



Rate Analysis and Development

Nevada Medicaid

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Program Overview

The Rate Analysis and Development (RAD) Unit is responsible for rate development, rate studies/reviews, rate appeals, Medicaid Rate Policies, the Quadrennial Rate Review process, letters of agreement, and scheduled rate updates. RAD is also responsible for fiscal impact analyses associated with these processes. Unit Policy is in the Medicaid Services Manual, Chapter 700.

Rate Changes

Changes to rate methodologies require a State Plan Amendment (SPA). Workshops and public hearings are held prior to submitting a SPA to the Centers for Medicare and Medicaid Services (CMS), allowing providers and stakeholders the opportunity to provide public comment. Proposed changes are sent to CMS for review and approval.

As of June 2021, there are over 65,000 active rates for Nevada Medicaid, covering 68 provider types. Most of these provider types have their own rate methodologies. Methodologies are classified under rate categories.

Rate Categories

Managed Care Capitated Rates (CAP) – A managed care capitated rate is a per member per month contracted rate based on client demographics, projected utilization, and plan administrative costs. Monthly capitated payments are made to the Managed Care Organizations (MCOs) in advance, creating a pool of funds from which the MCO reimburses for provided services and uses to cover administrative costs.

Fee for Service Rates (FFS) – A fee for service (FFS) rate is reimbursement for specific services provided, like an office visit or lab test, as opposed to a fixed amount per eligible person like a CAP rate. The FFS rate is specific to the service provided based on factors like complexity and who is providing the service. Some FFS rates are prospective, meaning that a flat amount is paid.

Fee Schedule based – Most FFS rates are set using the relevant Medicare Fee Schedules and formulas with data provided by CMS. These formulas incorporate factors like Relative Value Units (RVU), Geographic Practice Cost Index (GPCI), location of service, and conversion factors which measure the effort and expense associated with providing a service, adjusted for cost variances due to provider location.

Cost based – These FFS rates are set for specific services using cost factors such as: payroll and benefits, time studies, overhead, facility costs, insurance, etc.

Prospective Payment System Rates (PPS) - A Prospective Payment System (PPS) Rate is a method of reimbursement in which reimbursement is a predetermined, fixed amount. The rate for a service or encounter is derived based on the classification system of that service (for example, diagnosis-related groups for inpatient hospital services).

Per Diem Rates - An all-inclusive flat rate for services provided each day during a facility stay. Used by Nevada for Hospital and Skilled Nursing reimbursement.

Encounter Rates - Federally Qualified or Rural Health Clinics receive an all-inclusive flat rate for all services provided during an encounter. Different encounter codes are used to reflect the types of services that were utilized during an encounter (Medical, Dental or Behavioral Health). Rates are based on cost-report data.

CCBHC Rates - Certified Community Behavioral Health Center (CCBHC) rates are an all-inclusive flat rate covering behavioral health and primary care needs. Rates are based on cost-report data.

Negotiated Rates (Provider-specific) - Rates are set through negotiations with specific providers, typically to cover a percentage of billed charges or a specific flat rate that covers an acceptable portion of the provider's costs. (This is typically done for out of state providers and certain types of specialized care.)

Medicaid State Plan

The Medicaid and CHIP state plans are agreements between Nevada and the federal government describing how Nevada Medicaid administers these programs. It assures that Nevada will abide by federal rules and may claim federal matching funds for program activities. The state plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed and the administrative activities that are under way in the state.

When Nevada is planning to make a change to program policies or operational approach, Nevada Medicaid sends SPAs to CMS for review and approval. SPAs are also submitted to request permissible program changes, make corrections, or update the Medicaid or CHIP state plan with new information.

Section 4 is General Program Administration and the methods and standards used to determine rates for Nevada Medicaid are located in the Nevada State Plan under Section 4.19 – Payment for Services Attachments:

- 4.19-A Payment for Inpatient Hospital Services Assurances and Related Information
- 4.19-B Payment for Medical Care and Services
- 4.19-C Payment for Reserved Beds for Therapeutic Leave of Absence
- 4.19-D Payment for Long-Term Nursing Facility Services Methods and Standards

Resources

For a history of SPAs, see Medicaid.gov.

The Nevada Medicaid State Plan may be found on the Division of Health Care Financing and Policy's (DHCFP) website: <http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSP/MSPHome/>