Quadrennial Rate Review

Division of Health Care Financing and Policy
Rate Analysis and Development

October 2022

Steve Sisolak
Governor
State of Nevada

Richard Whitley, MS
Director
Department of Health and Human Services

Table of Contents

Executive Summary

The Division of Health Care Financing and Policy (DHCFP) has conducted Fee-for-Service (FFS) provider reimbursement rate reviews per the requirements of NRS 422.2704, which requires a comparison of providers' costs to Medicaid reimbursement rates. The provider types (PT's) included in this report are:

- PT 10 Outpatient Surgery
- PT 11 Hospital, Inpatient
- PT 12 Hospital, Outpatient
- PT 13 Psychiatric Hospital
- PT 16 Intermediate Care Facilities for Intellectually Challenged/Public
- PT 17-215 Special Clinics, Substance Abuse Agency Model (SAAM)
- PT 25 Optometrist
- PT 29 Home Health Agency (Includes Private Duty Nursing)
- PT 34 Therapy
- PT 35 Non-Emergency Medical Transportation (NEMT)
- PT 36 Chiropractor
- PT 38 Waiver for Individuals with Intellectual Disabilities
- PT 39 Adult Day Health Care
- PT 41 Optician, Optical Business
- PT 44 Swing Bed
- PT 45 End Stage Renal Disease Facility
- PT 46 Ambulatory Surgical Center
- PT 47 Indian Health Services (IHS) and Tribal Clinics
- PT 48 Senior Waiver (Frail Elderly)
- PT 51 Indian Health Services Hospital, Inpatient (Tribal)
- PT 52 Indian Health Services Hospital, Outpatient (Tribal
- PT 54 Targeted Case Management
- PT 55 Day and Residential Rehabilitation
- PT 56 Medical Rehabilitative Center and Special Hospital LTAC
- PT 57 Waiver for Elderly in Adult Residential Care
- PT 58 Physical Disabled Waiver
- PT 59 Assisted Living Waiver
- PT 60 School Based
- PT 63 Residential Treatment Centers
- PT 64 Hospice
- PT 65 Hospice, Long Term Care
- PT 78 Indian Health Services Hospital, Inpatient (Non-Tribal)
- PT 79 Indian Health Service, Outpatient (Non-Tribal)
- PT 81 Hospital Based End Stage Renal Disease Provider
- Anesthesia

To determine providers' costs, surveys were available for download on the DHCFP website. Response rates were lower than desired. The only provider types with a response rate at or greater than 10 percent were as follows:

- PT 39 Adult Day Health Care
- PT 48 Home and Community Based Services Waiver for the Frail Elderly
- PT 54 Targeted Case Management
- PT 55 Day and Residential Rehabilitation
- PT 57 Waiver for Elderly in Adult Residential Care
- PT 58 Home and Community Based Services Waiver
- PT 59 Assisted Living Waiver
- PT 63 Residential Treatment Centers (RTC)
- Anesthesia

The following provider types are not being recommended for rate increases as the analysis indicates these rates are paid at or above providers reported costs or there was no response to surveys for comparison:

- PT 10 Outpatient Surgery, Hospital Based
- PT 12 Hospital, Outpatient
- PT 29 Home Health Agency (Includes Private Duty Nursing)
- PT 38 Waiver for Individuals with Intellectual Disabilities (ID)
- PT 41 Optician, Optical Business
- PT 44 Swing-bed, Acute Hospital
- PT 45 End Stage Renal Disease (ESRD) Facility
- PT 48 Senior Waiver (Frail Elderly)
- PT 54 Targeted Case Management
- PT 55 Day and Residential Rehabilitation
- PT 56 Medical Rehabilitative Center & Long Term Acute Care (LTAC) Specialty Hospitals
- PT 58 Physically Disabled Waiver
- PT 60 School Based
- PT 81 Hospital Based End Stage Renal Disease (ESRD) Provider

Purpose

Nevada Medicaid and Nevada Check Up currently provide health care coverage to approximately 920,410 Nevadans as of June 2022. These recipients access health care through either a fee-for-service or managed care service delivery system. Health care providers frequently voice concerns about Nevada Medicaid's reimbursement rates being too low to cover their costs of providing services to Medicaid and Check Up recipients. If these providers stop serving Medicaid and Check Up recipients, these recipients may have difficulty obtaining treatment needed to maintain their health.

