Quadrennial Rate Review

Division of Health Care Financing and Policy
Rate Analysis and Development

July 2024

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Contents

Executive Summary

The Division of Health Care Financing and Policy (Division) 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 17-166 Special Clinic, Family Planning
- PT 17-167 Special Clinic, Genetic
- PT 17-169 Special Clinic, Obstetrical Care Clinic, Birthing Centers
- PT 17-171 Special Clinic, Methadone
- PT 17-174 Special Clinic, Public Health
- PT 17-179 Special Clinic, School Based Health Centers
- PT 17-180 Special Clinic, Rural Health Clinics
- PT 17-181 Special Clinic, Federally Qualified Health Centers
- PT 17-182 Special Clinic, Indian Health Services, Non-Tribal
- PT 17-183 Special Clinic, Comprehensive Outpatient Rehab Facilities (CORF)
- PT 17-188 Special Clinic, Certified Community Behavioral Health Clinic (CCBHC)
- PT 17-195 Special Clinic, Community Health Clinics – State Health Division
- PT 17-196 Special Clinic, Special Children's Clinics
- PT 17-197 Special Clinic, TB Clinics
- PT 17-198 Special Clinic, HIV
- PT 17-215 Substance Abuse Agency Model (SAAM)
- PT 19 Nursing Facility
- PT 20 Physician, M.D., Osteopath
- PT 21 Podiatrist
- PT 22 Dentist
- PT 23 Hearing Aid Dispenser & Related Supplies
- PT 24 Advanced Practice Registered Nurse (APRN)
- PT 27 Radiology & Noninvasive Diagnostic Centers
- PT 32-249 Community Paramedicine
- PT 32-932 Ambulance, Air or Ground
- PT 33 Durable Medical Equipment, Prosthetics, Orthotics & Supplies
- PT 43 Laboratory, Pathology/Clinical
- PT 68 Intermediate Care Facilities for Individuals w/Intellectual Disabilities / Private
- PT 72 Nurse Anesthetist
- PT 74 Nurse Midwife
- PT 75 Critical Access Hospital (CAH), Inpatient
- PT 76 Audiologist
- PT 77 Physician's Assistant

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

- PT 17-171 Special Clinic, Methadone
- PT 17-188 Special Clinic, Certified Community Behavioral Health Clinic (CCBHC)
- PT 19 Nursing Facility

The following provider types are not recommended for rate increases as there were no provider responses to the survey for comparison:

- PT 17-166 Special Clinic, Family Planning
- PT 17-169 Special Clinic, Obstetrical Care Clinic, Birthing Centers
- PT 17-174 Special Clinic, Public Health
- PT 17-180 Special Clinic, Rural Health Clinics
- PT 17-181 Special Clinic, Federally Qualified Health Centers
- PT 17-183 Special Clinic, Comprehensive Outpatient Rehab Facilities (CORF)
- PT 17-195 Special Clinic, Community Health Clinics – State Health Division
- PT 17-198 Special Clinic, HIV
- PT 23 Hearing Aid Dispenser & Related Supplies
- PT 27 Radiology & Noninvasive Diagnostic Centers
- PT 32-249 Community Paramedicine
- PT 43 Laboratory, Pathology Clinical
- PT 72 Nurse Anesthetist
- PT 74 Nurse Midwife
- PT 75 Critical Access Hospital (CAH), Inpatient

Purpose

Nevada Medicaid and Nevada Check Up currently provide health care coverage to approximately 917,627 Nevadans as of January 2024. 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 costs for providing services to Medicaid and Check Up recipients. It is important to maintain – and increase – the number of Nevada providers who serve Medicaid and Check Up recipients which allows beneficiaries to access the care they need. Reviewing reimbursement rates is one tool to address provider concerns.

