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State/Territory Name: Nevada

State Plan Amendment (SPA) #: 22-0005

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355 Kansas City,
Missouri 64106

Medicaid and CHIP Operations Group

July 29, 2024

Stacie Weeks, Administrator
Department of Health and Human Services
Division of Healthcare Financing and Policy
1100 East William Street, Suite 101
Carson City, NV 89701

Re: Nevada State Plan Amendment (SPA) NV-22-0005

Dear Administrator Weeks:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number NV-22-0005. This SPA revises Nevada's state plan for rehabilitative services in accordance with 1905(a)(13)(c). In addition, NV has added Mobile Crisis services in accordance with Section 1947 of the Social Security Act at the states option to provide qualifying community-based mobile crisis intervention services.

We have conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act. This letter is to inform you that Nevada Medicaid SPA NV-22-0005 was approved on July 29, 2024, with an effective date of March 30, 2022.

If you have any questions, please contact Cecilia Williams at 667-414-0674 or via email at Cecilia.Williams@cms.hhs.gov.

Sincerely,

[redacted]
Digitally signed by James G. Scott -S
Date: 2024.07.29 09:06:27 -05'00'

James G. Scott, Director
Division of Program Operations

Enclosures

cc: Jenifer Graham
Theresa Carston
Sarah Dearborn
Casey Angres
Jennifer Krupp

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22 — 0005

2. STATE: NV

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
March 30, 2022

5. FEDERAL STATUTE/REGULATION CITATION
State Plan Under Title XIX of the Social Security Act 1905(a)(13)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ (1,418,290)
b. FFY 2023 $ (5,174,021)

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19B ~~pages 4a - 4c~~ 3l-3n (New)
Attachment 3.1-A pages 6a.1-6a.14

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
~~Attachment 4.19B pages 4a - 4b~~ ~~New~~
Attachment 3.1-A pages 6a.1-6a.14

9. SUBJECT OF AMENDMENT
Adding Crisis Stabilization Centers (CSC) to the service array

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
RICHARD WHITLEY

13. TITLE
DIRECTOR, DHHS

14. DATE SUBMITTED
March 30, 2022

15. RETURN TO
Sandie Ruybalid, Deputy Administrator
DHCFP/Medicaid
1100 East William Street, Suite 101
Carson City, NV 89701

FOR CMS USE ONLY

16. DATE RECEIVED
March 30, 2022

17. DATE APPROVED
July 29, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
March 30, 2022

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]
Digitally signed by James G. Scott -S
Date: 2024.07.29 09:06:55 -05'00'

20. TYPED NAME OF APPROVING OFFICIAL
James G. Scott

21. TITLE OF APPROVING OFFICIAL
Director, Division of Program Operations

22. REMARKS

07/23/2024: NV concurred with pen and ink change to Box 5 via email.

07/24/2024: NV concurred with pen and ink changes to Boxes 7 & 8 via email.

07/25/2024: NV concurred to remove "NEW" from Box 8 via email.

07/26/2024: NV concurred to add New to Box 7 via email.

Instructions on Back

13D. Rehabilitative Services

The following Practitioners and Qualifications chart is applicable to each of the Mental Health Rehabilitation Services that follow in this section.

Licensed Professionals		
Provider Type/Qualifications	**Services Provided**	**Other Information**
Licensed Physician (M.D.), Osteopath (D.O.)	• Mental Health Screen • Behavioral Health Assessment • Evaluation • Medication Management • Medication Assisted Treatment • Intensive Crisis Stabilization Services • Crisis Intervention Services • Partial Hospitalization • Intensive Outpatient • Day Treatment • Individual Therapy • Group Therapy • Family Therapy • Psychosocial Rehabilitation • Basic Skills Training	NA
Licensed Physician Assistant (Psychiatry)		NA
Licensed Psychiatrist (M.D.)	• Mental Health Screen • Behavioral Health Assessment • Evaluation • Medication Management • Medication Assisted Treatment • Intensive Crisis Stabilization Services • Crisis Intervention Services • Partial Hospitalization • Intensive Outpatient • Day Treatment	NA