NRS 422.2704 requires DHCFP to review each Medicaid reimbursement rate every four years. The Quadrennial Rate Reviews (QRR) determine if current Nevada Medicaid reimbursement rates accurately reflect the actual cost of providing services or items needed by Nevada Medicaid and Check Up recipients. If DHCFP finds that a reimbursement rate does not accurately reflect the actual cost of providing the service or item, NRS 422.2704 requires DHCFP to calculate the rate of reimbursement that accurately reflects the actual cost of providing the service or item and recommend that rate to the Director for possible inclusion in the State Plan for Medicaid.

Background

As of July 2022, there are over 71,000 active rates for Nevada Medicaid, covering 79 provider types (PT). A provider type indicates who is providing a service. Provider types may include individuals, facilities, or other organizational structures. Most provider types and specialties have their own rate methodologies, and therefore, must be analyzed separately.

DHCFP developed a quadrennial rate review schedule by provider type. In developing the schedule, DHCFP prioritized provider types that had not recently received rate increases or reviews.

This report encompasses surveys received in calendar years 2019, 2020, and 2021 and includes the following provider types:

- PT 11 Hospital, Inpatient
- PT 13 Psychiatric Hospital, Inpatient
- PT 17 Special Clinics, Specialty 215 Substance Abuse Agency Model (SAAM)
- PT 25 Optometrist
- PT 29 Home Health Agency (Includes Private Duty Nursing)
- PT 34 Therapy
- PT 36 Chiropractor
- PT 39 Adult Day Health Care
- PT 46 Ambulatory Surgical Centers
- PT 48 Senior Waiver (Frail Elderly)
- PT 54 Targeted Case Management
- PT 55 Day and Residential Rehabilitation
- PT 57 Adult Group Care Waiver
- PT 58 Physically Disabled Waiver
- PT 59 Assisted Living Waiver
- PT 63 Residential Treatment Centers (RTC)
- Anesthesia

Note: PT 33 Durable Medical Equipment was surveyed in 2021 but is being delayed until the 2023 report to ensure accurate data capture and reporting.

Additionally, there are several provider types included in this report that were not surveyed, as will be explained below, and includes the following:

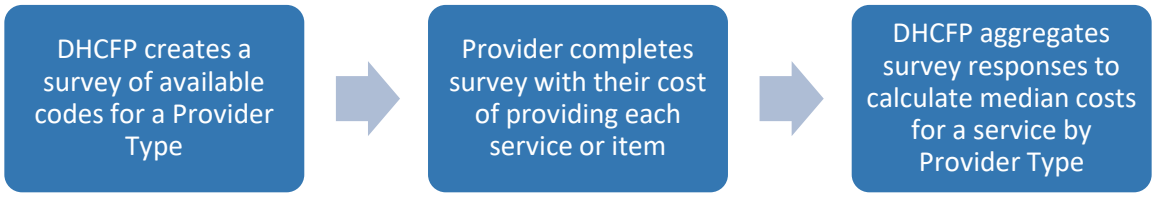
- PT 16 Intermediate Care Facilities for Intellectually Challenged / Public
- PT 35 Non-Emergency Medical Transport (NEMT)
- PT 38 Waiver for Individuals with Intellectual Disabilities (ID)
- PT 47 Indian Health Services (IHS) and Tribal Clinics
- PT 51 Indian Health Service Hospital, Inpatient (Tribal)
- PT 52 Indian Health Service Hospital, Outpatient (Tribal)
- PT 64 Hospice
- PT 65 Hospice, Long Term Care
- PT 78 Indian Health Service Hospital, Inpatient (Non-Tribal)
- PT 79 Indian Health Service Hospital, Outpatient (Non-Tribal)

Methodology

To assess provider costs, providers whose rates are under review are asked to complete a survey related to their costs of providing each service or item that is allowed under their provider type. DHCFP reached out to providers in multiple ways to encourage their participation in the cost surveys: website postings, web announcements and social media posts; email/fax outreach from Gainwell Technologies; and contact with provider associations and boards.

