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State/Territory Name: Nevada

State Plan Amendment (SPA) #: NV 13-017

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS-179
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

JAN 3 0 2014

Michael J. Willden, Director
Department of Health and Human Services
4126 Technology Way, Suite 100
Carson City, NV 89706

Dear Mr. Willden:

Enclosed is an approved copy of Nevada State Plan Amendment (SPA) 13-017. This SPA was submitted to my office on August 27, 2013 requesting to amend Attachment 4.19-B to clarify the reimbursement methodology for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) and to describe the change in scope process required for a rate review.

The approval is effective July 1, 2013. Attached are copies of the following pages to be incorporated into your State Plan:

- Attachment 4.19-B, Pages 1 (Continued) through 1 (Continued p. 4)
- Attachment 4.19-B, Page 1a
- Attachment 3.1-A, Page 1a

If you have any questions, please contact Brian Zolynas by phone at (415) 744-3601 or by email at Brian.Zolynas@cms.hhs.gov.

Sincerely,

/s/

Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

cc: Laurie Squartsoff, Administrator, DHCFP
Marta Stagliano, Chief, Compliance, DHCFP

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 13-017	2. STATE NEVADA
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE July 1, 2013	
5. TYPE OF PLAN MATERIAL (Check One):			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: State Plan Under Title XIX of the Social Security Act: 42 CFR 440.365		7. FEDERAL BUDGET IMPACT: a. FFY 2013 \$0 b. FFY 2014 \$0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: <u>Attachment 4.19-B, p. 1 (Continued) – Page 1</u> <u>(Continued p.4) & Page 1a</u> Attachment 3.1-A, Page 1a		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): <u>Attachment 4,19-B, p. 1 (Continued) – 1a</u> Attachment 3.1-A, Page 1a	
10. SUBJECT OF AMENDMENT: Revise and clarify the State Plan regarding the Rate Methodology for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC). The rate methodology is not being changed at this time; we are only adding clarifying details.			
11. GOVERNOR'S REVIEW (Check One):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input checked="" type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		<input type="checkbox"/> OTHER, AS SPECIFIED: The Governor's Office does not wish to review the State Plan Amendment.	
12. SIGNATURE OF AGENCY OFFICIAL: <i>[Signature]</i>		16. RETURN TO: Marta Stagliano, Chief, Compliance DHCFP/Medicaid 1100 East William Street, Suite 101 Carson City, NV 89701	
13. TYPED NAME: Michael J. Willden			
14. TITLE: Director, Department of Health and Human Services			
15. DATE SUBMITTED: AUG 27 2013			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: August 27, 2013		18. DATE APPROVED: JAN 30 2014	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2013		20. SIGNATURE OF REGIONAL OFFICIAL: /s/	
21. TYPED NAME: Gloria Nagle, Ph.D., MPA		22. TITLE: Associate Regional Administrator	
23. REMARKS: Pen and ink changes to Boxes 8, 9, and 11.			

1. Inpatient hospital services are limited to admissions certified for payment by Nevada Peer Review Organization.
- 2.a. Outpatient hospital services are limited to the same extent as physicians' services, prescribed drugs, therapy and other specific services listed in this Attachment.
- 2.b. Rural health clinic services are subject to the same limitations listed for specific services elsewhere in this Attachment.

Rural Health Clinic (RHC) Services are defined in section 1905(a)(2)(B) of the Social Security Act (the Act). RHC services include services provided by physicians (MD/DO), dentist, advanced practice registered nurse, physician assistants, nurse anesthetist, nurse midwives, psychologist, licensed clinical social workers, dental hygienist, podiatrist, radiology, optometrist, opticians (including eyeglasses dispensed), visiting nurses, clinical laboratory and other ambulatory services included in the state plan. RHC services also include services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant, nurse practitioner, or nurse midwife, and related medical supplies other than drugs and biologicals. Limitations on other ambulatory services furnished in the RHC are the same limitations as defined for those services in the State Plan.

- 2.c. Federally qualified health center services are subject to the same limitation as those of rural health clinics.

Federally Qualified Health Center (FQHC) Services as defined in section 1905(a)(2)(C) of the Social Security Act (the Act). FQHC services include services provided by physicians (MD/DO), dentist, advanced practice registered nurse, physician assistants, nurse anesthetist, nurse midwives, psychologist, licensed clinical social workers, dental hygienist, podiatrist, radiology, optometrist, opticians (including eyeglasses dispensed), visiting nurses, clinical laboratory and other ambulatory services included in the state plan. FQHC services also include services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant, nurse practitioner, or nurse midwife, and related medical supplies other than drugs and biologicals. Limitations on other ambulatory services furnished in the FQHC are the same limitations as defined for those services in the State Plan.

