



# Frequently Asked Questions

## Guidance Regarding Assembly Bill 3

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## Introduction

Economic conditions related to the COVID-19 pandemic are significantly straining Nevada's economy, resulting in a \$1.2 billion shortfall in the Fiscal Year 2020-21 budget. To address this shortfall, the Governor called the Legislature into session on July 8, 2020 where Assembly Bill 3 (AB 3) was presented, heard with opportunities for public comment, and passed. Assembly Bill 3 directs the Division of Health Care Financing and Policy (DHCFP) to reduce reimbursement rates in the fee schedule for providers by 6% (six-percent) and eliminate the increase in acute care per diem hospital reimbursement rates that passed during the 2019 legislative session. This required a Medicaid State Plan Amendment (SPA) to be submitted to the Center for Medicaid and Medicare Services (CMS). A DHCFP public hearing on the SPA was held on August 13, 2020. The State Plan Amendments were submitted to CMS by September 30, with a requested retroactive approval date of August 15.

Questions presented in public comment and in writing during the hearing on August 13, 2020, are addressed in these FAQs. Additional questions may be sent to [DHCFP@DHCFP.nv.gov](mailto:DHCFP@DHCFP.nv.gov) with the subject line: "AB3-Question."

## About Assembly Bill 3

The full text of AB 3 is available online. Please see Section 31, page 25.

<https://www.leg.state.nv.us/App/NELIS/REL/31st2020Special/Bill/7127/Text>.

*The reductions to the appropriations for Nevada Medicaid and the Nevada Check-Up Program for Fiscal Year 2020-2021 pursuant to this section include, without limitation:*

- 1. Reduction in reimbursement rates in the fee schedule for providers by 6 percent.*
- 2. Reductions in the reimbursement rate for neonatal intensive care unit services.*
- 3. Elimination of the increase in acute care per diem hospital reimbursement rates funded through section 7 of chapter 615, Statutes of Nevada 2019, at page 4017.*
- 4. Revision of the rate methodology for habilitation providers.*
- 5. Delay of non-capitated payments to managed care organizations until Fiscal Year 2021-2022.*
- 6. Implementation of a specialty pharmacy provider network*

## Assembly Bill 3 Questions

### Rate Reductions (UPDATED 12/11/2020)

#### How will the rate reduction be implemented? (UPDATED 12/11/2020)

DHCFP will be recouping dollars from the managed care plans and fee for service to reconcile the mandated reduction from 8/15 to the date of CMS approval. **DHCFP encourages providers to prepare for recoupment of 6% on reimbursement for services rendered from August 15 until CMS approval and technical implementation.** DHCFP recognizes these challenging circumstances and intends to communicate regularly through web announcements, as this process is implemented.

**UPDATED 11/2/2020:** Once CMS approves the State Plan Amendment, DHCFP will process the recycle with an effective date of August 15 to the date of CMS approval. The system will generate an accounts receivable for the 6% reduction previously paid which will be recouped from any new day claims processed with that financial cycle. DHCFP will announce to providers when the recycle will take place with time to directly provide those overpayments to assist with cash flow. In the event the accounts receivable is not recouped in a financial cycle, the DHCFP Recovery Office can work with providers on a repayment agreement. Please see Chapter 3300 of the Medicaid Services Manual regarding overpayments and recoveries. For more information, write to [DHCFP@DHCFP.nv.gov](mailto:DHCFP@DHCFP.nv.gov) with the subject line: "Recovery Office."

**UPDATED 12/11/2020:** CMS regulations prevent retroactive rate reductions to some provider types. The reductions for waiver providers (provider types 48, 57, 58, and 59) were approved with a December 1, 2020 start date. Reductions for provider type 39 Adult Day Health Care and provider type 55 Home Based Habilitation are still under review with CMS and will be effective upon approval.