The cost survey spreadsheets for each provider type lists available Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, descriptions, and modifiers. Providers fill in their cost information for each code that they use and submit their completed survey to DHCFP. DHCFP staff then analyze the survey data to determine the median cost of providing each service or item for each provider type. Median costs are used rather than average costs because the median minimizes the impact of outliers with extremely high or low costs reported on the provider surveys. *Note that DHCFP does not have the authority to audit the cost information submitted by providers in their survey responses*; DHCFP simply uses the information provided by providers to estimate the costs of providing services to Medicaid and Nevada Check Up recipients.

Figure 1: Provider Cost Calculation



To paint a more complete picture concerning Nevada Medicaid's reimbursement rates, DHCFP staff also analyze how Nevada Medicaid's rates compare to other states' Medicaid rates and to Medicare rates. The states used for comparison were Arizona, Colorado, New Mexico, Oregon, and Utah. These states were selected due to their proximity to Nevada as well as similarities in population distribution. Three states used in previous reports are no longer being used for comparison, it was discovered that their code for code comparison was limited and therefore, not useful for analysis. In researching other states' Medicaid reimbursement rates, every effort was made to find the rate that most closely aligned with Nevada Medicaid's rate. DHCFP staff researched fee schedules effective during the same timeframe as the survey period and attempted to find the reimbursement rates for matching provider types. In some instances, a compatible provider type did not exist in another state or services were not included in their fee schedules. Nevada Medicaid utilizes revenue codes to reimburse inpatient services. Most other states and Medicare have transitioned to Diagnosis Related Groups (DRGs) inpatient reimbursement for services delivered within a hospital. These two payment methodologies cannot be equitably compared. Staff calculated a median of the other states' Medicaid rates for each service to compare to Nevada's rates.

Once the comparison data was completed, a fiscal analysis for the upcoming 2024-2025 biennium was performed to demonstrate the impact of changing current Nevada Medicaid fee-for-service rates to align with providers' reported costs. Fiscal impact analyses were also completed for the additional scenarios of aligning with Medicare rates or the median of other states' Medicaid rates.

Whereas calculation of the fiscal impact of a fee-for-service rate increase is relatively straightforward, calculating a reimbursement rate change on managed care capitation payments is technically complex and challenging. The Centers for Medicare and Medicaid Services (CMS) requires Medicaid managed care capitation rates to be actuarially sound and Nevada Medicaid relies on contracted certified actuaries for capitation rate development. Actuarial development of the managed care portion of the fiscal impact estimates is beyond the scope of this project. Instead, DHCFP used managed care utilization data to gross up the fee-for-service estimates to reflect the potential changes in capitation rates due to a change in fee-for-service reimbursement rates.

The combined fee-for-service and managed care fiscal impact estimates were projected forward to the upcoming biennium (state fiscal years 2024 and 2025) using projected growth rates based on caseload projections from the Department of Health and Human Services Office of Analytics. The total computable estimates included both the federal and non-federal share of the projected impact. Federal Medical Assistance Percentage (FMAP) rates were applied to determine the non-federal share of each proposed rate change scenario.

Results

The rate reviews for 2019, 2020 and 2021 represent the third set of reviews completed under the Quadrennial Rate Review process. Provider responses were lower than desired, with most PT's having a response rate under 10%.

Table 1: Response Rates by Provider Type and Specialty

Provider Type, Specialty	Enrolled Providers	Codes in Fee Schedule	Responses Received	Response Rate
PT 10 Outpatient Surgery, Hospital Based	44	2,792	0	0%
PT 11 Hospital, Inpatient	142	67	*1	1%
PT 12 Hospital, Outpatient	197	9,761	0	0%
PT 13 Psychiatric Hospital, Inpatient	20	18	1	5%
PT 17 Special Clinics, Specialty 215 Substance Abuse Agency Model (SAAM)	65	52	2	3%
PT 25 Optometrist	521	212	6	1%
PT 29 Home Health Agency (Includes Private Duty Nursing)	62	108	5	8%
PT 34 Therapy	1,872	1,199	26	1%
PT 36 Chiropractor	49	11	2	4%
PT 38 Waiver for Individuals with Intellectual Disabilities (ID)	106	23	0	0%
PT 39 Adult Day Health Care	30	2	6	20%
PT 41 Optician, Optical Business	62	119	0	0%
PT 44 Swing-bed, Acute Hospital	9	1	0	0%
PT 45 End Stage Renal Disease (ESRD) Facility	55	2	0	0%
PT 46 Ambulatory Surgical Centers	64	2,792	3	5%
PT 48 Senior Waiver (Frail Elderly)	148	10	30	20%
PT 54 Targeted Case Management	9	1	1	11%
PT 55 Day and Residential Rehabilitation	6	4	3	50%
PT 56 Medical Rehabilitative Center & Long Term Acute Care (LTAC) Specialty Hospitals	14	51	0	0%
PT 57 Adult Group Care Waiver	180	5	46	26%
PT 58 Physically Disabled Waiver	175	11	33	19%
PT 59 Assisted Living Waiver	7	5	3	43%
PT 60 School Based	8	160	0	0%
PT 63 Residential Treatment Centers (RTC)	50	2	10	20%
PT 81 Hospital Based End Stage Renal Disease (ESRD) Provider	20	2	0	0%
Anesthesia	1,005	270	123	12%

