

Table of Contents

State/Territory Name: Nevada

State Plan Amendment (SPA) #: 15-003

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850



Financial Management Group

AUG 31 2015

Richard Whitley, Director
Nevada Department of Health and Human Services
4126 Technology Way, Suite 100
Carson City, NV 89706

RE: Nevada State Plan Amendment 15-003

Dear Mr. Whitley:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 15-003. This amendment extends and updates the pool amount for an inpatient hospital supplemental payment program for the state fiscal year ending June 30, 2016.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. This is to inform you that Medicaid State plan amendment 15-003 is approved effective July 1, 2015. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Mark Wong at (415) 744-3561 or Blake Holt at (415) 744-3754.

Sincerely,

A solid black rectangular box redacting the signature of Timothy Hill.

Timothy Hill
Director

A handwritten signature in black ink, appearing to be "TH", located to the right of the printed name and title.

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
15-003

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, 2015

5. TYPE OF PLAN MATERIAL (Check One):

- NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN 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 413.75- 447 Subpart C

7. FEDERAL BUDGET IMPACT:

a. FFY 2015 \$ 6,657,075.88
b. FFY 2016 \$27,300,763.66 20,475,573
c. FFY 2017 ----- \$20,922,422.73

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A, Pages 32b, 32d

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Attachment 4.19-A, Pages 32b, 32d

10. SUBJECT OF AMENDMENT:

The Division of Health Care Financing and Policy (DHCFP) is proposing to extend the supplemental payment for inpatient hospital services as described in the Nevada State Plan Attachment 4.19-A, Pages 32b and 32c through SFY 2016 and SFY 2017. The DHCFP is also proposing to increase the Non-Federal share of the supplemental payment program from \$11,245,692 each SFY to \$14,745,692 to each SFY.

11. GOVERNOR'S REVIEW (Check One):

- GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED:
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Richard Whitley

14. TITLE:
Director, Department of Health and Human Services

15. DATE SUBMITTED: June 30, 2015

16. RETURN TO:

Tammy Moffitt, Chief of Program Integrity
DHCFP/Medicaid
1100 East William Street, Suite 101
Carson City, NV 89701

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

AUG 31 2015

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

JUL 01 2015

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

Kristin Fan

22. TITLE:

Deputy Director, FMS

23. REMARKS:

Pen and ink changes made to Boxes 6, 7, 8, and 9 by CMS regional office with state concurrence.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nevada

Attachment 4.19-A

Page 32b

SUPPLEMENTAL PAYMENT FOR INPATIENT HOSPITALS

In order to preserve access to inpatient hospital services for needy individuals in the state of Nevada, effective on or after January 1, 2014, the state's Medicaid reimbursement system shall provide for supplemental payments to inpatient hospitals. These supplemental payments shall be determined on an annual basis and paid to qualifying private and public inpatient hospitals on a quarterly basis. The payments will be based on inpatient hospital Medicaid Fee-For-Service utilization. No payment under this section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

A. Amount for Distribution

1. The amount of funds to be distributed is the total computable of which the non-federal share is \$14,745,692 for the period from July 1, 2015 to June 30, 2016.
2. The aggregated amount of supplemental payments to inpatient hospitals shall not exceed the Upper Payment Limit (UPL) for each one of the respective period. The supplemental payment for the period of July 1, 2015 to June 30, 2016 will be accounted for the UPL room available for July 1, 2015 to June 30, 2016.

B. Eligibility

1. Nevada acute care inpatient hospitals (PT 11), that are not designated as Critical Access Hospitals (CAH) (PT 75), Psychiatric Inpatient Hospitals (PT 13), Rehabilitation, Specialty or Long Term Acute Care (LTAC) (PT 56), will be deemed to qualify.
2. Nevada acute care inpatient hospitals (PT 11) certified as Trauma I, Trauma II and Trauma III levels will additionally qualify for the distribution of the Trauma case portion of the allotment.

TN No. 15-003

Approval Date: AUG 31 2015

Effective Date: July 1, 2015

Supersedes

TN No. 13-032

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nevada

Attachment 4.19-A

Page 32d

- a. To calculate the 50% weighted trauma case amount, divide the 100% weighted trauma case by 2.
- b. Multiply the number of trauma cases of hospitals certified as trauma Level I and Level II by the 100% weighted amount determined in (g), to calculate the payment for each hospital in this category.
- c. Multiply the number of trauma cases of hospitals certified as trauma Level III by the amount determined in (h), to calculate the payment for each hospital in this category.
- d. Subtract the trauma portion of the allocation from the total allocation to determine the amount remaining for distribution to eligible hospitals as identified in step 2 (a).
- e. Multiply the number of each hospital's Medicaid Fee-For-Service days, by their Medicaid CMI to determine the number of adjusted days per hospital.
- f. Divide the remaining allocation (the amount in step (c) reduced by the amount in step (e)) by the total adjusted days to determine the per day rate.
- g. Multiply the per day rate times the individual hospital adjusted days to determine each hospital payment.
- h. Add hospital day rate payment amount to the trauma payment, if any, to determine the total payment to each hospital.

B. Payment

1. Payment issued to hospitals participating in the supplemental payment will be deducted and tracked to ensure that total Medicaid payments do not exceed the aggregate amount of (UPL) calculated for the corresponding period. (see A.2 above).
2. One fourth (25%) of the total annual allocation (not to exceed the aggregate amount of UPL for the corresponding period) will be paid out quarterly to each eligible hospital, in supplemental payments, in the last month of the quarter for which the payment is calculated (Effective 7/1/2015: e.g. the supplemental payment for SFY 2016 Quarter 1 will be issued in September 2015).
3. Each hospital will be issued the supplemental payment by EFT as a financial transaction through the MMIS.

TN No. 15-003
Supersedes
TN No. 13-032

Approval Date: AUG 31 2015

Effective Date: July 1, 2015