PUBLIC NOTICE TO SOLICIT COMMENT ON INTENT TO SUBMIT STATE PLAN AMENDMENTS TO AMEND REIMBURSEMENT METHODOLOGIES FOR INPATIENT CRITICAL ACCESS HOSPITALS (INCLUDING UNBUNDLING LONG-ACTING REVERSIBLE CONTRACEPTIVES), OUTPATIENT SERVICES PROVIDED BY A PUBLIC CRITICAL ACCESS HOSPITAL, AND SWING-BED SERVICES PROVIDED BY A CRITICAL ACCESS HOSPITAL

Date of Publication: July 15, 2024

Name of Organization: Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP)

General public comments are encouraged to be submitted in writing. You may submit comments in one of two ways. (Please choose only one of the ways listed below):

Electronically: You may email comments to DocumentControl@dhcfp.nv.gov . Write "Reimbursement Changes for Critical Access Hospitals" in the subject line.

Mail: You may mail written comments to the following address:
Division of Health Care Financing and Policy
ATTN: "Reimbursement Changes for Critical Access Hospitals"
1100 E. William Street, Suite 101, Carson City, Nevada 89701

Purpose:
The purpose of this notice is to provide the public with information and to collect public feedback regarding the state's intent to submit State Plan Amendments (SPAs) to amend the reimbursement methodology for critical access hospitals (CAHs) in several respects:

Inpatient Services: Change to cost-based rates and unbundling LARC services for CAHs

- The Division will be submitting a State Plan Amendment to change the current reimbursement methodology for inpatient services rendered by a critical access hospital:
  - Cost-settled reimbursement rates will shift to cost-based rates.
  - Long-acting reversible contraceptive (LARC) devices and insertion/removal will be separately billable in addition to maternity per diem rates.
  - Cost-based rates are not subject to cost-settlement.

Outpatient Services: Cost-based rates for public CAHs

- The Division will be submitting a State Plan Amendment to change the rate methodology for outpatient services provided by a public critical access hospital under provider type 12:
  - Providers will be reimbursed via cost-based rates rather than based off the provider type 12 fee schedule.
  - Cost-based rates are not subject to cost-settlement.
  - This change only applies to publicly owned critical access hospitals; the change does not apply to publicly owned general acute hospitals.

Swing-bed Services: Cost-settled rates for CAHs

- The Division will be submitting a State Plan Amendment to change the current reimbursement methodology for swing-bed services rendered by a critical access hospital:
    - Reimbursement rates will shift from being paid based off of the weighted budget neutral per diem rate designated for nursing facilities. Providers will instead be assigned provider-specific rates that will be settled to 100% of allowable costs upon completion of a cost report audit.

The new methodologies will be effective January 1, 2024. Proposed changes may apply to providers of hospital services including but not limited to provider type 75 (Critical Access Hospital), provider type 12 (outpatient hospital), and provider type 44 (swing-bed).

The Division intends to publish the draft SPA and other supporting materials on its website within the coming months at: http://dhcfp.nv.gov/ . Emails will be sent to such individuals as have requested public notice of SPAs and meetings (to request notifications please contact documentcontrol@dhcfp.nv.gov , or at 1100 East William Street, Suite 101, Carson City, Nevada 89701.