*Only a single survey was received from the Nevada Hospital Association who indicate that it contains aggregated responses from 18 hospitals.

DHCFP received a total of 301 cost survey responses across all provider types in this report. This count represents 6.12% of the 4,920 enrolled providers.

Table 2 below provides a high-level summary of the fiscal impact of reimbursement at provider costs for all provider types/specialties surveyed. The fiscal impact is calculated as the difference between estimated total computable expenditures under reimbursement at provider costs and the base scenario expenditures at current reimbursement rates. Negative numbers indicate that we currently pay above provider cost and an increase is not warranted.

Table 2: SFY 2024 and 2025 Fiscal Impact Estimates by Provider Type and Specialty

Provider Type, Specialty	Change in Expenditures to Match Median of Reported Provider Costs	
	Total Computable	Non-Federal Share
PT 10 Outpatient Surgery, Hospital Based	$0	$0
PT 11 Hospital, Inpatient	$1,076,033,643	$292,419,319
PT 12 Hospital, Outpatient	$0	$0
PT 13 Psychiatric Hospital, Inpatient	$44,460,798	$9,195,675
PT 17 Special Clinics, Specialty 215 Substance Abuse Agency Model (SAAM)	$6,972,318	$1,242,671
PT 25 Optometrist	$17,991,129	$4,699,581
PT 29 Home Health Agency (Includes Private Duty Nursing)	($22,014,152)	($4,951,011)
PT 34 Therapy	$58,447,341	$17,240,752
PT 36 Chiropractor	$103,452	$31,290
PT 38 Waiver for Individuals with Intellectual Disabilities (ID)	$0	$0
PT 39 Adult Day Health Care	$7,104,147	$2,324,710
PT 41 Optician, Optical Business	$0	$0
PT 44 Swing-bed, Acute Hospital	$0	$0
PT 45 End Stage Renal Disease (ESRD) Facility	$0	$0
PT 46 Ambulatory Surgical Centers	$14,205,076	$3,409,338
PT 48 Senior Waiver (Frail Elderly)	($2,193,157)	($798,440)
PT 54 Targeted Case Management	($866,516)	($304,096)
PT 55 Day and Residential Rehabilitation	($1,168,385)	($264,242)
PT 56 Medical Rehabilitative Center & Long Term Acute Care (LTAC) Specialty Hospitals	$0	$0
PT 57 Adult Group Care Waiver	$10,279,806	$3,870,806
PT 58 Physically Disabled Waiver	($2,772,116)	($1,041,882)
PT 59 Assisted Living Waiver	$2,174,772	$818,899
PT 60 School Based	$0	$0
PT 63 Residential Treatment Centers (RTC)	$23,700,626	$8,742,483

PT 81 Hospital Based End Stage Renal Disease (ESRD) Provider	$0	$0
Anesthesia	$79,690,530	$21,058,749

There are several important caveats to the estimates provided in Table 2.

- Provider costs are accepted as reported as DHCFP does not have the authority to audit the cost information submitted by providers in their survey responses.
- Provider costs may have changed after the submission of their cost surveys. Any post-survey changes in provider costs are not accounted for in the analysis.
- The estimates shown above include an estimated impact of fee-for-service rate increases on managed care capitation rates. For this analysis, managed care utilization was used to gross up the fee-for-service expenditure estimates. It is likely that the utilization imprecisely captures the impact of fee-for-service rate changes on managed care capitation rates. Managed care capitation rates must be actuarially sound and must be calculated by a certified actuary; that actuarial analysis is beyond the scope of this report.
- These fiscal impact estimates are subject to change dependent on updated caseload and FMAP projections for the upcoming biennium.

