHC services are those services that were identified and approved to be provided by the facility as it applies to HRSA in order to be deemed as an FQHC/RHC facility.

Beginning in Federal fiscal year 2002, and for each fiscal year thereafter, each FQHC/RHC is entitled to the payment amount (on a per visit basis) to which the center or clinic was entitled under the Act in the previous year, increased each October 1st (FFY) by the percentage increase (or decrease) in the Medicare Economic Index (MEI) for primary care services as defined in Section 1842 (i)(3) of the Social Security Act, which is intended to account for the basic cost increases associated with providing such services.

After February 6, 2016, the DHCFP will allow reimbursement for up to three encounters/visits per person per day provided that the FQHC has separate PPS rates for each reimbursable service type; medical, mental behavioral health and dental. FQHCs that only provide two of the specified service types will be allowed reimbursement for up to two encounters/visits per patient per day. For FQHCs that only have one PPS rate will be allowed reimbursement for only one encounter/visit per patient per day. For FQHCs that do not have separate Service Specific Prospective Payment Systems (SSPPS) rates already established, they may opt to change to an Alternative Payment Methodology (APM) wherein their costs/visits will be reviewed after a full year of providing and receiving reimbursement for up to three (or two) visits/encounters per patient per day, resulting in separate Service Specific Alternative Payment Methodology (SSAPM) rates being established.

FQHCs may choose to retain their current SSPPS rates and not bill up to three encounters/visits per patient per day, which will not result in a change to an SSAPM and a current review of their costs and visits.

PPS rates will not be subject to rebasing after their initial computation unless authorized by Congress. Only the actual costs related to any reported change in scope of services will be calculated (based on a full year of providing those services) and an adjustment or add-on to the baseline PPS rate will be made. Any other changes to the PPS rate(s) will be considered an APM and will be outlined below in this State plan.

Prospective Payment System (PPS)-Service Specific Reimbursement for New Facilities

Newly qualified FQHCs/RHCs after Federal fiscal year 2012 will have initial payments (interim Service Specific PPS (SSPPS) rates) established either by reference to payments to one or more other clinics in the same or adjacent areas with similar caseloads and/or similar scope of services or based on an average of rates for other FQHC/RHC clinics throughout the State.

Once their average per visit reasonable costs of providing Medicaid-covered services based on their first full year of operation can be determined, the initial interim SSPPS payments of the FQHC/RHC will be cost settled and any over or under payments will be reconciled and the SSPPS rate will then be established based on the actual cost to provide those services for their first full year. The per visit SSPPS rate(s) will then be adjusted annually every October 1st beginning at the next federal fiscal year by the percentage change in the Medicare Economic Index (MEI) for primary care services as defined in Section 1842 (i)(3) of the Social Security Act, for that calendar year as published in the Federal Register. The MEI adjustment is the mechanism used to account for the basic cost increases associated with providing such services. All required documentation of actual costs for the first full year of providing services must be furnished to the DHCFP no later than six months after completion of the first full year of services. If the required documentation is not received within six months after the completion of a full year of services, the annual MEI adjustments will be suspended until such time as the documentation is received and an actual SSPPS rate is determined.

PPS/SSPPS rates will not be subject to rebasing after their initial computation unless authorized by Congress. Only the actual costs related to any reported change in scope of services will be calculated (based on a full year of providing those services) and an adjustment or add-on to the baseline PPS/SSPPS rate will be made. Any other changes to the PPS/SSPPS rate(s) will be considered an Alternative Payment Methodology (APM) and will be outlined below in this State Plan.

Alternative Payment Methodology (APM) Reimbursement

For any fiscal year after FY 2002, a State may use an APM methodology other than the Medicaid PPS, but only if the following statutory requirements are met. First, the APM must be agreed to by the State and by each individual FQHC/RHC to which the State wishes to apply the methodology. Second, the methodology must result in a payment to the center or clinic that is a least equal to the amount to which the center or clinic is entitled under the Medicaid PPS. Third, the methodology must be described in the approved State plan.

Service Specific APM (SSAPM) rates are based on the specific service type being provided. SSAPM rates are set at 100% of the average of an FQHC/RHC per visit rate based on the reported reasonable and allowable costs of providing Medicaid-covered services during the time period under review (calculating the payment amount on a per visit basis per service type). For FQHCs that have separate service specific APM rates established, the DHCFP will allow reimbursement for up to three (or two) SSAPM encounters/visits per patient per day for the different service types: one medical, one behavioral health and one dental.

Effective October 1st (FFY) of each year after an SSAPM rate has been established, for services

furnished on or after that date, the DHCFP will adjust the SSAPM rate by the percentage increase in the MEI applicable to primary care services as published in the Federal Register for that calendar year, which will account for basic cost increases associated with providing such services.

APM to Reflect Other Payment Adjustments

FQHC/RHC's may request an APM to reflect other payment adjustments in the event of extraordinary circumstances, not otherwise reimbursed by other sources, including but not limited to acts of God; acts of nature; acts of terrorism and acts of war. However, if an FQHC/RHC's existing PPS/SSPPS/SSAPM rate is sufficient to cover its overall costs, including those associated with the extraordinary circumstances, other payment adjustment is not warranted. The FQHC/RHC must show that its PPS/SSPPS/SSAPM rate is not sufficient to cover the costs associated with the extraordinary circumstance. The adjusted rate will only apply to the extent, and only for the period of time, that the additional costs for the event are reimbursable under federal Medicaid law and regulations governing claims for federal financial participation (FMAP). The DHCFP will work with the provider to gather the appropriate data at the time the incident occurs and a written request for a rate adjustment is made by the Provider.

Change in Scope of Services

PPS/SSPPS/SSAPM rates may be adjusted to take into account any requested, documented and approved increase (or decrease) in the scope of services furnished by the FQHC/RHC in any given fiscal year. The FQHC/RHC must submit a written request detailing the change in scope of services to the Division within 60 days of the effective date of those changes in order for the rate adjustment to be retroactive to the date of the Change in Scope of Services. If a written request is not received within 60 days of those changes, the effective date for a rate adjustment will be the date the written request for a Change in Scope of Services was received by the DHCFP. Documentation and notification to support an increase or decrease in the scope of services is the responsibility of the provider and must specify all the changes up for review.

An FQHC/RHC requesting a rate adjustment for changes in scope of services must submit data/documentation/schedules that substantiate the changes in scope and the related adjustment of reasonable costs following Medicare principals of reimbursement.

An interim rate will be determined using the first three months of actual cost data available from the provider. After a full year of providing the services related to the change in scope, an analysis will be performed on the actual costs for a full year of service and an adjustment will be made to the PPS/SSPPS/SSAPM. Adjustments to the PPS/SSPPS/SSAPM rate for qualified/approved changes in scope will be based on Medicare Cost Reimbursement methodology, allocating costs related to patient care based upon a providers audited and approved costs for the change in scope services. The PPS/SSPPS/SSAPM rate adjustment will then be determined by dividing the approved allocated costs by the number of approved total visits for the given time period.

A Change in Scope of Services has been defined as a change in the type, intensity, duration and/or amount of any service that meets the definition of FQHC/RHC services as defined in Section 1905 (a)(2)(B) and (C) of the Social Security Act; and the service is included as a covered Medicaid service under the Medicaid state plan. General increases or decreases in costs associated with programs that were already a part of an established PPS/SSPPS/SSAPM rate do NOT constitute a Change in Scope. A Change in Scope must meet all of the following requirements:

- The change in the scope of services is a change in the type, intensity, duration, or amount of services, or any combination thereof as defined in Section 1905 (a)(2)(B) and (C) of the Social Security Act.

- The cost is allowable under Medicare reasonable cost principals set forth in 45 CFR Part 75 Uniform Administrative Requirements, Cost Principles and Audit Requirements for HHS Awards and /or 42CFR Part 413 Principles of Reasonable Cost Reimbursement.

- The net change in the FQHC/RHC's per visit PPS/SSPPS/APM rate must equal or exceed 4% for the affected FQHC/RHC site(s). For FQHC/RHC's that filed consolidated cost reports for multiple sites to establish the initial Prospective Payment reimbursement rate (PPS), the 4% threshold will be applied to the average per visit rate (medical, dental and mental health) of all sites that provide the specific service for the purposes of calculating the cost associated with a scope of service change. "Net change" means the per visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year for the specific service type.

A Change in Scope of Services includes any of the following:

- A change in the types of services offered, i.e., the addition of dental services, may qualify as a Change in Scope which may warrant an adjustment to the PPS/SSPPS/SSAPM rate or the establishment of a new PPS/SSPPS/SSAPM rate.

- A change in intensity/duration or character of services offered by an FQHC/RHC attributable to changes in the types of patients served may qualify, such as services to patients with HIV/AIDS or other chronic diseases and other special populations requiring more intensive and frequent care.

- A change in the magnitude, intensity or character of currently offered services, demonstrated and documented by an increase or decrease in the patient volume of certain high risk populations that require more intensive and frequent care, which may reasonably be expected to span at least one year may qualify.

- A change in the type, intensity, duration or amount of service caused by changes in technology and medical practice used may qualify.

If a Change in Scope rate increase request is denied, the provider may request a formal rate appeal from the DHCFP. Rate appeal procedures are defined in the Medicaid Service Manual (MSM) Chapter 700.

Definition of a "Visit"/"Encounter"

A "visit" or an "encounter" for the purposes of reimbursing FQHC/RHC services is defined as face-to-face contact with one or more qualified health professionals and multiple contacts with the same health professional that take place on the same day with the same patient for the same service type.

Qualified Health Professional

To be eligible for PPS/SSPPS/SSAPM reimbursement, services must be delivered exclusively by one or more of the following licensed Qualified Health Professionals or a provider working under his or her direct supervision: Physician, Osteopath, Podiatrist, Physician's Assistant, Advanced Practice Registered Nurse, Certified Nurse Midwife, Clinical Psychologist, Clinical Social Worker, Dentist or Dental Hygienist and other Medicaid Qualified Providers.

Documentation Required to Support a Request for Change in Scope of Services

- Year End Payroll Reports for identified time periods
- Trial Balances for all Revenues and Expenses for identified time periods
- Grouping Schedule/Mapping of Trial Balance Accounts to the Cost Reports
- Detailed General Ledger with Vendor Information for identified time periods
- Claims reports showing Unique Patient Visits, DOS, Procedure Codes, Service Facility ID#, Amount Paid and Payer
- Other Items as Deemed Necessary

Record keeping and Audit

All participating FQHC/RHC's shall maintain an accounting system which identifies costs in a manner that conforms to generally accepted accounting principles and must maintain documentation sufficient to support all cost/visit data.

The DHCFP, its fiscal agent or a designated and contracted financial entity may conduct periodic on-site or desk audits of all cost data, including financial and statistical records of the FQHCs/RHCs.

FQHCs/RHCs must submit information (statistics, costs and financial data or other data) as deemed necessary by the DHCFP or its fiscal agent. Failure to submit requested documentation may result in denial of a rate adjustment request.

The DHCFP will conduct one audit annually (at a minimum) to the claims submitted by the FQHC/RHC for supplemental payments.

Supplemental Payments for FQHCs/RHCs Enrolled with a Managed Care Entity (MCE)

FQHCs/RHCs that provide services under a contract with a Medicaid Managed Care Entity (MCE) will receive quarterly or monthly (as agreed upon between the provider and the state) supplemental payments for furnishing such services, that are a calculation of the difference between the payments the FQHC/RHC receives from the MCE(s) for all qualified Medicaid FQHC/RHC visits and the payments the FQHC/RHC would have received under the PPS/SSPPS or SSAPM methodology.

At the end of each payment period, the total amount of MCE payments received by the FQHC/RHC will be reviewed against the amount that the actual number of visits provided under the FQHC's/RHC's contract with MCE(s) would have yielded under the PPS/SSPPS/SSAPM methodology. If the amount exceeds the total amount of MCE payments, the FQHC/RHC will be paid the difference, if the amount is less, the FQHC/RHC will refund the difference to the DHCFP. The FQHC/RHCs must provide sufficient documentation (as requested) to the DHCFP to facilitate supplemental payment calculations. If the required documentation is not provided to support the supplemental payment, future supplemental payments may be suspended.

Documentation Required to Calculate/Support Supplemental Payments

The FQHC/RHC will submit an electronic request for supplemental payment which will contain at least the following information for each line item of every qualified encounter during the reporting time period (Quarterly or Monthly): Medicaid Billing Provider ID#, Recipient MCE ID Number, Recipient Medicaid ID Number, Date of Service, Procedure Code(s), MCE Name, Total Billed Amount, MCE Paid Amount, Other Paid Amount, Total Amount Paid and Recipient Date of Birth.

The FQHC/RHC will submit claim data for supplemental payment no later than 30 days after the end of the reporting period agreed upon with the DHCFP (Quarterly or Monthly).

Any discrepancy found in the audits will be adjusted based on the audit findings.

