



Joe Lombardo
Governor

NEVADA HEALTH AUTHORITY

Nevada Medicaid

4070 Silver Sage Drive
Carson City, NV 89701
NVHA.NV.GOV



Stacie Weeks
Director

Ann Jensen
Administrator

September 29, 2025

Courtney Miller
Director
CMS/Center for Medicaid & CHIP Services
Medicaid & CHIP Operations Group
601 E. 12th St., Room 355
Kansas City, MO 64106

Dear Director Miller:

Enclosed please find Nevada's State Plan Amendment (SPA) #25-0023. This SPA amends Nevada's State Plan effective July 1, 2025. The specific changes being made are as follows:

The Division intends to develop a bundled rate for two separate services: Assertive Community Treatment (ACT) to assist individuals with Serious mental Illness (SMI) and/or SMI with Co-Occurring Disorders and Coordinated Specialty Care for individual experiencing First Episode Psychosis (FEP).

State Plan Attachment 3.1-A Page 6b.7 – The addition of Coordinated Specialty Care for beneficiaries experiencing their first episode of psychosis. Coordinated specialty care (CSC) is the standard of care for treatment for individuals, typically in late adolescence to mid-20s experiencing their first episode of psychosis (FEP). It is an evidence-based, recovery-focused, team-based early intervention model that promotes access to care and shared decision-making among specialists, the person experiencing psychosis, and family member.

State Plan Attachment 3.1-A Page 6b.7 – The addition of Assertive Community Treatment (ACT) is for beneficiaries experiencing the most serious intractable symptoms of severe mental illness (SMI) and who, consequently, have the greatest difficulty with basic daily activities. It is an evidence-based, community-focused, team-based approach that aims to improve functioning and help people stay in their communities and out of inpatient treatment, with services delivered in vivo.

If you have any policy questions regarding this SPA, please contact Casey Angres, Chief of Division Compliance at (775) 684-3667 or cangres@dhcfp.nv.gov.

Sincerely,

A handwritten signature in blue ink, appearing to read "Stacie Weeks". The signature is fluid and cursive, with the first name "Stacie" and last name "Weeks" clearly distinguishable.

Stacie Weeks, Director
Nevada Health Authority

Enclosures

cc: Ann Jensen, Administrator, Nevada Health Authority (NVHA), Nevada Medicaid
Casey Angres, Chief of Division Compliance, NVHA, Nevada Medicaid

Joe Lombardo
Governor

Richard Whitley, MS
Director



DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH CARE FINANCING AND POLICY

Helping people. It's who we are and what we do.



Stacie Weeks,
JD MPH
Administrator

PUBLIC NOTICE TO SOLICIT COMMENT ON INTENT TO SUBMIT A STATE PLAN AMENDMENT TO ADD ASSERTIVE COMMUNITY TREATMENT

June 30th, 2025

Division of Health Care Financing and Policy,
Nevada Department of Health and Human Services

Public Comment

General public comments are encouraged to be submitted in writing. You may submit comments in one of two ways found below (please choose one).

Electronically: You may email comments to DocumentControl@dhcfp.nv.gov. Write "Assertive Community Treatment" in the subject line.

Mail: You may mail written comments to the following address:

Division of Nevada Medicaid
ATTN: Document Control
4070 Silver Sage Dr.
Carson City, NV 89701

Purpose:

The purpose of this notice is to provide the public with information and to collect public feedback regarding the state's intent to submit a State Plan Amendment (SPA) for federal approval of a new Medicaid benefit for Assertive Community Treatment. This SPA will be effective July 1, 2025.

The Division is developing a webpage dedicated to SPAs and intends to publish the draft SPA and other supporting materials on this website within the coming months. Emails related to the new SPA webpage and SPA submissions will be sent to individuals who have signed up to receive electronic notifications through the Nevada Medicaid Update ListServ. You can sign up to receive these notifications by visiting:

<https://dhcfp.nv.gov/Resources/NevadaMedicaidUpdate/NMUListserv/>.

