

State: NEVADA

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.

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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.

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- 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.

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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.

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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.

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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.

TN No. 03-09

Approval Date: July 6, 2004

Effective Date: July 18, 2003

Supersedes

TN No. 02-08

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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 Year	1.5%
iv. Maximum Age Years	40
v. Rental Rate Annually	9.0%
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	<u>\$7,300,000</u>
Depreciation Rate (1.5% x 10 Years)	15%
Depreciated Value (85%)	<u>\$6,205,000</u>
Rental Rate	9%
FRV Payment (Gross)	<u>\$558,450</u>
Divided by Greater of Actual or Minimum Days	33,580
Fair Rental Value Payment	<u>\$16.63</u>

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- 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.

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- 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.

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- 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.

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- 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.

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- 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.

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- 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.

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- a. **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.

- b. Effective October 1, 2017, The Weighted Average Budget Neutral Per Diem is \$128.33.

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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.

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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.

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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.

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E. Special Care Rates:

1. The Division of Health Care Financing and Policy shall establish special care rates for recipients ages 21 and over that are ventilator dependent, or behaviorally complex, and pediatric recipients less than 21 years of age with special high cost care needs and/or who are ventilator dependent. These special care rates will be all-inclusive per diem rates based on the costs of providing services to recipients.
 - a. Effective August 1, 2011 the per diem rate for recipients ages 21 and over that are ventilator dependent is the facility-specific fair rental value per diem, as computed under Section B.3.c. of this attachment, plus an add-on of \$495.00.
 - b. The per diem rate for behaviorally complex 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.

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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.

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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

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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

Divided by Total Dollars Available for Component
Equals 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:

Divided by Facility Occupied Medicaid NF and LTC Hospice Bed Days
Equals Facility Total Occupied Bed Days
Times Facility Medicaid Occupancy Rate
Equals 100
Times Facility Medicaid Occupancy Rate Modifier
Equals Facility Occupied Medicaid NF and LTC Hospice Bed Days
Times Facility Medicaid Occupancy Points
Equals 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

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

- iii. Quality Component: Distribution of 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

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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 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. Effective October 1, 2017, the weighted average budget neutral per diem is increased by 10%.

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

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

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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

Divided by Weighted Average Portion of Reimbursement Based on Acuity
Equals Weighted Average Full Rate Per Diem
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

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

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

Facility Specific Unit Reimbursement Value Based on Acuity

TN No. 11-012
Supersedes
TN No. NEW

Approval Date: April 6, 2012

Effective Date: October 1, 2011

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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.

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The state will make a one-time supplemental payment to each freestanding nursing facility that is not a state-owned or operated (SGO) or non-state government owned or operated (NSGO) for the quarter ending December 31, 2017. This payment will be equal to the difference between the individual facility's budget neutral per diem in effect for the quarter ending September 30, 2017 and what the individual facility's budget neutral per diem would have been with a 10% increase to the state's weighted average budget neutral per diem, multiplied by the facility's number of Medicaid Fee-for-Service days in the same quarter ending September 30, 2017.

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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.

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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.

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(Reserved for Future Use)

TN No. 04-01
Supersedes
TN No. 02-08

Approval Date: June 28, 2004

Effective Date: January 1, 2004

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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.

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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 diem rate will be selected. The per diem rate will not exceed the facility's usual and customary rate for similar services.

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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.

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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.

TN No. 12-005

Approval Date: July 18, 2012

Effective Date: July 1, 2012

Supersedes

TN No. NEW

CMS ID: 7982E