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State/Territory Name: NV

State Plan Amendment (SPA) #: 24-0013

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
Chicago, Illinois 60604

Financial Management Group

June 26, 2024

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

RE: TN 24-0013

Dear Administrator Weeks:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Nevada state plan amendment (SPA) to Attachment 4.19-B NV-24-0013, which was submitted to CMS on March 28, 2024. This plan amendment updates the payment methodology for Critical Access Hospitals (CAHs).

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

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 via email at blake.holt@cms.hhs.gov.

Sincerely,

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
2 4 — 0 0 1 3

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
42 CFR 424.575, 42 CFR 485.601-483.647 *SSA 1905(a)(2)(A)*

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ 881,976
b. FFY 2025 $ 1,298,104

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Nevada Medicaid State Plan Attachment 4.19-B, page i-page 1
pages 1 and 1. i

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Nevada Medicaid State Plan Attachment 4.19-B, page 1-page 1 (Cont)

9. SUBJECT OF AMENDMENT
This proposed amendment updates the reimbursement methodology for outpatient hospital services rendered by public critical access hospitals.

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

12. TYPED NAME
RICHARD WHITLEY

13. TITLE
DIRECTOR, DHHS

14. DATE SUBMITTED
March 28, 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 28, 2024

17. DATE APPROVED
June 26, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2024

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

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

22. REMARKS

6/18/24: State concurs with pen and ink changes to Boxes 5, 7, and 8.

FORM CMS-179 (09/24)

Instructions on Back

PAYMENT FOR MEDICAL CARE AND SERVICES

1. This paragraph intentionally left blank.
2. Outpatient Hospital
   a. Payments for services billed by Outpatient Hospitals using Current Procedural Terminology (CPT) codes will be calculated using the January 1, 2014 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:
      i. Surgical Codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 90% of the Medicare facility rate.
      ii. Radiology Codes 70000 – 79999 will be reimbursed at 100% of the Medicare facility rate.
      iii. Effective February 15, 2012, Radiopharmaceutical and Contrast codes will be reimbursed at the 2012 Medicare Mean Unit Cost plus 5%.
      iv. Medicine Codes 90000 – 99199 will be reimbursed at 85% of the Medicare facility rate.
      v. Vaccine Products require a National Drug Code (NDC) and will be reimbursed according to the drug reimbursement algorithm set forth on page 3 of Attachment 4.19-B.
      vi. Evaluation and Management Codes 99201 – 99499 will be reimbursed at 90% of the Medicare facility rate.
      vii. Obstetrical Service Codes 59000 – 59999 will be reimbursed at 90% of the Medicare facility rate.
      viii. Anesthesia Codes 00100 – 01999 will be reimbursed based on the Centers for Medicare and Medicaid Services (CMS) 2009 base units for anesthesia. Payment is determined by adding the base units plus time units and multiplying the result by the CMS 2013 anesthesia conversion factor of $22.57. Anesthesia Codes 01967 – 01969 are occurrence-based codes that are paid a flat rate. Anesthesia Codes 99100 – 99140 are not covered.
      ix. Prescribed drugs (Page 3, Paragraph 12a).
      x. Outpatient laboratory and pathology services (Page 1a, Paragraph 3).
      xi. Dental services (CDT Codes, Page 2c, Paragraph 10).
      xii. Durable medical equipment; prosthetics and orthotics (Page 2, Paragraph 7c); and disposable supplies (Page 2, Paragraph 7d).

   Assurance: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both public and private providers of the service. The agency's outpatient hospital fee schedule rates were set as of January 1, 2017 and are effective for services provided on or after that date. All rates are published on our website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/.

   b. Outpatient Hospital services rendered by public Critical Access Hospitals

1. Effective January 1, 2024, outpatient hospital services rendered by publicly owned Critical Access Hospitals will be reimbursed via a cost-based reimbursement structure.
   a. Beginning January 1, 2024, the most recently available audited cost report will be utilized to determine an outpatient cost-to-charge ratio.
      1. To determine each hospital's cost-to-charge ratio, the Division will compare the total outpatient costs for the given time period to the total outpatient charges.
      2. The cost-to-charge ratio will be inflated forward using the Medicare Economic Index (MEI) to inflate to the current time period. MEI will be applied beginning with the calendar year following the end of the fiscal year utilized to determine the cost-to-charge ratio. For example, if a provider's fiscal year ended June 30, 2022, the Division would apply MEI for calendar years 2023 and 2024 to determine the cost-to-charge ratio in effect January 1 – December 31, 2024.
   b. The cost-to-charge ratio will be inflated annually using MEI for two subsequent years with a rebase occurring every third year (with the first rebase occurring January 1, 2027), utilizing the most recently available audited cost report and continuing to follow the methodology above.
   c. The inflation adjusted cost-to-charge ratio will be applied to the billed charges from each facility's charge master on a per claim basis.
   d. Hospitals must notify the Division of any planned changes to the outpatient charge master for the following calendar year prior to December 1 of each year. The Division will utilize this information to determine if the cost-to-charge ratio must be adjusted to ensure payments do not exceed costs. If the charge master change would result in payments exceeding costs, then the cost-to-charge ratio will be decreased to account for the charge master increase.