

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nevada

Attachment 4.19-D

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E. Special Care Rates:

1. The Division of Health Care Financing and Policy shall establish special care rates for recipients ages 21 and over that are ventilator dependent, or behaviorally complex, and pediatric recipients less than 21 years of age with special high cost care needs and/or who are ventilator dependent. These special care rates will be all-inclusive per diem rates based on the costs of providing services to recipients.
  - a. Effective August 1, 2011 the per diem rate for recipients ages 21 and over that are ventilator dependent is the facility-specific fair rental value per diem, as computed under section B.3.c. of this attachment, plus an add-on of \$495.00.
  - b. The per diem rate for behaviorally complex ~~recipients individuals~~ is the facility-specific per diem rate plus an add-on ~~rate that will be determined based on the minimum staffing level multiplied by the Nevada Certified Nursing Assistant (CNA) median wage. The Median Hourly Wage for the State of Nevada published by the Bureau of Labor Statistics, Occupational Employment Statistics Survey will be used as the CNA median wage for the per diem calculation. The minimum staffing level is broken down into the following three categories:~~for each of the following three categories:
    - i. ~~1—8 hours, use 7.5 hours~~ Tier I. \$111.23
    - ii. ~~9—16 hours, use 15 hours~~ Tier II. \$222.45
    - iii. ~~17—24 hours, use 22 hours~~ Tier III. \$326.26

~~The Nevada CNA median wage will be reviewed on odd numbered years on July 1 and will become effective as of July 1 of the respective year.~~
  - c. The per diem rate for recipients less than 21 years of age with special high cost care needs that meet the Level of Care requirements for Pediatric Level I as defined, effective March 25, 2013, in the Medicaid Services Manual is \$635.00.
  - d. The per diem rate for recipients less than 21 years of age that meet the Level of Care requirements for Pediatric Level II as defined, effective March 25, 2013, in the Medicaid Services Manual is \$695.00.
2. The Division of Health Care Financing and Policy shall establish negotiated facility specific all-inclusive per diem rates for Medicaid recipients with unique high cost care needs. Nursing facilities may not bill the Medicaid program for special care recipients other than on a per diem basis using the established negotiated rate. Rates will address the following client care issues:
  - a. Patient's acuity
  - b. Availability of beds
  - c. Patient's freedom of choice
3. When special care rates are required or when multiple facilities are equally acceptable under E.2. above, the nursing facility with the lowest per diem rate will be selected. The per diem rate will not exceed the facility's usual and customary rate for similar services.

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Supersedes

TN No. ~~13-006 14-007~~

STATE/TERRITORY: NEVADA

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

METHOD FOR DETERMINING COST EFFECTIVENESS OF CARING FOR  
CERTAIN DISABLED CHILDREN AT HOME (KATIE BECKETT)

At the end of each calendar quarter, a computerized list of approved Katie Beckett Eligibility Option cases is generated by the Division of Health Care Financing and Policy (DHCFP) staff. The list shows the total Medicaid expenditure amount incurred quarterly which is compared to the maximum allowable costs. The maximum allowable costs are the costs of institutionalization in either a Skilled Nursing Facility (SNF), or an Intermediate Care Facility ~~for the Mentally Retarded (ICF/MR)~~ **for Individuals with Intellectual Disabilities (ICF/IID)**, which is determined by a level of care assessment. If the amount exceeds the maximum allowable, the ~~eligibility worker Case Manager~~ **Case Manager** at the appropriate Division ~~of Welfare and Supportive Services (DWSS)~~ **DHCFP** office ~~notifies is notified by DHCFP to contact~~ the participant and advises him/her: 1) of the requirement to keep costs at or below the maximum allowable amount; and 2) that failure to keep costs to allowable amounts will result in termination from the program. If the participant's incurred costs exceed the maximum allowable amount for two consecutive quarters, he/she will be terminated from the program effective the first day of the month following the date of the determination for non-compliance with program requirements.

A level of care assessment is conducted annually; therefore, allowable costs may fluctuate annually **based on the individual recipient's Level of Care (LOC).**