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Attachment 4.19-B
Page 1 (Continued)

c. **Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)**

FQHC and RHC reimbursement will adhere to section 1902(a) of the Social Security Act as amended by Section 702 of the Benefits Improvement and Protection Act of 2000 (BIPA). The reasonable cost-based reimbursement requirements for FQHC/RHC services previously described at paragraph (13) (C) are repealed and instead a Prospective Payment System (PPS) consistent with paragraph (15) payment described in section 1902(aa) of the Act for FQHCs/RHCs will be implemented. The Nevada Medicaid Prospective Payment System (PPS) is to take effect on January 1, 2001.

Prospective Payment System (PPS) Reimbursement for Existing Facilities

Beginning January 1, 2001 the State will pay current FQHCs/RHCs (including "FQHC look alike clinics") based on a PPS. The baseline for a PPS will be set at 100 percent of the average of an FQHC/RHC per visit rate based on the reported reasonable and allowable costs of providing Medicaid-covered services during the FQHC/RHC fiscal years 1999 and 2000, adjusted to take into account any reported increase (or decrease) in the scope of services furnished during FY 2001 by the FQHC/RHC (calculating the payment amount on a per visit basis). Medicaid-covered services that are considered to be FQHC/RHC services are those services that were identified and approved to be provided by the facility as it applies to HRSA in order to be deemed as an FQHC/RHC facility.

Beginning in Federal fiscal year 2002, and for each fiscal year thereafter, each FQHC/RHC is entitled to the payment amount (on a per visit basis) to which the center or clinic was entitled under the Act in the previous year, increased each October 1st (FFY) by the percentage increase in the Medicare Economic Index (MEI) for primary care services as defined in Section 1842 (i) (4) of the Social Security Act, and adjusted to take into account any reported increase (or decrease) in the scope of services furnished by the FQHC/RHC during that fiscal year.

Prospective Payment System (PPS) Reimbursement for New Facilities

Newly qualified FQHCs/RHCs after Federal fiscal year 2000 will have initial payments (interim rate) established either by reference to payments to one or more other clinics in the same or adjacent areas with similar caseloads and/or similar scope of services or based on an average of rates for other FQHC/RHC clinics throughout the State. Once their average per visit reasonable costs of providing Medicaid-covered services based on their first full year of operation can be determined, the initial payments of the FQHC/RHC will be cost settled and any over or under payments will be determined and the PPS rate will then be established based on actual cost to provide those services for their first full year. The per visit PPS rate will then be adjusted annually every October 1st beginning at the next federal fiscal year by the percentage change in the Medicare Economic Index (MEI) for primary care services as defined in Section 1842 (i) (4) of the Social Security Act, for that calendar year as published in the Federal Register, adjusted to take into account any reported change in scope of services, reported and requested during that year. All required documentation of actual costs for the first full year of providing services must be furnished to DHCFP no later than six (6) months after completion of the first full year of services. If the required documentation is not received within six (6) months after the completion of a full year of services, the annual MEI adjustments will be suspended until such time as the documentation is received and an actual PPS rate is determined.

TN No. 13-017

Approval Date: JAN 30 2014

Effective Date: July 1, 2013

Supersedes

TN No. 10-007

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Rebasing: Baseline PPS rates will not be subject to rebasing after their initial computation unless authorized by congress. The actual costs related to any reported change in scope of services will be calculated (based on a full year of providing those services) and an adjustment to the baseline PPS rate will be made.

Alternative Payment Methodology (APM) Reimbursement

For the period beginning January 1, 2001 and ending September 30, 2001, and for any fiscal year beginning with FY 2002, a State may, in reimbursing an FQHC/RHC for services furnished to Medicaid beneficiaries, use a methodology other than the Medicaid PPS, but only if the following statutory requirements are met. First, the APM must be agreed to by the State and by each individual FQHC/RHC to which the State wishes to apply the methodology. Second, the methodology must result in a payment to the center or clinic that is a least equal to the amount to which the center or clinic is entitled under the Medicaid PPS. Third, the methodology must be described in the approved State plan.

