Revision: HCFA-PM-91-4 (BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: Nevada

Citation
42 CFR
447.252
1902 (a) (13)
and 1923 of
the Act
1902 (e) (7) of
the Act

4.19 Payment for Services

(a) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, and sections 1902(a)(13) and 1923 of the Act with respect to payment for inpatient hospital services.

ATTACHMENT 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services.

___ Inappropriate level of care days are covered and are paid under the State plan at lower rates than other inpatient hospital services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act.

X Inappropriate level of care days are not covered.

Citation
42 CFR 447.201
42 CFR 447.302
52 FR 28648
1902 (a) (13) (E)
1903 (a) (1) and
(n), 1920, and
1926 of the Act

4.19(b) In addition to the services specified in paragraphs 4.19(a), (d), (k), (l), and (m), the Medicaid agency meets the follow requirements.

1. Section 1902 (a) (13) (E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under Section 1905 (a) (2) (C) of the Act. The agency meets the requirements of Section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services.

   ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost or budget reviews, or sample surveys).

2. Sections 1902 (a) (13) (E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan.

   ATTACHMENT 4.19-b describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.

1902 (a) (10) and

SUPPLEMENT 1 to ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for Medicare Part A and B deductible/ coinsurance.

1902 (a) (30) of
the Act

SUPPLEMENT 2 to ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for organ transplant services and out-of-state emergency services and the limitations placed on reimbursement of these services.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

OMB No.: 0938-0193

State/Territory: Nevada

Citation
42 CFR 447.40
AT-78-90

4.19(c) Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

X Yes. The State's policy is described in ATTACHMENT 4.19-C.

___ No.

Revision: HCFA-PM-87-9 (BERC) OMB No.: 0938-0193
AUGUST 1987

State/Territory: Nevada

Citation 4.19(d)

42 CFR 447.252
47 FR 47964
48 FR 56046
42 CFR 447.280
47 FR 31518
52 FR 28141

X (1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for skilled nursing and intermediate care facility services

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for skilled nursing and intermediate care facility services as well as the services covered by those rates.

(2) The Medicaid agency provides payment for routine skilled nursing facility services furnished by a swing-bed hospital.

X At the average rate per patient day paid to SNFs for routine services furnished during the previous calendar year.

___ At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

___ Not applicable. The agency does not provide payment for SNF services to a swing-bed hospital.

(3) The Medicaid agency provides payment for routine intermediate care facility services furnished by a swing-bed hospital.

X At the average rate per patient day paid to ICFs, other than ICFs for the mentally retarded, for routine services furnished during the previous calendar year.

___ At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

___ Not applicable. The agency does not provide payment for ICF services to a swing-bed hospital.

(4) Section 4.19(d)(1) of this plan is not applicable with respect to intermediate care facility services; such services are not provided under this State plan.

Revision: HCFA-AT-80-38 (BPP) OMB No.: 0938-0193
May 22, 1980

State/Territory: Nevada

Citation	
42 CFR 447.45(c) AT-79-50	4.19(e) The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims. ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State/Territory: Nevada

Citation

42 CFR 447.15
AT-78-90
AT-80-34
48 FR 5730

4.19(f) The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15.

No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.

Revision: HCFA-AT-80-38 (BPP) OMB No.: 0938-0193
May 22, 1980

State/Territory: Nevada

Citation	
42 CFR 447.201 42 CFR 447.202 AT-78-90	4.19(g) The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials.

Revision: HCFA-AT-80-60 (BPP) OMB No.: 0938-0193
August 12, 1980

State/Territory: Nevada

Citation	
42 CFR 447.201 42 CFR 447.203 AT-78-90	4.19(h) The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates.

Revision: HCFA-AT-80-38 (BPP) OMB No.: 0938-0193
May 22, 1980

State/Territory: Nevada

Citation	
42 CFR 447.201 42 CFR 447.204 AT-78-90	4.19(i) The Medicaid agency's payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

State/Territory: Nevada

Citation	
42 CFR 447.201 and 447.205	4.19(j) The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.
1903 (v) of the Act	(k) The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act.

Revision: HCFA-PM□92□7 (MB)
October 1992

OMB No.: 0938-0193

State/Territory: Nevada

Citation		
1903(i)(14) of the Act	4.19(1)	The Medicaid agency meets the requirements of section 1903(i)(14) of the Act with respect to payment for physician services furnished to children under 21 and pregnant women. Payment for physician services furnished by a physician to a child or a pregnant woman is made only to physicians who meet one of the requirements listed under this section of the Act.

Citation

4.19(m) Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program

1928(c)(2)(C)(ii) of Act (i) A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928(c)(2)(C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administrated as follows:

(ii) The State:

___ sets a payment rate at the level of the regional maximum established by the DHHS Secretary.

___ is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law.

X sets a payment rate below the level of the regional maximum established by the DHHS Secretary.

___ is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State.

1926 of the Act (iii) Medicaid beneficiary access to immunization is assured through the following methodology:

The Nevada State Health Division is designated as the lead Agency for the Pediatric Immunization Program. As such, the Health Division is responsible for the ordering, storage and shipping of vaccine from the Centers for Disease Control and Prevention as well as for the recruitment, education, and review of immunization practices of providers. The Nevada Medicaid Program (through the Division of Health Care Financing and Policy) reimburses health care professionals who are contracted with the Nevada Medicaid Program for the administration of immunizations provided to Medicaid eligible individuals.

The Division of Health Care Financing and Policy (Nevada Medicaid Program) and the Nevada State Health Division are sister agencies. Nevada Medicaid staff collaborate with the Health Division and staff of the District Offices to provide outreach regarding immunizations.

Nevada Medicaid Program Managed Care Organizations (MCO) require network providers to enroll in the Vaccines for Children (VFC) Program and to work with the Health Division regarding immunizations.

ASSURANCES

All general rates described in Attachment 4.19 may be accessed at:

http://dhcfp.nv.gov/RatesUnit.htm

PAYMENT FOR INPATIENT HOSPITAL SERVICES
ASSURANCES AND RELATED INFORMATION

A. State Assurances and Findings. The State assures that it has made the following findings:

1. 447.253(b)(1)(i) - The State pays for inpatient hospital services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

2. With respect to inpatient hospital services

   a. 447.253(b)(1)(ii)(B) - The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs.

   b. 447.253(b)(1)(ii)(B) - The State elects in its State Plan to cover inappropriate level of care services (that is, services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing services or intermediate care services) under conditions similar to those described in section 1861 (v)(1)(G) of the Act. The methods and standards used to determine payment rates specify that the payments for this type of care must be made at rates lower than those for inpatient hospital level of care services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act.

   c. 447.253(b)(1)(ii)(C) - The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

3. 447.253(b)(2) - The proposed rate will not exceed the upper payment limits as specified in 42 CFR 447.272:

   a. 447.272(a) - Aggregate payments made to hospitals for inpatient services when considered separately, will not exceed the amount that can reasonably be estimated would have been paid for under Medicare Payment principles.

   b. 447.272(b) - Aggregate payments to State-operated hospitals for inpatient services when considered separately will not exceed the amount that can reasonably be estimated would have been paid for under Medicare payment principles.

c. 447.272(c) B Aggregate disproportionate share hospital (DSH) payments do not exceed the DSH payment limits at 42 CFR 447.296 through 447.299.

d. OBRA 93 B DSH payments to each hospital, including those owned or operated by the state or an instrumentality or unit of government within the state, beginning in SFY 1996, are limited to 100% of uncompensated costs.

B. State Assurances. The State makes the following additional assurances:

1. For hospitals --

a. 447.253(c) - In determining payment when there has been a sale or transfer of the assets of a hospital, the State's methods and standards provide that payment rates can reasonably be expected not to increase in the aggregate solely as a result of changes of ownership, more than payments would increase under Medicare under 42 CFR 413,130, 414.134, 413.153 and 413.157 insofar as these sections affect payment for depreciation, interest on capital indebtedness, return on equity (if applicable), acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation.

2. 447.253(e) - The State provides for an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the State determines appropriate, of payment rates.

3. 447.253(f) - The State requires the filing of uniform cost reports by each participating provider.

4. 447.253(g) - The State provides for periodic audits of the financial and statistical records of participating providers.

5. 447.253(h) The State has complied with the public notice requirements of 42 CFR 447.205. Notice published on N/A (Amendment not significant).

6. 447.253(i) - The State pays for inpatient hospital services using rates determined in accordance with the methods and standards specified in the approved state plan.

C. Related Information

1. a. 447.255(a) - Inpatient hospital:

Estimated average proposed payment rate as a result of this amendment: $1,067

Estimated payment rate in effect for the immediately preceding rate period: $1,067

Amount of change: 0 Percent of change: 0%

b. 447.255(a) - DSH:

Estimated proposed payment per Medicaid day as a result of this amendment: $576.02

Estimated payment per Medicaid day for the immediately preceding rate period: $576.02

Amount of change: 0 Percent of change: 0%

Nevada=s aggregate DSH payment for this year and the immediately preceding year is $73,560,000. The DSH program this year is based on uncompensated costs for the majority of the hospitals, and not on Medicaid utilization. The amendment to the DSH methodology will have no effect on the payment per day.

2. 447.255(b) - The estimated short term and long term effect of the change in the estimated average rate on:

a. The availability of services on a statewide and geographic area basis: NONE

b. The type of care furnished: NONE

c. The extent of provider participation: NONE

d. The degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs.

The change in the disproportionate share program will restrict payment to those hospitals that specialize in providing mental health services to low income patients. Since payments to such specialized hospitals was minimal there is no indication that this change will limit provider participation, type of care provided or availability of services. In aggregate, none of the remaining hospitals will receive less and some will receive more as a result of the proposed change.

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.

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:

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

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.

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.

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.

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 6/30/13 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.

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

A. Inpatient hospital services which have been certified for payment at the acute level by the QIO-like vendor, as specified in the contract between the QIO-like vendor and Nevada Medicaid, upon final settlement are reimbursed allowable costs under hospital-specific retrospective Medicare principles of reimbursement in accordance with 42 CFR 413 and further described in CMS Publications 15-I and 15-II.

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

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

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

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

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

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

2. The CAH Medical/Surgery interim rate will be updated annually for each provider on either January 1st or July 1st, depending upon the facilities' fiscal year as reported on the Medicare/Medicaid cost report. The annual rate is not to exceed 150% or decrease more than 25% from the facilities' prior year interim rate.

3. The updated CAH Medical/Surgery interim rate will be calculated by dividing the total Title XIX program inpatient costs by the total program inpatient days as reported in the latest available as-filed or latest available audited Medicare/Medicaid cost report.

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

5. Maternity, newborn, Psychiatric/Substance Abuse and administrative days will be reimbursed at the rate paid to general acute care hospitals for the same in-patient services.

6. Critical Access Hospitals that do not have a CAH Medical/Surgery interim rate for the prior year based on the methodology in Paragraph VII.B.3, will be assigned either the prior years' Total Medicare inpatient per diem rate if available or the rate paid to general acute care hospitals for the same Medical/Surgery level of services until such time as the CAH Medical/Surgery interim rate can be updated according to the methodology detailed in Paragraphs VII.B.2 and VII.B.3.

Facilities accredited as Residential Treatment Centers by the Joint Commission on Accreditation of Health Organization (JCAHO) are not considered specialty or general acute hospitals. Residential Treatment Centers are paid in accordance with paragraph VI above.

III. 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 one percent;

ii. have at least two (2) 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: 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 87.97% of the total computable DSH allotment 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 1.69% of the total computable DSH allotment 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 5.86% of the total computable DSH allotment 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 1.34% of the total computable DSH allotment 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 3.14% of the total computable DSH allotment 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. 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 the same period of data as outlined on subparagraph A 1, the Division will calculate the DSH payments for each hospital as follows:

a. 50% 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 monthly 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 subparagraph 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 percent 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 percent 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 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.

   The state shall determine the annual supplemental amount payable to hospitals prospectively for period that will begin each July 1. On a quarterly basis, hospitals will receive a supplemental payment equal to twenty-five percent (25%) of the annually determined supplemental amount. A quarterly payment will be made in each calendar quarter during the state's fiscal year. 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.

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 July 1, 2017 to June 30, 2018 the total computable payment will be $87,233,867.32.

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 July 1, 2017 to June 30, 2018 will be accounted for in the UPL room available for July 1, 2017 to June 30, 2018.

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 (2) 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 three percent (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 (25%) 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 7/1/2015: 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.

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.

PAYMENT FOR MEDICAL CARE AND SERVICES

1. This paragraph intentionally left blank.
2. Outpatient Hospital
   a. Payments for services billed by Outpatient Hospitals using Current Procedural Terminology (CPT) codes will be calculated using the January 1, 2014 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:
      i. Surgical codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 90% of the Medicare facility rate.
      ii. Radiology codes 70000 – 79999 will be reimbursed at 100% of the Medicare facility rate.
      iii. Effective February 15, 2012, Radiopharmaceutical and Contrast codes will be reimbursed at the 2012 Medicare Mean Unit Cost plus 5%.
      iv. Medicine codes 90000 – 99199 will be reimbursed at 85% of the Medicare facility rate.
      v. Vaccine Products require a National Drug Code (NDC) and will be reimbursed according to the drug reimbursement algorithm set forth on page 3 of Attachment 4.19-B.
      vi. Evaluation and Management codes 99201 – 99499 will be reimbursed at 90% of the Medicare facility rate.
      vii. Obstetrical service codes 59000 – 59999 will be reimbursed at 90% of the Medicare facility rate.
      viii. Anesthesia codes 00100 – 01999 will be reimbursed based on the Centers for Medicare and Medicaid Services (CMS) 2009 base units for anesthesia. Payment is determined by adding the base units plus time units and multiplying the result by the CMS 2013 anesthesia conversion factor of $22.57. Anesthesia codes 01967 – 01969 are occurrence based codes that are paid a flat rate. Anesthesia codes 99100 – 99140 are not covered.
      ix. Prescribed drugs (page 3, paragraph 12a).
      x. Outpatient laboratory and pathology services (page 1a, paragraph 3).
      xi. Dental services (CDT codes, page 2c, paragraph 10).
      xii. Durable medical equipment; prosthetics and orthotics (page 2, paragraph 7c); and disposable supplies (page 2, paragraph 7d).

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

   b. (This paragraph intentionally left blank.)

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

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

Prospective Payment System (PPS) Reimbursement for Existing Facilities

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

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

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

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

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

Prospective Payment System (PPS)-Service Specific Reimbursement for New Facilities

Newly qualified FQHCs/RHCs after Federal fiscal year 2012 will have initial payments (interim Service Specific PPS (SSPPS) rates) established either by reference to payments to one or more other clinics in the same or adjacent areas with similar caseloads and/or similar scope of services or based on an average of rates for other FQHC/RHC clinics throughout the State.

Once their average per visit reasonable costs of providing Medicaid-covered services based on their first full year of operation can be determined, the initial interim SSPPS payments of the FQHC/RHC will be cost settled and any over or under payments will be reconciled and the SSPPS rate will then be established based on the actual cost to provide those services for their first full year. The per visit SSPPS rate(s) will then be adjusted annually every October 1st beginning at the next federal fiscal year by the percentage change in the Medicare Economic Index (MEI) for primary care services as defined in Section 1842 (i) (3) of the Social Security Act, for that calendar year as published in the Federal Register. The MEI adjustment is the mechanism used to account for the basic cost increases associated with providing such services. All required documentation of actual costs for the first full year of providing services must be furnished to the DHCFP no later than six months after completion of the first full year of services. If the required documentation is not received within six months after the completion of a full year of services, the annual MEI adjustments will be suspended until such time as the documentation is received and an actual SSPPS rate is determined.

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

Alternative Payment Methodology (APM) Reimbursement

For any fiscal year after FY 2002, a State may use an APM methodology other than the Medicaid PPS, but only if the following statutory requirements are met. First, the APM must be agreed to by the State and by each individual FQHC/RHC to which the State wishes to apply the methodology. Second, the methodology must result in a payment to the center or clinic that is a least equal to the amount to which the center or clinic is entitled under the Medicaid PPS. Third, the methodology must be described in the approved State plan.

Service Specific APM (SSAPM) rates are based on the specific service type being provided. SSAPM rates are set at 100 percent of the average of an FQHC/RHC per visit rate based on the reported reasonable and allowable costs of providing Medicaid-covered services during the time period under review (calculating the payment amount on a per visit basis per service type). For FQHCs that have separate service specific APM rates established, the DHCFP will allow reimbursement for up to three (or two) SSAPM encounters/visits per patient per day for the different service types: one medical, one behavioral health and one dental.

Effective October 1st (FFY) of each year after an SSAPM rate has been established, for services

furnished on or after that date, the DHCFP will adjust the SSAPM rate by the percentage increase in the MEI applicable to primary care services as published in the Federal Register for that calendar year, which will account for basic cost increases associated with providing such services.

APM to Reflect Other Payment Adjustments

FQHC/RHC's may request an APM to reflect other payment adjustments in the event of extraordinary circumstances, not otherwise reimbursed by other sources, including but not limited to acts of God; acts of nature; acts of terrorism and acts of war. However, if an FQHC/RHC's existing PPS/SSPPS/SSAPM rate is sufficient to cover its overall costs, including those associated with the extraordinary circumstances, other payment adjustment is not warranted. The FQHC/RHC must show that its PPS/SSPPS/SSAPM rate is not sufficient to cover the costs associated with the extraordinary circumstance. The adjusted rate will only apply to the extent, and only for the period of time, that the additional costs for the event are reimbursable under federal Medicaid law and regulations governing claims for federal financial participation (FMAP). The DHCFP will work with the provider to gather the appropriate data at the time the incident occurs and a written request for a rate adjustment is made by the Provider.

Change in Scope of Services

PPS/SSPPS/SSAPM rates may be adjusted to take into account any requested, documented and approved increase (or decrease) in the scope of services furnished by the FQHC/RHC in any given fiscal year. The FQHC/RHC must submit a written request detailing the change in scope of services to the Division within 60 days of the effective date of those changes in order for the rate adjustment to be retroactive to the date of the Change in Scope of Services. If a written request is not received within 60 days of those changes, the effective date for a rate adjustment will be the date the written request for a Change in Scope of Services was received by the DHCFP. Documentation and notification to support an increase or decrease in the scope of services is the responsibility of the provider and must specify all the changes up for review.

An FQHC/RHC requesting a rate adjustment for changes in scope of services must submit data/documentation/schedules that substantiate the changes in scope and the related adjustment of reasonable costs following Medicare principals of reimbursement.

An interim rate will be determined using the first three months of actual cost data available from the provider. After a full year of providing the services related to the change in scope, an analysis will be performed on the actual costs for a full year of service and an adjustment will be made to the PPS/SSPPS/SSAPM. Adjustments to the PPS/SSPPS/SSAPM rate for qualified/approved changes in scope will be based on Medicare Cost Reimbursement methodology, allocating costs related to patient care based upon a providers audited and approved costs for the change in scope services. The PPS/SSPPS/SSAPM rate adjustment will then be determined by dividing the approved allocated costs by the number of approved total visits for the given time period.

A Change in Scope of Services has been defined as a change in the type, intensity, duration and/or amount of any service that meets the definition of FQHC/RHC services as defined in section 1905 (a) (2) (B) and (C) of the Social Security Act; and the service is included as a covered Medicaid service under the Medicaid state plan. General increases or decreases in costs associated with programs that were already a part of an established PPS/SSPPS/SSAPM rate do NOT constitute a Change in Scope. A Change in Scope must meet all of the following requirements:

- The change in the scope of services is a change in the type, intensity, duration, or amount of services, or any combination thereof as defined in section 1905 (a) (2) (B) and (C) of the Social Security Act.

- The cost is allowable under Medicare reasonable cost principals set forth in 45 CFR Part 75 Uniform Administrative Requirements, Cost Principles and Audit Requirements for HHS Awards and /or 42CFR Part 413 Principles of Reasonable Cost Reimbursement.

- The net change in the FQHC/RHC's per visit PPS/SSPPS/APM rate must equal or exceed 4% for the affected FQHC/RHC site(s). For FQHC/RHC's that filed consolidated cost reports for multiple sites to establish the initial Prospective Payment reimbursement rate (PPS), the 4% threshold will be applied to the average per visit rate (medical, dental and mental health) of all sites that provide the specific service for the purposes of calculating the cost associated with a scope of service change. "Net change" means the per visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year for the specific service type.

A Change in Scope of Services includes any of the following:

- A change in the types of services offered, i.e., the addition of dental services, may qualify as a Change in Scope which may warrant an adjustment to the PPS/SSPPS/SSAPM rate or the establishment of a new PPS/SSPPS/SSAPM rate.

- A change in intensity/duration or character of services offered by an FQHC/RHC attributable to changes in the types of patients served may qualify, such as services to patients with HIV/AIDS or other chronic diseases and other special populations requiring more intensive and frequent care.