#### What provider types are not included in the rate reduction? (UPDATED 12/14/2020)

Section 31 of Assembly Bill 3 requires a "reduction in reimbursement rates in the fee schedule for providers by 6 percent." Provider types that are not on the fee schedule, that are not in the appropriations specified (Nevada Medicaid and the Nevada Check-Up Program), and those with provider-specific rates are not impacted. For accessibility purposes, the list below is Description (provider type).

- Psychiatric Hospital, Inpatient (13)
- Intermediate Care Facilities for Intellectually Challenge/Public (16)
- Rural Health Clinics (17, 180)
- Federally Qualified Health Centers (17, 181)
- Indian Health Services – Non-Tribal (17, 182)
- Certified Community Behavioral Health Clinic (17, 188)
- Nursing Facility (19)
- Pharmacy (28)
- Non-emergency Transportation (35)
- Home & Community-Based Waiver – MR Services (38)

- Tribal Indian Health Services and Tribal Clinics, Tribal and Non-Tribal Inpatient & Outpatient Indian Health Services Hospital (47, 51, 78, 79 & 52)
- Targeted Case Management (54)
- Medical Rehab Center & Long-Term Acute Care (LTAC Spec. Hospitals) (56)
- Residential Treatment Centers (63)
- Hospice & Hospice Long-Term Care (64, 65)
- Intermediate Care Fac. For Individuals w/Intellectual Disabilities/Private (68)
- Critical Access Hospital Inpatient (75)

How will the reinstatement of funding be implemented if it becomes available in the future? Assembly Bill 3 addresses the possibility of federal funding as a catalyst for offsetting state revenue shortfalls in Section 131.6. It provides in 131.6(4) in the fourth priority category “Disbursement for any other budgetary reduction in this act.” It does not address a priority within those budgetary reductions or provide guidance related to funding unrelated to the Federal Government. DHCFP is working to develop a plan to possibly mitigate these reductions. This will be dependent on the amount of funding that is available. Additional details will be made available later in the fiscal year if the budget allows for restorations. It is premature at this point to forecast the amount of funding that might support this, given caseload volatility and utilization trends.

#### Service Questions (UPDATED 12/16/2020)

Some services are particularly needed during the pandemic. Can those rate reductions be delayed until the end of the public health emergency?

The requirements of AB 3 do not include a mechanism to delay reductions. The effective date of the bill is upon passage and approval.

Do rate reductions affect all the specialties under Provider Type 20, Physicians?

Yes, all specialties under the applicable provider types will be affected. This includes all specialties under provider type 20.

Which services in Provider Type 11, Inpatient Hospital are impacted by the reductions?

All services provided under Provider Type 11 are subject to the 6% reductions.

Are “optional services” being reduced or eliminated?

No, although some optional service reductions were included in early proposals, those reductions were not included in the enacted version of Assembly Bill 3 (AB 3) from the 31<sup>st</sup> Special Session.

Is a limit on the number of physical therapy sessions being implemented in these changes? Is it an annual limit of 12 sessions?

No service reductions are being implemented, including the proposed limit to physical therapy services.

Are Federally Qualified Health Center (FQHC) wrap payments impacted by the rate reductions?  
No. FQHC wrap payments are not included in the fee schedule and therefore are not being reduced.

How will the changes discussed at the August 13, 2020, public hearing impact the implementation of the 1915(i) SPA for Specialized Foster Care (SFC) services? (UPDATED 12/16/2020)

The 1915(i) State Plan Option for Specialized Foster Care Services was approved by CMS and the policy will be presented at the September 2020 public hearing. The 6% decrease will be factored into the rate development for these services. The Division is exploring options related to rate reductions for new provider type SFC (PT 86) which was not included in the July Special Session or the 8/13 Public Hearing. No providers are enrolled in PT 86 at this time. The new provider type and codes are to go live on January 16<sup>th</sup>.

### Funding Questions

Why isn't the enhanced Federal Medical Assistance Percentage (FMAP) that was included in the federal public health emergency extension being used to support the Medicaid budget instead of rate reductions?

