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 COMMENTS ON NEVADA STATE PLAN AMENDMENT 22-0005 CRISIS SERVICES

Date of Publication: January 29, 2024

Name of Organization: The State of Nevada Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (DHCFP)

1. General public comment is encouraged to be submitted in writing. You may submit comments in one of two ways (please choose only one of the ways listed below):
   Electronically: You may email comments to DocumentControl@dhcfp.nv.gov . Write "State Plan Amendment 22-0005 Crisis Services" in the subject line.
   Mail: You may mail written comments to the following address: Division of Health Care Financing and Policy ATTN: "State Plan Amendment 22-0005 Crisis Services", 1100 E. William Street, Suite 101, Carson City, Nevada 89701.

2. This Public Notice is to inform the public of the following request for public comment:

DHCFP is requesting feedback for State Plan Amendment (SPA) 22-0005 originally submitted as Reimbursement Methodology for Crisis Stabilization Centers on March 30, 2022. Since submission of this SPA, reimbursement methodology for Intensive Crisis Stabilization Services (ICSS) and coverage language for Intensive Crisis Stabilization and Crisis Intervention has been amended. Additionally, coverage language for Section 1947 Mobile Crisis Services has been added to support development of Nevada's Designated Mobile Crisis Team model. Original reimbursement methodology was submitted on medical care and services pages Attachment 4.19-B, Pages 4a through 4c and inpatient hospital reimbursement pages Attachment 4.19- A, Pages 14-14C. Through further discussion with the Centers for Medicare and Medicaid Services (CMS) these services are outpatient and rehabilitative in nature and would need to be included within the reimbursement rehabilitation section of State Plan rather than inpatient hospital pages.

Additionally, as detailed in the posted reimbursement plan pages Attachment 4.19-B pages 3l-3n changes have been made for providers of ICSS who choose a Cost-Based Bundled Daily Rate. Rebasing of costs based on the most recently available cost reports will be performed for all providers with a cost-based rate, after 5 complete years of operation. Rebases will not occur outside of the defined periodicity unless requested by the provider not to exceed one additional time within the 5-year period. A provider's rate will be rebased automatically by the state every five years from the last time the rate was calculated using a cost report as described in Section B above and on an annual basis if requested by a CCBHC provider. A provider's rebased ICSS cost based bundled rate will be capped so that the rebased bundled rate will be no more than 150% or less than 75% of the provider's current rate. A provider's rebased bundled rate will not be lower than 75% or exceed 150% of the provider's current rate, based on the cost report. Rebased rates will be determined utilizing the most recent full fiscal year of performing services.

The DHCFP will post this public notice for 30 days per CMS public notice requirements. Any feedback must be submitted to the DHCFP via the instruction in Section 1 above.

This notice has been posted online at http://dhcfp.nv.gov, as well as Carson City, Las Vegas, Elko, and Reno central offices for DHCFP. Email notice has been made to such individuals as have requested notice of meetings (to request notifications please contact documentcontrol@dhcfp.nv.gov , or at 1100 East William Street, Suite 101, Carson City, Nevada 89701.

DHCFP, 1100 E. William St., Suite 101, Carson City, Nevada 89701
DHCFP, 1010 Ruby Vista Drive, Suite 103, Elko, Nevada 89801
DHCFP, 1210 S. Valley View, Suite 104, Las Vegas, Nevada 89102
DHCFP, 745 W. Moana Lane, Suite 200, Reno, Nevada 89509

If you require a physical copy of this notice, please contact documentcontrol@dhcfp.nv.gov , or at 1100 East William Street, Suite 101, Carson City, Nevada 89701.

Rehabilitative Services: Intensive Crisis Stabilization Services (ICSS)

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 Intensive Crisis Stabilization Services (ICSS). The State agency will reimburse providers of ICSS a facility-specific bundled daily rate.

These cost-based rates reflect the providers' unique costs and ensure that providers of ICSS receive at least their costs for providing services to Medicaid members. Payments will be limited to one payment per day, per recipient, regardless of the number of services received within a single day by center users accessing services from providers of ICSS. Encounters with more than one health practitioner and multiple encounters with the same health practitioner that take place on the same day and that share the same or like diagnoses constitute a single billable encounter.

A. Default Bundled Daily Rate

For the initial period establishing ICSS beginning March 30, 2022 through June 30, 2024 ICSS rates will be developed as follows:

- Anticipated costs will be inserted into the cost report by DHCFP with BLS wage information used for costs and Medicaid utilization data for crisis services which best align with the anticipated delivery of ICSS, used to establish service count estimate.