- A change in the magnitude, intensity or character of currently offered services, demonstrated and documented by an increase or decrease in the patient volume of certain high risk populations that require more intensive and frequent care, which may reasonably be expected to span at least one year may qualify.

- A change in the type, intensity, duration or amount of service caused by changes in technology and medical practice used may qualify.

If a Change in Scope rate increase request is denied, the provider may request a formal rate appeal from the DHCFP. Rate appeal procedures are defined in the Medicaid Service Manual (MSM) Chapter 700.

Definition of a "Visit"/"Encounter"

A "visit" or an "encounter" for the purposes of reimbursing FQHC/RHC services is defined as face-to-face contact with one or more qualified health professionals and multiple contacts with the same health professional that take place on the same day with the same patient for the same service type.

Qualified Health Professional

To be eligible for PPS/SSPPS/SSAPM reimbursement, services must be delivered exclusively by one or more of the following licensed Qualified Health Professionals or a provider working under his or her direct supervision: Physician, Osteopath, Podiatrist, Physician's Assistant, Advanced Practice Registered Nurse, Certified Nurse Midwife, Clinical Psychologist, Clinical Social Worker, Dentist or Dental Hygienist and other Medicaid Qualified Providers.

Documentation Required to Support a Request for Change in Scope of Services

- Year End Payroll Reports for identified time periods
- Trial Balances for all Revenues and Expenses for identified time periods
- Grouping Schedule/Mapping of Trial Balance Accounts to the Cost Reports
- Detailed General Ledger with Vendor Information for identified time periods
- Claims reports showing Unique Patient Visits, DOS, Procedure Codes, Service Facility ID#, Amount Paid and Payer
- Other Items as Deemed Necessary

Record keeping and Audit

All participating FQHC/RHC's shall maintain an accounting system which identifies costs in a manner that conforms to generally accepted accounting principles and must maintain documentation sufficient to support all cost/visit data.

The DHCFP, its fiscal agent or a designated and contracted financial entity may conduct periodic on-site or desk audits of all cost data, including financial and statistical records of the FQHCs/RHCs.

FQHCs/RHCs must submit information (statistics, costs and financial data or other data) as deemed necessary by the DHCFP or its fiscal agent. Failure to submit requested documentation may result in denial of a rate adjustment request.

The DHCFP will conduct one audit annually (at a minimum) to the claims submitted by the FQHC/RHC for supplemental payments.

Supplemental Payments for FQHCs/RHCs Enrolled with a Managed Care Entity (MCE)

FQHCs/RHCs that provide services under a contract with a Medicaid Managed Care Entity (MCE) will receive quarterly or monthly (as agreed upon between the provider and the state) supplemental payments for furnishing such services, that are a calculation of the difference between the payments the FQHC/RHC receives from the MCE(s) for all qualified Medicaid FQHC/RHC visits and the payments the FQHC/RHC would have received under the PPS/SSPPS or SSAPM methodology.

At the end of each payment period, the total amount of MCE payments received by the FQHC/RHC will be reviewed against the amount that the actual number of visits provided under the FQHC's/RHC's contract with MCE(s) would have yielded under the PPS/SSPPS/SSAPM methodology. If the amount exceeds the total amount of MCE payments, the FQHC/RHC will be paid the difference, if the amount is less, the FQHC/RHC will refund the difference to the DHCFP. The FQHC/RHCs must provide sufficient documentation (as requested) to the DHCFP to facilitate supplemental payment calculations. If the required documentation is not provided to support the supplemental payment, future supplemental payments may be suspended.

Documentation Required to Calculate/Support Supplemental Payments

The FQHC/RHC will submit an electronic request for supplemental payment which will contain at least the following information for each line item of every qualified encounter during the reporting time period (Quarterly or Monthly): Medicaid Billing Provider ID#, Recipient MCE ID Number, Recipient Medicaid ID Number, Date of Service, Procedure Code(s), MCE Name, Total Billed Amount, MCE Paid Amount, Other Paid Amount, Total Amount Paid and Recipient Date of Birth.

The FQHC/RHC will submit claim data for supplemental payment no later than thirty days after the end of the reporting period agreed upon with the DHCFP (Quarterly or Monthly).

Any discrepancy found in the audits will be adjusted based on the audit findings.

3. Laboratory and pathology services deemed to be Nevada Medicaid covered benefits will be paid at:

a. For codes 80000 - 89999, the lower of billed charges not to exceed 50% of the rate allowed by the 2014 Medicare Clinical Diagnostic Laboratory Fee Schedule for Nevada;

b. Allowed laboratory and pathology codes/services outside of the ranges listed in 3.1 and 3.2 or not listed in the Medicare Clinical Diagnostic Laboratory Fee Schedule for Nevada will be paid in accordance with other sections of this State Plan based on rendering provider type;

b. For "BR" (by report) and "RNE" (relativity not established) codes that fall within the code range 80000 - 89999, the payment will be set at 62% of billed charges; or

c. Contracted or negotiated amount.

4. EPSDT and Family Planning

I. Early and periodic screening, diagnosis and treatment (EPSDT) services will be reimbursed the lower of a) billed charge, or b) fixed fee per unit as indicated for specific services listed elsewhere in this attachment.

A. School Based Child Health Services (SBCHS) delivered by school districts and provided to children with disabilities in accordance with the Individuals with Disabilities Act (IDEA). Services include:

1. Physician's services,
2. Physician's assistant services,
3. Nursing services including registered nurses, licensed practical nurses and advanced nurse practitioners,
4. Psychological services,
5. Physical therapy services,
6. Speech therapy, language disorders and audiology services,
7. Occupational therapy services, and
8. Medical supplies, equipment and appliance services – Assistive Communication Devices, audiological supplies and other Durable Medical Equipment (DME).

B. SBCHS – Reimbursement Methodology

SBCHS described in Attachment 3.1-A, Page 2a-2h of the Nevada State Plan and provided by an enrolled school district are reimbursed the lower of: a) billed charges; or b) a fixed fee schedule.

A fixed fee schedule: as indicated for specific services listed elsewhere in this attachment e.g., psychologist services, nursing services, and therapy services. All rates are published on the agency's website:
http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

The Agency's rates are set as of July 1, 2009 and are effective for services on or after July 1, 2009.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of SBCHS and the fee schedule and any annual/periodic adjustments to the fee schedule are published on the agency's website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

C. Intensive Behavior Intervention services as stated in Nevada State Plan Attachment 3.1-A, Intensive Behavior Intervention.

Intensive Behavior Intervention Services (IBI) Reimbursement Methodology

IBI Services described in Attachment 3.1-A, Page 2i-2k of the Nevada State Plan and provided by an enrolled qualified medical professional according to IBI requirements listed in Attachment 3.1-A, Pages 2j and 2k, are reimbursed the lower of: a) billed charges; or b) a fixed fee schedule.

A fixed fee schedule: as indicated for specific services listed elsewhere in this attachment e.g., Intensive Behavior Intervention. All rates are published on the agency's website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

The Agency's rates are set as of January 1, 2016 and are effective for services on or after January 1, 2016.

Payments for services billed by IBI Qualified Medical Professionals will be reimbursed based on provider qualifications and procedure codes.

i. Nevada Licensed Physician (MD) or Board Certified Behavior Analyst (BCBA) or Psychologist with a specialty in Behavior Intervention (PhD) will be reimbursed at 65% of Medicare rates as published in the Federal Register on July 14, 2014. 42 CFR 411, 412, 416, *et al.*

ii. Board Certified Assistant Behavior Analyst (BCaBA) will be reimbursed at 60% of the IBI Physician rate as shown above in (i).

iii. Registered Behavioral Technicians (RBT) rate methodology:

a. The rates are based on several factors used to determine the cost associated with performing the applicable services. This model was developed to reflect provider requirements, operational service delivery, recruitment, credentialing, ongoing training/certification and administrative considerations. The following elements were used to determine the rates:

1. Wage Information – The wage is based on similarly qualified occupations (required education and training) identified by Medicaid staff as comparable.

2. Employee Related Expenses (ERE) – ERE includes paid vacation, sick leave, holiday, health/life insurance, disability, worker's compensation, payroll taxes, Medicare and Federal Income taxes.

3. Productivity Adjustment Factor – Costs include non-billable services that are required for normal business operations such as staff meetings, personnel requirements, travel time and mileage. This also includes non-billable time spent by staff to include required case documentation and record keeping and time associated with missed/cancelled appointments.

4. Allowances for Supervisory Time – Costs for the time spent supervising the field staff, which is not reimbursable under separate billing codes, as required by regulations.

5. Certification/Training Expenses – Costs include initial and ongoing certification and training costs required to maintain provider qualifications.

6. Administrative Overhead (10% Cap) – This includes costs associated with non-direct care activities required for normal business operations, such as building rent/utility costs, program support staff and office supplies, etc.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for governmental and private providers of Intensive Behavior Intervention (IBI) services and the related fee schedule is published on the agency's website:
http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/.

II. Family planning services and supplies: as indicated for specific services listed elsewhere in this attachment, e.g., physician services, prescribed drugs

5. Payments for services billed by Physicians using Current Procedural Terminology (CPT) codes will be calculated using the January 1, 2014 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:

   a. Surgical codes 10000 – 58999 and 60000 - 69999 will be reimbursed at 95% of the Medicare facility rate.

      1. Pediatric enhancement for recipients under the age of 21 will be the lesser of billed charges or 115% of the currently established Medicare Facility rates for respiratory, cardiovascular, hemic, lymphatic, mediastinum and diaphragm related surgical codes (30000-39999)

   b. Radiology codes 70000 – 79999 will be reimbursed at 100% of the Medicare facility rate. Effective February 15, 2012, Radiopharmaceutical and Contrast codes will be reimbursed at the 2012 Medicare Mean Unit Cost plus 5%.

   c. Medicine codes 90000 – 99199 will be reimbursed at 85% of the Medicare non-facility rate.

   d. Evaluation and Management codes 99201 – 99499 will be reimbursed at 90% of the Medicare non-facility rate effective July 1, 2015 through June 30, 2016. Effective July 1, 2016 Evaluation and Management codes 99201 – 99499 will be reimbursed at 95% of the Medicaid non-facility rate.

   e. Obstetrical service codes 59000 – 59999 will be reimbursed at 95% of the Medicare non-facility rate.

   f. Anesthesia codes 00100 – 01999 will be reimbursed based on the Centers for Medicare and Medicaid Services (CMS) 2009 base units for anesthesia. Payment is determined by adding the base units plus time units and multiplying the result by the CMS 2013 anesthesia conversion factor of $22.57. Anesthesia codes 01967 – 01969 are occurrence based codes that are paid a flat rate. Anesthesia codes 99100 – 99140 are not covered.

   g. Medicine codes 90281-90399, and all other pharmaceuticals that are not identified above, will be reimbursed according to the drug reimbursement algorithm set forth on page 3 of Attachment 4.19-B.

   Assurance: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both public and private providers of the service. The agency's physician fee schedule rates were set as of July 1, 2015 and are effective for services provided on or after that date. All rates are published on our website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/.

6. Medical care and any other type of remedial care provided by licensed practitioners:

a. Payment for services billed by a Podiatrist will be calculated using the January 1, 2014 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amount specified below:
   1. Surgical codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 75% of the Medicare facility rate.
   2. Radiology codes 70000 – 79999 will be reimbursed at 100% of the Medicare facility rate.
   3. Medicine codes 90000 – 99199 will be reimbursed at 85% of the Medicare non-facility rate.
   4. Vaccine Products require a National Drug Code (NDC) and will be reimbursed according to the drug reimbursement algorithm set forth on page 3 of Attachment 4.19-B.
   5. Evaluation and Management codes 99201 – 99499 will be reimbursed at 90% of the Medicare non-facility rate.

b. Payment for services billed by an Optometrist will be calculated using the January 1, 2014 unit values for the Nevada-specific RBRVS and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amount specified below:
   1. Surgical codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 75% of the Medicare non-facility rate.
   2. Radiology codes 70000 – 79999 will be reimbursed at 100% of the Medicare facility rate.
   3. Medicine codes 90000 – 99199 and Evaluation and Management codes 99201 – 99499 will be reimbursed at 90% of the Medicare non-facility rate. See also Page 3a, 12.d.

c. Payment for services billed by a Chiropractor will be calculated using the January 1, 2014 unit values for the Nevada-specific RBRVS and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amount specified below:
   1. Radiology codes 70000 – 79999 will be reimbursed at 100% of the Medicare facility rate.
   2. Medicine codes 90000 – 99199 will be reimbursed at 85% of the Medicare non-facility rate.
   3. Evaluation and Management codes 99201 – 99499 will be reimbursed at 90% of the Medicare non-facility rate.

d. Payment for services billed by an Advanced Practitioner of Nursing/Physician Assistant/Nurse-Midwife will be calculated using the January 1, 2014 unit values for the Nevada specific resource based relative value scale (RBRVS) and the 2014 Medicare Physicians Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:

1. Surgical codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 59% of the Medicare facility rate.
2. Radiology codes 70000 – 79999 will be reimbursed at 75% of the Medicare facility rate.
3. Medicine codes 90000 – 99199 and Evaluation and Management codes 99201 – 99499 will be reimbursed at 63% of the Medicare non-facility rate.
4. Obstetrical service codes 59000 – 59999 will be reimbursed at 75% of the Medicare non-facility rate.

e. Payment for community paramedicine services will be calculated using the January 1, 2014 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges or the amounts specified below:

1. Anesthesia codes 00100 – 01999 will be reimbursed based on the Centers for Medicare and Medicaid Services (CMS) 2009 base units for anesthesia. Payment is determined by adding the base units plus time units and multiplying the result by the CMS 2013 anesthesia conversion factor of $22.57. Anesthesia codes 01967 – 01969 are occurrence based codes that are paid a flat rate. Anesthesia codes 99100 – 99140 are not covered.
2. Surgical codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 59% of the Medicare facility rate.
3. Medicine codes 90000 – 99199 and Evaluation and Management codes 99201 – 99499 will be reimbursed at 63% of the Medicare non-facility rate.
4. Vaccine Products require a National Drug Code (NDC) and will be reimbursed according to the drug reimbursement algorithm set forth on page 3 of Attachment 4.19-B.

f. Payment for services billed by a Psychologist will be calculated using the January 1, 2014 unit values for the Nevada-specific RBRVS and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:

1. Medicine codes 90000 – 99199 will be reimbursed at 85% of the Medicare non-facility based rate.
2. Vaccine Products require a NDC and will be reimbursed according to the drug reimbursement algorithm set forth on page 3 of Attachment 4.19-B.
3. Evaluation and Management codes 99201 – 99499 will be reimbursed at 90% of the Medicare non-facility based rate.

Assurance: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both public and private providers of the service. The agency's Advanced Practitioner of Nursing/Physician Assistant/Nurse-Midwife fee schedule rates were set as of July 1, 2015 and are effective for services provided on or after that date. Podiatrist, Optometrist, Chiropractor, Nurse Anesthetist and Psychologist fee schedule rates were set as of January 1, 2017 and are effective for services provided on or after that date. All rates are published on our website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/.

7. Telehealth Services

Telehealth is the delivery of services from a provider of health care to a patient at a different location, through the use of information and audio-visual communication technology, not including standard telephone, facsimile or electronic mail.

a. The originating site provider will be paid a telehealth originating site facility fee per completed transmission. Payment for an originating site facility fee will be reimbursed at the rate established in the CY 2012 Medicare Physician Fee Schedule.

b. The distant site provider is paid the current applicable Nevada Medicaid fee for the telehealth service provided. Instructions for submitting billing claims may be found on the Nevada Medicaid website: https://www.medicaid.nv.gov/providers/BillingInfo.aspx.

c. A provider will not be eligible for payment as both the originating and distant site for the same patient, same date of service.

d. Fee schedule rates are the same for both governmental and private providers. The Nevada Medicaid fee schedules may be found on the following website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/.

7. Home Health Care Services:

a. Home health care services include the following services and items:
   1. physical therapy – 1 unit per 15 minutes,
   2. occupational therapy – 1 unit per 15 minutes,
   3. speech therapy – 1 unit per 15 minutes,
   4. family planning education – 1 unit per visit,
   5. skilled nursing services (RN/LPN visits) 1 unit per 60 minutes or 1 unit per 15 minutes for brief visits or 1 unit per 15 minutes for extended visits (after 1st hour),
   6. home health aide services – 1 unit per 60 minutes or 1 unit per 30 minutes for extended visits (after 1st hour),
   7. durable medical equipment, prosthetics, orthotics, and
   8. disposable medical supplies.

b. Reimbursements for Home Health Care services, listed above in a.1. through a.6, provided by Home Health Agencies (HHA) are the lower of a) billed charges, or b) a fixed fee schedule which includes the rate for each of the home health services and a rate for "mileage" as an add-on. The agency's rates were set as of July 1, 2016 and are effective for services on or after that date. All rates can be found on the official Web site of the Division of Health Care Financing and Policy at http://dhcfp.nv.gov/Resources/Rates/

   Effective July 1, 2016, pediatric enhancement rates do not apply for services listed above in a.5.

c. Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

   1. Reimbursement for purchase of DMEPOS is the lower of: a) usual and customary charge, or b) a fixed fee schedule.
   2. Reimbursement for rental of DMEPOS is the lower of: a) usual and customary charge, or b) a fixed fee schedule.

   Payments for DMEPOS will be calculated using the 2016 Nevada-specific non-rural fee schedule issued by the Centers for Medicare and Medicaid Services (CMS). Reimbursement will be set at 100% of the Nevada-specific rates.

d. Disposable supplies:

   1. If a supply item is billed through point of sale (POS), using a National Drug Code (NDC) number, reimbursement is the lower of: a) usual and customary charge, or b) gross amount due or c) Wholesale Acquisition Cost (WAC) + 8% as indicated on the current national drug data base utilized in Point-of-Sale plus a handling fee. For drugs without a WAC acquisition cost will be reimbursed plus a handling fee.

   2. All other supplies billed outside POS, using Healthcare Common Procedure Coding System (HCPCS) codes and/or Current Procedural Terminology (CPT) codes are reimbursed the lower of: a) billed charge, or b) fixed fee schedule. The Agency's rates were set as of January 1, 2017 and are effective for services on or after January 1, 2017.

Assurance: State developed fee schedule rates are the same for both public and private providers of the service and the fee schedule and any annual/periodic adjustments to the fee schedule(s) are published on our website: http://www.dhcfp.nv.gov.

8. Private duty nursing services: lower of a) billed charges, or b) fixed fee schedule. The Agency's rates were set as of July 1, 2000 and are effective for services on or after July 1, 2000.

Assurance: State developed fee schedule rates are the same for both public and private providers of the service and the fee schedule and any annual/periodic adjustments to the fee schedule(s) are published on our website: http://www.dhcfp.nv.gov.

9. Special clinic services: as indicated for specific services listed elsewhere in this attachment, e.g., physicians' services, prescribed drugs, therapy. Payment will be the lower of billed charges, or the amounts specified below:
   a. Surgical codes will be reimbursed at 69% of the Medicare facility rate.
   b. Radiology codes will be reimbursed at 100% of the Medicare facility rate.
   c. Medicine codes and Evaluation and Management codes will be reimbursed at 60% of the Medicare non-facility rate. Vaccine Products will be reimbursed at 85% of the Medicare non-facility rate.
   d. When codes 90465 – 90468, 90471 – 90474, 99381 – 99385 and 99391 – 99395 are used for EPSDT services, the reimbursement will be 85% of the Medicare non-facility rate.
   e. Obstetrical service codes will be reimbursed at 88% of the Medicare non-facility rate.
   f. Medicine codes 90281 – 90399, and all other pharmaceuticals that are not identified above, will be reimbursed according to the drug reimbursement algorithm set forth on page 3 of Attachment 4.19-B with the exception of the pharmacy dispensing fee component of the algorithm.
   g. Freestanding Obstetrical/Birth Centers will be reimbursed an all-inclusive (one time) rate for Procedure code 59409 that shall not exceed 80% of the Hospital In-patient Maternity daily rate. The rate will be reviewed and updated annually as necessary at the FFY (Oct. – Sept.).

Assurance: State developed fee schedule rates are the same for both public and private providers of the service and the fee schedule and any annual/periodic adjustments to the fee schedule(s) are published on our website: http://dhcfp.nv.gov/.

Dental services:

I. STANDARD DENTAL SERVICES

Current Dental Terminology (CDT) codes will be reimbursed based on the base units in the "Relative Values for Dentists" publication by Relative Value Studies; Incorporated for the year the specific CDT code was set in the system. Effective July 1, 2013, payment is determined by multiplying the base units by the conversion factor of $20.50.

