Quadrennial Rate Review

Pursuant to NRS 422.2704

NEVADA HEALTH AUTHORITY

Division of Nevada Medicaid

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Joseph Lombardo
Governor
State of Nevada

Stacie Weeks, JD MPH
Director
Nevada Health Authority

Ann Jensen
Administrator
Division of Nevada Medicaid

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Executive Summary

The Division of Nevada Medicaid (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. For the schedule of upcoming provider surveys, please go to QRR. The schedule can be found under *Links* on the upper right side of the page. The provider types (PT's) included in this report are:

- PT 11 Hospital, Inpatient
- PT 13 Psychiatric Hospital, Inpatient
- PT 22 Dentist, Including Maxillofacial Surgery
- PT 23 Hearing Aid Dispenser & Related Supplies
- PT 29 Home Health Agency and Private Duty Nursing Services
- PT 32-249 Community Paramedicine
- PT 32-932 Ambulance, Air or Ground
- PT 33 Durable Medical Equipment (DME), Disposable, Prosthetics
- PT 34 Therapy
- PT 36 Chiropractor
- PT 39 Adult Day Health Center
- PT 44 Swing-Bed, Acute Hospital
- PT 45 End Stage Renal Disease (ESRD) Facility
- PT 48 Home and Community Based Waiver for the Frail Elderly
- PT 55 Day and Residential Habilitation Services
- PT 56 Inpatient Rehabilitation and Long-Term Acute Care (LTAC) Specialty Hospitals
- PT 57 Home and Community Based Waiver for the Frail Elderly in Residential Facilities for Groups
- PT 58 Home and Community Based Waiver for Persons with Physical Disabilities
- PT 59 Home and Community Based Waiver for the Frail Elderly in an Assisted Living Facility
- PT 63 Residential Treatment Centers (RTC)
- PT 68 Intermediate Care Facilities for Individuals with Intellectual Disabilities, Private
- PT 75 Critical Access Hospital (CAH), Inpatient
- PT 77 Physician's Assistant
- PT 81 Hospital Based End Stage Renal Disease (ESRD) Provider
- PT 86 Specialized Foster Care

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

- PT 39 Adult Day Health Care
- PT 59 Home and Community Based Waiver for the Frail Elderly in an Assisted Living Facility
- PT 68 Intermediate Care Facilities for Individuals with Intellectual Disabilities / Private
- PT 81 Hospital Based End Stage Renal Disease (ESRD) Provider
- PT 86 Specialized Foster Care

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

- PT 23 Hearing Aid Dispenser & Related Supplies
- PT 32-932 Ambulance, Air or Ground

- PT 44 Swing-bed, Acute Hospital
- PT 45 End Stage Renal Disease (ESRD) Facility
- PT 55 Day and Residential Habilitation Services
- PT 56 Inpatient Rehabilitation and Long-Term Acute Care (LTAC) Specialty Hospitals

Purpose

Nevada Medicaid and Nevada Check Up currently provide health care coverage to approximately 800,000 Nevadans as of August 2025. 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. It is important to maintain – and increase – the number of Nevada providers who serve Medicaid and Check Up recipients to ensure access for beneficiaries to the care they need. Reviewing reimbursement rates is one tool to address provider concerns.

NRS 422.2704 requires the Division 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 Nevada Medicaid 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 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 August 2025, there are over 73,700 active rates for services covered by Nevada Medicaid. There are 67 provider types (PT), which indicate who is providing a service. PTs may include individuals, facilities, or other organizational structures. Most PTs and specialties within the type 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 encompasses surveys received in calendar year 2024 for the following provider types:

