

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

December 12, 2013

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: MARTA E. STAGLIANO, CHIEF OF PROGRAM INTEGRITY
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
MSM CHAPTER 700 – RATES AND COST CONTAINMENT

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 700 were made to add Section 702, which outlines the rules and certifications for provider participation in Nevada Private Hospital Upper Payment Limit (UPL) supplemental payment program.

These changes are effective December 13, 2013.

MATERIAL TRANSMITTED

MTL 21/13
CHAPTER 700 – RATES AND COST
CONTAINMENT

MATERIAL SUPERSEDED

MTL 16/12
CHAPTER 700 – RATES AND COST
CONTAINMENT

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
702	Eligibility	Section added to outline the rules and certifications for provider participation in Nevada Private Hospital Upper Payment Limit (UPL) supplemental payment program.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 700
MEDICAID SERVICES MANUAL	Subject: INTRODUCTION

700 INTRODUCTION

The Division of Health Care Financing and Policy (DHCFP) establishes the methods and standards for provider reimbursements for Medicaid services in accordance with the Code of Federal Regulations (CFR, Title 42, Part 447) and in consultation with providers and a public hearings process. The methods and standards for rate determinations are described in Nevada's approved State Plan under Title XIX of the Social Security Act (i.e. the Medicaid State Plan.)

Providers should consult the Medicaid State Plan, Section 4.19 – Payment for Services, for methods and standards for reimbursement. The following is a brief summary of the detail attachments to Section 4.19:

- a. Attachment 4.19-A describes methods and standards for reimbursing inpatient hospitals, residential treatment centers, Indian Health Service and Tribal 638 Health Facilities.
- b. Attachment 4.19-B describes the methods and standards for reimbursing medical services provided by licensed professionals in various settings and those items ancillary to licensed medical services, such as laboratory and x-ray, pharmaceuticals, dentures, prosthetic devices, eyeglasses, medical supplies, appliances and equipment, and transportation.
- c. Attachment 4.19-C describes the methods and standards for reimbursing reserved beds in various institutions excluding acute care facilities.
- d. Attachment 4.19-D describes the methods and standards for long-term care facilities including hospital-based and freestanding nursing facilities, intermediate care facilities for the mentally retarded and swing beds in hospitals.

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DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 701
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701 AUTHORITY

701.1 FEE TO INCREASE QUALITY OF NURSING CARE

NRS 442.3755 to NRS 422.379

701.2 COST REPORTS

CFR, Title 42, Part 413-Principles of Reasonable Cost Reimbursement, Section 413.24

a. Title XIX of the Social Security Act, Nevada State Plan for Medicaid, Attachment 4.19-D, Page 6, Section C.

701.3 MEDICAID RATE(S) APPEAL

The authority for provider rate(s) appeals exists under The Code of Federal Regulations (CFR, Title 42, Chapter IV, Part 447 – Payments for Services, Section 447.253 (e) – Other requirements). This section states, “The Medicaid agency must provide 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 agency determines appropriate, of payment rates.”

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702 ELIGIBILITY RULES FOR SUPPLEMENTAL PAYMENT PROGRAMS

702.1 RULES OF PARTICIPATION FOR INPATIENT UPPER PAYMENT LIMIT (UPL) FOR PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT PROGRAM

Attachment 4.19-A, Section XV, Part B of the Nevada State Plan for Medicaid authorizes Medicaid supplemental payments to certain private hospitals affiliated with Nevada units of government through a Low Income and Needy Care Collaboration Agreement. Participation in the program must be consistent with federal approval of the State Plan.

In order to be eligible to provide the non-federal share of these Medicaid supplemental payments, *a unit of government* must execute a certification that it will comply with the program limitations adopted by the Division of Health Care Financing and Policy (DHCFP) in its Nevada Medicaid Supplemental Payment Program Conditions of Participation (CoP). Each unit of government must execute this certification on a form promulgated by the DHCFP. Each unit of government’s participation must be consistent with federal approval of the State Plan.

In order to be eligible to receive Medicaid supplemental payments under this section of the Nevada State Plan for Medicaid, *a hospital* must execute a certification that it will comply with the program limitations adopted by the DHCFP in its Nevada Medicaid Supplemental Payment Program Conditions of Participation. Each hospital must execute this certification on a form promulgated by the DHCFP. Each private hospital’s participation must be consistent with federal approval of the State Plan.