Recommendations

Per the requirements of NRS 422.2704, DHCFP recommends rate increases for the following provider types:

- PT 11 Hospital, Inpatient
- PT 13 Psychiatric Hospital, Inpatient
- PT 17 Special Clinics, Specialty 215 Substance Abuse Agency Model (SAAM)
- PT 25 Optometrist
- PT 34 Therapy
- PT 36 Chiropractor
- PT 39 Adult Day Health Care
- PT 46 Ambulatory Surgical Centers
- PT 57 Adult Group Care Waiver
- PT 59 Assisted Living Waiver
- PT 63 Residential Treatment Centers (RTC)
- Anesthesia

The rate increases for the provider types listed above will better align Nevada Medicaid rates with the providers' reported costs. Note that not every rate for each of these provider types would be increased to align with provider costs; some rates would increase while others would decrease or remain unchanged. In addition, the fiscal impact estimates provided do not incorporate anything pending approval, including but not limited to, legislation or budget initiatives for SFY24 and SFY25.

Table 3 below summarizes the impact of each scenario analyzed by DHCFP. The Base Scenario represents the projected fiscal impact in the upcoming biennium based on current Nevada Medicaid rates. The other columns represent the additional costs of each rate change scenario.

Table 3: 2024-25 Biennium Non-Federal Share Fiscal Impact Estimates by Rate Increase Scenario

NRS 422.2704 - 2022 Report Summary

Non-Federal Share Fund Expenditures for SFY 24-25

Provider Type Specialty	Base Scenario *	Match Median Cost of Service †	Match Median Other States Rates †	Match Medicare Rates †	5% Increase †	10% Increase †	15% Increase †
PT 10 Outpatient Surgery, Hospital Based	$4,277,207	$0	$1,000,172	$7,844,763	$213,860	$427,721	$641,581
PT 11 Hospital, Inpatient	$277,486,042	$292,419,319	$0	$0	$13,874,302	$27,748,604	$41,622,906
PT 12 Hospital, Outpatient	$70,192,693	$0	($6,129,991)	$4,778,994	$3,509,635	$7,019,269	$10,528,904
PT 13 Psychiatric Hospital, Inpatient	$7,906,220	$9,195,675	$3,304,860	$0	$395,311	$790,622	$1,185,933
PT 17 Special Clinics, Specialty 215 Substance Abuse Agency Model (SAAM)	$4,586,051	$1,242,671	$430,339	$262,549	$229,303	$458,605	$687,908
PT 25 Optometrist	$21,121,710	$4,699,581	($6,243,552)	$937,194	$1,056,086	$2,112,171	$3,124,303
PT 29 Home Health Agency (Includes Private Duty Nursing)	$19,390,136	($4,951,011)	($834,991)	$0	$969,507	$1,939,014	$2,908,520
PT 34 Therapy	$32,382,360	$17,240,752	$2,527,108	$10,365,434	$1,619,118	$3,238,236	$4,857,354
PT 36 Chiropractor	$46,837	$31,290	($6,462)	($1,656)	$2,342	$4,684	$7,026
PT 38 Waiver for Individuals with Intellectual Disabilities (ID)	$169,752,387	$0	$17,729,239	$362,997	$8,487,619	$16,975,239	$25,462,858
PT 39 Adult Day Health Care	$6,327,293	$2,324,710	$2,145,581	$0	$316,365	$632,729	$949,094
PT 41 Optician, Optical Business	$2,298,571	$0	($1,064,563)	$0	$114,929	$229,857	$344,786
PT 44 Swing-bed, Acute Hospital	$14,363	$0	$0	$0	$718	$1,436	$2,154
PT 45 End Stage Renal Disease (ESRD) Facility	$37,274,371	$0	($379,770)	($238,364)	$1,863,719	$3,727,437	$5,591,156

