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 as described above 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/~~

For services performed on or after August 15, 2020, rates will be determined by multiplying a factor of 0.94 times the January 1, 2019 rate (for Basic Skills Training only) or times the January 1, 2006 rate (all other services described in this section). 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.
- For services performed on or after August 15, 2020, the rates for partial hospitalization and intensive outpatient program services will be determined by multiplying a factor of 0.94 times the rates in effect April 1, 2019.