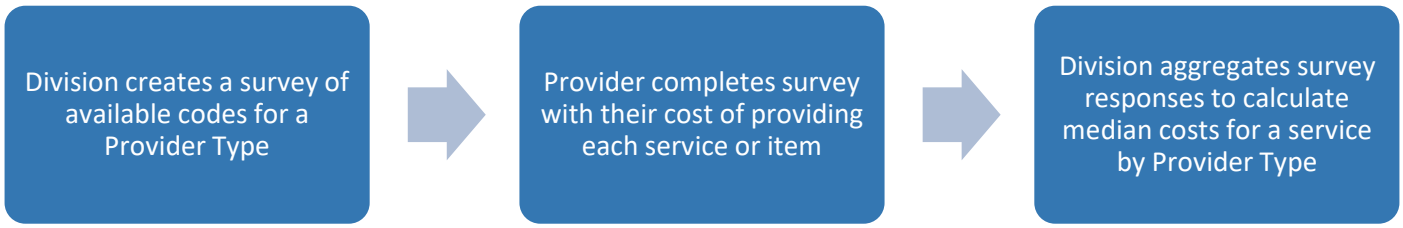
- PT 11 Hospital, Inpatient
- PT 13 Psychiatric Hospital, Inpatient
- PT 22 Dentist, Including Maxillofacial Surgery
- PT 29 Home Health Agency and Private Duty Nursing Services
- PT 33 Durable Medical Equipment (DME), Disposable, Prosthetics
- PT 34 Therapy
- PT 36 Chiropractor
- PT 39 Adult Day Health Care
- PT 48 Home and Community Based Waiver for the Frail Elderly
- PT 57 Home and Community Based Waiver for the Frail Elderly in Residential Facilities for Groups
- PT 58 Home and Community Based Waiver for Persons with Physical Disabilities
- PT 59 Home and Community Based Waiver for the Frail Elderly in an Assisted Living Facility
- PT 63 Residential Treatment Centers (RTC)
- PT 68 Intermediate Care Facilities for Individuals with Intellectual Disabilities / Private
- PT 75 Critical Access Hospital (CAH), Inpatient
- PT 77 Physician's Assistant
- PT 81 Hospital Based End Stage Renal Disease (ESRD) Provider
- PT 86 Specialized Foster Care

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 is made to find the rate that is most closely aligned with Nevada Medicaid's rate. Staff research fee schedules that were effective during the same timeframe as the survey period and attempt to identify reimbursement rates for matching provider types. In some instances, a compatible provider type does not exist in another state or services are not included in their fee schedules. In this situation, a broader list of states is used for comparison purposes. Using all identified data, staff calculate 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 for the 2026-2027 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 a relatively straightforward process, calculating the 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 projected forward to the current biennium (state fiscal years 2026 and 2027) using projected growth rates based on caseload projections from the Nevada Health Authority, Office of Analytics. The total computable figures reflect both the federal and non-federal 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 sixth set of reviews completed under the Quadrennial Rate Review process. Provider responses were lower than desired. The Division received a total of 97 cost survey responses across all provider types in this report. This count represents 1.36% of the 7,148 enrolled providers who were surveyed. Most PTs had a response rate at or below 8%.

Table 1 provides a summary of the response rates by provider type and specialty.

