PAYMENT FOR INPATIENT HOSPITAL SERVICES
METHODS AND STANDARDS

I. HOSPITALS UNDER PROSPECTIVE RATES

Types of rates: Inpatient hospital services, which have been authorized for payment at the acute level by a quality improvement organization (QIO-like vendor), as specified in the contract between the QIO-like vendor and Nevada Medicaid, are reimbursed by all-inclusive, prospective per diem rates by type of admission. The all-inclusive prospective rates cover routine and ancillary services furnished by the hospital, including direct patient care for professional services furnished to inpatients by hospital-staffed physicians and practitioners. All-inclusive per diem rates are developed for Maternity, Newborn, Neonatal, Rehabilitative/Specialty Hospital, Level I Trauma, Medical/Surgical, and Psychiatric/Substance Abuse Treatment admissions, as described in Sections II, III, and IV. All-inclusive rates for selected Organ Transplants are described in Section III. Administrative day rate development is covered in Section V. Critical Access Hospitals under Medicare retrospective cost reimbursements are described in Section VII.

II. PROSPECTIVE RATE DEVELOPMENT (Prior to September 1, 2003)

The primary goals of the inpatient hospital rate methodology are: Rates should be based on actual, reasonable and allowable hospital costs and the rate development method should comply with federal requirements. The prospective rates are inclusive of all ancillary services required by patients.

A. Basic data sources for tier rate development.

1. The most recently filed Hospital Health Care Complex Cost Report (HCFA 2552) was the basis for identifying allowable cost. Routine cost limits were not applied.

2. Paid claims and billing information were taken from the Nevada database for Medicaid claim payment history report for services provided during the period covered by the HCFA 2552.

B. Adjustments made to determine allowable cost.

The following adjustments were made to each individual hospital's cost report:

1. An audit adjustment was applied to the total Medicaid cost for each hospital. The adjustment was determined by using an average for each hospital of the audit adjustment percentages for the three most recent years available. Adjustments for two years were used if three were not available.

2. Since the hospitals' cost report periods vary, all cost data was indexed to the same period, using the Medicare inflation factor for non-prospective payment system (non-PPS) hospitals.

III. Conversion of Existing Tier Rates to Per Diem Rates as of September 1, 2003

The current hospital inpatient tier rates for Medical/Surgical, Maternity, and Newborn inpatient categories are in effect for Medicaid payments made through August 31, 2003.

In order to convert to a MMIS system on September 1, 2003, hospital reimbursement tier rates will be converted to per diem rates. The Maternity and Newborn service categories will be retained. The service category Medical/Surgical will be converted to Level I Trauma and Medical/Surgical categories.

These per diem rates will be effective for claims paid on or after September 1, 2003, with admission dates before September 8, 2008. The Level I Trauma will be retained at the September 1, 2003 amount.

A. Maternity Rate Conversion

An all-inclusive per diem rate is paid for obstetrical hospital admissions. The rate also covers related admissions such as false labor, undelivered OB, and miscarriages.

Historical Medicaid data for the Calendar Year (CY) ended December 31, 2002, has been extracted showing Medicaid Maternity admissions and Maternity patient days by tier. Projected Maternity payments for each tier are calculated as CY2002 Maternity admissions per tier times the current tier rate. Total projected Maternity payments are the sum of all projected tier payments.

The conversion per diem rate for Maternity has been determined by the following formula:

$$\frac{\text{Total Projected Maternity Payments}}{\text{CY2002 Historical Maternity Patient Days}} = \text{Maternity Per Diem Rate}$$

For services performed on or after January 1, 2006, the maternity per diem rate will be determined by multiplying a factor of 1.1001 times the conversion per diem rate.

For services performed on or after July 1, 2007, the maternity per diem rate will be determined by multiplying a factor of 1.0757 times the conversion per diem rate.

For services performed for claims with an admission date on or after September 8, 2008, the maternity per diem rate will be calculated as follows:

1. Charges submitted for claims paid in SFY 2007 were used from the Nevada Medicaid claims data.

2. The number of days admitted (the length of stay) for claims paid in SFY 2007 was used to calculate each claim's billed charges per day.

3. The per diem rate will be 34% of the median of billed charges per day for Nevada in-patient hospitals for obstetric services.

This rate will be used as a prospective rate until rebased as directed by the Department of Health and Human Services. There will be no cost settlement.

For services performed for claims with an admission date on or after July 9, 2015, the maternity per diem rate will be determined by multiplying a factor of 1.05 times the September 8, 2008 per diem rate.

For services performed for claims with an admission date on or after January 1, 2024, Long-Acting Reversible Contraceptive services will be carved out of the Maternity per diem rates as described on page 4.

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.

B. Newborn Rate Calculation

An all-inclusive per diem rate will be developed for newborns admitted through routine delivery at a hospital.

Historical Medicaid data for the Calendar Year (CY) ended December 31, 2002, has been extracted showing Medicaid Newborn admissions and Newborn patient days by tier. Projected Newborn payments for each tier are calculated as CY2002 Newborn admissions per tier times the current tier rate. Total projected Newborn payments are the sum of all projected tier payments.

The conversion per diem rate for Newborn has been determined by the following formula:

Total Projected Newborn Payments		
----------	=	Newborn Per
CY2002 Historical Newborn Patient Days		Diem Rate

For services performed on or after January 1, 2006, the newborn per diem rate will be determined by multiplying a factor of 1.1001 times the conversion per diem rate.

For services performed on or after July 1, 2007, the newborn per diem rate will be determined by multiplying a factor of 1.0757 times the conversion per diem rate.

For services performed for claims with an admission date on or after September 8, 2008, the newborn per diem rate will be calculated as follows:

1. Charges submitted for claims paid in SFY 2007 were used from the Nevada Medicaid claims data.

2. The number of days admitted (the length of stay) for claims paid in SFY 2007 was used to calculate each claim's billed charges per day.

3. The per diem rate will be 34% of the median of billed charges per day for Nevada in-patient hospital routine services related to the care of a newborn.

This rate will be used as a prospective rate until rebased as directed by the Department of Health and Human Services. There will be no cost settlement.

For services performed for claims with an admission date on or after July 9, 2015, the newborn per diem rate will be determined by multiplying a factor of 1.05 times the September 8, 2008 per diem rate.

For services performed for claims with an admission date on or after January 1, 2020, the reimbursement methodology described above will apply only to Revenue Codes 0170 and 0171.

For services performed for claims with an admission date on or after January 1, 2020, the newborn per diem rate will be determined by multiplying a factor of 1.25 times the July 9, 2015 per diem rate.

1. This increase applies only to Revenue Code 0172.

C. Neonatal Intensive Care Rate Calculation

For admissions prior to September 8, 2008:

A separate rate is used for patients admitted to Level III Neonatal Intensive Care Units. The current rate was developed from historical costs pursuant to Section II, Prospective Rate Development. The calculated cost per day of each neonatal unit was arrayed from highest to lowest. The prospective per diem rate was then calculated at the 55th percentile and indexed.

For admissions on or after September 8, 2008:

1. Charges submitted for claims paid in SFY 2007 were used from the Nevada Medicaid claims data.

2. The number of days admitted (the length of stay) for claims paid in SFY 2007 was used to calculate each claim's billed charges per day.