The Families First Coronavirus Response Act (FFCRA) conditionally increased the state's FMAP by 6.2%. This federal legislation included maintenance of effort requirements that limited the state's options to control spending in their Medicaid programs. Rate reductions are one mechanism that remains available to states.

The DHCFP is using enhanced federal funding in part to minimize rate reductions. The DHCFP continues to make both capitation payments for Managed Care plans, as well as reimburse all providers for Fee-For-Service (FFS) claims submitted. The 6.2% FMAP increase has allowed these expenses to be funded with additional federal funds, thus reducing the State General Fund match needed for those expenditures.

The DHCFP's current budget projection is for a small surplus at the end of the current biennium. The size of this projected surplus can change rapidly depending on enrollment changes due to economic conditions and variations in service utilization. The DHCFP continuously monitors the budget, considering the projected enrollment changes and spending on health care services. The increased FMAP that was approved as part of the Federal legislation to address the emergency is included in the projections, helped fund increases in caseload, and reduce the cuts of optional services that were proposed at one point in the discussion.

The DHCFP is carrying forward money from state fiscal year 2020 to state fiscal year 2021. Why aren't you using this funding instead of reducing rates?

The DHCFP is using carry-forward funding to minimize rate reductions. The DHCFP's current budget projection is for a surplus at the end of the current biennium. The size of this projected surplus can change rapidly depending on enrollment changes due to economic conditions and

variations in service utilization. The DHCFP continuously monitors the budget, considering the projected enrollment changes and spending on health care services. The balance-forward funding is included in the projections and helped to eliminate reductions in optional services that were proposed earlier during the process.

## Provider Concerns

How will providers continue to meet the needs of Medicaid recipients if reimbursement rates are reduced while providers' costs continue to increase?

The Rate Analysis and Development Unit continues to make progress on the research mandated by Assembly Bill 108 of the 2017 Legislative Session, which requires DHCFP to research and compare Nevada Medicaid rates to the cost of providing each service or item under every provider type. This information can be used in the future to guide decisions on where rate increases are needed based on feedback received directly from providers on their costs. The DHCFP strongly encourages all providers to complete surveys for their provider types as they become available. This data is vital for DHCFP to determine if rates are sufficient to cover the costs of providing services.

As required for the process of the rate reduction state plan amendments, DHCFP is updating the Access Monitoring Review Plan (AMRP), which requires data analysis and supporting information to reach conclusions on sufficient access for covered services provided under fee-for-service. In addition, the Rate Analysis and Development Unit maintains a webpage for information related to the Quadrennial Rate Reviews (*See* [http://dhcfp.nv.gov/Resources/Rates/AB\\_108\\_Reviews/](http://dhcfp.nv.gov/Resources/Rates/AB_108_Reviews/)). This webpage contains the schedule of when each review will occur, along with legislative information and completed reports.

My provider type is critical. Can it be excluded from the reductions?

Assembly Bill 3 requires the DHCFP to reduce rates included in the fee schedule. There is no mechanism within the bill to allow DHCFP to exclude particular provider types. Also, see the heading "Funding Questions" in this document.

## Access to Care Questions (UPDATED 12/14/2020)

Has Nevada Medicaid reviewed each service line and demonstrated sufficiency of access to care for patients following these rate reductions?

DHCFP is updating the Access Monitoring Review Plan (AMRP), which will include updating the comparative data. Per Federal regulations, the AMRP will be posted online for public comment for 30 days and will be submitted to CMS with the rate reduction State Plan Amendments. The managed care contract requires specific provider time and distance standards and specific appointment time standards based on the type of service. Compliance with these requirements will also be reviewed as part of this process.

Will Nevada Medicaid update its monitoring procedures and/or timelines to provide more real-time data should patient access to care be diminished?

Yes. As required for the process of the rate reduction State Plan Amendments, DHCFP is updating the Access Monitoring Review Plan (AMRP) includes updating comparative data. Federal regulations require the AMRP to be posted online for Public Comment for 30 days. The AMRP can be found here:

<http://dhcfp.nv.gov/Resources/AccessToCare/NevadaAccessToCareMonitoringReviewPlan/>

Are you concerned that rate reductions will significantly reduce access to care and/ or increase the overall cost of care?