3. Laboratory and pathology services deemed to be Nevada Medicaid covered benefits will be paid at:

a. For Codes 80000 - 89999, the lower of billed charges not to exceed 50% of the rate allowed by the 2014 Medicare Clinical Diagnostic Laboratory Fee Schedule for Nevada;

b. Allowed laboratory and pathology codes/services outside of the ranges listed in 3.1 and 3.2 or not listed in the Medicare Clinical Diagnostic Laboratory Fee Schedule for Nevada will be paid in accordance with other sections of this State Plan based on rendering provider type;

b. For "BR" (by report) and "RNE" (relativity not established) codes that fall within the Code Range 80000 - 89999, the payment will be set at 62% of billed charges; or

c. Contracted or negotiated amount.

4. EPSDT and Family Planning

A. Early and periodic screening, diagnosis and treatment (EPSDT) services, including School Health Services (SHS), will be reimbursed the lower of a) billed charge, or b) fixed fee per unit as indicated for specific services listed elsewhere in this attachment.

B. SHS – Reimbursement Methodology

SHS described in Attachment 3.1-A, Page 2a of the Nevada State Plan will be reimbursed the lower of: a) billed charges; or b) a fixed fee schedule.

School Health Services (SHS) delivered by Local Education Agencies (LEAs) and provided to children. Services include:

1. Physician's services,
2. Physician's assistant services,
3. Nursing services including registered nurses, licensed practical nurses and advanced nurse practitioners,
4. Psychological services,
5. Physical therapy services,
6. Speech therapy, language disorders and audiology services,
7. Occupational therapy services,
8. Applied Behavior Analysis (ABA),
9. Personal Care Services (PCS),
10. Home health care services,
11. Case management,
12. EPSDT preventative screenings,
13. Dental services,
14. Optometry services,
15. Non-Residential mental health rehabilitative services,
16. Outpatient alcohol and substance abuse services,
17. Medical supplies, equipment and appliance services – Assistive Communication Devices, audiological supplies and other Durable Medical Equipment (DME), and
18. Services provided by telehealth.
19. Community Health Worker services

All costs described within this methodology are for Medicaid services provided by qualified practitioners that have been approved under Attachment 3.1-A of the Medicaid state plan.

All providers and services are paid the same as providers and services outside of the school-based setting (with the same fee schedules as the rest of the state).

A fixed fee schedule: as indicated for specific services listed elsewhere in this

attachment. All rates are published on the agency's website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/ and are effective for services provided on and after January 1, 2024.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of SHS listed above.

4. EPSDT and Family Planning (cont.)

C. Applied Behavior Analysis (ABA) services as stated in Nevada State Plan Attachment 3.1-A, ABA

ABA Reimbursement Methodology

ABA Services described in Attachment 3.1-A, Pages 2i-2k of the Nevada State Plan and provided by an enrolled qualified medical professional according to ABA requirements listed in Attachment 3.1-A, Pages 2j and 2k, are reimbursed the lower of: a) billed charges; or b) a fixed fee schedule.

A fixed fee schedule: as indicated for specific services listed elsewhere in this attachment e.g., ABA. All rates are published on the agency's website: https://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

The Agency's rates are set as of January 1, 2016 and are effective for services on or after January 1, 2016.

Payments for services billed by ABA Qualified Medical Professionals will be reimbursed based on provider qualifications and procedure codes.

i. Nevada Licensed Physician (MD/DO) or Board-Certified Behavior Analyst (BCBA) or Psychologist with a specialty in Behavior Intervention (PhD) will be reimbursed at 65% of Medicare rates as published in the Federal Register on July 14, 2014. 42 CFR 411, 412, 416, *et al.*

ii. Board Certified Assistant Behavior Analyst (BCaBA) will be reimbursed at 60% of the ABA Physician rate as shown above in (i).

iii. Registered Behavioral Technicians (RBT) rate methodology:

a. For services performed on or after January 1, 2022, the rates are based on several factors used to determine the cost associated with performing the applicable services. This model was developed to reflect provider requirements, operational service delivery, recruitment, credentialing, ongoing training/certification and administrative considerations. The following elements were used to determine the rates:

1. Wage Information – The wage used to determine rates for Registered Behavior Technicians is $30 per hour.

2. Employee Related Expenses (ERE) – ERE includes paid vacation, sick leave, holiday, health/life insurance, disability, worker's compensation, payroll taxes, Medicare and Federal Income taxes.

3. Productivity Adjustment Factor – Costs include non-billable services that are required for normal business operations such as staff meetings, personnel requirements, travel time and mileage. This also includes non-billable time spent by staff to include required case documentation and record keeping and time associated with missed/cancelled appointments.

4. Allowances for Supervisory Time – Costs for the time spent supervising the field staff, which is not reimbursable under separate billing codes, as required by regulations.

5. Certification/Training Expenses – Costs include initial and ongoing certification and training costs required to maintain provider qualifications.

6. Administrative Overhead (10% Cap) – This includes costs associated with non-direct care activities required for normal business operations, such as building rent/utility costs, program support staff and office supplies, etc.

iv. For services performed by a Board Certified Behavior Analyst, Board Certified Assistant Behavior Analyst, or Registered Behavior Technician on or after July 1, 2023:

a. The Agency will determine reimbursement rates paid by other states' Medicaid programs for each affected specialty and procedure and calculate the median out-of-state rate.

b. The median out-of-state rate will be compared to the current Nevada Medicaid reimbursement rates determined in sections (i-iii) above.

1. If the median out-of-state rate exceeds the current Nevada Medicaid reimbursement rate, the Agency will set the reimbursement rate for that specialty and service at an amount comparable to the rates paid by other states.

2. If the median out-of-state rate is lower than the rates described in (i-iii) above, the reimbursement rates will remain unchanged and will follow the methodology described in (i-iii).

Except as otherwise noted in the plan, state developed fee schedule rates are the same for governmental and private providers of ABA services and the related fee schedule is published on the agency's website:
http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

II. Family planning services and supplies: as indicated for specific services listed elsewhere in this attachment, e.g., physician services, prescribed drugs.

5. Payments for services billed by Physicians using Current Procedural Terminology (CPT) codes will be calculated using the January 1, 2014 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:

   a. Surgical Codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 99.75% of the Medicare facility rate.

      1. Pediatric enhancement for recipients under the age of 21 will be the lesser of billed charges or 115% of the currently established Medicaid rates for Surgical Codes 10000 – 58999 and 60000 – 69999.

   b. Radiology Codes 70000 – 79999 will be reimbursed at 105% of the Medicare facility rate. Effective January 1, 2024, Radiopharmaceutical and Contrast codes will be reimbursed at the 2012 Medicare Mean Unit Cost plus 10.25%.

   c. Medicine Codes 90000 – 99199 will be reimbursed at 89.25% of the Medicare non-facility rate.

      1. Pediatric enhancement for recipients under the age of 21 will be the lesser of billed charges or 115% of the currently established Medicaid rates for Procedure Codes 93000 – 93350.

   d. Evaluation and Management Codes 99201 – 99499 will be reimbursed at 99.75% of the Medicare non-facility rate.

   e. Obstetrical Service Codes 59000 – 59999 will be reimbursed at 99.75% of the Medicare non-facility rate.

   f. Anesthesia Codes 00100 – 01999 will be reimbursed based on the Centers for Medicare and Medicaid Services (CMS) 2009 base units for anesthesia. Payment is determined by adding the base units plus time units and multiplying the result by an anesthesia conversion factor of $23.70. Anesthesia Codes 01967 – 01969 are occurrence-based codes that are paid a flat rate. Anesthesia Codes 99100 – 99140 are not covered.

   g. Medicine Codes 90281 – 90399, and all other pharmaceuticals that are not identified above, will be reimbursed according to the drug reimbursement algorithm set forth on Page 3 of Attachment 4.19-B.

Assurance: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both public and private providers of the service. The agency's physician fee schedule rates were set as of January1, 2024 All rates are published on our website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

6. Medical care and any other type of remedial care provided by licensed practitioners:

a. Payment for services billed by a Podiatrist will be calculated using the January 1, 2014 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amount specified below:
   1. Surgical Codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 75% of the Medicare facility rate.
   2. Radiology Codes 70000 – 79999 will be reimbursed at 100% of the Medicare facility rate.
   3. Medicine Codes 90000 – 99199 will be reimbursed at 85% of the Medicare non-facility rate.
   4. Vaccine Products require a National Drug Code (NDC) and will be reimbursed according to the drug reimbursement algorithm set forth on Page 3 of Attachment 4.19-B.
   5. Evaluation and Management Codes 99201 – 99499 will be reimbursed at 90% of the Medicare non-facility rate.

b. Payment for services billed by an Optometrist will be calculated using the January 1, 2014 unit values for the Nevada-specific RBRVS and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amount specified below:
   1. Surgical Codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 75% of the Medicare non-facility rate.
   2. Radiology Codes 70000 – 79999 will be reimbursed at 100% of the Medicare facility rate.
   3. Medicine Codes 90000 – 99199 and Evaluation and Management Codes 99201 – 99499 will be reimbursed at 90% of the Medicare non-facility rate. See also Page 3a, 12.d.

c. Payment for services billed by a Chiropractor will be calculated using the January 1, 2014 unit values for the Nevada-specific RBRVS and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amount specified below:
   1. Radiology Codes 70000 – 79999 will be reimbursed at 100% of the Medicare facility rate.
   2. Medicine Codes 90000 – 99199 will be reimbursed at 85% of the Medicare non-facility rate.
   3. Evaluation and Management Codes 99201 – 99499 will be reimbursed at 90% of the Medicare non-facility rate.

d. Payment for services billed by an Advanced Practitioner of Nursing/Physician Assistant/Nurse-Midwife will be calculated using the January 1, 2014 unit values for the Nevada specific resource based relative value scale (RBRVS) and the 2014 Medicare Physicians Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:

1. Physician Assistants:

   a. Surgical Codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 59% ofthe Medicare facility rate.
   b. Radiology Codes 70000 – 79999 will be reimbursed at 75% of the Medicare facility rate.
   a. Medicine Codes 90000 – 99199 and Evaluation and Management Codes 99201 –99499 will be reimbursed at 63% of the Medicare non-facility rate.
   When Community Health Worker (CHW) services are provided under the supervision of a Physician's Assistant, effective for dates of service on or after February 1, 2022, payment for services will be calculated using the January 1, 2014 unit values for the Nevada-specific RBRVS and the 2014 Medicare Physician Fee Schedule conversion factor or the first year the applicable code appears on the Medicare fee schedule, whichever is later. Payment will be the lower of billed charges, or the amounts specified below:
   Medicine Codes 90000 – 99199 will be reimbursed at 60% of the Medicare non-facility rate.
   b. Obstetrical Service Codes 59000 – 59999 will be reimbursed at 75% of the Medicare non-facility rate .

2. Advanced Practice Registered Nurse/Nurse Midwife:

   a. Surgical Codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 99.75% of the Medicare facility rate.
   Pediatric enhancement for recipients under the age of 21 will be the lesser of billed charges or 115% of the currently established Medicaid rates for Surgical Codes 10000 – 58999 and 60000 – 69999.
   b. Radiology Codes 70000 – 79999 will be reimbursed at 105% of the Medicare facility rate.
   c. Medicine Codes 90000 – 99199 will be reimbursed at 89.25% of the Medicare non-facility rate.
   Pediatric enhancement for recipients under the age of 21 will be the lesser of billed charges or 115% of the currently established Medicaid rates for Procedure Codes 93000 – 93350.

