MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

April 30, 2019

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 700 – RATES AND SUPPLEMENTAL REIMBURSEMENT

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 700 – Rates and Cost Containment are being proposed to update and clarify the information. The title of the Chapter is being changed from "Rates and Cost Containment" to "Rates and Supplemental Reimbursement." Section 705 – Letters of Agreement is being added.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary. Global changes were made in reference to the Medicaid State Plan in order that it be consistent throughout the chapter.

Entities Financially Affected: All provider types are affected by the proposed changes.

Financial Impact on Local Government: No financial impact is anticipated for local government.

These changes are effective May 1, 2019.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 10/19 MSM Ch 700 – Rates and Supplemental Reimbursement	MTL 21/13, 16/12, 19/09, 26/07 MSM Ch 700 – Rates and Supplemental Reimbursement

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
700(D)	**INTRODUCTION**	Revising language from "mentally retarded" to "Individuals with Intellectual Disabilities (ICF/IID)."
703.2(A)	**FEE TO INCREASE**	Changing the language from "non-Medicare" patients to "all" patients. Adding new language after that to read:

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
	QUALITY OF NURSING CARE	"during the preceding month listed by the type of insurance coverage for each patient day,…"
703.2(B)(1)		Changing the percent from 5.5% to 6.0% as that is the current federal limit the program is operating under.
703.2(B)(2)		Clarifying the reference by changing … "patients by the rate in 2.a" to "patients by the rate in 703.2(B)(1)."
703.2(B)(3)		Adding clarifying language when the January report is due as this differs from other months.
703.3(B)(1)	**COST REPORTS**	Revising language from "Mentally Retarded (ICF/MR)" to "ICF/IID."
703.3(C)(2)		Clarifying the reference by changing "any amounts due under 3.a" to "any amounts due under 703.3(A)."
704	**MEDICAID RATE(S) APPEAL**	Revising language referencing the Nevada Medicaid State Plan. Clarifying "Appeals" to "Rate appeals." Adding language to indicate "provider-specific rates." Changing "procedures" to "the methodologies" and clarifying "cannot be appealed and the policies outlined in MSM 704 would not apply." Adding information clarifying who may or may not file appeals.
704(G)(10)		Adding 10. to the list that reads: "That the basis for relief is fiscally acceptable under current and/or future budget authority."
704(I)		Removing "The decision on the appeal shall set forth Findings of Fact and Conclusions of Law" and adding "The DHCFP will contact the person designated in 704(F)(1) to provide an explanation of the decision and allow an opportunity to reconcile the dispute."
704 (J)		Clarifying the reference by changing "to the person designated in 704.2.a" … to "to the person designated in 704(F)(1)."
704(K)		Revising the language to read: "The Administrator's decision is considered final."

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
705	**LETTERS OF AGREEMENT**	This section is being added and provides information related to Letters of Agreement (LOA) for out-of-state providers.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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RATES AND SUPPLEMENTAL REIMBURSEMENT

700 INTRODUCTION

The Division of Health Care Financing and Policy (DHCFP) establishes the methods and standards for provider reimbursements for Medicaid services in accordance with the Code of Federal Regulations (CFR), Title 42, Part 447 and in consultation with providers and a public hearings process. The methods and standards for rate determinations are described in Nevada's approved State Plan under Title XIX of the Social Security Act (i.e. the Medicaid State Plan).

Providers should consult the Medicaid State Plan, Section 4.19 – Payment for Services, for methods and standards for reimbursement. The following is a brief summary of the detail attachments to Section 4.19:

A. Attachment 4.19-A describes methods and standards for reimbursing inpatient hospitals, residential treatment centers, Indian Health Service and Tribal 638 Health Facilities.

B. Attachment 4.19-B describes the methods and standards for reimbursing medical services provided by licensed professionals in various settings and those items ancillary to licensed medical services, such as laboratory and x-ray, pharmaceuticals, dentures, prosthetic devices, eyeglasses, medical supplies, appliances and equipment and transportation.