Proposed Changes:

The Division of Nevada Medicaid intends to submit a Medicaid State Plan Amendment (SPA) to Attachment 3.1-A and Attachment 4.19-B to add Assertive Community Treatment (ACT). ACT is an evidenced-based practice designed to assist individuals with Serious Mental Illness (SMI), and/or SMI with Co-Occurring Disorders. This practice includes a multidisciplinary team and delivers comprehensive, intensive, and integrated community and home-based care to

individuals with high service needs. During the 83rd Legislative Session (2025), the DHCFP budget was approved through Senate Bill 501 and included the addition of ACT.

These changes are effective July 1, 2025.

Methodology:

The Division intends to reimburse ACT providers through a daily rate, which will be set to reflect a bundled cost of services delivered to eligible recipients.

Estimated Expenditures:

Below is the estimated change in annual aggregate expenditure.

SFY 2026: \$ 12,040,087

SFY 2027: \$ 14,147,982

Notice Information

This notice has been posted online at <http://dhcfp.nv.gov>, as well as Carson City, Las Vegas, Elko, and Reno District Offices for DHCFP. Email notice has been made to such individuals as have requested notice of State Plan Amendments. To request notifications or a physical copy of this notice, please contact DocumentControl@dhcfp.nv.gov, or visit your local Nevada Medicaid office at:

1919 College Parkway, Suite 120, Carson City, Nevada 89701

1010 Ruby Vista Drive, Suite 103, Elko, Nevada 89801

1210 S. Valley View, Suite 104, Las Vegas, Nevada 89102

745 W. Moana Lane, Suite 200, Reno, Nevada 89509

A copy of this notice has also been sent to the following local agencies in each Nevada county for public review.

Carson City Library
900 North Roop Street
Carson City, NV 89702
<https://carsoncitylibrary.org/>

Churchill County Library
553 South Main Street
Fallon, NV 89406
<https://churchillcountylibrary.org/>

Clark County District Library
833 Las Vegas Boulevard North
Las Vegas, NV 89101
<https://thelibrarydistrict.org/>

Douglas County Library
1625 Library Lane
Minden, NV 89423
<https://library.douglascountynv.gov/>

Elko County Library
720 Court Street
Elko, NV 89801
<https://www.exploremybrary.org/>

Esmeralda County Library
(Corner of Crook and 4th Street)
PO Box 430
Goldfield, NV 89013
(No Website)

Eureka Branch Library
210 South Monroe Street
Eureka, NV 89316-0283
(No Website)

Henderson District Public Library
100 West Lake Mead Parkway
Henderson, NV 89105
<https://www.hendersonlibraries.com/>

Lander County Library
625 South Broad Street
Battle Mountain, NV 89820-0141
<https://www.landercountynv.org/>

Lincoln County Library
63 Maine Street
Pioche, NV 89043-0330
(No Website)

Lyon County Library
20 Nevin Way
Yerington, NV 89447-2399
<https://www.lyon-county.org/238/Library>

Mineral County Library
110 1st Street
Hawthorne, NV 89415-1390
<https://mineralcountylibrary.com/>

Pahrump Community Library
701 East Street
Pahrump, NV 89041-0578
<https://www.pahrumplibrary.org/>

Pershing County Library
1125 Central Avenue
Lovelock, NV 89419-0781
https://pershingcounty.net/community/county_library/

Storey County Library
175 Carson Street
Virginia City, NV 89440-0014
<https://storeycountycommunitylibrary.com/>

Tonopah Public Library
167 Central Street
Tonopah, NV 89049-0449
<https://www.tonopahnevada.com/tonopahlibrary/>

Washoe County Library
301 South Center Street
Reno, NV 89505-2151
<https://www.washoecountylibrary.us/>

White Pine County Library
950 Campton Street
Ely, NV 89301-1965
<https://www.whitepinecounty.net/284/Library>

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH CARE FINANCING AND POLICY

Helping people. It's who we are and what we do.



Stacie Weeks,
JD MPH
Administrator

PUBLIC NOTICE TO SOLICIT COMMENT ON INTENT TO SUBMIT A STATE PLAN AMENDMENT TO ADD COORDINATED SPECIALTY CARE FOR FIRST EPISODE PSYCHOSIS (FEP)

June 27, 2025

Name of Organization

Department of Health and Human Services, Division of Health Care Financing and Policy

Public Comment

General public comments are encouraged to be submitted in writing. You may submit comments in one of two ways found below (please choose one).