II. MEDICAL/SURGICAL PROCEDURES RELATED TO DENTAL SERVICES

Services billed using Current Procedure Terminology (CPT) codes will be calculated using unit values for the Nevada-specific resource based relative value scale (RBRVS) for the year that the specific CPT code was set in the system and the 2002 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:

a. Surgical codes 10000 – 58999 and 60000 - 69999 will be reimbursed at 100% of the Medicare facility rate.
b. Radiology codes 70000 – 79999 will be reimbursed at 100% of the Medicare facility rate.
c. Evaluation and Management codes 99201 – 99499 will be reimbursed at 85% of the Medicare non-facility rate.

Assurance: State developed fee schedule rates are the same for both public and private providers of the service and the fee schedule and any annual/periodic adjustments to the fee schedule(s) are published on our website: http://dhcfp.nv.gov/.

11. Physical therapy, occupational therapy, respiratory therapy and audiology services for individuals with speech, hearing and language disorders will be reimbursed the lower of a) billed charges, or b) fee schedule rate which is 77% of the Medicare non-facility rate. The Medicare non-facility rate is calculated using the January 1, 2014 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2014 Medicare Physician Fee Schedule conversion factor.

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

12. a. Nevada Medicaid will meet all reporting and provision of information requirements of section 1927(b)(2) and the requirements of subsections (d) and (g) of section 1927.

The State assures that the State will not provide reimbursement for an innovator multi-source drug, subject to the Federal Upper Limits (42 CFR 447.332(a)), if, under applicable State law, a less expensive non-innovator multi-source drug could have been dispensed.

1. Payment for multi-source drugs shall be the lowest of (a) Federal Upper Limit (FUL) as established by the Centers for Medicare and Medicaid Services (CMS) for listed multi-source drugs plus a professional dispensing fee of $10.17 per prescription; (b) State Maximum Allowable Cost (MAC) plus a professional dispensing fee of $10.17 per prescription; (c) Actual Acquisition Cost (AAC) plus a professional dispensing fee of $10.17 per prescription; or (d) the pharmacist's usual and customary charge.

2. Payment for covered outpatient drugs other than multi-source drugs shall not exceed the lower of (a) AAC plus a professional dispensing fee of $10.17 per prescription; or (b) the pharmacist's usual and customary charge to the general public.

3. Actual Acquisition Cost (AAC) is defined by Nevada Medicaid as the Agency's determination of the actual prices paid by pharmacy providers to acquire drug products marked or sold by specific manufacturers and is based on the National Average Drug Acquisition Cost (NADAC). Wholesale Acquisition Cost (WAC) + 0% will be offered for those drugs not available on NADAC, plus a professional dispensing fee of $10.17 per prescription.

4. A generic drug may be considered for MAC pricing if there are two or more therapeutically equivalent, multi-source, non-innovator drugs with a significant cost difference. The MAC will be based on drug status (including non-rebatable, rebatable, obsolete, therapeutic equivalency ratings) marketplace availability and cost. The obsolete drug status will be taken into account to ensure that the MAC pricing is not influenced by the prices listed for obsolete drugs. The ~~S~~MAC will be based on drug prices obtained from a nationally recognized comprehensive data file maintained by a vendor under contract with the Department.

5. Ingredient cost reimbursement for 340B covered entities shall be the lowest of (a) AAC, or (b) the 340B ceiling price. A professional dispensing fee of $10.17 will also be paid.

6. Drugs acquired through the federal 340B drug pricing program and dispensed by 340B contract pharmacies are not covered.

7. For drugs that are purchased outside the 340B program, the ingredient cost reimbursement will be based on AAC plus a professional dispensing fee of $10.17 per prescription.

8. For drugs purchased through the Federal Supply Schedule (FSS), the ingredient cost reimbursement is based on AAC plus a professional dispensing fee of $10.17 per prescription.

9. For drugs acquired at a nominal price (outside of 340B or FSS), the ingredient cost reimbursement is based on AAC plus a professional dispensing fee of $10.17 per prescription.

10. Providers that are approved to be reimbursed through an encounter rate(s) meet AAC requirements.

11. For drugs (such as specialty drugs) not distributed by a retail community pharmacy, and distributed primarily through the mail, the ingredient cost reimbursement is based on AAC plus a professional dispensing fee of $10.17 per prescription.

12. For drugs (such as a long-term care facility drugs) not distributed by a retail community pharmacy, the ingredient cost reimbursement will be based on AAC plus a professional dispensing fee of $10.17 per prescription.

13. For physician-administered drugs, the ingredient cost reimbursement shall be the lowest of (a) MAC; (b) AAC; or (c) the physician's usual and customary charge.

    a. For 340B physician-administered drugs, the ingredient cost reimbursement will be the lowest of (a) AAC or (b) 340B ceiling price.

14. For clotting factor drugs, ingredient cost reimbursement will be the lowest of AAC plus a professional dispensing fee of $10.17 per prescription, or the pharmacist's usual and customary charge.

    a. For clotting factor drugs provided by 340B entities, the ingredient cost reimbursement will be the lowest of (a) AAC, or (b) 340B ceiling price, plus a professional dispensing fee of $10.17 per prescription.

15. Out-of-state providers will be reimbursed a professional dispensing fee of $10.17 per prescription.

16. The state of Nevada does not cover investigational drugs.

12. b. Dentures: lower of a) billed charge, or b) fixed fee per unit value. See also 10.

c. Prosthetic devices: (1) hearing aids: wholesale cost plus fixed fee; (2) all others: retail charge less negotiated discount.

d. Eyeglasses: (1) frames: wholesale cost to a fixed maximum; (2) lenses: laboratory invoice cost; (3) material services: lower of a) billed charge, or b) fixed fee per Medicaid assigned unit value.

All Agency's rates were set as of April 1, 2002 and are effective for services on or after that date.

Assurance: State developed fee schedule rates are the same for both public and private providers of the service and the fee schedule and any annual/periodic adjustment to the fee schedule(s) are published on the Agency's website at: http://dhcfp.nv.gov/.

13. State developed fee schedule rates are the same for both public and private providers of the following services with the exception of 13.d. The fee schedule rates were set as of April 1, 2002 and are effective for services on or after that date. The agency's rates are published on the Agency's website at http://dhcfp.nv.gov/.

a. Other diagnostic services: lower of a) billed charges, or b) fixed fee per unit value.

b. Other screening services: lower of a) billed charges, or b) fixed fee per unit value.

c. Other preventive services: lower of a) billed charges, or b) fixed fee per unit value.

d. Other rehabilitative services: PROVIDED WITH LIMITATIONS

Other rehabilitative services: PROVIDED WITH LIMITATIONS:

1. Non-Residential Mental Health Rehabilitative Services

A. Reimbursement Methodology for Non-Residential Mental Health Rehabilitation Services provided by a state or local government entity:
Non-residential mental health rehabilitation services:
Examination, Psychiatric Diagnostic Interview - 1 unit per 75 to 80 minutes
Examination, Interactive Psychiatric Diagnostic Interview - 1 unit per 75 to 80 minutes
Individual Psychotherapy - 1 unit per 20 to 30 minutes; or 1 unit per 45 to 50 minutes; or 1 unit per 75 to 80 minutes
Psychoanalysis – 1 unit per 60 minutes
Family Psychotherapy – 1 unit per 60 minutes
Group Psychotherapy – 1 unit per 90 minutes; or 1 unit per 120 minutes
Individual Psychophysiological Therapy – 1 unit per 20 to 30 minutes; or 1 unit per 45 to 50 minutes
Biofeedback – 1 unit per 20 to 30 minutes; or one unit per 40 to 50 minutes
Psychological Testing – 1 unit per 60 minutes
Psychological Testing – 1 unit per 60 minutes
Developmental Testing – 1 unit per 60 minutes
Examination, Neurobehavioral Status – 1 unit per 60 minutes
Neuropsychological Testing – 1 unit per 60 minutes
Neuropsychological Testing – 1 unit per 60 minutes
Assessment, Health and Behavior – 1 unit per 15 minutes
Intervention, Health and Behavior – 1 unit per 15 minutes
Evaluation and Management – 1 unit per 10 minutes; or 1 unit per 15 minutes; or 1 unit per 25 minutes; or 1 unit per 40 minutes
Screening, Behavioral Health – 1 unit per 15 minutes
Out of Office Therapy – 1 unit per 15 minutes
Out of Office Assessment – 1 unit per 90 minutes
Medication training and support, out of office – 1 unit per 15 minutes
Medication training and support in office – 1 unit per 15 minutes
Peer to Peer support, individual – 1 unit per 15 minutes
Crisis Intervention, telephonic, face to face, team – 1 unit per 15 minutes
Day treatment – 1 unit per 15 minutes
Basic Skills Training, individual or group – 1 unit per 15 minutes
Psychosocial rehabilitation, individual or group – 1 unit per 15 minutes
Not all of the above unit values are billing units, for those codes that have a unit of measure defined as an “encounter” in the current Procedural Coding Expert, the values listed are time comparables for rate development.

Non-Residential Mental Health services provided by a state or local government entity are reimbursed according to a methodology used to certify costs as representing expenditures eligible for FFP and may be used only by providers who undergo all Medicaid cost identification, reporting, reconciliation and settlement procedures.

The lower of: a) billed charges; or b) an interim rate. The Interim rate is the rate for a specific service for a period that is provisional in nature, pending the completion of cost reconciliation and a cost settlement for that period.

To determine the Medicaid-allowable direct and indirect costs of providing Non-Residential Mental Health services the following steps are performed:

1. Interim Rates

   Governmental providers are reimbursed on an interim basis for direct medical services per unit of service at the lesser of the provider's billed charges or a provider-specific interim rate. A provider-specific interim rate is an annual rate for the specific services for a period that is provisional in nature, pending the completion of cost reconciliation and a cost settlement for that period. Interim rates are based on program experience and cost data reported during the prior fiscal year.

2. Annual Cost Report Process

   Each governmental provider will complete an annual cost report in the format proscribed by Nevada Medicaid in the Medicaid Operations Manual for all medical services delivered during the previous state fiscal year covering July 1 through June 30. The cost report is due on or before December 1 of the year following the close of the reporting period.

   The primary purposes of the cost report are to:

   a. document the provider's total Medicaid-allowable cost for delivering the medical services, including direct costs and indirect costs, based on the methodologies/steps described below.

   b. reconcile its interim payments to its total Medicaid-allowable costs.

   The annual Medicaid Cost Report includes a certification of funds statement to be completed, certifying the provider's actual, incurred allocable and allowable costs/expenditures. All filed annual Cost Reports are subject to audit by DCHFP or its designee.

To determine the Medicaid-allowable direct and indirect costs of providing covered services to Medicaid-eligible clients, the following steps are performed:

A. Facilities that are primarily providing medical Services:

(a) Direct costs for covered services include unallocated payroll costs and other unallocated costs that can be directly charged to covered medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct care staff. Other direct costs include costs directly related to the delivery of covered services, such as supervision, materials and supplies, professional and contracted services, capital outlay, and travel. These costs must be in compliance with Medicaid non-institutional reimbursement policy and are accumulated on the annual cost report, resulting in total direct costs.

(b) Total direct costs from Item (a) are reduced by any amount that is not in compliance with Medicaid non-institutional reimbursement policy and are further reduced by any federal payments for those costs, resulting in adjusted direct costs for covered services.

(c) Indirect costs are determined by applying the agency specific approved indirect cost rate to its net direct costs. If the provider has no approved indirect cost rate, the allocated indirect costs can be derived from the allocation process through the provider's approved cost allocation plan. These allocated indirect costs are reduced by any unallowable amount based on Medicaid non-institutional reimbursement policy. The indirect costs details are accumulated on the annual cost report.

(d) Net direct costs (Item b) and indirect costs (Item c) are combined.

(e) A CMS approved time study is required when providers of service do not spend 100% of their time providing the Medical services described in the applicable section 3.1-A State plan pages and is used to determine the percentage of time that medical service personnel spend on direct medical services, general and administrative time, and all other activities to account for 100 percent of the time to assure that there is no duplicate claiming. This CMS approved time study methodology will be used to separate administrative activities and direct services. The direct medical services time study percentage is applied against the net direct and indirect costs.

(f) Medicaid's portion of total allowable costs is calculated by multiplying the result from Item (e) above to the ratio of the total units of service provided to Medicaid eligible clients to the total units of service provided.

(g) Total Medicaid allowable costs (Item f) is reduced by any revenue, e.g. Medicaid co-payments, TPL, received for the same services to arrive at the total Medicaid net allocable and allowable costs.

B. Facilities that are used for multiple purposes and the provision of medical services are not the primary purpose:

(a) Direct costs include unallocated payroll costs and medical equipment and supplies. Unallocated payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct care staff. These costs are accumulated on the annual cost report.

(b) The Direct costs from Item (a) are reduced by any amount that is not in compliance with Medicaid non-institutional reimbursement policy and are further reduced by any federal payments for those costs, resulting in adjusted direct costs.

(c) Indirect costs are determined by applying the agency specific approved indirect cost rate to its net direct costs (Item b.). If the entity has no approved indirect cost rate, the allocated indirect costs can be derived from the allocation process through the provider's approved cost allocation plan. These indirect costs are reduced by any unallowable amount. For these facilities, allowable costs are only those cost that are "directly attributable" to the professional component of providing the medical services and are in compliance with Medicaid non-institutional reimbursement policy. For those costs incurred that "benefit" multiple purposes but would be incurred at the same level if the medical services did not occur are not allowed, e.g. room and board, allocated cost from other related organizations. The indirect cost details are accumulated on the annual cost report.

(d) Net direct costs (Item (b)) and indirect costs (Item (c)) are combined.

(e) A CMS approved time study is required when providers of service do not spend 100% of their time providing the Medical services described in the applicable section 3.1-A State plan pages and is used to determine the percentage of time that medical service personnel spend on direct medical services, general and administrative time, and all other activities to account for 100 percent of the time to assure that there is no duplicate claiming. This CMS approved time study methodology will be used to separate administrative activities and direct services. The direct medical services time study percentage is applied against the net direct and indirect costs.

(f) Medicaid's portion of the total net allocable and allowable costs is calculated by multiplying the result from Item (e) above to the ratio of total units of service provided to Medicaid eligible clients to the total units of service provided.

(g) Total Medicaid allowable costs (Item f) is reduced by any revenue received for the same services, e.g. Medicaid co-payments and TPL, to arrive at the total Medicaid net

(h) allocable and allowable costs.

3. Cost Reconciliation Process

Governmental providers will be responsible for reconciling total allowable computable costs reported on the cost report to the provider's Medicaid interim payments for Medicaid services delivered during the reporting period as document in the MMIS, resulting in cost reconciliation. The cost reconciliation process must be completed within twenty-four months of the end of the reporting period covered by the annual Cost Report.

4. Cost Settlement Process

If a governmental provider's interim payments exceed the actual, certified costs of the provider for services to Medicaid clients, the DHCFP will recoup the federal share of the overpayment using one of the following two methods:

1. Off-set all future claims payments from the provider until the amount of the federal share of the overpayment is recovered;
2. The provider will return an amount equal to the overpayment.

If the actual, certified costs exceed the interim Medicaid payments, the DHCFP will pay the federal share of the difference to the provider in accordance with the final actual certification agreement.

The DHCFP will issue a notice of settlement that denotes the amount due to or from the provider.

B. Reimbursement Methodology for Non-residential Mental Health Rehabilitation Services provided by non-governmental entities and governmental entities who do not undergo the Medicaid cost identification and reporting procedures:

Non-residential mental health rehabilitation services:

Examination, Psychiatric Diagnostic Interview – 1 unit per 75 to 80 minutes
Examination, Interactive Psychiatric Diagnostic Interview – 1 unit per 75 to 80 minutes
Individual Psychotherapy – 1 unit per 20 to 30 minutes; or 1 unit per 45 to 50 minutes; or 1 unit per 75 to 80 minutes
Psychoanalysis – 1 unit per 60 minutes
Family Psychotherapy – 1 unit per 60 minutes
Group Psychotherapy – 1 unit per 90 minutes; or 1 unit per 120 minutes
Individual Psychophysiological Therapy – 1 unit per 20 to 30 minutes; or 1 unit per 45 to 50 minutes
Biofeedback – 1 unit per 20 to 30 minutes; or one unit per 40 to 50 minutes
Psychological Testing – 1 unit per 60 minutes
Psychological Testing – 1 unit per 60 minutes
Developmental Testing – 1 unit per 60 minutes
Examination, Neurobehavioral Status – 1 unit per 60 minutes
Neuropsychological Testing – 1 unit per 60 minutes
Neuropsychological Testing – 1 unit per 60 minutes
Assessment, Health and Behavior – 1 unit per 15 minutes
Intervention, Health and Behavior – 1 unit per 15 minutes
Evaluation and Management – 1 unit per 10 minutes; or 1 unit per 15 minutes; or 1 unit per 25 minutes; or 1 unit per 40 minutes
Screening, Behavioral Health – 1 unit per 15 minutes
Out of Office Therapy – 1 unit per 15 minutes
Out of Office Assessment – 1 unit per 90 minutes
Medication training and support, out of office – 1 unit per 15 minutes
Medication training and support in office – 1 unit per 15 minutes
Peer to Peer support, individual – 1 unit per 15 minutes
Crisis Intervention, telephonic, face to face, team – 1 unit per 15 minutes
Day treatment – 1 unit per 15 minutes
Basic Skills Training, individual or group – 1 unit per 15 minutes
Psychosocial rehabilitation, individual or group – 1 unit per 15 minutes

Not all above unit values are billing units, for those codes that have a unit of measure defined as an "encounter" in the current Procedural Coding Expert, the values listed are time comparables for rate development.

1. Non-residential mental health rehabilitation services provided by private entities or governmental entities that do not undergo the Medicaid cost identification and reporting procedures will be reimbursed based on a statewide fee schedule.

   Rate Methodology:

   The rates are market based. This model is developed to reflect service definitions, provider requirements, operational service delivery and administrative considerations. The following elements are used to determine the rates:

   - Wage information is taken from the Bureau of Labor Statistics (BLS). The wage is based on similar occupations reported by BLS and identified by Medicaid staff as comparable to services provided under the mental health rehabilitation program.
   - Employee related expenses (ERE) percentage of 27% was based on input from the Task Force members and Medicaid Staff. It includes paid vacation, paid sick leave, holiday pay, health insurance, life insurance, disability, workers compensation, and legally required payroll taxes.
   - Productivity adjustment factor which accounts for the amount of non-billable time spent by staff. This includes the time staff needs to complete required documentation and record keeping, time associated with missed appointments and average travel time by the provider.
   - Program Support costs – costs based on average of 4 hours per day. This is to assist with paperwork and follow-up related to treatment.
   - Allowance for supervisory time - costs for the time directly spent in supervising the medical professional providing these services.
   - Allowances for capital costs – the costs are not included in the Administrative overhead. It includes the average hourly expense for building rental and maintenance, equipment leasing and utility expenses.
   - Administrative overhead, 10%, is the percentage of service costs that should result from non-direct care activities. It includes insurance, administrative staff, operations and management activities and office supplies. Capital and related expenses is not included. It also does not include staff training.

The following steps are used to determine the rates:

1. The State will use Nevada-specific hourly wages from the Bureau of Labor Statistics.
2. The hourly amount is increased by the 27% ERE.
3. A productivity factor is applied to the hourly compensation calculated in Item 2 to equal to the hourly rate.
4. The adjusted hourly rate per individual is the hourly rate per individual (Item 3) increased by the program support costs per hour per individual, allowance for supervisory time and capital costs per hours.
5. Administrative overhead (10%) is applied to the adjusted hourly rate per individual (Item 4).
6. Total hourly rate is the sum of the adjusted hourly rate per individual before administrative overhead (Item 4) and the administrative overhead (Item 5).
7. Total hourly rate is scaled to the proper unit based on the unit of service.
8. Group rate is the individual rate divided by the group size assumption.

These rates have been compared to other private sector fee-for-service rates. Documentation of the assumptions used, rate development methodology and fee schedule payment rates will be maintained by The Division of Health Care Financing and Policy.

The Agency's rates were set as of January 1, 2006 and are effective for services on or after January 1, 2006. All rates are published on the Agency's website at http://dhcfp.nv.gov/.

Services provided by an out-of-state provider require prior authorization by Nevada Medicaid, which must verify that the services required by Medicaid-eligible or pending-eligible clients are not available in Nevada. The out-of-state payment rate for services provided by an out-of-state provider is based on one of the following criteria:

a. The out-of-state provider will be paid the lesser of the provider's billed charges or the fee-for-service rate that is paid to an in-state provider for the service.
b. If the out-of-state provider refuses to accept this rate, then the out-of-state provider may be paid the lesser of the provider's billed charges or the same fee-for-service rate as it would be paid by its home state Medicaid program.

c. For services that cannot be provided by a provider that accepts payment under (A) or (B), 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."

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rates were set as of July 1, 2013 and are effective for services provided on or after that date. All rates are published on the agency's website: http://dhcfp.nv.gov/Resources/Rates/RatesMain/

14. RESERVED

15. RESERVED

16. RESERVED

17. RESERVED

18. Prior to the beginning of each rate year, governmental providers of emergency medical transportation, ground ambulance services, must select one of the reimbursement methodologies described below. Governmental providers must select their reimbursement methodology by April 30 for the rate year beginning July 1 and will not be able to change the selected reimbursement methodology until the following rate year.