3. The per diem rate will be 34% of the median of billed charges per day for Nevada in-patient hospital services for Neonatal Intensive Care.

This rate will be used as a prospective rate until rebased as directed by the Department of Health and Human Services. There will be no cost settlement.

For services performed for claims with an admission date on or after January 1, 2020, the per diem rate for Neonatal Intensive Care services will be determined by multiplying a factor of 1.25 times the September 8, 2008 per diem rates.

1. This increase applies only to Revenue Codes 0173 and 0174.

D. Rehabilitative and Specialty Hospital Rate Calculation

A few Nevada hospitals are licensed to provide acute care in single diagnostic category. Rehabilitative and specialty hospital patients generally have hospital stays of ninety or more days. The length of stay does not significantly influence the cost per day.

To the extent these hospitals participate in Medicaid, they are reimbursed as follows:

1. Inpatient hospital services which have been certified for payment at the acute level by a QIO-like vendor are reimbursed an all-inclusive per diem rate at the lowest rate acceptable to both parties. In establishing the lowest rate acceptable to both parties, Nevada Medicaid reviews cost information filed by the provider, amounts paid by other insurers and national literature on comparable costs for similar services. The rate cannot exceed the reasonable and customary charges of the facility for similar services.

E. Medical/Surgical Rate Development

The current tier rate will be paid for Medical/Surgical payments made on or prior to August 31, 2003. Beginning September 1, 2003, an all-inclusive per diem rate will be paid for general hospital admission, not meeting the criteria of patients described in Parts B. - D. and F. of this Section or Section IV.

Historical Medicaid data for the Calendar Year (CY) ended December 31, 2002, has been extracted showing Medicaid Medical/Surgical admissions and Medical/Surgical patient days by tier. Projected Medical/Surgical payments for each tier are calculated as CY2002 Medical/Surgical admissions per tier times the current tier rate. Total projected Medical/Surgical payments are the sum of all projected tier payments.

The conversion per diem rate for the Medical/Surgical category has been determined by the following formula:

$$\frac{\text{Total Projected Medical/Surgical Payments}}{\text{CY2002 Historical Medical/Surgical Patient Days}} = \text{Medical/Surgical Per Diem Rate}$$

For services performed on or after January 1, 2006, the medical/surgical per diem rate will be determined by multiplying a factor of 1.1001 times the conversion per diem rate.

For services performed on or after July 1, 2007, the medical/surgical per diem rate will be determined by multiplying a factor of 1.0757 times the conversion per diem rate.

For services performed for claims with an admission date on or after September 8, 2008, the medical/surgery per diem rate will be calculated as follows:

1. Charges submitted for claims paid in SFY 2007 were used from the Nevada Medicaid claims data.

2. The number of days admitted (the length of stay) for claims paid in SFY 2007 was used to calculate each claim's billed charges per day.

3. The per diem rate will be 22% of the median of billed charges per day for Nevada in-patient hospital services for medical/surgery procedures.

This rate will be used as a prospective rate until rebased as directed by the Department of Health and Human Services. There will be no cost settlement.

For services performed for claims with an admission date on or after July 9, 2015, the medical/surgical per diem rate will be determined by multiplying a factor of 1.05 times the September 8, 2008 per diem rate.

For services performed for claims with an admission date on or after January 1, 2020, the medical/surgical/ICU per diem rate will be determined by multiplying a factor of 1.025 times the July 9, 2015 per diem rate.

F. Pediatric Intensive Care Rate Calculation

For services performed on or after January 1, 2020:

A separate rate is used for patients admitted to a Pediatric Intensive Care Unit (PICU). The rate was developed by applying a multiplying factor of 1.15 percent to the July 9, 2015 Medical Surgical per diem rate.

1. This increase only applies to Revenue Code 0203.

F. Level I Trauma Centers

Nevada Medicaid will pay an enhanced rate for full trauma team cases at Level I Trauma Centers. For payments made on or before August 31, 2003, the enhanced trauma rate is 1.63 times the Medical/Surgical tier rate. For services paid September 1, 2003, and after the enhanced trauma rate is 1.63 times the Medical/Surgical rate in effect on September 1, 2003.

G. Transplants

A. Basic Date Sources for Rate Development
   1. 2014 Milliman Research Report – U.S. Organ and Tissue Transplant and Cost Estimate.
   2. 2013 The Lewin Group Study – Cost Benefit Analysis of Corneal Transplant

B. Rate Conversion
   1. Hospital Services will be reimbursed at 35% of the Hospital Billed Charges for each transplant procedure as listed in the 2014 Milliman Study.
   2. 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 set forth below 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	$139,685	$95,000
Kidney	$41,860	$84,400
Tissue		
Bone Marrow - Autologous	$74,305	$10,700
Bone Marrow - Allogeneic Related	$167,860	$55,700
Bone Marrow - Allogeneic Unrelated	$167,860	$55,700
Cornea	$7,000	$2,500

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

IV. PSYCHIATRIC/SUBSTANCE ABUSE TREATMENT RATE DEVELOPMENT

Psychiatric/substance abuse treatment admissions can vary from short stays to several weeks. The length of stay does not significantly impact the cost per day. Therefore, a per diem rate is a more appropriate method to pay acute care hospitals providing this type of service.

1. Psychiatric/substance abuse treatment costs for each hospital are divided by the number of psychiatric/substance abuse treatment days to determine a cost per day. The Medicaid related costs of freestanding psychiatric hospitals are determined using the steps in Section II, Parts A and B, then dividing their Medicaid costs by their total Medicaid days to determine the cost per day. The calculated cost per day of each general acute care hospital and freestanding psychiatric hospital is arrayed from highest to lowest. The prospective per diem rate is then calculated at the 55^{th} percentile and indexed in accordance with Section II, Part E of this plan.

    a. These rates do not apply to facilities accredited as Residential Treatment Centers by the Joint Commission on Accreditation of Health Organizations (JCAHO).

    For services performed on or after July 1, 2014, the psychiatric/substance abuse per diem rate will be determined as follows:

2. General acute hospitals providing inpatient psychiatric services will be reimbursed with a per diem.

    a. Billed charges for inpatient psychiatric claims paid in SFY ending June 30, 2013 were used from the Nevada Medicaid claims data.

    b. The aggregate average billed charges per day was calculated for all Nevada Medicaid enrolled general acute hospitals using this data.

    c. The per diem rate will be 37% of the aggregate average billed charges per day for Nevada Medicaid enrolled inpatient general acute hospital psychiatric services.

3. Freestanding psychiatric hospitals are reimbursed at the lowest rate acceptable to Nevada Medicaid and the provider. In establishing the lowest rate acceptable to both parties, Nevada Medicaid will review cost information filed by the provider, rates received from other state Medicaid programs and other information it deems pertinent to calculate an average cost per day. Considering this information, Nevada Medicaid will then assign an individual rate to each provider. This rate will remain in effect until the DHCFP authorizes a change. The rate cannot exceed the reasonable and customary charges of the facility.