   When Community Health Worker (CHW) services are provided under the supervision of an Advanced Practice Registered Nurse, effective for dates of service on or after February 1, 2022, payment for services will be calculated using the January 1, 2014 unit values for the Nevada-specific RBRVS and the 2014 Medicare Physician Fee Schedule conversion factor or the first year the applicable code appears on the Medicare fee schedule, whichever is later. Payment will be the lower of billed charges, or the amounts specified below:
   Medicine Codes 90000 – 99199 will be reimbursed at 60% of the Medicare non-facility rate.
   d. Evaluation and Management Codes 99201 – 99499 will be reimbursed at 99.75% of the Medicare non-facility rate.
   e. Obstetrical Service Codes 59000 – 59999 will be reimbursed at 99.75% of the Medicare non-facility rate.

e. Payment for community paramedicine services will be the lower of billed charges or the amounts specified below:
   1. The following Medicine codes and Evaluation and Management codes will be reimbursed at 63% of the Medicare non-facility rate: 90460, 90471-90474, 99341-99345, 99347-99350. The Medicare non-facility rate will be calculated using the January 1, 2014 unit values for the Nevada specific resource based relative value scale (RBRVS) and the 2014 Medicare Physicians Fee Schedule conversion factor.

f. Payment for services billed by a Nurse Anesthetist will be calculated using the January 1, 2014 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges or the amounts specified below:
   1. Anesthesia Codes 00100 – 01999 will be reimbursed based on the Centers for Medicare and Medicaid Services (CMS) 2009 base units for anesthesia. Payment is determined by adding the base units plus time units and multiplying the result by the CMS 2013 anesthesia conversion factor of $22.57. Anesthesia Codes 01967 – 01969 are occurrence-based codes that are paid a flat rate. Anesthesia Codes 99100 – 99140 are not covered.
   1. Surgical Codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 59% of the Medicare facility rate.
   2. Medicine Codes 90000 – 99199 and Evaluation and Management Codes 99201 – 99499 will be reimbursed at 63% of the Medicare non-facility rate.
   3. Vaccine Products require a National Drug Code (NDC) and will be reimbursed according to the drug reimbursement algorithm set forth on Page 3 of Attachment 4.19-B.

g. Payment for services billed by a Psychologist will be calculated using the January 1, 2014 unit values for the Nevada-specific RBRVS and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:
   1. Medicine Codes 90000 – 99199 will be reimbursed at 85% of the Medicare non-facility-based rate.
   2. Vaccine Products require a NDC and will be reimbursed according to the drug reimbursement algorithm set forth on Page 3 of Attachment 4.19-B.
   3. Evaluation and Management Codes 99201 – 99499 will be reimbursed at 90% of the Medicare non-facility-based rate.

h. Licensed Pharmacist

   Effective for dates of service on or after July 1, 2022, payment for 1905(a)(6) services billed by a Licensed Pharmacist will be calculated using the January 1, 2014 unit values for Nevada specific resource based relative value scale (RBRVS) and the 2014 Medicare Physicians Fee Schedule conversion factor or the first year the applicable code appears on the Medicare fee schedule, whichever is later. Payment will be the lower of billed charges, or the amount specified below:
      a. Evaluation and Management Codes 99201 – 99499 will be reimbursed at 63% of the Medicare non-facility rate.
         1. Laboratory codes 80000-89999 will be paid:
            a. The lower of billed charges not to exceed 50% of the rate allowed by the 2014 Medicare Clinical Diagnostic Laboratory Fee Schedule for Nevada;

Laboratory Fee Schedule for Nevada;

b. Allowed laboratory and pathology codes/services outside the Licensed Pharmacy 1905(a)(6) services described in State Plan Attachment 3.1-A or not listed in the Medicare Clinical Diagnostic Laboratory Fee Schedule for Nevada will be paid in accordance with other sections of this State Plan based on rendering provider type;

c. For "BR" (by report) and "RNE" (relativity not established) codes that fall within the Code Range 80000 - 89999, the payment will be set at 62% of billed charges.

Assurance: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both public and private providers of the service. The agency's Advanced Practitioner of Nursing/Physician Assistant/Nurse-Midwife fee schedule rates were set as of January 1, 2024 and are effective for services provided on or after that date. Podiatrist, Optometrist, Chiropractor, Nurse Anesthetist and Psychologist fee schedule rates were set as of January 1, 2017 and are effective for services provided on or after that date. Community Paramedicine fee schedule rates were set as of August 27, 2021 and are effective for services provided on or after that date. Licensed Pharmacist fee schedule rates were set as of July 1, 2022 and are effective for services provided on or after those dates. All rates are published on our website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

7. Telehealth Services

Telehealth is the delivery of services from a provider of health care to a patient at a different location, through the use of information and communication technologies, not including facsimile or electronic mail.

a. The originating site provider will be paid a telehealth originating site facility fee per completed transmission when applicable. Payment for an originating site facility fee will be reimbursed at the rate established in the CY 2012 Medicare Physician Fee Schedule.

b. The distant site provider is paid the current applicable Nevada Medicaid fee for the telehealth service provided. Instructions for submitting billing claims may be found on the Nevada Medicaid website: https://www.medicaid.nv.gov/providers/BillingInfo.aspx.

c. A provider will not be eligible for payment as both the originating and distant site for the same patient, same date of service.

d. Fee schedule rates are the same for both governmental and private providers. The Nevada Medicaid fee schedules may be found on the following website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/.

d. Fee schedule rates are the same for both governmental and private providers. The Nevada Medicaid fee schedules may be found on the following website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/ and are effective for services provided on and after January 1, 2024.

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7. Home Health Care Services:

a. Home health care services include the following services and items:

1. physical therapy – 1 unit per 15 minutes,
2. occupational therapy – 1 unit per 15 minutes,
3. speech therapy – 1 unit per 15 minutes,
4. family planning education – 1 unit per visit,
5. skilled nursing services (RN/LPN visits) 1 unit per 60 minutes or 1 unit per 15 minutes for brief visits or 1 unit per 15 minutes for extended visits (after 1st hour),
6. home health aide services – 1 unit per 60 minutes or 1 unit per 30 minutes for extended visits (after 1st hour),
7. durable medical equipment, prosthetics, orthotics, and
8. disposable medical supplies.

b. Reimbursements for Home Health Care services listed above in a.1. through a.6, provided by Home Health Agencies are the lower of a) billed charges, or b) a fixed fee schedule which includes the rate for each of the home health services and a rate for "mileage" as an add-on. The Division's rates were set as of January 1, 2024 and are effective for services on or after that date. All rates can be found on the official Website of the Division of Health Care Financing and Policy at http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

Effective July 1, 2016, pediatric enhancement rates do not apply for services listed above in a.5.

c. Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

1. Reimbursement for purchase of DMEPOS is the lower of: a) usual and customary charge, or b) a fixed fee schedule rate.
2. Reimbursement for rental of DMEPOS is the lower of: a) usual and customary charge, or b) a fixed fee schedule rate.
3. If there is no fee schedule available, reimbursement will be the lower of: a) manufacturer's suggested retail price (MSRP) less 25%, verifiable with quote or manufacturer's invoice that clearly identifies MSRP; b) if there is no MSRP, reimbursement will be acquisition cost plus 20%, verifiable with manufacturer's invoice; or c) the actual charge submitted by the provider.
4. Reimbursement for the Healthcare Common Procedure Coding System (HCPCS) codes E2609 (Custom fabricated wheelchair seat cushion, any size) and E2617 (Custom fabricated wheelchair back cushion, any size) will be the lower of: a) MSRP less 20% verifiable with submission of a quote or manufacturer's invoice that clearly identifies MSRP for HCPCS codes E2609 and E2617; b) if there is no MSRP, reimbursement will be acquisition cost plus 20% verifiable with manufacturer's invoice, or c) the actual charge submitted by the provider.
    a. This reimbursement methodology for procedure codes E2609 and E2617 apply only to Complex Rehab Technologies (CRT) providers.
    b. CRT products may only be provided by individuals who are certified, registered or otherwise credentialed by recognized organizations in the field of CRT and who are employed by a business specifically accredited by a Centers for Medicare and Medicaid (CMS) deemed accreditation organization to provide CRT.

Payments for DMEPOS will be calculated using the 2016 Nevada-specific non-rural fee schedule issued by the Centers for Medicare and Medicaid Services (CMS). Reimbursement will be set at 100% of the Nevada-specific rates.

d. Disposable supplies:

1. If a supply item is billed through point of sale (POS), using a National Drug Code (NDC) number, reimbursement is the lower of: a) usual and customary charge, or b) gross amount due or c) Wholesale Acquisition Cost (WAC) + 8% as indicated on the current national drug data base utilized in Point-of-Sale plus a handling fee. For drugs without a WAC acquisition cost will be reimbursed plus a handling fee.

2. All other supplies billed outside POS, using Healthcare Common Procedure Coding System (HCPCS) codes and/or Current Procedural Terminology (CPT) codes are reimbursed the lower of: a) billed charge, or b) fixed fee schedule.

Assurance: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both public and private providers of the service. The Division's Home Health Care Services fee schedule rates were set as of July 1, 2016 and are effective for services provided on or after that date.

The Division's Durable Medical Equipment, Prosthetics, Orthotics and Supplies fee schedule rates were set as of July 1, 2019 and are effective for services provided on or after that date. All rates are published on our website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

8. Private duty nursing services: lower of a) billed charges, or b) fixed fee schedule. The Agency's rates were set as of January 1, 2024 and are effective for services on or after January 1, 2024.

Assurance: State developed fee schedule rates are the same for both public and private providers of the service and the fee schedule and any annual/periodic adjustments to the fee schedule(s) are published on the official Website of the Devision of Health Care Financing and Policy at: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

9. Special clinic services: as indicated for specific services listed elsewhere in this attachment, e.g., physicians' services, prescribed drugs, therapy. Payment will be the lower of billed charges, or the amounts specified below:
   a. Surgical Codes will be reimbursed at 69% of the Medicare facility rate.
   b. Radiology Codes will be reimbursed at 100% of the Medicare facility rate.
   c. Medicine Codes and Evaluation and Management codes will be reimbursed at 60% of the Medicare non-facility rate. Vaccine Products will be reimbursed at 85% of the Medicare non-facility rate.
   d. When Codes 90465 – 90468, 90471 – 90474, 99381 – 99385 and 99391 – 99395 are used for EPSDT services, the reimbursement will be 85% of the Medicare non-facility rate.
   e. Obstetrical Service Codes will be reimbursed at 88% of the Medicare non-facility rate.
   f. Medicine Codes 90281 – 90399, and all other pharmaceuticals that are not identified above, will be reimbursed according to the drug reimbursement algorithm set forth on Page 3 of Attachment 4.19-B with the exception of the pharmacy dispensing fee component of the algorithm.
   g. Freestanding Obstetrical/Birth Centers will be reimbursed an all-inclusive (one time) rate for Procedure Code 59409 that shall not exceed 80% of the Hospital In-patient Maternity daily rate. The rate will be reviewed and updated annually as necessary at the FFY (Oct. – Sept.).

Assurance: State developed fee schedule rates are the same for both public and private providers of the service and the fee schedule and any annual/periodic adjustments to the fee schedule(s) are published on our website: http://dhcfp.nv.gov/

Dental services:

I. STANDARD DENTAL SERVICES

Current Dental Terminology (CDT) codes will be reimbursed based on the base units in the "Relative Values for Dentists" publication by Relative Value Studies; Incorporated for the year the specific CDT code was set in the system. Effective January 1, 2024, payment is determined by multiplying the base units by the conversion factor of $ 21.53.

II. MEDICAL/SURGICAL PROCEDURES RELATED TO DENTAL SERVICES

Services billed using Current Procedure Terminology (CPT) codes will be calculated using the January 1, 2014 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:

a. Surgical Codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 99.75 % of the Medicare facility rate, effective January 1, 2024.
b. Radiology Codes 70000 – 79999 will be reimbursed at 105% of the Medicare facility rate.
c. Evaluation and Management Codes 99201 – 99499 will be reimbursed at 99.75% of the Medicare non-facility rate, effective January 1, 2024.

Assurance: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both public and private providers of the service. The agency's rates for medical/surgical procedures related to dental services were set as of January 1, 2024 and are effective for services provided on or after that date. All rates are published on our website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/.

11. Physical therapy, occupational therapy, respiratory therapy and audiology services for individuals with speech, hearing and language disorders will be reimbursed the lower of a) billed charges, or b) fee schedule rate which is 77% of the Medicare non-facility rate. The Medicare non-facility rate is calculated using the January 1, 2014 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2014 Medicare Physician Fee Schedule conversion factor.

Assurance: State developed fee schedule rates are the same for both public and private providers of the service. The agency's therapy fee schedule rates were set as of January 1, 2017 and are effective for services provided on or after that date. All rates are published on our website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

12. a. Nevada Medicaid will meet all reporting and provision of information requirements of Section 1927(b)(2) and the requirements of subsections (d) and (g) of Section 1927.

The State assures that the State will not provide reimbursement for an innovator multi-source drug, subject to the Federal Upper Limits (42 CFR 447.332(a)), if, under applicable State law, a less expensive non-innovator multi-source drug could have been dispensed.

1. Payment for multi-source drugs shall be the lowest of (a) Federal Upper Limit (FUL) as established by the Centers for Medicare and Medicaid Services (CMS) for listed multi-source drugs plus a professional dispensing fee of $10.17 per prescription; (b) State Maximum Allowable Cost (MAC) plus a professional dispensing fee of $10.17 per prescription; (c) Actual Acquisition Cost (AAC) plus a professional dispensing fee of $10.17 per prescription; or (d) the pharmacist's usual and customary charge.

2. Payment for covered outpatient drugs other than multi-source drugs shall not exceed the lower of (a) AAC plus a professional dispensing fee of $10.17 per prescription; or (b) the pharmacist's usual and customary charge to the general public.

3. Actual Acquisition Cost (AAC) is defined by Nevada Medicaid as the Agency's determination of the actual prices paid by pharmacy providers to acquire drug products marked or sold by specific manufacturers and is based on the National Average Drug Acquisition Cost (NADAC). Wholesale Acquisition Cost (WAC) + 0% will be offered for those drugs not available on NADAC, plus a professional dispensing fee of $10.17 per prescription.

4. A generic drug may be considered for MAC pricing if there are two or more therapeutically equivalent, multi-sources, non-innovator drugs with a significant cost difference. The MAC will be based on drug status (including non-rebatable, rebatable, obsolete, therapeutic equivalency ratings) marketplace availability and cost. The obsolete drug status will be taken into account to ensure that the MAC pricing is not influenced by the prices listed for obsolete drugs. The MAC will be based on drug prices obtained from a nationally recognized comprehensive data file maintained by a vendor under contract with the Department.

5. Ingredient cost reimbursement for 340B covered entities shall be the lowest of (a) AAC, or (b) the 340B ceiling price. A professional dispensing fee of $10.17 will also be paid.

6. Drugs acquired through the federal 340B drug pricing program and dispensed by 340B contract pharmacies are not covered.

