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State/Territory Name: Nevada

State Plan Amendment (SPA) #: 24-0014

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

November 13, 2024

Stacie Weeks
State Medicaid Administrator
1100 East William Street, Suite 101
Carson City, NV 89701

RE: TN 24-0014

Dear Stacie Weeks:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Nevada state plan amendment (SPA) to Attachment 4.19-A and 4.19-D NV 24-0014, which was submitted to CMS on March 28, 2024. This plan amendment updates inpatient reimbursement methodologies of changing cost-settled rates for critical access hospitals to cost-based rates, unbundling long-acting reversible contraceptives from general acute and critical access hospital per diems, and allowing cost-settled rates for swing-bed providers.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2) of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of January 1, 2024. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Diana Dinh at 670-290-8857 or via email at diana.dinh@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director
Financial Management Group

Enclosures

DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24 — 0014

2. STATE: NV

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 485, 42 CFR 447

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ 258,455
b. FFY 2025 $ 391,487

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A, pages 4a, ~~15~~, 15-18, State Plan Attachment 4.19-D, page 14

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-A, pages 4a, 15, Attachment 4.19-D, page 14

9. SUBJECT OF AMENDMENT
Amendments to inpatient reimbursement methodologies: changing cost-settled rates for CAHs to cost-based rates, unbundling Long-Acting Reversible Contraceptives from general acute and critical access hospital inpatient per diems, allowing cost-settled rates for swing-bed providers.

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
RICHARD WHITLEY

13. TITLE
DIRECTOR, DHHS

14. DATE SUBMITTED
March 28, 2024

15. RETURN TO
Cynthia Leech, Agency Manager of Compliance
DHCFP/Medicaid
1100 East William Street, Suite 101
Carson City, NV 89701

FOR CMS USE ONLY

16. DATE RECEIVED
March 28, 2024

17. DATE APPROVED
November 13, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2024

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, Financial Management Group

22. REMARKS

Pen-and-ink change made to Box 7 by CMS with state concurrence

For services performed for claims with an admission date on or after January 1, 2024, Long-Acting Reversible Contraceptive services will be carved out of the Maternity per diem rates as described on page 4.

a. When a Long-Acting Reversible Contraceptive (LARC) is provided during an inpatient maternity stay, facilities may bill separately for the LARC device and insertion/removal procedure in addition to the maternity per diem payment.

b. LARC devices will be priced per the drug reimbursement algorithm described in Nevada Medicaid State Plan Attachment 4.19-B, page 3-page 3 (continued). LARC insertion/removal procedures will be paid based on the rendering provider type as described in State Plan Attachment 4.19-B.

VII. HOSPITALS UNDER MEDICAID RETROSPECTIVE COST REIMBURSEMENT (CRITICAL ACCESS HOSPITALS)

A few Nevada hospitals have been designated by Medicare as Critical Access Hospitals.

A. Inpatient hospital services which have been certified for payment at the acute level by the QIO-like vendor, as specified in the contract between the QIO-like vendor and Nevada Medicaid, will be reimbursed via cost-based rates adjusted for inflation. Provider must submit cost reports to the Division as follows:

1. Critical Access Hospitals (CAH) will use the CMS-2552-10 cost report form and apply Medicare cost principles and cost apportionment methodology.

2. Critical Access Hospitals will file this cost report with the state annually within five months of their respective fiscal year end.

B. On an interim basis, each hospital is paid for certified acute care at the Provider specific interim Medicaid inpatient per diem rate as follows:

1. Effective for dates of service on or after January 1, 2024, the Division will utilize the most recently available audited cost report to establish provider-specific, cost-based rates for Medical/Surgical/ICU days. Provider-specific, cost-based rates will also be established for hospitals that provide Maternity, Newborn, and Psychiatric/Detoxification services as applicable. There will be no cost settlement for Medical/Surgical/ICU, Maternity, Newborn, Psychiatric/Detoxification, or Administrative Day Services.

a. The provider-specific rates determined for each facility will be inflated forward using the Medicare Economic Index (MEI) to adjust expenses forward to the current time period.