	• Individual Therapy • Group Therapy • Family Therapy	
Licensed Psychologist	• Mental Health Screen • Behavioral Health Assessment • Neuro-cognitive/ Psychological & Mental Status Testing • Intensive Crisis Stabilization Services • Crisis Intervention Services • Partial Hospitalization • Intensive Outpatient • Day Treatment • Individual Therapy • Group Therapy • Family Therapy	N/A
Psychological Assistant Psychological Intern Psychological Trainee	• Mental Health Screen • Behavioral Health Assessment • Neuro-cognitive/ Psychological & Mental Status Testing • Intensive Crisis Stabilization Services • Crisis Intervention Services • Partial Hospitalization • Intensive Outpatient • Day Treatment • Individual Therapy • Group Therapy • Family Therapy	Psychological Assistant, Psychological Intern, Psychological Trainee may deliver services within scope under their Licensed Supervising Psychologist. The Licensed Supervising Psychologist is the billing agent for all services performed by a Psychological Assistant, Psychological Intern, or Psychological Trainee. All Psychological Assistants, Psychological Interns, and Psychological Trainees are registered through the Nevada Board of Psychological Examiners. Psychological Assistants are practicing in a postdoctoral supervised program. Psychological Interns

		and Trainees are enrolled in accredited doctoral programs.
Advanced Practice Registered Nurse (Psychiatry)	• Mental Health Screen • Behavioral Health Assessment • Medication Management • Intensive Crisis Stabilization Services • Crisis Intervention Services • Partial Hospitalization • Intensive Outpatient • Day Treatment • Individual Therapy • Group Therapy • Family Therapy	NA
Licensed Clinical Social Worker (LCSW) Licensed Marriage and Family Therapist (LMFT) Licensed Clinical Professional Counselor (LCPC)	• Mental Health Screen • Behavioral Health Assessment • Medication Assisted Treatment • Individual Therapy • Group Therapy • Family Therapy • Intensive Crisis Stabilization Services • Crisis Intervention Services • Partial Hospitalization • Intensive Outpatient • Day Treatment • Psychosocial Rehabilitation • Basic Skills Training	Services must be delivered within the scope of the individual provider's licensure
Licensed Clinical Alcohol and Drug Counselor (LCADC) Licensed Clinical Alcohol and Drug Counselor Intern (LCADC-I)	• Behavioral Health Screen • Behavioral Health Assessment • Medication Assisted Treatment • Individual SUD Counseling	

Licensed Alcohol and Drug Counselor (LADC)	• Group SUD Counseling • Intensive Crisis Stabilization Services • Crisis Intervention Services • Partial Hospitalization • Intensive Outpatient	
Certified Professionals		
Provider Type/Qualifications	**Services Provided**	**Other Information**
Certified Alcohol and Drug Counselor (CADC)	• Behavioral Health Assessment • Medication Assisted Treatment • Individual SUD Counseling • Group SUD Counseling • Intensive Crisis Stabilization Services • Crisis Intervention Services • Partial Hospitalization • Intensive Outpatient	NA
Certified Alcohol and Drug Counselor Intern (CADC-I)		NA
Certified Peer Recovery Support Specialist • A qualified individual currently or previously diagnosed with a mental health disorder or substance use disorder who has the skills and abilities to work collaboratively with and supervised by a licensed professional. • Minimum qualifications as a Qualified Behavioral Aide (QBA); • Certification as a Peer Recovery and Support Specialist (PRSS) from the Nevada Certification Board	• Peer-to-Peer Support Services • Intensive Crisis Stabilization Services • Crisis Intervention Services • Intensive Outpatient • Partial Hospitalization	N/A

• 20 hours of continuing education earned every two years, including six hours in ethics.		
Qualified Mental Health Professional		
Provider Type/Qualifications	**Services Provided**	**Other Information**
Licensed Clinical Social Worker Intern (LCSW-I) Licensed Marriage and Family Therapist Intern (LMFT-I) Licensed Clinical Professional Counselor Intern (LCPC-I)	• Mental Health Screen • Behavioral Health Assessment • Individual Therapy • Group Therapy • Family Therapy • Intensive Crisis Stabilization Services • Crisis Intervention Services • Partial Hospitalization • Intensive Outpatient • Day Treatment • Psychosocial Rehabilitation • Basic Skills Training	• May provide Direct Supervision under Clinical Supervision of an independently Licensed Professional • Must be enrolled under a Behavioral Health entity/agency/group and supervised by a licensed professional as listed above. • Must have current supervision by the appropriate state licensing board
Qualified Mental Health Associate (QMHA)		
Provider Type/Qualifications	**Services Provided**	**Other Information**
Registered Nurse (RN)	• Mental Health Screen • Medication Training and Support Services • Intensive Crisis Stabilization Services • Crisis Intervention Services • Partial Hospitalization • Intensive Outpatient • Day Treatment • Psychosocial Rehabilitation • Basic Skills Training	• Must be enrolled under a Behavioral Health entity/agency/group and supervised by a licensed professional as listed above.