Electronically: You may email comments to DocumentControl@dhcfp.nv.gov. Write "Coordinated Specialty Care for FEP" in the subject line.

Mail: You may mail written comments to the following address:

Division of Nevada Medicaid

ATTN: Document Control

4070 Silver Sage Dr.

Carson City, NV 89701

Purpose:

The purpose of this notice is to provide the public with information and to collect public feedback regarding the state's intent to submit a State Plan Amendment (SPA) for federal approval of a new Medicaid benefit for Coordinated Specialty Care for beneficiaries experiencing their first episode of psychosis. This SPA will be effective July 1, 2025.

The Division is developing a webpage dedicated to SPAs and intends to publish the draft SPA and other supporting materials on this website within the coming months. Emails related to the new SPA webpage and SPA submissions will be sent to individuals who have signed up to receive electronic notifications through the Nevada Medicaid Update ListServ. You can sign up to receive these notifications by visiting:

<https://dhcfp.nv.gov/Resources/NevadaMedicaidUpdate/NMUListserv/>.

Proposed Changes:

The Division of Nevada Medicaid intends to submit a Medicaid State Plan Amendment (SPA) to Attachment 3.1-A and Attachment 4.19-B to add Coordinated Specialty Care for beneficiaries experiencing their first episode of psychosis. Coordinated specialty care (CSC) is the standard of care for treatment for individuals, typically late in late adolescence to mid-20s experiencing their first episode of psychosis (FEP). It is an evidence-based, recovery-focused, team-based early intervention model that promotes access to care and shared decision-making among specialists, the person experiencing the psychosis, and family member. During the 83rd Legislative Session (2025), the DHCFP budget was approved through Senate Bill 501 and included the addition of services for First Episode Psychosis.

These changes are effective July 1, 2025.

Methodology: The Division intends to develop a bundled rate that reflects the core services delivered in this model, including screening and assessment, psychotherapy, family education and support, case management, medication management and supported employment and supported education services.

Estimated Expenditures: Below is the estimated change in annual aggregate expenditure.

SFY 2026: \$3,904,660

SFY 2027: \$3,915,943

Notice Information

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1010 Ruby Vista Drive, Suite 103, Elko, Nevada 89801

1210 S. Valley View, Suite 104, Las Vegas, Nevada 89102

745 W. Moana Lane, Suite 200, Reno, Nevada 89509

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<https://carsoncitylibrary.org/>

Esmeralda County Library
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PO Box 430
Goldfield, NV 89013
(No Website)

Churchill County Library
553 South Main Street
Fallon, NV 89406
<https://churchillcountylibrary.org/>

Eureka Branch Library
210 South Monroe Street
Eureka, NV 89316-0283
(No Website)

Clark County District Library
833 Las Vegas Boulevard North
Las Vegas, NV 89101
<https://thelibrarydistrict.org/>

Henderson District Public Library
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Henderson, NV 89105
<https://www.hendersonlibraries.com/>

Douglas County Library
1625 Library Lane
Minden, NV 89423
<https://library.douglascountynv.gov/>

Lander County Library
625 South Broad Street
Battle Mountain, NV 89820-0141
<https://www.landercountynv.org/>

Elko County Library
720 Court Street
Elko, NV 89801
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Lincoln County Library
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<https://mineralcountylibrary.com/>

Pahrump Community Library
701 East Street
Pahrump, NV 89041-0578
<https://www.pahrumplibrary.org/>

Pershing County Library
1125 Central Avenue
Lovelock, NV 89419-0781
https://pershingcounty.net/community/county_library/

Storey County Library
175 Carson Street
Virginia City, NV 89440-0014
<https://storeycountycommunitylibrary.com/>

Tonopah Public Library
167 Central Street
Tonopah, NV 89049-0449
<https://www.tonopahnevada.com/tonopahlibrary/>

Washoe County Library
301 South Center Street
Reno, NV 89505-2151
<https://www.washoecountylibrary.us/>

White Pine County Library
950 Campton Street
Ely, NV 89301-1965
<https://www.whitepinecounty.net/284/Library>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