4. State-operated Inpatient Psychiatric Hospitals are reimbursed under Medicare principles of retrospective reimbursement described in 42 CFR 413 and further specified in CMS Publication 15.

   a. In no case may payment exceed audited allowable costs.

   b. Interim rates will be based upon the most recent audited cost reports for the current state fiscal year. The interim rate for the initial year of operation will be based upon cost and utilization projections.

   c. Each facility is paid an interim rate subject to a cost settlement.

V. ADMINISTRATIVE DAY RATE DEVELOPMENT

For those patients who remain in an acute care hospital awaiting admittance to a long-term care facility, an administrative day rate is used. Services so reimbursed are call “administrative days.”

The administrative rate is based on statewide weighted average payment rate established in 2003 for skilled and intermediate levels of care. The administrative rate is lower than the hospital rate as described in Part II of the State Plan.

For services performed for claims with an admission date on or after July 9, 2015, the intermediate level administrative day per diem rate will be determined by multiplying a factor of 1.05 times the rate.

VI. RESIDENTIAL TREATMENT CENTERS

Nevada Medicaid will only pay for stays in facilities accredited by the Joint Commission on Accreditation Health Organizations (JCAHO) as Residential Treatment Centers (RTCs). All stays must be pre-approved by the QIO-like vendor. These services will be reimbursed at the lowest rate acceptable to both parties. In establishing the lowest rate acceptable to both parties, Nevada Medicaid reviews cost information filed by the RTC, amounts paid by other insurers, and national literature on costs for RTCs. Each facility will have a negotiated rate established for each general level of service. If a placement is being proposed which is different from the general level of care offered by the facility, a rate will be negotiated after considering the average cost per day of the facility and the additional will be reviewed based upon cost information received on or prior July 1 of the year of review. The rate cannot exceed the reasonable and customary charges of the facility for similar services.

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

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

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:

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.

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.

c. For hospitals that break out intensive care services separately from

medical/surgical services, the Intensive Care Unit 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. 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.

6. The interim rates 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.

7. 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. These rates are not adjusted for MEI if the provider does not add service areas as described below.

   a. If a provider adds a new service area (maternity, newborn, or psychiatric/detoxification services), the following methodology will be utilized to establish rates:

      i. Providers will be paid the general acute hospital rate until a cost report becomes available that reflects the new service area.

      ii. Upon receipt of the adjusted cost report reflecting the new service area, all inpatient reimbursement rates will be rebased to ensure ancillary costs are accurately reflected across service areas.

      iii. Reimbursement rates will be calculated as described above and made retroactive to the date on which the new service area began being provided. For claims that occurred in the same time period as the cost report used to set the rebased rates, MEI will not be applied. MEI would begin being applied on the first day of the provider's fiscal year following the cost reporting period. All inpatient rates would be made retroactive to the effective date of the new service; the retroactive rates do not solely apply to the new service area.

         a. For example, if a provider uses a calendar year fiscal year and begins providing psychiatric services July 1 of a given year in addition to existing medical/surgical services, MEI would not be applied from July 1 – December 31 of the same fiscal year for psychiatric, medical, and surgical services. MEI would be applied to all rates effective January 1 of the following fiscal year.

         b. The Division and the vendor contracted for cost report reviews will make every effort to ensure cost reports are reviewed in a timely manner upon receipt. However, claims will not be processed if they are more than two years past the original payment date, as federal match is not available. The Division encourages hospitals to ensure they are promptly responding to requests from the contracted vendor to ensure all claims are eligible for reprocessing.

iv. Providers with new service areas will still be subject to rebases following the standard schedule.

a. For example, if a provider adds a new service area in 2025 and undergoes a rebase as described above, they will still have rates rebased again effective January 1, 2027.

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.

10. Capital Renovations/Remodeling Projects: Providers who undergo a major renovation/replacement project completed within a 24-month period may request a capital add-on per diem be applied to the reimbursement rates as described above. The capital add-on will be applied beginning January 1 of the year following when the capital renovation/remodeling project is reported. Projects must be reported no later than September 1 of the preceding year and the cost must exceed $250,000.

a. Providers reporting a capital renovation/remodeling project must then undergo an additional rate rebase once an adjusted cost report reflecting the changes in capital costs becomes available. Reimbursement rates will be effective on a prospective basis 60 days after receipt of the adjusted cost report.

i. The capital add-on payment must be applied equally across all types of inpatient days provided by the facility (medical/surgical, intensive care, maternity, newborn, psychiatric/detoxification).

b. In the event the standard 3-year rebase would utilize a cost report not

reflecting the capital improvement costs, then rates would continue to be based on the first adjusted cost report reflecting the change. The provider would then have rates rebased during the next standard 3-year rate rebase.

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.

VIII. HOSPITALS SERVING LOW-INCOME PATIENTS
DISPROPORTIONATE SHARE HOSPITALS (DSH)

A. Eligibility – A Nevada hospital will qualify for DSH payment if it meets the conditions of either Paragraph 1 or 2.

1. Subject to the provisions of Subparagraph c, a Nevada hospital will be deemed to qualify for DSH payment if it meets either of the conditions under subparagraphs a or b. The data used to determine eligibility is from the prior State Fiscal Year ending June 30th. For example, eligibility for SFY 14 DSH is done in the third quarter of SFY 13, using data from SFY 12.

a. A hospital's Medicaid inpatient utilization rate (MIUR) is at least one standard deviation above the mean MIUR for hospitals receiving Medicaid payment in the State.

i. MIUR is the total number of inpatient days of Medicaid eligible patients, including patients who receive their Medicaid benefits through a health maintenance organization, divided by the total number of inpatient days of all patients during a fiscal year.

b. The hospital’s low-income utilization rate (LIUR) is at least 25%. LIUR is the sum (expressed as a percentage) of the fractions, calculated as follows:

i. Total Medicaid patient revenues paid to the hospital, plus the amount of the cash subsidies for patient service received directly from State and local governments in the cost reporting period, divided by the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the same cost reporting period; and,

ii. The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, less the portion of any cash subsidies received directly from the state or local government for inpatient hospital services, divided by the total amount of hospital charges for inpatient services in the hospital in the same period. The total inpatient hospital charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medicaid assistance under an approved Medicaid State plan), that is, reductions in charges given to other third-party payors, such as HMOs, Medicare or Blue Cross Blue Shield.

c. A hospital must:

i. have a MIUR of not less than 1%;

ii. have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget) the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. This does not apply to a hospital in which:

(a) the inpatients are predominantly individuals under 18 years of age; or

(b) non-emergency obstetric services were not offered as of December 22, 1987.

iii. not be an institution for mental disease or other mental health facility subject to the limitation on DSH expenditures under Section 4721 of the Balanced Budget Act of 1997.

2. Subject to the provisions of subparagraph 1c above, a hospital will qualify for DSH payments if it is:

a. a public hospital (i.e., hospital owned or operated by a Nevada hospital district, county or other unit of local government); or

b. in Nevada counties, which do not have a public hospital, the private hospital which provided the greatest number of Medicaid inpatient days in the previous year; or

c. a private hospital – located in a Nevada county which has a public hospital, if the public hospital has a MIUR greater than the average for all the hospitals receiving Medicaid payment in the State.