Table 1: Response Rates by Provider Type and Specialty

Provider Type, Specialty	Enrolled Providers	Codes in Fee Schedule	Responses Received	Response Rate
PT 11 Hospital, Inpatient	137	67	9	7%
PT 13 Psychiatric Hospital, Inpatient	14	18	1	7%
PT 22 Dentist, Including Maxillofacial Surgery	1,067	468	7	1%
PT 23 Hearing Aid Dispenser & Related Supplies	11	52	0	0%
PT 29 Home Health Agency and Private Duty Nursing Services	60	132	1	2%
PT 32-932 Ambulance, Air or Ground	81	15	0	0%
PT 33 Durable Medical Equipment (DME), Disposable, Prosthetics	410	3,096	1	0%
PT 34 Therapy	2,284	1,200	32	1%
PT 36 Chiropractor	47	14	2	4%
PT 39 Adult Day Health Care	26	2	3	12%
PT 44 Swing-bed, Acute Hospital	10	1	0	0%
PT 45 End Stage Renal Disease (ESRD) Facility	49	3	0	0%
PT 48 Home and Community Based Waiver for the Frail Elderly	143	11	11	8%
PT 55 Day and Residential Habilitation Services	18	3	0	0%
PT 56 Inpatient Rehabilitation and Long-Term Acute Care (LTAC) Specialty Hospitals	13	51	0	0%
PT 57 Home and Community Based Waiver for the Frail Elderly in Residential Facilities for Groups	176	6	1	1%
PT 58 Home and Community Based Waiver for Persons with Physical Disabilities	155	17	9	6%
PT 59 Home and Community Based Waiver for the Frail Elderly in an Assisted Living Facility	9	7	3	33%
PT 63 Residential Treatment Centers (RTC)	48	2	1	2%
PT 68 Intermediate Care Facilities for Individuals with Intellectual Disabilities / Private	10	1	5	50%
PT 75 Critical Access Hospital (CAH), Inpatient	18	67	1	6%
PT 77 Physician's Assistant	2,330	9,810	2	0%
PT 81 Hospital Based End Stage Renal Disease (ESRD) Provider	18	3	3	17%

Provider Type, Specialty	Enrolled Providers	Codes in Fee Schedule	Responses Received	Response Rate
PT 86 Specialized Foster Care	14	3	5	36%

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 11 Hospital, Inpatient	67	19	14	5	28%
PT 13 Psychiatric Hospital, Inpatient	18	1	1	0	6%
PT 22 Dentist, Including Maxillofacial Surgery	468	287	282	5	61%
PT 23 Hearing Aid Dispenser & Related Supplies	52	0	0	0	0%
PT 29 Home Health Agency and Private Duty Nursing Services	132	2	0	2	2%
PT 32-932 Ambulance, Air or Ground	15	0	0	0	0%
PT 33 Durable Medical Equipment (DME), Disposable, Prosthetics	3,096	157	31	126	5%
PT 34 Therapy	1,200	64	62	2	5%
PT 36 Chiropractor	14	7	7	0	50%
PT 39 Adult Day Health Care	2	2	2	0	100%
PT 44 Swing-bed, Acute Hospital	1	0	0	0	0%
PT 45 End Stage Renal Disease (ESRD) Facility	3	0	0	0	0%
PT 48 Home and Community Based Waiver for the Frail Elderly	11	8	3	5	73%
PT 55 Day and Residential Habilitation Services	3	0	0	0	0%
PT 56 Inpatient Rehabilitation and Long-Term Acute Care (LTAC) Specialty Hospitals	51	0	0	0	0%
PT 57 Home and Community Based Waiver for the Frail Elderly in Residential Facilities for Groups	6	2	0	2	33%
PT 58 Home and Community Based Waiver for Persons with Physical Disabilities	17	6	1	5	35%
PT 59 Home and Community Based Waiver for the Frail Elderly in an Assisted Living Facility	7	5	3	2	71%
PT 63 Residential Treatment Centers (RTC)	2	1	1	0	50%

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 68 Intermediate Care Facilities for Individuals with Intellectual Disabilities / Private	1	1	1	0	100%
PT 75 Critical Access Hospital (CAH), Inpatient	67	4	4	0	6%
PT 77 Physician's Assistant	9,810	208	199	9	2%
PT 81 Hospital Based End Stage Renal Disease (ESRD) Provider	3	2	1	1	67%
PT 86 Specialized Foster Care	3	3	3	0	100%

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. For most provider types, survey responses vary, and certain procedure codes show the need for an increase while others show that the current rate may be sufficient. Negative numbers indicate that the aggregate impact of aligning reimbursement rates with reported costs would result in a savings.