2. For all critical access hospitals, the base Medical/Surgical ICU interim rate will be determined by identifying the "Adjusted general inpatient routine service cost per diem" as listed on the CMS 2552-10.

a. For hospitals that provide Maternity services, the Maternity base rate will also utilize the Adjusted general inpatient routine service cost per diem.

b. For hospitals that provide Newborn services, the Nursery Average Per Diem as specified in the CMS 2552-10 will be utilized to establish the base rate.

c. For hospitals that break out intensive care services separately from

medical/surgical services, the Intensive Care Unit Average Per Diem as specified in the CMS 2552-10 will be utilized to establish the base rate.

3. To account for ancillary services, the Division will identify the "Program inpatient ancillary service cost" as reported in the cost report.

   a. For providers who only reported Medical/Surgical/ICU days in the cost reporting year, the ancillary service costs will be prorated based on the total program inpatient days as reported on the cost report.

   b. For providers who also reported Maternity and Newborn days in the cost reporting year, facilities will select how ancillary costs are to be attributed. Ancillary costs can either be solely divided among the Medical/Surgical/ICU/Maternity days or can also be attributed across Medical/Surgical/ICU/Maternity as well as Newborn services. Ancillary costs will be prorated accordingly. Providers must submit a statement in writing indicating how they prefer ancillary costs to be allocated across inpatient services.

   c. The prorated ancillary amounts will be added to the base rates to arrive at the interim rate prior to adjusting for inflation.

4. For providers who also provide inpatient psychiatric/detoxification services, the interim rate will be determined by identifying the "Adjusted general inpatient routine service cost per diem" as listed on the CMS 2552-10, Subprovider – Inpatient Psychiatric Facility.

   a. Ancillary costs will be prorated across corresponding inpatient psychiatric days to calculate the total psychiatric interim rate.

5. Provider-specific, cost-based rates as calculated in B.1-B.4 above will be inflated using the Medicare Economic Index (MEI) to inflate historical expenses to the current time period. MEI will be applied beginning with the calendar year following the end of the fiscal year utilized to determine the cost-to-charge ratio. For example, if a provider's fiscal year ended June 30, 2022, the Division would apply MEI for calendar years 2023 and 2024 to determine the interim rates in effect January 1 – December 31, 2024.

6. The interim rates will be inflated annually using MEI for two subsequent years with a rebase occurring every third year (with the first rebase occurring January 1, 2027), utilizing the most recently available audited cost report and continuing to follow the methodology above.

7. Providers whose cost reports do not include cost information for maternity, newborn, or psychiatric/detoxification services will have reimbursement rates set for these services based on the reimbursement rates paid to general acute hospitals. These rates are not adjusted for MEI if the provider does not add service areas as described below.

   a. If a provider adds a new service area (maternity, newborn, or psychiatric/detoxification services), the following methodology will be utilized to establish rates:

      i. Providers will be paid the general acute hospital rate until a cost report becomes available that reflects the new service area.

      ii. Upon receipt of the adjusted cost report reflecting the new service area, all inpatient reimbursement rates will be rebased to ensure ancillary costs are accurately reflected across service areas.

      iii. Reimbursement rates will be calculated as described above and made retroactive to the date on which the new service area began being provided. For claims that occurred in the same time period as the cost report used to set the rebased rates, MEI will not be applied. MEI would begin being applied on the first day of the provider's fiscal year following the cost reporting period. All inpatient rates would be made retroactive to the effective date of the new service; the retroactive rates do not solely apply to the new service area.

         a. For example, if a provider uses a calendar year fiscal year and begins providing psychiatric services July 1 of a given year in addition to existing medical/surgical services, MEI would not be applied from July 1 – December 31 of the same fiscal year for psychiatric, medical, and surgical services. MEI would be applied to all rates effective January 1 of the following fiscal year.

         b. The Division and the vendor contracted for cost report reviews will make every effort to ensure cost reports are reviewed in a timely manner upon receipt. However, claims will not be processed if they are more than two years past the original payment date, as federal match is not available. The Division encourages hospitals to ensure they are promptly responding to requests from the contracted vendor to ensure all claims are eligible for reprocessing.

iv. Providers with new service areas will still be subject to rebases following the standard schedule.

a. For example, if a provider adds a new service area in 2025 and undergoes a rebase as described above, they will still have rates rebased again effective January 1, 2027.