B. Distribution Pools: For the DSH state plan rate years effective July 1, 2022, hospitals qualified under Paragraph "A" above will be grouped into distribution pools on the following basis:

1. Distribution pools are established as follows:

a. All public hospitals qualifying under Paragraph A above and in counties whose population is 700,000 or more, the total annual disproportionate share payments will be 32.46% of the total Amount for Distribution as specified in B.2 for the State Fiscal Year.

b. All private hospitals qualifying under paragraph A above and in counties whose population is 700,000 or more, the total annual disproportionate

share payments will be 9.49% of the total Amount for Distribution as specified in B.2 for the State Fiscal Year.

c. All private hospitals qualifying under Paragraph A above and in counties whose population is 100,000 or more but less than 700,000, the total annual disproportionate share payments will be 32.90% of the total Amount for Distribution as specified in B.2 for the State Fiscal Year.

d. All public hospitals qualifying under Paragraph A above and in counties whose population is less than 100,000, the total annual disproportionate share payments will be 5.90% of the total Amount for Distribution as specified in B.2 for the State Fiscal Year.

e. All private hospitals qualifying under Paragraph A above and in counties whose population is less than 100,000, the total annual disproportionate share payments will be 19.25% of the total Amount for Distribution as specified in B.2 for the State Fiscal Year.

f. Note: There is no public hospital in counties whose population is 100,000 or more but less than 700,000.

2. Amount for Distribution: For the DSH state plan rate year of July 1, 2024 to June 30, 2025, the total computable payment will be $25,158,225.17. The total amount distributed to an individual hospital may not, under any circumstance, exceed the total uncompensated care costs (DSH limit) for that facility.

3. Total annual uncompensated care costs equal the cost of providing services to Medicaid inpatients, Medicaid outpatients and uninsured patients, less the sum of:

Regular Medicaid FFS rate payments (excluding DSH payments);
Medicaid managed care organization payments;
Supplemental/enhanced Medicaid payments;
Uninsured revenues; and
Federal Section 1011 payments for uncompensated services to eligible aliens with no source of coverage.

4. An "uninsured patient" is defined as an individual without health insurance or other source of third-party coverage (except coverage from State or local programs.based on indigency). A system must be maintained by the hospitals to report revenues on Medicaid and uninsured patient accounts to determine uncompensated care cost consistent with Section 1923 (g) of the Social Security Act and implementing regulations at 42 CFR 447 Subpart E. Costs for Medicaid and uninsured patients will be based upon the methodology used in the HCFA 2552 report. Revenue will be deducted from cost. The total costs on the report will be subject to an independent audit. The HCFA 2552 report must be submitted within six months of

the hospital's fiscal year end.

C. Calculation of Hospital DSH Payments

1. Using supplemental payment data for the DSH program year and the same period outlined on Subparagraph A.1 for all other data, the Division will calculate the DSH payments for each hospital as follows:

a. Fifty percent of the pool amount will be distributed based on the percent to total of the uncompensated care percentage of the hospitals within the pool.

i. Uncompensated Care Percentage is the uncompensated care cost of the hospital divided by the net patient revenues of the hospital, as reported on the Medicare Cost Report, which is required to be filed with the State.

(a) Net patient revenues are total patient revenues less contracted allowances and discounts. This comes from Medicare cost report, Worksheet G-3 Line 3, less any net patient revenue from non-hospital inpatient and non-hospital outpatient services.

b. The remaining 50% of the pool amount will be distributed based on the percent to total of the uncompensated care cost of the hospitals within the pool.

2. The DSH payments will be made quarterly to the eligible hospitals. Payments will be based on the State Fiscal Year. DSH payment will in no instance exceed a hospital’s DSH limit. If any hospital’s calculated DSH payment exceeds its DSH limit, the excess will be redistributed to the remaining hospitals within the pool using the same formula above.

D. Adjusting DSH payments based on DSH Independent Certified Audit results

1. The Division will audit each hospital for each year in which the hospital received a disproportionate share payment pursuant to NRS, NAC and in accordance with the provisions of Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq.

2. After conducting an audit, if a hospital’s eligibility changes or its initial DSH payment exceeded its audited DSH limit, the Division will recalculate the

following for all hospitals in the affected pool:

a. Audited uncompensated care costs

b. Audited uncompensated care percentages

c. Final DSH payment amounts using the same methodology as defined in Paragraph C. Final DSH payment amounts are calculated using the audited amounts in Subparagraphs D 2a and b.

d. The amount of monies available for redistribution within each pool based on a comparison of each hospital's final DSH payment amount and the initial DSH payment received by each hospital in the pool.

3. For all hospitals in the affected pool(s), the Division will reconcile each hospital's initial DSH payment to its final DSH payment as calculated in Paragraph D 2. Any hospital whose initial DSH payment is greater than the final DSH payment will return the difference to the Division, and any hospital whose initial DSH payment is less than the final DSH payment will be paid the difference. The final DSH payment amount for an individual hospital, as calculated in Paragraph D 2 and in accordance with the methodology in Paragraph C, will in no instance exceed that hospital's audited DSH limit.

4. If each hospital within a pool of hospitals has received the maximum amount of disproportionate share payments allowable by federal and state statutes and regulations, the Division will use the money returned to pay additional disproportionate share payments as follows in the method described in Paragraph C above:

a. If the money was returned by a hospital that is a member of Pool A, to hospitals in Pool B;

b. If the money was returned by a hospital that is a member of Pool B, to hospitals in Pool C;

c. If the money was returned by a hospital that is a member of Pool C, to hospitals in Pool D;

d. If the money was returned by a hospital that is a member of Pool D, to hospitals in Pool E; or

e. If the money was returned by a hospital that is a member of Pool E, to hospitals in Pool A.

IX. MEDICARE CROSS OVER CLAIMS

Payment of crossover claims will be as follows:

A. The lower of the Medicare deductible amount or the difference between the Medicare payment and Medicaid prospective payment for that service.

X. HOSPITALS OUT OF STATE

Elective out-of-state admissions require prior authorization by Nevada Medicaid's Peer Review Organization, which must verify medical services required by Medicaid-eligible or pending-eligible clients are not available in Nevada. The out-of-state payment rate for inpatient care is based on one of the following criteria, whether emergency or elective in nature.

A. For California hospitals, the following rates will be paid:

1. If the hospital has no signed contract with the State of California to provide Medi-Cal services, the California interim reimbursement Medi-Cal rate.

2. If the hospital has a signed contract with the State of California to provide Medi-Cal services, the Medi-Cal contract rate is paid. If the contract rate is not made available to Nevada Medicaid, the California interim Medi-Cal rate is paid.

B. For Utah hospitals the payment rate is 45% of billed charges.

C. For all other states' hospitals, the payment rate will be either the Nevada Medicaid prospective rate or the Medicaid rate for the state in which the hospital is located, but not more than billed charges. To receive the Medicaid rate for the state in which the hospital is located, the hospital must attach documentation to the UB-92 Billing Claim, produced and generated by that state's Medicaid program, verifying the state's payment rate to that hospital.

D. All other states' freestanding psychiatric/substance abuse hospitals are reimbursed 70% of billed charges.

E. For Medicare crossover claims, the payment will be the lower of the Medicare deductible amount or the difference between the Medicare payment and the Nevada Medicaid prospective payment for that service.