Overview: During the 2023 Nevada Legislative Session, Senate Bill (SB) 241 was passed and signed into law. Under the terms of the bill, the Division of Health Care Financing and Policy must submit a State Plan Amendment to alter the reimbursement methodologies that specify how payments are made to critical access hospitals (CAHs). Specifically, the Division must reimburse CAHs at a rate equal to cost for swing-bed services; additionally, the Division must reimburse CAHs at a rate equal to cost for outpatient services rendered by public CAHs.
Additionally, During the 2023 Nevada Legislative Session, Senate Bill (SB) 280 was passed and signed into law. SB 280 requires hospitals "to provide for the insertion or injection on certain long-acting reversible contraception if requested by a patient giving birth at a hospital." Although Medicaid is already in compliance with this bill in that providers may be reimbursed for LARC services provided directly after birth, unbundling the rates will allow hospitals to receive prompt reimbursement for devices to ensure equitable access in rural communities.
Lastly, the Division is proposing shifting cost-settled inpatient rates to cost-based rates to streamline reimbursement for hospitals and provide a greater level of predictability. Currently, the Division utilizes audited cost-reports to set reimbursement rates for inpatient medical, surgical, intensive care, and maternity services; newborn and psychiatric inpatient services are reimbursed at the same rates as general acute hospitals. Upon completion of the cost report audit for each facility, CAHs are cost-settled to 100% of allowable costs. The cost-settlement process can take up to two years from a provider's fiscal year end, which delays funds being received by the hospitals. Shifting to cost-based rates will allow the Division to reimburse CAHs at cost for impacted inpatient services without delay, ensuring the continued viability of these critical services in rural communities.

Methodology: The Division will utilize audited cost reports submitted by CAHs to establish rates.

- Inpatient Services: Upon implementation, DHCFP will utilize audited cost reports to develop cost-based, provider-specific rates for medical/surgical/intensive care services; maternity services; newborn services; and psychiatric/detoxification services. If a provider has not rendered certain categories of services (for example, psychiatric/detoxification services), that provider would have a rate set that aligns with the current reimbursement for general acute hospitals.
    - DHCFP will utilize the most recently available cost report to set the reimbursement rates and apply the Medicare Economic Index (MEI) to inflate historical costs to the current time period.
    - After the initial rates are set, MEI will be applied annually for the following years, with a rebase occurring every three years utilizing updated cost report data.
    - Additionally, language will be added that allows CAHs to bill long-acting reversible contraceptives (both the device and insertion/removal) separately from the maternity per diem payment. Payment for LARC devices/insertion/removal will follow existing rate methodologies outlined in State Plan Attachment 4.19-B.
    - Rates for administrative days ("skilled days") will not change.

- There will be no cost-settlement.

- Inpatient Services (Updated 7/12/24): The current pending State Plan Amendment language still reflects the inpatient methodology above. In the weeks leading up to the Public Hearing, several of the affected providers asked questions about how the reimbursement methodology would address specific situations; for example, capital improvements or hospitals that begin providing services in a new category. The pending State Plan language has been revised to address these situations.

  For critical access hospitals that do not have historical cost data for maternity, newborn, or psychiatric/detoxification services, rates will align with those paid to general acute hospitals.
  - If a CAH begins providing maternity, newborn, or psychiatric/detoxification services, the general acute hospital rate would likely not cover the cost of providing the service; however, the Division would not have cost data available specific to that facility. As such, the Division determined an alternative approach that will ensure that providers will still be reimbursed at cost for new service areas.
    - The facility must notify the Division that a new service area is beginning to be offered. Until cost report information is available, the provider will continue to be reimbursed at the same rate as general acute hospitals.
    - The first cost report reflecting the new service area will be utilized to set a provider-specific rate. Providers should ensure that the first cost report is submitted timely to ensure prompt review of the cost report.
    - Upon receipt of the adjusted cost report reflecting the new service area, all inpatient reimbursement rates will be rebased following the methodology outlined in this notice. Reimbursement rates for all inpatient services will be made retroactive to the date on which the new service area began being provided.
      - For claims that occurred in the same time period as the cost report used to set retroactive rates, MEI will not be utilized to inflate costs.
      - The Division and contracted vendor will make every effort to ensure prompt review of the cost report; however, claims will not be adjusted more than eight quarters after the original payment date, as federal match is unavailable.
    - Providers who undergo a rebase to add a new service area will still be subject to the standard rebase schedule.
  - Providers who undergo a major renovation/replacement project may request a capital add-on per diem be applied to the reimbursement rates if the cost report utilized to establish the rates does not reflect the new capital costs.
    - The capital add-on will be applied beginning January 1 of the year following when the project is reported. Projects must be reported by September 1 of the preceding year and must exceed $250,000.
    - Providers requesting a capital improvement add-on must undergo an additional rebase once an adjusted cost report reflecting the new costs becomes available.
    - In the event the standard 3-year rebase would utilize a cost report that does not reflect the new capital improvement costs, the rates would continue to be based on the first adjusted cost report reflecting the change. The next rebase would occur per the standard 3-year schedule.

