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State/Territory Name: Nevada

State Plan Amendment (SPA) #: 16-003

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

December 13, 2016

Richard Whitley, Director
Department of Health and Human Services
4126 Technology Way, Suite 100
Carson City, NV 89706

Dear Mr. Whitley:

Enclosed is an approved copy of Nevada State Plan Amendment (SPA) 16-003. The SPA allows providers to be reimbursed for up to three separate encounters per patient per day instead of requiring the patient to come on three different days to obtain all the necessary services (i.e. medical, behavioral health, and dental services). The SPA was submitted to my office on March 22, 2016.

The approval is effective February 6, 2016. Attached are copies of the following pages to be incorporated into your State Plan:

- Attachment 4.19-B, Page 1 (Continued) – Page 1 (Continued p. 5)

If you have any questions, please contact Peter Banks by phone at (415) 744-3782 or by email at Peter.Banks@cms.hhs.gov.

Sincerely,

/s/

Henrietta Sam Louie
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

cc: Marta Jensen: Acting Administrator, DHCFP

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 16-003	2. STATE: NEVADA
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE ~~February 1, 2016~~ 2/6/16 PB	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
State Plan Under Title XIX of the Social Security Act: 42 CFR 447	**a. FFY 2016 $0** **b. FFY 2017 $0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B, Page 1 (Continued) to Attachment 4.19-B, Page 1 (Continued ~~p.6~~)** p.5 PB	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-B, Page 1 (Continued) to Attachment 4.19-B, Page 1 (Continued p.4)**

10. SUBJECT OF AMENDMENT:
To allow providers to be reimbursed for up to 3 separate encounters per patient per day instead of requiring the patient to come on 3 different days to obtain all the necessary services, i.e. medical, mental health and dental services.

11. 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: The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO:
13. TYPED NAME: **Richard Whitley**	**Lynne Foster, Chief of Division Compliance** **DHCFP/Medicaid** **1100 East William Street, Suite 101** **Carson City, NV 89701**
14. TITLE: **Director, Department of Health and Human Services**	
15. DATE SUBMITTED: **March 11, 2016**	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 3/22/16	18. DATE APPROVED: December 13, 2016
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 2/6/16	20. SIGNATURE OF REGIONAL OFFICIAL: /s/
21. TYPED NAME: Henrietta Sam Louie	22. TITLE: Associate Regional Administrator

23. REMARKS:

Pen and Ink Request: NV requested that the proposed effective date in Box 4 be changed from 2/1/16 to 2/6/16.

Pen and Ink Request: NV requested that Box 8 be updated to correctly reflect the SPA pages being approved - changing "Attachment 4.19-B, Page 1 (Continued p.6)" to "Attachment 4.19-B, Page 1 (Continued p.5)"

c. **Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)**

Nevada Medicaid uses a Prospective Payment System (PPS) for FQHCs/RHCs as required by S.S.A. §1902 (a) (15) [42 U.S.C. § 1396a (a) (15)] and S.S.A. §1902 (bb) [42 U.S.C. §1396a (bb)]. The PPS for FQHCs/RHCs was implemented and took effect on January 1, 2001.

Prospective Payment System (PPS) Reimbursement for Existing Facilities

On January 1, 2001 the State began paying FQHCs/RHCs (including "FQHC look alike clinics") based on a PPS rate methodology, per CMS requirements. The baseline for a PPS was set at 100 percent 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 FQHC/RHC fiscal years 1999 and 2000, adjusted to take into account any reported increase (or decrease) in the scope of services furnished during FY 2001 by the FQHC/RHC (calculating the payment amount on a per visit basis). Medicaid-covered services that are considered to be FQHC/RHC services are those services that were identified and approved to be provided by the facility as it applies to HRSA in order to be deemed as an FQHC/RHC facility.

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 year, increased each October 1st (FFY) by the percentage increase (or decrease) in the Medicare Economic Index (MEI) for primary care services as defined in Section 1842 (i) (3) of the Social Security Act, which is intended to account for the basic cost increases associated with providing such services.

After February 6, 2016, the DHCFP will allow reimbursement for up to three encounters/visits per person per day provided that the FQHC has separate PPS rates for each reimbursable service type; medical, behavioral health and dental. FQHCs that only provide two of the specified service types will be allowed reimbursement for up to two encounters/visits per patient per day. For FQHCs that only have one PPS rate will be allowed reimbursement for only one encounter/visit per patient per day. For FQHCs that do not have separate Service Specific Prospective Payment Systems (SSPPS) rates already established, they may opt to change to an Alternative Payment Methodology (APM) wherein their costs/visits will be reviewed after a full year of providing and receiving reimbursement for up to three (or two) visits/encounters per patient per day, resulting in separate Service Specific Alternative Payment Methodology (SSAPM) rates being established.