NRS 422.2704 requires the Division to review Medicaid reimbursement rates for each provider type 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 the Division to calculate a rate of reimbursement that accurately reflects the actual cost of providing the service or item and recommends that rate to the Director for possible addition or amendment to the State Plan for Medicaid.

Background

As of December 2023, there are over 73,000 active rates for Nevada Medicaid, covering 80 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. The Division ensures rates for each PT are reviewed at least every four years.

This report includes surveys received in the calendar year 2022 for the following provider types:

- PT 17-171 Special Clinic, Methadone
- PT 17-188 Special Clinic, Certified Community Behavioral Health Clinic (CCBHC)
- PT 17-215 Substance Abuse Agency Model (SAAM)
- PT 19 Nursing Facility
- PT 20 Physician, M.D., Osteopath
- PT 21 Podiatrist

- PT 22 Dentist
- PT 24 Advanced Practice Registered Nurse (APRN)
- PT 32-932 Ambulance, Air or Ground
- PT 33 Durable Medical Equipment, Prosthetics, Orthotics & Supplies*
- PT 76 Audiologist
- PT 77 Physician's Assistant

**Note: PT 33 Durable Medical Equipment was surveyed in 2021; the results were 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 include the following:

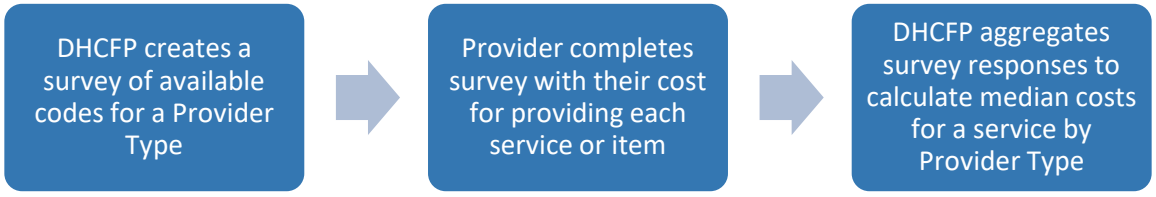
- PT 17-167 Special Clinic, Genetic
- PT 17-179 Special Clinic, School Based Health Centers
- PT 17-182 Special Clinic, Indian Health Services, Non-Tribal
- PT 17-196 Special Clinic, Special Children's Clinics
- PT 17-197 Special Clinic, TB Clinics
- PT 68 Intermediate Care Facilities for Individuals w/Intellectual Disabilities /Private

Methodology

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

The cost survey 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 service code and submit their completed survey to the Division. Staff 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 to minimize the impact of outliers with extremely high or low costs reported on the provider surveys.

Figure 1: Provider Cost Calculation



In addition to analyzing survey data provided by Nevada Medicaid providers, staff analyze how Nevada Medicaid's rates compare to other states' Medicaid rates and to Medicare rates. The states typically used for comparison are Arizona, Colorado, New Mexico, Oregon, and Utah. These states were selected due to their proximity to Nevada as well as similarities in population distribution. In researching other states' Medicaid reimbursement rates, every effort was made to find the rate that is most closely aligned with Nevada Medicaid's rate. Staff researched fee schedules that were effective during the same timeframe as the survey period and attempted to identify 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. In this occurrence, a broader list of states is used for comparison purposes. Using all identified data, staff calculated a median of the other states' Medicaid rates for each service to compare to Nevada's rates.

Once the comparison data was collected, a fiscal analysis was performed to identify the impact on Nevada Medicaid's budget in the 2024-2025 biennium if Nevada's Medicaid fee-for-service rates were changed 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. The fiscal impact analysis does not account for any provider rate increases implemented on January 1, 2024, as the analysis was completed prior to receiving federal approval for those rate changes.