Provider Type Specialty	Base Scenario *	Match Median Cost of Service †	Match Median Other States Rates †	Match Medicare Rates †	5% Increase †	10% Increase †	15% Increase †
PT 46 Ambulatory Surgical Centers	$22,106,151	$3,409,338	($1,814,817)	$26,932,948	$1,105,308	$2,210,615	$3,315,923
PT 48 Senior Waiver (Frail Elderly)	$2,453,343	($798,440)	$5,265,433	$0	$122,667	$245,334	$368,001
PT 54 Targeted Case Management	$3,677,010	($304,096)	($829,881)	$0	$183,850	$367,701	$551,551
PT 55 Day and Residential Rehabilitation	$3,280,187	($264,242)	$276,610	$0	$164,009	$328,019	$492,028
PT 56 Medical Rehabilitative Center & Long Term Acute Care (LTAC) Specialty Hospitals	$14,890,496	$0	$0	$0	$744,525	$1,489,050	$2,233,574
PT 57 Adult Group Care Waiver	$11,075,701	$3,870,806	($67,005)	$0	$553,785	$1,107,570	$1,661,355
PT 58 Physically Disabled Waiver	$3,980,603	($1,041,882)	$2,113,579	$0	$199,030	$398,060	$597,090
PT 59 Assisted Living Waiver	$609,510	$818,899	$615,930	$0	$30,476	$60,951	$91,427
PT 60 School Based	$6,651,553	$0	($2,116,017)	($834,445)	$332,578	$665,155	$997,733
PT 63 Residential Treatment Centers (RTC)	$25,605,872	$8,742,483	$13,829,452	$0	$1,280,294	$2,560,587	$3,840,881
PT 81 Hospital Based End Stage Renal Disease (ESRD) Provider	$31,306	$0	($10,682)	($119)	$1,565	$3,131	$4,696
Anesthesia	$13,593,185	$21,058,749	$3,570,920	($198,748)	$679,659	$1,359,318	$2,038,978

* Amount with no increase or decrease made. † The estimated amount of the increase.

PT 11 Hospital, Inpatient

Aligning Nevada Medicaid's PT 11 rates with the providers' reported costs represents an average increase of 114% per code. The estimated total computable impact is $1.1 billion for the upcoming biennium, with a non-federal share of $292.4 million. Please note that these calculations compare provider reported costs to Nevada Medicaid per diem rates. These figures do not account for supplemental payment programs that grant additional funding to hospitals, in addition

to the rates outlined on the fee schedule and used for this report. Examples of these supplemental payment programs includes but is not limited to: Disproportionate Share Hospital, Indigent Accident Fund, and Upper Payment Limit.

PT 13 Psychiatric Hospital, Inpatient

Aligning Nevada Medicaid's PT 13 rates with the providers' reported costs represents an average increase of 256% per code. The estimated total computable impact is $44.5 million for the upcoming biennium, with a non-federal share of $9.2 million.

PT 17 Special Clinics, Specialty 215 Substance Abuse Agency Model (SAAM)

Aligning Nevada Medicaid's PT 17, Specialty 215 rates with the providers' reported costs represents an average increase of 38% per code. The estimated total computable impact is $7 million for the upcoming biennium, with a non-federal share of $1.2 million.

PT 25 Optometrist

Aligning Nevada Medicaid's PT 25 rates with the providers' reported costs represents an average increase of 44% per code. The estimated total computable impact is $18 million for the upcoming biennium, with a non-federal share of $4.7 million.

PT 34 Therapy

Aligning Nevada Medicaid's PT 34 rates with the providers' reported costs represents an average increase of 335% per code. The estimated total computable impact is $58.4 million for the upcoming biennium, with a non-federal share of $17.2 million.

PT 36 Chiropractor

Aligning Nevada Medicaid's PT 36 rates with the providers' reported costs represents an average increase of 92% per code. The estimated total computable impact is $103.5 thousand for the upcoming biennium, with a non-federal share of $31.3 thousand.

PT 39 Adult Day Health Care

Aligning Nevada Medicaid's PT 39 rates with the providers' reported costs represents an average increase of 37% per code. The estimated total computable impact is $7.1 million for the upcoming biennium, with a non-federal share of $2.3 million.

