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Nevada Department of Health and Human Services
DIVISION OF HEALTH CARE FINANCING AND POLICY

Frequently Asked Questions-
Implementation of Assembly Bill 3

1. Introduction

The public hearing held by the Division of Health Care Financing and Policy (DHCFP) on August 13, 2020 addressed changes to the State Plan the Division is submitting to the Centers for Medicare and Medicaid Services (CMS) to implement reductions to the Medicaid budget that were passed in July during the 31st Special Session of the Nevada Legislature. Economic conditions related to the COVID-19 pandemic caused significant strain on Nevada's economy, resulting in a $1.2 billion shortfall in the state Fiscal Year 2020-21 budget. In order to address this shortfall, the Governor called the Legislature into session on July 8, 2020 where Assembly Bill 3 (AB 3) was presented and heard, along with opportunities for public comment. Assembly Bill 3 directs the Division of Health Care Financing and Policy to reduce reimbursement rates in the fee schedule for providers by 6% (six percent) and to eliminate the increase in acute care per diem hospital reimbursement rates that passed during the 2019 legislative session. These changes require amendments to the Medicaid State Plan and are required to implement AB 3. The State Plan Amendments will be submitted to CMS by September 30, with a requested retroactive approval date of August 15.

Due to the unusual circumstances of implementing a retroactive rate reduction, the DHCFP will be recouping dollars from the managed care plans and fee for service providers to reconcile the reduction from 8/15 to the point of implementation. **We encourage providers to prepare for a recoupment of 6% on reimbursement for services rendered from August 15 until CMS approval and technical implementation.** DHCFP recognizes that this is challenging. We will communicate regularly through web announcements, as this process is implemented.

Given the expedited timeline leading up to the hearing on August 13, 2020, DHCFP represented at the hearing that questions presented via public comment as well as in writing would be addressed in a "frequently asked questions" style format. What follows is the responsive document.

2. Assembly Bill 3, Generally

The full text of Assembly Bill 3 may be viewed online and the particularly relevant part of Section 31 is located on page 25 at: https://www.leg.state.nv.us/App/NELIS/REL/31st2020Special/Bill/7127/Text. For ease of access, it is also quoted below:

> ***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:***

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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***

3. Assembly Bill 3 Questions

a) What provider types are not included in the rate reductions?

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. The table below shows provider types that were excluded from the 6% rate reduction.

Provider Type	Specialty	Description
13	000	Psychiatric Hospital, Inpatient
16	000	Intermediate Care Facilities for Intellectually Challenged / Public
17	180	- Rural Health Clinics
17	181	- Federally Qualified Health Centers
17	182	- Indian Health Services – Non-Tribal
17	188	- Certified Community Behavioral Health Clinic (CCBHC)
19	000	Nursing Facility
28	000	Pharmacy
35	000	Non-emergency Transportation
38	000	Home & Community Based Waiver – MR Services
47	000	Indian Health Services (HIS) and Tribal Clinics
51	000	Indian Health Service Hospital, Inpatient (Tribal)
52	000	Indian Health Service Hospital, Outpatient (Tribal)
54	000	Targeted Case Management
56	000	Medical Rehabilitative Center & Long-Term Acute Care (LTAC) Specialty Hospitals

63	000	Residential Treatment Centers (RTC)
68	000	Intermediate Care Facilities for Individuals w/Intellectual Disabilities / Private
75	000	Critical Access Hospital, Inpatient
78	000	Indian Health Service Hospital, Inpatient (Non-Tribal)
79	000	Indian Health Service Hospital, Outpatient (Non-Tribal)

b) 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 for the DHCFP to delay these reductions the effective date of the bill is upon passage and approval.

4. Funding Questions

a) 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 options that states have to control spending in their Medicaid programs. Rate reductions are one mechanism that remain available to states.

The DHCFP is using this 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, taking into account 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 and helped fund increases in caseload and reduce the cuts of optional services that were proposed at one point in the discussion.

b) 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 the carry-forward funding to minimize rate reductions. 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, taking into account 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.

The DHCFP is working to develop a plan for to mitigate these reductions. This will be dependent on the amount of funding that is available, if any, as well as factors including enrollment and utilization. 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 volatility in caseload and utilization trends.

c) How will you prioritize reinstatement of funding should it become 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 guidance related to funding unrelated the Federal Government.

The 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 volatility in caseload and utilization trends.