Whereas calculation of the fiscal impact of a fee-for-service rate increase is a relatively straightforward process, calculating impact of rate changes on managed care capitation payments is more complex and challenging from a technical perspective. Determining the managed care portion of the fiscal impact of rate changes on monthly capitation payments is beyond the scope of this report. Instead, the Division used managed care utilization data and increased 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 calculated for the upcoming biennium (state fiscal years 2024 and 2025) using projections of Medicaid and Check Up enrollment from the Department of Health and Human Services Office of Analytics. The total computable figures reflect the Federal, State, and County shares of the projected impact on program expenditures. The applicable annual 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 this report represent the fourth set of reviews completed under the Quadrennial Rate Review process since 2018. These figures reflect responses to surveys sent to providers in calendar year 2022. Provider responses were lower than desired, with most PT's having a response rate lower than 10%. Table 1 provides a summary of the response rates by provider type and specialty. The Division received a total of 98 responses across all provider types surveyed for this report. This total represents 0.35% of the 28,137 total enrolled providers who were sent surveys by the Division.

Table 1: Response Rates by Provider Type and Specialty

Provider Type, Specialty	Enrolled Providers	Codes in Fee Schedule	Responses Received	Response Rate
PT 17-166 Special Clinic, Family Planning	2	131	0	0%
PT 17-169 Special Clinic, Obstetrical Care Clinic, Birthing Centers	1	1	0	0%
PT 17-171 Special Clinic, Methadone	5	4	1	20%
PT 17-174 Special Clinic, Public Health	5	157	0	0%
PT 17-180 Special Clinic, Rural Health Clinics	18	1	0	0%
PT 17-181 Special Clinic, Federally Qualified Health Centers	47	6	0	0%
PT 17-183 Special Clinic, Comprehensive Outpatient Rehab Facilities (CORF)	5	52	0	0%
PT 17-188 Special Clinic, Certified Community Behavioral Health Clinic (CCBHC)	8	1	1	13%
PT 17-195 Special Clinic, Community Health Clinics – State Health Division	25	120	0	0%
PT 17-198 Special Clinic, HIV	3	120	0	0%
PT 17-215 Substance Abuse Agency Model (SAAM)	76	71	3	4%
PT 19 Nursing Facility	71	5	21	30%

Provider Type, Specialty	Enrolled Providers	Codes in Fee Schedule	Responses Received	Response Rate
PT 20 Physician, M.D., Osteopath	19,027	16,780	12	0%
PT 21 Podiatrist	133	420	1	1%
PT 22 Dentist	1,167	1,315	22	2%
PT 23 Hearing Aid Dispenser & Related Supplies	12	52	0	0%
PT 24 Advanced Practice Registered Nurse (APRN)	4,124	9,864	25	1%
PT 27 Radiology & Noninvasive Diagnostic Centers	44	2,494	0	0%
PT 32-249 Community Paramedicine	11	34	0	0%
PT 32-932 Ambulance, Air or Ground	87	15	2	2%
PT 33 Durable Medical Equipment, Prosthetics, Orthotics & Supplies	433	3,085	5	1%
PT 43 Laboratory, Pathology Clinical	80	1,327	0	0%
PT 72 Nurse Anesthetist	517	120	0	0%
PT 74 Nurse Midwife	77	161	0	0%
PT 75 Critical Access Hospital (CAH), Inpatient	19	2	0	0%
PT 76 Audiologist	138	146	1	1%
PT 77 Physician's Assistant	2,002	9,846	4	0%

Table 2 provides additional details from the survey responses, including how many procedure codes within each fee schedule that the provider submitted to the Division.

