

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

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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/Surgical/Intensive Care Unit (ICU) interim rate for each CAH will be updated within 90 days of receipt of the most recently audited cost report from the contracted vendor. The interim rate is not to increase more than 50% or decrease more than 25% from the facilities' prior year interim rate.

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3. The updated CAH Medical/Surgical/ICU 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 audited Medicare/Medicaid cost report.
4. If Title XIX data reported in the latest available audited Medicare/Medicaid cost report is not sufficient to calculate the adjusted CAH Medical/Surgical/ICU interim rate, the CAH Medical/Surgical/ICU interim rate will default to the Medical/Surgical/ICU rate paid to general acute care hospitals for the same service. This applies only to Critical Access Hospitals that have an existing CAH Medical/Surgical/ICU 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.
  - a. Critical Access Hospitals with Obstetric/Maternity units may also request a provider-specific interim rate for Maternity services. Interim rates for Maternity services will be calculated by multiplying the hospital-specific Medical/Surgical/ICU rate by 77.8%. Obstetric/Maternity days for Critical Access Hospitals who do not request a provider-specific interim rate will be reimbursed at the rate paid to general acute care hospitals for the same inpatient services.
6. Critical Access Hospitals that do not have a CAH Medical/Surgical/ICU 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

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