Table 3: SFY 2026 and 2027 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	Average Change per Code
PT 11 Hospital, Inpatient	$348,478,329	$99,015,240	124%
PT 13 Psychiatric Hospital, Inpatient	$67,840,609	$14,107,975	60%
PT 22 Dentist, Including Maxillofacial Surgery	$215,121,743	$69,865,850	192%
PT 23 Hearing Aid Dispenser & Related Supplies	$0	$0	N/A
PT 29 Home Health Agency and Private Duty Nursing Services	($11,577,580)	($2,965,210)	-27%
PT 32-932 Ambulance, Air or Ground	$0	$0	N/A
PT 33 Durable Medical Equipment (DME), Disposable, Prosthetics	($11,411,011)	($3,080,233)	7%
PT 34 Therapy	$47,970,974	$14,847,015	56%
PT 36 Chiropractor	$30,977	$11,360	52%
PT 39 Adult Day Health Care	$20,668,015	$7,965,761	77%
PT 44 Swing-bed, Acute Hospital	$0	$0	N/A
PT 45 End Stage Renal Disease (ESRD) Facility	$0	$0	N/A
PT 48 Home and Community Based Waiver for the Frail Elderly	($810,116)	($322,780)	44%

Provider Type, Specialty	Change in Expenditures to Match Median of Reported Provider Costs		
	Total Computable	Non-Federal Share	Average Change per Code
PT 55 Day and Residential Habilitation Services	$0	$0	N/A
PT 56 Inpatient Rehabilitation and Long-Term Acute Care (LTAC) Specialty Hospitals	$0	$0	N/A
PT 57 Home and Community Based Waiver for the Frail Elderly in Residential Facilities for Groups	($524,143)	($210,806)	-24%
PT 58 Home and Community Based Waiver for Persons with Physical Disabilities	($1,144,142)	($457,932)	3%
PT 59 Home and Community Based Waiver for the Frail Elderly in an Assisted Living Facility	$3,606,500	$1,450,503	104%
PT 63 Residential Treatment Centers (RTC)	$48,118,643	$18,287,605	68%
PT 68 Intermediate Care Facilities for Individuals with Intellectual Disabilities / Private	$5,660,780	$2,217,916	33%
PT 75 Critical Access Hospital (CAH), Inpatient	$1,805,844	$533,577	151%
PT 77 Physician's Assistant	$2,617,170	$827,995	25%
PT 81 Hospital Based End Stage Renal Disease (ESRD) Provider	($109,064)	($23,722)	102%
PT 86 Specialized Foster Care	$3,857,977	$1,547,512	21%

Important limitations to the estimates provided in Table 3:

- Provider costs are accepted as reported. 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 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.

Table 4 summarizes the impact of each scenario analyzed by the Division. 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: 2026-27 Biennium Non-Federal Share Fiscal Impact Estimates by Rate Increase Scenario

NRS 422.2704 - 2025 Report Summary

Non-Federal Share Fund Expenditures for SFY 26-27

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 11 Hospital, Inpatient	$360,452,125	$99,015,240	$0	$0	$18,022,606	$36,045,213	$54,067,819
PT 13 Psychiatric Hospital, Inpatient	$27,248,151	$14,107,975	($3,844,729)	$0	$1,362,408	$2,724,815	$4,087,223
PT 22 Dentist, Including Maxillofacial Surgery	$68,456,473	$69,865,850	$14,244,818	$14,358,789	$5,912,992	$9,454,395	$12,995,798
PT 23 Hearing Aid Dispenser & Related Supplies	$495,524	$0	$140,173	$0	$24,776	$49,552	$74,329
PT 29 Home Health Agency and Private Duty Nursing Services	$16,597,037	($2,965,210)	$9,485,764	$0	$829,852	$1,659,704	$2,489,556
PT 32-932 Ambulance, Air or Ground	$16,450,697	$0	$9,094,275	$4,975,746	$822,535	$1,645,070	$2,467,605
PT 33 Durable Medical Equipment (DME), Disposable, Prosthetics	$31,745,934	($3,080,233)	($2,261,416)	$2,009,565	$1,587,297	$3,174,593	$4,761,890
PT 34 Therapy	$37,412,512	$14,847,015	$5,918,642	$8,293,894	$1,870,626	$3,741,251	$5,611,877
PT 36 Chiropractor	$23,038	$11,360	($3,456)	$1,626	$1,152	$2,304	$3,456
PT 39 Adult Day Health Care	$9,093,263	$7,965,761	$2,192,828	$0	$454,663	$909,326	$1,363,990
PT 44 Swing-bed, Acute Hospital	$65,623	$0	$0	$0	$3,281	$6,562	$9,843