Attachment 3.1-A
Page 6b.7

approved training program, CPR certification, and have completed an FBI criminal background check to ensure no convictions of applicable offenses have been incurred. QBA's are required to participate in and successfully complete an approved training program which includes basic training, periodic and continuing in service training. Training must be interactive and not solely based on self-study guides or videotapes and should ensure that a QBA will be able to interact appropriately with individuals with mental health disorders. Training must also include:

- Case file documentation;
- Recipient's rights;
- HIPAA compliance;
- Communication skills;
- Problem solving and conflict resolution skills;
- Communication techniques for individuals with communication or sensory impairments; and
- CPR certification

The entity that is providing supervision over the QBA shall provide annually a minimum of eight hours of service training for each QBA. The purpose of the annual training is to facilitate the development of specialized skills or knowledge not included in the basic training and/or to review or expand skills or knowledge included in the basic training. Consideration must be given to topics suggested by recipients. Documentation of the completed training and achieved competencies meeting this requirement must be maintained by the entity. Training requirements may be waived if the QBA can provide written verification of comparable education and training. The entity must document this validation.

14. **Assertive Community Treatment (ACT)**

Assertive Community Treatment (ACT) is an evidence-based service-delivery model recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services (DHHS). This model focuses on providing mental health services within the community, rather than in hospitals or residential facilities, to promote independence and societal integration. ACT employs an assertive, person-centered approach to support recovery, helping participants manage their mental health symptoms and develop essential skills for community integration.

Target Population: ACT is tailored for individuals with serious mental illness who face significant functional impairment and have unmet needs through traditional service methods. It supports those with substantial behavioral health needs and a history of frequent use of psychiatric hospitals, emergency rooms, residential treatment, criminal justice involvement, homelessness, or disengagement from traditional outpatient services.

TN No.: ~~05-015 25-0023~~
2006 July 1, 2025

Approval Date: ~~February 23, 2007~~

Effective Date: ~~January 1,~~

Supersedes

TN No. NEW05-0015

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Service Delivery: ACT services are provided by a multidisciplinary team of professionals, paraprofessionals, and peer support specialists, supervised by a Team Leader. Services are customized to each client's needs based on their input, relationships with ACT Team members, and medical necessity.

Most ACT services are delivered in vivo, offering in-person support in clients' environments, such as homes, workplaces, or community settings. These services meet clients where they are, providing personalized and immediate assistance to help manage mental health and daily living needs, promoting independence and enhancing quality of life.

Services, directed by an individual treatment plan, include:

- Crisis intervention
- Comprehensive evaluation for mental health and co-occurring care
- Substance use treatment
- Assessment
- Medication administration and management
- Psychiatric Care
- Case Management
- Illness management and recovery skills
- Individual supportive therapy
- Supportive employment and education
- Intervention with family and natural supports
- Peer Support Services
- Referral and Linkages

15. Coordinated Specialty Care

Coordinated Specialty Care is a recovery-focused, team-based early intervention model that promotes access to care and shared decision-making among specialists, the individual experiencing psychosis, and family member(s). The comprehensive, multidisciplinary program of services are expected to improve or maintain condition and functioning level of individuals experiencing First Episode Psychosis (FEP).

CSC services are provided by a multidisciplinary team of Licensed Professionals, QMHPs, Peer Support Specialists, Case Managers, and Supportive Employment and Education Specialists under the supervision of a Board-Certified Psychiatrist also known as the Team Leader. Each component of the CSC must be provided by enrolled and qualified providers within the scope of their practice.

Coordinated Specialty Care services provided within the team, as directed by an individual

TN No.: 25-0023

Approval Date:

Effective Date: July 1, 2025

Supersedes

TN No. NEW

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plan of care, include but are not limited to:

- Behavioral Health Assessment
- Individual Therapy
- Group Therapy
- Family Psychoeducation and Support
- Supported Employment and Education
- Case Management
- Peer Support Services
- Crisis Services
- Medication Management
- Primary Care Coordination
- Psychiatry

CSC services are for the direct benefit of the recipient. Services must be documented in the recipient's plan of care and delivered in coordination with a care coordinator or family team/multidisciplinary team.