PT 46 Ambulatory Surgical Centers

Aligning Nevada Medicaid's PT 39 rates with the providers' reported costs represents an average increase of 103% per code. The estimated total computable impact is $14.2 million for the upcoming biennium, with a non-federal share of $3.4 million.

PT 57 Adult Group Care Waiver

Aligning Nevada Medicaid's PT 57 rates with the providers' reported costs represents an average increase of 51% per code. The estimated total computable impact is $10.3 million for the upcoming biennium, with a non-federal share of $3.9 million

PT 59 Assisted Living Waiver

Aligning Nevada Medicaid's PT 59 rates with the providers' reported costs represents an average increase of 98% per code. The estimated total computable impact is $2.2 million for the upcoming biennium, with a non-federal share of $818.9 thousand.

PT 63 Residential Treatment Centers (RTC)

Aligning Nevada Medicaid's PT 63 rates with the providers' reported costs represents an average increase of 10% per code. The estimated total computable impact is $23.7 million for the upcoming biennium, with a non-federal share of $8.7 million.

Anesthesia

Aligning Nevada Medicaid's Anesthesia rates with the providers' reported costs represents an average increase of 194% per code. The estimated total computable impact is $79.7 million for the upcoming biennium, with a non-federal share of $21.1 million. *Note: Anesthesia services are billed under multiple different provider types.*

Provider Types Not Surveyed

The following provider types were not surveyed for this report and include an explanation why they were not surveyed.

PT 16 Intermediate Care Facilities for Intellectually Challenged / Public

The only PT 16 provider is a sister agency whose rates are updated annually and is cost-settled at the end of their fiscal year.

PT 35 Non-Emergency Medical Transport (NEMT)

NEMT PT35-000 has their rate set contractually and therefore cannot be adjusted via QRR survey. PT 35-987 is a newly established specialty and has no enrolled providers to date. There are at least 3 providers attempting to gain certification from HCQC. This certification is a requirement to enroll as a Medicaid provider. The rates for PT 35-987 are percentage based upon rates for PT 32 and would increase if PT 32 rates are increased.

PT 38 Waiver for Individuals with Intellectual Disabilities

Health Management Associates completed a rate survey for the Waiver for Individuals with Intellectual Disabilities during this survey period. As such DHCFP did not conduct an additional survey.

PT 47 Indian Health Services (IHS) and Tribal Clinics

The IHS rate is mandated by the Department of Health and Human Services and is published yearly in the Federal Register.

PT 51 Indian Health Service Hospital, Inpatient (Tribal)

The IHS rate is mandated by the Department of Health and Human Services and is published yearly in the Federal Register.

PT 52 Indian Health Service Hospital, Outpatient (Tribal)

The IHS rate is mandated by the Department of Health and Human Services and is published yearly in the Federal Register.

PT 64 Hospice and PT 65 Hospice, Long Term Care

Hospice rates are set using information from CMS. Updated rates and county wage adjustment percentages are delivered from CMS in late September. The Rate Analysis and Development unit applies the county wage adjustment percentage to the CMS rates to derive the final rates for the Federal Fiscal Year.

PT 78 Indian Health Service Hospital, Inpatient (Non-Tribal) and PT 79 Indian Health Service Hospital, Outpatient (Non-Tribal)

The IHS rate is mandated by the Department of Health and Human Services and is published yearly in the Federal Register.

Conclusion

This report has been provided to the Director of the Nevada Department of Health and Human Services for review and possible inclusion of the recommended rate increases in the Nevada State Plan for Medicaid. Reimbursement rate changes require a State Plan Amendment and approval from the Centers for Medicare and Medicaid Services. Although rate changes can be implemented during the current biennium or through the next Legislative Session, it is important to note that managed care organization capitation rates may need to be recalculated and recertified for any rate changes that do not align with the normal capitation rate setting cycle. Any rate changes that are implemented with an effective date other than January 1 require an amendment to the capitation rates, which results in approximately $70,000 in additional costs for actuarial services. If the Director recommends a rate change be included in the Nevada State Plan for Medicaid, DHCFP would update the fiscal impact analysis to reflect revised caseload projections, updated FMAP percentages, changes to Nevada Medicaid rates and alignment with the chosen start date.

Contact us:

1100 East William St
Carson City, NV 89701
775-684-3676
QRR@dhcfp.nv.gov
dhcfp.nv.gov