I. Reimbursement methodology for emergency medical transportation, ground or air ambulance services, provided by non-governmental entities and governmental entities that do not undergo the Medicaid cost identification, reporting, reconciliation and settlement procedures.

Emergency Medical Transportation: Ground Ambulance or Air Ambulance (fixed wing or rotary aircraft): lower of: a) billed charge, or b) fixed basic rate plus fixed fee per mile. Effective July 1, 2013, the reimbursement rates will be increased 15%.

II. Reimbursement methodology for emergency medical transportation, ground ambulance services, provided by a government entity which selects cost identification, reporting, reconciliation and settlement.

Governmental entities may select a reimbursement methodology for emergency medical transportation that is based on cost identification, reporting, reconciliation and settlement. This methodology reimburses governmental entities for uncompensated care costs for providing emergency medical transportation services to Nevada Medicaid beneficiaries. Uncompensated care costs are allowable costs in excess of payments made by Nevada Medicaid. This reimbursement will include a base payment per emergency medical transportation claim plus a final supplemental payment adjustment so that total reimbursement does not exceed or fall short of the total cost of providing services to Medicaid beneficiaries.

A. Definitions:

1. "Emergency Medical Transportation" is synonymous with "Emergency Medical Response." It includes both the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient, as well as the advanced, limited-advanced and basic life support services provided to an individual by emergency medical transportation providers before or during the act of transportation.

2. "Emergency Medical Response" is a cost objective that includes expenditures for medical services performed at the point of injury or illness, typically outside of a medical facility, to evaluate or treat a health condition. An emergency medical response is classified as "medical" by dispatch if the primary reason for the response is to provide medicalservices.

3. "Direct costs" means all costs that can be identified specifically with particular final cost objectives in order to meet all medical transportation mandates.

4. "Shared Direct Costs" are direct costs that can be allocated to two or more departmental functions or cost objectives on the basis of shared benefits.

5. "Indirect costs" means costs for a common or joint purpose benefitting more than one cost objective that are allocated to each benefitting objectives using an agency approved indirect rate or an allocation methodology. Indirect costs rate or allocation methodology must comply with 2 CFR, Part 200 and CMS non-institutional reimbursement policies.

6. "Service Period" means the period from July 1st through June 30th of each Nevada state fiscal year.

B. Provider Eligibility for Medicaid Reimbursement Based on Cost Identification.

To be eligible to receive reimbursement based on cost identification for emergency medical transportation, a provider must meet all of the requirements described below:

1. The provider is owned or operated by an eligible government entity to include the state, a city, a county, a consolidated city and county, a fire protection district organized pursuant to Nevada Revised Statutes Chapter 474 or a federally recognized Indian tribe.

2. The provider is enrolled as a Nevada Medicaid provider for the period being claimed.

3. The provider delivers emergency medical transportation services to Nevada Medicaid beneficiaries.

4. The provider has a Cost Allocation Plan (CAP) approved by the State Medicaid Agency on file with the State.

C. Interim Medicaid Payment

1. "Base Payment" is the interim reimbursement paid for each transport as a result of Medicaid claiming by the provider throughout the year. The base payment in the period October 1, 2015 through September 30, 2017 is determined by the Nevada Medicaid fee-for-service ambulance fee schedule. For periods beginning October 1, 2017, the base payment is the average cost per transport as determined in the most recent available cost report. The average cost per transport is determined by dividing the total allowable costs of providing emergency medical transportation services by the total number of emergency medical transports.

D. Methodology for Reimbursement of Emergency Medical Transportation Services Based on Cost Identification.

1. A provider's specific allowable cost per-medical transport rate will be calculated based on the provider's audited financial data reported on the CMS-approved cost report. The per-medical transport cost rate will be the sum of actual allowable direct and indirect costs of providing medical transport services divided by the actual number of medical transportation services provided for the applicable service period.

a. Direct costs for providing medical transport services include only the unallocated payroll costs for those emergency response staff who dedicate 100 percent of their time to providing medical transport services; medical equipment and supplies, and other costs directly related to the delivery of covered services, such as first-line supervision, materials and supplies, professional and contracted services, capital outlay, travel and training. These costs must be in compliance with Medicaid non-institutional reimbursement policies and are directly attributable to the provision of the medical transport services.

b. Shared direct costs for emergency medical transportation services as defined by Section A.1, must be allocated for personnel, capital outlay and other costs; such as, medical supplies, professional and contracted services, training and travel. The personnel costs will be allocated based on the percentage of total hours logged performing emergency medical transportation activities versus other activities. The capital and other direct costs will be allocated based on the percentage of total call volume.

c. Indirect costs are determined based on the provider's approved cost allocation plan.

d. The provider specific per-medical transport cost rate is calculated by dividing the total net medical transport allowable costs (Item 1.a, Item 1.b and Item 1.c) of the specific provider by the total number of medical transports provided by the provider for the applicable service period.

2. Medicaid's portion of the total allowable cost for providing emergency medical transportation services by each eligible provider is calculated by multiplying the total number of Medicaid FFS transports provided by the provider's specific per-medical transport cost rate (Paragraph D.1.d) for the applicable service period.

E. Eligible Provider Reporting Requirements:

Eligible provider shall:

1. Report and certify total computable allowable costs annually on a CMS-approved Nevada Medicaid Emergency Transportation Services Cost Report, which is to be submitted annually by December 1 to the State Medicaid Agency. The Cost Report includes a certification of expenditures statement that states the total costs reported are accurately reported and allowable.

2. Provide documentation to serve as evidence supporting the information on the cost report and the cost determination as specified by the State Medicaid Agency.

3. Keep, maintain and have readily retrievable, such records as specified by the State Medicaid Agency.

4. The provider will comply with the allowable cost requirements provided in 42 CFR, Part 413, 2 CFR, Part 200, and Medicaid non-institutional reimbursement policies.

F. State Medicaid Agency's Responsibilities:

1. The State will submit to CMS claims based on total computable certified expenditures for emergency transportation services provided that are allowable and in compliance with federal laws and regulations and Medicaid non-institutional reimbursement policies.

2. As part of its financial oversight responsibilities, the State will review each provider's Cost Report for reasonableness and accuracy and reconcile the Cost Report to the provider claims data obtained from the Medicaid Management Information System (MMIS). The state will complete the cost report review and settlement process of the interim payments for the service

period within three years of the postmark date of the cost report.

3. If the interim Medicaid payments exceed the actual certified costs of a provider, the State will recoup any overpayments and return the Federal share to the Federal government in accordance with 42 CFR 433.316. If the actual certified costs exceed the interim Medicaid payments, DHCFP will pay the federal share of the difference to the provider in accordance with the final actual certification agreement.

III. Non-emergency transportation:

A. Non-emergency transportation is authorized through a contracted NET Broker, as specified in Attachment 3.1-D.

B. Reimbursement Methodology for Non-Emergency Paratransit services provided by the Regional Transportation Commission (RTC) operated by local government entities:

1. The lower of: A) billed charges; or b) a cost based rate.

The cost based rate is calculated annually using each public provider's annual operating budget and service utilization forecast and an applicable 10% indirect cost rate. Each public provider will submit an annual operating budget and service utilization forecast at least 60 days before the start of the next fiscal year. The budget forecast must reflect a projection for allowable, necessary and proper direct cost in providing services. The cost based rate is calculated as follows:

a. Direct costs include the costs for fuel, tires and subcontracted costs that are directly related in providing the non-emergency transportation services. These costs must be in compliance with the Medicare reimbursement principle and OMB A-87.

b. The total direct costs (from Item A) are reduced by any federal grant funds received for the same services to arrive at the net allowable direct costs.

c. Indirect costs are determined by applying a ten percent indirect cost rate to the net allowable direct costs (from Item B).

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1. Net allowable costs is the sum of the net allowable direct costs (Item 2) and indirect costs (Item 3).
2. The cost based rate is the net allowable costs (from Item 4) divided by the total forecasted transportation service utilization.

15. a. Services of Religious non-medical Healthcare Institution nurses: NOT PROVIDED.

b. Services in Religious non-medical Healthcare Institutions sanitoria: NOT PROVIDED.

c. Hospice Services: Reimbursed at the established annual Medicaid rate regardless of billed charges. The agency's rates were set as of October 1, 2008 and are effective for services on or after that date. Rates are adjusted annually each year thereafter in accordance with 42CFR 418.

d. Hospice provided in a long-term care facility: Reimbursed 95% of the nursing facility daily rate for room and board provided by the nursing facility or long term care facility.

16. Emergency hospital services out-of-state: lower of: a) billed charges, or b) local Medicaid maximums. The agency's rates were set as of July 1, 2005 and are effective for services on or after that date.

17. Personal care services in recipients' home and setting outside the home: fixed hourly rate established by the State of Nevada legislative body. The agency's rates were set as of July 1, 2009 and are effective for services on or after that date.

18. RESERVED

All Targeted Case Management groups will be reimbursed using the following methodologies effective as of July 1, 2009.

23. Targeted Case Management (TCM) services will be reimbursed as follows:

Prior to the beginning of each rate year, each of the governmental providers providing TCM services must select one the reimbursement methodologies described below for reimbursement. For example, by April 30, 2009, governmental providers must select a methodology for the rate year beginning July 1, 2009. Once a selected methodology is determined for a rate year, governmental providers will not be able to change the selected methodology until the following rate year.

A. Reimbursement Methodology for Targeted Case Management Services provided by a non-governmental entity and governmental entities who do not undergo the Medicaid cost identification and reporting procedures:

I. TCM: One unit per 15 minutes.

II. TCM services provided by a private/non-governmental entity and governmental entities that do not undergo the Medicaid cost identification and reporting procedures will be reimbursed the lower of a) billed charges, or b) a fixed quarter hour rate.

III. The quarterly hour rate is a market based model. This model reflects service definitions, provider requirements, operational service delivery and administrative considerations. The following elements are used to determine the rate:

1. Wage Information is taken from the Bureau of Labor Statistics (BLS). The wage is based on similar occupations reported by BLS and identified by Medicaid staff as comparable to CM and TCM services.
2. Employee rated expenses (ERE) percentage of 27% was based on input from the Provider Rates Task Force members and Medicaid Staff. It includes paid vacation, paid sick leave, holiday pay, health insurance, life insurance, disability, workers compensation and legally required payroll taxes.
3. Productivity adjustment factor which accounts for the amount of non-billable time spent by staff. This includes the time staff needs to complete required documentation and record keeping, time associated with missed appointments and average travel time by the provider.
4. Allowance for supervisory time – costs for the time directly spent in supervising the professional providing this CM and/or TCM service.
5. Allowance for capital costs – the costs are not included in the administrative overhead. It includes the average hourly expense, for building rental and maintenance, equipment leasing and utility expenses.
6. Allowance for mileage – the average costs related to the miles to travel to clients.

7. Administrative overhead, 10%, is the percentage of service cost that should result from non-direct care activities. It includes insurance, administrative staff, operations and management activities and office supplies. Capital and related expenses is not included. It also does not include staff training.

IV. The following steps are used to determine the fixed quarter hour rate:

1. The State will use Nevada-specific hourly wages from the Bureau of Labor Statistics.
2. This hourly compensation is increased by the 27% ERE.
3. A productivity factor is applied to the hourly compensation calculated in Item 2 to equal the adjusted hourly rate.
4. Allowance for supervisory time is determined.
5. Administrative overhead (10%) is applied to the sum of adjusted hourly rate (Item 3) and the allowance for supervisory (Item 4).
6. Allowance for mileage cost is determined.
7. Allowance for capital costs is determined.
8. Fixed hourly rate is the sum of adjusted hourly rate (Item 3), allowance for supervisory time (Item 4), administrative overhead (Item 5), allowance for mileage (Item 6), and allowance for capital costs (Item 7).
9. Quarter hour rate is the fixed hourly rate (Item 8) divided by 4.

This rate has been compared to other private sector fee-for-service rates.

Documentation of the assumptions used, rate development methodology, and fee schedule payment rates will be maintained by the Division of Health Care Financing and Policy (DHCFP).

The Agency's rates were set as of January 1, 2006 and are effective for services on or after January 1, 2006. All rates are published on the Agency's website at www.dhcfp.nv.gov.

B. Reimbursement Methodology for Targeted Case Management Services provided by a state or local government entity:

Targeted Case Management services provided by a state or local government entity are reimbursed according to one of the following two payment methodologies. The second methodology must be used by providers who undergo all Medicaid cost identification, reporting, reconciliation and settlement procedures.

I. The lower of: a) billed charges; or b) a cost based rate. The cost-based rate is an annual rate developed based on historic costs. Cost based rates will be calculated annually and are determined by dividing estimated reimbursable costs of providing Medicaid-covered services by the projected total direct medical service utilization for the upcoming fiscal period.

Each public provider will submit an annual operating budget and service utilization forecast at least 60 days before the start of the next fiscal year. The budget forecast must reflect a projection for allowable, necessary and proper expenses in providing Medicaid-covered services. Allowable costs are those direct and indirect costs deemed allowable by CMS which are incurred and are proper and necessary to efficiently deliver needed services. Direct costs include unallocated payroll costs and other unallocated costs that can be directly charged to covered medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct care staff. Other direct costs include costs directly related to the delivery of covered services, such as supervision, materials and supplies, professional and contracted services, capital outlay, and travel. These direct costs are accumulated on the annual cost report, resulting in total direct costs.

The Agency's rates were set as of July 1, 2007 and are effective for services on or after July 1, 2009. All rates are published on the Agency's website at www.dhcfp.nv.gov.

II. The lower of: a) billed charges; or b) an interim rate. The Interim rate is the rate for a specific service for a period that is provisional in nature, pending the completion of cost reconciliation and a cost settlement for that period.

To determine the Medicaid-allowable direct and indirect costs of providing Targeted Case Management services the following steps are performed:

1. Interim Rates

Governmental providers are reimbursed on an interim basis for direct medical services per unit of service at the lesser of the provider's billed charges or a provider-specific interim rate. A provider-specific interim rate is an annual rate for the specific services for a period that is provisional in nature, pending the completion of cost reconciliation and a cost settlement for that period. Interim rates are based on program experience and cost data reported during the prior fiscal year.

2. Annual Cost Report Process

Each governmental provider will complete an annual cost report in the format prescribed by Nevada Medicaid in the Medicaid Operations Manual for all medical services delivered during the previous state fiscal year covering July 1 through June 30. The cost report is due on or before December 1 of the year following the close of the reporting period. The primary purposes of the cost report are to:

a. document the provider's total Medicaid-allowable cost for delivering the medical services, including direct costs and indirect costs.
b. reconcile its interim payments to its total Medicaid-allowable costs.

The annual Medicaid Cost Report includes a certification of expenditures statement to be completed, certifying the provider's actual, incurred allocable and allowable costs/expenditures. All filed annual Cost Reports are subject to audit by the DCHFP or its designee.

To determine the Medicaid-allowable direct and indirect costs of providing covered services to Medicaid-eligible clients, the following steps are performed:

A. Settings that are primarily providing medical services:

(a.) Direct costs for covered services include unallocated payroll costs and other unallocated costs that can be directly charged to covered medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct care staff. Other direct costs include costs directly related to the delivery of covered services, such as supervision, materials and supplies, professional and contracted services, capital outlay and travel. These costs must be in compliance with Medicaid non-institutional reimbursement policy and are accumulated on the annual cost report, resulting in total direct costs.

(b.) Total direct costs from Item (a) are reduced by any amount that is not in compliance with Medicaid non-institutional reimbursement policy and are further reduced by any federal payments for those costs, resulting in adjusted direct costs for covered services.

(c.) Indirect costs are determined by applying the agency specific approved indirect cost rate to its net direct costs. If the provider has no approved indirect cost rate, the allocated indirect costs can be derived from the allocation process through the provider's approved cost allocation plan. These allocated indirect costs are reduced by any unallowable amount based on Medicaid non-intuitional reimbursement policy. The indirect costs details are accumulated on the annual cost report.

(d.) Net direct costs (b) and indirect costs (c) are combined.

(e.) A CMS approved time study is required when providers of service do not spend 100% of their time providing the Targeted Case Management services described in the applicable section 3.1-A State plan pages and is used to determine the percentage of time that case management service personnel spend on direct Targeted

Case Management services, general and administrative time, and all other activities to account for 100 percent of the time to assure that there is no duplicate claiming. This CMS approved time study methodology will be used to separate administrative activities and direct services. The direct Targeted Case Management services time study percentage is applied against the net direct and indirect costs.

(f.) Medicaid's portion of total allowable costs is calculated by multiplying the result from item (e) above to the ratio of the total units of service provided to Medicaid eligible clients to the total units of service provided.

(g.) Total Medicaid allowable costs (f) is reduced by any revenue, e.g. Medicaid co-payments, TPL, received for the same services to arrive at the total Medicaid net allocable and allowable costs.

B. Facilities that are used for multiple purposes and the provision of medical services is not the primary purpose:

(a) Direct costs include unallocated payroll costs and medical equipment and supplies. Unallocated payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct care staff.

(b) The Direct costs from Item (a) are reduced by any amount that is not in compliance with Medicaid non-institutional reimbursement policy and are further reduced by any federal payments for those costs, resulting in adjusted direct costs.

(c) Indirect costs are determined by applying the agency specified approved indirect cost rate to its net direct costs (Item b.). If the entity has no approved indirect cost rate, the allocated indirect costs can be derived from the allocation process through the provider's approved cost allocation plan. These indirect costs are reduced by any allowable amount. For these facilities, allowable costs are only those costs that are "directly attributable" to the professional component of providing the medical services and are in compliance with Medicaid non-institutional reimbursement policy. For those costs incurred that "benefit" multiple purposes but would be incurred at the same level if the medical services did not occur are not allowed, e.g., room and board, allocated cost from other related organizations. The indirect cost details are accumulated on the annual cost report.

(d) Net direct costs (Item (b)) and indirect costs (Item (c)) are combined.

(e) A CMS approved time study is required when providers of service do not spend 100% of their time providing the Targeted Case Management services described in the applicable section 3.1-A State plan pages and is used to determine the percentage of time that case management service personnel spend on direct Targeted Case Management services, general and administrative time and all other activities to account for 100 percent of the time to assure that there is no duplicate claiming. This CMS approved time study methodology will be used to separate administrative activities and direct services. The direct Targeted Case Management services time study percentage is applied against the net direct and indirect costs.

(f) Medicaid's portion of the total net allocable and allowable costs is calculated by multiplying the result from Item (e) above to the ratio of total units of service provided to Medicaid eligible clients to the total units of service provided.

(g) Total Medicaid allowable costs (Item f) is reduced by any revenue received for the same services, e.g. Medicaid co-payments and TPL, to arrive at the total Medicaid net allocable and allowable costs.

3. Cost Reconciliation Process

Governmental providers will be responsible for reconciling total computable costs reported on the cost report to the provider's Medicaid interim payments for Medicaid services delivered during the reporting period as document in the MMIS, resulting in cost reconciliation. The cost reconciliation process must be completed within twenty-four months of the end of the reporting period covered by the annual Cost Report.

4. Cost Settlement Process

If a governmental provider's interim payments exceed the actual, certified costs of the provider for services to Medicaid clients, the DHCFP will recoup the federal share of the overpayment using one of the following two methods:

1. Off-set all future claims payments from the provider until the amount of the federal share of the overpayment is recovered;
2. The provider will return an amount equal to the overpayment.

If the actual, certified costs exceed the interim Medicaid payments, the DHCFP will pay the federal share of the difference to the provider in accordance with the final actual certification agreement.

The DHCFP will issue a notice of settlement that denotes the amount due to or from the provider.

24. RESERVED

25. Newly developed Current Procedural Terminology (CPT) codes determined to be for Nevada Medicaid covered services: Codes for those services with a rate methodology which uses resource based relative value scale (RBRVS), as specified elsewhere in this Attachment, will be entered into the system using the Nevada specific unit value developed by Medicare. The 2014 Medicare Physician Fee Schedule conversion factor will be used to calculate payment for these newly developed codes where the RBRVS is used. The maximum allowable will be established by multiplying the unit value and the 2014 conversion factor and then paying the appropriate percentage, as specified elsewhere in this Attachment, based on the provider type, service type and CPT code range.

    If a code is billed that has no Nevada specific Medicare rate, the Division will determine if there is national Medicare pricing. If so, the service will be paid at the appropriate percentage of the rate, as specified elsewhere in this Attachment. If there is no national Medicare pricing, the Division will establish pricing based on similar services.