- Outpatient Services: For public CAHs, upon implementation the Division will utilize audited cost reports to establish a provider-specific cost-to-charge ratio.
  - The cost-to-charge ratio will pay providers based on a percentage of billed charges.
  - DHCFP will utilize the most recently available cost report to set the reimbursement rates and apply the Medicare Economic Index (MEI) to inflate historical costs to the current time period.
  - After the initial rates are set, MEI will be applied annually for the following years, with a rebase occurring every three years utilizing updated cost report data.
  - There will be no cost-settlement.

- Swing-Bed Services: Upon implementation, DHCFP will utilize audited cost reports to develop provider-specific reimbursement rates for swing-bed services.
    - An interim rate will be determined using the most recently available cost report data.
    - Swing-bed services will be settled to 100% of allowable costs upon completion of the cost report audit.
- Swing-bed services (Updated 7/12/24): The Division will still utilize the methodology above. However, the original proposed language does not address new swing-bed providers without historical Medicaid cost data.
    - For new providers, the interim reimbursement rate will be set at the average of existing providers' swing-bed rates in the year services begin.
    - Services will be settled to 100% of allowable costs as described above.
    - Upon receipt of an adjusted cost report reflecting the provider's specific costs for swing-bed services, the provider-specific rate will be updated utilizing the cost report information.

Expected Expenditures: The state anticipates an increase to annual medical aggregate expenditures to the Division's budget as follows to implement the new reimbursement methodology addressed above:

- CAH Outpatient Cost-Based Rates (Public hospitals only):
    - SFY 2024: $784,494 total computable ($198,705 State Share)
    - SFY 2025: $1,817,345 total computable ($476,148 State Share)
- CAH Swing-Bed Cost-Settled Rates:
    - SFY 2024: $240,558 total computable ($81,310 State Share)
    - SFY 2025: $590,272 total computable ($207,402 State Share)
- CAH Inpatient Cost-Based Rates and LARC Carve-Out: The State is working to determine any potential financial impacts from the proposed changes.

Notice Information

This notice has been posted online at http://dhcfp.nv.gov, as well as Carson City, Las Vegas, Elko, and Reno Central Offices for DHCFP. Email notice has been made to such individuals as have requested notice of meetings (to request notifications please contact documentcontrol@dhcfp.nv.gov, or at 1100 East William Street, Suite 101, Carson City, Nevada 89701. DHCFP, 1100 E. William St., Suite 101, Carson City, Nevada 89701 DHCFP, 1010 Ruby Vista Drive, Suite 103, Elko, Nevada 89801 DHCFP, 1210 S. Valley View, Suite 104, Las Vegas, Nevada 89102 DHCFP, 745 W. Moana Lane, Suite 200, Reno, Nevada 89509.

If you require a physical copy of this notice, please contact documentcontrol@dhcfp.nv.gov, or at 1100 East William Street, Suite 101, Carson City, Nevada 89701.

Public Hearing

The Division will host a public hearing prior to submitting the State Plan Amendment to seek further public comment. This public hearing will be held by the end of the first quarter of calendar year 2024. This information will be posted online at http://dhcfp.nv.gov, as well as Carson City, Las Vegas, Elko, and Reno central offices for DHCFP. Email notice has been made to such individuals as have requested notice of meetings (to request notifications please contact documentcontrol@dhcfp.nv.gov, or at 1100 East William Street, Suite 101, Carson City, Nevada 89701. DHCFP, 1100 E. William St., Suite 101, Carson City, Nevada 89701 DHCFP, 1010 Ruby Vista Drive, Suite 103, Elko, Nevada 89801 DHCFP, 1210 S. Valley View, Suite 104, Las Vegas, Nevada 89102 DHCFP, 745 W. Moana Lane, Suite 200, Reno, Nevada 89509.