Setting of Default Bundled Daily Rate

The bundled default daily rate will be posted on the Crisis Services fee schedule. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of ICSS. The agency's fee schedule rate was set as of March 30, 2022 and is effective for services provided on or after that date. The landing page for all Nevada Medicaid rates can be found here: https://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

Subsequent year updates

For providers who wish to continue with the default bundled daily rate, this rate will be adjusted by the current Medicare Economic Index (MEI) adjusted effective July 1 of each year.

B. Optional Cost Report-Based Bundled Daily Rate

After the first complete year of operation as a provider of ICSS, providers of ICSS who choose to have a cost-based bundled daily rate will be required to submit a cost report inclusive of all actual costs to provide services for the most recent full fiscal year of operations. Once a provider of ICSS

has elected to have a cost-based bundled daily rate, they must continue with a cost-based bundled daily rate and cannot elect to be reimbursed on the default bundled daily rate.

Setting of Cost-Based Bundled Daily Rate

Allowable ICSS cost include total direct cost of ICSS plus indirect cost applicable to ICSS as defined at 2 Code of Federal Regulations (CFR) Part 200 as implemented for HHS at 45 CFR Part 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for the US Department of Health and Human Services (HHS) Awards.). Direct ICSS cost includes the actual salaries and benefits of Medicaid qualified providers of ICSS, costs of ICSS services provided under agreement, and other direct ICSS costs including medical supplies or professional liability insurance specific to the ICSS program. Total ICSS costs include all costs for ICSS and are inclusive of all payors. The provider of ICSS will also be required to identify the costs of providing "non-ICSS," so that related indirect costs can be excluded from the rate. Examples of "non-ICSS" that a provider of ICSS might provide include are psychiatric residential treatment programs and habilitative services.

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

Total ICSS visits include all visits for ICSS, including both Medicaid and non-Medicaid visits. An ICSS visit or an encounter, for the purposes of reimbursing ICSS is defined as face-to-face provision of ICSS with one or more qualified health professionals that takes place on the same day with the same patient. For the purpose of ICSS a day is defined as the 24-hour period which begins when a patient presents to the provider of ICSS.

This cost report will be used to calculate the bundled per visit ICSS rate by dividing total allowable ICSS service costs by total ICSS visits. Provider costs will be trended using the Medicare Economic Index to adjust from the midpoint of the cost period to the midpoint of the rate period. Cost and visit data vary based on provider of ICSS size, location, economy, and scope of services offered and must adhere to adhere to the cost principles described at 2 CFR part 200 as implemented for HHS at 45 CFR part 75. The provider of ICSS must submit all required documentation of actual costs for the first full year of providing services to Division of Health Care Financing and Policy (DHCFP) no later than 90 calendar days or 3 months after the first year of operations as a provider of ICSS. DHCFP will deem cost reports complete within 30 days of receipt.

Provider of ICSS will continue to be reimbursed at the ICSS Default Bundled rate until the ICSS Cost-Based Bundled Daily Rate has been calculated, accepted and entered into the Medicaid

Management Information System (MMIS). Once the cost-based daily bundled rate has been calculated using actual costs on the ICSS cost report submitted after the end of year one or requested fiscal year as approved by DHCFP, the rate effective date will be aligned with the start date of the subsequent State Fiscal Year. These rates will be paid prospectively and no cost settlement to prior state fiscal years will be performed.

Subsequent year updates

Thereafter, for each consecutive year on July 1st (SFY) the cost-based bundled daily rate will be updated by either of the following:

- Trending forward by the current Medicare Economic Index (MEI), as defined in Section 1842(i)(3) of the Social Security Act, to determine the subsequent ICSS-specific cost based daily bundled payment rate.
- Rebasing the ICSS with actual costs and visits from a provider submitted cost report for the requested fiscal year.

Rebasing

The rebasing process will replicate the process outlined under "Setting of Cost-Based Bundled Daily Rate." Rebasing of costs based on the most recently available cost reports will be performed for all providers with a cost-based rate after 5 complete years of operation. Rebases will not occur outside of the defined periodicity unless requested by the provider not to exceed one additional time within the 5-year period. A provider's rate will be rebased automatically by the state every five years from the last time the rate was calculated using a cost report as described in Section B above. A provider's rebased ICSS cost based bundled rate will be capped so that the rebased bundled rate will be no more than 150% or less than 75% of the provider's current rate. Rebased rates will be determined utilizing the most recent full fiscal year of performing services.