C. Attachment 4.19-C describes the methods and standards for reimbursing reserved beds in various institutions excluding acute care facilities.

D. Attachment 4.19-D describes the methods and standards for long-term care facilities including hospital-based and freestanding nursing facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and swing beds in hospitals.

701 AUTHORITY

701.1 FEE TO INCREASE QUALITY OF NURSING CARE

Nevada Revised Statute (NRS) 442.3755 to NRS 422.379

701.2 COST REPORTS

CFR, Title 42, Part 413-Principles of Reasonable Cost Reimbursement, Section 413.24

A. Title XIX of the Social Security Act (SSA), Medicaid State Plan, Attachment 4.19-D, Page 6, Section C.

701.3 MEDICAID RATE(S) APPEAL

The authority for provider rate(s) appeals exists under the CFR (CFR, Title 42, Chapter IV, Part 447 – Payments for Services, Section 447.253(e) – Other requirements). This section states, "The Medicaid agency must provide an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates."

702 ELIGIBILITY RULES FOR SUPPLEMENTAL PAYMENT PROGRAMS

702.1 RULES OF PARTICIPATION FOR INPATIENT UPPER PAYMENT LIMIT (UPL) FOR PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT PROGRAM

Attachment 4.19-A, Section XV, Part B of the Medicaid State Plan authorizes Medicaid supplemental payments to certain private hospitals affiliated with Nevada units of government through a Low Income and Needy Care Collaboration Agreement. Participation in the program must be consistent with federal approval of the State Plan.

In order to be eligible to provide the non-federal share of these Medicaid supplemental payments, *a unit of government* must execute a certification that it will comply with the program limitations adopted by the DHCFP in its Nevada Medicaid Supplemental Payment Program Conditions of Participation (CoP). Each unit of government must execute this certification on a form promulgated by the DHCFP. Each unit of government's participation must be consistent with federal approval of the State Plan.

In order to be eligible to receive Medicaid supplemental payments under this section of the Medicaid State Plan, *a hospital* must execute a certification that it will comply with the program limitations adopted by the DHCFP in its Nevada Medicaid Supplemental Payment Program CoP. Each hospital must execute this certification on a form promulgated by the DHCFP. Each private hospital's participation must be consistent with federal approval of the State Plan.

The State Plan, CoP, certification forms and other participation requirements are available to the public at the DHCFP's office and on the website at: https://dhcfp.nv.gov/hcfpdata.htm.

In order to be consistent with CFR Title 42, Chapter IV, Part 447, Subpart C, Section 447.272, the DHCFP:

A. Prohibits any cash or in-kind transfers from the private hospitals to the governmental entity that have a direct or indirect relationship to Medicaid payments;

B. Does not allow a governmental entity to condition the amount it funds the Medicaid program on a specified or required minimum amount of low income and needy care;

C. Does not allow a governmental entity to assign any of its contractual or statutory obligations to a private hospital receiving payments under State Plan Amendment (SPA) 10-002C;

D. Does not allow the governmental entity to recoup funds from a hospital that has not adequately performed under the Low Income and Needy Care Collaboration Agreement;

E. Prohibits each private hospital from returning any of the supplemental payments it receives under SPA 10-002C to the governmental entity that provides the non-federal share of the payments; and

F. Prohibits each governmental entity from receiving any portion of the supplemental Medicaid payments made to the private hospitals under SPA 10-002.

703 POLICY

703.1 INPATIENT HOSPITAL SERVICES

Inpatient hospital services, which have been authorized for payment at the acute level by a Quality Improvement Organization (QIO-like vendor), as specified in the contract between the QIO-like vendor and the DHCFP, are reimbursed by all-inclusive, prospective per diem rates by type of admission/service. The all-inclusive prospective rates cover routine and ancillary services furnished by the hospital, including direct patient care for professional services furnished to inpatients by hospital-staffed physicians and practitioners. For specific rate methods and standards for inpatient hospital services, refer to the State Plan, Section 4.19, Attachment A.