(Reserved for Future Use)

(Reserved for Future Use)

26. Surgical services provided in both hospital-based and freestanding Ambulatory Surgical Centers (ASC)

a. Payments for services billed by hospital-based and freestanding Ambulatory Surgical Centers (ASC) will be calculated using the Centers for Medicare & Medicaid Services (CMS) Ambulatory Payment Classification (APC) grouping as published in 42 CFR parts 405, 410, 412 ,413, 416 and 419. A Nevada ASC Base Rate will be established for each service by multiplying the associated 2016 ASC payment weight from the APC group (found in CMS-1633-FC-Addenda file) by the 2016 ASC conversion factor of 44.177 (found in CMS–1633–FC; CMS–1607–F2), then multiplying the result by the 2016 NV Wage Index of 0.9299 (Found in CMS-1633-FC Wage Index file).
   1. Surgical codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 85% of the NV ASC Base Rate.

b. Services that CMS identifies as excluded from payment in an ASC setting, but are deemed appropriate to be performed in that setting by NV Medicaid Policy, will be paid using the CMS Outpatient Prospective Payment System (OPPS) relative weight from the associated APC group for that service in place of the ASC payment weight to establish the NV ASC Base Rate.

c. In the case of multiple procedures, the following adjustments to the fee schedule are made:
   1) First procedure 100% of fee schedule
   2) Second procedure 50% of fee schedule
   3) Third procedure 25% of fee schedule
   4) Fourth procedure 10% of fee schedule
   5) Fifth and thereafter procedures 5% of fee schedule

d. Professional services are reimbursed as indicated in page 1c of Section 4.19-B.

e. Cornea Procurement will be reimbursed at 100% of the procurement charges as listed in the 2013 The Lewin Group Study.

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

Methods and Standards Used to Determine Payment
For Emergency Medical Services for Illegal Aliens

Hospital, emergency clinics and county social service/welfare departments have been informed about the availability of emergency medical services and application procedures for aliens who have not been lawfully admitted for permanent residence or otherwise are not permanently residing in the United States under color of law.

When a hospital, clinic or county social service department determines a person receiving emergency services is indigent and an illegal alien, the alien will be referred to the State Welfare Division District Office for application. If the applicant is unable or reluctant to go to the Welfare District Office, the hospital/clinic/social service department will assist the applicant in completing the application and gathering verification and will send the application and verification to the Welfare District Office with the billing(s).

The District Office eligibility worker will request from the provider a bill or other evidence services were rendered and will obtain an application (if not already completed) and necessary verifications/information. The eligibility worker will approve eligibility for the months in which services were rendered and the applicant meets income/resource and other criteria (e.g., disability or incapacity). (A Medicaid card will not be issued to the client.) Providers will be notified of client eligibility so applicable bills may be submitted to the Medicaid fiscal agent for payment determination and processing based on whether the alleged qualifying services actually met the emergency criteria. The fiscal agent will notify providers of the reason for any payment denial.

Medicaid will make payment only for the alien's care and services which are necessary for the treatment after sudden onset of an emergency medical condition. As defined in Section 1903(v), an "emergency medical condition means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

(A) placing the patient's health in serious jeopardy,

(B) serious impairment to bodily functions, or

(C) serious dysfunction of any bodily organ or part.

Payment for Qualified Medicare Beneficiaries (QMBs)

For Qualified Medicare Beneficiaries, Nevada Medicare will pay the Medicare deductibles and coinsurance subject to the following limitation: The Medicare payment (allowable charge) plus the deductible and coinsurance may not exceed the Medicaid maximum allowable payment. For Medicare services, which are not covered by Nevada Medicaid, or for which Nevada Medicaid does not have an established payment rate, Nevada Medicaid will pay the Medicare deductible and coinsurance amounts.

QMB claims for services which are covered by Medicare are not subject to Medicaid limitations. Medicaid will reimburse the deductible and coinsurance up to the Medicaid maximum allowable payment. Also, prior authorization is not required for Medicare allowable services for dually entitled QMBs. If Medicare benefits are exhausted or Medicare does not cover the service and the service is covered by Medicaid, prior authorization is required if the service or benefit normally requires it.

REIMBURSEMENT FOR INDIAN HEALTH SERVICE AND TRIBAL 638 HEALTH FACILITIES

Effective January 1, 2015, Nevada Medicaid will reimburse Indian Health Services facilities and Tribal 638 facilities in accordance with the most recent published Federal Register notice.

The published, all inclusive, rate is paid for up to five face-to-face encounters/visits per recipient per day. Encounters/visits are limited to healthcare professionals as approved under the Nevada Medicaid State Plan.

Enhanced Rates for Practitioner Services delivered by the
University of Nevada School of Medicine

In order to ensure access to University of Nevada School of Medicine (UNSOM) Practitioner Services by needy individuals in the state of Nevada and to recognize the higher cost of providing Practitioner Services in a teaching environment, UNSOM shall be paid a Supplemental Payment for such services to Medicaid recipients which is in addition to the Medicaid Base Rate(s) normally paid for said services.

The Supplemental Payment for any quarterly Service Period shall be calculated as:

((Medicare Equivalent Ratio X (sum of Medicaid Services paid for during the Service Period X Medicare Reimbursement Rates)) - (Medicaid Services paid for during the Service Period X Medicaid Base Rates) provided, however, that in no event shall total reimbursements (i.e., Medicaid Base Rate plus Supplemental Payments) during any Service Period exceed the Reimbursement Ceiling for that Service Period.

For the purposes of this policy, the following definitions shall apply:

- Medicare Equivalent Ratio means the Reimbursement Ceiling divided by the sum of the products of all Medicaid Services provided during the Base Period and the Medicare Reimbursement Rates for those services during the Base Period.

- Medicaid Services, when calculating Medicare Equivalent Ratio and Reimbursement Ceiling for the Base Period, means Practitioner Services enumerated by HCPCS/CPT code, delivered to Medicaid eligible recipients, and paid during the Base Period.

  As otherwise used herein, Medicaid Services means outpatient Practitioner Services enumerated by HCPCS/CPT code, and delivered to Medicaid eligible recipients, and paid during the Service Period.

  In all instances, the source of the service and payment data shall be the Nevada MMIS.

- Medicare Reimbursement Rate(s), when calculating Medicare Equivalent Ratio, means the applicable Medicare fee for service reimbursement rate(s) published for the Base Period by the U.S. Department of Health and Human Services - Centers for Medicare & Medicaid Services.

  As otherwise used herein, Medicare Reimbursement Rate(s) means the applicable Medicare fee for service reimbursement rate(s) published from time to time for the Service Period by the U.S. Department of Health and Human Services - Centers for Medicare & Medicaid Services.

- Medicaid Base Rate(s) means the applicable Medicaid fee for service reimbursement rate(s) published for the applicable Base Period or Service Period by the State of Nevada - Division of Health Care Financing and Policy.

- Reimbursement Ceiling, when calculating Medicare Equivalent Ratio, means the sum of the products of all Medicaid Services delivered and paid during the Base Period and the Average Reimbursement by Third Party Payers for those services for the same period.

  As otherwise used herein, Reimbursement Ceiling means the sum of the products of all Medicaid Services delivered and paid during the Service Period and the Average Reimbursement by Third Party Payers for those services for the same period.

- Average Reimbursement by Third Party Payers means, for each procedure (HCPCS/CPT) code, the average reimbursement amount of the top five commercial payers to UNSOM during the Base Period. "Commercial payers" exclude Medicare, Workers Compensation and any other payer(s) not subject to market forces.

- Service Period means a three-month period commencing on the effective date of this provision, the accompanying UNSOM supplemental payment analysis will be rebased every three years.

- Base Period means the one-year period commencing January of the previous year of the rebasing year and ending December 31 of the same year.

- Practitioner means an individual who is employed by the University of Nevada School of Medicine and is either a Physician (MD or DO), Physician Assistant (PA-C), Advanced Practitioner of Nursing (APN), Clinical Psychologist, Licensed Registered Nurse, Licensed Nurse Practitioner, Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Clinical Professional Counselor, Interns and Psychological Assistants.

- Practitioner Services means medical services (enumerated by HCPCS/CPT code) delivered to eligible Medicaid recipients by a Practitioner.

End Stage Renal Disease (ESRD) Dialysis Procedure Payment and ESRD Facilities

Hemodialysis (HD) and peritoneal dialysis (PD) services, CPT codes 90999 and 90945 respectively, will be paid the lower of 1.) billed charges, or 2.) a fixed fee. Dialysis services are all services provided in conjunction with the dialysis treatment as defined in the Medicare ESRD Facility Prospective Payment System.

The bundled prospective payment rate will be set according to the most current Centers for Medicare & Medicaid Services (CMS) ESRD Prospective Payment System base rate. The bundled rate will include all resources used in providing outpatient dialysis treatment, including biological, drugs and laboratory services.

The fixed fee for 90999 (HD) will be 100% of the Medicare ESRD Prospective Payment System (PPS) base rate multiplied by the current ESRD Wage Index Locality Factor for Nevada for independent and hospital-based facilities. The fixed fee for 90945 (PD) is set as an HD-equivalent session. This is accomplished by dividing HD rate by seven, and multiplying the result by three.

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

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

1915(i) Home and Community Based Services (HCBS) State Plan Services
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

1. Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate:

☐ HCBS Care Coordination

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☐ HCBS Homemaker

☐ HCBS Basic Homemaker
☐ HCBS Chore Services

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☐ HCBS Home Health Aide

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

☐ HCBS Personal Care

☐ HCBS Personal Care I
☐ HCBS Personal Care II
☐ HCBS Attendant Services
☐ HCBS Adult Companion
☐ HCBS Personal Emergency Response Systems
☐ HCBS Assistive Technology

1915(i) Home and Community Based Services (HCBS) State Plan Services
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

☒ Home and Community Based Services (HCBS) Adult Day Health Care (ADHC)

Reimbursement Methodology for Adult Day Health Care (ADHC) Services provided by a non-governmental entity and governmental entities who do not undergo the Medicaid cost identification and reporting procedures:

Prior to the beginning of each rate year, each of the governmental providers providing ADHC services must select one of the reimbursement methodologies described below for reimbursement. For example, by April 30, 2013, governmental providers must select a methodology for the rate year beginning July 1, 2013. Once a selected methodology is determined for a rate year, governmental providers will not be able to change the selected methodology until the following rate year.

The Agency's rates were set as of January 1, 2006 and are effective for services on or after January 1, 2006. All rates are published on the Agency's website at www.dhcfp.nv.gov.

The billable unit of service for ADHC is one unit per 15 minutes or the daily rate.

- If services are authorized and provided for less than six hours per day, provider should bill one unit for each 15 minutes;
- If services are authorized and provided for six hours or more per day, provider should bill the per diem rate.

Rate Methodology:
The rate is market based. This model is developed to reflect service definitions, provider requirements, operational service delivery and administrative considerations. The following elements are used to determine the rate:

- Wage information is taken from the Bureau of Labor Statistics (BLS). The wage is based on similar occupations reported by BLS and identified by Medicaid staff as comparable to ADHC services.
- Employee related expenses (ERE) percentage of 27% was based on input from the Task Force members and Medicaid Staff. It includes paid vacation, paid sick leave, holiday pay, health insurance, life insurance, disability, workers compensation, and legally required payroll taxes.
- Productivity adjustment factor which accounts for the amount of non-billable time spent by staff. This includes the time staff needs to complete required documentation and record keeping, time associated with missed appointments and average travel time by the provider.
- Administrative overhead, 10%, is the percentage of service cost that should result from non-direct care activities. It includes insurance, administrative staff, operations and management activities and office supplies. Capital and related expenses is not included. It also does not include staff training.

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- Allowances for capital costs – the costs are not included in the Administrative overhead. It includes the average hourly expense for building rental and maintenance, equipment leasing and utility expenses.

The following steps are used to determine the rate:

1. The State will use Nevada-specific hourly wages from the Bureau of Labor Statistics as of May 2004 inflated to June 2006.
2. This hourly compensation is increased by the 27% ERE.
3. A productivity factor is applied to the hourly compensation calculated in Item 2 to equal to the adjusted hourly rate.
4. Administrative overhead (10%) is applied to the adjusted hourly rate (Item 3).
5. Determine allowance for capital costs per hour.
6. Fixed hourly rate is the sum of adjusted hourly rate (Item 3), administrative overhead (Item 4) and capital costs (Item 5).
7. Fixed hourly rate is scaled to the proper unit based on the procedure code.

This rate has been compared to government entities who do not follow all cost reporting rules and other private sector fee-for-service rates. Documentation of the assumptions used, rate development methodology, and fee schedule payment rates will be maintained by The Division of Health Care Financing and Policy.

A. Reimbursement Methodology for Adult Day Health Care (ADHC) services provided by a state or local government entity:

ADHC services provided by a state or local government entity are reimbursed according to the following payment methodology. This methodology is used by providers who undergo all Medicaid cost identification, reporting, reconciliation and settlement procedures.

I. The lower of: a) billed charges; or b) an interim rate. The Interim rate is the rate for a specific service for a period that is provisional in nature, pending the completion of cost reconciliation and a cost settlement for that period.

To determine the Medicaid-allowable direct and indirect costs of providing Adult Day Health Care Services the following steps are performed:

1. Interim Rates

Governmental providers are reimbursed on an interim basis for direct medical services per unit of service at the lesser of the provider's billed charges or a provider-specific interim rate. A provider-specific interim rate is an annual rate for the specific services for a period that is provisional in nature, pending the completion of cost reconciliation and a cost settlement for that period. Interim rates are based on program experience and cost data reported during the prior fiscal year.

2. Annual Cost Report Process

Each governmental provider will complete an annual cost report in the format prescribed by Nevada Medicaid for all medical services delivered during the previous state fiscal year covering July 1 through June 30. The cost report is due on or before December 1 of the year following the close of the reporting period.

The primary purposes of the cost report are to:

a. document the provider's total Medicaid-allowable cost for delivering the medical services, including direct costs and indirect costs.
b. reconcile its interim payments to its total Medicaid-allowable costs.

The annual Medicaid Cost Report includes a certification of expenditures statement to be completed, certifying the provider's actual, incurred allocable and allowable costs/expenditures. All filed annual Cost Reports are subject to audit by the DHCFP or its designee.

B. Settings that are primarily providing medical services:

a) Direct costs for covered services include unallocated payroll costs and other unallocated costs that can be directly charged to covered medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct care staff. Other direct costs include costs directly related to the delivery of covered services, such as supervision, materials and supplies, professional and contracted services, capital outlay and travel. These costs must be in compliance with Medicaid non-institutional reimbursement policy and are accumulated on the annual cost report, resulting in total direct costs.

b) Total direct costs from Item (a) are reduced by any amount that is not in compliance with Medicaid non-institutional reimbursement policy and are further reduced by any federal payments for those costs, resulting in adjusted direct costs for covered services.

c) Indirect costs are determined by applying the cognizant agency approved indirect cost rate to its net direct costs. If the provider has no approved indirect cost rate, the allocated indirect costs can be derived from the allocation process through the provider’s approved cost allocation plan. These allocated indirect costs are reduced by any unallowable amount based on Medicaid non-institutional reimbursement policy. The indirect cost details are accumulated on the annual cost report.

d) Net direct costs (b) and indirect costs (c) are combined.

e) A CMS approved time study is required when providers of service do not spend 100% of their time providing the ADHC services described in the applicable section 3.1-A State Plan pages and is used to determine the percentage of time that service personnel spend on direct ADHC.

f) Services, general and administrative time, and all other activities to account for 100 Services, general and administrative time and all other activities to account for 100 per percent of the time to assure that there is no duplicate claiming. This CMS approved time study methodology will be used to separate administrative activities and direct services. The direct Adult Day Health Care Services time study percentage is applied against the net direct and indirect costs.

g) Medicaid's portion of total allowable costs is calculated by multiplying the result from item (e) above to the ratio of the total units of service provided to Medicaid eligible clients to the total units of service provided.

h) Total Medicaid allowable costs (f) is reduced by any revenue, e.g. Medicaid co-payments, TPL, received for the same services to arrive at the total Medicaid net allocable and allowable costs.

C. Facilities that are used for multiple purposes and the provision of medical services is not the primary purpose:

a) Direct costs include unallocated payroll costs and medical equipment and supplies. Unallocated payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct care staff.

b) The Direct costs from Item (a) are reduced by any amount that is not in compliance with Medicaid non-institutional reimbursement policy and are further reduced by any federal payments for those costs, resulting in adjusted direct costs.

c) Indirect costs are determined by applying the cognizant agency approved indirect cost rate to its net direct costs (Item b.). If the entity has no approved indirect cost rate, the allocated indirect costs can be derived from the allocation process through the provider's approved cost allocation plan. These indirect costs are reduced by any allowable amount. For these facilities, allowable costs are only those costs that are "directly attributable" to the professional component of providing the medical services and are in compliance with Medicaid non-institutional reimbursement policy. For those costs incurred that "benefit" multiple purposes but would be incurred at the same level if the medical services did not occur are not allowed, e.g., room and board, allocated cost from other related organizations. The indirect cost details are accumulated on the annual cost report.

d) Net direct costs (Item (b)) and indirect costs (Item (c)) are combined.

e) A CMS approved time study is required when providers of service do not spend 100% of their time providing the Adult Day Health Care Services described in the applicable section 3.1-A State Plan pages and is used to determine the percentage of time that service personnel spend on direct Adult Day Health Care Services, general and administrative time, and all other activities to account for 100 percent of the time to assure that there is no duplicate claiming. This CMS approved time study methodology will be used to separate administrative activities and direct services. The direct Adult

Day Health Care Services time study percentage is applied against the net direct and indirect costs.

f) Medicaid's portion of the total net allocable and allowable costs is calculated by multiplying the result from Item (e) above to the ratio of total units of service provided to Medicaid eligible clients to the total units of service provided.

g) Total Medicaid allowable costs (Item f) is reduced by any revenue received for the same services, e.g. Medicaid co-payments and TPL, to arrive at the total Medicaid net allocable and allowable costs.

3. Cost Reconciliation Process

Governmental providers will be responsible for reconciling total computable costs reported on the cost report to the provider's Medicaid interim payments for Medicaid services delivered during the reporting period as documented in the MMIS, resulting in cost reconciliation. The cost reconciliation process must be completed within twenty-four months of the end of the reporting period covered by the annual Cost Report.

4. Cost Settlement Process

If a governmental provider's interim payments exceed the actual, certified costs of the provider for services to Medicaid clients, the DHCFP will recoup the federal share of the overpayment using one of the following two methods:

1. Off-set all future claims payments from the provider until the amount of the federal share of the overpayment is recovered;
2. The provider will return an amount equal to the overpayment.

If the actual, certified costs exceed the interim Medicaid payments, the DHCFP will pay the federal share of the difference to the provider in accordance with the final actual certification agreement.

The DHCFP will issue a notice of settlement that denotes the amount due to or from the provider.

1915(i) Home and Community Based Services (HCBS) State Plan Services
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Services provided by an out-of-state provider require prior authorization by Nevada Medicaid, which must verify that the services required by Medicaid-eligible or pending-eligible clients are not available in Nevada. The out-of-state payment rate for services provided by an out-of-state provider is based on one of the following criteria:

a. The out-of-state provider will be paid the lesser of the provider's billed charges or the fee-for-service rate that is paid to an in-state provider for the service.

b. If the out-of-state provider refuses to accept this rate, then the out-of-state provider may be paid the lesser of the provider's billed charges or the same fee-for-service rate as it would be paid by its home state Medicaid program.

c. For services that cannot be provided by a provider that accepts payment under (A) or (B), 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.

1915(i) Home and Community Based Services (HCBS) State Plan Services
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

8. Fixed hourly rate is scaled to the proper unit based on the procedure code.

This rate has been compared to other private sector fee-for-service rates. Documentation of the assumptions used, rate development methodology, and fee schedule payment rates will be maintained by The Division of Health Care Financing and Policy.

The agency's rates were set as of January 1, 2006 and are effective for services on or after January 1, 2006. All rates are published on the agency's website at: http://dhcfp.nv.gov.

1915(i) Home and Community Based Services (HCBS) State Plan Services
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Services provided by an out-of-state provider require prior authorization by Nevada Medicaid, which must verify that the services required by Medicaid-eligible or pending-eligible clients are not available in Nevada. The out-of-state payment rate for services provided by an out-of-state provider is based on one of the following criteria:

d. The out-of-state provider will be paid the lesser of the provider's billed charges or the fee-for-service rate that is paid to an in-state provider for the service.

e. If the out-of-state provider refuses to accept this rate, then the out-of-state provider may be paid the lesser of the provider's billed charges or the same fee-for-service rate as it would be paid by its home state Medicaid program.

f. For services that cannot be provided by a provider that accepts payment under (A) or (B), 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.