Effective October 1st (FFY) of each year after an APM rate has been established, for services furnished on or after that date, DHCFP will adjust the APM rate by the percentage increase in the MEI applicable to primary care services as published in the Federal Register for that calendar year, which will account for basic cost increases associated with providing such services.

Change in Scope of Services

PPS/APM rates may be adjusted to take into account any requested, documented and approved increase (or decrease) in the scope of services furnished by the FQHC/RHC in any given fiscal year. The FQHC/RHC must submit a written request to the Division within 60 days of the effective date of those changes in order for the rate adjustment to be retroactive to the date of the Change in Scope of Services. If a written request is not received within 60 days of those changes, the effective date for a rate adjustment will be the date the written request for a Change in Scope of Services was received by DHCFP. Documentation and notification to support an increase or decrease in the scope of services is the responsibility of the provider.

An FQHC/RHC requesting a rate adjustment for changes in scope of services must submit data/documentation/schedules that substantiate the changes in scope and the related adjustment of reasonable costs following Medicare principals of reimbursement.

An interim rate will be determined using the first three months of actual cost data available from the provider. After a full year of providing the services related to the change in scope, an analysis will be performed on the actual costs for a full year of service and an adjustment will be made to the PPS/APM. Adjustments to the PPS/APM rate for qualified/approved changes in scope will be based on Medicare Cost Reimbursement methodology, allocating costs related to patient care based upon a providers audited and approved charges for the change in scope services. The PPS/APM rate adjustment will then be determined by dividing the Medicaid allocated costs by the number of Medicaid visits for the given time period.

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A Change in Scope of Services has been defined as a change in the type, intensity, duration and/or amount of covered Medicaid services (covered under the Medicaid State Plan and approved by CMS) that meet the definition of FQHC/RHC services as defined in section 1905 (a) (2) (B) and (C) of the Social Security Act. General increases or decreases in costs associated with programs that were already a part of an established PPS/APM rate do NOT constitute a Change in Scope unless all of the following requirements are met:

- The change in the scope of services is a change in the type, intensity, duration, or amount of services, or any combination thereof as defined in section 1905 (a) (2) (B) and (C) of the Social Security Act.
- The cost is allowable under Medicare reasonable cost principals set forth in 42CFR Part 413.
- The net change in the FQHC/RHC's per visit rate must equal or exceed 4% for the affected FQHC/RHC site. For FQHC/RHC's that filed consolidated cost reports for multiple sites to establish the initial Prospective Payment reimbursement rate (PPS), the 4% threshold will be applied to the average per visit rate of all sites for the purposes of calculating the cost associated with a scope of service change. "Net change" means the per visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year.

A Change in Scope of Services includes any of the following:

- A change in the types of services offered, i.e., the addition of dental services, may qualify as a Change in Scope which may warrant an adjustment to the PPS/APM rate.
- A change in intensity/duration or character of services offered by an FQHC/RHC attributable to changes in the types of patients served may qualify, such as services to patients with HIV/AIDS or other chronic diseases and other special populations requiring more intensive and frequent care.
- A change in the magnitude, intensity or character of currently offered services, demonstrated and documented by an increase or decrease in the patient volume of certain high risk populations that require more intensive and frequent care, which may reasonably be expected to span at least one year may qualify.
- A change in the type, intensity, duration or amount of service caused by changes in technology and medical practice used may qualify.

Definition of a "Visit"/"Encounter"

A "visit" or an "encounter" for the purposes of reimbursing FQHC/RHC services is defined as face-to-face contact with one or more qualified health professionals and multiple contacts with the same health professional that take place on the same day with the same patient. A single payment will be made for each "visit" or an "encounter" regardless of the type of service.

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Qualified Health Professional

To be eligible for PPS/APM reimbursement, services must be delivered exclusively by one or more of the following licensed Qualified Health Professionals or a provider working under his or her direct supervision: physician, physician's assistant, nurse practitioner, nurse anesthetist, nurse midwife, clinical psychologist, clinical social worker, dentist or dental hygienist.