703.2 FEE TO INCREASE QUALITY OF NURSING CARE

The DHCFP established the following policy to assess and collect fees to increase the quality of nursing care. NRS 422.3775 states: *"Each nursing facility that is licensed in this State shall pay a fee assessed by the Division to increase the quality of nursing care in this State."*

A. Reporting Requirements:

Each nursing facility shall file with the DHCFP each month a report setting forth the total number of days of care it provided to all patients during the preceding month listed by the type of insurance coverage for each patient day, the total gross revenue it earned as compensation for services provided to patients during the preceding month, and any other information required by the Division.

B. Payment of Fee:

1. The DHCFP shall annually establish a rate per non-Medicare patient day that is equivalent to 6.0%, or a percentage not to exceed any limitation provided under federal law or regulation, of the total annual accrual basis gross revenue for services provided to patients of all nursing facilities licensed in this state.

2. The DHCFP shall calculate the fee owed by each nursing facility by multiplying the total number of days of care provided to non-Medicare patients by the rate in 703.2(B)(1).

3. The monthly report and fee assessed pursuant to this section are due 30 days after the end of the month for which the fee was assessed. The January report is due not later than the last day of February.

C. Failure to Pay or Late Payment of Fee:

1. The DHCFP may assess a penalty of one percent of the fee for each day a fee is past due up to 10 days. The DHCFP may assess interest at the rate of 1.5% of the fee per month or fraction thereof for any past due fee. In the event a facility has not submitted the required monthly report, the DHCFP may estimate the fee due for purposes of assessing penalties and interest.

2. The DHCFP may withhold past due fees, penalties and interest from a facility's Medicaid claims payments until such past due amounts are paid in full.

703.3 COST REPORTS

The DHCFP established the following policy to collect Medicare/Medicaid cost reports. (A Medicare/Medicaid Cost Report is the standard Medicare Cost Report with the required Medicaid sections completed.)

The DHCFP adopts Medicare deadlines for the Medicare/Medicaid cost reports. These requirements are found in the CFR (CFR, Title 42, Part 413 – Principles of Reasonable Cost Reimbursement, Section 413.24). This section states, *"Due dates for cost reports. (i) Cost reports are due on or before the last day of the fifth month following the close of the period covered by the report. For cost reports ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period."*

The authority to collect Medicaid Cost Reports exists under Title XIX of the SSA, Medicaid State Plan, Attachment 4.19. Cost and other statistical information within the cost report must be reported in compliance with allowable and non-allowable cost definitions contained in the Medicare/Medicaid provider reimbursement manual (commonly referred to as Centers for Medicare and Medicaid Services (CMS) Publication 15).

A. Hospital Cost Reporting Requirements:

Hospital (including hospital-based nursing facility) annual Medicare/Medicaid cost reports are to be filed with the Medicaid program (DHCFP) following the cost report filing deadlines adopted in 42 CFR 413.24. If a facility requests an extension from the Medicare program, they must also request an extension from the DHCFP. Extension requests approved by Medicare will automatically be approved by the DHCFP, once the DHCFP receives evidence of Medicare approval from the facility.

B. Free-Standing Cost Reporting Requirements:

1. Free-standing nursing facilities and ICF/IID must complete and file an annual Medicare/Medicaid cost report with the DHCFP.

2. Cost reports are to be received by the DHCFP by the last day of the third month

following a facility's fiscal year end. If the facility is unable to complete their cost report within this time frame, a request for a 30-day extension can be requested from the DHCFP prior to the original cost report due date. Reasonable extension requests will be granted.

3. Minimum Direct Care Staffing Requirement: In the event that a nursing facility does not incur direct care cost at least equal to 94% of the direct care median, the DHCFP will have the option to recoup, from future payments to that provider, an amount equal to 100% of the difference between the provider's direct care rate and the actual cost the provider incurred. This provision is intended to encourage adequate direct care staffing. Any penalties collected shall accrue to the State General Fund and shall be used to offset Medicaid expenses.