The State Plan, Conditions of Participation, certification forms and other participation requirements are available to the public at the DHCFP’s office and on the website at: <https://dhcfp.nv.gov/hcfpdata.htm>.

In order to be consistent with the Code of Federal Regulation, Title 42, Chapter IV, part 447, Subpart C, Section 447.272, the DHCFP:

- Prohibits any cash or in-kind transfers from the private hospitals to the governmental entity that have a direct or indirect relationship to Medicaid payments;
- Does not allow a governmental entity to condition the amount it funds the Medicaid program on a specified or required minimum amount of low income and needy care;
- Does not allow a governmental entity to assign any of its contractual or statutory obligations to a private hospital receiving payments under State Plan Amendment (SPA) 10-002C;

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- Does not allow the governmental entity to recoup funds from a hospital that has not adequately performed under the Low Income and Needy Care Collaboration Agreement;
- Prohibits each private hospital from returning any of the supplemental payments it receives under SPA 10-002C to the governmental entity that provides the non-federal share of the payments; and
- Prohibits each governmental entity from receiving any portion of the supplemental Medicaid payments made to the private hospitals under SPA 10-002.

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703 POLICY

703.1 INPATIENT HOSPITAL SERVICES

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 the Division of Health Care Financing and Policy (DHCFP), are reimbursed by all-inclusive, prospective per diem rates by type of admission/service. 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. For specific rate methods and standards for inpatient hospital services, refer to the State Plan, Section 4.19, Attachment A.

703.2 FEE TO INCREASE QUALITY OF NURSING CARE

The DHCFP established the following policy to assess and collect fees to increase the quality of nursing care. Nevada Revised Statute (NRS) 422.3775 states: *“Each nursing facility that is licensed in this State shall pay a fee assessed by the Division to increase the quality of nursing care in this State.”*

a. Reporting Requirements:

Each nursing facility shall file with the DHCFP each month a report setting forth the total number of days of care it provided to non-Medicare patients during the preceding month, the total gross revenue it earned as compensation for services provided to patients during the preceding month, and any other information required by the Division.

b. Payment of Fee:

1. The DHCFP shall annually establish a rate per non-Medicare patient day that is equivalent to 5.5 percent, or a percentage not to exceed any limitation provided under federal law or regulation, of the total annual accrual basis gross revenue for services provided to patients of all nursing facilities licensed in this state.
2. The DHCFP shall calculate the fee owed by each nursing facility by multiplying the total number of days of care provided to non-Medicare patients by the rate in 2.a.
3. The monthly report and fee assessed pursuant to this section are due 30 days after the end of the month for which the fee was assessed.

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c. Failure to Pay, or Late Payment of, Fee:

1. The DHCFP may assess a penalty of one percent of the fee for each day a fee is past due up to ten (10) days. The DHCFP may assess interest at the rate of 1.5 percent of the fee per month or fraction thereof for any past due fee. In the event a facility has not submitted the required monthly report, the DHCFP may estimate the fee due for purposes of assessing penalties and interest.
2. The DHCFP may withhold past due fees, penalties, and interest from a facility's Medicaid claims payments until such past due amounts are paid in full.

703.3 COST REPORTS

The DHCFP established the following policy to collect Medicare/Medicaid Cost Reports. (A Medicare/Medicaid Cost Report is the standard Medicare Cost Report with the required Medicaid sections completed.)

The DHCFP adopts Medicare deadlines for the Medicare/Medicaid cost reports. These requirements are found in the Code of Federal Regulations (CFR, Title 42, Part 413 – Principles of Reasonable Cost Reimbursement, Section 413.24). This section states, “*Due dates for cost reports. (i) Cost reports are due on or before the last day of the fifth month following the close of the period covered by the report. For cost reports ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period.*”

The authority to collect Medicaid Cost Reports exists under Title XIX of the Social Security Act, Nevada State Plan for Medicaid, Attachment 4.19. 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 Centers for Medicare and Medicaid Services (CMS) Publication 15).

a. Hospital Cost Reporting Requirements:

Hospital (including hospital-based nursing facility) annual Medicare/Medicaid cost reports are to be filed with the Medicaid program (DHCFP) following the cost report filing deadlines adopted in 42 CFR 413.24. If a facility requests an extension from the Medicare program, they must also request an extension from the DHCFP. Extension requests approved by Medicare will automatically be approved by the DHCFP, once the DHCFP receives evidence of Medicare approval from the facility.

