MEDICAID OPERATIONS MANUAL
TRANSMITTAL LETTER

April 10, 2014

TO: CUSTODIANS OF MEDICAID OPERATIONS MANUAL

FROM: MARTA E. STAGLIANO, CHIEF OF PROGRAM INTEGRITY

SUBJECT: MEDICAID OPERATIONS MANUAL CHANGES
CHAPTER 1200 – COST BASED REIMBURSEMENT RATES

BACKGROUND AND EXPLANATION

This new chapter is to outline the process for Cost Based Reimbursement Rates for a state or local governmental entity/provider that provide medical services. The Division of Health Care Financing and Policy (DHCFP) may require the non-federal share of expenditures to be paid by the provider using Inter-governmental transfer of funds or Certified Public Expenditures (CPEs).

These policy changes are effective April 11, 2014.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 03/14 CHAPTER 1200 – COST BASED REIMBURSEMENT RATES	MTL – NEW CHAPTER 1200 – COST BASED REIMBURSEMENT RATES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1200	**Whole Chapter**	Development of a new chapter identifying authority, definitions, and policy.

COST BASED REIMBURSEMENT RATES

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1200 INTRODUCTION

Attachment 4.19-B of the Nevada Medicaid State Plan allows for state and local government entities to be reimbursed for their costs of providing certain Medicaid services such as Targeted Case Management (TCM) services and Non-emergency Paratransit Transportation services.

Office of Management and Budget (OMB) Circular A-87, Attachment A, Circular No. A-87 establishes principles for determining the allowable costs incurred by state and local governments (government units) under grants, cost reimbursement contracts, and other agreements with the Federal Government. The principles are for the purpose of cost determination and are designed to provide that Federal awards bear their fair share of cost recognized under the principles except where restricted or prohibited by law.

1201 AUTHORITY

1201.1 NON-EMERGENCY TRANSPORTATION

42 Code of Federal Regulations (CFR) Part 431.53, pursuant to the Social Security Act (SSA) 1902(a), requires Medicaid agencies to ensure that beneficiaries are provided with necessary transportation to and from Medicaid providers. Nevada Medicaid State Plan, Attachment 4.19-B, Page 4, 18.b.2, provides Nevada Medicaid will reimburse paratransit services the Regional Transportation Commission (RTC) operated by local government agencies at the lower of billed charges or a cost-based rate.

1202 DEFINITIONS

ANNUAL CALCULATION OF RATES

Cost-based rates are determined based on either a calendar year, State Fiscal Year (SFY) or Federal Fiscal Year (FFY) depending on what is agreed upon with the provider or defined in the Nevada Medicaid State Plan.

ANNUAL OPERATING BUDGET

The annual operating budget used to estimate expenditures for the rate period is the actual year end closing budget (actual revenues and expenditures) for the prior fiscal year.

COST ALLOCATION PLAN (CAP)

A CAP demonstrates how the provider allocates allowable direct and indirect costs to different benefiting cost pools or objectives. If staff do not spend 100% of their time on one benefiting program and/or service a time study is most likely required. The time study must be approved by the Centers for Medicare and Medicaid Services (CMS) when the CAP is used to reimburse the provider for Medicaid expenditures when using a cost based reimbursement methodology. If the provider has implemented a CAP, generally an indirect cost rate would not be used in addition to the CAP (see indirect cost rate below).

COST-BASED RATE

The cost-based rate is the amount per service unit Medicaid reimburses. Another example of a service unit is ridership, or the number of rides provided, by the Regional Transportation Commission (RTC) for non-emergency paratransit services. The cost rate is determined by dividing net allowable costs by the service utilization forecast.

COST REPORT

The cost report is a form provided by the Division of Health Care Financing and Policy (DHCFP) that state or local government entities use to submit costs and utilization data for determining the cost-based rate.

DIRECT COSTS

Direct costs are those allowable expenditures that can be directly traced to the provision of services.

INDIRECT COST RATE

Indirect cost rate is defined by the Nevada Medicaid State Plan, in most cases, at 10% of the net allowable direct costs. The indirect cost rate reimburses the provider for costs that benefit services provided in one or more cost objective(s).

NET ALLOWABLE COSTS

Net allowable cost is defined by the Nevada Medicaid State Plan as the sum of net allowable direct costs and indirect costs.

NET ALLOWABLE DIRECT COSTS

Net allowable direct costs are the direct costs minus any federal grant funds received for services minus any reimbursement outside the cost-based rate. For example, in the case of non-emergency transportation provided by the RTC, payments from the Medicaid non-emergency transportation broker that the RTC has received during the period of the cost report will be deducted from the total cost to provide the service.

SERVICE UTILIZATION FORECAST

The service utilization forecast, or in the case of non-emergency transportation services, transportation utilization forecast, is the actual number of Medicaid units of service in the prior fiscal year, as verified by authorizations provided by the Nevada Medicaid agency or its designated vendor.