The DHCFP is committed to ensuring that the provider network is adequate for recipients to receive the care they need. If recipients are unable to find providers, their entry point is often through higher-cost services such as emergency rooms. The Division will continue to monitor several factors, including emergency room use, provider enrollment, and service utilization. The DHCFP seeks to cultivate its relationship with providers and advocacy groups to maintain the network and support the increasing number of Nevadans who are covered by Medicaid. The Division will maintain compliance with the requirements of section 1902(a)(30)(A) of the Social Security Act.

The most recent document provided on the Department of Health and Human Services' (DHHS) website indicates the access review was last updated in January 2018 and is focused on Medicaid fee-for-Service. Is this the most current access review?

Yes, the January 2018 Access Monitoring Review Plan is the most recent version. The DHCFP is currently updating the AMRP for submission with the rate reduction state plan amendments. Federal regulations require the AMRP to be posted online for public comment for 30 days. Generally, this plan is updated every three years or in the event of significant changes such as this rate reduction.

Does DHCFP have an updated access review regarding managed care services and will it provide this review?

The managed care contract requires the plans to meet time and distance standards for certain provider types. The contract also includes specific appointment time standards based on the



type of services. These items are monitored continuously by the DHCFP. Compliance will be reviewed as part of this process.

The January 2018 access review uses comparative data from 2015 in Attachment A. Has Nevada Medicaid updated these comparisons and will DHCFP provide this to patients and providers?  
(UPDATED 12/14/2020)

DHCFP's updated Plan for Monitoring Healthcare Access is available on the website (<http://dhcfp.nv.gov/Resources/AccessstoCare/NevadaAccessstoCareMonitoringReviewPlan/>). Federal regulations require the AMRP to be posted online for public comment for 30 days. The 30days is complete, however, we value stakeholder input and continue to accept comments related to the plan.

Pursuant to 42 CFR § 447.203(b)(6) will Nevada Medicaid provide its most recent access review for each of the lines of service indicated on the revised agenda to CMS and will it be made available? (UPDATED 12/14/2020)

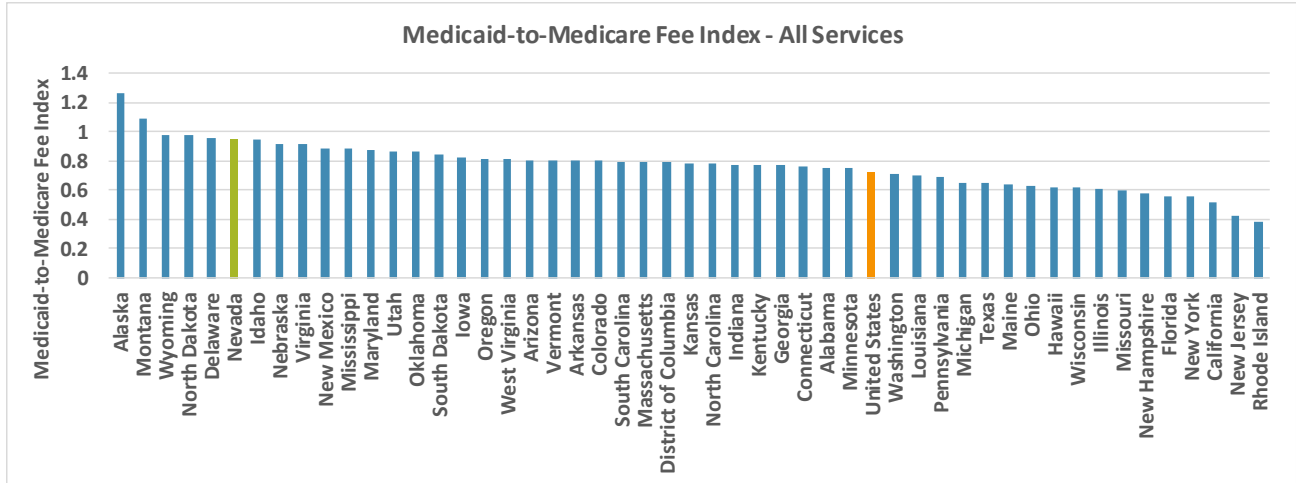
DHCFP's update Plan for Monitoring Healthcare Access is available on the website (<http://dhcfp.nv.gov/Resources/AccessstoCare/NevadaAccessstoCareMonitoringReviewPlan/>). Federal regulations require the AMRP to be posted online for public comment for a period of 30-days. The 30-day period has been complete, however, we value stakeholder input and continue to accept comments related to the plan.

