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.

Crisis Stabilization Centers (CSC):

1. The default 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:

   a. 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.
   b. 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.
   c. Productivity adjustment factor which accounts for the amount of nonbillable 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.
   d. Program Support costs – costs based on average of four hours per day. This is to assist with paperwork and follow-up related to treatment.
   ~~a.~~e. Allowance for supervisory time – costs for the time directly spent in supervising the medical professional providing these services.
   f. 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.

g. Administrative overhead, 10%, is the percentage of service costs that should result from non-direct care activities. It includes insurance, administrative staff,

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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 rate:

a. The State will use Nevada-specific hourly wages from the Bureau of Labor Statistics.
b. The hourly amount is increased by the 27% ERE.
c. A productivity factor is applied to the hourly compensation calculated in Item 2 to equal to the hourly rate.
d. 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 hour.
e. Administrative overhead (10%) is applied to the adjusted hourly rate per individual (Item 4).
f. Total hourly rate is the sum of the adjusted hourly rate per individual before administrative overhead (Item 4) and the administrative overhead (Item 5).
g. Total hourly rate is scaled to the proper unit based on the unit of service.
h. Group rate is the individual rate divided by the group size assumption.

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. 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 February 22, 2022 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/

These rates will remain in effect until unless the provider requests a cost-based rate as described in 2 in this section.

2. Once a full provider fiscal year of services have been provided under the Crisis Stabilization Center (CSC), providers will be eligible to complete a cost report and have their rate based off actual and allowable costs reported within this cost report.

a. Should a CSC choose this option they will be required to cover 50% of the costs to audit the cost report and calculate a rate. This money will need to be paid to DHCFP upon the request to pursue the cost report-based rate build.

b. CSCs will be required to submit a cost report inclusive of all actual costs to provide services for the first full provider fiscal year of operations to calculate the bundled per visit rate by dividing total allowable CSC services by total CSC visits. Cost and visit data vary based on CSC size, location, economy, and scope of services offered and must adhere to 45 Code of Federal

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c. 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.

d. The CSC must submit all required documentation of actual costs for the first full provider fiscal year of providing services to Division of Health Care Financing and Policy (DHCFP) no later than 150 calendar days or 5 months after the full provider fiscal year of operations as a CSC. DHCFP will deem cost reports complete within 15 days of receipt.

i. A CSC with missing documentation will be issued a cost report request letter, identifying missing documentation necessary to complete the cost report.

ii. The CSC will have 30 days from the date of the cost report request letter to submit additional documentation.

iii. If a CSC does not submit the required documentation to complete their cost report within 30 days, DHCFP reserves the right to suspend their Medicaid payments. This process will remain in effect until the CSC has provided a complete cost report.