



BRIAN SANDOVAL
Governor

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
1100 E. William Street, Suite 101
Carson City, Nevada 89701
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RICHARD WHITLEY, MS
Director

MARTA JENSEN
Acting Administrator

**NOTICE OF PUBLIC MEETING TO SOLICIT COMMENTS ON AMENDMENTS TO
THE STATE PLAN FOR MEDICAID SERVICES**

2nd REVISED AGENDA

Date of Publication: November 25, 2015

Date and Time of Meeting: December 29, 2015 at 9:00AM

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

Place of Meeting: Division of Public and Behavioral Health
4150 Technology Way, Room 303
Carson City, Nevada 89706

Place of Video Conference: Division of Health Care Financing and Policy
1210 S. Valley View Blvd., Suite 104
Las Vegas, Nevada 89102

Teleconference: (877) 336-1829

Access Code: 8793897

AGENDA

- 1. Public Comment**
- 2. Discussion of Amendments to the State Plan for Medicaid Services and Solicitation of Public Comments**

Subject: PT11 Transplants & PT75 Critical Access Hospital (CAH)

The DHCFP is proposing to submit a State Plan Amendment regarding PT 11 - Hospital transplant rate changes and PT 75 - Critical Access Hospital rate methodology addition for Psychiatric/Substance Abuse services.

State Plan Attachment 4.19-A, page 9a is being updated to reflect increased reimbursement rates for PT11 hospital services and procurement relating to

transplants. The methodology is being updated from 2008 data to 2013 data for cornea procurement and 2014 data for all other transplants and procurement. State Plan Attachment 4.19-A, page 15a is being updated to reflect the addition of Psychiatric/Substance Abuse services for PT75 - Critical Access Hospitals to the list of services reimbursed at the general acute care hospital rates.

This covers all public and private entities under this provider type. The DHCFP projects a change in annual aggregate expenditures as follows:

An estimated increase in reimbursement for SFY 2016 is \$1,645,965; and
An estimated increase in reimbursement for SFY 2017 is \$1,664,615.

The effective date of change is January 1, 2016.

3. Discussion of Amendments to the State Plan for Medicaid Services and Solicitation of Public Comments

Subject: Pediatric Enhancement and Mid Tier Radiology

The DHCFP is proposing to submit a State Plan Amendment regarding Pediatric Enhancement and Mid Tier Radiology Rate Methodology.

State Plan Attachment 4.19-B, Page 1c: The reimbursement methodology will be updated under the section entitled "Payment for services billed by physicians using Current Procedural Terminology (CPT) codes". Language added for a pediatric rate enhancement is as follows:

1. *Pediatric enhancement for recipients under the age of 21 will be the lesser of billed charges or 115% of the currently established rates for respiratory, cardiovascular, hemic, lymphatic, mediastinum and diaphragm related surgical codes (30000-39999).*

State Plan Attachment 4.19-B, Page 1d: Reimbursement methodology will be added under Section 6.d. for services billed by an Advanced Practitioner of Nursing/Physician Assistant/Nurse Midwife. The amendment will add language to include radiology codes 70000 – 79999 and will be as follows:

2. *Radiology codes 70000 – 79999 will be reimbursed at 75% of the Medicare facility rate.*

This covers all public and private entities under this provider type. The DHCFP projects a change in annual aggregate expenditures as follows:

An estimated increase in reimbursement for SFY 2016 (6 months) is \$186,575; and
An estimated increase in reimbursement for SFY 2017 is \$379,915.

The effective date of this change is January 1, 2016.

4. **General Public Comments** (Because of time considerations, the period for public comment by each speaker or organization may be limited to 5 minutes, and speakers are urged to avoid repetition of comments made by previous speakers.)
5. **Adjournment.**

Nevada Medicaid is unaware of any financial impact to other entities or local government due to this public hearing, other than as stated above.

PLEASE NOTE: Items may be taken out of order at the discretion of the chairperson. Items may be combined for consideration by the public body. Items may be pulled or removed from the agenda at any time. If an action item is not completed within the time frame that has been allotted, that action item will be continued at a future time designated and announced at this meeting by the chairperson. All public comment may be limited to 5 minutes.

This notice and agenda have been posted at <http://dhcfp.nv.gov/> and notice.nv.gov/.

Notice of this meeting and draft copies of the changes will be available on or after the date of this notice at the DHC FP Web site <http://dhcfp.nv.gov/> Carson City Central office and Las Vegas DHC FP. The agenda posting of this meeting can be viewed at the following locations: Nevada State Library; Carson City Library; Churchill County Library; Las Vegas Library; Douglas County Library; Elko County Library; Lincoln County Library; Lyon County Library; Mineral County Library; Tonopah Public Library; Pershing County Library; Goldfield Public Library; Eureka Branch Library; Lander County Library; Storey County Library; Washoe County Library; and White Pine County Library and may be reviewed during normal business hours.

