VII. HOSPITALS UNDER MEDICAID RETROSPECTIVE COST REIMBURSEMENT (CRITICAL ACCESS HOSPITALS)

A few Nevada hospitals have been designated by Medicare as Critical Access Hospitals.

~~To the extent these hospitals participate in Medicaid, they are reimbursed under Medicare's retrospective cost reimbursement, as follows:~~

A. Inpatient hospital services which have been certified for payment at the acute level by the QIO-like vendor, as specified in the contract between the QIO-like vendor and Nevada Medicaid, will be reimbursed via cost-based rates adjusted for inflation. Provider must submit cost reports to the Division as follows:;~~upon final settlement are reimbursed allowable costs under hospital-specific retrospective Medicare principles of reimbursement in accordance with 42 CFR 413 and further described in CMS Publications 15-I and 15-II.~~

1. Critical Access Hospitals (CAH) will use the CMS-2552-10 cost report form and apply Medicare cost principles and cost apportionment methodology.

2. Critical Access Hospitals will file this cost report with the state annually within five months of their respective fiscal year end.

~~3. In general, underpayments will be paid to the provider in a lump sum upon discovery and overpayments will either be recouped promptly or a negative balance set up for the provider. However, other solutions acceptable to both parties may be substituted.~~

~~4. The federal share of any overpayment is refunded to the federal government in accordance with 42 CFR 433 Subpart F.~~

B. On an interim basis, each hospital is paid for certified acute care at the Provider specific interim Medicaid inpatient per diem rate as follows:

1. Effective for dates of service on or after January 1, 2024, the Division will utilize the most recently available audited cost report to establish provider-specific, cost-based rates for Medical/Surgical/ICU days. Provider-specific, cost-based rates will also be established for hospitals that provide Maternity, Newborn, and Psychiatric/Detoxification services as applicable. There will be no cost settlement for Medical/Surgical/ICU, Maternity, Newborn, Psychiatric/Detoxification, or Administrative Day Services.

a. The provider-specific rates determined for each facility will be inflated

forward using the Medicare Economic Index (MEI) to adjust expenses forward to the current time period.

2. For all critical access hospitals, the base Medical/Surgical ICU interim rate will be determined by identifying the "Adjusted general inpatient routine service cost per diem" as listed on the CMS 2552-10.

   a. For hospitals that provide Maternity services, the Maternity base rate will also utilize the Adjusted general inpatient routine service cost per diem.

   b. For hospitals that provide Newborn services, the Nursery Average Per Diem as specified in the CMS 2552-10 will be utilized to establish the base rate.

3. To account for ancillary services, the Division will identify the "Program inpatient ancillary service cost" as reported in the cost report.

   a. For providers who only reported Medical/Surgical/ICU days in the cost reporting year, the ancillary service costs will be prorated based on the total program inpatient days as reported on the cost report.

   b. For providers who also reported Maternity and Newborn days in the cost reporting year, facilities will select how ancillary costs are to be attributed. Ancillary costs can either be solely divided among the Medical/Surgical/ICU/Maternity days or can also be attributed across Medical/Surgical/ICU/Maternity as well as Newborn services. Ancillary costs will be prorated accordingly. Providers must submit a statement in writing indicating how they prefer ancillary costs to be allocated across inpatient services.

   c. The prorated ancillary amounts will be added to the base rates to arrive at the interim rate prior to adjusting for inflation.

4. For providers who also provide inpatient psychiatric/detoxification services, the interim rate will be determined by identifying the "Adjusted general inpatient routine service cost per diem" as listed on the CMS 2552-10, Subprovider – Inpatient Psychiatric Facility.

   a. Ancillary costs will be prorated across corresponding inpatient psychiatric days to calculate the total psychiatric interim rate.

5. Providers whose cost reports do not include cost information for maternity,

newborn, or psychiatric/detoxification services will have reimbursement rates set for these services based on the reimbursement rates paid to general acute hospitals.

6. Provider-specific, cost-based rates as calculated in B.1-B.4 above will be inflated using the Medicare Economic Index (MEI) to inflate historical expenses to the current time period. MEI will be applied beginning with the calendar year following the end of the fiscal year utilized to determine the cost-to-charge ratio. For example, if a provider's fiscal year ended June 30, 2022, the Division would apply MEI for calendar years 2023 and 2024 to determine the interim rates in effect January 1 – December 31, 2024.

   a. MEI will not be applied to reimbursement rates as described in B.5.

7. The interim rates (excluding those described in B.5) will be inflated annually using MEI for two subsequent years with a rebase occurring every third year (with the first rebase occurring January 1, 2027), utilizing the most recently available audited cost report and continuing to follow the methodology above.

8. Administrative days will be paid in accordance with Nevada Medicaid State Plan Attachment 4.19-A, page 14.

9. Carve-out of Long-Acting Reversible Contraceptives (Device, Insertion, and Removal)

   a. When a Long-Acting Reversible Contraceptive (LARC) is provided during an inpatient maternity stay, facilities may bill separately for the LARC device and insertion/removal procedure in addition to the maternity per diem payment.

   b. LARC devices will be priced per the drug reimbursement algorithm described in Nevada Medicaid State Plan Attachment 4.19-B, page 3-page 3 (continued). LARC insertion/removal procedures will be paid based on the rendering provider type as described in State Plan Attachment 4.19-B.

~~1. Effective July 1, 2009, the base interim rate for Critical Access Hospitals (CAH) will be the FY2007 Total Medicare inpatient per diem rate. This interim rate is defined as total Medicare in-patient cost divided by total Medicare in-patient days, and applies to the revenue codes billed by general acute hospitals that fall under the Medical/Surgery level of service category for inpatient services.~~

~~3. The CAH Medical/Surgical/Intensive Care Unit (ICU) interim rate for each CAH will be updated within 90 days of receipt of the most recently audited cost report from the contracted vendor. The interim rate is not to increase more than 50% or decrease more than 25% from the facilities' prior year interim rate.The updated~~

~~CAH Medical/Surgical/ICU interim rate will be calculated by dividing the total Title XIX program inpatient costs by the total program inpatient days as reported in the latest available audited Medicare/Medicaid cost report.~~

4. ~~If Title XIX data reported in the latest available audited Medicare/Medicaid cost report is not sufficient to calculate the adjusted CAH Medical/Surgical/ICU interim rate, the CAH Medical/Surgical/ICU interim rate will default to the Medical/Surgical/ICU rate paid to general acute care hospitals for the same service. This applies only to Critical Access Hospitals that have an existing CAH Medical/Surgical/ICU interim rate for the prior year.~~

   a. ~~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.Critical Access Hospitals with Obstetric/Maternity units may also request a provider-specific interim rate for Maternity services. Interim rates for Maternity services will be calculated by multiplying the hospital-specific Medical/Surgical/ICU rate by 77.8%.~~

   b. ~~Obstetric/Maternity days for Critical Access Hospitals who do not request a provider-specific interim rate will be reimbursed at the rate paid to general acute care hospitals for the same inpatient services.~~

5. ~~Critical Access Hospitals that do not have a CAH Medical/Surgical/ICU 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/Surgical/ICU level of services until such time as the CAH Medical/Surgical/ICU 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.