F. For services that cannot be provided by a provider that accepts payments under (A) through (E), the State will maintain a list of other qualified out-of-state providers and will negotiate competitive rates that will not exceed the provider's customary charge.

XI. RATE ADJUSTMENTS

Payment is made for services provided in inpatient hospital facilities in accordance with Section 1902(a)(13) of the Social Security Act as amended by Section 4711 of the Balanced Act of 1997. Prospective payment rates are based using the most current hospital costs reports (HCFA 2552) and cost reimbursement series (CRS) reports following the steps described in Section II - V above. Rates in effect on June 30, 1999 will be continued without adjustment except as may be directed by the Department of Human Resources.

XII. MONITORING FUTURE RATES

Nevada Medicaid monitors cost and utilization experience of all hospitals by evaluation of the cost reports filed each year. Payments are examined closely. Should modification of any elements or procedures such as creation or deletion of a rate or group appear necessary, this State Plan Attachment will be amended.

XIII. ADVANCES

Upon request, each hospital may receive each month an advance payment that represents expected monthly Medicaid reimbursement to that facility. Each advance is offset by claims processed during the month. Month-end +/- discrepancies automatically adjust the advance issued the following month.

(Reserved for Future Use)

(Reserved for Future Use)

XIV. DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS

This section of the state plan contains the provisions for making additional Medicaid payments to recognize the additional direct costs incurred by hospitals with approved graduate medical education programs.

Fee-for-Service (FFS) Direct Graduate Medical Education (GME) Payments

A. Qualifying Hospitals:

Non-state government owned hospitals that participate in the Medicaid program are eligible for additional reimbursement related to the provision of Direct GME activities. To qualify for these additional Medicaid payments, the hospital must report costs associated with residents, interns or fellows who participate in an approved medical residency program on their CMS Form 2552, Hospital Cost Report.

If there is not a non-state government owned hospital located in a county, certain private hospitals may qualify for additional reimbursement related to the provision of Direct GME activities. To qualify for these additional Medicaid payments, the hospital must report costs associated with residents, interns or fellows who participate in an approved medical residency program on their CMS Form 2552, Hospital Cost Report. The private hospitals that qualify under this section are Northeastern Nevada Regional Hospital located in Elko County and Renown Regional Medical Center in Washoe County.

No payment under this section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

B. FFS Direct GME Definitions:

(i) Base Year Per Resident Amount - for hospitals receiving Medicaid GME supplemental payments prior to July 1, 2017, the base-year per resident amount is the Medicaid allowable inpatient direct GME cost as reported on CMS Form 2552-96, Hospital Cost Report; Worksheet B, Part I, Line 22, Column 22 and Line 23, Column 23, divided by the un-weighted FTE residents from Worksheet S-3; Part I; Line 12 and Line 14, Column 7 of the Hospital Cost Report ending in June 30, 2008.

For hospitals that begin receiving Medicaid GME supplemental payments on or after July 1, 2017, the base-year per resident amount is the Medicaid allowable inpatient direct GME cost as reported on CMS Form 2552-10, Hospital Cost Report; Worksheet B, Part I, Line 21, Column 21, and Line 22, Column 22, divided by the un-weighted FTE residents from Worksheet S-3; Part I; Line 27 of Column 9 of the Hospital Cost Report ending in June 30, 2015.

For hospitals that did not have approved GME program costs in its Hospital Cost Report for the period ending on June 30, 2015, the base year per resident amount will be calculated in the same manner as above for hospitals that begin participating in the GME supplemental payment on or after July 1, 2017 based on the first CMS Form 2552-10, Hospital Cost Report that includes the approved GME program costs.

(ii) Current Number of FTE Residents - means the number of FTE interns, residents or fellows who participate in an approved medical residency program, including programs in osteopathy, dentistry and podiatry, as required in order to become certified by the appropriate specialty board reported on CMS Form 2552-10, Hospital Cost Report; Worksheet S-3: Part I; Line 27, Column 9.

(iii) FFS Medicaid Patient Load – is the ratio of FFS Medicaid inpatient days to total hospital inpatient days. The FFS Medicaid patient load ratio is determined by the following: Medicaid inpatient days as reported on CMS Form 2552-10, Hospital Cost Report; Worksheet S-3, Part I; Lines 14, 16,17 and 18; Column 7; divided by the hospital's total inpatient days, as reported on worksheet S-3; Part I; Lines 14, 16, 17 and 18; Column 8.

(iv) The cost report data used to determine a hospital's GME payment amount is subject to state review to ensure compliance with federal principles, including those at 42 CFR 412, 42 CFR 413, and Provider Reimbursement Manual Part I and Part II.

C. Methodology for Determining FFS Direct GME Payments:

The hospitals that qualify for FFS Medicaid GME payments will have their hospital specific payment amount determined as follows:

(i) The base-year per resident amount is multiplied by the latest available market basket adjustment factor for each federal fiscal year used for Medicare Inpatient Prospective Payment Systems (IPPS) as published in the Federal Register. The market basket change reflects the Medicare payment increases before application of any Medicare adjustments.

(ii) The results in (i) are multiplied by the current number of FTE residents; the current number of FTE residents and the FFS Medicaid patient load will be updated annually using data from the most recent Medicare Hospital Cost Report (CMS Form 2552-10) submitted to Medicare by each qualifying hospital;

(iii) The results in (ii) are multiplied by the FFS Medicaid patient load which results in the total direct FFS GME payment for the hospitals;

(iv) The annual FFS direct GME supplemental payment for each hospital will be included in the FFS UPL calculation for the annual time period.

D. Payments of FFS Direct GME:

(i) The state will determine the annual direct FFS GME amount payable to qualifying hospitals prospectively for period that will begin each July 1. On a quarterly basis, each qualifying hospital will receive a FFS GME payment equal to 25% of the annually determined FFS GME amount. Quarterly payments will be made in each calendar quarter during the state's fiscal year.

Managed Care Organization (MCO) Direct GME Payments

A. Qualifying Hospitals:

Non-state government owned hospitals that participate in the Medicaid program are eligible for additional reimbursement related to the provision of Direct GME activities. To qualify for these additional Medicaid payments, the hospital must report costs associated with residents, interns or fellows who participate in an approved medical residency program on their CMS Form 2552, Hospital Cost Report.

If there is not a non-state government owned hospital located in a county, certain private hospitals may qualify for additional reimbursement related to the provision of Direct GME activities. To qualify for these additional Medicaid payments, the hospital must report costs associated with residents, interns or fellows who participate in an approved medical residency program on their CMS Form 2552, Hospital Cost Report. The private hospitals that qualify under this section are Northeastern Nevada Regional Hospital located in Elko County and Renown Regional Medical Center in Washoe County.

No payment under this section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a government entity.

B. MCO Direct GME Definitions:

(i) Base Year Per Resident Amount - for hospitals receiving Medicaid GME supplemental payments prior to July 1, 2017, the base-year per resident amount is the Medicaid allowable inpatient direct GME cost as reported on CMS Form 2552-96, Hospital Cost Report; Worksheet B, Part I, Line 22, Column 22 and Line 23, Column 23, divided by the un-weighted FTE residents from Worksheet S-3; Part I; Line 12 and Line 14, Column 7 of the Hospital Cost Report ending in June 30, 2008.