TN No.: 25-0023

Approval Date:

Effective Date: July 1, 2025

Supersedes

TN No. NEW

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Attachment 4.19-B

Page 3b

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

TN No.: 19-00425-xxxx

Approval Date: February 18, 2020

Effective Date: April 1, 2019

Supersedes

TN No.: 07-00919-004

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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~~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:~~

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Attachment 4.19-B
Page 3d

~~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.~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Attachment 4.19-B

Page 3c

~~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.~~

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Attachment 4.19-B
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~~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.~~

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State: NEVADA

Attachment 4.19-B

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~~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.~~

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- ~~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:

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- ~~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:~~

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- 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.~~

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- ~~e. 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.~~

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~~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>~~

~~Residential Substance Use Disorder Services:~~

~~The Medicaid program will provide coverage for a bundle of medically necessary rehabilitative services provided by practitioners employed by, or associated with, provider entities delivering services known as Residential SUD Services. The State agency will reimburse providers as defined in Attachment 3.1 A delivering Residential SUD Services a bundled daily rate. Any provider delivering Residential SUD Services through a bundle will be paid through that bundle's payment rate and cannot bill separately for the individual rehabilitative services. At least one service must be provided in order to receive the bundled payment rate. If a provider delivering Residential SUD Services is unable to provide the whole scope of Residential SUD Services as defined in Attachment 3.1 A, providers can be reimbursed for a separate service. The State agency will periodically monitor the actual provision of Residential SUD Services to ensure that beneficiaries receive the types, quantity, and intensity of services required to meet their medical needs and to ensure that the rates remain economic and efficient based on the services that are actually provided as part of the bundle.~~

~~Room and board are not reimbursable services through DHCFP.~~

~~The Division's rates were set as of July 31, 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/>.~~

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1. Providers of Rehabilitative Mental Health services as described in 3.1-A:
 - A. Payment for Providers of Rehabilitative Mental Health services who do not undergo the Medicaid cost described in Section B below is the rate specified in the Nevada Medicaid Fee Schedule (Fee Schedule). The Fee Schedule is published on the agency website: <http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/> and are effective for services provided on or after July 1, 2025.
 1. Providers for Intensive Outpatient Program (IOP) and Partial Hospitalization Program (PHP) are reimbursed according to the market-based model developed to reflect service definitions, provider requirements, operational service delivery and administrative considerations. The following elements are used to determine the rate:
 - a. Base Inputs
 1. Wage Assumptions: Hourly wages are sourced from the U.S. Bureau of Labor Statistics (BLS), using occupations deemed comparable to services delivered under this program. Nevada-specific wage data from May 2004 is used and inflated to reflect costs as of June 2006.
 2. Employee-Related Expenses (ERE): A flat 27% is added to wages to account for benefits including paid leave, health/life insurance, disability, workers' compensation, and mandatory payroll taxes. This percentage was derived from input by Task Force members and Medicaid staff.
 - b. Operations Adjustment
 1. Productivity Adjustment: Accounts for non-billable time (e.g., documentation, no-shows, travel).
 2. Program Support: Includes administrative assistance costs (estimated at 4 hours/day).
 3. Supervision: Reflects the cost of clinical oversight for service delivery.
 4. Capital Costs: Covers facility-related expenses (rent, utilities, equipment leasing) not included in administrative overhead .
 - c. Administrative Overhead
 1. 10% overhead rate is applied to the adjusted service cost. This accounts for management, admin staff, office supplies, and general operations. It excludes capital expenses and staff training.
 - d. Rate Calculation Steps
 1. Base Wage: Start with the hourly wage based on May 2004 Nevada BLS data, inflated to June 2006.
 2. Loaded Wage: Add 27% for Employee-Related Expenses (ERE) to determine total compensation

