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State/Territory Name: NV

State Plan Amendment (SPA) #: 24-0015

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 & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
230 South Dearborn Street
Chicago, Illinois 60604

Financial Management Group

January 15, 2025

Stacie Weeks, Administrator
Nevada Division of Health Care Financing and Policy
1210 S. Valley View, Suite 105
Las Vegas, NV 89702

RE: TN 24-0015

Dear Administrator Weeks:

We have reviewed the proposed Nevada State Plan Amendment (SPA) to Attachment 4.19-B NV-24-0015 which was submitted to the Centers for Medicare & Medicaid Services (CMS) on March 27, 2024. This SPA authorizes an Alternative Payment Methodology (APM) for the insertion and removal of Long-Acting Reversible Contraction (LARC) Services and for LARC devices when provided at Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).

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 Blake Holt at 303-844-6218 or blake.holt@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

DEPARTMENT OF HEALTH AND HUMAN 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 — 0015

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
Title XIX of the SSA

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ (905,746)
b. FFY 2025 $ (1,866,501)

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
State Plan Attachment 4.19-B, Page 1 (Continued p.6)
p. 1, 2, and 2a

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
N/A - This is a new page
Attachment 4.19-B, Page 1 (Continued p. 1 and p. 2)

9. SUBJECT OF AMENDMENT
SPA to allow for reimbursement to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) outside of their established Service Specific Prospective Payment Systems (SSPPS) Rates for Long-Acting Reversible Contraction Services (LARC). Services will include the cost for the device and insertion/removal of the devices.

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 27 2024

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

FOR CMS USE ONLY

16. DATE RECEIVED
March 27, 2024

17. DATE APPROVED
January 15, 2025

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
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, Division of Reimbursement Review

22. REMARKS
1/15/25: State concurs with pen and ink changes to Boxes 7 and 8.

Prospective Payment System (PPS) - Service Specific Reimbursement for New Facilities

Newly qualified FQHCs/RHCs after Federal fiscal year 2012 will have initial payments (Interim PPS service specific rates) established 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 interim PPS payments of the FQHC/RHC will be cost settled and any over or under payments will be reconciled and the PPS rate will then be established based on the actual cost to provide those services for their first full year. The per visit PPS rate(s) 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)(3) of the Social Security Act, for that calendar year as published in the Federal Register. The MEI adjustment is the mechanism used to account for the basic cost increases associated with providing such services. All required documentation of actual costs for the first full year of providing services must be furnished to the DHCFP no later than six months after completion of the first full year of services. If the required documentation is not received within six 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.

PPS rates will not be subject to rebasing after their initial computation unless authorized by Congress. Only 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 or add-on to the baseline PPS rate will be made. Any other changes to the PPS rate(s) will be considered an Alternative Payment Methodology (APM) and will be outlined below in this State Plan.

Alternative Payment Methodology (APM) Reimbursement

Effective October 1st (FFY) of each year after any APM rate has been established, for services furnished on or after that date, the DHCFP will adjust the PPS/MVSSAPM/LARCAPM 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. The state will ensure that the APM rates remain in compliance with the PPS Rate Methodology as required by CMS.

For any fiscal year after FY 2002, a State may use an APM 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 at 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. These specifications apply to all the following APMs.

Multi-Visit Service Specific Alternative Payment Methodology (MVSSAPM)

Multi-Visit Service Specific APM (MVSSAPM) rates are based on the specific service type being provided. MVSSAPM rates are set at 100% 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 time period under review (calculating the payment amount on a per visit basis per service type). For FQHCs that have separate Multi-Visit Service Specific APM rates established for all service types that they provide, the DHCFP will allow reimbursement for up to three (or two) MVSSAPM encounters/visits per patient per day for the different service types: one Medical, one Behavioral Health and one Dental.

Long Acting Reversible Contraceptive Alternative Payment Methodology (LARCAPM)

Effective January 1, 2024, payment for Long-Acting Reversible Contraceptive (LARC) devices and their insertion and/or removal, will be made to Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) in addition to the established FQHC/RHC's Prospective Payment System (PPS) reimbursement rates or their previously established Multi-Visit Service Specific Alternative Payment Methodology reimbursement (MVSSAPM) rate. Reimbursement for the costs associated with the LARC device will be the same rate as set forth in the State Plan for Pharmacy and the costs associated with insertion and/or removal of LARC devices will be the same as set forth in State Plan for Physicians and/or Advance Practitioners of Nursing (APRNs).

Change in Scope of Services

PPS/MVSSAPM 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 detailing the change in scope of services 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 the DHCFP. Documentation and notification to support an increase or decrease in the scope of services is the responsibility of the provider and must specify all the changes up for review.

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 principles of reimbursement.

An interim rate will be determined using the first three months of actual cost data available from the provider if requested by the provider as they believe their costs will greatly exceed the current average rates, otherwise the current average of existing base rates for FQHC/RHCs for similar services will be used as a more expeditious means of setting an Interim Rate. After a full year of providing the services related to the change in scope, an analysis will be performed on the actual reasonable costs for a full year of service and an adjustment will be made to the PPS /MVSSAPM. Adjustments to the PPS/ MVSSAPM 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 costs for the change in scope services. The PPS/MVSSAPM rate adjustment will then be determined by dividing the approved allocated costs by the number of approved total visits for the given time period.