For hospitals that begin receiving Medicaid GME supplemental payments on or after July 1, 2017, the base-year per resident amount is the Medicaid allowable inpatient direct GME cost as reported on CMS Form 2552-10, Hospital Cost Report; Worksheet B, Part I, Line 21, Column 21, and Line 22, Column 22, divided by the un-weighted FTE residents from Worksheet S-3; Part I; Line 27 of Column 9 of the Hospital Cost Report ending in June 30, 2015.

For hospitals that did not have approved GME program costs in its hospital cost report period ending in June 30, 2015, the base year per resident amount will be calculated in the same manner as above for hospitals that begin participating in the GME supplemental payment on or after July 1, 2017 based on the first CMS Form 2552-10, Hospital Cost Report that includes the approved GME program costs.

(ii) Current Number of FTE Residents - means the number of full-time-equivalent interns, residents or fellows who participate in an approved medical residency program, including programs in osteopathy, dentistry and podiatry, as required in order to become certified by the appropriate specialty board reported on CMS Form 2552-10, Hospital Cost Report; Worksheet S-3: Part I; Line 27, Column 9.

(iii) MCO Medicaid Patient Load – is the ratio of MCO Medicaid inpatient days to total hospital inpatient days. The MCO Medicaid patient load ratio is determined by the following: Medicaid inpatient days as reported on CMS Form 2552-10, Hospital Cost Report; Worksheet S-3; Part I; Lines 2, 3 and 4, Column 7 are divided by the hospital's total inpatient days, as reported on Worksheet S-3; Part I; Lines 14, 16, 17 and 18; Column 8.

(iv) The cost report data used to determine a hospital's GME payment amount is subject to state review to ensure compliance with federal principles, including those at 42 CFR 412, 42 CFR 413, and Provider Reimbursement Manual Part I and Part II.

C. Methodology for Determining MCO Direct GME Payments:

The hospitals that qualify for GME payments will have their hospital specific MCO payment amount determined as follows:

(i) The base-year per resident amount is multiplied by the latest available market basket adjustment factor for each federal fiscal year used for Medicare IPPS as published in the Federal Register. The market basket change reflects Medicare payment increases before application of any Medicare adjustments;

(ii) The results in (i) are multiplied by the current number of FTE residents; the current number of FTE residents and the MCO Medicaid patient load will be updated annually using data from the most recent Medicare Hospital Cost Report (CMS Form 2552-10) submitted to Medicare by each qualifying hospital;

(iii) The results in (ii) are multiplied by the MCO Medicaid patient load which results in the total direct MCO GME payment for the hospitals;

D. Payments of MCO Direct GME:

(i) The state will determine the annual direct MCO GME amount payable to qualifying hospitals prospectively for period that will begin each July 1. On a quarterly basis, each qualifying hospital will receive an MCO GME payment equal to 25% of the annually determined MCO GME amount. Quarterly payments will be made in each calendar quarter during the state's fiscal year.

XV. FEDERAL UPPER PAYMENT LIMIT

In order to preserve access to inpatient hospital services for needy individuals in the state of Nevada, the state's Medicaid hospital reimbursement system shall provide for supplemental payments to non-state, governmentally owned or operated hospitals and private hospitals. Supplemental payments shall be made to non-state, governmentally owned or operated hospitals effective for services provided on after January 1, 2002. Supplemental payments shall be made to private hospitals effective for services provided on or after January 2, 2010. These supplemental payments shall be determined on an annual basis and paid to qualifying hospitals on a quarterly basis. The supplemental payments to non-state, governmentally owned or operated hospitals shall not exceed, when aggregated with other payments made to non-state, governmentally owned or operated hospitals, 100% of a reasonable estimate of the amount that would be paid for such services under Medicare payment principles for non-state, governmentally owned or operated hospitals, except that payments for the period prior to May 14, 2002, such payments shall not exceed 150% of a reasonable estimate of the amount that would be paid for such services under Medicare payment principles for non-state, governmentally owned or operated hospitals. The supplemental payments to private hospitals shall not exceed, when aggregated with other payments made to private hospitals, 100% of a reasonable estimate of the amount that would be paid for such services under Medicare payment principles for private hospitals.

The upper payment limit will be determined on an annual basis. In general, this approach identifies the upper limit through the application of Medicare's prospective payment system, which is a diagnosis related group (DRG) payment system. The upper limit computes, for each hospital, the Medicare DRG payment amount for each Medicaid discharge by determining a Medicare equivalent case mix index based on Medicaid discharges. This upper limit also uses a payment per discharge calculation of the amount of Medicare pass-through and add-on reimbursement including but not limited to outlier, direct graduate medical education, organ acquisition, routine and ancillary pass-through, IME, DSH, and capital payments. The Medicare pass-through and add-on reimbursement are identified from the Medicare cost report and adjusted for Medicaid where applicable. The hospital's Medicare payment per discharge, which includes the DRG and the pass-through/add on amounts, are applied to the number of Medicaid discharges. The latest available information is used for Medicare DRG, Medicare pass-through and add-on payments, Medicare discharges, and Medicaid discharges. Inflation factors are accordingly applied to determine an individual hospital's Medicare payment for the UPL period. The sum of each hospital's estimated Medicare payment for Medicaid discharges is the aggregate upper payment limit for the hospital class.

SUPPLEMENTAL PAYMENT FOR NON-STATE GOVERNMENTALLY OWNED OR OPERATED HOSPITALS

The state will determine annually the payments to be made to non-state, governmentally owned or operated hospitals under this section of the plan using the following methodology:

1. Identify all non-state government owned (NSGO) or operated acute care hospitals.
2. For each facility identified in Step #1, compute total Medicaid Fee-for-Service inpatient hospital payments using latest available data projected to the current period.
3. For each facility, calculate the difference between payments identified in Step #2, and the hospital's Medicare UPL. This difference is the total maximum disbursement available under this section of the state plan.

These calculations will be set on a prospective basis and will not be retroactively adjusted to previous fiscal years.

A. Calculation of Supplemental Payment for NSGO Hospitals

The state shall determine the maximum annual supplemental amount payable to hospitals prospectively for period that will begin each July 1. The state shall determine the amount of supplemental payments to each facility using the following criteria:

a. Total supplemental payments under this section of the state plan will not exceed the difference between Medicaid payments and the Medicare UPL calculated in Step #3 above.
b. Facilities participating in the supplemental payment program will be identified.
c. Total supplemental payments will be apportioned to public hospitals participating in the supplemental payment program using each hospital's participation percentage. This percentage is calculated by dividing each supplemental payment hospital's Medicaid days by the total Medicaid days for all supplemental payment hospitals.
d. Medicaid days for each supplemental payment hospital shall be identified using the most recent Medicare cost report data available at the time the calculation are prepared.
e. Once these participation percentages are determined they will be final and not subject to recalculation, except when errors are found in the calculations. The state will not recalculate the percentages following receipt of more accurate data, such as a more current or audited Medicare cost report.