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 45 End Stage Renal Disease (ESRD) Facility	$32,443,445	$0	($566,099)	($456,183)	$1,622,172	$3,244,345	$4,866,517
PT 48 Home and Community Based Waiver for the Frail Elderly	$7,766,509	($322,780)	$14,257,924	$0	$388,325	$776,651	$1,164,976
PT 55 Day and Residential Habilitation Services	$5,548,820	$0	$8,015,822	$0	$277,441	$554,882	$832,323
PT 56 Inpatient Rehabilitation and Long-Term Acute Care (LTAC) Specialty Hospitals	$15,160,061	$0	$0	$0	$758,003	$1,516,006	$2,274,009
PT 57 Home and Community Based Waiver for the Frail Elderly in Residential Facilities for Groups	$14,089,536	($210,806)	$3,937,167	$0	$704,477	$1,408,954	$2,113,430
PT 58 Home and Community Based Waiver for Persons with Physical Disabilities	$8,215,563	($457,932)	$10,479,797	$0	$410,778	$821,556	$1,232,334

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 59 Home and Community Based Waiver for the Frail Elderly in an Assisted Living Facility	$881,428	$1,450,503	$869,330	$0	$44,071	$88,143	$132,214
PT 63 Residential Treatment Centers (RTC)	$26,836,200	$18,287,605	$0	$0	$1,341,810	$2,683,620	$4,025,430
PT 68 Intermediate Care Facilities for Individuals with Intellectual Disabilities / Private	$6,651,091	$2,217,916	$0	$0	$332,555	$665,109	$997,664
PT 75 Critical Access Hospital (CAH), Inpatient	$2,625,047	$533,577	$0	$0	$131,252	$262,505	$393,757
PT 77 Physician's Assistant	$4,272,968	$827,995	$1,633,966	$2,758,943	$213,648	$427,297	$640,945
PT 81 Hospital Based End Stage Renal Disease (ESRD) Provider	$98,885	($23,722)	($215)	($173)	$4,944	$9,889	$14,833
PT 86 Specialized Foster Care	$7,446,964	$1,547,512	$12,583,605	$0	$372,348	$744,696	$1,117,045

* Amount with no increase or decrease made.

† The estimated amount of the increase.

Recommendations

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

- PT 11 Hospital, Inpatient
- PT 13 Psychiatric Hospital, Inpatient
- PT 22 Dentist, Including Maxillofacial Surgery
- PT 33 Durable Medical Equipment (DME), Disposable, Prosthetics
- PT 34 Therapy
- PT 36 Chiropractor
- PT 39 Adult Day Health Care
- PT 48 Home and Community Based Waiver for the Frail Elderly
- PT 58 Home and Community Based Waiver for Persons with Physical Disabilities
- PT 59 Home and Community Based Waiver for the Frail Elderly in an Assisted Living Facility
- PT 63 Residential Treatment Centers (RTC)
- PT 68 Intermediate Care Facilities for Individuals with Intellectual Disabilities / Private
- PT 75 Critical Access Hospital (CAH), Inpatient
- PT 77 Physician's Assistant
- PT 81 Hospital Based End Stage Renal Disease (ESRD) Provider
- PT 86 Specialized Foster Care

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 not every rate for each of these provider types would be increased to align with provider costs; some rates would increase while others may decrease or remain unchanged. In addition, the fiscal impact estimates provided above do not incorporate anything pending approval, including but not limited to, legislation or budget initiatives for SFY26 and SFY27.