5. Provider Concerns

a) 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 provided under every provider type. This information can be utilized 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, as 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, 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/). This webpage contains the

schedule of when each review will occur, along with legislative information and completed reports.

b) 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. See also Section 3 and response 3(b) in this document.

6. Access to Care Concerns

a) 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 a period of 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.

b) Will Nevada Medicaid update its monitoring procedures and/or timelines in order 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 AMRP includes updating comparative data. Federal regulations require the AMRP to be posted online for Public Comment for a period of 30 days.

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

The DHCFP is committed to ensuring that we have a provider network adequate for recipients to get 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 a number of 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.

d) 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 a period of 30 days. Generally, this plan is updated every three years or in the event of significant changes such as this rate reduction.

e) Does DHCFP/Nevada Medicaid have an updated access review regarding managed care services? Will it provide this review to patients and providers?

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.

f) The January 2018 access review uses comparative data from 2015 in Attachment A. Has Nevada Medicaid updated these comparisons? Will Nevada Medicaid provide this to patients and providers?

DHCFP is currently updating the Access Monitoring Review Plan, which will include updating the comparative data. Federal regulations require the AMRP to be posted online for public comment for a period of 30 days.

g) 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? Will this be made available?

Yes, DHCFP is currently updating the Access Monitoring Review Plan. Federal regulations require the AMRP to be posted online for public comment for a period of 30 days.

7. National Rates and Policy Questions

a) 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 (See https://www.kff.org/medicaid/state-indicator/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 6th highest in the nation for All Services, 6th for Primary Care, and 13th for Obstetric Care. Calculations based 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%.

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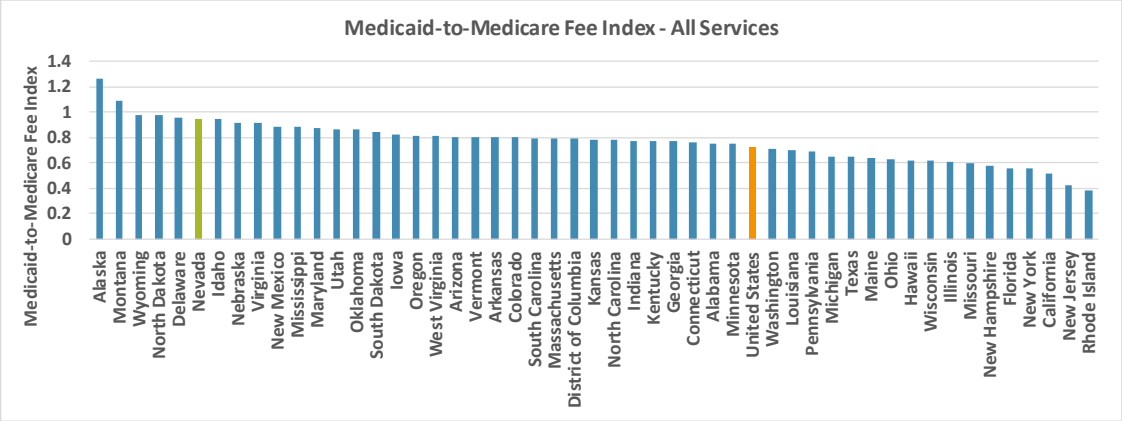

[Alternate text: A graph showing Medicaid-to-Medicare Fee Index on the y axis and on the x axis showing that Nevada (in green) is higher than the average for the US (in orange) with only Alaska, Montana, Wyoming, North Dakota, and Delaware ahead of it.]

Additionally, DHCFP's 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 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.

b) 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 31st 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.

c) Are you 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 to 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 requirements of section 1902(a)(30)(A) of the Social Security Act.

8. Managed Care Questions

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

Fee-for-service fee 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. Managed care rates are set based on fee-for-service rates to be actuarily sound to comply with federal requirements. The capitation payments across the managed care enrolled population are intended to be equal to what the plans would pay providers.

b) Will the managed care plans get to keep the money they were paid when services were not utilized during the pandemic-related closures?

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 August to December 2020 to reflect the approved fee-for-service reimbursement rate reductions.

9. Requests for Specific Clarification

a) Do these 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.

b) 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

c) Are "optional services" being reduced or eliminated? Is a limit on the number of physical therapy sessions being implemented in these changes? Is it an annual limit of 12 sessions?

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 31st Special Session. No service reductions are being implemented, including the proposed limit to physical therapy services.

d) Are the 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 not being reduced.

e) How will the changes discussed at the August 13, 2020 public hearing impact the implementation of the 1915(i) SPA for Specialized Foster Care Services?

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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.