7. For drugs that are purchased outside the 340B program, the ingredient cost reimbursement will be based on AAC plus a professional dispensing fee of $10.17 per prescription.

8. For drugs purchased through the Federal Supply Schedule (FSS), the ingredient cost reimbursement is based on AAC plus a professional dispensing fee of $10.17 per prescription.

9. For drugs acquired at a nominal price (outside of 340B or FSS), the ingredient cost reimbursement is based on AAC plus a professional dispensing fee of $10.17 per prescription.

10. Providers that are approved to be reimbursed through an encounter rate(s) meet AAC requirements.

11. For drugs (such as specialty drugs) not distributed by a retail community pharmacy, and distributed primarily through the mail, the ingredient cost reimbursement is based on AAC plus a professional dispensing fee of $10.17 per prescription.

12. For drugs (such as a long-term care facility drugs) not distributed by a retail community pharmacy, the ingredient cost reimbursement will be based on AAC plus a professional dispensing fee of $10.17 per prescription.

13. Payment for Physician Administered Drugs (PADs) is limited to the lesser of the Nevada Medicaid PAD fee schedule, Medicare Part B fee schedule, NADAC, WAC, or AAC.

    a. No dispensing fee is paid for a PAD.

    b. For 340B PADs, the ingredient cost reimbursement will be the lowest of (a) AAC or (b) 340B ceiling price.

14. For clotting factor drugs, ingredient cost reimbursement will be the lowest of AAC plus a professional dispensing fee of $10.17 per prescription, or the pharmacist's usual and customary charge.

    a. For clotting factor drugs provided by 340B entities, the ingredient cost reimbursement will be the lowest of (a) AAC, or (b) 340B ceiling price, plus a professional dispensing fee of $10.17 per prescription.

15. Out-of-state providers will be reimbursed a professional dispensing fee of $10.17 per prescription.

16. The state of Nevada does not cover investigational drugs.

12. a. Dentures: lower of a) billed charge, or b) fixed fee per unit value. See also 10.

b. Prosthetic devices: (1) hearing aids: wholesale cost plus fixed fee; (2) all others: retail charge less negotiated discount.

c. Eyeglasses: (1) frames: wholesale cost to a fixed maximum; (2) lenses: laboratory invoice cost; (3) material services: lower of a) billed charge, or b) fixed fee per Medicaid assigned unit value.

Assurance: State developed fee schedule rates are the same for both public and private providers for dentures, prosthetic devices and eyeglasses. The Agency's fee schedule rates were set as of January 1, 2017 and are effective for services provided on or after that date. All rates are published on the Agency's website at: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

13. a. Other diagnostic services: lower of a) billed charges, or b) fixed fee per unit value.

b. Other screening services: lower of a) billed charges, or b) fixed fee per unit value.

c. Other preventive services: lower of a) billed charges, or b) fixed fee per unit value.

1. Medical Nutrition Therapy
Payment for medical nutrition therapy services billed by a Licensed and Registered Dietician will be calculated using the January 1, 2014 unit values for the Nevada specific resource based relative value scale (RBRVS) and the 2014 Medicare Physicians Fee Schedule conversion factor. Payment for Medicine Codes 90000 – 99199 will be reimbursed the lower of billed charges or 63% of the Medicare non-facility rate.
2. Doula
Effective for dates of service on or after April 1, 2022, doula services provided during labor and delivery (includes antepartum and postpartum period) are reimbursed at the lower of billed charges or the amounts specified below:
   i. Codes 59409, 59514, 59612 and 59620; $150.00
   ii. Code S9445; $50.00

d. Other rehabilitative services: PROVIDED WITH LIMITATIONS

Assurance: State developed fee schedule rates are the same for both public and private providers for other diagnostic, screening, Medical Nutrition Therapy (MNT) services, Doula services and rehabilitative services. The Agency's fee schedule rates for MNT services were set as of January 1, 2018 and are effective for services provided on or after that date. The Agency's fee schedule rates for Doula services rates were set as of April 1, 2022 and are effective for services provided on or after that date. All rates are published on the Agency's

website at:
http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

Other rehabilitative services: PROVIDED WITH LIMITATIONS:

1. Non-Residential Mental Health Rehabilitative Services

A. Reimbursement Methodology for Non-Residential Mental Health Rehabilitation Services provided by a state or local government entity:

Non-residential mental health rehabilitation services:
Examination, Psychiatric Diagnostic Interview – 1 unit per 75 to 80 minutes
Examination, Interactive Psychiatric Diagnostic Interview – 1 unit per 75 to 80 minutes
Individual Psychotherapy – 1 unit per 20 to 30 minutes; or 1 unit per 45 to 50 minutes; or 1 unit per 75 to 80 minutes
Psychoanalysis – 1 unit per 60 minutes
Family Psychotherapy – 1 unit per 60 minutes
Group Psychotherapy – 1 unit per 90 minutes; or 1 unit per 120 minutes
Individual Psychophysiological Therapy – 1 unit per 20 to 30 minutes; or 1 unit per 45 to 50 minutes
Biofeedback – 1 unit per 20 to 30 minutes; or one unit per 40 to 50 minutes
Psychological Testing – 1 unit per 60 minutes
Developmental Testing – 1 unit per 60 minutes
Examination, Neurobehavioral Status – 1 unit per 60 minutes
Neuropsychological Testing – 1 unit per 60 minutes
Assessment, Health and Behavior – 1 unit per 15 minutes
Intervention, Health and Behavior – 1 unit per 15 minutes
Evaluation and Management – 1 unit per 10 minutes; or 1 unit per 15 minutes; or 1 unit per 25 minutes; or 1 unit per 40 minutes
Screening, Behavioral Health – 1 unit per 15 minutes
Out of Office Therapy – 1 unit per 15 minutes
Out of Office Assessment – 1 unit per 90 minutes
Medication training and support, out of office – 1 unit per 15 minutes
Medication training and support, in office – 1 unit per 15 minutes
Peer to Peer support, individual – 1 unit per 15 minutes
Crisis Intervention, telephonic, face to face, team – 1 unit per 15 minutes
Day treatment – 1 unit per 15 minutes
Basic Skills Training, individual or group – 1 unit per 15 minutes
Psychosocial rehabilitation, individual or group – 1 unit per 15 minutes
Partial Hospitalization – 1 unit per 60 minutes
Intensive Outpatient Program – per diem
Not all of the above unit values are billing units, for those codes that have a unit of measure defined as an “encounter” in the current Procedural Coding Expert, the values listed are time comparables for rate development.

FIN REF: Attachment 3.1-A, Page 6b.1 – 6b.3

Non-Residential Mental Health services provided by a state or local government entity 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.

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 Non-Residential Mental Health 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.

   b. reconcile its interim payments to its total Medicaid-allowable costs.

   The annual Medicaid Cost Report includes a certification of funds 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.

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) Total 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 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% 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. 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, TPL, received for the same services 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 are 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 cost 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 cost 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% 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. The direct medical services 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

(h) 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 24-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.

B. Reimbursement Methodology for Non-residential Mental Health Rehabilitation Services provided by non-governmental entities and governmental entities who do not undergo the Medicaid cost identification and reporting procedures:

Non-residential mental health rehabilitation services:

Examination, Psychiatric Diagnostic Interview – 1 unit per 75 to 80 minutes
Examination, Interactive Psychiatric Diagnostic Interview – 1 unit per 75 to 80 minutes
Individual Psychotherapy – 1 unit per 20 to 30 minutes; or 1 unit per 45 to 50 minutes; or 1 unit per 75 to 80 minutes
Psychoanalysis – 1 unit per 60 minutes
Family Psychotherapy – 1 unit per 60 minutes
Group Psychotherapy – 1 unit per 90 minutes; or 1 unit per 120 minutes
Individual Psychophysiological Therapy – 1 unit per 20 to 30 minutes; or 1 unit per 45 to 50 minutes
Biofeedback – 1 unit per 20 to 30 minutes; or one unit per 40 to 50 minutes
Psychological Testing – 1 unit per 60 minutes
Psychological Testing – 1 unit per 60 minutes
Developmental Testing – 1 unit per 60 minutes
Examination, Neurobehavioral Status – 1 unit per 60 minutes
Neuropsychological Testing – 1 unit per 60 minutes
Neuropsychological Testing – 1 unit per 60 minutes
Assessment, Health and Behavior – 1 unit per 15 minutes
Intervention, Health and Behavior – 1 unit per 15 minutes
Evaluation and Management – 1 unit per 10 minutes; or 1 unit per 15 minutes; or 1 unit per 25 minutes; or 1 unit per 40 minutes
Screening, Behavioral Health – 1 unit per 15 minutes
Out of Office Therapy – 1 unit per 15 minutes
Out of Office Assessment – 1 unit per 90 minutes
Medication training and support, out of office – 1 unit per 15 minutes
Medication training and support in office – 1 unit per 15 minutes
Peer to Peer support, individual – 1 unit per 15 minutes
Crisis Intervention, telephonic, face to face, team – 1 unit per 15 minutes
Day treatment – 1 unit per 15 minutes
Basic Skills Training, individual or group – 1 unit per 15 minutes
Psychosocial rehabilitation, individual or group – 1 unit per 15 minutes

Not all above unit values are billing units, for those codes that have a unit of measure defined as an "encounter" in the current Procedural Coding Expert, the values listed are time comparables for rate development.

1. Non-residential mental health rehabilitation services provided by private entities or governmental entities that do not undergo the Medicaid cost identification and reporting procedures will be reimbursed based on a statewide fee schedule.

   Rate Methodology:

   The rates are 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 rates:

   - 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 mental health rehabilitation 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 four hours per day. This is to assist with paperwork and follow-up related to treatment.
   - Allowance for supervisory time – costs for the time directly spent in supervising the medical professional providing these services.
   - Allowances for capital costs – the costs are 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 costs 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.

The following steps are used to determine the rates:

1. The State will use Nevada-specific hourly wages from the Bureau of Labor Statistics.
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 to the hourly rate.
4. The adjusted hourly rate per individual is the hourly rate per individual (Item 3) increased by the program support costs per hour per individual, allowance for supervisory time and capital costs per hours.
5. Administrative overhead (10%) is applied to the adjusted hourly rate per individual (Item 4).
6. Total hourly rate is the sum of the adjusted hourly rate per individual before administrative overhead (Item 4) and the administrative overhead (Item 5).
7. Total hourly rate is scaled to the proper unit based on the unit of service.
8. Group rate is the individual rate divided by the group size assumption.

Basic Skills Training rate effective January 1, 2019 was determined using wage information obtained from the provider network through a wage survey.

When a Nevada specific hourly wage cannot be determined using the Bureau of Labor Statistics, the State may use wage information obtained from the provider network.

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 Division of Health Care Financing and Policy.

The Agency's rates were set as of January 1, 2006 and are effective for services on or after that date. The Basic Skills Training rate that is established under SPA 18-010 will be effective January 1, 2019. All rates, including the Basic Skills Training rate, are published on the Agency's website at http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

Services provided by an out-of-state provider require prior authorization by Nevada Medicaid, which must verify that the services required by Medicaid-eligible or pending-eligible clients are not available in Nevada. The out-of-state payment rate for services provided by an out-of-state provider is based on one of the following criteria:

1. The out-of-state provider will be paid the lesser of the provider's billed charges or the Fee-for-Service rate that is paid to an in-state provider for the service.

2. If the out-of-state provider refuses to accept this rate, then the out-of-state provider may be paid the lesser of the provider's billed charges or the same Fee-for-Service rate as it would be paid by its home state Medicaid program.

c. For services that cannot be provided by a provider that accepts payment under (A) or (B), the State will maintain a list of other qualified out-of-state providers and will negotiate competitive rates that will not exceed the provider's customary charge."

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.

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 four 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.

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

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 for Provider Type 32, Ambulance, Air or Ground are published on the agency's website:
http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

14. RESERVED

15. RESERVED

16. RESERVED

17. RESERVED

18. Prior to the beginning of each rate year, governmental providers of emergency medical transportation, ground ambulance services, must select one of the reimbursement methodologies described below. Governmental providers must select their reimbursement methodology by April 30 for the rate year beginning July 1 and will not be able to change the selected reimbursement methodology until the following rate year.

    I. Reimbursement methodology for emergency medical transportation, ground or air ambulance services, provided by non-governmental entities and governmental entities that do not undergo the Medicaid cost identification, reporting, reconciliation and settlement procedures.

    Emergency Medical 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 15%.

    II. Reimbursement methodology for emergency medical transportation, ground ambulance services, provided by a government entity which selects cost identification, reporting, reconciliation and settlement.

Governmental entities may select a reimbursement methodology for emergency medical transportation that is based on cost identification, reporting, reconciliation and settlement. This methodology reimburses governmental entities for uncompensated care costs for providing emergency medical transportation services to Nevada Medicaid beneficiaries. Uncompensated care costs are allowable costs in excess of payments made by Nevada Medicaid. This reimbursement will include a base payment per emergency medical transportation claim plus a final supplemental payment adjustment so that total reimbursement does not exceed or fall short of the total cost of providing services to Medicaid beneficiaries.