Qualifying Individual with a bachelor's degree in a Human Services field Qualifying Individual with associate degree in a human services Field and Four (4) Years Verified Enrollment as a Qualified Behavioral Aide (QBA) Qualifying Individual with bachelor's degree in a Field Other Than Human Services and Four (4) Years Demonstrated Experience in Outpatient Treatment Services, Rehabilitative Treatment Services, Case File Documentation	• Mental Health Screen • Intensive Crisis Stabilization Services • Crisis Intervention Services • Partial Hospitalization • Intensive Outpatient • Day Treatment • Psychosocial Rehabilitation • Basic Skills Training	• Must be enrolled under a Behavioral Health entity/agency/group and supervised by a licensed professional as listed above. • May provide Direct Supervision of Rehabilitative Mental Health Services under Clinical Supervision of an independently Licensed Professional
Qualified Behavioral Aide (QBA)		
Provider Type/Qualifications	**Services Provided**	**Other Information**
Individual with a High School Diploma of GED Equivalent QBAs are required to participate in and successfully complete an approved 16-hour 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;	• Basic Skills Training • Intensive Crisis Stabilization Services • Crisis Intervention Services • Day Treatment Services • Partial Hospitalization • Intensive Outpatient	• Must be enrolled under a Behavioral Health entity/agency/group and supervised by a licensed professional as listed above.

• 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.		

2. Behavioral Health Rehabilitation Services

Behavioral health rehabilitation assists individuals to restore and/or retain psychiatric stability, social integration skills, personal adjustment and/or independent living competencies in order to experience success and satisfaction in environments of their

choice and to function as independently as possible. Interventions occur concurrently with clinical treatment and begin as soon as clinically appropriate. Depending on the specific services they may be provided in a group or individual setting. Rehabilitative services that are delivered to collaterals (i.e. the beneficiary's family, caregivers, significant others, etc.) is for the direct benefit of the beneficiary, in accordance with the beneficiary's needs and treatment goals identified in the beneficiary's treatment plan and for the purpose of assisting the beneficiary's recovery.

The services must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice and prescribed on an individualized treatment plan to achieve maximum reduction of a mental disability and restore the recipient to their optimal level of functioning.

Medicaid-eligible children under EPSDT, can receive these and all other medically necessary services.

Rehabilitative services do not include:

- Room and board;
- Services provided to residents of institutions for mental diseases;
- Services that are covered elsewhere in the State Medicaid plan;
- Educational, vocational and job training services;
- Recreational and social activities;
- Habilitation Services; and
- Services provided to inmates of public institutions.

Each individual service must be identified on a written rehabilitation plan. This is also referenced as the treatment plan. Providers are required to maintain case records. Components of the rehabilitation plan and case records must be consistent with the federal rehabilitation regulations. Rehabilitation services may only be covered by Medicaid if they are not the responsibility of other programs and if all applicable requirements of the Medicaid program are met. Services covered under the Title IV-E program are not covered under the rehabilitation program. Room and Board is not an allowable service under the mental health rehabilitative program. Services are not provided to recipients who are inmates of a public institution.

These services require utilization review according to the individual intensity of need and are time limited.

Services are based on an intensity of needs determination. The assessed level of need specifies the amount, scope and duration of mental health rehabilitation services required to restore, retain a recipient's level of functioning or prevent relapse. The determination cannot be based upon the habilitative needs of the recipient.

Intensity of needs determination is completed by a trained Licensed Professional, Qualified

Mental Health Professional (QMHP), Certified Professional, or Qualified Mental Health Associate (QMHA) and is based on several components related to person- and family-centered treatment planning. These components include:

- A comprehensive assessment of the recipient's level of functioning;
- The clinical judgment of the licensed professional, certified professional or QMHP; or
- The clinical judgment of the case manager working under clinical supervision who is trained and qualified in mental health intensity of services determinations; and
- A proposed Treatment Plan.

A re-determination of the intensity of needs must be completed every 90 days or anytime there is a substantial change in the recipient's clinical status.

Nevada Medicaid utilizes an intensity of needs grid to determine the amount, duration, and scope of services based upon the clinical level of care of the recipient. The grid is based upon the current level of care assessments: Level of Care Utilization System (LOCUS) for adults and Child and Adolescent Services Intensity Instrument (CASII) for children. The determined level on the grid guides the interdisciplinary team in planning treatment.