1915(i) Home and Community Based Services (HCBS) State Plan Services
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

☒ Habilitation

☒ Home and Community Based Services (HCBS) Home-Based Habilitation

The billable units of service for Home-Based Habilitation Services are:

- Half Day Medical Rehab – 1 unit is 3 hrs
- Full Day Medical Rehab – 1 unit is 6 hrs
- Residential Medical Rehab – 1 unit is 24 hours
- Community/work integration training – 1 unit per 15 mins

The Home-Based Habilitation Services are reimbursed the lower of a) billed charges for b) fee schedule rates of:

- Half Day Medical Rehab - $220.38/unit
- Full Day Medical Rehab - $440.75/unit
- Residential Medical Rehab - $651.00/per diem
- Community/work integration training - $5.38/unit

The fee schedule rates for the billing units of the Home-Based Habilitation services are developed based on the following components:

- Wage information – except for physician, wage information is based on reports from the Bureau of Labor Statistics (BLS) and identified by Medicaid staff as comparable to Home-Based Habilitation services. The healthcare professionals for home-based habilitation services include:
  - Case Managers
  - Therapists (PT/OT/ST)
  - Registered Nurses
  - Rehab Technicians
  - Psychologists

- Physician Contract Costs – estimate of hourly cost of contracted physician is based on BLS reports for gross salary of primary care physicians, grossed up to reflect ratio of practice revenue to pre-tax salary equivalent.

- Employee related expenses (ERE) percentage of 27% includes employee benefits such as life insurance, medical insurance, employee education benefits, etc. and statutory employer contributions such as social security, unemployment insurance, workers' compensation and Medicare.

- Other costs and economy factor: Approximately 35% of total business costs relate to non-direct care activities. Non-direct care activities include facility rent/lease, purchased services, accounting, legal, utilities, supplies, postage, copying, administrative/business travel, insurance, fidelity bond, etc.

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1915(i) Home and Community Based Services (HCBS) State Plan Services
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

The economy factor, approximately 15%, represents an additional premium in addition to direct and other costs to attract willing and qualified service providers.

The following steps are used to form a reasonable basis to determine the average fee schedule rates:

1. The State will use the hourly wage information of each healthcare professional, from the BLS and the contract rate estimate for physicians.
2. The hourly compensation for each professional is allocated to each billable service unit, i.e. half day, full day and 24 hours residential, based on the average proportion of the time each healthcare professional provided for each billable service unit.
3. The aggregate amount of each individual professional's allocated compensation by billable service unit (Item 2) is increased by 27% of ERE to equal to direct care costs by each billable service unit.
4. Other costs and economy factor are applied to the direct care costs by each billable service unit (Item 3) to equal the estimated amount of all other costs and economy factor by each billable unit.
5. The sum of direct care costs (Item 3) and other costs and economy factor (Item 4) of all the billable services is adjusted to account for the impact of utilization patterns to arrive at the fee schedule rate for each of the billable services. The utilization of each billable service unit is:

    - Half Day Medical Rehab - 5%
    - Full Day Medical Rehab - 50%
    - 24 hour Residential - 45%

The agency's rates were set as of January 1, 2006 and are effective for services on or after January 1, 2006. All rates are published on the agency's website at: http://dhcfp.nv.gov.

1915(i) Home and Community Based Services (HCBS) State Plan Services
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

For Individuals with Chronic Mental Illness, the following services provided by a government entity:

☒ Home and Community Based Services (HCBS) Day Treatment or Other Partial Hospitalization Services for Individuals with Chronic Mental Illness

Partial Hospitalization - 1 unit per 60 mins
Intensive Outpatient Program - per Diem

Rate Methodology:

HCBS Day Treatment or Other Partial Hospitalization services provided by a state or local government entity for individuals with chronic mental illness are reimbursed according to a methodology used to certify costs as representing expenditures eligible for FFP and may be used only by providers who undergo all Medicaid cost identification, reporting, reconciliation and settlement procedures.

I. the lower of: a) billed charges; or b) an interim rate. The Interim rate is the rate for a specific service for a period that is provisional in nature, pending the completion of cost reconciliation and a cost settlement for that period.

To determine the Medicaid-allowable direct and indirect costs of providing HCBS Day Treatment or Other Partial Hospitalization services the following steps are performed:

1. Interim Rates

Governmental providers are reimbursed on an interim basis for direct medical services per unit of service at the lesser of the provider's billed charges or a provider-specific interim rate. A provider-specific interim rate is an annual rate for the specific services for a period that is provisional in nature, pending the completion of cost reconciliation and a cost settlement for that period. Interim rates are based on program experience and cost data reported during the prior fiscal year.

2. Annual Cost Report Process

Each governmental provider will complete an annual cost report in the format proscribed by Nevada Medicaid in the Medicaid Operations Manual for all medical services delivered during the previous state fiscal year covering July 1 through June 30. The cost report is due on or before December 1 of the year following the close of the reporting period. The primary purposes of the cost report are to:

a. document the provider's total Medicaid-allowable cost for delivering the medical services, including direct costs and indirect costs, based on the methodologies/steps described below; and
b. reconcile its interim payments to its total Medicaid-allowable costs.

1915(i) Home and Community Based Services (HCBS) State Plan Services
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

The methodologies/steps are incorporated in the approved Cost Allocation Plan (PACAP) to facilitate the accumulation of Medicaid allocable and allowable cost.

The annual Medicaid Cost Report includes a certification of the provider's actual, incurred allocable and allowable Medicaid costs/expenditures. All filed annual Cost Reports are subject to audit by DCHFP or its designee.

To determine the Medicaid-allowable direct and indirect costs of providing covered services to Medicaid-eligible clients, the following steps are performed:

A. Facilities that are primarily providing medical services

(a) Direct costs for covered services include unallocated payroll costs and other unallocated costs that can be directly charged to covered medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct care staff. Other direct costs include costs directly related to the delivery of covered services, such as supervision, materials and supplies, professional and contracted services, capital outlay, and travel. These costs must be in compliance with Medicaid non-institutional reimbursement policy and are accumulated on the annual cost report, resulting in total direct costs.

(b) The direct costs from Item (a) are reduced by any amount that is not in compliance with Medicaid non-institutional reimbursement policy and are further reduced by any federal payments for those costs resulting in adjusted direct costs for covered services.

(c) Indirect costs are determined by either applying the agency specific approved indirect cost rate to its net direct costs. If the provider has no approved indirect cost rate, the allocated indirect costs can be derived from the allocation process through the provider’s approved cost allocation plan. These allocated indirect costs are reduced by any unallowable amount based on Medicaid non-institutional reimbursement policy. The indirect costs details are accumulated on the annual cost report.

(d) Net direct costs (Item b) and indirect costs (Item c) are combined.

(e) A CMS approved time study is required when providers of service do not spend 100% of their time providing the Medical services described in the applicable section 3.1-A State plan pages and is used to determine the percentage of time that medical service personnel spend on direct medical services, general and administrative time, and all other activities to account for 100 percent of the time to assure that there is no duplicate claiming. This CMS approved time study methodology will be used to separate administrative activities and direct services.

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The direct medical services time study percentage is applied against the net direct and indirect costs.

(f) Medicaid's portion of total allowable costs is calculated by multiplying the result from Item (e) above to the ratio of the total units of service provided to Medicaid eligible clients to the total units of service provided.

(g) Total Medicaid allowable costs (Item f) is reduced by any revenue, e.g. Medicaid co-payments and TPL, received for the same service to arrive at the total Medicaid net allocable and allowable costs.

B. Facilities that are used for multiple purposes, and the provision of medical services is not the primary purpose

(a) Direct costs include unallocated payroll costs and medical equipment and supplies. Unallocated payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct care staff. These costs are accumulated on the annual cost report.

(b) The Direct costs from Item (a) are reduced by any amount that is not in compliance with Medicaid non-institutional reimbursement policy and are further reduced by any federal payments for those costs, resulting in adjusted direct costs.

(c) Indirect costs are determined by applying the agency specific approved indirect cost rate to its net direct costs (Item b.). If the entity has no approved indirect costs rate, the allocated indirect costs can be derived from the allocation process through the provider's approved cost allocation plan.

These indirect costs are reduced by any unallowable amount. For these facilities, allowable costs are only those costs that are "directly attributable" to the professional component of providing the medical services and are in compliance with Medicaid non-institutional reimbursement policy. For those costs incurred that "benefit" multiple purposes but would be incurred at the same level if the medical services did not occur are not allowed, e.g. room and board, allocated cost from other related organizations. The indirect cost details are accumulated on the annual cost report.

(d) Net direct costs (Item (b)) and indirect costs (Item (c)) are combined.

(e) A CMS approved time study is required when providers of service do not spend 100% of their time providing the medical services described in the applicable section 3.1-A State plan pages and is used to determine the percentage of time that medical service personnel spend on direct medical services, general and administrative time, and all other activities to account for 100 percent of the time to assure that there is no duplicate claiming. This time study methodology will be used to separate administrative activities and direct services. The direct medical services CMS approved time study percentage is applied against the net direct and indirect costs.

(f) Medicaid's portion of the total net allocable and allowable costs is calculated by multiplying the result from Item (e) above to the ratio of total units of service provided to Medicaid eligible clients to the total units of service provided.

(g) Total Medicaid allowable costs (Item f) is reduced by any revenue received for the same services, e.g. Medicaid co-payments and TPL, to arrive at the total Medicaid net allocable and allowable costs.

3. Cost Reconciliation Process

Governmental providers will be responsible for reconciling total allowable computable costs reported on the cost report to the provider's Medicaid interim payments for Medicaid services delivered during the reporting period as document in the MMIS, resulting in cost reconciliation. The cost reconciliation process must be completed within twenty-four months of the end of the reporting period covered by the annual Cost Report.

4. Cost Settlement Process

If a governmental provider's interim payments exceed the actual, certified costs of the provider for services to Medicaid clients, the DHCFP will recoup the federal share of the overpayment using one of the following two methods:

1. Off-set all future claims payments from the provider until the amount of the federal share of the overpayment is recovered;
2. The provider will return an amount equal to the overpayment.

If the actual, certified costs exceed the interim Medicaid payments, the DHCFP will pay the federal share of the difference to the provider in accordance with the final actual certification agreement.

The DHCFP will issue a notice of settlement that denotes the amount due to or from the provider.

1915(i) Home and Community Based Services (HCBS) State Plan Services
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

For Individuals with Chronic Mental Illness, the following services provided by non-governmental entities and governmental entities who do not undergo the Medicaid cost identification and reporting procedures:

☒ Home and Community Based Services (HCBS) Day Treatment or Other Partial Hospitalization Services for Individuals with Chronic Mental Illness

The billable units of service for HCBS Day Treatment or Other Partial Hospitalization Services for Individuals with Chronic Mental Illness are:

Partial Hospitalization - 1 unit per 60 mins
Intensive Outpatient Program – per Diem

Rate Methodology:

The rate is market based. This model is developed to reflect service definitions, provider requirements, operational service delivery and administrative considerations. The following elements are used to determine the rate:

- Wage information is taken from the Bureau of Labor Statistics (BLS). The wage is based on similar occupations reported by BLS and identified by Medicaid staff as comparable to services provided under the intensive outpatient program and partial hospitalization program.
- Employee related expenses (ERE) percentage of 27% was based on input from the Task Force members and Medicaid Staff. It includes paid vacation, paid sick leave, holiday pay, health insurance, life insurance, disability, workers compensation, and legally required payroll taxes.
- Productivity adjustment factor which accounts for the amount of non-billable time spent by staff. This includes the time staff needs to complete required documentation and record keeping, time associated with missed appointments and average travel time by the provider.
- Program Support costs – costs based on average of 4 hours per day. This is to assist with paperwork and follow-up related treatment.
- Allowance for supervisory time – costs for the time directly spent in supervising the medical professional providing these services.
- Allowance for capital costs – the costs is not included in the Administrative overhead. It includes the average hourly expense for building rental and maintenance, equipment leasing and utility expenses.
- Administrative overhead, 10%, is the percentage of service cost that should result from non-direct care activities. It includes insurance, administrative staff, operations and management activities and office supplies. Capital and related expenses is not included. It also does not include staff training.

1915(i) Home and Community Based Services (HCBS) State Plan Services
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

The following steps are used to determine the rates:

1. The State will use Nevada-specific hourly wages from the Bureau of Labor Statistics as of May, 2004 inflated to June, 2006.
2. The hourly amount is increased by the 27% ERE.
3. A productivity factor is applied to the hourly compensation calculated in Item 2 to equal the hourly rate.
4. The hourly rate per individual is the hourly rate (Item 3) divided by the number of individuals based on staffing ratio assumption.
5. The adjusted hourly rate per individual is the hourly rate per individual (Item 4) increased by the program support costs per hour per individual, allowance for supervisory time and capital costs per hours.
6. Administrative overhead 10% is applied to the adjusted hourly rate per individual (Item 5).
7. Total hourly rate is the sum of the adjusted hourly rate per individual before administrative overhead (Item 5) and the administrative overhead (Item 6).
8. Total hourly rate is scaled to the proper unit based on the billable unit of service.

These rates have been compared to other private sector fee-for-service rates. Documentation of the assumptions used, rate development methodology, and fee schedule payment rates will be maintained by the Division of Health Care Financing and Policy (DHCFP).

The agency's rates were set as of January 1, 2006 and are effective for services on or after January 1, 2006. All rates are published on the agency's website at: http://dhcfp.nv.gov.

1915(i) Home and Community Based Services (HCBS) State Plan Services
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Services provided by an out-of-state provider require prior authorization by Nevada Medicaid, which must also verify that the services required by Medicaid-eligible or pending eligible clients are not available in Nevada. The out-of-state payment rate for services provided by an out-of-state provider is based on one of the following criteria:

a. The out-of-state provider will be paid the lesser of the provider's billed charges or the fee-for-service rate that is paid to an in-state provider for the services.

b. If the out-of-state provider refuses to accept this rate, then the out-of-state provider may be paid the lesser of the provider's' billed charges or the same fee-for-service rate as it would be paid by its home state Medicaid program.

c. For services that cannot be provided by a provider that accepts payments under (A) or (B), 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.

1915(i) Home and Community Based Services (HCBS) State Plan Services
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

2. Presumptive Eligibility for Assessment and Initial HCBS. Period of presumptive payment for HCBS assessment and initial services, as defined by 1915(i)(1)(J):

☒ The State does not elect to provide for a period of presumptive payment for individuals that the State has reason to believe may be eligible for HCBS.

☐ The State elects to provide for a period of presumptive payment for independent evaluation, assessment, and initial HCBS. Presumptive payment is available only for individuals covered by Medicaid that the State has reason to believe may be eligible for HCBS, and only during the period while eligibility for HCBS is being determined. The presumptive period will be 60 days (not to exceed 60 days).

2. OUTPATIENT HOSPITAL SUPPLEMENTAL PAYMENTS

This section of the state plan contains the provisions for making additional Medicaid payments, in order to preserve access to outpatient hospital services for needy individuals in the state of Nevada. Effective for services provided on or after March 1, 2010, the state's Medicaid hospital reimbursement system shall provide for supplemental outpatient payments to non-state, governmentally owned or operated hospitals. These supplemental payments shall be determined on an annual basis and paid to qualifying hospitals on a quarterly basis. The supplemental payments shall not exceed, when aggregated with other fee-for-services outpatient hospital 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 in accordance with the federal upper limit regulations at 42 CFR §447.321.

a. Methodology for Determining Outpatient Supplemental Payments:

The hospitals that qualify for outpatient supplemental payments will have their payment amount determined using a payment-to-charge ratio UPL methodology.

Outpatient supplemental payments for each hospital will be calculated using following method:

(i) Calculate Total Medicare Outpatient Payments from: CMS 2552-96 Wkst E Part B, Col 1, Line 17 + CMS 2552-96 Wkst E Part B, Col 1, Line 17.01 + CMS 2552-96 Wkst E Part B, Col 1, Line 21+22 [Add comparable fields for sub providers 1 and 2]

(ii) Calculate Total Medicare Outpatient Charges from: CMS 2552-96 Wkst D Part V, Line 104, Col 5 + CMS 2552-96 Wkst D Part V, Line 104, Col 5.01 + CMS 2552-96 Wkst D Part V, Line 104, Col 5.02 + CMS 2552-96 Wkst D Part V, Line 104, Col 5.03 [Add comparable fields for sub providers 1 and 2]

(iii) Calculate Medicare Outpatient Payment to Charge Ratio. The ratio is calculated by dividing the result of (i) by (ii)

[Total Medicare Outpatient Payments] ÷ [Total Medicare Outpatient Charges]

(iv) The result of (iii) is multiplied by Medicaid Outpatient charges in order to determine the Estimated Medicare Outpatient Services Upper Payment Limit. Total Medicaid Outpatient charges shall be derived from Nevada Medicaid Management Information System (MMIS) adjudicated claims data.

(v) Total Medicaid Outpatient Payments for the period are subtracted from the result (iv) to determine the annual amount of Outpatient Supplemental Payment. Total Medicaid Outpatient payment shall be derived from Nevada Medicaid Management Information System (MMIS) adjudicated claims data.

b. Outpatient Supplemental Payments:

(i) Each qualifying hospital will provide documentation of CMS form 2552 cost report for Medicare charge and payment information for the previous fiscal year to Medicaid by April 1st of each year.

(ii) Beginning April 2010, Medicaid will calculate the total outpatient supplement payment for qualifying hospitals using the methodology in section A. above. At the end of each calendar quarter, hospitals will receive a payment amount equal to 25% of the hospital's total outpatient supplemental payment.

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.

Other Provider-Preventable Conditions

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

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 Other Provider-Preventable Conditions

The State Agency's fiscal agent will review claims with dates of service on or after July 1, 2012 for OPPCs and report to the State. The state's Surveillance and Utilization Review (SUR) unit will review each claim identified in that report and recover payments associated with the OPPC.

Payment Adjustment

For OPPCs not present on admission, payment will be reduced to those costs not associated with an OPPC, using standard rates assigned to CPT and HCPCS codes for reimbursement by the DHCFP.

The existing appeals process will be available to providers who dispute the determination.

(Reserved for Future Use)

Assurances

These reimbursement methodologies are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that these services are available to the general population, as required by 42 CFR 447.204.

These rates comply with the requirements of Section 1902(a)(30) of the Social Security Act and 42 CFR 447.200, regarding payments and are consistent with economy, efficiency and quality of care.

Rate methodology and provider retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained.

Assurances

The reimbursement methodology described in Attachment 4.19B, page 5 will not exceed the federal upper payment limit for such services as described in 42 CFR 442.321. To the extend reimbursements exceed upper payment limits, the State will return to CMS any federal funds used to reimburse these providers in excess of this limit. To establish the federal upper payment limit for these services the following methodology is used:

1. Segregation: Providers are divided into two primary categories – hospital based providers and free-standing clinics. These two categories are further segregated three additional categories:
   a. Privately-owned or operated facilities.
   b. State government-owned or operated facilities
   c. Non-state government-owned or operated facilities

2. Free-Standing Privately-owned or operated facility UPL estimation
   a. A sample of at least one calendar quarter of Medicaid claims for these providers will be used as base data.
   b. Medicaid reimbursement is estimated for these claims using the methodology described in 4.19B, page 5.
   c. Medicare reimbursement is estimated using the guidelines established in the Medicare Claims Processing Manual and Transmittal AB-03-116.
   d. The amounts calculated in b. and c. are compared. If b. is less than c. Medicaid reimbursement is in conformance with the provisions of 42 CFR 422.321.

3. Free-Standing state and non-state government-owned or operated facilities – there are no facilities providing services under attachment 4.19B, page 5 in Nevada.

4. Hospital-based privately-owned or operated facilities.
   a. The methodology utilizes Medicare cost principles to estimate UPL
   b. The methodology includes all hospital outpatient services, including those provided under 4.19B, page 1 and page 5.
   c. The most recently filed Medicare cost report outpatient cost to charge ratio is used for each facility.
   d. A sample of at least one calendar quarter of Medicaid claims for the services described in 4.b. above will be used as base data.
   e. Medicaid reimbursement is estimated for these claims using the methodology described in attachment 4.19B.
   f. Medicare reimbursement is estimated by multiplying the total billed charges for each facility from d. above by the cost to charge ratio from b. above. The result is the Medicare UPL for these services.
   g. The amounts calculated in e. and f. are compared. If e. is less than f. Medicaid reimbursement is in conformance with the provisions of 42 CFR 422.321

5. Hospital-based state government-owned or operated facilities – there are no facilities providing services under attachment 4.19B, page 5 in Nevada.

6. Hospital-based non-state government owned or operated facilities estimations are based on the same methodology described in 4. above.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nevada

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

   For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item __ of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR."

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item __ of this attachment, for those groups and payments listed below and designated with the letters "NR".

