May 21, 2025

Nevada Medicaid Web Announcement 3640

Attention Provider Type 63 (Psychiatric Residential Treatment Facilities (PRTFs)): Update Regarding PRTF Rates

The Division of Health Care Financing and Policy (DHCFP) is currently on a Request for Additional Information (RAI) with the Centers for Medicare & Medicaid Services (CMS) regarding the Psychiatric Residential Treatment Facilities (PRTF) State Plan Amendment (SPA) # 25-0002 to amend the reimbursement rates for PRTFs.

Under the proposed change, the existing reimbursement methodology would be amended to change the reimbursement to a flat rate of $800 with the possibility of a $150 add-on option for intensive treatment services for children under age 10 and/or intensive treatment services for serving youth with specialized complex needs. The public hearing for the PRTF SPA, Attachment 4.19-A, Page 14 was held on December 30, 2024, with changes being effective January 1, 2025, dependent on CMS approval. DHCFP does not have an estimate of when this will be completed. If approved, a claims reprocessing effort will be done from January 1, 2025, to the date the system is updated. Keep a look out on the Nevada Medicaid website for any Web Announcements pertaining to this, as well as for other useful information for providers: Nevada Medicaid

As a reminder, PRTF providers, since they have had provider-specific cost-negotiated rates, have always had the ability to negotiate for higher rates via the Medicaid Rates Appeal process, discussed in detail in Chapter 700 of the Medicaid Services Manual, Section 704. Providers are welcome to submit a Rate Appeal while awaiting a decision from CMS.

Appeals must be submitted in writing to the address below and clearly marked as a Rate Appeal.

To ensure receipt of the appeal, certified mail or other commonly accepted delivery methods that clearly show the date of receipt are encouraged.

Appeal address: Administrator DHCFP, 4070 Silver Sage Drive, Carson City, NV 89701.

The appeal must contain the following information:

1. The name, address and telephone number of the person who has authority to act on behalf of the provider/appellant.
2. The specific rate(s) to be reviewed.
3. The basis upon which the provider believes relief should be granted, including supporting documentation:
    a. Claims documentation showing costs for Medicaid services not fully compensated by Medicaid payments is necessary, but not sufficient to form a basis for relief.
    b. The documentation should show that payments received from Medicaid for the appealed rate fail to compensate for costs attributable to providing services to Medicaid patients as well as for the rates in aggregate for the provider.
    c. The documentation must show how the specific circumstances of services provided to Medicaid recipients relative to other like-providers result in higher costs not adequately or appropriately considered in the development of the existing rate(s).

4. The relief requested, including the methodology used to develop the relief requested. Actual costs from the most recent prior year(s), or costs from part of the current year, may be used in developing the methodology for the relief request, so long as it is not a cost reimbursement methodology.
5. Any other information the provider believes to be relevant to the review.

As an additional reminder, the new PRTF policy was presented at the February 25, 2025, public hearing, and became effective February 26, 2025. Please review this new policy within Chapter 400, Section 403.7 to ensure understanding of these new PRTF requirements.

For further information or any other questions, please send an email to the DHCFP Behavioral Health Benefits and Coverage Unit at BehavioralHealth@dhcfp.nv.gov and/or the DHCFP Rates Unit at Rates@dhcfp.nv.gov