FQHCs may choose to retain their current SSPPS rates and not bill up to three encounters/visits per patient per day, which will not result in a change to an SSAPM and a current review of their costs and visits.

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 APM and will be outlined below in this State plan.

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

Newly qualified FQHCs/RHCs after Federal fiscal year 2012 will have initial payments (interim Service Specific PPS (SSPPS) rates) established either by reference to payments to one or more other clinics in the same or adjacent areas with similar caseloads and/or similar scope of services or 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 SSPPS payments of the FQHC/RHC will be cost settled and any over or under payments will be reconciled and the SSPPS rate will then be established based on the actual cost to provide those services for their first full year. The per visit SSPPS 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 (6) months after completion of the first full year of services. If the required documentation is not received within six (6) 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 SSPPS rate is determined.

PPS/SSPPS 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/SSPPS rate will be made. Any other changes to the PPS/SSPPS rate(s) will be considered an Alternative Payment Methodology (APM) and will be outlined below in this State Plan.

Alternative Payment Methodology (APM) Reimbursement

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 a 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.

Service Specific APM (SSAPM) rates are based on the specific service type being provided. SSAPM rates are set at 100 percent 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 service specific APM rates established, the DHCFP will allow reimbursement for up to three (or two) SSAPM encounters/visits per patient per day for the different service types: one medical, one behavioral health and one dental.

Effective October 1st (FFY) of each year after an SSAPM rate has been established, for services

furnished on or after that date, the DHCFP will adjust the SSAPM 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.

APM to Reflect Other Payment Adjustments

FQHC/RHC's may request an APM to reflect other payment adjustments in the event of extraordinary circumstances, not otherwise reimbursed by other sources, including but not limited to acts of God; acts of nature; acts of terrorism and acts of war. However, if an FQHC/RHC's existing PPS/SSPPS/SSAPM rate is sufficient to cover its overall costs, including those associated with the extraordinary circumstances, other payment adjustment is not warranted. The FQHC/RHC must show that its PPS/SSPPS/SSAPM rate is not sufficient to cover the costs associated with the extraordinary circumstance. The adjusted rate will only apply to the extent, and only for the period of time, that the additional costs for the event are reimbursable under federal Medicaid law and regulations governing claims for federal financial participation (FMAP). The DHCFP will work with the provider to gather the appropriate data at the time the incident occurs and a written request for a rate adjustment is made by the Provider.

Change in Scope of Services

PPS/SSPPS/SSAPM 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 principals of reimbursement.

An interim rate will be determined using the first three months of actual cost data available from the provider. After a full year of providing the services related to the change in scope, an analysis will be performed on the actual costs for a full year of service and an adjustment will be made to the PPS/SSPPS/SSAPM. Adjustments to the PPS/SSPPS/SSAPM 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/SSPPS/SSAPM rate adjustment will then be determined by dividing the approved allocated costs by the number of approved total visits for the given time period.

A Change in Scope of Services has been defined as a change in the type, intensity, duration and/or amount of any service that meets the definition of FQHC/RHC services as defined in section 1905 (a) (2) (B) and (C) of the Social Security Act; and the service is included as a covered Medicaid service under the Medicaid state plan. General increases or decreases in costs associated with programs that were already a part of an established PPS/SSPPS/SSAPM rate do NOT constitute a Change in Scope. A Change in Scope must meet all of the following requirements:

- The change in the scope of services is a change in the type, intensity, duration, or amount of services, or any combination thereof as defined in section 1905 (a) (2) (B) and (C) of the Social Security Act.

- The cost is allowable under Medicare reasonable cost principals set forth in 45 CFR Part 75 Uniform Administrative Requirements, Cost Principles and Audit Requirements for HHS Awards and /or 42CFR Part 413 Principles of Reasonable Cost Reimbursement.

- The net change in the FQHC/RHC's per visit PPS/SSPPS/APM rate must equal or exceed 4% for the affected FQHC/RHC site(s). For FQHC/RHC's that filed consolidated cost reports for multiple sites to establish the initial Prospective Payment reimbursement rate (PPS), the 4% threshold will be applied to the average per visit rate (medical, dental and mental health) of all sites that provide the specific service for the purposes of calculating the cost associated with a scope of service change. "Net change" means the per visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year for the specific service type.

A Change in Scope of Services includes any of the following:

- A change in the types of services offered, i.e., the addition of dental services, may qualify as a Change in Scope which may warrant an adjustment to the PPS/SSPPS/SSAPM rate or the establishment of a new PPS/SSPPS/SSAPM rate.