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item 1 of this attachment (see 3. above).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nevada

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A	SP Deductibles SP Coinsurance
	Part B	SP Deductibles SP Coinsurance
Other Medicaid Recipients	Part A	____ Deductibles ____ Coinsurance
	Part B	SP Deductibles SP Coinsurance
Dual Eligible (QMB Plus)	Part A	SP Deductibles SP Coinsurance
	Part B	SP Deductibles SP Coinsurance

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT METHODS AND STANDARDS FOR ESTABLISHING PAYMENT FOR ORGAN TRANSPLANT SERVICES AND OUT-OF-STATE EMERGENCY SERVICES

In order to ensure adequate access to organ transplant services and to emergency services for a recipient while outside of the State of Nevada, Nevada Medicaid uses the following general method for payment for professional services related to organ transplant services and out-of-state emergency services:

1. Scope: This section is applicable to all professional services rendered by a physician outside of those services provided by the acute care hospital. This includes charges for attendant physicians and post discharge care. Additionally, this applies to all organ search and match services and emergency transportation services.

2. Reimbursement: Provider reimbursements under this supplement must conform to the following:

   a) All providers are reimbursed by default according to Nevada Medicaid in-state provider rates as described in Attachment 4.19B of the State Plan.

   b) If the provider refuses to accept these rates, Nevada Medicaid will negotiate reimbursement at the applicable rate of the provider's home state Medicaid program.

   c) If the provider refuses to accept the rates in either a) or b) above, Nevada Medicaid will negotiate provider specific reimbursement agreements according to the following criteria:

      1) The service must only be available from a limited number of out-of-state providers. In Nevada Medicaid's judgment, the service provider which is most cost effective will be authorized to provide the service.

      2) Reimbursement agreements will be established only for a limited specific set of services applicable under this section and not for all general services the provider may render.

      3) Reimbursement agreements will be for a limited duration of time not to exceed two years to ensure the requirements in 1) above are met.

      4) Reimbursement agreements may be in the form of a total amount for the entire service (such as for a particular type of transplant), a percentage of billed charges, or a specific fee schedule.

      5) Under no circumstances will reimbursement agreements exceed the usual and customary charges of the provider.

Payments for Selected Critical Access Hospitals for Providing Telehealth Services

For dates of service beginning November 24, 2016 and ending July 31, 2019, Battle Mountain General Hospital, Grover C Dils Medical Center, Mount Grant General Hospital and Pershing General Hospital will be reimbursed for telehealth services using a cost-based methodology as described below:

1. Interim Payments

   a) Each facility identified above is reimbursed on an interim basis for telehealth services provided at the Nevada Medicaid outpatient hospital services fee-for-services rates.

2. Quarterly Cost Reconciliation/Payment Process

   a) Within 60 days after the end of each quarter each facility identified above will submit to the DHCFP a summary of all telehealth encounters paid during the previous quarter, identified by the telehealth Originating Site Facility Fee code, Q3014, and the related Medicaid charges.

   b) The DHCFP will determine the total Medicaid charges for each facility by totaling the Medicaid charges for all telehealth encounters submitted under #a above.

   c) The DHCFP will apply the facility's most current available Medicare approved telemedicine cost to charge ratio to the total Medicaid charges (see #b above) to determine the total cost of Medicaid telehealth services provided in the quarter.

   d) If the total quarterly actual costs for providing Medicaid telehealth services as determined under #c exceeds the total interim Medicaid payments for the quarter, the DHCFP will pay the facility the difference.

      If the facility's total interim quarterly Medicaid payments for the telehealth services exceeds the actual cost determined under #c above, the DHCFP will recoup the overpayment using one of the following two methods:

      i. Off-set all future claims payment from the facility until the amount of the overpayment is recovered;
      ii. The facility will return an amount equal to the overpayment.

State: Nevada

PAYMENT FOR RESERVED BEDS FOR THERAPEUTIC LEAVE OF ABSENCE

1. Payment for reserved beds will not be made in an acute care facility.

2. Payment for therapeutic leave of absence, or reserved beds, may be made in an institution for mental diseases (IMD), a skilled nursing facility (SNF), a nursing facility (NF), an intermediate care facility (ICF), or an ICF for the mentally retarded (ICF/MR), subject to the following conditions:

   a. The purpose of the therapeutic leave of absence is for rehabilitative home and community visits including preparation for discharge to community living;

   b. The patient's attending physician authorizes the therapeutic leave of absence and the plan of care provides for such absences;

   c. An IMD, SNF, NF, ICF, or ICF/MR will be reimbursed their per diem rate for reserving beds for Medicaid recipients who are absent from the facility on therapeutic leave up to a maximum of 24 days annually. For this purpose, annually is defined as a calendar year beginning on January 1 and ending on December 31 of the same year.

State: NEVADA

PAYMENT FOR NURSING FACILITIES
ASSURANCES AND RELATED INFORMATION

A. State Assurances and Findings. The State assures that it has made the following findings:

1. 447.253(b)(1)(i) - The State pays for long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations and quality and safety standards.

2. With respect to nursing facility services -

   a. 447.253(b)(1)(iii)(A) - Except for preadmission screening for individuals with mental illness and mental retardation under 42 CFR 483.20 (f), the methods and standards used to determine payment rates take into account the costs of complying with the requirements of 42 CFR part 483 subpart B.

   b. 447.253(b)(1)(iii)(B) - The methods and standards used to determine payment rates provide for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care under a waiver of the requirements in 42 CFR 483.30 (c) to provide licensed nurses on a 24-hour basis.

   c. 447.253(b)(1)(iii)(C) - The State has established procedures under which the data and methodology used to establish payment rates are made available to the public.

3. 447.253(b)(2) - The proposed rate will not exceed the upper payment limits as specified in 42 CFR 447.272:

   a. 447.272(a) - Aggregate payments made to nursing facilities when considered separately, will not exceed the amount that can reasonably be estimated would have been paid for under Medicare Payment principles. (There are no state-operated nursing facilities to which this assurance is applicable.)

   b. 447.272(b) - Aggregate payments to ICFs/MR will not exceed the amount that can reasonably be estimated would have been paid for under Medicare payment principles. And, aggregate payments to state-operated facilities (that is ICFs/MR) - when considered separately will not exceed the amount that can reasonably be estimated would have been paid for under Medicare payment principles.

B. State Assurances. The State makes the following additional assurances:

1. For nursing facilities and ICFs/MR

a. 447.253(d)(1) - When there has been a sale or transfer of the assets of a NF or ICF/MR on or after July 18, 1984, but before October 1, 1985, the State's methods and standards provide that payment rates can reasonably be expected not to increase in the aggregate, solely as a result of a change in ownership, more than payments would increase under Medicare under 42 CFR 413.130, 413.134, 413.153 and 413.157 insofar as these sections affect payment for depreciation, interest on capital indebtedness, return on equity (if applicable), acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation.

b. 447.253(d)(2) - When there has been a sale or transfer of the assets of a NF or ICF/MR on or after October 1, 1985, the State's methods and standards provide that the valuation of capital assets for purposes of determining payment rates will not increase (as measured from the date of acquisition by the seller to the date of the change of ownership) solely as a result of a change of ownership, by more than the lesser of:

(i) 1/2 of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Dodge construction index applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year; or

(ii) 1/2 of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Consumer Price Index for All Urban Consumers (CPI-U) United State city average) applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year.

2. 447.253(e) - The State provides for an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the State determines appropriate, of payment rates.

3. 447.253(f) - The State requires the filing of uniform cost reports by each participating provider.

4. 447.253(g) - The State provides for periodic audits of the financial and statistical records of participating providers.

5. 447.253(h) The State has complied with the public notice requirements of 42 CFR 447.205

   Notice published on: May 22, 1995

6. 447.253(i) - The State pays for long term care services using rates determined in accordance with the methods and standards specified in the approved state plan.

C. Related Information

1. 447.255(a)

   Estimated average proposed payment rate **for ICFs/MR** as a result of this amendment: $190

   Average payment rate **for ICFs/MR** for the immediately preceding rate period: $186

   Amount of change: $4 Percent of change: 2.15%

   Estimated average proposed payment rate **for nursing facilities** as a result of July 1, 1995 rebasing of rates: $82.94 (There is no change in the rate attributed to the amendment.)

   Average payment rate in effect **for nursing facilities** for immediately preceding rate period: $79.33

   Amount of change: $3.61 Percent of change: 4.55%

2. 447.255(b) - The estimated short term and long term effect in the estimated average rate on:

   (a) The availability of services on a statewide and geographic area basis: NONE

   (b) The type of care furnished: NONE

   (c) The extent of provider participation: NONE

PAYMENT FOR LONG TERM NURSING FACILITY SERVICES
METHODS AND STANDARDS

Payment is made for services provided in nursing facilities, including nursing facilities for the mentally retarded, in accordance with Section 1902(a) (13) of the Social Security Act as amended.

A. Hospital-Based Facilities: (Hospital-based facility is defined as: a) a facility sharing a common building or common tract of land with a hospital owned or operated by the state, or an instrumentality or unit of government within the state, located within a county of a population of 100,000 or less; or b) a facility (public or private) which prior to July 1, 1992, was paid for both inpatient hospital services under Attachment 4.19-A of the Medicaid State Plan and long-term nursing facility services under this section.)

1. Hospital-based nursing facility services are paid for under Medicare reasonable cost-based reimbursement principles, including the routine cost limitation (RCL), and the lesser of cost or charges (LCC).

   Effective October 1, 2001, hospital-based nursing facilities shall continue to be reimbursed under Medicare's cost based reimbursement principles, along with the other provisions of paragraphs A.2 and A.3.

   Under this methodology, payment will follow any and all applicable Medicare upper payment limitation (UPL) requirements such that payments will not exceed the UPL. The rates the State of Nevada would pay per day of nursing facility care comply with the Medicare upper payment limit at 42 CFR 447.272, as amended.

   The routine cost limit (RCL) used in cost settlements will be $160.14 per day, effective October 1, 2001. This RCL will apply to cost reports ending on or after October 1, 2001, and will only apply to the portion of the cost report period on or after October 1, 2001. For those cost reports beginning prior to October 1, 2001 and ending on or after October 1, 2001, a weighted average RCL will be used. The RCL applicable to the portion of the cost report period prior to October 1, 2001 will be the per diem routine service cost paid to the facility during the most current cost report period ending prior to October 1, 2001. The RCL applicable to the portion of the cost report period on or after October 1, 2001, will be the RCL of $160.14, as adjusted for inflation. For example: If a hospital-based facility with a June 30 year end was paid $140 per day for routine service cost during its year ending June 30, 2001, the $140 per day would be the RCL for this facility during the portion of the cost reporting year from July 1, 2001 through September 30, 2001. The RCL for the remainder of the year ending June 30, 2002 (October 1, 2001 through June 30, 2002) would be the $160.14 RCL, as adjusted for inflation.

   The $160.14 RCL will be indexed (adjusted for inflation) from October 1, 2001 to the midpoint of the cost-reporting period to which it is applied. The Skilled and Intermediate Care Facilities without capital (non-seasonally adjusted) Table 9: Percent Change in Medical Prices as published by MEI will be used in indexing the RCL. If this index becomes unavailable, a comparable index will be used.

The Medicaid program will re-base the RCL every other year, beginning July 1, 2003, using audited hospital-based nursing facility cost report data, input from the hospital-based nursing facility providers, and other information deemed appropriate.

1. In no case may payment for hospital-based nursing facility services exceed the provider's customary charges to the general public for these services.

2. Effective October 1, 2013, each facility will receive an interim payment of 100% of billed charges.

B. Free-standing Nursing Facilities (Free-standing nursing facility is defined as any other facility providing nursing facility services, except hospital-based nursing facilities.):

1. Reimbursement Methodology – January 1, 2002 through June 30, 2002:

a. In preparing the free-standing nursing facilities for a resource utilization group (RUG) based Medicaid reimbursement system; a transitional rate setting process will be adopted effective January 1, 2002. The significant elements of this system include the following:

b. Base operating rates will be calculated for each facility effective January 1, 2002. The base operating rates will be calculated for each free-standing nursing facility using the weighted average operating rate for each facility effective October 1, 2001, (excluding SNL-3 days and rates). The days used to prepare the weighted average operating rates will be paid nursing facility days from January 1, 2001 through June 30, 2001 (excluding SNL-3 days) as shown on a paid claims listing prepared in November 2001. Each facility's capital rate effective October 1, 2001, will be added to their weighted average operating rate. If the statewide Medicaid day weighted average operating and capital rates, calculated as described above, exceed the budget target rate of $121.02, a budget adjustment factor will be employed to adjust the calculated rates to meet the budget target.

c. For those facilities with unstable occupancy (i.e. facilities receiving their initial Medicaid certification on or after January 1, 2000), their base rate will be adjusted for changes in Medicaid acuity as follows:

1. A snapshot Medicaid average case mix index (CMI) will be calculated for each facility effective October 1, 2001.

2. Medicaid average CMIs will be prepared for these facilities as of January 1, 2002 and April 1, 2002, using the same weights as were used to prepare the October 1, 2001 snapshot.

3. The change in average Medicaid CMI, for each unstable occupancy nursing facility as measured from October 1, 2001 to January 1, 2002, and from October 1, 2001 to April 1, 2002, will be used to proportionally increase or decrease 40% of that facility's operating rate effective January 1, 2002 and April 1, 2002.

2. Reimbursement Methodology July 1, 2002 through June 30, 2003:

a. Effective July 1, 2002, each nursing facility's base rate (the rate in effect for each facility on June 30, 2002) will be adjusted for the change in their average Medicaid CMI. The ratio to use in this calculation will be developed using as its numerator each facility's simple average of their Medicaid CMI as of January 1, 2002 and April 1, 2002. The denominator will be the simple average of each facility's Medicaid CMI calculated as of October 1, 2001 and January 1, 2002.

b. The rates in 2.a. will be further acuity-adjusted quarterly. In preparing these rate adjustments, the denominator of the fraction described in item 2.a. above will remain unchanged for each facility. The numerator of the fraction for October 1, 2002 adjustment will reflect the simple average of each facility's Medicaid CMI as of April 1, 2002 and July 1, 2002. The July 2002 and October 2002 average Medicaid CMI will be used in the January 1, 2003 rate setting, while the October 2002 and January 2003 average Medicaid CMI will be used in the April 1, 2003 rate adjustments.

c. The acuity-adjusted rates, as described above in item 2.a. and b., will be further adjusted by an adjustment factor to not exceed the industry Medicaid weighted average per patient day rate effective January 1, 2002 as described in B. 1. b. above.

d. 40% of each facility's weighted average operating rate will be subject to the acuity adjustments described in this section.

e. Facilities that were initially certified between July 1, 1999 and December 31, 1999, will have their rates adjusted to reflect the adjustments to rates that were made to unstable occupancy facilities during the period of January 1, 2002 through June 30, 2002. These rate adjustments will be effective July 1, 2002. The intent of this provision is to treat facilities initially certified during this period as if they had been identified as unstable occupancy facilities during the period from January 1, 2002 through June 30, 2002.

(Reserved For Future Use)

3. Reimbursement Methodology – Effective July 1, 2003:

Effective July 1, 2003, a nursing facility price-based reimbursement system will be implemented. Individual facility rates will be developed from prices established for three separate cost centers: operating, direct health care and capital. The allowable cost used in these rate setting activities will be nursing facility health care cost determined to be allowable in accordance with the Medicare / Medicaid provider reimbursement manual, commonly referred to as HIM 15.

a. **Operating Cost Center** – The operating cost center will be comprised of all allowable cost excluding direct care cost, capital cost and direct ancillary service cost. The statewide price for this cost center will be set at 105% of the Medicaid day weighted median.

Direct Health Care Cost Center – The direct health care cost center will be comprised of allowable RN, LPN, and Nursing Aide salaries and wages; a proportionate allocation of allowable employee benefits; and the direct allowable cost of acquiring RN, LPN and Nurse Aide staff from outside staffing companies. The statewide price will be established for this cost center at 110% of the Medicaid day weighted median case mix neutralized cost. In preparing the case mix neutralization, a minimum of two calendar quarters from each facility's available quarterly facility wide case mix index information that most closely matches their base year cost report will be used to calculate the Medicaid day weighted average. On a quarterly basis, each facility's specific direct health care price is determined by adjusting the statewide price using as the numerator, the facility's most current quarterly Medicaid case mix index and as the denominator, the Medicaid day weighted average of the facility wide case mix indexes used in setting the statewide price.

c. **Capital Cost Center** – This cost center will be comprised of allowable depreciation, capital related interest, rent / lease, and amortization expenses. A fair rental value (FRV) reimbursement system will be used to determine each facility's capital rate. The following items will be used in determining each facility's FRV rate:

i. Value of New Beds (7/01/03) $73,000.00

ii. Bed Value Indexed Annually (using Marshall Swift, Class C nursing facility index)

iii. Rate of Depreciation 1.5%
Year

iv. Maximum Age 40
Years

v. Rental Rate 9.0%
Annually

vi. Minimum Occupancy Percent 92%

These values will be used to determine a facility's FRV payment as demonstrated below:
(Example facility has 100 beds and is 10 years old)

Licensed Beds	100
Times Value / Bed	$73,000
Gross Value	$7,300,000
Depreciation Rate (1.5% x 10 Years)	15%
Depreciated Value (85%)	$6,205,000
Rental Rate	9%
FRV Payment (Gross)	$558,450
Divided by Greater of Actual or Minimum Days	33,580
Fair Rental Value Payment	$16.63

1) **Capital Renovations / Remodeling Projects** – The fair rental value of each facility will be adjusted (increased) to reflect the cost of major renovation / replacement projects completed by each facility not to exceed a 24-month period. The renovation / replacement adjustment would be made at the start of the first rate year following completion of the renovation / replacement project.

The cost of renovation / replacement projects must be documented within each facility's depreciation schedule, must be reported to the Medicaid program by May 1st prior to the July 1st rate year when they would first be eligible for incorporation into the FRV rate setting process, and must exceed $1,000.00 per licensed bed in order to be considered a major renovation / replacement. The cost of these renovation / replacement projects will be depreciated at a rate of 4% per year, but will also be indexed (inflated) annually using the bed value indexing methodology incorporated into this fair rental value system.

2) **Initial Age of Nevada Nursing Facilities for July 1, 2003 FRV Calculations** – The initial age for each facility shall be determined as of July 1, 2003, using each facility's year of construction. This age will be reduced for renovations and/or additions of beds that have occurred since the facility was built. If a facility added beds, these new beds will be averaged in with the original beds and a weighted average age for all beds will be used as the initial age. If a facility performed a major renovation project between the time the facility was built and the time when the initial age is determined, the cost of the renovation project will be used to determine the equivalent number of new beds that project represents. The equivalent number of new beds would then be used to determine the weighted average age of all beds for this facility. The equivalent number of new beds from a renovation project will be determined by dividing the cost of the renovation project by the cost of a new bed (using the new bed valuation methodology incorporated into the FRV system) at the time the renovation project was completed. Facility ages will be rounded to the nearest whole number.

d. **Inflation Factor Used in Rate Setting** – When establishing the medians for the operating and direct health care cost centers, cost will be adjusted from the midpoint of each provider's base year cost report to the midpoint of each state fiscal year using the Nursing Home Services without capital (non-seasonally adjusted Table 9: Percent Change in Medical Prices) as published by MEI. If this index becomes unavailable, a comparable index will be used. In non-rebasing years, the Medians from the most recent rebasing period will be indexed forward to the midpoint of the current rate year using this indexing methodology.

e. **Base Year Cost Report (July 1, 2003 Rate Year) and Rebasing Frequency** – Cost reports used to establish the July 1, 2003 operating and direct care medians, and ultimate prices, will be the most current cost report for each facility whose audit or desk review was completed at least three (3) months prior to the July 1st rate effective date. Only audited or desk reviewed cost reports will be used in the rate setting process. New cost report information will be brought into the rate setting process on a periodic basis. The cost report information used to establish the operating and direct health care medians, and ultimate prices, will be rebased no less frequently than once every two (2) years.

f. **Minimum Direct Care Staffing Requirement** – In the event that a nursing facility does not incur direct care cost, at least equal to 94% of the direct care median, the Department will have the option to recoup from future Medicaid payments to that provider an amount equal to 100% of the difference between the provider's direct care rate and the actual cost the provider incurred. This provision is intended to encourage adequate direct care staffing.

g. **Rate Add-On to Reflect Changes in State / Federal Laws –** The Medicaid director can make adjustments to the operating price to reflect changes in state or federal laws, rules or regulations that have yet to be reflected in the base period cost report data.

h. **Budget Adjustment Factor –** In the event that the reimbursement system described in this section would result in anticipated payments to nursing facility providers being greater or less than the funding appropriated by the Nevada legislature, proportional increases or decreases will be made to the rates so that anticipated payments will equal legislative appropriations. This adjustment to rates will be made as a percentage increase or decrease in each provider's rate. The percentage will be determined in accordance with the following fraction: (Legislative appropriations / (The Sum of Each Facility's Calculated Rate Multiplied by Each Facility's Proportional Share of the Anticipated (Budgeted) Case Load for All Freestanding Nursing Facilities)). Medicaid days from the cost reports used in rate setting will be the basis for the proportional allocation of anticipated case load across all freestanding facilities.

