Nevada Department of Health and Human Services
DIVISION OF HEALTH CARE FINANCING AND POLICY

Provider Fees

Nevada Medicaid Fact Sheet
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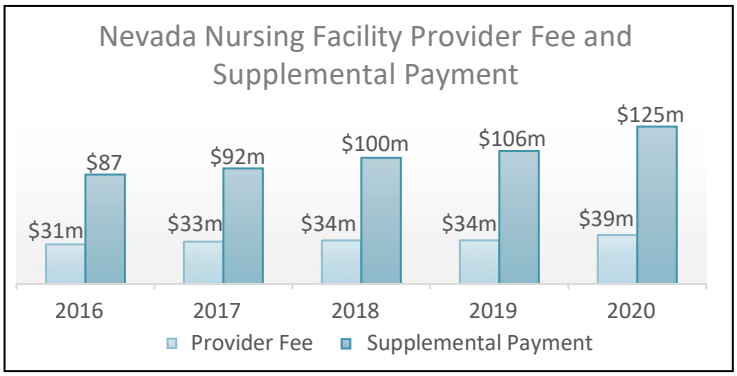
For more information: DHCFP@DHCFP.nv.gov

Provider fees are a valuable tool requested by medical providers. They leverage federal funds to increase reimbursement to providers and preserve and increase access to medical services for Nevadans. Nevada operates one provider fee program for Skilled Nursing Facilities, generating significant reimbursement for participating providers (see graph).



What is a provider fee?

Fees are assessed on health care providers or health care service to obtain federal Medicaid matching dollars for enhanced reimbursement to Medicaid providers. Enhanced reimbursement to providers helps to preserve access to vital medical services for Medicaid recipients in Nevada. Provider fees may be assessed on Managed Care Organizations, Ambulatory Surgical Centers, Nursing Facilities, ICF-IID Facilities, and the following services:

Midwife	Dental	Optician	Psychological Phy. Assistant	Physician & Physician Assistant
Podiatric	Chiropractic	Lab & X-Ray	Prescription Drugs	Inpatient & Outpatient Hospital
Therapy	Nursing	Home Health	Occupational Therapy	Emergency Ambulance & Paramedic

What is the authority?

States are permitted to impose a tax on specific health care providers or services equivalent to a maximum of 6% of net revenues (42 CFR 433.68). Federal law puts strict requirements on provider fee programs. If a provider fee program does not meet the requirements, the state must submit frequent waiver requests to the Centers for Medicare and Medicaid Services (CMS) for continued funding.

- They must be broad-based and apply to all providers within a group.
- States cannot guarantee that a provider will be "Held Harmless" or receive enough payments to offset taxes paid.

Nevada Medicaid was granted authority to develop and assess a provider fee for medical facilities and an operator of personal care assistance services on 6/1/2017, by SB509. Providers requested the development of these programs and would move forward with 67% approval of the provider group.

Who benefits?

Reimbursement to provider groups is restricted by the Upper Payment Limit (UPL). UPL is the amount that Medicare would have reimbursed a provider for a service. The difference between what Medicare would have paid for a service and what Medicaid actually paid is called the "UPL Gap." Provider fees can be leveraged to fill this gap.

Do other states have provider fees?

49 states and Washington, D.C. have at least one provider fee. Alaska does not. Many states are finding innovative ways to increase reimbursement. Some have created provider fee programs to fund the increased costs associated with the Affordable Care Act (ACA) expanded population costs. Eight Medicaid expansion states have plans to use provider taxes or fees to fund all or part of the state share of costs of the ACA Medicaid expansion: Arkansas, Arizona, Colorado, Illinois, Indiana, Louisiana, New Hampshire, and Ohio.