- A change in intensity/duration or character of services offered by an FQHC/RHC attributable to changes in the types of patients served may qualify, such as services to patients with HIV/AIDS or other chronic diseases and other special populations requiring more intensive and frequent care.

- A change in the magnitude, intensity or character of currently offered services, demonstrated and documented by an increase or decrease in the patient volume of certain high risk populations that require more intensive and frequent care, which may reasonably be expected to span at least one year may qualify.

- A change in the type, intensity, duration or amount of service caused by changes in technology and medical practice used may qualify.

If a Change in Scope rate increase request is denied, the provider may request a formal rate appeal from the DHCFP. Rate appeal procedures are defined in the Medicaid Service Manual (MSM) Chapter 700.

Definition of a "Visit"/"Encounter"

A "visit" or an "encounter" for the purposes of reimbursing FQHC/RHC services is defined as face-to-face contact with one or more qualified health professionals and multiple contacts with the same health professional that take place on the same day with the same patient for the same service type.

Qualified Health Professional

To be eligible for PPS/SSPPS/SSAPM reimbursement, services must be delivered exclusively by one or more of the following licensed Qualified Health Professionals or a provider working under his or her direct supervision: Physician, Osteopath, Podiatrist, Physician's Assistant, Advanced Practice Registered Nurse, Certified Nurse Midwife, Clinical Psychologist, Clinical Social Worker, Dentist or Dental Hygienist and other Medicaid Qualified Providers.

Documentation Required to Support a Request for Change in Scope of Services

- Year End Payroll Reports for identified time periods
- Trial Balances for all Revenues and Expenses for identified time periods
- Grouping Schedule/Mapping of Trial Balance Accounts to the Cost Reports
- Detailed General Ledger with Vendor Information for identified time periods
- Claims reports showing Unique Patient Visits, DOS, Procedure Codes, Service Facility ID#, Amount Paid and Payer
- Other Items as Deemed Necessary

Record keeping and Audit

All participating FQHC/RHC's shall maintain an accounting system which identifies costs in a manner that conforms to generally accepted accounting principles and must maintain documentation sufficient to support all cost/visit data.

The DHCFP, its fiscal agent or a designated and contracted financial entity may conduct periodic on-site or desk audits of all cost data, including financial and statistical records of the FQHCs/RHCs.

FQHCs/RHCs must submit information (statistics, costs and financial data or other data) as deemed necessary by the DHCFP or its fiscal agent. Failure to submit requested documentation may result in denial of a rate adjustment request.

The DHCFP will conduct one audit annually (at a minimum) to the claims submitted by the FQHC/RHC for supplemental payments.

Supplemental Payments for FQHCs/RHCs Enrolled with a Managed Care Entity (MCE)

FQHCs/RHCs that provide services under a contract with a Medicaid Managed Care Entity (MCE) will receive quarterly or monthly (as agreed upon between the provider and the state) supplemental payments for furnishing such services, that are a calculation of the difference between the payments the FQHC/RHC receives from the MCE(s) for all qualified Medicaid FQHC/RHC visits and the payments the FQHC/RHC would have received under the PPS/SSPPS or SSAPM methodology.

At the end of each payment period, the total amount of MCE payments received by the FQHC/RHC will be reviewed against the amount that the actual number of visits provided under the FQHC's/RHC's contract with MCE(s) would have yielded under the PPS/SSPPS/SSAPM methodology. If the amount exceeds the total amount of MCE payments, the FQHC/RHC will be paid the difference, if the amount is less, the FQHC/RHC will refund the difference to the DHCFP. The FQHC/RHCs must provide sufficient documentation (as requested) to the DHCFP to facilitate supplemental payment calculations. If the required documentation is not provided to support the supplemental payment, future supplemental payments may be suspended.

Documentation Required to Calculate/Support Supplemental Payments

The FQHC/RHC will submit an electronic request for supplemental payment which will contain at least the following information for each line item of every qualified encounter during the reporting time period (Quarterly or Monthly): Medicaid Billing Provider ID#, Recipient MCE ID Number, Recipient Medicaid ID Number, Date of Service, Procedure Code(s), MCE Name, Total Billed Amount, MCE Paid Amount, Other Paid Amount, Total Amount Paid and Recipient Date of Birth.

The FQHC/RHC will submit claim data for supplemental payment no later than thirty days after the end of the reporting period agreed upon with the DHCFP (Quarterly or Monthly).

Any discrepancy found in the audits will be adjusted based on the audit findings.