8. Administrative days will be paid in accordance with Nevada Medicaid State Plan Attachment 4.19-A, page 14.

9. Carve-out of Long-Acting Reversible Contraceptives (Device, Insertion, and Removal)

a. When a Long-Acting Reversible Contraceptive (LARC) is provided during an inpatient maternity stay, facilities may bill separately for the LARC device and insertion/removal procedure in addition to the maternity per diem payment.

b. LARC devices will be priced per the drug reimbursement algorithm described in Nevada Medicaid State Plan Attachment 4.19-B, page 3-page 3 (continued). LARC insertion/removal procedures will be paid based on the rendering provider type as described in State Plan Attachment 4.19-B.

10. Capital Renovations/Remodeling Projects: Providers who undergo a major renovation/replacement project completed within a 24-month period may request a capital add-on per diem be applied to the reimbursement rates as described above. The capital add-on will be applied beginning January 1 of the year following when the capital renovation/remodeling project is reported. Projects must be reported no later than September 1 of the preceding year and the cost must exceed $250,000.

a. Providers reporting a capital renovation/remodeling project must then undergo an additional rate rebase once an adjusted cost report reflecting the changes in capital costs becomes available. Reimbursement rates will be effective on a prospective basis 60 days after receipt of the adjusted cost report.

i. The capital add-on payment must be applied equally across all types of inpatient days provided by the facility (medical/surgical, intensive care, maternity, newborn, psychiatric/detoxification).

b. In the event the standard 3-year rebase would utilize a cost report not

reflecting the capital improvement costs, then rates would continue to be based on the first adjusted cost report reflecting the change. The provider would then have rates rebased during the next standard 3-year rate rebase.

Facilities accredited as Residential Treatment Centers by the Joint Commission on Accreditation of Health Organization (JCAHO) are not considered specialty or general acute hospitals. Residential Treatment Centers are paid in accordance with Paragraph VI above.

I. Swing-bed hospitals:

1. Inpatient hospital services furnished by a certified swing-bed hospital which have been certified by the Peer Review Organization for payment at the nursing facility level are reimbursed in accordance with 42 CFR 447.280.

2. Effective for dates of service on or after January 1, 2024, swing-bed hospital services will be reimbursed under Medicare principles of retrospective reimbursement described in 42 CFR 413 and further specified in CMS Provider Reimbursement Manual, Part 1, 15-1 and 15-2.

   a. In no case may payment exceed audited allowable costs.
   b. Interim rates will be determined using the most recent audited cost reports.
   c. Interim swing-bed rates for each facility will be calculated by dividing the total swing-bed cost by the total swing-bed days as reported on the CMS 2552 cost report form.
   d. In general, underpayments will be paid to the provider in a lump sum upon discovery. Overpayments will either be recouped promptly, or a negative balance will be set up for the provider. However, other solutions acceptable to both parties may be substituted.
   e. The federal share of any overpayment is refunded to the federal government in accordance with 42 CFR 433 Subpart F.
   f. For providers who do not have historical Medicaid cost data for swing-bed services, the initial reimbursement rate for swing-bed services will be set at the average of the existing providers' swing-bed rates in the year services begin. Total payments will be settled to 100% of allowable costs as described above. Upon receipt of an adjusted cost report reflecting the provider's specific costs for swing-bed services, the provider-specific rate will be updated utilizing the cost report information.

3. Ancillary services required by swing-bed patients are separately payable as "outpatient hospital services;" see Attachment 4.19-B, Item 2.a – 2.c.