Table 2: Detailed Breakdown of Survey Responses by Provider Type and Specialty

Provider Type, Specialty	Total Codes in Fee Schedule	Total Codes with Cost Response	Total Codes Where Median Cost Exceeds NV Rate	Total Codes Where Median Cost is At or Below NV Rate	Percentage of Codes with Cost Data
PT 17-166 Special Clinic, Family Planning	131	0	0	0	0%
PT 17-169 Special Clinic, Obstetrical Care Clinic, Birthing Centers	1	0	0	0	0%
PT 17-171 Special Clinic, Methadone	4	2	1	1	50%
PT 17-174 Special Clinic, Public Health	157	0	0	0	0%
PT 17-180 Special Clinic, Rural Health Clinics	1	0	0	0	0%
PT 17-181 Special Clinic, Federally Qualified Health Centers	6	0	0	0	0%
PT 17-183 Special Clinic, Comprehensive Outpatient Rehab Facilities (CORF)	52	0	0	0	0%
PT 17-188 Special Clinic, Certified Community Behavioral Health Clinic (CCBHC)	1	1	1	0	100%

Provider Type, Specialty	Total Codes in Fee Schedule	Total Codes with Cost Response	Total Codes Where Median Cost Exceeds NV Rate	Total Codes Where Median Cost is At or Below NV Rate	Percentage of Codes with Cost Data
PT 17-195 Special Clinic, Community Health Clinics – State Health Division	120	0	0	0	0%
PT 17-198 Special Clinic, HIV	120	0	0	0	0%
PT 17-215 Substance Abuse Agency Model (SAAM)	71	69	65	4	97%
PT 19 Nursing Facility	5	5	4	1	100%
PT 20 Physician, M.D., Osteopath	16,780	442	21	421	3%
PT 21 Podiatrist	420	21	20	1	5%
PT 22 Dentist	1,315	369	352	17	28%
PT 23 Hearing Aid Dispenser & Related Supplies	52	0	0	0	0%
PT 24 Advanced Practice Registered Nurse (APRN)	9,864	233	151	82	2%
PT 27 Radiology & Noninvasive Diagnostic Centers	2,494	0	0	0	0%
PT 32-249 Community Paramedicine	34	0	0	0	0%
PT 32-932 Ambulance, Air or Ground	15	12	12	0	80%
PT 33 Durable Medical Equipment, Prosthetics, Orthotics & Supplies	3,085	222	211	11	7%
PT 43 Laboratory, Pathology Clinical	1,327	0	0	0	0%
PT 72 Nurse Anesthetist	120	0	0	0	0%
PT 74 Nurse Midwife	161	0	0	0	0%
PT 75 Critical Access Hospital (CAH), Inpatient	2	0	0	0	0%
PT 76 Audiologist	146	22	13	9	15%
PT 77 Physician's Assistant	9,846	242	1	241	2%

Table 3 provides a high-level summary of the fiscal impact of increasing Medicaid reimbursement for each provider type 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. The impact is calculated as the difference between how much an adjusted rate would cost and how much the original rate costs. Survey responses vary, indicating reimbursement for certain procedure codes need an increase while others indicate the current rate is sufficient. Negative numbers indicate the aggregate impact of aligning reimbursement rates with reported costs would result in savings. Nevada Medicaid does not lower approved reimbursement rates.

Table 3: SFY 2024 and 2025 Fiscal Impact Estimates by Provider Type and Specialty

Provider Type, Specialty			
	Total Computable	Non-Federal Share	Average Change per Code
PT 17-166 Special Clinic, Family Planning	$0	$0	N/A
PT 17-169 Special Clinic, Obstetrical Care Clinic, Birthing Centers	$0	$0	N/A
PT 17-171 Special Clinic, Methadone	$466,213	$82,440	71%
PT 17-174 Special Clinic, Public Health	$0	$0	N/A
PT 17-180 Special Clinic, Rural Health Clinics	$0	$0	N/A