Within each level there are utilization standards for the amount of services to be delivered. The six levels are broken out by the following categories in order from less intense to more intense;

Level of Care Utilization System (LOCUS)

- Level 1- Recovery maintenance and health management,
- Level 2- Low intensity community-based services,
- Level 3- High intensity community-based services,
- Level 4- Medically monitored non-residential services,
- Level 5- Medically monitored residential services, and
- Level 6 -Medically managed residential services.

Child and Adolescent Services Intensity Instrument (CASII)

- Level 1- Basic services, Recovery maintenance and health management,
- Level 2-Outpatient services,
- Level 3- Intensive outpatient services,
- Level 4- Intensive integrated services,
- Level 5- Non-secure, 24-hour services with psychiatric monitoring,
- Level 6- Secure, 24-hour services with psychiatric management.

The American Society of Addiction Medicine (ASAM) patient placement criteria is used to establish guidelines for level of care placements within the substance use treatment continuum and is performed by licensed and certified professionals.

All mental health rehabilitation services must meet the associated admission and continuing stay criteria and go through utilization management per the intensity of needs grid.

Service Array:

1. *Assessments:* Performed by a Licensed Professional, Qualified Mental Health Professional, Certified Professional, or in the case of a Behavioral Health Screen a Qualified Mental Health Associate. Assessments are used for problem identification (diagnosis) and to establish measurable treatment goals and objectives. An assessment is not intended for entry into each of the services. It is provided as an overall assessment of the recipient's needs. Psychiatric Diagnostic Evaluations are limited to two per calendar year for adults with a LOCUS and four for youth with a CASII. Additional assessments may be prior authorized based upon medical necessity.

2. *Behavioral Health Screens*: Determine eligibility for admission to a treatment program. This is completed through a clinical determination of the intensity of need of the recipient. The objective of this service is to allow for the 90-day review for the intensity of needs determination and to determine either SED, SMI, or SUD if it has not already been determined.

3. *Neuro-cognitive/psychological and mental status testing:* This service is performed by a Licensed Professional. Examples of testing are defined in the CPT; neuropsychological testing, neurobehavioral testing, and psychological testing. Each service includes both interpretation and reporting of the tests. This service requires prior authorization.

4. *Basic Skills Training*: Services in this category are rehabilitative interventions that target concrete skill restoration such as: monitoring for safety, basic living skills, household management, self-care, social skills, communication skills, parent education, organization skills, time management, and transitional living skills. This service is provided in a variety of settings including community-based, outpatient services, and the home environment. The level of professional providing the services is dependent upon the needs of the recipient and the utilization management criteria. This service is provided by a licensed professional, QMHP or QMHA, under the direction of a licensed professional or QMHP, or provided by a QBA under the direct supervision of a licensed professional, QMHP, or QMHA. This may be provided in a group (four or more individuals) or in an individual setting. These services require utilization review according to the individual intensity of need and are time limited.

5. *Psycho-social Rehabilitation*: Services in this category are rehabilitative interventions that target specific behaviors. These services may include: behavioral management and counseling, conflict and anger management, interpersonal skills, collateral interventions with schools and social service systems, parent and family training and counseling, community transition and integration, and self-management. This service is provided in a

variety of settings including, community-based, outpatient services, and the home environment. The level of professional providing the services is dependent upon the needs of the recipient and the utilization management criteria. This is provided on an individual basis or in a group consisting of at least four individuals. Service is provided by a licensed professional, QMHP, or a QMHA. These services may be used to treat individuals determined to have severe emotional disturbance or serious mental illness. The level of care of the recipient is consistent with the high intensity community-based services. These services require utilization review according to the individual intensity of need and are time limited.

6. *Intensive Crisis Stabilization and Crisis Intervention*: Comprise two distinct services that includes supports, services, and treatments necessary to provide integrated crisis response, crisis stabilization interventions, and crisis prevention activities. Services are brief, immediate and intensive interventions designed to reduce symptoms, stabilize the recipient, restore the recipient to their previous level of functioning, and to assist the recipient in returning to the community as rapidly as possible, if the recipient has been removed from their natural setting.