B. Adjustment to Supplemental Payment for NSGO Hospitals to Preserve DSH

1. The total annual supplemental payment for each hospital will be the lesser of:

a) The total supplemental payment as calculated above in Paragraph A; or

b) If the uncompensated care limit of DSH Distribution Pool D per the Medicaid State Plan Attachment 4.19-A, Page 23 for the same time period beginning July 1 as above is less than the maximum amount of DSH payment available to the Distribution Pool, the supplemental payment as calculated in this section above for the individual hospitals in the DSH Distribution Pool will be reduced by the amount necessary to allow the Distribution Pool to receive the maximum DSH payment allowable. In no event will the adjustment for each individual hospital reduce the supplemental payment as calculated in Section A to less than $0.

2. For the purpose of the reduction discussed in Paragraph B.1.b above, the Supplemental Payment for NSGO Hospitals for all hospitals in each DSH Pool will be reduced by the lesser of:

a) The amount of the smallest calculated annual Supplemental Payment for NSGO Hospitals in Paragraph A, if there are sufficient DSH funds in the pool to distribute this DSH payment amount equally to all hospitals in the pool, or
b) The remaining amount of DSH funds available in the pool which will be distributed by dividing a hospital's maximum allowed DSH payment by the total maximum allowed DSH payments for the hospitals in the distribution calculation.

No hospital will receive a DSH payment greater than the hospital's uncompensated care limit. If a hospital in the pool is projected to have negative uncompensated care costs, as determined in Section VIII of this Attachment 4.19-A, prior to the adjustment calculation described in Paragraph B.2, the hospital will be excluded from the adjustment calculation; the Supplemental Payment for NSGO Hospitals for such hospital will be that as calculated in Paragraph A. If a hospital in the pool has its annual Supplemental Payment for NSGO Hospitals reduced to $0, this hospital will be removed from further repetitions of Paragraph B.2.

The process in Paragraph B.2.a – b will be repeated until all DSH funds allocated to the DSH Distribution Pool have been distributed or the annual Supplemental Payment for NSGO Hospitals for all hospitals in the DSH Pool have been reduced to $0.

C. Payment of the Supplemental Payment for NSGO Hospitals

On a quarterly basis, hospitals will receive a supplemental payment equal to 25% of the annually determined supplemental amount. A quarterly payment will be made in each calendar quarter during the state's fiscal year.

SUPPLEMENTAL PAYMENT FOR INPATIENT HOSPITALS

In order to preserve access to inpatient hospital services for needy individuals in the state of Nevada, effective on or after January 1, 2014, the state's Medicaid reimbursement system shall provide for supplemental payments to inpatient hospitals. These supplemental payments shall be determined on an annual basis and paid to qualifying private and public inpatient hospitals on a quarterly basis. The payments will be based on inpatient hospital Medicaid Fee-for-Service utilization. No payment under this section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

A. Amount for Distribution

1. For the period for the State Fiscal Year 2024, the total computable payment will be $70,196,969.01.

2. The aggregated amount of supplemental payments to inpatient hospitals shall not exceed the Upper Payment Limit (UPL) for each one of the respective periods. The supplemental payment for the period of State Fiscal Year 2024 will be accounted for in the UPL room available for State Fiscal Year 2024.

B. Eligibility

1. Nevada Acute Care Inpatient Hospitals (PT 11), that are not designated as Critical Access Hospitals (CAH) (PT 75), Psychiatric Inpatient Hospitals (PT 13), Rehabilitation, Specialty or Long-Term Acute Care (LTAC) (PT 56), will be deemed to qualify.

2. Nevada Acute Care Inpatient Hospitals (PT 11) certified as Trauma I, Trauma II and Trauma III levels will additionally qualify for the distribution of the Trauma case portion of the allotment.

C. Methodology

1. Data Source

a. Days count, by date of service, obtained from the Nevada Medicaid Management Information System (MMIS) for the Med/Surg/ICU, Maternity, NICU and Psych/Detox revenue codes.

b. Data used is from the calendar year two years prior.

i. For example, the calculation for payment in State Fiscal Year 2014 would be computed in calendar year 2013 using data from calendar year 2011.

c. Case Mix Index (CMI) is calculated using the same claims data described above, in (a) and (b) by Contractor University of Nevada Las Vegas, Center for Health Information Analysis (CHIA).

d. Trauma cases are determined using the same claims data described above, in (a) and (b) by counting the number of patient discharges which have a trauma revenue code.

2. Calculation – The calculation will be computed annually, based on the total allocation amount specified above in A.1 with quarterly payments to be made during calendar year quarters as described in D.1 using the following methodology:

a. Identify all eligible hospitals as described above in (A).

b. Determine which hospitals are trauma certified (Levels 1, 2 and 3).

c. Determine the total allocation.

d. Determine the total count of trauma cases for any trauma certified hospital.

e. Calculate 3% of the total allocation to determine the trauma portion of the allocation.

f. Level I and Level II trauma cases will be given a weight of 100% of the amount to be paid for each trauma case; Level III trauma cases will be given a weight of 50%.

g. Divide the number of Level I plus Level II plus half the number of Level III trauma cases into the product of 2 (e) above to determine the amount to be paid for each 100% weighted trauma case.

a. To calculate the 50% weighted trauma case amount, divide the 100% weighted trauma case by 2.

b. Multiply the number of trauma cases of hospitals certified as trauma Level I and Level II by the 100% weighted amount determined in (g), to calculate the payment for each hospital in this category.

c. Multiply the number of trauma cases of hospitals certified as trauma Level III by the amount determined in (h), to calculate the payment for each hospital in this category.

d. Subtract the trauma portion of the allocation from the total allocation to determine the amount remaining for distribution to eligible hospitals as identified in Step 2 (a).

e. Multiply the number of each hospital's Medicaid Fee-for-Service days, by their Medicaid CMI to determine the number of adjusted days per hospital.

f. Divide the remaining allocation (the amount in Step (c) reduced by the amount in Step (e)) by the total adjusted days to determine the per day rate.

g. Multiply the per day rate times the individual hospital adjusted days to determine each hospital payment.

h. Add hospital day rate payment amount to the trauma payment, if any, to determine the total payment to each hospital.

B. Payment

1. Payment issued to hospitals participating in the supplemental payment will be deducted and tracked to ensure that total Medicaid payments do not exceed the aggregate amount of (UPL) calculated for the corresponding period. (see A.2 above).

2. One fourth of the total annual allocation (not to exceed the aggregate amount of UPL for the corresponding period) will be paid out quarterly to each eligible hospital, in supplemental payments, in the last month of the quarter for which the payment is calculated (Effective July 1, 2015: e.g. the supplemental payment for SFY 2016 Quarter 1 will be issued in September 2015).

3. Each hospital will be issued the supplemental payment by EFT as a financial transaction through the MMIS.

B. SUPPLEMENTAL PAYMENT FOR PRIVATE HOSPITALS

In order to preserve access to inpatient hospital services for needy individuals in the state of Nevada, effective for services provided on or after January 2, 2010, the state's Medicaid hospital reimbursement system shall provide for supplemental payments to private hospitals affiliated with a state or unit of local government in Nevada through a Low Income and Needy Care Collaboration Agreement (Affiliated Private Hospitals). A Low Income and Needy Care Collaboration Agreement is defined as an agreement between a hospital and a state or unit of local government to collaborate for purposes of providing healthcare services to low income and needy patients. These supplemental payments shall be determined on an annual basis and paid to qualifying hospitals on a quarterly basis.