Provider Type, Specialty	Change in Expenditures to Match Median of Reported Provider Costs		
	Total Computable	Non-Federal Share	Average Change per Code
PT 17-181 Special Clinic, Federally Qualified Health Centers	$0	$0	N/A
PT 17-183 Special Clinic, Comprehensive Outpatient Rehab Facilities (CORF)	$0	$0	N/A
PT 17-188 Special Clinic, Certified Community Behavioral Health Clinic (CCBHC)	$5,171,881	$1,132,600	15%
PT 17-195 Special Clinic, Community Health Clinics – State Health Division	$0	$0	N/A
PT 17-198 Special Clinic, HIV	$0	$0	N/A
PT 17-215 Substance Abuse Agency Model (SAAM)	$3,789,086	$712,528	15%
PT 19 Nursing Facility	$454,200,225	$140,524,877	71%
PT 20 Physician, M.D., Osteopath	($126,866,897)	($35,076,100)	-26%
PT 21 Podiatrist	$1,299,072	$370,576	110%
PT 22 Dentist	$193,438,125	$61,347,858	307%
PT 23 Hearing Aid Dispenser & Related Supplies	$0	$0	N/A
PT 24 Advanced Practice Registered Nurse (APRN)	($26,156,051)	($7,767,486)	53%*
PT 27 Radiology & Noninvasive Diagnostic Centers	$0	$0	N/A
PT 32-249 Community Paramedicine	$0	$0	N/A
PT 32-932 Ambulance, Air or Ground	$326,800,789	$78,486,634	568%
PT 33 Durable Medical Equipment, Prosthetics, Orthotics & Supplies	$11,312,326	$2,963,596	79%
PT 43 Laboratory, Pathology Clinical	$0	$0	N/A
PT 72 Nurse Anesthetist	$0	$0	N/A
PT 74 Nurse Midwife	$0	$0	N/A
PT 75 Critical Access Hospital (CAH), Inpatient	$0	$0	N/A
PT 76 Audiologist	$501,675	$165,012	89%
PT 77 Physician's Assistant	($8,632,418)	($2,707,821)	-54%

*Reported cost (savings) and average increase per code are incongruent due to equal weighting of each code when determining average, but relative weights are applied when determining cost (savings).

Important limitations to the estimates provided in Table 3:

- Provider costs are accepted as reported as the Division 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, such as inflation, 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. It is likely that this process of estimation is imprecise. 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.

- These fiscal impact estimates do not capture any of the rate increases that were implemented 1/1/24 as the analysis was completed prior to those rate increases being approved by federal partners. Additionally, the increased reimbursement rates would not align with the time the surveys were issued and provider responses were captured.

Table 4 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 4: 2024-25 Biennium Non-Federal Share Fiscal Impact Estimates by Rate Increase Scenario

NRS 422.2704 - 2023 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 17-166 Special Clinic, Family Planning	$5,810	$0	$2,985	$688	$290	$581	$871
PT 17-169 Special Clinic, Obstetrical Care Clinic, Birthing Centers	$8,198	$0	($46)	($759)	$410	$820	$1,230
PT 17-171 Special Clinic, Methadone	$40,546	$82,440	$217,162	$0	$2,027	$4,055	$6,082
PT 17-174 Special Clinic, Public Health	$254,705	$0	$192,656	$235,445	$12,735	$25,470	$38,206
PT 17-180 Special Clinic, Rural Health Clinics	$4,039,839	$0	($1,298,969)	($1,745,630)	$201,992	$403,984	$605,976
PT 17-181 Special Clinic, Federally Qualified Health Centers	$5,163,666	$0	$956,326	($122,496)	$258,183	$516,367	$774,550
PT 17-183 Special Clinic, Comprehensive Outpatient Rehab Facilities (CORF)	$2,212	$0	$1,420	$1,865	$111	$221	$332
PT 17-188 Special Clinic, Certified Community Behavioral Health Clinic (CCBHC)	$7,765,453	$1,132,600	$0	$0	$388,273	$776,545	$1,164,818
PT 17-195 Special Clinic, Community Health Clinics – State Health Division	$7,282	$0	$5,362	$5,775	$364	$728	$1,092
PT 17-198 Special Clinic, HIV	$241	$0	$218	$253	$12	$24	$36