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b. Free Standing Cost Reporting Requirements:

1. Free-standing nursing facilities and Intermediate Care Facilities for the Mentally Retarded (ICF/MR) must complete and file an annual Medicare/Medicaid cost report with the DHCFP.
2. Cost reports are to be received by the DHCFP 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 DHCFP prior to the original cost report due date. Reasonable extension requests will be granted.
3. 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 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. Any penalties collected shall accrue to the State General fund and shall be used to offset Medicaid expenses.

c. Failure to File, or Late Filing of, Cost Reports

1. Facilities failing to file a Medicare/Medicaid cost report in accordance with these provisions may have their Medicaid payments suspended, or be required to pay back to the Medicaid program all payments received during the fiscal year period for which they were to provide a cost report. Facilities may also be subject to an administrative fine of up to \$500 per day for each day the required cost reports are delinquent.
2. The DHCFP may withhold any amounts due under 3.a. (above) from a facility's Medicaid claims payments until such amounts are paid in full.

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704 MEDICAID RATE(S) APPEAL

The following appeal procedure applies to reimbursement rates paid to providers for providing services under the State Plan for Medicaid to Medicaid recipients enrolled in the fee-for-service Medicaid program. Appeals are only applicable to individual providers. General rates, as determined by procedures set forth in the State Plan, cannot be appealed.

- a. Appeals must be submitted in writing to the address below and clearly marked as a Rate appeal.

To ensure receipt of the Appeal, certified mail or other commonly accepted delivery methods which clearly show the date of receipt are encouraged.

Appeal address: Administrator DHCFP, 1100 E. William Street, Suite 101, Carson City, Nevada 89701.

- b. The appeal must contain the following information:
1. The name, address and telephone number of the person who has authority to act on behalf of the provider/appellant; and
 2. The specific rate(s) to be reviewed;
 3. The basis upon which the provider believes relief should be granted including supporting documentation:
 - a. Claims documentation showing costs for Medicaid services not fully compensated by Medicaid payments is necessary, but not sufficient to form a basis for relief.
 - b. The documentation should show that payments received from Medicaid for the appealed rate fail to compensate for costs attributable to providing services to Medicaid patients as well as for the rates in aggregate for the provider.
 - c. The documentation must show how the specific circumstances of services provided to Medicaid recipients relative to other like-providers result in higher costs not adequately or appropriately considered in the development of the existing rate(s);
 4. The relief requested, including the methodology used to develop the relief requested.

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Actual costs from the most recent prior year(s), or costs from part of the current year, may be used in developing the methodology for the relief request, so long as it is not a cost reimbursement methodology;

5. Any other information the provider believes to be relevant to the review.
- c. The Administrator, or his designee, may consider the following factors in deciding whether to grant rate relief:
1. Whether there are circumstances related to the appellant when compared to other providers that cause the appellant to have higher Medicaid costs in the rate category reviewed;
 2. Whether the circumstances relating to the provider are adequately considered in the rate-setting methodology set forth in the State Plan;
 3. The extent to which comparable health care services are available and accessible for all people in the geographic area served by the appellant/provider;
 4. Whether Medicaid payments are sufficient to meet Medicaid costs in the appealed rate(s);
 5. The total Medicaid payments to the provider and all Medicaid payments for the appealed rate(s): In the case of hospitals, this includes total Medicaid costs to the hospital for inpatient care and the hospital's Medicaid costs for the appealed rate(s);
 6. Audit review information, if any;
 7. Information and data used to set the existing or appealed rate;
 8. Such other information or documentation as the Administrator, or his designee, deems relevant; and
 9. That the basis for relief results in uncompensated Medicaid costs to the provider, both in the appealed rate(s) and in aggregate Medicaid payments under the State Plan.
- d. The Administrator, or his designee, shall review the appeal and supporting documentation and issue a written decision within 90 calendar days of receipt of a properly submitted appeal. The Administrator, or his designee, may request any additional information from the provider, including independent verification by an unrelated third party of the provider's claims. If the Administrator, or their designee,

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requests additional information or verification, the period in which the Administrator or his designee must issue a decision is extended to 90 calendar days from the receipt of the requested information.

- e. The decision on the appeal shall set forth Findings of Fact and Conclusions of Law.
- f. The decision will be sent in writing by certified mail, return receipt requested, to the person designated in 704.2.a.
- g. The Administrator's decision may be appealed to the District Court in and for Carson City of the State of Nevada pursuant to NRS 422.306(3). Such appeal shall be filed within 30 calendar days from the date the decision of the Administrator is received.