If requested in writing, a draft copy of the changes will be mailed to you. Requests and/or written comments on the proposed changes may be sent to Lezlie Mayville at the Division of Health Care Financing and Policy, 1100 E. William Street, Suite 101, Carson City, NV 89701.

All persons that have requested in writing to receive the Public Hearings agenda have been duly notified by mail or e-mail.

We are pleased to make accommodations for members of the public who have disabilities and wish to attend the meeting. If special arrangements are necessary, notify the Division of Health Care Financing and Policy as soon as possible and at least ten days in advance of the meeting, by e-mail at: Lezlie.Mayville@dhcfp.nv.gov, in writing, at 1100 East William Street, Suite 101, Carson City, Nevada 89701 or call Lezlie Mayville at (775) 684-3681.



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**Division of Health Care Financing and Policy
Notice of Meeting to Solicit Public Comments and Intent to Act
Upon Amendments to the State Plan for Medicaid Services**

**Public Hearing December 29, 2015
Minutes**

Date and Time of Meeting: December 29, 2015 at 9:00AM
Name of Organization: State of Nevada, Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP)
Place of Meeting: Division of Public and Behavioral Health
4150 Technology Way, Room 303
Carson City, Nevada 89706
Place of Video Conference: Division of Health Care Financing and Policy
1210 S. Valley View Blvd., Suite 104
Las Vegas, Nevada 89102
Teleconference: (877) 336-1829
Access Code: 8793897

Attendees

In Carson City, NV

Marta Jensen, DHCFP
Rebecca Ritter, DHCFP
Joan Hall, NRHP
Chuck Damon, DHCFP
Lynne Foster, DHCFP

Jacob Douglas, DHCFP
Theresa Bawden, DHCFP
Parker Stremmel, Ferrari Public Affairs
Renee Necas, DHCFP
Tiffany Lewis, DHCFP

In Las Vegas, NV

Descan Courtney, Amerigroup

Teleconference

Darrell Faircloth, SDAG

Leah Cartwright

Introduction:

Ms. Lynne Foster, Chief of Division Compliance, Division of Health Care Financing and Policy (DHCFP), opened the Public Hearing introducing herself, Ms. Marta Jensen, Acting Administrator of the DHCFP and Mr. Darrell Faircloth, Senior Deputy Attorney General (SDAG).

Ms. Foster – The notice for this public hearing was published on November 25, 2015 in accordance with the Code of Federal Regulations 42 CFR 447.205 and the Nevada Revised Statute 422.2369.

1. Public Comment

No Comment

2. Discussion of Amendments to the State Plan for Medicaid Services and Solicitation of Public Comments

Subject: PT11 Transplants & PT75 Critical Access Hospital (CAH)

Ms. Tiffany Lewis:

The DHCFP is proposing to submit a State Plan Amendment regarding PT 11 - Hospital transplant rate changes and PT 75 - Critical Access Hospital rate methodology addition for Psychiatric/Substance Abuse services.

State Plan Attachment 4.19-A, page 9a is being updated to reflect increased reimbursement rates for PT11 hospital services and procurement relating to transplants. The methodology is being updated from 2008 data to 2013 data for cornea procurement and 2014 data for all other transplants and procurement. State Plan Attachment 4.19-A, Page 15a is being updated to reflect the addition of Psychiatric/Substance Abuse services for PT75 - Critical Access Hospitals to the list of services reimbursed at the general acute care hospital rates.

This covers all public and private entities under this provider type. The DHCFP projects a change in annual aggregate expenditures as follows:

An estimated increase in reimbursement for SFY 2016 is \$1,645,965; and
An estimated increase in reimbursement for SFY 2017 is \$1,664,615.

The effective date is January 1, 2016.

At the conclusion of Ms. Lewis' presentation, Ms. Foster asked Ms. Jensen, Acting Administrator, and Mr. Faircloth, SDAG, if they had any questions or comments.

Ms. Jensen's Comments:

- No Comment

Mr. Faircloth's Comments:

- No Comment

Public Comments:

- No Comments

Ms. Foster - Closed the Public Hearings for the SPA on PT11 Transplants & PT 75 Critical Access Hospital (CAH).

3. Subject: Pediatric Enhancement and Mid Tier Radiology

Ms. Tiffany Lewis:

The DHCFP is proposing to submit a State Plan Amendment regarding Pediatric Enhancement and Mid Tier Radiology Rate Methodology.