PT 11 Hospital, Inpatient

During the survey period, there were 137 providers enrolled in PT 11, and the fee schedule included 67 procedure codes. Nine survey responses were received, and cost data was provided for 19 procedure codes. The results of the analysis show that based on the survey responses, the median of the providers' reported costs indicates that there are five procedure codes where provider costs are *at or below* the current reimbursement rate, and 14 codes where the provider costs *exceed* the current reimbursement rate and should be recommended for an increase.

PT 13 Psychiatric Hospital, Inpatient

During the survey period, there were 14 providers enrolled in PT 13, and the fee schedule included 18 procedure codes. One survey response was received, and cost data was provided for one procedure code. The results of the analysis show that based on the survey responses, the median of the providers' reported costs indicates that there are zero procedure codes where provider costs are *at or below* the current reimbursement rate, and one code where the provider costs *exceed* the current reimbursement rate and should be recommended for an increase.

PT 22 Dentist, Including Maxillofacial Surgery

During the survey period, there were 1,067 providers enrolled in PT 22, and the fee schedule included 468 procedure codes. Seven survey responses were received, and cost data was provided for 287 procedure codes. The results of the analysis show that based on the survey responses, the median of the providers' reported costs indicates that there are five procedure codes where provider costs are *at or below* the current reimbursement rate, and 282 codes where the provider costs *exceed* the current reimbursement rate and should be recommended for an increase.

PT 33 Durable Medical Equipment (DME), Disposable, Prosthetics

During the survey period, there were 410 providers enrolled in PT 33, and the fee schedule included 3,096 procedure codes. One survey response was received, and cost data was provided for 157 procedure codes. The results of the analysis show that based on the survey responses, the median of the providers' reported costs indicates that there are 126 procedure codes where provider costs are *at or below* the current reimbursement rate, and 31 codes where the provider costs *exceed* the current reimbursement rate and should be recommended for an increase.

PT 34 Therapy

During the survey period, there were 2,284 providers enrolled in PT 34, and the fee schedule included 1,200 procedure codes. 32 survey responses were received, and cost data was provided for 64 procedure codes. The results of the analysis show that based on the survey responses, the median of the providers' reported costs indicates that there are two procedure codes where provider costs are *at or below* the current reimbursement rate, and 62 codes where the provider costs *exceed* the current reimbursement rate and should be recommended for an increase.

PT 36 Chiropractor

During the survey period, there were 47 providers enrolled in PT 36, and the fee schedule included 14 procedure codes. Two survey responses were received, and cost data was provided for seven procedure codes. The results of the analysis show that based on the survey responses, the median of the providers' reported costs indicates that there are zero procedure codes where provider costs are *at or below* the current reimbursement rate, and seven codes where the provider costs *exceed* the current reimbursement rate and should be recommended for an increase.

PT 39 Adult Day Health Care

During the survey period, there were 26 providers enrolled in PT 39, and the fee schedule included two procedure codes. Three survey responses were received, and cost data was provided for two procedure codes. The results of the analysis show that based on the survey responses, the median of the providers' reported costs indicates that there are zero procedure codes where provider costs are *at or below* the current reimbursement rate, and two codes where the provider costs *exceed* the current reimbursement rate and should be recommended for an increase.

PT 48 Home and Community Based Waiver for the Frail Elderly

During the survey period, there were 143 providers enrolled in PT 48, and the fee schedule included 11 procedure codes. 11 survey responses were received, and cost data was provided for eight procedure codes. The results of the analysis show that based on the survey responses, the median of the providers' reported costs indicates that there are five procedure codes where provider costs are *at or below* the current reimbursement rate, and three codes where the provider costs *exceed* the current reimbursement rate and should be recommended for an increase.

PT 58 Home and Community Based Waiver for Persons with Physical Disabilities

During the survey period, there were 155 providers enrolled in PT 58, and the fee schedule included 17 procedure codes. Nine survey responses were received, and cost data was provided for six procedure codes. The results of the analysis show that based on the survey responses, the median of the providers' reported costs indicates that there were five procedure codes where provider costs are *at or below* the current reimbursement rate, and one code where the provider costs *exceed* the current reimbursement rate and should be recommended for an increase.

