VII. HOSPITALS UNDER MEDICAID RETROSPECTIVE COST REIMBURSEMENT (CRITICAL ACCESS HOSPITALS)

A few Nevada hospitals have been designated by Medicare as Critical Access Hospitals.

To the extent these hospitals participate in Medicaid, they are reimbursed under Medicare's retrospective cost reimbursement, as follows:

A. Inpatient hospital services which have been certified for payment at the acute level by the QIO-like vendor, as specified in the contract between the QIO-like vendor and Nevada Medicaid, upon final settlement are reimbursed allowable costs under hospital-specific retrospective Medicare principles of reimbursement in accordance with 42 CFR 413 and further described in CMS Publications 15-I and 15-II.

1. Critical Access Hospitals (CAH) will use the CMS-2552-10 cost report form and apply Medicare cost principles and cost apportionment methodology.

2. Critical Access Hospitals will file this cost report with the state annually within five months of their respective fiscal year end.

3. In general, underpayments will be paid to the provider in a lump sum upon discovery and overpayments will either be recouped promptly or a negative balance set up for the provider. However, other solutions acceptable to both parties may be substituted.

4. The federal share of any overpayment is refunded to the federal government in accordance with 42 CFR 433 Subpart F.

B. On an interim basis, each hospital is paid for certified acute care at the Provider specific interim Medicaid inpatient per diem rate as follows:

1. Effective July 1, 2009, the base interim rate for Critical Access Hospitals (CAH) will be the FY2007 Total Medicare inpatient per diem rate. This interim rate is defined as total Medicare in-patient cost divided by total Medicare in-patient days, and applies to the revenue codes billed by general acute hospitals that fall under the Medical/Surgery level of service category for inpatient services.

2. The CAH Medical/Surgery interim rate will be updated annually for each provider on either January 1st or July 1st, depending upon the facilities' fiscal year as reported on the Medicare/Medicaid cost report. The annual rate is not to exceed 150% or decrease more than 25% from the facilities' prior year interim rate.