State Plan Attachment 4.19-B, Page 1c: The reimbursement methodology will be updated under the section entitled "Payment for services billed by physicians using Current Procedural Terminology (CPT) codes." Language added for a pediatric rate enhancement is as follows:

1. *Pediatric enhancement for recipients under the age of 21 will be the lesser of billed charges or 115% of the currently established rates for respiratory, cardiovascular, hemic, lymphatic, mediastinum and diaphragm related surgical codes (30000-39999).*

State Plan Attachment 4.19-B, Page 1d: Reimbursement methodology will be added under Section 6.d. for services billed by an Advanced Practitioner of Nursing/Physician Assistant/Nurse Midwife. The amendment will add language to include radiology codes 70000 – 79999 and will be as follows:

2. *Radiology codes 70000 – 79999 will be reimbursed at 75% of the Medicare facility rate.*

This covers all public and private entities under this provider type. The DHCFP projects a change in annual aggregate expenditures as follows:

An estimated increase in reimbursement for SFY 2016 (6 months) is \$186,575; and
An estimated increase in reimbursement for SFY 2017 is \$379,915.

The effective date, pending CMS approval, is January 1, 2016.

At the conclusion of Ms. Lewis' presentation, Ms. Foster asked Ms. Jensen, Acting Administrator, and Mr. Faircloth, SDAG, if they had any questions or comments.

Ms. Jensen's Comments:

- No Comment

Mr. Faircloth's Comments:

- No Comment

Public Comments:

- No Comments

Ms. Foster - Closed the Public Hearings for the SPA on Pediatric Enhancement and Mid Tier Radiology.

4. General Public Comments

- No Comments

There were no further comments and Ms. Foster adjourned the public hearing at 9:25AM.

**An Audio (CD) version of this meeting is available through the DHCFP Administration office. For more detailed information on any of the handouts, submittals, testimony and or comments please contact Lezlie Mayville at lezlie.mayville@dhehp.nv.gov or (775) 684-3681 with any questions.*

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nevada

Attachment 4.19-B

Page 1c

5. Payments for services billed by Physicians using Current Procedural Terminology (CPT) codes will be calculated using the January 1, 2014 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:
- a. Surgical codes 10000 – 58999 and 60000 - 69999 will be reimbursed at 95% of the Medicare facility rate.
 - 1. Pediatric enhancement for recipients under the age of 21 will be the lesser of billed charges or 115% of the currently established rates for respiratory, cardiovascular, hemic, lymphatic, mediastinum and diaphragm related surgical codes (30000 - 39999).
 - b. Radiology codes 70000 – 79999 will be reimbursed at 100% of the Medicare facility rate. Effective February 15, 2012, Radiopharmaceutical and Contrast codes will be reimbursed at the 2012 Medicare Mean Unit Cost plus 5%.
 - c. Medicine codes 90000 – 99199 will be reimbursed at 85% of the Medicare non-facility rate.
 - d. Evaluation and Management codes 99201 – 99499 will be reimbursed at 90% of the Medicare non-facility rate effective July 1, 2015 through June 30, 2016. Effective July 1, 2016 Evaluation and Management codes 99201 – 99499 will be reimbursed at 95% of the Medicaid non facility rate.
 - e. Obstetrical service codes 59000 – 59999 will be reimbursed at 95% of the Medicare non-facility rate.
 - f. Anesthesia codes 00100 – 01999 will be reimbursed based on the Centers for Medicare and Medicaid Services (CMS) 2009 base units for anesthesia. Payment is determined by adding the base units plus time units and multiplying the result by the CMS 2013 anesthesia conversion factor of \$22.57. Anesthesia codes 01967 – 01969 are occurrence based codes that are paid a flat rate. Anesthesia codes 99100 – 99140 are not covered.
 - g. Medicine codes 90281-90399, and all other pharmaceuticals that are not identified above, will be reimbursed according to the drug reimbursement algorithm set forth on page 3 of Attachment 4.19-B.