C. Cost Reporting Requirements:

1. Hospital-based and free-standing nursing facilities must complete and file an annual cost report with the Medicaid program. Cost and other statistical information within the cost report must be reported in compliance with allowable and non-allowable cost definitions contained in the Medicare/Medicaid provider reimbursement manual (commonly referred to as HIM 15).

2. Free-standing nursing facility cost reports are to be received by the Medicaid program by the last day of the third month following a facility's fiscal year end. If the facility is unable to complete their cost report within this time frame, a request for a 30 day extension can be requested from the Medicaid program (Division of Health Care Financing and Policy) prior to the original cost report due date. Reasonable extension requests will be granted.

3. Hospital-based nursing facility cost reports are to be filed with the Medicaid program following the cost report filing deadlines adopted by the Medicare program. If a facility requests an extension from the Medicare program, they must also request an extension from the Medicaid program (Division of Healthcare Financing and Policy). Extension requests approved by Medicare will automatically be approved by the Medicaid program, once the Division of Health Care Financing and Policy receives evidence of Medicare approval from the facility.

4. Facilities failing to file a Medicaid cost report in accordance with these provisions may have their payments suspended, or be required to pay back to the Medicaid program all payments received during the fiscal year period upon which they were to provide a cost report. Facilities may also be subject to late filing fees assessed in accordance with guidelines issued pursuant to the Medicaid Services Manual.

D. New Facilities and Change of Ownership:

1. New facilities are those entities whose beds have not previously been certified to participate in the Medicaid program. New free-standing facilities will be reimbursed an interim rate computed from the following Nursing Facility rate components in effect on the date of the facility's Medicaid certification:

   a. The Fair Rental Value per diem will be determined based upon an initial capital survey the new provider completes and submits to the Division of Health Care Financing and Policy, and upon the methodology described in section B.3.c. of this attachment.

   b. The operating component for the rate will be the 'Operating Statewide Price' as described in section B.3.a. of this attachment.

   c. The direct health care component will be the 'Statewide Direct Health Care Price' as described in section B.3.b.of this attachment.

   d. The 'Budget Adjustment Factor', as described in section B.3.h. of this attachment, will be applied to determine the Facility Medicaid Rate.

   This interim rate will be paid until such time that the rate is rebased under the provisions of Section B.3.e of this attachment.

2. New hospital-based facilities will receive an interim rate equal to the average rate (expressed as a percent of charges) paid to all other hospital-based nursing facilities effective at the start of the state fiscal year in which the facility began providing services to Medicaid recipients.

3. A change of ownership exists if the beds of the new owner have previously been certified to participate in the Medicaid program under the previous owner's provider agreement. Rates paid to free-standing nursing facilities that have undergone a change of ownership will be based upon the base rate and acuity data of the previous owner. The new owner's acuity data will be used to adjust the facility's rate following the rate adjustment schedule discussed in this rule. Facilities (hospital-based and free-standing) that undergo a change in ownership are required to file a closing cost report for the seller within 45 days of the date of sale. A new cost reporting period for the buyer will start on the effective date of the transaction. The interim rate paid to a new hospital-based owner will be the same interim rate the prior owner was receiving.

Case Mix Index Calculation (Free-standing Nursing Facilities Only):

1. In calculating the case mix for each facility, CMS-mandated RUG and MDS systems will be utilized.

2. Each nursing facility resident in a facility, with a completed and submitted MDS shall be assigned to a RUG classification group on the first day of each calendar quarter. These RUG assignments will be based upon each resident's most current MDS assessment available on the first day of each calendar quarter. Using the facility's simple average of the individual residents' case mix indexes, two case mix indexes (CMIs) will be calculated for the facility. One being a facility wide CMI, which will be based upon all of the facility's residents, and the other being the Medicaid CMI, which will be calculated using only the Medicaid residents for each facility. Both of these average case mix indexes will be rounded to four decimal places.

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 individuals is the facility-specific per diem rate plus an add-on rate for each of the following three tier categories. Tier definitions can be found in the Division of Health Care Financing and Policy Medicaid Services Manual Section 503.10, Page 15, as that section reads as of January 28, 2016.

Tier I.	$111.23
Tier II.	$222.45
Tier III.	$326.26

   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.

G. Nurse Aide Training Cost:

Nursing facilities are required to reimburse certified nurses aides (CNAs) if the CNA paid for the training within one year of being employed by the facility and has not previously been reimbursed. The amount nursing facilities are required to reimburse the CNA is limited to the cost of the class and books at Nevada community colleges. The aide is to be reimbursed after three months of employment in the facility. Nursing facilities must follow the procedures specified by Nevada Medicaid to receive reimbursement from Medicaid for their share of the amount paid to the CNA. Facilities which conduct a training program will continue to bill Medicaid for the cost of the training and competency evaluation.

Supplemental Payment to Free-Standing Nursing Facilities

Effective October 1, 2011, free-standing nursing facilities will receive a supplemental Medicaid payment in addition to its standard or special care per diem payment. Supplemental payments are not available for nursing facilities owned by the State of Nevada or any of its political subdivisions. Fifty percent of the supplemental payment is based on Medicaid occupancy, MDS accuracy, and quality measures. Fifty percent of the payment is based on acuity. The amount available for supplemental payments is computed quarterly and reimbursed in the quarter in three equal monthly payments.

A. The amount available for Supplemental Payments to Nursing Facilities (NF) will be calculated each quarter based on actual net revenues from patient services and actual patient days for each facility during the Base Quarter.

1. The Base Quarter is defined as the quarter beginning six months prior to the quarter in which the supplemental payments are being distributed. (For the quarter beginning October 1, 2011, the supplemental payment computation would be based on actual net revenues and bed days for the quarter April 1 through June 30, 2011.)

2. The total amount available for Supplemental Payments is calculated by multiplying the net revenues from patient services in the Base Quarter by 6%.

3. One percent (1%) of this amount each quarter is retained by Nevada Medicaid to pay administrative costs associated with the Supplemental Payment Program. The remaining funds are the amount available to pay the state share of Supplemental Payments to free-standing nursing facilities.

4. The amount available to pay the state share of Supplemental Payments to free-standing nursing facilities is matched by federal Medicaid funds calculated according to the formula in 42 CFR 433.10 (b).

B. Calculation of Fifty Percent of Supplemental Payments Based on Medicaid Occupancy, MDS Accuracy, and Quality

1. Fifty percent of the amount available to pay the state share of Supplemental Payments to Nursing Facilities is paid out based on the facility's Medicaid occupancy, MDS accuracy, and quality scores.

2. Calculations for the Medicaid occupancy and MDS accuracy components of Supplemental Payments require bed day counts, which are the actual bed days reported by the free-standing nursing facilities for the Base Quarter.

3. The Medicaid occupancy, MDS accuracy, and quality components are calculated by assigning points to each facility for each component according to the methodologies described below. The unit reimbursement value for each of the component points is

determined by calculating the amount available to pay the state share of Supplemental Payments to Nursing Facilities for that component plus the federal Medicaid matching funds and dividing by the total points in the component for all facilities receiving Supplemental Payments for that quarter.

Calculation of the Unit Reimbursement Value for a Component

	Total Dollars Available for Component
Divided by	Total Points for Component
Equals	Unit Reimbursement Value for Component

4. Supplemental Payment for Medicaid Occupancy, MDS Accuracy, and Quality Components

i. Medicaid Occupancy Component: Distribution of 82% of the state funds available for the portion of the Supplemental Payments based on Medicaid occupancy, MDS accuracy, and quality plus the federal Medicaid matching dollars is based on Medicaid occupancy. The facility receives a Medicaid occupancy rate modifier, which is the Medicaid nursing facility and LTC hospice bed days divided by total occupied bed days times 100. The facility's Medicaid occupancy rate modifier is multiplied by the number of Medicaid nursing facility and LTC hospice bed days to yield the Medicaid occupancy points. The Medicaid occupancy points will be multiplied times the unit reimbursement value to determine the Medicaid occupancy component of the facilities' reimbursement.

Calculation of the Facility Specific Medicaid Occupancy Component of the Supplemental Payment:

	Facility Occupied Medicaid NF and LTC Hospice Bed Days
Divided By	Facility Total Occupied Bed Days
Equals	Facility Medicaid Occupancy Rate
Times	100
Equals	Facility Medicaid Occupancy Rate Modifier
Times	Facility Occupied Medicaid NF and LTC Hospice Bed Days
Equals	Facility Medicaid Occupancy Points
Times	Medicaid Occupancy Component Unit Reimbursement Value
Equals	Facility Total Medicaid Occupancy Component Payment

ii. MDS Accuracy Component: Distribution of 9% of the state funds available for the portion of the supplemental payments based on Medicaid occupancy, MDS accuracy, and quality plus the federal Medicaid matching dollars are based on MDS accuracy rate from the most current review performed by Medicaid staff. To qualify for MDS accuracy payments, the facility must have an accuracy rate of 70% or higher. Accuracy rates will be rounded to the nearest

whole percentage. If the partial percentage point is less than 0.5%, it will be rounded down to the next whole percentage point. If the partial percentage point is 0.5% or greater, it will be rounded up to the next whole percentage point. Facilities who qualify for MDS accuracy payments will be assigned an MDS accuracy modifier as follows:

Accuracy Rate	Modifier
0 – 69%	0
70 – 79%	1
80 – 89%	3
90 – 100%	5

The MDS accuracy modifier is multiplied times the number of Medicaid nursing facility and LTC hospice bed days to determine MDS accuracy points. Each facility's MDS accuracy points will be multiplied by the unit reimbursement value to determine the facility's total reimbursement for MDS accuracy component.

Calculation of the MDS Accuracy Component

Facility MDS Accuracy Modifier
Times Facility Occupied Medicaid NF and LTC Hospice Bed Days
Equals Facility MDS Accuracy Points
Times MDS Accuracy Unit Reimbursement Value
Equals Facility Total MDS Accuracy Component Payment

iii. Quality Component: Distribution of nine percent (9%) of the state funds available for the portion of supplemental payments based on Medicaid occupancy, MDS accuracy, and quality plus the federal Medicaid matching dollars is based on quality measures. The quality component of the supplemental payment provides reimbursement for a facility's efforts to improve resident care and safety. Quality measures are selected from MDS data compiled by the Nevada State Health Division Bureau of Health Care Quality and Compliance (HCQC). Four quality measures are chosen based on MDS data and input from HCQC and stakeholders. The four quality measures currently selected include: 1) Percent of long-stay residents who have moderate to severe pain; 2) Percent of high risk long-stay residents who have pressure sores; 3) Percent of long-stay residents who had a urinary tract infection; 4) Percent of long-stay residents who lose too much weight. Facilities receive one quality point for each percentage point they are better than the Nevada MDS average for each measure. Quality measure percentages are rounded to the nearest whole percentage. If the partial percentage point is less than 0.5%, it is rounded down to the next whole percentage point. If the partial percentage point is 0.5% or greater, it is rounded up to the next whole percentage point. The facility's total quality points are multiplied by the unit reimbursement value for the quality component to determine the facility specific amount of the quality component of the supplemental payment. Nursing facilities that are identified by

the Centers for Medicare and Medicaid Services as Special Focus Facilities are not eligible for the quality component of the supplemental payments. Special Focus Facilities are nursing homes that have a history of persistent poor quality of care. These nursing homes have been selected for more frequent inspections and monitoring. A current list of Special Focus Facilities is available at the CMS Certification and Compliance website.

5. Facilities that do not have MDS or MDS Accuracy data available have MDS accuracy and quality component payments calculated using the average component points of all facilities receiving Supplemental Payments for which data is available. Facilities that are not enrolled as Medicaid providers are not eligible for payments of the MDS accuracy or quality components or any other components of this supplemental payment for the quarter.

C. Calculation of the Component of the Supplemental Payments Based on Acuity

1. Nursing facility standard per diem reimbursement is calculated for each Medicaid provider quarterly based on methodology described in the Medicaid State Plan, Attachment 4.19-D, Pages 5a through 5i. The per diem rate is adjusted for acuity and fair rental value. Fifty percent (50%) of the funds available for Supplemental Payments plus the Federal matching funds is paid under this acuity component as described below.

Calculation of the Supplemental Payment Portion Based on Acuity

The weighted average total amount of reimbursement based on acuity per Medicaid nursing and LTC hospice bed day is calculated by dividing the total for amount available for the acuity component of Supplemental Payments by the total nursing and LTC hospice bed days in the Base Quarter. This is added to the weighted average budget neutral per diem for all facilities to determine the total amount of reimbursement that will be based on acuity.

	Total Available for Supplement Payments
Times	50%
Equals	Total Available for Supplemental Payments Based on Acuity
	Total Available Supplemental Payments Based on Acuity
Divided by	Total Medicaid Nursing and LTC Hospice Days
Equals	Weighted Average Acuity Supplemental Payment Per Medicaid Day
	Weighted Average Budget Neutral Per Diem of $116.66
Plus	Weighted Average Acuity Supplemental Payment Per Medicaid Day
Equals	Weighted Average Portion of Reimbursement Based on Acuity

The full rate per diem is calculated by dividing the number of Medicaid nursing and LTC

hospice bed days in the Base Quarter for facilities receiving Supplemental Payments into the total amount of reimbursement these facilities would have received if they were paid at the full per diem amount. The full rate per diem is the amount the facilities would receive if the budget adjustment factor in Nevada Medicaid State Plan, Attachment 4.19-D, page 5i, were not applied to the per diem rates. The weighted average portion of reimbursement based on acuity is divided by weighted average full rate per diem to yield a budget adjustment factor for the acuity component of the Supplemental Payment.

Total Full Rate Reimbursement for Facilities Receiving Supplemental Payments

Divided by Total Nursing and LTC Hospice Days
Equals Weighted Average Full Rate Per Diem

Weighted Average Portion of Reimbursement Based on Acuity
Divided by Weighted Average Full Rate Per Diem
Equals Budget Adjustment Factor for Supplemental Payment

The budget adjustment factor for supplemental payments is applied to the facility specific full rate per diem to arrive at a facility specific unit reimbursement value based on acuity.

The facility specific NF per diem rate for each facility is calculated by multiplying the budget adjustment factor described in Attachment 4.19-D, page 5i, times the facility specific per diem rate. This budget adjustment factor also equals the weighted average budget neutral per diem for all facilities divided by the weighted average full rate per diem.

The facility specific NF per diem rate is subtracted from the facility specific unit reimbursement value based on acuity to yield the facility specific unit reimbursement value for the Supplemental Payment based on acuity. The facility specific reimbursement unit value for the Supplemental Payment portion based on acuity is multiplied by the number of Medicaid nursing facility and hospice days in the Base Quarter to determine the quarterly Supplemental Payment based on acuity.

Calculation of the Facility Specific Supplemental Payment Based on Acuity

Facility Specific Full Rate Per Diem
Times Budget Adjustment Factor for Supplemental Payment
Equals Facility Specific Unit Reimbursement Value Based on Acuity

Facility Specific Full Rate Per Diem
Times Budget Adjustment Factor for Base NF Rates
Equals Facility Specific NF Per Diem Rate

Facility Specific Unit Reimbursement Value Based on Acuity

Minus	Facility Specific NF Per Diem Rate
Equals	Facility Specific Unit Value of Supplemental Payment Based on Acuity
Times	Number of Medicaid NF and LTC Hospice Days in Base Quarter
Equals	Facility Specific Quarterly Supplemental Payment Based on Acuity

D. The facility Supplemental Payment based on Medicaid occupancy, MDS accuracy, and quality is added to the facility specific Supplemental Payment based on acuity to yield the total facility specific Supplemental Payment amount for the quarter. The quarterly facility specific amount is divided by three to calculate the monthly Supplemental Payment.

E. Nursing facilities with negotiated facility-specific rates that exceed the standard or special care rates in the Nevada Medicaid State Plan are ineligible for supplemental payments.

H. Intermediate Care Facilities for the Mentally Retarded (ICFs/MR):

1. ICFs/MR (state-operated):

a. ICFs/MR, excluding non-state-operated ICFs/MR, are reimbursed under Medicare principles of retrospective reimbursement described in 42 CFR 413 and further specified in HCFA Publication 15.

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

c. 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.

d. Each facility is paid an interim rate subject to settlement in accordance with a. through c. above.

2. ICFs/MR (non-state-operated):

a. Prospective Payment Rate: Non-state-operated ICFs/MR-Small ("small" is defined as facilities having six beds or less) will be paid a prospective payment rate for basic service costs, other than day training costs and property costs, on a per patient day basis. Day training costs and property costs, excluded from the basic prospective rate, will be reimbursed under Medicare principles of retrospective reimbursement as described in paragraph 1 above.

1. The initial basic prospective payment rate per patient day will be the average of costs (excluding residential staff wages and benefits) of the four private ICFs/MR-Small operating a full year, from 1993 audited cost reports. Costs will be indexed to the common time period of December 31, 1993. Residential staff wages and benefits cost is calculated, and added to the average, at the rate of $11 per hour for 6.4 full-time equivalents. The initial rate period is one year from July 1, 1995 through June 30, 1996. Therefore, the rate will be adjusted for inflation for the period June 30, 1993 - December 31, 1995 (the midpoint of the cost report period to the midpoint of the rate period) by the percentage change in the Consumer Price Index - All Urban and Clerical Workers (CPI), for calendar year 1993 times 2.5. The initial rate will be effective for private ICFs/MR-Small on July 1, 1995.

2. Rates in effect March 31, 2002, will be continued without adjustment. When rebasing, costs will be indexed to a common point in time, arrayed from highest to lowest, and the cost of the 60th percentile facility selected. The rate will further be adjusted for inflation by the CPI. Only audited cost reports of private facilities completed by March 31st of the same year will be used.

3. In addition, the rate will be adjusted for increased costs of services over basic inflation resulting from new federal or state guidelines.

4. Day training costs must be approved by the Division of Mental Health Developmental Services (MHDS). These approvals must be obtained annually on all patients and anytime there is an increase in service cost.

5. Property costs consist of a property lease (or in the case of an owned facility, interest and depreciation) as well as depreciation of equipment, property insurance and property taxes.

b. Prospective Payment Rate: Non state-operated ICFs/MR-Large ("large" is defined as facilities having more than six beds) will be paid an all-inclusive prospective per diem rate equal to the interim rate in effect at December 31, 2003.

1. These all-inclusive rates will be effective for services rendered after December 31, 2003, until the rates are rebased as directed by the Department of Health and Human Services.

(Reserved For Future Use)

I. Swing-bed hospitals:

1. Inpatient hospital services furnished by a certified swing-bed hospital which have been certified by the Peer Review Organization for payment at the nursing facility level are reimbursed in accordance with 42 CFR 447.280.

2. Average statewide weighted per diem payments for all nursing facility routine services (excluding ICF/MR) are calculated for a calendar year; each rate is rounded to the nearest even dollar and becomes the swing-bed rate for routine nursing facility services provided in the subsequent calendar year. Swing-bed rates are not subject to later adjustment.

3. Ancillary services required by swing-bed patients are separately payable as "outpatient hospital services;" see Attachment 4.19-B, Item 2.a.

J. Out-of-state nursing facilities and ICF/MRs:

Out-of-state nursing facilities and ICF/MRs are reimbursed according to the following:

1. The same rate that the facility is reimbursed by its own state Medicaid program (rounded up to the nearest dollar); or

2. A per diem rate may be negotiated when the following client care issues are such that the rate in J.1. is insufficient to provide placement:

   a. Patient's acuity

   b. Availability of beds

   c. Patient's freedom of choice

3. When negotiation is required or when multiple facilities are equally acceptable under J.1. & 2. above, the out-of-state nursing facility or ICF/MR with the lowest per deim rate will be selected. The per diem rate will not exceed the facility's usual and customary rate for similar services.

K. Nevada State Veterans Nursing Home:

1. The Nevada State Veterans Nursing Home is reimbursed under Medicare principles of retrospective reimbursement described in 42 CFR 413 and further specified in CMS (HCFA) Publication 15.

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

3. For cost reporting periods prior to November 30, 2004, Medicaid reimbursement will be less any per diem payments received by the Home from the Veteran's Administration, payments from the recipient, or other third party payments. For cost reporting periods on or after November 30, 2004 Medicaid reimbursement will not be reduced by any per diem payments received by the Home from the Veteran's Administration, but will be less payments from the recipient, or other third party payments.

4. 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.

5. The Home is paid at the lower of 1) billed charge; or 2) an interim rate subject to settlement in accordance with 1. through 3. above.

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.

Other Provider-Preventable Conditions

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

_**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 Other Provider-Preventable Conditions

The State Agency's fiscal agent will review claims with dates of service on or after July 1, 2012 for OPPCs and report to the State. The state's Surveillance and Utilization Review (SUR) unit will review each claim identified in that report and recover payments associated with the OPPC.

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.

State: Nevada

DEFINITION OF A CLAIM

For all services covered by the Nevada Medicaid program, the following definition applies:

Claim: A bill for services rendered by a provider. A bill may contain more than line item.