Documentation Required to Support a Request for Change in Scope of Services

- Year End Payroll Reports for identified time periods
- Trial Balances for all Revenues and Expenses for identified time periods
- Grouping Schedule/Mapping of Trial Balance Accounts to the Cost Reports
- Detailed General Ledger with Vendor Information for identified time periods
- HRSA Notice of Awards for all approved Changes in Scope of Services
- Claims reports showing Unique Patient Visits, DOS, Procedure Codes, Service Facility ID#, Amount Paid and Payor
- Other Items as Deemed Necessary

Other Payment Adjustments

FQHC/RHC's may request other payment adjustments in the event of extraordinary circumstances, not otherwise reimbursed by other sources, including but not limited to acts of God; acts of nature; acts of terrorism and acts of war. However, if an FQHC/RHC's existing PPS/APM rate is sufficient to cover its overall costs, including those associated with the extraordinary circumstances, other payment adjustment is not warranted. The FQHC/RHC must show that its PPS/APM rate is not sufficient to cover the costs associated with the extraordinary circumstance. The adjusted rate will only apply to the extent, and only for the period of time, that the additional costs for the event are reimbursable under federal Medicaid law and regulations governing claims for federal financial participation (FMAP). DHCFP will work with the provider to gather the appropriate data at the time the incident occurs and a written request for a rate adjustment is made by the Provider.

Record keeping and Audit

All participating FQHC/RHC's shall maintain an accounting system which identifies costs in a manner that conforms to generally accepted accounting principles and must maintain documentation sufficient to support all cost/visit data.

The DHCFP, its fiscal agent or a designated and contracted financial entity may conduct periodic on-site or desk audits of all cost data, including financial and statistical records of the FQHC/RHCs.

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Page 1 (Continued p.4)

FQHC/RHCs must submit information (statistics, costs and financial data or other data) as deemed necessary by the DHCFP or its fiscal agent. Failure to submit requested documentation may result in denial of a rate adjustment request.

The DHCFP will conduct one audit annually (at a minimum) to the claims submitted by the FQHC/RHC for supplemental payments.

Supplemental Payments for FQHCs/RHCs

FQHCs/RHCs that provide services under a contract with a Medicaid Managed Care Entity (MCE) will receive quarterly or monthly (as agreed upon between the provider and the state) supplemental payments for furnishing such services, that are a calculation of the difference between the payments the FQHC/RHC receives from the MCE(s) for all qualified Medicaid visits and the payments the FQHC/RHC would have received under the BIPA PPS methodology or APM.

At the end of each payment period, the total amount of MCE payments received by the FQHC/RHC will be reviewed against the amount that the actual number of visits provided under the FQHC's/RHC's contract with MCE(s) would have yielded under the PPS/APM methodology. If the amount exceeds the total amount of MCE payments, the FQHC/RHC will be paid the difference, if the amount is less, the FQHC/RHC will refund the difference to DHCFP. The FQHC/RHCs must provide sufficient documentation (as requested) to DHCFP to facilitate supplemental payment calculations. If the required documentation is not provided to support the supplemental payment, future supplemental payments may be suspended.

Documentation Required to Calculate/Support Supplemental Payments

The FQHC/RHC will submit a written/electronic request for supplemental payment which will contain at least the following information for each line item of every qualified encounter during the reporting time period (Quarterly or Monthly): Servicing and Billing Provider ID#, Recipient MCE ID Number, Recipient Medicaid ID Number, Date of Service, CPT Code(s), MCE Name, Total Billed Amount, MCE Paid Amount, Other Paid Amount and Total Amount Paid.

The FQHC/RHC will submit claim data for supplemental payment no later than thirty days after the end of the reporting period agreed upon with the DHCFP (Quarterly or Monthly).

Any discrepancy found in the audits will be adjusted based on the audit findings.

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Page 1a

3. Laboratory and pathology services deemed to be Nevada Medicaid covered benefits will be paid at:

- a. For codes 80000-89999, the lower of billed charges not to exceed 50% of the rate allowed by the 2005 Medicare Clinical Diagnostic Laboratory Fee Schedule for Nevada;
- b. Allowed laboratory and pathology codes/services outside of the ranges listed in 3.1 and 3.2 or not listed in the Medicare Clinical Diagnostic Laboratory Fee Schedule for Nevada will be paid in accordance with other sections of this State Plan based on rendering provider type;
- c. Newly developed laboratory and pathology codes that fall within the code range 80000-89999 will be priced at lower of billed charges not to exceed 50% of the rate allowed by the Medicare Clinical Diagnostic Laboratory Fee Schedule for Nevada for the year that the code(s) is listed in the fee schedule;
- d. For "BR" (by report) and "RNE" (relativity not established) codes that fall within the code range 80000-89999, the payment will be set at 62% of billed charges; or
- e. Contracted or negotiated amount.