The supplemental payments are payments for Medicaid Fee-for-Service inpatient hospital service. The supplemental payments shall not exceed, when aggregated with other payments made to private hospitals, 100% of a reasonable estimate of the amount that would be paid for such services under Medicare payment principles for private hospitals.

The state will determine the payments to be made under this section of the plan using the following methodology:

1. Identify all Nevada private hospitals. Non-state government owned or operated acute care hospitals and state owned hospitals do not qualify under this methodology.
2. For those facilities identified in Step #1, compute the Medicare UPL according to the methodology set out on Page 32 above.
3. The amount computed in Step #2, less the Medicaid Fee-for-Service inpatient hospital payments to those facilities identified in Step #1, is the total maximum disbursement available under this section of the state plan in each fiscal year. If the payments under this section of the plan exceed this total maximum disbursement, the state will calculate the percentage by which the Medicare UPL is exceeded and reduce payments to all hospitals under this section of the state plan by the same percentage.

The Medicaid director shall then determine the amount of supplemental payments to each facility using the following criteria.

1. Total supplemental payments under this section of the state plan will not exceed the difference between Medicaid payments and the Medicare UPL calculated in Step #3 above.
2. Facilities participating in the supplemental payment program will be identified. All Affiliated Private Hospitals are eligible to participate in the supplemental payment program.

3. Each Affiliated Private Hospital will receive quarterly supplemental payments. The annual supplemental payments in any fiscal year will be the lesser of:

   a) The difference between the hospital's Medicaid inpatient billed charges and Medicaid payments the hospital receives for services processed for Fee-for-Service Medicaid recipients during the fiscal year.
   b) For hospitals participating in the Nevada Medicaid DSH program, the difference between the hospital's total uncompensated costs (as defined in Section VIII) and the hospital's Medicaid DSH payments during the fiscal year.

UPPER PAYMENT LIMIT SUPPLEMENTAL PAYMENTS FOR INPATIENT HOSPITAL SERVICES AT PRIVATE HOSPITALS

In order to preserve access to inpatient hospital services for needy individuals in the State of Nevada, effective July 1, 2023, the state's Medicaid reimbursement system shall provide for certain upper payment limit (UPL) supplemental payments to all qualifying private hospitals in the State of Nevada. These supplemental payments shall be determined on an annual basis and paid to qualifying private hospitals on a quarterly basis. These supplemental payments are for Medicaid fee-for-service inpatient hospital services. The supplemental payments shall not exceed, when aggregated with other payments made to private hospitals under all other provisions of the state plan, 100% of a reasonable estimate of the amount that would be paid for such services under Medicare payment principles (i.e. the UPL).

1. Eligibility

All private hospitals, excluding critical access hospitals, in the State of Nevada are eligible to receive an Inpatient Hospital UPL supplemental payment.

2. Methodology

For purposes of these supplemental payments, private hospitals are subdivided into the following classes of hospitals:

a. Freestanding psychiatric hospitals
b. Rehabilitation hospitals
c. Long Term Acute Care hospitals (LTACs)
d. Short Term Acute Care hospitals (STACs)
e. Critical Access Hospitals (CAHs)

The annual payment amount for each hospital is calculated as follows:

a. For freestanding psychiatric hospitals, rehabilitation hospitals, and LTACs each hospital will receive a payment equal to its non-negative proportional contribution to the aggregate difference between Medicaid payments paid under all other provisions of the state plan and the UPL for that class of hospitals. CAHs are excluded from the supplemental payment.

b. For STACs, the payment to each hospital will be calculated as follows:

    1. First, the state will calculate the aggregate difference between Medicaid payments paid under all other provisions of the state plan and the UPL for all STACs.
    2. Second, each hospital will receive a share of the amount calculated in 2.b.1. above based on that hospital's proportion of the total fee-for-service paid Medicaid days provided by all STACs during the year used for the UPL demonstration.
    3. If an individual STAC maintains a psychiatric, rehabilitation, or LTAC subprovider, the non-negative amount associated with the subprovider will be added to the individual STAC's payment. Negative amounts associated with such subproviders will be disregarded.

c. If the total calculated amount to be paid to all eligible hospitals exceeds the estimated aggregate UPL margin (after excluding CAHs' UPL margin contributions) the payment to each hospital will be reduced by a proportional amount.

The annual payment amount will be paid in four equal quarterly amounts at the end of each quarter. However, for fiscal year 2024, the payment amount and timing will vary depending on SPA approval.

XVI. INPATIENT HOSPITAL SERVICES REIMBURSEMENT TO INDIAN HEALTH SERVICE AND TRIBAL 638 HEALTH FACILITIES

Effective January 1, 2000, Nevada Medicaid will reimburse Indian Health Services facilities and Tribal 638 facilities for inpatient hospital services a daily rate in accordance with the most recent published Federal Register notice. This rate does not include physician services.

Physician services are reimbursed in accordance with Attachment 4.19-B, Item 5 of the Nevada State Plan.

Citation

42 CFR 447, 434, 438 and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A and Sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A).

_X_ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19-A

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

____ Additional Other Provider-Preventable Conditions identified below *(please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) Nursing Facility Services, 4.19(b) Physician Services)* of the plan:

Methodology for Identifying Provider-Preventable Conditions

Beginning July 1, 2012, Nevada, which pays claims on a per-diem basis, will use two methods to identify PPCs: screening Prior Authorization requests and a retrospective review of claims.

PRIOR AUTHORIZATION (PA)

Prior Authorizations (PAs) will be screened for PPC codes and reviewed by the fiscal agent's medical review staff, which will make determinations for denials of payment for continued stay requests and/or level of care increases if the request appears to be related to a PPC. Payment denial does not consider medical necessity. Providers can appeal a PPC denial utilizing the existing appeals process.

RETROSPECTIVE REVIEW

Prior Authorization

A provider who caused a PPC may be discovered in the process of reviewing a PA request from a second provider from whom the patient seeks treatment. If it is determined in the PA screening that a provider other than the provider requesting the PA may be responsible for causing a PPC, a retrospective review of claims of the provider possibly causing the PPC will be done. Payments associated with treating the PPC will be recovered, from the original provider, if those increases in payments can be reasonably isolated to the PPC event.

Claims Review

Under NRS 449.485 and R151-8 the Nevada Division of Health Care Financing and Policy (DHCFP) and University of Nevada Las Vegas (UNLV) Center for Health Information and Analysis (CHIA) collects and maintains billing record fields for Nevada hospitals and ambulatory surgical centers. This data set captures the Present on Admission (POA) indicator for the UB-04 claims for principal and each secondary (other) diagnosis field. Claims data with dates of service on or after July 1, 2012 will be reviewed and those fitting the criteria for PPCs will be identified. Providers will be supplied information identifying claims with the potential PPCs and will be given 30 days to review and respond to any discrepancies. Provider-confirmed PPCs will be subject to payment adjustment.

Payment Adjustment

For per diem payments, the number of covered days shall be reduced by the number of days associated with any PPC not present on admission. Nevada will use nationally accepted standards to determine the number of days attributable to the diagnosis absent the PPC and the incremental number of days attributable to the PPC. Reimbursement may also be reduced for level of care changes attributable to a PPC.