XV. FEDERAL UPPER PAYMENT LIMIT

In order to preserve access to inpatient hospital services for needy individuals in the state of Nevada, the state's Medicaid hospital reimbursement system shall provide for supplemental payments to non-state, governmentally owned or operated hospitals and private hospitals. Supplemental payments shall be made to non-state, governmentally owned or operated hospitals effective for services provided on after January 1, 2002. Supplemental payments shall be made to private hospitals effective for services provided on or after January 2, 2010. These supplemental payments shall be determined on an annual basis and paid to qualifying hospitals on a quarterly basis. The supplemental payments to non-state, governmentally owned or operated hospitals shall not exceed, when aggregated with other payments made to non-state, governmentally owned or operated hospitals, 100% of a reasonable estimate of the amount that would be paid for such services under Medicare payment principles for non-state, governmentally owned or operated hospitals, except that payments for the period prior to May 14, 2002, such payments shall not exceed 150% of a reasonable estimate of the amount that would be paid for such services under Medicare payment principles for non-state, governmentally owned or operated hospitals. The supplemental payments to private hospitals shall not exceed, when aggregated with other payments made to private hospitals, 100% of a reasonable estimate of the amount that would be paid for such services under Medicare payment principles for private hospitals.

The upper payment limit will be determined on an annual basis. In general, this approach identifies the upper limit through the application of Medicare's prospective payment system, which is a diagnosis related group (DRG) payment system. The upper limit computes, for each hospital, the Medicare DRG payment amount for each Medicaid discharge by determining a Medicare equivalent case mix index based on Medicaid discharges. This upper limit also uses a payment per discharge calculation of the amount of Medicare pass-through and add-on reimbursement including but not limited to outlier, direct graduate medical education, organ acquisition, routine and ancillary pass-through, IME, DSH, and capital payments. The Medicare pass-through and add-on reimbursement are identified from the Medicare cost report and adjusted for Medicaid where applicable. The hospital's Medicare payment per discharge, which includes the DRG and the pass-through/add on amounts, are applied to the number of Medicaid discharges. The latest available information is used for Medicare DRG, Medicare pass-through and add-on payments, Medicare discharges, and Medicaid discharges. Inflation factors are accordingly applied to determine an individual hospital's Medicare payment for the UPL period. The sum of each hospital's estimated Medicare payment for Medicaid discharges is the aggregate upper payment limit for the hospital class.

A. SUPPLEMENTAL PAYMENT FOR NON-STATE GOVERNMENTALLY OWNED OR OPERATED HOSPITALS

The state will determine annually the payments to be made to non-state, governmentally owned or operated hospitals under this section of the plan using the following methodology:

1. Identify all non-state government owned or operated acute care hospitals.
2. For each facility identified in step #1, compute total Medicaid fee-for-service inpatient hospital payments using latest available data projected to the current period.
3. For each facility, calculate the difference between payments identified in step #2, and the hospital's Medicare UPL. This difference is the total maximum disbursement available under this section of the state plan.

These calculations will be set on a prospective basis and will not be retroactively adjusted to previous fiscal years.

The state shall determine the annual supplemental amount payable to hospitals prospectively for period that will begin each July 1. On a quarterly basis, hospitals will receive a supplemental payment equal to twenty-five percent (25%) of the annually determined supplemental amount. A quarterly payment will be made in each calendar quarter during the state's fiscal year. The state shall determine the amount of supplemental payments to each facility using the following criteria:

1. Total supplemental payments under this section of the state plan will not exceed the difference between Medicaid payments and the Medicare UPL calculated in step #3 above.
2. Facilities participating in the supplemental payment program will be identified.
3. Total supplemental payments will be apportioned to public hospitals participating in the supplemental payment program using each hospital's participation percentage. This percentage is calculated by dividing each supplemental payment hospital's Medicaid days by the total Medicaid days for all supplemental payment hospitals.
4. Medicaid days for each supplemental payment hospital shall be identified using the most recent Medicare cost report data available at the time the calculation are prepared.
5. Once these participation percentages are determined they will be final and not subject to recalculation, except when errors are found in the calculations. The state will not recalculate the percentages following receipt of more accurate data, such as a more current or audited Medicare cost report.

OS Notification

State/Title/Plan Number: Nevada State Plan Amendment 10-002B

Type of Action: SPA Approval

Effective Date of SPA: January 2, 2010

Required Date for State Notification: December 6, 2011

Fiscal Impact: $10,678,111 federal FFY 2010
$8,104,765 federal FFY 2011

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0
or
Eligibility Simplification:

Provider Payment Increase or Decrease: Increase

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: 0

Reduces Benefits: No

Detail: This State Plan Amendment provides for an increase to inpatient hospital supplemental payments to non-State governmental hospitals, subject to the non-State governmental inpatient hospital upper payment limit, effective January 2, 2010. The supplemental payments are funded by county intergovernmental transfers. All intergovernmental transfer agreements have been reviewed to ensure compliance with federal requirements. Certifications that these political subdivision transfers are voluntary and not required by the State have also been reviewed for compliance. The State has adequately responded to funding questions and provided a demonstration that these increased inpatient hospital supplemental payments are within the non-State governmental inpatient hospital upper payment limit. However, our review of the upper payment limit found that there are flaws in the State's methodology in estimating certain Medicare payment components, and we are requesting the State to correct this by the State plan rate year beginning 2013. Finally, there is no issue with public process and tribal consultation requirements.

Other Considerations: We do not recommend the Secretary contact the Governor.

Recovery Act Impact: The non-federal share funding of this supplemental payment is funded by county transfers which have been certified as voluntary. There is no other issue with Section 5001(g)(2) of the Recovery Act (political subdivision contribution). Additionally, we are not aware at this time of any other violations of the Recovery Act requirements, including eligibility maintenance of effort, prompt payment, and rainy day funds.

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