DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
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Center for Medicaid and CHIP Services

NOV -7 2011

Michael J. Willden, Director
Department of Health and Human Services
4126 Technology Way, Suite 100
Carson City, Nevada 89706-2009

RE: Nevada State Plan Amendment TN: 10-002C

Dear Mr. Willden:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 10-002C. This amendment provides for upper payment limit supplemental payments to private hospitals, effective January 2, 2010.

We conducted our review of your submittal according to the statutory requirements at sections 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 10-002C is approved effective January 2, 2010. We are enclosing the HCFA-179 and the amended plan pages.

We note however that in reviewing this amendment, we identified a few issues with the State's upper payment limit computation. Per 42 CFR 447.272, aggregate Medicaid payments for Medicaid inpatient hospital services, for each ownership category of hospitals, cannot exceed a reasonable estimate of the amount that would be paid for the services furnished by the group of hospitals under Medicare payment principles.

In Nevada's upper payment limit computation, it is noted that in including Medicare add-on and pass-through payments, there was no adjustment made to account for the acuity differences in Medicare and Medicaid services. The reimbursement amounts of Medicare payment components such as disproportionate share hospital adjustment, indirect medical education adjustment, capital prospective payment are all based on Medicare case mix-adjusted prospective payment rates and therefore are adjusted for Medicare acuity. To the extent that Medicare acuity differs from Medicaid acuity, there needs to be an adjustment to account for such difference before including the particular Medicare payment component (as what Medicare would pay for Medicaid services) in the upper payment limit computation.

Similarly, the reimbursement amounts of Medicare payment components such as outliers and routine and ancillary pass-through payments are computed, in part, using the charges or days and charges of a Medicare inpatient stay. To the extent that the charges or days and charges of an average Medicare inpatient stay differs from an average Medicaid inpatient stay, there needs to

be an adjustment to account for such difference before including the particular Medicare payment (as what Medicare would pay for Medicaid services) component in the upper payment limit computation.

It is also noted that in estimating Medicare payments for critical access hospitals and freestanding psychiatric hospitals, the State used the base rate from the Medicare acute care hospital prospective payment system, even though these two categories are reimbursed outside of that system.

The above issues contribute to an upper payment limit which may not be a reasonable estimate of what Medicare would have paid for the Medicaid inpatient hospital services. Therefore, the State must refine its upper payment limit computation to account for the above issues and submit a revised upper payment limit demonstration to CMS to support its inpatient hospital payments for no later than its State plan rate year beginning 2013.

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

Sincerely,

Cindy Mann
Director, CMCS

Enclosures

cc: Charles Duarte, Administrator, DHCFP
Elizabeth Aiello, Deputy Administrator, DHCFP
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