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 17-215 Substance Abuse Agency Model (SAAM)	$4,731,663	$712,528	$735,090	$492,758	$236,583	$473,166	$709,749
PT 19 Nursing Facility	$123,248,999	$140,524,877	$55,416,850	$0	$6,162,450	$12,324,900	$18,487,350
PT 20 Physician, M.D., Osteopath	$386,800,902	($35,076,100)	($43,792,595)	$26,721,053	$19,320,210	$38,659,311	$57,998,412
PT 21 Podiatrist	$1,558,541	$370,576	$3,504	$323,873	$77,927	$155,854	$233,781
PT 22 Dentist	$60,443,557	$61,347,858	$5,871,442	($16,422)	$3,022,178	$6,044,356	$9,066,534
PT 23 Hearing Aid Dispenser & Related Supplies	$267,731	$0	$125,822	$0	$13,387	$26,773	$40,160
PT 24 Advanced Practice Registered Nurse (APRN)	$23,862,527	($7,767,486)	$7,455,176	$13,817,087	$1,193,126	$2,386,253	$3,579,379
PT 27 Radiology & Noninvasive Diagnostic Centers	$3,840,866	$0	($422,765)	$55,848	$192,043	$384,087	$576,130
PT 32-249 Community Paramedicine	$711	$0	$180	$390	$36	$71	$107
PT 32-932 Ambulance, Air or Ground	$15,858,441	$78,486,634	$5,995,558	$14,879,694	$792,922	$1,585,844	$2,378,766
PT 33 Durable Medical Equipment, Prosthetics, Orthotics & Supplies	$32,816,185	$2,963,596	($4,800,377)	($689,892)	$1,640,809	$3,281,618	$4,922,428
PT 43 Laboratory, Pathology Clinical	$19,480,841	$0	$6,866,317	$6,632,890	$974,042	$1,948,084	$2,922,126
PT 72 Nurse Anesthetist	$11,153	$0	$4,342	$5,060	$558	$1,115	$1,673
PT 74 Nurse Midwife	$88,056	$0	$21,928	$12,446	$4,403	$8,806	$13,208
PT 75 Critical Access Hospital (CAH), Inpatient	$20,399	$0	$0	$0	$1,020	$2,040	$3,060
PT 76 Audiologist	$1,140,683	$165,012	$521,845	$19,194	$57,034	$114,068	$171,102
PT 77 Physician's Assistant	$7,276,368	($2,707,821)	$2,176,066	$4,234,290	$363,818	$727,637	$1,091,455

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

Recommendations

Per the requirements of NRS 422.2704, the Division recommends that the Director and legislature consider approving additional funds to support Medicaid rate increases for certain codes within the fee schedules for the following provider types:

- PT 17-171 Special Clinic, Methadone
- PT 17-188 Special Clinic, Certified Community Behavioral Health Clinic (CCBHC)
- PT 17-215 Substance Abuse Agency Model (SAAM)
- PT 19 Nursing Facility
- PT 20 Physician, M.D., Osteopath
- PT 21 Podiatrist
- PT 22 Dentist
- PT 24 Advanced Practice Registered Nurse (APRN)
- PT 32-932 Ambulance, Air or Ground
- PT 33 Durable Medical Equipment, Prosthetics, Orthotics & Supplies
- PT 76 Audiologist
- PT 77 Physician's Assistant

The recommended rate increases for certain codes for the provider types listed above will better align Nevada Medicaid rates with the providers' reported costs and market experience in other states. Note that the provider survey data does not indicate the need for a rate increase for all codes included on each of the respective fee schedules for the provider types listed above. In addition, the fiscal impact estimates provided above do not incorporate rates pending approval, including, but not limited to, legislation or budget initiatives for SFY24 and SFY25.