A. Definitions:

1. “Emergency Medical Transportation” is synonymous with “Emergency Medical Response.” It includes both the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient, as well as the advanced, limited-advanced and basic life support services provided to an individual by emergency medical transportation providers before or during the act of transportation.

2. "Emergency Medical Response" is a cost objective that includes expenditures for medical services performed at the point of injury or illness, typically outside of a medical facility, to evaluate or treat a health condition. An emergency medical response is classified as “medical" by dispatch if the primary reason for the response is to provide medicalservices.

3. “Direct costs” means all costs that can be identified specifically with particular final cost objectives in order to meet all medical transportation mandates.

4. “Shared Direct Costs" are direct costs that can be allocated to two or more departmental functions or cost objectives on the basis of shared benefits.

5. “Indirect costs” means costs for a common or joint purpose benefitting more than one cost objective that are allocated to each benefitting objectives using an agency approved indirect rate or an allocation methodology. Indirect costs rate or allocation methodology must comply with 2 CFR, Part 200 and CMS non-institutional reimbursement policies.

6. “Service Period” means the period from July 1st through June 30th of each Nevada state fiscal year.

B. Provider Eligibility for Medicaid Reimbursement Based on Cost Identification.

To be eligible to receive reimbursement based on cost identification for emergency medical transportation, a provider must meet all of the requirements described below:

1. The provider is owned or operated by an eligible government entity to include the state, a city, a county, a consolidated city and county, a fire protection district organized pursuant to Nevada Revised Statutes Chapter 474 or a federally recognized Indian tribe.

2. The provider is enrolled as a Nevada Medicaid provider for the period being claimed.

3. The provider delivers emergency medical transportation services to Nevada Medicaid beneficiaries.

4. The provider has a Cost Allocation Plan (CAP) approved by the State Medicaid Agency on file with the State.

C. Interim Medicaid Payment

1. "Base Payment" is the interim reimbursement paid for each transport as a result of Medicaid claiming by the provider throughout the year. The base payment in the period October 1, 2015 through September 30, 2017 is determined by the Nevada Medicaid Fee-for-Service ambulance fee schedule. For periods beginning October 1, 2017, the base payment is the average cost per transport as determined in the most recent available cost report. The average cost per transport is determined by dividing the total allowable costs of providing emergency medical transportation services by the total number of emergency medical transports.

D. Methodology for Reimbursement of Emergency Medical Transportation Services Based on Cost Identification.

1. A provider's specific allowable cost per-medical transport rate will be calculated based on the provider's audited financial data reported on the CMS-approved cost report. The per-medical transport cost rate will be the sum of actual allowable direct and indirect costs of providing medical transport services divided by the actual number of medical transportation services provided for the applicable service period.

a. Direct costs for providing medical transport services include only the unallocated payroll costs for those emergency response staff who dedicate 100% of their time to providing medical transport services; medical equipment and supplies, and other costs directly related to the delivery of covered services, such as first-line supervision, materials and supplies, professional and contracted services, capital outlay, travel and training. These costs must be in compliance with Medicaid non-institutional reimbursement policies and are directly attributable to the provision of the medical transport services.

b. Shared direct costs for emergency medical transportation services as defined by Section A.1, must be allocated for personnel, capital outlay and other costs; such as, medical supplies, professional and contracted services, training and travel. The personnel costs will be allocated based on the percentage of total hours logged performing emergency medical transportation activities versus other activities. The capital and other direct costs will be allocated based on the percentage of total call volume.

c. Indirect costs are determined based on the provider's approved cost allocation plan.

d. The provider specific per-medical transport cost rate is calculated by dividing the total net medical transport allowable costs (Item 1.a, Item 1.b and Item 1.c) of the specific provider by the total number of medical transports provided by the provider for the applicable service period.

2. Medicaid's portion of the total allowable cost for providing emergency medical transportation services by each eligible provider is calculated by multiplying the total number of Medicaid FFS transports provided by the provider's specific per-medical transport cost rate (Paragraph D.1.d) for the applicable service period.

E. Eligible Provider Reporting Requirements:

Eligible provider shall:

1. Report and certify total computable allowable costs annually on a CMS-approved Nevada Medicaid Emergency Transportation Services Cost Report, which is to be submitted annually by December 1 to the State Medicaid Agency. The Cost Report includes a certification of expenditures statement that states the total costs reported are accurately reported and allowable.

2. Provide documentation to serve as evidence supporting the information on the cost report and the cost determination as specified by the State Medicaid Agency.

3. Keep, maintain and have readily retrievable, such records as specified by the State Medicaid Agency.

4. The provider will comply with the allowable cost requirements provided in 42 CFR, Part 413, 2 CFR, Part 200 and Medicaid non-institutional reimbursement policies.

F. State Medicaid Agency's Responsibilities:

1. The State will submit to CMS claims based on total computable certified expenditures for emergency transportation services provided that are allowable and in compliance with federal laws and regulations and Medicaid non-institutional reimbursement policies.

2. As part of its financial oversight responsibilities, the State will review each provider's Cost Report for reasonableness and accuracy and reconcile the Cost Report to the provider claims data obtained from the Medicaid Management Information System (MMIS). The state will complete the cost report review and settlement process of the interim payments for the service

period within three years of the postmark date of the cost report.

3. If the interim Medicaid payments exceed the actual certified costs of a provider, the State will recoup any overpayments and return the Federal share to the Federal government in accordance with 42 CFR 433.316. 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.

III. Non-emergency transportation:

A. Non-emergency transportation is authorized through a contracted NET Broker, as specified in Attachment 3.1-D.

B. Non-Emergency Secure Behavioral Health Transports will be reimbursed for the following codes:

1. T2003 UA will be the base rate and reimburse at 70% of the BLS A0429 rate.

2. S0215 UA will be the mileage rate and reimburse at 70% of the mileage rate of A0380.

C. Reimbursement Methodology for Non-Emergency Paratransit services provided by the Regional Transportation Commission (RTC) operated by local government entities:

1. 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:

a. 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.

b. The total direct costs (from Item A) are reduced by any federal grant funds received for the same services to arrive at the net allowable direct costs.

c. Indirect costs are determined by applying a ten percent indirect cost rate to the net allowable direct costs (from Item B).

Continued on Page 4 (Addendum)

1. Net allowable costs are the sum of the net allowable direct costs (Item 2) and indirect costs (Item 3).

2. The cost-based rate is the net allowable costs (from Item 4) divided by the total forecasted transportation service utilization.

15. a. Services of Religious non-medical Healthcare Institution nurses: NOT PROVIDED.

b. Services in Religious non-medical Healthcare Institutions sanitoria: NOT PROVIDED.

c. Hospice Services: Reimbursed at the established annual Medicaid rate regardless of billed charges. The agency's rates were set as of October 1, 2008 and are effective for services on or after that date. Rates are adjusted annually each year thereafter in accordance with 42CFR 418.

d. Hospice provided in a long-term care facility: Reimbursed 95% of the nursing facility daily rate for room and board provided by the nursing facility or long-term care facility.

16. Emergency hospital services out-of-state: lower of: a) billed charges, or b) local Medicaid maximums. The agency's rates were set as of July 1, 2005 and are effective for services on or after that date.

17. Personal care services in recipients' home and setting outside the home: fixed hourly rate established by the State of Nevada legislative body.

For personal care services performed on or after January 1, 2024, fixed hourly rate will be determined by multiplying a factor of 1.4237 (equal to 42.37%) times the July 1, 2020 rate. Providers must pay direct home care workers a minimum hourly wage of at least $16.00 per hour as a condition of receiving the $25.00 per hour rate for personal care services eligible for reimbursement under this section. Providers who fail to pay direct care home workers at least $16.00 per hour will be reimbursed at the previous rates in effect December 31, 2023. This reduced rate will remain in effect until the provider complies with the wage requirement above.

The Agency's rates for personal care services will be updated on January 1, 2024 to reflect the rate increase, as specified above. All rates are published on the Agency's website at http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/.

18. RESERVED

All Targeted Case Management groups will be reimbursed using the following methodologies effective as of July 1, 2009.

23. Targeted Case Management (TCM) services will be reimbursed as follows:

Prior to the beginning of each rate year, each of the governmental providers providing TCM services must select one the reimbursement methodologies described below for reimbursement. For example, by April 30, 2009, governmental providers must select a methodology for the rate year beginning July 1, 2009. 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.

A. Reimbursement Methodology for Targeted Case Management Services provided by a non-governmental entity and governmental entities who do not undergo the Medicaid cost identification and reporting procedures:

I. TCM: One unit per 15 minutes.

II. TCM services provided by a private/non-governmental entity and governmental entities that do not undergo the Medicaid cost identification and reporting procedures will be reimbursed the lower of a) billed charges, or b) a fixed quarter hour rate.

III. The quarterly hour rate is a market based model. This model reflects service definitions, provider requirements, operational service delivery and administrative considerations. The following elements are used to determine the rate:

1. 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 CM and TCM services.
2. Employee rated expenses (ERE) percentage of 27% was based on input from the Provider Rates 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.
3. 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.
4. Allowance for supervisory time – costs for the time directly spent in supervising the professional providing this CM and/or TCM service.
5. Allowance for capital costs – the costs are not included in the administrative overhead. It includes the average hourly expense, for building rental and maintenance, equipment leasing and utility expenses.
6. Allowance for mileage – the average costs related to the miles to travel to clients.

7. 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.

IV. The following steps are used to determine the fixed quarter hour rate:

1. The State will use Nevada-specific hourly wages from the Bureau of Labor Statistics.
2. This hourly compensation is increased by the 27% ERE.
3. A productivity factor is applied to the hourly compensation calculated in Item 2 to equal the adjusted hourly rate.
4. Allowance for supervisory time is determined.
5. Administrative overhead (10%) is applied to the sum of adjusted hourly rate (Item 3) and the allowance for supervisory (Item 4).
6. Allowance for mileage cost is determined.
7. Allowance for capital costs is determined.
8. Fixed hourly rate is the sum of adjusted hourly rate (Item 3), allowance for supervisory time (Item 4), administrative overhead (Item 5), allowance for mileage (Item 6), and allowance for capital costs (Item 7).
9. Quarter hour rate is the fixed hourly rate (Item 8) divided by 4.

This rate has 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 www.dhcfp.nv.gov

B. Reimbursement Methodology for Targeted Case Management Services provided by a state or local government entity:

Targeted Case Management 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.

I. 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. 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.

The Agency's rates were set as of July 1, 2007 and are effective for services on or after July 1, 2009. All rates are published on the Agency's website at www.dhcfp.nv.gov

II. 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 Targeted Case Management 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 the 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. Settings 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.) Total 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 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-intuitional reimbursement policy. The indirect costs details are accumulated on the annual cost report.

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

(e.) A CMS approved time study is required when providers of service do not spend 100% of their time providing the Targeted Case Management services described in the applicable Section 3.1-A State plan pages and is used to determine the percentage of time that case management service personnel spend on direct Targeted

Case Management services, general and administrative time, and all other activities to account for 100% 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. The direct Targeted Case Management 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 (f) is reduced by any revenue, e.g. Medicaid co-payments, TPL, received for the same services 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.

(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 specified approved indirect cost rate to its net direct costs (Item b.). If the entity 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 indirect costs are reduced by any allowable 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 Targeted Case Management services described in the applicable Section 3.1-A State Plan pages and is used to determine the percentage of time that case management service personnel spend on direct Targeted Case Management services, general and administrative time and all other activities to account for 100% 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. The direct Targeted Case Management services 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 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.

24. RESERVED

25. Newly developed Current Procedural Terminology (CPT) codes determined to be for Nevada Medicaid covered services: Codes for those services with a rate methodology which uses resource based relative value scale (RBRVS), as specified elsewhere in this Attachment, will be entered into the system using the Nevada specific unit value developed by Medicare. The 2014 Medicare Physician Fee Schedule conversion factor will be used to calculate payment for these newly developed codes where the RBRVS is used. The maximum allowable will be established by multiplying the unit value and the 2014 conversion factor and then paying the appropriate percentage, as specified elsewhere in this Attachment, based on the provider type, service type and CPT code range.

    If a code is billed that has no Nevada specific Medicare rate, the Division will determine if there is national Medicare pricing. If so, the service will be paid at the appropriate percentage of the rate, as specified elsewhere in this Attachment. If there is no national Medicare pricing, the Division will establish pricing based on similar services.

(Reserved for Future Use)

(Reserved for Future Use)

26. Surgical services provided in both hospital-based and freestanding Ambulatory Surgical Centers (ASC)

a. Payments for services billed by hospital-based and freestanding Ambulatory Surgical Centers (ASC) will be calculated using the Centers for Medicare & Medicaid Services (CMS) Ambulatory Payment Classification (APC) grouping as published in 42 CFR Parts 405, 410, 412 ,413, 416 and 419. A Nevada ASC Base Rate will be established for each service by multiplying the associated 2016 ASC payment weight from the APC group (found in CMS-1633-FC-Addenda file) by the 2016 ASC conversion factor of 44.177 (found in CMS–1633–FC; CMS–1607–F2), then multiplying the result by the 2016 NV Wage Index of 0.9299 (Found in CMS-1633-FC Wage Index file).
   1. Surgical Codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 85% of the NV ASC Base Rate.

b. Services that CMS identifies as excluded from payment in an ASC setting, but are deemed appropriate to be performed in that setting by NV Medicaid Policy, will be paid using the CMS Outpatient Prospective Payment System (OPPS) relative weight from the associated APC group for that service in place of the ASC payment weight to establish the NV ASC Base Rate.

c. In the case of multiple procedures, the following adjustments to the fee schedule are made:
   1) First procedure 100% of fee schedule
   2) Second procedure 50% of fee schedule
   3) Third procedure 25% of fee schedule
   4) Fourth procedure 10% of fee schedule
   5) Fifth and thereafter procedures 5% of fee schedule

d. Professional services are reimbursed as indicated in Page 1c of Section 4.19-B.

e. Cornea Procurement will be reimbursed at 100% of the procurement charges as listed in the 2013 The Lewin Group Study.