C. Failure to File or Late Filing of Cost Reports

1. Facilities failing to file a Medicare/Medicaid cost report in accordance with these provisions may have their Medicaid payments suspended or be required to pay back to the Medicaid program all payments received during the fiscal year period for which they were to provide a cost report. Facilities may also be subject to an administrative fine of up to $500 per day for each day the required cost reports are delinquent.

2. The DHCFP may withhold any amounts due under 703.3(A) (above) from a facility's Medicaid claims payments until such amounts are paid in full.

704 MEDICAID RATE(S) APPEAL

The following appeal procedure applies to reimbursement rates paid to providers for providing services under the Medicaid State Plan to Medicaid recipients enrolled in the Fee-for-Service Medicaid program. Rate appeals are limited to individual providers requesting review of a provider-specific rate. For example, a provider who is reimbursed under a negotiated rate or by cost pursuant to the State Plan may seek review through the process outlined in Medicaid Services Manual (MSM) Chapter 704.

The rate appeal process may not be used to request a rate increase for general rates. General rates are determined by methodologies set forth in the State Plan and are not eligible for review through the process outlined in MSM Chapter 704.

In addition to the above, appeals may not be filed by the following:

A. Providers who are reimbursed under the Medicare principles of retrospective reimbursement described in 42 CFR 413 and further specified in CMS Publication 15;

B. Providers who are reimbursed under the Prospective Payment System (PPS) established by cost-based reporting as required by the SSA §1902(a)(15) (42 United States Code (USC) §1396a(a)(15)) and S.S.A. §1902(bb) (42 USC §1396a(bb));

C. Indian Health Services who are reimbursed in accordance with the most recent Federal Register Notice; and

D. Government providers who undergo a cost reconciliation or cost settlement reimbursement.

E. Appeals must be submitted in writing to the address below and clearly marked as a Rate appeal.

To ensure receipt of the appeal, certified mail or other commonly accepted delivery methods which clearly show the date of receipt are encouraged.

Appeal address: Administrator DHCFP, 1100 E. William Street, Suite 101, Carson City, Nevada 89701.

F. The appeal must contain the following information:

1. The name, address and telephone number of the person who has authority to act on behalf of the provider/appellant;

2. The specific rate(s) to be reviewed;

3. The basis upon which the provider believes relief should be granted including supporting documentation:

   a. Claims documentation showing costs for Medicaid services not fully compensated by Medicaid payments is necessary, but not sufficient to form a basis for relief.

   b. The documentation should show that payments received from Medicaid for the appealed rate fail to compensate for costs attributable to providing services to Medicaid patients as well as for the rates in aggregate for the provider.

   c. The documentation must show how the specific circumstances of services provided to Medicaid recipients relative to other like-providers result in higher costs not adequately or appropriately considered in the development of the existing rate(s).

4. The relief requested, including the methodology used to develop the relief requested.

   Actual costs from the most recent prior year(s), or costs from part of the current year, may be used in developing the methodology for the relief request, so long as it is not a cost reimbursement methodology; and

5. Any other information the provider believes to be relevant to the review.

G. The Administrator, or their designee, may consider the following factors in deciding whether to grant rate relief:

1. Whether there are circumstances related to the appellant when compared to other providers that cause the appellant to have higher Medicaid costs in the rate category reviewed;

2. Whether the circumstances relating to the provider are adequately considered in the rate-setting methodology set forth in the State Plan;

3. The extent to which comparable health care services are available and accessible for all people in the geographic area served by the appellant/provider;

4. Whether Medicaid payments are sufficient to meet Medicaid costs in the appealed rate(s);

5. The total Medicaid payments to the provider and all Medicaid payments for the appealed rate(s): In the case of hospitals, this includes total Medicaid costs to the hospital for inpatient care and the hospital's Medicaid costs for the appealed rate(s);

6. Audit review information, if any;

7. Information and data used to set the existing or appealed rate;

8. Such other information or documentation as the Administrator, or their designee, deems relevant; and

9. That the basis for relief results in uncompensated Medicaid costs to the provider, both in the appealed rate(s) and in aggregate Medicaid payments under the State Plan; and

10. That the basis for relief is fiscally acceptable under current and/or future budget authority.

H. The Administrator, or their designee, shall review the appeal and supporting documentation and issue a written decision within 90 calendar days of receipt of a properly submitted appeal. The Administrator, or their designee, may request any additional information from the provider, including independent verification by an unrelated third party of the provider's claims. If the Administrator, or their designee, requests additional information or verification, the period in which the Administrator, or their designee, must issue a decision is extended to 90 calendar days from the receipt of the requested information.

