V. ADMINISTRATIVE DAY RATE DEVELOPMENT

For those patients who remain in an acute care hospital awaiting admittance to a long-term care facility, an administrative day rate is used. Services so reimbursed are call "administrative days."

The administrative rate is based on statewide weighted average payment rate established in 2003 for skilled and intermediate levels of care. The administrative rate is lower than the hospital rate as described in Part II of the State Plan.

For services performed for claims with an admission date on or after July 9, 2015, the intermediate level administrative day per diem rate will be determined by multiplying a factor of 1.05 times the rate.

VI. RESIDENTIAL TREATMENT CENTERS

Nevada Medicaid will only pay for stays in facilities accredited by the Joint Commission on Accreditation Health Organizations (JCAHO) as Residential Treatment Centers (RTCs). All stays must be pre-approved by the QIO-like vendor. These services will be reimbursed at the lowest rate acceptable to both parties. In establishing the lowest rate acceptable to both parties, Nevada Medicaid reviews cost information filed by the RTC, amounts paid by other insurers, and national literature on costs for RTCs. Each facility will have a negotiated rate established for each general level of service. If a placement is being proposed which is different from the general level of care offered by the facility, a rate will be negotiated after considering the average cost per day of the facility and the additional will be reviewed based upon cost information received on or prior July 1 of the year of review. The rate cannot exceed the reasonable and customary charges of the facility for similar services.

VII. 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.
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, 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 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.
   c. 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.