PAYMENT FOR MEDICAL CARE AND SERVICES

1. This paragraph intentionally left blank.
2. a. Outpatient hospital services: as indicated for specific services listed elsewhere in this attachment Physicians' services (page 1c, paragraph 5); prescribed drugs (page 3, paragraph 12a); outpatient laboratory and pathology services (page 1a, paragraph 3); dental services (CDT codes, page 2c, paragraph 10); durable medical equipment; prosthetics and orthotics (page 2, paragraph 7c); and disposable supplies (page 2, paragraph 7d).
   b. (This paragraph intentionally left blank.)

c. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC): FQHC and RHC reimbursement will adhere to section 1902(a) of the Social Security Act as amended by Section 702 of the Benefits Improvement and Protection Act of 2000 (BIPA). The reasonable cost-based reimbursement requirements for FQHC/RHC services previously described at paragraph (13)(C) are repealed and instead a prospective payment system (PPS) consistent with paragraph (15) payment described in section 1902(aa) of the Act for FQHCs/RHCs is implemented. The Medicaid Prospective Payment System is to take effect on January 1, 2001.

In the period before a prospective rate is fully implemented, interim payments will be based on the current Medicare audited core rates.

During the period January 1, 2001 to September 30, 2001, the State will pay current FQHCs/RHCs 100 percent of the average of their per visit reasonable costs of providing Medicaid-covered services during the FQHC/RHC fiscal year 1999 and fiscal year 2000, adjusted to take into account any increase (or decrease) in the scope of services furnished during Federal fiscal year 2001 by the FQHC/RHC. The per visit rate is calculated using 100 percent of costs for Medicaid coverable services which are reasonable. These costs are added together for each year separately, then those individual year rates are added together and divided by two. Beginning in Federal fiscal year 2002, and for each fiscal year thereafter, each FQHC/RHC is entitled to the payment amount (on a per visit basis) to which the center or clinic was entitled under the Act in the previous fiscal year, adjusted by the percentage increase (or decrease) in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any documented increase (or decrease) in the scope of services furnished by the FQHC/RHC during that center/clinic's fiscal year which has been reviewed and agreed upon by the State. Documentation to support an increase or decrease in the scope of services is the responsibility of the provider. Newly qualified FQHCs/RHCs after Federal fiscal year 2000 will have initial payments established either by reference to payments to other clinics in the same or adjacent areas with similar caseloads and/or scope of services. Once their average per visit reasonable costs of providing Medicaid-covered services based on their first full year of operation can be determined, this data will be used to establish supplemental payments or recoveries from the provider and to establish a prospective per visit rate which will be adjusted by the percentage change in the Medicare Economic Index (MEI) for primary care services adjusted to take into account any documented increase (or decrease) in the scope of services furnished by the FQHC/RHC during that Center/clinic's fiscal year which has been reviewed and agreed upon by the State.

The State may, at its discretion and with the agreement of the FQHC/RHC, establish an alternative payment rate at least equal to the prospective rate under PPS methodology based on the center/clinic's allowable cost as established through cost reporting methods or Attachment 4.19 B Page 7a. After the initial year, a center/clinic with a rate established by an alternate payment method FQHC/RHC, except as outlined above detailed in Attachment 4.19 B Page 7a, is entitled to the payment amount (on a per visit basis) to which the center or clinic was entitled in the previous fiscal year, adjusted by the percentage change in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the FQHC/RHC during that fiscal year.

1. OUTPATIENT HOSPITAL SUPPLEMENTAL PAYMENTS

This section of the state plan contains the provisions for making additional Medicaid payments, in order to preserve access to outpatient hospital services for needy individuals in the state of Nevada. Effective for services provided on or after March 1, 2010, the state's Medicaid hospital reimbursement system shall provide for supplemental outpatient payments to non-state, governmentally owned or operated hospitals. These supplemental payments shall be determined on an annual basis and paid to qualifying hospitals on a quarterly basis. The supplemental payments shall not exceed, when aggregated with other fee-for-services outpatient hospital 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 in accordance with the federal upper limit regulations at 42 CFR §447.321.

a. Methodology for Determining Outpatient Supplemental Payments:

The hospitals that qualify for outpatient supplemental payments will have their payment amount determined using a payment-to-charge ratio UPL methodology.

Outpatient supplemental payments for each hospital will be calculated using following method:

(i) Calculate Total Medicare Outpatient Payments from: CMS 2552-96 Wkst E Part B, Col 1, Line 17 + CMS 2552-96 Wkst E Part B, Col 1, Line 17.01 + CMS 2552-96 Wkst E Part B, Col 1, Line 21+22 [Add comparable fields for subproviders 1 and 2]

(ii) Calculate Total Medicare Outpatient Charges from: CMS 2552-96 Wkst D Part V, Line 104, Col 5 + CMS 2552-96 Wkst D Part V, Line 104, Col 5.01 + CMS 2552-96 Wkst D Part V, Line 104, Col 5.02 + CMS 2552-96 Wkst D Part V, Line 104, Col 5.03 [Add comparable fields for subproviders 1 and 2]

(iii) Calculate Medicare Outpatient Payment to Charge Ratio. The ratio is calculated by dividing the result of (i) by (ii)

[Total Medicare Outpatient Payments] ÷ [Total Medicare Outpatient Charges]

(iv) the result of (iii) is multiplied by Medicaid Outpatient charges in order to determine the Estimated Medicare Outpatient Services Upper Payment Limit. Total Medicaid Outpatient charges shall be derived from Nevada Medicaid Management Information System (MMIS) adjudicated claims data.

(v) Total Medicaid Outpatient Payments for the period are subtracted from the result (iv) to determine the annual amount of Outpatient Supplemental Payment. Total Medicaid Outpatient payment shall be derived from Nevada Medicaid Management Information System (MMIS) adjudicated claims data.

b. Outpatient Supplemental Payments:

(i) Each qualifying hospital will provide documentation of CMS form 2552 cost report for Medicare charge and payment information for the previous fiscal year to Medicaid by April 1st of each year.

(ii) Beginning April 2010, Medicaid will calculate the total outpatient supplement payment for qualifying hospitals using the methodology in section A. above. At the end of each calendar quarter, hospitals will receive a payment amount equal to twenty-five percent (25%) of the hospital's total outpatient supplemental payment.