- *Intensive Crisis Stabilization:* Time-limited (24 hours), intensive, facility-based crisis treatment and stabilization services. Services include comprehensive assessment and observation; crisis intervention; psychiatric, substance, and co-occurring treatment; treatment and safety planning; and referral to ongoing treatment, with an emphasis on services necessary to stabilize and restore the individual to a level of functioning that can be managed at a lower level of care.

- *Crisis Intervention*: A brief intervention that includes safety and risk screening, assessment, stabilization and de-escalation and coordination with, and referral to, health, social, and other services and supports as needed. These services may be mobile, responding to the location of the recipient and may be provided in a variety of settings, including, but not limited to, psychiatric emergency departments, homes, hospital emergency rooms, schools, child protective custody, and homeless shelters. Crisis intervention services include follow-up and de-briefing sessions to ensure stabilization and continuity of care.

  The service may be provided telephonically, as long as the service meets the definition of crisis intervention. This service is allowable for all levels of care. These services require utilization review according to the individual intensity of need and are time limited. Recipients may receive a maximum of four hours per day over a three- day period (one occurrence) without prior authorization. Recipients may receive a maximum of three occurrences over a 90-day period without prior authorization. All service limitations may be exceeded with a prior authorization demonstrating medical necessity.

  - *Section 1947 Mobile Crisis Services (effective July 1, 2023)*: Mobile

crisis services under Section 1947 (Qualifying Community-Based Mobile Crisis Intervention Services) must meet all requirements under Section 1947 and are provided to Medicaid beneficiaries outside of a hospital or other facility setting and are available 24 hours per day, 7 days a week. Mobile crisis teams under Section 1947 must meet team composition requirements at 1947(b)(2)(A), which includes, at a minimum, one behavioral health professional who may conduct assessment within his or her authorized scope of practice under state law and other professionals or paraprofessionals with appropriate expertise in behavioral health care. At least one of the qualified practitioners must provide services in person with the Medicaid beneficiary.

7. *Substance Use Disorder (SUD) Counseling:* The application of counseling to reduce or eliminate the habitual use of alcohol or other drugs, other than any maintenance dosage of a narcotic or habit-forming drug administered. Provided by a licensed or certified professional for individual and group counseling with the recipient present. The intensity of SUD counseling services will be determined by medical necessity and utilization of ASAM patient placement criteria. A recipient may access SUD counseling services up to 26 total sessions for children and adolescents and up to 18 total sessions for adults per calendar year. All service limitations may be exceeded with prior authorization.

8. *Mental Health Therapy:* Provided by a licensed professional or QMHP for individual, group, and/or family therapy with the recipient present and for family therapy without the recipient present. Therapy delivered must be of a direct benefit to the recipient. Minimum size for group therapy is three individuals and a maximum therapist to participant ratio is one to ten. Mental health therapy is available at all levels of care. The intensity of the service increases based on the need of the recipient. These services require utilization review according to the individual intensity of need and are time limited. All service limitations may be exceeded with a prior authorization demonstrating medical necessity.

Level of Care	**Child & Adolescent**	**Adult**
Level 1	10 Total Sessions; Individual, Group and Family	6 Total Sessions; Individual, Group and Family
Level II	26 Total Sessions; Individual, Group and Family	12 Total Sessions; Individual, Group and Family
Level III	26 Total Sessions; Individual, Group and Family	12 Total Sessions; Individual, Group and Family
Level IV	26 Total Sessions; Individual, Group and Family	16 Total Sessions; Individual, Group and Family
Level V	26 Total Sessions; Individual, Group and Family	18 Total Sessions; Individual, Group and Family
Level VI	26 Total Sessions; Individual, Group and Family	18 Total Sessions; Individual, Group and Family

9. *Day Treatment Services*: A comprehensive array of direct mental health and rehabilitative services which are expected to restore an individual's condition and functioning level for effective community integration. Admission to this program requires: a recipient's clinical and behavioral functioning to require intensive, coordinated, multi-disciplinary intervention within a therapeutic milieu. Day treatment is provided in a structured therapeutic environment which has programmatic objectives such as but not limited to: development of skills to promote healthy relationships and learn to identify ingredients that contribute to healthy relationships, development of coping skills and strategies, development of aggression prevention plans, problem identification and resolution, ability to learn respectful behaviors in social situations, development of the ability to demonstrate self-regulation on impulsive behaviors, development of empathy for peers and family and develop a clear understanding of recipients cycles of relapse and a relapse prevention plan. Services must be provided by a licensed professional, QMHP or by a QMHA under the direct supervision of a licensed professional. The services provided may be directly attributable to an individual provider. The staff ratio is one to five participants. The average time per day this program is offered is three hours per day. All service limitations may be exceeded with a prior authorization meeting medical necessity.