Assurance: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both public and private providers of the service. The agency's outpatient surgery (ASC) fee schedule rates were set as of January 1, 2017 and are effective for services provided on or after that date. All rates are published on our website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

Methods and Standards Used to Determine Payment
For Emergency Medical Services for Illegal Aliens

Hospital, emergency clinics and county social service/welfare departments have been informed about the availability of emergency medical services and application procedures for aliens who have not been lawfully admitted for permanent residence or otherwise are not permanently residing in the United States under color of law.

When a hospital, clinic or county social service department determines a person receiving emergency services is indigent and an illegal alien, the alien will be referred to the State Welfare Division District Office for application. If the applicant is unable or reluctant to go to the Welfare District Office, the hospital/clinic/social service department will assist the applicant in completing the application and gathering verification and will send the application and verification to the Welfare District Office with the billing(s).

The District Office eligibility worker will request from the provider a bill or other evidence services were rendered and will obtain an application (if not already completed) and necessary verifications/information. The eligibility worker will approve eligibility for the months in which services were rendered and the applicant meets income/resource and other criteria (e.g., disability or incapacity). (A Medicaid card will not be issued to the client.) Providers will be notified of client eligibility so applicable bills may be submitted to the Medicaid fiscal agent for payment determination and processing based on whether the alleged qualifying services actually met the emergency criteria. The fiscal agent will notify providers of the reason for any payment denial.

Medicaid will make payment only for the alien's care and services which are necessary for the treatment after sudden onset of an emergency medical condition. As defined in Section 1903(v), an "emergency medical condition means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

(A) placing the patient's health in serious jeopardy,

(B) serious impairment to bodily functions, or

(C) serious dysfunction of any bodily organ or part.

Payment for Qualified Medicare Beneficiaries (QMBs)

For Qualified Medicare Beneficiaries, Nevada Medicare will pay the Medicare deductibles and coinsurance subject to the following limitation: The Medicare payment (allowable charge) plus the deductible and coinsurance may not exceed the Medicaid maximum allowable payment. For Medicare services, which are not covered by Nevada Medicaid, or for which Nevada Medicaid does not have an established payment rate, Nevada Medicaid will pay the Medicare deductible and coinsurance amounts.

QMB claims for services which are covered by Medicare are not subject to Medicaid limitations. Medicaid will reimburse the deductible and coinsurance up to the Medicaid maximum allowable payment. Also, prior authorization is not required for Medicare allowable services for dually entitled QMBs. If Medicare benefits are exhausted or Medicare does not cover the service and the service is covered by Medicaid, prior authorization is required if the service or benefit normally requires it.

REIMBURSEMENT FOR INDIAN HEALTH SERVICE TRIBAL 638 HEALTH FACILITIES

Nevada Medicaid reimburses Indian Health Services facilities and Tribal 638 facilities in accordance with the most recently published Federal Register.

The published, all inclusive, rate is paid for up to five face-to-face encounters/visits per eligible Medicaid recipient per day. Encounters/visits are limited to healthcare professionals as approved under the Nevada Medicaid State Plan.

Alternative Payment Methodology for Tribal Facilities Recognized as FQHCs

Outpatient health programs or facilities operated by a Tribe or Tribal organization that choose to be recognized as FQHCs in accordance with Section 1905 (I)(2)(B) of the Social Security Act and the Indian Self-Determination Act (Public Law 93-638) will be paid using an alternative payment methodology (APM) for services as described on Attachment 3.1-A, Page 1a, Paragraph 2c, that is the published, all-inclusive rate (AIR). The APM/AIR rate is paid for up to five face-to-face encounters/visits per recipient per day.

Nevada Medicaid will establish a Prospective Payment System (PPS) methodology for the Tribal facility so that the agency can determine on an annual basis that the published, all-inclusive rate is higher than the PPS rate. The PPS rate will be established by reference to payments to one or more other FQHCs in the same or adjacent areas with similar caseloads. If such an FQHC is not available, the PPS rate will be established by reference to payments to one or more other FQHCs in the same or adjacent areas with a similar scope of services. If there is no FQHC in the same or adjacent area with similar caseloads or similar scope of services, the PPS rate will be based on an average rate of other FQHCs throughout the state. The Tribal facility would not be required to report its costs for the purposes of establishing a PPS rate. The APM is effective for services provided on and after April 1, 2019.

Enhanced Rates for Practitioner Services
Delivered in a Teaching Environment

In order to ensure access to practitioner services by needy individuals in the state of Nevada and to recognize the higher cost of providing practitioner services in a teaching environment, enhanced payments will be made for services provided by Designated Practitioners through one of the following four eligible public teaching entities:

- University of Nevada, Las Vegas School of Dental Medicine
- University of Nevada, Las Vegas School of Medicine
- University of Nevada, Reno School of Medicine
- University Medical Center of Southern Nevada

Enhanced payments apply to claims paid on or after July 1, 2017 to Medicaid-enrolled Designated Practitioners providing approved Medicaid services through one of the eligible public teaching entities under the Nevada Medicaid State Plan. Medicaid Services must be billed under the Medicaid Billing Provider ID of a Designated Billing Provider.

The State of Nevada DHCFP must concur with the public teaching entity's designation of eligible practitioners in order for the payment adjustment to be applied.

The following Designated Practitioners are eligible for enhanced payments:

- Advanced Practitioner of Registered Nursing (APRN)
- Audiologist
- Clinical Psychologist
- Dentist
- Licensed Clinical Professional Counselor, Intern or Psychological Assistant
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Nurse Practitioner
- Licensed Registered Nurse
- Oral Surgeon
- Physician (MD or DO)
- Physician Assistant (PA-C)
- Speech Pathologist
- Optometrist
- Ophthalmologist
- Registered Dietician
- Registered Behavioral Technician

Rehabilitative Services: Certified Community Behavioral Health Center (CCBHC)

The Medicaid program will provide coverage for a bundle of medically necessary rehabilitative services under "Service Array" in Attachment 3.1A provided by practitioners employed by, or associated with, provider entities to be known as Certified Community Behavioral Health Center (CCBHCs). CCBHCs are provider entities certified by the Nevada Department of Public and Behavioral Health (DPBH) as meeting the State's qualifications for a CCBHC.

The State agency will reimburse CCBHC practitioners a facility-specific bundled daily rate applicable to providers affiliated with CCBHCs.

These cost-based rates reflect the center's unique costs and they ensure that CCBHCs receive at least their costs for providing services to Medicaid members. Payments will be limited to one payment per day, per recipient, regardless of the number of services received within a single day by center users accessing services from CCBHC practitioners. Encounters with more than one health practitioner and multiple encounters with the same health practitioner that take place on the same day and that share the same or like diagnoses constitute a single billable encounter. This also applies to encounters with multiple CCBHC providers in the same day. Only providers affiliated with the CCBHC who are designated as the principle behavioral health provider and holds the plan of care, will be issued a facility-specific bundled daily rate.

The CCBHC bundled daily reimbursement methodology is effective for services provided on and after August 1, 2019.

Interim bundled daily rate for year one (new facilities without an established rate)

The State will allow the use of anticipated allowable costs to determine first year bundled daily rates. To determine the interim bundled daily rate for the first year of CCBHC operations, the State will:

- Utilize the CCBHC Cost Report as reviewed by the Centers for Medicare and Medicaid Services (CMS) to calculate the bundled per visit rate by dividing total allowable anticipated CCBHC services by total anticipated CCBHC visits.
- Allowable CCBHC cost include total direct cost of CCBHC services plus indirect cost applicable to CCBHC services.
    - Direct CCBHC cost include the actual salaries and benefits of Medicaid qualified providers, costs of services provided under agreement, and other direct CCBHC costs such as medical supplies or professional lability insurance specific to the CCBHC program. The CCBHC will also be required to identify the costs of providing "non-CCBHC services," so that related indirect costs can be excluded from the rate. Examples of "non-CCBHC" services that a community behavioral health provider might provide include psychiatric residential treatment programs and habilitative services for developmentally disabled individuals.

- Indirect costs include site and administrative costs associated with providing all clinic services, including both CCBHC and non-CCBHC services. Indirect costs are allocated based on a pro-rated share of CCBHC costs to non-CCBHC costs.

- Total CCBHC visits include all visits for CCBHC services, including both Medicaid and non-Medicaid visits. A CCBHC "visit" or an "encounter" for the purposes of reimbursing CCBHC services is defined as face-to-face contact with one or more qualified health professionals that take place on the same day with the same patient.

Reconciliation of bundled daily rate following year one

After the first year of operation, the CCBHC will be required to submit a cost report inclusive of all actual costs to provide services for the first year of operations to calculate the bundled per visit rate by dividing total allowable CCBHC services by total CCBHC visits. Cost and visit data vary based on CCBHC size, location, economy, and scope of services offered and must adhere to 45 Code of Federal Regulations (CFR) 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for the US Department of Health and Human Services (HHS) Awards and 42 CFR 413 Principles of Reasonable Cost Reimbursement. The CCBHC must submit all required documentation of actual costs for the first full year of providing services to Division of Health Care Financing and Policy (DHCFP) no later than 150 calendar days or 5 months after the first year of operations as a CCBHC. DHCFP will deem cost reports complete within 15 days of receipt. CCBHCs with missing documentation will be issued a cost report request letter, identifying missing documentation necessary to complete the cost report. The CCBHC will have 30 days from the date of the cost report request letter to submit additional documentation. If a CCBHC does not submit the required documentation to complete their cost report within 30 days, DHCFP reserves the right to suspend their Medicaid payments or require the CCBHC to pay back state Medicaid program payments received during the fiscal year period for which they were to provide a complete cost report. This process will remain in effect until the CCBHC has provided a complete cost report.

The DHCFP will conduct an annual settlement based on the difference in the anticipated costs used to inform the interim year one rate and the actual year one costs as determined by the cost report. The settlement will apply to all claims from the first day of services until the day the new rate is determined, which could result in a payout or a recoupment. CCBHCs will continue to be reimbursed at the year one rate until the determination of payment or recoupment is determined and the final bundled daily rate is calculated. Reconciliation will be completed within 18 months of deeming the cost report complete.

Bundled daily rate for year two

Once the daily bundled rate has been calculated using actual costs on the CCBHC cost report submitted after the end of year one, the rate effective date will be aligned with the start date of year two.

Bundled daily rate for year three onward

Thereafter, for each consecutive year on July 1st (SFY) the bundled daily rate will be trended by the current Medicare Economic Index (MEI) for primary care services as defined in Section 1842(i)(3) of the Social Security Act, which is intended to account for the basic cost increases associated with providing such services.

Bundled daily rates will not be subject to rebasing after the year 2 rate is set.

Quality Incentive Payments

All CCBHC practitioners are eligible for a Quality Incentive Payment (QIP) based on achieving specific numerical thresholds with regard to state mandated performance measures. The performance period shall be a state fiscal year (7/1-6/30). The eligibility of each CCBHC practitioner to receive a QIP is judged independently; and in order for a provider to receive a QIP, the CCBHC must achieve the thresholds on all of state mandated performance measures. A CCBHC will have met the particular performance measure by meeting or exceeding the posted improvement target goal for the measure. If the State chooses a measure for which there is no improvement target goal, the CCBHC can achieve the threshold for that measure by meeting or exceeding statewide mean for the measure. Performance measures shall be calculated exclusively on the basis of data for Medicaid beneficiaries, excluding beneficiaries dually eligible for the Medicaid and Medicare programs.

Each CCBHC will be required to submit electronic health record data to the State on a quarterly basis for calculation of the measures on an ongoing basis. CCBHCs that fail to submit all required data within six months following the end of the performance year will not be eligible for a QIP. Final results of the performance of each CCBHC on the required measures will be posted by June 30 of each year on DPBH website CCBHC pages and shared directly with each CCBHC.

DPBH shall establish the minimum patient volume in each performance measure denominator necessary for the performance measure to be valid. The amount of QIP to a CCBHC will be based on multiplying the total facility-specific bundled rate payments made to the CCBHC in the performance period by a statewide percentage not to exceed 10% based on pay for reporting requirements in the first year and 15% in each consecutive year based on pay for performance and pay for reporting requirements.

In the first year a 10% QIP is issued for submitting the required datasets, if a full year is reported. For a CCBHC practitioner who comes online partially through a fiscal year and a full year of data is not submitted, then a prorated amount will be paid for each month reported. For example, a CCBHC practitioner who came online effective January 1 would be eligible for 50% of the payment they would otherwise be eligible for the entire year.

