PAYMENT FOR MEDICAL CARE AND SERVICES

1. This paragraph intentionally left blank.
2. Outpatient Hospital
   a. Payments for services billed by Outpatient Hospitals 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:
      i. Surgical Codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 90% of the Medicare facility rate.
      ii. Radiology Codes 70000 – 79999 will be reimbursed at 100% of the Medicare facility rate.
      iii. Effective February 15, 2012, Radiopharmaceutical and Contrast codes will be reimbursed at the 2012 Medicare Mean Unit Cost plus 5%.
      iv. Medicine Codes 90000 – 99199 will be reimbursed at 85% of the Medicare facility rate.
      v. Vaccine Products require a National Drug Code (NDC) and will be reimbursed according to the drug reimbursement algorithm set forth on page 3 of Attachment 4.19-B.
      vi. Evaluation and Management Codes 99201 – 99499 will be reimbursed at 90% of the Medicare facility rate.
      vii. Obstetrical Service Codes 59000 – 59999 will be reimbursed at 90% of the Medicare facility rate.
      viii. 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.
      ix. Prescribed drugs (Page 3, Paragraph 12a).
      x. Outpatient laboratory and pathology services (Page 1a, Paragraph 3).
      xi. Dental services (CDT Codes, Page 2c, Paragraph 10).
      xii. Durable medical equipment; prosthetics and orthotics (Page 2, Paragraph 7c); and disposable supplies (Page 2, Paragraph 7d).

Assurance: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both public and private providers of the service. The agency's outpatient hospital fee schedule rates were set as of January 1, 2017 and are effective for services provided on or after that date. All rates are published on our website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/.

b. ~~(This paragraph intentionally left blank.)~~ Rural Emergency Hospital Services

i. Effective January 1, 2024, payments to hospitals enrolled as a Rural Emergency Hospital will be calculated by multiplying a factor of 1.05 times the outpatient hospital rate as described above.

a. This methodology applies to surgical codes 10000 – 58999 and 60000 – 69999; radiology codes 70000-79999; radiopharmaceutical and contrast codes; medicine codes 90000-99199; evaluation and management codes 99201 – 99499; obstetrical service codes 59000 – 59999; anesthesia codes 00100 – 01999; outpatient laboratory and pathology services; dental services, and durable medical equipment, prosthetics, and orthotics.

b. Vaccine Products require a National Drug Code (NDC) and will be reimbursed according to the drug reimbursement algorithm set forth on page 3 of Attachment 4.19-B.

c. Prescribed drugs will be reimbursed according to the drug reimbursement algorithm set for on page 3 of Attachment 4.19-B.

c. Outpatient Hospital services rendered by public Critical Access Hospitals

i. Effective January 1, 2024, outpatient hospital services rendered by publicly owned Critical Access Hospitals will be reimbursed via a cost-based reimbursement structure.

a. Beginning January 1, 2024, the most recently available audited cost report will be utilized to determine an outpatient cost-to-charge ratio.

1. To determine each hospital's cost-to-charge ratio, the Division will compare the total outpatient costs for the given time period to the total outpatient charges.

2. The cost-to-charge ratio will be inflated forward using the Medicare Economic Index (MEI) to inflate 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 cost-to-charge ratio in effect January 1 – December 31, 2024.

b. The cost-to-charge ratio 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.

c. Hospitals must notify the Division of any planned changes to the outpatient charge master for the following calendar year prior to December 1 of each year. The Division will utilize this information to determine if the cost-to-charge ratio must be adjusted to ensure payments do not exceed costs. If the charge master change would result in payments exceeding costs, then the cost-to-charge ratio will be decreased to account for the charge master increase.

~~c.~~d. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

Nevada Medicaid uses a Prospective Payment System (PPS) for FQHCs/RHCs as required by S.S.A. §1902 (a) (15) [42 U.S.C. § 1396a (a) (15)] and S.S.A. §1902 (bb) [42 U.S.C. §1396a (bb)]. The PPS for FQHCs/RHCs was implemented and took effect on January 1, 2001.

Prospective Payment System (PPS) Reimbursement for Existing Facilities

On January 1, 2001, the State began paying FQHCs/RHCs (including "FQHC look alike clinics") based on a PPS rate methodology, per CMS requirements. The baseline for a PPS was set at 100% of the average of an FQHC/RHC per visit rate based on the reported reasonable and allowable costs of providing Medicaid-covered services during the FQHC/RHC fiscal years 1999 and 2000, adjusted to take into account any reported increase (or decrease) in the scope of services furnished during FY 2001 by the FQHC/RHC (calculating the payment amount on a per visit basis). Medicaid-covered services that are considered to be FQHC/RHC services are those services that were identified and approved to be provided by the facility as it applies to HRSA in order to be deemed as an FQHC/RHC facility.

Beginning in Federal fiscal year 2002, and for each fiscal year thereafter, each FQHC/RHC is entitled to the payment amount (on a per visit basis) to which the center or clinic was entitled under the Act in the previous year, increased each October 1st (FFY) by the percentage increase (or decrease) in the Medicare Economic Index (MEI) for primary care services as defined in Section 1842 (i)(3) of the Social Security Act, which is intended to account for the basic cost increases associated with providing such services.

After February 6, 2016, the DHCFP will allow reimbursement for up to three encounters/visits per person per day provided that the FQHC has separate PPS rates for each reimbursable service type; medical, mental behavioral health and dental. FQHCs that only provide two of the specified service types will be allowed reimbursement for up to two encounters/visits per patient per day. For FQHCs that only have one PPS rate will be allowed reimbursement for only one encounter/visit per patient per day. For FQHCs that do not have separate Service Specific Prospective Payment Systems (SSPPS) rates already established, they may opt to change to an Alternative Payment Methodology (APM) wherein their costs/visits will be reviewed after a full year of providing and receiving reimbursement for up to three (or two) visits/encounters per patient per day, resulting in separate Service Specific Alternative Payment Methodology (SSAPM) rates being established.

FQHCs may choose to retain their current SSPPS rates and not bill up to three encounters/visits per patient per day, which will not result in a change to an SSAPM and a current review of their costs and visits.

PPS rates will not be subject to rebasing after their initial computation unless authorized by Congress. Only the actual costs related to any reported change in scope of services will be calculated (based on a full year of providing those services) and an adjustment or add-on to the baseline PPS rate will be made. Any other changes to the PPS rate(s) will be considered an APM and will be outlined below in this State plan.