Level of Care	**Ages 3-6**	**Ages 7-18**	**Ages 19 and older**
Level I and II	No Services Authorized	No Services Authorized	No Services Authorized
Level III	Max. of 3 hrs per day	Max. of 4 hrs per day	No Services Authorized
Level IV	Max. of 3 hrs per day	Max. of 5 hrs per day	Max. of 5 hrs per day
Level V	Max. of 3 hrs per day	Max. of 6 hrs per day	Max. of 6 hrs per day
Level VI	Max. of 3 hrs per day	Max. of 6 hrs per day	Max. of 6 hrs per day

Mental health therapy and day treatment cannot be billed for the same time period. This service is consistent with intensive integrated outpatient services. These services require utilization review according to the individual intensity of need and are time limited.

10. *Peer-to-Peer Support Services*:

These services provide scheduled activities that encourage recovery, self-advocacy, developments of natural supports, and maintenance of community living skills. They promote skills for self-determination, community inclusion/participation, independence, and productivity. Peer Recovery and Support Specialists model skills to help individuals meet their rehabilitative goals. Peer-to-Peer Support Services are for the direct benefit of the beneficiary and assist individuals and their families in the use of strategies for coping, resiliency, self-advocacy, symptom management, crisis support, and recovery.

Services may be provided in an individual or group (requires five or more individuals) setting. The services are identified in the recipient's treatment plan and must be provided by a Peer Recovery and Support Specialists working collaboratively with the case manager or child and family team/interdisciplinary team. The selection of a Peer-to Peer Support service is based on the best interest of the recipient. A Peer Recovery and Support Specialists cannot be the legal guardian or spouse of the recipient. Services are offered

based on the intensity/frequency of needs and are time limited. Peer-to-Peer Support Services can be utilized for up to 18 hours/72 units annually before prior authorization is required. Additional hours may be granted when services are clinically indicated based on a recipient-centered approach and when determined medically necessary by the state.

11. *Intensive Outpatient Services:*

A comprehensive array of direct mental health and rehabilitative services which are expected to restore an individual's condition and functioning level for prevention of relapse or hospitalization. These services are provided to individuals who meet the state's medical necessity criteria for the services. Intensive outpatient group sizes are required to be within four to 15 recipients. Intensive outpatient services require the availability of 24/7 psychiatric and psychological services.

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 bundled daily rate. Any provider delivering ICSS through a bundle will be paid through that bundle's payment rate and cannot bill separately. At least one service must be provided in order to receive the bundled payment rate. If a provider of ICSS is unable to provide the whole scope of ICSS as defined in Attachment 3.1-A, providers can be reimbursed for a separate service. The bundled daily rate does not include costs related to room and board or other unallowable facility costs.

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

All providers of ICSS are paid the default bundled daily rate for ICSS provided in the first year of operation and continue to be paid this rate in subsequent years of operation unless they elect the Optional Cost Based Bundled Daily Rate described in Section B.

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

- Statewide 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.
- The ICSS default bundled daily rate is calculated by dividing the total statewide anticipated ICSS costs by the estimated ICSS visit count.

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 at 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 qualified providers of ICSS, costs of ICSS 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, an ICSS encounter is defined as the date of service on which a visit/encounter occurs. Visits spanning multiple dates of service, though less than a 24 hour period will be counted as a single daily visit.

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.

Providers 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). DHCFP will complete the cost based daily bundled rate calculation within 90 days after receiving a cost report determined by the state to be reasonable and complete per 2 CFR Part 200. The rate effective date will be aligned with the start date of the subsequent quarter. These rates will be paid prospectively and no cost settlement to prior state fiscal quarters 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.” Beginning January 1, 2025, bundled reimbursement rates for providers of ICSS must be rebased once within each designated 5-year period. Providers may select any full fiscal year of services within each designated 5-year period for the rebase to occur; however, a provider may not rebase their rate more than once within each designated 5-year period. When a provider indicates they are requesting a rebase of their rate, the most recent full fiscal year within the designated 5-year period, cost reporting data is utilized to determine the rebased rate; providers may not utilize an earlier cost report for the rebase. If a provider has not requested a rebase by the end of the designated 5-year period, their rate will be rebased based on the most recent full fiscal year of data and effective at the beginning of the next five-year period. 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.