In the second and subsequent years a 5% QIP will be issued if the required datasets are submitted. An additional 10% can be added to this payment and is broken down into 8.5% payment for attaining performance on all 6 required measures with another possible 1.5% payment for attaining performance for 1 optional measure (Plan All-Cause Readmission Rate).

When applicable, QIPs will be made in a lump sum payment, within 1 year following the end of the relevant measurement year (July 1 to June 30), and after all final data needed to calculate the QIP is received.

The state mandated QIP performance measures, technical specifications, patient volume minimums and target numerical thresholds for each measure are effective August 1, 2019 and are located at http://dpbh.nv.gov/Reg/CCBHC/CCBHC-Main/.

For the purposes of these enhanced payments for services provided by Designated Practitioners delivered in a teaching environment, the following definitions shall apply:

- Designated Practitioner means an individual practitioner or a practitioner group designated by one of the eligible public teaching entities as participating in medical education programs. To qualify for designation as a Designated Practitioner, the practitioner or practitioner group must be either an employee of the designating eligible public teaching entity or under contract with the designating eligible public teaching entity. Designations may apply to both public and private practitioners and practitioner groups.

- Designated Billing Provider means one of the eligible public teaching entities or a billing provider/provider group that facilitates meaningful medical education and is contracted by the designating eligible public teaching entity for billing Medicaid services provided by the Designated Practitioners.

  Medicaid Services means Fee-for-Service (FFS) practitioner services enumerated by Healthcare Common Procedure Coding System (HCPCS)/Common Procedural Terminology (CPT)/Code on Dental Procedures (CDT)/Code, delivered to Medicaid eligible recipients, and paid during the Claims Payment Period. The source of the service and payment data shall be the Nevada MMIS.

- The following services are excluded from the enhanced payment:

  - Services delivered to Medicaid eligible recipients enrolled in Medicaid Managed Care Organizations or Pre-Paid Ambulatory Health Plans (PAHP).
  - Clinical diagnostic lab procedures
  - Services provided to Medicaid recipients also eligible for Medicare
  - The technical component of radiological services
  - Services provided by practitioners/practitioner groups not designated by one of the eligible public teaching entities as Designated Practitioners for the entire Claims Payment Period
  - Services not billed by a Designated Billing Provider

- Medicaid Base Rate(s) means the applicable Medicaid FFS reimbursement rate(s) published by the DHCFP, applicable on the date of service.

- Claims Payment Period means the three-month period directly prior to the first day of each payment quarter.

- Base Period means the state fiscal year (July 1 – June 30) prior to the Claims Payment Period.

- Average Commercial Rate (ACR) means, for each procedure (HCPCS/CPT/CDT) code, the average reimbursement amount of the top five commercial payers to the public teaching entity. "Commercial payers" exclude Medicare, Workers Compensation and any other payer(s) not subject to market forces. The ACR for each procedure code is established separately for each public teaching entity every Base Period.

If an eligible public teaching entity's contracts with commercial payers do not include a rate for a Medicaid Service delivered by a Designated Practitioner, and the Designated Billing Provider's contracts with commercial payers do include a rate for the Medicaid Service, the designating public teaching entity's average ACR percentage increase over the Medicaid Base Rates will be applied to the Medicaid Base Rate for the Medicaid Service.

If an eligible public teaching entity does not have contracts in place with commercial payers during a Base Period, the ACRs will be calculated based on the public teaching entity's contracts with commercial payers in effect during the Claims Payment Period.

The enhanced payment for each eligible service will be the lesser of:

- The difference between Billed Charges and the Medicaid Base Rate.
- The difference between 100% of the ACR and the Medicaid Base Rate.

Each eligible public teaching entity will provide the following listings to the DHCFP no later than the fifth business day of the first month of a quarter:

- A list of Designated Practitioners to include the Practitioner Name, Practitioner National Provider Identification number (NPI), Designation Start Date, Designation End Date (if applicable) for the prior quarter.
- A list of Designated Billing Providers to include the Billing Provider Name, Billing Provider ID, Designation Start Date, Designation End Date (if applicable) for the prior quarter.

No later than the last business day of the first month of the quarter, the DHCFP will provide a separate report to each eligible public teaching entity which includes the utilization data for the services paid during the Claims Payment Period that were billed by their Designated Billing Providers and delivered by their Designated Practitioners. The public teaching entity must review the report and acknowledge the completeness and accuracy of the report no later than the last business day of the second month of the quarter. After receipt of this acknowledgement, the DHCFP will approve and process the quarterly enhanced payments for each Designated Billing Provider no later than the last business day of the last month of the quarter. The process includes a reconciliation that takes into account all valid claim replacements affecting claims previously processed, as well as a process for recoupment of erroneous enhanced payments.

The enhanced payments will be sent to the Designated Billing Providers through the identification number used to bill Medicaid under the FFS program.

Prior to July 1, 2023, the DHCFP used a date of payment based supplemental payment approach described above. Effective July 1, 2023, the DHCFP transitioned to using the date of service based supplemental payment approach described below.

Interim Payments

Effective for services provided on or after July 1, 2023, the DHCFP will make interim averaged quarterly payments on a quarterly basis. 180-days after the end of service period, the DHCFP will reconcile the interim averaged quarterly payment to date of service data from the applicable service period as described below.

Final Payment based on Date of Service methodology

Payment based on date of service data will be made using the same methodology in effect on June 30, 2023, but the following definitions will be in effect:

- Medicaid Services means Fee-for-Service (FFS) practitioner services enumerated by Healthcare Common Procedure Coding System (HCPCS)/Common Procedural Terminology (CPT)/Code on Dental Procedures (CDT)/Code delivered to Medicaid eligible recipients during the Service Period. The source of the service and payment data shall be the Nevada MMIS.

- Service Period means the three-month period that ends 180-days prior to the first day of each payment quarter.

- Base Period means the state fiscal year (July 1 – June 30) prior to the Service Payment Period.

- Interim Averaged Quarterly Payment means the Base Period payments added together and divided by three.

- Average Commercial Rate (ACR) means, for each procedure (HCPCS/CPT/CDT) code, the average reimbursement amount of the top five commercial payers to the public teaching entity. "Commercial payers" exclude Medicare, Workers Compensation and any other payer(s) not subject to market forces. The ACR for each procedure code is established separately for each public teaching entity every Base Period. The ACR for each procedure code is established separately for each public teaching entity every Base Period and is reported to the DHCFP by the first business day of August yearly.

- Reconciliation Period means the period of time that Interim Averaged Quarterly Payments are issued and reconciliations will be completed to compare the Interim Averaged Quarterly Payment issued and the Date of Service claims.

Following the exhaustion of a public teaching entities 180-day claim submission period, a date of service calculation will be completed. The calculation will be completed the first month of a quarter following the exhaustion of the 180-day claim submission period. No later than the last business day of the first month of the quarter, the DHCFP will provide a separate report to each eligible public teaching entity which includes the utilization data based on date of service data for services provided during the Service Period. The public teaching entity must review the report and acknowledge the completeness and accuracy of the report no later than the last business day of the second month of the quarter. After receipt of this acknowledgement, the DHCFP will approve and process the quarterly enhanced payments for each Designated Billing Provider no later than the last business day of the last month of the quarter. The process includes a reconciliation that considers all valid claim replacements affecting claims previously processed, as well as a process for recoupment of erroneous enhanced payments. The federal financial participation portion of the recouped payments will be returned to the federal agency.

The enhanced payments will be sent to the Designated Billing Providers through the identification number used to bill Medicaid under the FFS program.
Reconciliation Period:

During the transition period (July 1, 2023-March 31, 2024) an interim averaged quarterly payment will be provided to each public teaching entity the second month following the close of the quarter. The interim payments will be calculated by averaging the same quarter payments that were completed in previous state fiscal year. These payments will be completed for the first 3 quarters following July 1, 2023. Starting with the fourth quarter, a reconciliation will be completed for each of the next 3 quarters to compare the interim payment to the actual amount due to the public teaching entity based on date of service claims. Following the exhaustion of a public teaching entities 180-day claim submission period, a date of service calculation will be completed. The DHCFP will provide the results of this report to each eligible public teaching for review. The eligible public teaching entity must review the additional report and acknowledge the completeness and accuracy of the report no later than the 10th business day of the following month. After receipt of this acknowledgement, the DHCFP will approve and process the additional payment, if any is due. If during this reconciliation it is discovered that an overpayment of a quarter has occurred, the public teaching entity will refund the funds for the overpayment. The reconciliation period will end six quarters after July 1, 2023.

ACR after July 1, 2023:

If an eligible public teaching entity's contracts with commercial payers do not include a rate for a Medicaid Service delivered by a Designated Practitioner, and the Designated Billing Provider's contracts with commercial payers do include a rate for the Medicaid Service, the designating public teaching entity's average ACR percentage increase over the Medicaid Base Rates will be applied to the Medicaid Base Rate for the Medicaid Service.

If an eligible public teaching entity does not have contracts in place with commercial payers during a Base Period, the ACR will be calculated based on the public teaching entity's contracts with commercial payers in effect during the Service Period.

If the ACR is not provided at a procedure code level by the public teaching entity or the public teaching entity does not have contracts that meet the criteria for described in the previous two paragraphs, an average will be calculated by the DHCFP for the ACR by utilizing ACR data submitted for the Base Period by each of the public teaching entities participating in the program.

End Stage Renal Disease (ESRD) Dialysis Procedure Payment and ESRD Facilities

Hemodialysis (HD) and peritoneal dialysis (PD) services, CPT Codes 90999 and 90945 respectively, will be paid the lower of 1.) billed charges, or 2.) a fixed fee. Dialysis services are all services provided in conjunction with the dialysis treatment as defined in the Medicare ESRD Facility Prospective Payment System.

The bundled prospective payment rate will be set according to the most current Centers for Medicare & Medicaid Services (CMS) ESRD Prospective Payment System base rate. The bundled rate will include all resources used in providing outpatient dialysis treatment, including biological, drugs and laboratory services.

The fixed fee for 90999 (HD) will be 100% of the Medicare ESRD Prospective Payment System (PPS) base rate multiplied by the current ESRD Wage Index Locality Factor for Nevada for independent and hospital-based facilities. The fixed fee for 90945 (PD) is set as an HD-equivalent session. This is accomplished by dividing HD rate by seven, and multiplying the result by three.

Vaccine Products require a National Drug Code (NDC) and will be reimbursed according to the drug reimbursement algorithm set forth on Page 3 of Attachment 4.19-B.

Assurance: Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of ESRD services. The agency's fee schedule rates were set as of January 1, 2017, and are effective for services on or after that date. All rates are published on the agency's website at: http://dhcfp.nv.gov/Resources/Rates/RatesMain/.

29. Medication-Assisted Treatment (MAT) as described in Supplement to Attachment 3.1-A(29) are reimbursed as follows:

A. Counseling services and behavioral health therapies as part of the 1905(a)(29) mandatory MAT benefit for the treatment of OUD shall be reimbursed using the same methodology as described in Attachment 4.19-B page 3a(13)(d), 3g, 3h, 3i, and 3i (continued), and 3j(c) for covered outpatient services. Payment for codes 9000-99199 when billed as a 1905(a)(29) MAT service for treatment of OUD will be paid at the lower of billed charges or 63% of the 2014 Medicare non-facility rate.

B. Unbundled prescribed drugs dispensed or administered for MAT shall be reimbursed using the same methodology as described in Attachment 4.19-B page 3 and page 3 (continued) for covered outpatient drugs.

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Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☒	HCBS Adult Day Health
	Reimbursement Methodology for Adult Day Health Care (ADHC) Services provided by a non-governmental entity and governmental entities who do not undergo the Medicaid cost identification and reporting procedures: Prior to the beginning of each rate year, each of the governmental providers providing ADHC services must select one of the reimbursement methodologies described below for reimbursement. For example, by April 30, 2013, governmental providers must select a methodology for the rate year beginning July 1, 2013. 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. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of ADHC services. The Agency's rates were set as of October 1, 2017 and are effective for services on or after that date. All rates are published on the Agency's website at http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/. The billable unit of service for ADHC is one unit per 15 minutes or the daily rate. • If services are authorized and provided for less than six hours per day, provider should bill one unit for each 15 minutes; • If services are authorized and provided for six hours or more per day, provider should bill the per diem rate.

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 ADHC services.
- 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.
- 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.
- Allowances for capital costs – the costs are not included in the Administrative overhead. It includes the average hourly expense for building rental and maintenance, equipment leasing and utility expenses.

The following steps are used to determine the rate:

1. The State will use Nevada-specific hourly wages from the Bureau of Labor Statistics as of May 2004 inflated to June 2006.
2. This hourly compensation is increased by the 27% ERE.
3. A productivity factor is applied to the hourly compensation calculated in Item 2 to equal to the adjusted hourly rate.
4. Administrative overhead (10%) is applied to the adjusted hourly rate (Item 3).
5. Determine allowance for capital costs per hour.
6. Fixed hourly rate is the sum of adjusted hourly rate (Item 3), administrative overhead (Item 4) and capital costs (Item 5).
7. Fixed hourly rate is scaled to the proper unit based on the procedure code.