I. The DHCFP will contact the person designated in 704(F)(1) to provide an explanation of the decision and allow an opportunity to reconcile the dispute.

J. The decision will be sent in writing by certified mail, return receipt requested, to the person designated in 704(F)(1).

K. The Administrator's decision is considered final.

705 LETTERS OF AGREEMENT

Pursuant to the conditions and limitations prescribed in the Medicaid State Plan, the DHCFP may negotiate reimbursement rates for out-of-state providers to serve Nevada Medicaid recipients. The services of these providers are often necessary to ensure access to services for Medicaid and Nevada Check Up recipients that may not otherwise be available from in-state providers or in those instances where a recipient is in need of emergency care while outside of the State of Nevada.

705.1 SCOPE AND RESPONSIBILITY

The following procedure will be used for all out-of-state providers requesting a provider-specific rate. These procedures do not apply to external professional services billed outside of an inpatient or outpatient facility setting.

These procedures are applicable primarily to out-of-state inpatient and outpatient acute, psychiatric and specialty hospital services and other services associated with such treatment, including transportation and physician services.

The Rate Analysis and Development (RAD) unit of the DHCFP is responsible for administering the provision of this section. All agreements under this section are not final until they are fully executed by the Division's Administration.

705.2 PROCEDURES

A. Before an agreement under this section can be finalized, a provider must be enrolled as a current Nevada Medicaid provider. The provider must submit a list of their current active Nevada Medicaid provider numbers for which the agreement will apply.

B. If the service requires a prior authorization (PA), providers must present the PA number when requesting a Letter of Agreement (LOA). Information regarding PAs may be found in the MSM Chapter 100 – Medicaid Program.

C. The RAD unit will negotiate a provider-specific reimbursement agreement within the constraints of the Medicaid State Plan and the MSM. A percentage of usual and customary billed charges is the most common methodology, but other methods may be acceptable.

1. Negotiations will be conducted with the purpose of ensuring both fiscal responsibility and restraint, as well as providing access to services for Nevada Medicaid recipients.

D. Agreements may be for a single recipient or an individual provider. They are for all services rendered by the out-of-state provider. Methodologies may vary by type of service.

E. All agreements must have a reimbursement effective and expiration date. This allows for periodic review and updates of the methodology. In the event an agreement expires without renewal, the provider will be reimbursed on the same basis as in-state providers for the same service(s).

1. If a PA is not required, the effective date for the LOA is the time of the request. If a PA is required, the effective date for the LOA will be the authorized effective date on the PA issued by the fiscal intermediary for Nevada Medicaid. A retroactive LOA will only be provided if the service occurred over a weekend, or for emergencies, and must be approved by the DHCFP Administrator.

F. All agreements must be consistent with the capabilities of the Medicaid Management Information System (MMIS), which is used for processing billing claims.

G. The LOA template, as approved by the DHCFP, will be used to confirm the reimbursement agreement with the provider. The LOA may only be executed using the template approved by the DHCFP. Reproduced templates will not be accepted.

H. Copies of the fully executed agreement will be sent to the provider, the fiscal intermediary and the appropriate DHCFP Chiefs.

I. When submitting claims, the provider must include a copy of the LOA to ensure reimbursement will be at the provider-specific rate.

705.3 PERIODIC REVIEW

Agreements may be reviewed by the DHCFP as necessary to ensure compliance with Nevada Medicaid policy.

At any time, the out-of-state provider may request a review of the provider-specific rate for the LOA.