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3. Effective Hourly Rate: Apply the productivity adjustment to the loaded wage to account for non-billable time.
 4. Per-Individual Rate: Divide the effective hourly rate by the assumed staffing ratio to get the cost per individual served.
 5. Adjusted Rate: Add allocations for program support, supervision, and capital costs to the per-individual rate.
 6. Final Hourly Rate: Apply a 10% administrative overhead to the adjusted rate.
2. Residential Substance Use Disorder Services:
 - a. The Medicaid program will provide coverage for a bundle of medically necessary rehabilitative services provided by practitioners employed by, or associated with, provider entities delivering services known as Residential SUD Services. The State agency will reimburse providers as defined in Attachment 3.1-A delivering Residential SUD Services a bundled daily rate. Any provider delivering Residential SUD Services through a bundle will be paid through that bundle's payment rate and cannot bill separately for the individual rehabilitative services. At least one service must be provided in order to receive the bundled payment rate. If a provider delivering Residential SUD Services is unable to provide the whole scope of Residential SUD Services as defined in Attachment 3.1-A, providers can be reimbursed for a separate service. The State agency will periodically monitor the actual provision of Residential SUD Services to ensure that beneficiaries receive the types, quantity, and intensity of services required to meet their medical needs and to ensure that the rates remain economic and efficient based on the services that are actually provided as part of the bundle.
 - b. Room and board are not reimbursable services through NVHA.
 - c. The Division's rates were set as of July 31, 2024 and are effective for services on or after that date. All rates can be found on the official Website of the Nevada Health Authority at <http://dhcfp.nv.gov/Resources/Rates/FeeSchedule/>.
3. Assertive Community Treatment (ACT) Services:
 - a. The Medicaid program will provide coverage for a bundle of medically necessary services by practitioners employed by, or entities associated with delivering services known as Assertive Community Treatment (ACT) services, including screening and assessment, psychotherapy, family education and support, case management, medication management and supported employment and supported education services. The State agency will reimburse providers as defined in Attachment 3.1-A delivering Assertive Community Treatment (ACT)

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services. Any provider delivering ACT Services through a bundle will be paid through that bundle's payment rate and cannot bill separately for individual behavioral health services. At least one service must be provided in order to receive the bundled payment rate. The State agency will periodically monitor the actual provision of Assertive Community Treatment (ACT) Services to ensure that beneficiaries receive the types, quantity, and intensity of services required to meet their medical needs and to ensure that the rates remain economic and efficient based on the services that are actually provided as part of the bundle.

- b. The Division's rates were set as of July 1, 2025 and are effective for services on or after that date. All rates can be found on the official Website of the Nevada Health Authority at <http://dhcfp.nv.gov/Resources/Rates/FeeSchedule/>.

4. Coordinated Specialty Care (CSC) Services:

- a. The Medicaid program will provide coverage for a bundle of medically necessary services delivered by practitioners employed by, or entities associated with, providers of Coordinated Specialty Care (CSC). Services will be reimbursed under two distinct bundled rates:
 - 1. Introduction and Screening Bundle: Includes one assessment session, one initial diagnostic session, and one initial medication clinic visit.
 - 2. Weekly Service Bundle: Includes one hour of psychotherapy, one hour of case management, and one hour of peer support and family education with the patient.
- b. The State agency will reimburse providers, as defined in Attachment 3.1-A, for delivering CSC services under these bundles. Providers billing under a bundle must use the applicable bundled payment rate and may not bill separately for individual behavioral health services included in the bundle. To receive the bundled payment rate, at least one service from the bundle must be provided during the billing period. The State agency will periodically review the delivery of CSC services to ensure beneficiaries receive services in the type, quantity, and intensity necessary to meet their medical needs. The agency will also evaluate rates to ensure they remain economic and efficient based on the actual services provided within each bundle.
- c. The Division's rates were set as of July 1, 2025 and are effective for services on or after that date. All rates can be found on the official Website of the Nevada Health Authority at <http://dhcfp.nv.gov/Resources/Rates/FeeSchedule/>.

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B. Public Non-Residential Mental Health Rehabilitative 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

a. 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

a. 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:

1. 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.
2. 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,
3. allowable costs/expenditures. All filed annual Cost Reports are subject to audit by NVHA or its designee.

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

4. Facilities that are primarily providing medical Services:

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- 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 payment 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.
5. Facilities that are used for multiple purposes and the provision of medical services are not the primary purpose:

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- 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 allocable and allowable costs.

6. Cost Reconciliation Process

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- a. 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.
7. Cost Settlement Process
 - a. If a governmental provider's interim payments exceed the actual, certified costs of the provider for services to Medicaid clients, the NVHA 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.
8. If the actual, certified costs exceed the interim Medicaid payments, the NVHA will pay the federal share of the difference to the provider in accordance with the final actual certification agreement. The NVHA will issue a notice of settlement that denotes the amount due to or from the provider.

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