PT 59 Home and Community Based Waiver for the Frail Elderly in an Assisted Living Facility

During the survey period, there were nine providers enrolled in PT 59, and the fee schedule included seven procedure codes. Three survey responses were received, and cost data was provided for five procedure codes. The results of the analysis show that based on the survey responses, the median of the providers' reported costs indicates that there are two procedure codes where provider costs are *at or below* the current reimbursement rate, and three codes where the provider costs *exceed* the current reimbursement rate and should be recommended for an increase.

PT 63 Residential Treatment Centers (RTC)

During the survey period, there were 48 providers enrolled in PT 63, and the fee schedule included two procedure codes. One survey response was received, and cost data was provided for one procedure code. The results of the analysis show that based on the survey responses, the median of the providers' reported costs indicates that there are zero procedure codes where provider costs are *at or below* the current reimbursement rate, and one code where the provider costs *exceed* the current reimbursement rate and should be recommended for an increase.

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

During the survey period, there were 10 providers enrolled in PT 68, and the fee schedule included one procedure code. Five survey responses were received, and cost data was provided for one procedure code. The results of the analysis show that based on the survey responses, the median of the providers' reported costs indicates that there are zero procedure codes where provider costs are *at or below* the current reimbursement rate, and one code where the provider costs *exceed* the current reimbursement rate and should be recommended for an increase.

PT 75 Critical Access Hospital (CAH), Inpatient

During the survey period, there were 18 providers enrolled in PT 75, and the fee schedule included 67 procedure codes. One survey response was received, and cost data was provided for four procedure codes. The results of the analysis show that based on the survey responses, the median of the providers' reported costs indicates that there are zero procedure codes where provider costs are *at or below* the current reimbursement rate, and four codes where the provider costs *exceed* the current reimbursement rate and should be recommended for an increase.

PT 77 Physician's Assistant

During the survey period, there were 2,330 providers enrolled in PT 77, and the fee schedule included 9,810 procedure codes. Two survey responses were received, and cost data was provided for 208 procedure codes. The results of the analysis show that based on the survey responses, the median of the provider's reported costs indicates that there are nine procedure codes where provider costs are *at or below* the current reimbursement rate, and 199 codes where the provider costs *exceed* the current reimbursement rate and should be recommended for an increase.

PT 81 Hospital Based End Stage Renal Disease (ESRD) Provider

During the survey period, there were 18 providers enrolled in PT 81, and the fee schedule included three procedure codes. Three survey responses were received, and cost data was provided for two procedure codes. The results of the analysis show that based on the survey responses, the median of the providers' reported costs indicates that there is one procedure code where provider costs are *at or below* the current reimbursement rate, and one code where the provider costs *exceed* the current reimbursement rate and should be recommended for an increase.

PT 86 Specialized Foster Care

During the survey period, there were 14 providers enrolled in PT 86, and the fee schedule included three procedure codes. Five survey responses were received, and cost data was provided for three procedure codes. The results of the analysis show that based on the survey responses, the median of the providers' reported costs indicates that there are zero procedure codes where provider costs are *at or below* the current reimbursement rate, and three codes where the provider costs *exceed* the current reimbursement rate and should be recommended for an increase.

Provider Types Not Surveyed or No Usable Data Available

There was one provider type, PT 32-249 Community Paramedicine, that we were unable to do a fiscal analysis on. A survey was released, however, there were zero responses and no utilization data to analyze.

Conclusion

This report has been provided to the Director of the Nevada Health Authority 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, systems 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 to 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 to the 615 service codes across the 24 PT's surveyed.

Contact us:

4070 Silver Sage Dr
Carson City, NV 89701
775-684-3676
QRR@nvha.nv.gov
nvha.nv.gov