## National Rates and Policy Questions

Are Nevada Medicaid rates the lowest in the nation?

According to the latest national data available from the Kaiser Family Foundation's Medicaid-to-Medicare Fee Index, Nevada Medicaid's physician rates are 95% of Medicare. The overall average for the United States is 72%. Nevada's reimbursement rates were ranked 6<sup>th</sup> highest in the nation for All Services, 6<sup>th</sup> for Primary Care, and 13<sup>th</sup> for Obstetric Care. Calculations based on this index indicate that Nevada's rates for All Services exceeded the national average by 32%, Primary Care by 44%, and Obstetric Services by 20%. See the chart below. Additionally, DHCFP's Rate Analysis and Development Unit continue to make progress on the research mandated by Assembly Bill 108 of the 2017 Legislative Session, which requires DHCFP to research and compare Nevada Medicaid rates to the cost of providing each service or item provided under every provider type. As part of this analysis, Nevada rates are compared to the rates of surrounding states. This information can be used to guide decisions on where rate increases are needed if additional funding becomes available in the future.

Source: <https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index>



[Alternate text: A graph showing Medicaid-to-Medicare Fee Index on the y-axis and on the x-axis showing that Nevada (in green) is higher than the average for the US (in orange) with only Alaska, Montana, Wyoming, North Dakota, and Delaware ahead of it.]

Why is Nevada Medicaid reducing rates across-the-board while other states are not?

The Families First Corona Virus Response Act includes maintenance of effort and continuous coverage requirements as a condition of receiving the increased 6.2% FMAP. Assembly Bill 3 (AB 3) of the 31<sup>st</sup> Special Session directs DHCFP to make certain rate reductions to address the state’s budgetary shortfall. DHCFP is implementing these reductions to comply with AB 3.

Is DHCFP concerned that across-the-board rate reductions will cause a loss of access to some services that save money by improving health or reducing the severity of illness in the long run?

The DHCFP shares concerns about the impact on health services. We will continue to seek adequate access to appropriate care by monitoring factors including enrollment, emergency room usage, and primary care usage. The Division will maintain compliance with the requirement of section 1902(a)(30)(A) of the Social Security Act.

### Managed Care Questions (UPDATED 12/16/2020)

What is the relationship between managed care and fee-for-service rates?

Fee-for-service schedules do influence the reimbursement rates paid by the Medicaid managed care plans and dental benefits administrator. DHCFP will be working with its actuary to revise the payments to the managed care plans to reflect the impact of these fee-for-service rate reductions. The capitation payments across the managed care enrolled population are intended to be equal to what the plans would pay providers plus administrative costs for running the program

Will the managed care plans get to keep the money they were paid when services were not used during the pandemic-related closures? (UPDATED 12/14/2020)

Federal regulations include minimum loss ratio requirements, which limit the amount of profit managed care plans can make without spending those dollars on medical services and health improvement initiatives. The state can recover any funds over this amount. Further, DHCFP is adjusting capitation rates paid to managed care plans for September to December 2020 to reflect the approved fee-for-service reimbursement rate reductions. The certification of these revised rates will be submitted to CMS for review and approval before the end of December 2020.