This rate has been compared to government entities who do not follow all cost reporting rules and 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 Division of Health Care Financing and Policy (DHCFP).

A. Reimbursement Methodology for Adult Day Health Care (ADHC) services provided by a state or local government entity:

ADHC services provided by a state or local government entity are reimbursed according to the following payment methodology. This methodology is used 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 Adult Day Health Care 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 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 the DHCFP or its designee.

B. Settings 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) Total 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 applying the cognizant agency 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 cost details are accumulated on the annual cost report.

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

e) A CMS approved time study is required when providers of service do not spend 100% of their time providing the ADHC services described in the applicable section 3.1-A State Plan pages and is used to determine the percentage of time that service personnel spend on direct ADHC.

f) Services, general and administrative time, and all other activities to account for 100 Services, general and administrative time and all other activities to account for 100 per 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. The direct Adult Day Health Care Services time study percentage is applied against the net direct and indirect costs

g) 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.

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

C. 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.

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 cognizant agency approved indirect cost rate to its net direct costs (Item b.). If the entity 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 indirect costs are reduced by any allowable 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 Adult Day Health Care Services described in the applicable section 3.1-A State Plan pages and is used to determine the percentage of time that service personnel spend on direct Adult Day Health Care 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. The direct Adult Day Health Care Services 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.

1. 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 documented 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.

2. 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.

Services provided by an out-of-state provider require prior authorization by Nevada Medicaid, which must verify that the services required by Medicaid-eligible or pending-eligible clients are not available in Nevada. The out-of-state payment rate for services provided by an out-of-state provider is based on one of the following criteria:

a. The out-of-state provider will be paid the lesser of the provider's billed charges or the fee-for-service rate that is paid to an in-state provider for the service.

b. If the out-of-state provider refuses to accept this rate, then the out-of-state provider may be paid the lesser of the provider's billed charges or the same fee-for-service rate as it would be paid by its home state Medicaid program.

c. For services that cannot be provided by a provider that accepts payment under (A) or (B), the State will maintain a list of other qualified out-of-state providers and will negotiate competitive rates that will not exceed the provider's customary charge.

	Fixed hourly rate is scaled to the proper unit based on the procedure code. This rate has 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 Division of Health Care Financing and Policy. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of ADHC services. The agency's rates were set as of October 1, 2017 and are effective for services on or after that date. All rates are published on the agency's website at: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/
☒	HCBS Habilitation
	Rates paid to the private providers for: Day Habilitation, and Residential Support Services were set in 2002 by the Nevada Provider Rates Task Force. EP&P consultant was contracted by the DHCFP to conduct an analysis of provider rates and make recommendations on rate-setting. The base rate for these services were developed and adopted by the DHCFP using a provider cost survey and market analysis. The rates are comprised of 1. The level of staffing (FTEs) per billing unit; 2. The wage level for supervisor and direct care staff using wage information from the Bureau of Labor Statistics; 3. Employee related expenses at 27% which includes benefits such as paid vacation, paid sick leave, holiday pay, health insurance, etc.; amount of non-billable time spent by staff (productivity adjustment at 30 minutes per day) as well as staff training time; 4. 15% was added to the hourly direct care and ERE cost for non-direct care activities. This is the base rate for these services. Public testimony is allowed during the Legislative process when rate increases are proposed through the budget process. The base rate is the same for all private providers.

☐	HCBS Respite Care	
For Individuals with Chronic Mental Illness, the following services:		
	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☐	Other Services (specify below)	

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Methods and Standards for Establishing Payment Rates

1. Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☐	HCBS Habilitation
☐	HCBS Respite Care

For Individuals with Chronic Mental Illness, the following services:

	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)

☑	Other Services (specify below)
	Crisis Stabilization Services –
	Intensive In-home services and supports -

A. Reimbursement Methodology for Home and Community Based Services provided by a state or local government entity

Home and Community Based Services provided by a state or local government entity 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.

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 Home and Community Based 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.

b. reconcile its interim payments to its total Medicaid-allowable costs.

The annual Medicaid Cost Report includes a certification of funds 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.

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

1. 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. Total 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 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% 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. 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, TPL, received for the same services to arrive at the total Medicaid net allocable and allowable costs.

2. Facilities that are used for multiple purposes and the provision of medical services are 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 cost 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 cost 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% 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. The direct medical services 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

h. 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 24-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:

a. Off-set all future claims payments from the provider until the amount of the federal share of the overpayment is recovered;

b. 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.

B. Reimbursement Methodology for Home and Community Based Services provided by non-governmental entities and governmental entities who do not undergo the Medicaid cost identification and reporting procedures:

1. Home and Community Based Services:

- Crisis Stabilization Services: 1 unit per 15 minutes*
- Intensive In-Home Services and Supports – with coaching: 1 unit per 15 minutes*
- Intensive In-Home Services and Supports – without coaching: 1 unit per 15 minutes*

Services noted above provided by private entities or governmental entities that do not undergo the Medicaid cost identification and reporting procedures will be reimbursed on a statewide fee schedule.

Rate Methodology:

The rates are 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 rates:

- Wage information is derived 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 Home and Community Based Services program.
- Employee-related expenses (ERE) are calculated at 27% of the wages described above. This percentage aligns with the ERE factor applied for non-residential mental health rehabilitation services, which was determined from input from a Task Force and research conducted by Medicaid Staff. ERE includes paid vacation, paid sick leave, holiday pay, health insurance, life insurance, disability, workers compensation and legally required payroll taxes.
- A productivity adjustment factor was applied, 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.
- Allowance for supervisory time – costs for the time directly spent in supervising the individual providing these services (this does not apply to Intensive In-Home Supports Without Coaching).
- Mileage costs are included for Intensive In-Home Supports (With Coaching) and In-Home Crisis Stabilization. The estimated number of miles was multiplied by the IRS Standard Mileage Rate for 2019.
- Administrative overhead (15%) is the percentage of service costs that should result from non-direct care activities. It includes insurance, administrative staff, operations and management activities, and office supplies. Capital and related expenses, along with staff training, are not included.

The following steps are used to determine the rates:

1. The State will use Nevada-specific hourly wages from the Bureau of Labor Statistics.

2. The hourly amount is increased by the 27% ERE.

3. A productivity adjustment factor is applied to the hourly compensation calculated in Item 2 to equal the hourly rate.

4. The adjusted hourly rate per individual is the hourly rate per individual (Item 3) increased by the allowance amounts for supervisory time and mileage calculations (this step excludes Intensive In-Home Supports Without Coaching).

5. Administrative overhead (15%) is applied to the adjusted hourly rate per individual (Item 4).

6. The total hourly rate is the sum of the adjusted hourly rate per individual before administrative overhead (Item 4) and the administrative overhead (Item 5).

7. Total hourly rate is scaled to the proper unit based on the unit of service.

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1. OUTPATIENT HOSPITAL SUPPLEMENTAL PAYMENTS

This section of the state plan contains the provisions for making additional Medicaid payments, in order to preserve access to outpatient hospital services for needy individuals in the state of Nevada. Effective for services provided on or after March 1, 2010, the state's Medicaid hospital reimbursement system shall provide for supplemental outpatient payments to non-state, governmentally owned or operated hospitals. These supplemental payments shall be determined on an annual basis and paid to qualifying hospitals on a quarterly basis. The supplemental payments shall not exceed, when aggregated with other fee-for-services outpatient hospital payments made to non-state, governmentally owned or operated hospitals, 100% of a reasonable estimate of the amount that would be paid for such services under Medicare payment principles in accordance with the federal upper limit regulations at 42 CFR §447.321.

a. Methodology for Determining Outpatient Supplemental Payments:

The hospitals that qualify for outpatient supplemental payments will have their payment amount determined using a payment-to-charge ratio UPL methodology.

Outpatient supplemental payments for each hospital will be calculated using following method:

(i) Calculate Total Medicare Outpatient Payments from: CMS 2552-96 Wkst E Part B, Col 1, Line 17 + CMS 2552-96 Wkst E Part B, Col 1, Line 17.01 + CMS 2552-96 Wkst E Part B, Col 1, Line 21+22 [Add comparable fields for sub providers 1 and 2]

(ii) Calculate Total Medicare Outpatient Charges from: CMS 2552-96 Wkst D Part V, Line 104, Col 5 + CMS 2552-96 Wkst D Part V, Line 104, Col 5.01 + CMS 2552-96 Wkst D Part V, Line 104, Col 5.02 + CMS 2552-96 Wkst D Part V, Line 104, Col 5.03 [Add comparable fields for sub providers 1 and 2]

(iii) Calculate Medicare Outpatient Payment to Charge Ratio. The ratio is calculated by dividing the result of (i) by (ii)

[Total Medicare Outpatient Payments] ÷ [Total Medicare Outpatient Charges]

(iv) The result of (iii) is multiplied by Medicaid Outpatient charges in order to determine the Estimated Medicare Outpatient Services Upper Payment Limit. Total Medicaid Outpatient charges shall be derived from Nevada Medicaid Management Information System (MMIS) adjudicated claims data.

(v) Total Medicaid Outpatient Payments for the period are subtracted from the result (iv) to determine the annual amount of Outpatient Supplemental Payment. Total Medicaid Outpatient payment shall be derived from Nevada Medicaid Management Information System (MMIS) adjudicated claims data.

b. Outpatient Supplemental Payments:

(i) Each qualifying hospital will provide documentation of CMS Form 2552 cost report for Medicare charge and payment information for the previous fiscal year to Medicaid by April 1st of each year.

(ii) Beginning April 2010, Medicaid will calculate the total outpatient supplement payment for qualifying hospitals using the methodology in Section A. above. At the end of each calendar quarter, hospitals will receive a payment amount equal to 25% of the hospital's total outpatient supplemental payment.

UPPER PAYMENT LIMIT SUPPLEMENTAL PAYMENTS FOR OUTPATIENT SERVICE AT PRIVATE HOSPITALS

In order to preserve access to outpatient hospital services for needy individuals in the state of Nevada, effective July 1, 2023, the state's Medicaid reimbursement system shall provide for certain upper payment limit (UPL) supplemental payments to all qualifying private hospitals. These supplemental payments shall be determined on an annual basis and paid to qualifying private hospitals on a quarterly basis. The supplemental payments are for Medicaid fee-for-service outpatient hospital services. The supplemental payments shall not exceed, when aggregated with other payments made to private hospitals, 100% of a reasonable estimate of the amount that would be paid for such services under Medicare payment principles for private hospitals (i.e., the UPL).

1. Eligibility

All private hospitals in the State of Nevada are eligible to receive an Outpatient Hospital UPL supplemental payment.

To be eligible for payment, a private hospital must follow all policies or procedures deemed necessary by the state to ensure compliance with federal tax requirements. Otherwise, the State may deny or hold payment until federal compliance can be verified.

2. Methodology

The state will calculate the aggregate difference between Medicaid payments for outpatient hospital services made under all other provisions of the state plan and the UPL for such services. Cost report data and Medicaid claims data trended utilizing the CMS Medicare Outpatient Hospital PPS Market Basket rate from the base year to the payment year (demonstration year), will be used as the estimate for the UPL. Medicaid payments used to calculate the aggregate difference will be trended utilizing the CMS Medicare Outpatient Hospital PPS Market Basket rate from the base year to the payment year (demonstration year).

The annual payment amount for each hospital is calculated as follows:

a. First, the state will calculate the aggregate difference between outpatient Medicaid payments paid under the state plan and the UPL for all private hospitals.
b. Second, each hospital will receive a share of the amount calculated in (1) above based on paid outpatient fee-for-service (FFS) Medicaid claims. For purposes of this calculation, the outpatient FFS Medicaid claims paid are weighted for a Critical Access Hospital (CAH) by a factor of 2.3 and for a Sole Community Hospital by 1.15. Each remaining hospital will receive a share of the remaining funds based on that hospital's proportion of the total number of Medicaid claims paid for outpatient FFS for all non-CAH private hospitals during the year used for the UPL demonstration.
c. If the total calculated amount to be paid to all eligible hospitals exceeds the estimated aggregate UPL, the payment to each hospital will be reduced by a proportional amount.

The annual payment amount will be paid in four equal quarterly amounts at the end of each quarter. However, for fiscal year 2024, the payment amount and timing will vary depending on SPA approval.

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and Sections 1902(a)(4),1902(a)(6) and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions (OPPCs) for non-payment under Section(s) 4.19-B.

X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

____ Additional Other Provider-Preventable Conditions identified below *(please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) Nursing Facility Services, 4.19(b) Physician Services)* of the plan:

Methodology for Identifying Other Provider-Preventable Conditions

The State Agency's fiscal agent will review claims with dates of service on or after July 1, 2012 for OPPCs and report to the State. The state's Surveillance and Utilization Review (SUR) unit will review each claim identified in that report and recover payments associated with the OPPC.

Payment Adjustment

For OPPCs not present on admission, payment will be reduced to those costs not associated with an OPPC, using standard rates assigned to CPT and HCPCS codes for reimbursement by the DHCFP.

The existing appeals process will be available to providers who dispute the determination.

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