SUBCONTRACTOR

A subcontractor is a vendor who provides services or products to the servicing provider/vendor of Medicaid through a written contract between the Medicaid servicing provider/vendor and the subcontractor.

1203 POLICY

1203.1 SUBMISSION OF THE COST REPORT FOR THE REGIONAL TRANSPORTATION COMMISSION (RTC)

By October 31 of each year, each RTC will submit a cost report to determine the cost-based rate that will be effective from January 1 through December 31 of the coming calendar year.

Financial and ridership data will be provided for the fiscal year beginning on July 1 and ending on June 30 immediately prior to the October 31 cost report submission deadline. Financial data will be actual revenues and expenditures in the RTC's closing budget for the fiscal year reported. Total ridership data will be the actual number of total paratransit rides provided by RTC from July 1 to June 30 of the reporting period. Medicaid ridership will be the actual number of authorized Medicaid rides as verified by the Medicaid non-emergency transportation broker for the reporting period.

Where the RTC incurs direct costs for paratransit through use of subcontractors, the RTC must provide one copy of the contract to the Division of Health Care Financing and Policy (DHCFP) no later than the date that the cost report is submitted, on or prior to October 31. Where the RTC compiles direct costs separately for paratransit, fixed route, and any other service, this will be noted in the appropriate box on the cost report. The RTC will maintain records demonstrating that costs are compiled separately and that the costs entered on the cost report are accurate. Where the RTC does not compile costs for services essential to providing paratransit services separately from fixed route or other services, costs may be allocated by vehicle mile, vehicle hour, or another reasonable methodology approved by the DHCFP Administrator. Where costs are allocated, the RTC will maintain records of actual costs and data supporting the allocation.

The RTC will use the cost report form provided by the DHCFP. The cost report must be complete when submitted. The RTC shall provide any documentation requested by the DHCFP as it reviews the cost report to approve the RTC's rate.

1204 DETERMINATION OF THE COST-BASED RATE

The cost-based rate is the net allowable costs divided by the total number of rides or service units. The rate is generally set for a year period normally specified in the Nevada Medicaid State Plan Amendment (SPA). If the fiscal year is not specified in the SPA, then the fiscal year can be whatever is agreed upon by the Division of Health Care Financing and Policy (DHCFP) and the provider. Nevada Medicaid pays the federal share of the cost-based rate, and in most cases the servicing or billing provider provides the non-federal share of rate through an Intergovernmental Transfer payment. The Nevada Medicaid State Plan allows the DHCFP to set a single cost-based rate annually. The rates are effective at the beginning of the fiscal year designated, such as January 1 through December 31 of each year for the Regional Transportation Commission (RTC). The Medicaid State Plan makes no provision for adjusting the rate during the year. The DHCFP will not receive adjustments to cost or utilization data to increase the cost-based rate after the annual rate becomes effective. Federal regulation prohibits overpayment for Medicaid services. Therefore, corrections to financial or statistical data that demonstrate reimbursement should be decreased and must be submitted to the DHCFP as soon as these corrections are known to the provider. The DHCFP will arrange with the provider to recoup any overpayment(s).

1205 PAYMENTS FOR SERVICES

Payments for services can be made when billed as a medical claim through the Medicaid Management Information System (MMIS) or made on a quarterly basis as a non-claims financial transaction. If the payment is made as a non-claims financial transaction the payment is based on the cost-based rate effective for the designated fiscal year and the actual units of service or rides provided during the quarter. For non-claims financial transactions the provider submits a quarterly cost report within 60 days of the end of the quarter. The Division of Health Care Financing and Policy (DHCFP) remits payment following audit of the quarterly cost report. A monthly payment may be considered for non-claim based payments. The terms and method of payment for the individual providers are outlined in the provider's inter-local agreement.

1206 INTERGOVERNMENTAL TRANSFER PAYMENTS

In most cases, unless otherwise specified in the contract or inter-local agreement, the provider is responsible for payment of the state share of costs for services. The provider remits payment through an Intergovernmental Transfer made prior to the 30th day of the first month of the current quarter. For instance, the Intergovernmental Transfer payment providing the state share of costs for the quarter January through March is due by January 30 of that quarter. The Division of Health Care Financing and Policy (DHCFP) invoices the provider for the Intergovernmental Transfer payment by the tenth day of the month the payment is due.

The Intergovernmental Transfer payment is based on the actual utilization or ridership of the prior quarter plus any adjustment for underpayment or overpayment of the state share in prior quarters. The amount of the Intergovernmental Transfer is calculated by the following formula:

Actual service units or Ridership Prior Quarter X Current Rate = Estimated Total Current Quarter

Estimated Total Current Quarter ± Prior Quarter Adjustments = Total Payment
Total Payment X State Share (100% - FMAP) = Intergovernmental Transfer Payment