1915(i) Home and Community Based Services (HCBS) State Plan Services
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

☒ Home and Community Based Services (HCBS) Adult Day Health Care (ADHC)

Reimbursement Methodology for Adult Day Health Care (ADHC) Services provided by a non-governmental entity and governmental entities who do not undergo the Medicaid cost identification and reporting procedures:

Prior to the beginning of each rate year, each of the governmental providers providing ADHC services must select one of the reimbursement methodologies described below for reimbursement. For example, by April 30, 2013, governmental providers must select a methodology for the rate year beginning July 1, 2013. Once a selected methodology is determined for a rate year, governmental providers will not be able to change the selected methodology until the following rate year.

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 www.dhcfp.nv.gov.

The billable unit of service for ADHC is 1 unit per 15 minutes or the daily rate.

- If services are authorized and provided for less than 6 hours per day, provider should bill one unit for each 15 minutes;
- If services are authorized and provided for 6 hours or more per day, provider should bill the per diem rate.

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 ADHC services.
- 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.
- 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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- 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.

The following steps are used to determine the rate:

1. The State will use Nevada-specific hourly wages from the Bureau of Labor Statistics as of May, 2004 inflated to June, 2006.
2. This hourly compensation is increased by the 27% ERE.
3. A productivity factor is applied to the hourly compensation calculated in Item 2 to equal to the adjusted hourly rate.
4. Administrative overhead (10%) is applied to the adjusted hourly rate (Item 3).
5. Determine allowance for capital costs per hour.
6. Fixed hourly rate is the sum of adjusted hourly rate (Item 3), administrative overhead (Item 4) and capital costs (Item 5).
7. Fixed hourly rate is scaled to the proper unit based on the procedure code.

This rate has been compared to government entities who do not follow all cost reporting rules and 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.

A. Reimbursement Methodology for Adult Day Health Care (ADHC) services provided by a state or local government entity:

ADHC services provided by a state or local government entity are reimbursed according to the following payment methodology. This methodology is used by providers who undergo all Medicaid cost identification, reporting, reconciliation and settlement procedures.

I. 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 Adult Day Health Care 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 prescribed by Nevada Medicaid 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.
b. reconcile its interim payments to its total Medicaid-allowable costs.

The annual Medicaid Cost Report includes a certification of expenditures 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 DHCFP or its designee.

B. Settings 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 cognizant agency 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 cost details are accumulated on the annual cost report.

d) Net direct costs (b) and indirect costs (c) are combined.

e) A CMS approved time study is required when providers of service do not spend 100% of their time providing the ADHC services described in the applicable section 3.1-A State Plan pages and is used to determine the percentage of time that service personnel spend on direct ADHC.

f) Services, general and administrative time, and all other activities to account for 100 Services, general and administrative time, and all other activities to account for 100 per percent 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 Adult Day Health Care Services time study percentage is applied against the net direct and indirect costs.

g) 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.

h) Total Medicaid allowable costs (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.

C. Facilities that are used for multiple purposes and the provision of medical services is 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.

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 cognizant agency 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 allowable amount. For these facilities, allowable costs are only those costs 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 Adult Day Health Care Services described in the applicable section 3.1-A State Plan pages and is used to determine the percentage of time that service personnel spend on direct Adult Day Health Care Services, general and administrative time, and all other activities to account for 100 percent 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 Adult

Day Health Care 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.

3. Cost Reconciliation Process

Governmental providers will be responsible for reconciling total computable costs reported on the cost report to the provider's Medicaid interim payments for Medicaid services delivered during the reporting period as documented in the MMIS, resulting in cost reconciliation. The cost reconciliation process must be completed within twenty-four 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, 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, DHCFP will pay the federal share of the difference to the provider in accordance with the final actual certification agreement.

DHCFP will issue a notice of settlement that denotes the amount due to or from the provider.

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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:

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.

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.