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State Nevada

Attachment 4.19-B

Page 1d

6. Medical care and any other type of remedial care provided by licensed practitioners:
- a. Payment for services billed by a Podiatrist will be calculated using the April 1, 2002 unit values for the Nevada specific resource based relative value scale (RBRVS) and the 2002 Medicare Physicians Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amount specified below:
 1. Surgical codes will be reimbursed at 74% of the Medicare facility rate
 2. Radiology codes will be reimbursed at 88% of the Medicare facility rate
 3. Medicine codes and Evaluation and Management codes will be reimbursed at 66% of the Medicare non-facility rate. Vaccine Products will be reimbursed at 85% of the Medicare non-facility rate.
 4. When codes 90465-90468, 90471-90474, 99381-99385 and 99391-99395 are used for EPSDT services, the reimbursement will be 85% of the Medicare non-facility rate.
 - b. Payment for services billed by an Optometrist will be calculated using the April 1, 2002 unit values for the Nevada specific resource based relative value scale (RBRVS) and the 2002 Medicare Physicians Fee Schedule conversion factor. Payment will be the lower of billed charges, or 85% of the Medicare non-facility rate. See also 12.d.,
 - c. Payment for services billed by a Chiropractor will be calculated using the April 1, 2002 unit values for the Nevada specific resource based relative value scale (RBRVS) and the 2002 Medicare Physicians Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amount specified below:
 1. Medicine codes and Evaluation and Management codes will be reimbursed at 70% of the Medicare non-facility rate
 2. Radiology codes will be reimbursed at 32% of the Medicare facility rate.
 - d. Payment for services billed by an Advanced Practitioner of Nursing/Physician Assistant/Nurse-Midwife will be calculated using the January 1, 2014 unit values for the Nevada specific resource based relative value scale (RBRVS) and the 2014 Medicare Physicians Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:
 1. Surgical codes will be reimbursed at 59% of the Medicare facility rate.
 - ~~1.2.~~ **Radiology codes 70000 – 79999 will be reimbursed at 75% of the Medicare facility rate.**
 - ~~2.3.~~ Medicine codes and Evaluation and Management codes will be reimbursed at 63% of the Medicare non-facility rate.
 - ~~3.4.~~ Obstetrical service codes will be reimbursed at 75% of the Medicare non-facility rate.
 - ~~4.5.~~ When codes 90465-90468, 90471-90474, 99381-99385 and 99391-99395 are used for EPSDT services, the reimbursement will be 72% of the Medicare non-facility rate.

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Attachment 4.19-A
Page 9a

G. Transplants

1. Basic Data Sources for Rate Development

- a. 2014 Milliman Research Report – U.S. Organ and Tissue Transplant and Cost Estimate.
- b. 2013 The Lewin Group Study – Cost Benefit Analysis of Corneal Transplant.

2. Rate Conversion

- a. Hospital Services will be reimbursed at 35% of the Hospital Billed Charges for each transplant procedure as listed in the 2014 Milliman Study.
- b. Procurement will be reimbursed at 100% of the Procurement charges for each transplant procedure as listed in the 2014 Milliman Study with the exception of Cornea procurement. Cornea procurement will be reimbursed at 100% of the Procurement charges as listed in the 2013 The Lewin Group Study.

For hospitals with accredited transplant programs, Nevada Medicaid will pay the lower of 1) billed charges; or 2) an all-inclusive fixed fee for the entire admission period (from admission date to discharge date). Organ procurement is a separate reimbursable charge, over and above the facility inpatient component of the transplant service. Organ procurement is reimbursed the lower 1) billed charges; or 2) the maximum reimbursement set forth below.

The maximum reimbursement rate for organ transplant procedures and procurement are:

Organ	Hospital Services	Procurement
Liver	\$83,700 \$139,685	\$34,300 \$95,000
Kidney	\$30,600 \$41,860	\$27,500 \$84,400
Tissue		
Bone Marrow - Autologous	\$44,190 \$74,305	\$10,800 \$10,700
Bone Marrow - Allogeneic Related	\$97,020 \$167,860	\$10,800 \$55,700
Bone Marrow - Allogeneic Unrelated	\$136,080 \$167,860	\$10,800 \$55,700
Cornea	\$5,490 \$7,000	\$0 \$2,500

Commencing July 1, ~~2009-2016~~ and annually thereafter, the amounts listed above shall be adjusted for inflation using the Consumer Price Index for Inpatient Services; BLS Series CUUR0000SS5702.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Attachment 4.19-A
Page 15a

1. The updated CAH Medical/Surgery interim rate will be calculated by dividing the total Title XIX program inpatient costs by the total program inpatient days as reported in the immediate prior years' Medicare/Medicaid cost report as filed.
2. If Title XIX data reported in the immediate prior years' Medicare/Medicaid cost report is not sufficient to calculate the adjusted CAH Medical/Surgery interim rate, the CAH Medical/Surgery interim rate will default to the Medical/Surgery rate paid to general acute care hospitals for the same service. This applies only to Critical Access Hospitals that have an existing CAH Medical/Surgery interim rate for the prior year.
3. Maternity, newborn, **Psychiatric/Substance Abuse** and administrative days will be reimbursed at the rate paid to general acute care hospitals for the same in-patient services.
4. Critical Access Hospitals that do not have a CAH Medical/Surgery interim rate for the prior year based on the methodology in Paragraph VII.B.3, will be assigned either the prior years' Total Medicare inpatient per diem rate if available or the rate paid to general acute care hospitals for the same Medical/Surgery level of services until such time as the CAH Medical/Surgery interim rate can be updated according to the methodology detailed in Paragraphs VII.B.2 and VII.B.3.

Facilities accredited as Residential Treatment Centers by the Joint Commission on Accreditation of Health Organization (JCAHO) are not considered specialty or general acute hospitals. Residential Treatment Centers are paid in accordance with paragraph VI above.