Table 5: Summary of Provider Types with Codes Recommended for Increase

Provider Type, Specialty	Enrolled Providers	Responses Received	Codes in Fee Schedule	Total Codes with Cost Response	Total Codes Where Median Cost is At or Below NV Rate	Total Codes Where Median Cost Exceeds NV Rate	Number of Codes Recommended for Increase
PT 17-171 Special Clinic, Methadone	5	1	4	2	1	1	1
PT 17-188 Special Clinic, Certified Community Behavioral Health Clinic (CCBHC)	8	1	1	1	0	1	1
PT 17-215 Substance Abuse Agency Model (SAAM)	76	3	71	69	4	65	65
PT 19 Nursing Facility	71	21	5	5	1	4	4
PT 20 Physician, M.D., Osteopath	19,027	12	16,780	442	421	21	21
PT 21 Podiatrist	133	1	420	21	1	20	20
PT 22 Dentist	1.617	22	1,315	369	17	352	352
PT 24 Advanced Practice Registered Nurse (APRN)	4,124	25	9,864	233	82	151	151
PT 32-932 Ambulance, Air or Ground	87	2	15	12	0	12	12

Provider Type, Specialty	Enrolled Providers	Responses Received	Codes in Fee Schedule	Total Codes with Cost Response	Total Codes Where Median Cost is At or Below NV Rate	Total Codes Where Median Cost Exceeds NV Rate	Number of Codes Recommended for Increase
PT 33 Durable Medical Equipment, Prosthetics, Orthotics & Supplies	433	5	3,085	222	11	211	211
PT 76 Audiologist	138	1	146	22	9	13	13
PT 77 Physician's Assistant	2,002	4	9,846	242	241	1	1

Provider Types Not Surveyed or Survey Data Not Usable

The were several provider types that were not surveyed for this report, or they were surveyed, but the survey data received was not practical for use in the rate comparison. Those provider types are listed below and include an explanation for why they were not surveyed, or if the survey data provided was unusable.

PT 17-167 Special Clinic, Genetic

There were no providers enrolled in PT 17-167 when the surveys were conducted.

PT 17-179 Special Clinic, School Based Health Centers

There were no providers enrolled in PT 17-179 when the surveys were conducted.

PT 17-182 Special Clinic, Indian Health Services, Non-Tribal

At the time the surveys were issued, these clinics were reimbursed at the same rates as Indian Health Services and Tribal Clinics (Provider Type 47); these rates are 100% funded via federal match and are set by the federal government. This reimbursement methodology has since changed. As a result, PT 17-182 will be surveyed in a future Quadrennial Rate Review.

PT 17-196 Special Clinic, Special Children's Clinics

There were no providers enrolled in PT 17-196 when the surveys were conducted.

PT 17-197 Special Clinic, TB Clinics

There has been no utilization under this provider type within the last ten fiscal years. As such, the Division does not have the data needed for a fiscal analysis of these services.

PT 68 Intermediate Care Facilities for Individuals w/Intellectual Disabilities / Private

There are different rate methodologies under PT 68 dependent on the number of beds within the facility. "Large" intermediate care facilities with more than six (6) beds are paid a prospective reimbursement rate. "Small" intermediate care facilities with six (6) or fewer beds are cost-settled. Although surveys were issued for this provider type, the only survey responses received were from small/private ICFs. As these providers are cost-settled annually to 100% of allowable costs, there is no identified gap between the reimbursement rates and cost.

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. Most Medicaid reimbursement rate changes require additional state funding to be appropriated to the Division by the state legislature, a State Plan Amendment, system changes, 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 in the fee schedule if adequately funded at the state level, managed care organization capitation rates may need to be recalculated and recertified for those rate changes that do not align with the normal capitation rate setting cycle. Also, for the current contract period, which ends on December 31, 2025, managed care organizations are not required to align their network provider rates with fee schedule changes.

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 approves a rate change be included in the Nevada State Plan for Medicaid as a result of the recommendations in this report, the Division must first seek state legislative authority and funding in order to implement such changes.

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